

# JUCM™

THE JOURNAL OF URGENT CARE MEDICINE®

MARCH 2011  
VOLUME 5, NUMBER 6

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

## IN THIS ISSUE

### FEATURES

- 9** Pitfalls in Assessing and Managing Common Pediatric Injuries—Part 2
- 17** Bouncebacks: The Case of a 42-year-old Fireman with Shoulder Pain: When a Lifeline Becomes a Noose

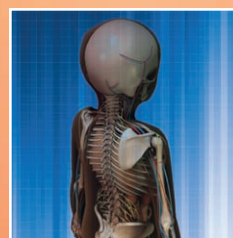
### DEPARTMENTS

- 25** Insights in Images: Clinical Challenge
- 29** Abstracts in Urgent Care
- 32** Health Law
- 34** Occupational Medicine
- 35** Coding Q&A
- 40** Developing Data



## PART 2

# Pitfalls in Assessing and Managing Common Pediatric Injuries



# WE ARE COMMITTED TO URGENT CARE

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



CONTACT US AT:

**800.333.9800**

[UC@PHYSICIANPARTNER.COM](mailto:UC@PHYSICIANPARTNER.COM)

[WWW.PHYSICIANPARTNER.COM](http://WWW.PHYSICIANPARTNER.COM)

OUR COMMITMENT IS YOUR SUCCESS

**MENTION THIS AD AND RECEIVE A \$250.00 AMERICAN EXPRESS GIFT CARD  
WITH YOUR INITIAL ORDER OF \$1000.00 OR MORE \***

\* OFFER VALID FOR NEW ACCOUNTS ONLY



## LETTER FROM THE EDITOR-IN-CHIEF

# Healthcare Laws vs. Newton's Laws



**N**ewton's Third Law: "To every action there is always an equal and opposite reaction." Medicine applies Newton's Third Law liberally, from physiology to pharmacology; negative feedback loops, down-regulation, compensatory states, and medication side effects all follow its principles.

The body, as we well know, is inclined to homeostasis, and any upset to this balance is met with resistance and dysfunction.

Unfortunately, well-meaning healthcare regulators, policy-makers—and, yes, even fellow physicians—have ignored Newton's Third Law and patient care has suffered.

Such trouble begins when a group of very smart people get into a room to determine policies meant to protect patients or reduce costs.

Nearly every rule and regulation in medicine was born this way. From patient privacy to documentation rules, from practice guidelines to STARK, we have taken *action* to improve quality and safety, reduce fraud and abuse but failed to assess the consequent *reaction*. Both individually and, perhaps even more important, in the aggregate, these rules and regulations have ultimately diminished quality and safety and all but abolished even innocuous free-market practices. (Remember professional courtesies? Yeah, well that's "fraud" now.)

How could this be? When you examine each in isolation, their intended result seems almost guaranteed: Privacy rules certainly seem to protect patient information, documentation rules would seem to limit errant billing, clinical guidelines support a best practice standard, and STARK rules probably limit disreputable self-referral practices.

What say ye, Newton?

Well, I would argue there is a much underappreciated reaction, deserving of closer examination and research to quantify its impact. If we as practitioners spend precious time, not to mention mental energy and focus, working to satisfy requirements by law or mandate, can we not assume that this will be a diversion from patient care? When I am covering my tracks, dotting my i's, or mechanically checking off my review of systems to make sure I am in compliance, I have added no value whatsoever to the encounter if, in fact, I would have been in compliance with the law's intentions in the first place.

The fact of the matter is that rules and regulations to limit the

impact of a few bad apples have had the unintended consequence of weakening the impact of the majority. A weakened majority, I would argue, is more detrimental to patient care than the protection gained from regulating the minority. We must not pat ourselves on the back until we have properly examined the overall impact to care.

I would also argue that the invention of said rules and regulations have simply shuffled money from one party to another. At what cost do we legislate, defend, oversee, and overstaff to support these rules? And for all this expense, penalties are rarely enforced on a percentage basis. Health systems and their well-paid lawyers have found loopholes around STARK. Ironically, it's the individual physicians that lose again. The hospitals are still getting their referrals, yet all the incentives that used to trickle down to physicians are gone. Nothing else has changed.

So, in the end, I think patient safety is a wash, or diminished, and cost of care is increased while productivity and revenue are shrinking. All on the backs of the vast majority of physicians working tirelessly to provide the best care imaginable for their patients.

In an attempt to account for every possible variable in medicine, and to protect against the malfeasance of a tiny minority, we have created an environment of fear, redundancy, waste, and inequity that has unequivocally distracted us from patient care. As if the practice of medicine wasn't hard enough! How much more can we really take?

While I, too, think it is critically important to eliminate fraud, and to promote patient safety and quality, I believe it to be equally important to minimize unnecessary burdens with no proven benefit. We need an honest look at healthcare policy and regulation that holds it accountable beyond simplistic gospel and politics. The health of medicine is at stake; homeostasis has been breached. ■

Lee A. Resnick, MD  
Editor-in-Chief

*JUCM, The Journal of Urgent Care Medicine*



# Discover Why Over 60,000 Physician Offices and Urgent Care Centers Rely On Us For Supplies and More.

Think Quality  
*Think* **McKESSON**

As the nation's largest, most experienced distributor of medical supplies, McKesson delivers a higher level of commitment to service, to increasing efficiency, and to reducing costs for our physician offices and urgent care centers. We not only offer 150,000+ quality products — but also comprehensive technology solutions, consistent pricing, and an easy-to-use online ordering system that can help your center grow.

**Contact your McKesson Medical-Surgical  
Account Manager for more information.  
Or call 866.McK.ANSWer (866.625.2679).**

## March 2011

VOLUME 5, NUMBER 6



### CLINICAL

## 9 Pitfalls in Assessing and Managing Common Pediatric Injuries—Part 2

Part 1 of this series sought to breed familiarity with the growth process and the unique properties of the immature skeleton. In its conclusion, the authors focus on assessment and management of specific fracture types common to the pediatric population.

*By Justin Kunes, MD, Shane R. Hanzlik, MD, and Allison Gilmore, MD*

### BOUNCEBACKS

## 17 The Case of a 42-year-old Fireman with Shoulder Pain: When a Lifeline Becomes a Noose

A healthy-appearing man with a physically demanding job presents with pain and severely limited motion in one shoulder a day after repeated heavy lifting. Would you presume it's simply a strain—or look deeper and reach the right diagnosis?

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



### WEB EXCLUSIVE

Understanding currently available testing, monitoring, and treatment options is essential to providing thoughtful consideration to patients who have been exposed to tuberculosis. Available exclusively at [www.jucm.com](http://www.jucm.com).

*By Jacqueline Dancy, PA-C, MPAS*

**7** From the UCAOA Executive Director

### DEPARTMENT

- 25** Insights in Images: Clinical Challenge
- 29** Abstracts in Urgent Care
- 32** Health Law
- 34** Occupational Medicine
- 35** Coding Q&A
- 40** Developing Data

### CLASSIFIEDS

- 37** Career Opportunities

### IN THE NEXT ISSUE OF JUCM

Owing to its reputation as the “great masquerader,” giant-cell arteritis (aka temporal arteritis) is an under-recognized and easily missed diagnosis, with potentially devastating consequences in older adults. We'll present an overview of the disease, along with laboratory tests that assist in diagnosis and guidance on management.

## JUCM EDITOR-IN-CHIEF

**Lee A. Resnick, MD**  
Case Western Reserve University  
Department of Family Medicine  
Institute of Urgent Care Medicine

## JUCM EDITORIAL BOARD

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

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

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

**Nahum Kovalski, BSc, MDCM**  
Terem Emergency Medical Centers

**Peter Lamelas, MD, MBA, FACEP, FAAEP**  
MD Now Urgent Care Medical Centers, Inc.

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

**Genevieve M. Messick, MD**  
Immediate Health Associates

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

**John Shufeldt, MD, JD, MBA, FACEP**  
Shufeldt Consulting

**Joseph Toscano, MD**  
San Ramon (CA) Regional Medical Center  
Urgent Care Center, Palo Alto (CA) Medical  
Foundation

**Mark D. Wright, MD**  
The University of Arizona

## JUCM ADVISORY BOARD

**Michelle H. Biros, MD, MS**  
University of Minnesota

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

**Gary M. Klein, MD, MPH, MBA, CHS-V, FAADM**  
mEDhealth advisors; Military Health Systems,  
Department of Defense

**Benson S. Munger, PhD**  
The University of Arizona

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

**Peter Rosen, MD**  
Harvard Medical School

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

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

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

**Robin M. Weinick, PhD**  
RAND

## UCAOA BOARD OF DIRECTORS



**Don Dillahunty, DO, MPH, President**

**J. Dale Key, Vice President**

**Cindi Lang, RN, MS, Secretary**

**Laurel Stoimenoff, Treasurer**

**Jeff Collins, MD, MA, Director**

**William Gluckman, DO, MBA, FACEP, CPE, CPC, Director**

**Jimmy Hoppers, MD, Director**

**Robert R. Kimball, MD, FCFP, Director**

**Peter Lamelas, MD, MBA, Director**

**Nathan Newman, MD, FAAFP, Director**

**Marc R. Salzberg, MD, FACEP, Director**

**Lou Ellen Horwitz, MA, Executive Director**

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

# JUCM

## EDITOR-IN-CHIEF

**Lee A. Resnick, MD**  
[editor@jucm.com](mailto:editor@jucm.com)

## EDITOR

**J. Harris Fleming, Jr.**  
[hj Fleming@jucm.com](mailto:hjfleming@jucm.com)

## CONTRIBUTING EDITORS

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

## ART DIRECTOR

**Tom DePrenda**  
[tdeprenda@jucm.com](mailto:tdeprenda@jucm.com)



65 North Franklin Turnpike, Second Floor,  
Ramsey NJ 07446

## PUBLISHERS

**Peter Murphy**  
[pmurphy@braveheart-group.com](mailto:pmurphy@braveheart-group.com)  
(201) 529-4020

**Stuart Williams**  
[swilliams@braveheart-group.com](mailto:swilliams@braveheart-group.com)  
(201) 529-4004

## Mission Statement

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

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

**JUCM** (ISSN 1938-002X) printed edition is published monthly except for August for \$50.00 by Braveheart Group LLC, 65 North Franklin Turnpike, Second Floor, Ramsey, NJ 07446. **JUCM** is pending periodical status at Mahwah Postal Annex, 46 Industrial Drive, Mahwah, NJ 07430 and additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 65 North Franklin Turnpike, Second Floor, Ramsey NJ 07446.

# It's here!

## MOXEZA™

(moxifloxacin HCl ophthalmic solution) 0.5% as base

Introducing  
the new morning & night  
bacterial conjunctivitis treatment.

☀-BID<sup>1</sup>☾

For patients  
4 months and up.<sup>1</sup>

### INDICATIONS AND USAGE:

MOXEZA™ Solution is a topical fluoroquinolone anti-infective indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms: *Aerococcus viridans*\*, *Corynebacterium macginleyi*\*, *Enterococcus faecalis*\*, *Micrococcus luteus*\*, *Staphylococcus arlettae*\*, *S. aureus*, *S. capitis*, *S. epidermidis*, *S. haemolyticus*, *S. hominis*, *S. saprophyticus*\*, *S. warneri*\*, *Streptococcus mitis*\*, *S. pneumoniae*, *S. parasanguinis*\*, *Escherichia coli*\*, *Haemophilus influenzae*, *Klebsiella pneumoniae*\*, *Propionibacterium acnes*, *Chlamydia trachomatis*\* (\*efficacy for this organism was studied in fewer than 10 infections).

### DOSAGE AND ADMINISTRATION:

Instill 1 drop in the affected eye(s) 2 times daily for 7 days.

### WARNINGS AND PRECAUTIONS:

- Topical ophthalmic use only.
- Hypersensitivity and anaphylaxis have been reported with systemic use of moxifloxacin.
- Prolonged use may result in overgrowth of non-susceptible organisms, including fungi.
- Patients should not wear contact lenses if they have signs or symptoms of bacterial conjunctivitis.

### ADVERSE REACTIONS:

The most common adverse reactions reported in 1-2% of patients were eye irritation, pyrexia, and conjunctivitis.

Please see prescribing information on adjacent page.

**Alcon**®

Licensed to Alcon, Inc. by Bayer Schering Pharma AG.  
©2010 Alcon, Inc. 11/10 VGZ10501JAD

NEW  
**Moxeza**™  
(moxifloxacin HCl ophthalmic solution) 0.5% as base



# NEW **Moxeza**<sup>TM</sup>

(moxifloxacin HCl ophthalmic solution) 0.5% as base

## HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use **MOXEZA**<sup>TM</sup> Solution safely and effectively.

See full prescribing information for **MOXEZA**<sup>TM</sup>.

**MOXEZA**<sup>TM</sup> (moxifloxacin hydrochloride ophthalmic solution) 0.5% as base  
Sterile topical ophthalmic solution  
Initial U.S. Approval: 1999

## INDICATIONS AND USAGE

**MOXEZA**<sup>TM</sup> Solution is a topical fluoroquinolone anti-infective indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms: *Aerococcus viridans*\*, *Corynebacterium macginleyi*\*, *Enterococcus faecalis*\*, *Micrococcus luteus*\*, *Staphylococcus arlettae*\*, *Staphylococcus aureus*, *Staphylococcus capitis*, *Staphylococcus epidermidis*, *Staphylococcus haemolyticus*, *Staphylococcus hominis*, *Staphylococcus saprophyticus*\*, *Staphylococcus warneri*\*, *Streptococcus mitis*\*, *Streptococcus pneumoniae*, *Streptococcus parasanguinis*\*, *Escherichia coli*\*, *Haemophilus influenzae*, *Klebsiella pneumoniae*\*, *Propionibacterium acnes*, *Chlamydia trachomatis*\*

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

## DOSAGE AND ADMINISTRATION

Instill 1 drop in the affected eye(s) 2 times daily for 7 days.

## DOSAGE FORMS AND STRENGTHS

4 mL bottle filled with 3 mL sterile ophthalmic solution of moxifloxacin hydrochloride, 0.5% as base.

## CONTRAINDICATIONS

None.

## WARNINGS AND PRECAUTIONS

- Topical ophthalmic use only.
- Hypersensitivity and anaphylaxis have been reported with systemic use of moxifloxacin.
- Prolonged use may result in overgrowth of non-susceptible organisms, including fungi.
- Patients should not wear contact lenses if they have signs or symptoms of bacterial conjunctivitis.

## ADVERSE REACTIONS

The most common adverse reactions reported in 1-2% of patients were eye irritation, pyrexia, and conjunctivitis.

To report SUSPECTED ADVERSE REACTIONS, contact Alcon Laboratories, Inc. or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

## Reference:

1. **MOXEZA**<sup>TM</sup> Solution package insert.

Licensed to Alcon, Inc. by Bayer Schering Pharma AG.

**Alcon**<sup>®</sup>

©2010 Alcon, Inc. 11/10 VGZ10501JAD



## JUCM CONTRIBUTORS

"Sticks and stones may break my bones...and isn't that enough reason for concern, especially among the pediatric population?"

In the conclusion of the two-part article Pitfalls in Assessing and Managing Common Pediatric Injuries (page 9), **Justin Kunes, MD, Shane R. Hanzlik, MD, Allison Gilmore, MD** focus on identifying and treating specific types of injuries.

Dr. Kunes is a Fellow at the Foundation for Orthopaedic Research and Education; Dr. Hanzlik is a third-year resident in Orthopaedic Surgery at University Hospitals Case Medical Center in Cleveland, OH; and Dr. Gilmore is assistant professor in the Division of Pediatric Orthopaedics at Rainbow Babies & Children's Hospital, University Hospitals Case Medical Center.

