

JUCM™

THE JOURNAL OF URGENT CARE MEDICINE®

APRIL 2008
VOLUME 2, NUMBER 7

www.jucm.com | The Official Publication of the Urgent Care Association of America

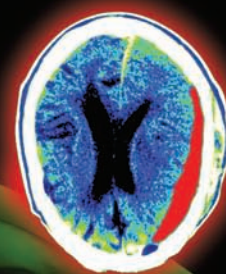
IN THIS ISSUE

FEATURES

- 11** Minor Traumatic Brain Injury: Applying the Evidence to Urgent Care
- 28** Creating a Health Surveillance Product Line
- 32** Playing to Win: Maximizing Profits in Urgent Care

DEPARTMENTS

- 20** Insights in Images: Clinical Challenge
- 23** Abstracts in Urgent Care
- 37** Health Law
- 39** Occupational Medicine
- 41** Coding Q&A
- 48** Developing Data



Minor TBI

*Applying the Evidence
to Urgent Care*

THE SECOND OF A TWO-PART SERIES

It's about time that your patients had immediate access to acute prescription medications at your Urgent Care without burdening your staff with responsibilities!

Only InstyMeds does it all!

Medications Dispensed Direct to Patient

No Special Staffing Requirements

Insurance, Replenishment, 24X7



Safe & Easy!

Just write the prescription using InstyMeds and give the order to your patient. InstyMeds does the rest!

Automatic Billing!

InstyMeds handles all the patient's payments. Insurance, credit card, debit card or cash!

Automatic Reordering!

InstyMeds automatically ships the replenishments to you!

Take Control!

Take control of outcomes by having the medications your patients need right at your Urgent Care!

Patient Satisfaction!

InstyMeds is a great way to increase patient satisfaction while giving yourself a competitive advantage!

Increase Revenues!

Our specialists can help you choose which InstyMeds dispenser would be right for you! Call (866) 467-8963 to learn more!

InstyMeds

We Make Patients Better, Quicker!

WWW.INSTYMEDS.COM (866) 467-8963





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 groundbreaking 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.

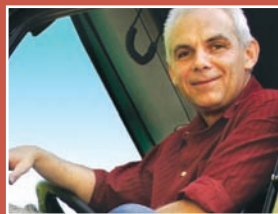
Market demand has created a niche which we, as urgent care professionals, are uniquely qualified to fill. What is most interesting is how the "genetic" make-up of this "urgent care professional" is so similar in every country, despite virtually no collaboration to date.

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



Introducing the **HOSTED SOLUTION** for **STIX**, the only EMR for Urgent Care and Occupational Medicine.



Faster. Easier. Comprehensive.

Integritas now offers a **HOSTED SOLUTION**, for the STIX package. Our server or yours—either option includes all the special functions you and your staff need. Stop trying to fit a round peg in a square hole and get the software built to get your job done.

Using the EMR/Practice management software designed specifically for your type of practice makes all the difference when it comes to peak performance and profitability.

**Call 800-458-2486 or email
stixsales@integritas.com
for your **FREE** product demonstration.**

www.integritas.com



- ☒ Now available as a hosted solution
- ☒ Designed specifically for Urgent Care and Occ Med
- ☒ Faster than a paper template (ask about Merlins!)
- ☒ Interactive forms (e.g. DOT, FAA)
- ☒ Clinic status "white board"
- ☒ Email or fax directly from the system
- ☒ Automated employer billing and Work Comp reporting

April 2008

VOLUME 2, NUMBER 7



CLINICAL

11 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

PRACTICE MANAGEMENT

28 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

32 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.

8

From the UCAOA
Executive Director

DEPARTMENTS

20 Insights in Images:
Clinical Challenge

23 Abstracts in Urgent Care

37 Health Law

39 Occupational Medicine

41 Coding Q&A

48 Developing Data

CLASSIFIEDS

43 Career Opportunities

JUCM EDITOR-IN-CHIEF

Lee A. Resnick, MD
Case Western Reserve University
Department of Family Medicine
University Hospitals Medical Practices

JUCM EDITORIAL BOARD

Jeffrey P. Collins, MD, MA
Harvard Medical School;
Massachusetts General Hospital

Tanise Edwards, MD, FAAEM
Author/editor (*Urgent Care Medicine*)

William Gluckman, DO, MBA, FACEP
St. Joseph's Regional Medical Center
Paterson, NJ
New Jersey Medical School

Nahum Kovalski, BSc, MDCM
Terem Immediate Medical Care

Peter Lamelas, MD, MBA, FAAEP
MD Now Urgent Care Walk-In
Medical Centers

Melvin Lee, MD
Urgent Care of America;
Raleigh Urgent Care Networks

Genevieve M. Messick, MD
Immediate Health Associates

Marc R. Salzberg, MD, FACEP
Stat Health Immediate Medical Care, PC

John Shufeldt, MD, JD, MBA, FACEP
NextCare, Inc.

Mark D. Wright, MD
The University of Arizona

JUCM ADVISORY BOARD

Michelle H. Biros, MD, MS
University of Minnesota;
Editor-in-Chief, *Academic Emergency Medicine*

Kenneth V. Iserson, MD, MBA, FACEP, FAAEM
The University of Arizona

Daniel R. Konow, PA-C, MBA
RediMed

Benson S. Munger, PhD
The University of Arizona

Emory Petrack, MD, FAAP
Petrack Consulting, Inc.;
Fairview Hospital
Cleveland, OH

Peter Rosen, MD
Harvard Medical School

David Rosenberg, MD, MPH
University Hospitals Medical Practices
Case Western Reserve University
School of Medicine

Martin A. Samuels, MD, DSc (hon), FAAN, MACP
Harvard Medical School

Kurt C. Stange, MD, PhD
Case Western Reserve University

Robin M. Weirnick, PhD
Harvard Medical School

UCAOA BOARD OF DIRECTORS



Lee A. Resnick, MD, President
Ken Palestrant, MD, Vice President
Cindi Lang, RN, MS, Secretary
Daniel R. Konow, PA-C, MBA, Treasurer
Jim Gore, MD, Director
John J. Koehler, MD, Director
William E. Meadows III, MD, Director
Kevin J. Ralofsky, MBA, Director
Marc R. Salzberg, MD, FACEP, Director
David Stern, MD, CPC, Director
Amy Tecosky, Director
Lou Ellen Horwitz, MA, Executive Director

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

JUCM

EDITOR-IN-CHIEF

Lee A. Resnick, MD
editor@jucm.com

EDITOR

J. Harris Fleming, Jr.
hffleming@jucm.com

CONTRIBUTING EDITORS

Nahum Kovalski, BSc, MDCM
Frank Leone, MBA, MPH
John Shufeldt, MD, JD, MBA, FACEP
David Stern, MD, CPC

ART DIRECTOR

Tom DePrenda
tdeprenda@jucm.com



2 Split Rock Road, Mahwah NJ 07430

PUBLISHERS

Peter Murphy
pmurphy@braveheart-group.com
(201) 847-1934

Stuart Williams
swilliams@braveheart-group.com
(201) 529-4004

Mission Statement

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

JUCM The Journal of Urgent Care Medicine (**JUCM**) makes every effort to select authors who are knowledgeable in their fields. However, **JUCM** does not warrant the expertise of any author in a particular field, nor is it responsible for any statements by such authors. The opinions expressed in the articles and columns are those of the authors, do not imply endorsement of advertised products, and do not necessarily reflect the opinions or recommendations of Braveheart Publishing or the editors and staff of **JUCM**. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested by authors should not be used by clinicians without evaluation of their patients' conditions and possible contraindications or dangers in use, review of any applicable manufacturer's product information, and comparison with the recommendations of other authorities.

Vaccines.
Injectables.
Medical
& Surgical
Supplies

What's the most
accurate in-office
strep test

What's new in
sterilization
products

What are the best
strategies to
prevent pertussis

Do you have college
meningitis
recommendations

When should we
immunize patients
going abroad



Go ahead, ask.

POWER TO YOUR PRACTICE.

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.



