

JUCM™

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Their success is in your hands. Here's how to help



Closed Hand Injuries

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LETTER FROM THE EDITOR-IN-CHIEF

Reforming Patient Expectations



In my last column, I addressed the contribution of unrealistic patient expectations to unsustainable healthcare costs. I postulated that the competing societal goals of preserving freedom of choice while providing healthcare for all will produce a futile

tug-of-war. I further warned that leaving the solutions to politicians and government administrators will inevitably lead to myopic reforms that threaten the doctor-patient relationship and fail to consistently incentivize good care. In this month's column, I'd like to take a closer look at some the specific sociological drivers that have created self-induced barriers to implementing high-quality and cost-effective healthcare in this country.

The "Money-Back Guarantee"

There is perhaps nothing more American than the money-back guarantee. We have grown dangerously accustomed to risk-free "purchases." Patients have been driven madly into the belief that medical decisions should also come with a guarantee. As clinicians, we are expected—for that matter *demand*—to "rule out" every possible malady for every possible presentation. MI's, CVA's, tumors, and the like all must be ruled out because there remains a possibility, no matter how slim, that they may exist. This is expected. If you do not deliver on this expectation, patients will leave unhappy, consider your care sub-par, and sue you if you're wrong. Just think of how many unnecessary admissions for chest pain you've done in the last year. Society has not given you permission to use your best judgment and will punish you for it, no less. You "gambled" on a decision and you were wrong. You WILL pay.

I had a mother bring in her 13-year-old daughter the other day with a headache for six hours. No effort was made to treat the headache with OTC pain relievers. I took a thorough history, performed a thorough exam, and looked for any red flags that this could represent a dangerous headache (far-fetched to begin with). Her headache was so benign and mild that I couldn't even call it a tension headache with a straight face. When asked what was causing her headache, I simply had to reply, "I don't know. People just get headaches sometimes." This of course drew a puzzled and angry look from her mother. "What do you mean you don't know? That's not a diagnosis! Can you guarantee me she doesn't have a tumor or bleeding? She needs an MRI!"

"He Who Dies With the Most 'Tests' Wins"

While perceived quality and risk aversion understandably drive utilization, less apparent and more stunning is the role peer pressure. Nowhere does this impact unnecessary testing more than with MRI's for simple knee pain. This bizarrely becomes apparent at every party, social hall, or assisted-living dining room. A veritable horserace ensues as people jockey for a leg up on the number of procedures and scans they have had. Low utilizers are considered ignorant or weak. "You tell your doctor you need an MRI" echoes across the room. While there is zero evidence supporting MRIs in the evaluation of simple, atraumatic knee pain of less than six weeks' duration, social pressures have become major market drivers. Yes, that's right, people use access to healthcare services as a social currency, and more is just simply better.

Who Will Pay for Reforming Expectations

According to the Kaiser Commission on Medicaid and the Uninsured, an additional \$48 billion per year over current healthcare expenditures would be required to insure all Americans. That's less than 7% of the \$700 billion wasted annually on unproven care. The expectation of healthcare reform in large part demands that the physicians tell their patients that they don't need these unproven tests and procedures. Unfortunately, if I had to talk every intervention seeker, scan seeker, and guarantee seeker out of all of their expectations, it would take me 10 times the amount time per encounter. The vast majority of hard-working, non-proceduralist physicians I know can barely make a respectable living without acquiescing to wild patient expectations. It will be a hard sell to get them to spend more time for less pay.

It is long overdue for Americans to take a hard look in the mirror and recognize the patients' role in driving up healthcare costs. Supporting measures that ensure more appropriate utilization by empowering *and* paying for a physician-led re-education without the expectation of a guarantee is the only solution. All sales final ... no refunds, returns, or exchanges. ■

Lee A. Resnick, MD
Editor-in-Chief
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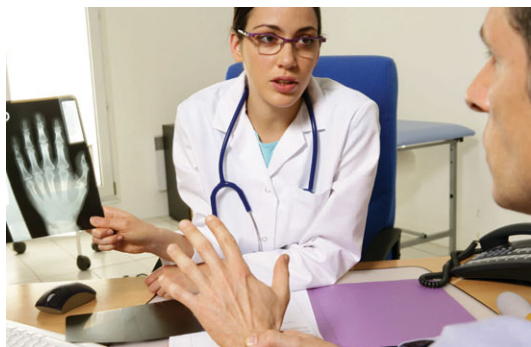
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CLINICAL

9 Closed Hand Injuries

Even a seemingly minor hand injury can result in lifelong disability if evaluation and treatment are incorrect.

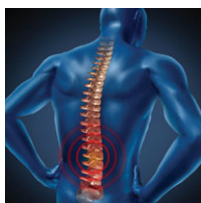
Tracey Quail Davidoff, MD

CASE REPORT

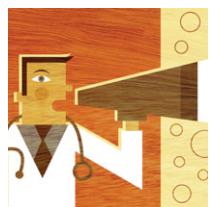
19 High-Risk Conditions Presenting as Back Pain

That back pain is common and typically without serious sequelae may result in misdiagnosis and mistreatment.

*Erica Marshburn, BS, BA, and
John Shufeldt, MD, JD, MBA, FACEP*



PRACTICE MANAGEMENT



23 Motivate Your Front-Line Staff With Enlightened Leadership

Registration specialists, medical assistants, and techs may be your lowest-paid employees, but the success of your urgent care is in their hands—and their success is in yours.

Alan A. Ayers, MBA, MAcc

WEB EXCLUSIVE

What Do Patients Want?

Understanding what patients seek from urgent care starts with understanding the different generations to which they belong. The needs and expectations of members of the Greatest Generation, Baby Boomers, Gen Xers, and Millennials are not the same.

Nicole Nicoloff

IN THE NEXT ISSUE OF JUCM

Oral and facial injuries commonly present to the urgent care provider. For patients, cosmesis is often the major concern. But for clinicians, ruling out serious or life-threatening injury is paramount. This could include skull fracture, intracranial injury, cervical spine fracture, spinal cord injury, foreign bodies (like tooth shards in a wound), mandible fractures, mandible displacements, maxillary fractures, and Ellis class 3 dental injuries. Our February cover article explains the elements of the physical examination needed to rule out these primary concerns, shows how to then conduct an oral and facial examination, and discusses treatment of oral and facial injuries in detail, including external lacerations, multilayer lacerations of the lip, buccal lacerations, tongue wounds, posterior pharynx and soft palate injuries, tooth injury, and mandible fractures. If oral and facial injuries are not your strong suit, this insightful review will enable you to perform diagnosis and treatment with greater knowledge, care, and confidence.

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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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Hand injuries, usually work- or sports-related, come in two forms: open and closed. In our cover article this month, Tracey Quail Davidoff, MD, focuses on closed hand injuries, including diagnosis and treatment of distal phalanx fractures, middle and proximal phalanx injuries, metacarpal fractures 2-5, thumb metacarpal injuries, dislocations, and closed tendon injuries.



"As humans, we are very dependent on our hands for earning a living; enjoying sports, the arts, and communication; and expression of emotion," Dr. Davidoff observes. "Loss of function can have a profound impact on the remainder of a patient's life. Improper management can result in permanent disability for the patient and litigation for you." Her article is intended to reduce these mishaps in the urgent care setting.

To that end, Dr. Davidoff discusses terminology and anatomy of the human hand, taking a good history, conducting a thorough physical examination, and which imaging studies to request. X-rays of distal phalanx fractures, boxer's fracture, metacarpal fractures, proximal interphalangeal (PIP) joint dislocation, and dislocation at the metacarpophalangeal (MCP) joint help to clarify key points.

Dr. Davidoff is a staff physician at Excelcare Medical Urgent Care and Urgent Care by Lifetime Health, both in Rochester, New York.

She is board-certified in internal medicine and worked for 18 years as an emergency physician before switching to urgent care four years ago. Her last article for JUCM was *Burns: Their Evaluation and Management in Urgent Care* (May 2011), available on the JUCM website. This month's article is adapted from a presentation on closed hand injuries that Dr. Davidoff will deliver at the UCAOA convention in Las Vegas next April.

In our Case Report this month, Erica Marshburn, BS, BA, and John Shufeldt, MD, JD, MBA, FACEP, discuss a 49-year-old male who presents at an



urgent care with a complaint of right-hand grip strength (a golf club flew out of his hand as he was taking a swing), as well as right shoulder pain radiating to the hand but no known trauma. The case is a springboard to an enlightening discussion of high-risk conditions presenting as back pain.

"Many high-risk conditions can present as back pain," the authors observe, "and back pain is a very frequent presenting complaint in urgent care medicine ... however, because of the frequency of the complaint and the infrequency of serious sequelae, providers may be prone to misadventures."

See if the correct diagnosis is in your differential before the au-



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thors reveal it.

Ms. Marshburn is an independent business consultant and principal of Medical Business Technologies in Scottsdale, Arizona. She plans on entering medical school this fall. John Shufeldt is principal of Shufeldt Consulting and sits on the editorial board of JUCM.



Registration specialists, medical assistants, and techs may be your lowest-paid employees, but they interact with your patients more than your providers do; as such, the success of your urgent care is in their hands. While most articles on getting the most from your front-line staff focus on how *they* should function and behave, in our practice management article this month, Alan A. Ayers, MBA, MAcc, approaches the problem from a different perspective. Instead, he discusses what urgent care owner/operators can do to motivate their front-line staffs with enlightened leadership.

To that end, Mr. Ayers discusses problem behaviors of urgent care managers, the effect of those behaviors on a center's culture, and what the cultural ideals ought to be. The goal is to reduce frequent turnover, poor-quality service, non-compliance with external policies and external regulations, and conflict among an urgent care's staff.

Mr. Ayers is Content Advisor to the Urgent Care Association of America and Vice President of Concentra Urgent Care in Dallas, Texas. His last article for JUCM was *Take Patient Satisfaction to the Next Level* (October 2011), available on the JUCM website.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, provides a much-needed primer on urgent care financing in his Health Law column this month. You don't need a million dollars to open an urgent care, he says, if you staff the clinic yourself, don't over-build, and lease only essential equipment. However, he adds, "lack of capital is the root cause of many business failures." Dr. Shufeldt explains what is necessary to separate bankers/investors from their money.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on current literature germane to urgent care, including routine prostate cancer screening in healthy men; female coffee drinkers and reduced depression risk; cell phone use not being a tumor risk; adenoidectomy not being recommended for recurrent respiratory infections in children; closely supervised MRIs appearing to be safe for most patients with pacemakers and ICDs; and recurrent UTIs in children not being a likely cause of chronic kidney disease. ■

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FROM THE EXECUTIVE DIRECTOR

End of an Era

■ LOU ELLEN HORWITZ, MA

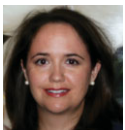
The first UCAOA National Urgent Care Convention was held at the Radisson Resort in Orlando from April 13-16, 2005. To put that in perspective, remember that UCAOA itself was incorporated in November of 2004—only five months earlier. Planning, marketing and hosting a national-scope convention when you have been in existence for a few short months is an audacious move!

The man who made that happen was Dr. John Koehler. Dr. Koehler was a founding board member of UCAOA, and took on the role of convention chair, working with UCAOA's only staff person at the time, Becky Burress. Between the two of them they found a location, planned a program, secured speakers, arranged for audiovisual, food and beverage, and on and on. They had 231 attendees and the meeting was a huge success.

For those of you who pull off complicated operations every day, and especially if you've ever been part of the planning of a major event (in a distant city), you know that success in these areas requires a certain combination of talents and characteristics. First, you have to have vision. What will the event look like and feel like? What do people want to know about? Who do we know that can talk about those things? You have to have a plan in mind.

Next, you have to have dedication and perseverance, because vision rarely takes on a life of its own this early in the game. You have to get personally involved. You have to get on the phone, send emails, negotiate (and occasionally beg), think about it all the time, bother your families with opinion solicitation, call in favors, and generally do whatever it takes to bring that vision to reality.

Of course, that's exactly what happened. Dr. Koehler brought all of his talents and personality to bear, and lo and behold, come April 13th when those 231 people showed up, there was a National Urgent Care Convention to meet them. Did I mention there was also an exhibit hall that first year?



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

"This April in Las Vegas will be our 7th Annual Convention, and whether every attendee knows it or not, the meeting has made it this far because of Dr. John Koehler's early vision and leadership."

Just for icing on the cake.

As the years have passed, under Dr. Koehler's direction the convention has grown and evolved. It has gotten bigger and better, been held in some fantastic venues, allowed us to expand the education programs significantly, and become the premier event in our industry. For all of us who have had the opportunity to see him in action, our hats are off to him for his intensity and drive and vision for the success of the event. This April in Las Vegas will be our 7th Annual Convention, and whether every attendee knows it or not, the meeting has made it this far because of Dr. Koehler's early vision and leadership.

