

# JUCM™

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VOLUME 4, NUMBER 1

THE JOURNAL OF **URGENT CARE** MEDICINE®

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## Preparing for Pandemic Influenza in the Urgent Care Setting



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## LETTER FROM THE EDITOR-IN-CHIEF

# What can YOU do for YOU?



I know this may sound like a funny way to start a column. It's a bit confrontational perhaps, maybe even a little insulting. Why is this guy calling me out on the carpet here? What did I ever do to him?

I have been involved in organized medicine for almost 10 years, at varying levels of responsibility. If I have learned one thing along the way, it is this: If you want it done, you better do it yourself! No matter how important, no matter how virtuous, no matter how intuitive... you have to take personal responsibility for seeing it through.

This is especially important in an evolving discipline like urgent care; there are no deep pockets to support a sophisticated staff to generate sophisticated programs to further our interests. There are no big marketing budgets to raise awareness. There are no big corporate sponsors to fund our agendas (think retail clinics!). There are no lobbyists to present our case to policymakers in Washington. There is little to no academic interest in what we do—in fact, most in academia are threatened by our very existence.

Without academic interest, there is very little research dedicated to the discipline, clinical or otherwise. There is no public funding for training programs that ensure we have the highest caliber of clinicians available to staff our clinics.

We are on a veritable island in the “house of medicine,” and no one is going to rescue us because of the value we bring to our patients and to the healthcare delivery system.

That said, we do have the potential to be a formidable collective force. There are over 8,000 urgent care centers in the United States, representing over 100 million patient visits a year.

By contrast, there are almost half as many emergency departments, and a far smaller number of retail clinics.

The Urgent Care Association of America and JUCM, *The Journal of Urgent Care Medicine*, are working hard to represent the interests of urgent care and the value we bring to healthcare. However, relying on UCAOA and JUCM alone is not enough.

If you want urgent care to be recognized as a critical force in healthcare delivery, then you have to represent it at the grassroots level. You have to sell the whole concept of urgent care to anyone who will listen.

*“Supporting the urgent care community... is critical to giving urgent care a ‘voice.’”*

- Write a letter to the editor of your local newspaper.
- Invite your local hospital executives to your clinic.
- Present to your local chamber of commerce.
- Participate in UCAOA's Urgent Care Awareness Week, scheduled this year for November 9–13. Details will be forthcoming on the UCAOA homepage ([www.ucaoa.org](http://www.ucaoa.org)).
- Submit a review article or case report to this journal via e-mail to [editor@jucm.com](mailto:editor@jucm.com).
- Teach residents and students.
- Find an academic partner and do some original research.
- Have your center accredited or certified to show your commitment to quality and safety.
- Come to the UCAOA convention and fall conference each year.
- Support vendors who have supported urgent care.
- Participate in UCAOA surveys

You may not see an immediate return on everything you do, but supporting the urgent care community and advancing the discipline is critical to giving urgent care a “voice.”

Without a “voice”, if an urgent care falls in the woods, will anyone hear? ■

Lee A. Resnick, MD  
Editor-in-Chief  
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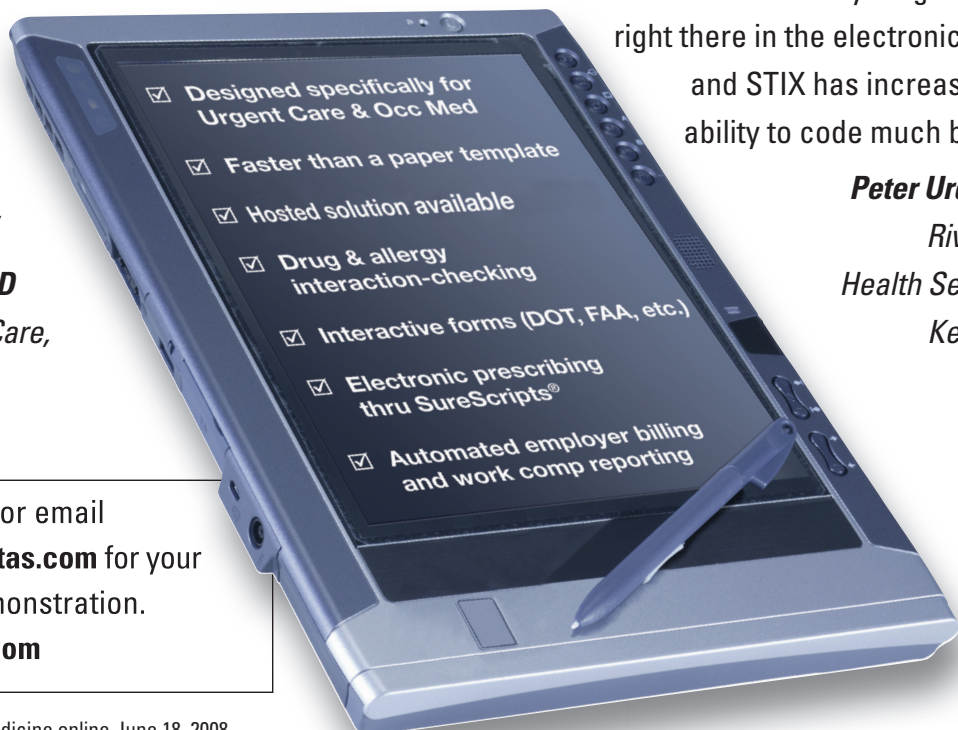


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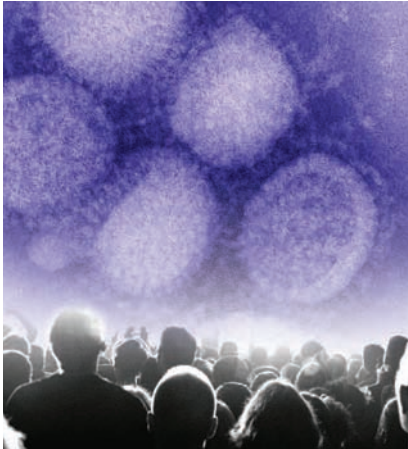
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\* New England Journal of Medicine online June 18, 2008.

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## October 2009

VOLUME 4, NUMBER 1



### CLINICAL

## 11 Preparing for Pandemic Influenza in the Urgent Care Setting

You've seen—and perhaps even tried to mitigate—the hype. What particular challenges can the urgent care clinician expect to face as flu season approaches, though? And how might your preparations help you in the event of other catastrophes?

By Gary Klein, MD, MPH, MBA, CHS-V, FAADM

### PRACTICE MANAGEMENT

## 32 Utilizing Social Media to Drive Visits to Your Website and Urgent Care Center

Most patients know their way around the Internet; you've probably heard your share of questions that sound like they're being repeated verbatim from an online medical forum. But how can you use the web—social media sites, in particular—to good advantage in marketing your services?

By Alan A. Ayers, MBA, MAcc



### WEB EXCLUSIVE

#### Valuation of an Urgent Care Center

How do you put a price on a business you built from the ground up (in some cases, literally)? The answer may be just as complex as the reasons that force a business owner to consider selling. Available only at [www.jucm.com](http://www.jucm.com).

By Keith Borglum, CHBC

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### IN THE NEXT ISSUE OF JUCM

*As the colder, indoor weather approaches, odds are you'll be seeing at least a few patients whose respiratory complaints have nothing to do with any flu virus. Due diligence and a responsible choice of the right medication will be the order of the day.*



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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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# Call for Articles

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

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

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

**Please e-mail your idea to**

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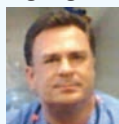
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In case you haven't heard, the public is a little concerned about the upcoming flu season.

People getting sick is no laughing matter, of course, but hype and general misinformation are spreading almost as fast as the H1N1 flu is perceived to. Warranted or not, the fear that the media and bloggers instill is likely to result in increased volume in urgent care centers.

The bottom line: The time to prepare is now.

Preparing for Pandemic Influenza in the Urgent Care Setting (page 11) looks at this challenge from both a medical and an emergency preparedness standpoint. As president of the American Academy of Disaster Medicine and an attending urgent & emergency care physician in the Department



of Defense's Military Health System, **Gary Klein, MD, MPH, MBA, CHS-V, FAADM** has both the perspective and experience to tackle this subject. Dr. Klein is also a member of the

JUCM Advisory Board.

While the Internet obviously is a popular medium for spreading suspect advice regarding the H1N1 flu, it also represents a golden, yet relatively low-cost, medium for marketing your urgent care center. Whether contributing to an online forum or setting up a Facebook page to keep your "friends" posted on your business, the right approach can go a long way toward reaching an untapped market. Check out Utilizing Social Media to Drive Visits to Your Website and Urgent Care Center (page 32), by **Alan A. Ayers, MBA, MAcc** for ideas on how to get started.

Mr. Ayers is assistant vice president, product development for Concentra Urgent Care, as well as content advisor for the Urgent Care Association of America. He will speak on marketing urgent care centers at the UCAOA Fall Urgent Care Conference in Dallas, October 23-24.



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Speaking of the web, our homepage ([www.jucm.com](http://www.jucm.com)) is the only place you can read Valuation of an Urgent Care Center, in which **Keith Borglum, CHBC** provides an overview of how to determine the market worth of your business, including a look at applicable laws, the importance of understanding circumstances and assumptions, and how outside factors can affect prices. Mr. Borglum is a certified healthcare business consultant and principal of Professional Management and Marketing.



**Also in this issue:**

**Emory Petrack, MD, FAAP, FACEP** explains the value of first impressions when treating young children in your urgent care center, starting literally from the parking lot and the waiting room.

**Nahum Kovalski, BSc, MDCM** reviews new abstracts on the predictive value of D-dimer tests to rule out pulmonary embolism, the new CDC guidance on H1N1 and school dismissals, and other topics relevant to the urgent care clinician.

**Matthew McGauran, PA-C** and **Bryan Holmes, NREMT-P** present an x-ray case that underscores the importance of being vigilant to the signs and symptoms of hip fracture.

**Frank Leone, MBA, MPH** implores readers to, in the words of Thoreau, "simplify, simplify, simplify" messages when promoting your urgent care occupational medicine services.

**John Shufeldt, MD, JD, MBA, FACEP** cautions about the practitioner's duty to report instances of suspected child abuse.

**David Stern, MD, CPC** answers queries on coding for incision and drainage, administering the DTaP vaccine, and procedures included in the E/M code.

Drs. Shufeldt and Stern are also among the faculty at the upcoming UCAOA Fall Urgent Care Conference.

Do you have an idea for an article or new feature? Maybe an interesting x-ray case to present? Let us know in an e-mail to **Lee A. Resnick, MD**, JUCM's editor-in-chief at [editor@jucm.com](mailto:editor@jucm.com). ■



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## FROM THE EXECUTIVE DIRECTOR

# Breathe Deeply

■ LOU ELLEN HORWITZ, MA

Is it just me, or is the world spinning a little faster than usual?

- Keeping up with the healthcare reform wave of the moment is nearly impossible.
- Retail clinics have been back in the headlines, and often confused with urgent care centers.
- Existing state laws supersede new federal laws, except when they don't.
- Seasonal flu season is upon us. The H1N1 vaccination campaign is in motion.
- Patients are confused about which shots they need and which shots they have already gotten.
- Waiting rooms are full.
- Plane tickets need to be booked for the Fall Conference.
- And what about holiday shopping?

It's enough to make you run for the hills, at the time when you absolutely cannot get time off to do so. Some days it seems there's not even enough room to breathe.

You already know the rest of the story; stress does all kinds of things to the body you aren't even noticing—and it has consequences. It's not your imagination that you are less patient, not eating as well, not sleeping as well, having a hard time concentrating and so on.

Guess what? Your patients are experiencing the same stress levels for exactly the same reasons. Put you both together in an exam room or registration area...well, you know the rest.

Given that, odds are good you are just now reading this October column in January!

My point this month is to remind you to stop (even if for just 30 seconds) and breathe in, breathe out, breathe in, breathe out, breathe in, breathe out... It makes an immedi-

*"For many incoming patients, this may be the only time they see a medical professional all year—even if it's 'just' for their flu shot."*

ate difference, you already know how to do it, there's no sweating involved, and it's free. The hard part is remembering that taking the 30 seconds is really, really worth it.

Happily, it's often easy to see in others what we can't see in ourselves—so I suggest you make a pact with your colleagues. Watch out for each other and your patients, and have a "Three Breaths" password to tell someone it's both okay and important for them to stop and take that 30 seconds. Five seconds in, five seconds out, repeat, repeat. In all seriousness, it could save a life.

For so many of your current incoming patients, this may be the only time they see any kind of medical professional all year—even if it's "just" for their flu shot. Remember that. Keep your eyes and ears open, and help them to focus on their health for just a couple of minutes. Your short visit may be the only chance they have to understand that their ongoing small problem could be a sign of something more serious. Training yourself to help them slow down for three breaths may make all the difference in the world.

I read a quote recently (a Chinese proverb) that appealed to both the gardener in me and the longing for a little more peace in the world. It went:

*"The best time to plant a tree is twenty years ago. The second best time is now."*

We are in the now—and if you miss this one, there will be a new one almost immediately following. Don't miss that one. ■



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



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FASTER THAN PAPER

## Preparing for Pandemic Influenza in the Urgent Care Setting

**Urgent message:** Between the current—and still growing—volume of H1N1 flu cases and fast-approaching influenza season, the urgent care physician will be challenged to distinguish among a variety of common cold and influenza-like conditions.

