JUCM™
THE JOURNAL OF URGENT CARE MEDICINE®
MARCH 2014
VOLUME 8, NUMBER 6
Urgent Care Association of America
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Also in this issue



Part 1

# Assessment and Management of Asthma Exacerbation in Urgent Care

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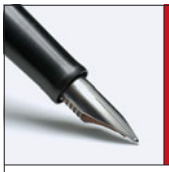
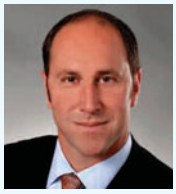


## LETTER FROM THE EDITOR-IN-CHIEF

# MOC...Part Duhhh!



I first wrote about the disaster that is Maintenance of Certification (MOC) in June 2012. As a refresher, MOC was adopted by all 24 American Board of Medical Specialties (ABMS) member boards in 2006. The move was promoted under the guise of a commitment to quality care and best practices. Despite no clear evidence that MOC works to achieve these goals, the requirements were adopted without debate. That's right, the nation's 800,000 certified physicians had absolutely no say in what has become the most expensive, time-consuming and unvalidated professional certification process in the world.

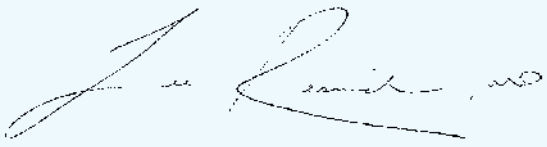
Unfortunately, the autocratic power wielded by ABMS has gone relatively unchallenged since its inception. Worse yet, the ABMS board chairmen have "millions" of reasons to maintain the status quo, seeing that many of them make Fortune 500 money to do so. Throw in the political power and legitimacy that we have granted them, and you have a recipe for collusion and self-promotion without any independent oversight. All said, you have an eerily mafia-like organization with the ABMS "Dom" overseeing the neighborhood mob bosses, lavishing them with money and power and thus ensuring that no one has any incentive or desire for reform.

Since my last column, for the most part and not surprisingly, ABMS has dug in their heels and negotiated even greater power through government mandates and CMS payment penalties. That's right, MOC is a requirement for the Physician Quality Reporting System (PQRS), and beginning in 2015, CMS begins enforcing penalties for not participating, a move many worry will trickle down into commercial contracts. Several previous moves by ABMS have been adopted as the standard by which insurance companies credential physicians for contracting purposes, including many that *require* ABMS board certification.

Who's representing the physicians in all this? The AMA? The AAFP? Hardly! The very physician societies created to represent the collective interest of its independent physicians stand to gain the most from MOC. Tasked with implementation and oversight, member boards have unearthed a river of gold, perpetually delivering millions of dollars a year in new revenue...money used to fatten the ever-burgeoning wallets of the ever-bloating executive rolls. To keep the doubters in physician societies like AAFP quiet, the "supposed to be independent" certifying board gives their academy counterparts a big piece of the action, accrediting all the modules with CME through the artificially inflated fees for their "prescribed" credit. These education monopolies provide the lifeblood for every one of these groups. Don't believe me? Just check their tax returns. They can be viewed at www.guidestar.com. This CME monopoly is being fed by the very MOC requirements established by the "independent" ABMS board. Sounds like "hush" money to me. And consider this: The AAFP and ABFM, the two "nonprofit" mega-organizations tasked with overseeing the interests of my designated specialty, have combined net assets of over $100 million and combined annual revenues of over $110 million. Despite representing a suffering specialty just trying to survive in a sea of regulation and inferior compensation, the executives and board members all fly first class with their spouses, have generous retirement plans, and earn Fortune 500 pay. All on the backs of their members.

Why do I pay nearly $1,000 per year as a member of an organization that *requires* me to obtain their expensive CME and maintain certification through their equally expensive MOC process? With all the challenges and regulations family physicians face, why are we devising new self-imposed rules that make it even harder? Well, you can't generate new income without new rules that force participation in unchecked, unproven, and unwanted legitimacy pathways. That's a great way to secure a fruitful financial future for the executives that control the coffers. Unfortunately, the future is not as bright for their members.

The overwhelming majority of practicing physicians oppose MOC in its current form—as many as 91% in one poll. Yet individual physicians carry little weight and are "represented" by a system of organized medicine that looks more like "organized crime" to me. It is highly unlikely that an already overwhelmed practicing physician is prepared to fight a battle against well-connected and well-resourced executives who spend all their time lobbying and positioning themselves as "untouchables." Unfortunately, we have created what appears to be an organizational structure whose executives and leaders are "made" men and women. Lawsuits are being considered, but as you can imagine, the odds are long and, with lopsided resources, may simply be an exercise in futility. For more information, go to www.changeboardrecert.com. ■



Lee A. Resnick, MD
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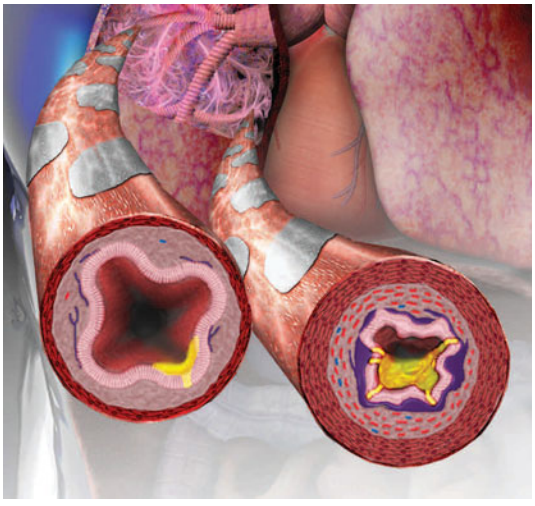


CLINICAL

## 9 Assessment and Management of Asthma Exacerbation in Urgent Care: Part 1

Asthma is increasing in prevalence and so, too, presentations of asthma in ambulatory settings. Urgent care providers have an important role to play in identifying and treating acute asthma exacerbations.

*Bradley M. Turner MD, MPH, MHA, FCAP, FASCP and Janet M. Williams, MD, FACEP*

*Left: Illustration of mild and chronic asthma, with details of the bronchial tubes.*

PRACTICE MANAGEMENT

## 20 Expert Perspectives on Grassroots Marketing in Urgent Care

Grassroots marketing tactics can be effective in engaging a center's providers and staff with the communities they serve while also educating prospective patients about the availability of urgent care.

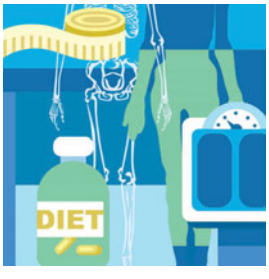
*Alan A. Ayers, MBA, MAcc, Tina Bell, Gary Derk, Felicia S. Fortune, and Hillary Myers*

CASE REPORT

## 29 Side Effects of New Weight Loss Medications

With the epidemic of obesity and recent FDA-approval of weight loss drugs, urgent care providers should be on alert for patient presentations related to side effects of these agents.

*Madison Bean and John Shufeldt MD, JD, MBA, FACEP*




### IN THE NEXT ISSUE OF *JUCM*

*When asthma exacerbation is the suspected diagnosis, efficient short-term management is critical for a positive outcome. The urgent care provider's role in asthma care, however, doesn't stop there. Effective long-term management of the disease—the subject of next month's cover story—requires appropriate use of pharmacotherapy, attention to the latest protocols for treatment, and provision of a written asthma action plan to patients at discharge.*

### DEPARTMENTS



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**Mission Statement**
*JUCM The Journal of Urgent Care Medicine* supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *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.

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





**Address Changes**
*JUCM* (ISSN 1938-002X) printed edition is published monthly except for August for $50.00 by Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey NJ 07446. Periodical postage paid at Mahwah, NJ and at additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey, NJ 07446.

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The epidemiology and pathophysiology of asthma is the subject of this month's cover story, the first of a two-part series. In it, authors Bradley M. Turner, MD, MPH, MHA, FCAP, FASCP and Janet M. Williams, MD, FACEP, provide guidance on key aspects of medical history-taking and examination in patients with a condition that is becoming more prevalent and commonly seen in urgent care clinics. Urgent care providers who see individuals with acute exacerbation of asthma have a unique opportunity to impact not only short-term outcome for these patients but also long-term management by providing them with a written asthma action plan.

Dr. Turner is an Assistant Professor of Pathology at the University of Rochester School of Medicine in Rochester, NY, and a staff physician with Team Health/Exigence Rochester Immediate Care in Rochester NY, and Team Health/Exigence Western New York Immediate Care in Buffalo, NY. Dr. Williams, previously Professor of Emergency Medicine at the University of Rochester School of Medicine, currently serves as the Medical Director of Team Health/Exigence Rochester Immediate Care in Rochester, NY.


More than 150 million Americans are estimated to be obese and when diet and exercise fail, many turn to prescription weight loss drugs. Such medication should only be used with a prescription from and under the supervision of a physician, as is underscored by this month's case report. In it, authors Madison Bean and John Shufeldt, MD, JD, MBA, FACEP, describe the outcome for a 46-year-old male who decided that more medication would equal faster weight loss in advance of his wedding. The moral of the story for urgent care providers is to be alert for potential side effects of FDA-approved weight loss drugs.

Madison Bean is a third-year pre-health student at Arizona State University. John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*.

This month's practice management article is a first for *JUCM*: An expert roundtable, moderated by *JUCM*'s Associate Editor, Practice Management, Alan A. Ayers, MBA, MAcc. The topic is effective use of grassroots marketing—such as community events and sponsorships—for urgent care clinics and the experts are Tina Bell, Gary Derk (not shown), Felicia S. Fortune, and Hillary Myers. During their live discussion, presented here in an edited transcript, they provided real-world examples of the hands-on approaches urgent care operations large and small are using right now to connect with prospective consumers, build relationships, and spur word-of-mouth in the community.




Mr. Ayers is on the Board of Directors, Urgent Care Association of America, Associate Editor, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care. Tina Bell is Director of Marketing and Chief Brand Officer for Healthcare Express Urgent Care and Occupational Medicine Clinic, Texarkana, TX. Gary Derk is Associate Director of Field Marketing for MedExpress Urgent Care, Morgantown, WV. Felicia S. Fortune is Director of Marketing for American Family Care, Hoover, AL. Hillary Myers is Director-Business Development and Marketing for Lansing Urgent Care, Lansing, MI.

**Also in this issue:**

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses trends in medical malpractice in urgent care and retail medicine. The column is coauthored by Andrew Sniegowski, RN, JD.

**Sean M. McNeeley, MD,** and **The Urgent Care College of Physicians** review new abstracts on literature germane to the urgent care clinician, including studies of antibiotics for COPD and steroids for pediatric asthma.

In Coding Q&A, **David Stern, MD, CPC**, discusses diagnosis codes, E/M guidelines, and ICD-10.

Our Developing Data end piece this month looks at the percentage of patients that urgent care centers assist in finding a primary care physician. ■

## To Submit an Article to *JUCM*

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

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

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

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P. JOANNE RAY

Organized medicine and the strength of our "Association" is critically important today. It's not difficult to imagine why. After all, we are living through some of the most dramatic changes to America's health care system in more than a century: Accountable Care Organizations, electronic health records, physician quality reporting, health insurance exchanges. And, let's face it – we didn't open urgent care centers and embark on our careers just so someone could tell us how to practice medicine or run our "practices."

Those who started UCAOA 10 years ago did so because they knew the value and the power of organized medicine. They knew that, if we were to grow, thrive, and succeed as individuals and as an industry, we would need to do so *TOGETHER*.

UCAOA consistently brings you urgent care-specific education and updates by:

- Setting the course from the outset with Clinic Startup;
- Enhancing and expanding the clinical and practice management skill sets of new and seasoned staff members;
- Informing owners, operators, and practitioners about how healthcare reform may affect urgent care;
- Providing eLearning and live webinars through the Online Education portal; and,
- Organizing views, statements and presentations to influence state and national leaders.

Recently, we witnessed the partnership between state and national leadership in addressing broad-sweeping regulatory recommendations from the Public Health and Health Policy Committee and the New York Department of Health. There are many chapters yet to be written in that endeavor. But thanks to the tireless efforts and industry experience and expertise of UCAOA board and staff and a very dedicated group of North East Regional Urgent Care Association volunteers, we were successful in squashing some of the inappropriate recommendations and barriers to practice such as the threat to require urgent care centers to take Medicaid or to limit the number of times patients could come to us. Now, we are focusing on helping to guide the way with the remaining regulations and how they are implemented. If you practice or own a center in New York, and you have not yet read up on the regulations being implemented, please visit the UConnect New York State Working Group at http://uconnect.ucaoa.org/group/New%20York for more details. And, send an email to jray@ucaoa.org if you wish to become more involved in the solutions.

The changes proposed will not only affect those urgent care center owners, practitioners, and patients in New York, but potentially patients and clinics across the country. The collective voice and energies of local and national entities working together have the power to make a difference.

Organized medicine has an astounding record of achievements in this country. Urgent care is new to this collective endeavor. Last month, Dr. Nate Newman highlighted the beginnings of key agency partnership meetings in Washington, DC. The collaborative influence we can wield will surely help to shape the environment within which we practice and operate.

More and more, media representatives including *The Wall Street Journal*, *The New York Times*, *The Huffington Post*, and NBC.com (to name a few) are turning to UCAOA representatives as the experts not only about urgent care but about the health care climate in general. We bring a unique perspective to the dialogue and our role is poised to continue to grow.

Together we can accomplish what none of us could have done alone. This is true in the health and public policy, practice management, clinical practice, and patient experience arenas alike. There is so much more to be learned, accomplished, and shared. Reach out to your colleagues. Encourage involvement by your staff. Embrace UCAOA and get engaged with the organization yourself. Contact the UCAOA office today to learn how you can join us and make a difference! ■

**P. Joanne Ray** is chief executive officer of the Urgent Care Association of America. She may be contacted at *jray@ucaoa.org*.

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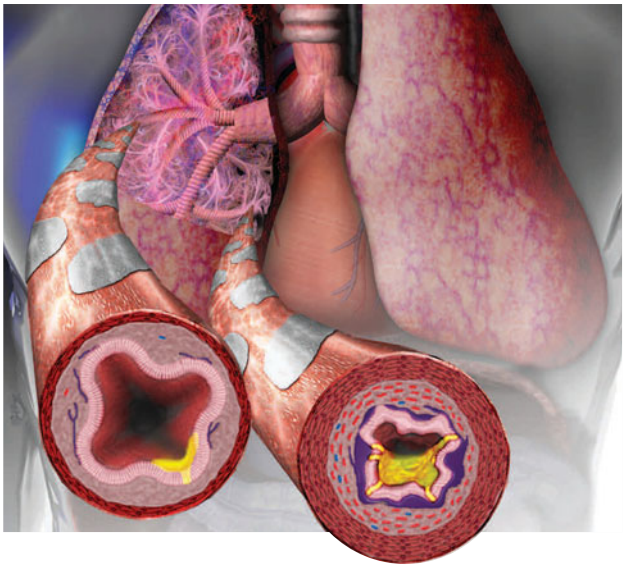
# Assessment and Management of Asthma Exacerbation in Urgent Care: Part 1

**Urgent message:** Asthma is increasing in prevalence and so, too, presentations of asthma in ambulatory settings. Urgent care providers have an important role to play in identifying and treating acute asthma exacerbations, including providing a written asthma action plan at discharge to improve long-term outcome.