We're also pleased to present a new article in the Bouncebacks! series (page 17), in which **Jill C. Miller, MD** and **Michael B. Weinstock, MD** offer a review of a seemingly common presentation that veered off into an ominous direction.

Dr. Miller is senior clinical instructor at Case Western Reserve University School of Medicine and practices at University Hospitals Medical Practices in Cleveland, OH. Dr. Weinstock is clinical assistant professor of emergency medicine at The Ohio State University School of Medicine and a clinician in the Mt. Carmel St. Ann's Emergency Department in Columbus, OH.

Finally, available only at [www.jucm.com](http://www.jucm.com), **Jacqueline Dancy, PA-C, MPAS** offers a look at evaluating patients who've been exposed to tuberculosis in Tuberculosis: Post-Exposure Testing and Management.

Ms. Dancy is compliance officer and clinical staff educator at Med+Stop Urgent Care Centers in San Luis Obispo, CA.

## Also in this issue:

**Nahum Kovalski, BSc, MDCM** reviews abstracts on a study of guidelines from the Infectious Diseases Society of America, probiotics for gastrointestinal issues, deep vein thrombosis, and cutaneous abscesses.

**John Shufeldt, MD, JD, MBA, FACEP** discusses some of the problems and challenges inherent in the growth of Accountable Care Organizations.

**Frank Leone, MBA, MPH** makes the case for embracing innovative techniques for marketing rather than relying on old stand-bys.

**David Stern, MD, CPC** addresses coding questions regarding debridement, seeing patients in multiple settings, detailed vs. expanded problem focused exams, and more.

If you have an idea for a case presentation or feature-length article, we'd like to know about it. Describe said idea in an email to our editor-in-chief, Lee A. Resnick, MD, at [editor@jucm.com](mailto:editor@jucm.com). ■





## FROM THE EXECUTIVE DIRECTOR

# Before You Get on the Bus, Consider Who's Driving

■ LOU ELLEN HORWITZ, MA

*"All politics is local."*

– Thomas O'Neill, Sr.

The more time goes by, the more it feels like we've been to this puppet show and already seen the strings. How can they keep selling tickets to us? I suppose it's because we keep buying them.

I first quoted Mr. O'Neill in my December 2009 column, entitled *Hands Across the Water*, about reaching out to your local primary care community to start talking about partnerships, connecting, serving their patients in their off-hours, etc.

That was over two years ago; three years before that, the term *Accountable Care Organization* was first used at a public meeting of the Medicare Payment Advisory Commission (MedPAC). Five years later, it's on everyone's lips and everyone's agenda, even if they aren't sure exactly what it is.

That would be a nice segue into one of my regular themes—healthcare moves slowly but urgent care life moves fast—but that's not where I'm headed. I'm headed back to Mr. O'Neill's revelation.

That quote about politics being local came about after young Thomas O'Neill, Jr. (later to be much more famously known by the nickname Tip) had run for—and lost—his first electoral seat. According to his father, he had not paid enough attention to his own neighborhood, not worked hard enough in his own backyard, so while he looked great in other locales, he lost his own. I think this is a critical lesson for urgent care owners.

Healthcare "fashions" come and go, but they are tremendously frightening most of the time. They threaten to impact your daily life and your livelihood. You cannot ignore them and must "chase" every single one to see if you should jump on the bus (or buy a ticket to the puppet show), or possibly be left behind at your pro-

fessional peril.

What's important, though, is not the chase; it's what you do once you get on the bus to see if it's where you want to go. The bus may have a federal label such as Accountable Care Organization Route 12, but the people on that bus have a local label: Nearby Hospital Administrator, My Payor Representative, My Elected Official, or "My Physician Colleague."

*"The most interesting urgent care success stories today are pretty out of the box."*

Don't just hand the bus driver your money, take your seat, and face forward quietly until the bus stops somewhere; it may never stop!

First, take a good look at who is driving that bus in your neighborhood, and introduce yourself. Then, start meeting the other people on the bus. Ask if you can sit down with them. See if you have shared interests and may want to grab the pull cord and get off at the next stop together for a while.

You get the idea.

I doubt there is a "global" answer for any question in healthcare right now (and if there is, I certainly don't know what it is). What I do believe is that what is happening in healthcare and where the innovation is taking place is mostly happening right where you live. If you want to decide whether you should be jumping on any bandwagons, you need to be reaching out to the important players in your community to see what they are doing and whether you can (and want to) be a part of it.

Keep your options open, stay creative, don't talk to the same old people you always talk to, and see what you can make for yourself.

The most interesting success stories I'm hearing from urgent care centers today are pretty out of the box. They are basically building their own buses, or at least repainting them. You might consider looking at your own world and giving that some thought. ■



**Lou Ellen Horwitz** is executive director of the Urgent Care Association of America. She may be contacted at [lhorwitz@ucaoa.org](mailto:lhorwitz@ucaoa.org).

# Sometimes... Dry is Better



## QBC: The World's Only *Dry* Hematology Systems

### Why dry is better:

- No liquid reagents or waste
- No more clogs and leaking tubes
- No start-up or shut-down cycles
- Easy to use with minimal training
- Small and compact

### Choose Your Special Offer:

**FREE** Controls Throughout 2011 **or**

**FREE** Moderately Complex Upgrade Program



QBC STAR

### To learn more:

[www.qbcdiagnostics.com](http://www.qbcdiagnostics.com) | [qbcsales@qbcdiag.com](mailto:qbcsales@qbcdiag.com) | +1-814-692-7661

 **QBC<sup>®</sup> Diagnostics**  
*Innovative Solutions for a Healthier World*  
Made in the U.S.A. Form No. 379 Rev. A

## Pitfalls in Assessing and Managing Common Pediatric Injuries

**Urgent message:** Fractures, in general, are relatively common among pediatric patients. Those most likely to be seen in the urgent care setting include injuries to the radius, ulna, humerus, lateral condyle, clavicle, tibia, and fibula. The second of two parts.

Justin Kunes, MD, Shane R. Hanzlik, MD, Allison Gilmore, MD

### Epidemiology

As noted in part 1 of this article (published in the February 2011 issue of *JUCM* and available at [www.jucm.com](http://www.jucm.com)), fractures are common injuries in the pediatric population. Among children seeking medical attention for an injury, approximately 20% will be found to have a fracture.<sup>1</sup> Boys are more likely than girls to experience a fractures, with an incidence of 42% between ages 1 and 16 years; for girls in this age range, the incidence is 27%.

This article will review assessment and treatment of the most common fracture sites: the distal radius, clavicle, hand, elbow, and tibia.<sup>2</sup>



© Getty Images / Composite: Tom DePrenda

### Distal Radius and Ulna Fractures

Distal forearm fractures (**Figure 1**) occur in falls onto outstretched hands (FOOSH). These are commonly apex volarly angulated.

#### Diagnosis

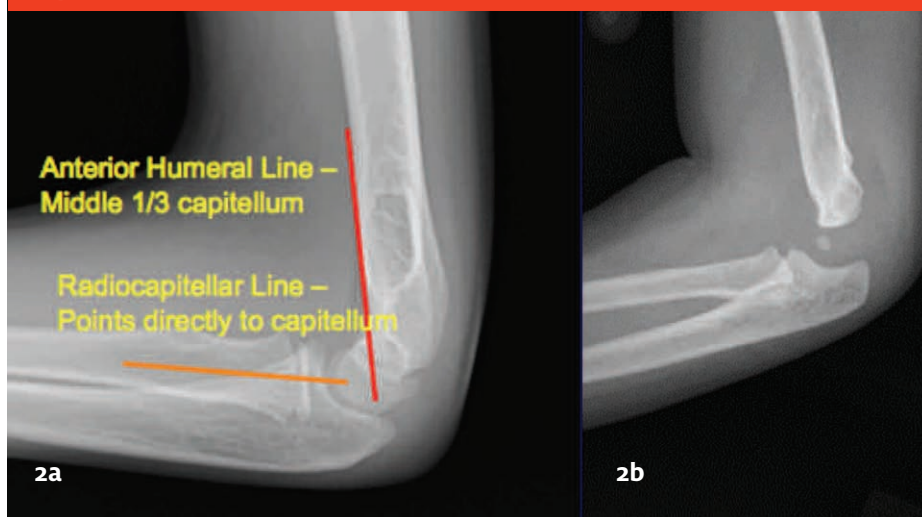
Distal radius fracture patterns include the torus fracture with a thickened ripple in the cortex, often best assessed on the lateral view of the wrist.

Greenstick fractures, in which one cortex may remain intact, are also quite common.

The third most common pattern is a complete transverse fracture.

#### Management

The goals in treating all fractures are the same: reduce

**Figure 1. Both bone forearm fracture.****Figure 2. Normal x-ray (2a), occult fracture (2b) with anterior and posterior fat pad.**

the fracture (manipulate unacceptable alignment to within acceptable limits) and immobilize the limb to minimize pain and prevent recurrent deformity.

In children, reduction often requires conscious sedation to alleviate suffering and allow muscle relaxation for reduction.

Fractures treated within 24 hours of injury should be immobilized in a splint, not a cast, to allow for swelling and prevent a compartment syndrome from forming due to circumferential restriction.

#### *Normal x-rays with pain and tenderness*

A distal radius or wrist injury is evaluated with clinical and radiographic examination, but sometimes no fracture is clearly identified. These injuries should still be immobilized and sent for follow-up within a week. Sometimes children have occult injuries that do not show up on initial radiographs, but a few weeks later demonstrate

abundant callus.

If in doubt, always err on the side of splinting a child. *Immobilization for distal radius fracture*

The most reliable means of immobilizing any wrist or forearm fracture is a sugar-tong splint. This prevents forearm rotation by being applied volarly, wrapping around the elbow posteriorly and coming up on the dorsal side of the forearm with the elbow bent.

Pre-fabricated, pre-padded fiberglass splints that are readily available in urgent care centers work well, as long as there is sufficient web-beril (cotton padding) over bony prominences. However, certain precautions must be applied in order to successfully apply such a splint.

1. Starting: Dorsally just below the metacarpophalangeal (MCP) joints.
2. Forearm in neutral rotation—patient seated upright, elbow held at the patient's hip, thumb pointing to the ceiling.
3. Elbow flexed to 90° degrees, the splint makes a 180° smooth curve against the triceps posteriorly.
4. End: Volarly at the proximal palmar crease (patient can flex the MCP joints to 90°).
5. Sling should be used (fracture can still bend in an ulnoradial direction).

#### **Elbow Fractures**

Elbow fractures include any bony injury to the distal portion of the humerus and the proximal ulna and radius. These comprise 10% of all fractures in children. While common, the diagnosis and management of these injuries is complex, and a good outcome requires early recognition and referral to an orthopedist. Most of these fractures involve the supracondylar anatomic region of the distal humerus.



### Supracondylar Humerus Fracture

#### Diagnosis

A child with a supracondylar humerus fracture may have mild swelling to marked swelling and pain at the elbow.

Severe injuries have puckered skin, blistering, ecchymosis, and palpable or visible bone.

Even more anatomic structures are at risk than at the wrist, and an even more detailed neurologic and vascular examination is warranted. The ability to flex (median) and extend (radial) the digits and thumb, oppose the thumb and index finger (anterior interosseous branch of median) and abduct and adduct the fingers (ulnar) should be checked.

Assess radial pulse by palpation, and check capillary refill in all digits. If these are absent, perform or refer for a Doppler exam; if pulses remain absent, suspect a brachial artery injury. This requires emergent orthopedic evaluation.

Radiographs should include an anterior-posterior and lateral view of the elbow. The lateral view of the elbow must be perpendicular to the distal portion of the

humerus. Then, a line is drawn down the anterior cortex of the humerus (the anterior humeral line).

In a normal elbow, this line should bisect the capitellum. The radial head should also point directly towards the capitellum (**Figure 2a**).

Sometimes, patients will have an occult injury with a lateral radiograph of the elbow demonstrating an anterior and posterior fat pad sign. An anterior fat pad sign can be normal but a posterior fat pad sign is always abnormal and suggestive of a fracture (**Figure 2b**).

#### Treatment

Nondisplaced fractures may be splinted in a posterior long arm splint (**Figure 3**) in 30° to 40° of flexion and referred to an orthopedic clinic in a few days.

A displaced fracture (**Figure 4**) must be splinted and transferred to an emergency department with pediatric orthopedic coverage. These fractures are fixed surgically the same evening or early the next morning and for best results treatment should not be delayed.



#### THE WOOD INSURANCE GROUP

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

#### Contact Us at:

4835 East Cactus Road, Suite 440

Scottsdale, Arizona 85254

(800) 695-0219 • Fax (602) 230-8207

David Wood at Ext 270

E-mail: davidw@woodinsurancegroup.com

## Urgent Care Clinic Medical Professional Liability Insurance

#### Our Total Quality Approach includes:

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

**Figure 3. Application of a long arm posterior splint used to immobilize an elbow fracture.**



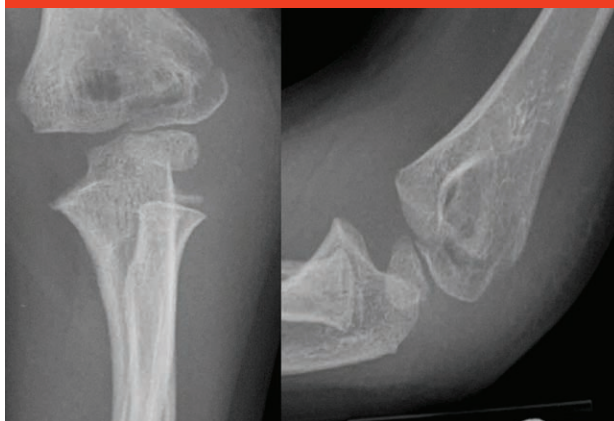
### Lateral Condyle Fractures

The second most common elbow fracture is actually the most common physal fracture of the elbow, involving the growth plate. The position and force direction for this injury is much the same as the other two fractures (FOOSH), with the addition of a varus movement about the joint.

**Figure 4. Displaced supracondylar humerus fracture.**



**Figure 5. AP and lateral of a lateral condyle fracture.**



### Diagnosis

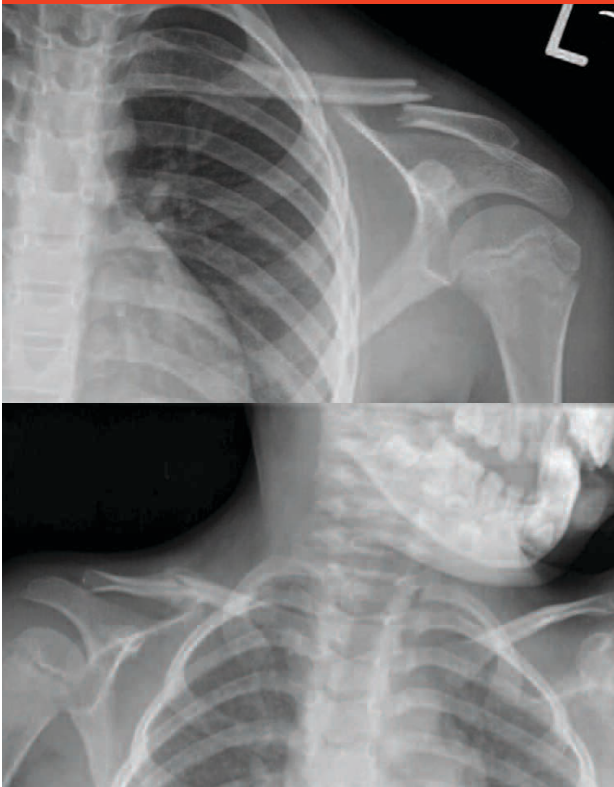
In lateral condyle fractures, there is focal swelling and pain at the lateral distal humerus. Evaluate just as you would for a supracondylar humerus fracture, but bear in mind that neurologic and vascular injuries are less common with this fracture pattern. Most require surgery, though not urgently.

