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Minor TBI
Applying the Evidence to Urgent Care
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LETTER FROM THE EDITOR-IN-CHIEF

Notes From the Field

I write to you from the beautiful landscapes of New Zealand, where I just participated in the first-ever international conference for urgent care. Representatives from all over the world joined to share ideas and experiences of their journeys into the development of urgent care as a discipline and an industry.

This international dialogue broadens our understanding of the clinical and market forces driving this global phenomenon, and strengthens our individual and group efforts to advance and legitimize the field.

The Accident and Medical Practitioners Association (AMPA) of New Zealand hosted the event with its partners from the Australian Society of Emergency Medicine (ASEM). The CEO of AMPA, Brenda Evitt, organized an outstanding program with significant relevance for the urgent care community both locally and globally. The atmosphere encouraged forward thinking and idea sharing. Representatives from New Zealand, Australia, Ireland, and the U.S. each had the opportunity to address the group and share the history of the evolution of urgent care in their respective countries.

The similarities are simply amazing, and attest to the congruence of forces driving the development of our discipline globally.

The establishment of an alliance between participating organizations to promote future collaboration on key universal issues of relevance to urgent care globally was discussed for the first time. We believe these efforts are critical for accelerating the evolution of the discipline within the house of medicine.

It was truly a privilege to participate in this ground-breaking event. For years now, the efforts have been grassroots, without much in the way of collaboration. Each country working on an island to define and identify a specialty and an industry.

What is most remarkable to me is how evolutionary forces in distinct healthcare systems and geographic isolation have led to almost impossible similarities in what we all now know as “urgent care medicine.” Darwin would be proud. We are at the doorstep of a sea change in the standing of urgent care in the house of medicine and the global healthcare delivery system. Our collaboration will only hasten our advancement.

Many wondered why urgent care has grown so rapidly in the U.S. and abroad.

The same forces appear to be at play across the globe: Urgent care is a market-driven phenomenon, not a scientific one. The “science” of urgent care is a collage of borrowed competencies from multiple specialties. These competencies have been blended to meet the market needs of the patients and health systems we serve. There is a global need for an efficient, convenient, cost-effective point of access for the 80% to 90% of acute care needs that are not life threatening. The over-burdened emergency departments are unable to efficiently provide for this level of care, and the general practice community either lacks the skill set required or the ability to mix into their existing practices effectively.

Market demand has created a niche which we, as urgent care professionals, are uniquely qualified to fill. What is most interesting is how the “genetic” make-up of this “urgent care professional” is so similar in every country, despite virtually no collaboration to date.

He or she is almost invariably entrepreneurial, frustrated with healthcare and the restraints of the entrenched systems of healthcare delivery, easily bored, and eager for change. Thus proving that Darwin’s theory of natural selection in the presence of similar evolutionary forces applies to healthcare, as well as to life.

We look forward to an exciting future for urgent care, and are eager to participate in an international discourse aimed at building on the strengths of our individual efforts.

Cheers,

Lee A. Resnick, MD
Editor-in-Chief
JUCM, The Journal of Urgent Care Medicine
President, UCAOA

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Come see us at booth 114 at the UCAOA convention in New Orleans
How urgent care practitioners can improve awareness, screening, identification, and management of drug-seeking patients.

By Joseph Toscano, MD

Minor Traumatic Brain Injury: Applying the Evidence to Urgent Care

In the absence of urgent care-specific studies, knowing and applying data gleaned from other acute care settings is imperative when identifying and managing patients with minor traumatic brain injury. The second in a two-part series.

By Joseph Toscano, MD

Creating a Health Surveillance Product Line

Helping patients stay healthy enough to perform job functions is a cornerstone of urgent care occupational medicine. What steps do you need to take to build a successful program?

By Donna Lee Gardner, RN, MS, MBA

Playing to Win: Maximizing Profits in Urgent Care

The most economically healthy urgent care practices are committed to achieving balance between increasing income and managing expenses.

By Alan Ayers, MBA, MAcc

Next month in JUCM:

How urgent care practitioners can improve awareness, screening, identification, and management of drug-seeking patients.
Go ahead, ask.

As VaxServe Customer Service Representatives, we’re the ones to turn to for any questions you may have. With our extensive training in vaccines, injectables, and medical products, you can count on us to know the answer. Even if we don’t have it top of mind, we know where to find it…and we always get back to you right away. Give us a call. When it comes to the products, the knowledge and the service your practice needs, we’re here to help power your practice.
Readers who read last month’s cover article probably learned a bit about the challenges of evaluating patients who present with symptoms of what are eventually confirmed to be minor traumatic brain injury. (And if you didn’t read it, you can still do so at www.jucm.com.)

Whether you did or did not read that article, however, you’ll want to read Minor Traumatic Brain Injury: Applying the Evidence to Urgent Care (page 11), the second part of this two-part series by Joseph Toscano, MD.

This month, Dr. Toscano delves deeper into considerations for imaging and discharge, and offers advice on how best to manage three representative patients.

His is not the only familiar name in the April issue, however.

We’re very pleased to also publish new, original contributions by Donna Lee Gardner, RN, MS, MBA and Alan Ayers, MBA, MAcc, both of whom represent our commitment to bring you more articles about occupational medicine- and practice management-related topics to supplement the clinical subject matter that remains the foundation of our content.

In Creating a Health Surveillance Product Line (page 28), Ms. Gardner, senior principal with RYAN Associates, examines how successful urgent care occupational medicine practices help patients stay healthy enough to perform on the job.

And Mr. Ayers, assistant vice president of product development for Concentra Urgent Care and content advisor to the Urgent Care Association of America, shares his approach to achieving balance between increasing income and managing expenses in Playing to Win: Maximizing Profits in Urgent Care (page 32).

All three of these authors are on the faculty of the 2008 Urgent Care Association of America National Convention, scheduled for April 29-May 2 in New Orleans.

Regular contributors John Shufeldt, MD, JD, MBA, FACEP (Health Law), David Stern, MD, PCP (Coding Q & A), Frank Leone, MBA, MPH (Occupational Medicine), and Michael Weinstock, MD (co-author, along with Ryan Longstreth, MD, FACEP, of the semi-monthly feature Bouncebacks) will share their expertise with attendees, as well. We’re sure Nahum Kovalski, BSc, MDCM (Abstracts in Urgent Care) would be there, too, if his practice were somewhat closer than Israel.

Finally, also among the dozens of faculty members and speakers are JUCM Editorial Board and Advisory Board members William Gluckman, DO, MBA, FACEP; Kenneth V. Iserson, MD, MBA, FACEP, FAAEM; Peter Lamelas, MD, MBA; Emory Petrack, MD, FAAP, FACEP; Marc Salzberg, MD, FACEP; and Robin M. Weinick, PhD, as well as a number of past and future authors whose work has appeared here.

Our editor-in-chief, Lee A. Resnick, MD, will be at the convention in his role as president of UCAOA. JUCM will be exhibiting there, too; feel free to stop by and say hello, and tell us how we’re doing.

To Submit an Article to JUCM

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

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

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

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

To Subscribe to JUCM

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

The Journal of Urgent Care Medicine (JUCM), the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

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

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

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

He will be happy to discuss it with you.
Embracing the Future, Leveraging Change

LOU ELLEN HORWITZ, MA

You may have seen this title phrase before. It’s on the cover of the 2008 UCAOA Urgent Care National Convention brochure. It’s one of those jazzy marketing phrases that look good on a brochure cover and are supposed to get you excited about what’s inside and what’s coming at the convention.

But does it really mean anything? It’s one of those “10,000 feet” phrases that it’s hard to disagree with. Of course we should embrace the future (fighting it is futile). Of course we should leverage change (rather than be steamrolled or left behind).

So what?

One thing I bet is true about most of you working in urgent care is that you do like a challenge. Uncertain future? Bring it on. Competition entering the market? Bring it on. Increasing scrutiny? Bring it on.

You are confident enough that you and your centers are good enough to weather the storms and come out still seaworthy on the other side. You are ready for the future. Bring it on.

But being ready to meet the future is not the same as embracing it—that means reaching out for the future, preparing for it, thinking about it often—getting ahead of it.

That’s what we are here to help you do, and a part of what the New Orleans Convention is all about.

On the Other Hand...

In contrast to getting ahead of the future, the idea of getting ahead of change is almost laughable. It’s already here! It happens every day, all day. Someone calls in sick. The flu finally arrives (hooray?). Drugs change. Insurance changes. Today’s research contradicts yesterday’s research. New codes. New protocols. New paperwork.

Change isn’t something that needs a “change strategy” anymore. Change is normal. Change is like breathing, or heartbeats; in other words, if it’s not present, you’re probably dead.

So the question now is one of leverage—not “dealing with it,” but using it to our advantage to be able to do things other providers cannot.

Your answers to the following questions may reveal a lot about your clinic’s state of readiness:

Is your center really good at dealing with the changes you see on a daily basis?

Is your staff well-trained, well-informed, and flexible (clinically and administratively alike)?

When a new form or treatment protocol comes out, does it bring you to a temporary halt or are you and your staff so good at understanding, disseminating, integrating, and moving on that your patients don’t even notice?

If you have more than one center, when something gets decided “on high,” how well and quickly does it trickle down to the front lines?

In practical terms, this concept can be very hard to bring to reality. It requires some letting go, and some stepping up, and if you are in a multicenter system or hospital-owned, it will require some speaking up—and learning how to make a case for yourself (probably over and over).

But hey, we do like a challenge, don’t we? Maybe not every day, but the challenges out there and the thrill of meeting those challenges successfully is what we show up for.

The Next Big Thing

If you aren’t already signed up to join us in New Orleans, I really think you should come (and not because it serves my interests as executive director).

Meeting the future head-on is exactly the kind of thing everyone talks about when we are together at conferences, and it’s a great thing to observe from my position. It must be absolutely fantastic to experience. Come and tap into that magic so you can take a little home with you to your center.

See you soon.

