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OCTOBER 2011
VOLUME 5, NUMBER 12
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Pediatric Foreign Bodies

Which can be removed in urgent care—and which can't

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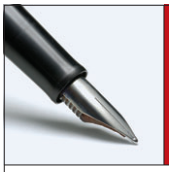


LETTER FROM THE EDITOR-IN-CHIEF

Primary Care Physicians ... the New Middle Class?

With all the renewed talk of tax hikes on the "rich" to pay for everything from healthcare to job creation, I can't help but see the with anger over how we define *rich* in this country.

The top tax rate targets incomes of $150,000-$200,000. This despite a rapidly growing "ultra-rich" class that consists of earners between $1 million and untold billions. Now millionaires and billionaires pay less as a percentage of earnings than the middle class does.

Huh? The tax system is glaringly biased, leaving working professionals with high taxes and mounting debt. Primary care physicians, for example, now earn less than many middle class wage earners over the course of their careers.

How did we get here?

Consider: a unionized structural iron worker earns over $50,000 per year plus benefits. After a paid apprenticeship of one to two years, graduates begin earning full paychecks when they are 19-20 years old. Earnings accrued through retirement age (62) equal $2 million. Assuming full-time work till then, a union ironworker can expect $100,000 per year for life at retirement, according to formulas used by the ironworkers union to calculate pensions. Based on average life expectancy, an ironworker's pension would total another $1.6 million, for lifetime earnings totaling $3.2 million. The ironworker is taxed at a marginal rate of 26% over the course of his lifetime, leaving him with $2.7 million dollars in disposable income accrued.

A primary care physician incurs $60,000-$120,000 in current dollars for a college education and $120,000-$200,000 for medical school, for a total cost of education of $180,000-$320,000 (for tuition only!). A three-year residency essentially delays real earning until the physician reaches age 30. Most family doctors earn between $150,000-$170,000 a year. Assuming the same retirement age of 62 as an ironworker (yeah, good luck), that physician would gross $4.8 million-$5.4 million over a lifetime.

That same physician is taxed at the marginal rate of 33%, so disposable income is $3.2 million-$3.6 million. Most family doctors will have no pension to speak of. An average total educational debt of $250,000-$300,000, amortized with interest over 30 years, brings the cost of education to $430,000-$620,000. Subtract that from disposable income, and lifetime earnings come to $2.7 million-$2.9 million, almost precisely that of the $50,000 a year ironworker.

"Primary care medicine has essentially been relegated to a public service."

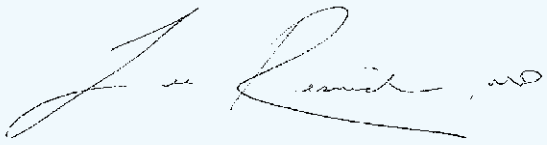
With tuition for higher education increasing at a rate of 10% per year, and physician reimbursements not even keeping pace with inflation, this is a recipe for disaster!

Where Do We Go From Here?

First, we must close the income gap between primary care physicians and specialists. Many non-surgical specialists earn more than double what the average primary doctor earns. This is unacceptable and largely unheard of in other developed nations, where the difference averages 20%-30%.

Second, we must radically revise how we pay for medical education. Primary care medicine has essentially been relegated to a public service. Fine ... then educational costs should be entirely covered for those choosing careers in primary care. While many of our European colleagues average incomes about 25% less than their American counterparts, they begin medical school straight from high school, and their entire education is government-financed.

Third, fix the tax code. We cannot continue to punish professionals with tax rates higher than those at either end of the income spectrum. Incentives for investing in professional degrees *and* a massive revamping of the tax brackets will ensure our nation's best and brightest are treated fairly. ■



Lee A. Resnick, MD
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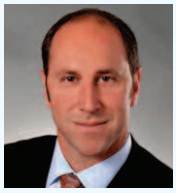
Primary Care Physicians ... the New Middle Class?



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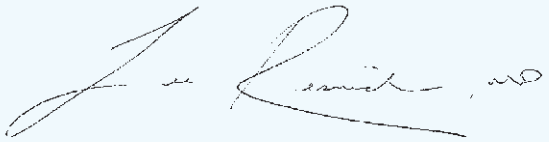

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October 2011

VOLUME 5, NUMBER 12

CLINICAL

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A variety of objects find their way into the ears, noses, and throats of children. Some can be lethal and require ED or specialist referral. Others can be safely removed in an urgent care setting.

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Companies like Apple and Nordstrom have raised the quality of customer experience to an art form, one that urgent cares would do well to emulate.

Alan A. Ayers, MBA, MAcc

WEB EXCLUSIVE

An Urgent Care Site That Maximizes Revenue

What is true in retailing is true in urgent care: nothing succeeds like address. Here is how to evaluate potential sites the way successful retailers do: by employing a layered approach.

Michael Zelnick, CCIM

IN THE NEXT ISSUE OF *JUCM*

The latest CDC statistics on STDs bring sobering news: during 2005-2009, the chlamydia rate in men increased 37.6%, in women 20.3%, and the number of cases of syphilis reported is at a 16-year high. Many patients with these and other STDs will present at urgent cares. As such, our review of the epidemiological trends and signs, symptoms, and treatments for HPV, herpes, hepatitis, HIV, gonorrhea, chlamydia, and syphilis is indeed urgent.

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

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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.

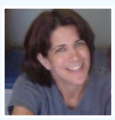
JUCM (ISSN 1938-002X) printed edition is published monthly except for August for $50.00 by Braveheart Group LLC, 65 North Franklin Turnpike, Second Floor, Ramsey, NJ 07446. *JUCM* has periodical status at Mahwah Postal Annex, 46 Industrial Drive, Mahwah, NJ 07430 and additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 65 North Franklin Turnpike, Second Floor, Ramsey, NJ 07446.

JUCM CONTRIBUTORS

Children will insert beads, toy parts, paper, magnets, and button batteries into their ears or nasal cavities. They will swallow coins, screws, staples, magnets, batteries, and an array of other objects. As Ann Mary Bacevice, MD, points out in our cover article this month, especially with young children, a high index of suspicion should be maintained for a foreign body even when the presenting symptoms seem to suggest an illness.

Dr. Bacevice discusses identification and removal of foreign bodies in the ear and nose, ingested objects, and aspirated foreign bodies. She explains which objects can be safely removed in the urgent care setting, which require specialist or ED referral, and which can be life-threatening. A child who swallows a lithium button battery, for example, may experience severe burns with sequelae in as little as two hours.

Dr. Bacevice is an Assistant Professor of Pediatric Emergency Medicine at Case Western Reserve University School of Medicine and Trauma Co-Director for Emergency Medicine and a Staff Physician at UH Rainbow Babies & Children's Hospital in Cleveland, Ohio.



This October, we welcome back Michael B. Weinstock MD, and Jill C. Miller, MD, who present their latest *Bounceback,* the harrowing case of a young mother with a common complaint—"the worst headache of my life"—that turned out to be much more than a bad headache. A misdiagnosis and a tragic result led to a malpractice suit. Drs. Weinstock and Miller not only present revealing highlights from the medical record, but using excerpts from actual trial testimony, they give a sense of the gripping courtroom drama that ensued.

Dr. Weinstock is a Clinical Associate Professor of Emergency Medicine at Ohio State University College of Medicine and an Attending Physician at Mt. Carmel St. Ann's Emergency Department in Columbus, Ohio. Dr. Miller is a Senior Clinical Instructor in Internal Medicine at Case Western Reserve University School of Medicine and an Attending Physician at Chagrin Highlands Urgent Care, UH Hospitals Medical Practices, in Cleveland, Ohio.

This *Bounceback* is adapted from *Bouncebacks! Medical and Legal* (Anadem Publishing), available on Amazon.com. For more on *Bouncebacks*, visit *www.embouncebacks.com*.

Rounding out our clinical offerings in this issue is a Case Report by Sean McNeeley, MD, in which a mother of three presents at an urgent care complaining of pregnancy symptoms—except that her pregnancy test is negative. Can you figure out what her problem is?

Dr. McNeeley is Medical Director at University Hospitals Urgent Care Network in Cleveland, Ohio, a member of the Board of Certification of Urgent Care Medicine, and Treasurer of the Urgent Care College of Physicians.

In "Take Patient Satisfaction to the Next Level," Alan A. Ayers, MBA, MAcc, writes that "if patients perceive all urgent care centers as equal in their ability to treat minor medical conditions,

they will migrate to providers who offer the best overall experience." Mr. Ayers considers companies—such as Apple, Starbucks, Ritz Carlton, and Nordstrom—that have elevated the customer experience to an art form, and he presents a three-phase action plan to help urgent cares do the same.

Mr. Ayers is Vice President of Concentra Urgent Care in Dallas, Texas, and Content Advisor for the Urgent Care Association of America.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, looks at what is involved in selling your practice in our Health Law column this month. Dr. Shufeldt discusses key details of the non-disclosure agreement, initial diligence request, letter of intent, formal due diligence process, and closing. When the process is over, he writes, the usual response is: "That was worth every minute. I never want to do it again."

In Coding Q&A, **David Stern, MD, CPC,** examines three variations on coding rule number one: code for services rendered. Among the issues Dr. Stern discusses: which CPT codes can be used for diagnosis codes to maximize a Medicare patient bill, and the legal and ethical issues involved in an emergency department re-coding an emergency visit as an urgent care visit based on the final diagnosis and/or time involved in treating a patient.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on current literature germane to the urgent care clinician. This month's column includes a new approach to managing young non-toxic-appearing febrile children, warming local anesthetics prior to injection, when a lumbar puncture is not necessary to detect a subarachnoid bleed, how patients understand clinical data best, and swimming as a risk factor for dysrhythmia in children with long QT syndrome.

Our Developing Data end piece examines two intriguing questions: What percentage of urgent cares measure quality and what percentage measure patient satisfaction? The number of centers that make no attempt to measure the latter is apt to raise eyebrows. ■

To Subscribe to *JUCM*

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Big News at UCAOA This Fall

LOU ELLEN HORWITZ, MA

Is it fall already? Fall is always a mixed blessing to me. Love the weather, love that kids are back in school, miss the long summer nights, and miss the semi-calm that seems to permeate the hotter months.

For UCAOA, fall means it is time to hit the road exhibiting, get those remaining new projects launched, prepare for the fall board meeting, and finalize plans for next year's spring convention.

Here's what's been keeping us busy lately:

Policy & Procedure Sample Manual

At long last, this idea will be coming to fruition. As I write this, it's still too early for an official availability date, but this project is well on its way to becoming a 500+ page treasure trove of sample policies written specifically by urgent care centers for urgent care centers.

White Paper on Our Industry

Thanks to the efforts of UCAOA staff and several gracious volunteers, we released our first white paper on urgent care last month. From this paper (which had to take a very "balanced" position), we'll be able to launch many more "pro-urgent care" pieces for both us and you to use to spread the word about the positive impact your centers have on accessibility and affordability of care.

Fall Conference

Another great group will gather in Dallas this month for several new courses, as well as new teaching formats. We are making some of our courses more "experiential"–case studies will be introduced in our clinical classes (not saved for straight lectures), and significant hands-on chart coding will be part of our advanced coding classes. We can't wait to hear your thoughts on this new interactivity.

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

Spring Convention

In 2012, we are headed back to Caesar's Palace in Las Vegas! We love Las Vegas as a meeting site, and we are in brand new space at Caesar's this time, with only a few steps between the classrooms and the exhibit hall–so no more stairwells for attendees! Be sure to save April 16-19 on next year's calendar.

New Membership Structure

Starting in 2012, no need to worry about who receives member benefits in your centers–*everyone* does. The Board of Directors voted, and Practice Memberships will now have unlimited members included. No more name replacements, no more swapping, no more having to share your log-in information. We are excited to open this up to everyone soon. Watch for more information in November.

2012 Benchmarking Survey

The Benchmarking Committee is already working on questions and improvements for next year's benchmarking survey. If you have submitted new measures you want to see, thank you. Anyone who has ideas but has not passed them on can email me at *lhorwitz@ucaoa.org*. I'll share them with the committee.

On the Road

September and October are the months we visit our colleagues at the American Academy of Family Physicians and the American College of Emergency Physicians during their Scientific Assemblies. Interesting observations always come out of those trips as we gain a larger perspective on our adjoining industries, and I'll share those once those trips are complete.

Expanding Our Capabilities

UCAOA is raising our vision to focus as much on making our industry successful as we do on making your individual centers successful. To do this, we needed to hire new staff to expand our ability to do new things while making sure our existing programs improve each year. We've welcomed three new full-time staffers since May, so our roster-building is well under way. Some of this work is the product of that expansion, but there is much more to come. Stay tuned. ■

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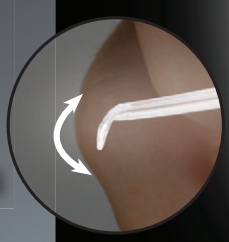

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Pediatric Foreign Bodies

Urgent message: A variety of objects find their way into the ears, noses, and throats of children. Some can be lethal and require ED or specialist referral. Others can be safely removed in an urgent care setting.

ANN MARY BACEVICE, MD

Introduction

In children who are brought to an urgent care for treatment, foreign bodies are common. Especially if they are between the ages of 18 months and four years, children will insert objects into their ears or nostrils as well as swallow sometimes very surprising things.

Commonly inserted foreign bodies include beads, food, toy parts, and paper. Common ingested foreign bodies include coins and toy parts. Magnets and button batteries can be ingested or inserted. The presence of either object requires special attention, as we shall see. Insects are a common accidental foreign body found in the ear.

The placement or ingestion of a foreign body can be obvious. It can be witnessed by a parent or caregiver. Sometimes a child will notify the parent after the event occurs. Or a well-meaning sibling may witness the event and notify an adult.

However, the presence of a foreign body can also be subtle. The timing of the placement or ingestion can be unknown. A child may present with purulent rhinorrhea or epistaxis and have a nasal foreign body as the cause.

As such, with pediatric patients—especially young children—a high index of suspicion for a foreign body should be maintained even when the presenting symptoms seem to suggest an illness. Not all purulent rhinorrhea, for example, is sinusitis, especially if it is unilateral. While nose picking is a common cause of acute nosebleed, it may also be that a button battery or magnet is lodged in the nasal cavity and causing necrosis.