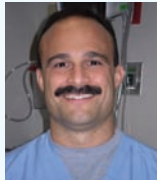
VAXSERVE®
A sanofi pasteur company

800.752.9338 | VAXSERVE.COM



JUCM CONTRIBUTORS

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

JUCM is distributed on a complimentary basis to medical practitioners—physicians, physician assistants, and nurse practitioners—working in urgent care practice settings in the United States. If you would like to subscribe, please log on to www.jucm.com and click on "Free Subscription."

To Find Urgent Care Job Listings

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."

Urgent Care Centers:

HAVE YOUR CAKE AND EAT IT, TOO

Increase income and improve patient satisfaction with the DRx medication dispensing program. Join today's most progressive urgent care centers and dispense medications at the point of care. Everyone wins.

- ✓ **INCREASED INCOME**
Earn \$5 to \$15 per prescription
- ✓ **INCREASED SATISFACTION**
Patients appreciate the convenience
- ✓ **"CASH AND CARRY" MODEL**
No insurance claims, no hassles



TAKE THE NEXT STEP.

Call 866.935.8069 or visit us online
for a free informational package.

 **DRx**
MEDICATION DISPENSING
www.drxdispensing.com
866.935.8069

Come see us at booth 416 at the UCAOA convention in New Orleans



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.



FROM THE EXECUTIVE DIRECTOR

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"



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

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. ■

What are your **URGENT** care needs?

Are you thinking of opening a new urgent care center? Maybe you're ready to expand services or add a new facility?

As the demand for new urgent care centers increases, the need for information, guidance and expertise in the urgent care marketplace increases as well. With over twenty years of experience in the urgent care industry, our team is uniquely positioned to offer the very best turn-key solutions to those interested in starting an urgent care facility in their area.

Why waste precious time and resources struggling to find solutions when we have the knowledge and network of vendors to help you with everything from start-up to daily operations.

Call today to see how National Med Network can assist you with your new start up or existing Urgent Care facility.



NATIONAL
Med Network
CONSULTANTS IN URGENT CARE

General Offices

National Med Network

10100 Forest Hills Road
Machesney Park, IL 61115
(877) 875-4200

Patrice Pash, RN BSN COHC
Senior Consultant

www.nationalmednetwork.com



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.

JUCM
THE JOURNAL OF URGENT CARE MEDICINE



Comprehensive results without restrictions



**The wait is over! Now you can run
CLIA waived CMPs on the Piccolo xpress™**

*On-the-spot lab results without the lab
Reference grade chemistry analysis in minutes
3 easy steps, no special skills required
Improve patient care and increase productivity
Diagnose with confidence*

Piccolo xpress CLIA waived chemistry menu:

Comprehensive Metabolic Panel	Lipid Panel
Basic Metabolic Panel	Lipid Panel Plus
General Chemistry 13	Liver Panel Plus
General Chemistry 6	Kidney Check
Electrolyte Panel	

For more information call **1.800.822.2947**
or log on to: **www.abaxis.com/piccolouc**

© 2007 Abaxis, Inc. 3240 Whipple Road, Union City, CA 94587 / Piccolo Xpress is a trademark of Abaxis, Inc. 888-3021 Rev.A

piccolo *xpress*™
chemistry analyzer

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.

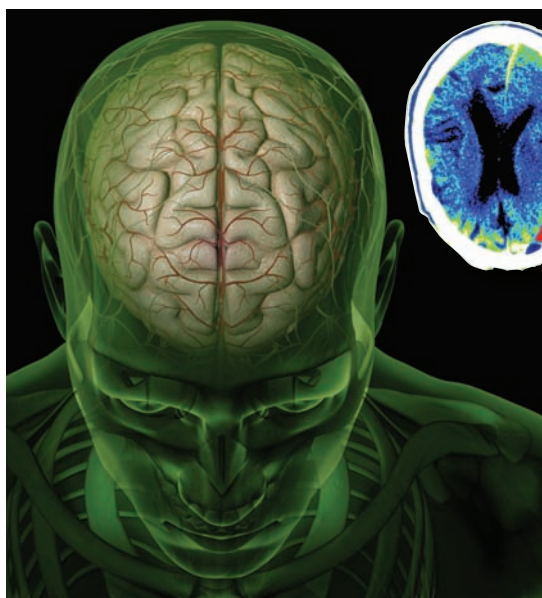
Joseph Toscano, MD

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



© Illustration: Getty.com/MedicalRF.com; MRI of Brain: PhotoResearchers, Inc.

After rapidly recognizing and stabilizing any potentially life- or limb-threatening injuries, the chief diagnostic decision when evaluating these patients in the acute care setting 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

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.

Patients without such high risk features can be triaged and evaluated in the same manner as any other stable patient. Once the patient is in the treatment area, a more in-depth history should be obtained; traditionally, this includes establishing whether there was any duration of loss of consciousness, amnesia, post-traumatic seizure, headache, nau-

"Some patients can be combative or uncooperative. 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 rules³⁻⁵ do exist to support decisions regarding the need for cervical spine radiographs. The thoracic and lumbar spines, extremities, and torso can be exam-



OSSUR IS URGENT CARE SOLUTIONS

When you work in an environment that's so unpredictable, it's reassuring to know that you can rely on Ossur's variety of urgent care products to help deliver successful outcomes for a range of patient needs. Whether it's casting tape, splints, soft supports, slings, collars, or a host of other urgent care solutions, Ossur's products are a perfect blend of economy, comfort and design.

That's why, out of more than 100 different walker designs on the market today, our Equalizer® walker boots remain the industry standard. And with 3 models to choose from — Standard, Air, and Pre-inflated Air — plus low top and standard height versions of each, you can be confident that there is an Equalizer solution for every unique patient.

Contact Ossur Customer Service at (800) 521-0601 today to learn more about our urgent care product line.

WWW.OSSUR.COM



Life Without Limitations

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.

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.

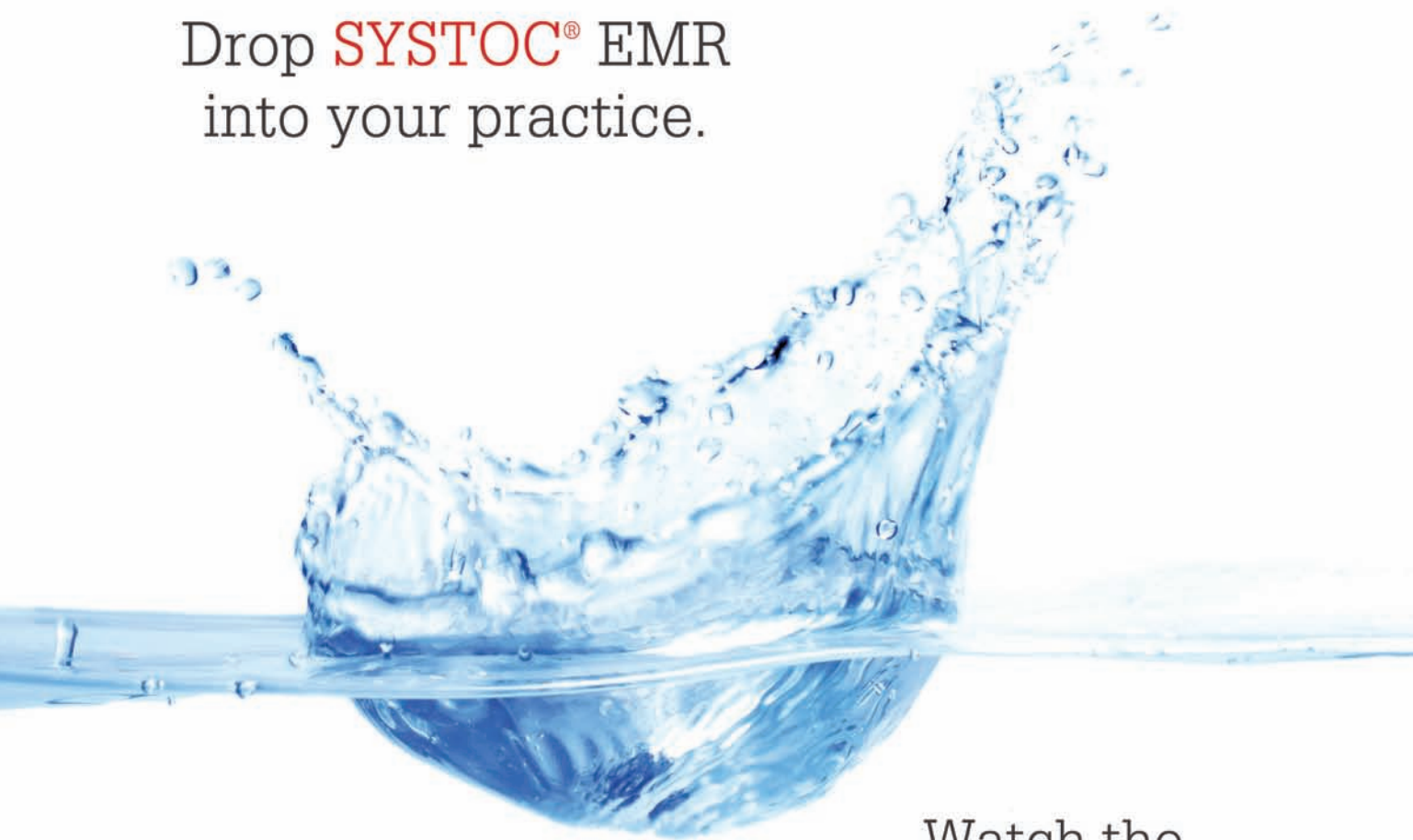
Because of the small risk of delayed intracranial bleeding, there may be at least a theoretical advantage of acetaminophen over non-steroidal anti-inflammatory drugs to treat pain. Clinical judgment should prevail, and as always, basing treatment decisions on a mutual understanding of the individual 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 the 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-