Gary Klein, MD, MPH, MBA, CHS-V, FAADM

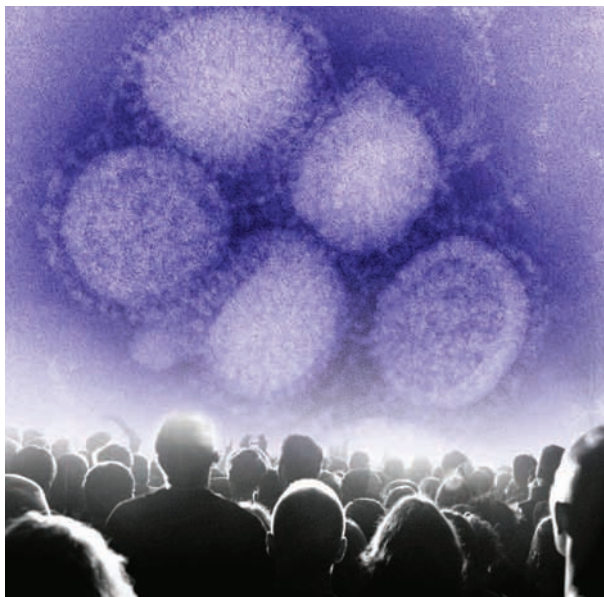
### Introduction

The mainstream media have certainly accomplished the mission of alerting the public to the dangers of H1N1 flu—perhaps to the point that many are tempted to dismiss their dire predictions as “hype.”

Here are the facts: As of September 4, 2009, the Centers for Disease Control and Prevention was reporting 9,079 patients hospitalized with H1N1; 593 deaths had been attributed.

In the very near future—if not today, even—the urgent care physician will be faced with many patients who present with influenza-like symptoms or concerns that they have “the flu.”

As is the case with other urgent care concerns, appropriate and timely diagnosis will depend on history of present illness, history of recent travel, history of close family members’ illnesses, and a thorough phys-



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ical examination.

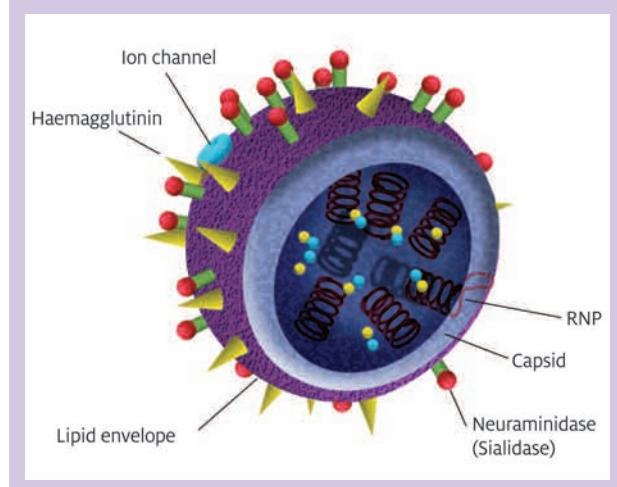
The use of the latest rapid urgent care tests is also important, but these tests should be used to support one’s clinical judgment, not as a substitute for the exam.

### Epidemiology

Influenza is classified as an acute respiratory illness caused by influenza A or B viruses, which occurs in outbreaks throughout the world to varying degrees each year. This epidemiologic pattern reflects the rapidly changing nature of the antigenic properties of

the influenza viruses; spread of the viruses depends upon the susceptibility of the population at large.

Influenza “A” virus, in particular, has the remarkable ability to undergo quick changes in the antigenic characteristics of its envelope glycoproteins, the hemagglutinin and neuraminidase (**Figure 1**).

**Figure 1. Influenza virus.**

Influenza hemagglutinin is a surface glycoprotein that binds to sialic acid residues on respiratory epithelial cell surface glycoproteins. It is this interaction that is key for the initiation of infection. Once viral replication takes place, the new virions are also able to bind to the host cell, and it is the neuraminidase which cleaves these links and liberates the new virions.

Major changes in these glycoproteins, called antigenic *shifts*, are associated with epidemics and pandemics of influenza A. Minor changes referred to as antigenic *drifts* are associated with more regionalized, local outbreaks.

### Clinical Findings

Urgent care physicians have to rely on their clinical acumen when diagnosing influenza because of the variety of signs and symptoms that are presented. These signs and symptoms can be caused by a variety of bacteria, cold viruses, and influenza viruses (Table 1).

Patients usually present with additional symptoms such as ocular injection and photophobia, as well as a decrease in leukocyte count. Typically, a chest x-ray, ordered to rule out pneumonia if hilar rales or wheezes are noted, will be negative.

### Rapid Testing: Point-of-Care Tests

The newer rapid influenza tests avail-

able on the market, based on viral antigen detection and immunofluorescence, can assist in the difficult task of diagnosing influenza. This assumes the urgent care clinician understands their use and limitations, however.

Prompt diagnosis is important because antiviral therapy, if chosen, is more effective within 36 to 48 hours of onset of illness. Proper use of the new rapid tests may also be beneficial in curbing inappropriate use of antibiotics, by virtue of reducing the risk of misdiagnosis.

In patients presenting to the urgent care center with fever, cough, and ear pain, testing for influenza is indicated:

- when the clinical presentation and diagnosis is not clear
- if antiviral therapy is an option
- in cases of pandemic influenza.

A rapid laboratory diagnosis of influenza can be made by the detection of influenza viral antigen or nucleic acid within the respiratory tract.

Other laboratory methods include influenza viral isolation, which takes anywhere from 72 hours to a week, and serological detection of influenza antibodies, which takes two weeks to confirm. The choice of which test to order is up to the clinician based on the patient's duration of symptoms, prevalence of influenza in the community, and the proximity to a lab testing facility.

The urgent care physician must be cognizant of the type and quality of the specimen during collection, as this may affect the sensitivity of the test. Nasal aspirates in young children and paired nasal and throat swabs in adults using the specialized viral swabs are best. A good quality respiratory tract specimen is very important for rapid antigen detection, which relies on the presence of adequate numbers of infected respiratory epithelial cells.

As you can see from Table 2, point-of-care tests are the

**Table 1. Comparison of Influenza and the Common Cold**

Symptoms	Influenza	Common cold
Onset	Sudden and abrupt	Gradual
Fever	High (upwards of 101°F to 104°F)	Usually not present or very mild elevation of 1°
Myalgia	Common	Not common
Anorexia	Common	Not common
Headache	Common	Mild if at all present
Malaise	Common	Mild if at all present
Sore throat	Mild	Very common
Sinus symptoms	Mild	Very common



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**Table 2: Rapid Tests for Influenza<sup>1</sup>**

Test	Time to results	Sensitivity	Specificity	Advantages	Disadvantages
Point-of-care	15-25 min	60%-94%	76%-100%	Fast; easy to perform; no lab needed	False positive; lower sensitivity; limited shelf life
Immunofluorescence assay	2-4 hours	7%-90%	90%	Fast; inclusion of other respiratory virus; subtyping for influenza A is possible	Labor intensive; lab tech needed; less sensitive than nucleic acid tests
Nucleic acid test	24-48 hours	99%	99%	Highly sensitive; specimen quality; less crucial typing and subtyping possible	Expensive; may be affected by viral genetic drift; high infrastructure requirements

most useful during the influenza season when the prevalence of influenza is high and the positive predictive value of the test is greatest. A positive test result in this situation is highly suggestive of influenza infection. Patients who are suspected of having influenza and have negative point-of-care tests during the influenza season should be referred for further testing with more sensitivity.

Alternatively, during periods of low influenza activity, point-of-care tests have a low positive predictive value and a false positive result is more probable. In the urgent care setting, these point-of-care tests should be utilized during high influenza periods.

### Immunofluorescence Assays

These tests are based on the same concepts as point-of-care tests (i.e., detecting and interaction between viral antigens and specific antibodies), but must be performed in a laboratory.

The *direct* method of immunofluorescence assays involves placing the sputum specimen onto a slide and then staining with specific antibodies fixed to a fluorescent dye.

The *indirect* method of immunofluorescence adds the additional step of a second fixed antibody, which increases both the sensitivity of the test and the time to obtain results. Both tests require that the slides be viewed with a fluorescence microscope to detect nuclear and cytoplasmic fluorescence staining.

Influenza immunofluorescence assays have a rapid turnaround time of three to five hours, with the additional bonus of screening for other respiratory viruses, allowing alternative diagnosis or detection of viral co-infections.

The sensitivity of immunofluorescence assays is 70% to 90%, with specificity at 90%.<sup>2</sup> However, performing these tests requires a specialized laboratory equipped with a fluorescence microscope and pathologists with technicians, making it more labor intensive and more costly.

Urgent care clinicians should employ this option during severe pandemics or when diagnosis is not easily concluded.

### Nucleic Acid Tests

Today, there are a variety of commercially available assays for the detection of the influenza virus nucleic acid. In addition, different nucleic acid tests (NATs) may detect and characterize the influenza virus by type (A or B), usually targeting the matrix protein, or by the subtype using primers directed against the hemagglutinin or neuraminidase genes. Commonly, the test involves a reverse transcriptase polymerase chain reaction.

Nucleic acid tests are the most sensitive diagnostic tests for influenza, with sensitivity and specificity approaching 100%.<sup>1</sup> Due to this very high sensitivity and specificity to detect both the viable and non-viable virus, the quality and timing of specimen collection is not as important as with the other antigen detection technique; though it is less labor intensive than immunofluorescence assays, the NAT is the most expensive, secondary to the extremely expensive equipment and technical expertise.

### Bottom Line Thoughts

The public health and urgent care benefits of a rapid diagnosis of influenza cannot be overstated. Quick detec-



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tion of influenza is important not only for the patient, who may benefit from early diagnosis and the starting of antiviral medications, but also for the area served by the urgent care setting, which will help reduce the outbreak and transmission of the virus. This will, in turn, help reduce the already over-burdened emergency rooms, as well.

While rapid point-of-care tests can be very convenient, the urgent care clinician must remember that they can miss a significant number of true infections. Though a positive result usually means the patient is infected, a negative result is not very useful.

In the end, the practitioner must use his or her clinical acumen, along with the patient's risk factors, as the best way to judge a case of influenza. **Figure 2** summarizes the clinical decision-making process.

### Preparing for Flu Season

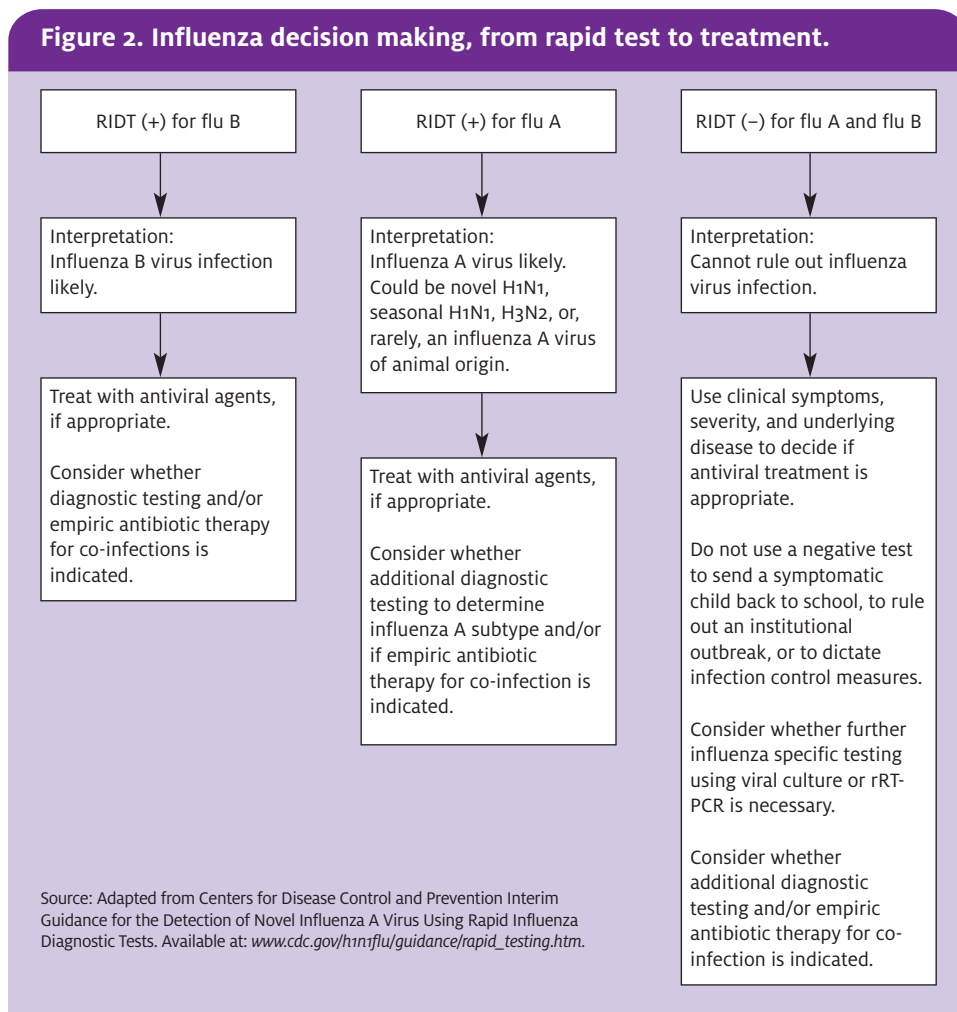
Up to this point, we have focused on urgent care, influenza, and the point-of-care testing available for diagnostic purposes. Now, we turn our attention to urgent care's role and the preparation needed in the event of a global outbreak of influenza.

This could very well include the H5N1 avian influenza, as well.

Imagine a scenario whereby the CDC announces that the avian flu is now a pandemic. Is your urgent care center ready? Have you considered what such an announcement would mean in terms of surge capacity to the clinic?

Each urgent care facility will need to conduct an assessment on current policies and procedures, identify areas

**Figure 2. Influenza decision making, from rapid test to treatment.**



that need updating, and create a pandemic/preparedness plan that will establish the way your urgent care clinic will respond during a national crisis.

