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IN THIS ISSUE

Management of Patients Presenting with Constipation

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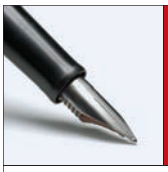

LETTER FROM THE EDITOR-IN-CHIEF

The Only Constant is Change

As I contemplate my own professional transition, from an academic mega-hospital to a private urgent care venture, I have been through the usual roller-coaster of emotions that accompany any major life change:

- Stress (physical, mental, and emotional): Change requires simultaneously managing the process you are changing from *and* the process you are changing to. That's double the work. In a complex profession like ours, I think everyone will agree there's enough stress managing just one.
- Anxiety: Change causes much uncertainty, leaving one feeling vulnerable and anxious. Fear of what's on the "other side" of change is the most common reason we resist change.
- Guilt: When change involves leaving a job, you are leaving behind your "job family." If you have nurtured those relationships, especially over long periods of time, there is a sense of abandonment when you leave.
- Sadness: Change inevitably results in a spiritual and physical "loss." When we experience a loss, we grieve.
- Excitement: Yes, there are *positive* emotions that can result from change. Change creates opportunity, and opportunity can be very energizing.

In a profession like medicine, there exists what I'll call a "change paradox."

On the one hand, medicine is a practice of repetition: fund of knowledge, formulas, algorithms, policies and procedures, protocols, standards, guidelines, and routines. These fundamentals of practice allow us to ensure patient safety, reproducible outcomes, and a little sanity. Repetition is critical in the chaotic, high-risk practice conditions in which we work.

On the other hand, the practice of medicine requires aptitude at managing change: science changes, best practices change, disease states change, technology changes, insurance changes, regulatory environments change, and laws change. That's a lot of change—dizzying, really!

Physicians are notoriously resistant to change. It penetrates and threatens what little control and security they have left in their practices and personal lives. Most physicians feel they are at the tipping point—"One more change and I'll collapse."

It reminds me of the popular family game Jenga. You build a solid tower of wood blocks and each player takes a turn pulling out a block, one at a time, until the tower falls. There is tremendous uncertainty and anxiety about whether the next "change" will cause the tower to collapse.

"Life-long learning requires a commitment to managing change."

However, as physicians, we have made a commitment to life-long learning, and life-long learning requires a commitment to managing change. So, here are a few things you can do to help yourself:

- Don't forget to see the "opportunity." Focusing on, or complaining about, what you lose in the change process is an obstacle to fully embracing a chance to grow both personally and professionally, and shows an unwillingness to learn.
- Accept a little uncertainty. Informed decision making is prudent, but perseverating over decisions is a major hurdle to change. Doctors like to do this; don't!
- Trust yourself. You didn't get to where you are because of incompetence. You can handle more than you think.

Exercise, eat right, and nurture yourself and your personal relationships. Nothing breeds more confidence in the face of major life changes than being of sound mind, body and spirit.

Are you ready? ■

Lee A. Resnick, MD
Editor-in-Chief
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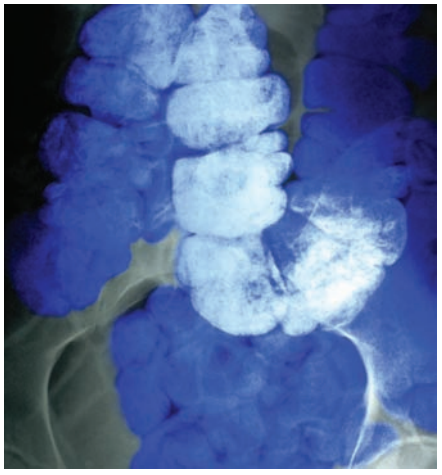

CLINICAL

9 Management of Patients Presenting with Constipation

Constipation should not be dismissed as merely a nuisance for the patient or the practitioner. The urgent care clinician's approach must begin with ruling out potentially serious etiologies, followed by evacuation and patient education.

By Claire West, MD, Samuel M. Keim, MD, MS, and Peter Rosen, MD

BOUNCEBACKS

15 The Case of a 28-Year-Old Pregnant Female with Shortness of Breath

What are your obligations when you and a patient have a difference in risk tolerance—or there are obstacles to effective communication? Being prepared can increase the odds of a good outcome and keep you on the right side of any legal or ethical dilemmas.

By Michael B. Weinstock, MD and Jill C. Miller, MD

URGENT CARE UPDATE

27 The Quality of Care at Urgent Care Centers

Existing methods for measuring quality of care tend to apply more readily to the hospital environment than to urgent care. Nonetheless, urgent care compares favorably in several key quality indicators.

By Robin M. Weinick, PhD, Steffanie J. Bristol, BS, and Catherine M. DesRoches, DrPH

***In the next issue of* JUCM:** *In response to reader requests for more advertising and marketing content, the March issue will feature an introduction to urgent care advertising, along with more new articles addressing key clinical topics from an urgent care perspective.*

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

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JUCM CONTRIBUTORS

To call constipation a common problem would probably be an understatement. If history is any indication, 2.5 million times this year a patient will walk into a doctor's office in the United States complaining of constipation—and that leaves out the legions who ignore their discomfort, just try over-the-counter products, or simply change their diet in the hope of finding relief.

And yet, to dismiss a primary complaint of constipation as merely a nuisance to the patient or the practitioner would be a mistake—and possibly one with life-threatening consequences.



In Management of the Patient Presenting with Constipation (page 9), authors **Claire West, MD**, **Samuel M. Keim, MD, MS**, and **Peter Rosen, MD** review possible causes for acute, subacute, and chronic constipation and discuss elimination of potentially serious etiologies before focusing on various treatment options.

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

Another common presenting complaint, shortness of breath, is the genesis of this month's Bouncebacks feature. However, The Case of a 28-Year-Old Pregnant Female with Shortness of Breath (page 15) is complicated both by a language barrier and a difference of opinion between the patient and the physician regarding risk tolerance.


Starting with this installment of Bouncebacks, **Michael B. Weinstock, MD**, is joined by a new co-author in **Jill C. Miller MD**, a clinician who practices at University Hospitals Chagrin Highlands Health Center. She is also a senior clinical instructor at Case Western Reserve University School of Medicine, and contributed a case report, A 55-Year-Old Woman with Abdominal Pain, to the April 2007 issue of *JUCM*.

Dr. Weinstock is a clinical assistant professor of emergency medicine at The Ohio State University College of Medicine and a physician at Mt. Carmel St. Ann's Emergency Department in Columbus, OH. He is scheduled to present at the UCAOA Annual Convention in Las Vegas, April 20-23. In addition to hosting an interactive *Bounceback* session, he will speak on evaluation of chest pain, highlighting a unique approach designed to help the clinician avoid missing a needle in a haystack.

Information on other *JUCM* contributors scheduled to appear at the UCAOA conference will be forthcoming in the March and April issues.

Finally, we're happy to publish a second article based on data revealed in the latest UCAOA benchmarking report. In The Quality of Care at Urgent Care Centers (page 27), **Robin M. Weinick, PhD, Steffanie J. Bristol, BS, and Catherine M. DesRoches, DrPH** note the challenges of assessing quality of care in the urgent care environment, but also identify key indicators that show urgent care comparing favorably with other practice environments.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews abstracts of new articles on uninsured patients and remote orthopedic consultation, as well as MRSA and the healthcare worker and other topics concerning or relevant to urgent care.

John Shufeldt, MD, JD, MBA, FACEP advises readers who are considering putting their urgent care centers up for sale.

Frank Leone, MBA, MPH offers advice on how to adjust your strategy for promoting your urgent care occupational medicine business in these rough economic waters.

David Stern, MD, CPC continues his discussion of how various regulations identify new vs. established patients.

We'd like to offer you the opportunity to contribute to future issues of *JUCM*, too. If you have an idea for an article, send it to Editor-in-Chief **Lee A. Resnick, MD**, at *editor@jucm.com*. If you find a topic of interest, chances are your colleagues will, too.

To Submit an Article to *JUCM*

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

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

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

As We Gather

LOU ELLEN HORWITZ, MA

It's a well-known fact that most people don't like meetings. They are an intrusion on "our" day. They are often in the service of other people and their ideas. They take at least an hour and sometimes don't accomplish much. They require preparation and listening and "consensus."

It would be so much better if they could be all about us, wouldn't it? If we were the only ones who could call a meeting, and everyone who attended had done their homework and were there to help us figure out how to make our lives easier, better, more rewarding?

I will confess now that the above is a set-up to talk to you about the upcoming National Urgent Care Convention.

It seems contrived, I realize, but it's also true. As I was writing, and thinking about gatherings and why people usually come together—and how it usually goes (see paragraph 1)—I realized that the Convention is the antithesis of your regular meetings; it really *is* that "fantasy meeting" (see paragraph 2) we all dream about.

Here's why:

- Highly trained people spend at least 10 months doing their "homework" and coming up with a meeting agenda that is *all about you*.
- We invite the top people we can find to come and talk about topics that you have already told us you want to know more about (plus a few new ideas to keep you all on the cutting edge).
- We invite all of your professional colleagues and friends to the meeting, so you cannot only learn from our experts, but share ideas with each other and reunite with old acquaintances.
- We also invite 100 or so industry suppliers, just in case you need to do some organizational shopping, or need to learn about a great product or technology or service you hear about during the meeting.
- So you can have a little fun and relax during your "fantasy meeting," we have a party every now and then—with better refreshments than the typical office cake.
- We also have a full-time staff ready to answer questions, give direction, facilitate introductions, and provide whatever else you need during your meeting (even if it's just another notepad).
- Since there are so many people at your fantasy meeting (because it's their fantasy meeting too!), we also give you a contact list for everyone, so you can easily reach out to them after it's over.

The only catch is that you do have to come to Las Vegas to be at the meeting...but as catches go, that's a pretty good one!

As you can tell, I am both proud of what the Convention Committee has put together, and excited to share it all with you. Without you, obviously, it's just a bunch of good ideas waiting for a place to happen; it is all of you who make it actually happen.

This presumes, of course, that you will be in attendance when we convene at Caesars Palace April 21–23. If you haven't had the chance to register for this "fantasy" meeting yet because you've been stuck in the more mundane variety described previously, I urge you to do so now. The online registration form, along with all the details you'll need to know, can be found at *www.ucaoa.org/convention*.

With everyone talking about how bad the economy is and what impact that will have on meetings like ours, we are encouraged by how many of you have already signed up—exhibitors and participants alike. So, thank you for giving us (and yourselves) the gift of your attendance. I can promise you, it is an investment that will pay dividends in the years and months to come, and we can't wait to see you. ■

On a somewhat related note....

Soon, all UCAOA members will be hearing from us with a Call for Nominations for the April election of new members of the Board of Directors, which will take place during the Convention. These new leaders will join our existing Directors in charting the future for UCAOA, so we encourage all of you to give that serious consideration.