By the title of this column, however, you probably already have an inkling that Dr. Koehler will soon be passing the torch to a new Chair, who we'll be announcing at the Convention in April. That person will have big shoes to fill, but as an organization and an industry, we are always moving forward and evolving and the convention will continue to do so as well.

Dr. Koehler, we thank you and we salute you. ■

P.S. Speaking of leadership, you will also notice a new "co-host" of the convention this year, our colleagues at the Urgent Care College of Physicians. UCCOP's leadership has been working with UCAOA to further develop the clinical programs at the meeting, and you will start to notice some changes brought on by that relationship in 2012, with more to come. By the time you read this, registration will be open, so we'll look forward to seeing your name added to the roster!



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Closed Hand Injuries

Urgent message: Even a seemingly minor hand injury can result in lifelong disability if evaluation and treatment are incorrect.

TRACEY QUAIL DAVIDOFF, MD

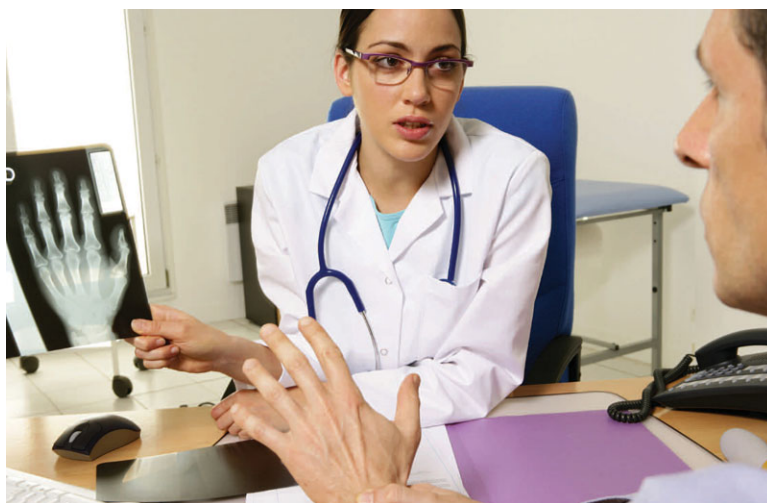
Introduction

The hand is a vital part of human anatomy allowing us to interact with our environment in nearly infinite ways. The functional aspects of the hand are a direct extension of the brain, allowing us to initially make stone tools, play musical instruments, make intricate crafts, type, communicate, and appreciate our environment through gestures and touch.¹

Our hands are also generally exposed to others, so not only must the hand work properly, it must not appear deformed, lest it be a source of discomfort and embarrassment. For these reasons, injuries to the hand can be seriously disabling. The best possible outcome often depends on accurate initial evaluation and treatment. Proper evaluation and treatment of hand injuries is essential because what often seems like relatively minor injuries can result in lifelong disability. The most common complication of hand injuries is chronic pain and stiffness.²

Hand injuries are very common and account for a large part of urgent care visits. Many of these are work- or sports-related. Hand injuries can be divided into open and closed. Due to constraints of space and different management of these injuries, only closed injuries will be discussed here. Injuries proximal to the carpometacarpal (CMC) joint will not be discussed

Tracey Quail Davidoff is a staff physician at Excelcare Medical Urgent Care and Urgent Care by Lifetime Health, both in Rochester, New York. She is board-certified in internal medicine and worked for 18 years as an emergency physician before switching to urgent care four years ago. Her last article for JUCM was *Burns: Their Evaluation and Treatment in Urgent Care* (May 2011), available on the JUCM website. This article is adapted from a presentation on closed hand injuries that Dr. Davidoff will deliver at the UCAOA convention in Las Vegas next April.



Terminology

Accurate charting is essential in the evaluation and treatment of hand injuries. Specialist referrals are common, and subsequent providers need to compare what they currently see with what happened when you first saw the patient. Your chart will communicate to the specialist (and malpractice, disability, and/or workmen's compensation attorney) the specifics of mechanism of injury, functional impairment, and deformity, as well as treatment you provided. Uniform terminology and adequate documentation is key to making sure everyone understands what you have seen and done.

The surfaces of the hand and digits are described as "dorsal" (top) and "volar" (palm). Each side of the hand and finger is described as "radial" and "ulnar," respectively. The muscle at the base of the thumb is called the "thenar eminence," and the corresponding opposite side is the "hypothener eminence." The names of the fingers can often be confusing if numbers are used, so it is recommended that each finger be named individually; thumb, index, middle, ring, and pinky, little, or

small, as opposed to one through five.

Anatomy

The hand is a highly mobile set of gliding bones connected by tendons and ligaments to a fixed center. It consists of 27 bones: 14 phalangeal bones, five metacarpals, and eight carpal bones, arranged in five “rays,” atop two rows of four carpal bones each. Each ray contains a metacarpal and three phalangeal bones, except for the thumb, which has only two phalanges.

The carpometacarpal joints are mobile at the thumb, ring, and pinky and fixed at the index and middle rays, allowing a grasping motion around a fixed center. Capsular or collateral ligaments of each joint provide stability, and the tendons of the intrinsic muscles of the hand provide mobility. Their origins and insertions lie within the hand and include the muscles of the thenar and hypothenar eminences, adductor pollicis, the interossei, and the lumbricals. The flexor tendons insert on the volar surface of the hand, originating in the forearm, and the extensor tendons insert on the dorsal surface of the hand, also originating in the forearm. For a more comprehensive review of anatomy, please refer to your favorite anatomy text.

History

When a patient presents for a hand injury, the history should include the date and time of injury, the mechanism of injury, the position of the fingers and hand during the injury, and what the patient did immediately after the injury. Other useful facts to note are hand dominance, age, gender, occupation, hobbies that require manual dexterity, whether the injury occurred at work, previous injuries in the same area, and any pre-existing diseases such as arthritis or vascular disease.

The mechanism of injury should be detailed, such as crush, forced flexion or extension, or jammed, the direction of force, and whether chronic repetitive trauma is an issue. It is important to know the profession or hobbies of the patient—eg, surgeon, pianist, or construction worker—as these patients may carry a more significant morbidity than those patients who do not rely on fine motor skills for their income.

Physical Exam

All patients with hand injuries require a thorough physical evaluation. Most providers find it useful to have a standard exam that they perform on all patients so that an occult injury is never missed. This exam should include testing of all tendons and motor, sensory, and

vascular components. The injured hand should be compared to the uninjured hand. Inspection should start with the hand in neutral position and then balled into a fist. Include any evidence of deformity, bruising, swelling, lacerations, etc. When the patient makes a fist, injury is suspected when the nail beds do not form a straight line or all fingers of the closed hand do not point to the proximal scaphoid. Careful attention should be given to note any rotational malalignment of the fingers out of their normal position.

The bones and joints should be palpated to assess for point tenderness. Range of motion of the fingers should be tested passively, actively, and against resistance. This includes flexion and extension, as well as stability of the collateral ligaments. Abnormal passive range of motion may indicate laxity of joints caused by a complete or partial tendon rupture. Pain in motion against resistance may be the only clue of an occult partial tendon injury.

Ask the patient to make a fist and resist your trying to pull his fingers out. Move the injured area passively, then have the patient move it, and then test flexion and extension against resistance. Bending the distal phalanx while holding the middle phalanx stable tests the *flexor digitorum profundus*. Bending a finger while the others are held in extension against a flat surface tests the *flexor digitorum superficialis*. Bending the tip of the thumb while the proximal phalanx is stabilized tests the *flexor pollicis longus*. Spreading fingers tests the dorsal interossei muscles, and unspreading them tests the palmar interossei. Have the patient oppose his thumb to the tip of the each finger and then resist as you try to separate them. Finally, ask the patient to place his hand palm down on a table and lift the thumb.

Vascular status should be assessed by testing pulses or capillary refill distal to the injury. Capillary refill in most hemodynamically stable patients is <3 seconds. Sensation distal to the injury should be tested grossly to light touch and pain. Finally, two-point discrimination should be tested in the fingertips. Normal two-point discrimination should be <6mm but is often <2mm. This should be tested at least two times on either side of the pad of the affected digit.

A well-planned exam will test all joints; flexor, extensor, and intrinsic muscles; median, ulnar and radial nerves, both sensory and motor; and vascular status.

Imaging

Generally, three views of the hand or injured distal finger should be completed: anteroposterior (AP), lateral, and oblique. Do not settle for suboptimal films, as sub-

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Figure 1. Proximal phalanx fractures.

Fractures are noted in the proximal phalanx of the ring and pinky fingers. Impaction and angulation are present. Surgical reduction is required.

tle findings may only be seen in one view. Additional views may be ordered to further delineate injuries. Comparison views with the uninjured side may also be helpful in discriminating Salter fractures in children.

Classification and Treatment

Distal phalanx injuries

Distal phalanx fractures represent about one-third of all hand fractures.² The mechanism of injury is usually crush or shearing force, such as a missed grab during sports. Tendon injuries are common with fractures of the distal phalanx, as both flexor and extensor tendons attach to it. These tendons can easily cause avulsion fractures when subjected to excessive stress. On exam, there is loss of function of the tip of the finger, which is easily demonstrated by holding the middle phalanx stable and asking the patient to bend/extend the tip of the finger. On x-ray, only a small avulsion may be seen.

Extra-articular fractures of the distal phalanx usually result from a direct blow to the tip of the finger. The force of the blow determines the severity of the fracture. Comminuted fractures are the most common. On examination, there is typically tenderness and swelling over the distal phalanx. Subungual hematomas are

Figure 2. Metacarpal fracture.

Fracture of the fifth metacarpal head with significant angulation ("boxer's" fracture).

common and indicate a laceration of the nail bed. Complete or incomplete avulsion of the nail plate may also occur with these injuries. AP and lateral views are the best for diagnosing this fracture.

Non-displaced or minimally displaced fractures are best managed with a splint, elevation, and pain medication. A volar or hairpin splint is recommended to accommodate swelling, which can be severe. Typically splinting is required for three to four weeks. Comminuted fractures can remain painful for several months. Fractures with significant displacement or angulation should be reduced. Volar splinting should be applied and the radiographs repeated to confirm reduction. Reduction is often difficult due to severe soft tissue swelling that may lodge between the fragments. If reduction is not satisfactory, a Kirshner wire (K-wire) may be needed to prevent non-union and subsequent loss of function.

Subungual hematomas should be drained for patient comfort. If the nail plate is intact, it need not be removed to repair the nail bed. Trephination using electrocautery or a heated 18-g needle can be used for drainage if the hematoma is greater than 50% and less than 24 hours old. If the nail plate is disrupted, the fracture is considered open, but can still be repaired in the urgent care center (see *Assessment and Initial Care of Fingertip and Nailbed Injuries* [November 2008], posted on the JUCM website).

Intra-articular fractures of the distal phalanx can be dorsal or volar. Dorsal intra-articular fractures are referred to as "mallet finger" and result from forced flexion with the finger in taut extension. This commonly occurs in sporting injuries (eg, basketball, baseball, and softball players) when the ball accidentally hits the tip of the finger causing forced flexion. It is the most common finger injury in athletes.³ If the tendon is completely ruptured the patient will not be able to actively extend the fingertip. The tendon may rupture without a fracture being present.

The tendon may also stretch without being ruptured. In this case, some degree of active extension may still be present. Occasionally, dislocation may also occur. Nail plate injuries may also occur. A lateral view of the finger is the best for demonstrating this injury.

Non-displaced or minimally displaced fractures with reliable patients can be treated conservatively with a dorsal splint with the distal interphalangeal (DIP) joint in extension. The finger *must* be maintained in this position for six to eight weeks continuously. Flexion at any point during this period may result in a chronic flexion deformity. If the splint needs to be changed the patient should place his hand on a table to prevent bending. Unreliable patients should have the finger casted. Most patients should be referred to a hand specialist. In some cases, surgical fixation with K-wires may be performed. Improper treatment of these fractures may result in a swan-neck deformity from the imbalance between the ruptured extensor tendon and the unopposed distal flexor tendon.

Volar intra-articular fractures are associated with injury to the flexor profundus tendon insertion. This is an uncommon injury resulting from forceful hyperextension while the finger is tightly flexed. The patient will be unable to flex the distal phalanx. There may be tenderness over the volar aspect of the distal phalanx or even the palm due to tendon retraction after injury. *Patients with traumatic swelling and tenderness over the volar aspect of the distal phalanx with additional palmar pain should be considered to have a rupture of the flexor profundus tendon until proven otherwise.*² The lateral view is the best for demonstrating this fracture.

