

# JUCM™

THE JOURNAL OF URGENT CARE MEDICINE®

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## Managing Foot Fractures

*in Urgent Care*  
*Second in a Two-part Series*





## Get rid of the pink in a blink.\*

VIGAMOX® solution erases 99% of *Streptococcus pneumoniae* pathogens *in vitro* in as little as an hour.<sup>1,\*†</sup>

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

**Vigamox®**  
(moxifloxacin HCl ophthalmic solution) 0.5% as base

\*The dosing of VIGAMOX® solution is one drop in the affected eye(s) 3 times daily for 7 days.

### IMPORTANT SAFETY INFORMATION

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

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Please see brief summary of prescribing information on adjacent page.

## Vigamox®

(moxifloxacin hydrochloride ophthalmic solution) 0.5% as base

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

### CLINICAL PHARMACOLOGY:

#### Microbiology:

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

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

#### Aerobic Gram-positive microorganisms:

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

#### Aerobic Gram-negative microorganisms:

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

#### Anaerobic microorganisms:

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

#### Other microorganisms:

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

#### Clinical Studies:

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

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

#### Aerobic Gram-positive microorganisms:

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

#### Aerobic Gram-negative microorganisms:

*Acinetobacter lwvaffi\**  
*Haemophilus influenzae*  
*Haemophilus parainfluenzae\**

#### Other microorganisms:

*Chlamydia trachomatis*

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

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

#### WARNINGS:

NOT FOR INJECTION.

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

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

#### PRECAUTIONS:

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

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

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

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

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

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

Moxifloxacin was not mutagenic in four bacterial strains used in the Ames *Salmonella* reversion assay. As with other quinolones, the positive response observed with moxifloxacin in strain TA 102 using the same assay may be due to the inhibition of DNA gyrase. Moxifloxacin was not mutagenic in the CHO/HGPRT mammalian cell gene mutation assay. An equivocal result was obtained in the same assay when V79 cells were used. Moxifloxacin was clastogenic in the V79 chromosome aberration assay, but it did not induce unscheduled DNA synthesis in cultured rat hepatocytes. There was no evidence of genotoxicity *in vivo* in a micronucleus test or a dominant lethal test in mice.

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

#### Pregnancy: Teratogenic Effects.

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

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

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

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

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

#### ADVERSE REACTIONS:

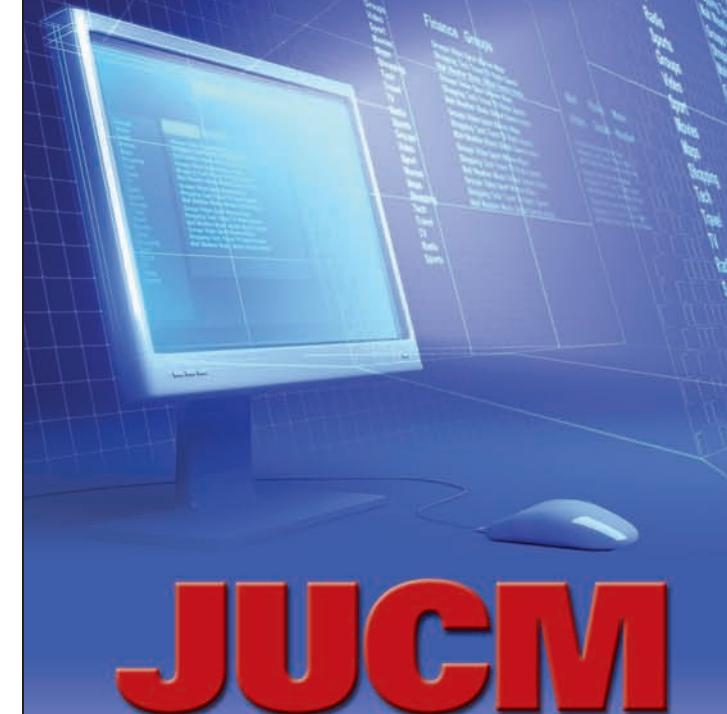
The most frequently reported ocular adverse events were conjunctivitis, decreased visual acuity, dry eye, keratitis, ocular discomfort, ocular hyperemia, ocular pain, ocular pruritus, subconjunctival hemorrhage, and tearing. These events occurred in approximately 1–6% of patients. Nonocular adverse events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

#### Rx Only

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#### Reference:

1. Data on file. Alcon Laboratories, Inc.



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## Session 1: Decision Points in Fracture Management

### Keynote presenter:

Will Gluckman, DO, MBA, FACEP

St. Joseph's Regional Medical Center

Paterson, NJ

New Jersey Medical School

**Date: Wednesday,  
February 18, 2009  
Time: 12:00 p.m., EST**

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  - how to choose the right management options
- Discussion of related coding issues
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## LETTER FROM THE EDITOR-IN-CHIEF

# Crisis in the ER: Quantifying the Impact of Urgent Care



**M**uch has been written lately on the growing crisis in emergency services: diversions, overcrowding, uncompensated care, lack of hospital beds, and the high cost of care in emergency department settings.

Much has also been written of late about the growing crisis in primary care: poor reimbursement, declining numbers of primary care physicians and trainees, and declining access to primary care as a result. This has caused increased wait times and limited same-day availability.

All of this, most agree, has led to increased utilization of the emergency department for non-emergencies. Several studies have attempted to identify the extent to which this occurs. All have their flaws, but the data are still worth interpreting in an effort to develop solutions to the growing crisis.

1. The most recent CDC (August 2008) Emergency Department Summary revealed the following:
  - 15% of all visits to U.S. emergency departments were deemed "emergent" (need to be seen within 15 minutes).
  - 36% of visits were deemed "urgent" (need to be seen in 15-60 minutes).
  - 22% of visits were deemed "semi-urgent" (should be seen in 2-24 hours).
  - 12% were deemed non-urgent.
  - 13% had unknown triage.
  - The most common diagnoses were upper respiratory infection, fever, ear infection, sprains and strains, laceration, contusions, abdominal pain, chest pain, and back disorders.
  - Approximately 75% of ED visits occurred 8 a.m.-10 p.m. (typical hours for most urgent care centers).
  - While a significant proportion of those triaged as "urgent" would likely meet criteria for being seen in an urgent care center, a full 34% of all ED visits were deemed semi-urgent or non-urgent.
2. Solucion analyzed acuity of emergency department visits by analyzing CPT codes. All visits coded 99281 through 99283 (a range from minor to moderate complexity) were deemed "non-emergent." An approximate average of 80% of emergency department visits met these criteria.
3. The Agency for Healthcare Research and Quality's most re-

cent expenditure data for ED visits, published in January 2006 and representing 2003 data:

- Average payment for ED visits was \$560
- Services involving a surgical procedure (including, but not limited to lacerations, I&Ds, chest tubes, LPs, etc.) averaged \$904. These accounted for 7% of total services.
- Other visits requiring special services such as x-ray, lab test, EKG, CT, etc. received an average payment of \$637. These accounted for 64% of visits.
- A full 29% of visits required no special services, and the average payment was \$302.
- Emergency visit payments for the simplest of visits requiring no special services were three times higher than office-based visits.

Using the most conservative estimates, these data support the assumption that somewhere between 30% and 80% of ED visits (35 to 95 million visits) could be managed in the urgent care setting, if that option is available. Seventy-five percent of these visits occur during standard urgent care hours (25 to 75 million visits).

With accessibility, diagnostic capacity, and convenient hours of operation, urgent care centers are uniquely positioned to provide this care, significantly reducing the unnecessary use of our strained emergency services.

Based on the assumptions stated above, and a conservative three times multiple cost of care for similar services in the ED vs. urgent care, the potential cost savings to the healthcare system is a staggering \$5 billion to \$15 billion per year.

We will continue to make the case for the legitimate role of urgent care in the solution of our nation's emergency services crisis. ■

Lee A. Resnick, MD  
Editor-in-Chief  
*JUCM, The Journal of Urgent Care Medicine*  
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## Mission Statement

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

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**CLINICAL**

## 13 Managing Foot Fractures in Urgent Care

### Second in a Two-part Series

Management of foot fractures—starting with the decision on which patients to treat and which to refer to the ED or orthopedist—depends to a large extent on the location and mechanism of the injury. In the conclusion of this two-part series, the author address injuries to the midfoot and hind foot.

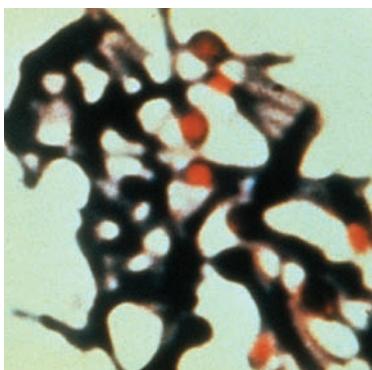
By Phillip H. Disraeli, MD, FAAFP

**CASE REPORT**

## 21 A 25-Year-Old Male with Tetanus

Tetanus may be an unusual presentation in the 21st century, but the patients most likely to be affected might be more inclined to seek treatment in an urgent care center than in any other setting.

By Curtis G. Kommer, MD, Latha Shankar, MD, and Mario Kapetsonis, MD

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From the UCAOA Executive Director

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## URGENT CARE UPDATE



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Are hospital-affiliated urgent care centers part of the solution to overcrowded emergency rooms and a boon to the hospital system, or more a threat to revenues that typically go to the ED?

By Alan A. Ayers, MBA, MAcc



### 38 The Search for the Urgent Care Center

It is generally accepted that urgent care is a growing marketplace. The tricky part is defining the discipline and ensuring that your facility is on the radar screen in your community.

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

### In the next issue of JUCM:

As one of the frequent reasons for utilization of emergency or urgent care services, constipation is a complaint physicians must be comfortable evaluating and treating. Ruling out serious—and possibly life-threatening—etiologies is imperative.

# Afraid you missed something?

The Journal of Urgent Care Medicine™ is the official journal of the Urgent Care Association of America (UCAOA). Each issue of JUCM contains a mix of general clinical and practical and practice management articles which address the distinct clinical and practice needs of today's busy urgent care medicine specialists.

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From the Executive Director

Contributors

Clinical

Bouncebacks

Practice Management

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## JUCM CONTRIBUTORS

**W**hen a patient stubs his toe, he knows it. It may be a day or two before he seeks medical attention, but it's unlikely the acute pain and swelling of a fractured hallux will go ignored for long.

But what if the patient didn't experience that kind of sharp, blinding pain and thus wasn't compelled to seek medical attention for weeks (or longer)? Would delay in treatment compound the risk of a poor outcome?

Such are the dangers of certain injuries that occur beyond the forefoot, the pain of which may be mild at first but grows progressively worse (as does the chance of a positive outcome for the patient)—just one of the principles discussed in part 2 of *Managing Foot Fractures in Urgent Care* (page 13) by **Phillip H. Disraeli, MD, FAAFP**.

Where part 1 (*JUCM*, December 2008) discussed the role of the urgent care clinician in evaluating and treating or referring patients with various fractures of the great toe, metatarsals, and the forefoot in general, part 2 addresses the same concerns as they apply to fractures of the cuboid, cuneiforms, navicular, talus, and calcaneus.

Dr. Disraeli is a partner in Metro Urgent Care in Frisco, TX, and director of clinical programs for the Urgent Care Association of America.



Of course, before a patient can seek treatment in an urgent care center, he or she has to find it—a feat more challenging than one might assume, according to new research commissioned by UCAOA. *The Search for the Urgent Care Center* (page 38) by **Robin M. Weinick, PhD, Steffanie J. Bristol, BS, Jessica E. Marder, and Catherine M. DesRoches, DrPH** seeks first to articulate what distinguishes urgent care from other settings, and then to determine how many such centers exist in the U.S., using methods that are probably similar to those a patient might use on a random Tuesday evening.

The team's findings provide excellent rationale for ensuring you're easy to locate.

Especially hard to identify were urgent care centers affiliated with hospitals, even though this practice model is becoming more and more attractive across the country. In *Making a Case for Hospital Urgent Care* (page 34), **Alan A. Ayers, MBA, MACC** explains why that's the case, and how hospital urgent care might be a partial solution to over-

crowded emergency rooms while also helping the hospital capture new revenue.

Finally, we're pleased to present a case report on a presentation rarely seen in most settings these days—though, as they authors explain, urgent care clinicians may be more likely see patients with symptoms of tetanus than their colleagues in family or emergency medicine.

A 25-Year-Old Male Presenting with Tetanus, by **Curtis G. Kommer, MD, Latha Shankar, MD, and Mario Kapetsonis, MD** starts on page 22.

Dr. Kommer has been a board-certified family practitioner for over 20 years. He is a staff physician at Walk-In Medical Care in Flagstaff, AZ. Before relocating there recently, he worked at Columbia-St. Mary's Cathedral Square Urgent Care Center in Milwaukee, where Drs. Shankar and Kapetsonis remain as colleagues. Dr. Shankar has co-authored/published various medical research articles in other journals. In addition to urgent care, Dr. Kapetsonis is interested in medical acupuncture, integrative medicine, and preventative medicine.



### Also in this issue:

**Nahum Kovalski, BSc, MDCM** reviews abstracts of new articles on establishing criteria for running blood cultures, advising parents on how to prevent scald burns to their children, the benefits of pre-hospital notification when transferring or transporting stroke patients, and other topics of high interest to the urgent care clinician.

**John Shufeldt, MD, JD, MBA, FACEP** discusses the urgent care center's obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA) and offers sage advice on how to communicate with physicians on the receiving end of emergent referrals.