Ann Mary Bacevice is an Assistant Professor of Pediatric Emergency Medicine at Case Western Reserve University School of Medicine, Trauma Co-Director for Emergency Medicine at UH Rainbow Babies & Children's Hospital, and a Staff Physician at Rainbow Babies & Children's Hospital in Cleveland, Ohio.

Difficulty breathing or a chronic cough is not always due to a respiratory infection. A foreign body can be a surprise finding on a routine ear exam.

For any clinician caring for children, knowledge of pediatric foreign bodies, including how to perform an evaluation to rule them out and how to remove them if discovered, is therefore essential.

Preparation for Removal

Even if an ear or nose foreign body is identified and can be removed without difficulty, some preparation is still needed to best facilitate the procedure. Educating the child and caregiver about what is going to occur is of great importance. Explaining the procedure to the older child will often lead to better success. In the younger child, distraction with a book or toy may be helpful. A less-cooperative child may require immobilization. A papoose board, if available, can help immobilize the child's arms and legs. If a papoose board is not available,

wrapping the child in a bed sheet to secure the arms and legs can accomplish the same goal.

Sedation for the removal of an ear or nose foreign body is often not necessary. The experienced provider with the appropriate staff and resources may use oral midazolam for light sedation and anxiolysis. A dose 0.25 mg/kg-0.5 mg/kg may be given 30 minutes prior to the procedure. In some settings, intranasal midazolam is available. The dose is 0.2mg/kg and can be administered 10-30 minutes prior to the procedure. Any patient receiving any level of sedation should be observed until he or she is back to baseline.

"A battery lodged in the nose can cause epistaxis or septal necrosis with perforation."

Foreign Bodies in the Ear

The external ear canal is divided into two regions: the lateral third and the medial two-thirds. The medial two-thirds of the canal is narrow, very vascular, and quite sensitive. Foreign bodies in the medial two-thirds are often more difficult to remove, especially if the foreign body is close to the eardrum.

Spherical-shaped foreign bodies such as beads or BBs are often difficult to remove. It can be challenging trying to grasp a spherical foreign body. Irregular-shaped and/or soft foreign bodies such as paper, tissue, or cotton are easier to remove. If a button battery has been inserted in the ear, it should be removed as soon as possible. A battery lodged in the ear can cause tympanic membrane perforation or stenosis of the external auditory canal.[1]

Various tools are available for foreign-body removal. Alligator forceps are the most common tool used for removal by non-ENT physicians. However, alligator forceps are not ideal for spherical-shaped foreign bodies. They are most useful when the foreign body can be directly visualized in the external canal.

Curettes are readily available in urgent care settings. They come in many shapes and sizes and can be metal or plastic. A curette can be carefully manipulated past the foreign body and then slowly withdrawn to remove the object.

Irrigation can be performed with a 20 mL-50 mL syringe and a flexible IV catheter tip. Inject a constant stream of water to flush the external ear canal. It is preferable to use water at body temperature to avoid discomfort to the child. Irrigation is not recommended for foreign bodies that are spongy or expansile when wet, such as vegetable matter.

An insect in the ear can cause great discomfort to a child, especially if the insect is still alive. Viscous lidocaine can be applied to the ear canal both to anesthetize the canal and "drown" the insect. The non-moving insect can then be removed with forceps or irrigation.

Cyanoacrylate is not recommended to facilitate the removal of foreign bodies. It is commonly thought that a fast-acting adhesive applied to a swab or curette can adhere to the foreign body and make it easier to remove. The likely result, however, is that instead of having one foreign body in the ear canal, you will now have two: the initial foreign body and cyanoacrylate![2]

Earrings can get embedded in the earlobe. This is often because the earring back is too tight. The earring can become posteriorly displaced. Cellulitis may be associated as well. To remove the earring, provide local anesthesia with lidocaine (no epinephrine). Sometimes the earring can be pushed through; at other times a small incision is required to facilitate removal. If cellulitis is present, a course of oral antibiotics is indicated.[3]

Foreign Bodies in the Nose

The same types of objects placed in the ear can be inserted into the nose—and often are. If a button battery has been inserted into nose, it should be removed immediately. A battery lodged in the nose can cause epistaxis or septal necrosis with perforation.[1]

Magnets inserted into the nose also require prompt removal. Magnets can adhere to each other across the nasal septum, causing septal hematoma or septal necrosis. Often forceps are not strong enough to break the magnetic force. There are case reports of using a household magnetic pickup device, generally a wand-like tool, to separate the magnets.[4]

There are various techniques to extract a nasal foreign body. The simplest method this is to have the child to blow his or her nose while compressing the non-occluded nostril. Administering positive pressure is another means of removal.

"Parent's Kiss" has been described in the literature.[5,6] Position the child in the parent's lap in a semi-recumbent position. Then have the parent deliver a sharp mouth-to-mouth breath while compressing the non-occluded nostril. The same technique can be accomplished with

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Another option is mechanical extraction. Forceps and curettes, described in the section on removing ear foreign bodies, can be used in the same fashion for nasal foreign bodies. In addition, a Foley catheter can be used to remove a posteriorly placed foreign body. Manipulate the Foley past the foreign body, inflate the balloon, and gently pull to remove.[2,7,8]

"Coins account for 50%-75% of swallowed foreign bodies."

Lastly, saline washout, similar to the technique used to collect mucus for viral studies, can be performed with about 7 mL of saline injected at high pressure into the non-occluded nostril.

Ingested Foreign Bodies

Objects impacted in the esophagus are the most common and potentially the most problematic consequence of a gastrointestinal foreign body. Coins account for 50%-75% of swallowed foreign bodies. Foreign bodies in the esophagus tend to lodge in three sites: the thoracic inlet, the aortic arch, and the gastroesophageal junction. The majority of foreign bodies lodge at the thoracic inlet. Objects that pass safely into the stomach are likely to pass through the remainder of the GI tract without complications. This includes pointed objects such as screws and staples. While it is commonly thought that objects greater than 5 cm are less likely to pass, there are no definitive length guidelines. However, sewing needles appear to pose a higher risk for causing perforations.[9,10]

Coin Ingestion

Patients presenting with airway symptoms–cough, stridor, or respiratory distress–are likely to have a foreign body in the proximal esophagus. Patients presenting with pain, drooling, and/or dysphagia often have the foreign body lodged in the middle to distal esophagus. The precise location of an ingested coin is often determined by radiograph.

A prospective study looked at the spontaneous passage of esophageal coins in asymptomatic patients. The investigators found that coin location was important in predicting spontaneous passage, whereas coin type and size were not. Coins in the distal esophagus had up to a 67% spontaneous passage rate in study subjects, whereas coins in the proximal and middle esophagus had 14% and 43% spontaneous passage rates, respectively. The results suggested that an asymptomatic patient could be observed for 8-16 hours to determine if the coin would pass.[11]

For coins needing removal, endoscopy is the mainstay of management. Other modalities have been tried as well. Glucagon, for example, produces relaxation of the smooth muscle of the esophagus and has been used to promote passage of esophageal foreign bodies. However, one study failed to corroborate the effectiveness of glucagon for this use in children.[12]

Several studies in children have investigated the use of the bougienage procedure to advance an esophageal foreign body into the stomach with documented success. In the appropriately screened child and in the appropriate setting, this may be an option, provided the physician has the required skill set to perform this procedure.[13,14]

Battery Ingestion

With the proliferation of battery-powered toys and electronic devices of every sort, disk batteries have become common foreign body ingestions in children, most likely due to their increased use. A review of three national databases revealed a 6.7-fold increase in button battery ingestions from 1985-2009 with major or fatal outcomes.[15] The size of the battery and its composition play a role in the outcome. Thirty-one of 33 cases with major outcomes or fatalities involved batteries greater than 20mm. Lithium batteries have more clinically significant outcomes that other battery types, with severe burns with sequelae occurring in just 2-2.5 hours. Almost all batteries greater than 20mm were of lithium composition in this analysis.

Batteries can cause injury in three ways. First, batteries can generate an external electrolytic current at the negative pole that can hydrolyze tissue fluids and produce hydroxide. Second, batteries can leak alkaline electrolyte, which is poisonous. Third, a battery can exert physical pressure on adjacent tissues, creating a choking hazard.

Ingested lithium batteries are particularly worrisome. While they do not tend to leak an irritating chemical or produce local damage, lithium batteries have a higher capacitance than other batteries, thus generating more current. This means that more hydroxide is generated more rapidly than with other batteries. Hydroxide burns and causes ulcers in adjacent tissue. As it burns through the walls of the esophagus or gastrointestinal canal, hydroxide can cause catastrophic internal bleeding.[15]

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When evaluating a child with known or suspected battery ingestion, in most situations, an initial radiograph is required. An older child (>12 years) with a known small battery (<12 mm) ingestion may not necessarily need an x-ray, as significant complications are unlikely.

If there is a battery present in the esophagus, it must be removed emergently, ideally within two hours. If a battery is in the stomach or intestine, and the patient is asymptomatic, the battery may be left to pass spontaneously. In a smaller child who ingests a larger battery, a follow-up radiograph in four days is suggested to ensure that it has passed.[15,16]

Consult with an ENT specialist or gastroenterologist sooner rather than later when a child has ingested or inserted a button battery. Phoning the National Battery Ingestion Hotline (202-625-3333) can help determine the course of treatment a child needs. In addition, the National Capital Poison Center offers a useful an algorithm for button battery ingestion triage and treatment (*www.poison.org/battery/guideline.asp*).

Magnet Ingestion

Magnets can be used in toys, crafts, or jewelry. A single ingested magnet poses complications no different from any other solitary ingested foreign body. However, multiple magnets ingested, or a magnet ingested with other metallic objects, can cause many severe gastrointestinal complications.

When a magnet becomes aligned with another magnet or metallic object, the bowel wall can be dragged along. A section of bowel wall trapped between magnets can develop pressure necrosis leading to perforation, peritonitis, or obstruction. If a blood vessel gets trapped between magnets, hemorrhage can occur. If a large loop of bowel is involved in the magnetic attraction, volvulus can occur.

Much like any other ingested foreign body, a plain radiograph is often obtained to determine the location of the magnet. It may be hard to differentiate one magnet from two or more magnets on imaging, even with a CT scan. Maintaining a high index of suspicion for multiple magnet ingestion is therefore advised.

If a magnet is beyond the reach of an endoscope and the patient is asymptomatic, hospital admission for observation, serial abdominal exams, and serial radiographs is recommended. If at any point during the evaluation or hospital course, the patient develops worsening abdominal pain or signs of obstruction, surgical intervention is indicated.[17-19]

As with battery ingestion, involve an ENT specialist or gastroenterologist early in the patient's care. As is always recommended when deep sedation or anesthesia may be required, keep the patient NPO.

Aspirated Foreign Bodies

Foreign bodies lodged in the upper airway can be immediately life-threatening. If the airway is partially occluded, respiratory distress, stridor, and labored breathing will likely be present. If the airway is completely occluded, basic life support should be performed. In the awake patient, the Heimlich maneuver can be performed if the child is older. Back blows with chest compressions can be used even in a child less than one year of age. In the unconscious child, chest compressions should be performed. Such children need to see an ENT specialist emergently.

Foreign bodies lodged in the lower airway have a much more subtle presentation. These most commonly present in the child less than three years of age. Food accounts for most aspirations, with peanuts being the most common.

If a child presents with a witnessed choking episode, the diagnosis is often made more quickly. Focal lung findings on physical exam and focal hyperinflation on chest radiograph are often—but not always—present. If there is a good history of choking or any focality on evaluation, the patient should be referred to an ENT specialist or pulmonologist for further evaluation and possible bronchoscopy.

The child with an unwitnessed choking episode is more problematic. Symptoms seen with lower-airway foreign bodies are similar to some common childhood illnesses, including asthma, bronchiolitis, and pneumonia. In evaluating the child presenting with chronic cough or new-onset wheezing, a history for possible foreign-body aspiration should be explored.

The type of radiograph to obtain is often the subject of debate. A plain chest radiograph may have focal findings but can often appear normal. Inspiratory and expiratory films are often recommended, but given the age group that commonly presents with aspirated foreign bodies, these may be difficult to obtain. Right and left lateral decubitus films can also obtained in the less-cooperative younger child as another way to evaluate for air trapping. If an abnormality is present on any type of imaging, the patient should be referred for further evaluation.