The usual fracture line on the AP film extends from the lateral distal humeral metaphysis to just medial to the capitellum (**Figure 5**) and exits distally into the joint. These fractures are more subtle and may be nondisplaced.

### Treatment

Apply a long arm splint and have the patient follow up with an orthopedist in one to three days to discuss surgery vs. nonoperative treatment.

**Figure 6: Clavicle fracture (left) acute, fracture 3 weeks later (right) healed.**



### Clavicle Fractures

Clavicle fractures occur from a direct fall onto the shoulder, a fall onto an outstretched hand, and, less commonly, from a direct blow. Eighty percent occur in the middle third of the shaft, 15% in the distal third, and 5% proximally.<sup>3</sup> Patients present with localized pain and discomfort over the fracture site, and pain with shoulder motion.

### Diagnosis

A child with an acute clavicle fracture holds the elbow of the injured limb with the opposite hand and tilts the head toward the injured side to minimize the displacing pull by the sternocleidomastoid and trapezius muscles. Obvious deformity is likely visible, with point tenderness over the fracture site and subcutaneous crepitus. Breaks in the skin near the fracture indicate a possible open fracture.

Often, AP views (**Figure 6**) of the shoulder are sufficient, but a serendipity view (40° cephalad-directed tube angle) may be helpful.

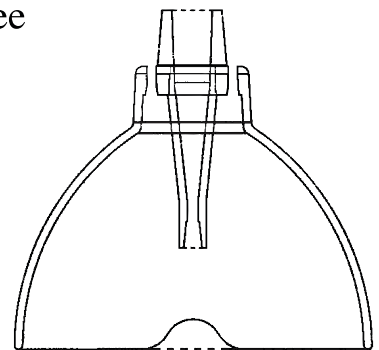
## The **ZEROWET SUPERSHIELD**

is used by emergency physicians more often for high-pressure wound irrigation than all other shields combined.

**Five times**  
**more often.**

Find out why so many docs don't want to use anything else.

Call 1-800-438-0938,  
or visit [zerowet.com](http://zerowet.com)  
for your free  
samples.



 **ZEROWET<sup>®</sup>**  
**S U P E R S H I E L D<sup>™</sup>**

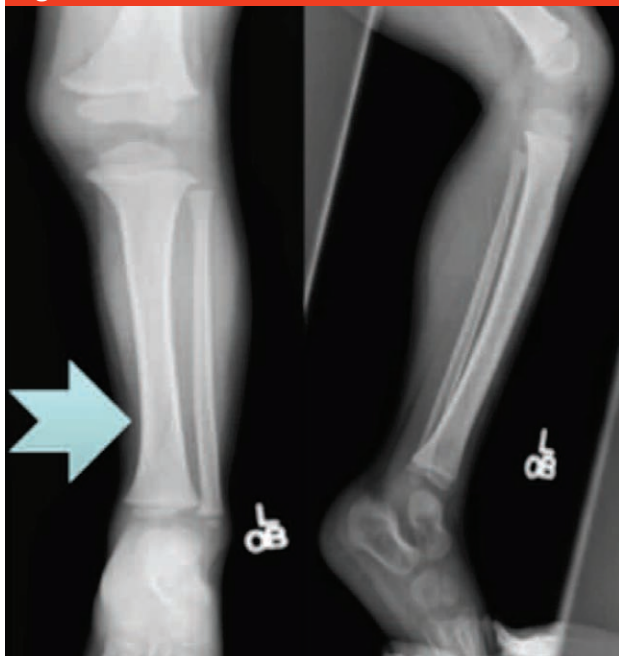
Faster. Easier. **BETTER!!!**



**Figure 7. AP and lateral of a tibia and fibula shaft fracture.**



**Figure 8. Toddler's fracture of a tibia.**



#### Management

Most pediatric and adolescent clavicle fractures are managed non-operatively with a figure-of-eight band-

age or a simple sling. It is important to inform the parents and child that a noticeable bump will be visible over the fracture site due to healing callus.

Typically, simple fractures will remodel over six to nine months with no resulting functional impairment.

Children with appropriate histories and point tenderness over the clavicle should be treated with the presumption that a fracture has occurred.

Skin tenting and laceration demand emergency room transfer and urgent orthopedic consultation. For the rare open or shortened fracture, surgical management will be necessary.

#### Tibia and Fibula Fractures

Fractures of the tibia and fibula shaft are among the most common injuries involving the lower extremities in pediatrics. They occur in falls with a twisting movement to the foot, resulting in oblique or spiral fracture configurations. Direct trauma often produces a transverse or segmental fracture pattern. These are the most common long bone fractures of the lower extremity (15% of all pediatric fractures).<sup>4</sup>

#### Diagnosis

The most common presenting complaint will be pain and an inability to bear weight. Many will be non-displaced with no obvious deformity. Tenderness to palpation at the fracture site should lead to radiographic analysis which includes an AP and lateral radiograph (**Figure 7**) of the tibia and fibula including the knee and ankle joints.

A thorough neurovascular exam must be documented including the presence of the dorsalis pedis and posterior tibial pulses and capillary refill. Document active and passive range of motion at the ankle joint and of the toes. Tight compartments and severe pain with passive great toe extension indicate compartment syndrome, especially in high-energy displaced or segmental tibia fractures.

#### Acute management

Most non-displaced fractures may be treated with a long leg splint with long side slabs from the foot to two-thirds up the thigh; 20° to 30° of knee flexion will help prevent weight-bearing, and keeping the foot plantar flexed 10° to 15° will keep the pull of the long toe flexors from displacing the fracture further.

These patients need to follow up with an orthopedist within one week.

Many urgent care centers have prefabricated splints which



can be used, as long as care is taken to avoid pressure over the heel, which can lead to a heel ulcer.

Displaced fractures may be treated by an orthopedic doctor with a closed reduction under conscious sedation to obtain near anatomic alignment.

Fractures not amenable to closed treatment should be admitted to the hospital and prepared for surgery.

Any closed reduction should be followed by a careful repeat of the neurovascular examination of the leg and foot.

### Toddler's Fractures

Children less than 2 years of age or just beginning to walk may suffer a non-displaced spiral or oblique fracture of the tibia known as a "toddler's fracture." These result from a seemingly harmless event, such as tripping while walking or running, stepping on a ball or toy, or falling from a modest height.

#### Diagnosis

Children with a toddler's fracture often fail to bear weight or may limp. Findings are often subtle. Most do not have any soft tissue swelling, ecchymosis, or deformity. Localized tenderness to palpation is the most common physical finding. It is important to examine the hip, thigh, knee, and ankle joint, as well, to rule out any other causes.

AP and lateral radiographs of the entire tibia and fibula (**Figure 8**) may demonstrate a spiral fracture of the distal third of the tibia, but they may also be normal. Characteristically, a faint oblique fracture line is seen crossing the distal tibial diaphysis, terminating medially. If a fracture is suspected and not seen, oblique views may be beneficial.<sup>5</sup> The fracture line may be visualized on only one film or not visualized at all. Halsey and associates reported that of 39 children with a suspected toddler's fracture and negative initial radiographs, 16 (41%) had a toddler's fracture confirmed on follow-up radiographs.<sup>6</sup>

#### Acute management

In small children refusing to bear weight with localized tenderness of the tibia, a long leg plaster splint is indicated even in the setting of negative radiographs. They should be seen by an orthopedist within one week.

### Ankle Fractures

Most ankle fractures in children involve the growth plate. Children usually sustain an ankle injury from running or jumping during sports or play.

**Figure 9: Ankle fracture involving the growth plate.**



**Figure 10. Short leg posterior splint with side slabs.**



#### Diagnosis

Children with ankle fractures present with obvious swelling and pain over the malleoli. They usually can not bear weight. Radiographs include AP, lateral, and mortise radiographs (**Figure 9**). A good neurologic exam is important.

#### Management

Displaced fractures involving the growth plate should be reduced under conscious sedation or admitted for surgery the next morning. Injuries at the growth plate in an ankle need to be close to anatomic alignment to prevent further deformity, pain and or arthritis. Nondisplaced fractures can be treated in a short leg posterior

*Continued on page 31*

Connect with Urgent Care Employers  
**Find Your New  
Job TODAY!**



**FREE Online Job Board:**

**Receive  
New Jobs  
Via Email**

**Apply  
Online**

**Save  
Jobs**

**Upload  
Your  
Resume**

**JUCM** CAREERCENTER  
THE JOURNAL OF URGENT CARE MEDICINE



Open a barcode scanner app on your smartphone. Position your phone's camera over this QR code to scan.

**www.UrgentCareCareerCenter.com**  
**(800) 237-9851 • info@urgentcarecareercenter.com**

# Bouncebacks

## The Case of a 42-year-old Fireman with Shoulder Pain: When a Lifeline Becomes a Noose

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

Cases are adapted from the book *Bouncebacks! Emergency Department Cases: ED Returns*, coauthored by Michael B. Weinstock and Ryan Longstreth with risk management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians, and discussions by other nationally recognized experts.

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

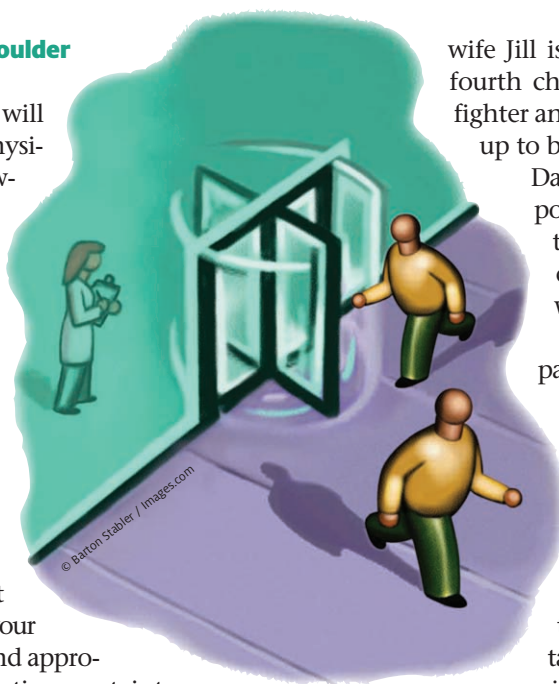
### A 42-year-old Fireman with Shoulder Pain

There are some diagnoses that will be missed by nine out of 10 physicians; this is one of them. However, our goal is not to meet "Standard of Care" but to provide excellence in care:

- Take every patient at face value, without trying to guess their intentions for secondary gain.
- Ensure you are aware of the chief complaint stated to the staff in the urgent care center.
- Be an open book in your impression and plan. You don't always have to be right, but your reasoning should be clear and appropriate. In the case of diagnostic uncertainty, discuss in a progress note if your thought process cannot be intuited from the chart.
- Discharge instructions should be time- and action-specific.

### The Patient's Story

David Lykins is a devoted father and husband whose



wife Jill is 15 weeks pregnant with their fourth child. His career started as a firefighter and paramedic; he worked his way up to battalion chief.

David likes to spend as much time as possible with his family. Jill brings the boys to the firehouse every few days and he spends several hours with them.

On Feb. 24, 1999, a 911 call dispatched the team to the scene of a worker with his leg caught in an auger "wrapped around like a piece of spaghetti." Though this was a new situation, David took charge and directed everyone, including officers his own rank.

During the 45 minutes it took to extricate the worker, "David talked to me, as I was laying there, waiting to get untrapped. [He] asked

me how many kids I had and what my name was and, you know, tried to keep me conscious, and I did stay conscious ... After my accident... I was in the hospital and Mr. Lykins came to the hospital after a run and just checked on me to see how I was doing. I was lucky to be alive and he was glad to see me alive."

In early March 2000, David has problems of his own.

He has severe left shoulder pain and presents to the emergency department at Shady Valley Hospital.

### THE DOCTOR'S VERSION

(The following, as well as other case notes to be included, is the actual documentation of the provider, including any punctuation and spelling errors.)

**Chief complaint per triage RN (March 2, 2000 at 10:30AM):** c/o left shoulder pain ... (see below) Arrives via wheel chair (WC).

**CHIEF COMPLAINT (physician assistant, Ed Heller) at 10:45:**

flex his elbow and pronate and supinate. He has good distal light touch sensation, pulses and capillary refill.

### TESTING (10:55):

Left shoulder and clavicle XR: No fracture of shoulder or clavicle

### EMERGENCY DEPARTMENT COURSE:

**11:05** – Demerol 50mg, Phenergan 25mg IM

**12:25** – Phenergan 25mg IM

**12:50** – Repeat vitals: Pulse 102, Resp 16, BP 102/65

APPROVAL/TRIAGE TIME: 1030	APPROVAL VIA: <input checked="" type="checkbox"/> Ambulatory <input checked="" type="checkbox"/> EMT <input type="checkbox"/> Emergency Medical Service	(stabilized) <input type="checkbox"/> Yes
CHIEF COMPLAINT: 40 left shoulder pain		
INITIAL ASSESSMENT: status by [signature] [signature] [signature] [signature] [signature]		

This is a 42-year-old male who is a fire fighter for Fairtown. He says he was lifting patients yesterday. He complains of left shoulder pain. He says he is unable to move his left arm. He has had no trauma as far as a fall. He has done only lifting. He never had anything like this before. Review of systems is otherwise negative. There is no chest pain, shortness of breath, diarrhea or constipation. No dysuria. No numbness or tingling of the extremities. No peripheral edema.

### PAST MEDICAL HISTORY:

**Allergies:** NKDA

**Meds:** None

**PMH:** He has a history of abdominal pain two weeks ago. CT scan was done. He does not know the results or what they were looking for. He is vomiting here possibly due to the pain that he has.

**SH:** Unremarkable

**FH:** Unremarkable

### PHYSICAL EXAMINATION:

The patient is alert and oriented. He is somewhat inappropriate as far as pain and physical examination in relation to complaint and history. He refuses to move his arm. He is in an extreme amount of pain when I try to move his arm or touch him whether on his arm or on his clavicle. He has good grip. He is able to extend and

### PROGRESS NOTE (PA Ed Heller):

I talked with Dr. Oster [the primary care doctor] who says the patient tends to sometimes overreact to his health care needs, and it does not surprise him that the gentleman will not move his arm and that his physical examination is not in proportion with his complaint and history.

### DIAGNOSIS (12:57):

Left shoulder pain/strain

### DISPOSITION:

Rx: Vicodin. Left arm in a sling with instructions to rest with no lifting. Apply ice and return to ED if worse. Soft diet. Dr. Oster will see him in the next two to three days.

### ATTENDING NOTE:

(Actual documentation from ED attending physician, Dr. Timothy Vaughn.) This is an attending note to accompany the dictation by the PA: He is a healthy male firefighter. He apparently has had some left shoulder pain after doing some lifting of patients over the last couple of days. It is very painful with range of motion and any palpation. He has no abdominal pain, chest pain or shortness of breath. Apparently, these symptoms started roughly at the same time. He has had no fever. He has had no skin breaks to that shoul-

Vital Signs						
Date	Time	Temp (°F)	Pulse	Resp	Syst	Diast
3/2/00	10:30	97.8	111	18	102	67



der. He is very uncomfortable with any movement of his shoulder. On palpation, there is no erythema or swelling. His left upper extremity neurovascular examination is intact. The x-rays are normal. The patient is vomiting, and I do not have a good clue as to the cause of this, other than the pain from his shoulder. We have given him Phenergan on two occasions with some improvement. This looks to be more musculoskeletal, and certainly, I see no evidence of any referred pain. This is very joint specific. There is nothing on his examination or in his history that makes me think this is a septic joint.

