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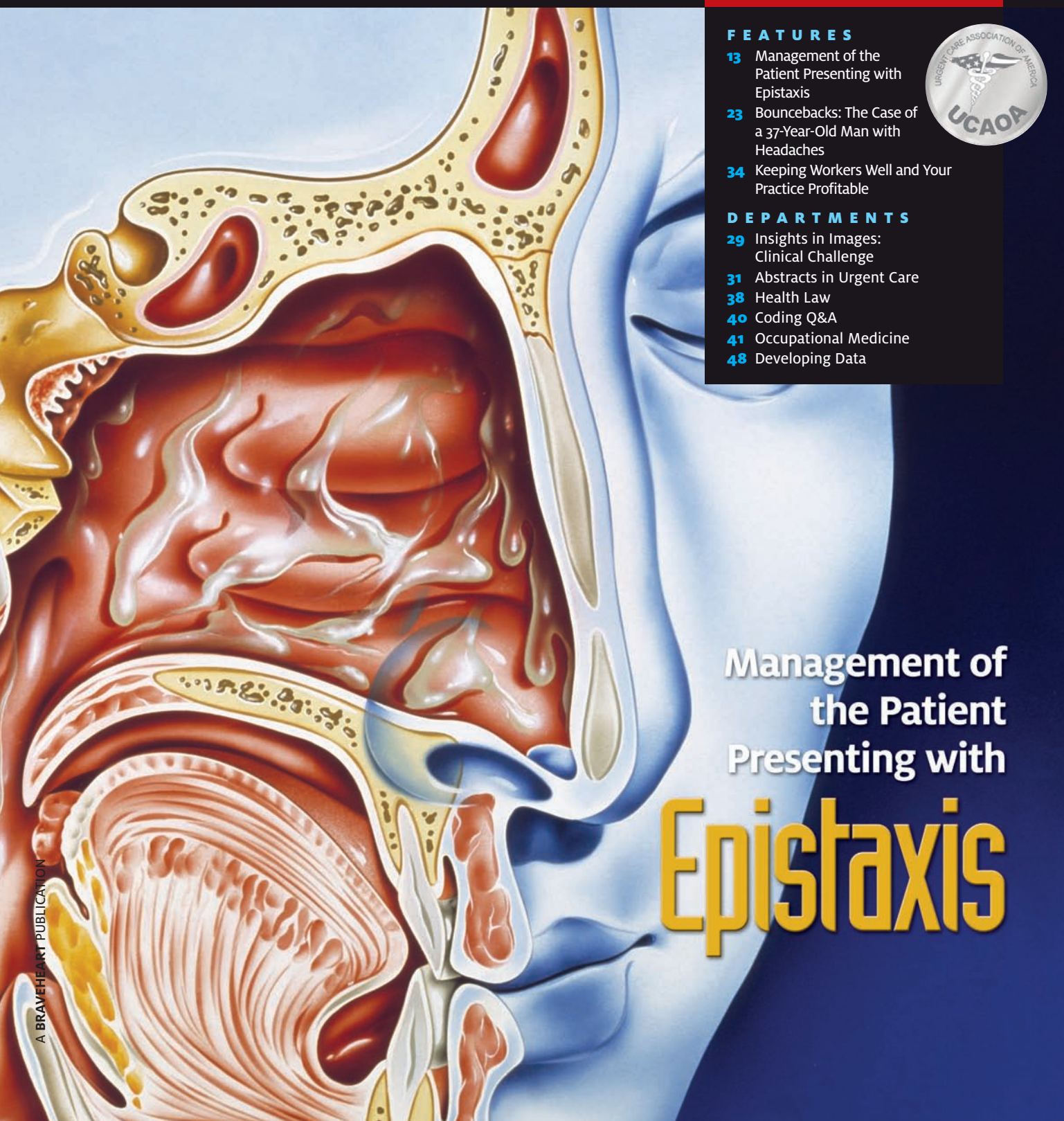
IN THIS ISSUE



Management of the Patient Presenting with Epistaxis

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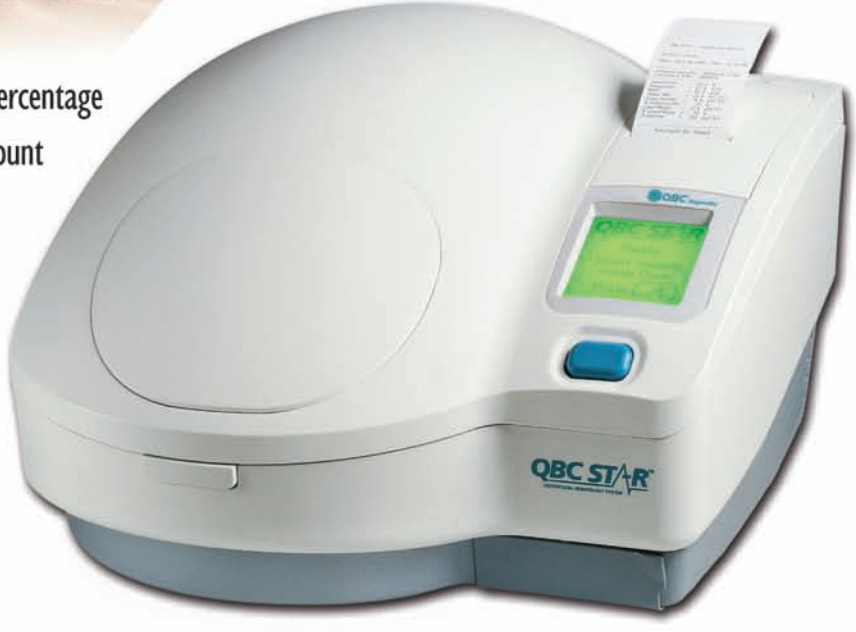

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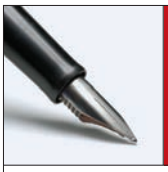


LETTER FROM THE EDITOR-IN-CHIEF

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.

