JUCM™
THE JOURNAL OF URGENT CARE MEDICINE®
OCTOBER 2013
VOLUME 8, NUMBER 1
Urgent Care Association of America
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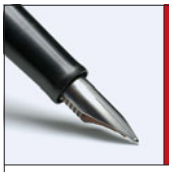
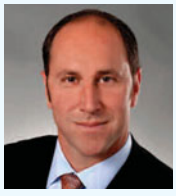


LETTER FROM THE EDITOR-IN-CHIEF

Regional Health System Integration: Charting Your Course



"The wind and the waves are always on the side of the ablest navigator." — Edmund Gibbon

These are indeed stormy and transformational times. While no one can seem to agree on the political path to reform, change is nonetheless happening at a rapid pace in health care. Previous efforts to manage health care costs and quality on a national scale sunk at sea (the HMOs and Managed Care Organizations of the 80s and 90s). But the current path to reform appears unstoppable to me, regardless of what Congress and the White House do to rock the boat. The reason is quite simple really: Earlier managed care efforts focused on a set of "rules" set by the insurance companies that determined the flow of patients through "closed" (albeit leaky) networks of providers and the utilization of their members' health care services. The insurance companies were left looking like they were interfering in health care decisions between doctor and patient and were ultimately left with a big PR problem. Consumers ultimately determined the fate of the HMOs and the entire managed care industry.

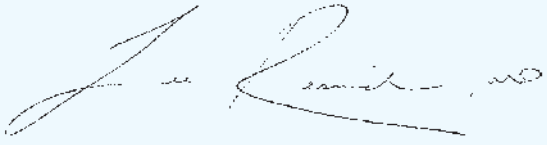
What's different now? The government and insurance companies have realized that the best way to manage cost is to manage reimbursement. By paying for "population health" and rewarding health care efficiencies, they are removing the incentives for costly and unnecessary procedures and driving health care systems to manage and control their own costs. It's managed care flipped upside down, with the health systems and providers motivated, not forced, to control costs and manage care more efficiently. Health systems around the country are forming Accountable Care Organizations (ACOs) or equivalent system architectures designed to close off networks, manage patient flow, and control costs. Genius!

So where does that leave the urgent care industry? What can we do to protect our interests, maintain our independence, and ensure a relevant role in the future of health care? These are not easy questions to answer, but sitting on our hands is certainly not an option. The challenges and local health care politics are different for each of us, but a few considerations are relevant for all.

Prediction: There will be a significant consolidation of regional health systems and integrated networks will dominate in most regions. These networks will make every effort to control the flow of patients and prevent leakage outside of the network. The cost of care for the consumer will be incentivized such that it won't make sense for patients to seek care outside the network, except perhaps for super-specialized care for rare diseases. In a metro area of tightly networked health systems, independents risk being squeezed out.

What can an independent urgent care owner do to survive? Significant opportunity exists for urgent cares in this model for those willing to explore it early. Health systems need points of access for their closed networks to work. Their challenge is to find convenient, efficient, cost-effective and consumer-friendly points of access. Primary care and emergency care do not fit that bill. Enter urgent care. After years of ignoring urgent care, major health systems are champing at the bit to build urgent care networks. Most realize (at least the smart ones) that it will take years to build these networks de novo. Whether you're a single urgent care or an established multisite network, there will be interest from your regional health systems to create everything from alliances to allegiances, affiliations and acquisitions. No matter what relationship best fits your urgent care center, opting out of some form of integration is going to be a risky matter. There are many favorable ways to align, and many relationships will allow you to maintain your independence while helping you grow your business. When exploring opportunities like this, go in eyes wide open and with counsel experienced in understanding the legal and business implications of such ventures.

While it is easy to be overwhelmed by the gale force of the regional and national health care winds of change, it is critical to learn as much as possible about the dynamics of your local health system players and the system's potential impact on your urgent care centers. With an eye on these critical changes and evolution of urgent care's role in the health care delivery system, UCAOA has spearheaded a health reform task force dedicated to education, advocacy, and support. Many initiatives are forthcoming that should assist you in assessing your regional integration opportunities and in learning from the stories of others who have successfully navigated these stormy waters. Happy sailing! ■



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October 2013

VOLUME 8, NUMBER 1

CLINICAL

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Tissue adhesives are quick, painless, and result in a good cosmetic outcome, making them well-suited for use to treat wounds in urgent care.

Simon Tanksley, M.D.

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19 Perichondritis

With the popularity of piercing of the ear cartilage, urgent care providers need to be on the alert for perichondritis and to treat it promptly.

Shailendra K. Saxena, MD, PhD, and Mikayla Spangler, Pharm D, BCPS

PRACTICE MANAGEMENT

22 Achieving Consistency and Scalability in Urgent Care Service Delivery

Investing time in designing repeatable processes and documentation can pay off in a more efficient, effective, and scalable urgent care operation.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

According to the Centers for Disease Control and Prevention (CDC), every year, about 385,000 health care workers in hospitals suffer sharps-related injuries and it's possible that many more such cases go undocumented. More than 30 different pathogens are known to cause infection in health care workers or hospital personnel following exposure to blood or body fluids, the most serious of which are hepatitis B and C and HIV. Next month's cover story—the first of a two-part series—reviews the current CDC guidelines for body substance exposures that carry risk of hepatitis and HIV transmission, the definition and management of the "source patient," and pre-exposure prophylaxis and post-exposure management for hepatitis B and C.

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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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Over the past 2 decades, multiple studies have shown that when used appropriately, tissue adhesives can produce cosmetic results similar to sutures in treatment of wounds. This month's cover story looks at advantages and disadvantages of these products, which are faster to apply and quicker to attain proficiency in than sutures. They are also ideal for closing simple lacerations, particularly on the faces of children, and for use on the thin, fragile skin of the elderly that is prone to tearing and strangulation. In our article, author Simon Tanksley, MD, offers a primer for the urgent care provider on tissue adhesives that reviews factors that should influence a physician's choice of a wound closure method, techniques for proper application of sutureless products, and tips for troubleshooting and coding for this type of laceration repair.

Dr. Tanksley is an urgent care fellow at University Hospitals in Cleveland, OH.

With the increased interest in recent years in ear piercing through the cartilage, urgent care providers should be on the alert for patients with a presentation similar to that described in this month's case report. In it, authors Shailendra K. Saxena, MD, PhD, and Mikayla Spangler, Pharm D, BCPS, describe the case of a 26-year-old female with a 2-week history of swelling of the right pinna that failed to resolve after a 10-day course of amoxicillin. The diagnosis? Perichondritis, which is most often caused by *Pseudomonas aeruginosa* and most commonly associated with penetrating injuries to the ear such as acupuncture and cartilage piercing.

Dr. Saxena is an Associate Professor in the Department of Family Medicine at Creighton University School of Medicine in Omaha, NE. Dr. Spangler is an Assistant Professor at Creighton University School of Pharmacy and Health Professions and School of Medicine, Department of Family Medicine.

In this month's practice management article, author Alan A. Ayers, MBA, MAcc, provides expert perspective on the benefits to an urgent care practice of developing repeatable processes—tasks that can be performed over and over again with a level of predictability in the quality of output. Repeatable processes are documented, tested, and integrated with other processes, unlike steps "passed down" or learned "by doing." They take time to design and document and must be continually measured and monitored but the results, says Mr. Ayers, are an efficient, effective, and scalable urgent care operation.

Mr. Ayers is Content Advisor, Urgent Care Association of America, Associate Editor, *JUCM*, and Vice President, Concentra Urgent Care.

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses how physicians' negative comments to patients about their colleagues in the profession can sow seeds of distrust that reap a harvest in malpractice claims.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of testicular torsion in boys, chest pain, and NSAIDs.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for a supervising physician, physician rotation, and critical care.

Our Developing Data end piece this month looks at the average per-visit reimbursement for urgent care centers.■

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. The information you provide should be of practical use to our readers, who have come to practice in an urgent care setting from a variety of clinical backgrounds. Your article should take their perspective into account by considering several key issues, such as: What immediate management is indicated? What labs or diagnostics are required? What are the next steps; with whom should the patient follow up? Who should be admitted or referred to the emergency room? Imagine yourself in the reader's shoes and ensure your article includes the answers to questions you'd be asking.

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

Help UCAOA develop tools and resources to meet the everchanging needs of its membership. Take a few minutes to provide the information requested on the Call for Volunteers form (found at www.ucaoa.org/volunteers) so your name can be added to our volunteer database.

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Ask yourself what you seek in return and what you are willing to contribute. Is it primarily access to policies and procedures, educational offerings, and conference opportunities? Can't make conference calls during working hours? There are even opportunities that you can fulfill on your own time, such as serving as a host of a UConnect group (online community special interest group). Think about the new connections you can make, what you'll learn from each other, and how YOU can make a difference.

For more information on how you can bring your energy to the mix, please e-mail me at jray@ucaoa.org. Indicate "Ready to Step Up" in the subject line or go to www.ucaoa.org and click on the Volunteer Opportunities link. A brief profile application and submission of a bio will be required to help match you to the committee or opportunity that most closely fits your needs. Sign up today and help us shape the future of our Association and of the urgent care industry. ■

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Using Tissue Adhesives in Urgent Care

Urgent message: Tissue adhesives are quick, painless, and result in a good cosmetic outcome, making them well-suited for use to treat wounds in urgent care.