BRADLEY M. TURNER MD, MPH, MHA, FCAP, FASCP and JANET M. WILLIAMS, MD, FACEP

Patients often seek assistance in urgent care centers for acute presentations of asthma. This provides unique opportunities for short- and long-term management in the urgent care setting. Identification of relevant history, adequate treatment, and appropriate follow-up are essential, and are areas where the urgent care provider plays an important role. Protocols can be helpful in short-term management of the asthmatic patient presenting to an urgent care center. A written asthma action plan at discharge may help to improve long-term outcomes. In the first of a two-part series, we review the epidemiology and pathophysiology of asthma, and provide guidance on key aspects of medical history-taking and examination of the patient who presents for urgent care with symptoms suggestive of asthma. Part 2, in a subsequent issue, will review both short and long-term management of asthma through the use of pharmacotherapy, protocols for treatment, and a written asthma action plan at discharge.

**Bradley M. Turner** is an Assistant Professor of Pathology at the University of Rochester School of Medicine in Rochester, NY and a staff physician with Team Health/Exigence Rochester Immediate Care in Rochester NY, and Team Health/Exigence Western New York Immediate Care in Buffalo, NY. **Janet M. Williams**, previously Professor of Emergency Medicine at the University of Rochester School of Medicine, currently serves as the Medical Director of Team Health/Exigence Rochester Immediate Care in Rochester, NY.





## Introduction

Asthma is a multifactorial chronic disorder of the air-

**Table 1. Key Indicators for Considering a Diagnosis of Asthma ***

**History**
- Cough, worse at night
- Recurrent wheeze
- Recurrent difficulty in breathing
- Recurrent chest tightness

**Review of symptoms**
- Symptoms occur or worsen
  - Exercise
  - Viral infections
  - Animals with fur or hair
  - House-dust mites
  - Mold
  - Smoke
  - Pollen
  - Changes in weather
  - Strong emotional expression
  - Airborne chemical or dusts
  - Menstrual cycles
  - At night, awakening the patient

**Physical exam**
- Wheezing

*Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].Consider a diagnosis of asthma and either performing or referring for spirometry if any of these key indicators are present

ways, characterized by variable and recurring symptoms, airflow obstruction, bronchial hyper-responsiveness, and an underlying chronic airway inflammation.[1-3] Inflammation is a central feature of asthma, and continues to be the foundation for assessment of asthma severity and control of the disease. The prevalence of asthma increased dramatically in the last decade,[4] and ambulatory care use for asthma has also continued to increase during this period.[2,5] These statistics suggest that urgent care facilities will continue to play a vital role in the short and long-term management of asthma patients.

It is essential that urgent care providers understand the underlying pathogenesis of asthma, and inquire about the risk factors associated with asthma exacerbations. The medical history and subsequent focused examination will provide the foundation for effective short-term management of asthma in the urgent care setting, and proper discharge planning in order to facilitate better long-term management of the disease.

## Epidemiology

Asthma data are reported as prevalence (percentage of current population) because there are no national mechanisms in place to measure incidence (rate at which new cases of asthma occur in a population).[3] Approximately 34 million Americans (24 million adults and 10 million children) have a diagnosis of asthma.[3,6-8] Approximately 12 million (35%) have an asthma exacerbation (a worsening in asthma symptoms that requires a change in the intensity of treatment to prevent further deterioration in clinical status) over a 1-year period.[2,3] The prevalence of asthma is higher in non-Hispanic African Americans and individuals with lower socioeconomic status.[2-4] The prevalence of asthma increased approximately 12.3% between 2001 and 2009, with an estimated $50.1 billion spent on asthma-related costs in the United States in 2010.[4,9] A percentage of these costs were generated by increased use of ambulatory care settings by patients who had an acute asthma exacerbation. Of note, the rates of emergency department (ED) visits, hospitalizations, and mortality for asthma have either held steady or, more importantly, declined over the last decade.[3] These patterns suggest that an increasing number of patients with acute asthma exacerbations may present to urgent care centers for treatment and short-term management. In addition, if the pattern of decreased ED visits and hospitalizations is to continue, it is imperative for urgent care providers to provide appropriate and adequate discharge instructions for patients with the goal of preventing future asthma exacerbations. Understanding the pathogenesis is a fundamental building block to this end.

## Pathophysiology

Central to the pathogenesis of asthma is presence of underlying airway inflammation.[1,3] Airway inflammation is the result of many cell types, whose interactions ultimately result in epithelial cell injury and subsequent airflow limitation. Airflow limitation results in airway hyperresponsiveness and/or airway obstruction, both of which result in clinical symptoms of cough, wheeze, and shortness of breath. These clinical symptoms present in a variety of severity patterns that reflect different aspects of the disease, such as intermittent versus persistent asthma, and well versus poorly controlled asthma. Understanding the fundamentals of asthma pathogenesis is a key factor in understanding the rationale behind both short-term and long-term management. Short-term management for asthma exacerbation is directed at controlling inflammation and airflow limitation, using drugs to reduce inflammation and relax the airway musculature in hopes of reversing air-

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**References: 1.** Asthma and Allergy Foundation of America. Allergy facts and figures. www.aafa.org/display.cfm?id=9&sub=30#_ftn1. Accessed January 23, 2014. **2.** Bromfed DM [package insert]. Morton Grove, IL: Morton Grove Pharmaceuticals, Inc; 2010. **3.** US Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research. *Approved Drug Products With Therapeutic Equivalence Evaluations*. 33rd ed. 2013. www.fda.gov/cder/orange/obannual.pdf. Accessed January 23, 2014.

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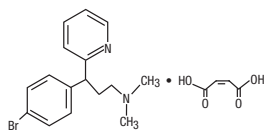

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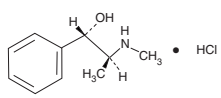
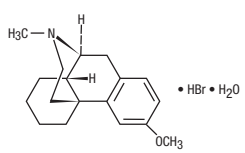
Brompheniramine Maleate, USP
(±)-2- *p*-Bromo-α-2-(dimethylamino)ethylbenzylpyridine maleate (1:1)



$C_{10}H_{15}NO \bullet HCl$ M.W. 201.69

Pseudoephedrine Hydrochloride, USP
(+)-Pseudoephedrine hydrochloride



$C_{18}H_{25}NO \bullet HBr \bullet H_2O$ M.W. 370.32

Dextromethorphan Hydrobromide, USP
3-Methoxy-17-methyl-9α, 13α, 14α - morphinan hydrobromide monohydrate

Antihistamine/Nasal Decongestant/Antitussive syrup for oral administration.

## CLINICAL PHARMACOLOGY

Brompheniramine maleate is a histamine antagonist, specifically an $H_1$-receptor-blocking agent belonging to the alkylamine class of antihistamines. Antihistamines appear to compete with histamine for receptor sites on effector cells. Brompheniramine also has anticholinergic (drying) and sedative effects. Among the antihistaminic effects, it antagonizes the allergic response (vasodilation, increased vascular permeability, increased mucus secretion) of nasal tissue. Brompheniramine is well absorbed from the gastrointestinal tract, with peak plasma concentration after single, oral dose of 4 mg reached in 5 hours; urinary excretion is the major route of elimination, mostly as products of biodegradation; the liver is assumed to be the main site of metabolic transformation.

Pseudoephedrine acts on sympathetic nerve endings and also on smooth muscle, making it useful as a nasal decongestant. The nasal decongestant effect is mediated by the action of pseudoephedrine on α-sympathetic receptors, producing vasoconstriction of the dilated nasal arterioles. Following oral administration, effects are noted within 30 minutes with peak activity occurring at approximately one hour.

Dextromethorphan acts centrally to elevate the threshold for coughing. It has no analgesic or addictive properties. The onset of antitussive action occurs in 15 to 30 minutes after administration and is of long duration.

## INDICATIONS AND USAGE

For relief of coughs and upper respiratory symptoms, including nasal congestion, associated with allergy or the common cold.

## CONTRAINDICATIONS

Hypersensitivity to any of the ingredients. Do not use in the newborn, in premature infants, in nursing mothers, or in patients with severe hypertension or severe coronary artery disease. Do not use dextromethorphan in patients receiving monoamine oxidase (MAOI) inhibitors (see **Drug Interactions**).

Antihistamines should not be used to treat lower respiratory tract conditions including asthma.

## WARNINGS

Especially in infants and small children, antihistamines in overdosage may cause hallucinations, convulsions, and death.

Antihistamines may diminish mental alertness. In the young child, they may produce excitation.

## PRECAUTIONS

**General:** Because of its antihistamine component, Bromfed® DM Cough Syrup should be used with caution in patients with a history of bronchial asthma, narrow angle glaucoma, gastrointestinal obstruction, or urinary bladder neck obstruction. Because of its sympathomimetic component, Bromfed® DM Cough Syrup should be used with caution in patients with diabetes, hypertension, heart disease, or thyroid disease.

**Information for Patients:** Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating dangerous machinery.

**Drug Interactions:** Monoamine oxidase (MAO) inhibitors-Hyperpyrexia, hypotension, and death have been reported coincident with the coadministration of MAO inhibitors and products containing dextromethorphan. In addition, MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines and may enhance the effect of pseudoephedrine. Concomitant administration of Bromfed® DM Cough Syrup and MAO inhibitors should be avoided (see **CONTRAINDICATIONS**).

Central nervous system (CNS) depressants-Antihistamines have additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, antianxiety agents, etc.).

Antihypertensive drugs-Sympathomimetic may reduce the effects of antihypertensive drugs.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Animal studies of Bromfed® DM Cough Syrup to assess the carcinogenic and mutagenic potential or the effect on fertility have not been performed.

**Pregnancy:**

**Teratogenic Effects – Pregnancy Category C:** Animal reproduction studies have not been conducted with Bromfed® DM Cough Syrup. It is also not known whether Bromfed® DM Cough Syrup can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. It should be given to a pregnant woman only if clearly needed.

Reproduction studies of brompheniramine maleate (a component of Bromfed® DM Cough Syrup) in rats and mice at doses up to 16 times the maximum human doses have revealed no evidence of impaired fertility or harm to the fetus.

**Nursing Mothers:** Because of the higher risk of intolerance of antihistamines in small infants generally, and in newborns and prematures in particular, Bromfed® DM Cough Syrup is contraindicated in nursing mothers.

**Pediatric Use:** Safety and effectiveness in pediatric patients below the age of 6 months have not been established (see **DOSAGE AND ADMINISTRATION).**

## ADVERSE REACTIONS

The most frequent adverse reactions to Bromfed® DM Cough Syrup are: sedation; dryness of mouth, nose and throat; thickening of bronchial secretions; dizziness. Other adverse reactions may include:

***Dermatologic:*** Urticaria, drug rash, photosensitivity, pruritus.

***Cardiovascular System:*** Hypotension, hypertension, cardiac arrhythmias, palpitation.

***CNS:*** Disturbed coordination, tremor, irritability, insomnia, visual disturbances, weakness, nervousness, convulsions, headache, euphoria, and dysphoria.

***G.U. System:*** Urinary frequency, difficult urination.

***G.I. System:*** Epigastric discomfort, anorexia, nausea, vomiting, diarrhea, constipation.

***Respiratory System:*** Tightness of chest and wheezing, shortness of breath.

***Hematologic System:*** Hemolytic anemia, thrombocytopenia, agranulocytosis.

## OVERDOSAGE

**Signs and Symptoms:** Central nervous system effects from overdosage of brompheniramine may vary from depression to stimulation, especially in children. Anticholinergic effects may be noted. Toxic doses of pseudoephedrine may result in CNS stimulation, tachycardia, hypertension, and cardiac arrhythmias; signs of CNS depression may occasionally be seen. Dextromethorphan in toxic doses will cause drowsiness, ataxia, nystagmus, opisthotonos, and convulsive seizures.

**Toxic Doses:** Data suggest that individuals may respond in an unexpected manner to apparently small amounts of a particular drug. A 2½-year-old child survived the ingestion of 21 mg/kg of dextromethorphan exhibiting only ataxia, drowsiness, and fever, but seizures have been reported in 2 children following the ingestion of 13-17 mg/kg. Another 2½-year-old child survived a dose of 300-900 mg of brompheniramine. The toxic dose of pseudoephedrine should be less than that of ephedrine, which is estimated to be 50 mg/kg.

**Treatment:** Induce emesis if patient is alert and is seen prior to 6 hours following ingestion. Precautions against aspiration must be taken, especially in infants and small children. Gastric lavage may be carried out, although in some instances tracheostomy may be necessary prior to lavage. Naloxone hydrochloride 0.005 mg/kg intravenously may be of value in reversing the CNS depression that may occur from an overdose of dextromethorphan. CNS stimulants may counter CNS depression. Should CNS hyperactivity or convulsive seizures occur, intravenous short-acting barbiturates may be indicated. Hypertensive responses and/or tachycardia should be treated appropriately. Oxygen, intravenous fluids, and other supportive measures should be employed as indicated.

## DOSAGE AND ADMINISTRATION

Adults and pediatric patients 12 years of age and over: 10 mL (2 teaspoonfuls) every 4 hours. Children 6 to under 12 years of age: 5 mL (1 teaspoonful) every 4 hours. Children 2 to under 6 years of age: 2.5 mL (½ teaspoonful) every 4 hours. Infants 6 months to under 2 years of age: Dosage to be established by a physician.

Do not exceed 6 doses during a 24-hour period.

## HOW SUPPLIED

Bromfed® DM Cough Syrup is a clear, light pink-colored, butterscotch-flavored syrup containing in each 5 mL (1 teaspoonful) brompheniramine maleate 2 mg, pseudoephedrine hydrochloride 30 mg and dextromethorphan hydrobromide 10 mg, available in the following sizes:

15 mL (Professional Sample-Not For Resale)
4 fl oz (118 mL)
1 Pint (473 mL)

RECOMMENDED STORAGE

**Store at 20 ° to 25 °C (68 ° to 77 °F) [See USP Controlled Room Temperature].**

**KEEP TIGHTLY CLOSED**

Dispense in a tight, light-resistant container as defined in the USP.

**Rx Only**

Product No.: 8837



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**Table 2. Risk Factors for Death From Asthma***

**Asthma history**
- Previous severe exacerbation requiring intubation or intensive care unit admission for asthma
- Two or more hospitalizations for asthma in the past year
- Three or more emergency department (ED) visits for asthma in the past year
- Hospitalization or ED visit for asthma in the past month
- Using >2 canisters of a short-acting beta$_2$-agonist per month
- Using >2 canisters of a short-acting beta$_2$-agonist per month
- Sensitivity to Alternaria

**Social history**
- Low socioeconomic status
- Inner city residence
- Illicit drug use
- Major psychosocial problems

**Comorbidities**
- Cardiovascular disease
- Other chronic lung disease
- Chronic psychiatric disease

**Other**
- Lack of a written asthma plan

*Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].

**Table 3. Differential Diagnosis of Asthma in Infants, Children, and Adults***

**Infants and Children**
- Upper airway disease
  - Allergic Rhinitis and Sinusitis
- Obstructions involving large airways
  - Foreign body in trachea or bronchus
  - Vocal cord dysfunction
  - Vascular rings or laryngeal webs
  - Laryngotracheomalacia
  - Tracheal stenosis
  - Bronchostenosis
  - Enlarged lymph nodes
  - Tumor
- Obstructions involving small airways
  - Bronchiolitis
  - Cystic Fibrosis
  - Bronchopulmonary dysplasia
  - Heart disease
- Other
  - Recurrent cough not due to asthma
  - Aspiration (swallowing defect or reflux disease)

**Adults**
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Pulmonary embolism
- Pulmonary disease (i.e. fibrosis, eosinophilia)
- Tumor
- Vocal cord dysfunction
- Drugs, including pharmaceuticals (i.e. angiotensin converting enzyme inhibitors)

*Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].

flow obstruction. While short-term management can, to a large extent, reverse some of these processes, reversibility of airflow limitation may be incomplete in some patients with asthma. Long-term management is directed at prevention, through avoidance of triggers, and using drugs that help to reduce airway inflammation, airway hyper-responsiveness, and airflow obstruction. Understanding the rationale behind short and long-term management will lead more efficient assessment and management of patients presenting to an urgent care center with suspected asthma exacerbation.