In the child presenting with chronic cough or new-onset wheezing, if there is no history of possible aspiration and imaging is normal, follow-up with the primary

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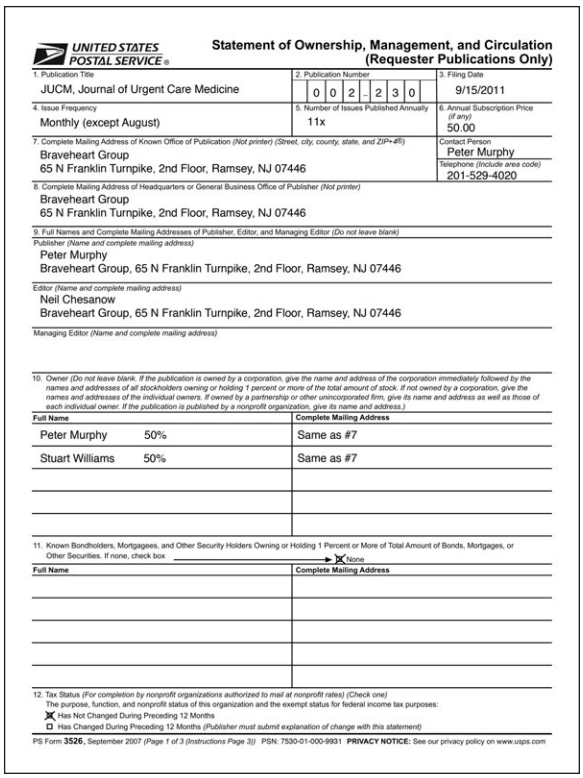

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Statement of Ownership, Management, and Circulation (Requester Publications Only)

1. Publication Title	2. Publication Number	3. Filing Date
JUCM, Journal of Urgent Care Medicine	0 0 2 - 2 3 0	9/15/2011
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price (If any)
Monthly (except August)	11x	50.00

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4®) — Contact Person: Peter Murphy; Telephone (Include area code): 201-529-4020
Braveheart Group
65 N Franklin Turnpike, 2nd Floor, Ramsey, NJ 07446

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer)
Braveheart Group
65 N Franklin Turnpike, 2nd Floor, Ramsey, NJ 07446

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)
Publisher (Name and complete mailing address)
Peter Murphy
Braveheart Group, 65 N Franklin Turnpike, 2nd Floor, Ramsey, NJ 07446

Editor (Name and complete mailing address)
Neil Chesanow
Braveheart Group, 65 N Franklin Turnpike, 2nd Floor, Ramsey, NJ 07446

Managing Editor (Name and complete mailing address)

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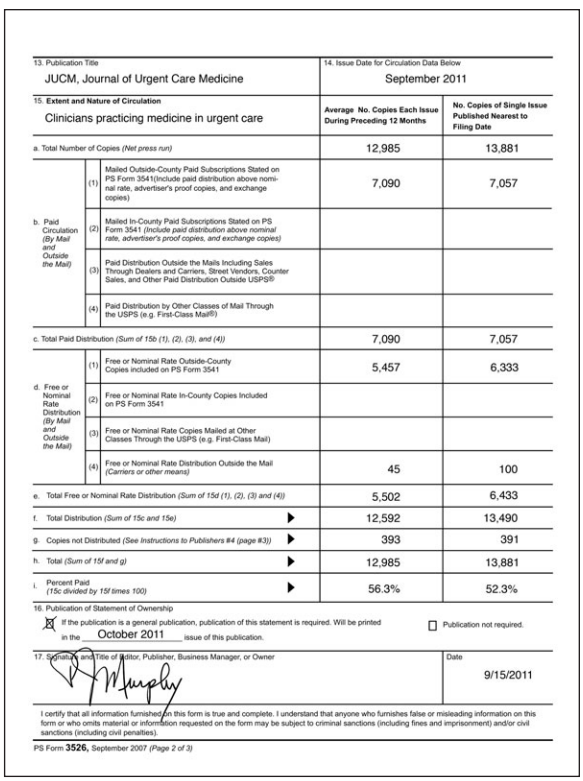

13. Publication Title	14. Issue Date for Circulation Data Below
JUCM, Journal of Urgent Care Medicine	September 2011

15. Extent and Nature of Circulation: Clinicians practicing medicine in urgent care			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)			12,985	13,881
b. Paid Circulation (By Mail and Outside the Mail)	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541(Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	7,090	7,057
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d. Free or Nominal Rate Distribution (By Mail and Outside the Mail)	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541	5,457	6,333
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	(4)	Free or Nominal Rate Distribution Outside the Mail (Carriers or other means)	45	100
e. Total Free or Nominal Rate Distribution (Sum of 15d (1), (2), (3) and (4))			5,502	6,433
f. Total Distribution (Sum of 15c and 15e)			12,592	13,490
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))			393	391
h. Total (Sum of 15f and g)			12,985	13,881
i. Percent Paid (15c divided by 15f times 100)			56.3%	52.3%

16. Publication of Statement of Ownership
☒ If the publication is a general publication, publication of this statement is required. Will be printed in the October 2011 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date: 9/15/2011

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care provider should be arranged, keeping in mind that unwitnessed aspiration of a foreign body often takes longer to correctly diagnose.[20-22]

Conclusion

Many foreign bodies inserted into the pediatric ear or nose can be evaluated and removed in the office or urgent care setting. Knowing the size and makeup of an ingested foreign body is important. A radiograph can help determine its presence, size, and location. Objects lodged in the esophagus, as well as magnets or button batteries lodged in any location, should be referred to the ED for further evaluation by the appropriate subspecialist. Foreign bodies that are aspirated can have very obvious or very subtle presentations. Always maintain a high index of suspicion for the presence of a foreign body in a child presenting for evaluation. When a foreign body is recognized, prompt referral to the ED or an appropriate subspecialist will ensure appropriate care. ■

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Bouncebacks

The Case of a 32-year-old Woman With Headache:

When an Uncommon—Potentially Catastrophic—Diagnosis Is Masked by a Common Complaint

In Bouncebacks, *which appears quarterly in* JUCM, *we provide documentation of an actual patient encounter, discuss patient safety and risk management principles, and then reveal the patient's "bounceback" diagnosis. This* Bouncebacks *case is unique in that it also went to trial, excerpts from which are also presented.*

This case is adapted from the Bouncebacks! Medical and Legal *(Anadem Publishing) by Michael B. Weinstock, MD, and Kevin Klauer, DO, with risk management commentary by Gregory L. Henry, MD, past president of the American College of Emergency Physicians, and discussions by other nationally recognized medical and legal experts. It is available on Amazon.com. For more on* Bouncebacks, *visit* www.embouncebacks.com.

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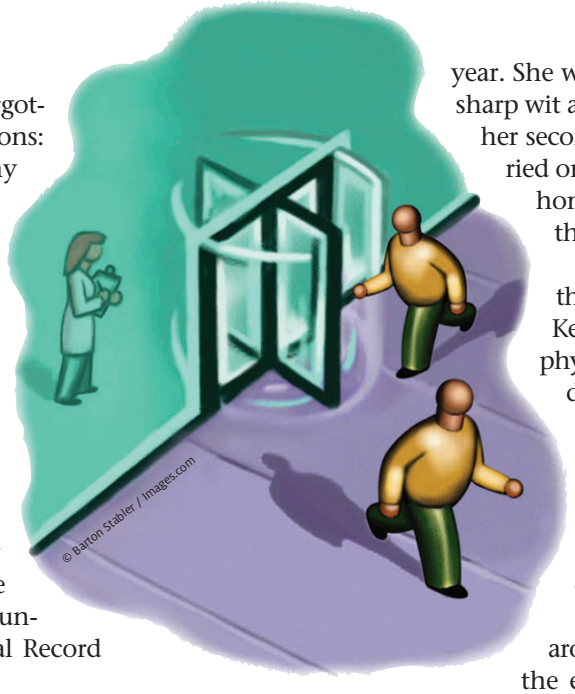

Authors' Note

A case like this is not soon forgotten. It raises haunting questions: Is the "worst headache of my life" pathopneumonic for *anything?* How do we reconcile abnormal results with a conflicting clinical story? Have you ever been guilty of "diagnosis momentum"? What is the role of advanced-line antibiotics in the treatment of sinusitis?

Why such questions are haunting will soon become evident. A young mother of three. A common complaint. A tricky diagnosis. A tragic result. Like TV's *Law and Order,* this case unfolds in two parts: The Medical Record and The Legal Record.

PART I. THE MEDICAL RECORD

The Patient's Story

In 1999, Kelli Flood, age 32, had held a good job at Stem Outdoor Advertising. She made just under $50,000 per year. She was smart and pretty and had a sharp wit and a good work ethic. She and her second husband, Shane, were married on October 28, 1998, and took a honeymoon at a *Sandals* resort in the Caribbean.

Several days after the birth of their son, Jacob, on July 30, 1999, Kelli presented to her primary care physician with a headache and was diagnosed with sinusitis. She was given amoxicillin. The headaches continued to the point where, on August 8, she said her head pain was "indescribable, like my head was going to come off or split in two."

That afternoon, a Sunday, at around 6 pm, Shane drove Kelli to the emergency department of the local hospital. Here is the first of two perspectives on what happened next.

The Doctor's Version

(The following, as well as other case notes to be pre-

sented, is from the actual documentation of the providers involved.)

Chief complaint as noted by the triage RN (August 8, 1999: 18:32): Throbbing head, migraine comes on suddenly.

Nurse's note: Headache has happened 3 times in past 7 days, c/o pain in the forehead and back of head. This headache was of sudden onset ½ hour ago. Had an epidural (with delivery). Ice to forehead, crying, headache 10/10.

History of present illness (18:55): This patient is a 32-year-old female who is 8 days postpartum. [Headache] began spontaneously at 1800 and is the worst one of her life. She was asleep and awoke with the discomfort. She was dx with sinusitis 5 or 6 days ago by her primary care doctor and placed on amoxicillin 500 mg tid. Since that time, the patient has had 2 other headaches, which were not quite as severe. HA is frontal and bi-temporal with photophobia and nausea but no vomiting. There is no phonophobia, numbness, or tingling.

"It is difficult to diagnose sinusitis without symptoms of sinusitis."

PAST MEDICAL HISTORY

Allergies: Sulfa (swelling)
Meds: Amoxicillin, Tylenol extra strength, prenatal vitamins
PMH/PSH: Negative
Surgery: C-section 1987, broke arm 16 years ago, laparoscopic surgery 1990
FH: Father—diabetes

PHYSICAL EXAMINATION

Constitutional: A&O x 3. Patient does appear to be moderately uncomfortable.
Skin: No lesions are identified.
Eyes: EOMI. PERRL. Fundi are normal.
ENT: Minimal nasal mucosal erythema. The pharynx is normal. Bifrontal tenderness to palpation.
Neck: Supple, without masses. No LAN.
Lungs: CTAB.
Heart: RRR without rubs, clicks, or murmurs.
Neurologic: Evaluation includes sensory, motor, cerebellar, and cranial nerve II-XII. Examination is intact. No meningeal signs are present.

MEDICAL DECISION MAKING

19:50: After discussing the possible effect of narcotics on the baby, who is being breast fed, mother did agree to an injection of Demerol 75mg IM and Phenergan 25mg IM.

20:15: Repeat vitals: pulse 64, respirations 18, BP 176/50.

Doctor's progress note
Patient had moderate relief of pain with meds. She has cephalgia, which I believe is related to sinusitis, and I will switch her to Biaxin, Darvocet, and Entex LA. Recheck in 3 to 4 days if there is no improvement in the overall symptoms, sooner if worse. Released ambulatory at 20:35.

DIAGNOSIS

1. Acute sinusitis.
2. Acute cephalgia

Seth Hockenberry, MD

Patient Safety and Risk Management Issues
(Authors' note: It is obvious from the progress note that this doctor cared about his patient. He not only spent a lot of time with her, he informed her when and why to return. The following are some considerations about the initial evaluation.)

Error 1: Anchoring bias and diagnosis momentum
Discussion: Once the emergency physician found erythematous nasal mucosa and "sinus tenderness," he *anchored* on a diagnosis of sinusitis. This was likely coupled with *diagnosis momentum,* as the patient was actually taking amoxicillin for a previous diagnosis from her primary care doctor.[1] Curiously, there was no documentation of clinical sinus symptoms such as rhinorrhea, post nasal drip, facial/tooth pain, or fever.

Teaching point: It is hard to diagnose sinusitis without symptoms of sinusitis.

Error 2: Differential diagnosis was too narrow
Discussion: Whereas the two most immediately-concerning diagnoses in patients with nontraumatic

Vital Signs								
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headache remain subarachnoid hemorrhage (SAH)[2-4] and meningitis, there are other "can't miss" secondary causes of headaches, including:

- Brain mass
- Temporal arteritis
- Pseudotumor cerebri (idiopathic intracranial hypertension)
- Carbon monoxide toxicity
- Acute angle-closure glaucoma
- Carotid artery dissection
- Cavernous sinus thrombosis
- Preeclampsia/eclampsia[5-6]

"Kelli began to shake all over, her eyes rolled back in her head, and she was foaming at the mouth. Shane called 911."

Regarding the "can't miss" diagnosis of SAH, Kelli did give a history of sudden-onset headache, a symptom more concerning than "the worst headache of my life" (which also was present in her story). The onset always needs to be elicited in the headache history, and when a patient answers "sudden," further questioning should establish whether it reached maximum intensity in one minute or less.

The "worst headache of life" is a commonly elicited history but really doesn't mean much. After all, the first headache of your life is, by definition, both the worst and most benign headache you have ever had. But the fact that this patient had both sudden onset *and* intense pain required the physician to exclude SAH by a combination of CT scan and lumbar puncture (if the CT is negative).

Preeclampsia was concerning in Kelli Flood's case since her headache was coupled with increased blood pressure. Preeclampsia/eclampsia can occur up to 30 days postpartum. The problem is that a headache (pain) can also cause the blood pressure to go up. Additional findings with preeclampsia may include:

- Hyperreflexia/clonus
- Abdominal pain
- Proteinuria
- Lack of a previous history of hypertension

Note: These are clinical signs that can be easily evaluated in an urgent care setting. Another easily derived diagnosis is post-dural puncture headache. These are worse when sitting up and better when lying flat, a diagnosis arrived at by history alone. Kelli was postpartum but history of delivery was not elicited.

Primary headaches include the following:

- Migraine
- Tension
- Cluster
- Narcotic withdrawal
- Stress headaches

However, none of these was consistent with Kelli's presentation.

Teaching point: Maintain a high index of suspicion for high-risk headache patients.

Error 3: Over-reliance on antibiotics for sinusitis
Discussion: Sinusitis is usually viral. The number needed to treat (NNT) with antibiotics to get one patient better faster is between 8 and 12. When the decision is made to use a second-line antibiotic (eg, macrolide, quinolone) instead of a first-line antibiotic (eg, amoxicillin, TMP/SMZ, doxycycline), the NNT skyrockets to 100.[7] In other words, when a patient fails on amoxicillin, you would need to dispense 100 prescriptions at a cost of $100 for each medication (total cost: $10,000) to get one patient better faster. While it would have been okay to "bump up" the antibiotic from amoxicillin to clarithromycin in Kelli's case, that she failed to improve on an antibiotic in the first place should have prompted a re-evaluation of the diagnosis.

Teaching point: Sinusitis is overdiagnosed and effect of antibiotics is overstated.

Error 4: Medical decision-making
Discussion: "Confirmation bias" is the practice of finding evidence to support a diagnosis (as opposed to looking for data to disprove it).[1] If an objective third party had looked at Kelli's history without knowledge of her recent treatment for sinusitis, it is unlikely that doctor would have arrived at this diagnosis.

Teaching point: Gather evidence first and make a diagnosis based upon your findings.