Ed Heller, PA

Timothy Vaughn, DO

*(Author's note: This seems like a straightforward shoulder strain, pain with motion and palpation. But is this the whole story? Let's first look at patient safety issues with this chart.)*

### Patient Safety and Risk Management Issues:

**Error #1:** Not reading nursing notes.

**Discussion:** Can you decipher the hieroglyphics recorded by the nurse? Neither could the doctor. There was no effort to speak with the nurse to discover what was recorded. When this case ended up in court, her deposition testimony finally revealed the answer: Complaints of left shoulder pain, *chills and fever*. Not reading the nurses/triage notes is a common theme in medical malpractice cases.

**Teaching point:** Always read the nurses' notes. If the notes cannot be understood, speak with the nurse.

**Error #2:** Poor correlation of mechanism.

**Discussion:** The patient had been lifting, but when? How soon after the lifting did the pain start? This documentation does not build a case for a reliable mechanism.

**Teaching point:** Correlate the symptoms with the presumed mechanism.

**Error #3:** Too narrow of a differential diagnosis.

**Discussion:** Just because *most* patients with shoulder pain have a strain, that doesn't mean they all do. Could shoulder pain in a 42-year-old man be from a pulmonary or cardiac etiology? Absolutely! Questioning as to exertional symptoms, diaphoresis and dyspnea, fever and chills (which was recorded), and cardiac risk factors is advisable. An ECG is a simple and inexpensive screening test, as is a chest x-ray.

**Teaching point:** Maintain a high index of suspicion for atypical presentations of life-threatening diagnoses—especially when a patient's pain seems out of proportion to the diagnosis.

**Error #4:** Including conjecture in the note.

**Discussion:** Some may make the argument that it is important to note that a "patient tends to sometimes overreact to his health care needs," but doing so does up the ante. And how does this help with medical decision making? Think of it this way: If the patient actually is over-reacting, it doesn't help you. And if the patient actually has

"GUARANTEED RESULTS FOR YOUR  
URGENT CARE CENTER"



JOHN SHUFELDT, MD, JD, MBA, FACEP

FOUNDER AND FORMER CEO AND CHAIRMAN  
OF NEXTCARE URGENT CARE

480-221-8059

JSHUFELDT@SHUFELDTCONSULTING.COM

## URGENT CARE CONSULTING

IMPROVE THE BOTTOM LINE



IMPROVE YOUR CENTER'S  
EFFICIENCY AND THROUGHPUT



REDUCE YOUR MEDICAL  
MALPRACTICE RISK



HEALTH PLAN  
CONTRACT REVIEW



FINANCIAL MODELING



COMPLIANCE PLAN REVIEW



POLICY AND  
PROCEDURE REVIEW



REVENUE CYCLE  
MANAGEMENT ANALYSIS



PROPOSED NEW SITE  
ANALYSIS

WWW.SHUFELDTCONSULTING.COM

something bad, it *definitely* doesn't help you.

**Teaching point:** The time for conjecture is on the call, not in the note.

### BACK TO THE FUTURE (ONE DAY BEFORE THE EMERGENCY ROOM VISIT):

As it turns out, our patient's pain actually started the previous day. This is also part of the "ancient Egyptian writing" recorded by the triage nurse: *"symptoms started yesterday afternoon."*

David and his wife have a meeting with a lawyer to discuss estate planning matters. As they leave the office David comments that his shoulder is bothering him. Later that night, the pain is stronger and he takes 800 mg of ibuprofen. The next day at 8 a.m., Jill calls their primary care physician, who cannot see him until 11 a.m. David is unable to wait that long, so is referred to urgent care.

### THE URGENT CARE RECORD PER DR. BENJAMIN ROTH:

- **Triage (9:39AM):** Complains of intense pain left shoulder which began yesterday
- **History:** Pt works for fire dept, was lifting patients, pain started hours after. Has headache, nausea, vomiting and feels dehydrated. Pt. feels it is not cardiac related but like it's in the muscle. Pt. iced and took ibuprofen. Unable to move shoulder, had fever all night, couldn't sleep secondary to the pain.
- **PE:** Vitals: temp 97.5, pulse 116, resp 16, BP 120/78. Possibly swollen, extremely tender, no redness. ROM is zero. A&O X 3
- **Urgent Care course:** Vomited in clinic X 1
- **Diagnosis:** Severe left shoulder pain, needs septic arthritis ruled out
- **Doctor note:** Discussed with ER at Shady Valley. Will send him down there for evaluation.

### THE ED BOUNCEBACK:

David is discharged from the ED at 12:57 p.m., and his wife drives him to the pharmacy to pick up the prescription for Vicodin. On the way, they stop for gas. David vomits, then gets out of the car and urinates on the gas pump. When they arrive at home, David goes to bed. Jill can hear him moaning in pain.

His situation worsens over night:

- Midnight: Pain is increasing and David asks for pain medicine.
- 2 a.m.: Asks for more pain medicine.
- 3:30 a.m.: Jill calls the primary care doctor and "on call" who tells her to go back to the ED if worse, or

wait until the morning. David says he does not want to return to the ED because they had not done anything for him when he was there.

- 6:30 a.m.: David wants to take a bath before going to the doctor. His wife notices reddening and swelling up David's arm to the shoulder. It looks like a bruise.
- 8:30 a.m.: David presents to his primary care doctor hyperventilating and acutely ill, appearing with edema over the left shoulder to the nipple and over the sternum medially but "no discoloration, warmth or erythema. Marked pain with motion of the shoulder." He is sent immediately to the ED.

### ED VISIT #2, MARCH 3, 2000 (ALMOST 22 HOURS AFTER THE INITIAL ED DISCHARGE)

- 10:15 a.m.: Temp 91.3, pulse 61, resp 20, BP 93/80. The ED team jumps into action.
- 10:25 a.m.: David is seen by Dr. Timothy Vaughn (same doctor as yesterday): "Extremely ill-appearing and much worse than when I had seen him yesterday. Skin on chest is ecchymotic and some areas of necrosis and crepitation are noted underneath. We immediately initiated 2 large bore IVs."
- 10:40 a.m.: Acute change in vitals: Pulse increases to 145 and SBP drops to 70; David receives IV fluids and dopamine.
- 10:50 a.m.: Blood cultures taken. Started on ticarcillin and clindamycin.
- CBC is normal. Creatinine is 2.5. Elevated liver enzymes.
- **Assessment:** Extremely critical condition with probable multisystem failure, probably from sepsis secondary to some underlying myofascial infection.
- Dr. Anderson, general surgeon, is called to the ED to evaluate the patient and observes a discolored, darkened spot about the size of a 50-cent piece; it grows to the size of a softball in a short period of time.

### ED diagnosis

1. Acute soft tissue infection, left side of chest
  2. Septic shock
  3. Multiple organ failure with acute renal and hepatic failure
- At 11:30 a.m., David is taken from the ED to a CT scan suite to define extension of the process. Results show necrotizing fasciitis of left anterior chest wall and possibly upper, anterior mediastinum.

### HOSPITAL COURSE:

- 12:15 a.m.: From CT, the patient is immediately taken to surgery. Dr. Anderson performs extensive debridement of the left anterior chest wall.
- David is found to have acute inflammation of the gall bladder. Further surgery confirms this diagnosis, but also shows right colonic necrosis, which necessitates a right hemicolectomy. This is thought to be from the vasopressors.
- The renal failure worsens, requiring dialysis. David suffers extensive necrosis of the digits of both hands and feet.
- Diagnosis of acute respiratory distress syndrome; David remains on the ventilator.
- David continues a slow, steady, downward spiral. After a multidisciplinary assessment, it is determined that he does not have a chance of recovering. This is discussed with his family, and comfort measures are taken.
- With his family in attendance, David expires, exactly two weeks after his bounceback visit.

### FINAL DIAGNOSIS:

Necrotizing myositis, septic shock, acute respiratory failure, acute respiratory distress syndrome, multisystem organ failure.

### Case Discussion

It remains unclear if the emergency room doctor was aware the patient had been to an urgent care previously, or what they wanted “ruled out.” Additionally, it is questionable whether the doctor knew the patient had been having fevers; the nurse’s note was illegible. Both of these issues were prominent in the malpractice case that followed David’s death.

Whether a better outcome would have resulted if an earlier diagnosis was made will never be known. Imagine, however, how differently you might react depending on how this case was presented in one sentence at an M&M conference:

1. *This is a 42-year-old healthy fireman who was lifting patients, then presented with shoulder pain, worse with movement.* Impression: I see this patient every day, 10

# Make your competitors red with envy.



Distinguish your urgent care center with Joint Commission accreditation. The Joint Commission’s name recognition helps win customers, attract and retain qualified staff, and can improve visibility with networks and payors.

**Become the apple of everyone’s eye!**

Get more information at:  
[www.jointcommission.org/UC](http://www.jointcommission.org/UC)

**Table 1. Laboratory Risk Indicator for Necrotizing Fasciitis (LRINEC) Scoring System**

White blood cell count 15,000/mcL to 25,000/mcL >25,000/mcL	1 point 2 points
Creatinine >1.6 mg/dL	2 points
C-reactive protein ≥150 mg/L	4 points
Serum glucose >180 mg/dL	1 point
Hemoglobin 11 g/dL to 13.5 g/dL ≤11 g/dL	1 point 2 points
Serum sodium <135 meq/L	2 points
A total score of >6 should raise suspicion, while a score of >8 was highly predictive (>75%).	

times a day: ibuprofen, pain control, sling, discharge.

2. *This is a 42-year-old healthy fireman who has fever and shoulder pain so severe the range of motion is zero. He was sent from the urgent care to r/o septic arthritis.* Impression: Now I'm not so sure....

First, what happened at the gas station? *La Belle indifférence*—an apathetic demeanor observed in patients with necrotizing fasciitis/myositis. He was obviously in the throes of the disease when he walked out of the emergency department. Did the confusion start after he walked out the door, or was it present but unrecognized during the initial ED visit?

Did he “overreact to his healthcare needs,” as he was accused of doing on occasion? We have a 42-year-old career firefighter, a battalion chief with a new complaint of shoulder pain to the point he needs to be brought back to his room in a wheelchair. That would be a *serious* overreaction. We are taught early in our careers that abdominal pain out of proportion to exam equals mesenteric ischemia. But how about pain out of proportion to our diagnosis in the setting of unexplained vomiting?

Remember the ED doctor's note: “The patient is vomiting and I do not have a good clue as to the cause of this, other than the pain from his shoulder.” It is common for orthopedic patients with a broken bone to have nausea and vomiting from pain, but how common is it to have nausea and vomiting from a shoulder strain from lifting?

Necrotizing myositis is extremely rare and difficult to diagnose. However, the classic symptoms were present: fever, chills, severe pain, vomiting. The problem is these that symptoms are so nonspecific they can be pres-

ent with the flu, strep throat, or...a simple shoulder strain. So, knowing what we know now, how could this diagnosis have been made?

- When presented with clinical symptoms and signs that don't necessarily fit into our initial impression, we need to dig a little deeper to rule out other causes. He had shoulder pain, but how did history of fever play into the picture?
- We must be vigilant in trying to keep a broad differential, and especially in always considering atypical presentations of life-threatening diseases. The urgent care physician appropriately referred for septic arthritis evaluation. Unfortunately, this information was lost by the ED physician.
- Always read the nurses' notes. If the ED doc had known of history of fever, maybe this would have prompted an expanded differential.
- Progress notes: Two were done, and well done. There were a lot of data from which to defend this case. (Of course, it's better if it doesn't even go to trial in the first place.)
- Be careful about using conjecture in the chart. Even the defense attorney told the jury that use of the word “overreact” was unfortunate. Remember, if the patient actually is overreacting, it doesn't help you. And if the patient actually has something bad, it definitely hurts you.
- Ensure that protocols exist so records are not discarded inappropriately. Pen your initials, date, and time on the records before scanning into the chart.
- Discuss diagnostic uncertainty with the patient and the family so they know when and why to return.

### Diagnosis and Management of Necrotizing Fasciitis and Myositis

Necrotizing fasciitis and myositis are deep-seated infections that cause extensive tissue damage and systemic toxicity, and may rapidly progress from an unapparent process to death. Cruelly, it often spares the overlying skin, which makes this diagnosis extremely difficult. The diagnostic gold standard remains surgical exploration.

Definitive treatment involves surgical debridement, along with appropriate antibiotics and hemodynamic supportive measures. Unfortunately, even with prompt and optimal treatment, morbidity and mortality of these diseases remains extremely high; necrotizing fasciitis has a mortality of 14% to 40%, and necrotizing myositis 80% to 100%, even with appropriate and aggressive treatment. Unexplained pain, as in our case, may be the first manifestation of infection.



Making this diagnosis is even more challenging due to the common practice of patients offering alternative explanations for their symptoms, such as the IV drug abuser thought to be “seeking,” the postsurgical patients thought to have pain secondary to weaning off pain medications—or the fireman who has been lifting.

On the flip side is the diabetic with neuropathy who may present with no pain. Skin abrasions, blunt trauma, or overuse injuries may predispose to the development of spontaneous gangrenous myositis, but no etiology is found in over 50% of the cases.

The Laboratory Risk Indicator for Necrotizing Fasciitis (LRINEC) scoring system (**Table 1**) was retrospectively developed for the diagnosis of necrotizing fasciitis, though this is of questionable utility in the urgent care setting: The components were largely derived from advanced obvious cases, and it is unclear whether it would be consistently reliable in relatively early cases like the one presented here.

Imaging should not delay surgical exploration. Soft tissue x-rays, CT scans, and MRI are most helpful if there is gas in the tissue. A non-contrast CT may be the most expedient test for the presence of air. Gas, though very specific, is not very sensitive. Most imaging shows only soft tissue swelling, which may not be so unusual in the post-traumatic or post-surgical patient.

The take-home point with this case is that necrotizing fasciitis and myositis is a clinical diagnosis which will never be made if it is not in the differential. ■

### Resources and Recommended Reading

- Wong CH, Khin LW, Heng KS, et al. The LRINEC (Laboratory Risk Indicator for Necrotizing Fasciitis) score: A tool for distinguishing necrotizing fasciitis from other soft tissue infections. *Crit Care Med*. 2004;32(7):1535-1541.
- Bisno AL, Cockerill FR 3rd, Bermudez CT. The initial outpatient–physician encounter in group A streptococcal necrotizing fasciitis. *Clin Infect Dis*. 2000;31(2):607-608.
- Stevens DL. Invasive Group A streptococcus infections. Stevens DL. *Clin Infect Dis*. 1992;14(1):2-11.
- Yoder EL, Mendez J, Khatib R. Spontaneous gangrenous myositis induced by *Streptococcus pyogenes*: Case report and review of the literature. *Rev Infect Dis*. 1987;9(2):382-385.

## Recruit Urgent Care Professionals online at JUCM CareerCenter

### Tools for Employers:

- Post Jobs Online
- Manage Resumes
- Track Job Performance
- Upgrade Opportunities



### Post an Urgent Care Job Today!



Open a barcode scanner app on your smartphone. Position your phone's camera over this QR code to scan.

**JUCM** CAREERCENTER  
THE JOURNAL OF URGENT CARE MEDICINE

[www.UrgentCareCareerCenter.com](http://www.UrgentCareCareerCenter.com)  
(800) 237-9851 • [sales@urgentcarecareercenter.com](mailto:sales@urgentcarecareercenter.com)



# Corporate Support Partners

UCAOA would like to thank all of our Corporate Support Partners for their ongoing support in helping UCAOA achieve its mission and vision.