**David Stern, MD, CPC** tackles the thorny issue of how to determine who's a new patient and who is an "established" patient in the eyes of the American Medical Association and the Centers for Medicare & Medicaid Services.



**Frank Leone, MBA, MPH** offers rationale on the judicious use of "freebies" when promoting an urgent care center's occupational medicine business. Looking beyond pens and refrigerator magnets may work to your advantage without adding to your marketing budget.

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## FROM THE EXECUTIVE DIRECTOR

# Integration

■ LOU ELLEN HORWITZ, MA

I've been thinking a lot about quality lately.

For too long, there have been no national benchmarks for urgent care centers. Now that we have some, though, how will that change the conversations you are having in your clinics? Will learning about ourselves as an industry make us more aware and accountable to each other for our performance? And how do we manage those improvements when it feels like our resources are already stretched to their limits sometimes?

**"Quality means doing it right when no one is looking."** - Henry Ford

The world at large could judge the "quality" of the product Henry Ford put his name on, but few could see what went on inside the walls of his factories. Ford recognized that the countless small tasks that occur far from public view determine the ultimate quality of the finished product, whether that product be an automobile or excellent patient care and customer satisfaction.

If you are seeing the same news feeds and print media that I am, you are seeing urgent care in those stories more and more. Not only stories about new centers opening, but also stories about how those centers affect their local healthcare delivery systems.

So far, most of these stories start out as "ER Crisis" stories, with urgent care featured as a piece of the solution. All this coverage fuels additional awareness of urgent care, as evidenced by the growing number of calls we get from the media here in the office.

The point is, people are "looking" now; urgent care has definitely arrived and is on everyone's radar.

So, what does any of this have to do with the subject of integration?

In the past two years of working with The Joint Commission, we have had literally hundreds of conversations with centers



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about quality standards and the upcoming benchmarking results and what they mean for the future of urgent care. What has become clear in all of these conversations is that quality is all about integration. It's not about what's in the policy manuals or procedures (though those are important); it's about what you are doing and how you are doing it—day in and day out.

But of course, that's the hard part. Ultimately, it's easier to write a policy and put it in a binder than it is to change the behavior of an entire group of people, or even just one individual. Or even ourselves.

**"Quality is not an act, it is a habit."** – Aristotle

They say if you can do something every day for 30 days it becomes a habit; does that mean for processes that you only do every other day it takes twice as long? That math gets depressing pretty quickly. But, that is the challenge that is before us all. As Aristotle pointed out, quality can be assured only when it becomes so ingrained in our behavior that it stops being the focus of our attention and becomes the essence of who we are and what we do.

As you look out at 2009 and all that faces us as an industry and a country, I hope that instead of being depressed by the mountain of challenges, you are encouraged by the larger understanding that as you move up the mountain the view gets better and better. The more we can take small steps together toward integrating improvements in the quality of our care and our service, the more we can climb that mountain and see the next peak.

### Convention Reminder

Building a quality urgent care business is not an easy thing. However, many of your colleagues have done just that, and many others are in the process of doing so. There's no better place to learn from them—or for them to learn from you—or to be exposed to the clinical skills and experience of the best clinicians among us than the UCAOA Annual Convention, this year scheduled for April 20-23 at Caesars Palace in Las Vegas. Visit [www.ucaoa.org/convention](http://www.ucaoa.org/convention) for information on the curriculum and registration. Hope to see you there! ■

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# Managing Foot Fractures in Urgent Care

*Second in a Two-part Series*

**Urgent message:** Acute injuries to the midfoot and hind foot require immediate treatment or emergent referral. Close attention to the location and mechanism of injury at the urgent care site may facilitate efficient care and prevent long-term disability.

Phillip H. Disraeli MD, FAAFP

## Introduction

In keeping with the tone of part 1 of this two-part series (*JUCM*, December 2008), this article will discuss the urgent care clinician's approach to foot fractures by emphasizing the following (but shifting our focus toward the cuboid, cuneiforms, navicular, talus, Chopart joint, and calcaneus, as well as compartment syndrome):

1. Proper management of and follow-up for simple nondisplaced fractures in the foot.
2. The role of the urgent care clinician in patients with other significant fractures, the vast majority of which will need to be referred to orthopedics for definitive care. The important pitfall to avoid is under-diagnosing the seriousness of a midfoot or hind foot injury, and not protecting



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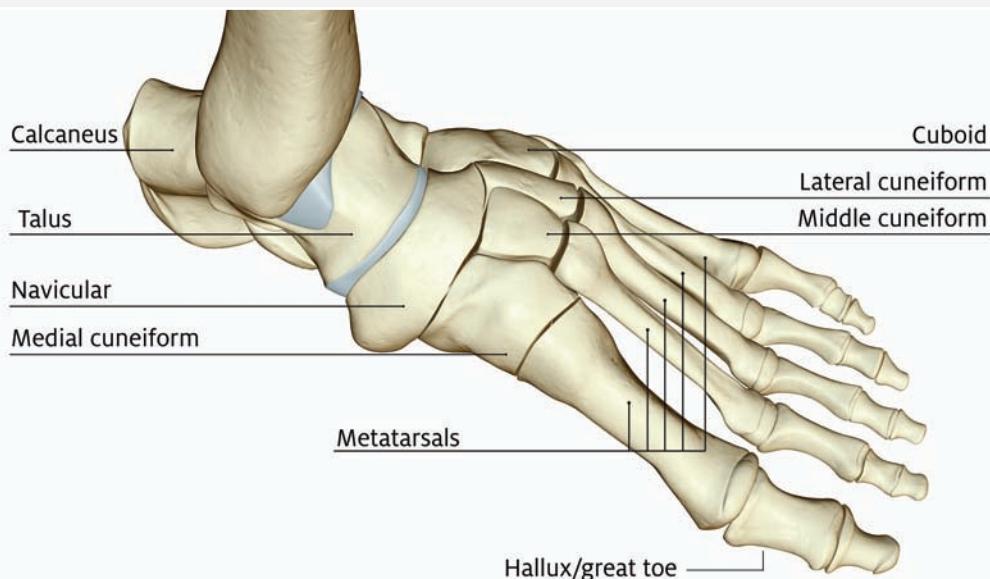
the patient with proper splinting and crutches.

## Cuboid and Cuneiform Fractures

Taken together, the cuboid, cuneiforms, navicular, talus, and calcaneus make up the tarsal bones of the foot. See **Figure 1**.

The joint between the tibia and talus is referred to as the talar joint, while the joint between the talus and the calcaneus underneath is the sub-talar joint. The talar joint allows normal motion in plantarflexion and dorsiflexion of the ankle, while the sub-talar joint allows inversion and eversion of the ankle.

The cuboid and cuneiforms combine to form an important part of the arch of the foot. This area of the midfoot is quite rigid. The bones are shaped in a trapezoidal fashion to form the arch, with the second

**Figure 1.** Relevant key anatomy of the foot.

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cuneiform forming the “keystone” of the arch.

Traumatic forces applied to one side of the midfoot are transmitted to the other side, so the clinician must look to both sides of the foot for damage. Midfoot fractures may result from forced eversion, inversion, plantar flexion or dorsiflexion, or crushing of the foot.

Injuries to the midfoot must be examined carefully for dislocations, ligamentous disruptions, and fractures. On exam, look for point tenderness of the midfoot and inability to bear weight on toe-walking. These injury patterns are characterized by the high amount of force required to disrupt the extremely stable midfoot complex. If the injuring force was high, have a low threshold for orthopedic referral.

Cuboid fractures are rare in isolation, and usually result from a direct blow or crush mechanism. They may present as impacted buckle fractures, where there is a small increase in the density appearance of the bone on x-ray, or as a small chip fracture. In cases where the mechanism is more of a torque on the midfoot, the clinician must look very carefully for additional fractures and ligamentous instability. In these circumstances, an MRI or CT of the foot may be indicated.

Fractures may also be associated with lateral subluxation or even dislocation of the tarsal-metatarsal joint

(Lisfranc disruption; see *JUCM* December 2008).

Cuneiform fractures are unusual, especially in isolation. When they do occur, they usually involve the medial cuneiform and tend to be part of a more global midfoot injury pattern, such as a Lisfranc disruption. Therefore, the presence of a cuneiform fracture should signal the need to carefully evaluate and identify concomitant fractures or instability patterns. Failure to diagnose a Lisfranc disruption is an important pitfall in urgent care.

In the rare instances in which cuneiform fractures do occur in isolation, they are most likely to result from a crush injury or direct impact, as opposed to the high-energy mechanisms responsible for the more diffuse injury patterns.

Small isolated fractures of the cuboid or cuneiforms with intact ligamentous support may be treated conservatively. The foot should be immobilized in a high-top walking boot, or CAM walker, if the patient can tolerate weight bearing. If not, the patient should be splinted with crutches and converted to a walker after two to three weeks. Total immobilization should last a minimum of six weeks, though some patients require longer in a CAM walker or post-operative shoe for persistent symptoms.

The key to conservative treatment is that the

patient should not have any pain on ambulation or limping.

Operative repair is always indicated for severely displaced or impacted cuboid or cuneiform fractures. Also, patients with significant intra-articular involvement or articular displacement require surgery. If the medial or lateral columns of the midfoot are not aligned perfectly, long-term disability can result. The best outcomes in these circumstances are obtained with reestablishment of normal anatomy of the bony arch utilizing bone grafting, and stable open reduction and internal fixation (ORIF).

### **Navicular Fractures**

The tarsal navicular bone is a sail-shaped bone of the midfoot that lies on the medial column between the talus and cuneiforms. A normal navicular and intact talonavicular joint are essential for normal gait.

The talonavicular joint is crucial for normal pronation (cushioning heel strike) and normal supination (strengthening push-off) of the foot. Fractures of this bone must be carefully sought and treated.

Like the scaphoid of the wrist, the navicular bone has a vascular watershed at its waist, making it susceptible to non-union and poor healing. The bone is easily palpated. The examiner can locate a bony prominence medially, 2 cm below the medial malleolus. Navicular fractures are divided into three types: acute traumatic, acute avulsion, and stress fractures.

### **Acute traumatic fractures**

Acute traumatic fractures of the navicular are rare in the urgent care center. They require high-energy forces, such as those commonly associated with motor vehicle accidents, applied axially or by forced eversion of the foot. When suspected, they can be easily identified using standard three-view x-rays of the foot (antero-posterior [AP], lateral, and oblique). Occasionally, a CT will be necessary to assess the surrounding anatomy and rule out concomitant ligamentous injuries.

Most of these fractures will have an intra-articular component.

Acute fractures of the navicular should be splinted non-weight bearing and referred to orthopedics for ORIF. Unstable or displaced fractures should be referred to the emergency room for stabilization and emergent surgery.

### **Acute avulsion fractures**

Acute avulsion fractures are more common in urgent

care. They may occur as the result of forced eversion of the foot, resulting in a dorsal fragment being created from the strong deltoid ligament or tear of the joint capsule superiorly. One may also encounter an avulsion medially on the navicular, caused by the insertion of the posterior tibial tendon.

When viewing x-rays of the navicular, careful attention must be paid to avoid confusing an avulsion with one of the accessory bones of the navicular. Contralateral films may help clarify the situation.

Small avulsion fractures can be treated with a CAM walker, while larger or displaced fragments should undergo operative repair.

### **Stress fractures**

Stress fractures of the navicular are a common entity seen in urgent care. They comprise 35% of all stress fractures in some series and usually occur in running and jumping athletes. An athlete may complain of midfoot pain that worsens with activity and after activity.

Such fractures are notoriously difficult to diagnose, with a mean of seven months lapsing from the onset of symptoms to diagnosis. They are also frequently confused with anterior tibial tendonitis, as both present with pain on the dorsal/medial aspect of the midfoot.

Suspect a stress fracture if the athlete has progressed training too rapidly, or has a rigid or abnormal foot. The navicular may be tender and pain may be elicited with vibration from a low-pitch tuning fork. The patient will have pain with hopping on the affected foot. The fracture is difficult to visualize because it always runs vertically in the plane of the AP film. Look for sclerosis in the waist of the navicular or periosteal reaction. CT scanning may be helpful and can delineate partial from complete stress fractures.

Treatment of stress fractures of the navicular must always include a period of non-weight bearing, typically at least four weeks in a cast for an incomplete stress fracture. This is in distinction to other stress fractures of the foot, which may heal with protected weight bearing. Failure to make the patient non-weight bearing initially is another common pitfall in urgent care.

Complete stress fractures or those with displacement will require operative repair. All athletes have a prolonged recovery and delayed return to sports. If the fracture is not identified early enough, the injury could be career-ending.

### **Talus Fractures**

The talus bone plays the crucial role of transferring

**Figure 2. Fracture of the talar neck.**

Source: Rosen P, Doris PE, Barkin RM, et al. *Diagnostic Radiology in Emergency Medicine*. St. Louis: Mosby, 1990.

weight and energy from the leg onto the foot. Precise anatomy is essential for normal painless gait in humans. Seventy-five percent of the surface is covered with articular cartilage, as it articulates with several bones.

The word *talus* comes from the Latin root for "dice," so named because Roman soldiers used horse tali as dice in games. It is a hard and dense bone with a tenuous blood supply that is easily disrupted in fractures or dislocations. The talus has no tendon or muscle attachments, but numerous ligaments are attached.

The talus is divided into four zones for the purposes of our discussion:

- The head of the talus is anterior and articulates with the navicular and calcaneus bones; 10% of fractures occur here.
- The body of the talus is wider and forms the posterior portion of the bone. It articulates with the calcaneus; 20% of fractures occur here.