Areas that need to be viewed as critical include:

- leadership
- clinical care
- human capital
- legal
- operations and supplies.

Careful planning *now* will be vital to ensure that the urgent care facility has taken the necessary steps to provide clinical care during a pandemic or other disaster situation. Whether an owner or a staff physician at an urgent care center, it is up to the medical director and clinic management to implement and practice a pandemic disaster plan.

By planning ahead, the leadership is ensuring that the

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**Table 3. Preparing for Seasonal Flu Vaccinations**

### Inventory

- Have enough stock on hand, including extra vaccines as a contingency.
- Be sure that refrigeration is not an issue, and that a back-up refrigerator is available if necessary.

### Documentation

- Coding and proper documentation is important, as some states now require a vaccine registry. If there is an adverse event, proper documentation will be required by the FDA and other regulatory agencies.

### Reimbursement

- Most payors will pay just enough to cover the cost of the vaccine; consider adding an additional administration fee that must be paid at the time of service. Hopefully, this will at least cover the costs of storage and vaccine syringes, as well as waste disposal for both nasal vaccines and needle handling.

### Compliance

- Expect that the swine and seasonal vaccines will require proper storage- handling and may also require special administration instructions on delivery.
- Always make notations in the patient's chart regarding the date and time, and the site the vaccine was administered.

clinic is able to respond and assist within the community it services without being disrupted. The leadership will communicate to all staff the benefits of having a plan, the benefits of practicing and implementing the plan, and including all staff members in the development of the plan.

The pandemic/disaster plan at its core will address training for employees, to include individual roles and responsibilities, information about threats, bio-hazards and protective actions, notification and communication, means for locating family members, emergency response procedures, and location of equipment, as well as clinic shutdown procedures.

Build *preparedness* into the clinic's culture. Orientation for new clinic staff should include an overview of the contents and a copy of the clinic's pandemic/preparedness manual.



**Table 4. Analyzing Risks: Factors to Consider**

<i>Recent</i>	What types of disasters, such as the flu, are occurring now in your area, or in nearby states?
<i>Historical</i>	What types of disasters have occurred recently, such as hurricanes, fires, and floods?
<i>Geographic</i>	Where is your urgent care center situated? Is it near a flood zone, power plant, nuclear plant, hazardous chemical production plant, or transportation hub (airport, train station, or freight rail)?
<i>Physical</i>	How is your urgent care constructed? Does the facility have enhanced construction, or store hazardous or biologic material? Are there proper exit and evacuation routes? Is there a shelter nearby?
<i>Technology</i>	What happens if your computers crash? Do you have the ability to handwrite the details of a patient encounter? Do you have patient superbills?
<i>Other</i>	What happens if you lose electricity or a ruptured gas pipe explodes?

### Preparing for Vaccinations

This year, urgent care will be concerned about swine, seasonal, and avian flu.

At the time of this writing, the transmission of avian flu virus (H5N1) from person to person is rare.

Also at the time of this writing, the swine flu virus (H1N1) continues to cause illness, hospitalizations, and death in some cases. This has resulted in a rush for a separate and novel vaccine against the H1N1 virus to be developed. This novel vaccine is *not* intended to replace the seasonal influenza vaccine. The author recommends that each urgent care facility monitor the CDC's website ([www.cdc.gov/h1n1flu/](http://www.cdc.gov/h1n1flu/)) or stay in close contact with state and local public health officials.

**Table 3**, which advises on steps to take to prepare for season influenza vaccinations, can serve as an example of preparedness planning.

### In Consideration of Other Possible Disasters

Many of the pre-emptive steps recommended here in anticipation of a surge related to seasonal or other flu outbreaks will be useful in helping the urgent care center prepare for many disasters.

Part of writing a clinic disaster plan is thinking



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with preparedness is  
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of all the things that could possibly go wrong and to have a contingency plan in place. The goal is not to create a separate plan addressing every possible risk, but to create one overarching plan. For example, creating a plan that addresses pandemic influenza but not a hurricane or mass casualty situation does not make sense.

Your urgent care center needs one plan that can address all realistically imaginable disaster scenarios. **Table 4** offers examples of what should be included in your disaster and pandemic plan.

#### **A Final Word About Insurance**

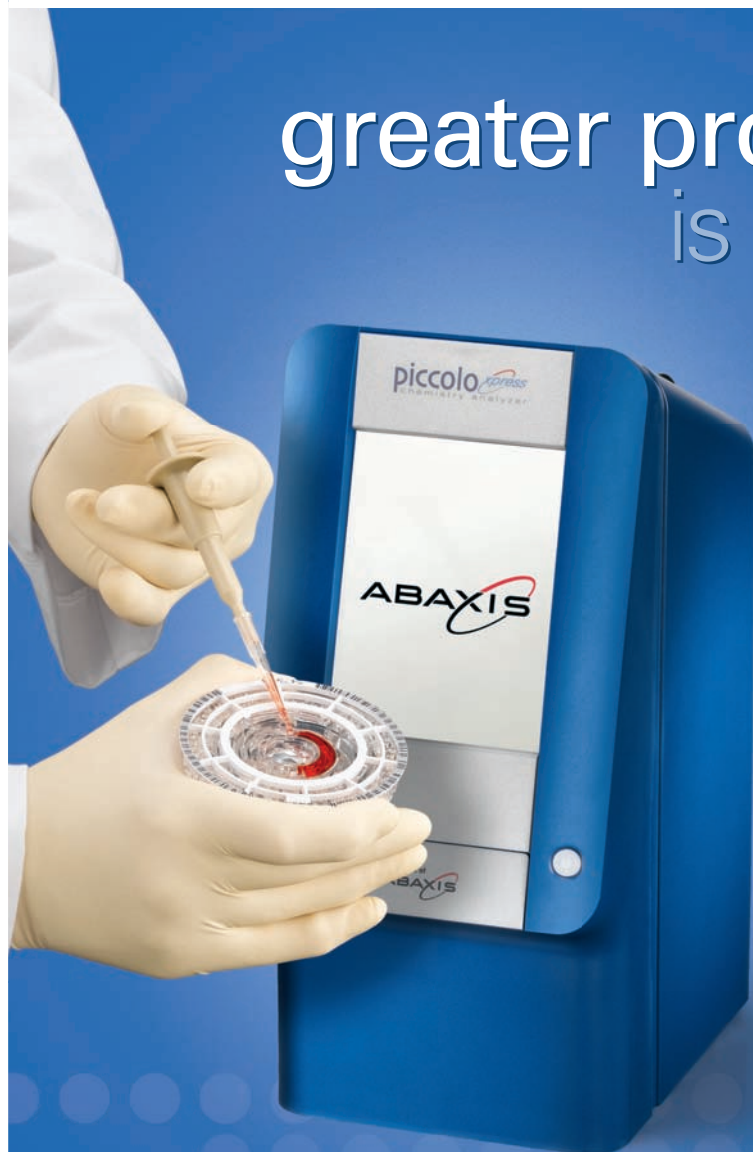
Make sure that your urgent care center has adequate insurance coverage to cover your losses in the event of a particular disaster, and be certain to check whether the coverage is for replacement value vs. current fair market value. Medical equipment might be old, and the actual value, factoring depreciation, may not be even close to the replacement costs for such expensive items. The same may hold true for the building itself.

As with the clinical consideration discussed earlier in this article, however, awareness coupled with preparation is the best insurance for keeping your patients healthy and your practice safe. ■

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CHOL, CHOL/HDL\*, HDL, LDL\*, TRIG, VLDL\*

ALT, AST, CHOL, CHOL/HDL\*, GLU, HDL, LDL\*, TRIG, VLDL\*

ALB, ALP, ALT, AMY, AST, GGT, TBIL, TP

ALT, AST, BUN, CRE, GGT, GLU

ALB, ALP, ALT, AMY, AST, BUN, Ca, CRE, GGT, GLU, TBIL, TP, UA

Cl<sup>-</sup>, K<sup>+</sup>, Na<sup>+</sup>, tCO<sub>2</sub>

BUN, CRE

ALB, BUN, Ca, Cl<sup>-</sup>, CRE, GLU, K<sup>+</sup>, Na<sup>+</sup>, PHOS, tCO<sub>2</sub>

BUN, CK, Cl<sup>-</sup>, CRE, GLU, K<sup>+</sup>, Na<sup>+</sup>, tCO<sub>2</sub>

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# Good First Impressions Set the Tone for Good Clinical Care

■ Emory Petrack, MD, FAAP, FACEP

It has been said that first impressions are formed in the first *seven seconds* of an encounter. It's also been said that there is no second chance to make a good first impression.

The reality is that first impressions *do* matter—a lot. A family bringing a sick or injured child to your urgent care center will quickly form an impression based on assessments they may be making without even knowing it.

- Is the center clean and well-lit?
- Is the waiting room filled with seemingly disgruntled, bored, or otherwise wait-weary patients?
- Do front-line staff appear welcoming, caring, friendly—or hassled, off-putting, unconcerned?

The family's initial impression is critically important, as it can impact not only their overall satisfaction, but also the clinical care you deliver.

If a family has a great initial experience, their clinical encounter will be off to a solid start. Even if something minor (such as an unexpected delay in care or lab results) goes awry after the first impression has been made, a positive initial experience lays the foundation for a positive clinical encounter.

However, if the initial experience was not positive, the family may be in a sour mood as you begin to provide clinical care. Unfortunately, while you as the provider may have had nothing to do with the initial experience, it may impede your ability to get an accurate and complete history.

How does a family judge the quality of care their child is receiving? Unless a family member has a medical background, the family really has no way to know. They don't know if we've chosen the correct antibiotic for that otitis, or made the correct decision to use dermal glue instead of suturing.



**Emory Petrack** is president of Petrack Consulting, Inc. ([www.petrackconsulting.com](http://www.petrackconsulting.com)), based in Shaker Heights, OH and medical director of the Pediatric Emergency Department at Fairview Hospital in Cleveland. He also sits on the Advisory Board of JUCM. Dr. Petrack may be contacted at [epetrack@petrackconsulting.com](mailto:epetrack@petrackconsulting.com).

Instead, parents generally gain an overall impression of the clinic as a whole, which starts to form the moment they arrive. And, for better or worse, this impression may be what they use as a *substitute* for their sense of the *quality* of care you provide.

What, then, are the components of a “first impression”?

### From the Parking Lot to the Waiting Room

First is the physical facility, which begins to create the family's experience the moment they arrive:

- Is parking a hassle at your center?
- Is the entranceway clean and inviting?
- Does the waiting room make it clear that children are welcome and valued as patients?

The first step toward assuring a positive response to the last question is ensuring that the room has been child-proofed. Safety covers on open electrical outlets, for example, not only enhance safety, but also demonstrate to parents that your center is child-friendly. An accessible, visible stash of books and toys for children of varying ages sends a similar message.

### Communication Counts

After taking in the initial impression of the physical facility, the family next focuses on the second critical component of their visit: the communication that takes place.

This may involve a greeter or, typically, a receptionist. It is essential that this person sends out truly welcoming vibes. Both the words, and the way the words are communicated, need to make it clear to the family that the center is *delighted* in their choice of provider.

Expressing genuine concern about the chief complaint, or sometimes just acknowledging parental anxiety, goes a long way in establishing positive communications. The parents feel that their concerns are being heard, and the nurse and provider who subsequently see the child and family will have a much easier time.

## Ask for Help

As we all know, sometimes the most obvious things—the things right before our eyes—are the hardest to detect; becoming aware of issues related to first impressions is no exception.

How can you tell if your clinic has issues in this area?

- At the beginning of their encounter with you, the clinician, ask a few parents how their experience has been so far. This will arm you with anecdotal information that may highlight concerns or trends.
- Develop a brief questionnaire for the receptionist to give to parents to complete while they are waiting. The results will provide data that focuses on initial impressions—before they have been “contaminated” by the rest of the visit.
- Hire a consultant, or simply ask several friends with children to come to the clinic as patients. The critical component is getting a relatively distanced, objective perspective on what the initial encounter looks like.

There is tremendous opportunity for your urgent care center to provide great care to children and families and, in so doing, to increase market share in the communities you serve.

When families experience exceptionally positive encounters, they will tell others, and pediatric volume will increase.

An essential component of creating those positive encounters revolves around how well you establish a fantastic first impression.

In her Executive Director comments for the December, 2008 issue of *JUCM*, Lou Ellen Horwitz noted that “everything speaks.” When it comes to pediatric care in your urgent care center, everything really *does* speak, and that speech is always heard through the ears of children and their parents.

Focus on improving your center’s “opening lines,” and you will soon be on your way to improving both child-centered care and pediatric volume. ■

## How are we doing?

If you have a question or opinion to share on anything you read in this issue of *JUCM*, let us know with an e-mail to [editor@jucm.com](mailto:editor@jucm.com). We'll share it with your colleagues in an upcoming issue.

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# On Ruling Out PE, Guidance on School Dismissals, Obtaining Urine from Young Children, and Travel and VTE

■ 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.

### Another Validation of Clinical Assessment and D-Dimer to Rule Out PE

**Key point:** Among patients with low or intermediate risk, the sensitivity and negative predictive value of D-dimer testing were 100%.

**Citation:** Gupta RT, Kakarla RK, Kirshenbaum KJ, et al. D-dimers and efficacy of clinical risk estimation algorithms: Sensitivity in evaluation of acute pulmonary embolism. *AJR Am J Roentgenol*. 2009;193:425-430.

Despite research showing that clinically important pulmonary embolism (PE) can be excluded when patients with low clinical probabilities have negative D-dimer test results, many clinicians continue to order pulmonary computed tomography angiograms (CTAs) in virtually every patient with suspected PE.