## Medical History and Exam

Patients may present to an urgent care center without a known diagnosis of asthma. While it may not be practical to *diagnose* asthma in the urgent care setting, an urgent care provider can at least *suspect the diagnosis* and provide appropriate follow-up care for a patient. A patient's medical history is essential in establishing whether a diagnosis of asthma is a consideration. Although short-term management of a patient in respiratory distress may be similar in different diseases, establishing a specific diagnosis of "asthma exacerbation" is particularly important in patients without a known diagnosis for proper short-term and long-term management. The provider trying to establish a diagnosis of asthma should determine that episodic symptoms of airflow obstruction are present and that airflow obstruction is at least partially reversible. Alternative diagnoses should be excluded.[1]

**Table 1** highlights key indicators that have been suggested by the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3 (EPR-3) for considering a diagnosis of asthma. Although these indicators are not by themselves diagnostic, multiple key indicators increase the likelihood of a diagnosis of asthma.[1] In the initial history and review of symptoms, an urgent care provider should attempt to identify precipitating factors (e.g., exposure at home, work, daycare, or school to inhalant allergens, or irritants such as tobacco smoke, or

**Table 4. Components and Classification of Asthma Severity***

| Components of Severity | | Age Group | Classification of Severity | | | |
|---|---|---|---|---|---|---|
| | | | | Persistent | | |
| | | | Intermittent | Mild | Moderate | Severe |
| Impairment<br>Normal $FEV_1/FVC$:<br>8-19 years: 85%<br>20-39 years: 80%<br>40-59 years: 75%<br>60-80 years: 70% | Symptoms | 0-4<br>5-11<br>≥12 | ≤2 days/week | >2 days/week but not daily | Daily | Throughout the day |
| | Nighttime awakenings | 0-4 | 0 | 1-2 times a month | 3-4 times a month | >1 time a week |
| | | 5-11<br>≥12 | ≤2 times per month | 3-4 times a month | >1 time a week, but not nightly | Often, 7 times a week |
| | Short-acting $beta_2$-agonist use for control (not prevention) | 0-4<br>5-11<br>≥12 | ≤2 days/week | >2 days/week but not daily<br>>2 days/week but not >1 time per day | Daily | Several times per day |
| | Interference with normal activity | 0-4<br>5-11<br>≥12 | None | Minor limitation | Some limitation | Extremely limited |
| | Lung Function | 0-4 | N/A | N/A | N/A | N/A |
| | | 5-11 | • Normal $FEV_1$ between exacerbations<br>• $FEV_1$ >80% predicted<br>• $FEV_1/FVC$ > 85% | • $FEV_1$ = 80% predicted<br>• $FEV_1/FVC$ >80% | • $FEV_1$ = 60-80% predicted<br>• $FEV_1/FVC$ = 75-80% | • $FEV_1$ <60% predicted<br>• $FEV_1/FVC$ <75% |
| | | ≥12 | • Normal $FEV_1$ between exacerbations<br>• $FEV_1$ >80% predicted<br>• $FEV_1/FVC$ normal | • $FEV_1$ ≥80% predicted<br>• $FEV_1/FVC$ normal | • $FEV_1$ >60 but <80% predicted<br>• $FEV_1/FVC$ reduced 5% | • $FEV_1$ <60% predicted<br>• $FEV_1/FVC$ reduced 5% |
| Risk | Exacerbations requiring oral systemic corticosteroids | 0-4 | 0-1/year | ≥2 exacerbations in 6 months requiring oral steroids, or ≥4 wheezing episodes per year lasting >1 day AND risk factors for persistent asthma | | |
| | | 5-11<br>≥12 | | ≥2 exacerbations requiring oral steroids in 1 year | | |

*Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].

viral respiratory infections) and comorbidities that may aggravate asthma (e.g., sinusitis, rhinitis, gastroesophageal reflux disorder, obstructive sleep apnea).

The physical exam should focus on the upper respiratory tract, chest, and skin. Physical findings that increase the probability of asthma include[1]:

- *Hyperexpansion of the thorax,* especially in children; use of accessory muscles; appearance of hunched shoulders; and chest deformity
- *Sounds of wheezing during normal breathing, or a prolonged phase of forced exhalation* (typical of airflow obstruction). Wheezing may only be heard during forced exhalation.
- *Increased nasal secretion, mucosal swelling, and/or nasal polyps*
- *Atopic dermatitis/eczema* or any other manifestation of an allergic skin condition.

Note that wheezing is not a reliable indicator of airway limitation; however, it is the *only* physical exam finding that has been suggested as a key indicator for likelihood of a diagnosis of asthma. Although hyperexpansion of the thorax, nasal findings (i.e. nasal polyps), and skin findings (i.e. eczema) are often associated with asthma, they have not been suggested as key indicators by the EPR-3.

Once a diagnosis of asthma is suspected, the provider should consider risk factors associated with worse outcomes (**Table 2**), which may become important when considering discharge and follow-up.

Laboratory testing is essential in assessing the severity of a patient's presentation. The EPR-3 recommends that office-based physicians who care for asthma patients have access to spirometry. For diagnostic purposes, spirometry is generally recommended over measurements with a peak flow meter because there is wide variability even in the published predicted peak expiratory flow (PEF) reference values. Spirometry, which meas-

ICD 10

**CODE: W58.03XD**
Crushed by alligator, subsequent encounter

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**Table 5. Components and Classification of Asthma Control***

| Components of Control | | Age Group | Classification of Control | | |
|---|---|---|---|---|---|
| | | | Well Controlled | Not Well Controlled | Poorly Controlled |
| Impairment | Symptoms | 0-4 | ≤2 days/week | >2 days/week | Throughout the day |
| | | 5-11 | ≤2 days/week but not more than once on each day | >2 days/week or multiple times on ≤2 days/week | |
| | | ≥12 | >2days/week | >2 days/week | |
| | Nighttime awakenings | 0-4 | ≤1 time a month | >1 time a month | >1 time a month |
| | | 5-11 | | ≥2 times a month | ≥2 time a week |
| | | ≥12 | ≤2 times a month | 1-3 times per week | ≥4 time a week |
| | Short-acting $beta_2$-agonist use for control (not prevention) | 0-4 | ≤2 days/week | >2 days/week but not daily | Several times per day |
| | | 5-11 | | >2 days/week | |
| | | ≥12 | | | |
| | Interference with normal activity | 0-4 | None | Some limitation | Extremely limited |
| | | 5-11 | | | |
| | | ≥12 | | | |
| | Lung Function | 0-4 | N/A | N/A | N/A |
| | | 5-11 | • $FEV_1$ or peak flow >80% predicted or personal best<br>• $FEV_1$/FVC >80% | • $FEV_1$ or peak flow 60-80% predicted or personal best<br>• $FEV_1$/FVC 75-80% | • $FEV_1$ or peak flow <60% predicted or personal best<br>• $FEV_1$/FVC <75% |
| | | ≥12 | • $FEV_1$ or peak flow >80% predicted or personal best | • $FEV_1$ or peak flow 60-80% predicted or personal best | • $FEV_1$ or peak flow <60% predicted or personal best |
| | Validated questionnaires:<br>• ATAQ[a]<br>• ACQ[a]<br>• ACT[a] | 0-4 | N/A | N/A | N/A |
| | | 5-11 | | | |
| | | ≥12 | • 0<br>• ≤0.75[b]<br>• ≥20 | • 1-2<br>• ≥1.5[b]<br>• 16-19 | • 3-4<br>• N/A<br>• ≤15 |
| Risk | Exacerbations requiring oral systemic corticosteroids | 0-4 | 0-1/year | 2-3 times per year | >3 times per year |
| | | 5-11 | | ≥2 exacerbations requiring oral steroids in 1 year | |
| | | ≥12 | | | |
| | Reduction or progressive loss of lung function | 0-4 | N/A | | |
| | | 5-11 | Evaluation requires long term follow-up care | | |
| | | ≥12 | | | |
| | Treatment-related adverse effects | 0-4 | Consider treatment-related effects in the overall assessment of risk. Patients with worrisome treatment-related side effects may be at higher risk of poor control (i.e. non-compliance). | | |
| | | 5-11 | | | |
| | | ≥12 | | | |

*Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].
a. Asthma Control Questionnaire (Juniper et al. 1999)[11]; Asthma Therapy Assessment Questionnaire (Vollmer et al. 1999)[12]; Asthma Control Test (Nathan et al. 2004)[13]
b. ACQ values of 0.76-1.4 are intermediate regarding well controlled asthma. Another validated questionnaire might be more useful

ures the rate at which the lung changes volume during forced breathing maneuvers, should be performed using equipment and techniques that meet standards developed by the American Thoracic Society. Basic spirometry can be performed in the urgent care setting with relative ease and inexpensive equipment (CPT code 94010 for normal spirometry and both CPT codes 94010 and 94060 for abnormal spirometry with the addition of a pre versus post bronchodilator spirometry test).

Normal spirometry implies a forced vital capacity (FVC) and forced expiratory volume in 1 second ($FEV_1$) of 80% to 120% predicted, and an absolute $FEV_1$/FVC ratio >0.7. The normal ranges for spirometry values vary depending on a patient's height, weight, age, sex, and racial or ethnic background. Contraindications to spirometry include vomiting, nausea, vertigo, hemoptysis, pneumothorax, recent abdominal surgery, recent eye surgery, recent myocardial infarction or unstable angina, and thoracic aneurysms.[10] If a diagnosis of asthma is not already documented, and cannot be established with spirometry in the urgent care setting, PEFs can act as surrogate data. Any abnormal results should be documented by the provider and the patient should be referred back to either a primary care provider or a

specialist with a "suspected diagnosis" of asthma exacerbation.

A differential diagnosis should be established (**Table 3**), with additional laboratory testing in to rule out other possible etiologies. Once a suspected diagnosis of asthma exacerbation has been established, information obtained from the diagnostic evaluation should be used to characterize a patient's asthma severity and control in order to guide decisions for therapy (**Tables 4 and 5**).[11-13] For clinical management, the emphasis should be on assessing asthma severity for initiating therapy and assessing control for monitoring and adjusting therapy.[1] Asthma severity is defined by the EPR-3 as the intrinsic intensity of the disease process,[1] or the difficulty in controlling asthma with the patient's current treatment.[3] Severity is most easily measured in a patient not receiving long-term-control therapy,[1] and should be evaluated after exclusion of modifiable factors such as poor adherence, smoking, and comorbidities. Severity largely reflects the required level of treatment and the activity of the underlying disease state during initial treatment.[3] During a patient's initial presentation, if he or she is not currently taking long-term control medication, asthma severity is assessed to guide clinical decisions on the appropriate medication and other therapeutic interventions.[1] Asthma control is defined by the EPR-3 as the degree to which the manifestations of asthma (symptoms, functional impairments, and risks of untoward events) are

*"If a diagnosis of asthma is not already documented, and cannot be established with spirometry in the urgent care setting, PEFs can act as surrogate data."*





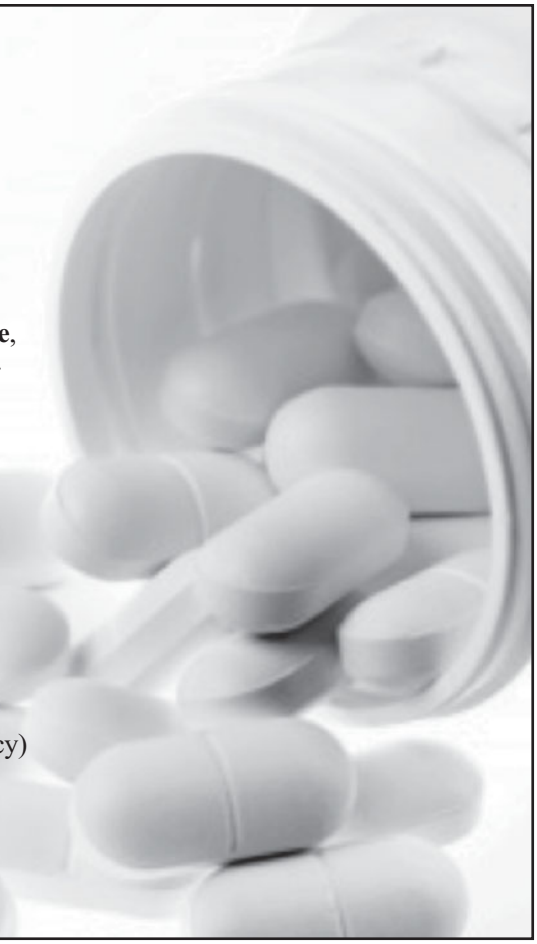

**TABLE 6. Classifying Severity of Asthma Exacerbations and Control in the Urgent Care Setting***

| | | | |
|---|---|---|---|
| Mild | Dyspnea only with activity, or tachypnea in young children | PEF ≥70% predicted or personal best | • SABA as needed should provide prompt relief<br>• Possible short course of oral systemic corticosteroids |
| Moderate | Dyspnea interferes with or limits usual activity | PEF 40% to 69% of predicted or personal best | • Scheduled inhaled SABA use should provide relief<br>• Oral systemic corticosteroids Symptoms may persist for 1-2 days after treatment is begun |
| Severe | Dyspnea at rest; interferes with conversation | PEF <40% of predicted or personal best | • Scheduled inhaled SABA use should provide relief<br>• Oral systemic corticosteroids Symptoms may persist for >3 days after treatment is begun<br>• Adjunctive therapies might be helpful<br>• May require admission |
| Life-threatening | Too dyspneic to speak; perspiring | PEF <25% predicted or personal best | • Minimal or no relief from inhaled SABA<br>• Intravenous corticosteroids<br>• Adjunctive therapies might be helpful<br>• Requires admission |

*Adapted from the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report [EPR-3].

SABA = Short-acting beta$_2$-agonist; FEV = forced expiratory volume; PEF = peak expiratory flow

minimized and the goals of therapy are met.[1] Asthma control not only encompasses a patient's current clinical state, but also considers future risk. If a patient has a documented established diagnosis, the emphasis for clinical management should be on assessment of asthma severity and control. The level of asthma control will guide decisions to either maintain or adjust therapy.[1] Asthma severity and control should be based on both the patient's impairment over the last 2 to 4 weeks and the most severe impairment or risk category. In patients aged 5 years and older, spirometry or peak flow measurements should also be used to assess asthma control. **Table 6** outlines an example of how asthma severity and control might be assessed in the urgent care setting based on the EPR-3 guidelines.

## Conclusion

The increase in prevalence of asthma with increasing presentations to ambulatory care settings presents unique opportunities in short and long-term management for the urgent care provider. An appreciation of the fundamental pathogenesis of airway inflammation in asthma and the variable, interactive expressions of airway hyperesponsiveness and airway obstruction will give an urgent care provider a better understanding of the opportunities to control the disease. Suspecting a diagnosis of "asthma exacerbation" is particularly important in the patient without a known diagnosis for proper short-term and long-term management. Knowledge of key indicators for a diagnosis of asthma on history and examination is important in further evaluating risk factors for worse outcomes in patients with asthma. Part 2 of this topic, in a subsequent issue, will review both the short- and long-term management of the disease in the urgent care setting. ■

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10 years

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# Expert Perspectives on Grassroots Marketing in Urgent Care

**Urgent message:** Grassroots marketing tactics can be effective in engaging a center's providers and staff with the communities they serve while also educating prospective patients about the availability of urgent care.