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

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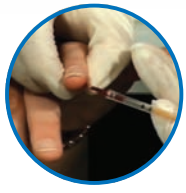

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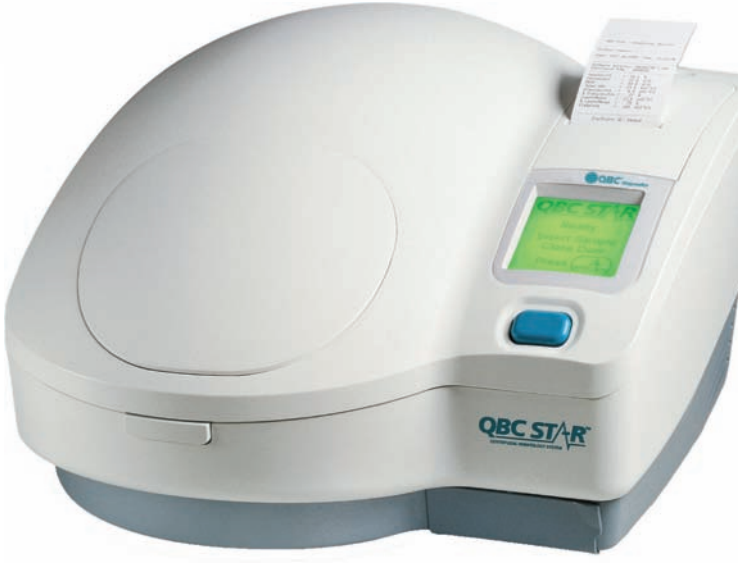

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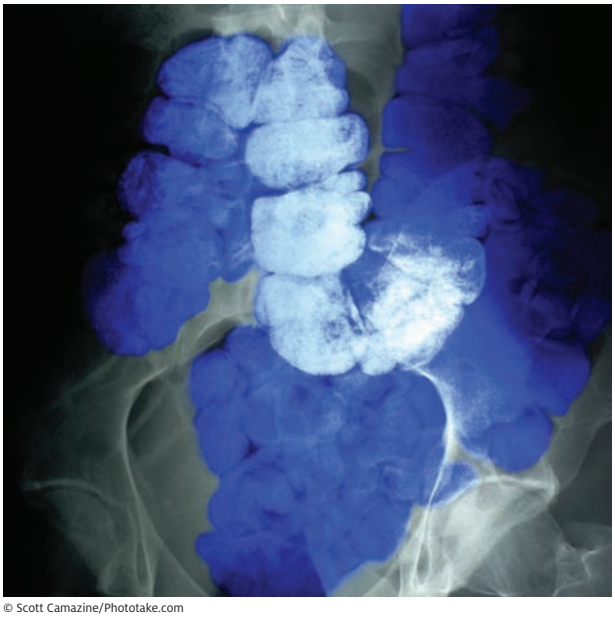
Management of Patients Presenting with Constipation

Urgent message: Constipation can be a sign of serious—even life-threatening—etiologies. Once non-benign causes have been ruled out, emphasis should be on evacuation and dietary and lifestyle changes to prevent recurrence.

Claire West, MD, Samuel M. Keim, MD, MS, and Peter Rosen, MD

INTRODUCTION

Constipation is a common complaint, accounting for approximately 2.5 million doctor visits annually. With increasing difficulty in obtaining a quick appointment with a primary care physician, more and more of these patients are utilizing urgent care facilities.



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Although it is most often seen in children, women, and patients over age 70, it is a reality that most people have experienced constipation at some time. It is a common and often benign complaint that is easy to disregard as a minor nuisance. Nevertheless, it is associated with a wide range of etiologies, including some serious problems; initiation of effective therapy must begin with their elimination as possible factors.

Constipation is defined as infrequent, firm, difficult-to-pass stools. *Obstipation* is the inability to pass either stool or flatus.

Since constipation is often a symptom of a more important underlying disease, it is necessary to clarify with the patient the actual characteristics, such as frequency, stool consistency, how these vary from normal for the patient, and other associated symptoms such as pain, bleeding, straining, nausea, vomiting, and weight loss.

As a sudden new symptom in a patient, constipation should raise the level of concern for non-benign etiologies and not be presumed to be an autonomous entity.

Ruling out serious and possibly life-threatening etiologies is imperative. However, without other concerning associated symptoms, empiric treatment and outpatient evaluation of constipation is generally appropriate.

Goals for treatment of functional constipation in urgent care focus on initial evacuation and prevention of recurrence. Education regarding dietary and lifestyle changes is often warranted.

Table 1. Rome Criteria for Chronic Constipation[2]

Adults	≥2 of the following for at least 12 weeks (not consecutive) in the preceding 12 months, and at least 6 months prior to diagnosis: ■ Straining during ≥25% of bowel movements ■ Lumpy or hard stools for ≥25% of bowel movements ■ Sensation of incomplete evacuation for ≥25% of bowel movements ■ Manual maneuvers to facilitate ≥25% of bowel movements (e.g., digital evacuation or support of the pelvic floor) ■ <3 bowel movements per week ■ Loose stools not present, and insufficient criteria for irritable bowel syndrome met ■ Sensation of anorectal obstruction or blockage ≥25% of the time
Infants and children	■ Pebble-like, hard stools for most bowel movements for at least 2 weeks, or ■ Firm stools ≤2 times per week for at least 2 weeks and no evidence of structural, endocrine, or metabolic disease

Table 2. Additional Causes of Constipation[4]

Acute or subacute	■ GI: obstructing cancer, volvulus, stricture, hernia, adhesion, pelvic or abdominal masses, inflammation ■ Medicinal: addition of new med (e.g., antipsychotic, anticholinergic, narcotic analgesic, antacids) ■ Environmental: change in defecation regimen (e.g., forced to use bedpan) ■ Exercise and diet: decrease in level of exercise, fiber intake, fluid intake
Chronic	■ GI: slow-growing tumor, colonic dysmotility, paraplegia, cerebral palsy ■ Endocrine: diabetes, hypothyroidism, hyperparathyroidism ■ Rheumatologic: scleroderma ■ Toxicological: lead poisoning

There are many treatment options available; unfortunately, good evidence for many of these remedies is lacking. The strongest evidence supports the efficacy of bulk-forming agents, such as psyllium, and osmotic agents, such as polyethylene glycol.[1]

Classically, chronic constipation has been defined by the Rome criteria as presented in **Table 1**.[2]

The definition of constipation can range from a patient's simple complaint of decreased bowel movement frequency to the gastroenterologists' more complex and specific Rome criteria.

PATHOPHYSIOLOGY

Constipation is usually a multifactorial problem. It is often associated with low dietary fiber, inadequate fluid intake, and immobility or a sedentary lifestyle.

Changes in diet and daily routine such as travel, pregnancy, or other alterations in lifestyle can also lead to constipation. There is, however, minimal evidence in the literature regarding the actual contribution of many of these factors.[3]

Constipation can also be caused by medications—a most important offender being opiates—or pathological processes such as a mass or a stricture, as well as neurological and connective tissue disorders.

Often, infants are presumed to be constipated when they appear to be straining; this is referred to as infant dyschezia. This circumstance requires parental reassurance more than treatment.

In older children, the etiology is likely to involve toilet training, a change in diet, and disruption of bowel habits, such as entering school.

Table 2 and **Table 3** show the myriad additional etiologies of constipation.

DIAGNOSIS

History

Initially, it is important to determine exactly what the patient means by the complaint of "constipation." Some patients complain of constipation when they mean *obstipation*, and some use the term for a change in the consistency of the stool.

Clarify, to the extent possible, the actual frequency and the character of stools, and whether there is a dif-

ference from the patient's normal pattern. Try to differentiate between acute and chronic conditions. Inquire about the duration, frequency, and progression of symptoms.

Chronic constipation can be strictly defined by the Rome criteria, as previously noted, but may also be more loosely defined as symptoms lasting longer than three months.[5] Although chronic constipation is most commonly benign and can be treated empirically without an extensive work-up, it is important to determine what recent changes led the patient to seek care.

Table 3. Medications Associated with Constipation

- Anticholinergics
  - antihistamines
  - tricyclic antidepressants (TCAs)
  - phenothiazines
  - antiparkinsonian agents
  - antispasmodics
- Antacids, specifically non magnesium-containing types
- Antihypertensives
  - diuretics
  - calcium channel blockers
  - clonidine
- Opioids
- Sympathomimetics
  - ephedrine
  - phenylephedrine
  - terbutaline
- Laxatives
- NSAIDs
- Iron, phenytoin, barium, bismuth, sucralfate

Complaints of acute constipation are often worrisome for a diagnosis of bowel obstruction, but if this can be eliminated by assessment of presenting symptoms and imaging studies, most of the

Table 4. Treatment Dosages

Medication	Adult	Pediatric
Psyllium & methylcellulose	12-60 g/day	7.5-15 g/day
Docusate	50-360 mg/day	25-180mg/day
Polyethylene glycol (PEG)	17 g/day	0.8 g/kg/day
Milk of magnesia (MOM)	15-30 mL	7.5-15 mL/day
Magnesium citrate	½ to 1 full bottle (up to 300 mL)	0.5 mL/kg, up to a maximum of 200 mL
Senna	2-4 tabs/day	2-6 years 0.5-1 tab 6-12 years 1-2 tabs
Bisacodyl	8-15 mg PO 10 mg PR	5-10 mg/day PO

ensuing work-up can be done on an outpatient basis. Complaints that might raise concerns include:

- nausea and vomiting
- inability to pass flatus (suggestive of obstruction)
- abdominal pain
- fever
- hematochezia
- recent weight loss
- a history of a significant gastrointestinal (GI) disease, such as regional enteritis.

If a GI history is warranted, it should include:

- diet, including recent changes
- physical activity level
- history of similar complaints
- laxative use
- abdominal surgery
- diverticulosis
- irritable bowel syndrome
- inflammatory bowel disease
- family history of gastrointestinal disease

A complete review of systems may reveal concomitant diseases that are the actual cause of the complaint.

Pay attention to systemic complaints or other symptoms that the patient may not associate with the GI symptoms. For example:

- Cold intolerance, hair and skin changes, and fatigue suggest hypothyroidism that may be the actual cause.
- Weight loss may be due to a malignancy or malabsorption.
- Fatigue and pallor can be indicative of anemia.

Inquire about new medications and dosage changes, dietary changes, psychological factors such as work or family stress, and travel.

For pediatric patients, ask about alterations in formula, progression to solid foods, symptoms of painful defecation, toilet training, and entering school or daycare.

Physical Examination

The patient should, overall, appear to be relatively well, with normal vital signs. Any abnormal vital signs should be investigated before narrowing the differential to constipation alone.

Evaluate the abdomen for evidence of tenderness, hernia, abdominal mass, distension, surgical scars, or peritoneal signs. Unfortunately, the abdominal examination is often normal even with a serious etiology present. Maintain a high index of suspicion when important historical features, as well as any abnormal abdominal examination features, are present.

A rectal examination is useful to detect rectal tumors, fecal impaction, rectal tone, gross or occult blood, fissures, and hemorrhoids.

Diagnostics

Diagnostic studies for complaints of chronic symptoms are not needed emergently, and can be obtained by the primary care physician or gastroenterologist in follow-up.[6]

Exceptions would be patients with additional concerning acute symptoms, as previously mentioned. Studies useful under these circumstances include:

- hemoccult testing
- abdominal plain imaging studies to evaluate for obstruction (as demonstrated by air-fluid levels and distended loops of bowel) or stool burden
- computed tomography (CT scan) with and without contrast
- a complete blood count to evaluate for anemia
- metabolic panel or other chemistries to look for pancreatitis or hepatitis, as well as to assess hydration and renal function.

Referrals

Typically, patients presenting with complaints confined to constipation with no indication of serious concomitant disease should be treated symptomatically, with referral to the primary care physician for follow-up for any diagnostic studies that may be indicated.

"Many children suppress bowel movements for a variety of psychological reasons, such as resistance to overly enthusiastic toilet training, shyness, and power struggles with a parent."

In addition to the tests listed previously, other studies might include colonoscopy, a barium enema, rectal barostatic testing, balloon expulsion testing, and even sacral nerve stimulation. Clearly, these are beyond the scope of an urgent care clinic and need to be obtained through follow-up.

TREATMENT

The goal of treatment for isolated constipation in an urgent care setting focuses on an initial pharmaceutical bowel cleansing regimen followed by emphasis on adequate fiber and fluid intake, along with increased physical activity in order to maintain a regular bowel routine. (See **Table 4**).

If a reversible underlying cause is not apparent on initial presentation, follow-up is important to investigate and treat the primary etiology.

In cases of fecal impaction, manual disimpaction must be performed. Enemas often do not work well for impacted stool, and although the task is unpleasant for the medical personnel and painful for the patient, manual disimpaction may be the only method to start the patient back on the path of a normal regular bowel movement. This should be followed by medication, of which a bulk-forming fiber is usually tolerated the best.