Researchers conducted this study at a community teaching hospital in Chicago to determine the accuracy of clinical risk assessment plus D-dimer testing in 627 emergency department patients in whom clinicians considered PE as a diagnostic possibility.

According to Geneva scores, the proportions of patients with low, intermediate, and high probability of PE were 45%, 53%, and 3%, respectively. Outcomes were as follows:

- Among 69 low-probability patients with negative D-dimer test results ( $<1.2$  mg/L), CTA showed no PE cases.



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

- Among 103 intermediate-probability patients with negative D-dimer test results, CTA showed no PE cases.
- Among 212 low-probability patients with positive D-dimer test results, CTA showed six cases of PE.
- Among 227 intermediate-probability patients with positive D-dimer test results, CTA showed 17 cases of PE.

Among patients with low or intermediate risk for PE, the sensitivity and negative predictive value of D-dimer testing were 100% (i.e., no false-negatives were reported).

For patients with high clinical probability, the current consensus is to skip D-dimer testing and go directly to imaging.

[Published in *J Watch Gen Med*, August 13, 2009—Allan S. Brett, MD.] ■

### CDC Issues Guidance for School Districts for Upcoming Academic Year

**Key point:** Social disruption should be considered in decisions to dismiss students due to H1N1 flu.

**Citation:** Updated guidance for schools for the fall flu season. Centers for Disease Control and Prevention. 2009. Available at: [www.pandemicflu.gov/plan/school/schoolguidance.html](http://www.pandemicflu.gov/plan/school/schoolguidance.html).

When contemplating school dismissals for flu, officials should balance the goal of reducing exposure to H1N1 virus against the social disruption associated with sending students home, the CDC recommends in new guidance issued for the upcoming academic year (grades K–12).

If H1N1 severity is the same as during the spring outbreak, the CDC advises that:

- ill students and staff should remain at home for 24 hours



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- RELENZA is not recommended for treatment or prophylaxis of influenza in individuals with underlying airways disease (such as asthma or chronic obstructive pulmonary disease)
- Serious cases of bronchospasm, including fatalities, have been reported during treatment with RELENZA in patients with and without underlying airways disease. Many of these cases were reported during postmarketing and causality was difficult to assess
- If use of RELENZA is considered for a patient with underlying airways disease, the potential risks and benefits should be carefully weighed. Use in these patients should be done only under conditions of careful monitoring of respiratory function, close observation, and appropriate supportive care including availability of fast-acting bronchodilators
- Discontinue RELENZA and initiate appropriate treatment if an allergic reaction occurs or is suspected
- Patients with influenza, particularly pediatric patients, may be at an increased risk of seizures, confusion, or abnormal behavior early in their illness. Monitor for signs of abnormal behavior
- Safety and efficacy have not been demonstrated in patients with high-risk underlying medical conditions
- RELENZA has not been proven effective for prophylaxis of influenza in the nursing home setting
- RELENZA is not a substitute for early influenza vaccination on an annual basis as recommended by the Centers for Disease Control's Immunization Practices Advisory Committee
- Influenza viruses change over time. Emergence of resistance mutations could decrease drug effectiveness. Other factors (for example, changes in viral virulence) might also diminish clinical benefit of antiviral drugs. Prescribers should consider available information on influenza drug susceptibility patterns and treatment effects when deciding whether to use RELENZA

For more information on RELENZA visit [www.relenza.com](http://www.relenza.com)

Please see Brief Summary of Prescribing Information on next page.

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# RELENZA®

## (ZANAMIVIR) INHALATION POWDER

### BRIEF SUMMARY

#### RELENZA® (zanamivir) Inhalation Powder

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**1.2 Prophylaxis of Influenza:** RELENZA is indicated for prophylaxis of influenza in adults and pediatric patients 5 years of age and older.

#### 1.3 Important Limitations on Use of RELENZA

- RELENZA is not recommended for treatment or prophylaxis of influenza in individuals with underlying airways disease (such as asthma or chronic obstructive pulmonary disease) due to risk of serious bronchospasm [see *Warnings and Precautions* (5.1)].
- RELENZA has not been proven effective for treatment of influenza in individuals with underlying airways disease.
- RELENZA has not been proven effective for prophylaxis of influenza in the nursing home setting.
- RELENZA is not a substitute for early influenza vaccination on an annual basis as recommended by the Centers for Disease Control's Immunization Practices Advisory Committee.
- Influenza viruses change over time. Emergence of resistance mutations could decrease drug effectiveness. Other factors (for example, changes in viral virulence) might also diminish clinical benefit of antiviral drugs. Prescribers should consider available information on influenza drug susceptibility patterns and treatment effects when deciding whether to use RELENZA.
- There is no evidence for efficacy of zanamivir in any illness caused by agents other than influenza virus A and B.
- Patients should be advised that the use of RELENZA for treatment of influenza has not been shown to reduce the risk of transmission of influenza to others.

#### 4 CONTRAINDICATIONS

Do not use in patients with history of allergic reaction to any ingredient of RELENZA including lactose (which contains milk proteins) [see *Warnings and Precautions* (5.2) and *Description* (11) of full prescribing information].

#### 5 WARNINGS AND PRECAUTIONS

**5.1 Bronchospasm:** RELENZA is not recommended for treatment or prophylaxis of influenza in individuals with underlying airways disease (such as asthma or chronic obstructive pulmonary disease).

Serious cases of bronchospasm, including fatalities, have been reported during treatment with RELENZA in patients with and without underlying airways disease. Many of these cases were reported during postmarketing and causality was difficult to assess.

RELENZA should be discontinued in any patient who develops bronchospasm or decline in respiratory function; immediate treatment and hospitalization may be required.

Some patients without prior pulmonary disease may also have respiratory abnormalities from acute respiratory infection that could resemble adverse drug reactions or increase patient vulnerability to adverse drug reactions.

Bronchospasm was documented following administration of zanamivir in 1 of 13 patients with mild or moderate asthma (but without acute influenza-like illness) in a Phase I study. In a Phase III study in patients with acute influenza-like illness superimposed on underlying asthma or chronic obstructive pulmonary disease, 10% (24 of 244) of patients on zanamivir and 9% (22 of 237) on placebo experienced a greater than 20% decline in FEV<sub>1</sub> following treatment for 5 days.

If use of RELENZA is considered for a patient with underlying airways disease, the potential risks and benefits should be carefully weighed. If a decision is made to prescribe RELENZA for such a patient, this should be done only under conditions of careful monitoring of respiratory function, close observation, and appropriate supportive care including availability of fast-acting bronchodilators.

**5.2 Allergic Reactions:** Allergic-like reactions, including oropharyngeal edema, serious skin rashes, and anaphylaxis have been reported in postmarketing experience with RELENZA. RELENZA should be stopped and appropriate treatment instituted if an allergic reaction occurs or is suspected.

**5.3 Neuropsychiatric Events:** Influenza can be associated with a variety of neurologic and behavioral symptoms which can include events such as seizures, hallucinations, delirium, and abnormal behavior, in some cases resulting in fatal outcomes. These events may occur in the setting of encephalitis or encephalopathy but can occur without obvious severe disease.

There have been postmarketing reports (mostly from Japan) of delirium and abnormal behavior leading to injury in patients with influenza who were receiving neuraminidase inhibitors, including RELENZA. Because these events were reported voluntarily during clinical practice, estimates of frequency cannot be made, but they appear to be uncommon based on usage data for RELENZA. These events were reported primarily among pediatric patients and often had an abrupt onset and rapid resolution. The contribution of RELENZA to these events has not been established. Patients with influenza should be closely monitored for signs of abnormal behavior. If neuropsychiatric symptoms occur, the risks and benefits of continuing treatment should be evaluated for each patient.

**5.4 Limitations of Populations Studied:** Safety and efficacy have not been demonstrated in patients with high-risk underlying medical conditions. No information is available regarding treatment of influenza in patients with any medical condition sufficiently severe or unstable to be considered at imminent risk of requiring inpatient management.

**5.5 Bacterial Infections:** Serious bacterial infections may begin with influenza-like symptoms or may coexist with or occur as complications during the course of influenza. RELENZA has not been shown to prevent such complications.

**5.6 Importance of Proper Use of DISKHALER:** Effective and safe use of RELENZA requires proper use of the DISKHALER to inhale the drug. Prescribers should carefully evaluate the ability of young children to use the delivery system if use of RELENZA is considered [see *Use in Specific Populations* (8.4)].

#### 6 ADVERSE REACTIONS

**6.1 Clinical Trials Experience:** The placebo used in clinical studies consisted of inhaled lactose powder, which is also the vehicle for the active drug; therefore, some adverse events occurring at similar frequencies in different treatment groups could be related to lactose vehicle inhalation.

*Treatment of Influenza: Clinical Trials in Adults and Adolescents:* Adverse events that occurred with an incidence  $\geq 1.5\%$  in treatment studies (patients  $\geq 12$  years of age) are listed in Table 1.

**Table 1. Summary of Adverse Events  $\geq 1.5\%$  Incidence During Treatment in Adults and Adolescents**

Adverse Event	RELENZA		Placebo (Lactose Vehicle) (n = 1,520)
	10 mg b.i.d. Inhaled (n = 1,132)	All Dosing Regimens (n = 2,289)	
<b>Body as a whole</b>			
Headaches	2%	2%	3%
<b>Digestive</b>			
Diarrhea	3%	3%	4%
Nausea	3%	3%	3%
Vomiting	1%	1%	2%
<b>Respiratory</b>			
Nasal signs and symptoms	2%	3%	3%
Bronchitis	2%	2%	3%
Cough	2%	2%	3%
Sinusitis	3%	2%	2%
Ear, nose, and throat infections	2%	1%	2%
<b>Nervous system</b>			
Dizziness	2%	1%	<1%

\*Includes studies where RELENZA was administered intranasally (6.4 mg 2 to 4 times per day in addition to inhaled preparation) and/or inhaled more frequently (q.i.d.) than the currently recommended dose.

Additional adverse reactions occurring in less than 1.5% of patients receiving RELENZA included malaise, fatigue, fever, abdominal pain, myalgia, arthralgia, and urticaria.

The most frequent laboratory abnormalities in Phase III treatment studies included elevations of liver enzymes and CPK, lymphopenia, and neutropenia. These were reported in similar proportions of zanamivir and lactose vehicle placebo recipients with acute influenza-like illness.

*Clinical Trials in Pediatric Patients:* Adverse events that occurred with an incidence  $\geq 1.5\%$  in patients 5 to 12 years old receiving treatment doses of RELENZA in 2 Phase III studies are listed in Table 2.

**Table 2. Summary of Adverse Events  $\geq 1.5\%$  Incidence During Treatment in Pediatric Patients\***

Adverse Event	RELENZA		Placebo (Lactose Vehicle) (n = 318)
	10 mg b.i.d. Inhaled (n = 291)		
<b>Respiratory</b>			
Ear, nose, and throat infections	5%		5%
Ear, nose, and throat hemorrhage	<1%		2%
Asthma	<1%		2%
Cough	<1%		2%
<b>Digestive</b>			
Vomiting	2%		3%
Diarrhea	2%		2%
Nausea	<1%		2%

\*Includes a subset of patients receiving RELENZA for treatment of influenza in a prophylaxis study.

In 1 of the 2 studies described in Table 2, some additional information is available from children (5 to 12 years old) without acute influenza-like illness who received an investigational prophylaxis regimen of RELENZA: 132 children received RELENZA and 145 children received placebo. Among these children, nasal signs and symptoms (zanamivir 20%, placebo 9%), cough (zanamivir 16%, placebo 8%), and throat/tonsil discomfort and pain (zanamivir 11%, placebo 6%) were reported more frequently with RELENZA than placebo. In a subset with chronic pulmonary disease, lower respiratory adverse events (described as asthma, cough, or viral respiratory infections which could include influenza-like symptoms) were reported in 7 of 7 zanamivir recipients and 5 of 12 placebo recipients.

*Prophylaxis of Influenza: Family/Household Prophylaxis Studies:*

Adverse events that occurred with an incidence of  $\geq 1.5\%$  in the 2 prophylaxis studies (patients  $\geq 5$  years of age) are listed in Table 3.

**Table 3. Summary of Adverse Events  $\geq 1.5\%$  Incidence During 10-Day Prophylaxis Studies in Adults, Adolescents, and Children\***

Adverse Event	Contact Cases	
	RELENZA 10 mg inhaled once daily (n = 1,068)	Placebo (n = 1,059)
<b>Lower respiratory</b>		
Viral respiratory infections	13%	19%
Cough	7%	9%
<b>Neurologic</b>		
Headaches	13%	14%
<b>Ear, nose, and throat</b>		
Nasal signs and symptoms	12%	12%
Throat and tonsil discomfort and pain	8%	9%
Nasal inflammation	1%	2%
<b>Musculoskeletal</b>		
Muscle pain	3%	3%
<b>Endocrine and metabolic</b>		
Feeding problems (decreased or increased appetite and anorexia)	2%	2%
<b>Gastrointestinal</b>		
Nausea and vomiting	1%	2%
<b>Non-site specific</b>		
Malaise and fatigue	5%	5%
Temperature regulation disturbances (fever and/or chills)	5%	4%

\* In prophylaxis studies, symptoms associated with influenza-like illness were captured as adverse events; subjects were enrolled during a winter respiratory season during which time any symptoms that occurred were captured as adverse events.

*Community Prophylaxis Studies:* Adverse events that occurred with an incidence of  $\geq 1.5\%$  in 2 prophylaxis studies (patients  $\geq 5$  years of age) are listed in Table 4.