THE ED BOUNCEBACK

The next day, Kelli's headache worsened. She fixed dinner but didn't eat anything. "I went into the bedroom, because that's where Jake was, and I couldn't see him," she testified later in court. "I yelled for Shane and said, 'I can't see the baby.' So I sat down on the steps of the bathroom and I just don't remember anything else."

Kelli began to shake all over, her eyes rolled back in her head, and she was foaming at the mouth. Shane called 911.

EMS note
Found sitting on steps. She does not respond to verbal commands and is disoriented as to time and place. Glucose is 92.

"Who has ever consulted a neurologist and been talked out of an LP? This is a reportable event!"

The ED record

- **Chief complaint (21:32):** Possible seizures.
- **Vital signs**: Temp 97.4, pulse 78, resp 16, BP 172/99, sat 97% RA.
- **PE**: Pt. moaning with pain and shaking her head from side to side and crying. Knows answers to questions. At times ignores questions. No gross neurological deficits.
- **CT brain:** No bleed or shifts. Small ventricles without signs of cerebral edema.
- **Testing:** Labs normal. CXR: no infiltrates. UA normal.
- **ED course**: The patient's BP did go up to 190/115, with worsened headache and crying. Mental status remains unchanged. Lasix IVP. Nipride drip. Demerol 25 mg and Phenergan 25 mg IV.
- **Discussion with spouse:** I stated to the husband that she may have encephalitis, and an LP was indicated. Further, acyclovir will be started, depending upon the results of the LP.
- **Neuro consult:** I spoke with Dr. Quinn, the neurologist on call, and the decision was made not to do the LP since our lab is limited. The patient was admitted to the ICU.

FINAL DIAGNOSIS

1. Severe cephalgia with acute mental status change and possible first-time seizures.
2. Consider encephalitis, herpes simplex.
3. Cannot entirely rule out a herald bleed with undetectable subarachnoid hemorrhage at this time.

Robert Carozza, MD

(Authors note: Hmmm … who has ever consulted a neurologist and been talked out of an LP? This is a reportable event! There were still several diagnostic possibilities on the table, which the second ED physician had not ruled out, including subarachnoid hemorrhage, herpes encephalitis, meningitis, and eclampsia.)

HOSPITAL COURSE

- MRI showed ischemic changes in the right cerebellar cortex. EEG was unremarkable. Lumbar puncture: WBC 1, RBC 84, protein 77, glucose 46.
- Repeat MRIs showed cerebral infarcts in the frontal, parietal, and occipital lobes.
- On August 19, 1999, 10 days after admission, Kelli had another seizure and was transferred to a tertiary care facility.
- The differential now included postpartum cerebral angiopathy, cerebral vasculitis, and eclampsia. Kelli was treated presumptively with high-dose IV steroids and magnesium.
- At discharge, Kelli was mildly responsive and occasionally interactive.

FINAL OUTCOME

Kelli was left irreversibly triplegic. She lives at home and is cared for by her husband.

PART 2. THE LEGAL RECORD

Why sue?
Kelli Flood had a horrible outcome: a young mother, now triplegic, requiring lifelong medical care and assistance. Before her turn for the worse, she was sitting in the hospital room playing cards with her husband, waiting to go home to be with her family and newborn child. Suddenly she experienced a seizure from which she would never recover. It is not difficult to see why this family would file a malpractice suit.

Plaintiff attorney to Kelli Flood (plaintiff) on Day 6 of the trial
Q. Would you describe Jacob for us?
A. He's a wonderful little boy. He's three and a half. He is extremely active. He's just … I can't say enough about him. I'm a very proud mother.
Q. What are some of the things that you like to do with Jacob?
A. I like to help him count and teach him his alphabet. I like to play "This Little Piggy" with him. He climbs up and sits on my lap. I let him brush my hair. He likes to read to me. He can't read, but he likes to tell me stories that he makes up. He pretends. He likes to help me with anything I ask him to do. If I ask him, "Get Mommy a drink of water, would you, Jacob?," he'll run and get it. If I need a Kleenex, he runs and gets it.
Q. Does Jacob love you?
A. Yes, he does.
Q. How do you know that?
A. Because he tells me so. He throws his arms around my

neck and says, "Mommy, I love you."

THE ACCUSATION/CAUSE OF ACTION

Civil complaint

Plaintiff requires the use of a wheelchair and has only the use of her left hand. Prior to this event, plaintiff was the active mother of three children. She seeks past medicals of $561,266, future medicals of $10,393,754, and future wage loss of $1,300,000.

Synopsis of the court record

At trial, Kelli's attorney argued that Seth Hockenberry, the first emergency physician to see her, failed to differentially diagnose postpartum preeclampsia and/or eclampsia and failed to presumptively treat her with magnesium sulfate.

THE TRIAL (January 2003)

(Author's note: What follows are selected excerpts of testimony from the actual court record. Have you ever sat in a courtroom for two weeks while eight non-physicians decided whether your care was appropriate? Close your eyes, visualize world peace … then make sure your headache differential includes preeclampsia.)

Judge's instructions to the jury

Good morning, ladies and gentlemen. Today is the 15th of January, 2003. We convene in Flood vs Hockenberry. Opening statements will give you a preview of what the respective attorneys believe this case will show. In any lawsuit, the plaintiffs go first because they have the burden of proof.

This is not a criminal case and the burden of proof that you may have heard of about "beyond a reasonable doubt" does not apply in this case. In a civil lawsuit, the plaintiffs have the burden of proving their suit by a *preponderance of the evidence,* which is the greater weight of the evidence. That is evidence that you believe because it outweighs in your mind the evidence opposed to it. Are counsels ready to proceed with opening statements?

Opening statement by the plaintiff attorney

Good morning, ladies and gentlemen. I want to start out by talking a little bit about some rules that doctors follow, rules they learn in medical school and apply every day. Doctors have a duty to use ordinary care—what a reasonably cautious doctor would do in the same situation. Those are rules you'll follow, too, when you decide this case. There's going to be a word mentioned by every doctor who testifies in this case. That word is "eclampsia." It has been known for many, many years.

A couple of things about eclampsia. Number one, fifty thousand women a year die from eclampsia. Number two, that's in the world, okay? In the United States, ninety thousand to a hundred thousand women are diagnosed with a condition called "preeclampsia." It is the second-leading cause of maternal death in the United States. Every textbook that's on the subject talks about it. Every doctor knows, or should know, what it is.

What is eclampsia? Eclampsia is a disease. These are not disputable things. Any woman who is pregnant or has recently delivered a baby can get it. Some people used to think that it was a toxin, a poison that would go through your body. That's why it was [once] called "toxemia." I look at it like a snake bite. If you get a snake bite, you've got to do something quick. If the poison goes through, well, what do you do? You go get the serum, right, to stop the poison. Well, there's a serum in talking about eclampsia. It's a drug called magnesium sulfate. Doctors use the [term] that it's the "drug of choice." That's what they say. It's *the* drug. In a study published in the *New England Journal of Medicine,* there were 1,049 patients who had eclampsia. They gave them magnesium sulfate. Guess how many of the thousand forty-nine continued to have seizures? Zero. It's been known for a hundred of years. It's the drug of choice.

Now, I mentioned preeclampsia; you have preeclampsia before you have eclampsia. The body gives out warning signs. So, what are the warning signs? There's not much dispute here. Number one, you've got to be pregnant or postpartum. Number two is high blood pressure. There's also often a severe headache, visual disturbances like photophobia, protein in the urine, brisk reflexes, nausea, and upper quadrant [abdominal] pain.

How does a doctor go about finding these signs? Easy. He takes a history. What happened? Are you pregnant? Recently been pregnant? Have you had headaches? Visual disturbances? Nausea? What's the second way they do it? Lab tests, for example, proteinuria. What's the third? An exam. So, history, exam, and testing.

Some other things about eclampsia that will be interesting to you. I call them truisms because they're true about this disease. Number one, it gets worse if it's untreated. It can move from preeclampsia to eclampsia in a short amount of time. That's why it's a medical emergency. How do you treat it? Mag Sulfate.

Okay. July 30, 1999, we've got a couple proud parents. Kelli Flood delivered a baby—it was a pretty happy time. On August 8th, eight days postpartum, it's the first opportunity to help Kelli. Kelli is seen by Dr. Hockenberry. Kelli

was in bad shape. She was crying. She had [a severe] headache, she had visual changes, photophobia, nausea. He takes her blood pressure. It's 156/95. Dr. Hockenberry thought that a cold was causing the most severe headache of her life and that the high blood pressure was caused by the pain. So he gave her a shot of Demerol. The headache got better, but the blood pressure went up. The pain was less and the blood pressure was more. It went from 156 to 176.

"A defense offer of $500,000 to settle the case had already been declined, but an emergency call from the insurance company reached the defense attorney, cell phone in hand. The new offer: $750,000."

Do you know what he didn't do? Order a urinalysis. This is no big complicated test; you pee into a bottle and check it with a dipstick. He didn't do that. [And] He didn't check her reflexes.

Kelli was a career woman. She made $45,000 a year. She hasn't worked since and will never work again. This is a picture of her family, her kids. [Shows photo to jury.] She can do a few things. She can read to them if the print is big or if she has a magnifying glass. She can count numbers a little bit. But she can't throw a ball. She can't drive to soccer. Kelli is frozen in her own body, and it was preventable.

Direct examination of the plaintiff expert witness by the plaintiff attorney

Q. You would agree that Mrs. Flood had a condition difficult to diagnose?

A. No, I wouldn't agree to that, actually.

Q. I take it that you have criticisms of the physician?

A. That's correct.

Q. In your review, were you able to formulate a diagnosis as to Mrs. Flood's condition?

A. Yes.

Q. And would you please tell me what your diagnosis was in that regard?

A. I believe she had eclampsia. It is a continuum of the disease, and she presented in two different stages.

Q. Did you make a differential diagnosis?

A. Yes. First was eclampsia, second would be eclampsia, third would be eclampsia, fourth would be other causes of an intracranial process. And I'm going to lump them together for you: various forms of stroke, vasculitis, or infection—but these would fall far beneath [eclampsia in probability]. Given the symptom complex and its findings, [eclampsia] is far and away the most likely diagnosis.

(Author's note: There was much more to this trial: a claim that Kelli in fact did not have eclampsia but a different diagnosis called "postpartum cerebral angiopathy," allegations against other players involved in her care—including the neurologist, and striking testimony from Kelli herself, given from her wheelchair. We jump now to the verdict.)

The judge's Instructions to the jury (January 29, 2003)

The Court has given you the instructions on the law applicable to this case. In a civil case, again, such as the present one, at least six members of the jury [out of a total of eight] must agree upon a verdict. Each of you must decide this case for yourself, but you should do so only after a discussion of the case with your fellow jurors.

THE TWIST

As the jurors left the courtroom to deliberate, there was a flurry of activity on both sides. A defense offer of $500,000 to settle the case had already been declined, but an emergency call from the insurance company reached the defense attorney, cell phone in hand. The new offer: $750,000. This was conveyed to the plaintiff attorney who, after deliberating with Kelli in a hotel room across the street, declined the offer.

Panic ensued as the insurance company was told of the rejection. The ante was upped to $1 million. Additional telephone calls were placed, but the offer was again rejected by the plaintiff.

A pre-verdict assessment by the defense attorney

I felt from a scientific standpoint we had a winner, but I kept looking at a lady in a wheelchair. I was not confident [the jury] would walk away from her. They were asking for $15 million, which I did not think they would get, but I would not be surprised with $4-$5 million. Our defendant was very good.

THE VERDICT

Judge: It's January 29, 2003. The record should reflect that the parties are all present, with counsel. The jury has indicated that they have reached verdicts. Mr. Long,

I understand you were selected as the foreperson.
Jury foreman: Yes, Your Honor.
Judge: Congratulations. Have you reached verdicts?
Jury foreman: Yes, we have, sir. We, the jury, being duly impaneled, sworn, and affirmed, find for the defendants with respect to the claim against the defendant.

Summary
Seven jurors found for the defendant physician, Seth Hockenberry.

Judge: Ladies and gentlemen of the jury, this obviously was a long and very difficult case. Throughout the trial, as I would look over and watch you folks, I know you didn't take your job lightly. I appreciate [the sacrifice of your time]. The parties had a dispute they couldn't resolve. Our system says that we call upon eight citizens to help resolve the issues. You did everything you were called upon to do. You should be proud of your service.

(Author's note: The jury split 7-1, voting for the physician defendants. After the trial, the lead defense attorney was standing in the hall and saw the plaintiff being wheeled out of the courthouse. The wheelchair was being pushed by two people; one was the lone juror who voted for the plaintiff. When they exited the courthouse, she helped load the defendant into the van.)

POST-TRIAL REFLECTIONS FROM THE ATTORNEYS WHO ARGUED THIS CASE

The defense attorney
The jury didn't buy whether two ED doctors ought to have been able to diagnose postpartum eclampsia when an OB [who had testified at 450 trials] had only seen it once.

The plaintiff attorney
- I think about this case at least once a week.
- The ED docs won the case as they [the jury] thought, "If a neurologist couldn't diagnose it, how could we expect an ED doc to [make the diagnosis]."

URGENT CARE EVALUATION OF POSTPARTUM HEADACHE

Evaluation of headache in the urgent care is tricky, as most headaches are benign and self-limiting—except the headaches that are life-threatening! It is the bold and risk-taking physician who ignores abnormal findings while continuing to "play the odds" with a diagnosis of sinusitis.

Whereas blood pressure is often increased from pain, the plaintiff attorney was exactly right: Why would the repeat BP be higher if Kelli's pain was less?

Including preeclampsia (which can occur up to 30 days postpartum) in the differential would have allowed for simple bedside testing of reflexes, including clonus and proteinuria, and possibly an OB consult.[5-6] If a 30-second phone call had been made to Kelli's obstetrician, you might not be reading this case.

So, how can we find a needle in the haystack of common diagnoses?