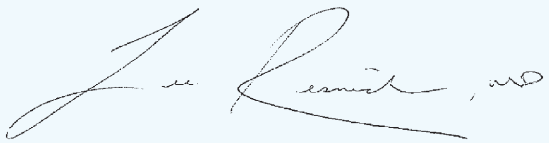
Beyond the obvious efficiencies and lower cost of urgent care services, family physicians in urgent care settings offer two real advantages over their emergency medicine colleagues:

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. ■



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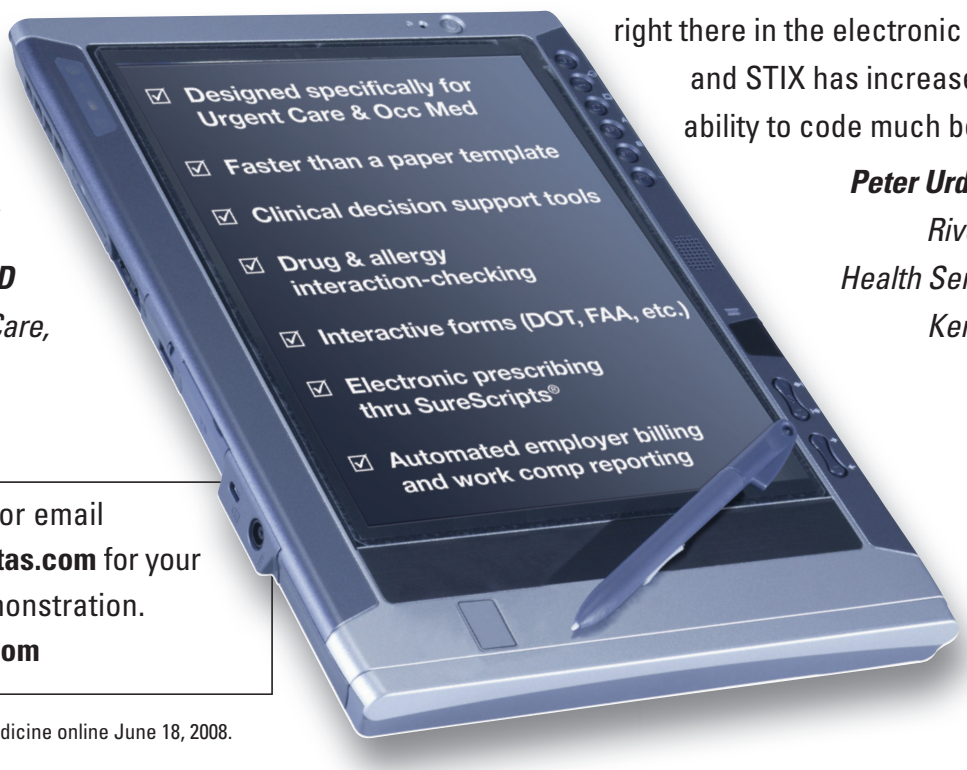

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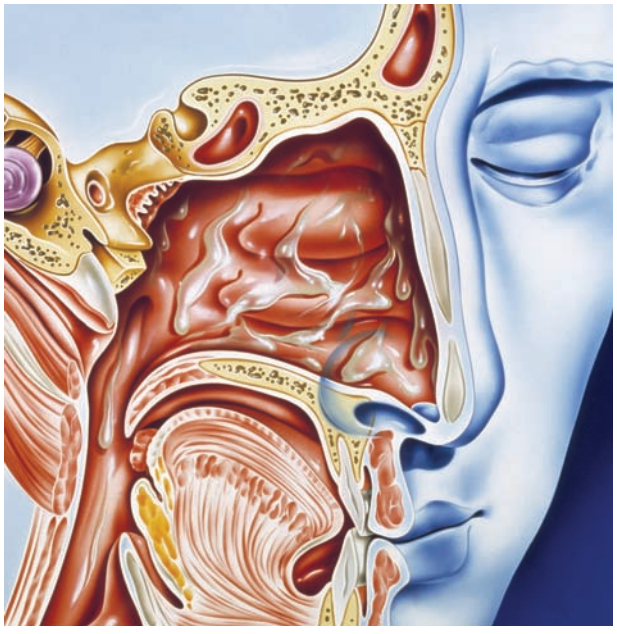

CLINICAL

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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

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Could a case of "diagnostic momentum" impede you from recognizing key clues regarding a patient's condition?

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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

***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.*

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

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The Kindness of Strangers

LOU ELLEN HORWITZ, MA

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.

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

"You have the opportunity to shape the futures of an industry and a specialty."

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.

National Urgent Care Awareness Week is November 10-14

UCAOA is pleased to support the newest event in healthcare: National Urgent Care Awareness Week!

By now, you should have started to hear some news about this initiative and how your centers can participate.

Your participation in Awareness Week, at whatever level works for your centers, helps raise awareness of the services urgent care can provide.

Visit *www.ucaoa.org* and go to "Get Involved" to learn more about how you can join in this great event!

Special thanks to all the members of the Urgent Care Awareness Committee.

JUCM CONTRIBUTORS

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.



In Management of the Patient Presenting with Epistaxis (page 13), authors **Nathaniel Arnone, MD**, **Samuel M. Keim, MD, MS**, and **Peter Rosen, MD** review the relevant anatomy, how to elicit the history from the patient, and treatment options most practical for urgent care.

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*.

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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*:

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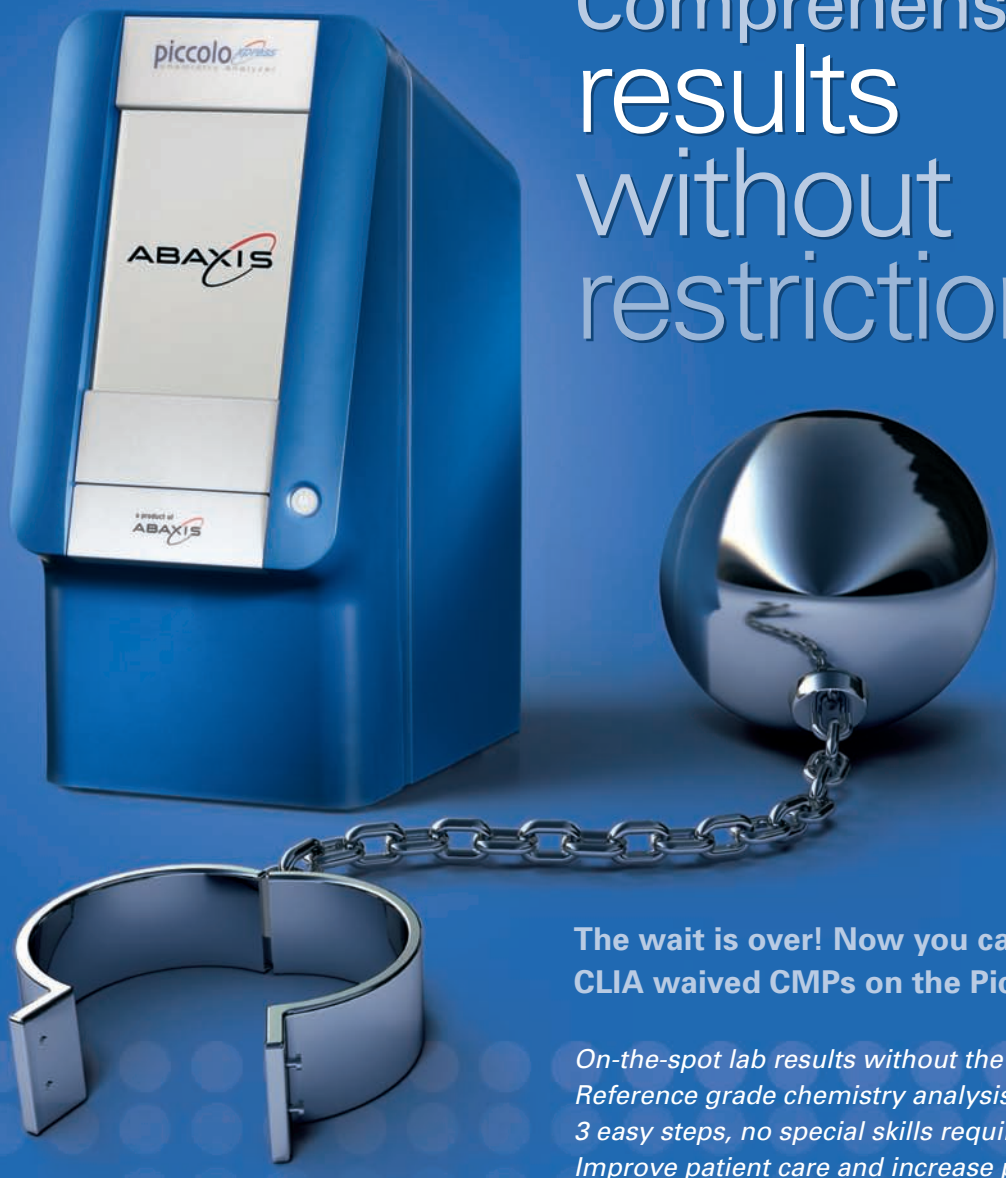