**Table 4. Summary of Adverse Events  $\geq 1.5\%$  Incidence During 28-Day Prophylaxis Studies in Adults, Adolescents, and Children\***

Adverse Event	RELENZA 10 mg inhaled once daily (n = 2,231)		Placebo (n = 2,239)
<b>Neurologic</b>			
Headaches	24%		26%
<b>Ear, nose, and throat</b>			
Throat and tonsil discomfort and pain	19%		20%
Nasal signs and symptoms	12%		13%
Ear, nose, and throat infections	2%		2%
<b>Lower respiratory</b>			
Cough	17%		18%
Viral respiratory infections	3%		4%
<b>Musculoskeletal</b>			
Muscle pain	8%		8%
Musculoskeletal pain	6%		6%
Arthralgia and articular rheumatism	2%		<1%
<b>Endocrine and metabolic</b>			
Feeding problems (decreased or increased appetite and anorexia)	4%		4%
<b>Gastrointestinal</b>			
Nausea and vomiting	2%		3%
Diarrhea	2%		2%
<b>Non-site specific</b>			
Temperature regulation disturbances (fever and/or chills)	9%		10%
Malaise and fatigue	8%		8%

\* In prophylaxis studies, symptoms associated with influenza-like illness were captured as adverse events; subjects were enrolled during a winter respiratory season during which time any symptoms that occurred were captured as adverse events.

#### 6.2 Postmarketing Experience:

**Allergic Reactions:** Allergic or allergic-like reaction, including oropharyngeal edema [see *Warnings and Precautions* (5.2)]. **Psychiatric:** Delirium, including symptoms such as altered level of consciousness, confusion, abnormal behavior, delusions, hallucinations, agitation, anxiety, nightmares [see *Warnings and Precautions* (5.3)]. **Cardiac:** Arrhythmias, syncope. **Neurologic:** Seizures. **Respiratory:** Bronchospasm, dyspnea [see *Warnings and Precautions* (5.1)]. **Skin:** Facial edema; rash, including serious cutaneous reactions; urticaria [see *Warnings and Precautions* (5.2)].

#### 7 DRUG INTERACTIONS

The concurrent use of RELENZA with live attenuated influenza vaccine (LAIV) intranasal has not been evaluated. However, because of potential interference between these products, LAIV should not be administered within 2 weeks before or 48 hours after administration of RELENZA, unless medically indicated. The concern about possible interference arises from the potential for antiviral drugs to inhibit replication of live vaccine virus.

Trivalent inactivated influenza vaccine can be administered at any time relative to use of RELENZA [see *Clinical Pharmacology* (12.4) of full prescribing information].

#### 8 USE IN SPECIFIC POPULATIONS

**8.1 Pregnancy: Pregnancy Category C.** There are no adequate and well-controlled studies of zanamivir in pregnant women. Zanamivir should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Zanamivir has been shown to cross the placenta in rats and rabbits. In these animals, fetal blood concentrations of zanamivir were significantly lower than zanamivir concentrations in the maternal blood.



**8.3 Nursing Mothers:** Studies in rats have demonstrated that zanamivir is excreted in milk. However, nursing mothers should be instructed that it is not known whether zanamivir is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when RELENZA is administered to a nursing mother.

**8.4 Pediatric Use:** Treatment of influenza: Safety and effectiveness of RELENZA for treatment of influenza have not been assessed in pediatric patients less than 7 years of age, but were studied in a Phase III treatment study in pediatric patients, where 471 children 5 to 12 years of age received zanamivir or placebo [see Clinical Studies (14.1) of full prescribing information]. Adolescents were included in the 3 principal Phase III adult treatment studies. In these studies, 67 patients were 12 to 16 years of age. No definite differences in safety and efficacy were observed between these adolescent patients and young adults.

In a Phase I study of 16 children ages 6 to 12 years with signs and symptoms of respiratory disease, 4 did not produce a measurable peak inspiratory flow rate (PIFR) through the DISKHALER (3 with no adequate inhalation on request, 1 with missing data), 9 had measurable PIFR on each of 2 inhalations, and 3 achieved measurable PIFR on only 1 of 2 inhalations. Neither of two 6-year-olds and one of two 7-year-olds produced measurable PIFR. Overall, 8 of the 16 children (including all those under 8 years old) either did not produce measurable inspiratory flow through the DISKHALER or produced peak inspiratory flow rates below the 60 L/min considered optimal for the device under standardized in vitro testing; lack of measurable flow rate was related to low or undetectable serum concentrations [see Clinical Pharmacology (12.3), Clinical Studies (14.1) of full prescribing information]. Prescribers should carefully evaluate the ability of young children to use the delivery system if prescription of RELENZA is considered.

**Prophylaxis of Influenza:** The safety and effectiveness of RELENZA for prophylaxis of influenza have been studied in 4 Phase III studies where 273 children 5 to 11 years of age and 239 adolescents 12 to 16 years of age received RELENZA. No differences in safety and effectiveness were observed between pediatric and adult subjects [see Clinical Studies (14.2) of full prescribing information].

**8.5 Geriatric Use:** Of the total number of patients in 6 clinical studies of RELENZA for treatment of influenza, 59 patients were 65 years of age and older, while 24 patients were 75 years of age and older. Of the total number of patients in 4 clinical studies of RELENZA for prophylaxis of influenza in households and community settings, 954 patients were 65 years of age and older, while 347 patients were 75 years of age and older. No overall differences in safety or effectiveness were observed between these patients and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. Elderly patients may need assistance with use of the device.

In 2 additional studies of RELENZA for prophylaxis of influenza in the nursing home setting, efficacy was not demonstrated [see Indications and Usage (1.3) of full prescribing information].

#### 10 OVERDOSAGE

There have been no reports of overdosage from administration of RELENZA.

#### 17 PATIENT COUNSELING INFORMATION

See FDA-Approved Patient Labeling (17.6).

**17.1 Bronchospasm:** Patients should be advised of the risk of bronchospasm, especially in the setting of underlying airways disease, and should stop RELENZA and contact their physician if they experience increased respiratory symptoms during treatment such as worsening wheezing, shortness of breath, or other signs or symptoms of bronchospasm [see Warnings and Precautions (5.1)]. If a decision is made to prescribe RELENZA for a patient with asthma or chronic obstructive pulmonary disease, the patient should be made aware of the risks and should have a fast-acting bronchodilator available.

**17.2 Concomitant Bronchodilator Use:** Patients scheduled to take inhaled bronchodilators at the same time as RELENZA should be advised to use their bronchodilators before taking RELENZA.

**17.3 Neuropsychiatric Events:** Patients with influenza (the flu), particularly children and adolescents, may be at an increased risk of seizures, confusion, or abnormal behavior early in their illness. These events may occur after beginning RELENZA or may occur when flu is not treated. These events are uncommon but may result in accidental injury to the patient. Therefore, patients should be observed for signs of unusual behavior and a healthcare professional should be contacted immediately if the patient shows any signs of unusual behavior [see Warnings and Precautions (5.3)].

**17.4 Instructions for Use:** Patients should be instructed in use of the delivery system. Instructions should include a demonstration whenever possible. For the proper use of RELENZA, the patient should read and follow carefully the accompanying Patient Instructions for Use.

If RELENZA is prescribed for children, it should be used only under adult supervision and instruction, and the supervising adult should first be instructed by a healthcare professional [see Dosage and Administration (2.1)].

**17.5 Risk of Influenza Transmission to Others:** Patients should be advised that the use of RELENZA for treatment of influenza has not been shown to reduce the risk of transmission of influenza to others.

**17.6 FDA-Approved Patient Labeling and Instructions for Use:** See separate leaflet.

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## ABSTRACTS IN URGENT CARE

after they are free of fever (without use of fever-lowering drugs);

- those who are sick at school should be separated from others until they can be sent home.

If the virus shows *increased* severity compared with the spring outbreak:

- students and staff should be screened on arrival at school and sent home if ill;
- people at high risk for complications or with ill household members should stay home;
- sick people should stay home for at least 7 days, even if they become asymptomatic. ■

### Obtaining Urine Specimens in Young Children: Bag vs. Catheter

**Key point:** Don't rely on bag-obtained specimens alone.

**Citation:** Etoubleau C, Reveret M, Brouet D, et al. Moving from bag to catheter for urine collection in non-toilet-trained children suspected of having urinary tract infection: A paired comparison of urine cultures. *J Pediatr.* 2009;154:803-806.

Urine collection methods in young children who are not toilet trained are difficult and unreliable. In this prospective cohort study, researchers from two emergency departments in France collected urine specimens by bag and then by catheter in 192 children (age <3 years; 72% girls) who had unexplained fever and positive urinalysis results from bag-obtained specimens.

Catheter-obtained specimens were positive (defined as  $\geq 10^3$  CFU/mL, one species only) in 53% of children, negative in 38%, and contaminated in 8%.

Corresponding results for bag-obtained specimens were 48% positive, 21% negative, and 30% contaminated. Compared with results from catheter-obtained specimens, bag-obtained specimen cultures had a false-positive rate of 7.5% and a false-negative rate of 29%.

[Published in *J Watch General Med*, July 7, 2009—Howard Bauchner, MD.] ■

### Travel and Venous Thromboembolism

**Key point:** Results of a meta-analysis showed a significant elevation in risk that increased with the duration of the journey.

**Citation:** Chandra D, Parisini E, Mozaffarian. Travel and risk for venous thromboembolism. *Ann Intern Med.* 2009;151(3): 180-190.

Concern about travel-related venous thromboembolism (VTE) has recently attracted public attention. To examine the risk for VTE in travelers, these investigators conducted a literature analysis of 14 studies (two cohort, 11 case-control, and one case-crossover) with a total of 4,055 cases of VTE. The mode of travel in the studies varied (five air-only, nine air or surface), and the outcomes evaluated were deep venous thrombosis alone in seven, pulmonary embolism (PE) or DVT in five, and PE alone in two.

Compared with non-travelers, the pooled relative risk for VTE in travelers across all studies was 2.0 ( $P<0.001$ ). However, significant heterogeneity resulted from differences in study design—specifically, in the selection criteria for controls.

The pooled risk estimate was somewhat higher for air travel than for surface travel. When duration of travel was assessed, the risk for VTE rose at a statistically significant 18% per two-hour increase in travel duration.

[Published in *J Watch Cardiol*, August 12, 2009—Joel M. Gore, MD.] ■





## A 57-Year-Old Woman with Acute Pain After a Fall

The patient is a 57-year-old woman who presented to urgent care complaining of severe pain in her right foot, leg, hip, and elbow. She reported that she fell three to four hours prior to presentation while outside walking her dog; she was “tripped up” in the pet’s leash.

She presented ambulatory, but was unable to bear any weight on her right leg.

### Past medical history

Hyperlipidemia  
Hypothyroidism  
Diabetes type 1

### Vital signs

Temp: 98.3°F  
RR: 18  
Sat: 100%  
HR: 88  
BP: 113/70

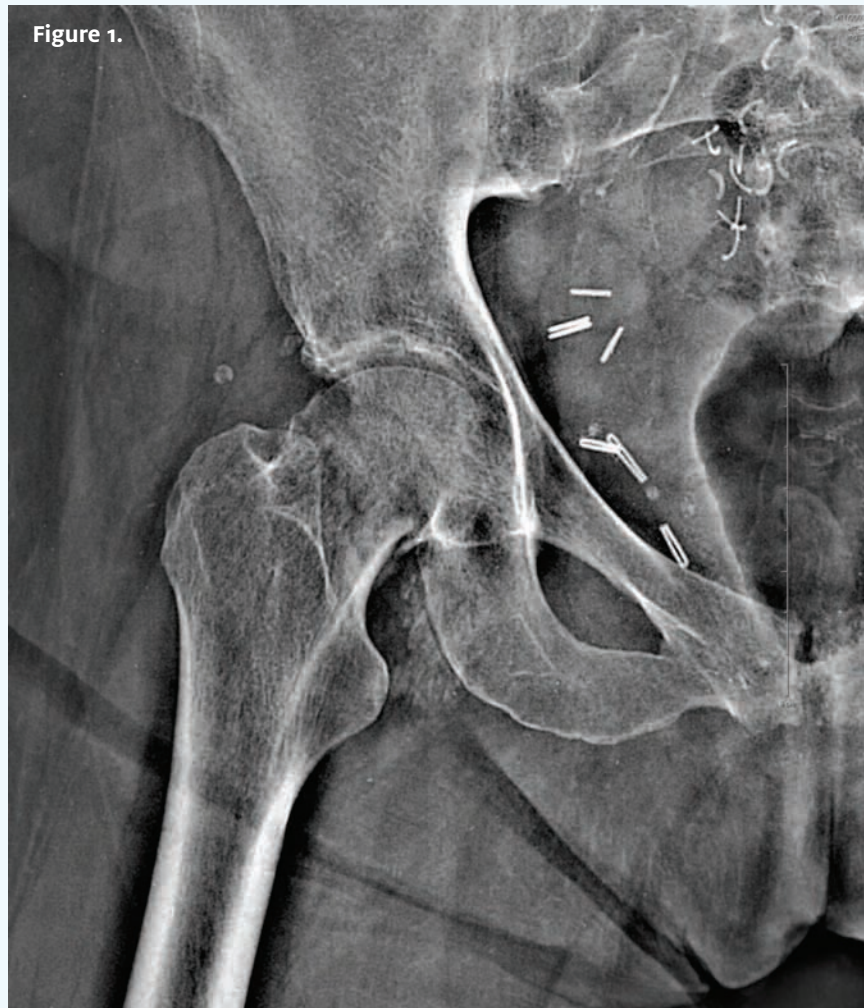
Per in-house triage system and protocols, the patient was triaged immediately due to her complaint of severe pain. She was brought in by wheelchair and placed on a gurney, where she requested to lay down.

The patient was noted to have lateral rotation of her right foot, along with an obvious (1½” to 2”) shortening of the right leg.