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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Share Your Insights

At its core, JUCM, The Journal of Urgent Care Medicine is a forum for the exchange of ideas and a vehicle to expand on the core competencies of urgent care medicine. Nothing supports this goal more than Insights in Images, where urgent care practitioners can share the details of actual cases, as well as their expertise in resolving those cases. After all, in the words of UCAOA Executive Director Lou Ellen Horwitz, everyday clinical practice is where “the rubber meets the road.”

Physicians, physician assistants, and nurse practitioners are invited to submit cases, including x-rays, EKGs, or photographic displays relating to an interesting case encountered in the urgent care environment. Submissions should follow the format presented on the preceding pages.

If you have an interesting case to share, please e-mail the relevant images and clinical information to editor@jucm.com. We will credit all whose submissions are accepted for publication.
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Clinical

Minor Traumatic Brain Injury: Applying the Evidence to Urgent Care

Urgent message: While few data specific to the urgent care setting exist, applying the medical evidence gleaned from other acute care settings can enable the clinician to effect positive outcomes in patients presenting with symptoms indicative of minor TBI.

Joseph Toscano, MD

Introduction

Head trauma is among the most important problems evaluated in acute-care medicine. Estimates from the Centers for Disease Control and Prevention indicate that each year in the United States, approximately 1.4 million individuals suffer traumatic brain injury (TBI). Of these, 1.1 million are evaluated and released from emergency departments, 235,000 are hospitalized, and 50,000 die.1

While the exact number of patients with TBI who are cared for in urgent care centers is unknown, anyone working in that setting can attest that these patients present regularly for evaluation; over a quarter of TBIs result from falls, 20% from motor vehicle crashes, 11% from assaults, and the remainder from other head contusions and impacts.

A study published in January 2007 indicated that 911 calls from urgent care clinics occurred for patients with head injury more often than for patients with EKG changes, GI bleeding, dehydration, and several other causes.2

After rapidly recognizing and stabilizing any potentially life- or limb-threatening injuries, the chief diagnostic decision when evaluating these patients involves the ordering of CT scanning of the head. As discussed in the previous article in this series (JUCM, March 2008), several clinical decision instruments can help clinicians choose whom to image, though none may significantly reduce the number of CT scans performed, compared with clinical judgment alone.

This article will focus on the urgent care clinic application of the existing medical evidence (of which there is little that is high-quality and patient-oriented, unfortunately) and other recommendations for the care of these patients, and discuss some of the basic elements of treating minor TBI, as well as injury prevention.

Patient Scenarios
It is a busy, full-moon Saturday at the urgent care
The Journal of Urgent Care Medicine | April 2008

MINOR TRAUMATIC BRAIN INJURY: APPLYING THE EVIDENCE TO URGENT CARE

- clinic and your medical assistant informs you that the staff has just roomed three patients, all with some degree of head injury:
  - Patient A is a 3-month-old baby girl who, her mother reports, rolled off her dressing table and fell three feet onto the carpeted floor. The child did not lose consciousness, but slept for about two and a half hours. When she awoke, the mom noted some bruising and swelling of the child’s scalp and so brought her in.
    - The child had a normal feeding since the fall, has not vomited, and is behaving normally. Your exam confirms a scalp hematoma but is otherwise normal.
    - How would you approach this patient? Would it be any different if the scenario and exam were similar, but the child was 4-years-old and fell to the ground while jumping like a monkey on his bed?
  - Patient B is a 22-year-old who presents to the urgent care clinic with a friend two days after being hit in the side of the head by another friend’s knee during a backyard football game. It’s unclear, but he may have briefly lost consciousness; unfortunately, he has some retrograde amnesia and so cannot remember what he’s been told was a spectacular touchdown catch.
    - He has a moderate generalized headache which has not changed since the incident, but has not vomited and otherwise feels well. His physical exam is normal, except for some scalp tenderness in the area of impact.
    - Does he need imaging and further treatment? Would your decision-making be different if you were evaluating him within an hour after the injury?
  - Patient C is a 68-year-old patient who comes to the urgent care center with his wife several hours after he tripped and fell at home, hitting his temple on a table. He did not lose consciousness and feels entirely normal. His exam reveals only a small abrasion on his temple. Nonetheless, he is concerned because a friend of his with a similar injury ended up being a “vegetable.”
    - What would you advise? Would you advise differently if the situation were the same, except that he were taking warfarin or another “blood-thinner”?
    - We will discuss rationale for management of these patients later in this article.

Urgent Care Evaluation

It is intuitive that urgent care clinics develop procedures based on their capabilities for the rapid assessment of the (thankfully, rare) high-risk patient who presents with a history or symptoms which are suspicious for a significant intracranial injury. Such patients include those with abnormal behavior, obvious or highly suspicious skull fracture, any focal neurological deficits, drug- or alcohol intoxication, or Glasgow Coma Score (GCS) less than 15.

- Staff should be trained to identify and promptly bring these patients to the treatment area of the clinic and notify the clinician. The clinician should perform a rapid primary general assessment, including obtaining a description of mechanism of injury, the patient’s past medical history, a determination of GCS, and an HEENT, neck, and neurological examination.

- Clinical staff should carefully immobilize the patient, obtain vital signs, and examine the patient for other injuries while preparations are made for ambulance transfer to the nearest emergency department that could care for such a patient.

- Any necessary stabilizing care that is within the clinic’s capabilities should be provided, including helping maintain a patent airway, providing ventilation and oxygenation, ensuring adequate circulation, and stabilizing any other injuries. Obtaining IV access and providing pain control are other potentially beneficial interventions.

- Some of these patients can be combative or uncooperative and their care can be very difficult. Being prepared with standard protocols for such situations is advisable.
sea, or vomiting, though the exact implication of any of these findings in isolation is uncertain.

Inquiring about other areas of bodily injury can direct subsequent physical examination.

For patients involved in falls or collisions, asking about possible syncope or lightheadedness prior to the incident may indicate the need for further evaluation. Important past medical history includes whether the patient has a known or possible coagulopathy or takes medications such as warfarin, clopidogrel, or aspirin.

Physical examination of a patient with head injury often begins with inspection of the face and head. Ecchymoses in the infraorbital location (raccoon’s sign) or over the mastoid process (Battle’s sign) can indicate basal skull fracture.

Any areas of head impact should be palpated for possible closed fractures. With fractures, the skull may feel irregular, unstable, or boggy due to associated bleeding into adjacent soft tissues.

Examine children carefully—particularly those 2 years of age and under—for scalp hematomas, as these are associated with increased risk of intracranial injury.

If a scalp wound is present, the clinician should gently palpate the area searching for fracture, externally at first. Wounds thus examined and without suspicion of skull fracture can then be examined internally in standard fashion, with subsequent wound debridement, irrigation, and closure as indicated if no fracture is seen.

If a skull fracture is present on internal exam, it should not be further manipulated, but rather dressed with a sterile dressing, held in place with minimal external pressure.

An EENT exam should focus on possible associated injuries in these areas, as well as examining for hemotympanum, another indirect sign of a basal skull fracture. Young children may be examined for retinal hemorrhages, reported to be pathognomonic for child abuse. Horizontal or rotatory nystagmus may indicate vestibular dysfunction as a result of concussion, while vertical nystagmus is specific for cerebellar injury.

Because head impact can result in cervical spine injury, closely examine the patient’s neck for possible trauma. Reliable, high-quality clinical decision rules do exist to support decisions regarding the need for cervical spine radiographs. The thoracic and lumbar spines, extremities, and torso can be exam-
ined if the history and symptoms suggest the need. There is no reported standard neurological exam; however, assessing orientation and memory, cranial nerves, motor and sensory systems, cerebellar function, and gait can be done relatively quickly and would represent a reasonably complete exam.

**Initial Imaging Decisions and Treatment**

Though clinical judgment should prevail, a proposed algorithm for evaluating and treating patients with head injury was described in the previous article (available at www.jucm.com). Clinicians may care for other injuries—e.g., splinting of probable fractures and initial wound cleansing and dressing—in those who require referral for CT scanning and/or extended observation if this does not significantly delay transfer. Those who do not require referral may receive definitive evaluation and care for other injuries based on clinic capabilities.

Patients cared for in the urgent care clinic after head injury may be asymptomatic or present with a variety of symptoms (Table 1). The term concussion or post-concussive syndrome is used to describe the common clinical sequelae of mild TBI. Symptoms can range from mild to severe; the specific neural insult in concussion, though not known for sure, probably relates to mild injury to the brain axons (more severe cases of diffuse axonal injury usually result in stupor or coma).

Concussive symptoms, in and of themselves, do not mandate CT scanning in the acute setting, though some type of imaging is typically performed if they persist or worsen. In situations where CT scanning is performed, the scan is usually normal in patients with concussion.

Many patients with concussion often desire relief from the associated symptoms. Initial management is typically directed toward the symptom itself—analgesics for headache, antiemetics for nausea, and meclizine for vertigo or dizziness can be considered. There are no data to elucidate which are the best treatments, or even whether treatment is any better or worse than non-treatment, but most references recommend avoiding opiates, benzodiazepines, and other sedatives and hypnotics. Some of these have been shown to delay recovery in animal studies.

Because of the small risk of delayed intracranial bleeding, there may be at least a theoretical advantage of acetaminophen over nonsteroidal anti-inflammatory drugs to treat pain. Clinical judgment should prevail, and as always, basing treatment decisions on a mutual understanding of the individual risks and benefits for each patient is probably best.

In addition to symptom management, ongoing observation is key in the management of any patient with head injury. The incidence and epidemiology of significant head injury becoming apparent on a delayed basis is not known, so all head injury patients should be given clear instructions regarding warning symptoms (such as those suggested in the box on this page) and should have a reliable caregiver available, with ready access to follow-up medical care if needed.

The optimum period of observation is uncertain, but clinicians should convey the need for evaluation for any new or worsening symptoms in the hours to days after a head injury. Any patient with worsening level of consciousness or mental status, abnormal behavior, recurrent seizures, repeated vomiting, or the develop-

### Table 1. Concussion Symptoms

- Loss of consciousness
- Headache
- Nausea
- Vomiting
- Visual disturbance
- Drowsiness
- Sleep disturbance
- Concentration, memory, and other cognitive difficulties
- Dizziness
- Vertigo
- Mood or behavior changes

*Note: Patients may have one or a combination of symptoms to define a concussion or post-concussive syndrome.*
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Follow-up Imaging Decisions and Treatment

There is no specific guidance available for the best timing of return visits, but patients should be advised to seek care for worsening or ongoing concussion symptoms anytime after the initial visit. Likewise, the clinician should be aware that patients may not seek care immediately after the injury, but present for their initial evaluations on a delayed basis.