■ The dome of the talus is the superior part of the body and forms the ankle mortise, along with the tibia and fibula; 20% of fractures occur here.

■ The neck of the talus lies between the head and body. It does not articulate with other bones, but it possesses the crucial blood supply and accounts for 50% of talar fractures. Fractures in this area have the highest incidence of non-union and avascular necrosis.

Talar fractures can be classified as avulsion type, osteochondral, and acute traumatic. They are best evaluated radiographically by both foot and ankle films, with the best single view being the true lateral of the ankle. In particular, look carefully at the neck of the talus for fracture lines (**Figure 2**).

#### **Avulsion type fractures**

Avulsion type fractures of the talus are seen commonly in urgent care, as they result from severe inversion and eversion ankle sprains or torsion of the foot. The required energy forces are lower than those required in acute fractures, and the strong ligaments pull fragments of bone free. Fracture fragments noted on x-ray should investigate further search for other soft

tissue injuries to the joints or ligaments. When found in isolation, avulsion fractures can be treated with conservative therapy of RICE (rest, ice, compression, and elevation) and weight bearing when tolerated in a CAM walker.

#### **Osteochondral fractures**

Osteochondral fractures occur from a severe axial load to the ankle, in severe ankle sprains, and in syndesmotic injuries of the ankle. They are located on the dome of the talus. The clinician should examine the mortise view of the ankle carefully, looking for a small defect on the talar dome. If the plain films are negative and a high index of suspicion exists, CT scanning will identify the defect. A clue to a possible osteochondral fracture is the presence of an ankle effusion. All patients with acute ankle effusion should receive a CT if the plain films are negative. One should also consider

an osteochondral fracture in patients who have persistent pain four weeks after an ankle sprain. The fracture fragment may need to be excised arthroscopically. When diagnosed acutely, patients should be splinted non-weight bearing and referred to orthopedics as an outpatient.

#### **Acute traumatic fractures**

Acute traumatic fractures of the talus occur as the result of high-energy forces, such as motor vehicle accidents, falls from a height, and severe football collisions. Even with proper treatment, these injuries commonly lead to post-traumatic complications such as avascular necrosis, arthritis, tarsal coalition, and chronic pain.

As a rule of thumb, all acute traumatic fractures of the talus should be referred to orthopedics. If there is no displacement or dislocation, the referral can be made as an outpatient as long as the ankle is protected and non-weight bearing. Fractures with displacement need urgent referral and the orthopedist should be contacted to give advice on disposition. These patients will probably need to go the ED. These injuries require early ORIF to prevent non-union and early return to weight bearing. Most orthopedists will request a CT scan to clarify the injury and for pre-operative planning.

The Hawkins classification developed in 1970 is still used today for talar neck fractures. As one progresses into more complex fractures and displacement in the scheme, the risk of avascular necrosis and non-union rises to a level of 90%. Fractures that are visible on plain films are probably displaced to some degree. The presence of a fracture also suggests a high impact force that could cause other concomitant injuries to the ankle and deltoid ligament. Therefore, orthopedic referral and ORIF are advised when found.

Fractures of the lateral process of the talus may occur from severe inversion injuries to the ankle. These fractures are often diagnosed initially as ankle sprains, and the patient fails to improve with RICE and early weight bearing. Hence, one should suspect this injury whenever ankle sprains fail to remit after two weeks of conservative therapy.

Such injuries result from an axial load with the ankle in dorsiflexion and are often referred to as "snowboarder's fracture." The lateral process has strong ligamentous attachments from the anterior talofibular ligament and the lateral talocalcaneal ligament. On exam, the patient will have tenderness over the lateral tubercle—the bony prominence located just inferior to the tip of the lateral malleolus. Most of these fractures can be seen with a true mortise view of the ankle, especially with the foot held in plantar flexion. Small fragments may be treated with cast immobilization; larger fragments will require ORIF. For ideal results, surgery must take place before week 4. For later diagnoses, the fracture fragment may need to be excised.

On the posterior talus, fractures may occur from extreme forced plantar flexion of the ankle. The patients will be tender anterior to

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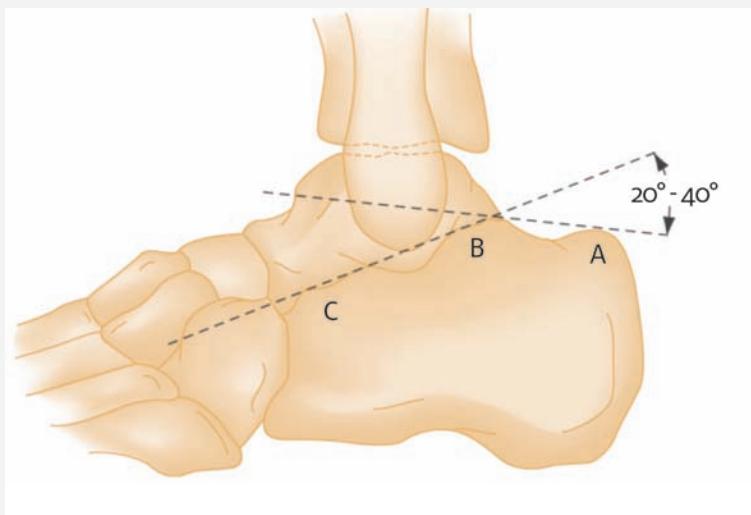
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**Figure 3.**

Boehler's angle is obtained by drawing two lines—one extending from the posterior tuberosity (A) to the apex of the posterior facet (B), and the other between the apex of the posterior facet (B) and the apex of the anterior process (C). A value of <20 degrees suggests a calcaneal compression fracture.

Source: Rosen P, Doris PE, Barkin RM, et al. *Diagnostic Radiology in Emergency Medicine*. St. Louis: Mosby, 1990.

the Achilles tendon. On x-ray, one must distinguish between an acute fracture and the accessory bone, *os trigonum*. The *os trigonum* is located on the posterior talus and is present in 50% of individuals, often bilaterally. Contralateral films may help. One should note that acute fractures have an irregular contour compared with the accessory bone. Fractures are treated the same way as those of the lateral process, as explained previously.

### **Chopart Joint Injury**

Chopart's joint consists of the talonavicular and the calcaneocuboid joints. Injury to this joint is less common than injuries to Lisfranc's joint. Disruption of the ligaments can occur with significant forced dorsiflexion of the ankle, and should be considered in any patient with a fracture of the tarsal bones. The patient will experience pain, swelling, and inability to bear weight. There may be tenderness over Chopart's joint.

The disruption is difficult to diagnose in the urgent care center, but must be sought on the plain films. If

a high index of suspicion is present, or significant force was involved, a CT will be helpful in assessing the joint. One should also entertain the diagnosis if an ankle sprain fails to heal properly in two to four weeks. Most of these injuries will require operative fixation and may lead to chronic disability.

### **Calcaneus**

The calcaneus is the largest bone of the foot and the most frequently fractured tarsal bone. It articulates with the talus superiorly and with the cuboid on its anterior aspect. Fractures to the calcaneus usually result from the impact of a fall.

A significant force is necessary to fracture this dense bone. Therefore, one must look for concomitant injuries. Seven percent of the injuries are bilateral; approximately one quarter of patients have other foot or ankle injuries, and one in 10 have spinal injuries (usually, compression fractures). On exam, one may note a loss of height in the heel when viewed from behind, bruising on the plantar

surface of the foot. There will be exquisite tenderness of the heel and the patient will be unable to bear weight on the heels.

All suspected calcaneal injuries should be evaluated initially with plain radiographs of the foot in standard AP, lateral, and oblique projections.

From an urgent care perspective, the clinician needs to determine if the sub-talar joint is involved, and if there is depression in the posterior facet of the calcaneus. On the lateral view of the foot, it is helpful to measure Boehler's angle to determine a compression fracture of the calcaneus (**Figure 3**).

In addition, a calcaneal or axial (Harris) view is critically important in all suspected calcaneus fractures. If a fracture is found, additional views of the ankle should be obtained to rule out talar disruption and concomitant injuries, such as those mentioned previously.

Standard films, though helpful, tend to underestimate the displacement in calcaneal fractures. Therefore, all patients with calcaneal fracture should undergo a CT scan soon after diagnosis.

The vast majority of calcaneal fractures reveal some displacement on CT scanning. Patients cannot tolerate a loss of height in the calcaneus or change in the tilt angle of the sub-talar joint. For this reason, most fractures are treated operatively with screw fixation. Occasionally, a fracture can be managed with closed reduction. In all such instances, it is advisable to refer these patients to orthopedics. Even with minor fractures, the patient will be cast immobilized for a minimum of six to eight weeks.

In the urgent care center, the patient should be placed in a well-cushioned posterior splint with the ankle in neutral position. Care should be taken during splinting to avoid exacerbating any soft tissue injury and to allow for swelling that will occur. Patients should be non-weight bearing until they are seen by the orthopedist.

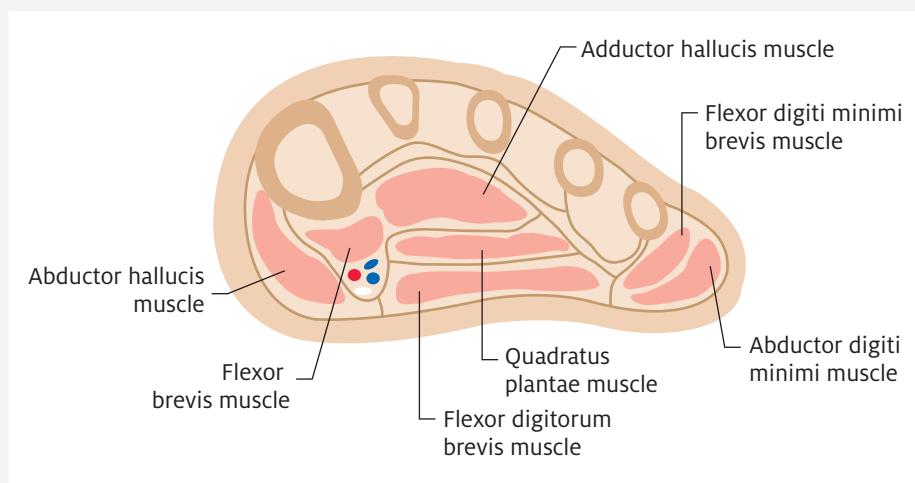
If the x-ray reveals a displaced fracture or involvement of the sub-talar joint, the orthopedist should be consulted immediately for assistance in the disposition of the patient; they may want to evaluate the patient in the ED. Be alert for significant soft-tissue injury that may be present, and for concomitant injuries. The foot and ankle must be assessed critically for neurovascular compromise. Some patients will need to be admitted to the hospital for observation of neurovascular status, soft-tissue compartments, and pain control.

#### **Younger patients**

With regard to children, the calcaneus is largely cartilaginous. Fractures are less common than in adults, but may occur with falls. Children can also develop stress fractures of the calcaneus.

A condition unique to skeletally immature children is Sever's disease, a type of apophysitis of the heel in which the calcaneal apophysis develops a second-

**Figure 4.**



The foot has nine individual muscle compartments, as described by Manoli. Medially, they can communicate with the deep posterior compartment of the leg, and thus swelling in one area can affect the other. Any physician treating traumatic foot injuries should be familiar with the deep compartmental anatomy of the foot in the event that a compartment syndrome requires release.

ary ossification center at age 10 and eventually fuses with the calcaneus by age 15. During that interval, the strong pull of the Achilles tendon inserts on the apophysis and can lead to apophysitis. It is more common in boys who participate in jumping and running sports.

The urgent care clinician should be aware that there is an apophysis of the heel that is normally fragmented. This can be confused with a fracture on the lateral film. Sever's disease is considered to be an overuse injury, due to repetitive microtrauma. It heals with modification of activities and heel cushioning.

#### **Compartment Syndrome**

Urgent care clinicians also need to be aware of the possibility of a compartment syndrome in patients who have sustained trauma to the foot. Compartment syndrome occurs when the pressure within a confined fascial compartment exceeds the arterial pressure leading into it, and the blood flow and nerve function are compromised. There are several small compartments within the foot; see **Figure 4**.

The usual sequence of events is one of acute trauma to the foot, coupled with exaggerated elevation of the

leg at home. As with any injured extremity, RICE therapy is the hallmark of treatment. However, if the injured leg is held too high, the arterial inflow into a tight compartment may not be sufficient for adequate perfusion. Risk may be minimized with elevation limited 12 to 18 inches above the heart, and ensuring that any compression from a splint or elastic wrap is not too tight. Compartment syndrome in the foot is notoriously difficult to detect. Any severe injury, whether it is a fracture or severe sprain, may lead to a compartment syndrome.

The physician should be alert for tense swelling, exaggerated pain in the foot, or loss of two-point discrimination as the first signs of vascular compromise. Two-point discrimination is superior to light touch in assessing for neural compromise. Particular attention should be paid to pain out of proportion to the injury, elicited during passive extension of the toes. Compartment syndrome is a surgical emergency that should be referred to the ED immediately.

### **Conclusion**

We have examined the common fractures and injury patterns of the foot, with a concentration on those that are most likely to present to an urgent care center.

As one progresses from the toes to the heel, more force is needed to fracture the larger and denser bones. Paying careful attention to the mechanism of injury raises suspicion for certain fractures and dislocations.