A stat hip x-ray (**Figure 1**) revealed an impacted right hip fracture.

The patient was immobilized on the x-ray table with a pillow providing support under her right knee. An IV was established with normal saline at a keep vein open rate; 5 mg of morphine was given a slow IV push.

After a call to 911, the patient was transported to a neigh-



boring hospital by ambulance. There, she was evaluated by orthopedics and taken directly to surgery.

### Risk Factors for Osteoporosis

Several risk factors increase the likelihood of osteoporosis. Such factors include age, race, gender, body frame, dietary deficiencies, physical inactivity, and family history. Increasing age is the greatest risk factor in the development of

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## RESOLUTION

osteoporosis, with the highest incidence in females over the age of 50.

In addition, women of Caucasian and Asian ethnicity tend to have higher rates of osteoporosis compared with women in other ethnic groups. Petite and thin women also possess an increased risk for osteoporosis, due to lower bone mineral density measurements.

Other factors include family history of osteoporosis, physical inactivity, calcium deficiencies, use of certain medications (such as glucocorticoids), postmenopausal status, history of tobacco use, excessive alcohol consumption, and chronic renal failure.

#### *The diabetes connection*

Type 1 diabetes—which was discovered in eliciting this patient's history—has long been associated with low bone density. The Nord-Trondelag Health Survey from Norway showed an increase in fracture rates among female type 1 patients compared to non-diabetic patients.

In the Iowa Women's Health Study, women with type 1 diabetes were 12 times more likely to report a fracture as compared with non-diabetic women. Due to the fact that type 1 diabetes has a young age of onset when bone mass is being accrued, low bone mass would seem to be a likely complication for type 1 diabetic patients.

Unlike patients with type 1 diabetics, type 2 patients often present overweight and sedentary. For these patients, coordination and balance factors that protect people from falls are impaired or not present. Hence, we might intuit that patients with a larger body size and relatively high bone mass may have a higher fracture rate.

Bone quality changes may also be affected by microvascular events common to diabetes. The Study of Osteoporotic Fractures confirmed that women with type 2 diabetes experience higher fracture rates in regions of the hip, humerus, and foot than do non-diabetic women.

Regardless of the type of diabetes, though, diabetic patients are at increased risk for diabetic retinopathy, advanced cortical cataracts, and diabetic peripheral neuropathy—all of which have been associated with increased fractures. Visual impairment and alterations in balance and gait may also be risk factors for increased falls.

#### **Vigilance for Hip Fracture**

Signs and symptoms of hip fracture may include:

- severe pain in the hip and/or groin
- inability to put weight on the leg on the side of the injured hip
- stiffness, bruising, and swelling in and around the hip area
- shorter leg on the side of the injured hip
- lateral rotation of the foot and/or leg on the side of the injured hip.

Pre-hospital care administered in the urgent care center should include:

- addressing the ABCs and immobilizing the cervical spine as appropriate
- immobilization of the hip while on a bed, stretcher, or backboard
- if fracture or deformity of the femur is obvious, applying a traction splint and placing an intravenous (IV) line for hydration.
- if the patient is hypotensive or tachycardic, initiating crystalloid fluid bolus and placing patient on supplemental oxygen
- assisting with pain control
- transport to the emergency department by ambulance.

If hip fracture is suspected and urgent care imaging is inconclusive, treatment regimens should remain the same as above.■

*Acknowledgment: Case presented by Matthew McGauran, PA-C, and Bryan Holmes, NREMT-P, Advanced Urgent Care, Las Vegas, NV.*



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# Practice Management

## Utilizing Social Media to Drive Visits to Your Website and Urgent Care Center

**Urgent message:** As more Americans turn to the Internet for health-care direction, “social media” provide a mechanism for urgent care operators to shape patient perceptions and drive center visits.

Alan A. Ayers, MBA, MAcc

### Introduction

In *Creating a Web Presence to Raise Awareness of Urgent Care (JUCM, July/August 2009)*, we described how a well-designed website, optimized for retrieval by major search engines, enables highly targeted and localized promotion of an urgent care center.

But establishing a web presence is just the beginning; driving “clicks” to the website and “feet” to the center is enhanced by creating “buzz” in online communities.

Historically, word-of-mouth—spread in-person or by telephone—has been the number-one reason patients choose a medical provider, accounting for more than 50% of referrals.<sup>1</sup> Today, word-of-mouth manifests as content, experiences, and opinions shared with potentially millions of other patients on Internet blogs, forums, social networks, and video- and photo-sharing websites.

Tapping into such “social media” can help urgent



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care operators better understand patient needs and attitudes, providing an opportunity to demonstrate the value of urgent care and ultimately drive visits to their centers. (**Table 1** provides a summary of social media tactics.)

### Social Media and Consumer Influence

Americans are spending an ever-increasing amount of time on the Internet. More than 227 million Americans access the Internet at home and 118 million are “active” users, spending an average of 10

hours per week online. That’s in addition to the 63 million people spending an average of 19 hours per week online at work.<sup>2</sup>

Time spent online is quickly transitioning from routine transactions like paying bills and booking trips to interacting with others.

When it comes to healthcare, consumers use the Internet to solicit feedback on medical providers, discuss



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<sup>†</sup>*In vitro* data are not always indicative of clinical success or microbiological eradication in a clinical setting.

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

**IMPORTANT SAFETY INFORMATION**

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

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Please see brief summary of prescribing information on adjacent page.



## Vigamox<sup>®</sup>

(moxifloxacin hydrochloride ophthalmic solution) 0.5% as base

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

### CLINICAL PHARMACOLOGY:

#### Microbiology:

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

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

#### Aerobic Gram-positive microorganisms:

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

#### Aerobic Gram-negative microorganisms:

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

#### Anaerobic microorganisms:

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

#### Other microorganisms:

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

#### Clinical Studies:

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

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

#### Aerobic Gram-positive microorganisms:

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

#### Aerobic Gram-negative microorganisms:

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

#### Other microorganisms:

*Chlamydia trachomatis*

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

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

#### WARNINGS:

##### NOT FOR INJECTION.

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

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

#### PRECAUTIONS:

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

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

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

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

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

#### Carcinogenesis, Mutagenesis, Impairment of Fertility:

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

Moxifloxacin was not mutagenic in four bacterial strains used in the Ames *Salmonella* reversion assay. As with other quinolones, the positive response observed with moxifloxacin in strain TA 102 using the same assay may be due to the inhibition of DNA gyrase. Moxifloxacin was not mutagenic in the CHO/HGPRT mammalian cell gene mutation assay. An equivocal result was obtained in the same assay when v79 cells were used. Moxifloxacin was clastogenic in the v79 chromosome aberration assay, but it did not induce unscheduled DNA synthesis in cultured rat hepatocytes. There was no evidence of genotoxicity *in vivo* in a micronucleus test or a dominant lethal test in mice.

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

#### Pregnancy: Teratogenic Effects.

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

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

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

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

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

#### ADVERSE REACTIONS:

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

#### Rx Only

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## UTILIZING SOCIAL MEDIA

options for managing chronic illness, exchange tips on wellness and self-care, and express opinions on healthcare reform.<sup>3</sup>

And just as consumers are more inclined to trust word-of-mouth from like-minded peers than from traditional advertising verbiage, they are also likely to trust the real-life opinions and experiences posted by other Internet users.

## Social Media Tactics

### Blogging

A blog is a website that provides news and commentary on a specific topic—typically appealing to a narrowly defined group of subscribers who respond by posting their own opinions and experiences.

Whether an urgent care operator starts a blog or contributes to other blogs, postings should address topics that encourage utilization of urgent care, such as emergency room overcrowding, healthcare accessibility and affordability, or prevention of injury and illness. Posts should be compelling enough to capture attention, but should also avoid controversial viewpoints that could create negative perceptions.

When readers find blog entries useful, insightful, or relevant, they are likely to visit the blogger's website, return to read future blog postings, or forward the blog's content to others. All increase the number of Internet users that become aware of the blog and, by extension, urgent care.

Because popular blogs distribute user-generated content to Internet newsfeeds and search engines, blog entries should include keywords like the name and location of the urgent care center, services offered and conditions treated, and the center's website address. The blog should also be submitted to leading blog directories, which likewise categorize blogs by topics and keywords; examples include Technorati, Blogarama, and BlogExplosion.

Related to blogging is posting comments on news websites—particularly those of local newspapers—and Internet discussion threads. Not only do other readers scan the comments, but postings are often read by editors in planning future stories. Being identified as an “expert” on healthcare topics can lead to additional press coverage for an urgent care provider. When possible, comments should include the name of the urgent care center and a link to its website (e.g., “It is standard

procedure at Hometown Urgent Care to send patients home with specific instructions on when to return to see us or head to the emergency room”).

### *Social networking*

“Social networking” describes websites where a user creates an online profile or “persona;” links that profile to other users who share the same relationships, lifestyles, or political views; and then engages those users by sharing messages, articles, and media files.<sup>4</sup>

Social networking accounted for 23% of total Internet utilization in March 2009—an 83% increase over 2008.<sup>2</sup> Much of this increase is attributed to the popularity of the website Facebook ([www.facebook.com](http://www.facebook.com)), which reported 200 million users in July, 2009—up 100% from the previous year.<sup>5</sup>

There are two ways to establish a presence on Facebook and other social networking sites:

1. Providers and practice managers—individuals generally considered the “faces” of an urgent care center—create their own personal “profiles.” A typical profile highlights one’s professional background, academic interests, civic involvement, family relationships, and leisure pursuits.
2. Create a business “page” for the urgent care center. The center’s page should describe its location, operating model, and services offered—complete with pictures and links to the center’s website, blog, and reviews.

Once a profile or page is created, a network is started by inviting friends, family, employees, and business partners known to the provider and center to become “friends” or “fans.”

In other words, users link to another user’s profile or an organization’s page to receive all communication posted by that user or organization.

Facebook and other social networking websites tap into a user’s e-mail address book to invite known contacts to visit the user’s personal profile or business page and link it to their own. When users become “fans” of an urgent care center, such is indicated on the urgent care’s page and the user’s profile—increasing awareness of each among the other’s network.

Thus, an urgent care center can raise its visibility on Facebook by becoming a “fan” of other organizations. For example, an urgent care operator



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**Table 1. Social Media Marketing Strategies**

Social media are used to raise awareness of an urgent care center among a networked group of Internet users while also providing a mechanism for understanding and shaping consumer perceptions of urgent care. The more information that is available about an urgent care center on the Internet, the more likely the center is to appear when consumers search for healthcare information using major search engines.

Social media	What is it?	Examples	Promotional tactics
<b>Blog</b>	A website maintained by an individual—a “blogger”—for the purpose of posting commentary or news on a particular subject or maintaining a diary of activities or events. Blog entries include text, pictures, video, and links to other websites.	Blogger Blogspot LiveJournal WordPress	<ul style="list-style-type: none"> <li>• Start a blog on healthcare-related topics to capture a regular following of established and potential urgent care patients.</li> <li>• Contribute to blogs maintained by others to raise awareness and share the benefits of urgent care.</li> </ul>
<b>Social networking</b>	Web applications used to facilitate communication among a group of users interconnected by shared relationships, affiliations, opinions, or lifestyles.	Facebook Twitter MySpace LinkedIn Bebo	<ul style="list-style-type: none"> <li>• Create a page or profile for the urgent care center and each provider or practice manager viewed as an opinion leader.</li> <li>• Build a network by searching for, and linking the center's page to, users who are interested in receiving updates from the urgent care center.</li> <li>• Encourage utilization of urgent care by sharing announcements and promotions with the network.</li> </ul>
<b>Review websites</b>	A website where patients post comments (often anonymously) about their experiences and perceptions of healthcare providers and facilities.	Yelp Epinions.com Google Local Angie's List RateMDs.com	<ul style="list-style-type: none"> <li>• Monitor review websites for feedback about the urgent care center to understand public perceptions and identify operational improvements.</li> <li>• Encourage patients to post their positive experiences online as a trusted resource for potential patients.</li> </ul>
<b>Video and photo sharing</b>	A website that hosts video or photographic content. Most allow users to search, evaluate, and comment on videos and photos posted.	Video YouTube MySpaceTV Google Video Photos Flickr PhotoBucket	<ul style="list-style-type: none"> <li>• Start by posting any existing commercials or other video content.</li> <li>• Post pictures or create a video tour of the urgent care center to set patient expectations of the experience.</li> <li>• Create compelling video content—such as provider interviews on current health topics—that would interest potential urgent care patients.</li> </ul>

who becomes a fan of the Urgent Care Association of America's (UCAOA) page on Facebook not only receives news and announcements posted by UCAOA, but the urgent care center also becomes visible to UCAOA's other fans, some of whom may choose to also become fans of the center.

Another popular social networking site that functions like a blog is Twitter. “Twitters” create 140-character posts (called “tweets”) about their activities and opinions, which are read in real time by interested followers—many of whom receive the posts on handheld devices, through e-mail or instant messaging applications, or on social networking websites.

For example, “followers” of UCAOA on Twitter receive news updates on urgent care and announcements regarding UCAOA conferences and activities.

The value of such interconnected networks is that

when the urgent care operator posts announcements and promotions to the center's page, such updates are instantly shared with all followers. Patient visits can then be driven by announcements like “Flu vaccine has arrived,” “The deadline for sports physicals is approaching,” or “We offer relief for seasonal allergies.”

Using social networking websites, it's also possible to search for posts on topics, businesses, or people of interest. Users re-post interesting messages for their own followers to read—frequently, unusual content or links to breaking news stories—which exponentially expands a user's audience.

Following the posts of other network members provides insights on patient experiences and perceptions related to urgent care, allowing the urgent care provider to further tailor his or her messages to the interests and perspectives of the network.