The decision rules described in the earlier article were derived and tested in patients within the first 24 hours after injury, and the value of their application beyond this time is uncertain. Typically, however, standard practice involves performing some type of neuroimaging for patients who develop worrisome symptoms on a delayed basis or for those who have ongoing symptoms and did not initially undergo CT scanning.

The pathophysiological rationale for this relates to the possibilities of slow or delayed hemorrhage or edema development. In patients with initially normal imaging results and no worsening or new symptoms, there is no need for repeat imaging after an initial normal scan has been obtained.

When the imaging findings are normal or do not require intervention, ongoing symptom management is often the patient’s chief concern. In the majority of cases, symptoms decrease progressively over time; however, some degree of discomfort or cognitive or emotional difficulty may persist, in some patients for up to a year or more. Unfortunately, there is little evidence to inform the best approach for these patients, and many factors—e.g., underlying identifiable or occult brain injury, the patient’s general health and coping abilities, psychosocial stressors—can combine to lead to ongoing symptoms.

A multidisciplinary approach is often required.

Treatment options at the urgent care level include low-dose tricyclic agents and selective serotonin reuptake inhibitors, which can help relieve many post-concussive symptoms. For patients with specific vestibular symptoms after concussion, vestibular rehabilitation with a physical therapist trained in these techniques can be helpful.

Patients with refractory or complicated symptoms require referral to a neurologist. Often, electroencephalography or specialized neurocognitive testing is helpful. Requesting ophthalmology consultation for ongoing visual complaints is also prudent.

Return to Activities

In general, patients may return to most activities on an “as tolerated” basis after head injury.

This excludes, however, sports and other activities...
If you can afford this—

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Film Development Time
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where there is a potential for repeated head injury. Several groups have published guidelines, based on consensus opinion, regarding when an athlete may return to play, based on the severity and repetitiveness of injury.6,7

Having the athlete, once asymptomatic, return to light conditioning activities, where there is no potential for head injury, can help assess fitness for return to practice and play. In each case, the recommended delays assume that the athlete is asymptomatic at rest and with exertion for the prescribed interval, prior to return to sports (Table 2).

Recommendations for evaluating athletes on the field after head injury involve more complex determinations. Physicians in this role should become familiar with the recommended “sideline” neurological and physical examination and controversies prior to returning athletes to play on the same day.

Whether on the field or off, clinicians should emphasize the importance of proper equipment wear, fit, and usage to help decrease the impact of recurrent injuries.

Returning to work after a head injury can be a more complicated process. The American College of Occupational and Environmental Medicine practice guidelines, unfortunately, include no mention of the subject so clinicians must use their judgment based on the severity of the injury, nature of any ongoing symptoms, and the patient’s specific job demands.

A supervised return to work-related tasks, with gradually and progressively increasing physical and mental demands, should be guided by regular reassessment to determine how the employee is tolerating such advancement. Any persistent subjective complaints can be further evaluated with specific neurocognitive and other objective testing, to assist with ongoing case management and any necessary disability determinations.

**Prevention**
Clinicians should reinforce principals of proper helmet and protective equipment wear whenever possible, but particularly when a patient is being seen for a head injury. Reviews of various studies demonstrate that wearing a helmet during bike riding or motorcycle riding significantly reduces the chance and severity of head injury.8,9 It is reasonable to conclude that this may also be the case with roller skating and skateboarding.

**Return to Patient Scenarios**

**Patient A**
Based on the presence of a scalp hematoma alone, this infant should be referred for CT scanning. Final disposition would then be based on the results of the scan.

Head trauma can be a presenting injury in children who are victims of abuse; hence, when the mechanism of injury is uncertain or difficult to believe, additional screening for child abuse is warranted.

Because 3-month-olds are not physically capable of rolling, asking for some clarification of the history is important in this case.

If the patient were a 4-year-old with a reasonable history of injury and a scalp hematoma as the only abnormality, discharge with recommendations regarding standard observation and follow-up (and maybe some admonishment regarding, "No more monkeys jumping on the bed!") would be reasonable.

**Patient B**
If this patient had presented within 24 hours of injury, there would be no specific indication for CT imaging.
except perhaps for his amnesia, though this would be a “judgment call.” With the history of two days of constant moderate symptoms, many clinicians would consider, for risk management reasons, ordering some type of neuroimaging.

While the patient’s lack of deterioration argues against a lesion that would require intervention, his persistent symptoms probably do increase the chance of some sort of abnormality, which, if discovered subsequently, could be construed as representing poor judgment on the initial clinician’s part.

In this situation, discussing the possibilities with the patient, with good documentation and follow-up instructions, is important.

**Patient C**
The available clinical decision rules indicate that clinicians should maintain a very low threshold for imaging patients over age 60 or 65 who sustain any degree of head impact, even with a normal exam and no worrisome features. If this patient (or a patient of any age) were taking warfarin or an antiplatelet agent (including aspirin), the need for CT scanning is increased to the point that it would be considered necessary.

Indeed, the chance of injury in patients who are anticoagulated is high enough that a period of ED or inpatient observation is additionally performed, even after a normal scan, due to the higher probability of delayed bleeding.

**References**

**Suggested Reading**

**Note:** A link to a printer-friendly patient handout, Questions Commonly Asked About Concussions, is available at the end of the online version of this article at www.jucm.com.
In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of dermatologic conditions that real urgent care patients have presented with.

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

**FIGURE 1**

The patient is an 82-year-old man who presented after having fallen backwards and landing on his back. He did not lose consciousness; nor did he vomit. The patient entered the clinic using a walker, which he reported using on a regular basis. Examination revealed an abrasion over his forehead and over the anterior right tibia. The neurological exam showed no acute changes.

The patient was specifically tender over the shoulder, but there was no spiny tenderness.

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.
Every article that has appeared in JUCM, The Journal of Urgent Care Medicine is available on our website. Simply log on to www.jucm.com and click on the Past Issue Archive button to see every issue we’ve published.
The patient experienced a fracture of the distal clavicle. He was placed in a sling, with instructions to follow up with an orthopedist the following day.

As noted in Wheeless’ Textbook of Orthopaedics, distal fractures account for 10% to 15% of all clavicle fractures. Typically, these have a high incidence of non union; most are asymptomatic, with relatively few requiring surgery.¹

The location of the fracture along the clavicle has a great effect on prognosis. Lateral fractures, such as the one seen here, tend to heal spontaneously and often do not require surgical intervention; medial fractures can be more serious, however.

Reference

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM.
Non-Steroidal Anti-Inflammatory Drugs for Low-Back Pain (Review)

Key point: NSAIDS are more effective than placebo, are all similar in efficacy, and do have significant side effects. COX-2 seems to have fewer side effects; however, the recent data on CV side effects is a concern.


The authors searched the MEDLINE and EMBASE databases and the Cochrane Central Register of Controlled Trials up to and including June 2007, selecting randomized trials and double-blind controlled trials of NSAIDs in non-specific low-back pain with or without sciatica.

In total, 65 trials (N=11,237 patients) were included in this review. Twenty-eight trials (42%) were considered high quality.

Statistically significant effects were found in favor of NSAIDs compared with placebo, but at the cost of statistically significant more side effects.

There is moderate evidence that NSAIDS are not more effective than paracetamol for acute low-back pain, but paracetamol had fewer side effects.

There is moderate evidence that NSAIDS are not more effective than other drugs for acute low-back pain.

There is strong evidence that various types of NSAIDS, including COX-2 NSAIDS, are equally effective for acute low-back pain. COX-2 NSAIDS had statistically significantly fewer side-effects than traditional NSAIDS.

In the authors’ view, the evidence from the 65 trials suggests that NSAIDS are effective for short-term symptomatic relief in patients with acute and chronic low-back pain without sciatica. However, effect sizes are small.

Furthermore, there does not seem to be a specific type of NSAID which is clearly more effective than others. The selective COX-2 inhibitors showed fewer side effects compared with traditional NSAIDS in the RCTs included in this review. However, recent studies have shown that COX-2 inhibitors are associated with increased cardiovascular risks in specific patient populations.

Dr. Kovalski thanks Dr. Noam Ofek for this reference.

Venous Thrombosis After Minor Injury

Key point: Minor injuries were associated with a threefold greater relative risk for venous thrombosis.

Citation: van Straalen KJ, Fosendaal FR, Doggen CJM. Minor In-
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– Steve Rebnord, Clinic Manager
## A B S T R A C T S  I N  U R G E N T  C A R E

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### Abstracts in Urgent Care

#### Delayed Treatment of Severe Pain.


Inadequate pain management in the emergency department has received much attention recently, including by the Joint Commission. ED crowding is one of the many postulated contributors to inadequate or delayed emergency pain management.

In a retrospective study of nearly 14,000 patients who presented to an urban ED with severe pain (score of 9 or 10 on a 10-point scale), the authors examined whether ED crowding contributed to delayed pain management. The two measures of delay were administration of pain medication more than one hour after triage, and administration more than one hour after arrival in a treatment area.

Measures of crowding were ED occupancy, total number of patients in the waiting room, and aggregate number of patient hours (length of stay) for all patients in the ED at the time the study patient presented.

During the 17-month study period, 49% of patients who reported severe pain received analgesia. Of those, 79% experienced delays: 59% waited more than one hour after triage, and 20% waited more than one hour after arrival in a treatment area.

The numbers of patients in the waiting room and ED occupancy were independently associated with both nontreatment of pain and delayed treatment.