Other take-home points from this two-part series include:

- Of all the toes, the great toe is the most important for weight bearing and for treatment; displaced fractures of the great toe require operative treatment.
- The midfoot is commonly injured acutely and in stress fractures.
- The Lisfranc joint between the flexible forefoot and more rigid midfoot holds special significance for clinicians. One should suspect this injury if the force was an axial one with the forefoot in dorsiflexion. X-rays are imperative and must be examined for proper alignment on the medial aspect of each tarsal-metatarsal joint.
- Fractures of the midfoot require more force and are rarely isolated. Only small fractures or avulsions can be treated conservatively. The majority will have some displacement and will require operative intervention. If the injuring force to the

## *Mechanism of injury may raise suspicion for certain fractures and dislocations.*

midfoot was significant, and the patient has pain with toe-walking, the clinician would be wise to immobilize the patient and refer to orthopedics for follow-up.

- Fractures of the hind foot require even more force and usually result from a fall from a height or motor vehicle accident. One should look carefully for associated injuries and compartment syndrome or neurovascular compromise. These patients need to be splinted carefully and referred immediately.
- Tarsal fractures most common to the urgent care setting include:
  - avulsion fracture of the talus
  - stress fracture of the navicular.

In order to properly care for acute foot fractures in the urgent care center, the clinician must focus on several items:

- Take a careful history to determine the mechanism of injury and current symptoms, keeping in mind injuries likely to occur.
- Detailed and methodical exams of the foot for tenderness, deformity, neurovascular status, and ligament stability are needed. Before diagnosing a minor sprain, have all patients walk on their toes to rule-out a more significant injury.
- One must have immediate access to quality plain films of the foot and ankle. It is often helpful to examine these films with a hot light and magnification to see subtle fractures. Access to timely and high-quality CT scans is important for the equivocal cases. These can be ordered at an imaging center and further disposition made if necessary. Or, the clinician may decide to splint and refer to orthopedics in borderline cases.
- One must be able to place a patient in a temporary splint with crutches, as some patients should not bear any weight.
- For disposition, the clinician needs an excellent working relationship with a local orthopedist, preferably one with foot and ankle expertise.
- For severe fractures, significant displacement, or possible compartment syndrome, emergent therapy is warranted. Depending on the local situation, this would entail a call to the orthopedist for instructions or a direct referral to the ED.

For Resources and Suggested Reading associated with this article, log on to [www.jucm.com](http://www.jucm.com). ■

# Case Report

## A 25-Year-Old Male Presenting with Tetanus

**Urgent message:** Unusual as the diagnosis may be in 2009, patients with symptoms of what is later confirmed to be tetanus may be more likely to present to urgent care than to other practice settings.

Curtis G. Kommer, MD, Latha Shankar, MD, and Mario Kapetsonis, MD

### Introduction

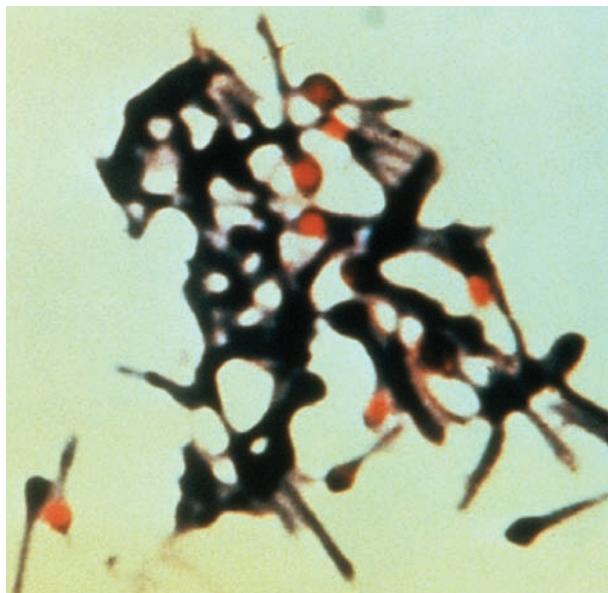
Tetanus, a toxin-mediated infection of gram-positive bacteria *Clostridium tetani*, is a rare presentation in the 21<sup>st</sup> century. Since 2000, there have been fewer than 50 cases per year reported in the United States.<sup>1</sup>

However, at-risk patients such as unimmunized children, unboostered adults, intravenous drug (particularly heroin) users, undocumented workers, or foreign travelers may still present with this potentially lethal infection (10% to 20% mortality).<sup>2</sup>

Due to their appeal to underserved or itinerant patients, urgent care clinicians may be called upon to diagnose this uniquely dangerous condition more frequently than those practicing in other settings, as evidenced by the encounter detailed here.

### Case

MJ, a 25-year-old Hispanic male landscaper, presented to the Cathedral Square Urgent Care Center in down-



Micrograph of *Clostridium tetani* bacteria.

Source: Centers for Disease Control and Prevention Public Health Image Library (<http://phil.cdc.gov>).

town Milwaukee six days after sustaining a puncture wound to the right thigh while pruning bushes. Initially, he cleaned the wound with water and peroxide, then dressed it with a triple-antibiotic ointment.

At presentation, he complained of a three-day history of fever, chills, and generalized muscle aches, culminating in a one-day history of increasingly severe tightness and pain of his jaw, chest, and abdominal muscles. He stated that he was unable to open his mouth, complained of difficulty swallowing, and felt short of breath.

MJ's medical and surgical history was negative; he was taking no medications, and had no allergies. He was a non-smoker, rare alcohol drinker, and admitted to occasional (nasal) cocaine use.

Born in Mexico, he had lived and worked in the United States for eight years. He was unaware of his childhood immunization history, and had never re-

### Differential Diagnosis for Tetanus

- Dystonic drug reaction
- Globus hystericus/conversion disorder
- Hypocalcemia
- Rabies
- Black widow envenomation
- Thyrotoxicosis
- Strychnine poisoning
- Meningitis/encephalitis
- Subarachnoid hemorrhage/hemorrhagic stroke

ceived a booster for tetanus.

Initial exam revealed the following:

- Temperature: 103.4° F
- Pulse: 106
- Respiration: 28 breaths/minute, shallow
- BP=110/68
- Pulse oximetry 97% room air

MJ appeared anxious and dyspneic, without cyanosis. There was no rash or lymphadenopathy. Bilateral masseter muscle spasm was palpable, and the patient was unable to open his mouth more than 2 cm.

Cardiopulmonary exam was normal, and the abdomen was scaphoid. Visible and palpable thoracic and abdominal muscle spasm was noted. His right thigh wound appeared to be healing well, without erythema or swelling.

A clinical diagnosis of tetanus was made and the patient was given advanced cardiac life support transport to a nearby hospital, where he was admitted to the intensive care unit.

### Remarkable studies

- WBC: 12.6 (normal <10), 80% neutrophils
- C-reactive protein: 4.5 (normal <0.5)
- Renal, hepatic, electrolytes, calcium, and thyroid tests: normal
- Urine: + for cocaine, otherwise unremarkable
- Chest x-ray: clear
- 12-lead EKG: sinus tachycardia without ectopy
- CT scan of the neck: normal

In the ICU, the patient was treated with IV crystalloid, IV diazepam, and IV penicillin G 4 million units every four hours. He also received tetanus immunoglobulin 3000 units IM. Rapid clinical improve-

ment was documented over the next 48 hours, and the patient was discharged on hospital day 3 feeling well.

At discharge, his WBC was 9.4, he was afebrile, and blood and urine cultures were negative.

### Pathogenesis

*Clostridium tetani* is a spore-forming bacterium found universally in soil, feces, and animal intestinal tracts. It is resistant to heat, desiccation, and disinfectants. Entering the body through a wound, the spores germinate, forming tetanospasmin, a CNS toxin that spreads through blood and lymphatics to block the release of neurotransmitters. This leads to unopposed muscle contraction and spasm, and, occasionally, seizures and autonomic dysfunction. The shortest peripheral nerves are the first to deliver toxin to the CNS, which leads to the early symptoms of facial spasm and back and neck stiffness.

### Clinical Features

The median incubation period for *Clostridium tetani* is seven to eight days, typically with the shorter incubation time equating to more severe illness.

There have been three clinical tetanus syndromes described:

- Local tetanus, involving muscle spasm in the immediate area of an inoculating wound (rare).
- Cephalic tetanus, with isolated cranial nerve involvement (usually CN VII) following head trauma or middle-ear infection (rare).
- Generalized tetanus (80% of all cases), characterized by trismus (lockjaw), widespread muscle spasm, and difficulty swallowing due to pharyngeal muscle involvement. Fevers, sweats, hypertension, tachycardia are common. Rarely, dysrhythmias and seizures can occur and raise concern for a poor prognosis.

A diagnostic bedside test, described as the "spatula test,"<sup>3</sup> requires touching the posterior oropharynx with a tongue blade, with a normal response triggering a gag reflex. If tetanus is present, however, a reflex spasm of the masseter muscles causes the patient to bite down on the tongue blade.

In 400 patients, this test had a sensitivity of 94% and a specificity of 100%; no adverse events (i.e., laryngospasm) were provoked by the test.

There are no laboratory findings diagnostic for tetanus. A modest leukocytosis is common, but wound cultures are positive in only 30% of cases, and blood cultures are rarely positive even in the presence of generalized tetanus. Laboratory

tests are most helpful in excluding other causes of tetanic spasms (i.e., thyroid-stimulating hormone, low blood calcium, toxin screens).

A focused history (including medications, exposures, medical problems, and prodromal symptoms), and a thorough physical exam will usually eliminate most of the previously listed conditions. A febrile patient with possible tetanus exposure, clear mentation, a non-focal neurologic exam, and generalized tetany and spasm should be considered to have tetanus until proven otherwise.

### **Medical Management**

Once the diagnosis of tetanus is seriously considered, a dark and quiet environment should be secured for the patient to prevent reflex spasms, and unnecessary procedures and manipulations should be avoided. Transport to an ICU setting should be initiated quickly, as about two-thirds of patients with more severe clinical manifestations eventually require intubation and ventilation.

Tetanus immune globulin (TIG) is recommended for all patients suspected of having tetanus. It is effective in removing unbound toxin from the patient, but cannot affect toxin already bound to nerve endings, so early use is advised. The generally recommended dose is 3000 units to 5000 units IM for adults and children. Infiltration of a small portion of the dose around the wound, if identified, is recommended, but has not been conclusively proven effective.

Metronidazole is the current antimicrobial of choice (30mg/kg/day given q6hrs, maximum 4 g/day) given PO or IV.

Parenteral penicillin G (100,000 U/kg/day given q4hours, maximum 12 million U/day) has been relegated to second-line status due to its propensity to increase spasticity in tetanus patients.

In patients unable to tolerate metronidazole or penicillin, second- or third-generation cephalosporins or tetracyclines have been used successfully. Treatment should continue for 10 to 14 days.

Once the patient is in the ICU setting, adjunctive therapies include surgical debridement of the wound, the use of antispasmodics, analgesics, and sedatives, and intensive airway management if required.

Full recovery can take up to six weeks. Common complications include nosocomial infections, pulmonary emboli, abnormal heart rhythms, and decubiti. Permanent neurological sequelae, often



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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](mailto:editor@jucm.com). We will credit all whose submissions are accepted for publication.

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## Tetanus Prophylaxis and Wound Management

	Clean, minor wounds	All other wounds*		
Vaccination history	Td†	TIG	Td+	TIG
Unknown or < 3 doses	Yes	No	Yes	Yes
≥3 doses	Only if last dose >10 yrs	No	Only if last dose >5 yrs	No

\*Such as, but not limited to, wounds contaminated with dirt, feces, soil, and saliva; puncture wounds; avulsions; any wounds resulting from missiles, crushing, burns, and frostbite.

†If patient is <7 years of age, give DTaP. If patient is between 7 and 10 years of age, or ≥65 years, give Td. Otherwise (i.e., between 11 and 64 years of age) give Tdap.

Source: Adapted from VPD Surveillance Manual, 4th Edition, 2008. Tetanus: Chapter 16. Available at: [www.cdc.gov/vaccines/pubs/surv-manual/default.htm](http://www.cdc.gov/vaccines/pubs/surv-manual/default.htm).

seen in neonatal tetanus survivors, are less common in children and adults.

### Immunization

In addition to thorough cleansing and debridement of a potentially infected wound, post-exposure immunization for tetanus is critical for prevention and treatment. The nature of the wound and the patient's immunization history dictate the recommended uses of tetanus toxoid (Td, Tdap, DT, DTaP) and TIG.

Patients who received their primary vaccination series but who have not received a tetanus booster within 10 years should receive a toxoid booster dose. If the wound is considered high-risk (e.g., contaminated with dirt, feces, or saliva, or deep or necrotic wounds), a toxoid booster should be given if the patient has not been boosted within five years.

Patients with unknown or uncertain vaccination history should receive both tetanus toxoid and TIG (250 U IM at a site distant from the toxoid administration) unless the wound is minor and clean, due to the fact that the toxoid alone (in the absence of previous immunization) will not be sufficient to produce a protective antibody response.

TIG (3000 units to 6000 units IM) should be administered as soon as possible to any patient exhibiting symptoms of or suspected of having tetanus.

### Specific Recommendations:<sup>4</sup>

A primary series consists of a minimum of three doses

of tetanus and diphtheria containing vaccine.

For infants <6 weeks of age, TIG (250 U IM) without toxoid is indicated for "dirty" wounds.

For infants and children >6 weeks up to 7-years-old, DTaP is recommended.

For persons 7- through 9-years-old, and those >65-years-old, Td is given.

For persons age 10 through 64 years, Tdap is preferred; if the patient has previously received Tdap, however, then Td is given.