Codonix



URGENTCARE ALLIANCE



Please visit [http://ucaoa.org/getinvolved\\_sponsor.php](http://ucaoa.org/getinvolved_sponsor.php) to learn more about these companies and their services.

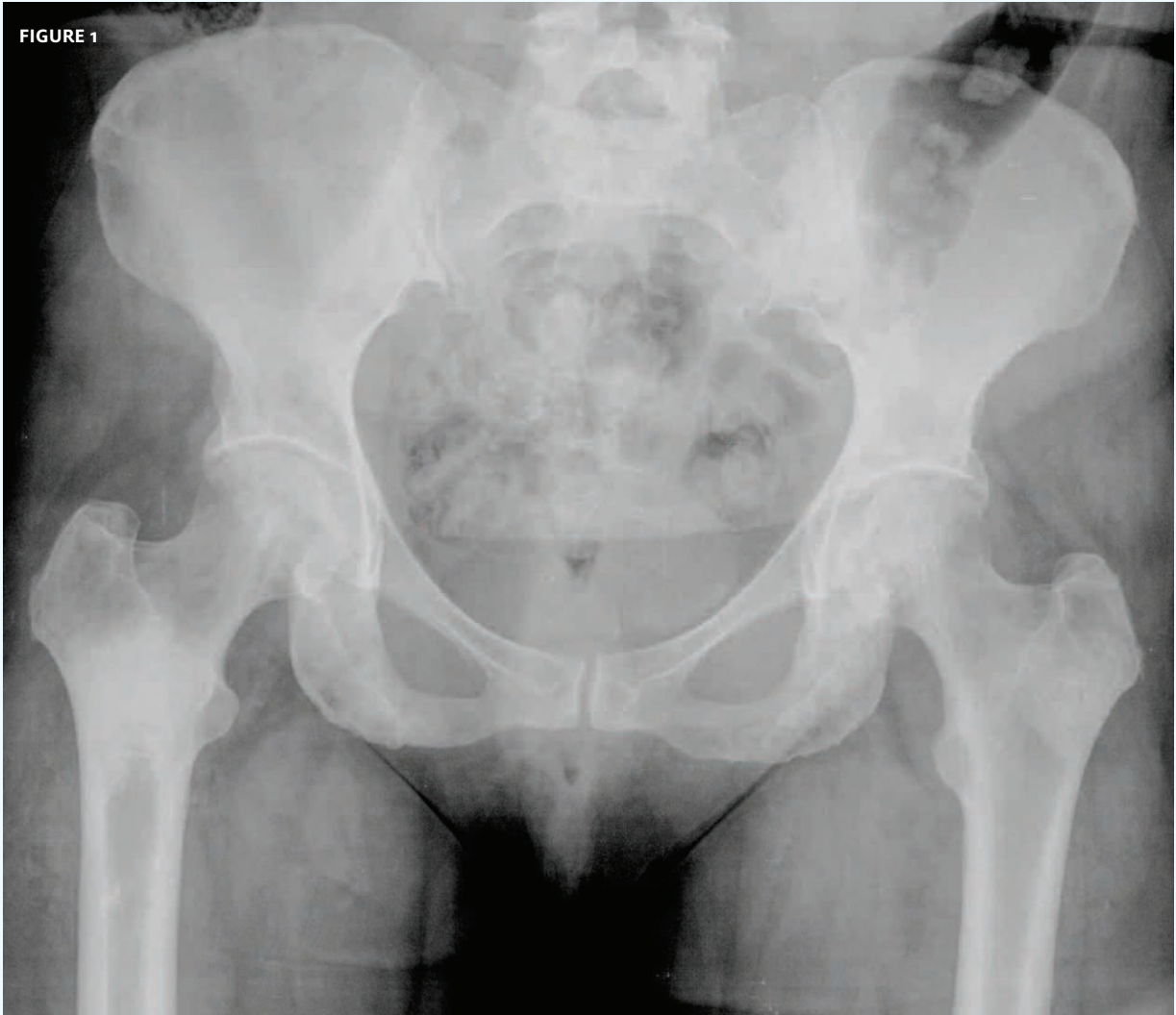


## CLINICAL CHALLENGE: CASE 1

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](mailto:editor@jucm.com).

FIGURE 1



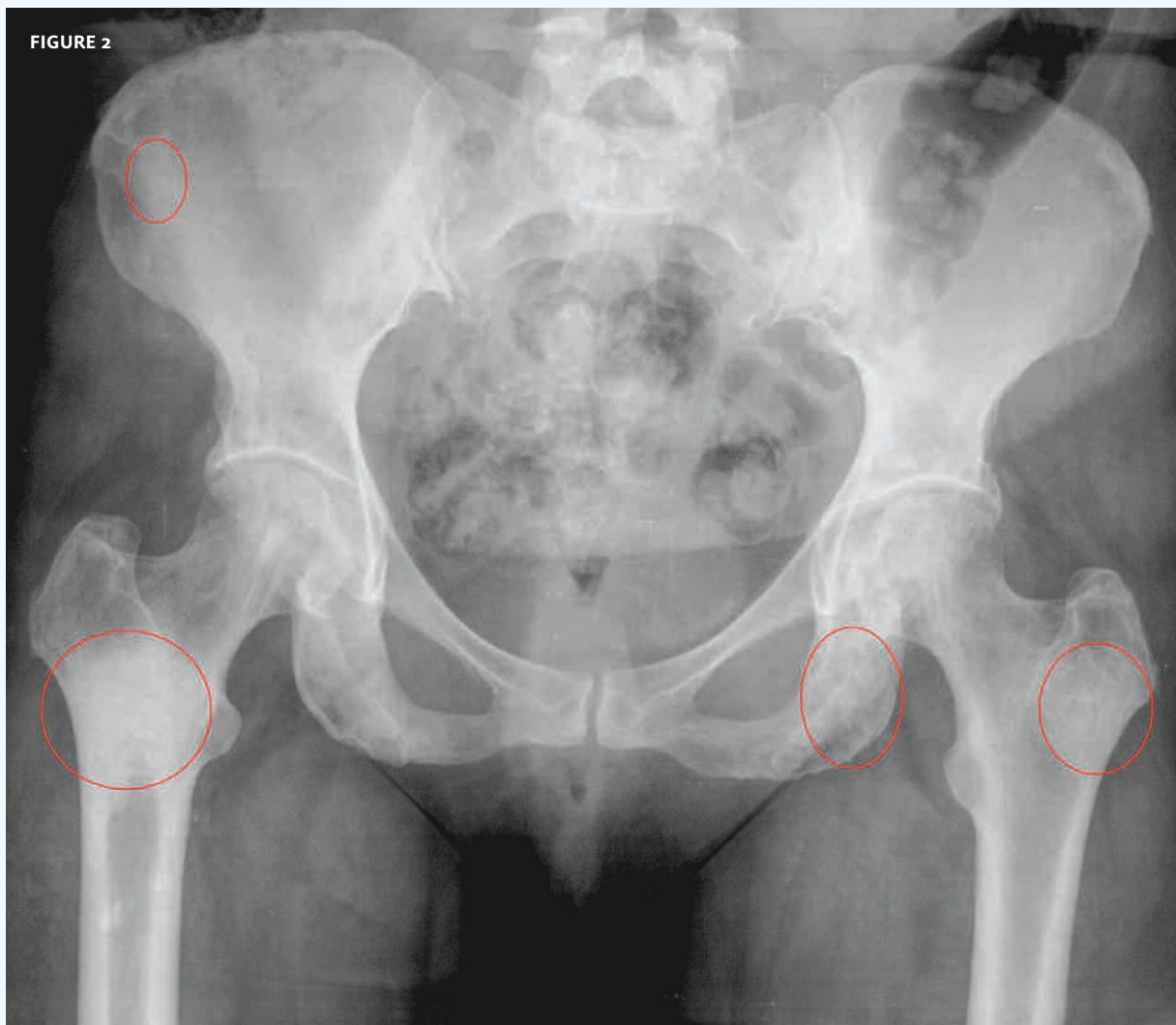
The patient is a 64-year-old woman who presents with sudden onset, bilateral hip pain. She otherwise appears healthy, but reveals that she has a history of breast cancer. Examination reveals nothing remarkable.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



The x-ray reveals multiple osteoblastic lesions that are consistent with metastatic disease. This patient was referred for work-up, including a bone scan.

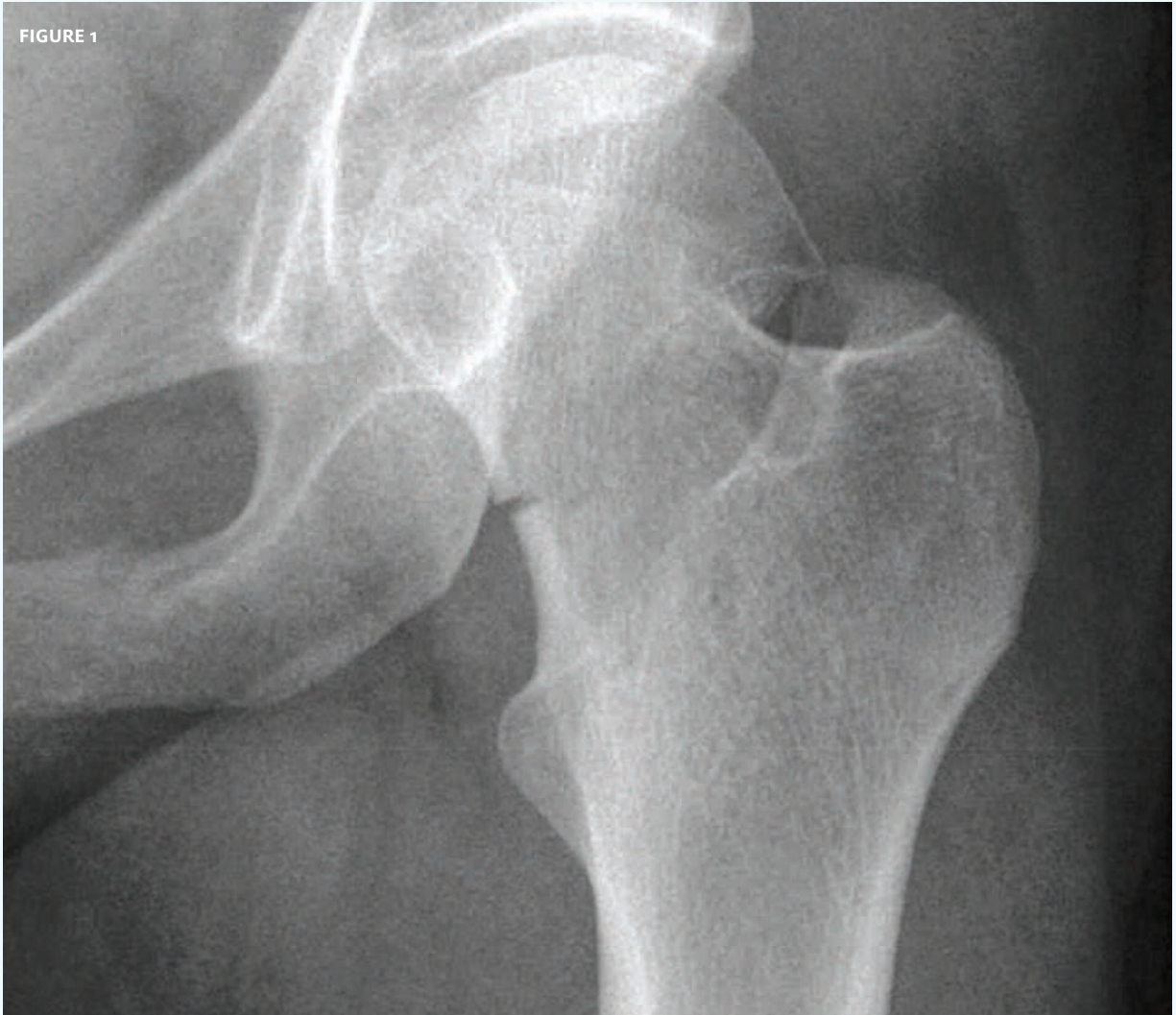
This case is an excellent reminder that pathology is not limited to trauma, regardless of the presenting complaint. A thorough survey is necessary to ensure a complete assessment and accurate diagnosis.

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





FIGURE 1



The patient is a 37-year-old woman in her second trimester of pregnancy. She presents a day after experiencing a fall, with impact to her left hip.

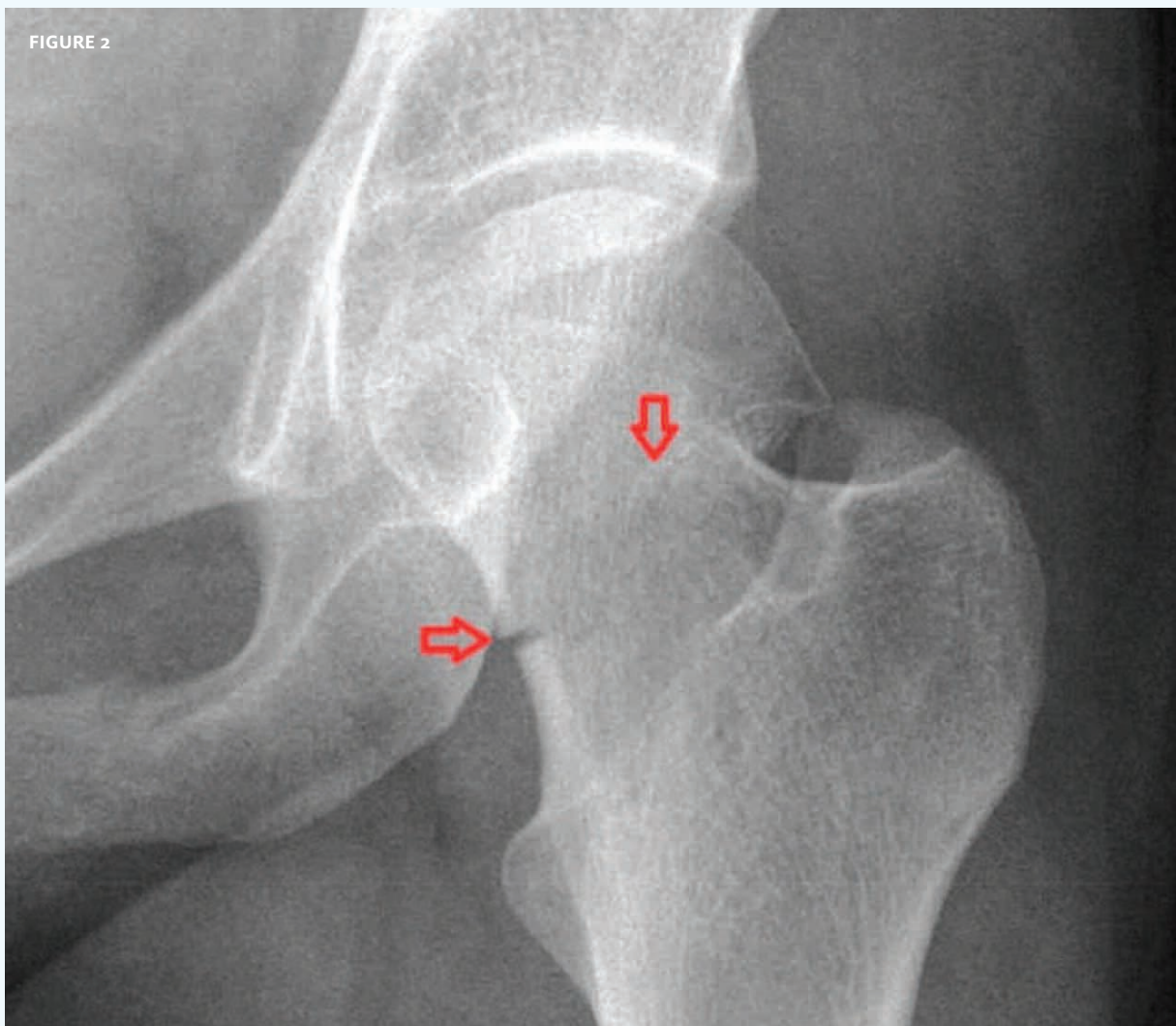
She is walking, but with a noticeable limp.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



The x-ray shows a fracture of the neck of the femur.