First, just as a patient with untreated AIDS and a headache would automatically bring to mind meningitis or a mass, our postpartum patient represents a unique subset of patients. Consideration should be given to preeclampsia as well as to headaches that occur in postpartum patients, such as post-LP headache, cerebral venous sinus thrombosis, pituitary apoplexy, and subarachnoid hemorrhage.[8]

Second, if sinusitis is not improving, the first consideration should be to reassess the diagnosis.[9-12] The data shows that the NNT with a second-line antibiotic compared to a first-line antibiotic for sinusitis (amoxicillin, TMP/SMZ, doxycycline) is 100. Do we really think that Kelli had the 1 in 100 case that needed advanced antibiotics?

Third, though this sounds like a broken record, *vital signs* are called *vital* for a reason. The plaintiff attorney had a field day with the second (elevated) blood pressure check. "Why would the blood pressure go up," he repeatedly asked, "if the pain went down?"

If there is an abnormal test result, particularly in light of diagnostic uncertainty, a note should be recorded explaining the medical decision-making process. ■

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with reduced creatinine clearance will have diminished clearance of the drug. SPRIX® is contraindicated in patients with advanced renal impairment. Patients treated with SPRIX® should be adequately hydrated. Use SPRIX® with caution in patients with impaired renal function, heart failure, liver dysfunction, those taking diuretics or ACE inhibitors, and the elderly. Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury such as interstitial nephritis and nephrotic syndrome.

Anaphylactoid Reactions. As with other NSAIDs, anaphylactoid reactions may occur in patients with or without a history of allergic reactions to aspirin or NSAIDs and in patients without known prior exposure to ketorolac. SPRIX® should not be given to patients with the aspirin triad.

Cardiovascular Effects

• Cardiovascular (CV) Thrombotic Events

Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious CV thrombotic events, myocardial infarction and stroke, which can be fatal. Patients with known CV disease or risk factors for CV disease may be at greater risk. To minimize the potential risk for an adverse CV event in patients treated with an NSAID, the lowest effective dose should be used for the shortest duration possible.

• Hypertension

NSAIDs can lead to onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Patients taking thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs.

• Congestive Heart Failure and Edema

Fluid retention, edema, retention of NaCl, oliguria, and elevations of serum urea nitrogen and creatinine have been reported in clinical trials with ketorolac. Therefore, only use SPRIX® very cautiously in patients with cardiac decompensation or similar conditions.

Skin Reactions. NSAIDs, including ketorolac, can cause serious skin adverse events such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. Inform patients about the signs and symptoms of serious skin manifestations, and discontinue use of the drug at the first appearance of skin rash or any other sign of hypersensitivity.

Pregnancy. Starting at 30 weeks gestation, SPRIX® can cause fetal harm when administered to a pregnant woman due to an increased risk of premature closure of the ductus arteriosus. If SPRIX® is used at or after 30 weeks gestation, the patient should be apprised of the potential hazard to a fetus.

Hepatic Effects. Use SPRIX® with caution in patients with impaired hepatic function or a history of liver disease. Borderline elevations of one or more liver tests may occur in up to 15% of patients taking NSAIDs, including ketorolac. In addition, rare cases of severe hepatic reactions, including jaundice, fulminant hepatitis, liver necrosis, and hepatic failure, some of them with fatal outcomes, have been reported.

Inflammation and Fever. The pharmacological activity of SPRIX® in reducing inflammation and fever may diminish the utility of these diagnostic signs in detecting infections.

Preexisting Asthma. Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Since cross reactivity, including bronchospasm, between aspirin and other NSAIDs has been reported in such aspirin-sensitive patients, do not administer SPRIX® to patients with this form of aspirin sensitivity, and use with caution in patients with preexisting asthma.

Eye Exposure. Avoid contact of SPRIX® with the eyes. If eye irritation occurs, wash out eye with water or saline, and consult a physician if irritation persists for more than one hour.

ADVERSE REACTIONS

The most frequently reported adverse reactions were related to local symptoms, i.e., nasal discomfort or irritation. These reactions were generally mild and transient in nature. The most common drug-related adverse events leading to premature discontinuation were nasal discomfort or nasal pain (rhinalgia).

The data described below reflect exposure to SPRIX® in patients enrolled in placebo-controlled efficacy studies of acute pain following major surgery. Most patients were receiving concomitant opioids, primarily PCA morphine.

Table 1. Post-operative Patients with Adverse Reactions Observed at a rate of 2% or more and at least twice the incidence of the placebo group.

	SPRIX® (N=455)	Placebo (N= 245)
Nasal discomfort	15%	2%
Rhinalgia	13%	<1%
Lacrimation increased	5%	0%
Throat irritation	4%	<1%
Oliguria	3%	1%
Rash	3%	<1%
Bradycardia	2%	<1%
Urine output decreased	2%	<1%
ALT and/or AST increased	2%	1%
Hypertension	2%	1%
Rhinitis	2%	<1%

In controlled clinical trials in major surgery, primarily knee and hip replacements and abdominal hysterectomies, seven patients (N=455, 1.5%) treated with SPRIX® experienced serious adverse events of bleeding (4 patients) or hematoma (3 patients) at the operative site versus one patient (N=245, 0.4%) treated with placebo (hematoma). Six of the seven patients treated with SPRIX® underwent a surgical procedure and/or blood transfusion and the placebo patient subsequently required a blood transfusion.

DRUG INTERACTIONS

Ketorolac is highly bound to human plasma protein (mean 99.2%). There is no evidence in animal or human studies that ketorolac induces or inhibits hepatic enzymes capable of metabolizing itself or other drugs.

Warfarin, Digoxin, Salicylate, and Heparin. Therapeutic concentrations of digoxin, warfarin, ibuprofen, naproxen, piroxicam, acetaminophen, phenytoin, and tolbutamide did not alter ketorolac protein binding.

Aspirin. When ketorolac is administered with aspirin, its protein binding is reduced, although the clearance of free ketorolac is not altered. The clinical significance of this interaction is not known; however, as with other NSAIDs, concomitant administration of SPRIX® and aspirin is not generally recommended because of the potential of increased side effects.

Diuretics. Clinical studies, as well as postmarketing observations, have shown that ketorolac can reduce the natriuretic effect of furosemide and thiazides in some patients.

Probenecid. Concomitant administration of oral ketorolac and probenecid resulted in decreased clearance and volume of distribution of ketorolac and significant increases in ketorolac plasma levels (total AUC increased approximately threefold from 5.4 to 17.8 mcg/h/mL), and terminal half-life increased approximately twofold from 6.6 to 15.1 hours. Therefore, concomitant use of SPRIX® and probenecid is contraindicated.

Lithium. NSAIDs have produced an elevation of plasma lithium levels and a reduction in renal lithium clearance. The mean minimum lithium concentration increased 15%, and the renal clearance was decreased by approximately 20%. Thus, when SPRIX® and lithium are administered concurrently, observe patients carefully for signs of lithium toxicity.

Methotrexate. NSAIDs have been reported to competitively inhibit methotrexate accumulation in rabbit kidney slices. This may indicate that they could enhance the toxicity of methotrexate. Use caution when SPRIX® is administered concomitantly with methotrexate.

ACE Inhibitors/Angiotensin II Receptor Antagonists. Concomitant use of ACE inhibitors and/or angiotensin II receptor antagonists may increase the risk of renal impairment, particularly in volume-depleted patients. Reports suggest that NSAIDs may diminish the antihypertensive effect of ACE inhibitors and/or angiotensin II receptor antagonists. Consider this interaction in patients taking SPRIX® concomitantly with ACE inhibitors and/or angiotensin II receptor antagonists.

Antiepileptic Drugs. Sporadic cases of seizures have been reported during concomitant use of ketorolac and antiepileptic drugs (phenytoin, carbamazepine).

Psychoactive Drugs. Hallucinations have been reported when ketorolac was used in patients taking psychoactive drugs (fluoxetine, thiothixene, alprazolam).

Pentoxifylline. When ketorolac is administered concurrently with pentoxifylline, there is an increased tendency to bleeding. Therefore, concomitant use of SPRIX® and Pentoxifylline is contraindicated.

Nondepolarizing Muscle Relaxants. In postmarketing experience there have been reports of a possible interaction between ketorolac and nondepolarizing muscle relaxants that resulted in apnea.

Selective Serotonin Reuptake Inhibitors (SSRIs). There is an increased risk of gastrointestinal bleeding when selective serotonin reuptake inhibitors (SSRIs) are combined with NSAIDs.

Fluticasone/Oxymetazoline. The rate and extent of absorption of ketorolac from SPRIX® administration were assessed in subjects with allergic rhinitis before and after the administration of a single daily dose of fluticasone and oxymetazoline. There was no effect on the pharmacokinetic characteristics of SPRIX® that can be considered clinically significant.

DRUG ABUSE AND DEPENDENCE

Ketorolac does not bind to opiate receptors.

Symptoms and Signs. Symptoms following acute NSAID overdose are usually limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain, which are generally reversible with supportive care. Gastrointestinal bleeding can occur. Hypertension, acute renal failure, respiratory depression, and coma may occur, but are rare.

Treatment. Manage patients using symptomatic and supportive care following an NSAID overdose. There are no specific antidotes.

PATIENT COUNSELING INFORMATION

Instruct patients to read the NSAID Medication Guide that accompanies each prescription dispensed.

BS8880
Revised 7/2011

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Case Report

A Surprising Cause for "Pregnancy"

Urgent message: When a test does not confirm a patient's theory about the cause of her symptoms, both patient and provider must look elsewhere.

SEAN MCNEELEY, MD

Introduction

When a mother of three complains of symptoms of pregnancy, the test usually confirms that she is right. Occasionally, however, the results are surprising, as this case illustrates.

Case Presentation

WM, a 28-year-old female, presented to an urgent care with concerns that she might be pregnant and was very worried because she currently had a Mirena® IUD in place. For the past three months, she had noted fatigue, weight changes, breast discharge, and nausea, just as she had experienced in her previous three pregnancies. The discharge was milky in appearance and was noted on her clothing and during showering.

WM had not been pregnant or nursing for more than two years but was certain the symptoms were indicative of pregnancy. Her periods had stopped several years earlier, after her IUD was placed. She had noted a dull headache for several months but denied visual changes. Other than nausea, gastrointestinal symptoms such as diarrhea, constipation, or emesis were absent.

WM had tried two home pregnancy tests. To her dismay, both were negative. Past medical history was otherwise negative. She denied oral medications and is allergic to latex.

Sean McNeeley is Medical Director for University Hospitals Urgent Care Network, a member of the Board of Certification of Urgent Care Medicine, and Treasurer of the Urgent Care College of Physicians.

Observation and findings

On exam, WM was in no distress. Her vital signs were normal:

- T: 98.4° F
- P: 66
- R: 12
- BP: 114/70
- O_2 sat: 100%

WM's head and eyes, including fundal exam, were normal. She had no gross visual field defect. Her ears, nose, and throat revealed no abnormalities. Her neck was supple, without adenopathy. Her thyroid was not enlarged; no nodules were noted. Her heart rate was regular and no murmurs, gallops, or rubs were present. Her lung exam was without distress; no wheezes, rales, or rhonchi were present. Her breast exam revealed no masses. No discharge was noted during the exam. Her abdomen was soft. Her

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bowel sounds were normal. No masses or palpable fundus was present. Her neurological exam, including deep tendon reflexes, was unremarkable.

Laboratory Results

Urine dipstick was normal and urine pregnancy test was again negative. A serum pregnancy test, performed at WM's request, was also negative. Because of the patient's unusual symptoms, prolactin level and TSH tests were sent to the main hospital lab. WM was sent home to follow up based on the test results. Both prolactin level 43.7 (6.0-20.0) and TSH 31.00 (0.36-3.74) were elevated. A referral to endocrinology was made to help determine the cause of these elevations.

Discussion

Many disease processes can mimic the signs or symptoms of pregnancy. Amenorrhea can be caused by premature ovarian failure, hypothyroidism, hyperthyroidism, polycystic ovarian disease, stress, weight change, exercise, and hyperprolactinemia. Abdominal mass or swelling can be the result of disorders such as constipation, tumor, or obstruction. Nausea, fatigue, and weight gain have numerous causes. When added to the sudden onset of galactorrhea years after WH's last pregnancy, a fourth pregnancy would have made sense.

A negative pregnancy test, however, mandates consideration of other causes. Although the patient's own diagnosis can often be helpful, care should be taken not to allow it to cloud the process of evaluating symptoms. When WM's symptoms were considered in view of her negative pregnancy test, a pituitary or other endocrine cause then led the differential.

Originally a pituitary cause such as an adenoma was considered. Pituitary adenomas may present as symptoms from the hormones they produce (prolactin, TSH, gonadotropins, etc.) or as symptoms from compression of adjacent tissue such as headache, visual changes, or decreased hormone production. Pituitary tumors comprise 10% of CNS tumors and are usually benign. Prolactinomas are the most common secretory tumor, followed by growth-hormone-secreting tumors. TSH-producing tumors are the most infrequent type.

Diagnosis depends on the type of tumor and symptoms present. Secretory tumors can be diagnosed by inappropriate increases in the hormones they produce. To confirm these and diagnose non-secretory-type tumors, an MRI with contrast is usually performed.

Tumors of the pituitary gland are treated based on their symptoms and whether they are causing symptoms secondary to compression. Most tumors are slow-growing. Possible treatments include surgery, radiation, or medications. Surgery is indicated when the tumor secretion is not easily controlled by medications or when the growth compresses adjacent structures, such as the optic nerves. Radiation is usually used as an adjunct to medications or surgery to help shrink the tumor mass. Medical therapy is only used for secretory tumors and is aimed at the specific hormone secreted. Prolactinomas are treated with dopamine agonists.

Although the possibility of a pituitary lesion initially made sense, several factors ultimately rendered it less likely. Most adenomas are single-hormone tumors. The level of prolactin was relatively low for a true adenoma, while the TSH was quite elevated. A third consideration is that the most likely differential for prolactinoma is primary hypothyroidism. The reason for this is that thyrotropin-releasing hormone (TRH) causes the release of prolactin as well as TSH. This better explains the patient's lab results.

Follow-up labs proved the free T4 to be very low, consistent with the final diagnosis of primary hypothyroidism. ■

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Take Patient Satisfaction to the Next Level

Urgent message: Companies like Apple and Nordstrom have raised the quality of customer experience to an art form, one that urgent cares would do well to emulate.