Dr. Zane noted that ED crowding, in addition to being a growing problem and a symptom of a struggling healthcare system, might be associated with delay in pain treatment. Strategies to address severe-pain treatment in the setting of ED crowding include providing physicians or physician extenders at triage to initiate therapy and instituting standing orders for the administration of analgesia. The mystery in this study, though, is why 51% of patients who reported 9/10 or 10/10 pain did not receive any analgesia at all, crowded ED or not. (Published in J Watch Emerg Med, February 8, 2008—Richard D. Zane, MD, FAAEM.)

#### Imaging After Trauma to the Neck

**Key point:** Plain radiography is often used to image the neck after trauma, but computed tomography and magnetic resonance imaging provide further useful information and should be considered.

Citation: Wee B, Reynolds JH, Bleietman A. *BMJ.* 2008;336:154-157.

Technically adequate radiographs of the cervical spine are essential to avoiding missed injuries. Most missed spinal injuries occur in the upper and lower cervical regions, areas that are often not well visualized on poor quality films.

| If a patient is alert and stable, taking an appropriate history, carrying out a clinical examination, and using guidelines such as the Canadian cervical spine rules allow safe and reliable risk stratification to guide decisions about radiographic tests |
| Computed tomography of the cervical spine is an appropriate first-line investigation in patients with suspected spinal injuries who have altered mental status, distracting injuries, or neurological deficits. It should also be considered in patients with multisystem trauma or severe head injury, which have a high incidence of cervical spine injuries |
| Magnetic resonance imaging provides excellent visualization of ligament and cord injuries if the patient is stable enough to be safely scanned. It may also provide valuable information in patients with an acute neurological deficit. |

**Dr. Kovalski thanks Dr. Noam Ofek for this reference.**

#### Not a NICE CT Protocol for the Acutely Head Injured Child

**Key point:** Adherence to the NICE head injury guidelines would have resulted in a three-fold increase in the total number of CT examinations of the head.


The purpose of this study was to assess the impact of the introduction of the Birmingham Children's Hospital (BCH) head injury computed tomography guidelines, when compared with the National Institute of Health and Clinical Excellence (NICE) guidelines, on the number of children with head injuries referred from the emergency department undergoing a CT examination of the head.

All children attending BCH ED over a six-month period with any severity of head injury were included in the study. Indications for a CT examination according to both NICE and BCH head injury guidelines—and whether or not CT examinations were performed—were recorded. A total of 1,428 children attended the BCH ED following a head injury in the six-month period. The median age was 4 years (range 6 days to 15 years); 65% were boys. Four percent of children were referred for a CT using BCH guidelines and were appropriately examined. If the NICE guidelines had been strictly adhered to, a further 8% of children would have undergone a CT examination of the head. All of these children were discharged without complication. The remaining 88% had no indication for CT examination by either BCH or NICE and appropriately did not undergo CT.

Adherence to the NICE head injury guidelines would have resulted in a three-fold increase in the total number of CT examinations of the head.

The BCH head injury guidelines are both safe and appropriate in the setting of a large children’s hospital experienced in the management of children with head injuries.
To best meet the needs of employers, an urgent care occupational medicine (UCOM) clinic should feature five basic product lines:

- health surveillance
- injury/loss management
- rehabilitation
- prevention services
- on-site services

This article will address the first of these product lines, health surveillance; the other four will be discussed in subsequent articles in JUCM.

The health surveillance product line is critically important to employers because it helps ensure that employees are physically capable of performing their jobs without posing undue risk to themselves or others.

Essential components of the health surveillance product line include physical exams, drug screening and breath-alcohol testing, and exams mandated by the Occupational Health and Safety Administration (OSHA).

**Pre-placement Screening**

The UCOM clinical staff should be prepared to provide pre-placement/post-offer physicals to evaluate a potential employee’s physical fitness for a specific job.

Certain aspects of these exams are standardized. For example, a basic pre-placement physical typically includes a medical and occupational history, a physical and functional exam, and reports vital signs, height, weight, and visual acuity.

Each standard exam should be customized based on the functional demands of the job in question. At a minimum, the examining provider should obtain functional job descriptions from the employer for each position for which examinations will be performed.

If such descriptions are not available, a comprehensive UCOM practice should be equipped to assist the employer with job analyses and the preparation of written job descriptions, which support many of the components involved in an effective job-placement process.

There are two classifications of job analysis:

- **Quantitative** job analysis involves measurements such as weight, distance, force, repetition, and speed.

- **Qualitative** job analysis may be used to identify specific physical factors that can be addressed through ergonomic interventions and must be done by a professional with evaluation skills.

The importance of taking a functional approach to a pre-placement exam cannot be underestimated. An evaluation based on a functional job description pro-
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Cough relieved. Rest assured.™
DESCRIPTION: Each Teaspoonful (5 mL) of TUSSIONEX® Pennkinetic Extended-Release Suspension contains hydrocodone polistirex equivalent to 10 mg of hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg of chlorpheniramine maleate. TUSSIONEX® Pennkinetic Extended-Release Suspension provides up to 12-hour relief per dose. Hydrocodone is a centrally-acting narcotic antitussive. Chlorpheniramine is an antihistamine. TUSSIONEX® Pennkinetic Extended-Release Suspension is for oral use.

Inactive Ingredients: Acetic acid, D&C Yellow No. 10, erythrosine, FD&C Yellow No. 6, flavor, high fructose corn syrup, methylparaben (polysorbate 80), polyethylene glycol 3350, polysorbate 80, pregelatinized starch, sodium hydroxide, purified water, sucrose, vegetable oil, xanthan gum.

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

Chlorpheniramine is an antihistamine drug (H1 receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

Hydrocodone and chlorpheniramine are not metabolized in the body to any significant extent. Hydrocodone is primarily excreted in the urine. Chlorpheniramine is primarily excreted in the urine and feces. It is not known whether the drug appears in human milk.

CLINICAL PHARMACOKINETICS: After administration of a single dose of TUSSIONEX® Pennkinetic Extended-Release Suspension to 20 healthy volunteers, mean (S.D.) peak plasma concentrations of 90.6 (29.3) ng/mL occurred at 4.2 hours. Chlorpheniramine mean (S.D.) peak plasma concentration of 13.6 (5.6) ng/mL occurred at 3.6 hours following multiple dosing. Chlorpheniramine exposure was increased at the time of the peak plasma levels obtained with an immediate-release syrup compared at approximately 1.5 hours for hydrocodone and 3.8 hours for chlorpheniramine. The plasma half-lives of hydrocodone and chlorpheniramine have been reported to be approximately 4 and 16 hours, respectively.

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

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

The use of TUSSIONEX® Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age.

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

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

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

Obstructive Bowel Disease: Chronic use of narcotics may result in obstructive bowel disease, especially in patients with underlying interstitial or muscular disease.

Pediatric Use: In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory impairment (e.g., croup; see PRECAUTIONS).

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

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

Information for Patients: As with all narcotics, TUSSIONEX® Pennkinetic Extended-Release Suspension may produce market dryness and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly. TUSSIONEX® Pennkinetic Extended-Release Suspension must not be diluted with fluids or mixed with other drugs as this may alter the release and change the absorption rate, possibly increasing the toxicity. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, clonic convulsions, respiratory depression, increased-static, shivering, yawning, and diarrhea. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: As with all narcotics, administration of TUSSIONEX® Pennkinetic Extended-Release Suspension to the mother shortly before delivery may result in a decrease in the frequency of respirations and/or in the newborn especially of higher order are used.

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

Pediatric Safety: Safety and effectiveness of TUSSIONEX® Pennkinetic Extended-Release Suspension in pediatric patients have not been established.

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

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

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

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

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

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

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery may be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, clonic convulsions, respiratory depression, increased-static, shivering, yawning, and diarrhea. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: As with all narcotics, administration of TUSSIONEX® Pennkinetic Extended-Release Suspension to the mother shortly before delivery may result in a decrease in the frequency of respirations and/or in the newborn especially of higher order are used.

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

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

The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.
tects both the prospective employee and the employer by identifying pre-existing conditions that may put the worker at risk of further injury.

In addition, to comply with the Americans with Disabilities Act, an employer may need to take reasonable steps to accommodate a disabled applicant who is otherwise qualified for a job.

Physicians, nurse practitioners, or physician assistants perform the physical exams; clinical technicians provide screening and testing.

In addition to knowledgeable examiners and technicians, however, the UCOM practice will find that physical and occupational therapists are valuable team members. These rehabilitation professionals may either be on staff or under contractor to the practice.

It is incumbent upon UCOM practitioners to educate employers in their market about the need for functional job analysis and other appropriate assessments for job applicants.

**DOT Screening**
The U.S. Department of Transportation’s (DOT) physical examination, urine drug screening, and breath-alcohol testing requirements can generate a considerable amount of business for a UCOM practice or clinic network that is able to handle high patient volumes efficiently.

The Omnibus Transportation Employee Testing Act of 1991 requires urine drug screening and breath-alcohol testing of transportation employees in the aviation, trucking, railroad, mass transit, pipeline and other transportation industries. The DOT publishes rules on who must conduct these tests, how to conduct them, and what procedures to use when testing. These regulations cover more than 12 million people.

A DOT physical examination is conducted by a licensed medical examiner. The term medical examiner includes, but is not limited to, MDs, DOs, PAs, advanced practice nurses, and chiropractors. The required medical examination report form may be downloaded off the Internet by visiting the Federal Motor Carrier and Safety Administration’s website (www.fmcsa.dot.gov/documents/safetyprograms/medical-report.pdf).

Medical review officer (MRO) services must also be provided as part of any DOT drug screening service. Many UCOM practices sell drug screening and MRO services as a package.

The MRO may be an in-house physician who has obtained certification or a subcontractor. The professional MRO is a licensed physician (MD or DO) who is an expert in drug and alcohol testing and the application of federal regulations to the process.

When called upon, the MRO serves as a consultant to business, industry, labor, government, or academia on issues relating to prevention, detection, and control of drug abuse in the workplace.

Sources for MRO training include the Medical Review Officer Certification Council (www.mrocc.com), the American Association of Medical Review Officers (www.aamro.com) and the American College of Occupational and Environmental Medicine (www.acoem.org).