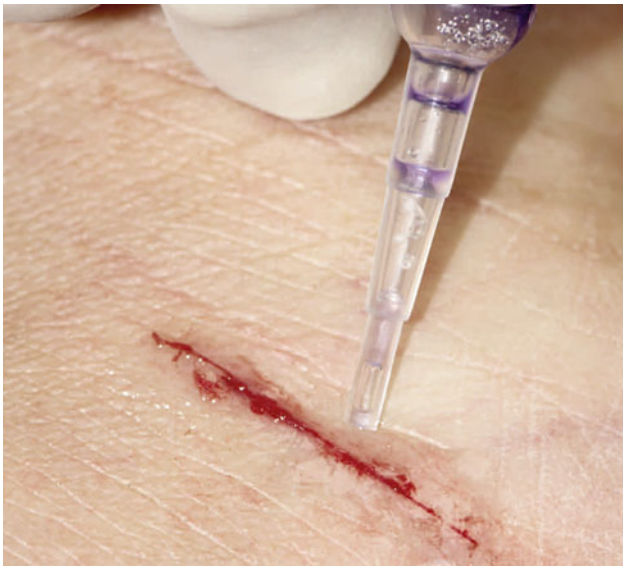
SIMON TANKSLEY, M.D.

Introduction

Tissue adhesives are ideal for closing simple lacerations, especially on the face of children. [1-3] Such repairs are quick, painless, and do not require removal of sutures. They are also excellent for treating large skin tears in the elderly (**Figure 1**) and particularly useful for thin, fragile skin because unlike sutures, the adhesives do not tear through the tissues or strangulate them.[4] Tissue adhesives are also a needless method of wound repair that eliminates the chance of a needle-stick injury.[5] In the last 20 years, numerous studies have proven that, when used appropriately, the 3-month cosmetic appearance of wounds treated with tissue adhesives is equivalent to that of sutures. [6-12] It has also been shown that tissue adhesives are faster to apply and quicker to attain proficiency in than sutures. [7-13]

Most tissue adhesives are based on cyanoacrylate, the active ingredient in superglue. The mechanism of action of cyanoacrylate is a polymerization process rather than an evaporative process. On contact with anionic substances, such as blood or moisture on the skin, cyanoacrylate changes from a monomer to a polymer forming a solid film that holds the apposed wound edges together. Several different formulations of tissue adhesives have been marketed in the last 40 years, including butyl-cyanoacrylate marketed under the Histoacryl®, Indermil®, PeriAcryl® and LiquiBand® brand names. The most popular formulation used today is 2-octyl-cyanoacrylate, also known as Dermabond® or SurgiSeal®. This article reviews factors to take into account when considering use of tissue adhesives, technique for application, aftercare, tips for troubleshooting and billing for such repairs.

Simon Tanksley, MD, is an urgent care fellow at University Hospitals in Cleveland



Choosing A Wound Closure Method

Numerous factors must be considered when choosing a wound closure method. **Table 1** summarizes the most important factors to take into account when evaluating a wound.[14]

The advantages and disadvantages of tissue adhesives are summarized in **Tables 2 and 3**. When any of the conditions in **Table 2** are present, tissue adhesive

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INDICATED FOR CHILDREN 6 MONTHS OF AGE AND OLDER[2]

- No Contraindications
- Sklice Lotion should be used in the context of an overall lice management program

IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

- The most common adverse reactions (incidence <1%) were conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation

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- One tube. One time.
  - — Patients received a **single 10-minute treatment** and were instructed not to nit comb
  - — 14 days after treatment, no live lice were observed in 76.1% (54/71) and 71.4% (50/70) of patients

PRODUCT APPLICATION[2]

- 10-minute treatment
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  - — However, a fine-tooth comb or special nit comb may be used to remove dead lice and nits

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INDICATION

Sklice Lotion is a pediculicide indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

ADJUNCTIVE MEASURES

Sklice Lotion should be used in the context of an overall lice management program:

- Wash (in hot water) or dry-clean all recently worn clothing, hats, used bedding and towels
- Wash personal care items such as combs, brushes and hair clips in hot water

A fine-tooth comb or special nit comb may be used to remove dead lice and nits.

IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

In order to prevent accidental ingestion, Sklice Lotion should only be administered to pediatric patients under the direct supervision of an adult.

The most common adverse reactions (incidence <1%) were conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation.

Please see brief summary of full Prescribing Information on following page.

For more information, please visit www.Sklice.com/HCP.

[a] Two randomized, double-blind, vehicle-controlled trials in patients 6 months of age and older with head lice infestations. The primary endpoint was assessed as the proportion of patients who were free of live lice at day 2 and through day 8 to the final evaluation 14 (+2) days following a single application.[2]

Sklice Lotion is manufactured by DPT Laboratories Ltd. and distributed by Sanofi Pasteur Inc.

References: 1. US Food and Drug Administration. Sklice Lotion approval letter, February 7, 2012. http://www.accessdata.fda.gov/drugsatfda_docs/appletter/2012/202736s000ltr.pdf. Accessed January 9, 2013. **2.** Sklice Lotion [Prescribing Information]. Swiftwater, PA: Sanofi Pasteur Inc.; 2012.

Sklice® (ivermectin) Lotion, 0.5%

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SKLICE® **Rx Only**
(ivermectin) Lotion, 0.5% for topical use

Brief Summary of Prescribing Information

1 INDICATIONS AND USAGE

1.1 Indication

SKLICE® Lotion is indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

1.2 Adjunctive Measures

SKLICE Lotion should be used in the context of an overall lice management program:

- Wash (in hot water) or dry-clean all recently worn clothing, hats, used bedding and towels.
- Wash personal care items such as combs, brushes and hair clips in hot water.
- A fine-tooth comb or special nit comb may be used to remove dead lice and nits.

2 DOSAGE AND ADMINISTRATION

For topical use only. SKLICE Lotion is not for oral, ophthalmic, or intravaginal use.

Apply SKLICE Lotion to dry hair in an amount sufficient (up to 1 tube) to thoroughly coat the hair and scalp. Leave SKLICE Lotion on the hair and scalp for 10 minutes, and then rinse off with water.

The tube is intended for single use; discard any unused portion.

Avoid contact with eyes.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Ingestion in Pediatric Patients

In order to prevent ingestion, SKLICE Lotion should only be administered to pediatric patients under the direct supervision of an adult.

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The data described below reflect exposure to a single 10 minute treatment of SKLICE Lotion in 379 patients, ages 6 months and older, in placebo-controlled trials. Of these subjects, 47 subjects were age 6 months to 4 years, 179 subjects were age 4 to 12 years, 56 subjects were age 12 to 16 years and 97 subjects were age 16 or older. Adverse reactions, reported in less than 1% of subjects treated with SKLICE Lotion, include conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

There are no adequate and well-controlled studies with SKLICE Lotion in pregnant women. SKLICE Lotion should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

No comparisons of animal exposure with human exposure are provided due to the low systemic exposure noted in the clinical pharmacokinetic study *[see Clinical Pharmacology (12.3) in the full prescribing information]*.

Human Data

There are published reports of oral ivermectin use during human pregnancy. In an open label study, 397 women in their second trimester of pregnancy were treated with ivermectin tablets and albendazole at the labeled dose rate for soil-transmitted helminths and compared with a pregnant, non-treated population. No differences in pregnancy outcomes were observed between treated and untreated populations.

Animal Data

Systemic embryofetal development studies were conducted in mice, rats and rabbits. Oral doses of 0.1, 0.2, 0.4, 0.8, and 1.6 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–15) to pregnant female mice. Maternal death occurred at 0.4 mg/kg/day and above. Cleft palate occurred in the fetuses from the 0.4, 0.8, and 1.6 mg/kg/day groups. Exencephaly was seen in the fetuses from the 0.8 mg/kg group. Oral doses of 2.5, 5, and 10 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–17) to pregnant female rats. Maternal death and pre-implantation loss occurred at 10 mg/kg/day. Cleft palate and wavy ribs were seen in fetuses from the 10 mg/kg/day group. Oral doses of 1.5, 3, and 6 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–18) to pregnant female rabbits. Maternal toxicity and abortion occurred at 6 mg/kg/day. Cleft palate and clubbed forepaws occurred in the fetuses from the 3 and 6 mg/kg groups. These teratogenic effects were found only at or near doses that were maternally toxic to the pregnant female. Therefore, ivermectin does not appear to be selectively fetotoxic to the developing fetus.

8.3 Nursing Mothers

Following oral administration, ivermectin is excreted in human milk in low concentrations. This has not been evaluated following topical administration. Caution should be exercised when SKLICE Lotion is administered to a nursing woman.

8.4 Pediatric Use

The safety and effectiveness of SKLICE Lotion have been established for pediatric patients 6 months of age and older *[see Clinical Pharmacology (12.3) in the full prescribing information and Clinical Studies (14) in the full prescribing information]*.

The safety of SKLICE Lotion has not been established in pediatric patients below the age of 6 months. SKLICE Lotion is not recommended in pediatric patients under 6 months of age because of the potential increased systemic absorption due to a high ratio of skin surface area to body mass and the potential for an immature skin barrier and risk of ivermectin toxicity.

8.5 Geriatric Use

Clinical studies of SKLICE Lotion did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients.