“Patients may not seek care immediately after the injury, but present for their initial evaluation on a delayed basis.”

Drop **SYSTOC**® EMR
into your practice.



Watch the
benefits ripple.

- equally effective in
 - occupational health
 - urgent care
 - rehab services
 - wellness programs
- bill the employer, insurer, or patient
- tap2chart technology eliminates the entire dictation cycle
- superb support from our team of experts



BOOTH #209

Don't miss us at UCAOA in
New Orleans, April 29 – May 2



Sample Urgent Care Head Injury Discharge Instructions

Most concussion symptoms resolve over one to three days. **If any of these symptoms get worse, however, seek medical care promptly.**

When to Seek Immediate Care

Seek immediate care if you (or those caring for you) notice any of the following:

- worsening headache
- difficulty walking, speaking, or with coordination
- weakness, numbness, or tingling of the face, body, arms, legs, hands, feet, fingers, or toes
- vomiting beyond what has already occurred
- drainage of clear fluid from the nose or ears
- double vision, blurry vision, or other difficulty seeing
- a seizure or convulsion
- confusion or increasing memory difficulty
- behavior change, excessive irritability or sleepiness
- significant side effects from medications (such as rash, lightheadedness, trouble breathing)

Because the injured person might not always be the best judge of whether certain symptoms are getting worse, it is important that patients with concussion have someone available to observe them frequently over the next 24-48 hours.

This is especially important when a child has a concussion. Unless advised otherwise, it is not necessary to be awakened every two hours to be checked, though this may be recommended if the head injury occurred within two to three hours of bedtime.

ment of focal findings should be evaluated promptly, preferably in the emergency department, in conjunction with CT scanning of the head. An isolated but worsening headache after head trauma, though non-specific, would also prompt imaging in most instances.

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

stryker®

Imaging

If you can afford this—

Processor, Chemicals and Film

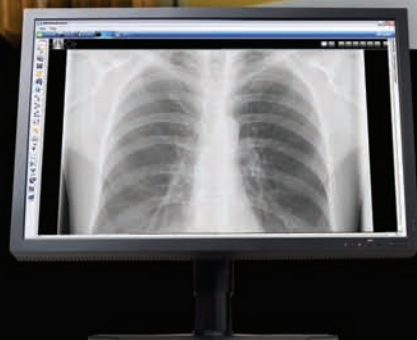
Film Development Time

Envelopes and Labels

Filing and Retrieval Time

Lost Films and Retakes

Courier Fees and Storage Space



—you can afford to go digital.

Go digital for what you currently spend on conventional x-ray.
Let us show you how.

OfficePACS® **Power**
Digital Imaging

Stryker Imaging
www.stryker.com/newsletter
800 870 6051

TABLE 2.

Recommended Waiting Periods Before Returning to Sports Activities

Concussion severity	Waiting Period	
	First concussion	Second concussion
No LOC, symptoms last <15 minutes	No waiting period	1 week
No LOC, symptoms last ≥15 minutes	1 week	2 weeks
LOC="a few seconds"	1 week	1 month or more
LOC >1 minute	2 weeks	1 month or more
CT/MRI abnormality	Full season or permanent	Full season or permanent
LOC, loss of consciousness		

Adapted from the American Academy of Neurology's Practice Parameter: The Management of Concussion in Sports.⁷ Recommended waiting periods assume a normal neurological exam and comprise an interval with no symptoms at rest or with exertion (progressive conditioning and non-contact practice activities).

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 re-assessment 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

1. National Center for Injury Prevention and Control TBI homepage. Centers for Disease Control and Prevention website. Available at: www.cdc.gov/ncipc/tbi/TBI.htm. Accessed 11/15/07.
2. Dachs RJ, Back E, Glick B. Emergencies in the office: Why are 911 calls placed from family medicine and urgent care offices? *J Urgent Care Med.* 2007;1(3):19-25. Personal communication with Dr. Dachs, 12/2/07.
3. Hoffman JR, Mower WR, Wolfson AG, et al. Validity of a set of clinical criteria to rule out injury to the cervical spine in patients with blunt trauma. *N Engl J Med.* 2001;343:94-99.
4. Stiell IG, Wells GA, McKnight RD, et al. Canadian C-spine rule study for alert and stable trauma patients. I. Background and Rationale. *Can J Emerg Med.* 2002;4:84-90.
5. Stiell IG, Wells GA, McKnight RD, et al. Canadian C-spine rule study for alert and stable trauma patients. II. Study Objectives and Methodology. *Can J Emerg Med.* 2002;4:185-193.
6. American Academy of Neurology. Practice Parameter: The management of concussion in sports. Available at: www.aan.com/professionals/practice/pdfs/pdf_1995_thru_1998/1997.48.581.pdf. Accessed 1/23/08.
7. American College of Sports Medicine, American Academy of Family Practice, American Academy of Orthopedic Surgeons, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine. Concussion (mild traumatic brain injury) and the team physician: A consensus statement. Available at: www.acsm.org/AM/Template.cfm?Section=Search§ion=Team_Physician_Consensus_Statements&template=/CM/ContentDisplay.cfm&ContentFileID=723. Accessed 1/23/08.
8. Macpherson A, Spinks A. Bicycle helmet legislation for the uptake of helmet use and prevention of head injuries. Cochrane Database of Systematic Reviews 2007; Issue 2. Art no.: CD005401.
9. Liu BC, Ivers R, Norton R, et al. Helmets for preventing injury in motorcycle riders. Cochrane Database of Systematic Reviews 2004; Issue 2. Art no.: CD004333.

Suggested Reading

1. Anderson TA, Heitger M, Macleod AD. Concussion and mild head injury. *Practical Neurol.* 2006;6:342-357.
2. Ropper AH, Gorson KC. Concussion. *New Engl J Med.* 2007;356(2):166-172.

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.

Urgent Care Medicine Medical Professional Liability Insurance

The Wood Insurance Group, a leading national insurance underwriter, offers significantly discounted, competitively priced Medical Professional Liability Insurance for Urgent Care Medicine. We have been serving the Urgent Care community for over 20 years, and our UCM products were designed specifically for Urgent Care Clinics.