In the urgent care setting, the patient should be placed in a volar splint. The patient should be referred to a hand specialist for early surgical fixation. Complications of this injury include non-union and loss of flexion of the distal phalanx.

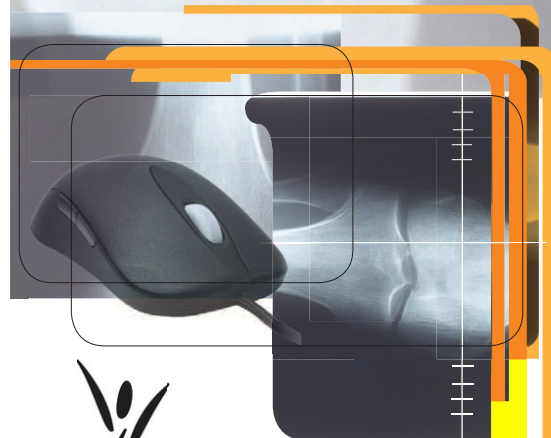
Middle and Proximal Phalanx

Anatomically, in mechanisms of injury, and in treatment, the mid-

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Figure 3. Mid-shaft metacarpal fractures.

Spiral fractures are visible in the shafts of the third and fourth metacarpals.

Figure 4. PIP dislocation.

Dorsal dislocation of the PIP of the pinky.

dle and proximal phalanx are similar and will be discussed together.

There are no tendons that attach to the proximal phalanx. When fractured, unopposed tension of the interosii and extensor tendons causes volar angulation. When middle phalanx fractures occur, it is usually in the thinner shaft. Middle phalanx fractures are relatively uncommon, as axial forces subjected during injury are more likely to be absorbed by the proximal phalanx, making its fracture more common.⁴ Dislocations at the proximal interphalangeal (PIP) joint are more likely to occur than middle phalanx fractures. Although long tendons do not attach at the middle phalanx, they do lie in close proximity, which needs to be considered when treating fractures and dislocations in this area.

Middle and proximal phalanx fractures should never be immobilized in full extension. They should always be in a position of function to prevent stiffness and contractures. If the fracture or dislocation is reduced but can

only be maintained in full extension, the patient should be referred to a hand specialist urgently for surgical fixation (**Figure 1**).

Metacarpal Fractures 2-5

The second and third metacarpals are generally immobile; therefore, they should be treated like long-bone fractures with reduction to anatomic position. Since the fourth and fifth metacarpals are mobile, some displacement can be tolerated. Patients with metacarpal fractures may also have (CMC) joint dislocations, which can easily be missed on initial presentation.³

Metacarpal fractures can be classified as head, neck, shaft, or base. Head fractures are usually due to direct blow, crush, or penetrating force. They are often comminuted. Urgent care consists of ice, elevation, and splinting. Referral to a hand specialist is indicated.

The most common metacarpal neck fracture is the fifth metacarpal "boxer's fracture" (**Figure 2**), although

this fracture can occur in the third and fourth metacarpals as well. In the fifth metacarpal, the fracture is usually unstable with volar angulation. Angulation of up to 40 degrees in the fifth metacarpal, 20 degrees in the fourth metacarpal, and 15 degrees in the second and third metacarpals will not result in limitation of function. More angulated fractures should be reduced. The hand should be splinted with the wrist in about 20 degrees of extension and the metacarpals at 90 degrees of flexion. Second or third metacarpals may ultimately require fixation to preserve anatomic position.

Metacarpal shaft fractures usually occur from a direct blow. Rotational deformity is common due to the forces of the interossei. Most of these fractures require operative fixation. Urgent care management should include splinting and referral to a hand specialist (**see Figure 3**).

Metacarpal base fractures are usually due to a direct blow and are commonly associated with carpal fractures as well. Base fractures at the fourth and/or fifth metacarpal can result in paralysis of the ulnar nerve. Urgent referral is recommended.

Thumb Metacarpal Injuries

Because the thumb metacarpal is so mobile, fractures usually occur at the base. Extra-articular fractures are the result of a direct blow or impaction. Twenty degrees of angulation is functionally tolerated; otherwise reduction is required. Treatment is with a thumb Spica splint for four weeks. A spiral fracture may require fixation. Intra-articular fractures can be caused by impaction from striking a fixed object. A thumb Spica splint should be applied and the patient should be referred to a hand specialist.

Dislocations

Dislocations of the DIP are rare due to the firm attachment of the skin and subcutaneous tissue to the bone underneath. Stability is also provided by the flexor and extensor tendons. Most dislocations are dorsal when they occur. Digital block should be performed for pain

Figure 5. Dislocation at the MCP.



management. Reduction is accomplished by longitudinal traction and hyperextension followed by pressure on the dorsum of the base of the distal phalanx. The patient should be splinted for 10-21 days.⁵ Specialist evaluation is only necessary if the dislocation is irreducible. This can occur from entrapment of an avulsion fracture, the profundus tendon, or the volar plate itself.

PIP dislocations are common hand injuries, especially in athletes (**Figure 4**). Dorsal dislocation is due to rupture of the volar plate. Lateral dislocation occurs when a collateral ligament ruptures—usually the radial collateral—causing ulnar deviation of the finger. Volar dislocations are rare. Reduction is accomplished in the same manner as for DIP, following a digital block. After reduction, active motion and strength should be tested. If these are normal, the patient should be splinted in 30 degrees of flexion for three weeks. When the joint is irreducible or motion and strength is abnormal, the patient should be referred to a specialist for operative repair.

Metacarpophalangeal (MCP) joint dislocations are due to hyperextension causing disruption of the volar plate. The direction of dislocation is dorsal. Subluxation is actually more common. On exam, the joint appears dislocated but on radiographs the articular surfaces are

still intact. Care should be taken when relocating not to hyperextend the joint, which could convert a subluxation into a dislocation. Instead, the wrist should be flexed and then pressure applied to the dorsum of the proximal phalanx in a distal and volar direction. The joint should be splinted in flexion.

CMC joint dislocations are very rare due to the extensive connective tissue and ligamentous structures in this area. Significant force is required; therefore, this type of dislocation is only seen in motor vehicle collisions, falls from heights, and crush injury.³ Most of these patients go to the emergency department based on mechanism alone and are rarely, if ever, seen in the urgent care setting. ED referral is warranted.

Thumb dislocations are treated differently than the other digits. Dislocation at the DIP is usually open. Dislocation at the MCP (**Figure 5**) results from a hyperextension force causing volar dislocation. The volar plate is usually ruptured. Reduction is completed with pressure directed distally on the base of the proximal phalanx, with the metacarpal in flexion and abducted.

Rupture of the ulnar collateral ligament of the MCP of the thumb is called “gamekeeper’s thumb” or “skier’s thumb.” The injury is caused by forced radial deviation, such as when a skier falls with the hand firmly grasping the pole. Weakness of pincer function is common in these injuries and can be permanent. In the urgent care setting, the patient should be placed in a thumb Spica splint and referred to a hand specialist.

Closed Tendon Injuries

A “jersey finger” results when an athlete grabs an opponent’s jersey and the DIP is forcefully extended from the flexed position. The index finger is most commonly involved,² but any finger can be affected. A subtle flexion deformity may be noted on inspection, and the patient will be unable to flex the distal phalanx when the PIP is extended. Contractures may occur in untreated patients. The patient should be placed in a dorsal splint and referred to a specialist for surgical repair.

Rupture of the central slip of the extensor tendon results from three mechanisms: deep contusion of the PIP, forceful flexion of the extended PIP joint, or volar dislocation of the PIP. Loss of complete extension with decreased strength or pain against resistance is suspicious for this injury in conjunction with the correct mechanism of injury. If untreated, the result is a “boutonniere deformity,” which may not occur until seven to 14 days after the injury.⁶ The PIP joint should be splinted in constant, complete extension. The patient should be

referred to a hand specialist to determine the length of time the patient should be splinted or whether operative repair is required.

“Boxer’s finger” occurs from a traumatic blow to the MCP resulting in rupture of the extensor hood, as when punching. There is marked swelling and decreased mobility, and the tendon may relocate when the MCP is extended, causing pain. The radiograph is negative for fracture. The patient should be splinted in extension with the tendon relocated and referred to a hand specialist for further management.

Be Prepared

Talk to local hand specialists and compile a referral base of several physicians for your patients with hand injuries. Check to ensure that each practice will follow-up with your patients in a timely fashion, not make them wait for weeks before evaluating them. Make sure that your specialist of choice takes the same insurances you do, so that won’t be an obstacle to care. Keep a supply of that doctor’s business cards, printed contact/address information for the doctor, and perhaps driving instructions so the patient can easily find the doctor’s office. Keep the doctor’s fax number on file and fax over your evaluation so the doctor knows what to expect when the patient calls, of course maintaining HIPAA compliance at all times.

Conclusion

Hand injuries are a common presenting complaint in the urgent care center. Loss of function can have a profound impact on the remainder of a patient’s life. Improper management can result in permanent disability for the patient and litigation for you. Learning everything you can about hand injuries, developing a process of examination that encompasses all aspects of hand function, and knowing when to refer patients to a specialist is key in successfully treating these injuries and ensuring an optimum outcome for both you and your patients. ■

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Case Report

High-Risk Conditions Presenting as Back Pain

Urgent message: That back pain is common and typically without serious sequelae may result in misdiagnosis and mistreatment.

ERICA MARSHBURN, BS, BA, AND JOHN SHUFELDT, MD, JD, MBA, FACEP

Overview

Many high-risk conditions can present as back pain, is a very frequent presenting complaint in urgent care medicine. Most back pain is muscular in origin and responds well to conservative intervention. However, because of the frequency of the complaint and infrequency of serious sequelae, providers may be prone to medical misadventures.

Case Presentation

A 49-year-old male presents with a complaint of right-hand grip-strength weakness. He noticed that the club flew out of his hands during his golf game. In addition, he has pain in the right shoulder radiating to his hand but no known trauma. On presentation, the patient is mildly tachycardic; his other vital signs are normal.

Pertinent Physical Exam

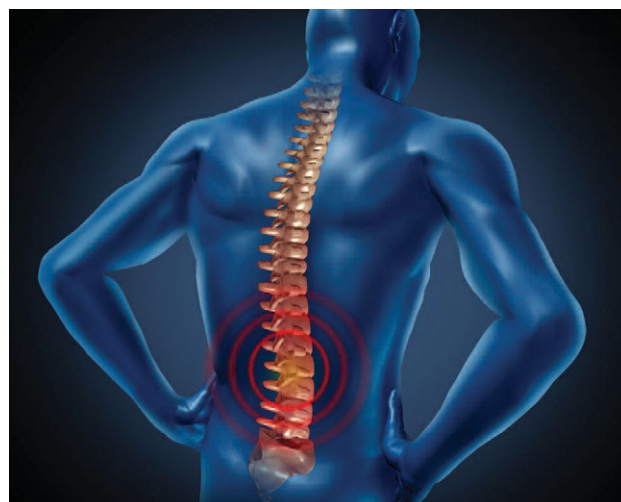
General: Awake and alert; no obvious distress.

Neurological exam: CNII-XII intact; normal sensation to light touch; 3+/5 strength on R wrist extension and index and thumb flexion. DTR's are symmetrical and intact. Remaining exam is normal.

Labs/Imaging

A cervical spine radiograph may be obtained at the center; however, this will likely not be diagnostic given

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the history. To that end, outpatient CT myelography or MRI of his C-spine should be obtained to properly evaluate the cause of the patient's weakness.

CT scanning can be helpful in assessing acute fractures. CT scanning with myelography provides even more valuable imaging by showing better detail of the spinal canal. But MRI is best for detecting soft-tissue pathology like disc herniation. MRI is currently the study of choice in most patients for the initial neuroimaging evaluation of the cervical spine, unless there is a contraindication. In this case, the lateral view of the MRI shows disc-space narrowing (**Figure 1** and **Figure 2**).