10 OVERDOSAGE

In accidental or significant exposure to unknown quantities of veterinary formulations of ivermectin in humans, either by ingestion, inhalation, injection, or exposure to body surfaces, the following adverse effects have been reported most frequently: rash, edema, headache, dizziness, asthenia, nausea, vomiting, and diarrhea. Other adverse effects that have been reported include: seizure, ataxia, dyspnea, abdominal pain, paresthesia, urticaria, and contact dermatitis.

In case of accidental poisoning, supportive therapy, if indicated, should include parenteral fluids and electrolytes, respiratory support (oxygen and mechanical ventilation if necessary) and pressor agents if clinically significant hypotension is present. Induction of emesis and/or gastric lavage as soon as possible, followed by purgatives and other routine anti-poison measures, may be indicated if needed to prevent absorption of ingested material.

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Figure 1.

Class I skin tear (left) treated with octylcyanoacrylate after irrigation and reapproximation of the wound edges (right).

Reprinted with permission from Xu X, et al.[20]

should be considered. However, the presence of any factors listed in **Table 3** should be seen as a contraindication for the use of tissue adhesives. For example, for a 3-year-old with a simple chin laceration, tissue adhesive would be ideal because the repair time is fast, it affords a water-resistant covering, and there is no need for a traumatic procedure and or subsequent removal of sutures. In contrast, for an adult with a finger laceration who washes dishes at work, sutures would be best because dishwashing is a high-tension and high-moisture environment.

Many studies have demonstrated that tissue adhesive is equivalent in strength to a 4-0 nylon suture.[15-17] In my professional experience, however, I have found it best to limit use of tissue adhesives to wounds that might otherwise have required a 5-0 nylon suture in order to minimize the risk of dehiscence.

Actively bleeding wounds present two challenges to using tissue adhesive. First, bleeding must be controlled to allow the tissue adhesive adhere to the skin. I have found that tissue adhesive polymerizes instantly on contact with blood, which prevents it from adhering to the skin. The second problem is hematoma formation, which I have seen in one patient on warfarin who had a skin tear on the forearm. On the day of the repair, the wound was hemostatic. She returned the next day with a large hematoma underneath the skin that had to be drained. On the third day, the hematoma was small but did not require drainage.

Accurate approximation of the lacerated edges of the dermis is the most crucial step in attaining the best cosmetic outcome with tissue adhesives. It is at this layer that collagen is generated, resulting in healing and closure of the gap in the wounded skin. Thus, a single, linear laceration from a sharp object would be a good candidate for repair with tissue adhesive, whereas a stellate laceration from a crush injury is best sutured because the operator can use different suturing techniques to perfectly match each side of the torn dermal layer.

Whether a wound is clean, clean contaminated, contaminated or dirty must also be considered. Most of the wounds encountered in the urgent care setting will be either clean contaminated or contaminated. Tissue adhesives should never be used to close contaminated or dirty wounds such as animal bites or road abrasions. Stellate lacerations have ragged, devitalized wound edges that are at increased risk of infection due to tissue necrosis and should not be closed with a tissue adhesive. The decision whether or not to close a clean-contaminated wound with tissue adhesive is based on clinical judgment. One study found that, assuming cleansing and preparation are equal, wounds closed with tissue adhesives have lower bacterial counts than wounds closed with sutures.[18] That is believed to be due to the antimicrobial properties of the polymer. However, if wound cleansing and preparation are abbreviated, which often happens because of the ease of use of tissue adhesive, an increase in infection rate does occur.[10]

The size and age of the wound are the last factors to take into account. While most clinicians are not comfortable closing large lacerations with tissue adhesives, there is evidence that is an acceptable practice. A study of 209

Table 1. Wound Evaluation[14]

Wound History	Medical History	Physical Exam	Procedure
• Mechanism of injury	• Anticoagulants	• Location	• Anesthesia
• Age of wound	• Last tetanus	• Length	• Wound cleansing
• Foreign body	• Diabetes	• Depth	• Debridement
	• Allergies	• Cleanliness	

Table 2. Advantages of Tissue Adhesives[10]

- Maximum strength in 2 ½ minutes
- Wound integrity same as sutures at 7 days
- Faster repair time
- Water-resistant, bacteriostatic covering
- Does not require removal of sutures
- No needles = better patient acceptance

Table 3. Contraindications to Tissue Adhesives[10]

- Bites, punctures or crush wounds
- Jagged or stellate lacerations
- Contaminated wounds (especially animal bites)
- Bleeding wounds (hematoma formation)
- Mucosal surfaces, axilla and perineum (high-moisture areas)
- Hands, feet and joints (unless kept dry and immobilized)

patients with lacerations with a mean length of 16 cm (range 4-69 cm) found that high-viscosity tissue adhesive provided epidermal wound closure equivalent to that of other sutures with a trend of decreased incidence of wound infection.[19] Another case report showed that tissue adhesive can be used to close a very large skin tear on the dorsum of the forearm of an elderly person.[21] Despite this, most clinicians are not comfortable with closing large lacerations and agree that tissue adhesive should not be used for lacerations on high-tension areas of the body such as the lower leg. One group of plastic surgeons recommends that tissue adhesives be used for lacerations 4 cm and smaller.[20] Lastly, although there is no available literature, most clinicians would agree that wounds over 24 hours old should not be closed using tissue adhesives. One small study found that skin tears of all types treated within 8 hours after injury—including very large ones—can be safely closed using topical adhesive.[22]

Application

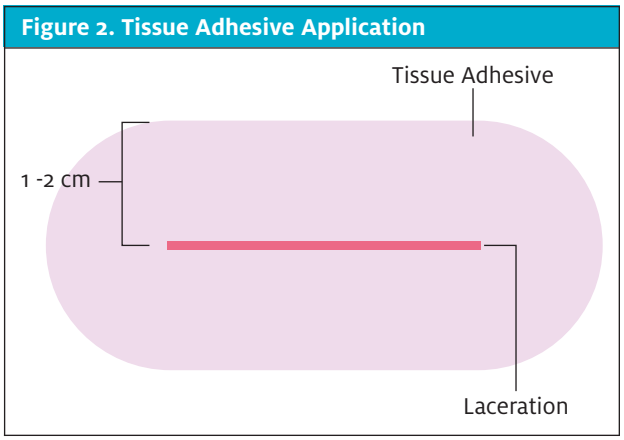
Using tissue adhesives is significantly quicker than using sutures. The manufacturer's product information provides step-by-step instructions for application.[23] One study found that time in a pediatric emergency department was reduced from 106 minutes to 69 minutes by using tissue adhesive instead of sutures The most important thing when using tissue adhesives is to not allow the glue to enter into the wound or dribble to important structures near the wound, such as the eye. Two studies have definitively shown that interposing glue into the wound results in greater scarring.[2,24] Techniques to avoid migration of tissue adhesive into the eye are discussed in the troubleshooting section of this article.

Tissue adhesive should be applied so that there is 1 to 2 cm of width on either side of the laceration, as shown in **Figure 2**. This is very important because the most common cause of tissue adhesive failure is substrate failure. Increasing the area that the tissue adhesive is in contact with skin can minimize substrate failure. One exception to this rule is when using tissue adhesive on a finger. To prevent it from acting as a constricting band, care should be exercised to ensure that adhesive is not applied circumferentially around the finger.

When using tissue adhesives on children, it is also good to be cognizant that the polymerization reaction causes heat to be released. Most adults have thicker skin and will not notice this, however, occasionally young children may become scared when they feel the adhesive become warm.[3] This usually lasts no more than 2 to 3 seconds. Also, because tissue adhesive works by a polymerization process and not an evaporative process, blowing air on the liquid adhesive will not make it polymerize any faster and doing so risks causing contamination from spewed saliva.

It is also advisable to avoid references to tissue adhesives as "superglue" in front of patients or parents. One case report found that a parent, trying to save money, applied superglue to his child's wound thinking it was the same thing as tissue adhesives. Superglue polymerizes much faster than tissue adhesives and actually caused significant first-degree burns to the child in the case report.[25] Thus, clinic staff should be careful to

Figure 2. Tissue Adhesive Application



avoid using the term "superglue" when referring to tissue adhesives.

Aftercare

Tissue adhesive films form excellent microbial barriers and are effective in protecting wounds from external bacterial invasion and reducing bacterial contamination.[26,27] Because tissue adhesives form their own waterproof, antimicrobial barrier, no additional dressings are required.[28] Most tissue adhesive manufacturers recommend not soaking the film and only letting it get wet briefly in the shower. While this is reasonable, a study found that exposure of tissue adhesive to daily soaking in warm, soapy water for an hour at a time shortens the sloughing time by only 1 day (5.2 to 4.2 days).[29] It is important to emphasize to the patient not to apply antibiotic ointment to the wound, as that will dissolve the tissue adhesive.

Troubleshooting

The main challenge of applying tissue adhesive is its tendency to migrate away from the wound site. Newer high-viscosity tissue adhesives are less likely to migrate than older, lower-viscosity tissue adhesives.[30] Currently, Dermabond Advanced® is the most viscous tissue adhesive available and has been shown to migrate the least distance from the wound site.[31] However, even when using high-viscosity tissue adhesive, special care should be taken when working in proximity to the eyes to avoid inadvertent tarsorrhaphy.[32] Placing the patient in the Trendelenburg position before repairing lacerations above the eyes can prevent runoff into the eyes.