For non-regulated employers, the UCOM practice may assist employers by offering drug screening in compliance with established standards and providing policies and procedures for the development of a drug-free workplace program. (For a sample policy, visit www.dol.gov/elaws/asp/drugfree/drugs/screen2.asp)

**Other Mandated Exams**
Many workplaces are subject to medical surveillance requirements under the Occupational Safety and Health Act. UCOM practitioners must be prepared to evaluate exposure hazards and develop appropriate health exams and screenings to provide employers with baseline data in compliance with federal regulations, which are enforced by OSHA. Testing must be performed by certified staff and supported with documentation.

Key components include respiratory surveillance and hearing conservation.

Respiratory surveillance involves pulmonary function screening and respirator monitoring. Technicians are considered competent in this area upon completion of a National Institute of Occupational Safety and Health (NIOSH)-certified training course. Licensure of health professionals is typically the function of a state board, and issuance of a course certificate does not im-

“UCOM practitioners must be prepared to evaluate exposure hazards and develop appropriate health exams and screenings.”

Continued on page 36.
Practice Management

Playing to Win: Maximizing Profits in Urgent Care

**Urgent message:** The financial health of your practice depends on a balanced approach that takes into account both increasing income and reducing expenses.

Alan A. Ayers, MBA, MAcc

From an economic perspective, the independent urgent care owner/operator has a dual goal: to build the long-term value of the medical practice while maximizing cash that can be taken out of the business in the form of income.

To achieve both of these goals—to expand revenues while reducing costs—both a strong offense and a strong defense are required.

**Finding Cash in the Practice**

Cash is the lifeblood of any medical practice; it flows in through patient service revenues and flows out through the payment of salaries and expenses. Changing the direction of cash flow can be a difficult undertaking, but it is possible by uncovering the common “hiding places” of cash. These include accounts receivable (AR), accounts payable, inventory, and administrative expenses.

**Accounts receivable days,** calculated as accounts receivable divided by annual sales times 365, is the traditional benchmark for the effectiveness of cash collection and consists of both insurance and patient balances. If your practice AR is greater than 45 days and 20% or more consists of patient balances, the answer to accelerating cash flow may be found at your front desk.

How well does your front desk staff understand insurance and medical billing terminology? Does your front desk staff verify insurance eligibility and collect copays, deductibles, and prior balances from every patient? And how accurately are they recording patient demographic information, including guarantors and coinsurance? These common shortcomings at the front desk translate to extra work and delays in charge entry, billing, and collections on the back end.

For example, a patient presents a PPO membership card that does not list an urgent care copay. The staff interprets this as “no urgent care copay,” allows the patient to see the doctor, and the claim gets submitted to insurance.

When the Explanation of Benefits is received 20 days later, it turns out that the patient had a $5,000 deductible policy with “no urgent care benefit.” Your billing company invoices the patient without response and only after referring the account to the col-
We are Committed to Urgent Care

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Our commitment is your success
lections agency—and paying a 25% to 30% commission—do you get your cash about six months later.

In effect, you provided the patient with a sizable discount and “no money down, no interest, and no payment financing”—unlike car dealerships and furniture stores that make the same appeal, however, you got no marketing lift from your generosity. Worse, in a certain percentage of cases, patients will never pay the bill, resulting in a write off of the revenue in addition to billing and collections costs.

Had the front desk verified coverage and the presence of a deductible, and understood the difference between “no urgent care copay” and “no urgent care benefit,” the urgent care center could have collected the patient’s financial responsibility at time of service, thus reducing the risk of non-payment and avoiding back-end billing and collections expense.

Although it takes time at registration to contact the insurance company for every patient, doing so is critical to getting paid in today’s fast-changing insurance market. Figure 1 lists the most common reasons why urgent care accounts receivable can grow to excessive levels.

Cash may also be found by improving the efficiency of the back-office billing operation.

Charge entry delays, aging insurance balances and low gross collection ratios may indicate a shortage of billing and collections staff. If you have outgrown your ability to effectively perform billing and collections tasks in-house, evaluate whether new practice management software is in order or if an outsourced billing company can perform more effectively for the same or reduced cost.

Also, sending unpaid patient balances to a collections agency sooner (e.g., after 60 or 90 days instead of 120 days) results in lower commissions and higher collections rates.

**Finding Cash in Expense Management**

When starting an urgent care practice, physicians often imagine all of the different types of cases that could present at the center and, to be prepared, order a wide range of medical supplies. But supply inventories, including vaccines and injections, can grow to expensive levels when not controlled.

Do you find that a large number of supplies expire before use? Often, supplies are packaged in minimum quantities of 25, 50, or 100 per box, so it’s difficult for a start-up practice to avoid some excess inventory levels. Periodic review of expired supplies may reveal inventory that isn’t needed, however.

Supplies should represent the acuity and frequency of cases that present at the center, as well as the scope of practice.

For example, if the practice treats minors only on a limited basis, there probably isn’t a need to stock a pediatric speculum and intubation kits of various sizes. If standard procedure is to refer high-acuity cases to the emergency room, and squad service is readily available, it may also be unnecessary to stock supplies for critical care or advanced life support.

Vendors are more than willing to present the start-up urgent care with lists of “everything you need to be successful,” but remember that their objective is to sell more medical supplies.

For the established practice, negotiating with vendors on a yearly basis can often yield lower prices or more favorable terms, including the ability to return expired/unused items. Existing vendors want to protect their current accounts and competing vendors want to win new business—particularly if they believe a practice is growing. Likewise, group buying organizations can secure lower prices from existing supply vendors by consolidating the demand of many medical practices.
It’s Like Money in the Bank
Banks are hungry for cash, and physician practices flow significant cash through bank services. Banks are also eager to serve doctors, who tend to borrow and invest more than the average customer.

Because banks assess the value of relationships in terms of profitability, they are usually willing to negotiate lower interest rates and service charges if they can sell more services, including lines of credit, treasury management, and credit card processing.

Compare the services of different financial institutions and evaluate ways that interest paid on cash balances can offset fees. Treasury management offerings such as sweep accounts, direct deposit, in-office check scanning, and lockbox can accelerate cash deposits of third-party payments.

Online bill pay can improve the management of payables, assuring that a practice takes advantage of vendor discounts for prompt payment, avoids service charges for late payments, and stretches payments to the maximum allowed by the vendor contract.

Almost any expense can be a potential source of cash for your practice. Challenge your staff to constantly identify expenses that can be cut and processes that can be improved—sharing some of the savings with staff ups the ante and aligns staff incentives to the practice ownership.

The Best Defense is a Good Offense
While it’s impossible to build a successful medical practice on cost cutting alone, managing costs is always easier than growing top-line revenue. On a typical profit-and-loss statement, there are many lines that describe costs such as labor, rent, and supplies, but all revenue is typically summarized in one or two lines: “urgent care fees, net of adjustments.”

As a result, revenue is the most misunderstood and neglected measure in business. Vague statements such as a “slow flu season,” “unseasonably warm weather,” and “increasing competition,” are often used to explain away revenue that falls short of projection.

Moreover, while expenses are incurred on a day-to-day basis, daily revenues are the culmination of many decisions over time that influence consumer demand and preferences, including location, marketing/branding, and customer service.

“In its simplest terms, revenue is determined by multiplying the number of visits by the average charge per visit.”

Today’s actions don’t necessarily translate into immediate revenue and it can often take years to overcome strategic mistakes made in the past.

In its simplest terms, revenue is determined by multiplying the number of visits by the average charge per visit.

Growing volume is a marketing and customer service discussion too involved to cover here; instead, let’s concentrate on the two components of charges, which are the fee schedule and physician coding.

Fee Schedules: Leave No Money on the Table
In an ideal world, an urgent care fee schedule would represent what a physician thinks his or her service is worth based on skills and training (including board certifications), office location and hours, and the clientele attracted. But this is just the retail price—more important is the discount price offered to third-party payors.

All too often, practices just accept whatever fee schedule is sent to them by payors, without negotiating specific volumes or payment terms.

When was the last time you met with a payor to ask what you are receiving in return for the discount you are offering them? Accepting whatever payors offer has become so routine for urgent care centers that the retail fee schedule matters little.

Insurance contracts pay the “higher of contract or billed charges,” so to assure that no money is left on the table, urgent care fee schedules are typically set at 150% to 200% of Medicare fees.

In no case should billing be less than the highest paying contract for a particular CPT code. Many urgent care centers further discount these fees for cash pay patients.

When negotiating insurance contracts, you should examine the 20% of CPT codes that make up 80% of urgent care revenue by setting up a spreadsheet listing reimbursement by payor and CPT code. This spreadsheet will demonstrate variances between payor and the volume effect on total revenue.

Although a very favorable contract may pay an average 20% premium to Medicare, if the reimbursement on the most frequently used CPT codes is less than that, the contract could be less “favorable” than you thought.
A $5 to $10 variance on one or two high-volume codes could result in lower revenue—perhaps thousands of dollars per year. Consequently, negotiation should focus on the codes used most frequently in your practice; if you can get a good rate on your top 20%, it may be worthwhile accepting less on the others. (Of course, good reimbursement on a CPT code is only meaningful insofar as the practice codes correctly.)

Provider Chart Review
Physician knowledge of evaluation and management (E/M) coding has a direct impact on the ability to charge accurately for the services provided. If a provider codes visits too low, or does not document visits to justify a higher potential code, then money may be left on the table.

A simple chart review, which can be either retroactive (examining past services) or proactive (before the claim is submitted), can help identify possible loss of revenue and red flags that could invite a letter of requested information from a third-party payor.

Chart reviews can be conducted by a certified medical coder in your billing organization, by an outside accounting or consulting firm, or by a physician in the practice skilled in the complexities of medical billing.

The chart review identifies examples of over- and under-coding that affect level of service billing. History, exam, and medical decision making documentation must all support the selected code; when they do not, the practice should bill at the level supported by the documentation, which may result in “lost” revenue if the code billed is less than what actually occurred.

If documentation and coding issues cause one physician to “lose” $10 to $15 in potential revenue per patient, over the course of a year an average urgent care practice would forego more than $100,000 in revenue.