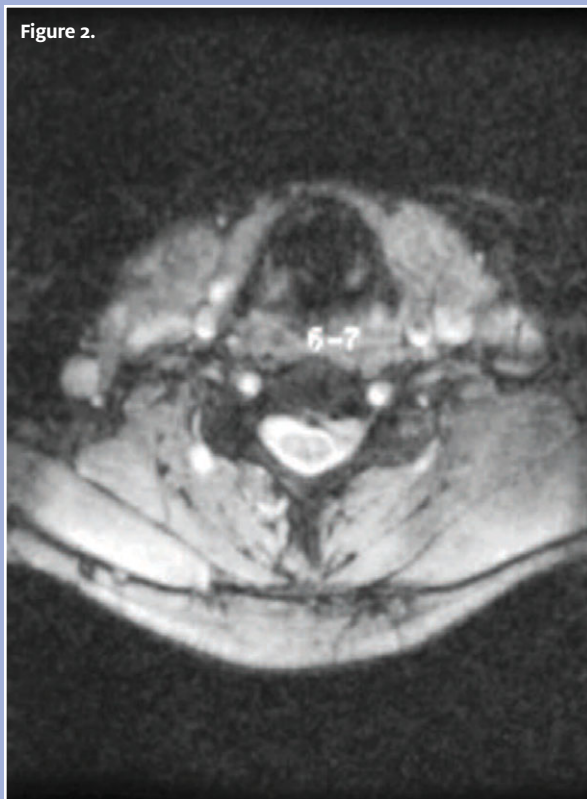
Magnetic resonance of the cervical spine is usually abnormal in patients with compressive radiculopathy. However, imaging may be completely normal in non-compressive radiculopathy.

Figure 1.



Lateral view of MRI shows disc-space narrowing.

Figure 2.



MRI shows compression of the spinal cord by the cervical disc.

Diagnosis

Cervical radiculopathy is a dysfunction of a nerve root emanating from cervical spine. Its causes can be divided into compressive and non-compressive etiologies.

The majority of radiculopathies arise from nerve root compression. The two predominant mechanisms of compressive cervical radiculopathy are cervical spondylosis and disc herniation. Disc herniation counts for 20%-25% of cervical radiculopathy cases. In the older patient, cervical radiculopathy is often a result of foraminal narrowing from osteophyte formation, decreased disc height, and degenerative changes of the vertebral joints anteriorly and of the facet joints posteriorly.

The foraminal compression test, or Spurling's test, is probably the best test for confirming the diagnosis of cervical radiculopathy. It is performed by positioning the patient with the neck extended and the head rotated and then applying downward pressure on the head. The test is considered positive if pain radiates into the limb on the same side to which the head is rotated.

Neurologic problems that do not involve nerve root

compression must be considered when evaluating a patient with neck pain. Differential diagnoses that should be considered include brachial plexus injury, cervical disc injuries, cervical discogenic pain syndrome, cervical facet syndrome, cervical spine sprain/strain injuries, and rotator cuff injury.

A radiculopathy is inferred by pain with *unilateral* signs or symptoms usually involving the posterior aspect of the extremity on the side of the nerve encroachment. It would be extremely rare for a disc herniation to protrude on both sides, causing bilateral extremity symptoms. But, a posterior disc herniation can cause the signs and symptoms of a transverse myelopathy.

Cauda equina or a conus medullaris syndrome has a much more ominous prognosis because cord viability is jeopardized secondary to spinal stenosis. Signs of spinal stenosis are usually bilateral. Any time urinary or fecal incontinence is a complaint and bilateral leg signs or symptoms are elicited in a patient with back pain, spinal cord function should be tested and the patient referred for an emergent MRI of the LS spine.

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

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Cardiovascular Effects

• Cardiovascular (CV) Thrombotic Events

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

• Hypertension

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

• Congestive Heart Failure and Edema

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

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

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

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

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

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

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

ADVERSE REACTIONS

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

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

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

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

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

DRUG INTERACTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DRUG ABUSE AND DEPENDENCE

Ketorolac does not bind to opiate receptors.

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

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

PATIENT COUNSELING INFORMATION

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

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Course and Treatment

Initially treatment should be directed at reducing pain and inflammation, including NSAIDs, local icing, rest, and any measures that can reduce the compression forces on the nerve root. A temporary cervical collar can be used for comfort and support. Cervical epidural steroids and acupuncture may be useful if other treatment methods have not succeeded. Surgical intervention may be sought as a last resort. The end point of treatment occurs when the patient regains full pain-free range of movement and normal neurologic function and has a negative Spurling's test.

Discussion

Onset of symptoms is most frequently acute when caused by a herniated disk and typically has a slower onset when caused by degeneration of spinal vertebra via osteoarthritis. Pain in the neck or arm occurs in nearly all patients with cervical radiculopathy, but it is usually not of value to try to determine the nerve root. Pain may be in the cervical region or referred to the upper limb, the shoulder, or the interscapular region. In addition, the pain may be atypical and present as chest pain (pseudo-angina), breast pain, or pain in the face.

Paresthesia, or numbness in a nerve root distribution, occurs in 80% of patients, but it also is frequently non-localizing. Because of extensive overlap of dermatomes, it is unusual to have well-demarcated, dense sensory loss in lesions of a single root, even if the radiculopathy is severe. Subjective weakness is less common than paresthesias.

Tenderness is usually noted on palpation of the cervical paraspinal muscles and is more pronounced along the ipsilateral side of the affected nerve root. Patients can have muscle tenderness in the muscles where symptoms are referred. Manual muscle testing is important for determining the affected nerve root level and detecting subtle weakness. Sensory examination shows a decrease of loss of sensation in a gross dermatomal distribution.

A history of difficulty walking, lower extremity or trunk symptoms, or bowel and bladder dysfunction are suggestive of myelopathy rather than radiculopathy. A history of fever, chills, unexplained weight loss, immunosuppression, cancer, or intravenous drug use should raise suspicion for tumor or infection as the cause of the radiculopathy.

Reported antecedent events with cervical radiculopathy have included physical exertion or trauma immediately preceding symptom onset. Playing golf, shoveling snow, and diving from a board have also been reported to be antecedent events, although most cases have no readily identifiable precipitant.

Cervical and lumbar pain are frequent presenting complaints in urgent care; providers can be lulled into a false sense of security given the relative rarity of significant pathology. Document all potential diagnoses you have considered before arriving at the ultimate discharge diagnosis.

The few extra minutes it takes to consider and document the pertinent negatives or add them to the differential may save you from liability and your patient from harm. ■

Practice Management

Motivate Your Front-Line Staff With Enlightened Leadership

Urgent message: Registration specialists, medical assistants, and techs may be your lowest-paid employees, but the success of your urgent care is in their hands—and their success is in yours.

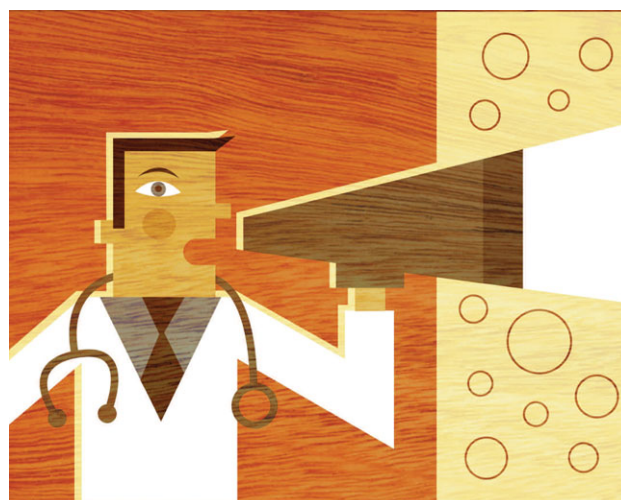
ALAN A. AYERS, MBA, MACC

Introduction

Urgent care is a service business whose long-term viability depends on patient loyalty and word of mouth. That's why urgent care entrepreneurs spend tens of thousands of dollars in selecting the right locations, equipping them with the latest technology, and then devising creative marketing campaigns to bring new patients through the door. But while these investments all contribute to business success, they're still minor compared to the one that makes the greatest impression on patients—the front-line staff.

The “front line” includes any staff member who regularly interacts with patients. In an urgent care center, this typically refers to registration specialists, medical assistants, and technicians who support physicians and other providers.

Consider how a registration specialist greeting a patient walking through the door contributes to that patient's lasting “first impression”. No matter how well clinicians treat a patient, a disengaged or disgruntled front-office employee can undermine the entire operation. Because most urgent care visits are reimbursed by insurance, errors or shortcuts in benefits verification and data entry at registration can result in costly re-work by the billing department, patient frustration with the collections process, and, ultimately, in the center going unpaid for services administered. Yet despite their obvi-



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ous importance, all too often registration specialists are viewed as an expense to be “controlled.” Because they're typically the center's least-educated and lowest-paid employees, they're often excluded from center meetings, their opinions on how to improve operations are frequently overlooked, and in extreme cases, they may be treated as “disposable” and easily replaced.

Anyone who debates the value of the front-line staff should consider the operational impact of a practice manager taking a day off—the operation will continue without a supervisor—but when a center is short of front-line staff, everything can spiral into chaos. Moreover, when the needs of front-line staff are ignored, consequences include:

- Frequent turnover—contributing to periods of

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Table 1. Seven Reasons to Focus on Developing the Front-line Staff

- The majority of a patient's interactions are with the front-line staff, not medical providers
- Front-line staff enables the medical services for which the center exists
- Front-line staff assures the center gets paid for the services it provides
- Front-line staff controls communication between patients and providers
- Front-line staff controls patient flow and documentation
- Front-line staff knows most intimately patient expectations, impressions, and satisfaction
- Front-line staff is typically the largest expense item on the center's profit and loss statement, after medical providers

short-staffing, high unemployment premiums, and increased hiring and training costs

- Poor quality service—contributing to patient hostility and negative word of mouth
- Non-compliance with internal policies and external regulations—contributing to mistakes and legal liability
- Conflict and power struggles between staff members, staff and managers, and staff and patients—contributing to the development of subversive sub-cultures

Each of these consequences impacts the bottom line. Turnover, for example, incurs direct costs like recruiting, on-boarding, and training—as well as indirect costs such as service interruptions and lost productivity—with each incident costing the average employer 30% of a workers annual wage.¹ This means a center that replaces a front-office person earning \$13 per hour three times per year incurs more than \$25,000 in additional costs due to turnover—the equivalent of an additional full-time registration specialist.

Table 1 illustrates how the attitude, efficiency, competence, sense of urgency, attention to detail, and communication of the front-line staff impacts a patient's willingness to return to the center and tell others to do likewise.

The Role of Center Leadership in Cultivating Front-line Staff

Upon entering an urgent care center, one can almost immediately characterize the center's leadership (which may include owners, hired managers, and clinical

providers) by the greeting one receives from the front-office staff. Is the staff approachable—bright-eyed, smiling, and outgoing? Then it's often no surprise that the center's leadership is extraverted, excited about the business, and authentic in word and deed.

Or does the staff seem bored, detached, and more focused on processes than patients? Not surprisingly, rarely is a “zombie” staff working for anyone who's not dull at best or abrasive at worse, with a mix of dysfunction in between. These observations reflect that, to a great extent, a center's culture is determined by the communication and behavior of its leadership.

Problem of the Ambiguity of Work

Effective leadership starts with an understanding of the importance of work to the front-line employee. Work provides the cash required for basic sustenance and leisure pursuits. Work gives people a sense of purpose, it creates structure in their lives, it offers social interaction, and (rightly or wrongly) the size of one's paycheck provides external validation of an individual's “worth”. In fact, work is so important that, while individuals spend only about a third of their time working, thoughts related work consume more of a person's concentration than relationships, entertainment, and religious or intellectual interests.

Human nature is to seek stability and peace—which should result from steady work—but for many individuals, work is characterized by uncertainty and stress. With so many people living from paycheck to paycheck, the loss of a job for just a few weeks could devastate many families. Influenced by a myriad of factors from commodity prices to government regulation and the confidence of consumers, the ongoing availability of work seems well beyond the control of any one person. And while people would like to believe that securing, maintaining, and advancing in a job depends on intelligence, skill, personal interest, and hard work, they see far too many instances in which personal connections, charm or good looks, political savvy, or simply “luck” dictate an individual's success in the workplace.

Stability and peace come from having a sense of control over one's life. “Luck” is defined as “good or bad fortune in life caused by accident or chance, and attributed by some to reasons of faith or superstition.” By definition, a belief in “luck” is a belief in “no control”—meaning the most significant activity in an individual's life (work) is all too often subject to ebbs and flows well beyond the individual's understanding. Is there any

wonder why people feel powerless and anxious about their jobs?

The role of an urgent care leader is to provide a stable, predictable environment governed by processes and systems, and characterized by open communication, in which front-line staff can demonstrate their skills and talents.

Two Types of Workplaces

Workplaces, including urgent care centers, fit into one of two categories, places in which employees are:

- secure, well-adapted, have a purpose, go above and beyond the call of duty, and are happy, or ...
- insecure, maladapted, there for a paycheck, doing the minimum they can get away with, and are miserable

The category for a particular center—in most cases—is determined by the communication and behavior of that center's leader. Effective leaders foster an environment of security and peace—one in which "luck" has no role but rather where work is stable, predictable, and transparent. By contrast, "bad" leaders create an environment of fear and uncertainty in which people get thrown off base, become defensive, and eventually lose interest in their jobs.