This case demonstrates the need to x-ray even during pregnancy, when indicated.

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

*These cases are among hundreds that can be found in Terem's online X-ray Teaching File, with more being added daily. Free access to the file is available at <https://www2.teremi.com/xrayteach/>. A no-cost, brief registration is required.*



## ABSTRACTS IN URGENT CARE

# On IDSA's New Guidelines, Probiotics for GI Complaints, Ruling Out DVT, Cutaneous Abscesses, Imaging for Low Back Pain, and Antimicrobials for Acute Otitis Media

■ 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.

### Not All Infectious Diseases Society of America Practice Guidelines Are Created Equal

**Key point:** More than 1/2 of recommendations in guidelines from the Infectious Diseases Society of America rely on low-quality evidence.

**Citation:** Lee DH, Vilemeyer O. Analysis of overall level of evidence behind Infectious Diseases Society of America practice guidelines. *Arch Intern Med.* 2011;171(1):18-22.

Researchers examined 41 guidelines published by the Infectious Diseases Society of America (IDSA) since 1994. Of the 4,200 individual recommendations in those guidelines, 55% were supported by level III quality of evidence (e.g., expert opinions), while only 14% were guided by level I evidence (e.g., randomized controlled trials).

Five guidelines were updated during the study interval. In these updates, the number of recommendations increased between 20% and 400%, but only two updates saw an increase in the number of recommendations based on high-quality evidence.

An editorialist said that one of the main take-home messages of this study "is to be wary of falling into the trap of 'cookbook medicine.' The existence of guidelines is probably better than no guidelines, but guidelines will never replace critical thinking in patient care." ■



Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the JUCM Editorial Board.

### Are Probiotics a Panacea for Gastrointestinal Complaints?

**Key point:** Probiotics are helpful agents for a growing number of indications.

**Citation:** Francavilla R, Miniello V, Magistà AM, et al. A randomized controlled trial of *Lactobacillus* GG in children with functional abdominal pain. *Pediatrics.* 2010;126:e1445-31452.

In this randomized clinical trial, 141 children (mean age: 6 years) in Italy with irritable bowel syndrome (IBS) or functional abdominal pain (FAP) received either *Lactobacillus rhamnosus* GG (LGG) or placebo in double-blind fashion for eight weeks.

Although the probiotic group had a significant reduction in the overall frequency of episodes and severity of pain (assessed on a visual analog scale and the Faces Pain Scale), the effect was confined to the 83 children with IBS. Significantly more children in the probiotic group than in the placebo group achieved treatment success (i.e., at least 50% reduction in the number and intensity of pain episodes) at the end of therapy (82% vs. 45%) and after an additional eight weeks of follow-up (87% vs. 50%).

In a related clinical report, the American Academy of Pediatrics Committee on Nutrition reviewed the health benefits of probiotics in children for treatment of acute infectious and antibiotic-associated diarrhea; prevention and treatment of atopic disease, colic, and allergy; and treatment of ulcerative colitis, Crohn disease, and IBS. They conclude that probiotics might be beneficial in children with IBS. This clinical trial supports their conclusion.

Published in *J Watch Pediatr Adolesc Med*, January 5, 2011—Howard Bauchner, MD. ■

## Which Guideline Rules for Ruling Out DVT?

**Key point:** In primary care, DVT can be ruled out using either of two rules in combination with D-dimer testing on site.

**Citation:** van der Velde EF, Toll DB, Ten Cate-Hoek AJ, et al. Comparing the diagnostic performance of two clinical decision rules to rule out deep vein thrombosis in primary care patients. *Ann Fam Med*. 2011;9(1):31-36.

The Wells rule is widely used for clinical assessment of patients with suspected deep vein thrombosis (DVT), especially in the secondary care setting. Recently, a new clinical decision rule for primary care patients (the primary care rule) has been proposed because the Wells rule is not sufficient to rule out DVT in this setting. The objective was to compare the ability of both rules to safely rule out DVT and to efficiently reduce the number of referrals for leg ultrasound investigation that would result in a negative finding.

Family physicians collected data on 1,086 patients to calculate the scores for both decision rules before leg ultrasonography was performed. In all patients, D-dimer testing was performed using a rapid point-of-care assay.

A venous thromboembolic event occurred during follow-up in seven patients with a low score and negative D-dimer finding, both with the Wells rule and the primary care rule.

Using the Wells rule, 45% of patients would not need referral for further testing compared with 49% of patients when using the primary care rule (McNemar  $P < .001$ ).

In primary care, suspected DVT can safely be ruled out using either of the two rules in combination with a point-of-care D-dimer test. Both rules can reduce unnecessary referrals for compression ultrasonography by about 50%. ■

## No Concurrence in Identifying Cutaneous Abscesses

**Key point:** Physician agreement on the presence of abscess and the need for drainage was only fair to moderate.

**Citation:** Marin JR, Bilker W, Lautenbach E, et al. Reliability of clinical examinations for pediatric skin and soft-tissue infections. *Pediatrics*. 2010;126:925-930.

Most cutaneous abscesses require incision and drainage but not systemic antibiotics. By contrast, patients with cellulitis need systemic antibiotics, but incision and drainage are unnecessary and sometimes harmful. Distinguishing between these two disorders, therefore, is important.

In this study from an emergency department in an urban, tertiary care, pediatric hospital, 349 immunocompetent children with 394 lesions affecting the abdomen, legs, buttocks, or arms were evaluated for presence of an abscess and for the necessity for drainage.

Agreement among the physicians was assessed by kappa statistic (poor,  $<0.0$ ; slight,  $0.0-0.20$ ; fair,  $0.21-0.40$ ; moderate,

$0.41-0.60$ ; substantial,  $0.61-0.8$ ; nearly perfect,  $0.81-1.00$ ). The kappa value for agreement was 0.39 on the presence of an abscess (fair) and 0.43 on the necessity for drainage (moderate). More-experienced examiner pairs did not have better agreement than less seasoned physicians.

This study demonstrates a substantial and disturbing lack of agreement among clinicians about fundamental issues in children with apparent skin infections—namely, whether a cutaneous abscess was present and whether drainage was required.

Published in *J Watch Dermatol*, January 7, 2011—Jan V. Hirschmann, MD. ■

## Diagnostic Imaging Should Not Be Automatic for Low Back Pain

**Key point:** Routine diagnostic imaging for low back pain doesn't improve outcomes and only increases complications and costs.

**Citation:** Chou R, Oaseem A, Owens DK, et al. Diagnostic imaging for low back pain: Advice for high-value health care from the American College of Physicians. *Ann Int Med*. 2011;154(3):181-189.

The authors revisit the guidelines issued by the American College of Physicians and the American Pain Society in 2007 and add evidence from a meta-analysis of six clinical trials. Here are their principal recommendations:

Use an initial trial of therapy rather than immediate imaging. However, imaging is warranted when the patient has major risk factors for cancer or shows severe or progressive neurologic deficits.

Risk factors or signs of vertebral infection or the cauda equina syndrome, although rare, also warrant more immediate imaging.

The authors state that routine imaging “cannot be cost-effective” and conclude that “efforts to reduce use of imaging should be multifocal and address clinician behaviors, patient expectations, and financial incentives.”

## A Placebo-Controlled Trial of Antimicrobial Treatment for Acute Otitis Media

**Key point:** Children with acute otitis media benefit from antimicrobial treatment as compared with placebo. There is an advantage to treatment less evident in time to initial resolution of symptoms but more evident in failure rate

**Citation:** Tähtinen PA, Laine MD, Huovinen P, et al. A placebo-controlled trial of antimicrobial treatment for acute otitis media. *N Engl J Med*. 2011;364:116-126.

In this randomized, double-blind trial, children 6 to 35 months of age with acute otitis media, diagnosed with the use of strict criteria, received amoxicillin-clavulanate (161 children) or placebo (158 children) for seven days. The primary outcome was the time to treatment failure from the first dose until the end-



of-treatment visit on day 8. The definition of treatment failure was based on the overall condition of the child (including adverse events) and otoscopic signs of acute otitis media.

Treatment failure occurred in 18.6% of the children who received amoxicillin–clavulanate, as compared with 44.9% of the children who received placebo. The difference between the groups was already apparent at the first scheduled visit (day 3), at which time 13.7% of the children who received amoxicillin–clavulanate, as compared with 25.3% of those who received placebo, had treatment failure.

Overall, amoxicillin–clavulanate reduced the progression to treatment failure by 62% and the need for rescue treatment by 81% (6.8% vs. 33.5%).

Analgesic or antipyretic agents were given to 84.2% and 85.9% of the children in the amoxicillin–clavulanate and placebo groups, respectively.

Adverse events were significantly more common in the amoxicillin–clavulanate group than in the placebo group. A total of 47.8% of the children in the amoxicillin–clavulanate group had diarrhea, as compared with 26.6% in the placebo group; 8.7% and 3.2% of the children in the respective groups had eczema.

Children with acute otitis media benefit from antimicrobial treatment as compared with placebo, although they have more side effects. Future studies should identify patients who may derive the greatest benefit, in order to minimize unnecessary antimicrobial treatment and the development of bacterial resistance. ■

### Recession Leads to Historically Low Health Spending

**Key point:** *Healthcare spending is growing at a slower pace than that of the overall economy.*

Martin A, Lassman D, Whittle L, et al. *Health Affairs*. 2011;30(1):11-22.

In 2009, U.S. healthcare spending grew 4%—a historically low rate of annual increase—to \$2.5 trillion, or \$8,086 per person. Despite the slower growth, the share of the gross domestic product devoted to health spending increased to 17.6% in 2009 from 16.6% in 2008.

The growth rate of health spending continued to outpace the growth of the overall economy, which experienced its largest drop since 1938. The recession contributed to slower growth in private health insurance spending and out-of-pocket spending by consumers, as well as a reduction in capital investments by healthcare providers.

The recession also placed increased burdens on households, businesses, and governments, which meant that fewer financial resources were available to pay for healthcare. Declining federal revenues and strong growth in federal health spending increased the health spending share of total federal revenue from 37.6% in 2008 to 54.2% in 2009. ■

*“If in doubt, it is better to splint a suspected fracture in a child.”*

splint with side slabs (**Figure 10**); displaced fractures should be splinted with a long leg splint all the way up the thigh to prevent rotation of the fracture. The knee should be slightly bent, and the patient should be sent home non weight-bearing on crutches and be told to elevate the leg until follow-up with an orthopedist.

Morbidity is increased with poorly placed splints. Care must be applied to take pressure off of the heel.

### Conclusion

Nearly 20% of children coming to the urgent care with an injury will have a fracture. It is important to remember that physeal injuries are very common and may present with no radiographic findings.

Occult injuries are also possible in the shaft of the bone in children. If in doubt, it is still better than not to splint a suspected fracture in a child.

If a fracture displaces, a physeal arrest may occur.

A thorough history and exam, adequate radiographs, and a good splint with care to avoid pressure over bony prominences will help patients and their families get through the healing process with minimal discomfort.

Typically, children heal quickly and usually return to full preinjury activity level. ■

### References

1. Buckley SL, Gotschall C, Robertson W Jr, et al. The relationships of skeletal injuries with trauma score, injury severity score, length of hospital stay, hospital charges, and mortality in children admitted to a regional pediatric trauma center. *J Pediatr Orthop*. 1994;14(4):449-453.
2. Landin LA. Fracture patterns in children. Analysis of 8,682 fractures with special reference to incidence, etiology and secular changes in a Swedish urban population 1950-1979. *Acta Orthop Scand Suppl*. 1983. 202:1-109.
3. Stanley D, Trowbridge EA, Norris SH. The mechanism of clavicular fracture. A clinical and biomechanical analysis. *J Bone Joint Surg [Br]*. 1988;70(3):461-464.
4. Shannak AO. Tibial fractures in children: Follow-up study. *J Pediatr Orthop*. 1988;8(3):306-310.
5. Dunbar JS, Owen HF, Nogrady MB, et al. Obscure tibial fracture of infants—The toddler's fracture. *J Can Assoc Radiol*. 1964;25:136-144.
6. Halsey MF, Finzel KC, Carrión WV, et al. Toddler's fracture: Presumptive diagnosis and treatment. *J Pediatr Orthop*. 2001;21(2):152-156.



## Accountable Care Organizations, Where do Urgent Care Centers Fit?

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Under the Affordable Care Act, the Centers for Medicare and Medicaid Services will pioneer a number of new projects which affect the delivery of healthcare in the United States.

Among these projects, the most ambitious is the proliferation of the Accountable Care Organizations (ACOs). Other initiatives include pay-for-performance (P4P) and quality improvement agendas proffered by organizations responsible for accreditation, all focusing on clinical delivery pathways or “care paths.”

### The Problem

The genesis of the term “ACOs” can be traced to Elliot Fisher, MD, MPH, who heads up the Atlas Project at the Dartmouth Medical Schools. Dr. Fisher and his team determined that there is a wide range of cost and quality across the country, and that higher cost does not necessarily mean better quality.

For example, in 2006, in New York State, the average Medicare spending per enrollee was \$9,564, compared with \$6,122 in Oregon and \$8,304 nationally.

Moreover, an analysis by Price Waterhouse Coopers’ Health Research Institute determined that out of the \$2.5 trillion spent on healthcare, \$1.2 trillion could be eliminated or significantly reduced by the adoption of clinical delivery pathways, operational controls, and behavior modification as it relates to obesity, smoking, alcohol abuse, and non-adherence to prescribed treatment regimens.

### Current Model vs. the Proposed Future

In our existing fee-for-service model, doctors and hospitals get paid more by ordering more services and, generally

speaking, admitting more patients. Under the ACO model, hospitals and doctors would be paid based upon their ability to hold down costs of Medicare beneficiaries.

In essence, pay would be based on improving care, not driving it. If ACOs fail to meet cost and quality standards, they would receive a lower payment from Medicare.

The outcome of this model is to force providers and health systems into becoming integrated models à la Mayo Clinic and Kaiser, both of which were early pioneers in this model.

The challenge, of course, is cobbling together a group of primary and specialty physicians along with a hospital system to share risk (and rewards) under the ACO model.

### The Challenges

This all looks great on paper, but as you can imagine, there are significant challenges in the execution. The delivery of quality care for serious illnesses requires the longitudinal coordination of services among multiple providers and institutions. Handoffs between these entities account for much of the quality gap and cost inflation.

For example, it is very common to have a patient who was just discharged after a surgical procedure performed in another facility present in the ED or an outpatient setting with a post-op issue. Or, like a patient of mine yesterday who had a complete outpatient work-up done in one state (including MRIs and neurosurgical evaluation) show up in our emergency department (on Sunday when his PCP and outpatient imaging centers were closed) requesting a second opinion and complaining of issues requiring an immediate duplication of his tests in order to determine the seriousness of his emergent complaints.