When coding and compliance issues are uncovered in the chart review, the solution is education. Urgent care physicians need to have a clear understanding of Medicare reimbursement guidelines and documentation requirements. Chart reviews should be repeated until the physician is compliant.

The process should not be punitive, but rather, focused on helping the physician attain appropriate coding levels. Another solution is to implement an electronic medical records system that includes a coding engine.

Conclusion
Consistently winning in the game of business requires both a calculating offense and a steadfast defense. Success comes from balancing revenue growth against cost savings. Successful urgent care practices constantly evaluate all aspects of their operation to find ways to improve efficiency while also increasing customer satisfaction and quality of care that assure long-term increases in volume.

PLAYING TO WIN: MAXIMIZING PROFITS IN URGENT CARE

HEALTH SURVEILLANCE PRODUCT LINE

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The “O-Ring” in Medical Malpractice Cases

JOHN SHUFELDT, MD, JD, MBA, FACEP

The moment is forever etched in my mind. It occurred while I was in my fourth year of medical school during a radiology rotation in Scottsdale, AZ. I was doing everything I could not to fall asleep while sitting in the dark film-reading room, listening to a tonally flat radiologist dictate plain film reports.

I got up to splash some cold water on my face and as I was walking back from my drinking fountain bath, I witnessed history. On that cold day in January (36 degrees in Florida at launch time) the Challenger spacecraft took off from Cape Canaveral, FL carrying six astronauts and one civilian school teacher.

Fifty-nine seconds into the flight, two “O-rings” failed which allowed hot gasses and flames from the booster engine to burn through the joints holding the solid rocket booster to the external fuel tank, ultimately causing an explosion and the disintegration of the Challenger.

The subsequent 12,000-page document produced by the blue ribbon panel appointed to review the disaster opened Chapter 5 of their report with this understatement; “The decision to launch the Challenger was flawed.”

Engineers at Morton Thiokol, the group that designed the solid rocket motor, never tested the O-rings below 53 degrees. They warned NASA engineers repeatedly about their concerns and argued unsuccessfully to delay the launch. NASA, at the time, was under immense pressure to get the flight off and ultimately disregarded the warnings.

I use the Challenger disaster to illustrate a point common to most medical malpractice events: It is seldom one mistake or error that leads to a medical misadventure that ultimately results in a malpractice suit.

I will use a case I recently was involved in as an attorney to further illustrate this point. At the end of the brief overview, I will review all the different medical “O-rings” which allowed the event to occur unchecked.

Case History

A health plan nurse triage line instructed a 35-year-old obese woman complaining of chest pain and shortness of breath to go to a local urgent care center for evaluation. Dutifully, the patient presented to an urgent care center located in her Eastern seaboard hometown with the complaint of a non-productive cough, URI symptoms, and chest pain with deep breath.

Upon questioning, she admitted to dyspnea on exertion and was in fact tachypneic on presentation. Her heart rate was recorded at 120 beats per minute. Her temperature, weight, and BP were not recorded. Her pulse ox was 92%. She was a smoker and on oral contraceptives; however, neither of these facts were recorded on the patient-completed medical history assessment because the pen she was given ran out of ink and the staff were in a hurry to close up for the day so they accepted the partially completed form.

Further history was not obtained.

If it had been, however, it would have revealed that the patient had just returned from Hawaii three days before her visit. The patient’s brief exam was recorded as unremarkable.

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on a check-box sheet form. A chest x-ray was performed and read as “possible hilar infiltrate” by the second-year family practice resident moonlighting in the clinic.

“Urgent care medicine is like emergency medicine [in that] it is incumbent upon the provider to exclude life threats and document the reason for their exclusion.”

An EKG was not ordered. No blood tests were performed despite the fact that the clinic was able to perform a d-dimer (the patient’s health plan refused to pay for the test). Her old history was not obtained from previous records (the patient had a family history of DVT).

The patient was diagnosed with bronchitis versus early pneumonia and was prescribed a short course of an oral antibiotic and discharged home with instructions to follow up in five- to seven days if she was not better. Her vitals were not rechecked before discharge.

Typically, the clinic called patients two days after their visit to inquire about their status. However, in this case, the second post-visit day fell on a Sunday and the weekend crew historically had not been performing these calls (they felt they were too understaffed make them).

On the third day post-visit, the patient called the clinic to report that she was coughing up mucus mixed with blood. The call was taken by a medical assistant who told her that this was normal with a diagnosis of bronchitis.

By day 4 the patient was dead. She collapsed in her kitchen in front of her children while taking her antibiotic. Cause of death was determined on autopsy to be a pulmonary embolus.

Medical O-Ring Analysis
Inappropriate triage by nurse call line: The triage may have been appropriate if the urgent care center was set up to evaluate patients with suspect pulmonary embolism. In fact, this clinic was set up to evaluate the presence of blood clots, but the plan refused to reimburse the center for the cost of the d-dimer test so it was not performed.

Misaligned health plan reimbursement: The health plan paid urgent care providers on a case-rate (flat fee) basis. The head of their contracting section stated that their “system could only handle case rates billed via a dummy code.” The plan refused to pay urgent care providers on a fee-for-service basis, so providers were reluctant to order high-cost tests on the particular plan’s enrollees.

Inadequate history completion by patient: The inclusion of the recent plane flight, the use of the oral contraceptive, history of smoking, or the family history of DVTs would have probably led the provider to consider the correct diagnosis.

Incomplete vital signs by staff: The patient was tachycardic and tachypneic, both of which are consistent with PE (as well as with other potential life threats). Her pulse ox was low on presentation and no effort was made to see if this was her baseline from her old records.

Failure of the clinic to utilize standing orders for specific complaints: Standing orders for selected complaints are useful for a variety of reasons, the most important of which is to ensure the patient receives the appropriate tests when the clinic’s staff is busy and the provider is being pulled in multiple directions.

In this case, an EKG should have been performed, as well as the d-dimer. Even if the clinic elected to send the test out to an outside lab, they would have had the results back within two days and could have warned the patient.

Inexperience of physician staffing the clinic: Few second-year residents have the breadth of experience or have treated enough patients to have a great gut instinct. In this instance, the resident had telephone back-up available but did not want to bother the on-call physician on the weekend.

Urgent care medicine is like emergency medicine inasmuch as it is incumbent upon the provider to exclude life threats and document the reason for their exclusion.

Some of the issues with the care of this patient are inadequate history and exam, misreading the x-ray, and failure to appreciate the potential for a life-threatening illness given the patient’s vitals, which ultimately led to the incorrect diagnosis and treatment.

No mechanism to have films over-read by a radiologist: The center’s owners testified that having 100% of their films over-read by a radiologist was too expensive given their health plan reimbursement.

Not completing pre-discharge vital signs: I suspect that this patient’s discharge vitals would have been similar to her admission vitals and would have clued the provider in to the fact that something more serious was wrong.

Inappropriate follow-up instructions: The majority of urgent
Do you hire an experienced salesperson and train him or her in occupational health, or hire an occupational health professional and train that person in sales?

The former brings sales experience but needs to learn the “product;” the latter brings product knowledge but needs to learn fundamental sales skills.

Given this choice, my answer is the former. It is easier to train an experienced salesperson in product knowledge than vice versa. However, there are numerous exceptions. For example, an insider with product knowledge may be a natural salesperson who could easily adapt to the occupational health sales role.

Regardless of which approach you adopt, keep in mind that mediocre personnel beget mediocre results. The most important thing is to hire the right individual.

When Openings Occur
Having an open operational position may hinder efficiencies and increase burden on remaining staff, but at least the program is saving money (the salary for the open position) for this period.

However, each day a sales position remains open means no sales calls and less revenue for your clinic. Hence, you must move quickly to initiate the recruiting/interviewing/hiring process when you have an open sales position.

Often, programs minimize their outreach out of fear that the candidate pool will become too large. But the greater danger is missing out on the best candidates. The best strategy is to concurrently use multiple modalities to build an extensive candidate pool. The wider the net, the more likely you will catch the big fish.

Such modalities might include:
- A professional recruiting firm—Utilize one or more firms that specialize in the recruitment of sales personnel. This provides the best chance to find a candidate who has “been there, done that.” A contingency fee and/or relocation cost may well be offset by the new hire’s ability to bring in more dollars more quickly.
- Advertising—Depending on the size and nature of your market, newspaper advertising may be valuable.
- Internet recruiting—Internet recruiting tools such as www.monster.com are increasingly viable methods for enlarging your prospect base.

Narrow the Field
The tactics described above may produce a candidate pool the size of Jupiter. Now what?

The ideal candidate would be someone who has experience in your market. Such a candidate is likely to bring clients and contacts, market knowledge, and potentially valuable competitive intelligence to your program.

Assuming this dream candidate does not surface, however, you will need an effective approach to narrow down the pool:
- Require that both objective and subjective criteria be included in a candidate’s first response. Request a letter of interest, including why the candidate is considering your position at this time, their compensation requirements, and their current responsibilities. Many candidates can be eliminated after a brief glance.
- Send remaining candidates materials describing the position and your organization. Dissemination of such information at this juncture eliminates candidates that may not be interested in the position, saves time during the interview (providing more time to get to know the applicants), and measures an applicant’s diligence.
- Ask the candidate to call your office during a specific time period to schedule a telephone interview. Many would-be candidates don’t get around to it, or fail to call during the specified time period. Rule them out now and save time later.

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.
Conduct a telephone interview. A gracious, self-confident telephone presence is important in sales and can be readily judged. Ask the candidate what questions they may have about the position after reading your materials. Minimal questions or comments are generally a negative.

Invite final candidates for a personal interview. Send them, via e-mail, a hypothetical sales scenario and ask that they come prepared to discuss the scenario. Some candidates will be intimidated by this process and back down. Those you do interview will provide you with a tangible series of comparable skills such as preparedness, articulateness, problem-solving, and basic sales instincts.