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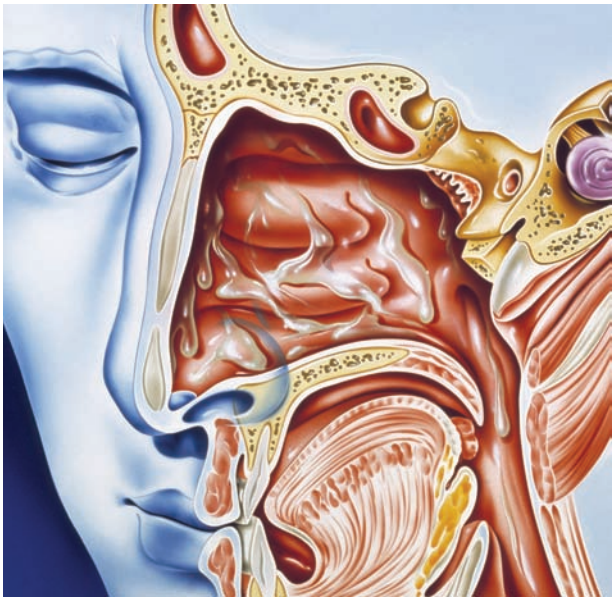
Management of the Patient Presenting with *Epistaxis*

Urgent message: Though patients with posterior and bilateral epistaxis should be admitted to the hospital, the vast majority of epistaxis episodes can be treated safely and effectively in the urgent care setting.

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

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.



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Anterior vs. Posterior Origin

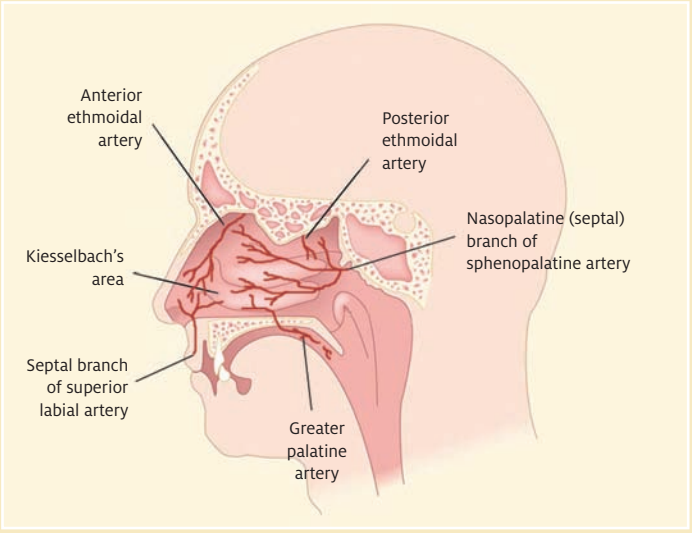
It is useful to classify epistaxis as either anterior or posterior in origin.

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

Figure 1.



Identification of anterior vs. posterior origin may be aided by familiarity with key arteries.

Table 1. Etiologies of Epistaxis

Local
■ Trauma (including nose picking and nasal foreign bodies)
■ Upper respiratory infections
■ Allergies
■ Nasal polyps
■ Low environmental humidity
■ Postoperative
■ Tumors
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

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.

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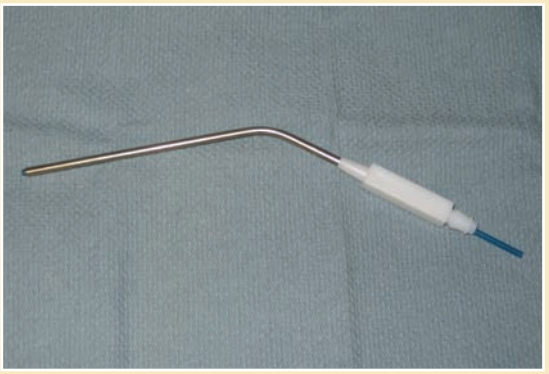
Figure 2.

Forehead lamp. (Photo by Nathaniel Arnone, MD.)

Figure 3.



Frazier suction catheter. (Photo by Nathaniel Arnone, MD.)

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

- 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.

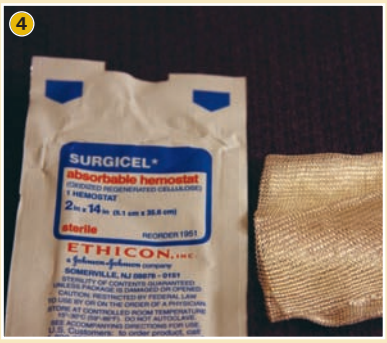
Electrocautery can be attempted if the silver nitrate doesn't work, but requires some special technique. The metal suction tip cannot be used since it will transmit the electric current, and lead to necrosis of the nasal septum. Suction can be achieved by using a glass dropper, since glass does not transmit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

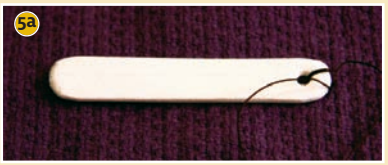
Absorbent Gelatin Foams, Oxidized Cellulose, and Nasal Tampons

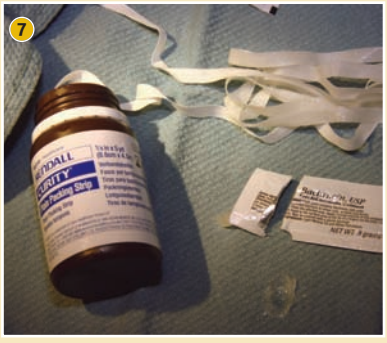
If there is bleeding from multiple small anterior sites, or if bleeding recurs after cauterization, an absorbent gelatin foam product such as Gelfoam (Pfizer) or oxidized cellulose such as Surgicel (Johnson & Johnson; **Figure 4**) may be used.