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### Patient Review Websites

Given the importance of word-of-mouth as a referral source, satisfied patients should be encouraged to share their experiences on their blogs and social networks and when using common review websites like Yelp, Google Local, and Angie's List. There is an authenticity to actual patient comments that prospective patients trust, and the availability of patient feedback can add credibility to an urgent care provider.

The risk, however, is that an ex-spouse, disgruntled employee, or competitor can pose as a patient and anonymously describe fictitious bad experiences to the broad marketplace, damaging the practice's reputation. Due to privacy regulations, there is little that an urgent care operator can do to verify the accuracy of information posted, and the policy of most review websites is that they will not monitor or take responsibility for what's posted. It can be very difficult, if not impossible, to have negative feedback removed from a credible review website.

Providers complain that emotionally fueled comments cannot objectively evaluate the quality of medical services, and online review sites are a skewed sample lacking statistical controls. In response, companies like Medical Justice offer Internet anti-defamation services that require patients to sign an agreement not to post comments online. Other services go so far as to investigate and sue individuals making libelous posts.<sup>6</sup>

However, the most readily available response to negative online feedback is to understand what's driving authentic bad experiences, make operational changes to prevent similar negative experiences from occurring in the future, and then encouraging a sufficient number of counter-balancing positive patient remarks for consumers to reach their own conclusions about the quality of the urgent care center.

### Online Video and Photo Sharing

In April 2009, 70% to 80% of Internet users watched video online via sites like YouTube ([www.youtube.com](http://www.youtube.com)), downloading about 16 billion videos in a one-month period.<sup>7</sup> Video may be integrated into blogging or social networking posts or uploaded to video-sharing websites that allow users to rank or score videos, share opinions, and create lists of "favorites." The descriptions associated with online videos are often picked up by search engines, driving future views.

For an urgent care operator, developing an online video strategy may start with placing any existing television or radio advertising online, creating a custom

video showcasing the facility's capabilities, or recording a medical provider speaking on a newsworthy topic.

Similar to video, urgent care operators can use photo sharing websites to post pictures of their centers to set expectations of the quality of the experience before patients arrive. Seeing pictures of a facility's interior can reduce anxiety and alleviate uncertainty as to what an urgent care visit entails. Some photo sharing websites integrate "geo-tags" and other data picked up by search engines, so pictures of the center will appear when consumers search for "urgent care" in a particular locale.

As with other forms of social media, video and photo content is most compelling when it's created by patients. Thus, some organizations offer incentives or create contests that encourage consumers to share their experiences through various social media.<sup>8</sup>

### Conclusion

Although the Internet is a global resource, it enables otherwise traditional word-of-mouth in focused and localized communities of interest. Using social media to tap into these communities raises visibility of urgent care as a patient-centered healthcare alternative, facilitates communication with established patients, and lets new patients know about the existence of a center and its capabilities.

As social media websites are often integrated with major Internet search engines, a social media strategy is essential to raising the rank and relevance of a local urgent care center when consumers look online for health information. Social media tactics also complement more conventional advertising methods to meet the ultimate goal of increasing awareness and driving greater numbers of to a local urgent care center. ■

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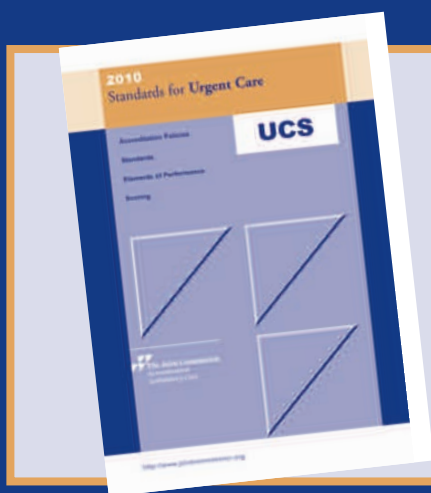
*To see just how influential social media can be among visitors to U.S. hospitals and urgent care centers, turn to Developing Data on page 48.*



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# Simplify Communication to Get Your Message Across

■ FRANK H. LEONE, MBA, MPH

I routinely receive more than 75 e-mails every day, have about 100 cable television stations to choose from, can look up virtually any topic on the Internet, receive scores of mail pieces each week, and have an untold number of voice messages daily.

It is not surprising that the average person is receptive to but a fraction of information before them. Thus, there is a dilemma: How do I get *my* message across in such an information-saturated world?

Effectively reaching your audience begins with an understanding of mass communication. Follow three principles when competing for the finite attention of an audience:

1. Keep your message simple.
2. Keep repeating the message.
3. Use multiple modalities to communicate the message.

### Simplicity

Communicate with short, simple, and focused messages. The more you clutter your message with tangential information, the more likely the core message will be minimized or overlooked.

Do not go “on and on” and overpower the other party with the sheer volume of your information. Concentrate on making one or two key points. When I review something I just wrote (e.g., e-mail, letters, reports), my first objective is to delete non-essential words, sentences, or concepts. You should do the same.

### Repetition

Express a key point for 10 seconds six different times rather than make the same point once for 60 seconds. Simplifying

and then repeating a point increases the odds of that point lodging in the prospect's mind.

### Multiplicity

People respond differently to different communication modalities. If you plan to communicate a message four times, communicate once by phone, voicemail, e-mail, and letter. By using all four modalities or others to convey the same message, you hedge your bet that a given modality might not be most effective to a given recipient.

### Time Efficiency

Focus on making your finite time more efficient while showing genuine respect for the prospect's time constraints:

1. Shorten every communication. Limit e-mails to two sentences, not five paragraphs. Leave a 10-second voicemail message, not one that lasts a minute. Write a one- or two-paragraph letter, not pages. In every instance, the central point of your communication becomes more clear. And, the aggregate time saving for both the prospect and yourself can be considerable.
2. Use generic documents and customize them as needed. Many communications are a variant on the same theme; for example, a thank you follow-up note following a sales call. Take time to craft one well-written note and avoid “re-inventing the wheel.” Likewise, recurrent voicemail messages that say roughly the same thing can be scripted and easily repeated.
3. Play the voicemail “card” when you have little chance of reaching the other party. There are times when you prefer *not* to reach the other party, as a dialogue consumes valuable time and may not be particularly important at that juncture. Such voicemail messages can be delivered with confidence (i.e., you know going in that you'll be leaving a voicemail), and many messages can be delivered in a short time.

*Continued on page 42*



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



# Duty to Report

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

A few years ago, in a semi-rural town in Arizona, a woman brought her 4-year-old son to a physician assistant named James, who staffed a walk-in clinic. James knew the boy and his family very well. He was essentially their PCP and had treated the little boy in the past. In fact, he watched him grow from a toddler to a rambunctious little bundle of energy.

On this particular visit, the little boy had a low-grade fever and non-productive cough. James, being a conscientious, thorough provider, had the little boy disrobe down to his Superman underwear. James laughed with and tickled the little boy but when he exposed his back to palpate his flank and listen to his lungs, he noticed what appeared to be belt marks in varying stages of healing.

James was appalled and made it very clear to the little boy's mother that this "spare the rod, spoil the child" mentality was unacceptable. The mother confessed that her husband occasionally got "carried away" while disciplining the little boy and that she would make sure it never happened again.

James admonished her further and stated that he would be happy to speak to her husband if she felt that it would help. He also threatened her that he would notify the authorities if he ever saw any more signs of physical abuse on the child.

The woman assured James that she would take care of this and that it would never happen again. James dutifully recorded his physical exam findings and his discussion with the woman in the boy's medical record.

Five days later, the little boy was rushed to the emergency department after he collapsed during kindergarten recess. Ultimately, the little boy died of an acute epidural hematoma secondary to his skull fracture, which occurred after his father threw him into a wall when the little boy spilled his dinner plate.



**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](mailto:JJS@shufeldtlaw.com).

*"Failure to report abuse can lead to both criminal and civil liability."*

James was interviewed by the police, who did not believe the "fell out of his bunk bed" story the parents were describing.

James related his experience with the mother and her "confession" about the belt marks. When asked why he did not report his physical exam findings, James stated that, "he had a come-to-Jesus talk with the little boy's mother and believed that nothing further would happen to the little boy."

In the end, everybody lost. James lost his ability to practice medicine and was ultimately prosecuted as a criminal. The little boy's parents both went to jail. In fact, the father will spend the rest of his life in jail.

In 2003, the most recent year for which statistics are available, it is estimated there were more than 2.9 million cases of suspected child abuse in the United States, with an estimated 1,400 fatalities. And yet, more than 58% of child abuse reports to child protective agencies are found to be unsubstantiated.<sup>1</sup>

One cause for the difficulty in obtaining accurate statistics is that there is no universally accepted definition of "child abuse." Some states define abuse as an action resulting in actual injury, whereas in other states, the mere *potential* for injury is defined as child abuse.

Statutes may impose liability for excessive corporal punishment or exposure to drug-related activity, and may require "reasonable suspicion" or diagnosable mental or physical injury to prosecute.

In the landmark work, *The Battered Child*, Helfer and Kempe opine that the diagnosis of abuse "should be considered in any child exhibiting evidence of fracture of any bone, fail to thrive, soft tissue injury or skin bruising, and any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma."<sup>2</sup>

In addition, some authorities consider the physical exam findings of retinal hemorrhages to be pathognomonic of child abuse.

Historically, under common law, there was no duty to report even known cases of child abuse. Today, all 50 states mandate that specific individuals report suspected child maltreatment. Among those required to report are teachers, medical providers, nurses, mental health workers, sometimes clergy, and dentists. Check your specific state statutes to determine which agencies should be notified about suspected child abuse.

In addition, the Child Welfare Information Gateway offers advice and state-by-state reporting contact information on the How to Report Suspected Child Maltreatment page of its website, available at [www.childwelfare.gov/responding/reporting.cfm](http://www.childwelfare.gov/responding/reporting.cfm).

Most states grant immunity to any professional who, in good faith, reports suspected child abuse. This means that the person reporting suspected abuse cannot be sued for alerting the authorities, provided that the report was made with a reasonable belief that abuse had occurred. Moreover, in at least 42 states, the *failure* to report abuse can lead to both criminal and civil liability upon professionals who fail to notify the authorities despite having a reasonable belief that the child has been mistreated.

The take-home point is this: Urgent care centers across the United States see children every day who are victims of abuse. In fact, I suspect that we see a disproportionate number of abused children inasmuch as the abusers bring their children to these centers knowing that urgent care providers may not be as familiar with patterns of abuse as their emergency department counterpart.

If you suspect abuse, report it to the appropriate state agency as defined in your state's statutes. Doing so may save the child's life. Not doing so may end your career and, more importantly, the precious life of a child.

As I write this, a little girl I treated in the emergency department last month lies in a persistent vegetative state, trached and on a ventilator, in a long-term pediatric hospital in Phoenix. She presented posturing and unresponsive via paramedic ambulance after 911 was called by the mother's boyfriend, who stated the child was "not acting right." I intubated her and sent her emergently for a CT scan; she was found to have multiple skull fractures, an acute subdural hematoma, and diffuse cerebral swelling.

She, too, "fell out of bed." ■

#### References

1. U.S. Department of Health and Human Services National Clearinghouse on Child Abuse and Neglect Information. *Fatalities: Statistics and Interventions*. 2004.
2. Helfer RE, Kemp CH. *The Battered Child*. Chicago: University of Chicago Press, 1968; page 105.

4. Consider a low-cost/high-impact public relations blitz. Set aside one hour starting at 6 p.m. (or over a weekend) and leave 50 or more employer contacts a message such as:

*"Hello, this is Dr. Maginnis calling from Downtown Urgent Care. I am calling to thank your company for your business, find out how we are doing, and see if you have any problems that we can address. I am available most afternoons at 453-1834; call me if I can be of help."*

#### Getting Started

Begin developing a communications strategy by creating a list of communication actions that are amenable to a generic document or script.

##### Generic e-mails

1. Confirming a meeting
2. Meeting follow-up
3. Confirming a "closed" account
4. Just checking in
5. Announcing a new service, location, or employee

##### Generic letters

1. Annual thank you plus questionnaire
2. Introductory letter
3. Contractual cover sheet (as appropriate)

##### Scripted voicemail messages

1. Just checking in (alternate with e-mails)
2. Confirming a meeting
3. Thank you for meeting/summary follow-up

##### Generic documents

1. Formal proposals
2. Reference list (updated constantly)
3. Staff profiles

#### Summary

In order to get the most out of your communications strategy, you must:

- proactively develop a communications plan.
- develop a generic document and/or script in support of each plan component.
- execute the plan as an integral part of each workday.

The slogan, "reach out and touch someone," applies more than ever in an increasingly impersonal, frenzied world. Such an "in their face" approach increases the probability of potential clients knowing who you are and using your clinic when the time is right. ■





# Coding for I&D, DTaP, and Procedures Included in the E/M Code

■ DAVID STERN, MD, CPC

**Q.** An urgent care that I do billing for has presented a question I would like your input on. A sales rep has stated that urgent care centers are now administering the DTaP vaccine (CPT 90715). Is it appropriate to administer DTaP in urgent care, and, if so, what is the difference between the reimbursement of the Td (90714) and the DTaP (90715)?

– Lynn Gray, Eastern Hills Medical Billing, Cincinnati, OH

**A.** Patients may use urgent care centers when they have difficulty getting timely appointments for an immunization with a primary care physician. In general, place of service should not change whether it is appropriate or not to administer the vaccine. Any payor, however, may choose to deny a code, based on a contract with the provider or individual payor policies.