Migration of glue into the eye. If the eyes are inadvertently glued closed, that can easily be fixed with repeated application of a petroleum-based ointment such as

bacitracin to speed up the breakdown process. Tissue adhesive can also be removed using silver sulfadiazine, but that should not be used in the eye. Do not forcefully separate the eyelids because that can cause cosmetic deformity. If some tissue adhesive inadvertently gets directly onto the cornea or sclera, the first step should be to try and flush it out while it is still liquid, using the eyewash station, but that must be done in less than 10 seconds. If the tissue adhesive has already polymerized prescribe bacitracin ophthalmic ointment to be applied into the affected eye 4 times a day while the patient waits to see an ophthalmologist. Although the patient may be frightened, upset, and have a painful bloodshot eye from the heat released by the polymerization reaction, emergency ophthalmology consult is not necessary. An urgent appointment in 1 to 2 days to remove any remaining tissue adhesive and to evaluate damage to the cornea is adequate. Some tissue adhesives are actually being tested as treatment for corneal abrasions and corneal lacerations.[33] However, the author reminds the reader that runoff of tissue adhesive into the eye is preventable.

Another simple method to avoid tissue adhesive migration is to create a wall of bacitracin ointment in the surrounding area. The ointment physically stops the migration of the liquid and also chemically prevents it from binding to the skin to which it is applied. Once the tissue adhesive has polymerized, the ointment should be wiped away from the wound while taking care not to let it come in contact with the polymerized film.

Tissue adhesive failure. There are three types of failure of a tissue adhesive: cohesive, adhesive and substrate failure.[34] When failure occurs with tissue adhesives, it is usually due to substrate failure as a result of the adhesive peeling away from the skin surface. It is not usually due to failure of the mechanical properties of the polymer.[35] In cases of wound dehiscence, the failure appears to be at the skin-glue interface (substrate failure) rather than because of direct failure of the glue (cohesive failure). One study suggests that skin edges be prepared with alcohol to minimize oil interposition and increase skin adhesion in order to minimize the probability of substrate failure.[21]

On fingers, rubber bands can be used as tourniquets to control bleeding and allow for easier application. After allowing 60 seconds for the adhesive to polymerize, the tourniquet can be removed. Minimize the chance of blood seepage or hematoma formation by having the patient keep his or her hand elevated above the level of the heart for at least 2 hours.

If a patient returns with a dehisced wound, Steri-Strips® are often all that is needed support the healing wound. If a non-infected wound is not a candidate for healing by secondary intention or use of wound tapes, the laceration to convert into a fresh wound before re-applying tissue adhesive or suturing. Of note, if a child or a developmentally disabled patient removed the tissue adhesive, do not re-apply. Support the wound with Steri-Strips® or, if needed, close with sutures.

Allergic reactions. There is clinical evidence that in some cases, use of tissue adhesive can lead to a foreign body reaction.[36] One case report showed that a young hair dresser developed an allergic contact dermatitis to two "instant glues" used to attach false hair.[37] Another case report was of allergic eyelid contact dermatitis caused by ethyl-cyanoacrylate containing eyelash adhesive.[38]

In the arena of wound repair, however, foreign body reaction to tissue adhesive is mitigated if the polymer is not allowed to interpose into the wound. The degradation product of polymerized cyanoacrylate is cyanoacetate and formaldehyde. While it is true that formaldehyde is toxic, the longer alkyl chains of modern tissue adhesives slow degradation, significantly limiting accumulation of byproducts to amounts that can be effectively eliminated by tissues.[14] However, tissue adhesive remains contraindicated in people allergic to formaldehyde.

Reimbursement

Tissue adhesive repair is reimbursed by commercial insurance other than Medicare at the same level as a laceration repair with sutures. When billing for tissue adhesive repair with Medicare, you must use the G0168 code. The G0168 code is a flat rate reimbursement irrespective of the length of the laceration.

Medicare assigns tissue adhesive repair a lower RVU (relative value unit) than suture repair, and thus reimburses at a lower rate, which varies in each state or may not be reimbursed at all. However, if a single laceration is closed with a combination of both sutures and tissue adhesive, the provider can bill for the higher-paying laceration repair CPT code (12001-13160). As with laceration repair with sutures, location, length, and depth must be documented. Billing for multiple lacerations using both tissue adhesive and sutures is beyond the scope of this article and the author advises the reader to consult appropriate references as needed.

Uses Beyond Wound Closure

Tissue adhesives have been used for over 100 different "off-label" applications, including skin graft fixation,

temporary otoplasty, dental trauma, corneal abrasions, wound sealant, aneurysm embolization, and clitoral avulsion.[39-41] Tissue adhesives can also be used to safely repair nail bed lacerations, without magnification, and with only basic surgical training.[15] Tissue adhesives appear to be an ideal tool for repairing a split nail plate, no matter how fragmented, and for reaffixing the small pieces of nail for protection of the injured nail bed.[15,42,43] When using tissue adhesive for nail bed laceration repair, do not to glue the eponychium to the nail bed because that will interfere with nail growth.

One study found that tissue adhesives excel in the treatment of painful superficial finger fissures caused by the cold temperatures of living in Antarctica.[44] Another group also found that tissue adhesive could be used to aid scalp laceration repair using the modified version of the hair apposition technique. In this technique, hair is used to close a laceration by tying knots from opposite sides of the wounds. A single drop of tissue adhesive is used to hold the hair knots together.[45] Unfortunately, clinicians cannot bill for a laceration repair using that technique. ■

References

1. Penoff J. Skin closures using cyanoacrylate tissue adhesives. Plastic Surgery Educational Foundation DATA Committee. Device and Technique Assessment. *Plastic Recon Surg*. 1999;103(2):730-731.
2. Watson DP. Use of cyanoacrylate tissue adhesive for closing facial lacerations in children. *BMJ*. 1989;299(6706):1014.
3.Osmond MH. Pediatric wound management: the role of tissue adhesives. *Ped Emerg Care*. 1999;15(2):137-140.
4.Milne CT, Corbett LQ. A new option in the treatment of skin tears for the institutionalized resident: formulated 2-octylcyanoacrylate topical bandage. *Geriatric Nursing*. 2005;26(5):321-325.
5.Gordon CA. Reducing needle-stick injuries with the use of 2-octyl cyanoacrylates for laceration repair. *J Acad Nurse Pract*. 2001;13(1):10-12.
6. Singer AJ, Hollander JE, Valentine SM, Turque TW, McCuskey CF, Quinn JV. Prospective, randomized, controlled trial of tissue adhesive (2-octylcyanoacrylate) vs standard wound closure techniques for laceration repair. Stony Brook Octylcyanoacrylate Study Group. *Acad Emerg Med*. 1998;5(2):94-99.
7. Hollander JE, Singer AJ. Application of tissue adhesives: rapid attainment of proficiency. Stony Brook Octylcyanoacrylate Study Group. *Acad Emerg Med*.1998;5(10):1012-1017.
8. Quinn J, Maw J, Ramotar K, Wenckebach G, Wells G. Octylcyanoacrylate tissue adhesive versus suture wound repair in a contaminated wound model. *Surgery*. 1997;122(1):69-72.
9. Wilbur L, Seupaul R. Evidence-based emergency medicine. Are tissue adhesives an acceptable alternative for simple lacerations? *Annals Emerg Med*. 2011;58(4):373-374.
10. Bruns TB, Worthington JM. Using tissue adhesive for wound repair: a practical guide to dermabond. *Am Family Phys*. 2000;61(5):1383-1388.
11. Singer AJ, Quinn JV, Clark RE, Hollander JE, TraumaSeal Study G. Closure of lacerations and incisions with octylcyanoacrylate: a multicenter randomized controlled trial. *Surgery*. 2002;131(3):270-276.
12. Quinn J, Wells G, Sutcliffe T, et al. A randomized trial comparing octylcyanoacrylate tissue adhesive and sutures in the management of lacerations. *JAMA*. 1997;277(19):1527-1530.
13. Resch KL, Hick JL. Preliminary experience with 2-octylcyanoacrylate in a pediatric emergency department. *Ped Emerg Care*. 2000;16(5):328-331.