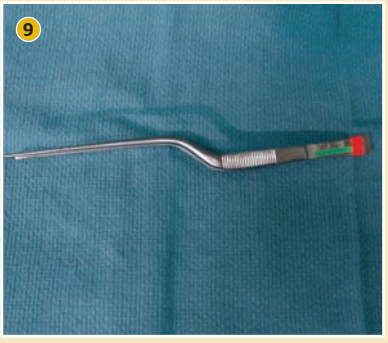
If cautery or absorbent sponges are ineffective, the anterior septum should be packed to provide hemostasis. Packing is uncomfortable for the patient, and analgesia and anxiolytics will be necessary. Remove

Figures 4 - 10.









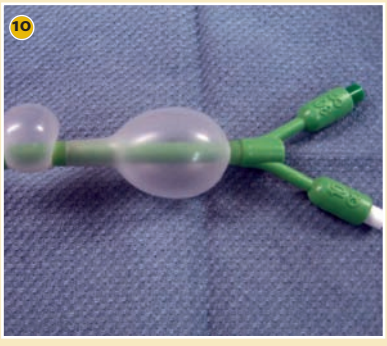


Figure 4. Surgicel.
Figure 5a and 5b. Merocel nasal tampon, before and after expansion.
Figure 6. Rapid Rhino nasal tampon.
Figure 7. Bacitracin-laden gauze packing strips.
Figure 8. Xeroform gauze.
Figure 9. Bayonet forceps.
Figure 10. Dual balloon nasal catheter for posterior epistaxis.

Photos by Nathaniel Arnone, MD.

any clots that have formed, and reapply a topical anesthetic and vasoconstriting 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

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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 Po_2 and an increase in Pco_2.

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, cauterization, or nasal packing. ■

References and Suggested Reading

1. Josephson GD, Godley FA, Stiema P. Practical management of epistaxis. *Med Clin North Am*. 1991;75:1311-1320.

2. Wurman LH, Sack JG, Flannery JV Jr, et al. The management of epistaxis. *Am J Otolaryngol*. 1992;13:193-209.

3. Weiss NS. Relation of high blood pressure to headache, epistaxis, and selected other symptoms. *N Engl J Med*. 1972;287:631-633.

4. Nitu IC, Perry DJ, Lee CA. Clinical experience with the use of clotting factor concentrates in oral anticoagulation reversal. *Clin Lab Haematol*. 1998; 20:363-367.

5. Tan LK, Calhoun KH. Epistaxis. *Med Clin North Am*. 1999;83:43-56.

6. Breda SD, Jacobs JB, Lebowitz AS, et al. Toxic shock syndrome in nasal surgery: A physiochemical and microbiologic evaluation of Merocel and NuGauze nasal packing. *Laryngoscope*. 1987;97:1388-1391.

7. Koh E, Frazzini VI, Kagetsu NJ. Epistaxis: Vascular anatomy, origins, and endovascular treatment. *AJR Am J Roentgenol*. 2000;174:845-851.

8. Jacobs JR, Levine LA, Davis H, et al. Posterior packs and the nasopulmonary reflex. *Laryngoscope*. 1981;91:279-284.

9. Loftus BC, Blitzer A, Cozine K. Epistaxis, medical history and the nasopulmonary reflex: What is clinically relevant? *Otolarnygol Head Neck Surg* .1994;110:363-369.

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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.

Reference: 1. US Food and Drug Administration. FDA takes action to stop marketing of unapproved hydrocodone products [press release]. Available at: http://www.fda.gov. Accessed June 6, 2008.

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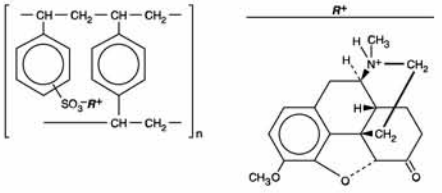
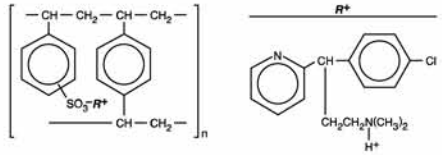
Hydrocodone Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 4,5α-epoxy-3-methoxy-17-methylmorphinan-6-one.



Chlorpheniramine Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 2-[p-chloro-α-[2-(dimethylamino)ethyl]-benzyl]pyridine.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Shake well before using.

Keep out of the reach of children.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

General Disorders and Administration Site Conditions: Death

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

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

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

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

Skin and Subcutaneous Tissue Disorders: Rash, pruritus.

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

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

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

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

Shake well before using.

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

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

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

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

NDC 53014-548-67 473 mL bottle

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

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

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

TUSSIONEX Pennkinetic Extended-Release Suspension
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Rev. 01/2008 TU1186-0308 1E

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.*

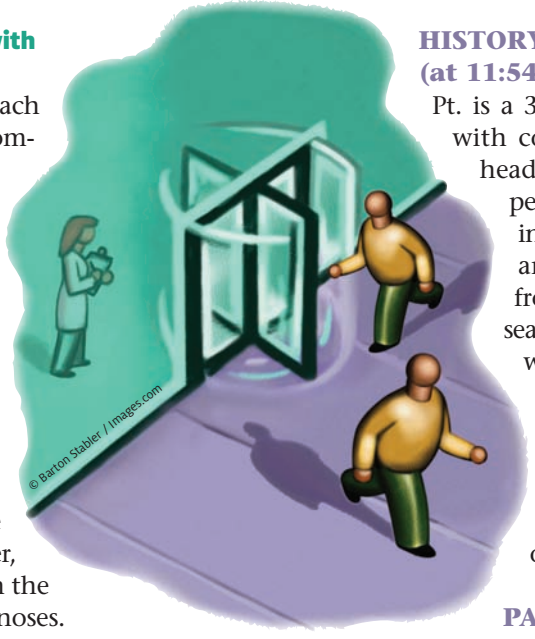
The cases are adapted from the book Bouncebacks! Emergency Department Cases: ED Returns *(2006, Anadem Publishing, www.anadem.com; also available at amazon.com and www.acep.org), which includes 30 case presentations with risk management commentary by Gregory L. Henry, past president of The American College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

Temp	Pulse	Resp	Syst	Diast
98.9	104	18	112	68

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

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 nucal 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 percocet. 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.[2] *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.[3] 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.[4] 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).