Most urgent care centers are entrepreneurial physician practices. Starting as small businesses and experiencing rapid growth, they typically promote from within—with management coming from expert functions like nursing, billing, or medical technology—and with the physician-owner himself also thrust into a leadership role. The result is a leadership team that has strong technical expertise but often little or no formal training in the intricacies of motivating and managing people.

Because they are "working managers," urgent care leaders are typically busy tending to the delivery of clinical services. So when they enforce a rule on Tuesday, but not on Wednesday, or when they hold Jack accountable but not Jane—they usually don't intend malice. Rather, focused on keeping the operation going, they are simply unaware how their communication and behavior instills uncertainty among staff.

Table 2 illustrates some common management misbehaviors, how they create ambiguity, and their impact on center staff.

When a culture becomes infiltrated with gossip, backstabbing, favoritism, and other petty behavior, trust and security are lost as employees realize they could easily fall victim to a slander costing them their reputation or their job. A manager who engages in these activities will soon find the staff is gossiping about him and undermining his own authority. The result is a toxic environment in which time and energy are expended on game playing rather than serving patients. Petty behavior in the workplace undermines a leader's credibility and authority. To maintain control of the operation and create an environment in which employees will feel secure, communication should be professional, focused on a strategy or task, authentic, free of ulterior motives, and in the spirit of full disclosure.

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Table 2. Common Problem Behaviors of Urgent Care Managers (continued on page 21)

Management Behavior	Effect on Culture	Cultural Ideal
After reviewing timecards and discovering excess overtime reported, the manager reprimands employees and immediately implements a zero-overtime policy.	Employees, afraid of getting in trouble when overtime is inevitable, start shorting their own timecards. Feeling cheated of legitimate overtime—and seeing the manager co-opt them in violating labor laws—employees then feel justified in “getting even” with the business by stealing or shirking on their jobs. Additionally, to avoid overtime and its consequences, employees begin turning away patients 45 minutes prior to center closure. The legal risk, lost revenue, and damage to reputation far exceed any incremental staffing costs.	“No exceptions” rules—particularly those adopted as a knee-jerk reaction to a failed management control—take away staff flexibility to utilize judgment in serving patients. Parameters should be set in which employees exercise some discretion in their roles but are also held accountable for results. This does not mean that employees are given carte blanche to do whatever they want, but, in the case of overtime, exceptions should be made if the employee demonstrates that it benefits the business. Eventually, trusted employees who “don’t want to let management down” will control their own overtime levels.
A medical provider is moody on some days, snapping at and openly criticizing his medical assistants, but on other days is polite and complimentary to the staff.	Uneven temperament of a leader puts employees on an emotional roller-coaster. Having been scorned in the past and not knowing how the leader will react, employees become hesitant to communicate with the leader at all. Employees who cower like broken dogs—or simply choose to ignore the leader—cannot effectively fulfill their job responsibilities. But ultimately, it’s the leader who loses control of the operation.	Due to higher levels of education, pay, and social status, professionals are held to a high standard of integrity. Thus, they are expected to be predictable and consistent in their demeanor and level-headed in their communication and behavior. Emotional outbursts, petty comments, and political game-playing are far below their stature. Instead, professionals should communicate authentically—without pretense and focused on making a genuine connection with the other person.
An employee suggests a new idea to improve the business. The manager ignores the idea, dismisses the idea without hearing the details, promotes the idea to others as his/her own, or approves the idea conditionally, saying, “If it doesn’t work, you’ll be looking for a new job.”	The manager has created a risk-adverse culture focused on maintaining the status quo and defending the current business. New ideas are aplenty in employee’s minds but are never spoken lest there be negative consequences. Opportunities to differentiate and grow the business are therefore lost and the business is beat by competitors who encourage creativity and controlled risk-taking.	Managers are responsible for making decisions and then being held accountable for those decisions. Thus, managers don’t have to approve every new idea. If the manager hasn’t bought into the risk, he should explain why in a way that acknowledges the employee’s initiative, respects the employee’s desire to improve the operation, and increases the employee’s understanding.
A manager says to an employee, “At the end of your shift, stop by my office—we need to talk about some things.”	The manager has created uncertainty. Productivity is lost and morale is hampered as the employee spends the day worrying about the reason for the meeting—most likely assuming the worst. When it turns out the meeting is for “good news,” the positive impact has already been contradicted by the stress experienced.	Employees should never be left in suspense. Managers should clearly communicate the purpose of any meetings, let the employee know what he can do to prepare, or wait until an appropriate time to pull the employee aside for a private discussion. If there are performance issues, there should have been sufficient ongoing disclosure so that the employee is not surprised by the manager’s feedback.
There is growing frustration with an employee’s sub-par performance, but never having engaged the employee in a performance improvement plan, the manager fires the employee at the end of the day.	Employees do not communicate their performance issues to one another, so morale suffers as co-workers perceive firings are arbitrary, due to political game playing, and reflect management’s insensitivity to the economic impact of unemployment on individuals and families. If employees believe there is no legitimate reason behind layoffs, they start to think they may be next—and employees with the greatest marketability “select themselves out” by seeking jobs elsewhere. In addition, employees who perceive an employer has no loyalty toward them will feel justified in being disloyal toward the employer.	Managers should take great care in hiring and firing decisions. Adequate numbers of prospects should be interviewed to assure the right person for the job and investment should be made in training and development. A 90-day review process should be in place and conditional employment terminated if an employee never catches up to speed. A tenured employee whose performance has fallen should be given a structured improvement plan: if performance does not improve, the employee will either leave on his own or will have no surprise upon being terminated.
An employee provides bad news to the manager regarding an issue with the operation. The manager blows up, responding angrily at the employee’s comments.	“Shooting the messenger” leads employees to withhold potentially negative information from managers. Management loses visibility to the front line, believes things are running smoothly when they aren’t, and then spends inordinate amounts of time resolving crises that could have been prevented they had been aware of issues early on.	Managers should periodically engage employees in respectful, constructive dialogue on what is working, what is not working, and what can be improved. Such discussions help employees feel greater ownership of the operation, resulting in greater initiative to voice legitimate business concerns to management as they arise.

When management desensitizes staffers by reprimanding, demoting, or firing co-workers, demonstrating inconsistent demeanor—including moodiness or snappiness, showing favoritism, withholding perform-

ance feedback, obscuring information about the business, playing games that pit coworkers against one another, or making cutting, abrasive, or dehumanizing remarks—employees end up in a constant state of panic.

Table 2. Common Problem Behaviors of Urgent Care Managers (continued from page 20)

Management Behavior	Effect on Culture	Cultural Ideal
An owner submits personal expenses for reimbursement by the urgent care center, carries non-working family members on the center's health insurance plan, uses a company-owned vehicle for non-business purposes, and flaunts expensive purchases in front of employees.	Employees who see management act unethically will feel justified in acting unethically themselves. Particularly in matters of finance, employees will blame owners who use the business as a personal bank for the employees' lesser pay and benefits. To get even, some employees will steal cash or supplies, give away services, pad timecards, or shirk on the job. After all, they feel the owners can definitely afford it and probably even deserve it.	There should be clear separation between an owner's personal and business financial affairs. Care should go well beyond IRS guidelines. Owners should always be cognizant of how their words and actions could be perceived by others. Expectations should be set that everyone in the center will conduct themselves with absolute integrity—meaning zero tolerance for unethical behavior—with controls in place to monitor and enforce rules. Few employees will feel justified in cheating a boss who has been fair and honest.
A business owner—spending time in the operation—speaks negatively of decisions that hired managers have made, tells employees that a manager is incompetent, or reverses decisions the manager has made.	Owners who undermine a hired manager's autonomy demonstrate to employees that the manager has no control of the business. Employees learn that if they don't like what the manager is doing, they can go straight to the owners to get what they want. The owners begin to micromanage the operation, overriding management, resulting in inconsistent decision-making. Eventually, the organization becomes a free-for-all driven by politics and devoid of meaningful management control.	Prior to hiring or promoting a manager, a business owner should assure that the manager's values, vision, and style are aligned with those of the owners. Once a manager is in place, the owners must defer day-to-day decision-making to the manager. Owners maintain control through reporting systems and by assuring the manager's incentives are aligned with those of the owners.
A manager gossips with one employee about another employee's performance or personal affairs.	When a culture becomes infiltrated with gossip, backstabbing, favoritism, and other petty behavior, trust and security are lost as employees realize they could easily fall victim to a slander costing them their reputation or their job. Also, a manager who engages in these activities will soon find the staff is gossiping about him and undermining his own authority. The result is a toxic environment in which time and energy are expended on game playing rather than serving patients.	Petty behavior in the workplace undermines a leader's credibility and authority. To maintain control of the operation and create an environment in which employees will feel secure, communication should be professional, focused on a strategy or task, authentic, free of ulterior motives, and in the spirit of full disclosure.

After a time, they burn out, becoming numb to it all, and the result is staff who is emotionless, bored, with no aspiration, and could care less whether the operation succeeds. Their focus becomes their paycheck and time spent at work is like being in prison. These “zombie” workers need to be brought back to life.

Mechanisms to Establish Authority

The urgent care leader has two mechanisms to engage staff around the center's mission and values and to get staff members to enthusiastically follow. First is authority by title: “I am your boss and therefore you must do what I say.” Such managers derive power from their ability to scrutinize, question, punish, harass, or even terminate an employee. Although they may spur action, the undesirable result is staffers who question the manager's competence, resent the manager's interference in their work, ignore the manager's commands, go over the manager's head, or who simply do the minimum work required to avoid the manager's scrutiny. Staffers rarely trust a manager whose authority comes by title.

The second mechanism involves winning the hearts and minds of the staff. If you want to motivate someone to act, you have to establish affinity with that per-

son. Affinity is a liking, agreement, or resemblance to another person that is the basis of becoming “real” to that individual. Until you establish affinity, being “non-real” is the same as being “non-human.” And one cannot effectively lead if he is considered an “object” and not a “person.” Is there any wonder why surveys show that up to two-thirds of American workers do not trust their bosses?

Affinity establishes a leader's “personhood” and thus willingness for staff to follow. To establish affinity with front-line staff, urgent care operators cannot be wishy-washy leaders. They must have a firm understanding of the values that guide the center and be personally committed to those values. Managers get exactly what they focus on. So if an urgent care operator believes, for instance, that patients are human beings who are invaluable to the center's success—he will develop staffers who treat patients with respect, compassion, and understanding. However, if the operator believes that patients are merely a means to an end—such as the center meeting its financial objectives—staffers will begin to treat patients as “objects” to be “processed” or, in extreme cases, “annoyances” to be dealt with.

Fortunately, unlike other service industries like retail

Table 3. Suggestions for Establishing Affinity With Front-line Staff

- Know and use the first name of every staff member.
- Make eye contact with staff members and acknowledge them by name when passing.
- Smile and be happy to see staff members. Ask how their day is going or how their weekend was.
- When choosing between helping an employee and finishing a report, choose to help the employee.
- When choosing between answering an employee's question and socializing with a superior, choose the employee.
- When meeting with staff members, give your full attention and do not rush. You are investing in your staff.
- Protect staff from abuse from providers, patients, vendors, injuries, and overwork at every turn.
- Get to know employees and the people important to them (eg, their spouses and children). Remember to ask about what you know is important to your staff members, but request permission before asking a personal question.
- Respect personal space and working territory. Keep the staff restroom and break room clean and well-attired.
- Treat staff equally and courteously. Stay person-centered not task-centered.
- Listen when staffers speak. Do not discount what they say or how they feel, and never speak down to them or correct them in front of others.
- Know the staff's assigned schedules. Ease the return of a staffer after a maternity or paternity leave with encouragement and flexible schedules.
- Jump in to help with any task when needed in a crisis or when short-staffed. (This is different than solving others' problems or taking over because no one else knows how to do something or does it well enough.)
- Allow and expect staffers to solve problems. Allow them to improve processes. Allow them to suggest solutions.
- Recognize staff achievement—both individually and collectively—through verbal recognition and tangible rewards that are visible to everyone associated with the center. Make the staff look good in front of others (eg, other staffers, their families, and patients).
- Surprise staffers by providing lunch on busy days, rewarding worthy recipients with spot bonuses, or hosting unexpected recognition activities.

and hospitality, where front-line staffers “happen upon” employment without giving a thought to their values and beliefs, many individuals choose employment in healthcare because they sincerely want to help people. A successful urgent care manager will tap into the staff's innate desire to provide a welcoming, compassionate, and skillful experience to every patient served.