If the patient has signs and symptoms of bowel obstruction, the patient will need evaluation in the ED, as well as a surgical consultation.

If possible on site while preparing for transfer, and if indicated, start IV fluid replacement with normal saline at a rapid bolus of 20 cc/kg for children and 100 cc to 500 cc total for adults, based on consideration of possible comorbidities, along with nasogastric decompression.

When discharging non-obstructed patients with medications, make sure they understand what signs and symptoms should prompt a return to an emergency department.

Bulk-forming agents

These agents increase mass and stimulate peristalsis through distension of the colon. Options include psyllium (Metamucil), calcium polycarbophil (FiberCon), methylcellulose (Citrucel) and wheat bran. Only the efficacy of psyllium is adequately supported by evidence.[5]

All of these products require adequate fluid intake to be effective. Doses range from 15 g to 60 g of fiber with a recommended eight glasses of water daily.

Following initial treatment, dietary sources of fiber should be recommended for maintenance of regular bowel habits; these include whole grain breads and cereals, legumes, nuts, fruits, and vegetables.

Emollients/Stool Softeners

Stool softeners such as docusate sodium (Colace) are also available but seem to be less effective than psyllium.[6]

Adverse effects of both bulk-forming agents and stool softeners appear to be minimal, but include bloating and cramping.

Osmotic laxatives

Polyethylene glycol (PEG [Miralax]), lactulose, magnesium citrate, and magnesium hydroxide (milk of magnesia [MOM]) also have shown efficacy.[6] These agents draw fluid into the bowel, increasing colonic distension and stimulation of peristalsis.

PEG has been shown to be safe, and the most effective option, and is well tolerated in pediatric patients.[7-9] Adverse effects are generally mild, and include cramping and bloating.

MOM and magnesium citrate may cause electrolyte abnormalities (especially hypermagnesemia), particularly in children and patients with renal failure.

Stimulants/irritants

Senna (Senakot, ex-lax) and bisacodyl (Dulcolax) stimulate gastrointestinal motility, as well as increase secretion of water. Risk of decreased motility due to a chronic effect on the myenteric plexus has been suggested and long-term use is generally not advised, but few studies have been able to demonstrate this consequence.[1]

Stimulants are not recommended for infants. They can be given to older children but are preferred for re-

fractory cases rather than initial treatment.[10]

Bisacodyl is also available in suppository form for patients unable to tolerate medications by mouth.

A mild non-pharmacologic but useful stimulant is stewed prunes. The patient may start with half a dozen, and increase daily consumption by six a day until bowel movements commence. They are also useful to help the patient retrain erratic bowel habits into having a bowel movement at a specific time of day.

Enemas

Enemas, including warm water, work by causing colonic distension and by softening the stool. Sodium phosphate enemas (Fleet) also have an osmotic property and have the potential to cause water and electrolyte disturbances such as hyperphosphatemia and hypocalcemia.[11] This may be especially true in children and older patients with multiple comorbidities, such as renal dysfunction.[11,12]

Typically, enemas performed in the clinic setting are reserved for refractory or severe cases in conjunction with manual fecal disimpaction.

Enemas are also psychologically difficult for children, who often don't understand the purpose. Many children, especially young boys around the age of 3 to 6, voluntarily suppress their bowel movements for a variety of psychological reasons, such as resistance to overly enthusiastic toilet training, shyness about using toilets away from home, stubborn unwillingness to be toilet trained, and power struggles with a parent. They may view an enema as punishment, which could worsen the problem.

Alternatively, these children may benefit from prunes, along with positive reinforcement for having a successful bowel movement, and a careful avoidance of punishment for having an "accident." Often their peer group pressure at school is even more effective than the home forces in inducing toilet training.

Lubricants

Lubricants such as mineral oil, taken by mouth, can be helpful when constipation is secondary to painful rectal lesions such as fissures or abscesses. Care in administration of these in children and in elderly patients with altered mentation is prudent to minimize the risk of aspiration of the mineral oil.

DISPOSITION

Serious and immediate life-threatening etiologies should be considered; if they cannot be excluded in the urgent care clinic, the patient should be transferred to an emergency department.

Transfer and admission with surgical consultation is indicated for evidence of obstruction, as well as for systemic disease needing immediate evaluation or intervention.

Early follow-up is important for most other patients, such as those with evidence of systemic disease not requiring immediate attention, and for those patients with refractory symptoms.

Patients who are being discharged should be educated regarding reasons to seek medical attention immediately (such as increasing pain, vomiting, and other concerning symptoms listed previously), as well as lifestyle changes to prevent future problems.

Potential complications if symptoms continue untreated include prolapse of hemorrhoids, or the onset of inguinal or femoral hernias secondary to straining, anal fissures, rectal prolapse, fecal impaction, obstruction, intestinal pseudo-obstruction, megacolon, and sigmoid volvulus.

SUMMARY

Constipation is a very common gastrointestinal complaint heard in the urgent care clinic. Identification of the etiology in this setting is not always possible, or practical. It is important to distinguish emergent disease processes from those that can be treated symptomatically and followed up on an outpatient basis. ■

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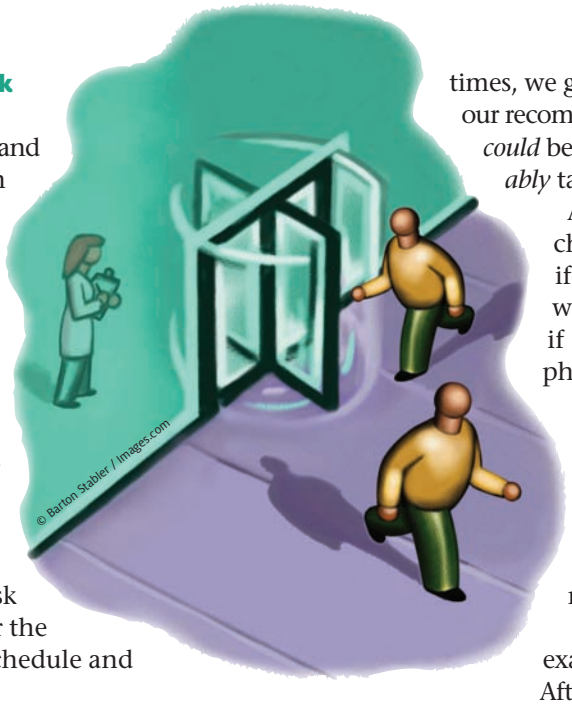
Bouncebacks

The Case of a 28-Year-Old Pregnant Female with Shortness of Breath

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

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

Michael B. Weinstock, MD and Jill C. Miller, MD



Approaching Differences in Risk Tolerance (Part 1 of 2)

What happens when the patient and physician disagree on approach to treatment, due to differences in risk tolerance? Physicians tend to be risk averse, due to the quantity of patients they see.

For example, a 2% risk of heart attack may be low enough for a patient to decide to forgo hospital admission, but be unacceptably high for an urgent care physician who sees 100 patients with chest pain per year. Patients may be more comfortable with small risk and ask their physician to tailor the diagnostic approach to their schedule and preference.

The physician, after all, is in essence a contracted consultant; an adult patient of sound mind and body is not required to accept his or her recommendations. Sometimes, we give advice but the "strength of our recommendation" is not strong; "This *could* be cellulitis and you should *probably* take an antibiotic."

A reasonable patient may choose to defer therapy and see if their symptoms improve, and we might choose to do the same if we were in their shoes as a physician-patient.

Other times, our recommendations are very strong but the patient still chooses to defer therapy despite potentially catastrophic consequences. The picture then becomes murkier.

The case presented here is an example of one of those situations. After the case presentation, we will explore specific documentation issues and detail elements which need to be included on the chart when a patient leaves against medical advice (AMA).

Initial Visit

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

CHIEF COMPLAINT: **Difficulty breathing**

VITAL SIGNS

Time	Temp (F)	Rt.	Pulse	Resp
02:57	97.4	O	78	2
04:51			116	30

Syst	Diast	O2 Sat O2%
64	96	Room air
64	100	4 liters nasal cannula

HISTORY OF PRESENT ILLNESS:

This is a 28-year-old pregnant female, G1P0, approximately 38 weeks pregnant, who presents with 2 weeks of shortness of breath and dyspnea with exertion, orthopnea, and leg swelling. Also diffuse chest pain worse with exertion. Was seen by the family doctor and told that there was "no problem" (per husband). She denies fever or chills, cough, or chest pain. She has no other complaints today. She is non-English speaking and history is all from her husband and from a Somalian interpreter at the bedside. No fever, vomiting, rhinorrhea, headache, rash, blurred vision.

PAST MEDICAL HISTORY/TRIAGE:

Allergies: Penicillin
Medications: Robitussin and Tylenol
No significant medical history. No significant surgical history.

PHYSICAL EXAM:

General: Well-appearing; she is tachypnea with a resting respiratory rate of 26 on my exam
Neck: No JVD or distended neck veins
Resp: Normal chest excursion; breath sounds clear and equal bilaterally; no wheezes, rhonchi, or rales
Card: Regular rhythm, without murmurs, rub or gallop
Abd: Gravid; non-tender, soft, without rigidity, rebound or guarding, no pulsatile mass
Chest: No pain with palpation
Skin: Normal for age and race; warm and dry without diaphoresis ; no apparent lesions
Extremities: Pulses are 2 plus and equal times 4 extremities, 2+ pitting edema of both LE

LAB RESULTS:

CBC, electrolytes, BUN/creat, LFT all nl. except Hb 11

RADIOLOGY:

CXR: Bilateral interstitial lung opacity, suspect represents interstitial edema

PROCEDURES:

FHT were 132 ausculatated by doppler in the RUQ .

PROGRESS NOTES:

Physician at 05:32: This patient is hypoxic and needs to be evaluated to rule out blood clot. The patient wants to leave. I told her she does not have a choice as she's putting the fetus at risk if she wishes to leave and I'm not allowing it. Security is at the bedside.

RN at 05:37: We got to the elevator for the CT scan and pt refused to get in. Pt informed of risks to herself and the fetus and states "if I go home and die in my bed so be it". With much encouragement pt finally agreed to return to the ED. Pt refuses to wear oxygen or be on cardiac monitor. OB resident called. Somalian interpreter called.

Physician at 05:52: I called the hospital's risk management team and informed of patient's desire to leave—she is 38+ weeks pregnant and is hypoxic—my concern is that she is putting the unborn fetus at risk. She will call me back.

Social work consultation at 06:06: I paged the department manager who advised that the physician has a right to hold the pt against her will—she can be held long enough to pursue a probate court order to force treatment. The OB clinic social worker was also contacted.

Physician at 06:37: I had a long discussion with the patient and her husband regarding her critical illness. The Somalian interpreter was present. I told the patient that her oxygen level is too low to go home and she is at risk of dying. Her unborn baby is also at risk of dying. With the help of the interpreter, the patient repeated this back to me and states that she understands. Risk management concurs that she can leave AMA.

RN progress note at 06:57: The patient signed the AMA form in the presence of her husband and the interpreter. The husband was also asked to sign since he was

taking the patient home, but he refused to sign. The risks of refusing treatment (including the potential of death) were discussed and the patient stated understanding.

DIAGNOSIS:
1. Hypoxia
2. Dyspnea
3. Pregnant

DISPOSITION:
The patient and her husband left against medical advice. The next day, there was a message left through interpreter for patient return immediately to the ED for admission. Mother answered phone—states that patient doesn't live there and she will attempt to get in touch with her.

Discussion of Documentation and Risk Management Issues at Initial Visit

If the patient is an adult of sound mind and body, the physician is obliged to respect their wishes to forgo treatment, no matter how illogical their reasoning. These principles were laid out by Justice Benjamin Cardozo (1870-1938), appointed to the Supreme Court by President Herbert Hoover to succeeded Justice Oliver Wendall Holmes; Cardozo was so widely respected that the *New York Times* noted, "Seldom, if ever, in the history of the Court has an appointment been so universally commended."