- 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

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.[5] 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.[6] 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.[7]

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

1. Sklar DP, Crandall CS, Loeliger E, et al. Unanticipated death after discharge home from the emergency department. *Ann Emerg Med*. 2007;49:735-745.
2. Croskerry, P. Achieving quality in clinical decision making: Cognitive strategies and detection of bias. *Acad Emerg Med*. 2002;9:1184-1204.
3. Snow V, Mottur-Pilson C, Hickner JM, et al. Principles of appropriate antibiotic use for acute sinusitis in adults. *Ann Intern Med*. 2001;134:495-497.
4. American College of Emergency Physicians. Clinical Policy: Critical issues in the evaluation and management of adult patients presenting to the emergency department with acute headache. June 24, 2008. Available at: *www.acep.org/workarea/downloadasset.aspx?id=8802*. Accessed Sept. 15, 2008.
5. Centers for Disease Control and Prevention. Notice to readers: Approval of a new rapid test for HIV antibody. *MMWR*. 2002;51:1051.
6. Powderly WG. Cryptococcosis. In: *AIDS Therapy*. Dolin R, Masur H, Saag M, eds. New York, NY: Churchill Livingstone, 1999:400-411.
7. van der Horst CM, Saag MS, Cloud GG, et al. Treatment of cryptococcal meningitis associated with the acquired immunodeficiency syndrome. *N Engl J Med*. 1997;337:15-21.

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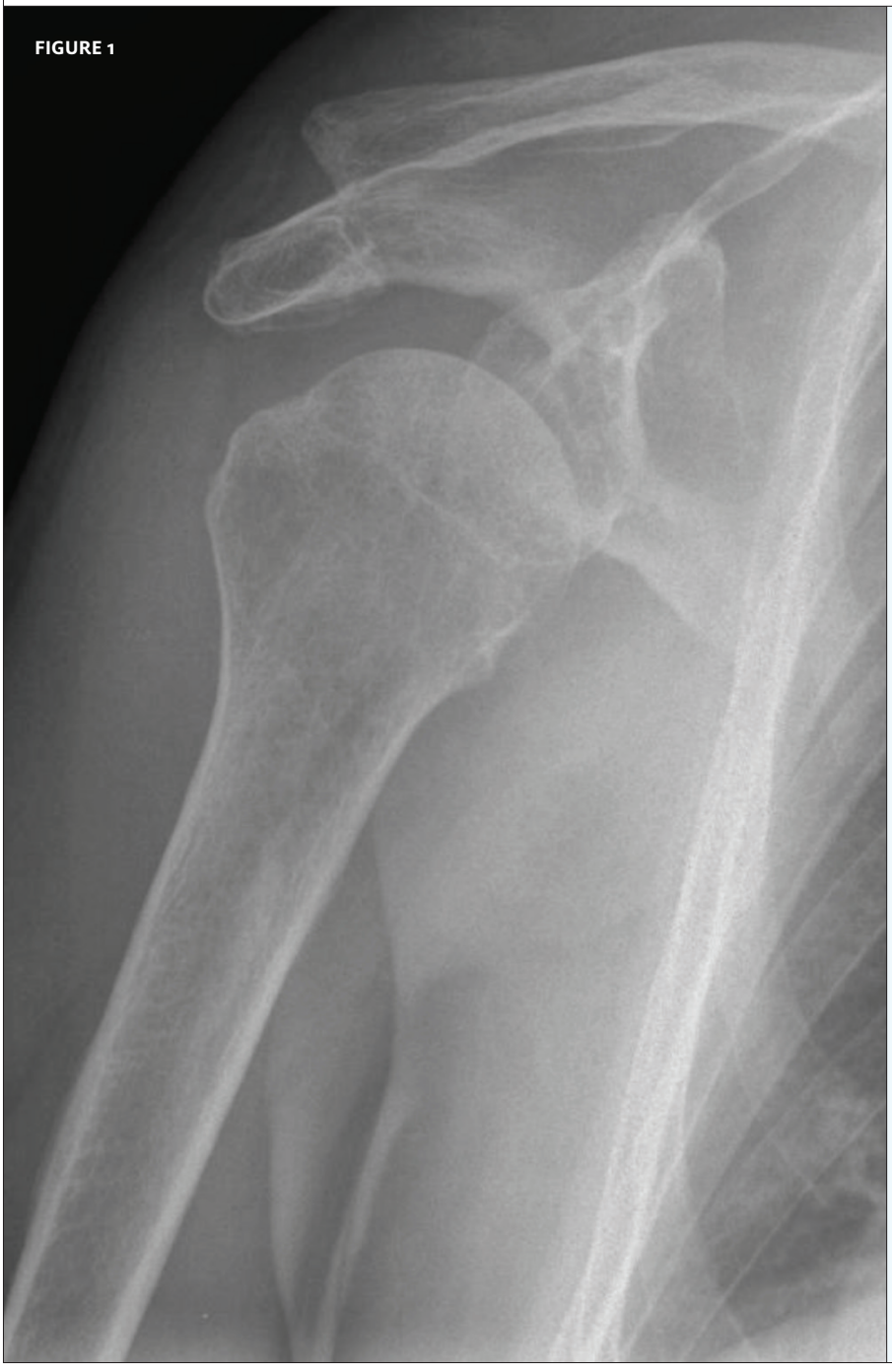
INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