## Introduction

This roundtable focuses on grassroots marketing for urgent care centers, which differs from traditional advertising in that it involves more interaction with prospective patients and requires a hands-on approach to building relationships and spurring word-of-mouth in the community. The panel of experts we've assembled will share their unique perspectives and experience in use of marketing techniques beyond traditional advertising media to help educate and inform urgent care providers about methods they might adopt for grassroots marketing in their own centers.

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## Grassroots and community marketing as part of a center's overall marketing plan

***Alan Ayers:*** What is the role of grass roots and community marketing in your center's overall marketing plan?

***Tina Bell:*** Healthcare Express has seven urgent care centers in four states; two more centers will be opening in the spring. Roughly 80% of our marketing plan is focused around community marketing and we hire community educators in each community we're in. Our organization is dedicated to giving back to the community and to growing through the positive word-of-mouth generated by community involvement.

***Hillary Myers:*** Lansing Urgent Care has three urgent care centers, all in greater Lansing, and about 40% of my resources and budget each year are dedicated to grassroots and community marketing. We are highly tradi-

PARTICIPANTS: **Alan A. Ayers, MBA, MAcc** (moderator), Content Advisor, Urgent Care Association of America, Associate Editor, *JUCM*, and Vice President, Concentra Urgent Care; **Tina Bell**, Director of Marketing and Chief Brand Officer for Healthcare Express Urgent Care and Occupational Medicine Clinic, Texarkana, TX; **Gary Derk**, Associate Director of Field Marketing for MedExpress Urgent Care, Morgantown, WV; **Felicia S. Fortune**, Director of Marketing for American Family Care, Hoover, AL; and **Hillary Myers**, Director-Business Development and Marketing for Lansing Urgent Care, Lansing, MI;

tional, but sponsorship of community events is a huge part of what we do and what my team does in terms of attending, supporting and planning these events.

***Gary Derk:*** Grassroots marketing plays a fairly large role in every market that MedExpress Urgent Care is in. Our goal is to maintain a local feel for the 127 centers we have in nine different states. Grassroots and community marketing really gives us the ability to react quickly to whatever is going on in a market, which is especially important for newer centers as well. It offers a good avenue to support our overall campaign calendar.

***Felicia Fortune:*** American Family Care has 44 urgent care centers open 4 states (AL, GA, TN and FL) and another 16 in development. Anywhere from 50% to 60% of our marketing effort is devoted to grassroots and community marketing. We do sports-related community events, health fairs involving churches and we sponsor health-related nonprofit organizations and participate in health expos to "give back" to the community. Our "Meet the Doctor" events are designed to help increase patient volume for new doctors and clinics or older facilities that are not seeing a lot of patients. We encourage community members to come out to "Meet the Doctor," get a blood pressure check, and learn about our services and hours of operation. We also set up onsite flu clinics and health fairs where patients can get a flu shot during flu season; at other times, we may offer glucose testing or cholesterol screening.

## Staffing for and Execution of Grassroots Marketing Campaigns

***Alan Ayers:*** Who in your organization is responsible for identifying and executing grassroots marketing opportunities?

***Tina Bell:*** We have a community educator in each market who identifies specific opportunities. At the end of every year, we also ask all of our team members which organizations they want to support and what kind of activities they want to be involved in throughout the next year. We rely not just on the community educators but very, very heavily on a volunteer effort within the community from all of the team members at our different clinics. We want our community educators to be very, very passionate about giving back to the community and all of our team members to also share that spirit because it is such an important part of our plan for marketing and for growth. Team members include front office staff, medical assistants, and physicians and they are required to participate in at least two

community events a year.

***Alan Ayers:*** Could you describe the role of the "Community Educator"?

***Tina Bell:*** Our community educators are empowered to go out and educate and teach people on a daily basis. They help answer questions about what an urgent care center does and what an occupational medicine clinic does. Ninety percent of patient complaints relate to not understanding insurance billing and our community educators can help answer those questions. They used to be called "marketing coordinators" but we didn't want them to feel like they were out there marketing and selling our company.

*"We rely on local staff to be the local eyes and ears of the community and when they identify something that will help the community, we support what they want to accomplish."*

**Gary Derk**

***Alan Ayers:*** Hillary, in your organization, who is responsible for identifying and executing grassroots marketing opportunities?

***Hillary Myers:*** With our model, every employee of Lansing Urgent Care shares what organizations or community groups are important to them. I oversee all of the grassroots activities and coordinate and determine what we're going to focus our efforts on in a given year. We also require that every staff member participate in at least one event per year, although some people come to every event.

***Alan Ayers:*** What is your process for gathering input from team members about organizations, community groups, or events? Do you send out a survey or is there a sign-up period for each event?

***Hillary Myers:*** We use our intranet to notify staff about upcoming events a month in advance and through the home page, they can volunteer electronically. The calendar is very visible and the volunteer information can be integrated into an individual's schedule request down the road, which is important if an event has special meaning to a staff member.

***Alan Ayers:*** Gary, your organization has a footprint spread out over a larger area. Who in it is responsible for identifying and executing the grassroots marketing opportunities?

***Gary Derk:*** We have marketing teams in each of our regions. A field marketing manager in each region takes a high-level view of how we are marketing in that specific area, overseeing national and statewide relationships and sponsorships.The field marketing coordinators, in contrast, are focused specifically on grassroots efforts and community involvement. They help to bring to fruition what staff at individual urgent care centers want to do. Their job is to support our staff because our best marketing tool are our centers and we want to get the people who are providing great care out into the community. We could have just our field marketing coordinators doing the events, but we think it's better that people also see the staff who are going to take care of them when they come to MedExpress as patients. So, it's a team effort. We rely on local staff to be the local eyes and ears of the community and when they identify something that will help the community, we support what they want to accomplish.

***Alan Ayers:*** Felicia, who at American Family Care is responsible for grassroots marketing activities?

***Felicia Fortune:*** With our model, I rely heavily on our clinic managers to help me identify community events. The CEO and President of AFC are responsible for major sponsorship opportunities. We use a "team approach" to identify successful activities in the community.

## Dealing With Budgetary Issues

***Alan Ayers:*** What type of budget do you allocate for grassroots marketing activities?

***Tina Bell:*** Our budgets differ by market, depending upon what activities are going on in a given market. In a market with a single clinic in a smaller town, we may spend as little as $800 a month, whereas in one with multiple clinics, it may be as much as $6,500 a month. Every November, our team looks at the previous year's events and plans for events and budget for the coming year.

***Hillary Myers:*** Our three clinics are all in the same community and grassroots marketing accounts for about 40% of our overall budget, which may be as much as triple what other urgent care centers are spending. We, too, look at the activities we've done each year and track and plan for the following year based on feedback from our patients. We track social media activity leading up to and following certain events or initiatives against the information that we've put out there. We take into account that social media "buzz" and while certain events are more expensive, the resulting exposure is greater as well. We also align ourselves with organiza-

tions that are trying to come up with new and different ways of supporting the community. For example, we work very closely with a children's museum in Lansing and every year they come up with new ways in which to drive membership and interest in support of that museum. We are learning from them as they go.

***Alan Ayers:*** How specifically do you get feedback from patients on your grassroots marketing activities? Do you ask on the intake form for new patients at registration?

***Hillary Myers:*** Our electronic medical record includes a required field for new patients that can be modified to capture information as specific or as broad as we'd like. We sometimes use that field to ask about specific events and sometimes ask about the broad category of events.

***Alan Ayers:*** Gary, what type of budget does MedExpress have for grassroots marketing?

***Gary Derk:*** I'm sure all of the panelists would agree that there is never enough money for grassroots marketing. Like the other organizations, our budget has regional variance, and as we grow across the nation, we find that in some areas, the public is a little more educated about urgent care than in other areas. So, it's important for us to educate consumers, not only about MedExpress, but also about what urgent care as a specialty has to offer. The level of awareness of urgent care plays a large role in determining on how much time, effort and money we spend in a specific community on education.

***Alan Ayers:*** How do you gauge a community's awareness of urgent care?

***Gary Derk:*** Our analytics department looks at the number of urgent care centers and utilization of emergency departments in a region vs. primary care vs. urgent care centers (if they do exist). Members of our marketing team also go out into the community and survey the public about what options they have for care and where they would prefer to go for care if they were sick or hurt. We do a lot of due diligence when we move into a market because we want to be as efficient as we can with our staff.

***Alan Ayers:*** Felicia, what is American Family Care's budget for grassroots marketing?

***Felicia Fortune:*** Grassroots marketing accounts for approximately 50% to 60% of our overall marketing budget and we allocate approximately $500 to $1,000 per center per year, depending on a center's location and need to raise awareness. If, for example, a single event that costs $750 will achieve the awareness we're trying to get, then we'll add to that center's overall budget so they are not left with just $250 for the rest of the year.

## Measuring Return on Investment

***Alan Ayers:*** How do you measure the financial return on investment (ROI) for grassroots marketing? In my experience, that's the number one question that comes up about it. But urgent care isn't a discretionary purchase so measuring ROI can be very difficult because of the time lag between an event and a community member's use

of a center.

***Tina Bell:*** We don't have a true way to measure so I can't tell you we spent $2500 on this event and it brought "x" number of patients to the door and so our true ROI is such and such a percentage. We do have systems in place for measuring ROI for traditional marketing, but what we really look at with grassroots efforts is social media. What type of responses are we getting from the community and participation in those events? We pull a "how did you hear about us" report on a monthly basis and one of the things we ask about is community events. We also look at how many e-mail addresses we collected at an event because e-mail marketing is a big part of our overall plan. The big thing we've learned over the 8 years since the first Healthcare Express opened is that we can expect an increase in patient growth at an urgent care center 3 to 6 months after we put in place a good community educator who follows our marketing plan—especially the grassroots side—and who really gets out there and talks to people. If we don't have those community educators out in the community talking to people, our patient numbers will show that, too, about 3 to 6 months down the road.

*"We can expect an increase in patient growth at an urgent care center 3 to 6 months after we put in place a good community educator who follows our marketing plan—especially the grassroots side."*

**Tina Bell**

***Alan Ayers:*** What type of social media are you looking at and how do you evaluate responses to it?

***Tina Bell:*** Facebook is our primary social media tool. We have Instagram and Pinterest accounts but they are not as active. We post pictures from our events on Facebook and track how many people "like" the pictures and comment about the events and whether they were excited that we were going to be there. For example, last year, one community had its first Mardi Gras parade and there was confusion about where it was happening. So, we used our Facebook page to tell people we were going to be there and we provided information on our booth and a map of the parade route. We had more clicks on that page for the parade map than anything else we had ever posted, so we know that a lot of our patients and Facebook fans were following us. Looking at the "likes" and the interaction on the page is important.

***Alan Ayers:*** Hillary, how does Lansing Urgent Care measure financial return on grassroots marketing?

***Hillary Myers:*** We collect as much data as possible from our patients but that is challenging because they are not always feeling their best when they come here, so their memory doesn't always serve them that well. For us, grassroots marketing has a twofold return on investment. One is the financial impact in terms of the number of new patients and the existing patient base it helps us retain. The second return is what it does for our staff as community members who get to interact with patients outside of our walls. The feeling that they get, knowing that their company is representing and participating in a charity that means something to them, is a retention tool. It's fantastic when our staff is out shaking hands, kissing babies, and talking to everyone in the community and a neighbor says, "I had no idea you worked for Lansing Urgent Care." Our company has grown year over year for the past 8 years and our budgets dedicated to traditional and grassroots efforts have also continued to increase. There is a correlation and it's hard to pinpoint it exactly, but we're confident that what we're doing is working.

***Alan Ayers:*** Tina, have you had a similar experience with staff engagement or impact?

***Tina Bell:*** When we hire, we tell candidates that we're looking for people who want to give back to the community because that is a huge part of our company culture. In every community we're in, one of the things we're most known for is community service and it helps us attract and retain candidates. They see that we're really big on having a fun workplace and that the fun and family environment carries over to the community events that we do. Every year, we have 100% participation in the Susan G. Komen Race for the Cure in the Texarkana market, and it's had a great, great positive impact on the staff in both recruitment and retention.

***Alan Ayers:*** Gary, how does MedExpress measure financial return on grassroots marketing activities?

***Gary Derk:*** The ultimate goal is to increase new revenue while maintaining an increase in patient loyalty but as the other panelists have mentioned, we also reap benefits in employee morale and accountability. By setting our center teams up for success in getting out into the communities, we've seen the culture shift in our centers to where a center's staff is excited to see their center suc-

ceed. We look at it as it's the staff's center and their business and they're going to promote it and help it succeed.

To measure ROI, we use a site called "Patient Impact." Every patient that comes into MedExpress receives a survey and an e-mail address through which they can help give feedback about how they heard about us. Word of mouth is the most common way that folks hear about any business, but it can mean a number of things. We also drill down on community events. For example, if we send out a direct mail piece or distribute flyers about free flu shots, we cross-reference the names on the distribution list against the names of patients who came to our center at 30, 60, or 90 days later to see if there is a correlation. Our Facebook page has more than 10,000 "likes" right now and we use it as a way to communicate to a large number of people for a number of reasons. Right now, for example, we're talking about winter ailments such as colds and flu on Facebook. Field marketing does help increase our social media exposure. For example, we might collaborate with a local school system on a "banner contest" in which students support their local athletic team by creating banners with a MedExpress logo. We post the banners on Facebook, friends and family vote for best banner, and the winning school's athletic department gets a donation from us. It's a win-win-win for everybody. It educates folks about MedExpress and urgent care in general and the schools have a lot of fun with it.

Colleges and universities are a major area of our focus. Being a parent, I know what it's like to have a child away at school who calls home unsure about where to go for medical care. We want to help educate both the students and their parents about urgent care and let them know that they'll receive great care at any MedExpress location.

***Alan Ayers:*** Felicia, how does your organization measure ROI for grassroots marketing?

***Felicia Fortune:*** We routinely ask patients how they heard about us, record that information in the patient's electronic medical record, and track changes in the

clinic's patient volume. If there has been an increase in patient volume and revenue, then the employees are rewarded from a program called "PS: It's All About YOU!" Our goal is 100% patient satisfaction for all our patients. These factors determine whether our ROI was a success. The employees receive a bonus and the patients receive exceptional customer service.

## Grassroots and Community Marketing Success Stories

***Alan Ayers:*** What types of grassroots and community marketing activities has your organization found to be most effective and why?

***Tina Bell:*** The most effective thing we've done is create a mascot who makes appearances at school systems and community events. We never dreamed, when we brought him on 3 years ago, that Klondike would become as recognizable in the community to some people as Tony the Tiger is to Frosted Flakes. Everywhere we go, little kids say, "There's Klondike, there's Klondike." Klondike spends a large part of his time at athletic events, daycare centers, and schools because those venues are most beneficial for us. (Our CEO is a fan of polar bears and she suggested him as a mascot and our team agreed. Klondike is a big hit because he's unusual in the south but I wouldn't recommend that anybody get a white mascot because his feet are really, really difficult to keep clean.)