HIV positive patients should receive TIG regardless of previous immunizations.

### Summary

As urgent care providers, we are many times on the front line of wound management, and all wounds present a potential risk for tetanus. An understanding of the signs and symptoms of tetanus, the importance of a good immunization history, and the role of vaccination in the prevention and treatment of this potentially lethal infection will help us keep our patients protected. ■

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FIGURE 1

5



The patient is a 35-year-old female who got her finger caught in a metal staircase banister one day prior to presentation.

Physical examination is significant for R 5th finger PIP hyperextension and DIP hyperflexion (swan neck deformity). Her PIP flexion limited to about 20°, while her contralateral PIP joint shows about 100 degrees of flexion. No sensory or motor deficits noted.

View the x-rays taken (**Figures 1 and 2**) and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

## THE RESOLUTION



FIGURE 2

**Figure 3** shows PIP hyperextension of the R 5th finger to about 30° beyond neutral.

Initially, subluxation was suspected, a digital block was performed, and the PIP joint was unsuccessfully reduced.

Post-reduction films showed mild straightening, but persistent PIP joint hyperextension.

This patient has a volar plate disruption of her R 5th PIP joint.

The volar plate forms the floor of the PIP joint, ligamentous at its origin on the proximal phalanx and cartilaginous in its insertion onto the middle phalanx.

A volar plate disruption is usually caused by a hyperextension injury or dislocation of the PIP joint; a mild force may rupture the plate at its distal insertion which will cause a swan neck deformity. Occasionally, a volar plate disruption may also be associated with a fracture of the base of the middle phalanx, which appears on x-ray with a small fragment of bone avulsed from the volar aspect.

As long as the PIP joint is slightly flexed, the joint is considered stable.

A lateral x-ray should be done to confirm that the joint is reduced, and the finger should be splinted in a slightly flexed position with follow-up within three to five days with an orthopedist. If the joint remains dislocated, the patient should be referred immediately.

*Acknowledgment: Case presented by Gloria Kim, MD, an urgent care Fellow at University Hospitals Urgent Care, Cleveland, OH.*

*H.C. Chin, MD*  
Anshin Medical Healthcare  
New York, NY



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FIGURE 1



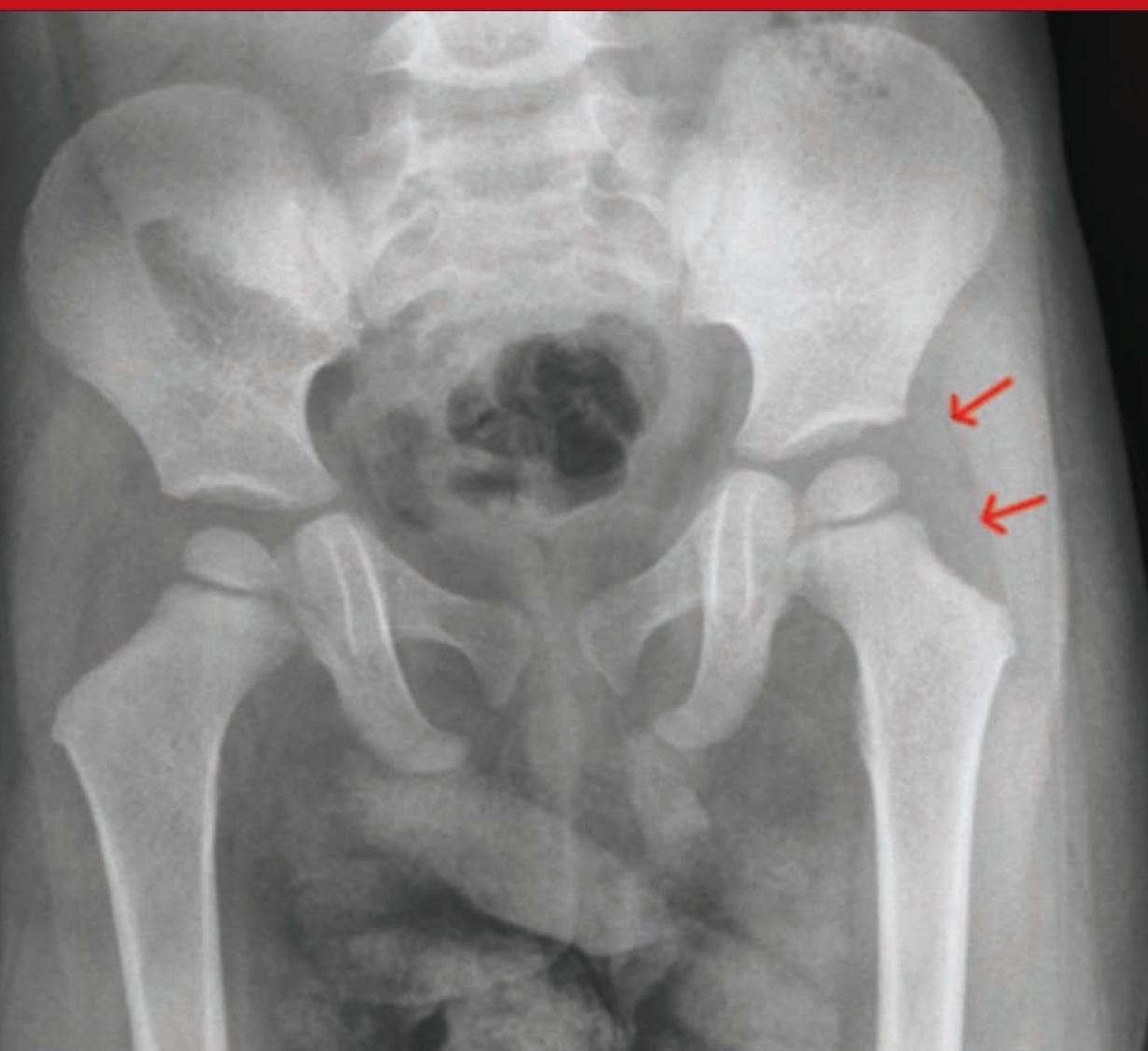
The patient is a boy, age 2 years 8 months, who presents with the complaint of pain in the left leg that started five hours ago. There is no history of trauma.

On exam, the child looks well and has a temp of 98.96° (axillary) and a pulse of 114. In addition, he has a WBC of 17.7, with 73.7% granulocytes.

The child's leg has no external findings. There is clear pain on movement at the hip joint. He cannot bear weight.

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

**THE RESOLUTION**



The x-ray showed fluid in the area of the hip joint, which can fit the picture of a toxic synovitis. Given the presentation and elevated WBC, the child was referred to hospital to rule out a septic arthritis.

*Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM; the patient was treated by Dr. Eliyahu Sheleg.*



## ABSTRACTS IN URGENT CARE

# On Blood Cultures in the ED, Scald Burns and the Microwave Oven, Pre-hospital Notification for Stroke Patients, Atrial Fibrillation in Observation Units, Venous Access Pain in Children, and Coronary CT

■ 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.

### Who Needs a Blood Culture in the ED?

**Key point:** Use of a prediction rule might reduce use of cultures in low-risk patients.

**Citation:** Shapiro NI, Wolfe RE, Wright SB, et al. Who needs a blood culture? A prospectively derived and validated prediction rule. *J Emerg Med*. 2008;35(3):255-264.

Although blood cultures often are obtained for patients in the emergency department, little evidence is available to guide patient selection for such testing. Currently, general indications for testing are poorly defined, and only 4% to 8% of blood cultures yield growth.

Such low yield suggests that opportunity exists to save both ED and laboratory resources and considerable costs.

In a prospective, observational cohort study of adult patients who had blood cultures obtained at a single academic ED (annual census: 50,000) over the course of one year, researchers developed a decision rule to assess risk for bacteremia. Of 3,730 patients, 8.2% had true bacteremia. Two thirds of the 3,730 patients were randomly selected as the derivation group and the remaining one third as the validation group.

In multiple logistic regression analysis, the researchers identified 13 independent predictors of bacteremia, categorizing them as major or minor criteria based on the strength of the association:



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

#### ■ Major criteria

- Temperature  $>39.5^{\circ}\text{C}$
- Indwelling vascular catheter
- Clinical suspicion of endocarditis

#### ■ Minor criteria

- Temperature  $38.3^{\circ}\text{C}-39.4^{\circ}\text{C}$
- Age  $>65$
- Chills
- Vomiting
- Hypotension (systolic blood pressure  $<90\text{ mm Hg}$ )
- Neutrophil percent  $>80\%$
- White blood cell count  $>18,000\text{ cells/mm}^3$
- Bands  $>5\%$
- Platelets  $<150,000\text{ cells/mm}^3$
- Creatinine  $>2.0\text{ mg/dL}$

According to the decision rule, blood cultures are indicated if at least one major criterion or two minor criteria are present. Less than 1% of patients who did not meet any of the criteria had positive blood cultures. In the validation group, the rule had a sensitivity of 97%, a specificity of 29%, a positive predictive value of 11%, and a negative predictive value of 99%. The authors estimate that use of the rule could reduce use of blood cultures by 27%.

This clinical decision rule for predicting bacteremia may be a reasonable starting point for further research, but the authors' inability to prospectively control which patients had blood cultures casts doubt on many of the criteria. ■

## ABSTRACTS IN URGENT CARE

[Published in *J Watch Emerg Med*, November 21, 2008—Aaron E. Bair, MD, MSc, FAAEM, FACEP.]

### Scald Burns—Beware the Microwave Oven!

**Key point:** Nine percent of unintentional scald burns in young children were related to use of microwave ovens.

**Citation:** Lowell G, Quinlan K, Gottlieb LJ. Preventing unintentional scald burns: Moving beyond tap water. *Pediatrics*. 2008;122(4):799-804.

Scald burns are the most common type of serious burn in young children. Reminding parents to lower hot-water heater temperatures to  $\leq 120^{\circ}\text{F}$  to prevent scald burns has been a key preventive measure; now, most scalds in children do not involve hot tap water. To determine the leading causes of scald burns among young children, investigators examined data from 104 patients <5-years-old who were admitted to a Chicago hospital for scald burns in 2002 through 2004. Nineteen children with intentional burns and 14 with tap-water burns were excluded.

The most common mechanisms of injury by non-tap-water scalds were children pulling containers on themselves (39%), someone else spilling a hot substance on the child (15%), children climbing to reach a hot substance (11%), children opening a microwave oven and removing the heated substance (9%), and children being scalded while being carried by another person (5%).

The mechanisms of injury paralleled developmental stages predictably: Infants often were burned while being carried, while most toddlers were burned when they pulled a container on themselves. Children as young as 18 months were burned while they were removing a heated substance from a microwave oven. Older children (age range, 7–14 years) were involved or cooking during 16% of scald burns to younger children.

Most scald burn accidents involved hot foods or liquids that were heated on the stove, but the microwave oven also deserves mention when providing anticipatory guidance about home safety and burn prevention in young children. ■

[Published in *J Watch Pediatr Adolesc Med*, November 5, 2008—Cornelius W. Van Niel, MD.]

### Benefits of Pre-hospital Notification for Stroke Patients

**Key point:** Pre-hospital ED notification decreased door-to-CT time by 23% and doubled use of thrombolytic therapy.

**Citation:** Abdullah AR, Smith EE, Biddinger PD, et al. Advance hospital notification by EMS in acute stroke is associated with shorter door-to-computed tomography time and increased likelihood of administration of tissue-plasminogen activator. *Prehosp Emerg Care*. 2008;12(4):426-431.

To examine the effects of advance notification of the arrival of stroke patients, researchers retrospectively analyzed data for 118 patients with acute stroke who were transported by emergency medical services directly from the scene to a single tertiary care emergency department within six hours of symptom onset during a 16-month period.

EMS staff provided advance notification to ED staff for 44 patients. No significant differences in age, sex, stroke history, or median National Institutes of Health Stroke Scale scores were noted between patients for whom pre-hospital notification was and was not given. Pre-hospital notification was associated with significantly shorter door-to-computed tomography time than no pre-hospital notification (median time, 40 vs. 47 minutes).

In multivariable linear regression modeling, pre-hospital notification reduced door-to-CT time by 23%. Nine patients for whom pre-hospital notification was given and none for whom notification was not given had prolonged door-to-CT times (two to five hours).

All patients were evaluated by a vascular neurologist.

Overall, 29% of patients received thrombolytic therapy (intravenous tissue plasminogen activator [TPA] in 20; IV TPA followed by intra-arterial thrombolysis in 12; and intra-arterial thrombolysis alone in two). Patients who arrived at the ED after pre-hospital notification were twice as likely as those who arrived without advance notice to receive thrombolytic therapy (42% vs. 21%).

As expected, pre-hospital notification of the ED allows mobilization of hospital resources for incoming stroke patients. Pre-hospital notification for stroke already is a class I recommendation of the American Heart Association. Why advance notification was not given for 63% of patients in this study is not known.

Most disturbing is that even when advance notification was provided, patients did not get CT scans within the recommended 30 minutes. Although it has been reported elsewhere that the window of time for stroke treatment is widening to 4.5 hours, that is not a license for delay. ■

[Published in *J Watch Emerg Med*, November 7, 2008—Kristi L. Koenig, MD, FACEP.]

### Treatment of AF in an ED Observation Unit: Faster and Better?

**Key point:** Compared with patients who received traditional inpatient care, patients managed in an ED observation unit had comparable outcomes and significantly shorter stays.

**Citation:** Decker WW, Smars PA, Vaidyanathan L, et al. A prospective, randomized trial of an emergency department observation unit for acute onset atrial fibrillation. *Ann Emerg Med*. 2008;52(4):322-328.