FIGURE 1

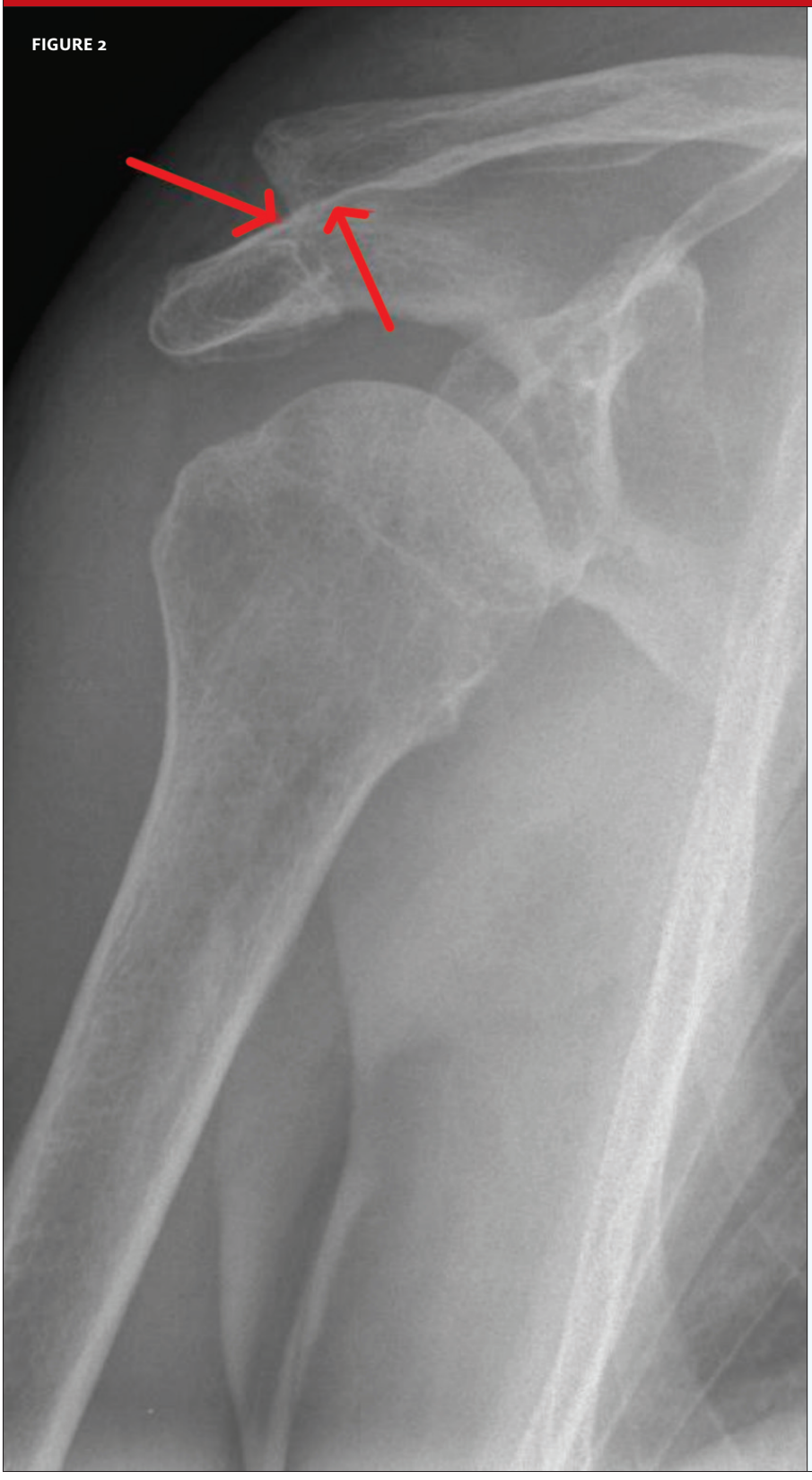


The patient is an 82-year-old man who slipped on the street, experiencing a blow to his right shoulder. He has significant local swelling in the injured shoulder—specifically, over the acromioclavicular joint—as well as significantly limited range of motion. His distal pulses are normal.

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 RESOLUTION

FIGURE 2



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 nonoperatively with rest, ice, sling, and analgesics, as was the case with this patient.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM

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 KOVALSKI, BSc, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

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.

Citation: Papa L, Seaberg DC, Rees E, et al. Does a waiting room video about what to expect during an emergency department visit improve patient satisfaction? ***CJEM***. 2008;10:347-354.

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% rated the visit as "excellent" or "very good." Satisfaction with the perceived amount of time spent in the waiting room did not differ between the two groups.

After adjustment for age, sex, and ED length of stay, satisfaction with perceived waiting room time and viewing the video were the strongest predictors of overall satisfaction.

In addition, calls to the hospital's outpatient clinic referral line increased significantly after the video was introduced (from 1.5 to 4.5 calls per month). The authors note that many patients come to EDs because they are unaware of alternate sources for urgent care.

Many people might not know what to expect during an ED visit, so it makes sense that informing patients about the ED experience would improve satisfaction. A waiting room video is one more tool to add to other interventions (such as decreasing waiting time to see a physician) to help increase patient satisfaction. ■

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

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%.

Citation: Plint AC, Johnson DW, Patel H, et al. for Pediatric Emergency Research Canada (PERC). 2008 CAEP/ACMU Scientific Abstracts—Plenary Presentations: 1-4.

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

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 department 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 bronchiolitis 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 syndromes. *Acad Emerg Med*. 2008;15:537-543.

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 cardiovascular 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 ordered 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 (flattening 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 diagnostic 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 abnormalities 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 media treatment failure and relapse. *Pediatrics*. 2008;121:674-679.

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 significantly, 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 associated with a different antibiotic prescription before completion 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 incidence 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.

Citation: Young J, De Sutter A, Merenstein D, et al. Antibiotics for adults with clinically diagnosed acute rhinosinusitis: A meta-analysis of individual patient data. *Lancet*. 2008; 371:908-914.

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 serious complication 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.

Citation: Snir N, Moskovitz B, Nativ O, et al. Papaverine hydrochloride for the treatment of renal colic: An old drug revisited. A prospective, randomized study. *J Urol*. 2008;179:1411-1414.

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.

Citation: *The Lancet*. Vestergaard M, Pedersen MG, Ostergaard JR, et al. Death in children with febrile seizures: A population-based cohort study. 2008;372:457-463.

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." ■

Keeping Workers Well and Your Practice Profitable

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

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

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.

  Clinical personnel, such as a registered nurse, seem to be best prepared to answer questions employers may have about blood-borne exposures and vaccines.
- *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.

  There are many vendors providing online HRA-related services, including online and paper instruments and health coaching. The cost varies by product complexity.
- *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.

  The trainer must be a qualified fitness trainer, exercise physiologist, physical therapist, or sports medicine professional. An understanding of how certain muscles are used to perform specific work tasks is necessary. The program may include workstation evaluations.
- *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.

Data Validate the Need for Corporate Wellness Services

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 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

program provides an overview of fitness, explains how to start a personal training program, do's and don'ts 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.

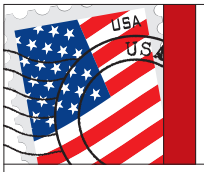
- *Wellness Programs*—A variety of wellness services may be packaged and sold to meet all of an employer's wellness and health promotion needs. The UCOM clinic partners with qualified vendors to provide the services.

  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. ■



LETTERS TO THE EDITOR

Regarding Our July/August Issue

Acute Ankle Injuries in the Urgent Care Setting

To the Editor:

Acute Ankle Injuries in the Urgent Care Setting (Janet D. Little, MD and William E. Saar, DO, *JUCM*, July/August 2008) was a thorough review. However, there was no mention of referrals to physical therapy for ongoing rehabilitation.

It was standard procedure in our small ED to refer any ortho injuries to physical therapy within two days of their injury to facilitate maximized positive outcomes from ED treatment. The patients would routinely follow up with primary care or orthopaedics when an appointment was available during the next several weeks.