ALAN A. AYERS, MBA, MACC

Introduction

Urgent care is positioned as a consumer-focused delivery channel for low-acuity medical services—differentiated from hospital emergency departments and primary care practices by retail-facing locations, extended evening and weekend hours, and walk-in convenience. As with airlines, restaurants, and other service businesses, urgent care thrives on repeat visits and positive word of mouth from satisfied patients. Fostering patient loyalty requires an urgent care center to not only resolve the medical problem that is the reason for the patient's visit—efficiently and courteously—but to do so in a way that creates a positive emotional connection with the patient.

Focus on the Patient Experience

When was the last time you had a negative customer service encounter? Do you think the investors, management, and employees of the operation deliberately set out to disappoint you? If you ask most frontline employees whether they deliver "good service," their answer should be a unanimous Yes. The problem is that service providers and consumers often have different perspectives on what constitutes good service.

For example, an airline may arrive on schedule and without a safety incident—successfully delivering its "service"—but passengers who encounter drab terminals, long lines, bitter staff, and cramped seats will hardly "rave" about the experience. Merely delivering a "service" makes for a commodity provider that, by definition, has no brand loyalty and no competitive advantage.

If patients perceive all urgent care centers as equal in their ability to treat minor medical conditions, they will migrate to providers who offer the best overall experience. This means an urgent care operator who defines good service only in terms of clinical outcomes will rarely see the profitability and growth of a center that demonstrates passion, ingenuity, and authenticity in every detail of a patient visit. So how do you practice good medicine *and* offer good service from a patient perspective?

Alan A. Ayers is Vice President of Concentra Urgent Care in Dallas, Texas, and Content Advisor for the Urgent Care Association of America.

Table 1: Statement of Mission, Vision, and Values for Concentra Urgent Care

Mission	Vision	Values
Improving America's health one patient at a time	■ We will redefine patient care by treating individuals to a welcoming, respectful, and skillful experience ■ We will raise the standard of healthcare by putting individuals first, treating them with clinical excellence, and focusing on their ongoing wellness ■ We will succeed through innovation and the expertise of our colleagues in an environment of trust, support, and community	■ A healing focus ■ A selfless heart ■ A tireless resolve

Phase One: Clarify Who You Are and Who You Hope to Become

When an urgent care operator realizes the need to improve the patient experience, he typically starts looking to implement quick and easy fixes. But rarely do solutions that address no specific problem make an impact, particularly when the center's strategic priorities are undermining the patient experience.

"No successful business has cost-cut itself to prosperity."

Consider how an urgent care operator focused on maximizing daily profit margin (as opposed to growing net profits) can achieve his goals by short-staffing the center, limiting hours, and spending capital only when absolutely necessary. The result is a cost-driven culture that attracts the lowest paid workers to a shoddy facility with poorly maintained equipment, which, over time, patients will shun, given better choices. No successful business has ever cost-cut itself to prosperity. Growth requires investment in the people and infrastructure that deliver the service patients expect. There are no sufficient superficial fixes to impact an operation that, by design, sees the patient experience as an expense to be eliminated.

Undifferentiated commodity providers focus on controlling cost, but leading consumer brands invest millions to grow revenue by developing an emotional connection with consumers. Viewed as "cool," "real," "unique," "original," or "edgy," they integrate products, people, processes, systems, and environments to create an experience that's fundamentally better than competitors.

Short of inventing something completely new, an urgent care operator can borrow elements of leading consumer brands to create a culture that is aspirational yet achievable. The starting place is to identify one or two service cultures that relate to consumers exceptionally well. Consider whether your center strives for the brand attributes of, for example, Apple vs Hewlett-Packard, Starbucks vs McDonald's, Southwest Airlines vs American Airlines, Ritz Carlton vs Holiday Inn, or Nordstrom vs Walmart.

Once you identify brands that represent how you'd like patients to view your center, your "desired" state manifests in the form of a mission, vision, and values statement. Consider the mission, vision, and values statement for Dallas, Texas-based Concentra Urgent Care, with over 310 centers in 40 states (**Table 1**). It describes why the operation exists, what it intends to accomplish, and the values that direct its activities.

A center's mission, vision, and values don't need to reflect the reality of today's operation. More often, they are guiding principles that point to where an organization strives to be in the future. So if you envision your front-office staff giving repeat patients a warm welcome like a Starbucks barista—but today your staff is better described as "crisp" and "efficient"—expectations can be set as to *who* the staff *will* become.

Measure the Patient Experience

Once the center's service and cultural attributes are defined, a measurement system is needed to assess how well the center is delivering on patient expectations and provide evidence that improvement initiatives are working. Otherwise, "proud" providers and staff may persist in behaviors they *believe* constitute good service but which have no impact on patient perceptions. A patient experience survey—elicited by in-center comment cards or a mail, telephone, or email survey (or a combination of these)—provides quantitative and qualitative data for evaluating operations:

■ Quantitative data can be compiled from numerical

assessments: surveys in which questions are answered on a scale of 1 to 10, with 1 being poor and 10 excellent. Questions should include patient satisfaction with the visit, whether a patient would recommend the center to friends/family, and satisfaction with staff communication of wait times. Responses are then tracked over time to identify trends. Quantitative survey data should be regularly posted in an area visible to providers and staff. Tracking progress spurs continuous quality improvement.

- Qualitative data consists of patient compliments, complaints, and suggestions for improvement—all of which require a response from the urgent care operator. Qualitative feedback should be shared in staff meetings to recognize individuals delivering outstanding service, explore ways to implement patient suggestions, and devise remediation plans for the complaints.

An urgent care operator should strive for continual improvement. The reason for the patient's complaints should be immediately resolved while also assessing the root causes. For long-term planning, the real value of patient feedback is the insight it provides into the patient's mind. What one patient sees and speaks out about is silently in the thoughts of hundreds of other patients. So the answer to the question, *What does good service look like?*, can typically be found in patient comments.

The challenge, of course, is that patient intentions are not always clear. Consider the following two patient "complaints" written on a visit comment card:

- "The exam table cover had duct tape on it."
- "The front office staff was slow and rude."

The first complaint is easily resolved by repairing upholstery. But the second complaint not only begs the question, *What constitutes slow and rude?,* but the resolution involves the complex interdependencies of hiring, training, operating procedures, and systems (see *Action Plan for Phase One: Defining the Brand and Culture*).

Phase Two: Identify and Resolve Barriers to Good Service

Urgent care is a "people" business—not only are people needed to deliver clinical services, but people are the largest expense on the center's profit-and-loss statement. Therefore, it's logical that the biggest barriers to good service involve people. If there are providers or staff who actively undermine the center's mission, vision, and values—or who are simply incapable of delivering the desired service levels—then seriously consider letting them go. They are hurting the business and will stand in the way of any meaningful change. When backfilling their roles, interviewing for attitude, personality, and behavioral traits (in addition to technical competence) can help improve the odds that new team members are willing and able to perform as expected. Once the right team is in place, "fixing what's broken" entails setting standards based on patient expectations and then educating providers and staff.

Service standards define the experience that everyone in the urgent care center is responsible for delivering. They affect all aspects of an operation, including which programs are shown on the television in the waiting room, how the telephone is answered, and what documentation is provided to a patient at discharge. Service standards should be specific, detailed, and baked into the center's written policies and procedures. There should also be a mechanism for managers to hold staff accountable for their execution. To this end, service standards may be:

Action Plan for Phase One: Defining the Brand and Culture

Benchmarking Organizations

Start by identifying "best in class" service organizations and understanding why they have captured so many devoted customers. For example, Apple's brand image is its independent thinking, cutting-edge technology, and interactive product design that create an emotional connection with users. This connection manifests in its retail stores as expert knowledge, modern aesthetics, and "hands-on" product sampling.

Mission, Vision, and Values

Next, develop a strategic framework defining why the urgent care center exists, what it does, and the principles that guide it moving forward. The center's "mission, vision, and values" are aspirational—they describe more what the center wants to become rather than its current state. Providers and staff must "buy into" fulfilling the mission, achieving the vision, and living the values. It is the urgent care owner's challenge to get this buy-in. Without their commitment, the exercise becomes merely words on paper.

Patient Experience Survey

Last, develop a mechanism to gather feedback on patient's perceptions of the center and insight into how well it's delivering on its mission, vision, and values. A structured, ongoing patient survey will provide quantitative measures that can tracked over time and compared to benchmark organizations. Qualitative feedback—solicited through free-form comment fields on the survey—reveals what's important to patients and is the basis for Phase Two, which entails "fixing what's broken."

Action Plan for Phase Two: Fixing What's Broken

Interviewing/Hiring Practices
It's difficult to deliver a good patient experience with incompetent, disgruntled, or dissatisfied staffers. Everyone who joins the team should embrace and aspire to the center's culture and management's ideals. Even if an urgent care operator is desperate to fill a position and too busy to conduct a lot of interviews, waiting for the candidate with the right mix of technical skills and personal attitude will save time dealing with complaints, discipline, or turnover later on. Align job descriptions and interviewing methods with the desired personal qualities—empathy, attention to detail, and a sense of urgency—that will set the stage for delivering the desired patient experience.

On-boarding/Training/Development
When new providers and staff join an urgent care center, they are often thrust to the front line, forced to quickly learn systems and procedures with "as-needed" support from peers. Taking time to train individuals in their respective roles—and orient them to the center's culture—should result in higher productivity, service levels, and organizational commitment. Service standards—taught through role-playing—are useful in demonstrating what the expected patient experience should look like. And remember, training isn't just for new hires. Identify staff members who are capable of expanded responsibilities and define a career path that will keep them engaged and challenged long term.

Physical Facility Appearance
Typically a patient's initial impression of an urgent care center is based on the condition and cleanliness of the physical facility. Evaluate your facility from a patient's perspective—what impressions might a patient get turning into the parking lot from the street, finding a parking space, entering and approaching the front desk for sign-in, and waiting in the lobby or exam room?

Next, identify improvements to flow, signage, and aesthetics that would improve patient perceptions. Small investments in cleaning carpets, freshening paint, or replacing upholstery can go a long way toward improving patient satisfaction. After the initial assessment, incorporate how the facility should look into service standards, document it, and then continue "managing by walking around" throughout the day—picking up trash, straightening furniture, and wiping down surfaces.

Patient Amenities
In addition to assuring the facility is clean and presentable, pay attention to the "little things" that will enhance a patient's comfort. For example, is there a television present? If so, is it large and visible? Is the programming of interest to patients? What is the volume level? Are magazines current and relevant to patients' ages and lifestyles? Are water, coffee, soft drinks and snacks offered? What about Wi-Fi Internet access? Which activities (coloring sheets, books, videos, etc.) are offered to children? How accessible is the restroom? How often is it cleaned and stocked?

Re-trace a patient's movement through the center to identify additional amenities that could make the patient's stay more pleasant. Every detail of the patient experience should be incorporated into measurable standards, documented, and staff trained and held accountable for meeting the new standards.

Staff Appearance and Demeanor
Because urgent care is a "people" business, those working in the center should reflect the desired "brand." A consistently enforced, nondiscriminatory dress code or uniform policy developed in collaboration with providers and staff can assure that everyone looks professional and like they are members of the same "team." In addition, set expectations as to how staff is to behave—do they greet patients as they enter the door, address them as "Sir" and "Ma'am," and smile during every interaction? Behavioral expectations can be trained through roleplaying activities, but ultimately the personality and attitude of providers and staff should be assessed for good cultural fit during the hiring process.

- Descriptive—such as "every exam room should have no fewer than three magazines, in good repair, with no torn pages, water damage, or stains, with each issue current, no more than 30 days old, with separate titles appealing to women, children, and general interest"—in which case an operator may randomly spot-check exam rooms to assure compliance
- Measured—such as "time elapsed from sign-in to discharge should not exceed 60 minutes"—in which case the operator utilizes billing system data to report how consistently providers and staff meet the standard

Service standards are effective insofar as they align with the center's mission, vision, and values; are developed in collaboration with providers and staff; and are frequently communicated so that everyone (including patients) knows what to expect. To assure consistency in execution, training is essential. Photographs, testimonials, and role-playing activities illustrating "good" and "bad" service can help orient providers and staff to the patient's perspective. When shortcomings are revealed, they should be pointed out immediately so staff can take corrective action and be more aware and sensitive going forward (see *Action Plan for Phase Two: Fixing What's Broken*).

Phase Three: Align and Focus the Operation in Execution

Buzzwords like "empowered" and "engaged" are commonly used to describe teams who deliver a consistently high level of service—resulting in benchmark brands like Starbucks and Nordstrom—but rarely can urgent care providers and staff, who struggle just to keep the patient flow moving, change the quality of service entirely on their own. Even the most committed teams require a leader to set priorities, allocate resources, remove barriers, and instill measures to hold team members accountable for positive results. Thus, "Phase Three" entails changing management methods to leverage the front-line knowledge and creative instincts of providers

and staff by aligning activities and incentives with operational priorities.

For example, an urgent care operator identifies that long patient waits are adversely impacting patient satisfaction. The center team meets to identify how everyone's role affects wait times. Collaboratively, the team comes up with a plan of action—a commitment of each individual to change his/her way of doing something. Accountability comes by setting a measurable goal, such as: "Reduce average length of stay by 10 minutes by November 1." Incentives (such as a paid vacation day or a cash bonus) are put in place if the goal is met or exceeded. Management provides regular reports on the team's progress. Everyone works together to affect change until the goal is met, at which point the changes are permanently adopted into policies and procedures and the process repeats for the next priority.

Develop Authentic Relationships

Engaging the front line to make an impact on the patient experience requires the urgent care operator to abandon pretense and hidden agendas in favor an authentic, transparent environment where everyone is working toward the same purpose. While slogans and buzzwords may have been useful in orienting employees in Phases One and Two, "bottom-up" management requires employees who are fully empowered to do what's necessary to please the patient.