## ABSTRACTS IN URGENT CARE

The management of uncomplicated acute atrial fibrillation (AF) has evolved during the last few years, with early rate control and cardioversion gaining favor.

Here, researchers compared traditional inpatient care with management in an emergency department observation unit in a prospective, randomized trial of 153 adult patients who presented to an academic ED with acute (<48 hours' duration) uncomplicated AF.

Patients in both groups underwent initial pharmacologic rate control followed by electrical cardioversion, if needed. Patients were followed up after 30 days and six months.

Rates of conversion to sinus rhythm did not differ significantly between patients managed in the ED observation unit and those who received traditional inpatient care (85% vs. 73%;  $P=0.06$ ), but patients managed in the ED observation unit had significantly shorter mean lengths of stay (12.6 vs. 50.1 hours). Recurrence rates, adverse events, and use of healthcare services during the six months after treatment were similar in the two groups.

The finding that comparable outcomes were achieved with shorter lengths of stay is a compelling argument for management of uncomplicated acute AF in an ED observation unit. ■

[Published in *J Watch Emerg Med*, October 30, 2008—Richard D. Zane, MD, FAAEM.]

### Pharmacologic Approaches for Reducing Venous Access Pain in Children

**Key point:** *Multiple approaches for topical local anesthesia, some of which are effective within minutes.*

**Citation:** Zempsky WT. Pharmacologic approaches for reducing venous access pain in children. *Pediatrics*. 2008;122 Suppl 3:S140-S153.

A variety of pharmacologic options are available to clinicians who want to provide effective and safe topical local anesthesia to children undergoing venous access procedures. These options can be distinguished on the basis of how they deliver active drug through the impermeable outer layer of skin, the stratum corneum, to pain receptors located in the dermis and epidermis.

Three general methodologies are typically used to bypass the stratum corneum:

- direct injection of local anesthetics, usually via a small-gauge hypodermic syringe
- passive diffusion from topical creams or gels
- active needle-free drug strategies that enhance the rate of drug passage into the dermis and epidermis

Examples of the latter mechanisms include heat-enhanced diffusion, iontophoresis, sonophoresis, laser-assisted transdermal passage, and pressurized gas delivery of powdered drug particles.

Pharmacologic options in this setting can also be distin-

guished on the basis of the time to onset of full anesthetic effect. Several available agents induce significant local anesthesia within one to three minutes of administration or faster, allowing easy integration into the skin preparation and subsequent venous access procedure. In combination with nonpharmacologic approaches, these agents can be used to dramatically lessen this significant source of pediatric pain.

### Coronary Computed Tomography: Still Searching for a Reason to Believe

**Key point:** *In a multicenter study, 64-row coronary CT performed well, but not well enough to justify its use as a first-line diagnostic tool.*

**Citation:** Miller JM, Rochitte CE, Dewey M, et al. Diagnostic performance of coronary angiography by 64-Row CT. *N Engl J Med*. 2008;359:2324-2336.

Coronary computed tomography with 64 detectors has been heralded in some quarters as a noninvasive diagnostic tool that could replace conventional coronary angiography.

To evaluate the accuracy of this technique, investigators compared results of 64-row coronary CT with those of conventional coronary angiography in 291 patients with Agatston calcium scores  $\leq 600$  who were evaluated for symptoms of coronary artery disease at nine centers.

Fifty-six percent of the participants had at least one obstructive stenosis ( $\geq 50\%$ ); 27% had single-vessel disease. The median time between the two tests was 10 hours. The sensitivity of coronary CT for the detection of an obstructive stenosis of  $\geq 50\%$  was 85%, and its specificity was 90%. Coronary CT had a positive predictive value of 91% and a negative predictive value of 83%.

In a vessel-based analysis, coronary CT had a sensitivity of 75%, a specificity of 93%, a positive predictive value of 82%, and a negative predictive value of 89%. The mean radiation dose for CT was 13.8 mSv for men and 15.2 mSv for women.

Multidetector CTs' performance was reasonably close to that of the gold standard, coronary angiography, in patients with suspected CAD. The authors conclude, however, that the positive and negative predictive values of CT in this population are insufficient to recommend that the new technique replace conventional coronary angiography.

In an accompanying perspective piece, Redberg and Walsh note that the study "does not advance our knowledge of the appropriate use and possible benefits of the technology." Until we have solid evidence of such benefits—and clarity about how best to incorporate the evidence into decision making—we should avoid the routine use of coronary CT to assess patients for CAD. ■

[Published in *J Watch Cardiol*, November 26, 2008—Harlan M. Krumholz, MD, SM.]

# *Urgent Care Update*

## Making a Case for Hospital Urgent Care

**Urgent message:** Availability of hospital-affiliated urgent care can not only lower the burden on overcrowded EDs, but also help capture new business and keep existing patients within the health system.

Alan A. Ayers, MBA, MAcc

Hospitals have operated urgent care centers for over 25 years; today, estimates of how many centers are affiliated with hospitals range from 15% to 20%. In recent years, hospitals grappling with overcrowded emergency rooms and increased competition for outpatient visits have rediscovered urgent care as a way to shift low-acuity cases out of the ED while increasing revenue for affiliated providers and ancillary services.

### **The Cause of Long Emergency Room Waits**

Over the past 10 years, private and government payors have focused on reducing inpatient hospital stays as a way to curb rising healthcare costs. In response, hospitals have invested in new clinical technologies and elegant outpatient facilities. These neighborhood facilities—often anchored by an ambulatory surgery center—host a myriad of integrated services, including diagnostic imaging, physical rehabilitation, women's health, occupational medicine, and sleep services.

Despite an aging population and deteriorating per-



sonal health, the combined efforts of hospitals and payors have been successful in reducing inpatient days per 1,000 approximately 7% between 1999 and 2006, according to the Kaiser Family Health Foundation.

Progress, indeed—but with an unintended consequence.

Up to 40% of hospital emergency departments are overcrowded, the Institute of Medicine reported in 2006. Average wait times in hospital EDs have increased each of the past 10 years; in some cities, the time to be treated and discharged by an emer-

gency physician is now eight hours or longer, according to the U.S. Centers for Disease Control and Prevention.

The leading cause of emergency room overcrowding is the declining number of inpatient beds due to falling reimbursement and the shift to outpatient facilities, concludes the American College of Emergency Physicians. Without enough inpatient beds, hospitals "board" more patients in their emergency departments—which occupies beds there and increases wait times for new patients.

### A Solution for Crowded Emergency Rooms

Of all the reasons hospitals are interested in urgent care (**Table 1**), it seems the most common is to decompress an overcrowded ED. Besides long wait times, emergency room crowding makes it difficult to hire and retain good emergency physicians and nurses, increases the potential for medical errors, prolongs pain and suffering, and diminishes patient satisfaction.

In addition, ambulance diversion to other facilities can cause life-threatening treatment delays and preclude a hospital's ability to handle any type of volume "surge"—an essential defense against terrorist attack or natural disaster.

Up to 70% of emergency room visits could have been treated in a lower-acuity setting or avoided altogether if early treatment had occurred before the condition progressed into an emergency, states a 2005 New York University study.

Between 1996 and 2006, visits to hospital emergency rooms rose from 90 million to 119 million—a 32% increase, according the CDC. And in 2007, the Advisory Board Company, which conducts best practices research and analysis, projected that annual ED visits will continue to increase to roughly 124 million by 2015.

If low-acuity patients could be treated in settings other than hospital emergency departments, capacity would be freed to focus on trauma care and hospital admissions.

### ED Resistance to Urgent Care

When a more convenient, lower-cost alternative to the ED is made available, it's logical that consumers will use it. The challenge for some hospital and emergency department administrators is that while emergency room charges can be four to six times higher than urgent care, the incremental cost of treating a low-acuity patient in the ED can be very low, provided all resources are already in place. And when low-acuity patients have good insurance, their visits often subsidize losses on charity care and public assistance programs.

High margins from low-acuity, privately insured patients incentivize many hospital emergency departments to advertise "fast tracks," "service guarantees," and "zero wait" policies.

The legitimate fear among administrators is that losing privately insured and self-pay patients to urgent care will adversely affect ED margins. Because even when urgent care is available, there is a base of lower-margin patients—including Medicaid, indi-

# Call for Articles

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

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

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

#### Please e-mail your idea to

*JUCM Editor-in-Chief  
Lee Resnick, MD at  
[editor@jucm.com](mailto:editor@jucm.com).*

He will be happy to discuss it with you.



**Table 1. Common Value Propositions for Hospital Urgent Care**

#### **Branding**

Urgent care is an inexpensive way to bring a hospital's brand and resources to the consumers where they live, work, and play. Not only does urgent care increase accessibility to a hospital's array of services, but a "halo" effect occurs as consumers associate a hospital-affiliated urgent care with higher quality and deeper capabilities. Urgent care can be integrated with a hospital's advertising and grassroots marketing efforts and serve as a venue for community events and screenings that promote the entire health system.

#### **Flanking/catchment**

Urban hospitals often use suburban urgent care centers to "capture" consumers into their system and "push" them back to the primary campus through referrals. If not for this neighborhood access point, consumers may prefer to utilize more convenient suburban hospitals. As a defensive measure, some hospitals "flank" competing hospitals with a ring of urgent care centers to capture patients from the competitor's catchment area. Urgent care can also be a solution when building a full-service hospital facility is cost-prohibitive or certificate of need requirements cannot be met.

#### **Referrals/downstream revenue**

Urgent care generates direct revenue for hospital services, including diagnostic imaging, laboratory, clinical specialists, and physical therapy. The availability of urgent care may also increase early detection of cancer, heart disease, and other chronic conditions. Downstream revenue generated to a hospital system through referrals and ancillary service utilization is often a multiple of the profitability of the urgent care as a freestanding entity.

#### **Offset emergency department volume**

Hospitals with emergency room crowding see urgent care as a way to shift low-acuity cases out of the ED into a lower-cost treatment setting, as well as a way to prevent acutely rising conditions from turning into medical emergencies.

#### **Overflow and after-hours coverage for primary care**

With coordinated medical records, an urgent care center can serve a primary care provider's patients when the office is closed or the schedule is booked. In exchange, urgent care provides primary care referrals for follow-up and management of chronic conditions. Functions like x-ray and lab collection can also be consolidated at the urgent care center.

#### **Practice opportunities and equity participation for physicians**

Hospitals often try to attract and retain high-quality providers by offering equity ownership. Many hospital-affiliated urgent care centers are joint ventures with physicians or management companies. Urgent care may also serve as a training ground for residents, a venue for midlevel providers to meet state practice requirements, or as supplemental income for various practice groups.

gent, mentally ill, and non-working uninsured populations—who are unlikely to change their behavior of using the ED as a stop-gap or access point for primary care.

#### **Urgent Care as an Alternative to the Emergency Room**

Despite concerns that urgent care will "cherry pick" the most profitable ER cases, studies show the percentage of indigent or charity care patients presenting to the ER with low-acuity conditions is relatively low. A 2005 report in the *Annals of Emergency Medicine* indicates that as many as 85% of emergency room patients have health insurance and 70% have incomes above the federal poverty level. Many patients use the ED not because they have to—but because they want to.

Affluent and fully insured patients expect convenience and demand quality—hospital emergency rooms are available 24 hours a day, seven days a week and consumers perceive that hospital affiliation and staffing by emergency physicians results in broader capabilities and a higher standard of care.

In order to woo premium patients away from the emergency room, urgent care must offer a superior experience—one that is closer to home, has shorter wait times, incurs less hassle with billing, and is delivered in a warm and friendly atmosphere. Lower copays built into an increasing number of insurance plans also help direct patients to urgent care, as do high-deductible health plans that make consumers responsible for the cost of their visit.

If hospitals don't embrace urgent care, emergency room capacity problems will only get worse and insured patients will be targeted by entrepreneurial urgent care centers, retail health clinics, walk-in family practices, and other delivery models. Each of these emerging players promotes itself as an "alternative to the emergency room," and while they

may help the hospital achieve its goal of offsetting ED volume, in many cases they will not contribute anything back to the hospital in return for the revenue lost.

**Table 2. Considerations Unique to Hospital Urgent Care****Ownership and management structure**

A hospital may offer urgent care as an extension of the emergency department, as fully controlled ancillary service, as an equity joint venture, or as a landlord/tenant relationship. Partners may include physicians, physician groups, private developers, or urgent care management companies. Management—including billing, marketing, staffing, and operations oversight—may be by the hospital, joint venture investors, or a management company. The ownership and management model selected—including branding, financing, and controlling interests—must support the goals and objectives of all investors in the urgent care initiative.

**Facility fee**

Unlike a hospital emergency room that provides separate bills for the facility, medical provider, radiology, lab, and other services, a typical advantage of urgent care is one consolidated, easy-to-understand bill.

A hospital may charge a facility fee for urgent care under the following conditions:

- If the urgent care center is located physically in the hospital building or on the hospital campus; it must have the same licensure as the hospital, integrated clinical services, billing, and financial administration with the hospital, and be recognized by the public as being part of the hospital.
- If the urgent care center is located away from the hospital campus, either in a freestanding building or hospital ambulatory facility, it must have common ownership, control, administration, and supervision with the hospital and be located in the “immediate vicinity” of the hospital.
- If the urgent care center is a hospital joint venture, it must be partially owned by the hospital, located on the main campus of the hospital that is an owner, and designated by the Centers for Medicare & Medicaid Services as a “provider-based facility.”