The physical therapists appreciated getting the patients early in course of their rehabilitation, and the primary and orthopaedic physicians appreciated the coordinated care. The patients appreciated literally getting back on their feet and back to their regular activities of daily living because of the prompt involvement of physical therapy in their treatment at the ED."

Mary B. Sebas, MS, RNC, FNP
Minneapolis, MN

Dr. Saar responds: Thank you for the insightful thoughts. I agree that patients with ankle sprains and instability who undergo physical therapy that concentrates on proprioceptive exercises do seem to return to pre-injury level sooner. However, I have two concerns.

First, a small number of patients with apparent ankle "sprains" may be referred to a therapist, and an exercise rehab protocol recommended. If the patient had sustained an occult fracture, therapy could exacerbate the symptomatology.

This brings up the second issue, which probably varies from state to state. Some patients may not be able to see a physical therapist for evaluation, due either due to legal reasons or insurance protocols, without a prior prescription from their primary care physician or specialist. I am unclear as to how a prescription from either an urgent care or emergency department would factor into this equation. ■

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.

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*.

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.

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' 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).

They also said that they are looking at whether these codes were paid in error in the past, and there's talk about reclaiming those dollars. We recently received a letter from them requesting reimbursement back to 2006 for the claims where they paid us "in error" for 99051. So there is precedent for them going back and requesting reimbursement for claims paid in so-called "error."

My question is, what error? And do they have a legitimate claim to require us to refund these clams?

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

Continued on page 42

David E. Stern, MD, CPC, *is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity (www.practicevelocity.com), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.*

Occupational Health Sales and Marketing as a Team Sport

FRANK H. LEONE, MBA, MPH

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.

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

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. ■

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 S9088, 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. ■

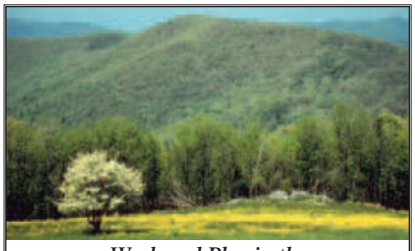
Disclaimer: JUCM *and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.*

Career Opportunities

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

URGENT CARE IN LAKELAND, FLORIDA SEEKS BE/BC physician. Must be comfortable with pediatrics and minor adult care. Excellent salary, benefit package, and bonuses. Future partnership available. Fax CV to (863) 666-6089.

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 America 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 7p-7a, comprehensive benefits package, paid relocation, 20 days paid vacation, paid malpractice, CME days and allowance, 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**

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SEATTLE, WASHINGTON – URGENT CARE Live the good life! As a MultiCare urgent care physician, you will benefit from a flexible, rotational, and "tailor-made" shift schedule with awesome work-life balance. Multispecialty medical group seeks B/C family medicine, IM/Peds or ER physician for a full-and part-time positions. All urgent care clinics are located within 40 minutes of downtown Seattle. Integrated inpatient/outpatient EMR, excellent compensation/benefits, flexible shifts, and system-wide support. Take a look at one of the northwest's most progressive health systems. Year round temperate climate affords outdoor enthusiasts endless recreational opportunities, such as biking, hiking, climbing, skiing, and golfing. For more information call (800) 621-0301; or email your CV to MultiCare Health System Provider Services at blazenewtrails@multicare.org; or fax to (866) 264-2818. Web site: www.multicare.org. Refer to opportunity #513-623. "MultiCareHealth System is a drug-free workplace".

URGENT CARE ARNP OR PA – WESTERN WASHINGTON full-time opening for a nurse practitioner or physician assistant to provide quality healthcare to patients of all ages in one of our urgent care centers located within 40 minutes of downtown Seattle. Experience in urgent care and family practice is preferred. Candidates must be qualified for licensure and certification in Washington State as a PA or NP. You will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. You'll live the northwest lifestyle and experience the best of northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. For more information regarding this opportunity, contact Provider Services at (800) 621-0301 or send your CV to blazenewtrails@multicare.org. Refer to opportunity ID#734-910.

Illinois

Seeking a BE/BC Urgent care physician to work in a clinic setting. Work 40 hours a week. Flexible scheduling. NO-CALL. Competitive salary, full benefits including paid relocation. Only a short commute to Chicago, Madison or Milwaukee! Excellent schools and affordable cost of living.

Enjoy cultural events, shopping and dining areas!

Contact Paul Santos at (800) 398-2923 or psantos@hortonsmithassociates.com. Job #1232

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Contact: Trish O'Brien
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Email: jucm@rja-ads.com

GEORGIA - URGENT CARE MEDICAL DIRECTOR needed, Atlanta Vicinity. Get in on the ground floor! Seeking 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 experienced 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.

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Employee, partnership track, BC EM,FM or IM
- 36 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 leave first year.

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

Allegiance HEALTH

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 weekends a month. Second schedule is: 4-12am with flexibility-equates 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 Spielberg at
(800) 547-1451
Email: mspielberg@sourceonestl.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 Noeth
OSF Physician Recruitment
Call: (309) 677-8351 or (800) 232-3129 press 8
Fax: (309) 677-8338
marie.k.noeth@osfhealthcare.org
www.osfhealthcare.org

McLeod Health
The Choice for Medical Excellence.

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 life style 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.

Locations

Sutter Medical Group
- Roseville
- Sacramento

Sutter West Medical Group
- Davis

* Other opportunities available

Sutter Health
Sacramento Sierra Region
Community Based, Not For Profit

Physician Recruitment - 800.650.0625 / 916.643.6677 fax / develops@sutterhealth.org

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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

Morton Plant Mease Primary Care

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MEDPRO 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

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
800-755-3104

Isn't it time for something better?

Find Your Passion Here
Urgent Care Opportunities-Washington

Group Health Permanente, 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

EOE/AA

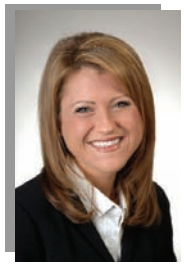
www.ghc.org/greatjob GroupHealth

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.

NORTON HEALTHCARE

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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 (1:00 – 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

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:

EMO Medical Care

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

Career Opportunities

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. Competitve compensation includes malpractice, 401(k), productivity bonus, deferred comp plan, etc.

Inquiries and CV to: kmitchell@UCImedinc.com

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.

Gundersen Lutheran
HEALTH SYSTEM

Urgent Care Physician

Gundersen Lutheran Health System, based in La Crosse, Wisconsin is seeking an Urgent Care physician to join our neighboring, Onalaska Clinic. The La Crosse and Onalaska Urgent Care Department consists of 12 physicians which will enable you to lead a balanced lifestyle in a collegial environment. The successful candidate will be BC/BE in Family Medicine, Emergency Medicine, Internal Medicine or related.