14. Trott AT. Cyanoacrylate tissue adhesives. An advance in wound care. *JAMA*. 1997;277(19):1559-1560.
15. Yam A, Tan SH, Tan AB. A novel method of rapid nail bed repair using 2-octyl cyanoacrylate (Dermabond). Plastic and reconstructive surgery. 2008 Mar;121(3):148e-9e.
16. Shapiro AJ, Dinsmore RC, North JH, Jr. Tensile strength of wound closure with cyanoacrylate glue. The American surgeon. 2001 Nov;67(11):1113-5.
17. Wackett A SA. The role of topical skin adhesives in wound repair. Emer Med. 2009(41):31-5.
18. Bresnahan KA, Howell JM, Wizorek J. Comparison of tensile strength of cyanoacrylate tissue adhesive closure of lacerations versus suture closure. Annals of emergency medicine. 1995 Nov;26(5):575-8.
19. Mattick A, Clegg G, Beattie T, Ahmad T. A randomised, controlled trial comparing a tissue adhesive (2-octylcyanoacrylate) with adhesive strips (Steristrips) for paediatric laceration repair. Emergency medicine journal : EMJ. 2002 Sep;19(5):405-7.
20. Xu X, Lau K, Taira BR, Singer AJ. The current management of skin tears. The American journal of emergency medicine. 2009 Jul;27(6):729-33.
21. Lo S, Cullen K, Giele H, Buckley P. Concerns over the use of tissue adhesive in facial lacerations: recommendations and a suggestion to increase lag bond strength. Plastic and reconstructive surgery. 2005 Oct;116(5):1562-3.
22. Singer AJ, Dagum AB. Current management of acute cutaneous wounds. The New England journal of medicine. 2008 Sep 4;359(10):1037-46.
23. Dermabond Advanced® Instructions for Use. 2013 [cited; Available from: http://www.dermabond.com/product/index.html
24. Swan MC, Descamps MJ, Broadhurst A. Scar tattooing following the use of tissue adhesive. Plastic and reconstructive surgery. 2006 Mar;117(3):1054-5.
25. Cascarini L, Kumar A. Case of the month: Honey I glued the kids: tissue adhesives are not the same as "superglue". Emergency medicine journal : EMJ. 2007 Mar;24(3):228-9.
26. Narang U, Mainwaring L, Spath G, Barefoot J. In-vitro analysis for microbial barrier properties of 2-octyl cyanoacrylate-derived wound treatment films. Journal of cutaneous medicine and surgery. 2003 Jan-Feb;7(1):13-9.
27. Mertz PM, Davis SC, Cazzaniga AL, Drosou A, Eaglstein WH. Barrier and antibacterial properties of 2-octyl cyanoacrylate-derived wound treatment films. Journal of cutaneous medicine and surgery. 2003 Jan-Feb;7(1):1-6.
28. Singer AJ, Quinn JV, Hollander JE. The cyanoacrylate topical skin adhesives. The American journal of emergency medicine. 2008 May;26(4):490-6.
29. Carleo C, Singer AJ, Thode HC, Jr. Effect of frequent water immersion on the rate of tissue adhesive sloughing: a randomized study. Cjem. 2005 Nov;7(6):391-5.
30.Singer AJ, Nable M, Cameau P, Singer DD, McClain SA. Evaluation of a new liquid occlusive dressing for excisional wounds. Wound repair and regeneration : official publication of the Wound Healing Society [and] the European Tissue Repair Society. 2003 May-Jun;11(3):181-7.
31.Singer AJ PL. A comparative study of the surgically relevant mechanical characteristics of topical skin adhesives. Academic emergency medicine : official journal of the Society for Academic Emergency Medicine. 2012;19:1281-6.
32.Rouvelas H, Saffra N, Rosen M. Inadvertent tarsorrhaphy secondary to Dermabond. Pediatric emergency care. 2000 Oct;16(5):346.
33.Papadopoulou DN, Sionga A, Karayannopoulou G, et al. Experimental application of tissue adhesives in corneal traumas. European journal of ophthalmology. 2013 Mar 4:0.
34.Quinn JV. Tissue adhesives in clinical medicine. 2nd ed. Hamilton: BC Decker, Inc.; 2005.
35.Singer AJ ZT, Rooney J, Cameau P, Rudomen G, McCain SA. Comparison of wound bursting strength and surface characteristics of FDA approved tissue adhesives for skin closure. J Adhes Sci Technol. 2004;18:19-27.
36.Dragu A, Unglaub F, Schwarz S, et al. Foreign body reaction after usage of tissue adhesives for skin closure: a case report and review of the literature. Archives of orthopaedic and trauma surgery. 2009 Feb;129(2):167-9.
37.Tomb RR, Lepoittevin JP, Durepaire F, Grosshans E. Ectopic contact dermatitis from ethyl cyanoacrylate instant adhesives. Contact dermatitis. 1993 Apr;28(4):206-8.
38.Bhargava K, White JM, White IR. Eyelid allergic contact dermatitis caused by ethyl cyanoacrylate-containing eyelash adhesive. Contact dermatitis. 2012 Nov;67(5):306-7.
39. Hallock GG. Expanded applications for octyl-2-cyanoacrylate as a tissue adhesive. Annals of plastic surgery. 2001 Feb;46(2):185-9.
40.Gulalp B, Seyhan T, Gursoy S, Altinors MN. Emergency wounds treated with cyanoacrylate and long-term results in pediatrics: a series of cases; what are the advantages and boards? BMC research notes. 2009;2:132.
41.Berger A, Worly B. Clitoral Avulsion Successfully Repaired with 2-Octylcyanoacrylate. The journal of sexual medicine. 2013 Feb 27.
42. Hallock GG, Lutz DA. Octyl-2-Cyanoacrylate adhesive for rapid nail plate restoration. The Journal of hand surgery. 2000 Sep;25(5):979-81.
43. Richards AM, Crick A, Cole RP. A novel method of securing the nail following nail bed repair. Plastic and reconstructive surgery. 1999 Jun;103(7):1983-5.
44. Ayton JM. Polar hands: spontaneous skin fissures closed with cyanoacrylate (Histoacryl Blue) tissue adhesive in Antarctica. Arctic medical research. 1993 Jul;52(3):127-30.
45. Karaduman S, Yuruktumen A, Guryay SM, Bengi F, Fowler JR, Jr. Modified hair apposition technique as the primary closure method for scalp lacerations. The American journal of emergency medicine. 2009 Nov;27(9):1050-5.

Case Report

Perichondritis

Urgent message: With the popularity of piercing of the ear cartilage, urgent care providers need to be on the alert for perichondritis and to treat it promptly.

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Case Presentation

A 26-year-old female presented with complaints of a swollen right pinna for 2 weeks. The swelling progressively worsened over time. In addition, she also complained of severe pain of the right pinna, with an intensity of 7/10, with no radiation and no aggravating or relieving factors. One week previously, she had been examined in an urgent care facility and was given a 10-day course of amoxicillin for presumed acute otitis externa. However, the infection continued to worsen. There was no history of trauma to the ear and no other significant medical history.

Physical Exam

On examination, the patient had an inflamed, erythematous and tender right pinna (Figure 1). The pre- and post-auricular lymph nodes were enlarged and tender. Examination of the rest of the ear was normal and hearing was not impaired. She was afebrile and all other systemic examinations were normal.

Diagnosis

Perichondritis

Anatomy of the External Ear

The external ear consists of the pinna, a fan-like projection that works to collect sound, and the external acoustic meatus. The pinna is composed of elastic cartilage covered by a layer of connective tissue called perichondrium.[1] The blood supply to the ear arises from the posterior auricular and superficial temporal arteries.

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Differential Diagnoses

Table 1 lists differential diagnoses. The patient had no exposure to swimming and no involvement of deeper structures or soft tissues. With involvement of the pinna, diagnosis of perichondritis was favored.

Perichondritis is an infection of the skin and soft tissues surrounding the cartilage of the external ear, including the pinna. The tissues of the pinna receive less humoral circulation, therefore, any injury or infection takes longer to heal, and any edema and exudates take longer to be absorbed, increasing the likelihood of secondary infection and abscess formation.[2]

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Figure 1.

The pinna is inflamed, erythematous, and tender.

Table 1. Differential Diagnosis

- Simple otitis externa ("swimmer's ear")
- Malignant external otitis
- Cellulitis
- Perichondritis
- Abscess

Causes

The most common bacteria that cause perichondritis are *Pseudomonas aeruginosa*. *Staphylococcus aureus, Escherichia coli* and *Proteus* species, with *P. aeruginosa* being the most common culprit.[3] Perichondritis is usually a result of secondary infection of the ear after traumatic injury.

In recent years, penetrating injuries to the ear such as acupuncture and cartilage piercing have increasingly becoming causes of perichondritis.[4] In fact, ear piercing through the cartilage is probably the most significant risk factor today.[5] The cartilage itself is relatively avascular, and trauma via piercing devascularizes it even further, providing a good medium for bacteria that could be introduced by the piercing needle or gun.[5]

Surgery and burns can also cause perichondritis, and there have been rare cases of the infection occurring secondary to furunculosis, chronic ear discharge, congenital intra-auricular sinuses, allergy, diffuse lesions following herpes zoster, or insect bites.[2,3] Perichondritis can also develop secondary to malignant otitis externa.[3]

Symptoms

Perichondritis usually presents first as a dull pain that increases in severity, accompanied by redness and swelling.[2] The redness usually surrounds an area of injury, such as a cut or scrape. The infection begins in the helix and anti-helix, and resembles cellulitis, a simple skin infection; however, it quickly worsens and involves the perichondrium. In severe cases, an abscess can develop, peeling the perichondrium off the cartilaginous layer and resulting in necrosis of the cartilage[1,4] and deformation of the ear, known as "cauliflower ear."[2] In such advanced cases, the patient may be febrile, and there may be fluid draining from the wound.

Exams and Tests

Perichondritis is diagnosed based on the patient's medical history and by examination of the ear. If there is a history of trauma to the ear and the ear is red and tender, perichondritis is the most likely diagnosis. There may be a change in the normal shape of the ear.