Justice Cardozo established principles of *informed consent* and *respondeat superior* (translated literally from Latin as "let the master answer") with the case of Schloendorff v. Society of New York Hospital in 1914.

The plaintiff in that case, Mary Schloendorff, was admitted to New York Hospital and consented to being examined under ether, but withheld consent to an operation. The physician disregarded Schloendorff's wishes and operated to remove a tumor.

Cardozo ruled that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained."

Justice Cardozo's opinion continues to resonate today.

In the urgent care setting, several principles need to be established before a patient is allowed to leave against medical advice. For example:

1. The patient is an adult or emancipated minor.
2. The patient is of sound mind; this should be specif-

ically documented (i.e. A&O X 3, not inebriated, no dementia, etc.).
3. The patient has been informed of potential consequences of non-treatment. Ensure the patient understands by having them repeat back what you explained.
4. Involve family, friends, or the patient's physician.
5. Have the patient, family member, physician, and nurse sign the AMA form.

The first three of these are the most important. Having a nurse sign the AMA form without documenting that the patient is able to make a medical decision and understands the consequences of non-treatment, for example, does little to protect the physician from medical liability.

The big question with our case is whether the patient was capable of making a medical decision. It could be argued that a tachycardic patient who requires 4 L of oxygen was *not* in a state to make a medical decision. But the physician documented that she understood and could repeat back the implications of leaving; in other words, the patient demonstrated that she was capable of making her own decision.

Involving risk management was a helpful step—not common, but very smart, as there was an additional non-vocal party: the unborn infant.

Evaluation of Shortness of Breath During Pregnancy

Up to 70% of healthy women complain of dyspnea or a "sense of breathlessness" during pregnancy; its evaluation is challenging.

More often than not, dyspnea during pregnancy may be attributed to a normal increase in minute ventilation or the restrictive process of a gravid uterus preventing full expansion of the lungs. However, several potentially life-threatening emergencies must be ruled out, including asthma, pneumonia, pulmonary embolism, or pulmonary edema due to preeclampsia or dilated cardiomyopathy of pregnancy.

Asthma

Asthma, the most common respiratory disorder complicating pregnancy, affects one in 100 pregnant women. Management of asthma during pregnancy is not much different than in non-pregnant patients and includes inhaled beta agonists (albuterol) and prednisone. Our patient did not have a history of asthma or wheezing on lung exam, making the diagnosis of asthma unlikely.

Pneumonia

Pneumonia is the most common non-obstetrical infectious cause of maternal death during pregnancy; the alteration in a pregnant woman's thorax makes clearing of respiratory secretions more difficult. The most common cause of bacterial pneumonia is *S pneumoniae*, as it is among non-pregnant patients. Quinolones are contraindicated during pregnancy, making macrolides such as azithromycin first-line therapy.

Without fever or atypical CXR appearance, however, bacterial pneumonia is unlikely in our patient.

Cardiomyopathy

The term *cardiomyopathy* refers to a broad spectrum of disorders, both acute and chronic, that affect the myocardium. Cardiomyopathies are divided into three categories: dilated, hypertrophic, and restrictive.

Cardiomyopathy of pregnancy is a dilated, high-output form of cardiac failure which is often transient. It can occur during the last month of pregnancy, but most cases are encountered in the first three months postpartum.

Risk factors for developing cardiomyopathy of pregnancy include advanced age, African-American multiparas, and preeclampsia. Complications include development of a mural thrombus and subsequent pulmonary embolism. The chest x-ray may show cardiomegaly, with signs of pulmonary edema such as Kerley B lines or interstitial infiltrates. The 2D echo will reveal dilated chambers and thin cardiac walls. Cardiomyopathy remains in the differential diagnosis.

Pulmonary embolism

Pulmonary embolism (PE) is a condition which scares all physicians; symptoms can be very innocuous, as seemingly insignificant as a feeling of fatigue, an elevated heart rate, or pain with a deep breath.

There are approximately 650,000 PEs per year in the United States, causing 200,000 deaths, making it one of the leading causes of death.

The concerns with misdiagnosis are twofold:
1. A small PE causing minimal symptoms which may not result in death but often heralds a larger, fatal PE
2. The disease can strike young, healthy-appearing people who are in the prime of their lives.

In fact, if the diagnosis is missed, the mortality can be as high as 30%. Pregnancy induces a hypercoagulable state, increasing the risk of pulmonary embolism. PE remains in our differential diagnosis.

Table 1. Estimated Radiation Dose to Fetus

Modality	*Estimated exposure (mrad)*
C-spine	<1
Chest x-ray	1-3
Kub	200-500
Pelvis x-ray	200-500
L-spine	600-1000
CT head/chest with abdominal shielding	<1000
CT abdomen	3000
CT pelvis	3000-9000
V/Q scan	<55
CT pulmonary angiogram	<50 via brachial with abdominal shielding

Source: Adapted from Harwood Nuss, et al. The Clinical Practice of Emergency Medicine; 2001(3rd ed): 621. Philadelphia: Lippincott Williams and Wilkins and Rosen et al. *Emergency Medicine Concepts and Clinical Practice*; 1998(4th ed): 2335. St Louis: Mosby-Year Book, Inc.

Diagnostic Imaging in Pregnancy

When considering radiological investigations in the pregnant patient, one must weigh the potential risks of radiation to the developing fetus against the risk to both the mother and the fetus of misdiagnosis.

The two main concerns are teratogenic and oncogenic.

Teratogenic risks include congenital malformations or embryonic death; this is of greatest concern during the first seven weeks, when organogenesis is occurring. In addition, several studies have shown a small but statistically significant increase in the relative risk of developing childhood cancer after the unborn fetus is exposed to radiation.

Significant risk is unlikely when the fetus is exposed to less than 10 rads (10,000 mrad) during the course of the pregnancy. With exposure to 15 rads or greater, there is a 6% chance of severe mental retardation and 15% chance of microsomia.

The fetus will be exposed to an average of 50 mrad to 100 mrad of naturally occurring radiation during nine months of pregnancy. **Table 1** lists estimated radiation dose to the fetus by imaging modality.

For example, between 3,000 and 10,000 chest x-rays can be safely done during pregnancy. It is always helpful to discuss this with the patient prior to ordering the test so they don't have undue worry during their subsequent pregnancy.

Traditional teaching suggested that a nuclear ventilation-perfusion (V/Q) scan was the test of choice to rule out PE, providing a safe level of radiation exposure to the unborn fetus. More than 200 V/Q scans would result in total exposure of less than 10 rads.

However, a 2002 study showed that helical CT is better. This study compared fetal radiation dose between nuclear scan and CT and concluded that the average fetal radiation dose with CT was substantially less during all three trimesters.

Additionally, the CT may reveal another diagnosis such as pneumonia, cardiac effusion/tamponade, or aortic dissection. The authors stated "pregnancy should not preclude use of helical CT for the diagnosis of PE."

Patient Follow-Up: ED Return Two Days Later

- Heart rate 133, O2 sat 100%
- Physical exam: Tachypnic, marked 4+ peripheral edema pitting up to the knees
- Chest CT: Bilateral pleural effusions and increased heart size. No PE.
- Labs: WNL
- ED course: Lasix 40mg IVP
- ED diagnosis: Acute pulmonary edema associated with pregnancy
- Inpatient course: ECHO shows severe mitral valve regurg from rheumatic mitral valve. EF 55%
- Labor was induced to decrease fluid volume and workload on the heart. Pt. began to desat while in labor and was taken for emergent c-section. She was not able to be taken off the vent and became hypotensive. After 5 days she was discharged from the ICU and extubated and finally discharged from the hospital on cozaar, lasix, potassium and toprol.
- Diagnosis: Mitral valve regurgitation secondary to rheumatic valvular disease
- Returned to the hospital 2 weeks later in respiratory distress and admitted. Cardiothoracic surgeon agreed to perform valve surgery but patient wanted family to help make decision so she was discharged and subsequently lost to follow up

Heart Disease and Pregnancy

The normal physiologic changes in pregnancy can precipitate cardiac symptoms in previously stable women. What makes matters more difficult is that many of the normal symptoms of pregnancy can mimic cardiovascular disease.

However, while fatigue, decreased exercise tolerance, palpitations, lower extremity edema, and a soft-flow murmur are common in pregnancy, chest pain worse with exertion, any clinically significant dyspnea, a loud murmur greater than grade 3, or any diastolic murmur is not. A more careful exam, including an echocardiogram, is warranted.

"One of the most difficult patients to take care of is the one who doesn't understand you (or one that you don't understand)."

Of note, B-type natriuretic peptide is slightly elevated normally in pregnancy. Cardiac enzymes are not, but both of these tests can and should be used for diagnostic purposes.

Predictors of high risk in women with heart disease include a previous or current history of heart failure with impaired functional status NYHA class >II, a significant cardiac arrhythmia, left-sided valve obstruction, i.e., significant aortic or mitral stenosis, pulmonary hypertension, Marfan's syndrome, and hypertrophic cardiomyopathy.

Medications safe to use in pregnancy include digoxin, beta-blockers, diuretics, hydralazine and unfractionated heparin. Medications contraindicated are warfarin, ACE inhibitors, ARBs, and amiodarone.

Summary

During our patient's initial presentation, she was hypoxic, with orthopnea and chest pain; she left AMA, possibly for cultural reasons. She returned with a BP of 158/70, pulmonary edema, and 4+ pitting edema of her extremities. She was ultimately found to have severe mitral regurgitation.

Always be aware of the potential red flags; the primary care physician who initially evaluated this patient felt that her symptoms were from normal physiologic changes of pregnancy (per husband's report), but when she presented to the emergency room she clearly had symptoms that should never be attributed to the pregnancy itself.

One of the most difficult patients to take care of is the one who doesn't understand you (or one that you don't understand); this case illustrates that point beautifully. Though you don't have control over the patient's decision to leave, you do have control over how you document this high-risk encounter.

Put this chart aside to review at the end of the shift and make sure that your documentation is complete. Be aware that the ability for the patient to sign out AMA is a direct function of that individual's state of mind. It must be clear that no physical or mental impairment is interfering with the decision making.

In our case, the patient is an adult of normal mental capacity who has been fully informed of the risk to herself and the unborn fetus and who has fully comprehended the risks being explained to her, and she is able to repeat that risk back to you in front of family members, an interpreter, and other medical personnel.

Furthermore, if there is any doubt about ethical questions, as in this case regarding the unborn fetus, obtaining a legal consultation is advisable.

Resources and Suggested Reading

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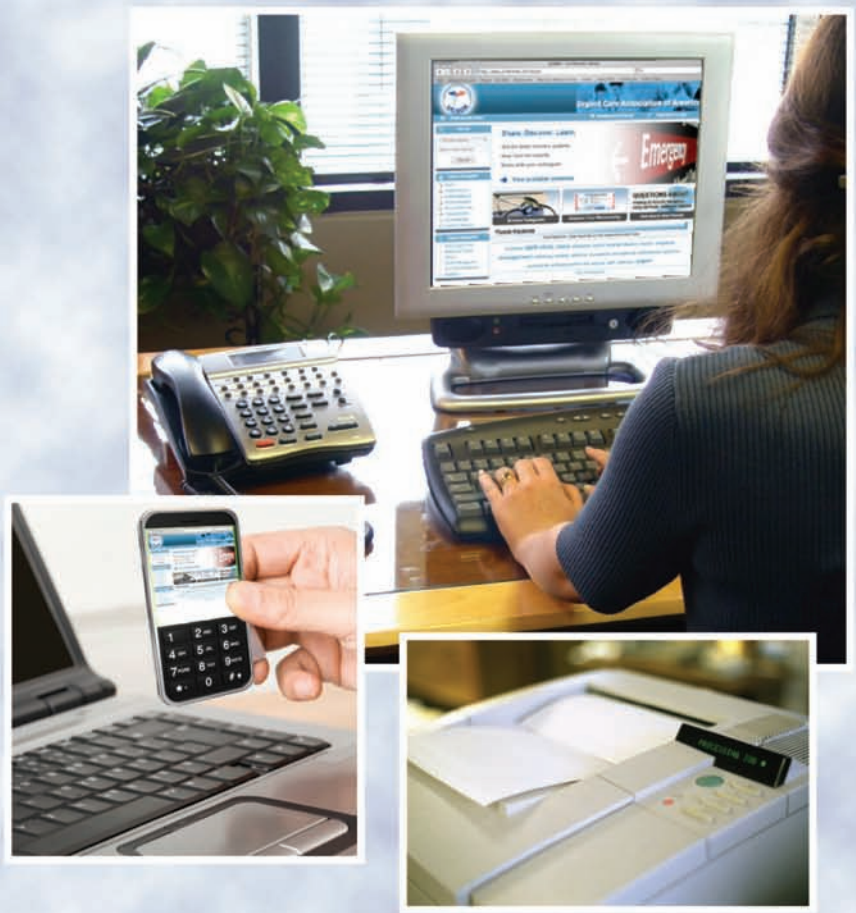

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On Uninsured Patients, Remote Orthopedic Consultation, MRSA and Healthcare Workers, UTI in Non-pregnant Women, and Active Bed Management

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.