Also, when the flu hit hard recently in Texas, we created flu kits to take to area schools and restaurants as our way of giving back. We talked to people one-on-one about what we do and how to stay safe from the flu. Not only was it effective from the PR side but we also got lots of e-mails from individuals and one lady posted on Facebook how grateful she was that we had come to her business. In four communities, we got front-page press coverage. It was really an effective grassroots activity.

***Alan Ayers:*** I understand that you use the mascot for photo opportunities and share the photos with the participants at these events. Could you provide a little bit more detail about that?

***Tina Bell:*** We usually do a 20-minute educational presentation at daycare centers, after which kids can take pictures one-on-one with Klondike. They get a coloring page to take home that has a letter on the back that tells the parents that their child's photo was taken today at the daycare with Klondike the healthcare bear. It gives a unique photo number and an e-mail address to which they can write to get their child's photo and explains that by accepting the photo, they agree to be added to the list for our e-mail newsletter. We originally posted the photos on Facebook but that posed privacy issues so we switched to the individual photos. That has worked out better in the long run because we get to do the ongoing communication with the parents and build a relationship through our patient newsletter.

***Alan Ayers:*** Hillary, what types of grassroots and community marketing activities has Lansing Urgent care found to be most effective and why?

***Hillary Myers:*** Michigan State University is adjacent to two of our urgent care centers so we do a lot of college events and they've been very successful. We give the students free stuff because they love free stuff and it affords the opportunity to talk to them. Still, it's tough to pinpoint how college students get their information because it changes so fast. Every year I have a new crop of freshmen to whom I have to introduce myself to and I work hard to get their business during their tenure at the school. College students tend to think they are indestructible and they are fairly healthy for the most part. When they're away from home, as was mentioned, they often turn to Mom & Dad to make decisions about health care, so some of our events are for parents as well. We've been invited to some of the open houses that the university hosts, which is just an incredible opportunity to introduce us to college students and their parents.

We've also been focusing on business-to-business effort aimed at getting referrals from primary care offices. We have an extremely strong and growing relationship with approximately 60 different primary care, pediatric, and internal medicine offices in great Lansing. Our goal is to educate them and their staff about who we are, what we do, and how we are there to support their efforts and not to compete with them. At first, they were very skeptical and reluctant to introduce their patients to an urgent care for fear of competition. Once they understood our services and processes for referral back to primary care for follow up, we developed a strong referral business. To break the ice, what we did was to spend an hour or two in the break room of a primary care practice talking to staff over a gourmet catered lunch that we provided. It's been very successful and we now do a lunch with each practice twice a year and we also collaborate with them on charitable events and activities.

***Alan Ayers:*** I appreciate your perspective on primary care referrals because urgent care operators often forget to put effort into making and keeping those relationships.

Gary, what types of grassroots and community marketing activities has MedExpress found to be most effective?

***Gary Derk:*** Our approach has changed over the years as

we've grown from a single center to 127 but we've continued to try to maintain a local feel while going global, which can be difficult. One way we accomplish that is with the "MedExpress Ambassador Program," which empowers our center staff to get out there and get involved. When a center opens or a center manager comes onboard, representatives from the regional marketing team review with the manager how we do community marketing and the local tapestry segmentation and they work together on an annual plan. We offer our expertise from a marketing standpoint but also take into account their local expertise in the market, which is important and can't be discounted.

Sitting down and explaining how we really want to be a direct reflection of their business has also worked well in helping primary care practices become comfortable referring their patients to a place where they are going to receive quality care. The MedExpress Ambassador Program really gives us the optics into the local market via our center staff to know where we should be going and how much time we should be spending in each location.

***Alan Ayers:*** Felicia, what grassroots activities has American Family Care found to be effective?

***Felicia Fortune:*** Our "Meet the Doctor" community health fairs have been most effective because community members actually get a chance to see who's going to be their physician before they need care and they learn about the services that we offer. That eliminates patients coming into the center and saying, "I didn't know you had full lab or full x-ray." The community health fairs give us a chance to reach a lot of people with information and to do different kinds of screenings. We market to daycare centers and schools and this gets the word out that our clinics see pediatric patients and do sports physicals.

## Lessons Learned From Grassroots Activities

***Alan Ayers:*** Have you found any types of grassroots or community activities that have not worked for your organization?

***Gary Derk:*** Some things work better than others and it's a lot of trial and error when it comes to type of initiative. If a center manager really wants to support a community event that doesn't hit our target market, we will try to find a way to get involved. It may turn out to be valuable or a center manager may learn that it's not the best investment of our time. An example might be a Harley Davidson rally. People aren't really there to learn about healthcare but we can't discount the sheer number of people that such an event will attract. Some activities provide better ROI than others, but we like to be involved in the community in all aspects.

***Alan Ayers:*** Tina, are there any grassroots or community marketing activities that have not worked for Healthcare Express? Can you provide some insight as to why?

***Tina Bell:*** When I first started, we were inundated with sponsorship requests. We quickly realized that if we're donating money or supporting an event, we have to be able to talk to people one-on-one as part of the outreach. The exception is donation of school supplies. Just having your name on a banner is great for branding but we just

truly didn't see any other return on that. We had a marketer who was convinced that handing out water to runners at every 5K run in our community was the thing to do. We let her try it but by the fourth one, she realized that the events attract people who aren't necessarily from the community and runners have no clue who is providing the water they grab and there is no opportunity to talk one-on-one. So, we scratched giving out water at 5K races. We may run in them as a company to give back if they're supporting us or an organization that way.

*"Just because an event has been great the past 5 years doesn't mean it will be great for the next 5 years. You have to really pay attention to every event and ask if it's growing."*

**Hillary Myers**

***Alan Ayers:*** It sounds as if Healthcare Express, like MedExpress, built in some flexibility for your community educators to try things, learn from experiences, and move on to other things if necessary.

***Tina Bell:*** We've found it helpful to give somebody a plan that explains what has worked and what hasn't worked. Our handbook gives an overview of the Healthcare Express brand, explains why we hire community educators, and goes through our marketing budget process and what we look for in a community. It explains the marketing ROI we've found with traditional tactics since we opened our first urgent care center in January 2006 and includes notes from every community educator we've ever had about what they've done. The booklet is a tool on which to base decisions, but at the same time, they have the freedom to say, "Sorry; I know that will never work in this community" or "I'm convinced it's going to work in this community." We give them the leeway, if it's not going to break the company's budget, to try something once or twice.

***Alan Ayers:*** Hillary, has Lansing Urgent Care tried any grassroots activities that haven't worked?

***Hillary Myers:*** There is a lot of trial and error and there are also going to be events that lose their luster Just because an event has been great the past 5 years doesn't mean it will be great for the next 5 years. You have to really pay attention to every event and ask if it's growing or are we seeing the same people over and over again or losing attendees. A $300 banner at a local ball field is great but being there and being involved—having staff there for several nights during the season to be introduced to all the attendees—that's a better use of our dollars. It's names and faces and getting deeper into the community and really building relationships.

***Alan Ayers:*** Often, we find that urgent care providers are looking for a silver bullet or secret sauce that is going to work on every occasion, but it sounds like your grassroots strategies have evolved over time. It's been a learning process, with activities that you tried and learned from, and events that were hot one year but didn't work the next year. Is your overall experience one of constant change?

***Hillary Myers:*** Most definitely. In one community, a big event was successful for 10 years and then the organization's focus changed. The next year, I saw that the attendance had dropped by 75% because I was paying attention to historical numbers but the staff that attended had no idea that it was a poor event compared to years past. There has to be someone paying attention and having a pulse on all that information and data because year over year you send different people to events. A single point of contact is critical because we work hard to give back to the community and we want to do the right thing. It's not just about the numbers; it's about what your goal is when you're out in that community, too.

***Alan Ayers:*** Felicia, what has your experience been?

***Felicia Fortune:*** I would not say that we have done any grassroots activities that did not work, but certain activities are market-specific. Community-based health fairs, for example, work with certain demographics.

I would recommend that urgent care centers brand their name by getting involved in the community. Being involved in community events allows you to find out who has used your center, and if they used your center, whether the visits were a success. If our patients are not satisfied, then there's no need to be in business. The best form of advertisement is word of mouth.

Last year, we started a "Patient Ambassador Program" which allows us to get feedback from our patients about their visit at AFC. If they had a bad experience we try to solve their problem as quickly as we can. We ask that all of our patients who had a great experience tell everyone they know. We have to make sure that we take care of the customers that we already have because they are the ones who will bring more customers. ■

*Case Report*

# Side Effects of New Weight Loss Medications

**Urgent message:** With the epidemic of obesity and recent FDA-approval of weight loss drugs, urgent care providers should be on alert for patient presentations related to side effects of these agents.

MADISON BEAN and JOHN SHUFELDT MD, JD, MBA, FACEP

## Overview

An estimated 154.7 million Americans over the age of 20 are currently overweight or obese. These Americans are at increased risk of disease, including diabetes mellitus, cardiovascular disease, end-stage renal disease and cancer. If current trends remain unchanged, an estimated $861 to $957 billion in health care costs in 2030 will be attributed to obesity. This obesity epidemic has resulted in an increase in advertisement of products aiding weight loss.

Many Americans use drug therapy as a last resort or an attempt at quick weight loss. That is not true in all cases, but whatever the motivation, a decision to use drug therapy for weight loss should be carefully considered and directed by a physician knowledgeable about weight loss management.

Before a weight loss drug can be prescribed to patients, it must receive approval from the US Food and Drug Administration (FDA). In 2012, the FDA approved two drugs—Qysmia and Belviq—as safe to use for weight management alongside a reduced-calorie diet and regular exercise. Before that, it had been 13 years since a weight loss drug—Orlistat—was approved in 1999.

The US Federal Food and Drug Administration (FDA) requires approval of weight loss drug therapies before it can be prescribed to patients. Until 2012, the FDA has not approved a drug therapy since Orlistat in 1999. In the summer of 2012 the FDA approved two drugs—Qysmia and Belviq—to be used for weight management along with a reduced-calorie diet and exercise.




The FDA initially declined to approve either drug in 2010 because of potential side effects, but both were approved in 2012 when the FDA determined that the benefits outweighed the risks. To be prescribed these medications, patients must have body mass index (BMI) >27 kg/m$^2$ with weight-related disease or BMI >30 kg/m$^2$ without secondary illness.

## Case Presentation

A 46-year-old obese male presents to an urgent care with

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his significant other, complaining of hallucinations and an unremitting, painful erection.

The patient has been experiencing auditory and visual hallucinations that began 24 hours ago. He describes his hallucinations as dissociation as if he is standing next to himself.

In addition, the patient has had non-sexually stimulated painful erection the last 6 hours without relief or testicular swelling. He denies the application of any devices designed to maintain erections.

*"With the potential for serious side effects, Belviq should not be prescribed without careful deliberation and a thorough history and physical examination."*

The patient's history is significant for poorly controlled diabetes mellitus and hypertension. He denies any alcohol, tobacco or illicit drug use. His associated symptoms consist of a generalized headache, upper respiratory symptoms, lethargy and loss of appetite, but he denies any chest pain, shortness of breath or fever.

Upon further questioning, the patient states he began using Belviq 2 weeks ago to aid his weight loss and control his diabetes. His significant other then states he has been taking double the recommended dose of Belviq in order to hasten his weight loss for their upcoming wedding.

## Observation and Findings

Physical examination of the patient reveals the following:

- Pulse: 63
- BP: 169/102
- RR:18 $O_2$ Sat: 97%
- Temp: 98.7°F
- Pain Scale: 8/10
- GEN: The patient is diaphoretic and in moderate distress.
- HEENT: Horizontal nystagmus on lateral gaze
- CV: Heart is without murmur,
- Abdominal exam: Protuberant, soft and non-tender.
- Genitourinary exam: Positive for an erection, unchanged for 6 hours per the patient.
- Extremities: Tremors to all four extremities.

Mental Status: He is oriented to date, time, and place but some of his answers are nonsensical.

## Labs/Imaging

It is clear from the patient's presentation that he needs to be transferred to a higher level of care.

While waiting for the ambulance to arrive, a basic set of labs are obtained. The results are as follow:

- Point-of-Care Blood Sugar: 43mg/dL
- CBC: WBC 2.3, H/H 10.1/31
- U/A: Unable to obtain
- CXR: Cardiomegaly
- EKG: Sinus tachycardia

## Diagnosis and Treatment

The first clue in this bizarre constellation of symptoms and findings is that the patient admits to taking a more than the prescribed dose of Belviq. Typical dosing of Belviq is 10 mg twice a day. This patient admits to taking 40 mg per day in divided doses.

Side effects of Belviq include priapism and hallucinations. Treatment consists of the patient discontinuing use of Belviq and closely monitoring his glucose levels. The patient ultimately needs to follow up with his primary care physician for changes to his antidiabetic drug regimen. In the interim, he needs to be emergently transferred to the Emergency Department for evaluation and treatment of his priapism.

Patients who take Belviq and have Type II diabetes mellitus are at high risk of profound hypoglycemia. Priapism associated with Belviq is a result of the drug's 5-HT2c-receptor agonism mechanism of action.

Bradycarida, leukopenia, and decreases in hemoglobin and hematocrit are also side effects of Belviq. Psychiatric disorders including euphoria, hallucination, and dissociation have been noted in patients who exceeded the usual dose.

In addition, the serotonin syndrome side effects of Belviq include mental status changes, autonomic instability, neuromuscular aberrations, and gastrointestinal symptoms. Patients may also experience dyspnea, dependent edema, congestive heart failure, and a new cardiac murmur.

It should be clear that with the potential for serious side effects, Belviq should not be prescribed without careful deliberation and a thorough history and physical examination.

## Qsymia

Qsymia is the second weight loss management drug approved by the FDA in 2012. Qsymia is a combination drug consisting of phentermine and topiramate with

alternating dosages at Weeks 2 and 12 of therapy.

Side effects of Qsymia include headache, upper respiratory symptoms, acute loss of vision, eye pain, constipation, insomnia, dizziness, paresthesia, palpitations, back pain, nausea, and diarrhea.

Renal effects consist of increased serum creatinine in patients, which occurs primarily 4 to 8 weeks into treatment. Topiramate has been associated with glaucoma and hyperthermia.

Hyperchloremic metabolic acidosis can occur due to decreased serum bicarbonate concentrations from increased renal bicarbonate loss. Patients on Qsymia who are also taking antihypertensive medications may experience hypotension; therefore, close monitoring of blood pressure and adjustment of medication is recommended in these cases.

Patients who start on Qsymia and begin to experience untoward side effects should be slowly weaned off the medication over 7 days to minimize the risk of seizure.

## Summary

Both Qsymia and Belviq can cause serious side effects and they should not be prescribed unless to patients who have not failed other modalities of weight control.

Along with diet, exercise, and lifestyle modifications, drug therapy—when used appropriately—may be a helpful component of treatment for obese patients.

Given the number of patients who are plagued by morbid obesity, it is clear that urgent care providers will be treating patients exhibiting some of the effects and side effects of weight loss therapy. ■

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*Priapism is defined as a persistent erection of the penis or clitoris that is not associated with sexual stimulation. Experts differ on the length of time of erection used to define priapism, but most agree it is an erection lasting at least 4 hours.*

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# Malpractice Trends in Urgent Care and Retail Medicine

JOHN SHUFELDT, MD, JD, MBA, FACEP with ANDREW SNIEGOWSKI, RN, JD CANDIDATE 2014

Over the last 6 years I have written a number of articles on medical malpractice in urgent care medicine. The good news is that I am seeing fewer cases despite the fact that there are more urgent care centers and more patient visits. The bad news is that I am still seeing the same fact patterns time and again.