The Remedy for Ambiguity

When employees don't know what's going on with a business, when they don't understand the reasons for decision making, they begin to think everything is arbitrary or by chance. Lack of disclosure may encompass politi-

cal or competitive changes affecting the operating model, the center's financial performance, hiring or firing of key personnel, development plans for individual workers, and specific plans for the future of the business. Authentic communication—honest self-expression that's free of pretense and judgment and empathetic to the needs of others—is the only remedy for uncertainty.

By focusing on employee's underlying needs for stability and peace, an urgent care operator who communicates authentically will spend less time judging, analyzing, complaining, and comparing—and spend more time addressing the challenges that impact the operation and cultivating connection and compassion with the staff.

The most important component of authentic communication is full disclosure: letting employees know where the business is headed, the values that guide the operation's path, and what each employee's role in the center's future is.

Authentic communication is fair, respects the individual, and avoids game playing and politics. At its root, it is one human being reaching out to another human being with the integrity that mutual respect demands. The result is that the staff always knows where it stands and guessing and assumptions become unnecessary. Confident that management has a plan, employees feel more secure and satisfied in their roles, which reflects in their engagement with patients and the qual-

ity of service they provide.

Creating Affinity With Front-line Staff

Winning the hearts and minds of the staff entails helping them feel that they are important to the leader and the organization. Through the leader's authentic communication, the staff comes to understand the humanity of the leader, realizes that they actually do share the same values, and believes that the leader has everyone's best interests at heart.

By contrast, activities that limit communication or put staffers “in their place” rely on formal structure for authority. This results in attitudes that the manager is

Table 4. Best Practices for Improving Work-life Balance for Hourly Employees	
Online Scheduling	Online scheduling is the wave of the future. Employers can use online scheduling services at a cost of \$1.25-\$5 a month per employee. This means that, for the first time, even small employers can shift to online scheduling.
Flex-time	Flex-time schedules allow workers flexibility in when they start and stop work. Typically a range of flex hours are set, such as arriving between 7 am and 9 am and leaving between 4 pm and 6 pm.
Compressed Workweeks	Compressed workweeks are full-time schedules compressed into fewer days per week.
Telework	A common assumption is that hourly jobs are place-bound jobs. Some are, but many are not. In fact, much routine white-collar work can be performed remotely.
Job Sharing	Job sharing is when two employees split one job; typically they work different days, with some overlap to aid coordination.
Retention Part-time Employment	Retention part-time jobs are jobs with benefits where employees have chosen to reduce their hours.
Gradual Return to Work	This policy allows someone returning from childbirth or other health-related leave to start part-time and gradually increase to a full-time schedule.
Part-year Work	Employees can vary their working hours during the course of the year. Salaries and paid time off are pro-rated, and flex-year workers are eligible for promotions and pay incentives.
Shift Swapping	Shift swapping is a key way hourly workers can shift their working hours so as to respond to family responsibilities, particularly unexpected ones. Cross-training can greatly facilitate shift swapping because it qualifies a broader range of employees to perform a given job. (Cross-training also has many other benefits, such as enabling easier coverage during vacations.)
Sick Leave for Care of Dependents	Employees often face the need to care for children and other dependents who are ill, but not sick enough to amount to a "serious health condition" covered by the Family Medical Leave Act. Much of the cost of a policy allowing employees to use their sick leave to care for sick children or dependents already is incurred as employees call in sick when, in fact, it is their children who are sick.
Comp Time	Comp time programs allow employees to take time off instead of receiving pay when they work extra hours. Employers need to be mindful of relevant state and federal labor laws when setting up these programs; a handful of states require an overtime premium for work in excess of eight or 10 hours a day, in addition to the federal law requirement for work in excess of 40 hours per week.
Shifting Work Hours	Employees, with approval of their work teams, can work up to two hours at the end of the shift directly before they are scheduled to work or at the beginning of the shift directly after they are scheduled to work. Other members of their team cover the two hours not covered by the employee who is shifting his working time.
Floater	A floater's job is to cover shifts for employees who are unable to work. The additional costs may well be defrayed by the amounts saved by preserving efficiency without having to keep on employees after the end of their scheduled work day. The most efficient floaters have been cross-trained so that they can fill a number of roles.
Redesigning Overtime Systems	In many workplaces, one group of workers passionately wants overtime while, for another group (mothers and tag-teamers), an order to work overtime on short notice can mean losing their jobs. The first step is to rely on volunteers to the extent possible. Two alternative ways of handling mandatory overtime exist when it is unavoidable. One is to give coupons that workers can use to buy out of overtime or claim additional work hours. The second is to divide employees into four groups and have one group on call for possible overtime during the first week of every month, the second on call during the second week, and so on. This enables workers to arrange for back-up child care during the week they are on call.
Leave Banks	"Leave banks" allow employees to donate unused leave to a colleague and are often used in situations where a worker, or a worker's relative, is seriously ill. Leave banks also enable colleagues to help a woman who has recently borne a child.
Reference Adapted from Williams JC, Huang P. Improving work-life fit in hourly jobs: an underutilized cost-cutting strategy in a globalized world. University of California Hastings College of Law, Center for WorkLife Law. 2011;1-71. Available at: http://www.worklifelaw.org/pubs/ImprovingWork-LifeFit.pdf . Accessed November 21, 2011.	

self-centered, without feeling, and unworthy of the staff's energy and passion.

Which of the following multi-unit urgent care operators do you think is more effective in motivating staff to deliver a first-rate patient experience?

- When one operations director arrives at the center, he spends most of his time cloistered away with the center's supervisors discussing staff-related issues. He paces the hallway with his cell phone, text messaging and talking with his superiors, and

when he does look up at staff members, he neither acknowledges them nor calls them by name. After the operations director departs, the center's supervisor "slams down" the staff for everything the director observed that was wrong.

- Another operations director makes it a point to spend one day a month at every center, memorize every employee's name, and actively listen to employee concerns and suggestions. She purchased a portable charcoal grill to personally make hot dogs and hamburgers for the hurried staff in the summer months. As staff members take their breaks to grab a bite, the director asks about their hobbies, interests, and workplace challenges. The act of humility in not only buying—but actually preparing and serving—lunch creates a strong affinity between the staff and the leader.

To create an emotional connection with the center's front-line staff—to get the staff to like and trust you as a leader—consider the following activities in **Table 3**.

Scheduling Flexibility: Making Life Easier for Front-line Staff

In addition to engaging employees through authentic communication, successful urgent care centers are also adapting working hours and schedules to meet the needs of front-line staffers. These individuals are more likely to be women who are single parents and caregivers, hold down multiple jobs, rely on family members for child care (including "tag-teaming" with a spouse who works different shifts), and tend to have greater personal healthcare needs.

"Work-life balance" and associated benefits—paid time off, control over work schedules, flexibility in starting times and breaks—are taken for granted by professionals but are rarely available at the bottom of the pay scale, even though front-line workers potentially need them most. That's because lower-level jobs are still largely viewed as a cost to be controlled rather than an opportunity to cultivate a loyal workforce.

For a center to operate, front-line positions must be filled at all times the center is open. Therefore, front-line employees are expected to punch-in and -out, work overtime or cover additional shifts on demand, or face corrective action for being late or leaving early to tend to family affairs. Under progressive disciplinary systems, all too often a staff person will find herself out of a job because of "one too many" personal emergencies.

Researchers are finding that when low-wage, mostly part-time workers receive benefits traditionally reserved

for management—flexible working hours, time off when needed, and the ability to lock in a schedule of shifts a full month (rather than a few days) in advance—the result is higher morale, productivity, customer service and revenues, and reduced turnover and labor costs.²

Table 4 outlines best practices for improving work-life balance for front-line employees that could be easily integrated into the staffing model of an urgent care center.

Conclusion

An engaged and happy front-line staff is essential to a well-run and sustainable urgent care operation. Urgent care operators who dismiss, overlook, or neglect their front-line staff will experience dissatisfied patients, negative word of mouth, increased operating costs, instability in operations, and increased risk. People want security and peace in their lives, but the ambiguity of work often creates a state of chaos in which individuals feel powerless—attributing workplace opportunity to chance and believing their success is determined by luck. The best remedy for winning the hearts and minds of the front-line staff is to create affinity—that is, through communication, to become "real" to them by realizing shared values, demonstrating humility, and emphasizing their importance to the operation. The results can be seen in satisfied patients who not only return more frequently for services (and tell others to do the same) but who also post testimonials on Facebook, Twitter, and other social networking websites about the "bright-eyed, smiling, and outgoing staff" they encountered. ■

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2. Villano D. Work-life balance benefits low-wage workers, employers. Miller-McCune.com. Available at: www.miller-mccune.com/business-economics/work-life-balance-benefits-low-wage-workers-employers-35733. Accessed November 22, 2011.

Had Any Interesting Cases Lately?

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Overview of Urgent Care Financing

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

You've researched the industry, have a site picked out, and have a name reserved. Now comes the million dollar question. Wait, that is the question: Where do I get a million dollars to start an urgent care? Do you really need a million? My noncommittal "attorney answer" is: "possibly." I have had friends lose a lot more than that before being forced to close the doors.

That said, you can certainly do it for a lot less money if you are staffing the clinic yourself, don't over-build, and lease only the really necessary equipment. However, beware: lack of capital is the root cause of many small business failures. In addition, inadequate capitalization can be used by an attorney as a justification to "pierce the corporate veil" and attack your personal assets.

Where do you look for capital to start an urgent care center? The first place is in the mirror. How much do you have to invest in the business? Look into your savings, stocks, bonds, cash-value life insurance, and real estate assets. If you cannot put in some of your own money, you will have a difficult time convincing other investors/creditors to contribute their money. Fortunately, even if you are turned down by one lender, others, because of differences in lending policies, may finance the same or a similar proposal.

Key Questions

Before you start your capital-raising process, be prepared to answer the following questions:

- How much capital do I need? (Be conservative.)
- What are my uses of capital? (Be exact. Your salary is probably not a compelling use of funds to an outside investor.)



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- How much of my own money can I afford to put into the venture? (Be conservative.)
- Am I willing to personally guarantee the debt? (For traditional bank financing, you will probably have to guarantee the amount or have sufficient capital pledged against the debt facility.)
- What information do I need to convince someone to invest in the business? (Business plan, pro forma financials, etc.)

Succinctly, your ability to finance the venture will depend upon:

- How much of your own capital you are putting into the venture
- How well thought-out your plan is (competition, financing, marketing, etc.)
- Your track record and banking history if you plan on using traditional bank debt

The Five C's of Credit

If you are going the traditional bank route, banks still lend based on the "five C's of Credit":

Character: To a lender, this is their way to determine whether you have the integrity to live up to your word and will make every effort to pay off the debt as opposed to attempting to simply walk away. You need to be up front (with yourself and with the lender) about your strengths, weaknesses, and plans to fill any gaps.

Capacity: If your venture fails, do you have the capacity to pay off the loan? Here is where it helps to be a provider. Despite market vagrancies, medical providers are always needed and we can typically find work that pays enough to pay down a note over time. Be prepared to answer tough questions about your capacity to handle debt payback if the venture tanks.

Collateral: Not only do banks want to know you have the financial capacity or available cash flow to pay off debt, they also want you to pledge assets that more than cover the



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HEALTH LAW

amount of the note. Typical sources of collateral are equity in a home, cash-value life insurance, and stocks or other liquid securities. Before agreeing to something, think of the worst-case scenario. If the business fails, can you stomach losing your kids college funds? (The world needs ditch diggers, too, Danny.)

Conditions: Other than educating the lender, you have little control over broad economic indicators. If you tried borrowing money or raising capital after the fall of Lehman Brothers, you and many pre-IPO companies postponed or were unable to complete their rounds of financing as investors looked for shelter.

Capital: This is the put-up-or-shut-up aspect of credit. A lender will want to see that you have "skin in the game" as opposed to being able to simply walk away if it blows up. A lender will not be willing to put up 70%-80% of the capital needs of a new business. New businesses fail at an alarming rate and lenders cannot afford (particularly in the "new normal") that level of risk.

Types and Sources of Capital

There are a variety of types of capital as well as sources of capital. Different financing needs require different sources of capital. For example, if you are building your own center, you will use construction financing, which can ultimately roll into a term loan for the property and building. For your equipment, you may secure a capital lease. If you have short-term cash needs in a business that is generating cash, you may want to factor in your receivables (ie, sell them off at a discount). To cover initial start-up losses, you may want to negotiate a line of credit that is partially secured by third-party-payer receivables and a personal guarantee and equity in your home, which ultimately converts to a term loan without a prepayment penalty.