**Emergency Medical Treatment and Active Labor Act (EMTALA)**

A hospital-affiliated urgent care center may be required to provide—with regard to a patient’s ability to pay—a medical screening and transfer for emergency conditions if the urgent care is located on a hospital campus, is within 250 yards of the hospital emergency department, or the urgent care center bills under the hospital’s provider number.

**Downstream Referrals Generated by Urgent Care**

Hospital-affiliated urgent care allows hospitals to offset ED volume but still build their revenue base. When urgent care is integrated with affiliated practice groups and ancillary services, it becomes an entry point to the health system. Pediatrics, internal medicine, orthopedics, physical medicine, general surgery, and podiatry are just a few of the specialties that benefit from urgent care referrals.

Moreover, urgent care provides direct revenue to hospital ancillary services like diagnostic imaging, laboratory, and physical rehabilitation, which are also utilized by referral providers.

The degree to which urgent care is integrated with affiliated providers and ancillary services—including location

in the same facility, shared electronic medical records, and consolidated billing— influences how effective the health system will be in capturing referrals and retaining downstream revenue.

In addition to supporting existing services, a professionally staffed and well-equipped urgent care provides visibility and access to consumer and business markets—allowing a hospital to enter new lines of business such as occupational or travel medicine. These new business lines generate additional referrals and further utilization of ancillary services. Hospitals may also use the urgent care center to make services otherwise provided in the hospital—such as laboratory collections—more convenient for consumers.

**‘Front Door’ to the Health System**

The result of fewer inpatient admissions and continued hospital investment in outpatient capabilities is increased competition among hospitals in many communities—with hospitals trying to establish themselves as having the most locations, greatest patient satisfaction, highest quality rankings, and widest range of capabilities to attract new patients and retain providers.

The very essence of urgent care is that it is a consumer-centric healthcare delivery model—a convenient, extended hours, walk-in facility. Urgent care can establish a hospital’s brand in a community and provide a “front door” by which consumers can access all of the hospital’s services.

While hospital urgent care does face some unique operational challenges (**Table 2**) not common to independent, freestanding urgent care centers, hospital-branded urgent care centers benefit from the halo effect described previously.

Although the case for hospital urgent care is appealing on the surface, in practice it isn’t so cut-and-dried. Hospitals are large, complex organizations filled with a spectrum of financial, social, and clinical interests which need to be continually reconciled. Therefore, the business case for urgent care needs to be carefully constructed to meet the expectations of all interested parties in an integrated health system. ■

# *Urgent Care Update*

# The Search for the Urgent Care Center

**Urgent message:** Efforts to define and accurately count urgent care centers in the U.S.—which may be crucial to the industry's continued growth—are ongoing, and will require the commitment of trade organizations and individual urgent care owners alike.

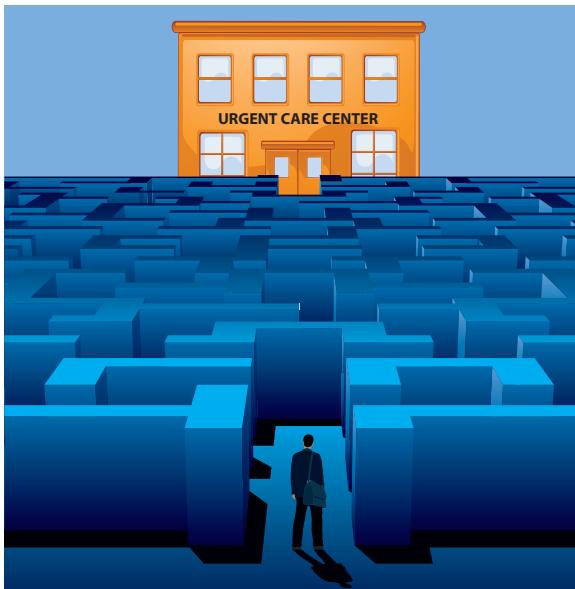
Robin M. Weinick, PhD, Steffanie J. Bristol, BS, Jessica E. Marder, and Catherine M. DesRoches, DrPH

Our quest to provide accurate, scientifically rigorous benchmarking data for urgent care centers began with the decision to conduct a survey. Before you can administer a survey, though, you need to be able to identify the individuals or organizations that you want to answer your questions.

## Defining Urgent Care

The first challenge was deciding what counts as an urgent care center. For example, consider three types of practices that one of us visited early in 2008:

- Dr. A has a family practice and sees scheduled patients, primarily. She provides the usual scope of primary care services. Located in a strip mall, her practice has a sign in the window that reads "walk-ins welcome."
- Dr. B runs a storefront clinic. He sees walk-in



Photos: iStockPhoto.com; Digital composite: Tom DePenda

patients, primarily, although they do take some appointments. He does not accept insurance, and charges \$25 cash for a visit. He performs few procedures in his office.

■ Dr. C describes his practice as half family medicine, half urgent care. They do suturing, splinting, and casting on site, and have a dedicated room for x-rays and film storage. They're open every evening, as well as every Saturday, and they have a significant occupational medicine practice.

It's probably safe to say that Drs. A and B are not running urgent care cen-

ters, but Dr. C is.

To move beyond the "I know one when I see one" approach, however, we needed a formal definition of what would count and what would not.

Working with the UCAOA Benchmarking Committee and basing our definition on previous work,<sup>1</sup> we de-

cided that to be counted as an urgent care center, a practice would need to meet *all* of the following criteria:

- Provides care primarily on a walk-in basis.
- Has evening office hours Monday through Friday.
- Has office hours at least one day over the weekend.
- Provides suturing for minor lacerations.
- Provides x-rays on site.

### Finding Urgent Care Centers

The next step was to locate as many urgent care centers as we could. This involved a three-part strategy: using health insurers' websites, Internet searches, and the UCAOA/JUCM mailing list.

#### *Health insurers' websites*

We developed a list of major insurance carriers by reviewing the government-operated website of the insurance commissioner for each state, as well as websites sponsored by trade associations of insurers, and those designed to help consumers in finding health insurance coverage. Any carrier that provided insurance solely for anything other than health coverage, such as life insurance, was removed from the list.

Then we searched each insurance carrier's website separately, using any available documents that listed their contracted urgent care centers. In addition, we searched the provider directory on each website to identify urgent care centers—if any—based on physician and center specialty.

#### *Internet searches*

We also searched Internet directories, using Rhode Island and the Los Angeles metropolitan area as trial locations to determine the best search terms based on advice from UCAOA staff and the UCAOA Benchmarking Committee (**Table 1**).

When we identified chains of urgent care centers, we went to each chain's website to ensure that we included all of its locations.

In general, the Internet directory searches yielded comparatively few urgent care centers that had not already been identified via the health insurer website search. For example, in North Carolina, the insurance carrier search yielded 267 urgent care centers, and the

**Table 1. Search Engines and Key Phrases**

<a href="http://www.yellowpages.com">www.yellowpages.com</a>	<a href="http://www.superpages.com">www.superpages.com</a>	<a href="http://www.switchboard.com">www.switchboard.com</a>
Urgent care	Urgent care centers	Urgent care centers
Urgent care centers	Drop-in clinic	
Emergent care	Urgent care centers	
Walk-in clinic		

Internet directory search netted an additional 70 urgent care centers.

#### *UCAOA/JUCM mailing list*

Finally, we used the UCAOA/JUCM mailing list, stripped of all retail clinics based on the names of known retail clinic chains, as well as any organizations listed as being inside a Walmart, Rite Aid, CVS, or Walgreens.

#### **What We Found**

We found about 8,000 urgent care centers—far fewer than previous estimates of 12,000-20,000.

So, then, why the difference? We know that our count does not necessarily represent a complete and accurate count of all facilities in the U.S. for three reasons:

- First, there may be urgent care centers that we could not find using our search strategy.
- Second, it's likely that we're systematically missing urgent care centers that are part of hospitals. We tried to identify these centers by purchasing data from the American Hospital Association's annual survey, which asks the hospital executive completing the survey if that hospital has an urgent care center. (The definition offered on the back of their survey notes that an urgent care center is "A facility that provides care and treatment for problems that are not life threatening but require attention in the short-term.")

When we tried to find mailing addresses for these centers, however, many of them turned out to be the fast-track or minor-care area of the hospitals' emergency departments. Many hospitals operate walk-in clinics or urgent care centers, but this list left us with no way to locate them.

- Third, we know that many of the centers we

**Table 2. Ownership and Time in Operation**

	% or mean	Standard error
<i>Ownership (n=400)</i>		
Owned by a corporation as part of a chain or network	17.5	1.9
Independently owned by one physician	21.8	2.1
Independently owned by two or more physicians	32.3	2.3
Hospital–physician joint venture	3.8	1.0
Hospital-owned on campus	2.8	0.8
Hospital-owned off campus	22.0	2.1
<i>How long this center has been in operation (n=424)</i>		
<1 year	6.0	1.1
≥1 year but <2 years	9.2	1.4
≥2 years but <5 years	18.2	1.9
≥5 years	66.6	2.3

identified during our search would not meet our criteria. As a result, we excluded a variety of organizations, such as student health centers on college campuses, consulting and practice management firms, a surprising number of urgent lawn care businesses (in case those dandelions constitute an emergency!), a Volkswagen car dealership, and a veterinary center.

### The Survey

And then, we conducted our anonymous survey.

Of the 1,703 surveys that we mailed out, ultimately 595 respondents did not meet our definition of an urgent care center. That's more than one-third, even after carefully checking over our lists before sending out the surveys. Another 415 turned out to be wrong addresses, wrong phone numbers, or were otherwise unreachable.

What types of urgent care centers did answer our survey? As **Table 2** shows, they are primarily physician-owned organizations, although corporations own a significant proportion of these centers. Not surprisingly, given what we learned from the hospital list we purchased, we found very few centers owned by hospitals and operated on their campuses.

The organizations that responded to our survey had been in business for a while; approximately two-thirds had been in operation for five or more years. This probably is not representative of the field as a whole, however, since more established (i.e., "older")

organizations may be more likely to have staff with time available to answer survey questions.

### What We Learned

People ask us how many urgent care centers there are in the U.S.; however, there is no way to provide an exact answer to that question. The number we found (8,113, to be exact) reflects both significant undercounting and a lot of anonymous organizations that aren't really urgent care centers.

Realizing that this question is partly unanswerable, at present, provides valuable insight into the industry and could be a call to action, however.

Consider this: If a team of research professionals finds it difficult to identify every urgent care center in the country, how many patients that might be coming to you for care simply don't know you exist?

Anything you can do to promote awareness of your practice will contribute to establishing systematic ways of locating urgent care centers. And that will be good business for the entire marketplace.

*[Editor's note: Future issues of JUCM will look at the challenge of getting your urgent care center noticed and strategies that have proven effective for your colleagues.]*

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# What, When, Who, and How to Offer ‘Freebies’

■ FRANK H. LEONE, MBA, MPH

**H**istorically, marketing occupational health services has often meant producing various commodities with your clinic's name on it: pens, hats, mini-flashlights, refrigerator magnets, note pads, even t-shirts. Cute, perhaps—but these trinkets cost money, took time to distribute, and quickly faded from the recipient's mind, if not their possession.

Should your clinic's outreach strategy include “freebies?” If so, what should they be, how should they be distributed, and who should receive them?

### What to Offer

Free goods and services should fall into two categories: something of educational value or something that allows recipients to “feel” or experience your clinic.

Educational offerings might include episodic e-mail blasts about new workplace regulations or other current topics, regular e-mail tips, or efforts to leverage a program's website as an informational source.

In turn, your clinic might develop a monthly e-mail briefing at, say, \$49 a year. If marketed aggressively, it could be a revenue source in its own right (e.g., 200 employer subscribers a year at \$49=\$9,800 in gross revenue). Such a product is:

- A low-cost way to make a prospect a “mini-client” of your clinic. A prospect may not be ready to move their business over to your clinic, but may be comfortable with a \$49 subscription. Hence, you remain on the prospect's radar screen, emphasize your clinic's mastery of occupational health, and are poised to move the company into the client column at a later date.
- Renewable, as a subscription keeps on giving. A \$49

“close” can easily grow to a \$490 close over 10 years.

- A way to begin or build a relationship with a prospect. When all else fails, the salesperson can always fall back on the following offer: “I would like to offer you a complimentary one-year subscription to our *Occupational Health Update*. I am confident that you will find it valuable and it would allow us to begin a relationship with your company.”

The second approach for offering a freebie involves a hands-on, active experience with your clinic. For example, you can provide a free mini-annual physical to decision makers from high-priority prospects.

If time is set aside for one physical exam per week, your 50 highest-profile prospects can gain a hands-on experience in your clinic every year.

When you provide low-cost or free services, you are not losing revenue but incurring costs per unit of complimentary service. The free one-year subscription is a no-brainer: an incremental e-mail subscription costs your program virtually nothing (to say nothing of prospective paid renewal revenue). Provided that you schedule complimentary physicals during traditionally low-volume hours in your clinic, that cost is minimal, as well.

### When and to Whom?

A free subscription or analogous low-cost product is best reserved for the moment it becomes evident that a close is unlikely. Rather than merely a “Thank you, perhaps sometime in the future,” you can now offer the one-year “getting to know us” free subscription. The free subscription option is applicable to virtually any prospect, regardless of their priority or future volume potential.

The “free physical” option applies primarily to your “A” prospects. Such an amenity is best offered to prospects that have not closed the door but are not quite committed,



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*Continued on page 44.*



# Determining New vs. Established Patients for E/M Coding

■ DAVID STERN, MD, CPC

**Q.** We are in the process of adding urgent care services to our occupational medicine clinic. How do we determine when to use a new or established E/M code for the patients who are seen for urgent care services?