Our Total Quality Approach includes:

- Preferred Coverage Features
 - Per visit rating (type & number)
 - Prior Acts Coverage
 - Defense outside the limit
 - Unlimited Tail available
 - Exclusive “Best Practice” Discounts
- Exceptional Service Standards
 - Knowledgeable, friendly staff
 - Easy application process
 - Risk Mgmt/Educational support
 - Fast turnaround on policy changes
 - Rapid response claim service



THE WOOD
INSURANCE
GROUP

4835 East Cactus Road, Suite 440
Scottsdale, Arizona 85254
(800) 695-0219 • (602) 230-8200
Fax (602) 230-8207

E-mail: davidw@woodinsurancegroup.com
Contact: David Wood Ext 270



INSIGHTS IN IMAGES

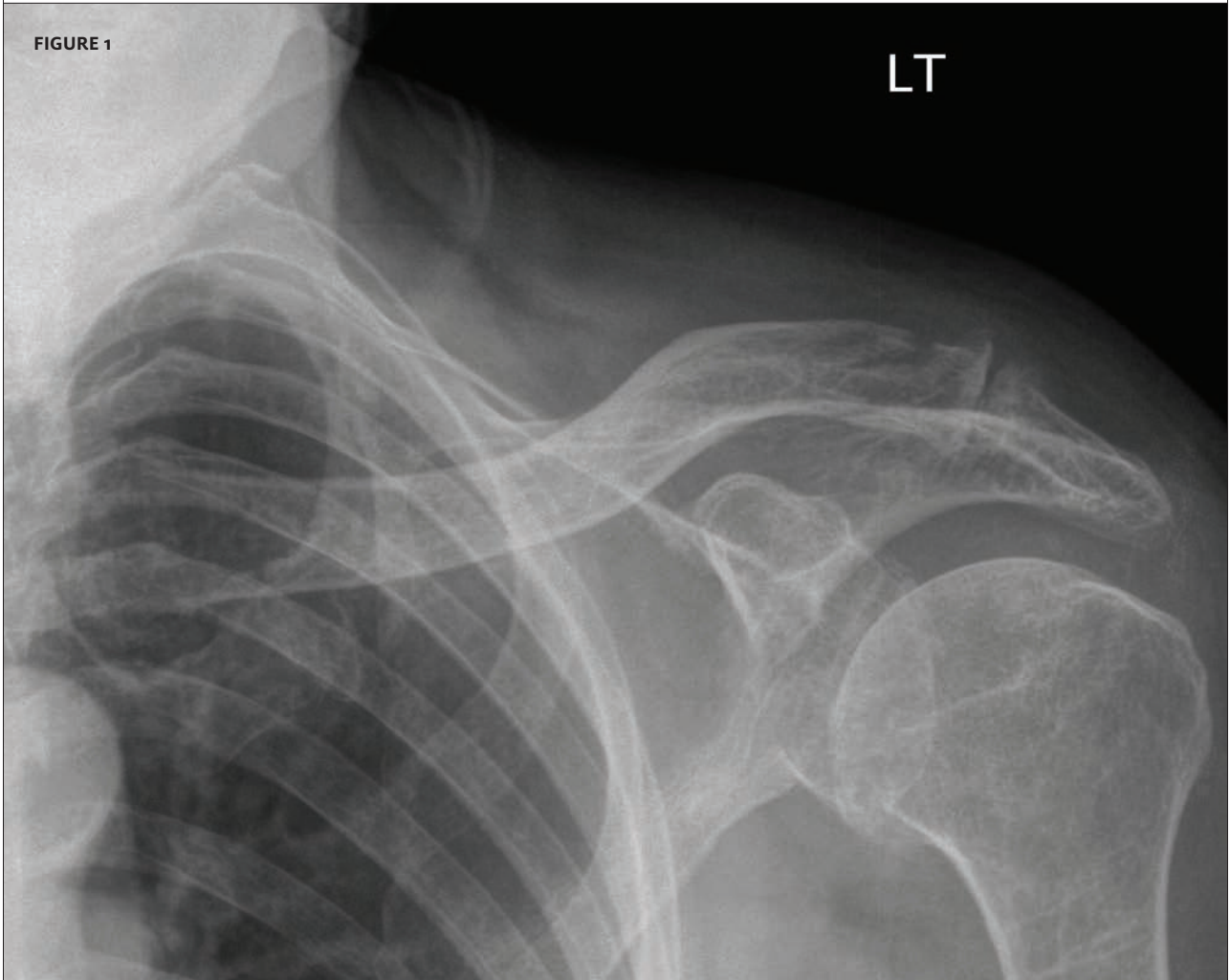
CLINICAL CHALLENGE

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

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

FIGURE 1

LT



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.

Xpress holds the pieces to your Urgent Care puzzle

Free
60 day trial

Test it free and see
higher reimbursements.

Ask for details.

Maximize reimbursement

Proven to minimize risk

Deliver better ROI

xpressCare™

Chief Complaint Physician Charting

Prescription Writing

Multiple Discharge Instructions

Administrative Reporting

Come see us at UCAOA in New Orleans, April 29th 2008

For more information call 877-291-5024 | www.xpresstechnologies.com



Afraid you missed something?



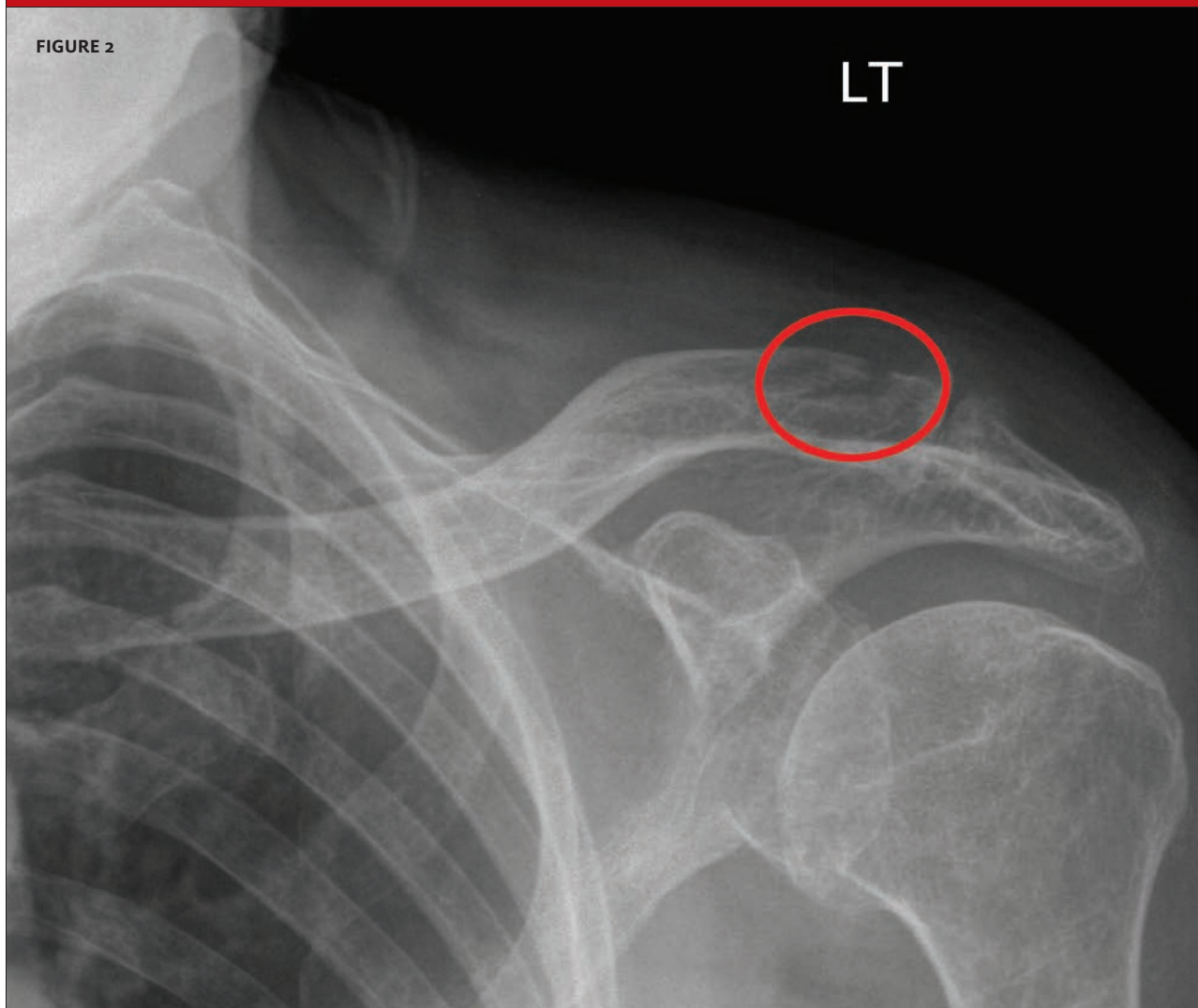
Every article that has appeared
in *JUCM, The Journal of Urgent
Care Medicine* is available on our
website. Simply log on to
www.jucm.com and click on the
Past Issue Archive button to see
every issue we've published.