But just because an employee is "empowered" doesn't mean he or she is "engaged" in delivering an excellent patient experience. In fact, many employees see work as their primary social outlet and are engaged with one another in "solidarity" against management and patients. Many managers believe that compensation is the key to motivating such employees, but staff that is focused on a paycheck will do the minimum, play games, evade problems, and undermine change. In the short term, they may be motivated by incentives such as receiving a bonus or evading disciplinary action, but over the long term, consistent execution requires people to act from their hearts and minds. Recognition or praise for exhibiting the "right" behaviors, the ability to engage in interesting and challenging work, and training and development with an eye toward promotion do more to motivate employees than a mere salary or bonus.

Authoritarian, punitive, top-down leadership will not work when an urgent care operator needs providers and staff to take personal responsibility for the patient experience. Ultimately, "winning over" employees requires an urgent care operator to understand and align employees' long-term interests with that of owners and management. The most engaged employees find a sense of personal meaning in their work and in the center's mission, vision, and values. "Inspired" employees who feel personal responsibility for creating good patient experiences should be more productive, more creative, demonstrate greater integrity, and work better in team environments than those who are merely doing a "job."

Anticipate Change

The American railroad industry got pummeled because of competition from trucks, airplanes, and automo-

Action Plan for Phase Three: Consistent Execution of Phase 1 and 2 Initiatives

Focus, Measure, and Report

Urgent care operators usually fail in their efforts to improve the patient experience because they tackle too many problems at once. Providers and staff who juggle the day-to-day demands of patient flow skeptically view large-scale cultural change as management's "flavor du jour"—thinking "this too will pass."

Instead of a complete service overhaul, center teams are typically more successful focusing on one goal at a time, which becomes the overarching theme for all their activities. Therefore, the role of the urgent care operator is to prioritize goals according to their biggest impact on the patient experience, foster a sense of ownership by aligning the goals with provider and staff job responsibilities (areas individuals can influence), measure progress using relevant and time-sensitive metrics, and create accountability through incentive plans.

Employee Empowerment and Engagement

Emerging management wisdom is that "if you take care of your employees, they will take care of your customers." Employee "empowerment" entails treating people as they "can be" rather than "who they are today," removing artificial constraints on their ability to impact changes and providing them with the skills, processes, and systems needed to serve patients effectively. Employee "engagement" results as employees' needs and interests are aligned with those of the center (as articulated in the center's mission, vision, and values), from regular performance feedback, and by management encouraging "right" behaviors through relevant incentives.

Process and System Leadership

While providers and staff are possibly the most salient contributors to the patient experience, urgent care operators should not underestimate the role of process and technology in creating a good patient experience. Consider what air travel was like before online reservations, mobile check-in, self-service kiosks, in-flight Wi-Fi, and seatback television. Likewise, urgent care faces an unprecedented opportunity to implement Internet technologies that will reduce wait times, flatten peaks and ebbs in patient flow, speed collections, increase staffing efficiencies, and improve clinical outcomes. Urgent care operators should look beyond the industry status quo to identify ways to use technology to differentiate themselves from competitors, thus freeing staff to offer the personal service expected by patients.

biles. The problem was that railroads saw themselves as being in the "train" rather than the "transportation" business, and as customer needs evolved, railroads were regarded as rigid and slow. Likewise, urgent care centers shouldn't see themselves as being in the business of treating "low-acuity medical conditions" but rather of treating patients well.

Leading service companies not only view themselves in terms of meeting a customer need, their technology and procedures anticipate and adapt to change. Take Wells Fargo, which, over the course of 150 years, has migrated from a stagecoach courier service, to a coast-to-coast bank branch network, to offering Internet and mobile "financial management tools" available wherever a consumer might be. To avoid being left behind when new technologies like online medical records and telemedicine become more commonplace, urgent care centers should likewise evolve.

For urgent care operators, technology that improves the patient experience can be a differentiator. For example, Internet pre-registration and scheduling reduce patient waits, improve billing accuracy, and free center staff to focus on the care provided to patients. The task for urgent care operators is to identify creative uses for technology and make the investments required (see *Action Plan for Phase Three: Consistent Execution of Phase 1 and 2 Initiatives* on page 33).

Conclusion

"Superior service" has been the mantra of consumer-facing organizations for years, which means the general public has many preconceived notions of what an urgent care encounter should and should not entail. An urgent care center delivering an experience that falls short of patient expectations—regardless of the quality of clinical outcomes—will find revenue growth slow and hard to come by. By progressing through the three phases outlined, however, an urgent care operator can identify what's important to patients, engage providers and staff around a common purpose, devise measures, and ultimately hold the team accountable for anticipating and responding to patients' evolving needs. ■

Selling Your Urgent Care? Here's What's Involved

JOHN SHUFELDT, MD, JD, MBA, FACEP

A large urgent care group has just offered to buy your centers. So now what?

First, get some advice. This process is incredibly time-consuming inasmuch as the amount of material and the degree of detailed information required before a sale is consummated is daunting. Also, the way you position and promote your center and the thoroughness of your disclosures will speak volumes about your abilities and will ultimately be reflected in the eventual purchase price. To that end, find a consultant who understands the industry, the players, and the process and engage him or her early, even before signing the non-disclosure agreement (NDA). Here is an overview of the process:

The Non-Disclosure Agreement

The NDA basically says that neither party (in a bilateral agreement) can disclose information that is not already within the public domain. This does not mean that the purchaser cannot enter your market (unless they agree not to and add it to the document). Nor does it mean that the purchaser cannot use the information to their competitive advantage if a deal is not ultimately consummated.

The Initial Diligence Request

This is a much-scaled-back request for documents and information you have to divulge after the Letter of Intent (LOI). The initial diligence request simply allows the purchaser to estimate the profitability of your business and make you a non-binding offer pending formal due diligence.

The Letter of Intent or Term Sheet

The initial letter may come in a draft format so that by the time the actual LOI is proffered, all relevant terms will have been previously disclosed and vetted. In the LOI, the buyer makes an offer to buy (as a stock or asset purchase) your business at either a certain multiple (five times earnings before interest, taxes, depreciation, and amortization [EBITDA]) or a specific dollar amount (eg, $1,500,000). This amount will be contingent on formal due diligence. The LOI will also "lock you down" for a pre-negotiated amount of time. This means that during the diligence period you won't be able to market your centers to other potential acquirers.

The Formal Due Diligence Process

This is where the exhaustive list of documents, contracts, and financials is required. Often this period lasts 45-90 days, depending on your ability to gather and present all the requested information, as well as the purchaser's level of engagement and ability to devote staff to evaluating the business. During this period, you will be in frequent contact with the prospective buyer's acquisition team. Also, during this period, the buyer will request an opportunity to tour your centers and interview key staffers.

The Closing

This is the phase where the all the details are hammered out by the parties' advisors and legal teams. As the owner, you will be asked to review Investor Rights Agreements (if you are retaining some stock), Stock Purchase Agreements, Employment and Non-Compete Agreements, and Transfer Restriction Agreements. Once reviewed and negotiated, these documents are signed during the formal closing. The closing is often the most time-consuming and nerve-racking part of the process. However, when it is finally over, the usual response is: "That was worth every minute. I never want to do it again!"

Get some help and go into these discussions with your eyes wide open. The good news is that I know the majority of the groups that are acquiring centers and, for the most part, they are led by individuals who have solid reputations for fair business dealings. That said, at the end of the day, it *is* business and they have a duty to strike the best deal possible—as do you. ■

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

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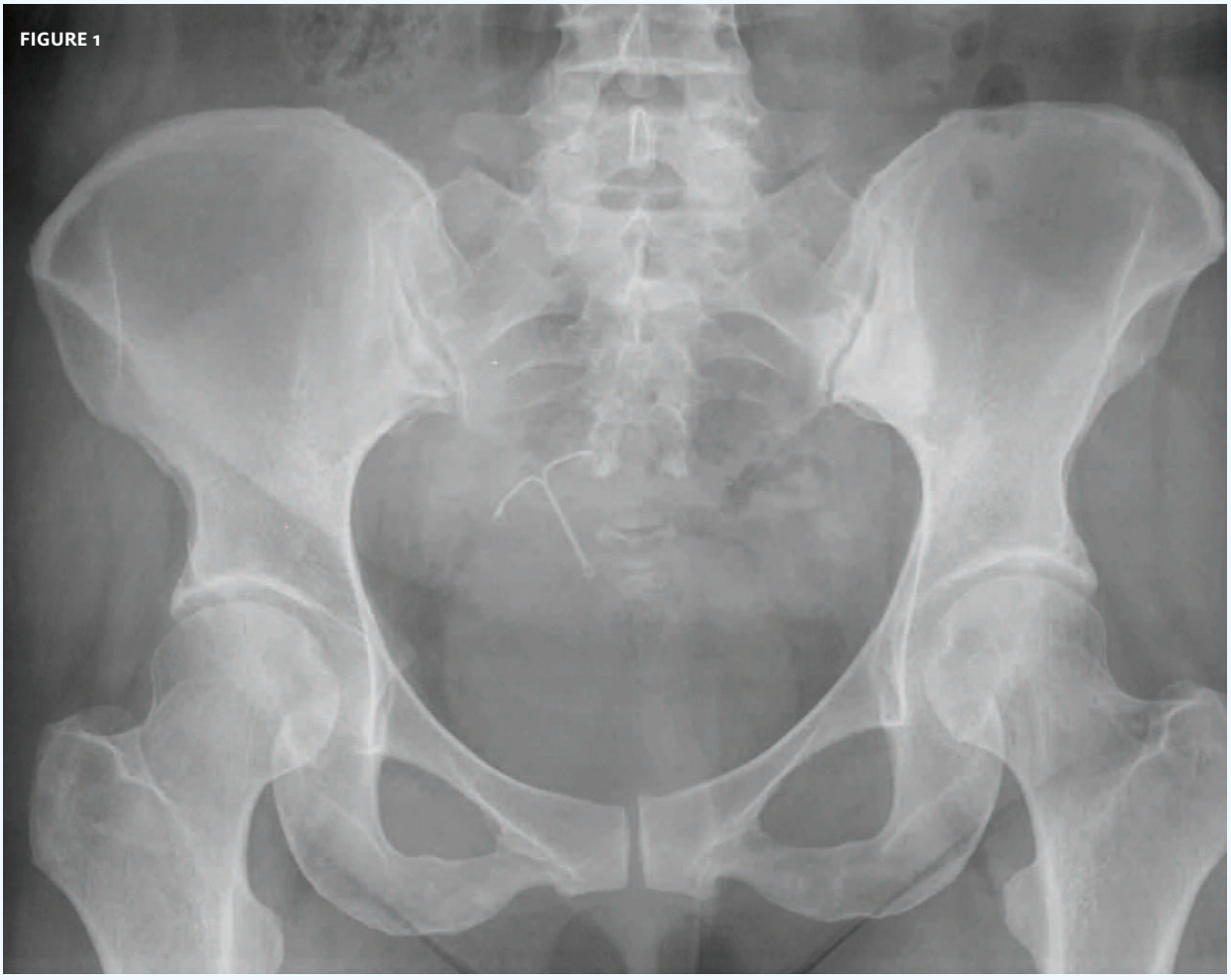
INSIGHTS IN IMAGE

CLINICAL CHALLENGE

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

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

FIGURE 1



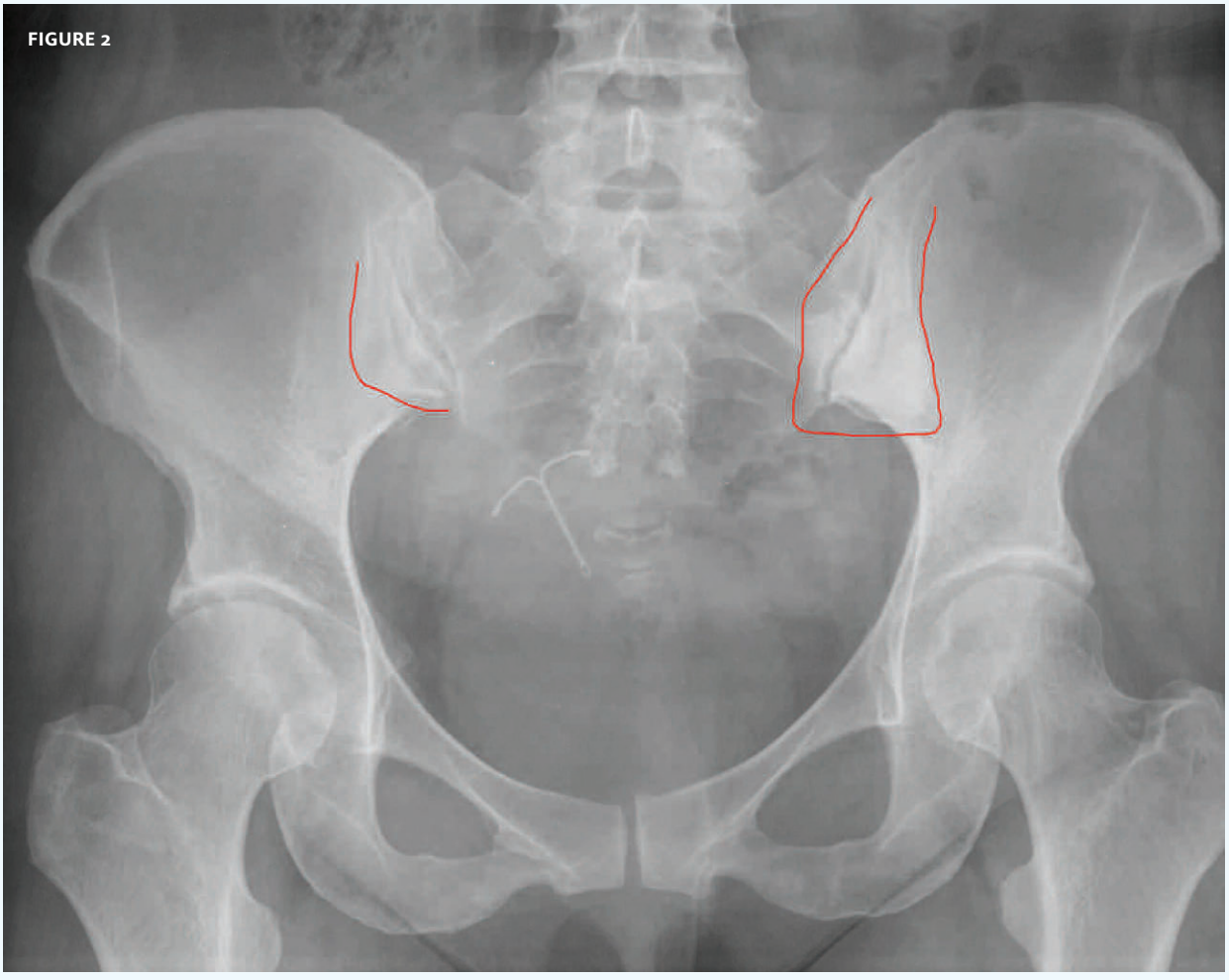
The patient, an otherwise-healthy 42-year-old, presented with bilateral back pain around the pelvis.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Note: on the left, that is a sclerotic process along the right sacroliac joint, and less so over the right. This is consistent with a sacroileitis.