Treatment

Treatment consists of broad antibiotic coverage, either by mouth or directly into the bloodstream via an intravenous line. Because most of the cases are associated with *P. aeruginosa* bacteria, empiric treatment would include a fluoroquinolone, as these drugs are the only oral treatment effective against these bacteria.[4] If there is a trapped collection of pus or abscess formation, surgical intervention, such as needle aspiration or incision and drainage, may be necessary to drain the fluid and remove any dead skin and cartilage. Recent studies have also shown success with the newly developed method

of aspiration, injection of streptomycin and hyaluronidase directly into the infected site, and finally triamcinolone to restrict inflammation.[2]

Complications

If antibiotics are taken early, full recovery from perichondritis is expected. In more advanced cases, the infection can involve the ear cartilage. This is called "chondritis," and with such an infection, part of the ear may die and need to be surgically removed. A perichondrial abscess may also develop. If so, plastic surgery will be needed to restore the ear to its normal shape.[2-4]

Prevention

The best way to prevent perichondritis is to avoid piercing one's ear through the cartilage, as opposed to the ear lobe. The popularity of cartilage piercing has led to a significant increase in the number of perichondritis and chondritis cases.[5]

Conclusion

Although ear piercing was not the cause of the perichondritis in our patient, the culture of ear piercing in young adults has increased recently. If it is not done properly and sterile techniques are not used carefully, young adults may end up having the complication of perichondritis. It is important for urgent care physicians to be familiar with this common condition and treatment should be started as early as possible to prevent permanent damage to a soft cartilage. ■

References

1. Moore KL, Dalley AF. Clinically Oriented Anatomy, Fifth Edition. Philadelphia: Williams & Wilkins, 2006:1022-1024.
2. Pattanaik S. Effective, simple treatment for perichondritis and pinna haematoma. *J Laryngol Otol.* 2009;123:1246-1249.
3. Prasad HK, Sreedharan S, Prasad HS, Meyyappan MH, Harsha KS. Perichondritis of the auricle and its management. *J Laryngol Otol.* 2007;121:530-534.
4. Davidi E, Paz A, Duchman H, Luntz M, Potasman I. Perichondritis of the auricle: analysis of 114 cases. *Isr Med Assoc J.* 2011;13:21-24.
5. van Wijk MP, Kummer JA, Kon M. Ear piercing techniques and their effect on cartilage, a histologic study. *J Plast Reconstr Aesthet Surg.* 2008;61:S104-S109.

Achieving Consistency and Scalability in Urgent Care Service Delivery

Urgent message: Investing time in designing repeatable processes and documentation can pay off in a more efficient, effective, and scalable urgent care operation.

ALAN A. AYERS, MBA, MAcc

Introduction

Despite management's best intentions to deliver extraordinary patient experiences, many times employees just don't know what to do. Front-line staff members are often conflicted between "doing what's right" for the business, avoiding management scrutiny, exerting extra unrewarded effort, and "doing what's right" for the patient.

Ultimately, employees should act in ways that exemplify the center's "brand promise"—what identifies the center in the minds of consumers, distinguishes it from competitors, and constitutes the reason patients choose the center over other options. For successful urgent care centers, the "brand promise" typically focuses on delivering an outstanding patient experience.

But lack of employee direction leads to inconsistency in service delivery—among patient encounters, between center locations, in quality of care, and in medical outcomes—which necessarily undermines the brand. Employees should never be left guessing what to do, which is why successful urgent care centers implement documented, measurable, improvable processes supported by technology.

What Is a Repeatable Process?

Because many urgent care centers have not documented their operational processes, employees spend time recreating processes every time they're carried out. Staff may be intent on satisfying patients, but they perform their jobs on-the-fly and the processes they follow may vary significantly in terms of order, attention to detail, and quality. While a majority of patients may experience the "brand promise," there will be significant variation between those who are highly satisfied and highly dissatisfied with the service received. Consider the dif-

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- OsteoArthritis® Centers of America

JUCM-0913

Please visit http://www.ucaoa.org/vendors_csp.php to learn more about these companies.

Table 1: Tribal Knowledge vs. Repeatable Processes

Tribal knowledge is "information that is known to individuals within a group but not to those outside of it." Unlike a process that can be trained, tribal knowledge is "passed down" as staff learns "by doing," from other colleagues, and through "trial-and-error." The problem with tribal knowledge in an urgent care center is that it's not scalable, there's a significant productivity ramp-up period for new hires, knowledge leaves the organization with its employees, its effectiveness is speculative and hypothetical, and it can change over time based on ideas and experiences that may not serve the center's best business interest.

By contrast, a *repeatable process* is documented, tested, and integrated with other processes before staff is formally trained in its execution. A repeatable process is facilitated by technology and is designed around metrics that can be tracked over time to evaluate the efficiency, effectiveness, and consistency of the process. When processes are documented, internal communication improves as managers can ask staff, "What phase are you in with this patient?" The manager will then know what the staff member is working on, what the next steps should be, and how the manager can help expedite flow or resolve any issues. This common understanding of what everyone in the center should be doing is the basis for having a "service culture."

ferences between "tribal knowledge" and "repeatable processes" in **Table 1**.

A "repeatable process" refers to performing a task numerous times with a certain level of predictability in terms of the quality of the output. For example, when registering a patient, certain steps should occur, such as scanning identification cards, verifying the patient's correct address and phone number, ensuring that insurance coverage is valid, and collecting co-pays, deductibles, and prior balances. If a front-office assistant fails to follow these steps consistently, the center will see increases in rejected claims, patient receivables, returned mail, and operating losses.

The major processes in an urgent care center should be documented and from those processes, policies and instructions created for employees to carry out their responsibilities. Once standardized, a process can be measured, which allows monitoring and facilitates improvements over time.

How To Develop Repeatable Processes

The urgent care operator's goal should be a "playbook" for every position in the center. In football, the coach's playbook contains descriptions and diagrams of plays that the team has practiced and is capable of executing in a game. More succinct, a playbook is a collection of tactics and methods that have been tested and tried. In an urgent care center, an operational playbook includes roles and responsibilities, policies and procedures, workflows, checklists, templates, forms, and various other job aids.

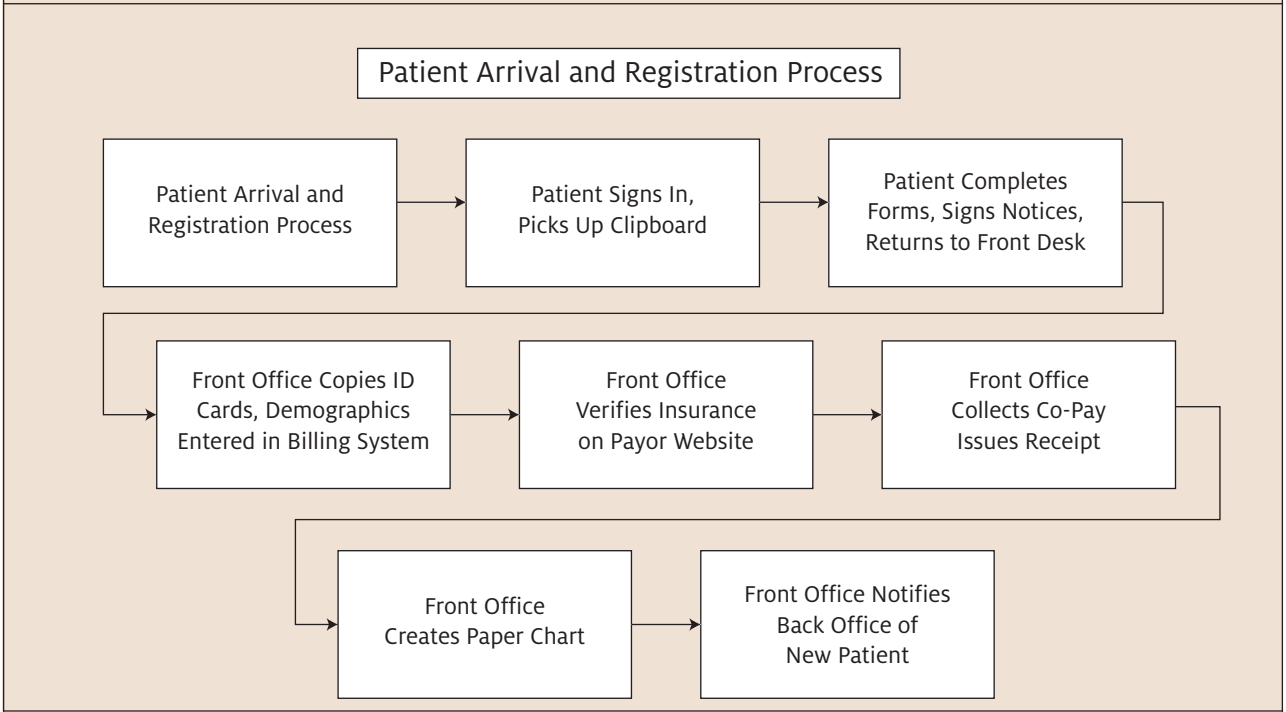
"Employees should never be left guessing what to do, which is why successful urgent care centers implement documented, measurable, improvable processes supported by technology."

It's difficult to come up with the ideal repeatable process unless you fully grasp how the center is functioning today. The development of a playbook starts with documenting all the processes and procedures currently used in the urgent care center. As illustrated in **Figure 1**, simple flow diagrams can be used to understand every process in the center. Involve front-line staff, medical providers, center support functions, and senior management in process documentation via brainstorming sessions, individual interviews, and direct observation. Engaging everyone in the center can provide a 360-degree view as to how things are working, bottlenecks and pain points, and opportunities for improvement.

After the process is understood, the next step is to identify measures around the processes. Measures related to time, quantity, errors, cost, supplies, resource count, and profit should be tied to the performance of a specific process, such that the process can be monitored over time. Monitoring should be detailed to the level of a center, position, or employee. For example, when looking at the accuracy of front-office data entry, the number of "zero EOBs" is a good metric, but the ability to tie an EOB to a specific event and then aggregate those events to demonstrate trends will demonstrate where the process is and is not being followed. Corrective action can thus follow.