Question submitted by Mari Lukowski

**A.** I continue to receive questions regarding the "when to code new or established patient E/M codes" conundrum, so let's try to simplify the issue.

The official CPT definition of **new patient** is: A patient who has **not** received **professional services** from a **physician** or another **physician of the same specialty** in the **same practice** within the **past three years**. [Emphasis added.]

One problem with this definition is that the scope of professional services that counts here is defined differently by the American Medical Association and the Centers for Medicare & Medicaid Services:

- AMA (i.e., CPT): includes any "professional services" as establishing a patient.
- CMS: limits these services to face-to-face E/M services.

**Figure 1** shows how to use the CMS algorithm to determine if a patient is a new or established patient.

**Figure 2** shows how to use the AMA algorithm to determine if a patient is a new or established patient.

Many practices have chosen to use the CMS definition for all payors, but a particular payor may insist on the AMA rules.

The big question for your practice when making this conversion is this: Will you count occupational medicine visits toward establishing patients in the urgent care?

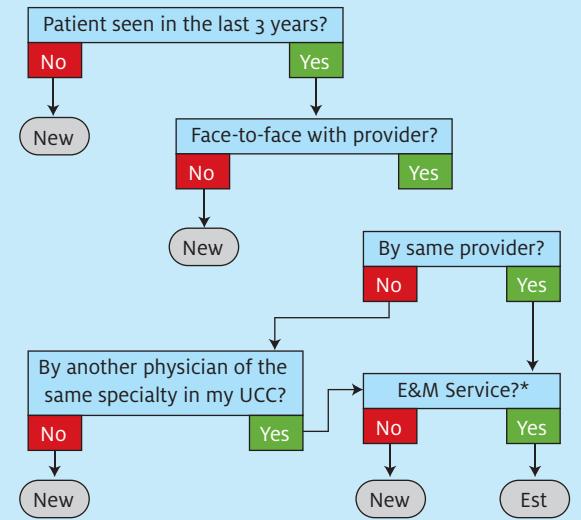
The simplest (but not necessarily the most profitable) way

*Continued on page 44.*

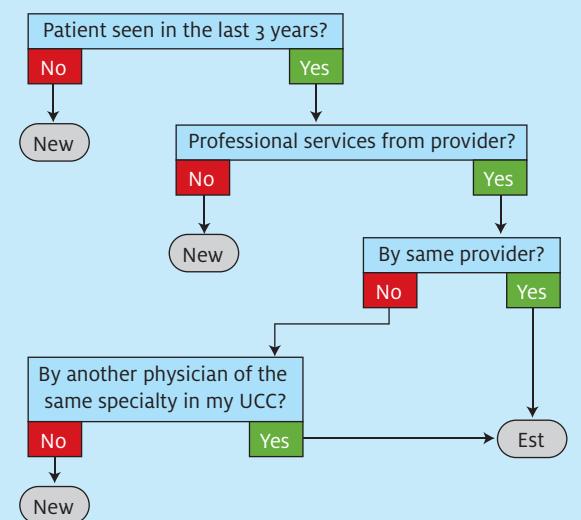


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**Figure 1. New vs. established patient: CMS Algorithm**



**Figure 2. New vs. established patient: AMA Algorithm**





# EMTALA and Transferring Patients to the Emergency Department

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

I was an emergency medicine resident on the south side of Chicago in the mid-1980s and, truth be known, I sometimes played inappropriate practical jokes on residents at other area trauma centers. One of my favorites was calling over the "patch phone" with a report that a patient whose penis was "Lorena Bobbitted" by a pit bull was en route; the paramedics were bringing in both the patient and the dog so that a "reimplantation" could be attempted post vivisection of the dog.

My other favorite was the one where multiple severely handicapped children were coming in post minor bus accident for evaluation, with their parents not readily available.

Anyway, usually the calls concluded with the recipient resident saying things like, "Oh yeah, why don't you bite me?"

Calling emergency departments from an urgent care is sometimes a traumatic experience made worse by some ED physician giving you the third degree about "what you are dumping on us?" and muttering something about EMTALA (the Emergency Medical Treatment and Active Labor Act) and hanging up phone while saying "bite me!"

## Urgent Care Obligations

Do urgent care centers have any obligation under EMTALA? The answer is: it depends.

If the urgent care center is owned and operated by the hospital and is under the same Medicare provider number and meets the Centers for Medicare & Medicaid Services' definition of a "dedicated emergency department" by meeting one of the following criteria: 1) is licensed by the state as an emergency department; 2) holds itself out to the public as providing emergency care; or, 3) during the preceding calendar year, provided at least one-third of its visits for the treatment of emergency conditions,



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then the answer is yes.

However, does EMTALA apply if the urgent care center operates independently from the hospital (different provider number) and sees less than 33% walk-in patients with emergency conditions?

Or, what if an urgent care advertises that it only treats urgent conditions and not emergent conditions; is that center exempt from EMTALA?

The answer to both these scenarios is (I hate to answer like a lawyer) more likely than not, EMTALA does not apply. CMS does retain the right to review claims on a case-by-case basis. In other words, they can use the dreaded "retrospectoscope" to evaluate the relationship and then pass judgment.

The take-home point is this: If you are working at a hospital-owned urgent care center which makes no distinction on the types of patients treated and sees patients who may qualify as an "emergency," you have some EMTALA exposure. Therefore, the same EMTALA policies used in the emergency department should be in place at the hospital urgent care center. For example, not taking insurance information until an appropriate screening exam is completed, stabilizing prior to appropriate transfers, and providing an appropriate screening exam for all comers.

Occasionally, urgent care physicians tell me that when they do call to alert an emergency physician, they are given the third degree by the recipient and are often told that the ED won't accept the patient.

Do you *need* to call an emergency department from a physician-owned urgent care prior to transfer? Absolutely not!

In a perfect world, communicating with a receiving provider should be commonplace; this direct communication facilitates the continuum of care and allows the sending provider to alert the receiving provider about what has already transpired and what the concerns or issues are regarding the patient.

What should *not* occur, however, is the sending provider receiving the third degree by some overworked, burned out EM physician.

At the end of the day, the emergency department cannot refuse the patient no matter how inappropriate they believe the

## HEALTH LAW

transfer, unless the ED is closed to ambulance traffic. And even if they are closed to ambulance transfers, they cannot refuse a patient who is being transferred by private vehicle.

### Effective Provider-to-Provider Communication

There are other ways to communicate important facts germane to the patient who is changing venues to the emergency department.

When I work in the ED, I don't necessarily want to hear from an urgent care provider who is transferring a patient to my care. I simply don't want to be biased by their concerns.

What I do expect, however, is a written record of the history, exam, radiographs, and lab results, as well as a written statement identifying the UC provider's concern. "This 67-year-old diabetic patient presents with abdominal pain out of proportion to exam findings and I am concerned about the possibility of ischemic bowel."

If you feel more comfortable communicating directly with the receiving physician, more power to you, although don't let yourself be the recipient of any abuse.

When I transfer a patient, I call *after* the patient has already left the urgent care and I keep my communication fact-based: "I just sent you a 48-year-old man with a good story for acute coronary syndrome. His EKG, CXR and troponin are normal, as well as his d-dimer. He has hypertension and a family history for coronary artery disease and should be there in about 10 minutes."

This leaves the emergency physician no out; the patient is on his way.

Compare this method with "I'm thinking about sending a patient who may have angina. Everything else is normal but I'm not sure what else to do. Would you mind if I sent him your way?"

You get the picture. If you are constantly getting pushback from the ED, choose another receiving hospital or, if you have to use the particular ED, quit calling. After all, you are sending them a patient who will augment their income; why should you be abused?

### Epilogue

You know the old saying, "what goes around...." Well, you guessed it. A short while after placing one of the calls I confessed to previously, I was on the actual receiving end of one of these scenarios.

A bus load of handicapped kids were involved in a minor accident and they all arrived unexpectedly—"unexpected" only because I did hang up on the University of Chicago EM resident who called on the patch phone. And I did say "bite me!"

Lesson learned. <sup>n</sup>

## OCCUPATIONAL MEDICINE

or to the highest-priority prospects that for the moment have little interest. The offer is usually made toward the end of the sales call when the disposition of the call is apparent.

### How to Make the Offer

It is not what you say; it is how you say it. When offering a complimentary service, you need to go beyond simply offering the product/service by mentioning its value; give an honest appraisal of why the prospect should accept the free commodity.

That is, you should quantify both the dollar value of the product or service and the functional value (e.g., what's in it for the prospect) in the same breath that you are offering the complimentary service.

Your clinic should be well past the trinket era and focused on providing complimentary services of genuine value and/or offer a true hands-on experience to prospects.

Developing a plan on what to offer, who to offer, when to make the offer, and how to verbalize the offer can provide your clinic with a cost-effective yet excellent marketing tool for converting both near- and non-prospects into clients. <sup>n</sup>

## CODING Q & A

to answer this is this: *If the patient has been seen in the urgent care or occupational medicine clinic in the past three years (not counting drug screens), then the patient is established.*

If the urgent care and the occupational medicine clinics are incorporated separately, you may be able to count most new patient visits to the urgent care center as new patients, even if the patient has been previously seen in the occupational medicine clinic.

One exception must always be considered: If the patient has been seen for evaluation and management by the same physician (whether it be in a private practice, emergency department, occupational medicine clinic, or any other setting), then for three subsequent years the patient is an established patient for that particular physician in any practice setting.<sup>n</sup>

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# Career Opportunities

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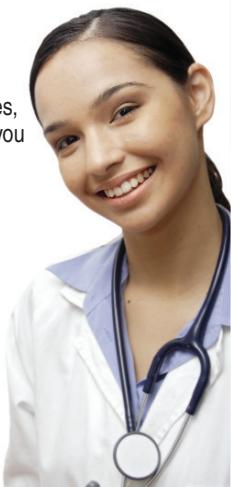
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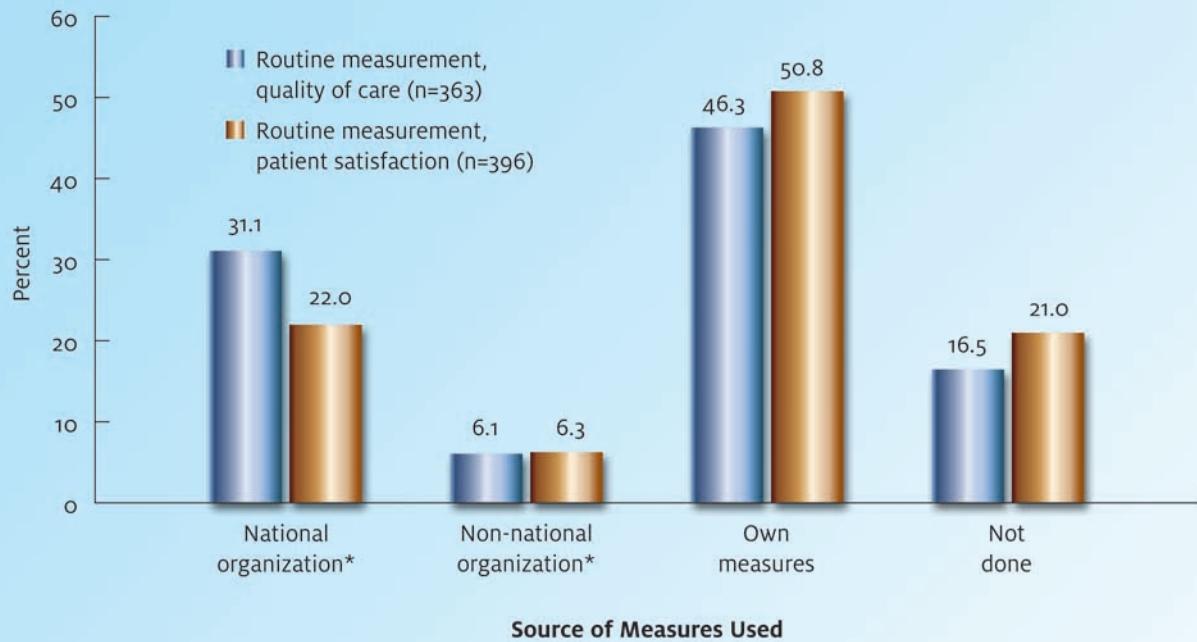
## DEVELOPING DATA

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

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

*In this issue:* Of those urgent care centers that responded to questions about how they measure quality of care and patient satisfaction, what percentage use standards set forth by national organizations, by non-national organizations, using standards developed by the center itself, or not at all?

### MEASURING QUALITY



\*For quality of care, examples of "national organizations" that propose quality measures include HEDIS, The Joint Commission and others; for patient satisfaction, the term might apply to organizations such as CAHPS, Press-Ganey, or others.

Source: Weinick RM, Bristol SJ, DesRoches CM. The Quality of Care at Urgent Care Centers. In press. *J Urgent Care Med.* 2009.

The authors suggest that the centers that choose not to measure patient satisfaction might be missing an opportunity to understand patient perception of their services—which, ultimately, could impact the economic health of the center.

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



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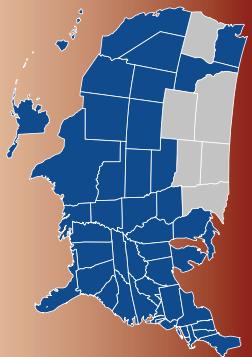
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