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

ABSTRACTS IN URGENT CARE

- Managing Febrile Children
- Warming Local Anesthetics
- LP and SAH Detection
- Patients and Clinical Data
- Swimming and LQTS

NAHUM KOVALSKI, BSc, MDCM

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

A New Approach to Managing Young Non-Toxic-Appearing Febrile Children

Key point: Researchers suggest an emphasis on more-limited evaluation, now that vaccines have greatly reduced the likelihood of serious bacterial infections.

Citation: Jhaveri R, Byington CL, Klein JO, Shapiro ED. Management of the non-toxic-appearing acutely febrile child: a 21st century approach. *J Pediatr.* 2011;59(2):159:181.

Since the 1970s, considerable attention has been paid to the management of febrile children aged ≤3 years without an obvious focus of infection. Recommendations have emphasized detection of serious bacterial infections (SBIs), including occult bacteremia (OB), and empirical antibiotic treatment for children considered to be at high risk. Management has been determined using a combination of clinical appearance, age, and laboratory tests, with more testing recommended for infants aged <3 months than for those aged 3 to 36 months.

Effective vaccines against *Haemophilus influenzae* type b (Hib) and *Streptococcus pneumoniae,* the two major causes of occult SBIs, have been universally available in the US since 1988 and 2000, respectively. The incidence of invasive Hib infection in children aged <5 years dropped by 99% between 1987 and 2007, and the incidence of pneumococcal OB is currently <0.5%. Urinary tract infections (UTIs) are now the most common SBI in febrile children without localizing signs. Considering these changes, researchers from four major pediatric departments suggest that recommendations for managing such children be updated.

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

These researchers state that new guidelines should emphasize the importance of immediate antimicrobial therapy for an infant who is seriously ill or toxic appearing and a complete clinical and laboratory evaluation for high-risk febrile infants aged ≤30 days, as we have been doing. However, for intermediate-risk infants aged 31 to 90 days, acceptable management can range from complete evaluation to simply observation and follow-up. And for infants aged 3 to 36 months who have received ≥2 doses of both Hib and pneumococcal conjugate vaccines, evaluation only for UTI is warranted.

Published in *J Watch Infect Dis.* August 17, 2011—Robert S. Baltimore, MD. ■

Warm Local Anesthetics Prior to Injection

Key point: Warming reduces pain, even when the anesthetic is buffered.

Citation: Hogan ME, vanderVaart S, Perampaladas K, et al. Systematic review and meta-analysis of the effect of warming local anesthetics on injection pain. *Ann Emerg Med.* 2011;58(1):86-98.e1.

Injection of local anesthetics causes pain at the injection site before providing anesthesia. Postulated methods to mitigate this pain include slowing the rate of injection; avoiding epinephrine, when possible; buffering; and warming the local anesthetic to body temperature prior to injection. These authors assessed injection pain in a meta-analysis of 18 randomized studies involving 831 patients who received either warmed (body temperature) or unwarmed (room temperature) subcutaneous or intradermal local anesthetic injections. The anesthetic was unbuffered in 10 studies.

Patients reported pain on either visual analog or numeric rating scales. Methods of warming included water baths, incubators, fluid warmers, baby food warmers, warming trays, and syringe warmers.

Patients reported less pain with warmed anesthetic than with room-temperature anesthetic (mean difference, 11 mm on a 100-mm scale). Even with buffered anesthetic, patients reported less pain with warming (mean difference, 7 mm).

Published in *J Watch Emerg Med.* August 12, 2011—Richard D. Zane, MD, FAAEM. ■

When LP Is Not Necessary to Detect Subarachnoid Bleed

Key point: CT performed within 6 hours of symptom onset in neurologically intact patients had 100% negative predictive value in this prospective multicenter study.

Citation: Perry JJ, Stiell IG, Sivilotti ML, et al. Sensitivity of computed tomography performed within six hours of onset of headache for diagnosis of subarachnoid haemorrhage: prospective cohort study. *BMJ.* 2011;343:d4277.

Standard teaching is that lumbar puncture (LP) is essential in patients with suspected subarachnoid hemorrhage (SAH) despite normal head computed tomography (CT) scans. Researchers prospectively enrolled 3132 consecutive neurologically intact patients older than 15 who underwent head CT with third-generation multislice scanners to evaluate nontraumatic acute headache or headache with syncope at 11 tertiary emergency departments in Canada from 2000 to 2009. LP was performed at the discretion of the treating physician. Experienced radiologists who were blinded to the study interpreted all CT scans. SAH was defined by subarachnoid blood on CT, aneurysm on cerebral angiography, or xanthochromia in cerebrospinal fluid.

Mean headache peak pain severity was 8.7 on a 0–10 scale. LP was performed in 49% of patients after negative CT scans. Overall, 240 patients (7.7%) were diagnosed with SAH. The sensitivity of head CT for SAH was 92.9%, and the negative predictive value (NPV) was 99.4%. Emergency physicians identified all but three cases of SAH; all three patients were scanned >6 hours after headache onset. Among 953 patients who were scanned within 6 hours of symptom onset, head CT had 100% sensitivity and 100% NPV. Follow-up at 1 and 6 months did not identify any cases of missed SAH.

Published in *J Watch Emerg Med.* August 5, 2011—Kristi L. Koenig, MD, FACEP. ■

Patients Comprehend Clinical Data Best When Expressed as Percentages

Key point: In this relatively educated population, one-third fully understood the data. This has implications for leaving treatment decisions solely to patients.

Citation: Woloshin S, Schwartz LM. Communicating data about the benefits and harms of treatment: A randomized trial. *Ann Intern Med.* 2011;155(2):87-96.

To determine how best to present data to patients on the benefits and harms of treatments, researchers randomly assigned nearly 3000 US adults from a nationally representative cohort to receive drug information in one of five numeric formats. Data were presented in tables as natural frequencies (*x* in 1000); variable frequencies (*x* in 100, *x* in 1000, etc., as needed to maintain the numerator >1); percentages; percentages and natural frequencies; or percentages and variable frequencies. Participants were asked 18 questions that assessed their interpretation of the data, which outlined the expected benefits and adverse effects associated with treatment. The study was conducted online.

The mean number of correct responses was between 13 and 14 in all five groups. However, the proportion of participants who correctly answered at least 16 of the 18 questions was greatest for those receiving data as percentages and variable frequencies (35%) or percentages only (34%); it was lowest for data presented only as frequencies (26%).

Published in *J Watch Gen Med.* August 23, 2011—Jamaluddin Moloo, MD, MPH. ■

Loss of Consciousness While Swimming: Think of Long QT Syndrome

Key point: In a case series of 10 children with LQTS and documented history of water-related syncope, failure to consider LQTS after the event was common

Citation: Albertella L, Crawford J, Skinner JR. Presentation and outcome of water-related events in children with long QT syndrome. *Arch Dis Child.* 2011;96(8):704-707.

Exercise, including swimming, is a known risk factor for dysrhythmia in children with long QT syndrome (LQTS). Investigators examined the presentation, outcomes, and time to final diagnosis in 10 children with LQTS and a history of water-related syncope prior to diagnosis.

Age at the time of the water-related syncope event ranged from 3-14 years. Six children developed syncope during underwater swimming (three while racing), two developed syncope after swimming, one child had loss of consciousness and slipped through a flotation device, and another had a near drowning that required prolonged resuscitation and caused severe neurocognitive deficits. Diagnosis of LQTS was made at the time of the water event in six children and after 1 to 17 years in the others. One child who had been diagnosed with epilepsy and was receiving antiepileptics later died during a hockey game. Posthumous diagnosis of LQTS was made with genetic analysis. Five patients had a family history of sudden death or water-related syncope events. All patients were treated with β-blockers, and three required intracardiac defibrillators (two also had left cardiac sympathectomy). The initial corrected QT interval ranged from 450-600 milliseconds. Nine patients had LQTS type 1 with mutations of the *KCNQ1* gene; the genotype could not be identified in one case.

Published in *J Watch Pediatr and Adolesc Med.* August 3, 2011—F. Bruder Stapleton, MD. ■

CODING Q&A

Rule Number One: Code for Services Rendered

DAVID STERN, MD, CPC

Q. Which CPT codes can be used for diagnosis codes 786.50 (unspecified chest pain) and 414.9 (chronic ischemic heart disease-unspecified) to maximize a Medicare patient bill?

A. The basic rule of coding is that you should code for the services rendered, not to "maximize a patient bill." In other words, you should code the best codes that indicate the actual services that were performed. For these codes, you could code for a cardiac bypass surgery or a simple E/M; it would just depend on what services you had rendered. You both maximize coding compliance and revenue when you make sure that all codes for services rendered are included in the claim.

Q. Is there any legal or ethical reason why an emergency department should not re-code an emergency visit as an urgent care visit based on the final diagnosis and/or time involved in treating the patient who presented himself to the ED?

A. The coder should apply the best code that describes the service. E/M code sets are based on the place of service. If the service was rendered in a hospital ED, then the coder should use E/M codes (99281-99285) that are designated for services rendered in a hospital ED. It is not appropriate to change to another E/M code set (eg, 99201-99215 for office or other outpatient visit) simply because of the level of service.

For example, it would not best describe the services in your case to say, "Office or other outpatient visit for the evaluation and management ...," which is part of the description of the E/M codes used for urgent care services. Rather, the best description for the services rendered is, "Emergency department visit for the evaluation and management of a patient ...," which is part of the description of E/M codes used for visits to a hospital ED.

In this case, the place of service determines the code set to be used. The level of service rendered will determine the appropriate code within that code set.

Q. I am confused about a common billing issue. A medical doctor (not an ophthalmologist) is billing CPT Code 92002 when a patient presents to urgent care for an eye injury such as ICD-9 918.1. Is this appropriate? Based on the description of CPT code 92002, it appears that an ophthalmologist should be performing this service. Wouldn't an E&M code 99202-99205 be more appropriate?

A. CPT codes are based on the service rendered, not necessarily on the specialty of the physician. If a general surgeon or a family doctor delivers a baby, she can code for delivering the baby. If an urgent care physician performs the services described by 92002 ("Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient"), then he can submit a claim for 92002.

The medical record should indicate that a proper level of evaluation and management occurred. For 92002, the intermediate eye examination codes require an external ocular and adnexal examination, whereas the comprehensive examination (92004) requires, in addition, gross visual fields, basic sensorimotor evaluation, and an ophthalmoscopic examination.

Medicare carriers have mandated specific elements to be documented to qualify for these codes. Most carriers list 10 elements, requiring at least three elements to qualify for 92002 and at least eight elements to qualify for a comprehensive examination. Simple eye exams with less than three elements should be coded with the regular E/M codes 99201-99215.

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

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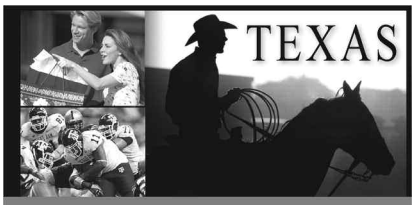

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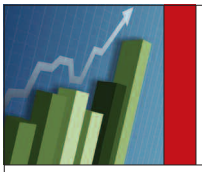

DEVELOPING DATA

These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to "full-fledged urgent care centers," the qualifications for which included accepting walk-ins during all hours of operation, as well as having a licensed provider on site, x-ray and labs on site, the ability to administer IV fluids and perform minor procedures, and being open seven days a week, at least four hours per day.

In this issue: What percentage of urgent cares measure quality and what percentage measure patient satisfaction using either national recognized or self-developed measures?

QUALITY AND PATIENT SATISFACTION: WHO MEASURES—AND HOW?

Quality Measures	2008 Percentages	2010 Percentages
Nationally Recognized Measures	31.1	NA
HEDIS[a]		6.1
AQA[b]		1.0
Joint Commission[c]		16.7
PQRI[d]		8.6
Non-national Measures	6.1	5.6
Self-developed Measures	46.3	43.4
None	16.5	5.1

[a]HEDIS = Health Employer Data Improvement Set.
[b]AQA = formerly the Ambulatory Care Alliance.
[c]Joint Commission = formerly the Joint Commission on Accreditation of Hospital Organizations (JCAHO).
[d]PQRI = Physician Quality Reporting Initiative (now known as the "Physician Quality Reporting System").

In the 2010 Urgent Care Benchmarking Survey, as in the 2008 survey, results showed that a majority of centers, while measuring quality, used internally developed rather than nationally recognized measures, or a combination of both. Self-developed measures let you measure your current performance against your previous performance. Nationally recognized measures let you measure your current performance against that of other urgent cares nationwide.

Patient Satisfaction Measures	2008 Percentages	2010 Percentages
Nationally Recognized Measures (CAHPS,[a] Press Ganey,[b] etc.)	22	23.4
Non-national Measures	6.3	NA
Self-developed Measures	50.8	58.6
None	21.0	18.0

[a]CAHPS = Consumer Assessment of Healthcare Providers and Systems.
[b]Press Ganey = the industry's recognized leader in healthcare performance improvement.

Results for patient satisfaction were similar to those of quality: a majority of urgent cares use self-developed rather than nationally recognized measures. Note that nearly 20% of urgent cares do not measure patient satisfaction at all. If your center is one of them, be sure to read Take *Patient Satisfaction to the Next Level* on page 29.

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

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