Figure 1. Mapping of Steps from Arrival to Departure

Anyone who has spent more than 30 minutes in the front office of a busy urgent care center would make the same observation—the same basic steps occur for every patient who arrives at the center. Understanding that customer service is a process means that every activity in a center can be documented using simple flow charts as illustrated. The starting point of creating an operations playbook is to follow a patient through the center and note every time the patient acts or is acted upon.



Ayers A. Measuring Patient Flow in Urgent Care, Urgent Care Association of America Convention, Chicago, May, 2011.

Continual Improvement

Even when a process is intended to be repeated without variation, that doesn't mean the process can't adapt and change over time. As the details of health care reform become more defined, urgent care centers can expect to see significant changes related to billing, reimbursement, technology, and patient utilization. In addition, as new competitors enter the fray, urgent care centers will be forced to examine their staffing models, marketing tactics, and product line offerings. So, to be successful over time, it's clear that a center's processes must be able to adapt and change.

In addition to monitoring metrics, an urgent care operator should engage key stakeholders including front-line staff, providers, center support functions, and even patients in periodically reviewing and suggesting improvements to processes. Once a detailed playbook is in place, updating processes is as easy as replacing pages in the playbook because the structure and context for the process is already in place.

Before implementing a process in a center, however, the process should be piloted. A pilot is a small-scale preliminary study conducted in order to evaluate the feasibility, efficiency, dependencies, and adverse impact of a process prior to its full implementation. Once a process has been piloted, refined, and agreed upon by the stakeholders, then the playbook can be updated and the process implemented through staff training.

Technology Integration

Technology forms the backbone of repeatable processes. Consider the use of technology to support front-end processes in another industry—the airlines. Whereas all passenger transactions—simple or complex—were at one time handled at the ticket counter, today customers largely use self-service technologies to buy tickets online, check-in for flights using a smart phone app, and check bags using a street-side kiosk. These technologies have

Table 2: The Conundrum: Repeatable Processes or Repeatable Results?

Repeatable processes are a defining feature of an "efficient bureaucracy"—an organizational structure with concentrated administrative power, hierarchical management, and precisely defined rules and procedures. Unfortunately, when we think of bureaucracy, we often think of red tape, de-motivated employees, and an internal focus that disregards customer service. Government agencies like the Postal Service or Bureau of Motor Vehicles frequently come to mind. It is true that in many fields, a rigid bureaucracy that prioritizes process over results can be a hindrance to growth, service, and profitability. But consider the difference between:[1]

- Focusing on the Process: Taking the same route to work every single day, without regard to weather, construction, school in session, or traffic patterns; and
- Focusing on the Results: Arriving at work at 8:30 am every day, varying the route and the method (auto, bicycle, train/bus) as changing conditions demand.

Theoretically, management should not care about the process, but rather, the results. However, when the nature of work is regulated, repetitive, constant, and measurable—such as an urgent care center's front-office function—the only way to achieve consistent results over time is by identifying the most efficient way to do the work, building systems and processes to facilitate, and then repeating for every transaction. Experienced managers learn that operational results can only be attained consistently when everyone is following the same playbook. Such is the definition of an "efficient bureaucracy."

Adapted from Amber SW. "Bureaucracy Isn't Discipline," IBM developerWorks Blog, 18 Nov 2008. Accessed January 4, 2013.

not only reduced the costs of operating the ticket counters, but they've also freed airline agents to spend more time helping those customers most "in need" with cancelled flights or missed connections.

Likewise, an urgent care center should have technology that fully supports its processes. The packaged practice management and electronic medical record systems used in most urgent care centers are built around best-practice workflows, therefore, a center ideally should adapt its processes to the technology in place. As organizations grow, they acquire the means to build custom technology solutions or modify existing technology to meet their specific process needs.

Why Repeatable Processes Are Necessary for Growth

There are a number of ways that an urgent care center can grow. As patient volume increases, the center can extend its hours, expand its square footage, and hire more providers. It can also introduce new services, perhaps expanding into occupational medicine and travel health. Or, it can open additional locations to increase its presence in a community. Regardless of how it grows, an urgent care center cannot grow if its operating model is not scalable.

Scalability refers to the ability of a process or system to accommodate increased volume. Absent a focus on developing repeatable processes, organizations typically become more complex as they grow. The demands of an expanding number of products, systems, and protocols can be overwhelming to staff. As matrix layers of management become further removed from front-end delivery, ever-increasing demands of the front-line mean that productivity, quality, and the patient experience begin to suffer. Growth stalls and from a profit and loss perspective, the organization may end up worse off than if it had remained small and focused. Key to scalability is thus simplicity and flexibility—processes and systems that are easy to use and can be modified to fit an increasing number of business scenarios.

Table 2 demonstrates that when work is repetitive in nature and output is measurable, the most effective organizational structure is one built around repeatable processes.

Conclusion

The development of repeatable processes is the basis for building and running an efficient, effective and scalable urgent care operation. Achieving consistent quality results is therefore dependent on investing time in process design and documentation. Once an operational playbook is developed and processes are implemented, they must be measured and monitored in the pursuit of continuous operational improvement. ■

Additional References

"The Strategic Principles of Repeatability," James Allen and Chris Zook, Bain & Company, May 4, 2012.
http://www.bain.com/publications/articles/the-strategic-principles-of-repeatability.aspx Accessed January 4, 2013

Allen J, Zook C. Repeatability: Build Enduring Businesses for a World of Constant Change. 2012. Harvard Business Press Books

Latham A. Are We STILL Making Mistakes? - Five Keys to Predictable, Repeatable Processes. 2005. www.uncommonclarity.com

Kennedy P, Leathley C, Hughes C. Clinical practice variation. MJA. 2010;193(8)

Madsen L. Healthcare Business Intelligence: A Guide to Empowering Successful Data Reporting and Analytics. 2012. Wiley

Page S. Power of Business Process Improvement - 10 Simple Steps to Increase Effectiveness, Efficiency, and Adaptability. 2010

INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

FIGURE 1

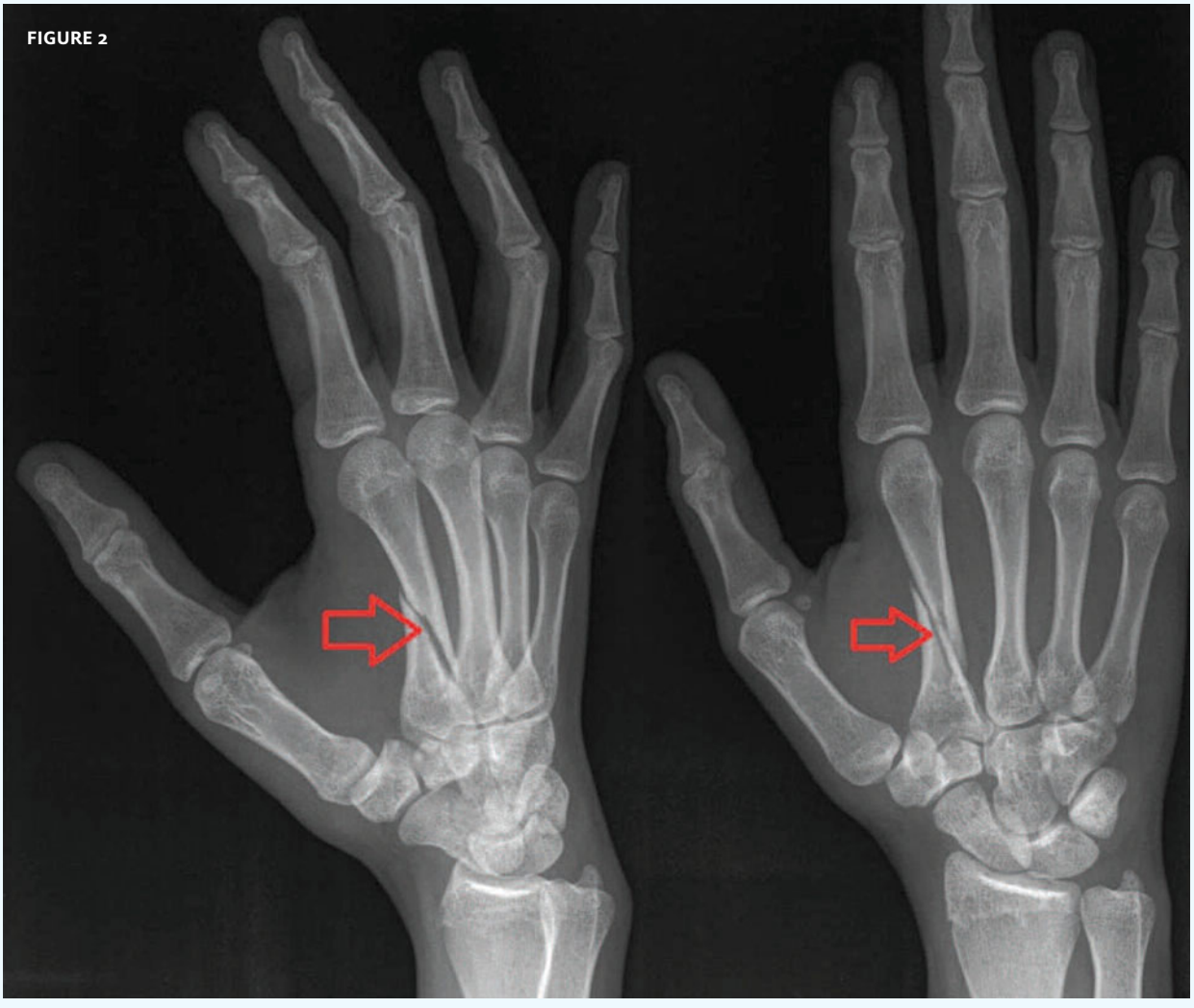
The patient, a 16-year-old male, presented after a blow to his right hand.