Assumptions About Uninsured Patients in U.S. EDs: More Fiction Than Fact

Key point: Commonly held beliefs were either debunked or found to be equally true for insured patients.

Citation: Newton MF, Keirns CC, Cunningham R, et al. Uninsured adults presenting to U.S. emergency departments: Assumptions vs. data. *JAMA*. 2008;300:1914-1924.

Recent physician testimony before Congress asserts that uninsured and underinsured patients unnecessarily drain emergency department medical resources. To evaluate the evidence for this and other common assumptions about uninsured ED patients, researchers conducted a MEDLINE search for citations published from 1950 to 2008 that focused on uninsured adult patients (age range, 18 to <65) who were treated in U.S. EDs.

The following three assumptions were *not supported*:

- 1a - uninsured patients present with non-urgent problems
- 1b - cause ED crowding
- 1c - present more often than insured patients

The following three were equally true for uninsured and insured patients:

- 2a - patients lack access to primary care
- 2b - are presenting to EDs with increasing frequency
- 2c - are more expensive to treat in the ED than elsewhere

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The following three, less widely held assumptions were supported by the literature:

- 3a - uninsured patients present with higher illness acuity
- 3b - delay getting care
- 3c - receive less care

Both insured and uninsured patients reported that they prefer to use the ED for care because they perceive that the ED has more highly skilled practitioners.

Unquestionably, EDs face enormous challenges, including overcrowding; an aging population; new responsibilities for surveillance and disaster preparedness; and more-complex diagnostic and management strategies for syndromes such as acute myocardial infarction, stroke, sepsis, trauma, and resuscitation. According to this study, conventional "wisdom" about the burden of uninsured patients on some aspects of ED care lacks credibility. Healthcare-delivery policies that are predicated on inaccurate assumptions can further compromise the ability to provide emergency care and unfairly blame an already vulnerable population, with the potential to widen health disparities.

[Published in *J Watch Emerg Med,* December 12, 2008—John A. Marx, MD, FAAEM, FACEP.] ■

Effect of Remote Orthopedic Consultation on Hospital Referrals in a Community-Based Urgent Care Facility

Key point: The referral rate for fractures decreased from 24% to 14% after introduction of the technology.

Citation: Kovalski N, Zimmerman D, Fields S, et al. *Israeli J Emerg Med*. 2008;8(3):29-33.

The purpose of this study was to describe the contribution of a remote messaging and x-ray viewing tool integrated into the emergency medical records of a chain of privately run urgent care clinics in order to facilitate orthopedic consultation and decrease orthopedic referrals to hospital emergency departments.

Non-orthopedic physicians were trained in simple splinting and casting techniques and given access to a remote telecommunications tool. Hospital referral rates for orthopedic traumatic injury were compared between three-month periods before and after implementation of the technology and, after its implementation, between times with and without physician access to remote orthopedic consultation.

The referral rate for fractures decreased from 24% to 14% after introduction of the technology ($p<.0001$). During the 14 months of the tool's implementation, the mean referral rate was 4.3% when it was available and 6.3% when it was not ($p<.0001$). Survey of the physicians involved yielded 100% satisfaction with the ability to obtain virtual orthopedic consultations. ■

Healthcare Workers and MRSA

Key point: In a single-site study, nasal samples from 15% of ED workers tested positive for MRSA.

Citation: Bisaga A, Paquette K, Sabatini L, et al. A prevalence study of methicillin-resistant *Staphylococcus aureus* colonization in emergency department health care workers. *Ann Emerg Med*. 2008;52:525-528.

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a common cause of morbidity and mortality in institutionalized patients, and community-acquired MRSA is now the most common cause of purulent skin and soft-tissue infections in adults. Healthcare workers colonized with MRSA can transmit it to patients and colleagues, as well as develop clinical infections.

In a prospective cohort study, researchers assessed MRSA nasal-colonization rates in a convenience sample of 105 emergency department attending physicians, nurses, and technicians at a single institution in Illinois. Nasal samples from 16 workers (15%) were MRSA-positive.

The prevalence of MRSA colonization among ED healthcare workers in this single-site study is alarming and highlights the importance of following infection control practices.

[Published in *J Watch Emerg Med*, December 24, 2008—Richard D. Zane, MD, FAAEM.] ■

New Guidelines for Management of Urinary Tract Infection in Non-pregnant Women

Key point: A new ACOG practice bulletin offers recommendations and weights evidence regarding a problem that affects approximately 11% of U.S. women annually.

Citation: ACOG Practice Bulletin No. 91: Treatment of Urinary Tract Infections in Non-pregnant Women. *Obstet Gynecol*.

2008;111(3):785-794.

The American College of Obstetricians and Gynecologists (ACOG) has issued a practice bulletin to address the diagnosis, treatment, and prevention of uncomplicated acute bacterial cystitis and acute bacterial pyelonephritis in non-pregnant women. An estimated 11% of U.S. women report at least one physician-diagnosed urinary tract infection (UTI) per year, and the lifetime probability that a woman will have a UTI is 60%.

Acute bacterial cystitis usually presents with dysuria, urinary frequency and urgency, sometimes with suprapubic pain or pressure, and rarely with hematuria or fever. The symptoms of acute urethritis from *Neisseria gonorrhoeae* or *Chlamydia trachomatis* infection, or genital herpes simplex virus type 1 and herpes simplex virus type 2, may be similar, and these conditions should be ruled out.

These guidelines do not address management of complicated UTIs (e.g., those occurring in patients with diabetes mellitus, abnormal anatomy, previous urologic surgery, a history of kidney stones, an indwelling urinary catheter, spinal cord injury, immunocompromise, or pregnancy). Upper UTI or acute pyelonephritis often presents with fever, chills, flank pain, and varying degrees of dysuria, urgency, and frequency.

Specific practice recommendations and their accompanying level of scientific evidence are as follows:

- In non-pregnant, premenopausal women, screening for and treatment of asymptomatic bacteriuria is not recommended (level of evidence, A).
- Antibiotic class should be changed when resistance rates are higher than 15%–20% (level of evidence, A).
- Patients with acute pyelonephritis should complete 14 days of total antimicrobial therapy, regardless of whether treatment is on an inpatient or outpatient basis (level of evidence, A).
- For uncomplicated acute bacterial cystitis in women, including women ≥65 years of age, antibiotics should be administered for three days (level of evidence, A).
- Urine culture is not required for the initial treatment of a symptomatic lower UTI with pyuria or bacteriuria, or both (level of evidence, B).
- For the treatment of acute uncomplicated cystitis, beta-lactams, including first-generation cephalosporins and amoxicillin, are less effective than the preferred antimicrobials listed as treatment regimens (level of evidence, C).
- For the diagnosis of bacteriuria in symptomatic patients, decreasing the colony count to 1,000 to 10,000 bacteria per mL will improve sensitivity without significantly reducing specificity (level of evidence, C).
- A proposed performance measure is the percentage of women diagnosed with acute pyelonephritis who receive antimicrobial treatment for 14 days.

For uncomplicated acute bacterial cystitis, recommended treatment regimens are as follows:

- Trimethoprim–sulfamethoxazole: One tablet (160 mg trimethoprim–800 mg sulfamethoxazole) twice daily for three days. Adverse effects may include fever, rash, photosensitivity, neutropenia, thrombocytopenia, anorexia, nausea and vomiting, pruritus, headache, urticaria, Stevens-Johnson syndrome, and toxic epidermal necrosis.
- Trimethoprim 100 mg twice daily for three days. Adverse effects may include rash, pruritus, photosensitivity, exfoliative dermatitis, Stevens-Johnson syndrome, toxic epidermal necrosis, and aseptic meningitis.
- Ciprofloxacin 250 mg twice daily for three days, levofloxacin 250 mg once daily for three days, norfloxacin 400 mg twice daily for three days, or gatifloxacin 200 mg, once daily for three days. Adverse effects may include rash, confusion, seizures, restlessness, headache, severe hypersensitivity, hypoglycemia, hyperglycemia, and Achilles tendon rupture (in patients >60 years old).
- Nitrofurantoin macrocrystals 50 mg to 100 mg four times daily for seven days, or nitrofurantoin monohydrate 100 mg twice daily for seven days. Adverse effects may include anorexia, nausea, vomiting, hypersensitivity, peripheral neuropathy, hepatitis, hemolytic anemia, and pulmonary reactions.
- Fosfomycin tromethamine, 3 g dose (powder) single dose. Adverse effects may include diarrhea, nausea, vomiting, rash, and hypersensitivity. ■

Active Bed Management by Hospitalists and Emergency Department Throughput

Key point: It was possible to decrease the average time that admitted patients spent in the emergency department by over 90 minutes.

Citation: Howell E, Bessman E, Kravet S, et al. Active Bed Management by Hospitalists and Emergency Department Throughput. *Ann Int Med*. 2008;149(11):804-810.

Active bed management by hospitalists can improve emergency department throughput and decrease ambulance diversion, according to a single-institution study.

The study found that a four-month hospitalist intervention decreased the average time that admitted patients spent in the emergency department by over 90 minutes. The percentage of hours that ambulances had to be diverted because of crowding or a lack of ICU beds also fell substantially.

The program involved a hospitalist assessing the real-time availability of inpatient beds, regularly visiting the emergency department, and helping to triage admitted patients, among other things. ■

INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

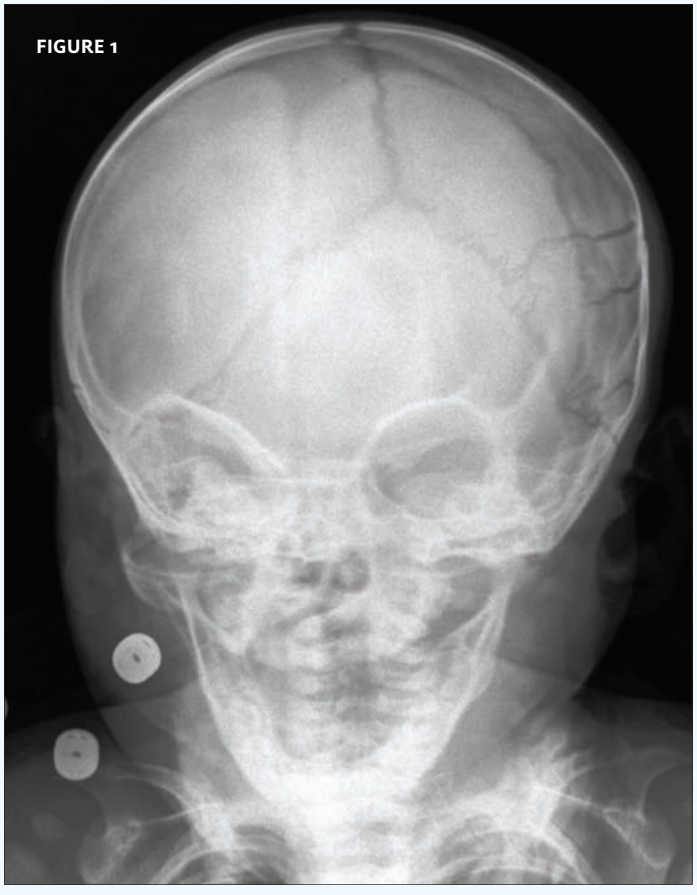


FIGURE 1

The patient is a 7-month-old boy who presents with his parents one day after falling from a bed. The parents state that there was no loss of consciousness; the child looks well and has not vomited.