Gundersen Lutheran is a large multi-specialty group practice than employs over 440 medical staff and serves a population base of 500,000 through its La Crosse campus and 20+ regional clinics based in Southwest Wisconsin, Southeast Minnesota, and Northeast Iowa.

We will consider full or part time employment. Our physician lead organization emphasizes quality and compassionate care.

Contact: Jon Nevala, Medical Staff Recruitment,
Gundersen Lutheran Health System,
(800) 362-9567, ext. 54224 or email JPNevala@gundluth.org

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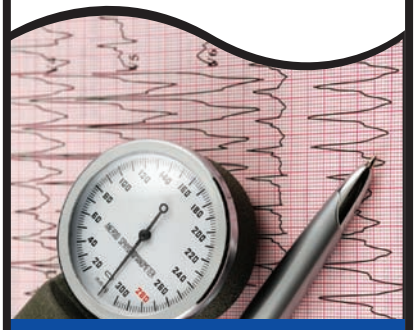

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Trish O'Brien
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Email: jucm@rja-ads.com

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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.

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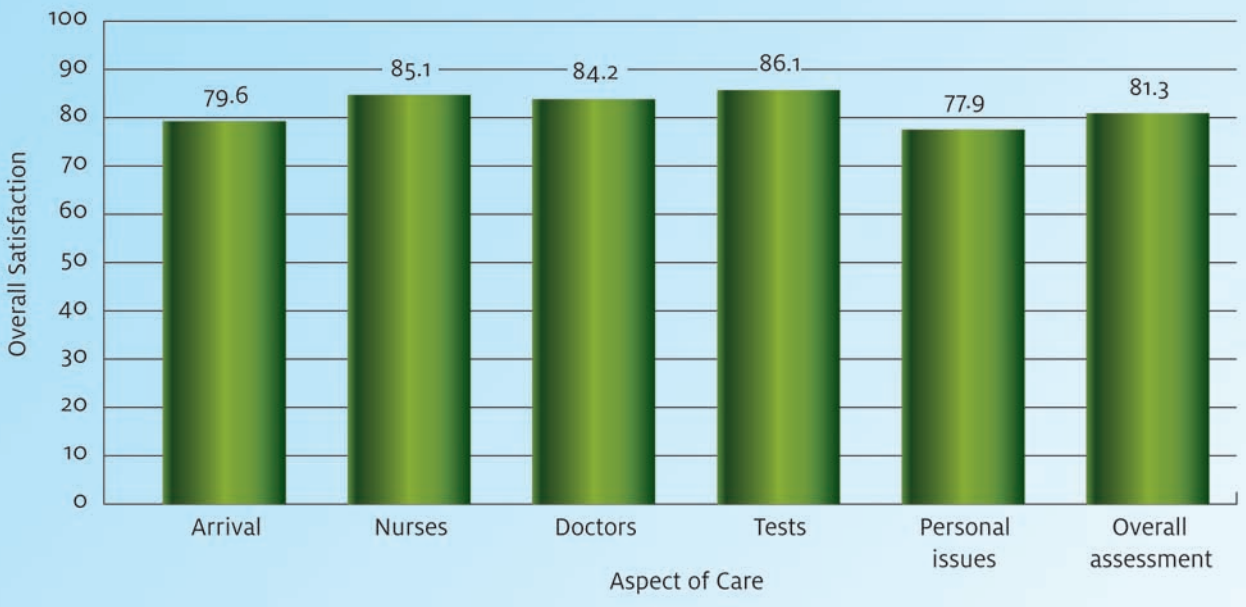
DEVELOPING DATA

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

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

In this issue: 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



Source: *Emergency Department Pulse Report 2008. Patient Perspectives on American Health Care.* ©2008 by Press Ganey, Inc. Based on a population of 1.5 million patients treated at 1,656 U.S. emergency departments in 2007.

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!

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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
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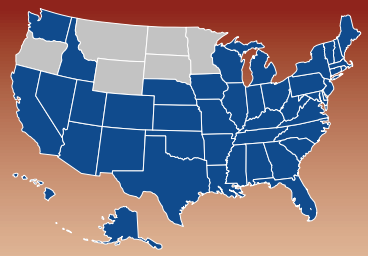

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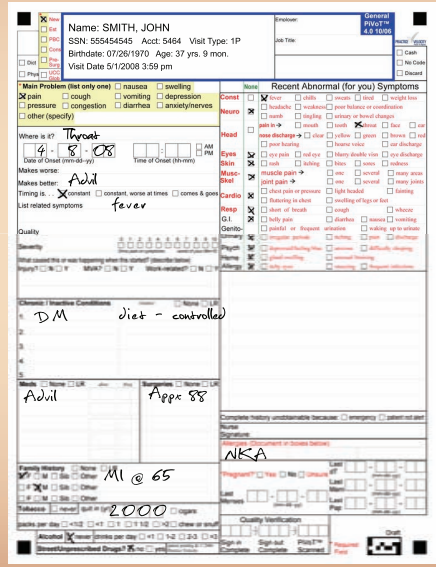

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— David Stern, MD, CPC
CEO Practice Velocity

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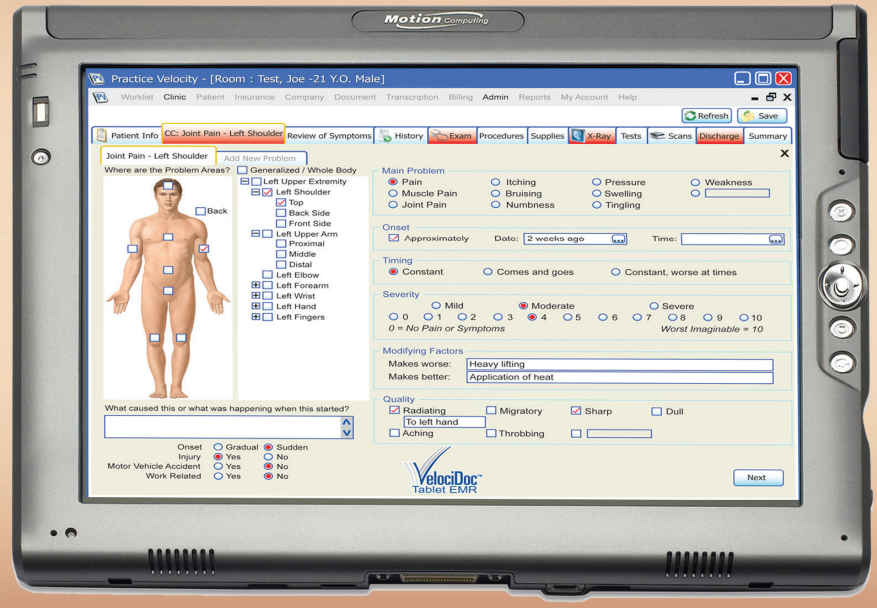

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