What to Look for During the Interview
Evaluating the candidates who make it to the interview stage is just as important as the steps you've taken up to this point. Knowing what to look for will help illuminate who you are looking for:

- The “glow” — I often base hiring decisions more on persona than on objective qualifications. You can usually tell in a few seconds if a person has the “glow” that is vital for sales professionals. Be willing to sacrifice some technical qualifications if you can bring in such a winner.
- A good fit for your marketplace — I would hire a different candidate in midtown Manhattan than in Topeka. Look for the candidate who best fits your market and who would feel at home with the prototype decision-makers at local companies.
- A sense of commitment — Strive for minimal turnover. Scrutinize a candidate’s work history. Have they moved around a lot and, if so, why? What is the likelihood they are going to stay in your city/town for a long time? Is your sales position something they really want to do or do they feel it is “just another job?”

The most useful questions are those that help you learn as much as possible about each applicant. Examples include:

- “If I asked the 10 people who know you best what your very best trait as a person, what would they say?” (Follow-up probe: “Why do you think they feel this way?”)
- “If you were me and you were hiring a person for this position, what four traits would you look for in a candidate? Why?”
- “You’ve had the chance to review our program materials. If an employer asked you why they should use our program, what would you say?”
- “If you could use only one word to describe yourself, what would that word be?”
- “What is the most important value your parents taught you?”


**HEALTH LAW**

“It is seldom one mistake that leads to a misadventure.”

care patients should be advised to follow up with their PCP or back with the center in two days. This prescribed follow-up is a good insurance policy which helps to engage the patient and their PCP into the treatment plan. If the patient had followed up with either her PCP or back with the clinic, chances are good that another set of eyes would have “beamed up” to the patient’s diagnosis.

**Not calling selected patients back post visit:** This is another means of risk mitigation. If patients are not better or are worse on the follow-up call, they should be directed to return to the center, their PCP, or the emergency department. Again, in this instance, the patient would have been referred back for additional tests and a new set of eyes.

**Inappropriate information given when patient called back:** Here was the final nail in the coffin. The patient called back with additional symptoms which are consistent with a PE (and other potentially serious diagnoses) and was given incorrect advice by a medical assistant who should not have been giving medical advice at all.

Disaster could have been averted and the patient’s life saved at every one of the aforementioned system or personnel breakdowns.

Retrospectively, two of the staff members admitted that they felt this patient was misdiagnosed from the outset; however, when asked during their depositions why they didn’t clue the physician in to the seriousness of the patient’s condition, they responded that this particular physician was “very nice and kind of timid” so they did not want to step on her toes.

Marcia Bacon, commenting on the Challenger disaster, had this to say: “It is a sad fact about loyalty that it invites...single-mindedness.”

In this instance, the final stop-gap measure was other staff in the clinic who suspected the patient may have been seriously ill, yet they did not want to appear disloyal to the neophyte physician so they elected not to sound the warning—at the cost of the patient’s demise.

Medical malpractice risk is a cost of doing business. However, it is seldom one mistake that leads to a misadventure. Protecting your patients and your practice from these compounding mistakes should be the primary goal of all center owners.

**Reference**

The Finer Points in Determining New vs. Established Patients

DAVID STERN, MD, CPC

Q. Our urgent care practice serves a 70-physician primary care group. The UC uses the three-year rule; if the patient has been seen by any physician in the medical group within the last three years, he/she is an established patient—even if the patient has never been previously seen in the urgent care. A comparable UC center in a nearby city applies the three-year rule differently; if the patient has been seen in the urgent care within the last three years, he/she is an established patient. The urgent care center does not count visits to a physician in the medical group. Can you tell me who is correct?

Urgent Care Physician, California

A. According to CPT, a “new” patient is a patient “who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.”

The definition sounds quite simple, but the application is quite complex.

For a patient presenting to this urgent care center for the first time in the past three years, several different scenarios might apply:

Established Patient
Scenario A: Code as an established patient (no exceptions) if the urgent care physician has performed professional services on the patient in the past three years in any setting—urgent care, physician practice, hospital, hospital emergency department, nursing home, or any other place of service.

Scenario B: Code as an established patient:
1. if the urgent care physician is a member of the same primary care group practice
2. and the physician (who has seen the patient in the group practice) practices the same specialty as the urgent care physician.

New Patient
Scenario A: You may code as a new patient:
1. if the urgent care is a separate business (operating under a separate TIN) from the group practice
2. and the urgent care physician is not a member of the primary care practice.

Scenario B: You may code as a new patient:
1. if the urgent care operates under the same TIN or a different TIN (it makes no difference) as the group practice
2. and the urgent care physician is a member of the group practice
3. and the urgent care physician has never performed professional services on the patient
4. and the patient has been seen in the group practice, but the physician who performed professional services in the group practice is of a different specialty than any physician who has performed professional services on the patient.

Stand-Alone Urgent Care
For an urgent care center that is not affiliated with a group practice, a corollary of the above explanation is that an urgent care center can code any patient as a new patient if that patient is being seen by a physician who is of a different specialty than any other physician who has already seen the patient in the urgent care center.

Several payors (but not all payors queried) have personally communicated to me that they find this coding method perfectly acceptable.

Example: A patient has been seen multiple times in the ur-
urgent care center by internists, by family practice physicians, and by pediatricians. Today, the patient is being seen by a physician who specializes in emergency medicine. Even though the patient has been seen multiple times in the urgent care center, you could code this patient as a new patient.

Arguments Against Such Implementation

Although these creative methods for coding new patient visits are compliant, there are arguments to be made against using them, as follows:

- Every patient must be established by practice, physician, and by specialty of physician. This presents significant tracking difficulties in maintaining and updating such a complex database.
- Since some physicians may actually be board eligible or board certified in more than one specialty, a patient may become “established” in the urgent care for two or three specialties when receiving an encounter with a single physician.
- Many payors may find these coding methods inappropriate and may seek to recover so-called “overpayments” for many previous years.
- Coding separately for every different specialty represented in an urgent care seems to contradict the contention of organized urgent care medicine that urgent care physicians are practicing a unique specialty. When a physician is practicing in an urgent care setting, she is not practicing internal medicine, family practice, or some other specialty; she is practicing urgent care medicine.
- It is hoped that at some point in the future legitimate board certification in urgent care might be established and recognized by the larger community of organized medicine.
- Patients who have been seen multiple times in the urgent care practice may not be happy to be classified, coded, and billed as new patients.
- These methods may follow the letter of regulations, but they do not seem to fall within the intent of the regulations on new and established patients.

Thus, my personal recommendations are these:

- If a patient has received professional services from any physician of any specialty in the urgent care, then subsequent visits within a three-year time frame may be coded as established patient visits.
- If the urgent care has the same ownership as a practice, and the urgent care center is staffed by completely separate physicians from the group practice, then patient visits should be coded as established if the patient has received professional services in the urgent care center only. Visits to the group practice are not taken into account.

**“Professional Services”:** What constitutes professional services has been defined by CPT as “those face-to-face services rendered by a physician and reported by a specific CPT code(s).” The following services can be reported with a specific CPT code but are not rendered “face-to-face,” so a subsequent face-to-face encounter would be coded as a new patient:

- Example 1: If the physician reads an EKG on a hospital patient that the physician did not see face-to-face, this would not constitute a “face-to-face” encounter. If the patient is seen subsequently for the first time in the urgent care, then the patient visit would be coded as a new patient.
- Example 2: The physician calls in an antihypertensive medication for a patient who has moved into the community and has a first appointment in a week. When the patient visits the clinic, the visit is coded as a new patient visit.
- Example 3: The physician sutures a laceration on a patient in a hospital emergency department. Six months later, the physician sees the patient in an urgent care center. This is an established patient.

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WellStar Physicians Group is seeking full-time and part-time BC/BE Emergency Medicine or Family Medicine Physicians to join Urgent Care facility in Smyrna. This office is located 15 miles northwest of downtown Atlanta. Candidates must have excellent interpersonal and communication skills. Malpractice coverage, no call, flexible schedule, excellent benefits and competitive compensation! Send CV to: provider.positions@wellstar.org or fax to (770) 792-1738

The Journal of Urgent Care Medicine | April 2008

With a circulation of 13,000 Urgent Care subscribers, there are plenty of reasons why your company should be a part of The Journal of Urgent Care Medicine’s 11 monthly issues.

Phone: (800) 237-9851 • Fax (727) 445-9380
Career Opportunities

**Northern California**

Urgent Care & FP Opportunities

Sutter Medical Group (SMG) is seeking FP physicians to staff an urgent care clinic located in Roseville & Sacramento. SMG is a multi-specialty group of 200+ physicians.

- FT and PT opportunities are available.
- Clinic hours of operation: Mon.-Fri. 6 p.m. - 10 p.m., Sat.-Sun. 8 a.m. - 8 p.m.

The Sacramento Sierra Region is centrally located, an hour and a half from the mountains of Lake Tahoe or the bay of San Francisco. For the wine connoisseur, scenic Napa Valley is just a short drive away.

Other Family Practice opportunities are also available throughout the surrounding Sacramento areas.

**United Medical Associates**

United Medical Associates, P.C. (UMA) is seeking two BC/BE Family Practice physicians to join our 135 physician multi-specialty group in upstate New York. We are expanding our urgent care services to include a fourth site.

Qualified physicians will be assigned to one site but may be required to work in all sites if need arises.

UMA is affiliated with United Health Services Hospitals, the regional leader in healthcare. Opportunities for teaching medical students and residents exist.

Binghamton, a university town, offers quality education, a high-tech industrial base, safe living environment and diverse cultural opportunities. A family-friendly community with a large variety of outdoor recreation on nearby lakes, ski resorts and golf courses. The practice balances a unique ability to provide extraordinary care with life style.

We offer an attractive compensation package with incentive opportunities. Family healthcare coverage, dental vision, LTD, paid malpractice insurance, vacation and CME are included.

Contact Mary Gibson, Director of Physician Services
Phone (800) 295-1788 • Fax: (607) 763-6717
Email: mary_gibson@uhs.org
See our website: www.uhs.net/uma and Binghamton University: www.binghamton.edu for additional group and community information.

**Urgent Care Physician Needed in North Central Wisconsin**

Very competitive compensation – full-time, starting at $185,000+

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- Flexible Scheduling
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- No Hospital Rounds

BC/BE required, walk-in experience preferred.