The parents brought the child in out of concern from the fall. You opt to do a skull x-ray for the same reason.

View the x-ray taken (**Figure 1**) and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

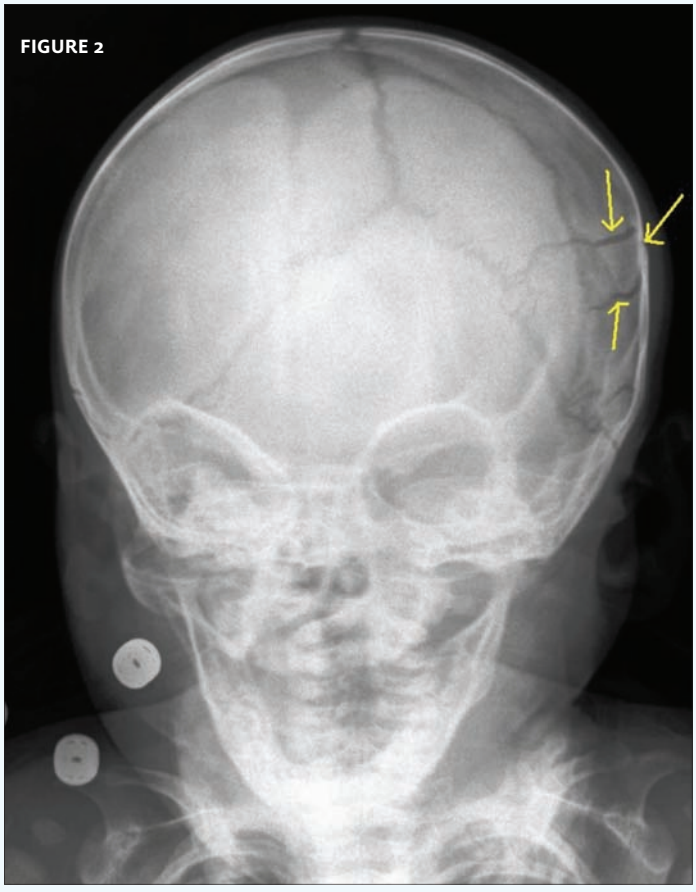


FIGURE 2

The x-ray shows a skull fracture with a step off. The lines of the fracture are clearly different than the opposite side of the skull. Given the finding and the boy's age, he was referred for neurosurgical evaluation.

The issue of x-rays vs. computed tomography for head trauma and diagnosis of skull fracture and intracranial injury remains controversial. In many facilities, CT has replaced plain films as the standard of care due to its accuracy in detecting skull fractures, as well as intracranial bleeding or injury. This may be especially true in cases like this, where there is a palpable step off or depression. In the urgent care center where this patient was evaluated, however, the protocol for patients under 1 year of age is to allow the treating physician to employ his imaging medium of choice.

As noted by BestBETs (Best Evidence Topics; *www.bestbets.org*), "The absence of skull fracture does not predict absence of ICI as seen on CT." As such, had the x-ray *not* shown a fracture, this still would not have ruled out ICI. At any rate, the unambiguous skull fracture justified referral.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, TEREM Immediate Medical Care, Jerusalem, Israel.

The Quality of Care at Urgent Care Centers

Urgent message: New data reveal that urgent care compares favorably with other practice environments when it comes to select key quality indicators.

Robin M. Weinick, PhD, Steffanie J. Bristol, BS, and Catherine M. DesRoches, DrPH

Developing methods to assess the quality of healthcare in any clinical area is a complicated affair. Many individuals have devoted large parts of their careers to quality measurement, and several national organizations—such as The Joint Commission and the National Quality Forum—exist solely for the purposes of measuring and ensuring the quality of healthcare delivered to patients in the U.S.

© Photos: iStockPhoto.com; Digital composite: Tom DePrenda

In the urgent care arena, however, the field is less well developed. Very few measures that have been developed for ambulatory care apply to the urgent care setting, with its focus on episodic care, because historically such measures have focused on providing longitudinal care for a panel of patients. These include common measures such as those related to HgA1c testing for diabetic patients, the initiation and maintenance of antidepressant use, and utilization and timeliness of preventive screening tests such as mammograms.

On the hospital side, most measures focus on either inpatient services (such as hand washing or postsurgical infection rates) or on care for a very narrow range of conditions (such as providing aspirin for patients with acute myocardial infarction). Again, this makes such measures less applicable to urgent care centers.

As part of a larger project to survey urgent care centers and provide benchmarking data, we asked centers to tell us about a variety of activities related to quality of care, including how they are integrated with the rest of the healthcare system, their use of clinical practice guidelines, and how they measure quality of care and patient satisfaction.

What We Did

As noted in the January issue of *JUCM*, we identified urgent care centers for our benchmarking initiative using three methods.

Table 1. Integration with the Healthcare System

	%	Standard error
Centers at which at least one physician has admitting privileges at a local hospital (n=410)	54.9	2.5
Referrals		
Centers maintaining a list of primary care physicians to whom they can refer patients (n=420)	85.7	1.7
Centers maintaining a list of specialty physicians to whom they can refer patients (n=422)	95.0	1.1
After seeing a patient who has a regular physician, urgent care centers do the following: (n=412)*		
Nothing	33.4	2.3
Send copy of chart to regular physician	48.4	2.5
Send consult note to regular physician	36.1	2.4
Call regular physician	23.0	2.1
*Percentages do not add to 100 because urgent care centers may use more than one of these approaches.		

First, we searched the website of each state's health insurance commissioner, as well as websites sponsored by insurers' trade associations to identify all health insurance carriers doing business in every state. Each insurance carrier's website was searched to locate all urgent care centers that are identified as having contracts or referral arrangements with that carrier.

Second, we searched *www.yellowpages.com*, *www.superpages.com*, and *www.switchboard.com* using a variety of terms such as "urgent care" and "walk-in clinic," retaining only relevant listings.

Third, we used the UCAOA and *JUCM* mailing lists.

Duplicates that emerged from these three methods were counted only once.

Next, we selected urgent care centers at random from within four geographic areas of the U.S. (Northeast, Midwest, South, and West). Selected centers were invited to participate in a mail survey; those that did not respond were contacted multiple times by telephone.

The survey, which was conducted between January and March 2008, included questions on a wide range of topics, such as services provided, hours of operation, connections to other sectors of the healthcare system, use of health information technology, staffing, and financial data.

Prior to completing the survey, all organizations were screened to ensure that they were urgent care centers. To qualify, an urgent care center was required to:

- provide care primarily on a walk-in basis
- be open every evening Monday through Friday
- be open at least one day over the weekend
- provide suturing for minor lacerations, and
- provide onsite x-rays.

This definition has been used in previous work, and was developed in conjunction with the UCAOA Benchmarking Committee.[1]

Our final results are based on responses from 436 urgent care centers. The survey response rate, calculated using Response Rate 3 from the American Association for Public Opinion Research *Standard Definitions*, was 50.2%.[2]

What We Learned

Table 1 shows information on how urgent care centers are integrated with the rest of the healthcare system.

Overall, 55% of centers have at least one physician with admitting privileges at a local hospital. By comparison, 77% of practicing family physicians have admitting privileges.[3] This difference is to be expected, however, since urgent care centers typically do not follow their patients over time or if they are hospitalized.

Referring

Many centers maintain lists of primary care (86%) and specialty (95%) physicians to whom they can refer patients. However, approximately 14% of centers do

Figure 1. Board Certification and Onsite Physicians

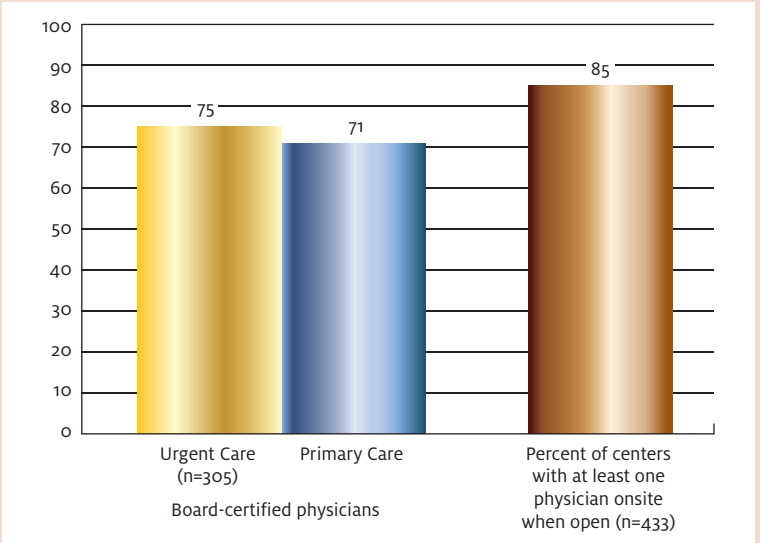
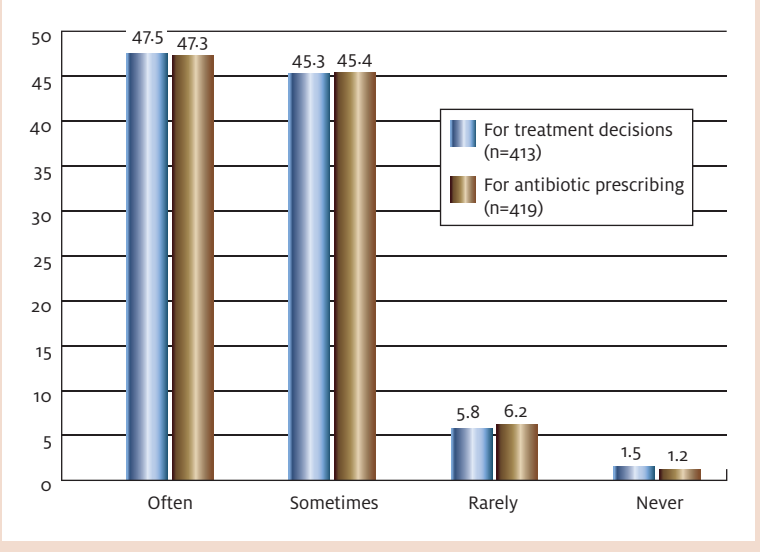


Figure 2. Percent of Physicians Using Clinical Guidelines



not have such lists of primary care physicians.

Maintaining lists such as these can be beneficial for those centers looking to build relationships with other practices in their community.

In addition, continuity of care is one key component of healthcare quality, as it can affect the efficiency with which services are delivered (eliminating duplication) and the patient-centeredness of the care provided. Maintaining such lists can help urgent care centers increase continuity of care for their patients.

Post-visit follow-up

Urgent care centers take a variety of actions after seeing a patient, including not contacting the patient's regular physician, sending a copy of the chart or a consult note to the regular physician, or calling the regular physician. The action selected for any individual patient may depend on a variety of factors, such as whether the patient has a regular physician, how acute and/or serious the patient's condition is, and the urgent care center's policies and practices.

Again, since continuity of care is one significant aspect of healthcare quality, providing follow-up information to patients' regular physicians can be a key component of high-quality urgent care.

Board-certified physicians

Approximately three quarters of physicians working in urgent care are board certified (see **Figure 1**), which compares well against the 71% of primary care physicians who are board certified.[4]

Eighty-five percent of centers have at least one physician on staff whenever the site is open.