Under our current reality, most physicians in the United States still practice in small groups; therefore, integrating the large number of “unaffiliated” providers across the healthcare continuum is a daunting task. Moreover, given the diminishing numbers of primary care providers, who is going



**John Shufeldt** is principal of Shufeldt Consulting and sits on the Editorial Board of JUCM. He may be contacted at [JohnShufeldt@shufeldtconsulting.com](mailto:JohnShufeldt@shufeldtconsulting.com).

to act as gatekeeper and coordinator responsible for the longitudinal delivery of care within the advanced medical home concept?

Physician practice has long been characterized by a high degree of professional independence and a culture of individual responsibility. Team-based medical education remains a concept of the future. This is further reinforced by current professional malpractice liability programs and our current payment mechanism, which focuses on price control of individual services yet continues to reward high-technology procedures, as well as those providers who own their facilities or increase their volume of services.

The outcome has been an increase in direct competition between physicians and hospitals and the growing unwillingness of community-based specialty physicians to take emergency department calls without a stipend.

Finally, the lack of primary care physicians who follow their patients into the hospital has led to the need for full-time hospital-based physicians.

These obstacles and many others will lead to significant friction in the adoption of the sweeping changes proposed by Medicare.

### Unscheduled Care and Associated Costs

In the aforementioned Price Waterhouse study, \$14 billion of the \$1.2 trillion spent on avoidable care was for unnecessary emergency department visits.

As everyone reading this article is aware, our industry exists for four reasons:

1. Inability of patients to see a primary care provider (if they have one) on-demand. Primary care providers spend the majority of their time coordinating care and performing scheduled health screenings of their patients.
2. The overcrowding and high cost of emergency departments. ED visits across the country continue to rise. Interestingly, insured patients account for the greatest portion of that growth.
3. The consumer-centric demands of the populace. No one feels comfortable anymore waiting to see if they get better. "Tincture of time" is a phrase from a bygone era.

I recently saw a patient in the ED who complained of having a sore throat for 30 minutes. Since she had been waiting 45 minutes to see me, I asked her if she developed her sore throat while waiting in the lobby. Her response: "Yes." I did not ask any other follow-up questions since I was afraid to learn anything else.

4. The medical illiteracy of much of the population. Earlier this week, I took care of a "family plan" in the ED. Both parents and two kids. The children "felt warm" per

*"Should the urgent care industry position itself differently, knowing that a sea change is just around the corner?"*

Mom and were bundled up so much that only their nose and mouth were visible (I practice in Phoenix and it was 75° degrees outside). The father's complaint: "I noticed some hair on my pillow and I may be going bald." The mother weighed at least 350 pounds and complained of knee pain.

You get the point; "the fix" has to include either the ability to move low-acuity patients to a lower cost setting once they walk through the ED doors or a massive educational effort directed towards patients who are using the system inappropriately.

My analysis of the government's proposal is that it does little, if anything, to cogently address these issues. Thus, urgent care has a significant role in the future provision of care, particularly as it relates to the non-emergent, unscheduled delivery of healthcare.

In the recent past, retail clinics were seen as a mechanism to stem the tide of the rapidly escalating costs associated with on-demand care. Unfortunately, these clinics, given their size constraints, overhead, and slow revenue growth, have been unable to meet the high expectations of the healthcare industry and are currently evaluating alternative options within the care continuum (chronic disease management, for example). In fact, in 2010 alone, 106 retail clinics closed their doors. Even MinuteClinic has yet to break even and according to Tom Ryan, CEO of MinuteClinic parent company CVS Caremark, will not do so until mid-2012.

Therefore, given the above, my question to you is: Should the urgent care industry position itself differently, knowing that a sea change in healthcare delivery and payment mechanisms is just around the corner? Or, have we as an industry been moving toward this eventuality for years and now, finally, the rest of the healthcare industry is catching up?

My take is that more consolidation in our industry is just around the corner as consolidators look to improve margins through operating efficiencies and economies of scale. Also, many of the smaller operators will find it increasingly difficult to survive in this environment and slowly get their margins squeezed even tighter. The good news is that we are an industry of innovators and if the past foreshadows the future, to paraphrase Gloria Gaynor, *we will survive*. ■



# Innovation in Occupational Health Marketing

■ FRANK H. LEONE, MBA, MPH

In a recent episode of the popular television show *Mad Men*, super ad man Don Draper opined to his up-and-coming colleagues that “marketing is all about innovation.”

He’s right.

But the best-laid plans often sink into the abyss of the “same old, same old.” After all, if marketing is about distinguishing one’s organization from its competitors, why not rely on the tried and true to punctuate the difference?

This reasoning is flawed, however; marketing should be all about going *against* the tide, not rolling with it.

Playing the stock market offers a compelling analogy. How often have you ignored the “buy low/sell high” axiom? Investors often buy a “hot” stock, only to find out that it was at or near its peak and will go down from there. But those who choose to assume some risk by investing in an emerging stock frequently ride it to the winner’s circle.

The same mindset should apply to marketing. It is important to pay attention to trends and modify what’s “in” at the moment in accordance with your clinic’s situation, rather than replicate marketing tactics that seem to work for others. If your clinic emulates current best practices, you are unlikely to distinguish yourself from the urgent care services pack and may fall behind as competitors move forward with marketing innovations.

Old marketing habits die hard, especially in healthcare. Urgent care clinics are often steeped in yesterday’s practices, resistant to change, and risk-averse. Many healthcare marketing professionals continue to mount the horse that brought them there, embracing what worked before rather than rolling the dice on what might work even better in the future.

I believe there is a continued over-reliance on 1980s market-

ing tactics such as print ads, radio and television spots, billboards, or, oversized wads of collateral material that throw benefits to the wind in the name of providing a comprehensive list of services. Relying on catch-up ball to get to a 2011 mindset, such marketers now are focused on high-touch tactics such as the use of social media, networking, email, and text messaging.

About 10 years ago, email blasts were the latest innovation. Now email blasts are common, even tired. Yet many in healthcare still view them as a breakthrough marketing technique. We have to stop thinking 2011 and start thinking 2016 and beyond.

1. *Look beyond healthcare.* Look beyond the innovation-resistant world of healthcare. Whether you are examining a product, service, or cause, ask yourself what is really getting through to you and if it is being marketed in a manner that you haven’t seen before. When you find such examples, examine them and determine whether they might apply to your clinic’s marketing needs.
2. *Follow politics.* Once you get beyond the sleaze and distortions that permeate modern political campaigns, there are considerable lessons to be learned. Watch how campaigns develop and reinforce their message (e.g., simple, repetitive, on message), pace their outreach, and mix their modalities.
3. *Diversify your tactic portfolio.* De-emphasize and then phase out current practices over time while incrementally adding new approaches. Rapidly adapt to social media and other networking mechanisms and use them proportionately compared with techniques such as printed materials and email blasts.
4. *Let others do the work for you.* Transmitting marketing information to a cohort of prospects with the intent of having them share the information with others is a great leveraging tool. A concerted effort should be made to encourage recipients of email blasts to forward them to others within or beyond their organization or to personal friends. If your distribution list is 1,500, and 10% of those recipients forward your message to 10 individuals, you have doubled your outreach and touched many people you otherwise would not have touched.

*Continued on page 36*



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





## CODING Q & A

# Coding Concerns: Versajet Debridement, Time Frame for New/Established Patients, Detailed Exams, Denial of S9088, –57 Modifier, and Billing for Injections

■ DAVID STERN, MD, CPC

**Q.** How do I code when using Versajet to debride an ulcer?

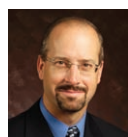
**A.** For Versajet debridement, you should report CPT code 97597 (removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high-pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel, and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 sq. cm).

When the physician uses a scalpel or scissors for debridement, use codes 11040-11044 (depending on the depth of layer removed).

**Q.** If I saw a patient in the emergency department up to three years ago and then see the patient in urgent care, is this a new patient or established patient? The emergency department and urgent care have different EIN (employer identification numbers) and corporate structures since the emergency department is non-profit and urgent care is for-profit.

- Reggie Reginella, MD, Pennsylvania

**A.** Different businesses and for-profit or non-profit status make no difference in determining new or established patients. If the physician has performed professional services for the patient in any setting in the past three years, then the patient is coded as an established patient.



**David E. Stern, MD, CPC** is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Dr. Stern speaks frequently at urgent care conferences. He is CEO of Practice Velocity ([www.practicevelocity.com](http://www.practicevelocity.com)), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

**Q.** How do you differentiate between an expanded problem focused exam (EPF) and a detailed exam for coding purposes?

For an expanded problem to be coded as “detailed,” numerous sources state two to seven organ systems are needed to equal detailed. However, the hospital and one of the payor representatives wants to partition this out as two to five systems for EPF and six to seven systems or 4x4 [four elements examined in four body areas or four organ systems] for detailed. I use any number between two and seven for an exam to equal detailed, but they want to down-code their own charts based on the above arbitrary criteria.

Is this criteria published somewhere, or is the payor just making more money for itself?

- Reggie Reginella, MD, Pennsylvania

**A.** Neither method is published by CMS. In the 1995 guidelines, you must document “an extended examination of the affected body area(s) and other symptomatic or related organ system(s).” Per the 1997 guidelines, you must simply document at least 12 specified elements from at least two areas/systems to qualify for a detailed exam.

Ask the payor for an official CMS (or AMA) publication that documents this six- to seven-system rule. It is often cited, but it appears to be an urban legend without any official verification.

**Q.** It seems that as of 2010 some insurance companies are denying the S9088 (services provided in an urgent care center) code now. We are getting “will not reimburse S9088. S9088 is informational as it pertains to the place of service, not the specific service provided.” We were billing the code with our standard 99204 (office or other outpatient visit for the evaluation and management of a new patient) and 99214 (established outpatient) and the S9088.

## Is there a new code now for 2010 for urgent care?

- Steven Fields, Laguna Niguel, CA

**A.** It is true that some payors have stopped paying the S9088 code. This was partly due to massive abuse by family practices, which used it for any walk-in patients. There are at least four reasons that a payor may be denying this S9088:

- The practice is not specifically contracted as an urgent care center.
- The practice does not meet the UCAOA criteria as an urgent care center.
- The payor will not pay unless reimbursement for the code is specified in your contract.
- The payor has made a blanket decision to no longer pay for the code.

There is no code out there that replaces the S9088 code. However, you may want to consider:

- *Opening negotiations* with the payor for additional reimbursement for the additional costs of operating an urgent care center.
- *Coding 99051*: This code can be used when you provide services "during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service."
- *Maximize coding capture*: We have found that many physicians significantly undercode E/M codes. Although this may be done from a good motivation to reduce patient costs or minimize audit risks, it is not compliant and can reduce clinic revenues by 10% to 20% or even more.

**Q.** Can you explain the logic behind using the -57 modifier just because the patient had a procedure with a 90-day global period during the same visit? Let's say we perform restorative treatment for a fracture; wouldn't we add modifier -57 to the E/M code even though the doctor did not necessarily make a decision for surgery?

- Stephanie Boling

**A.** Modifier -57 is used when the E/M involves a so-called "decision for surgery." This modifier is used to report an E&M service that resulted in a decision to perform a major surgical procedure on the day of or the day before the surgery.

It is easy to get confused by the word "surgery" in this situation. Payors, however, define any procedure with a 90-day global period as major surgery.

This surgery question is the same question that you may get from patients when they get their EOBs. Patients ask, "Why did you charge for 'surgery' when you only splinted my fracture?" Payors and CPT calls a fracture code a "surgery code," but this is not "surgery" in the sense that we normally think of the term. In this case, the "decision for surgery" was really the decision to perform restorative treatment on the fracture.

**Q.** When patients present for a B-12 injection, Depo-Provera injection, antibiotic-only injection, etc., how would you bill for those services?

- Abbi Olson, Bowling Green, KY

**A.** In a situation such as this, you should bill the HCPCS code for the medication and the CPT code for the injection. For example:

- J0696 x4: ceftriaxone (Rocephin) 1g
- 90772: Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

**Note:** If you are not being reimbursed (i.e., are getting payment denials) for B-12 injections, you may need to look at the ICD-9 that you are using with the injection code. In order to get reimbursement, many payors (including Medicare) limit reimbursement to visits coded for specific conditions related to B-12 deficiency, such as pernicious anemia and dementias secondary to vitamin B-12 deficiency. ■

*Note: CPT codes, descriptions, and other data only are copyright 2011, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).*

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

# OCCUPATIONAL MEDICINE

5. *Brainstorm—without judgment.* Innovations are often spawned by "silly" ideas. Sit down with a colleague and jointly list every conceivable marketing tactic, no matter how seemingly off-the-wall, and you will undoubtedly emerge with several great ideas.

6. *Swing for the fences.* Innovation is all about a willingness to fail

some of the time as you search for a few real winners. Many of the greatest personal and institutional success stories in history involved people who failed many times, learned valuable lessons from their failures, and then got it exceptionally right. Resistance to innovation is a ticket to mediocrity for both your clinic and yourself. ■

# CAREERS

**NASHVILLE** - Immediate need for an urgent care physician to work in a brand-new facility in Nashville, Tennessee. Preferred candidate will be board-certified in family medicine, emergency medicine, med/ped or internal medicine. An entrepreneurial inclination is desired as the company hopes to grow rapidly. Excellent compensation with potential for productivity and/or hourly bonuses. Comprehensive benefits provided as well. Contact Todd Dillon (800) 883-7345; tdillon@cejkasearch.com; or visit: www.cejkasearch.com. ID#136577C14.

**APPLICATIONS INVITED FROM FLORIDA** - Licensed Physicians for new clinic (downtown Tampa). Prefer experience in urgent care. Must have Florida License and DEA. Salary commensurate to experience. Email resume to: zgokak@verizon.net; fax: 813-684-5500, or call Zulf Gokak: (813) 397-7566. Center Manager, Urgi-care Tampa, LLC.

## SAVANNAH GEORGIA

Excellent opportunity for well-qualified Primary Care Physician to join a stable, established group to staff our Immediate Care Centers. Work with a collegial group of physicians, focused on providing quality occupational and family medical care while living only minutes from the beach. Visit our website: [www.geamba.com](http://www.geamba.com) or email CV to: [pbashlor@geamba.com](mailto:pbashlor@geamba.com) Call (912) 691-1533 for information.

**URGENT CARE PHYSICIAN** - northwest Alabama. Part-time available, walk-ins/appointments, six days a week. Fax CV: (256) 757-9426, call: (256) 335-6568.

**URGENT CARE PHYSICIAN** - St. Louis, Missouri. Interested in a high volume, fast-paced, and well compensated full or part-time position? Email: donna.coughenour@samcstl.org

**SARASOTA, FLORIDA** - working with Sarasota Memorial Hospital Urgent Care Centers. Emergency Medicine or Family Practice. Immediate need for part-time or full-time physicians. Bonus pay for working weekends. Primary need is weekend coverage. Email resume to: kamm@comcast.net or contact Dr. Steve Kamm: 941-780-6171. A great place to work and live!

## Dunkirk and Solomons, Maryland

Seeking part-time BC/BE EM, IM, and FP physicians to practice urgent care medicine at Dunkirk and Solomons Urgent Care Centers in Calvert County, Maryland. Enjoy a collegial relationship with nurses, mid-level providers, and urgent care support staff, excellent work environment, a flexible schedule, and competitive compensation.

Send CV: Emergency Medicine Associates  
20010 Century Blvd, Suite 200  
Germantown, MD 20874  
Fax: (240) 686-2334  
Email: [Recruitment@EMAonline.com](mailto:Recruitment@EMAonline.com)

**FLORIDA** - Leading medical company with two established walk-in medical clinics in Naples and Estero, Florida is seeking to hire an excellent board-certified family practice physician for immediate hire, full-time plus benefits. Qualified applicants comfortable seeing 20-30 patients per day should send a CV and a cover letter detailing their background and experience to: [resumes@NaplesUrgentCareOnline.com](mailto:resumes@NaplesUrgentCareOnline.com). Prior urgent care and minor surgical experience a plus.