**Excellent schools, endless outdoor activities, fine dining and cultural experiences await you in North Central Wisconsin.**

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Contact Karen Lindstrum, Physician Recruiter, today about this outstanding opportunity.
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Email: karenl@aspirus.org
www.aspirus.org

**Centra Care**

Immediate Orlando Urgent Care Opportunity

Practice medicine in one of the most enjoyable places in the country. Centra Care is an established, Florida Hospital-owned, urgent care system in Central Florida. Centra Care has 16 centers and 2 more under construction, all with on-site x-ray, lab and electronic medical records.

We need BC/BE Family Practice, Urgent Care or Emergency Medicine Physicians. Centra Care offers competitive compensation, productivity bonuses, paid vacations, paid CME and malpractice insurance, excellent benefits package including health, life and employer matched 401B.

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**JUCM** The Journal of Urgent Care Medicine | April 2008 www.jucm.com
**Career Opportunities**

**URGENT CARE MEDICAL DIRECTOR**

**Lansing, Michigan**

Sparrow Health System, the largest Regional Medical Center in Mid-Michigan, is seeking a Medical Director for its’ three Urgent Care Centers located in the Lansing, Michigan area. This position is responsible for assessing and improving all aspects of patient care, implementing policies and ensuring the delivery of safe, high quality, cost effective care in the Urgent Care setting. Experience in business development, patient satisfaction and quality indicators are desired.

This full-time position is employed by Sparrow Health System and is a mix of 50% Clinical and 50% Administrative responsibilities. In 2007 the three urgent care practices provided care for more than 34,000 patients.

The preferred candidate will be Board Certified in Emergency Medicine, Family Practice, Pediatrics or Internal Medicine with significant experience in Urgent Care. We offer competitive pay and an excellent benefits package including relocation expenses, dental, medical, vision insurance and a generous CME package.

Lansing is Michigan’s State Capital, the heart of the Great Lakes State with a population of 250K. Lansing boasts the influence of state government and Michigan State University (MSU). The campus of MSU is only 5 minutes from Sparrow Hospital. Lansing is located within driving distance to Chicago and close to Detroit and several lakes.

To learn more about this exciting opportunity, please contact:

Barb Hilborn, Manager, Physician Recruitment
Sparrow Health System
1210 West Saginaw, Lansing, MI 48915
Phone: 1-800-968-3225 • Fax: 517-364-6266
e-mail: barbara.hilborn@sparrow.org

**URGENT CARE**

**New York, Mid-Hudson Valley**

Opportunities for BC/BE Family Practice & Emergency Medicine physicians.

65 miles from Manhattan. Outstanding opportunity for personal and professional growth in the fastest growing practice in New York State, located in one of the fastest growing regions in New York State!

- **Unique Urgent Care facility integrated with premier multi-speciality group medical practice.**
- **State-of-the-art facility.**
- **Electronic medical records.**
- **In-house digital imaging.**
- **Excellent compensation/partnership track.**

Please Write, Fax or Email to:
Hal Teitelbaum, MD, MBA, Managing Partner
155 Crystal Run Road, Middletown, NY 10941
Fax: 845. 703. 6201
Email: teitelbaum@crystalarunhealthcare.com

Crystal Run Healthcare

www.crystalarunhealthcare.com

**PHYSICIAN OPENING**

**Tennessee Urgent Care Associates**, an established Urgent Care/Occupational Medicine organization with four locations in the Nashville area, has excellent opportunities for BE/BC physicians.

The successful candidates will hold a current Tennessee license and be board-eligible or board-certified in the specialty of family practice, emergency medicine, internal medicine, urgent care or occupational medicine.

**Tennessee Urgent Care Associates** has operated in the Nashville area since 1983, providing quality medical care by highly experienced and respected provider staff while meeting both the family and corporate medical needs of the community.

We offer an attractive compensation package, 401(k) retirement plan, generous vacation, CME reimbursement, malpractice coverage and a predictable schedule with no-call. Come join our outstanding staff of physicians and enjoy a desirable lifestyle in Middle Tennessee!

Mail CV to:
TN Urgent Care Associates
2510 Murfreesboro Road, Suite 2
Nashville, TN 37217

or email to recruiting@tnurgentcare.com

Visit our website at www.tnurgentcare.com
URGENT CARE OPPORTUNITIES ~ GRAND RAPIDS, MICHIGAN

Spectrum Health, one of the nation’s top integrated healthcare systems and the largest tertiary referral center in West Michigan, is looking for a Medical Director and full/part-time staff physicians of its Urgent Care Network located in the Grand Rapids metropolitan area. This position is responsible for assessing and improving all aspects of patient care, implementing medical staff policies, and ensuring the delivery of safe, cost effective, high-quality, and efficient care in the Urgent Care setting.

This full-time Medical Director position, directly employed by Spectrum Health, is a mix of administrative and clinical duties. Each year, the current five locations provide care for more than 130,000 patients and are open from 8:00am until 10:00pm, 7 days per week. Qualifications for all positions include Board-certification or Board-eligibility in either Emergency Medicine, Family Medicine, or Urgent Care. Competitive salary/benefits package, including relocation allowance.

Grand Rapids is a prosperous and rapidly-growing city, (metropolitan population of 750,000), 45 minutes from Lake Michigan, and is known as the cultural, educational, and economic hub of West Michigan.

For further information, contact: Wendy Jones, Spectrum Health Physician Recruitment, Phone: (800) 788-8410; Fax: (616) 774-7471 or email: wendy.jones@spectrum-health.org
Career Opportunities

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

*Please Contact: Marie Noeth, OSF Physician Recruitment*
Call: 309-677-8351 or 800-232-3129 press 8
Fax: 309-677-8338
marie.k.noeth@osfhealthcare.org
www.osfhealthcare.org

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

*Please contact: Marie Noeth, OSF Medical Group Physician Recruitment*
Call: 309-677-8351 or 800-232-3129 press 8
Fax: 309-677-8338
marie.k.noeth@osfhealthcare.org
www.osfhealthcare.org

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

- **Regional Medical Director • Medical Director • Urgent/Primary Care Attending**
  - Our locations in Monmouth and Union Counties offer flexible schedules, competitive compensation and excellent benefits.
  - *If you are interested in learning more, please submit your CV to:*
  - Soti Lluberes, Physician Recruiter
  - 877-692-4665 Ext. 1134
  - Fax: 973-740-5895
  - Email: lluberess@emomedicalcare.com

**ASHEVILLE, NORTH CAROLINA - URGENT CARE OPPORTUNITIES**
Come to the mountains of scenic Western North Carolina! Sisters of Mercy Services in Asheville, North Carolina seeks Physicians, **Physician Assistants and Nurse Practitioners** for our busy Urgent Care locations in Asheville and immediate surrounding areas (all in Buncombe County).

- Full-time and part-time opportunities, 12 hour shifts, no call, job share available within this Multi-specialty group.
- Must show clinical competency in Minor surgical procedures (i.e. I&D, wound care, foreign body removal), trauma stabilization and transport, non-life threatening medical emergencies, fracture/sprain diagnosis and splinting, laceration repair, urgent care includes obstetric urgent/emergent care. Fast paced environment requires rapid delivery. Must be comfortable with patients of all ages and gender. Team work essential. Preferred Emergency Medicine or Urgent Care experience. Ability to speak a second language helpful!

**Physician requires:** Board-Certified/Board-Eligible (Urgent Care, Family Practice, ER, Internal Med.,Surgery). Requires ACLS/PALS certification, Medical License to practice in North Carolina.

- Physicians hired by contract: $180K-200K Annual DOQ.

**Physician Assistant/Nurse Practitioner requires:** NC Licensed, Certified Physicians Assistant or Family Nurse Practitioner, ACLS/PALS certification.

- Competitive salary and full benefits package including 403b.

Send resume to: Shana Duncan, Executive Director
Sisters of Mercy Urgent Care, Inc.
445 Biltmore Ave., Suite 501, Asheville, NC 28801
E-mail: Shana@urgentcares.org • Phone (828) 281-2598
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**CHAMPAIGN, IL - Christie Clinic**
is a multispecialty group of 90 physicians that is recruiting for a physician with management and work experience in urgent care. Christie Clinic has three urgent care centers and will have two more in a year. The new physician will become the Medical Chief of the urgent care system. Metro population of 150,000. Extremely livable area.

Home of the University of Illinois, with comfortable college town lifestyle and outstanding cultural opportunities. 2.5 hours south of Chicago.

*Send CV to Christopher Kashnig ckashnig@christieclinic.com or call 217-366-5374.*

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COLUMBUS, OHIO – Turnkey Urgent Care facility. 3600–sq.ft. building, parking for 30 cars, extra space; 50,000 traffic count daily. Great location/potential. Buy or lease building. Please contact DeBorah Morrison at (614) 866-9191.

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Please email experience and fees to urgent_care@live.com

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

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

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

In this issue: What trend is emerging in how participating urgent care practices bill for services, according to the first two UCAOA benchmarking surveys?

**BILLING SERVICES**

![Bar chart showing billing services for in-house, contracted outside, and other types of services with data for 2006, 2007, and 2008.](chart)

Source: Benchmarking Your Urgent Care, 2007. Urgent Care Association of America (www.ucaoa.org).

The sample sizes of the first two surveys were relatively small, but provide a glimpse into the different approaches practices take to tasks such as billing, and comparison of one year’s results with another’s can give a hint of developing trends in the industry.

Future issues of JUCM will present new data from the third—and, to date, the most ambitious—UCAOA benchmarking survey.

The full report derived from that survey will be revealed at the 2008 Urgent Care Association of America National Convention (April 29 – May 2 in New Orleans). For more information about the conference, log on to www.ucaoa.org.

Are you aware of new data that highlight how urgent care is helping to fill gaps in patient satisfaction, or healthcare in general? Let us know in an e-mail to editor@jucm.com. We’ll include them in an upcoming issue and on our website.
The UCAOA National Convention: A Growing Trend

2005 attendance: 231
2006 attendance: 376
2007 attendance: 533
2008 attendance: 683*

congratulate UCAOA on its most successful national convention to date!

*projected
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