Figure 2 illustrates the use of clinical practice guidelines in urgent care centers. For both general treatment decisions and specifically for antibiotic prescribing, slightly less than half of urgent care centers report using clinical practice guidelines "often." While there are no benchmarking data available regarding how often primary care physicians refer to such guidelines, previous research has shown that patients typically receive only about half of the care that is recommended, with little difference in compliance with recommen-

Table 2. Quality of Care

	%	Standard error
Routine measurement of quality of care (n=363)		
Done using nationally recognized measures such as HEDIS, or Joint Commission, or others	31.1	2.4
Done using measures developed by a non-national organization	6.1	1.3
Done using measures developed by the center	46.3	2.6
Not done	16.5	2.0
Routine measurement of patient satisfaction (n=396)		
Done using nationally recognized measures such as CAHPS®, Press-Ganey, or others	22.0	2.3
Done using measures developed by a non-national organization	6.3	1.2
Done using measures developed by the center	50.8	2.5
Not done	21.0	2.0

dations for acute care, chronic condition care, and preventive services.[5]

Quality of care

Finally, we asked how urgent care centers measure quality (**Table 2)**.

Approximately 30% of urgent care centers routinely measure quality of care using nationally recognized measures such as the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS), measures from The Joint Commission, or others.

By comparison, 20% of all physicians nationally report receiving quality of care data about the proportion of their patients who receive recommended care, and 18% receive data on patients' clinical outcomes (such as glycemic control for diabetic patients).[6]

However, 46% of urgent care centers assess quality using measures they have developed themselves, and 16.5% do not measure the quality of the care they provide.

Patient satisfaction

Twenty-two percent of urgent care centers routinely assess patient satisfaction using nationally recognized tools such as CAHPS®, Press-Ganey, or other satisfaction surveys. By comparison, 25% of all physicians nationally report receiving data from patient surveys on experiences with care.[6]

Just over half of all centers report assessing patient satisfaction using measures they developed themselves. This may include assessing patient complaints or referrals, or using other methods for understanding how satisfied patients are. However, if centers are developing their own questionnaires to measure satisfaction, these measures may not have been validated using established survey methods.

One out of five urgent care centers does not assess patient satisfaction at all, which may represent a missed opportunity to understand patient perception of their services.

Measuring Quality

Measuring the quality of healthcare in the U.S. is essential to ensuring that such services make an optimal contribution to improving Americans' health.

The Institute of Medicine has defined six components of high-quality healthcare:

1. safety
2. timeliness
3. effectiveness
4. efficiency
5. patient-centeredness
6. equality.[7]

Without assessing each of these dimensions on a periodic basis, it is impossible to understand the state of the quality of care provided at urgent care centers, and

See Quality, continued on page 32

How to Say 'Farewell and Adieu' to Owning Your Business

JOHN SHUFELDT, MD, JD, MBA, FACEP

How do you know when it's time to cut bait? Remember the scene in *Jaws* when Chief Martin Brody (Roy Scheider) is throwing fish guts into the ocean and comes face to face with the shark? He remarks, somewhat casually, "You're going to need a bigger boat."

Despite the fact that everyone in the theater is yelling "run for your life," the trio then decides to continue after the shark even though the boat is horribly outmatched when compared with the size of the great white. (Parenthetically, if it were me, I would have come back with the Exxon Valdez.)

Anyway, this poor choice ultimately causes Quint (Robert Shaw) to not only lose his other leg, but the rest of his body, as well. Kind of like "reverse sushi."

So, when is it time to stop throwing good money after bad and either try to sell the urgent care or simply take your lumps, close it, and move on? I have been receiving quite a few calls and e-mails recently about urgent care centers that are quickly going under. Some of these failures are due to poor planning/execution, some are due to an initial lack of capitalization, and, finally, some are due to the credit crunch (banks promised a line of credit but then called the note or cancelled the line).

Preparing to Sell

Let's first discuss how to get your center ready to sell and what to expect during due diligence.

If the reason your center is failing falls into the first category—poor planning or execution—chances are that it is going to be tough to sell. The field of groups buying urgent care centers is very sparse, and believing they are going to pay cash for your mistake is unrealistic unless the initial mistake is easily correctable and, but for your lack of financing, you could fix it yourself.

If, however, the reason your center is struggling is secondary to lack of initial capitalization and/or the credit crunch, you may be in a position to sell or at least have a group assume the liabilities, allowing you to exit the business somewhat intact.

What will the potential buyer expect when evaluating your center? The first and foremost is brutal honesty. Trying to hide some bad facts (failure to pay taxes, undisclosed lawsuits, less than arm's length transactions, etc.) is not only deceitful, it will delay and, most likely, ultimately derail the sale once discovered.

Due diligence is much like an awake colonoscopy; the preparation is awful, the procedure painful, and neither party enjoys the process very much. The ultimate purchase agreement is only as sound as the parties signing the document, and if the relationship starts with a lie, it is doomed for ultimate failure.

The second expectation the potential buyer will have is that your books are accurate, hopefully accrual-based, and timely. The value of your business will most likely be based upon the EBITDA (earnings before interest, taxes, depreciation, and amortization) generated during the last 12 months, referred to as "trailing 12 months EBITDA" or "TTM EBITDA."

If your books are "cash basis," the prospective buyers will want to convert them to an accrual basis, which will take some time.

The cleaner and more accurate your books, the shorter the process and the more likely the sale will actually close. At the very least, have the following documents on hand prior to any serious discussions:

- Health plan contracts
- Building leases
- Equipment leases
- Employee contracts
- Provider contracts
- Cash flow, balance sheets, and profit-and-loss statements

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- Pending lawsuits
- Payroll data
- Licenses
- Collection history
- Payor aging reports
- Patient volume reports

This list just scratches the surface, but at least it will get you and the potential buyer started.

Types of Transactions

One of two types of sales transactions will most likely take place. An *asset purchase* simply means that the buyer will buy the assets of the business that are specified in the purchase agreement. The seller retains non-operating assets and liabilities and keeps the "legal shell" of the business and all of liabilities not included in the purchase agreement.

From a tax point of view, an asset transaction is generally favored by buyers, inasmuch as it allows them to set higher values for assets which depreciate quickly, and lower values for assets that depreciate slowly or not at all. Thus, the purchaser acquires a new cost basis in the assets, which may allow a larger depreciation deduction to be taken.

Most transactions of this size are asset transactions, since a purchaser will want to limit their liability and obtain a more advantageous tax treatment.

Conversely, in a *stock transaction*, the legal shell of the selling company is being purchased by the buyer. This includes all existing and future or unknown assets and liabilities.

Stock deals often make the actual transfer of the operation easier for the buyer, since usually all existing contracts (leases, payroll, employee benefit plans, etc.) are transferred to the new owner. Generally, a stock transaction offers the seller tax advantages which are partially dependant on whether the business is a C-Corp., S-Corp., or Limited Liability Corp.

If there is no profit (EBITDA) on a trailing 12-month basis, the best you can probably hope for is that the buyer simply assumes your lease and agrees to cover some or all of your liabilities. This approach gets you off the hook and stops the bleeding, but will most likely not make you whole.

Operating a business in these economic times is like hunting for a great white in a small wooden boat. Bad things can happen quickly and without much warning; consequently, it is not for the faint of heart or ill-prepared.

Sometimes you just have to "cut bait" and chalk it up to a great learning experience and realize, as Matt Hooper (Richard Dreyfus) did, that "this was no boating accident!" ■

"Quality," continued from page 30

where there may be opportunities for improvement.

At the same time, not all measures are created equal, and careful thought needs to be given to developing and selecting appropriate measures.

"Careful thought needs to be given to developing and selecting appropriate measures."

Someone who is not a clinician but has had a few infections may have some knowledge of antibiotics, but it is still preferable to have someone with clinical training and experience decide whether an antibiotic is necessary and which one is most appropriate. Similarly, individuals and organizations with expertise in quality measurement can help urgent care centers develop appropriate measures and survey tools, and can help to effectively tell the story of the quality of care provided at urgent care centers and the role they play in the larger healthcare system. ■

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The authors thank Jessica E. Marder for her assistance in developing the sample frame.

Select data points from the benchmarking study will be highlighted over the course of 2009 in *Developing Data*, found on the last page of every issue of *JUCM*.

Adjust Your Strategy for a Down Economy

FRANK H. LEONE, MBA, MPH

There is a broad consensus that our country's current recession will advance to become the harshest economic crisis we have faced since the Great Depression.

On the surface, spiraling unemployment and broad-based financial pressures portend trouble for most urgent care clinics. Yet, crisis inevitably breeds opportunity if clinic owners avoid being caught like a deer in the headlights and proactively move forward.

This month's column addresses economic realities and what clinics can do now—not just to stay afloat, but to prosper in lean times.

The Effect

A climbing unemployment rate means fewer hires and less discretionary spending by employers (i.e., your customers). With fewer active workers in the workplace, there are undoubtedly fewer work-related incidents, as well. Although unemployment numbers do vary by state and specific market, most markets are feeling a severe pinch.

The Silver Lining

Things may not be as bad as they seem, however. Having been involved with occupational health programs since 1985, I speak from experience:

The provider-based occupational health program economy does not historically run parallel to the national economy. In fact, the opposite has often been true. For example, during our last notable national recession in 1992, I was pleasantly surprised that well-run programs not only weathered the storm but were thriving.

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

During economic downturns, the strong tend to get stronger and the weak disappear. My company provides an illustrative example. Demand for our consulting services has been high in recent months. Why? Because occupational health programs are looking for ways to *increase* their efficiency and *sustain* their business. They need our counsel during perilous times and are willing to spend their finite funds in order to do the right thing.

The same is likely true for many companies; during such times, they need to turn to well-informed outside sources to ensure they are on the right track. This suggests it is possible for good urgent care occupational health programs to offset declining volumes by acquiring new clients who leave less-effective competitors.

What to Do

Scrub your contact base. High unemployment rates, turnover, and consolidation all contribute to the likelihood of a changing of the guard at many companies. This is a good time to establish contact with a new liaison at an old company or follow up with an established ally who has changed employment.

Shift some of your sales effort to marketing. Revenue growth during a recessionary period is more likely to come from new business generated by smaller companies than from an increase in business from large non-client targets. Comparatively inexpensive, high-visibility marketing tactics are likely to pay proportionately better dividends.

Emphasize return on investment. One might surmise that price is king during a down economy, but I believe just the opposite is true in our sector: quality, positive return-on-investment relationships take on added importance among buyers who cannot afford to make wrong choices at this time. Remember, there are many defensive-minded buyers whose purchasing decisions are driven more by fear than by

Continued on page 35

CODING Q&A

An Update on New vs. Established Patients

DAVID STERN, MD, CPC

Q. I read your column about new vs. established patient coding in the January issue of *JUCM*. Although the information provided was correct at one time, I believe that Medicare has updated its algorithm to come closer to the algorithm provided by AMA for new vs. established patients.

Question submitted by Seth Canterbury, University of Florida, Jacksonville Physicians

A. You are correct. In a somewhat obscure and rarely referenced information release, (*www.cms.hhs.gov/MLNMattersArticles/downloads/MM4032.pdf)* CMS did change its position on this issue: "Physicians should note that this article clarifies and corrects the definition of 'new patient' and 'physician in a group practice' for billing evaluation and management (E/M) services...."

The release (which denotes new language in bold and italic) further advises:

> **"Interpret the phrase** 'new patient' to mean a patient who has not received any professional services, ***i.e., evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure)*** from the physician or ***physician group practice (same physician specialty)*** within the previous three years. For example, if a professional component of a previous procedure is billed in a three-year time period, e.g., a lab interpretation is billed and no ***E/M service or other face-to-face*** service ***with the patient*** is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an ***E/M service or other face-to-face*** service ***with the patient*** does not affect the designation of a new patient."