JUCM
THE JOURNAL OF URGENT CARE MEDICINE

THE RESOLUTION

FIGURE 2

LT



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

1. *Wheeless' Textbook of Orthopaedics*. Clavicle Fractures. Available at www.wheelessonline.com/ortho/clavicle_fractures. Accessed March 14, 2008.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM.



ABSTRACTS IN URGENT CARE

On NSAIDs for Back Pain, Post-Injury Venous Thrombosis, NT-proBNP Testing, Headache Following Mild TBI, ED Crowding and Pain Management, and Imaging After Neck Trauma

■ NAHUM KOVALSKI, BSc, MDCM

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

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.

Citation: Roelofs PDDM, Deyo RA, Koes BW, et al. Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD000396. DOI: 10.1002/14651858.CD000396.pub3.

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.



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

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 Stralen KJ, Fosendaal FR, Doggen CJM. Minor In-

We still make **house calls.**



Rely on DocuTAP for real, live EMR and Practice Management support. At implementation, we work side-by-side with you and provide personalized, onsite training for your entire staff. And when your solution is up and running, our dedicated, highly qualified account manager becomes your partner for ongoing success.

At DocuTAP, we're here for the life of your EMR and Practice Management solution. It's continuity of care – with house calls included.

Establishing Meaningful Relationships™

Visit with us April 30-May 2, 2008 during the UCAOA Annual Urgent Care Convention, New Orleans, LA, at the New Orleans Marriott.

1.877.697.4696 • www.docutap.com/JUCM • sales@docutap.com



**See our Powerfully Simple solution
at the UCAOA Annual Convention.**

- DocuTAP is proud to be a Silver Sponsor of the UCAOA.
- Stop by our booth (#316) for demonstrations, one-on-one consultations and exciting product announcements.
- Register to win a pair of Bose® Quiet Comfort® 3 Headphones!
- Relax and stay connected at the conference Internet Café, courtesy of DocuTAP.
- Please join us at the DocuTAP sponsored welcome reception from 6-7 p.m. on April 30.

“Their exceptional software aside, DocuTAP offers what a lot of the large EMR companies do not: one-on-one support and careful attention to the client relationship. With DocuTAP, the implementation process was completed quickly with personalized support throughout.”

– Steve Rebnord, Clinic Manager

DocuTAP

juries as a Risk Factor for Venous Thrombosis. *Arch Intern Med.* 2008;168:21-26.

Major injuries are a well-recognized risk factor for venous thrombosis; however, risk posed by *minor* injuries has not been fully studied.

In a case-control study, researchers in the Netherlands enrolled more than 2,400 consecutive patients with first venous thromboses and 3,500 controls to assess risk for developing venous thrombosis after minor injury. Patients who were undergoing surgery and those with malignancy, casts, or prolonged bed rest were excluded.

Nearly 290 adults with venous thromboses (11.7% of cases) and 4.4% of control subjects had experienced minor injuries (e.g., ankle sprain, knee sprain, "sural muscle rupture") during the preceding three months; the odds ratio for developing venous thrombosis was 3.1 with a minor injury, and this risk was greatest during the four weeks following an injury.

Individuals with minor injuries and positive family histories (first-degree relatives) for venous thrombosis had a 12-fold higher risk, compared with those without injuries or family histories. In addition, carriers of factor V Leiden who experienced minor injuries were 30 times more likely to develop venous thrombosis than were noncarriers without injuries.

Dr. Moloo noted that this case-control study highlights the need to remain vigilant of risk for venous thrombosis, even among individuals who suffer only minor injuries. Risk appears to be particularly high among individuals with family histories of venous thrombosis and among carriers of factor V Leiden. [Published in *J Watch Gen Med*, January 31, 2008—Jamaluddin Moloo, MD, MPH.] ■

Amino-Terminal Pro-B-Type Natriuretic Peptide Testing for the Diagnosis or Exclusion of Heart Failure in Patients with Acute Symptoms

Key point: NT-proBNP for the evaluation of the patient with suspected acute HF is useful, cost-effective, and may reduce adverse outcomes compared with standard clinical evaluation without natriuretic peptide testing

Citation: Januzzi JL Jr., Chen-Tournoux AA, Moe G. *Am J Cardiol.* 2008;101(3):S29-S38.

When used for the evaluation of patients with acute symptoms in the emergency department setting, amino-terminal pro-B-type natriuretic peptide (NT-proBNP) testing is highly sensitive and specific for the diagnosis or exclusion of acute destabilized heart failure (HF), with results comparable to those reported for B-type natriuretic peptide (BNP) testing.

However, the optimal application of NT-proBNP is in concert with history and physical examination, adjunctive testing, and

with the knowledge of the differential diagnosis of an elevated NT-proBNP level. Studies indicate a dual use for NT-proBNP, both to exclude acute HF (where NT-proBNP concentrations <300 ng/L have a 98% negative predictive value), as well as to identify the diagnosis.

To identify acute HF in patients with dyspnea, an age-independent NT-proBNP cut point of 900 ng/L has a similar value as that reported for a BNP value of 100 ng/L. However, age stratification of NT-proBNP using cut points of 450 ng/L, 900 ng/L, and 1,800 ng/L (for age groups of <50, 50–75, and >75 years) reduces false-negative findings in younger patients and false-positive findings in older patients, and improves the overall positive predictive value of the marker without a change in overall sensitivity or specificity.

Clinically validated, cost-effective algorithms for the use of NT-proBNP testing exist. Therefore, the logical use of NT-proBNP for the evaluation of the patient with suspected acute HF is useful, cost-effective, and may reduce adverse outcomes compared with standard clinical evaluation without natriuretic peptide testing. ■

A Prospective Controlled Study in the Prevalence of Post-traumatic Headache Following Mild Traumatic Brain Injury

Key point: Over 15% of patients with minor head injuries had persistent headaches at three months compared with 2.2% of the control group.

Citation: Faux S, Sheedy J. *Pain Med.* 2008 Feb. 5: 18266807 (Online Early Articles).

This was a prospective controlled study of patients admitted with a diagnosis of mild traumatic brain injury and matched orthopedic controls over 12 months during 2004, in a level-two inner-city emergency department in Sydney, Australia. One hundred eligible sequential admissions with mild traumatic brain injury, as defined by American Congress of Rehabilitation Medicine, 1993, and 100 matched minor injury controls with non-deceleration injuries were included.

Main measures were the reporting of headache "worse than prior to the injury" and concordant with the definition of post-traumatic headache according to International Headache Society Classification of Headache Disorders, 2003.

Of those with minor head injury, 15.34% continued to complain of persistent post-traumatic headache at three months compared with 2.2% of the minor injury controls.

To the authors' knowledge, this is the first controlled prospective study in the prevalence of post-traumatic headache following mild traumatic brain injury. ■

ED Crowding and Pain Management

Key point: Crowding is associated with nontreatment and

delayed treatment of severe pain.

Emergency Department Crowding is Associated with Poor Care for Patients with Severe Pain. Pines JM, Hollander JE. *Ann Emerg Med.* 2008;51(1): 1-5; discussion 6-7.