Failure to diagnose is still the most common claim in all malpractice suits, including those in urgent care medicine.[1] One study of primary care, including urgent care centers, found that "[p]neumonia, decompensated heart failure, acute renal failure, cancer, and urinary tract infections were the most commonly missed diagnoses, although each consisted of less than 10% of the errors."[2,3] Other accounts vary in regard to which diagnoses are most commonly missed.[4]

To date, there has not yet been a malpractice suit against a retail health clinic (RHC) that I have been able to discover. However, physician supervisors in RHCs may face liability under an agency theory for the actions of (NPs) and physician assistants who act as the primary providers in these settings.

An urgent care center's status is not exactly a primary care office, but also not an emergency department, making it unique both in the marketplace and in terms of liability exposure.[5] In addition, physicians may face vicarious liability suits for negligent care given by midlevel providers under their supervision.[6] Although there does not seem to be a compilation of malpractice statistics for urgent care centers, the anecdotal evidence available from these practices closely matches the overall statistics for primary care.

Failure to diagnose is the most common malpractice allegation against primary care providers, representing 20% of all claims.[1] One study suggests that this may be due in large part to failure to reevaluate patients appropriately during the course of their illness.[7] In addition, providers often fail to adequately document pertinent negatives, leaving themselves open to suit for conditions that were not present or were not detectable at the time a patient was evaluated.[7] Another common theme is a lack of continuity of care in urgent care centers.

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### Overview and Urgent Care Case Sample

Each of the following fact patterns is consistent with failure to diagnose. In addition, they are also consistent with other causes of action that may be unique to the urgent care setting. Specifically, they are illustrative of failure to report patients' conditions to a primary care provider, failure to appropriately provide for follow-up care, and failure to refer patients to a more appropriate setting for their specific emergent conditions.

### $3.75M Settlement for Failure to Diagnose Cerebral Hemorrhage

A 37-year-old woman presented to an urgent care center complaining of new-onset headache, nausea, and dizziness.[8] No imaging was ordered nor performed. The patient was given a Toradol injection and instructed to return if the headache did not subside. She returned the following morning with continued headache. A different physician saw her, prescribed intramuscular Toradol and Vistaril, and discharged the woman with instructions to return if the headache returned. The woman returned that evening and while being seen by a third physician at the same urgent care center, she lost consciousness. The woman was transferred to the emergency department where computed tomography revealed a hemorrhaging arteriovenous malformation. The patient survived but with severe impairment. There is some suggestion that the payout would have been even larger, but the woman had returned to her native country (Honduras) for ongoing care, thus reducing her lifetime cost of care.

**Take-Home Point:** Important to document nature of headache (thunderclap); if it is the worst headache of the patient's life; the absence of meningeal signs and focal neurological deficits, and any family history of cerebral aneurysms.

### $250,000 Arbitration Award for Failure to Diagnose Glass Fragments in Superficial Laceration

A 9-year-old girl was brought to an urgent care center after cutting her knee on a glass surface.[9] The laceration was cleaned and sutured, but not x-rayed. Two years later, the girl developed sudden swelling and tenderness in the effected knee. Investigation revealed glass left in the knee, which required surgical removal. Cartilage damage was significant enough to force the girl to stop participating in gymnastics. These facts are consistent with reports that failure to appropriately image or evaluate wounds is a common problem for acute care practitioners.[8]

**Take-Home Point:** When in doubt, x-ray and explore. If you x-ray and don't see it and explore and document lack of a foreign body, you have at least met the standard. The standard does not require perfection, only that you thought about a foreign body and attempted to locate it.

### Failure to Diagnose Pulmonary Emboli

A 44-year-old man reported to an urgent care center with pleuritic pain.[10] He was initially prescribed PO anti-inflammatories and pain medication.[1] When his pain did not subside, the man returned to the urgent care center. This time, an x-ray was performed, revealing atelectasis and an early infiltrate. The physician diagnosed pneumonia and prescribed PO antibiotics. The man's pain improved, but he developed hemoptysis. The urgent care center physician instructed the man to continue the antibiotics and return for a follow-up chest x-ray in 6 to 8 weeks. The man died of pulmonary embolism 13 days after he first presented to the urgent care center. A malpractice suit against the urgent care center and physicians resulted in a settlement for an undisclosed amount.

In a similar case, a patient reported to an urgent care center after experiencing 6 to 8 weeks of "trouble breathing, chest tightness, sore throat, runny nose, chills, and fatigue."[11] The physician auscultated rhonchi and rales and performed a chest x-ray. The patient was diagnosed with pneumonia, and prescribed PO antibiotics and pain medications. The patient was instructed to return or to see her primary care physician if her symptoms got worse or if she vomited. Two days later the patient was transported from home to the emergency department with sudden onset of nausea and vomiting. She died of a pulmonary embolus (PE). The jury in this case returned a verdict for the defense.

**Take-Home Point:** Always consider PE for any patient presenting with respiratory symptoms. PE is an underdiagnosed, high-risk miss in urgent care medicine. Documenting a PERC or WELLS score on the chart goes a long way to demonstrate that you met the standard of care.

*"Always consider PE for any patient presenting with respiratory symptoms."*

### Failure to Diagnose Sepsis

A patient reported to an urgent care center with severe "flu-like" symptoms.[12] His vital signs were taken by a nurse, and he was evaluated by the urgent care physician, who diagnosed a pulled abdominal muscle and prescribed rest and acetaminophen. The patient was told to return to the urgent care center if his symptoms continued. Ultimately, the patient was suffering from sepsis. The next morning he suffered cardiac arrest and died less than 24 hours later after being seen in the urgent care center.

Unfortunately, the published opinion did not include the patient's vital signs, or any other details of the evaluation at the urgent care center. Specifically, the decision does not include the patient's heart rate, blood pressure, or temperature, which may have been indicative of his impending septic shock. However, the fact pattern is consistent with a study reporting that 16% of patients with a very abnormal vital sign were discharged from urgent care centers without reevaluation of that vital sign.[7]

**Take-Home Point:** Document vital signs. If abnormal, address the abnormality and retake.

### Failure to Diagnose Cancer

A patient reported to an urgent care center with a painful lump in her thigh. The physician diagnosed a pulled muscle and discharged her.[13] She returned with the same problem and a different physician diagnosed thigh strain after ruling out a deep venous thrombus. Two months later the patient returned with the same complaint, which was diagnosed as muscle spasm. Five months later the patient returned, this time with significant swelling of the thigh. A CT scan was performed, and in combination with a biopsy a week later, revealed cancer.

**Take-Home Point:** The facts in this case are a bit vague. My only admonition is that when a patient keeps coming back without resolution of the symptoms, consider a referral for further evaluation. The provider did order a venous Doppler, which was a good thought. I wonder in this particular case if an x-ray of the patient's femur would have showed the lesion.

Each of these fact situations is representative of an urgent

care provider's failure to diagnose. These situations are consistent with the statistics showing that failure to appropriately reevaluate is a common contributor to malpractice suits based on inappropriate diagnosis. In addition, urgent care centers may be open for liability under other theories. RHCs, on the other hand, are not a common target for malpractice suits but may be an emerging source of physician liability.

## Retail Health Clinics

RHCs differ significantly from urgent care centers both in the market and in terms of liability exposure. As of the latest available information, there has never been a malpractice suit against a RHC.[14] That may be due to most RHCs' practices of transferring or referring any patient who presents with anything other than the most straightforward of complaints. Although on the surface, this seems like a logical course of malpractice risk mitigation, identifying subtle presentations of significant pathology is in itself very challenging.

Also note, the physician-as-distant-supervisor model potentially opens physicians to significant liability. In addition, recent developments in the law surrounding NPs may increase the potential for physician liability in these settings.[14]

## Emerging Areas of Physician Liability for Remote Supervision

Courts have consistently held that physicians may be liable under a respondeat superior theory for the negligence of NPs under the physician's supervision.[14,15] In addition, physicians may be directly liable for failure to meet the standards of supervision.[14] This, combined with two developments in NP law, likely creates increased liability exposure for supervising physicians.

First, there has been a sharp increase in malpractice suits against NPs. It has been speculated that this is due primarily to the increased number of NPs practicing in America, but the true cause of the increase in the number of suits is not known. However, the reason for this increase may not matter to physicians attempting to avoid liability. What is important to the physician is that as the number of suits against NPs rises, the inevitability of a suit against a NP under the physician's supervision becomes a reality. Given the likelihood that the physician is believed to have "deeper pockets" and may be better insured, it is also likely that physicians will increasingly be named in these suits under a theory of vicarious liability.

Second, in part because of increasing concern over the popularity of RHCs and the increased number of lawsuits against NPs, many states have begun instituting stricter requirements for NP practice and supervision.[16] The idea behind these regulations is to decrease the possibility of NPs delivering care that is below the standard. Whether that policy goal will be realized remains to be seen. However, the regulations also create greater demand on the physicians acting as the NPs' supervisors. Although it is not yet entirely clear what the legal ramifications will be for a supervising physician whose subordinate NP fails to meet these new requirements, it is certain that supervising physicians must remain vigilant to ensure they understand the regulations and are aware of whether they are being followed.

RHCs arguably serve a vital role in alleviating a significant problem with access to affordable primary care.[17] They also create unique liability concerns for physicians attempting to oversee the care provided in this setting. To our knowledge, there has not yet been a successful malpractice suit filed against a RHC, but it seems that such a suit is inevitable. In addition, recent legal developments point to increased avenues for physician liability in this setting, and increased complexity in the liability issues physicians will face.

## Conclusion

No malpractice statistics specific to urgent care centers have yet been compiled. However, the anecdotal evidence reflects the fact that urgent care malpractice suits closely follow the overall patterns of primary care. Although it is not clear which conditions are most commonly missed, failure to diagnose is almost certainly the most common cause of action against urgent care centers and physicians. RHCs, on the other hand, have not yet faced a malpractice suit. Nonetheless, these suits and some theories of liability unique to the RHC setting seem to be inevitable. ■

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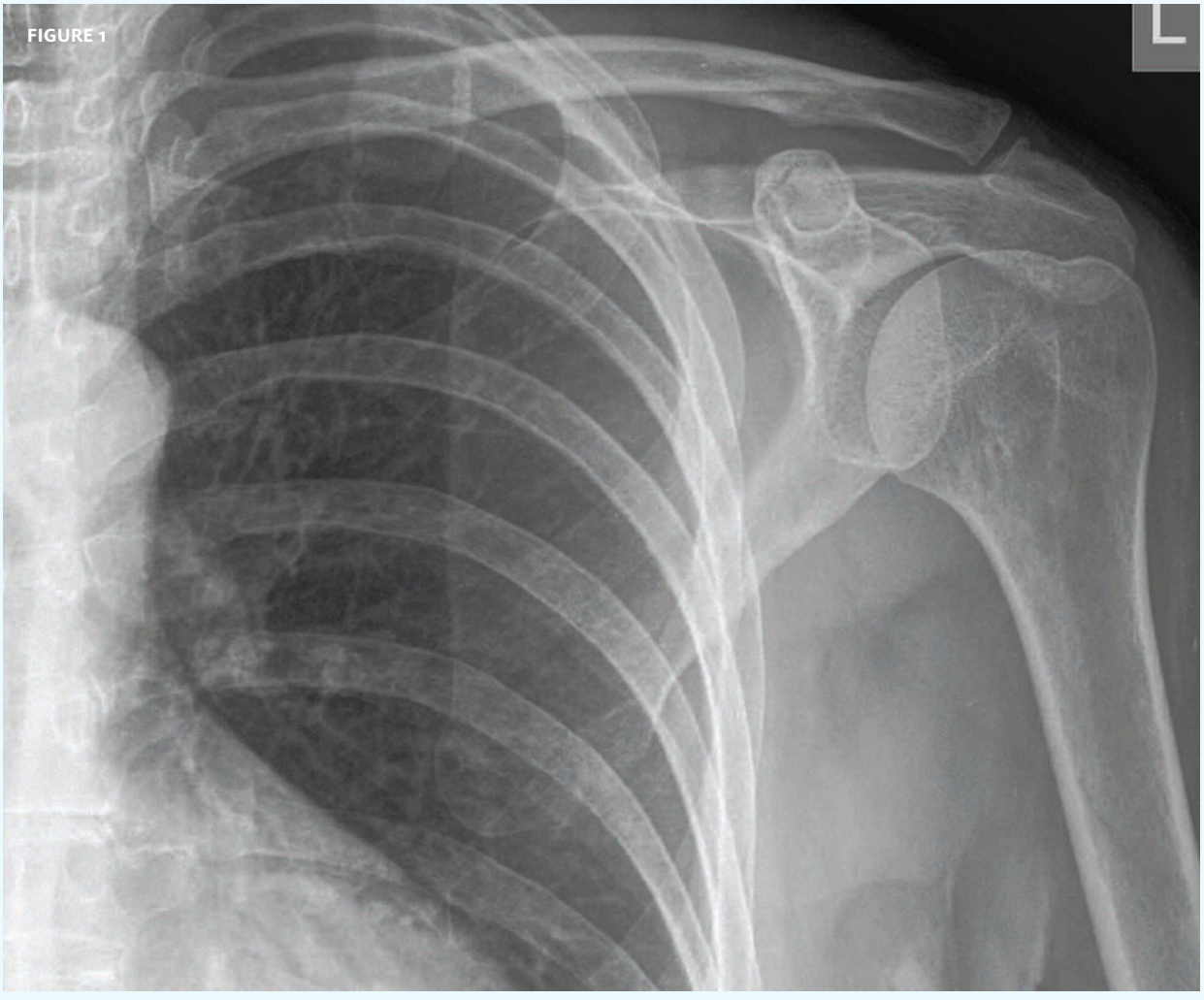
INSIGHTS IN IMAGES

# CLINICAL CHALLENGE: CASE 1

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

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

FIGURE 1



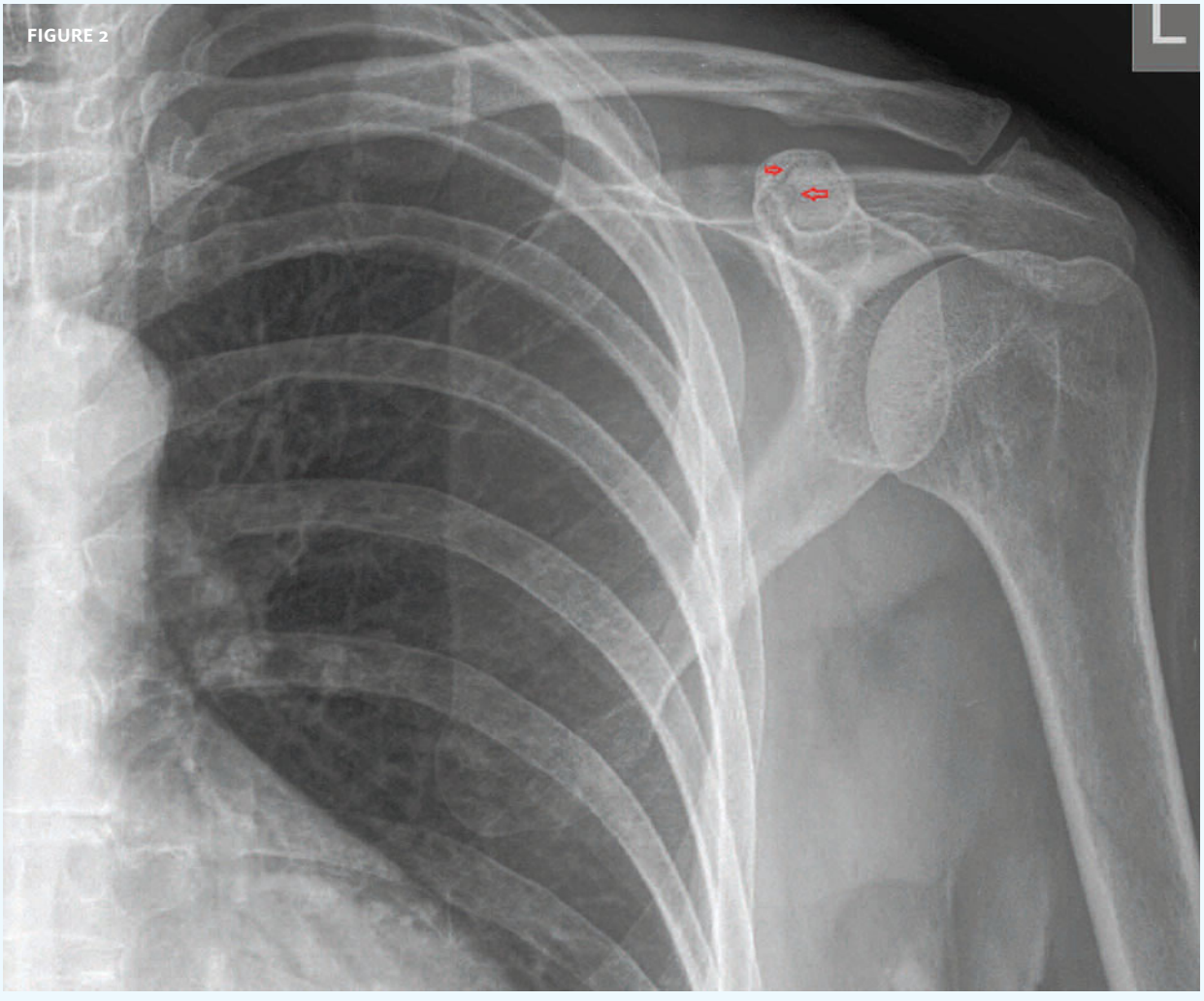

The patient, a 67-year-old man, presented after a blow to his left shoulder.