When it comes to actual reimbursement, fee schedules are set by payors, so you will need to check with each payor to determine the fee schedule rate for each code. Of course, the code that you use should not be based on reimbursement levels; rather, the code should correlate with the specific service that has been provided. ■

**Q.** What is the best code to use when we do not repair a laceration and are just cleaning a scrape or contusion?

– Misha Doctor, Nason Medical Center, Charleston, SC

**A.** CPT and CMS consider cleansing a wound to be a minor procedure that is not separately reported with a CPT or HCPCS code. It is included in the E/M service, and performing this service does not alter the algorithm for calculating the E/M code. ■



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

**Q.** When one of our providers places an ear wick, they write in the code 69399. I've looked in the 2009 CPT code book, and this code is listed under reconstruction auditory canal and is an unlisted procedure, external ear. Do you know if there is another code that we should use for an ear wick?

– Adam Walker, Physicians Care, Chattanooga, TN

**A.** Again, CPT and CMS consider insertion and/or removal of an ear wick(s) as a minor procedure that is not separately reported with a CPT or HCPCS code. Ear wick insertion is included in the E/M service, and performing this service does not alter the algorithm for calculating the E/M code. ■

**Q.** How do we code for multiple visits for repeat procedures—for example, when a patient makes several daily clinic visits for removal of packing and repacking of the abscess after an incision and drainage (I&D) of the abscess?

– Scott Cooney, Bellevue Urgent Care, Greater Omaha Area, NE

**A.** Every procedure code has an associated global period. This global period includes much of the follow-up care during that global period. Examples of procedures and their associated global periods include:

- 96372: IM injection, 0-day global period
- 12001: Simple laceration repair, 10-day global period
- 26720: Fracture finger (when definitive care is performed), 90-day global period

In the case that you describe, wound packing and repacking during the global period for the I&D would be included in the global package. Of course, in some cases the patient does require multiple visits during the global period. Each of these visits would be coded with code 99058, which has no associated reimbursement.

In the case of fractures, however, some follow-up care (i.e., x-rays, cast supplies, and cast reapplications and modifications) is not included in the global care. This even applies to the

global period for definitive fracture care. You may code for these services and supplies in addition to the procedure code for fracture care. ■

**Q. What procedure code would I use on incision and drainage of a large (8 cm) skin abscess near the medial right periscapular border? It required probably three times more supplies and time than a usual skin abscess. It was, however, superficial to all muscles. The 20000 code wouldn't seem to reimburse enough.**

– Alan L. Carpenter, DO, Upper Valley Urgent Care Center, El Paso, TX

**A.** There is one code specific to the body area that might apply here: 21501 – Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax.

With several other codes for “deep incision and drainage,” CPT is specific in defining “deep” as “subfascial.” With this code, however, CPT and CPT Assistant are silent on the definition of

“deep.” Thus, you should use your clinical judgment to determine whether the abscess would fit the definition of “deep.”

There are two general codes for I&D of an abscess:

- 10060 – Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
- 10061 – Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
- The second code, 10061, is probably the best code to use for the procedure you describe. Make sure that your procedure note makes it clear that this was a complicated procedure.

Note: There are also codes for I&D of abscesses (or hematomas) in some specific situations or of anatomic locations (**Table 1**). Because these codes most accurately describe the procedure performed, you should use these codes when they apply. ■

**Table 1. I&D Codes for Specific Anatomic Locations**

Code	Description
10040	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
10080	Incision and drainage of pilonidal cyst; simple
10081	Incision and drainage of pilonidal cyst; complicated
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic
22015	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral
23930	Incision and drainage, upper arm or elbow area; deep abscess or hematoma
23931	Incision and drainage, upper arm or elbow area; bursa
25028	Incision and drainage, forearm and/or wrist; deep abscess or hematoma
25031	Incision and drainage, forearm and/or wrist; bursa
27301	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region
27603	Incision and drainage, leg or ankle; deep abscess or hematoma
27604	Incision and drainage, leg or ankle; infected bursa
28001	Incision and drainage, bursa, foot
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space
28003	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas
30000	Drainage abscess or hematoma, nasal, internal approach
30020	Drainage abscess or hematoma, nasal septum
42700	Incision and drainage, abscess; peritonsillar
46050	Incision and drainage, perianal abscess, superficial
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
69000	Drainage external ear, abscess or hematoma; simple
69005	Drainage external ear, abscess or hematoma; complicated
69020	Drainage external auditory canal, abscess

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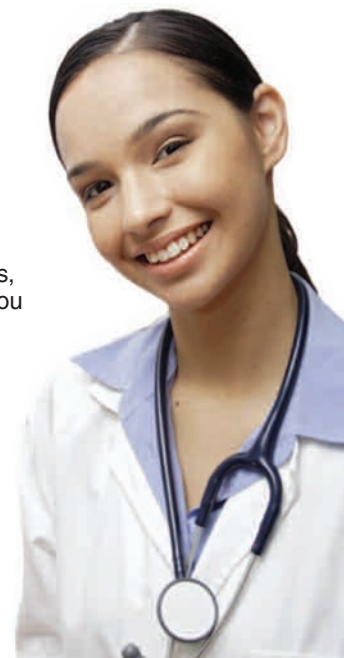
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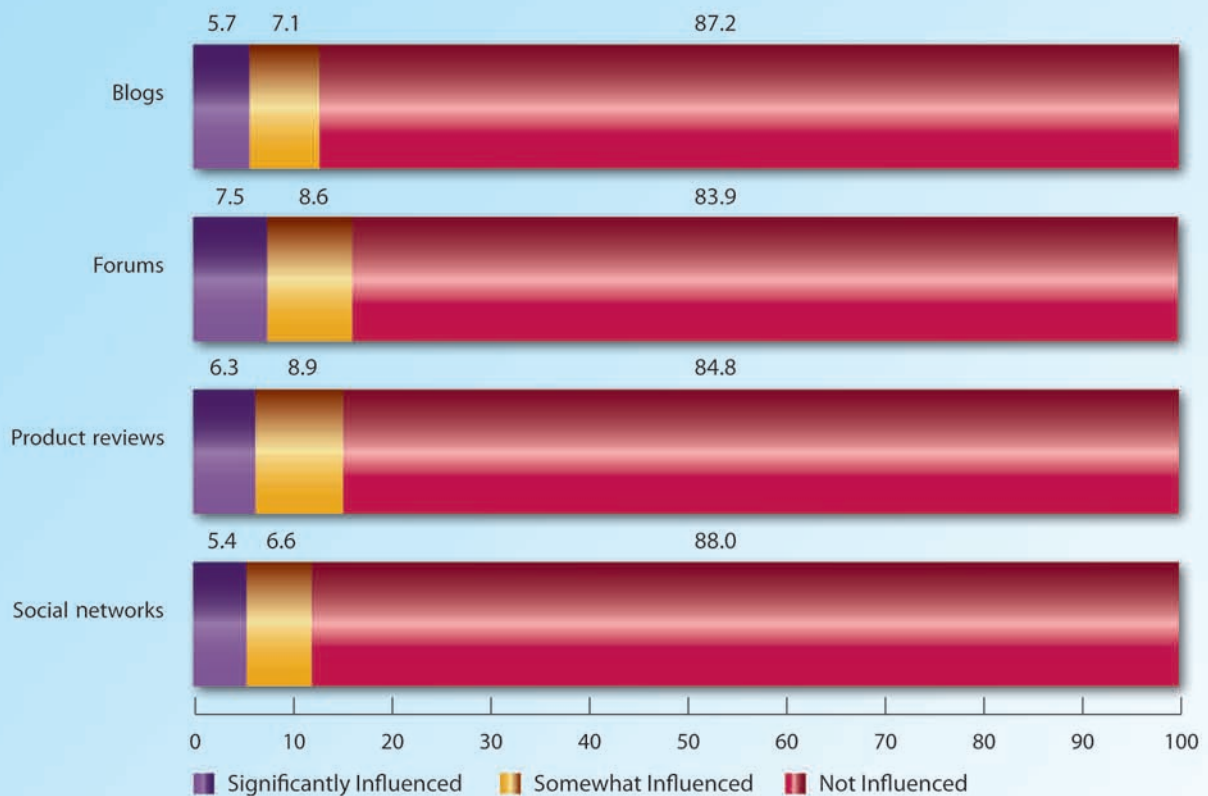
## DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we look further into the notion that social media on the Internet may be a golden opportunity to extend your marketing reach (also see Utilizing Social Media to Drive Visits to Your Website and Urgent Care Center, by Alan Ayers, page XX).

A survey by Ad-ology Research this year revealed that 38.5% of U.S. adults report being somewhat or significantly influenced by social media. Of even greater interest, though, are the data reflecting the views of visitors to urgent care centers and hospitals in the U.S.

So, to what degree are visitors to urgent care centers or the hospital influenced by information and advertising from social media—and which online resources tend to be the most influential?

### SOCIAL MEDIA INFLUENCE ON VISITORS TO URGENT CARE AND HOSPITALS



Adapted from Spring 2009 Ad-ology Media Influence on Consumer Choice Survey; used by permission.

People in certain demographic groups tended to report being significantly or somewhat influenced by social media, namely those 25- to 34-years old and 18- to 24-years-old (53.2% and 51.4%, respectively) and those with higher income or with children living at home (each 49.4%). Female respondents were more likely to be significantly or somewhat influenced by social media than males (45.9% to 31.8%).

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



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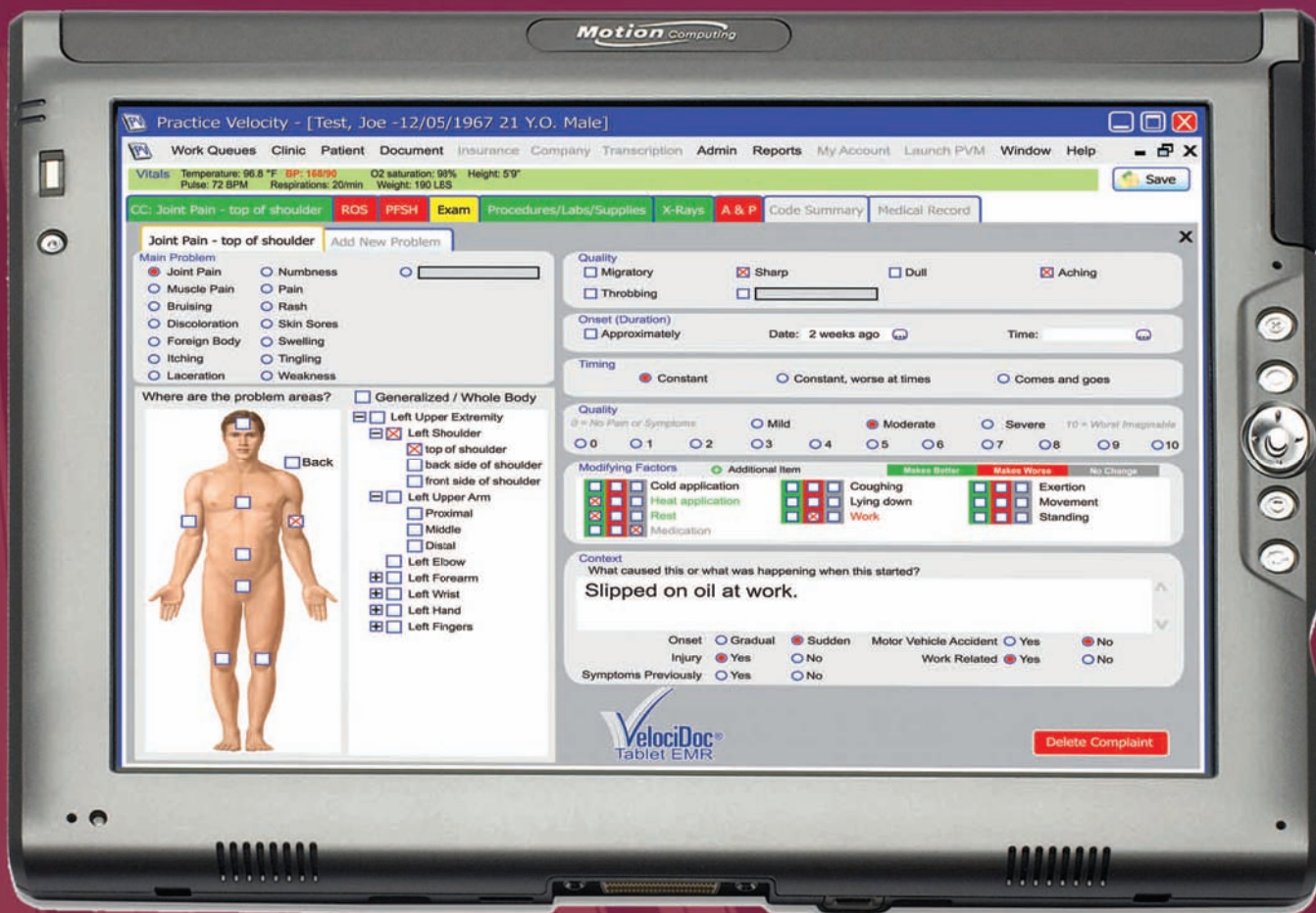
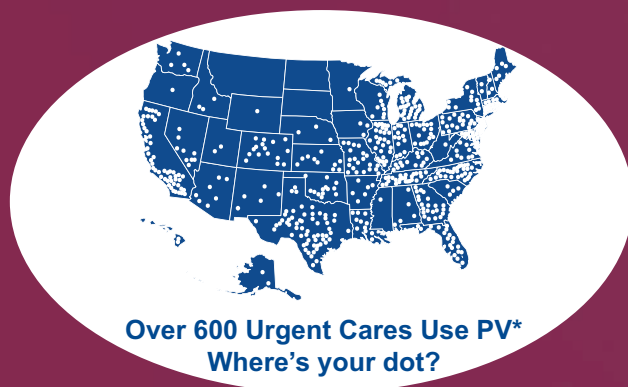
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