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, Bleetman 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.

Citation: Willis AP, Latif SA, Chandratre S, et al. *Clin Radiol.* 2008;63(2):165-169.

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. ■

Practice Management

Creating a Health Surveillance Product Line

Urgent message: Keeping patients able to perform their jobs is critical to the success of an urgent care occupational medicine program.

Donna Lee Gardner, RN, MS, MBA

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 in-



cludes 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-



**It's Sunday evening, and her cough
requires an urgent care visit...**

Tussionex®: **The only FDA-approved** **12-hour Rx syrup** **antitussive**

- Extended action helps patients to have restful nights and productive days



IMPORTANT SAFETY INFORMATION

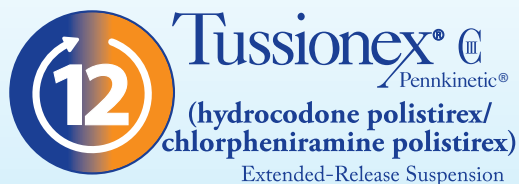
TUSSIONEX® is indicated for the relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older. Each teaspoonful (5 mL) of TUSSIONEX® contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate. TUSSIONEX® is contraindicated in the presence of known allergy or sensitivity to hydrocodone or chlorpheniramine and in children less than 6 years of age. The most common adverse reactions associated with TUSSIONEX® are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks. As with any other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.

Please see full Prescribing Information on reverse.

UCB Medical Affairs Department: 1-800-477-7877

TUSSIONEX®, PENNKINETIC®, and COUGH RELIEVED. REST ASSURED.™ are trademarks of the UCB Group of companies.

UCB Marketed by UCB, Inc.
Manufactured by UCB Manufacturing, Inc. ©2008 UCB, Inc. All rights reserved. TU1149-0108 Printed in U.S.A.



Cough relieved. Rest assured.™

Tussionex[®] Pennkinetic[®]

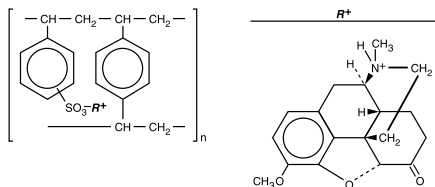
(hydrocodone polistirex and chlorpheniramine polistirex)
Extended-Release Suspension

R_x Only

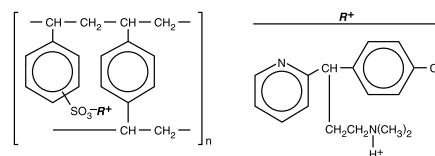
TU1186-0807
4000622

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 only.

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



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



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

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

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

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

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

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

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

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

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

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

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

Pediatric Use: 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 embarrassment (e.g., croup) (see PRECAUTIONS).

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

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

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

Keep out of the reach of children.

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

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

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

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

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

Pregnancy: Teratogenic Effects – Pregnancy Category C

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

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

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

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

Pediatric Use: Safety and effectiveness of TUSSIONEX Pennkinetic Extended-Release Suspension in pediatric patients under six have not been established (see WARNINGS).

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

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

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

Dermatologic System: Rash, pruritus.

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

Genitourinary System: Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

Respiratory Depression: TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE).

Respiratory System: Dryness of the pharynx, occasional tightness of the chest.

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

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

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

DOSAGE AND ADMINISTRATION

Shake well before using.

Adults and Adolescents ≥ 13 Years of Age

5 mL (1 teaspoonful) every 12 hours; do not exceed 10 mL (2 teaspoonfuls) in 24 hours.

Children 6-12 Years of Age

2.5 mL (1/2 teaspoonful) every 12 hours; do not exceed 5 mL (1 teaspoonful) in 24 hours.

It is important that TUSSIONEX be measured accurately. A household teaspoonful is not an accurate measuring device and could lead to overdose, especially when half a teaspoon is to be measured. It is strongly recommended that an accurate measuring device be used. A pharmacist can provide an appropriate measuring device and can provide instructions for measuring the correct dose. Please ask a pharmacist for advice.

This medicine is not intended for children under 6 years of age (see CONTRAINDICATIONS).

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

NDC 53014-548-67 473 mL bottle

For Medical Information

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

Storage:

Shake well. Dispense in a well-closed container.

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

TUSSIONEX Pennkinetic Extended-Release Suspension

Manufactured for:
UCB, Inc.
Smyrna, GA 30080



TUSSIONEX and PENNKINETIC are trademarks of UCB, Inc., or its affiliates.
© 2007, UCB, Inc., Smyrna, GA 30080.

All rights reserved. Printed in the U.S.A.

TU1186-0807

tests 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).

The DOT's Office of Drug & Alcohol Policy & Compliance provides authoritative interpretations of drug and alcohol-screening rules, which are contained in 49 Code of Federal Regulations, Part 40 (refer to www.dot.gov/ost/dapc).

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-

Continued on page 36.

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

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

- UNPARALLELED CUSTOMER SERVICE
- FULL LINE OF PREPACKAGED PHARMACEUTICALS
- NO FEE, WEB BASED DISPENSING SYSTEM
- EXPERT EMR INTEGRATORS
- GUARANTEED WORK COMP AND OCCUPATIONAL HEALTH BILLING SERVICES



**GOLD
SPONSOR**

Proud Gold Sponsor of UCAOA

COME SEE US AT THE
UCAOA CONFERENCE
IN NEW ORLEANS
BOOTH #223



CONTACT US AT:

800.333.9800

UC@PHYSICIANPARTNER.COM

WWW.PHYSICIANPARTNER.COM

OUR COMMITMENT IS YOUR SUCCESS

Figure 1. Common drivers of excessive urgent care accounts receivable balances.

- Misuse or no use of modifiers—part of charge entry.
- Not verifying insurance eligibility—no coverage at time of service.
- Not entering correct demographic information—insurance cannot identify the patient.
- Not verifying deductible—patient is responsible for the visit.
- Not verifying primary insurance for coordination of benefits.
- Incorrect or missing guarantor/insured information for minors and dependents.
- Collecting incorrect copay amounts.
- Patient statements that are confusing or lacking description—patients do not understand why they owe a balance. Examples:
 - Claim applied to patient deductible.
 - Claim denied due to need for additional patient information.
 - Insurance paid—balance due is coinsurance.

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. ■

Continued from page 31.

ply that NIOSH has certified that student as a pulmonary function technician. (For resources, visit www.cdc.gov/niosh.)

The hearing conservation program includes certified audiology screening, annual monitoring, employee education, and policies and procedures for hearing-protection devices and documentation. This service also requires specialized training; certification is typically obtained through the Council for Accreditation in Occupational Hearing Conservation (www.caohc.org).

Hearing testing and conservation services may be provided by internal staff or certified vendors.

Steps to Success

When establishing a health surveillance product line, taking the following steps will get your practice off to a good start:

1. Identify companies that are likely to produce high volumes and schedule at least one company visit per week in which the UCOM medical director can participate. The objective is to identify applicable workplace regulations and mandatory and optional health surveillance service needs.
2. Establish policies, procedures, and processes for delivering each product line component.
3. Develop written forms for each exam.
4. Define clinical roles for staff; designate functions that require special training, and establish a process to maintain clinical competency.
5. Coordinate entry of client information into the UCOM clinic database to ensure compliance with company protocols and accuracy in billing.
6. Establish processes for client feedback.
7. Review costs-per-procedure and seek out quality vendors for services such as radiology, lab, MRO, hearing conservation, and occupational rehabilitation, as necessary. ■



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.



John Shufeldt is the founder of the Shufeldt Law Firm, as well as the chief executive officer of NextCare, Inc., and sits on the Editorial Board of JUCM. He may be contacted at JJS@shufeldtlaw.com.