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

Resolution of the case is described on the next page.

## THE RESOLUTION

FIGURE 2

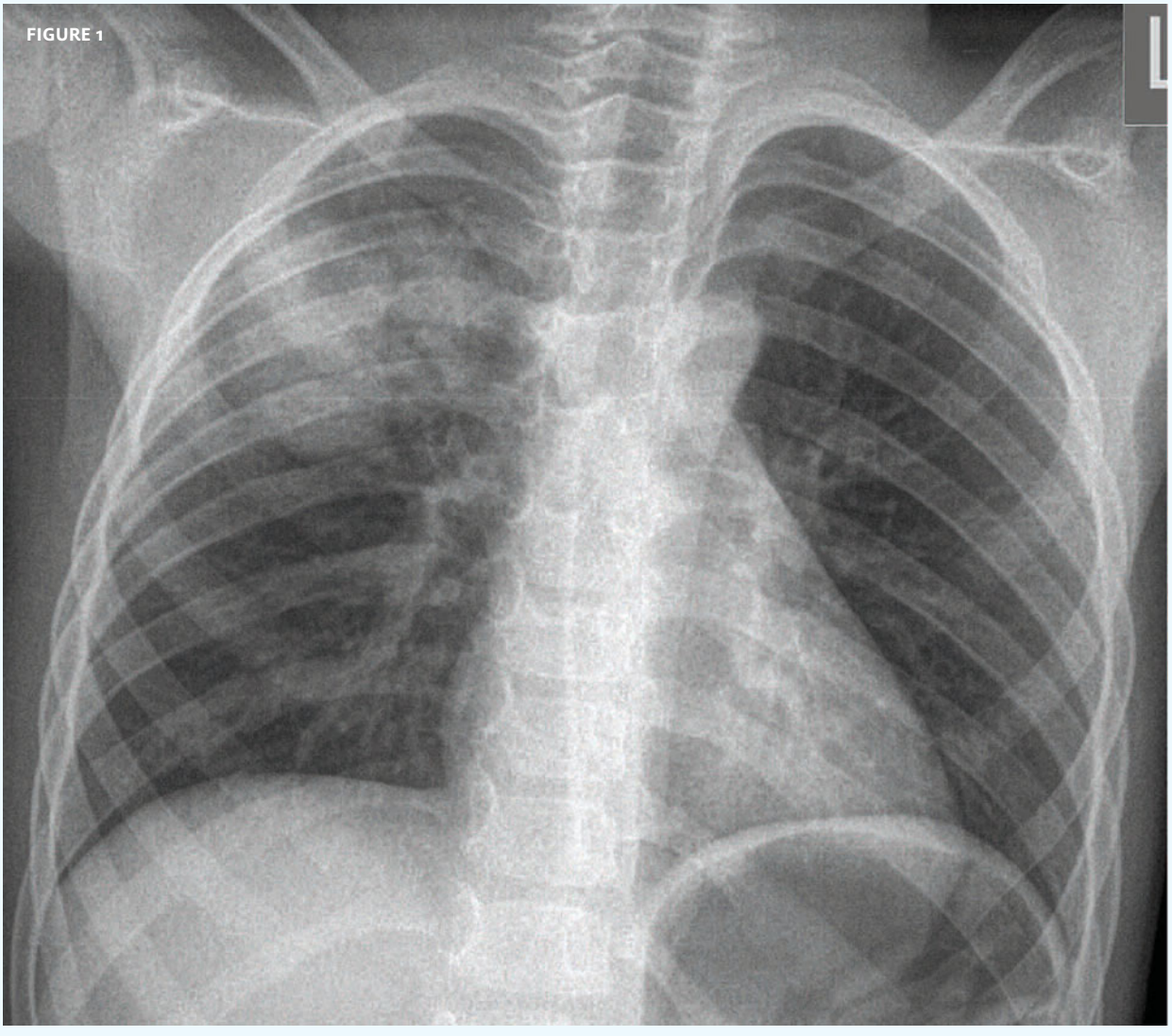


Diagnosis: The x-ray reveals a fracture of the acromion (arrows). A sling and follow up with orthopedics are appropriate for this patient.

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

# CLINICAL CHALLENGE: CASE 2

FIGURE 1



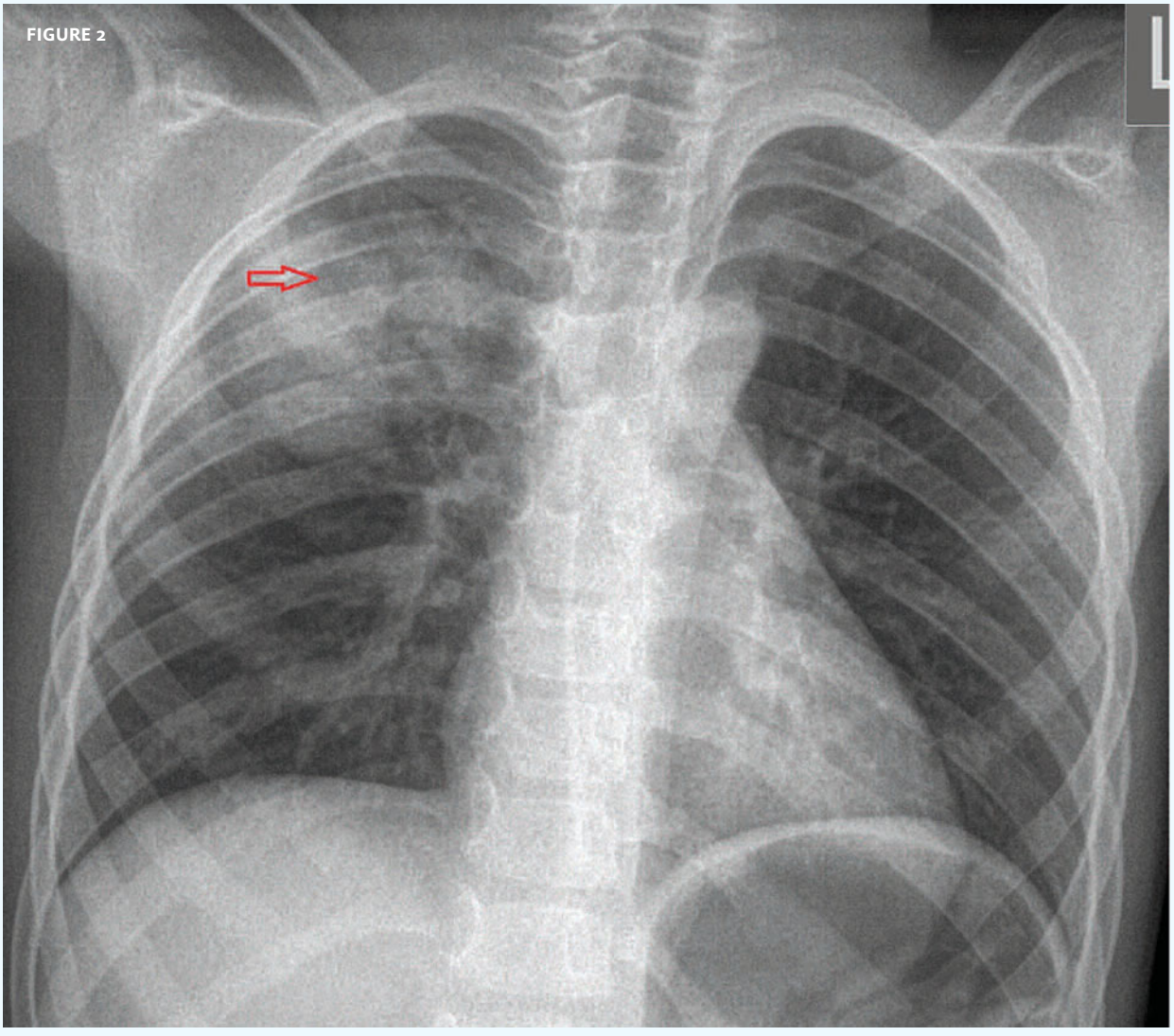
The patient, a 6-year-old girl, presented with a fever and cough.

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

Resolution of the case is described on the next page.

## THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals consolidation in the right upper lobe and within the consolidation, there is an opacity (arrow). That does not necessarily mean that an abscess is forming but the patient should be followed closely.

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

# ABSTRACTS IN URGENT CARE

- Antibiotics for COPD
- Steroids for pediatric asthma
- Antibiotics for skin and soft-tissue infections
- Viscous lidocaine for pediatric mouth pain
- Post-concussion rest
- Duration of cold and earache in children
- ER visits for concussion
- Predictors of sore throat complications

SEAN M. McNEELEY, MD

Each Month the Urgent Care College of Physicians (UCCOP) provides a handful of abstracts from or related to urgent care practices or practitioners. Sean McNeeley, MD, leads this effort.

## Reconsidering antibiotics for COPD exacerbation

***Key point: Prescribing antibiotics to patients with mild-to-moderate COPD exacerbations who have no change in sputum probably is unnecessary.***

**Citation: Miravitlles M, Moragas A, Hernandez S, et al. Is it possible to identify exacerbations of mild to moderate COPD that do not require antibiotic treatment? *Chest*. 2013;144(5): 1571-1577.**

The decision to prescribe antibiotics to patients with moderate to mild-to-moderate chronic obstructive pulmonary disease (COPD) exacerbations is usually based on increased sputum, sputum purulence or worsening dyspnea. Because most patients fall into the mild-to-moderate category, determining the true need for antibiotics could greatly reduce the use of antibiotics.

In this small study, the authors reviewed the control group of patients who were part of a randomized study to see if amoxicillin/clavulanate was better than placebo in mild-to-moderate exacerbations of COPD. Criteria for exclusion due to severity was FEV1 <50% predicted.

Of the 152 patients examined only 20% of patients clinically failed without antibiotics. A statistical review of the performance of these criteria as well as point-of-care C-reactive protein (CRP) levels resulted in only two criteria capable of reducing the clinical failure rate to 10%. Ten percent was the failure rate with antibiotics in the original trial. The successful criteria included a change in purulence in sputum and a CRP >40 mg/L. Because most urgent care centers do not perform point-of-care CRP testing, sputum change would be most helpful to providers. Although this is a small study in need of prospective confirmation, it does call into question use of antibiotics for all patients with COPD exacerbations. ■

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## Steroids for infants at risk of asthma

***Key point: Infants at risk of asthma who are diagnosed with bronchiolitis may benefit from steroids.***

**Citation: Alansari K, Sakran M, Davidson BL, et al. Oral dexamethasone for bronchiolitis: A randomized trial. *Pediatrics*. 2013;132(4):e810-816.**

Bronchiolitis is a frequent diagnosis in young children at urgent care centers. Most cases have a viral cause and little treatment has found to be beneficial. Some guidelines recommend a trial of albuterol and only suggest further prescription if clinical improvement is noted. Whether this indicates possible future asthma is uncertain.

This study evaluated another common asthma treatment in patients with bronchiolitis and risk of asthma. The authors looked at 200 children at risk of asthma with an average age of 3.5 months and a diagnosis of bronchiolitis. A risk of asthma was defined as a diagnosis of atopic dermatitis or a family history of asthma in a first-degree relative.

Patients in the treatment group were given dexamethasone 1 mg/kg on day 1 and then 0.6 mg/kg for 4 more days. The measured outcome was time to discharge from an observation unit, which was reduced with dexamethasone from 27.1 to 18.6 hours.

It is hoped that further investigation will be done with a larger population and more urgent care-appropriate outcomes,

such as duration of symptoms or reduced need for admission. For now, consideration of steroids in patients at risk of asthma and whose clinical status requires further observation or admission seems appropriate. ■

## Antibiotics for skin and soft-tissue infections

*Key point: Some antibiotics prescribed for skin and soft-tissue infection may be avoidable.*

**Citation: Hurley HJ, Knepper BC, Price CS, et al. Avoidable antibiotic exposure for uncomplicated skin and soft tissue infections in the ambulatory care setting. *Am J Med*. 2013;126 (12):1099-1106.**

Antibiotic resistance continues to be a major concern. Prescriptions for soft-tissue infections are common. The authors of this study attempted to understand better what prescribing practice of physicians are for soft-tissue infections and if any reduction would be appropriate.

In a retrospective manner the authors reviewed the use of antibiotics for cellulitis, wound infection and cutaneous abscess. Avoidable antibiotic exposure was defined as the use of antibiotics with broad gram-negative activity, combination antibiotic therapy, or 10 days or longer of therapy. The authors examined 364 cases and determined that almost half of the patients had avoidable antibiotic exposures by their definition.

This study, although interesting, has several limitations. First the authors' definition of avoidable antibiotic exposure is far from universally accepted. The first part regarding gram-negative coverage is very reasonable, considering that most soft-tissue infections are caused by *Staphylococcus* or *Streptococcus*. Further studies are necessary to confirm that not using combination antibiotics is inappropriate. With the recent increase in the price of doxycycline, use of a cephalosporin such as cephalexin plus a sulfa has become more common to cover methicillin-resistant *Staphylococcus aureus* and *Streptococcus*.. The 10-day treatment cut-off also was unusual, considering that the guidelines referenced by the authors cite durations of 5 to 10 days. The definition of "uncomplicated" also left few patients in the study group.