## PHYSICIAN WANTED COLORADO

Urgent emergency medicine physician needed for "Urgent Care Clinic" system. Seeking board-certified/residency trained MD experienced in acute care, emergency medicine or family medicine, surgery and internal medicine.

Physician run, well-established company 25 plus years with five clinics in beautiful Colorado Springs and Pueblo, Colorado.

Competitive pay and malpractice insurance provided.

Contact: Robert S. Hamilton, MD  
[rshamilton2@earthlink.net](mailto:rshamilton2@earthlink.net)  
Fax: (719) 577-4088

Email: [JUCM@russelljohns.com](mailto:JUCM@russelljohns.com)



## Enjoy work/life balance at our Walk In facilities

### Seeking BC/BE Family Medicine or Med/Peds physicians for Wisconsin

Locations include:

Rhineland, Stevens Point, Wausau, Weston, and Wisconsin Rapids

- Very competitive salary— full-time, starting at \$185,000 — sign on bonus
- No call, pager or hospital rounds
- Flexible scheduling
- Epic EMR, with time built into your shift for charting
- Generous benefits package including exceptional CME & retirement plan
- Relocation allowance available
- On site lab, radiology, and excellent nursing support staff
- Walk in experience preferred, but not required

Not a Visa Opportunity

Contact: Karen Lindstrum Physician Recruiter, for more information about this outstanding opportunity

Phone: 800-792-8728 • [karen.lindstrum@aspirus.org](mailto:karen.lindstrum@aspirus.org) • [www.aspirus.org](http://www.aspirus.org)





## FREE Ocean City, MD Condo Enjoy the Beach Life!

**PHYSICIANS, PA'S & NP'S**  
P/T Now – F/T Summer '11

FREE Luxury beach condo with pool. Sun and fun with us at our friendly urgent care/family practice center. Salary, malpractice, flexible schedule, license fees and all condo costs included. NO ON-CALL! NO HMO!

**Summer Sign-on Bonus.**

**Contact: Dr. Victor Gong**  
75<sup>th</sup> St. Medical Center  
Ocean City, MD  
(410) 524-0075 • Fax: (410) 524-0066  
vgongmd@yahoo.com  
[www.75thstmedical.com](http://www.75thstmedical.com)



### How to Use:

Open a barcode scanner app on your smartphone. Position phone's camera over QR code and scan.

### Want one of these?

To place a QR code in your CLASSIFIEDS advertisement, call us at: (800) 237-9851.

## Wisconsin Outpatient Opportunity!

Family Medicine Convenient Care Opportunity near the Fox River Valley!

**Practice at the Next Door Health Clinic located within a major retail store. Join a nurse practitioner and see patients in the walk-in clinic conveniently located just inside the facility. Be a part of this new venture and affiliate with a large, healthy integrated network.**

- Located near the southern shore of Lake Winnebago, the state's largest lake and Green Lake, the deepest lake, offering every recreational activity.
- University town within a 45 minute drive of the Fox Cities, one hour to Milwaukee and Green Bay and 2.5 hours to Chicago.

You don't have to choose between a great career and quality of life. Get both with this opportunity!

Contact Jane Dierberger today at  
(800) 243-4353 or  
jdierberger@strelcheck.com  
All inquiries are confidential.



**Righttime**  
MEDICAL CARE

## PHYSICIAN EMPLOYMENT OPPORTUNITIES

Righttime Medical Care, a physician-owned urgent care, is currently recruiting full and part-time physicians to meet the ever-increasing patient care needs of our growing healthcare business.

Founded in 1989, Righttime Medical Care has delivered on its mission of quality medical care and exceptional patient service to more than one million adults and children in 7 central Maryland locations.

Our promise of being there when our patients need us most, 365 days a year, offers our physician employees exceptional schedule flexibility. We offer competitive compensation and benefits, training and a dynamic environment focused on patient care.



Please email your CV to [mdrecruitment@myrighttime.com](mailto:mdrecruitment@myrighttime.com) or call 443.336.4624 for more information

**myRighttime.com**

## URGENT CARE MEDICAL DIRECTOR

Growing urgent care practice in Buffalo, New York, seeks a Medical Director to provide clinical leadership for a new facility. Western New York Immediate Care is a state-of-the-art, spa-like facility that includes triage, treatment and procedure rooms, a CLIA-certified laboratory and digital diagnostic imaging - including CT-scan. We strive to create an environment and experience that exceeds expectations.

Western New York Immediate Care Medical Directors work as Independent Contractors, receiving: a competitive hourly rate, annual Medical Director stipend, performance incentives, full malpractice with tail coverage and an 18-month track to Partnership/Profit-Sharing.

The ideal candidate will have: an active New York State Medical License; board certification in Emergency Medicine (preferred) or Internal Medicine/Family Practice with significant emergency medicine/urgent care experience; at least 5 years medical experience post-residency; familiarity with pediatric medicine; ability to perform procedures such as laceration repair and splinting; ability to interpret diagnostic imaging and laboratory results; ACLS certification; and an ability to supervise, train, and evaluate medical providers and staff. Prior Medical/Program Director experience preferred.

Western New York Immediate Care is managed by The Exigence Group, a national healthcare management organization. We understand the opportunities and challenges associated with planning, developing and managing a successful urgent care practice. We currently own and operate urgent care facilities in New York and Texas.

Send inquires to Susan Luff:  
[sluff@theexigencegroup.com](mailto:sluff@theexigencegroup.com)  
or call (716) 908-9264  
[www.theexigencegroup.com](http://www.theexigencegroup.com)

## Urgent Care Physician



## Finding Balance

HealthCare Partners Medical Group is a multi-specialty medical group that is recognized for its quality of care and high rates of patient satisfaction. HealthCare Partners has over 3,500 employees, including 500+ primary care and specialty physicians, caring for more than 500,000 patients throughout Los Angeles County and Northern Orange County.

As part of our continued growth, we are currently seeking outgoing **Urgent Care Physicians** to join our team in **Long Beach**.

In this role, you will have the opportunity to provide care and support to a wide variety of patients working in fast-paced Urgent Care Centers. Candidates should be Board Certified in Family Medicine, and be ACLS and PALS certified. Board eligible candidates will also be considered.

For immediate consideration or to learn more about our company, please email your CV to John Haigh at [jhaigh@healthcarepartners.com](mailto:jhaigh@healthcarepartners.com).

You can also visit us at:  
[www.healthcarepartners.com](http://www.healthcarepartners.com)



**HealthCare Partners.**  
Medical Group and Affiliated Physicians



## 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 2 physicians to join the PMG Medical Group.

- BE/BC Family Practice **Medical Director to lead our Urgent Care Department.**
- BE/BC Family Practice Urgent Care MD for full time clinical services.

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 a competitive salary; relocation; CME allowance; 403(b) with match; 457(b); health, life, AD&D, disability insurance; 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

1-866-757-5263 or fax 505-923-5388

# JUCM

The official Journal of the  
Urgent Care Association of  
America (UCAOA)

The Nation's  
Largest Urgent  
Care Conference!

## National Urgent Care Convention

**May 10 - 13, 2011**

Receive maximum exposure with circulation  
and bonus distribution by placing your  
classified advertisement in our **May** issue.

Contact: Trish O'Brien

(800) 237-9851, ext. 237 • Fax (727) 445-9380

Email: [jucm@russelljohns.com](mailto:jucm@russelljohns.com)

[www.russelljohns.com](http://www.russelljohns.com)



For convention information please visit:  
[www.ucaoa.org/convention](http://www.ucaoa.org/convention)

## MARKETPLACE

### MEDICAL EQUIPMENT

### EKG Machines for LESS!!

Medical Device Depot sells the BEST  
NAME BRANDS at the LOWEST prices!

Choose from one of these  
Great SPECIALS:

AT-1i: Multi-channel EKG  
w/interpretation \$1,398

AT-2i: Multi-channel EKG  
w/interpretation & full page  
printout \$1,856

AT-2 light: Multi-channel EKG  
w/interpretation, full page  
printout & alphanumeric  
keyboard \$2,275

AT-2 plus: Multi-channel EKG  
w/interpretation, full page  
printout, alphanumeric keyboard  
& EKG waveform display \$2,677  
Add spirometry for \$1,000

**3 YEAR  
WARRANTY**  
AT-2 plus combo, EKG  
w/Spirometry pictured

*See before  
you buy!!*

Our machines  
come with a  
longterm  
warranty and  
in office  
training.

**Medical Device Depot**  
INC.

Call for on-site demonstration or more info!  
Toll Free 877-646-3300

[www.medicaldevicedepot.com](http://www.medicaldevicedepot.com)

Email: [JUCM@russelljohns.com](mailto:JUCM@russelljohns.com)

## Recruit Urgent Care Professionals on the New JUCM CareerCenter

- Post Jobs
- Manage Resumes
- Track Job Posting Performance
- Upgrade Opportunities

**UCAOA members receive up to 20% discount.  
POST YOUR JOB OPENINGS TODAY!**



[www.UrgentCareCareerCenter.com](http://www.UrgentCareCareerCenter.com)

**JUCM CAREERCENTER**  
THE JOURNAL OF URGENT CARE MEDICINE

(800) 237-9851 • [sales@urgentcarecareercenter.com](mailto:sales@urgentcarecareercenter.com)



Open a barcode  
scanner app on  
your smartphone.  
Position your  
phone's camera  
over this QR code  
to access.

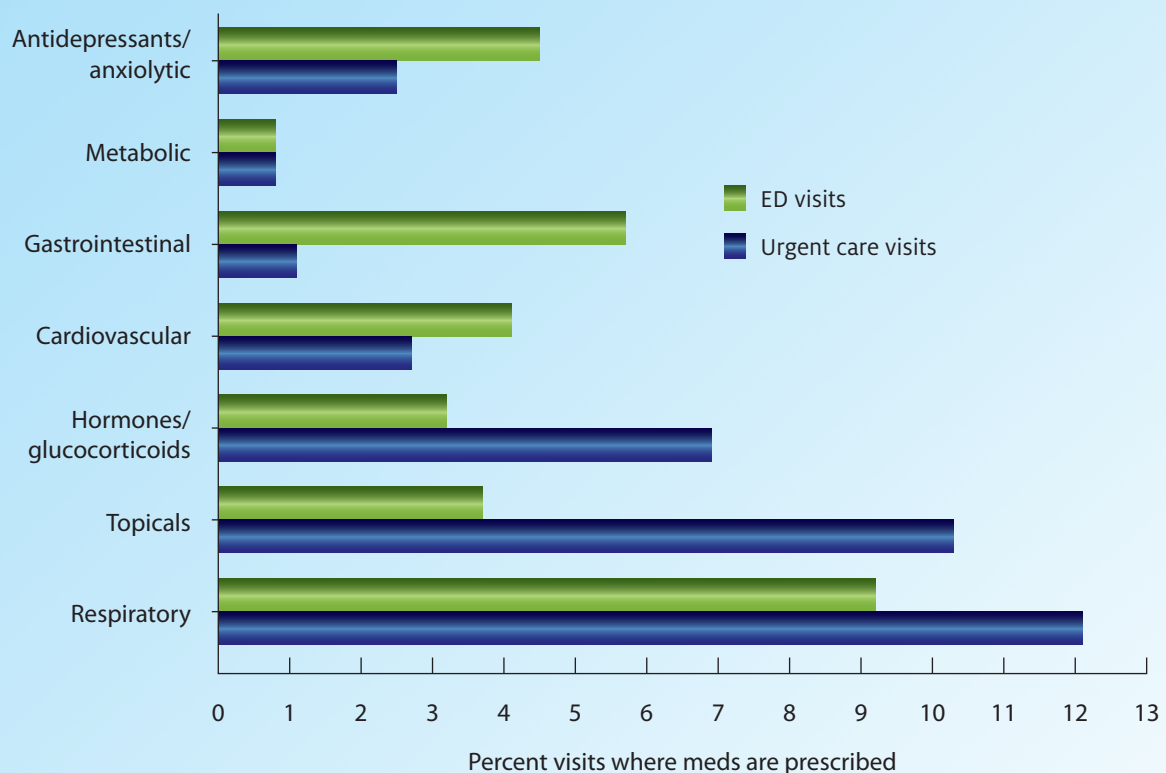


## DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we offer one more snapshot of data presented in a *Health Affairs* article entitled *Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics*,<sup>1</sup> in which prescribing trends in the urgent care setting are compared with trends in other settings, such as the emergency room and retail clinics.

Below, we share a comparison between urgent care and in the ED in prescribing respiratory agents (e.g., antihistamines and bronchodilators), topical agents (e.g., steroid creams), hormones/glucocorticoids, cardiovascular agents (e.g., antihypertensives), gastrointestinal agents (e.g., laxatives, drugs for acid reflux), and metabolic agents (e.g., diabetes medications).

### PRESCRIBING OF MISCELLANEOUS CLASSES



#### Reference

1. Weinick RM, Burns RM, Mehrotra A. *Health Affairs*. 2010;29(9):1630-1636.

This information may be most valuable to the urgent care practitioner as a barometer of patient preferences when choosing which site best suits their needs.

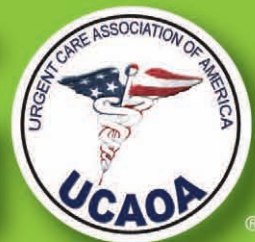
Whether or not these data reflect what occurs in your facility, “go to school” on them to gain insight into how patients view the capabilities of urgent care as a whole compared with the ED. If they don’t know what your capabilities are, educate them.

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



SPRING 2011

# CHICAGO



May 10-13, 2011



## National Urgent Care Convention

### **Tuesday, May 10** **PreConference**

- Starting a New Urgent Care
- Growing Your Urgent Care
- Advanced Financial Management
  - New Clinical Course
  - Urgent Care Billing

### **Wednesday-Friday, May 11-13** **Main Convention**

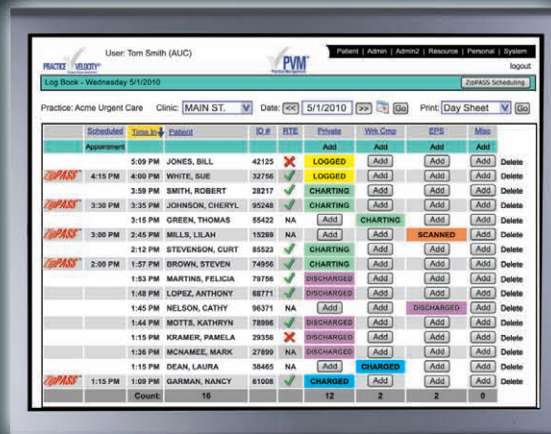
- Industry Leader Panels
- 22+ Practice Management Sessions
  - 22+ Clinical Sessions
- Hospital-Affiliated Track
- Formal and Informal Networking Sessions
  - Only Exhibit Hall Exclusively for Urgent Care

**Open Now! Regular tuition ends April 15**  
**Not on our mailing list?**

[www.ucaoa.org](http://www.ucaoa.org) • 877-698-2262



# Need More than the Best EMR?



## We Can Do That!

Billing  
Services

365 Live  
Support

Credentialing

Startup  
Consulting

e-Rx

Contracting

Urgent  
Care  
Centered

ExitCare®

>20 years  
Experience

Occupational  
Medicine

GoUrgentCare.com

Automated  
Coding

Online  
Appointments

In-house  
Dispensing

Reporting

Marketing

practicevelocity.com

888-357-4209



**PRACTICE VELOCITY®**  
Urgent Care Solutions®