Thus, CMS no longer limits the definition of such face-to-face services to those services defined by an E/M code. Now any face-to-face service with a physician will suffice to establish a patient in a practice. This brings the CMS definition of a "new patient" more into line with the AMA (CPT) definition of the "new patient."

One discrepancy does still exist. CMS restricts the use of the definition of "same physician specialty" to the specific specialties defined by CMS with two-digit physician specialty codes. This list of these specialties and their two-digit designations can be found on the Internet at *www.cms.hhs.gov/GEM/Downloads/GEMMethodologies.pdf*. AMA (CPT), however, does not specifically define what constitutes a physician of "same physician specialty."

This discrepancy can make a practical difference when a patient is seen in a practice by a physician who is practicing a specialty that is not defined by a two-digit CMS code.

For example, occupational medicine is a recognized specialty with a board certification. CMS, however, does not have a two-digit specification for an "occupational medicine" physician. Board certification in occupational medicine, however, is actually performed by the American Board of Preventive Medicine, and CMS does list specialty code 84 as designating a specialist in occupational medicine.

Thus, if a patient has been evaluated and treated in your urgent care center by a physician who is board certified in occupational medicine (i.e., by the American Board of Preventive Medicine) for an injury covered under workers compensation, and if the patient is subsequently seen for an illness by a physician specializing in family practice, then you may code the second visit with an E/M code for a "new patient."

If, however, the first visit was with a physician specializ-

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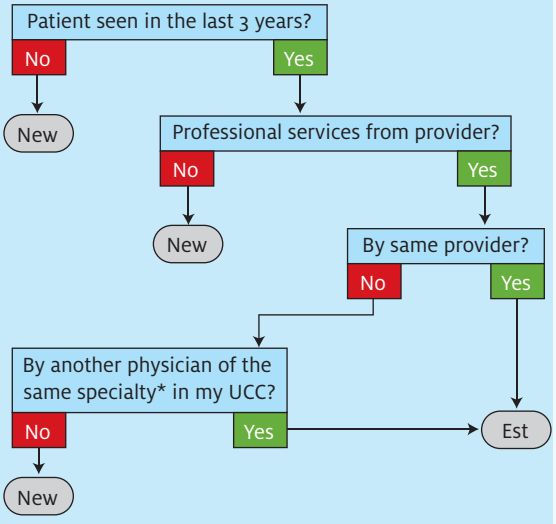
ing in "urgent care medicine," which CMS does not recognize with a two-digit code, then the second visit would have to be coded as an "established patient" visit.

Under AMA (CPT) rules, we are not limited to a specific, defined list of physician specialties. Again, whether the first visit was with a specialist in occupational medicine or a specialist in urgent care medicine, the second visit might be coded as a "new patient" visit, since the second visit was with a "specialist" in a different specialty.

One might recommend caution, however, when using undefined specialties such as "urgent care" that are not recognized by CMS nor have board certifications that are generally recognized by the medical establishment, as this may place the coder in the uncomfortable position of having to defend the legitimacy of a specialty that is not generally recognized.

The diagram below updates the one published in the January 2009 issue of *JUCM*. ■

New vs. established patient



**Specialty is narrowly defined by CMS, but not specifically defined by AMA.*

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strategic thinking (see Fear as a Factor in Occupational Health Sales, *JUCM*, September 2008).

Promote on-site services. Growing numbers of large companies are offering on-site medical services. A 2008 survey by Watson Wyatt noted that "nearly 30% of large employers had a clinic on site or planned to open one by 2009." Your clinic may well have the expertise to contribute to the operation of such clinics in a manner that provides the employer with superior management at a lower overall cost. Incremental losses in patient volume can be more than offset by just one significant on-site services contract.

Reactivate dormant relationships. The blog ieYou Marketing suggests that a clinic should contact past clients to persuade them to do business with you again. It boils down to a numbers game: make 10 such calls and you are likely to reactivate at least one dormant account.

Lock in client loyalty. Don't take your clients for granted. Call each and every one—soon—and ask if there is anything more your clinic can do to better serve them. Saving potential revenue from attrition is just as good as generating that same revenue anew.

Troll for a big fish. Most clinics consider some employers in their market off limits; they are either too big, have an in-house orientation, or have an established relationship with a competitor. But these companies are facing a recession, too. All of a sudden, your clinic's "Let us help you control your health and safety costs" pitch might have considerably more appeal. Nothing ventured, nothing gained.

Plan ahead. Recessions do not last forever. Meanwhile, there will be a pent-up demand for exceptional occupational health services.

Occupational health sales and marketing professionals who focus on establishing and cultivating relationships during the first half of 2009 with the expectation that financially strapped companies will be better positioned several months down the road are likely to see a payoff.

Change is in the air. This appears to be one of those watershed years in which change in almost any form is perceived as positive, and status quo is out of fashion. In this environment, there are opportunities to woo business from competitors and/or introduce new products, services, or concepts in your market. This can best be done through a vigorous and focused sales effort that trumpets innovation and value.

Be a contrarian. Be an optimist when others are forlornly predicting economic doom. Put greater effort into sales and marketing when others put their collective sales/marketing heads in the sand. People tend to be attracted to optimists during a storm. Be the star upon which your clients and prospects can hitch a ride. ■

Career Opportunities

URGENT/PRIMARY CARE - Doctor needed for weekends plus coverage in Lansing, Michigan. Walk-ins. Please fax resume to: (517) 627-9339.

NORTHERN VIRGINIA/D.C. SUBURBAN – Full- and part-time positions available at hospital affiliated urgent care centers. Send CV to: Se curemedical@gmail.com.

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

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

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

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OSF Physician Recruitment
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or (800) 232-3129 press 8
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stacey.e.doolittle@osfhealthcare.org
www.osfhealthcare.org

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

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36 S. State Street, 21st Floor,
Salt Lake City, UT 84111
(800) 888-3134,
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Contact: Jon Nevala, Medical Staff Recruitment,
Gundersen Lutheran Health System,
(800) 362-9567, ext. 54224 or email JPNevala@gundluth.org

Career Opportunities

Marketing

Practices for Sale

Services

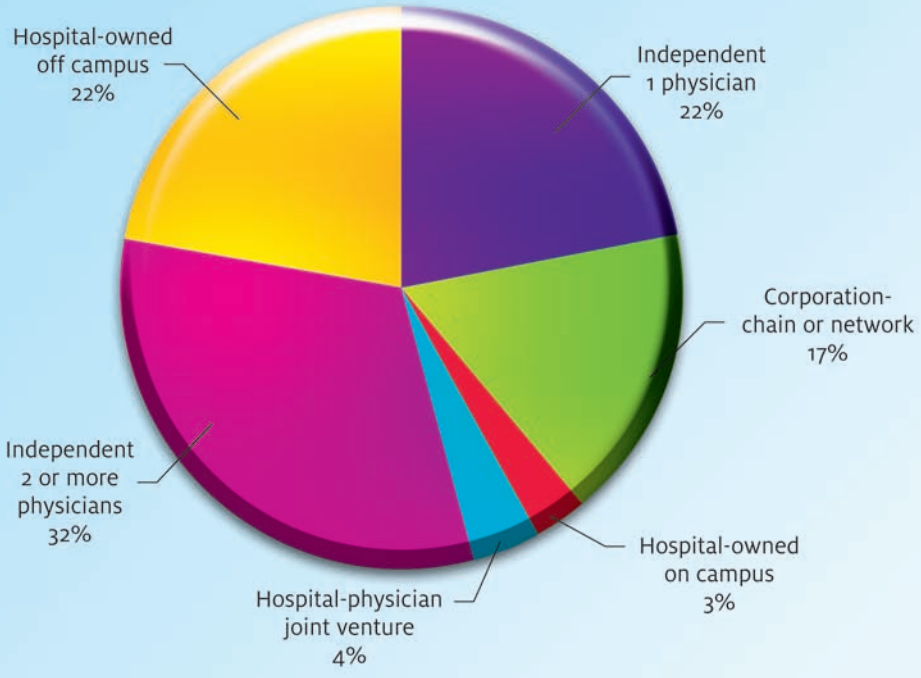
DEVELOPING DATA

In early 2008, UCAOA revamped its annual survey in conjunction with researchers at Massachusetts General Hospital and Harvard University with the goal of assuring that the UCAOA Benchmarking Committee's efforts produced a scientifically valid report.

Over the coming months in Developing Data, *JUCM* will present some of the findings from this landmark survey, to which 436 urgent care centers responded.

In this issue: Who owns all those urgent care centers, anyway?

OWNERSHIP OF U.S. URGENT CARE CENTERS



Note that the entrepreneurial nature of urgent care continues to be reflected in these data, though hospitals and corporations have staked an interest in the marketplace. It will be interesting to compare this chart with future iterations, considering that the current economic climate may be harder for independent owners to weather than it is for larger entities.

Acknowledgment: Data submitted by Robin M. Weinick, PhD, assistant professor, Harvard Medical School and senior scientist, Institute for Health Policy, Massachusetts General Hospital. Dr. Weinick is also a member of the *JUCM* Advisory Board. Financial support for this study was provided by UCAOA.

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

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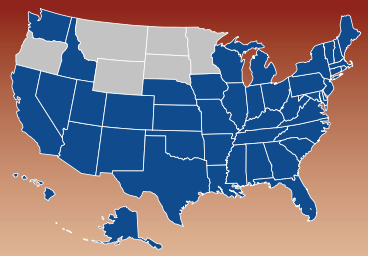

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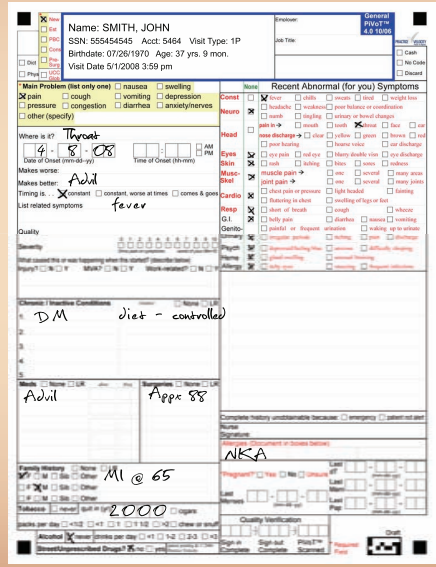

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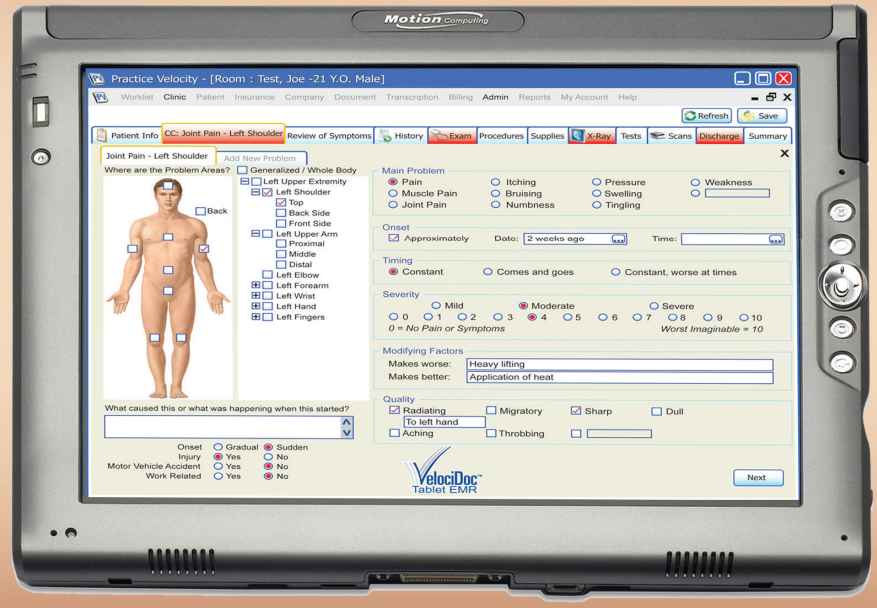

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