Considering these limitations further study would be helpful before the authors' findings are universally applied. ■

## Rethinking viscous lidocaine for pediatric oral pain

*Key point: Viscous lidocaine is no more beneficial than placebo for improving oral intake in children with painful mouth infections.*

**Citation: Hopper SM, McCarthy M, Tancharoen C, et al. Topical lidocaine to improve oral intake in children with painful infectious mouth ulcers: A blinded, randomized, placebo-controlled trial. *Ann Emerg Med*. 2013 Nov 7; pii: S0196-0644 (13)01335-8. doi: 10.1016/j.annemergmed.2013. 08.022. [Epub ahead of print]**

Maintaining hydration in children with painful mouth lesion is difficult. The investigators in this study attempted to see if 0.15 mL/kg of 2% viscous lidocaine would perform better than flavored placebo at 60 minutes. One hundred patients ages 6 months to 2 years were randomized in a double-blind fashion and fluid intake was assessed at 60 minutes with 4 mL considered a significant difference. No difference in consumption was noted between the groups.

This study, although small, should make us rethink use of a potentially toxic medication without definitive benefit in fluid intake. Pain scores were not obtained during this study, so this patient outcome was not evaluated.

## Post-Concussion Physical *and* Cognitive Rest

*Key point: Once again cognitive rest is proven to be important to speed of recovery.*

**Citation: Brown NJ, Mannix RC, O'Brien MJ et al. Effect of cognitive activity level on duration of post-concussion symptoms. *Pediatrics*. 2013 Jan 6; [e-pub ahead of print].**

Concussions continue to be a hot topic in the media and with patients. We continue to learn more about how these injuries in children should be treated.

The investigators in this study compared times to recovery with amount of cognitive activity. This study was performed in a prospective cohort fashion. A total of 335 patients ages 8 to 23 were assessed by Post-Concussion Symptom Scale as well as rating of their cognitive activity on a scale of zero to four on items such as reading, video game playing, and homework.

The mean duration of symptoms was 43 days, which may not have been longer than expected because this patient population had persistent symptoms at follow up within 3 weeks of injury. Still, 43 days is surprising.

The investigators concluded that cognitive activity was associated with longer duration of recovery. This study provides further reason to be sure patients understand that rest after a concussion includes both physical and cognitive function. Also, with a mean duration of 43 days, the importance of follow up should be stressed. ■

## Duration of cold and earache in children

*Key point: The duration of the common cold and earaches in children is longer than expected.*

**Citation: Thompson M, Vodicka TA, Blair PS, et al. Duration of symptoms of respiratory tract infections in children: Systematic review. *BMJ*. 2013;347:f7027.**

Pediatric illnesses such as the common cold, earache, sore throat and cough are frequently diagnosed. The expected duration of symptoms with these conditions is important to families and providers alike but to date, data on it have been conflicting. The authors of this study performed a systematic review of randomized controlled and observational studies to determine the duration of these illnesses. Although this analysis is retrospective, the information definitely adds to our understanding of symptom duration.

The duration of the following illness is expected to be as follows:

- Earache: 7 to 8 days
- Sore throat: 2 to 7 days
- Croup: 2 days
- Bronchiolitis: 21 days
- Acute cough: 25 days
- Common cold: 15 days
- Nonspecific upper respiratory infection: 16 days

It is hoped that this information will help parents understand how long to expect that their children may have symptoms. ■

## ER visits for concussion

*Key point: Emergency room visits for concussion have almost doubled in 10 years, but admissions have not increased.*
**Citation: Colvin JD, Thurm C, Pate BM, et al. Diagnosis and acute management of patients with concussion at children's hospitals. *Arch Dis Child*. 2013;98(12):934-938.**

As mentioned before, concussions are receiving more attention. The investigator of this study reviewed medical records from a large pediatric network to determine the percentage of children who were seen for concussion as well as the absolute number of admissions associated with that diagnosis.

As expected, the percentage of children seen in emergency rooms (ERs) for concussion increased from 0.36% to 0.62% between 2001 and 2010. The number of admissions during that same period, however, increased only minimally, from 525 to 555. Although more investigation is needed, this may be evidence that more patients presented to ERs for evaluation with low-risk concussions. Perhaps medical costs could be reduced if more of these patients were seen in urgent care centers rather than ERs.

The only factors that might confound that hypothesis are the high percentage of use of computed tomography (CT) in this study (over 60%) and the relatively low ER cost per visit. The median adjusted cost per visit without CT was only $191, whereas with CT it was $695. Unfortunately the investigators did not look at how the decision to scan compared to current guidelines, which also would alter the cost of the visits. ■

## Predictors of sore throat complications

*Key point: History and physical exam are not predictive of suppurative complications of sore throat. Antibiotics also did not appear to reduce occurrence.*
**Citation: Little P, Stuart B, Hobbs FD, et al. Predictors of suppurative complications for acute sore throat in primary care: Prospective clinical cohort study. *BMJ*. 2013;347:f6867**

Sore throat is a common complaint in the acute care setting. The investigators in this study looked at 14,610 patients with complaints of sore throat. The total percentage of suppurative complications was just over 1%. Suppurative complications included peritonsilar abscess, otitis media, sinusitis, cellulitis or impetigo. History and physical findings were not significantly predictive of these complications. Treatment either at the time of visit or delayed did not alter the incidence of suppurative complications. The only limitation to this study was a lack of comparison of type of antibiotics, which might have altered the results. The authors concluded that availability of follow up was the best way to discover and treat the low percentage of unpredictable complications. ■

## Return to Play Plan for Pediatric Concussion

*Key point: Return to play has been a focus of recent concussion guidelines. This article proposes that a return to learn plan is another aspect that needs our attention.*
**Citation: Halstead ME, McAvoy K, Devore CD, et al. Returning to learning following a concussion. *Pediatrics*. 2013;132(5):948-957.**

When a child with a concussion should return to school can be just as complex a decision as when to return to play. Concussions are a difficult diagnosis for both parents and educators and unlike a broken ankle, they are associated with few visible signs. This article details the issues and types of plans necessary for a child with a concussion to return to learn (RTL) as the authors define it. A team approach to slowly integrate a student back to school is recommended. The team should consist of parents, physician, school nurse and teachers. Education about the common symptoms of concussion and ways to assist are provided in both tables and forms to test improvement similar to forms used for return to play. (Samples plans are listed below).

1. Headaches – reduce duration, frequent breaks
2. Visual symptoms – wear sunglasses, reduce brightness of screens
3. Noise – avoid gyms, band, and crowded corridors between glasses
4. Concentration/memory – reduce demands
5. Sleep disturbances – alternate schedules, shorter days, naps ■


CODING Q&A

# Urgent care codes, E/M Guidelines, ICD-10

■ DAVID STERN, MD, CPC

**Q. Is there a defined set of diagnosis codes for urgent care services and is there a diagnosis code that indicates the services were urgent?**

A. All facilities use the same set of ICD-9 codes to report the patient's diagnosis. There are no diagnosis codes to represent urgent care services, but there are certain procedure codes you can use to indicate that services were rendered in an urgent care clinic and also procedure codes to indicate that the services were urgent.

Healthcare Common Procedure Coding System (HCPCS) Code S9088, "Services provided in an urgent care center (list in addition to code for service)," can be billed for every visit in an urgent care center with an Evaluation and Management (E/M) code. This code is an add-on code and cannot be billed alone.

CPT code 99051, "Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service," is another code that could be billed. Evening hours are generally considered to start at 5 p.m. This code was designed to compensate your practice for the additional costs to provide services during these extended hours and typically is billed to patients seen after 5 p.m. on Monday through Friday, and all day on Saturday, Sunday, and federal holidays.

CPT code 99058, "Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service," could also be used for patients who required immediate emergency services. However, some billers do not use this for services rendered in walk-in clinics.

You will want to check state regulations as well as payor contracts to see whether any of these codes should be billed or not. Medicare does not reimburse for any of these codes. ■

**David E. Stern, MD** is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

**Q. Is it true that we can now mix 1995 and 1997 guidelines when determining the level of service for an office visit?**

A. No. You must use only one set of guidelines for any specific encounter and you are not required to state which set of guidelines you are using.

For services performed on or after September 10, 2013, the status of three or more chronic conditions qualifies as an extended HPI for either the 1997 or 1995 guidelines. This criterion for an extended HPI is part of the 1997 guidelines and previously could only be applied when using the 1997 guidelines. The Centers for Medicare & Medicaid Services (CMS) announced this change in a FAQ on 1995 and 1997 Documentation Guidelines for Evaluation & Management Services (http://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/em-faq-1995-1997.pdf). This is especially good news for centers that provide primary care services to manage chronic medical conditions. ■

**Q. My employer is not providing any ICD-10 training. What can I do on my own in order to learn more about ICD-10 without paying hundreds of dollars?**

A. There are several entities that offer training, but there is usually a cost involved. If you are a member of the American Academy of Professional Coders (AAPC), check with your local chapter or the AAPC national website for classes, seminars, and boot camps at www.aapc.com.

There are several code translator applications that are also helpful. AAPC offers one without requiring a membership at http://www.aapc.com/ICD-10/codes/index.aspx. I would recommend that you also purchase an ICD-10-CM manual and practice looking up the codes manually. Learn the coding guidelines and focus on situations you are most likely to encounter. Run

a report of your top 100 ICD-9 codes and translate them to ICD-10 codes. Be aware that if you are accustomed to coding "not-otherwise-specified" (N.O.S.) ICD-9 codes, you will need to dig further into more specific codes in ICD-10.

The ICD-10 code set is so extensive because of its increased specificity over ICD-9. For example, today we code a finger fracture as 816.00, "closed fracture of phalanx or phalanges of hand, unspecified." In ICD-10, you will select a code that indicates whether it's an index finger, middle finger, etc., and whether it is an initial encounter for the fracture or a follow-up visit.

To further illustrate this example, a patient presents with a displaced fracture of the medial phalanx of her right middle finger. When using ICD-9, you would use code 816.01, "Closed fracture of middle or proximal phalanx or phalanges of hand." In ICD-10, you would code S62.622A, "displaced fracture of medial phalanx of right middle finger, initial encounter." Not only does the code represent the fracture, but it also reports laterality and the type of encounter. When reporting fracture codes, you will be required to use a 7th digit that represents:

- Initial encounter for closed fracture (A)
- Initial encounter for open fracture (B)
- Subsequent encounter for fracture with routine healing (D)
- Subsequent encounter for fracture with delayed healing (G)
- Subsequent encounter for fracture with nonunion (K)
- Sequela (S)

There are also instances where you are instructed to report external cause codes. For example, when coding diagnoses from Diseases of the Respiratory System (J00-J99), you are instructed to use additional codes that report:

- Exposure to environmental tobacco smoke (Z77.22)
- Exposure to tobacco smoke in the perinatal period (P96.81)
- History of tobacco use (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)

Along with practicing looking up the codes, you will also want to review physician documentation to ensure you are able to code to the higher specificity of ICD-10 codes. ■

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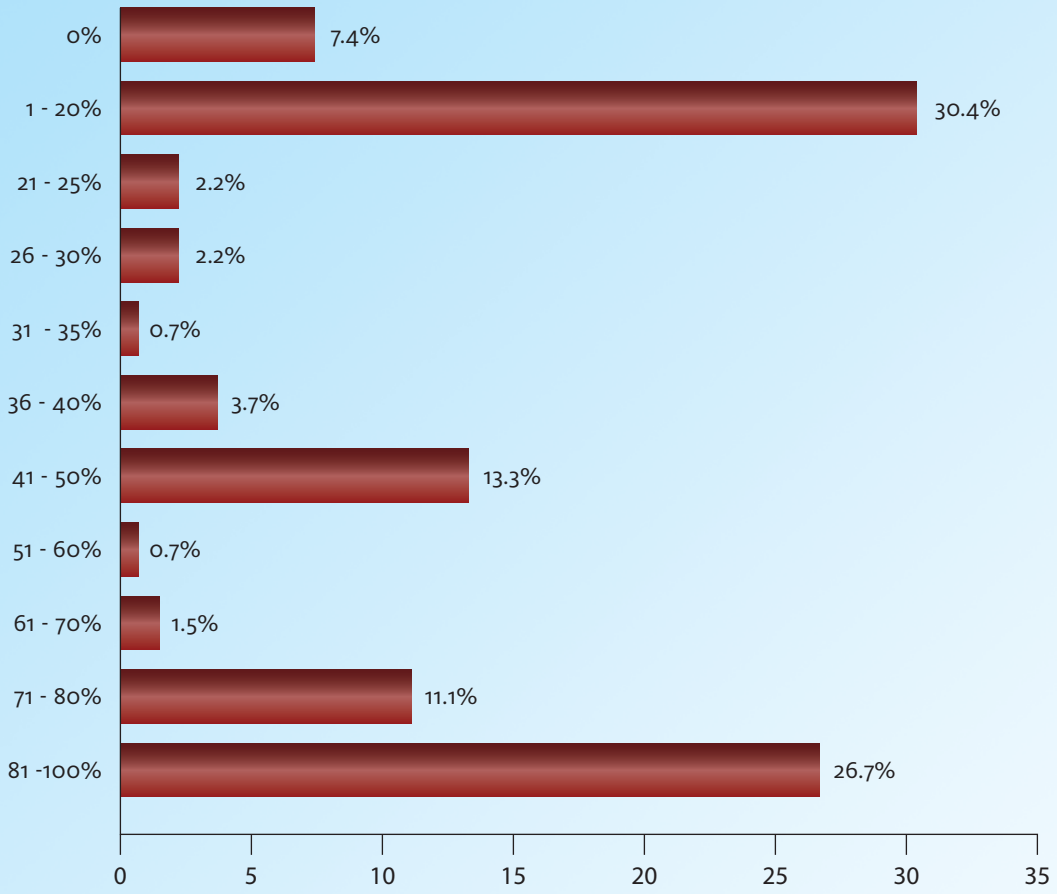
# DEVELOPING DATA

These data from the 2012 Urgent Care Industry Benchmarking Study are based on a sample of 1,732 urgent care centers; 95.2% of the respondents were UCAOA members. Among other criteria, the study was limited to centers that have a licensed provider onsite at all times; have two or more exam rooms; typically are open 7 days/week, 4 hours/day, at least 3,000 hours/year; and treat patients of all ages (unless specifically a pediatric urgent care).

*In this issue:* What Percentage of Patients Do Urgent Care Centers Assist in Finding a Primary Care Physician?

## PERCENTAGE OF PATIENTS URGENT CARE CENTERS ASSIST IN FINDING A PRIMARY CARE PHYSICIAN




81% of urgent care centers have a "standard process" in place for helping patients without a regular physician to find one (n=137). In practice, about 48.4% of patients are actually assisted with a new regular physician (n=135); however, that average belies the phenomenon that is actually occurring, as shown in this chart. Assistance is provided either at very high or very low levels, likely tying into whether centers formally provide primary care internally.

*Acknowledgement: The 2012 Urgent Care Industry Benchmarking Study was funded by the Urgent Care Association of America and administered by Anderson, Niebuhr and Associates, Inc. The full report can be purchased at www.ucaoa.org/benchmarking.*

# The Urgent Care Association of America congratulates the following centers that recently earned their Certified Urgent Care designation.

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Pediatric Immediate Care, Smithtown, NY
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Sentara Urgent Care Little Creek, Norfolk, VA
Sentara Urgent Care New Town, Williamsburg, VA
Simplicity Urgent Care, Arlington, VA
Temple ReadyCare, Fort Washington, PA
Texan Urgent Care, Bastrop, TX
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