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

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 ba-

sis, 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

Continued on page 40



Hiring the Best Occupational Health Sales Professionals

■ FRANK H. LEONE, MBA, MPH

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?" ■

"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."¹

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

1. Marcia Bacon. *The Moral Status of Loyalty*. Dubuque: Kendall/Hunt Publishing, 1984.



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-



David Stern is a partner in Physicians Immediate Care, with nine urgent care centers in Illinois and Oklahoma, and chief executive officer of Practice Velocity (www.practicevelocity.com), a provider of charting, coding and billing software for urgent care. He may be contacted at dstern@practicevelocity.com.

gent 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 group practice, and the same physicians may see patients in either the group practice or the urgent care, then patient visits may be coded as established if the patient has received professional services from any physician

in either practice.

- 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.

Note: CPT codes, descriptions, and other data only are copyright 2007 American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

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

Do you have a coding question? Send it to us at editor@jucm.com or to Dr. Stern directly at dstern@practicevelocity.com. We'll share it with other readers in an upcoming issue of JUCM.

Career Opportunities

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

COLORADO – URGENT CARE. NO NIGHTS. Outstanding opportunity in a growing practice with five locations. Residency trained and board certified emergency/occupational/family or surgery. Locum Tenens and full-time. Excellent salary and benefits package; \$175,000 - \$220,000 plus. Email: rshamilton2@earthlink.net or fax (719) 577-4088.

URGENT CARE – FAMILY MEDICINE – STUART, southeast Florida. BC/BE family medicine physician, competitive salary with productivity bonus, malpractice insurance fully covered with great benefits, 401(k) and flexible work schedule. Martin Memorial Health Systems is a not-for-profit, community based healthcare organization comprised of two hospitals, numerous physician practices and ambulatory care clinics throughout Martin and St. Lucie Counties on Florida's Treasure Coast. Martin County offers a great quality-of-life with excellent schools. Not J-1 or H1B eligible. Visit our website: www.mmhs.com; and email your CV to: jkoerselman@mmhs-fla.org.

BAKERSFIELD, CALIFORNIA – EXCEPTIONAL opportunity for qualified family medicine physician for ED services. Stable group with excellent reputation seeks B/C or B/E provider full-time. Excellent compensation, facility and colleagues. Please contact Terry Hilliard at (661) 323-5918; or fax CV to Emergency Medical Services Group, (661) 323-4703. Email: HLTGUY@aol.com.

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

FRESNO, CALIFORNIA – CONCENTRA, A leading provider of healthcare, seeks an experienced Urgent Care physician for a full-time position in Fresno, California. Excellent salary plus benefits including Medical Liability Insurance and generous paid time off, CME Allowance; License fee and 401(k). Board-certified or Board-eligible preferred. Current state license, ACLS and PALS certification required. Apply online at www.concentra.com. For more information, please contact Carole Fleming at (800) 232-3550 ext 6468, fax your CV to (866) 354-1104; or by email to carole_fleming@concentra.com. EOE.

AUSTIN, TEXAS – CONCENTRA, A LEADING provider of healthcare, seeks an experienced urgent care physician for a full-time position in Austin, Texas. Excellent salary plus benefits, including medical liability insurance and generous paid-time off, CME allowance; license fee and 401(k). Board certified or board eligible preferred. Current state license, ACLS and PALS certification required. Apply online at www.concentra.com. For more information, please contact Lasca Pierson at (800) 232-3550 ext 8168; fax your CV to (877) 744-9074; or by email to recruiting6@concentra.com. EOE.

WELLSTAR

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

SHARP REES - STEALY MEDICAL GROUP

a 375 plus physician multispecialty group in San Diego, is seeking full-time BC/BE family medicine or emergency medicine physicians to join our urgent care staff. We offer a competitive compensation package, excellent benefits, and shareholder opportunity after two years.

Please send CV to SRSMG, Physician Services
2001 Fourth Ave., San Diego, CA 92101
Fax: 619-233-4730

Email: Lori.Miller@sharp.com

Primary Care

Loyola University Health System



LOYOLA
MEDICINE

*We also treat the human spirit.**

Loyola University Health System, in suburban Chicago, seeks full-time and part-time physicians for our immediate care facility in Homer Glen. Evening and weekend shifts only. Loyola University Health System is a quaternary care health-care system.

BC/BE candidates licensed to see children and adults who are dynamic individuals with excellent clinical backgrounds should send

their CV and cover letter to:

Holly Nandan
Director of Physician Recruitment
Loyola University Physician Foundation
2 Westbrook Corporate Center
#600, Westchester, IL 60154

E-mail: hnandan@lumc.edu
Fax: (708) 216-4878

www.LoyolaMedicine.org

Loyola University Health System is an equal opportunity and affirmative action employer/educator and is committed to a drug-free and smoke-free workplace.



JUCM
THE JOURNAL OF URGENT CARE MEDICINE

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

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.

Physician Recruitment
800-650-0625
916-643-6677 fax
develops@sutterhealth.org
www.sutterhealth.org



United Health Services

United Medical Associates

URGENT CARE

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.



**ASPIRUS
CLINICS**

Passion for excellence. Compassion for people.

Urgent Care Physician Needed in North Central Wisconsin

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

With...

- Exceptional CME Allowance
- Generous Retirement Plan
- Flexible Scheduling
- No Call
- No Pager
- 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.

Not a Visa Opportunity

Contact **Karen Lindstrum**, Physician Recruiter,
today about this outstanding opportunity.
Phone: 800-792-8728 • Fax: 715-847-2742

Email: karenl@aspirus.org
www.aspirus.org

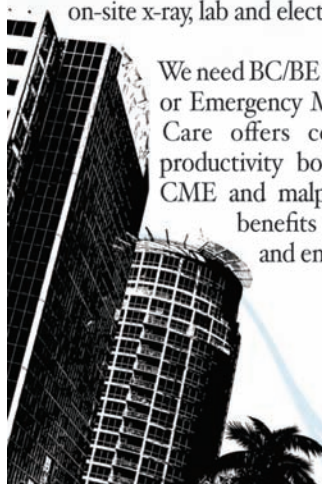


Immediate Orlando Urgent Care Opportunity

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 two 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 403B.

www.centracare.org
407.200.2833



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

**Openings 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-specialty 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: hteitelbaum@crystalrunhealthcare.com



CRYSTALRUNHEALTHCARE.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/Emergency Medicine

We are seeking **BC/BP Family Medicine, EM or GIM Physicians** for:

ER/UC openings at our Centers in:

- Park Falls
- Rice Lake
- Ladysmith

Guaranteed starting salaries as high as \$204,800.

Urgent Care openings at our Centers in:

- Marshfield
- Minocqua
- Wausau
- Eau Claire

Guaranteed starting salaries as high as \$192,300.

In addition, we offer a comprehensive benefit package including: malpractice, health, life, disability, and dental insurance; generous employer contributed retirement and 401K plans; \$5,800 education allowance with 10 days of CME; four weeks vacation 1st year; up to \$10,000 relocation allowance; and much more.

Please contact: **Sandy Heeg, Physician Recruitment**, Marshfield Clinic, 1000 N. Oak Avenue, Marshfield, Wisconsin 54449. Phone: 800-782-8581, extension 19781; Fax #: 715-221-9779. **E-mail:**

heeg.sandra@marshfieldclinic.org
Website: www.marshfieldclinic.org/recruit



MARSHFIELD CLINIC

Where the future of medicine lives

Marshfield Clinic is an Affirmative Action/Equal Opportunity employer that values diversity. Minorities, females, individuals with disabilities and veterans are encouraged to apply. Sorry, not a health professional shortage area.

Career Opportunities

Occupational Medicine – Urgent Care Los Angeles, California

Exciting opportunity for an experienced, outgoing, and motivated Urgent Care/Occupational physician to join our rapidly growing practice. Located near Los Angeles International Airport, you will see patients from around the world. A truly unique opportunity.

For more information, contact:
mlebow@laxclinic.net • Fax: (310) 546-1641

URGENT CARE OPPORTUNITY available for a BE/BC physician in EM/IM/FP with a well-established, democratic group in the western and southwestern suburbs of Chicago, Illinois. Competitive salary, comprehensive benefits package and opportunity for profit sharing available.