If you do not have the capacity to secure the necessary debt financing, you will need to sell equity in the future business. If a business owner takes on equity by selling shares or an ownership interest in a corporation, the capital is not repaid (unless it is a convertible debt instrument), but the investor now has an ownership interest in the company and may (depending on the way the agreements are drafted) have the right to siphon off profits.

As you enter into this endeavor, it is important to have at least a basic understanding of sources of capital and how to go about obtaining financing. Consultants who are knowledgeable in the urgent care space and your accountant should be able to guide you to the best source of capital for your financing needs.

In my next column, we will take a deeper dive into the various sources of debt and equity capital as well their pros and cons. ■

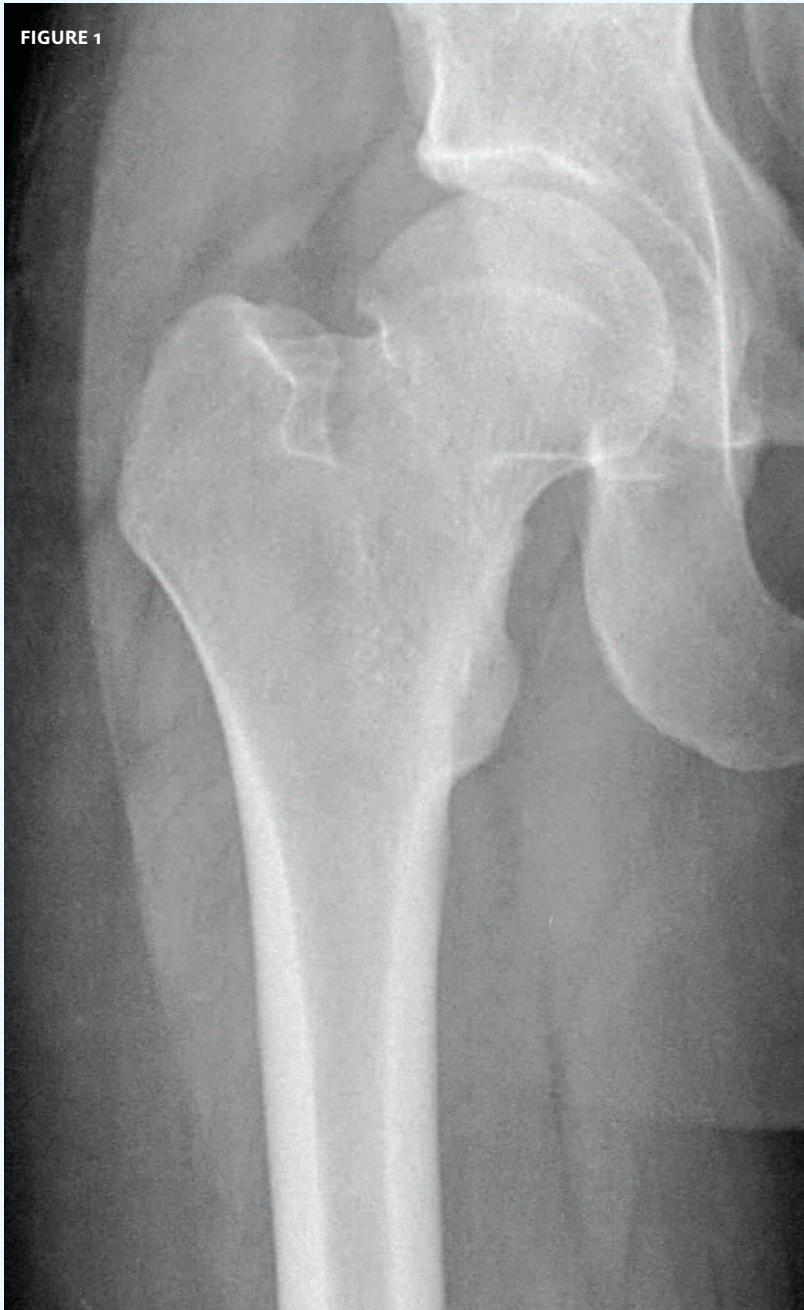


INSIGHTS IN IMAGE CLINICAL CHALLENGE

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

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

FIGURE 1



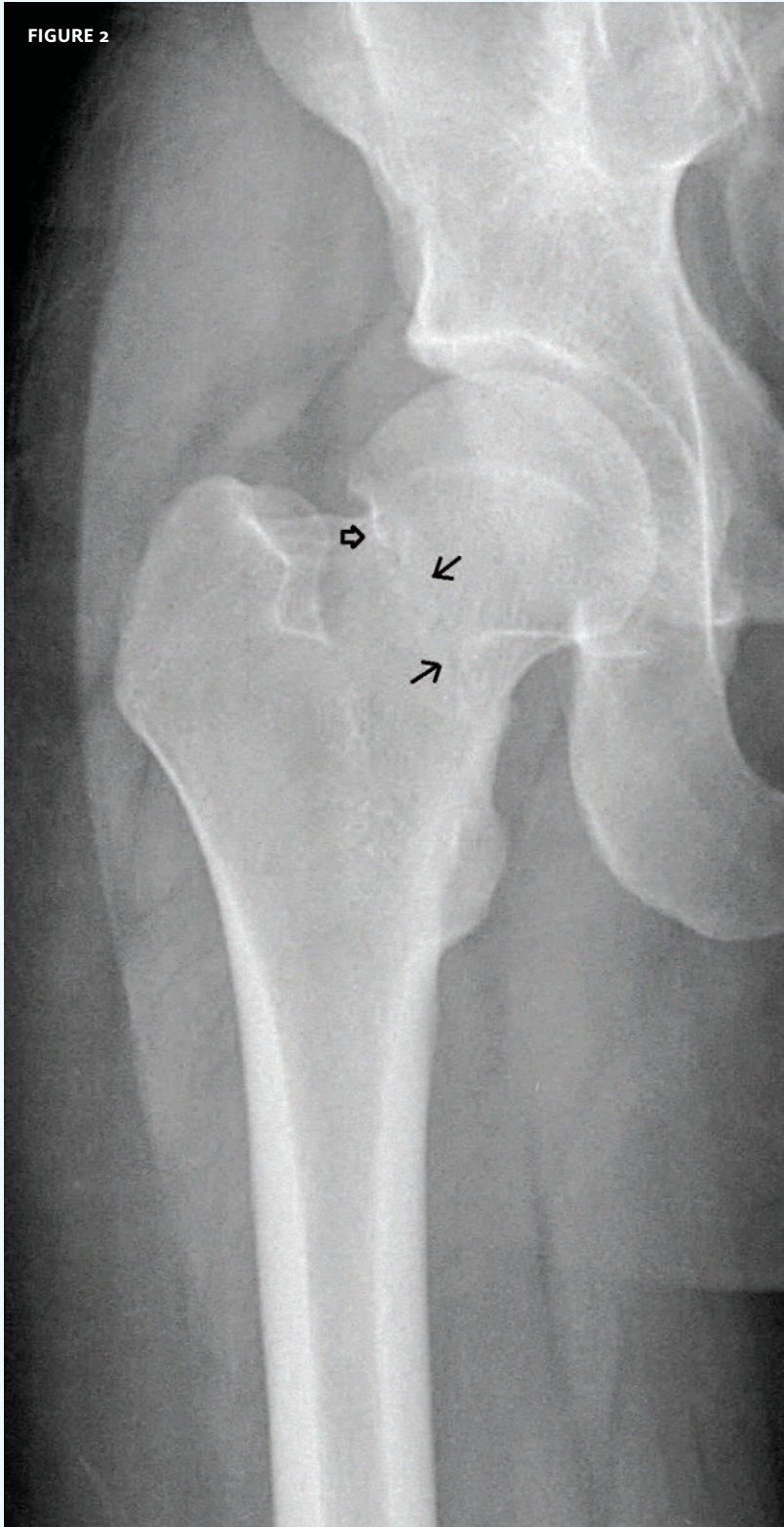
The patient, an otherwise healthy 25-year-old, fell and suffered a blow to the right hip. The injury was not weight-bearing.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



The diagnosis is fracture of the neck of the femur. Femoral neck fractures are frequently missed, and it is not uncommon for patients to be able to weight bear. Occult fractures occur in 2%-9% of cases. If the fracture is not readily apparent on x-ray, MRI is the study of choice. Maintain a high index of suspicion in elderly falls. Refer to hospital for orthopedic evaluation.

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



ABSTRACTS IN URGENT CARE

- Routine Prostate Cancer Screening
- Coffee Drinking Lowers Depression Risk
- Cell Phones and Brain Tumor Risk
- Adenoidectomy for Recurrent URIs
- MRIs Are Safe With Pacemakers, ICDs
- UTI and Chronic Kidney Disease

■ 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.

USPSTF to Advise Against Routine Prostate Cancer Screening

Key point: *The US Preventive Services Task Force has concluded that healthy men should not undergo routine prostate-specific antigen testing.*

Citation: Harris G. US panel says no to prostate screening for healthy men. New York Times website. Available at: www.nytimes.com/2011/10/07/health/07prostate.html. Accessed December 6, 2011.

The recommendation was based on an analysis of five trials and applies to men of all ages. The *Times* quotes the task force's chairwoman: "Unfortunately, the evidence now shows that this test does not save men's lives ... This test cannot tell the difference between cancers that will and will not affect a man during his natural lifetime."

In 2008, the USPSTF recommended against PSA testing in men aged 75 or older, and said evidence was insufficient to recommend for or against testing in younger men. ■

Depression Is Less Common in Women Who Drink Coffee

Key point: *Four or more cups daily seemed to protect against developing depression.*

Citation: Lucas M, Mirzaei F, Pan A, et al. Coffee, caffeine, and

risk of depression among women. *Arch Intern Med.* 2011;171(17):1571.

One prospective study involving men showed a reduced risk for depression with increased coffee consumption (*Public Health Nutr.* 2010;13:1215), and several studies have shown an association between increased coffee consumption and decreased risk for suicide. Using data from the Nurses' Health Study, investigators studied about 50,000 women who were free of depression at baseline; coffee consumption and new diagnoses of depression were documented during 10 years of follow-up.

In analyses adjusted for numerous clinical and demographic variables, risk for depression in women who drank four or more cups of coffee daily was 20% lower than in women who drank one cup or less weekly. No association was observed between risk for depression and consumption of either decaffeinated coffee or caffeine from other sources (eg, tea, chocolate); however, non-coffee sources probably contributed too little caffeine for meaningful assessment.

Published in *J Watch Gen Med.* October 6, 2011—Thomas L. Schwenk, MD. ■

Cell Phones Not Linked to Tumor Risk in Large Danish Study

Key point: *Mobile phones do not increase risk for brain tumors.*

Citation: Frei P, Poulsen AH, Johansen C, et al. Use of mobile phones and risk of brain tumours: update of Danish cohort study. *BMJ.* 2011;343:d6387.

Use of mobile phones does not increase the risk for brain tu-



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mors, a Danish national cohort study finds. The results, reported in *BMJ*, update an earlier study that reported findings until 2002, to which 5 years of follow-up data (to 2007) have now been added.

Researchers compared the incidence of brain tumors in nearly 360,000 subscribers to mobile phone services with the incidence in the rest of the population over a 17-year period. They found that tumors of the central nervous system occurred at a similar rate in both groups.

Editorialists say that continued monitoring of such cohorts is warranted, but new studies “are not needed.” Earlier this year, WHO called cell phones “possibly carcinogenic.” ■

Say No to Adenoidectomy for Recurrent Upper Respiratory Infections

Key point: *For children referred to surgeons because of frequent URIs, adenoidectomy conferred no clinical benefit over watchful waiting.*

Citation: van den Aardweg MTA, Boonacker CWB, Rovers MM, et al. Effectiveness of adenoidectomy in children with recurrent upper respiratory tract infections: open randomised controlled trial. *BMJ*. 2011;343:d5154.

Many children with chronic or recurrent upper respiratory infections (URIs) undergo adenoidectomy with or without myringotomy tube placement. Investigators in the Netherlands evaluated the efficacy of this practice in an open multicenter randomized trial that included 111 children (age range, 1-6 years) with recurrent URIs who were selected by surgeons for treatment with adenoidectomy. The children underwent adenoidectomy with or without myringotomy within 6 weeks or watchful waiting.

During 2 years of follow-up, the incidence of URI episodes per person-year (the primary outcome) did not differ significantly overall or during the first or second years between the adenoidectomy and watchful-waiting groups (overall incidence, 7.9 and 7.8 per person-year, respectively). Severity of URI also did not differ, although children in the adenoidectomy group had significantly more days with fever (20.0 vs 16.5 days per person-year, respectively). Forty percent of children in the control group eventually underwent adenoidectomy or other related surgery; however, these children did not differ from those in the control group who did not undergo surgery in number of infections during the year before surgery or the primary outcome. Two children had complications related to surgical procedures (1 broken tooth and 1 postoperative hemorrhage).

Published in *J Watch Pediatr Adolesc Med*. October 19, 2011—Peggy Sue Weintrub, MD. ■

Closely Supervised MRIs Seem Safe for Most Patients with Pacemakers and ICDs

Key point: *Most patients with implanted cardiac devices could safely undergo magnetic resonance imaging using a protocol evaluated in the Annals of Internal Medicine.*

Citation: Nazarian S, Hansford R, Roguin A, et al. A prospective evaluation of a protocol for magnetic resonance imaging of patients with implanted cardiac devices. *Ann Int Med*. 2011;155(7):415-424.

The protocol was tested prospectively in some 440 patients (median age, 66) with pacemakers or implantable cardioverter-defibrillators who had clinical indications for MRI. The scanners all had magnetic field intensities of 1.5 T, and the cardiac devices were mostly manufactured after 1998 (pacemakers) and 2000 (ICDs). Patients were monitored closely during MRI by clinicians experienced in advanced cardiac life support.

Power-on-reset events occurred in three patients. No changes were required in the device leads or programming after MRI.

The authors conclude: “Using a protocol based on device selection and programming, MRI can be performed safely in patients with certain pacemaker and ICD systems.” Editorialists write that the presence of rhythm-management devices “should no longer be considered an absolute contraindication to MRI.” ■

Recurrent UTI in Childhood an Unlikely Cause of Chronic Kidney Disease

Key point: *Contrary to common belief, recurrent UTIs in childhood appear to be only a rare cause of chronic kidney disease.*

Citation: Salo J, Ikaheimo R, Tapiainen T, Uhari M. Childhood urinary tract infections as a cause of chronic kidney disease. *Pediatrics*. 2011;128(5):984-985.

Researchers in Finland conducted a literature review for studies on childhood UTIs and kidney disease. None of the 1600 patients identified had childhood UTI as the main cause of kidney disease.

The researchers also studied some 370 patients treated for chronic kidney disease at their own hospital in 2005–2006. Most of the patients had a specific noninfectious cause of kidney disease. Of 13 who had a history of UTI, all had structural abnormalities identified on their first kidney imaging study. There was just one patient in whom UTI was a possible cause of kidney disease.

The authors point out that ultrasonography, rather than radiologic imaging, could have identified the abnormalities identified after the first kidney examination, thus sparing patients unnecessary radiation exposure. ■

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Virginia - Urgent Care Physicians

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Roanoke, Virginia, a five-time "All America City," population over 300,000, and one of the top rated small cities in the US. Nestled in the gorgeous Blue Ridge Mountains and close to 500 mile shoreline Smith Mountain Lake. The New River Valley region comprises the localities of Christiansburg, Blacksburg, and Radford, with a population of 175,000, home to Virginia Tech and Radford University. The region is affordable, safe, progressive and just minutes away from the Blue Ridge Parkway and the Appalachian Trail.

Carilion Clinic is the largest, not-for-profit integrated health system in southwest Virginia with 7 hospitals, 100+ multi-specialty clinics, 9 residency and 7 fellowship programs affiliated with the Virginia Tech Carilion School of Medicine.

Benefits include competitive compensation with incentive, relocation, paid malpractice, and much more.

Please contact **Andrea Henson, Physician Recruiter**
ahenson@carilionclinic.org or 540-224-5241



A message from Lee Resnick, MD, Editor in Chief,
JUCM, The Journal of Urgent Care Medicine/Chief Medical Officer,
WellStreet Urgent Care.

WellStreet Urgent Care is currently seeking qualified physicians to join its growing urgent care practice in Atlanta, GA. With plans to open 12 high-end facilities in 2012, this is a great opportunity to become part of a world class team that is redefining the urgent care experience.

WellStreet offers outstanding practice opportunities for board-certified family medicine, emergency medicine, and med/peds physicians. Successful candidates will bring outstanding clinical acumen and a desire to provide a top-notch patient experience.

You can look forward to outstanding earning potential including base salary plus incentive, health, dental and vision insurance, CME allowance, paid time off, relocation assistance, and malpractice coverage. This is a great opportunity to join a growing organization and have the opportunity to shape the practice and advance your career.

Positions are currently available in Atlanta - which consistently appears on top ten lists of the best places to live. Find out more about Atlanta life at: <http://www.atlanta.net>.

If you feel this could be a good fit for your interests and skills, we would appreciate hearing from you. Please send your CV to: cspringfield@wellstreet.com or call: 404-382-9902. You can also check us out online at: www.wellstreet.com.



PRESBYTERIAN HEALTHCARE SERVICES Albuquerque, New Mexico

Presbyterian Healthcare Services (PHS) is New Mexico's largest, private, non-profit healthcare system and named one of the "Top Ten Healthcare Systems in America". PHS is seeking four BE/BC Family Practice Physicians to work in our Urgent Care Centers. There are five Urgent Care Centers in Albuquerque and full time providers work 14 shifts per month or average around 144 hours per month.

Enjoy over 300 days of sunshine, a multi-cultural environment and casual southwestern lifestyle. Albuquerque has been recognized as "One of the Top Five Smart cities to Live." It is also home to University of New Mexico, a world class university.

These opportunities offer: competitive salary * relocation * CME allowance * 403(b) with match * 457(b) * health, life, AD&D, disability insurance, life * dental * vision * pre-tax health and child care spending accounts * malpractice insurance, etc. (Not a J-1, H-1 opportunity) EOE.

For more information contact:
Kay Kernaghan, PHS
PO Box 26666, ABQ, NM 87125
kkernagh@phs.org
866-757-5263



FLORIDA URGENT CARE OPPORTUNITIES

Titan Emergency Group is seeking qualified BE/BC Family Medicine or Internal Medicine physicians for Fast Track inside the Emergency Department. No overnights or call. Excellent compensation with incentive bonus to include full-time with benefits or independent contract options available.

Jacksonville, Florida

Servicing two main emergency department fast tracks in Jacksonville:

Memorial Hospital, a 353 bed tertiary care center with 15 bed Fast Track located aside the main ED. 12 hour shifts (10a-10p) with midlevel and scribe support. Orange Park Medical Center, a 252 bed facility seeking Level II Trauma Center, with 12 bed Fast Track located aside the main ED. 8 hour shifts with midlevel and scribe support.

Tallahassee, Florida

Capital Regional Medical Center (198 bed hospital) services the community of Tallahassee, FL. 8 bed Fast Track located inside the main ED. Nine hour shifts with midlevel and scribe support.

For more information, contact Alisha Lane at:
904-332-4322 or a.lane@titandoctors.com

Urgent Care position Manchester, New Hampshire

Elliot Health System in Manchester, New Hampshire offers an outstanding practice opportunity for family medicine physicians with an interest in urgent care. The position offers a variety of urgent care cases including pediatric and qualified candidates should be comfortable with suturing, casting and reading x-rays and EKG's.

Enjoy outstanding compensation, full benefits and flexibility through a request driven scheduling process. As a member of this highly cohesive team, you will share equally in providing weekday, weekend and night coverage. This is an excellent opportunity to join a dynamic group that is involved and dedicated to caring, quality patient care.

Elliot Hospital is a 296-bed, JCAHO-accredited acute care facility and Level II Regional Trauma Center distinguished not only by its highly regarded Emergency Department, but also by an extensive Primary Care Physician Network, Women's Health Program, Geriatrics Programs, a Regional Cancer Center and a Level III NICU.

Recently, Elliot Hospital was named one of healthcare's Top Wired Hospitals in the country according to Hospitals & Health Networks Magazine. Elliot Health System has made information technology a priority in patient care, implementing electronic medical records, My E Chart (which allows patients to manage their personal medical records), wireless internet access for hospitalized patients, and a wealth of information provided to both patients and staff via the internet.

Manchester is located in southern New Hampshire and is less than one hour to Boston, Massachusetts. As the state's largest city, Manchester offers the best of both worlds—the amenities of a charming New England community with the advantages of cultural and social options for every taste. You will enjoy four-season climate and have access to both the White Mountains and the Atlantic Ocean. Outdoor activities are a way of life in this desirable community. Come see what tax-free New Hampshire has to offer!

Contact: Molly Alderson at: 800-678-7858 x64507
malderson@elliottphysicianjobs.org
ID#140867C14

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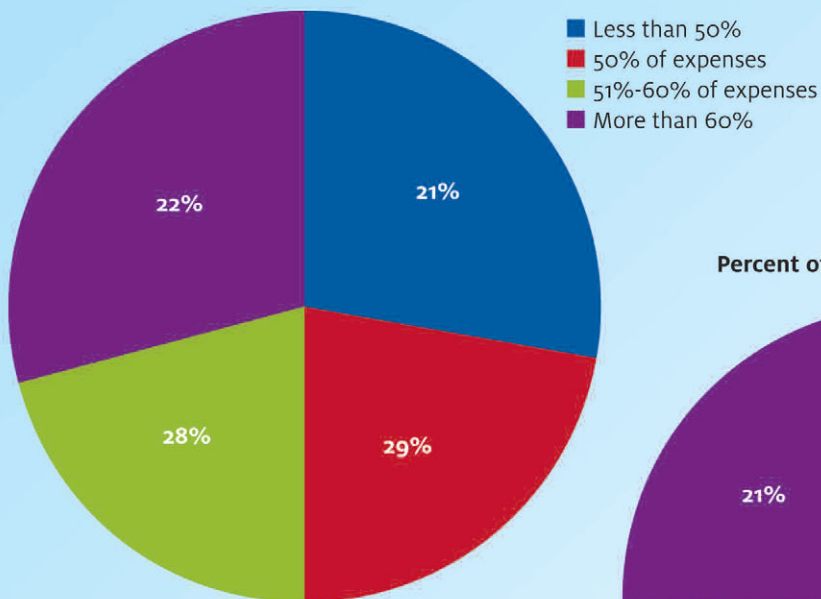
DEVELOPING DATA

These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to “full-fledged urgent care centers” accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment onsite; the ability to administer IV fluids and perform minor procedures; and having minimal business hours of seven days per week, four hours per day.

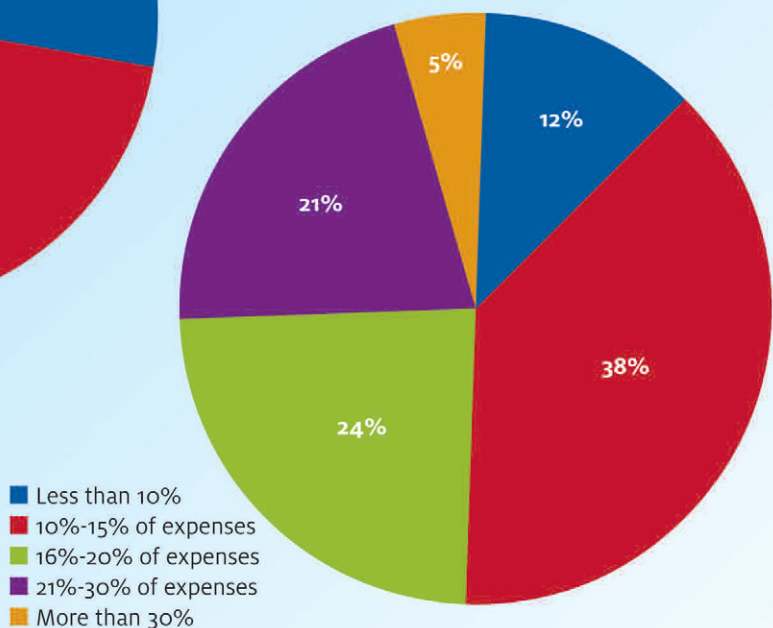
In this issue: What percent of total urgent care expenses go to employee costs (salaries and benefits)?

EMPLOYEE COSTS (SALARIES AND BENEFITS)

Percent of Total Expenses to Salaries



Percent of Total Expenses to Benefits



Employee costs are the largest areas of expense for all centers. Half the centers count over 50% of their expenses as salary, but the mix is quite spread out compared to benefits. This is likely due to the variety of clinical staffing models. Seventy-four percent of centers count 20% or less of their expenses as additional benefits.

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

National Urgent Care Convention

Urgent Care Association of America



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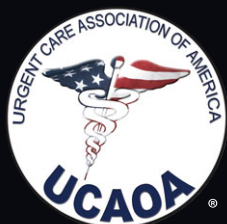
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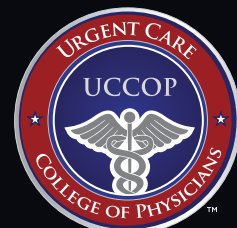
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