Send cover letter/CV to Lemont Walk-In Facility,
15900 W. 127th St., Lemont, IL 60439
Attn: S. Mininni, M.D., Medical Director
Du Page Convenient Care, LLC

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



One System. Many Options.



Carolinus HealthCare
URGENTCARE

Urgent Care Opportunities

Due to tremendous expansion and growth, flexible positions are available throughout the greater Charlotte, NC area for BC/BE Family Medicine or Emergency Room Physicians within our existing and new Urgent Care practices. Carolinus HealthCare System offers one of the largest Urgent Care networks in the Southeast.

- Sign On Bonus!
- Salary guarantee with incentives
- Employer paid benefits
- No call or inpatient care
- Episodic care only
- Full time and job share opportunities
- 12 hour shifts
- Flexible schedule - work only 7 days within a two week period
- A lifestyle you deserve!

To discover more, visit our website:
www.carolinushealthcare.org/careers/physicians
or contact: Leisa Lackey, Physician Services:
leisa.lackey@carolinushealthcare.org
or call: (704) 355-5643; fax: (704) 355-5033
EOE/AA

www.carolinushealthcare.org/careers/physicians

WELCOME BACK TO YOUR LIFE!!



Join Freeman's BEST!!

- TWO established free-standing Urgent Care Facilities
- Minor injuries and illnesses
- Walk in patients only
- Lab and x-ray on site
- Must be BC/BE, Residency Trained Physician
- Hospital based, FP or Urgent Care experience preferred
- Schedule is 4 days on and 4 days off
- EXCELLENT salary and benefits

JOPLIN, MISSOURI

- Service area of 450,000 provides metro city amenities while maintaining small town atmosphere and comfort
- Ranked lowest cost of living in the Nation
- Sporting paradise with lakes, boating, fishing, and hunting, numerous golf courses and campus community wellness center
- Excellent public and private schools
- Easy access to Kansas City, Tulsa, and St. Louis
- Strong diverse, stable economic base
- Mild climate – four seasons

For more information contact: Tracy Myers 800-353-6812
Email: ttmyers@freemanhealth.com, or fax CV to 417-347-0022

Redefine your work week...



- No call or hospital rounds
- 100% of malpractice insurance covered
- On-site management to handle all administrative issues
- Flexible schedules
- State-of-the-art facilities with on-site lab and digital X-ray
- Excellent compensation, bonus plan and benefits package

Solantic operates 15 state-of-the-art facilities in Florida and will open 7 more by 2009.



solantic
walk-in urgent care

Great care. Fast and fair.

Contact
Heather Miller
904-248-4075

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

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.**

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 Lluberres, Physician Recruiter
877-692-4665 Ext. 1134**

Fax: 973-740-9895

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

Equal Opportunity Employer

Practices for Sale

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.

**WANTED A EXPERIENCED
URGENT CARE
PRACTICE APPRAISER.**

**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.

Marketing

**ITS A NEW YEAR...
MAKE IT GREAT!!!**

Dominate your marketplace

Magnet Post Cards

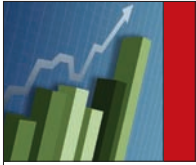
Turn-Key Product – you touch **NOTHING** – we handle everything, including mailing!!!



Any Imprinted Item – Guaranteed Lowest Prices!!!

877-750-DONE

www.ConsiderItDoneDirect.com



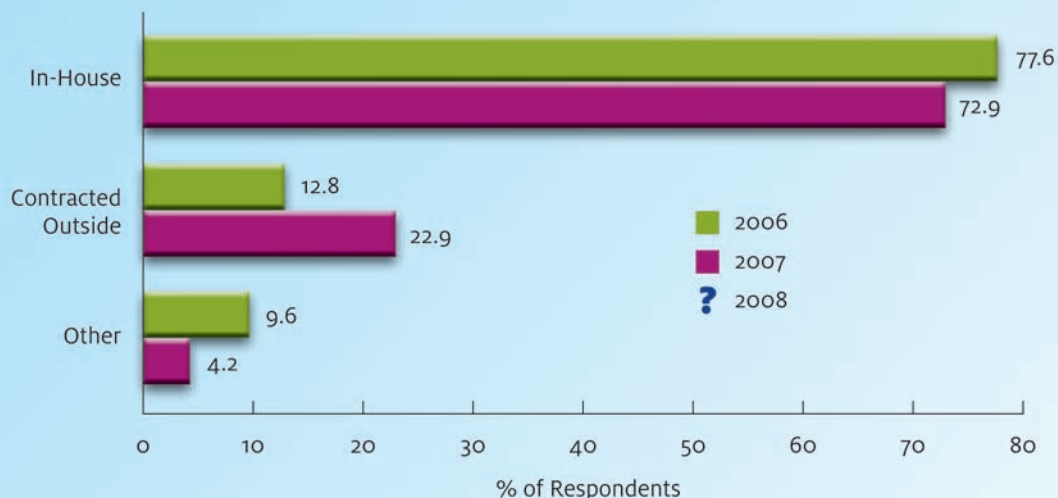
DEVELOPING DATA

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

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

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

BILLING SERVICES



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 offer 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*

JUCMTM and
THE JOURNAL OF URGENT CARE MEDICINE®

Braveheart
Publishing

congratulate UCAOA on its most
successful national convention to date!

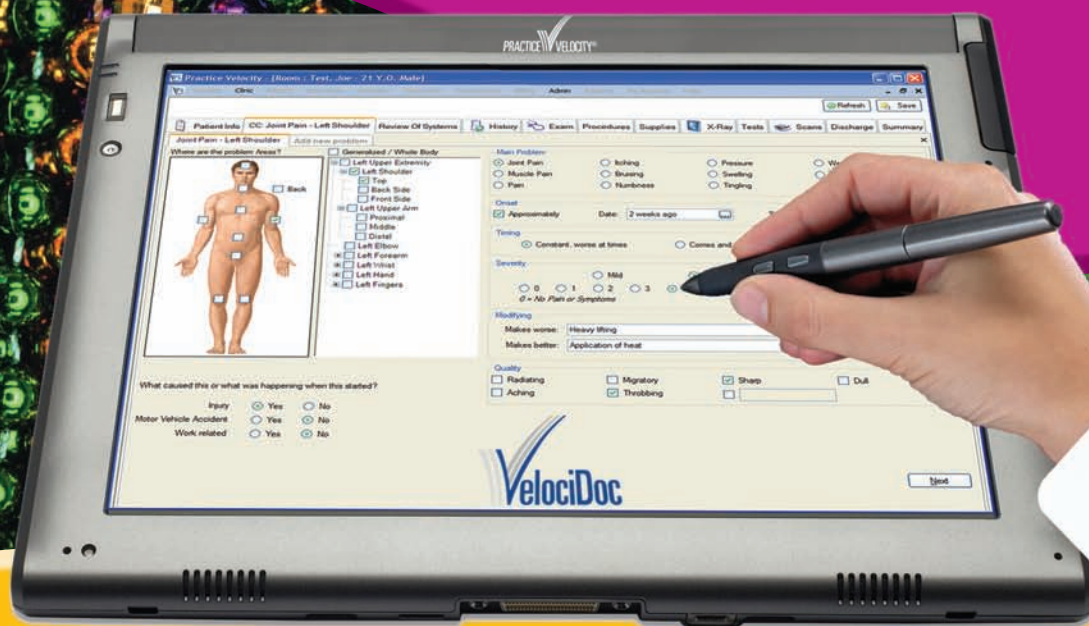


JUCM is the product of a partnership between
Braveheart Publishing and UCAOA.

Visit *JUCM* at the UCAOA convention in Booth 101.

*projected

Big News for Urgent Care



Urgent Care EMR: See it at UCAOA in New Orleans.



Our Guarantee:

"Try Practice Velocity charting & coding for 30 days. If it does not improve your profitability or you are not thrilled with the product for any reason, simply stop using our systems and pay us nothing."

— David Stern, MD, CEO, Practice Velocity



**PLATINUM
SPONSOR**

**Practice Velocity Systems Are Used in Over
500 Urgent Care Centers in 42 States**