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 second metacarpal (arrow). Oblique fractures are at risk for rotational deformity and should prompt immediate referral when deformity is present.

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

The New Normal of Medical Malpractice and How We Are Making it Worse

JOHN SHUFELDT, MD, JD, MBA, FACEP

I am tangentially involved in a medical malpractice suit in which the physician in question complied completely with the standard of care. Her documentation was great, her care exceptional, there was no discrepancy between her charting and the nurses' charting, the doctor-to-doctor hand-off went well, and she communicated with the patient and family. Unfortunately, the ultimate patient outcome was horrible. In the aftermath, the physician was named in a wrongful death suit simply because of what another physician said to the family. Parenthetically, the information relayed by that physician to the family was completely false and outside the scope of the physician's knowledge base.

The malpractice climate clearly has changed over the past few years, as demonstrated by data from Medscape's 2013 Malpractice report.[1] Here are some highlights from the report, which is based on data from 3,480 respondents representing 25 specialties who discussed their malpractice history and perspective.

- Sixty percent of physicians surveyed reported they had never been named in a malpractice suit. Thirty-one percent claimed that they were one of many parties named in a suit, whereas 9% said they were the only party named.
- Specialties most often named: Internal medicine (15%), family medicine (13%) OB/GYN (89%), psychiatry (8%), cardiology (6%), gastroenterology (6%), pediatrics (5%), emergency medicine (4%). The primary reason for these numbers is that there are more primary care physicians than specialty physicians.
- Of those sued, 35% of the time it was for failure to diagnose, 17% for failure to treat, and 4% for failure to give informed consent. The rest were made up of other categories that I suspect included wrongful death, loss of consortium, loss of a chance, and battery.
- Sixteen percent of the cases went all the way through trial and verdict, 5% said the case settled prior to the verdict being rendered, 18% went to depositions before being dismissed from the case, 27% related that the case was settled after depositions, and 24% were dismissed from the suit before the depositions.
- Twenty-eight percent of those surveyed spent more than 40 hours preparing their defense and 30% of the respondents spent more than 40 hours in court and on trial-related matters.
- The majority of cases (61%) were settled in less than 2 years and 89% of the cases were completed in less than 5 years. Of all the suits filed, physicians were completely exonerated 48% of the time. For 38% of cases, settlement was reached at some point before the verdict. In 95% of the cases, the plaintiff received either no award or some number less than $1 million.
- Although many states have "I'm sorry" laws, 93% of physicians surveyed felt that saying they were sorry would not have helped.
- Seventy percent of the physician surveyed stated that the insurer did not require or force them to settle. Note: You should check your policy to see if it states that the insurer can settle without your consent or, conversely, that you are responsible for any award greater than the amount for which the case could have been settled. This is called a hammer clause and it is not always readily apparent in malpractice contracts.
- In only 2% of the cases, the physician had to pay out of pocket and in 1% of the cases, the physician had to cover the award personally. Generally speaking, when physi-

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"Denigration of the care of ambulatory care providers by physicians (generally hospital-based physicians) was the prime causative factor in many malpractice suits."

cians have to pay the award personally it typically is due to alteration of the medical record, punitive damages, gaps in malpractice coverage, or if a choice to pay the damages personally. If the settlement is paid out of the provider's own funds rather than those of a professional corporation or business entity, it is not reportable to the National Practitioner Databank. Thus, on some occasions, physicians opt to pay personally as opposed to having the loss reported.

- Most physicians surveyed stated that their patients either didn't know about or were very supportive during the lawsuit process. In addition, most physicians believed that the suit had little effect if any upon their professional or employment relationships.
- Twenty-nine percent of those sued stated that they no longer trust patients and treat them differently. Six percent left the practice setting and 63% wrote that there was no change in how they practice or treated patients. Sixty-two percent of physicians surveyed felt that the results were fair.

Most importantly, when asked what advice they would give other doctors, the physicians who were sued offered the following advice:

- Follow-up on a patient's lab, pathology, and imaging reports even when you think the bases are covered.
- Practice defensive medicine. This may be somewhat taken out of context, inasmuch as we don't know the practice style before they were sued. For example, a physician may have been loath to document, provide informed consent, make appropriate referrals, or to order appropriate imaging.
- Document thoroughly and more often. Again, not knowing their baseline, the statement may be misleading.
- Dismiss patients in your practice who are rude, demanding or noncompliant.

Now let's get back to the malpractice case in which a colleague of mine was thrown under the proverbial bus by another physician. I'll often hear the plaintiff's bar say that the reason they do what they do is because we as physicians have "failed to police our own." A recent study published in *The Journal of General Internal Medicine*[2] seems to disprove this assertion, at least to the extent that we seem not to hesitate to be openly critical.

The authors of the study trained three actors on how to portray a patient with advanced lung cancer. The scenario the "pretend" patients gave was that they had recently moved to town after being treated by a physician who was ultimately unsure about their diagnosis and prognosis. Complete medical records were fabricated but all the documentation contained in the "pretend" records met or exceeded the applicable standard of care. These actors/patients made a total of 34 office visits among various primary care physicians and oncologists working in the community.

The actors were specifically told not to seek or to ask for opinions regarding the care rendered by their previous physician. Nevertheless, researchers found that in 41% of the cases, the physicians offered their opinion about the previously rendered care. Surprising, the vast majority of these opinions were harshly critical.

In my practice, I see this type of scenario play out almost daily. A patient presents from an urgent care and the emergency physician reviews the record, rolls his or her eyes, and says, "Wait, he sent you here for what?" Or, a consultant is called down to the emergency department (ED) and is overheard saying to the patient, "The ER doctor doesn't know what he's doing so they called me." Or, the patient is discharged from the ED and follows up with his or her primary care physician, who tells the patient that the diagnosis and treatment plan given in the ED was incorrect.

Why do we as professionals do this? Many of us were not trained in the team-based learning style popular today so we are not used to and were not trained in the supportive atmosphere of a team. Some of us may be in the habit of disparaging others to improve our own status or self-worth. Whatever the reason, overt or subconscious, the effect it has on our profession and our patients is very damaging. In fact, the Medscape Report on Malpractice recounts that denigration of the care of ambulatory care providers by physicians (generally hospital-based physicians) was cited as the prime causative factor in many malpractice suits.

Not to bring poor Rodney King into this (again) but why can't we all get along? Team-based care is for the betterment of our patients. Denigrating our own teammates, whether on our team or the competitor's team down the street, ultimately hurts the profession as a whole by sowing the seeds of distrust in our patients while providing a steady stream of cases for the plaintiff's bar. ■

References

1. Medscape Malpractice Report: The Experience of Getting Sued http://www.medscape.com//features/slideshow/malpractice-report/public#2 Accessed on September 5, 2013

2. McDaniel SH, Morse DS, Reis S, et al. Physicians criticizing physicians to patients. *J Gen Intern Med*. May 2013. http://link.springer.com/article/10.1007%2Fs11606-013-2499-9 Accessed July 29, 2013.

ABSTRACTS IN URGENT CARE

- Clinical decision tool for testicular torsion
- Walgreens' Take Care Clinics
- Morning-sickness pill
- Chest pain in the ER
- GI complications of NSAIDs

NAHUM KOVALSKI, BSc, MDCM

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

Clinical Decision Tool Identifies Boys at Low Risk of Testicular Torsion

Key point: No child with a normal testicular lie, age <11 years, and absence of nausea or vomiting had torsion.

Citation: Shah MI, Chantal CA, Mendez DR. Prospective pilot derivation of a decision tool for children at low risk for testicular torsion. *Acad Emerg Med.* 2013;20(3): 271-278.

To develop a clinical decision tool for identifying children at low risk for testicular torsion, investigators prospectively enrolled patients <21 years of age presenting to a pediatric emergency department with scrotal pain for ≤72 hours. History and physical exam findings used to derive the decision tool were recorded before diagnostic imaging or surgical evaluation.

Of 228 patients (mean age, 10 years) who were evaluated for testicular pain over a 32-month period, 21 (9%) were diagnosed with testicular torsion. Among 222 patients (97%) who underwent Doppler ultrasound, the two most common pathological diagnoses were torsion of the appendix testis (23%) and epididymitis/orchitis (20%). Among the 6 patients who did not undergo ultrasound, 1 had immediate surgical exploration and was diagnosed with torsion, and 5 had no evidence of torsion at follow-up.

All 21 patients with testicular torsion were identified by three factors: abnormal testicular lie (strongly associated with absence of a cremasteric reflex), age 11 to 21 years, and nausea or vomiting. The absence of all three factors identified 92 patients (40%) as low risk for torsion, with a negative predictive value of 100%, sensitivity of 100%, specificity of 44%, and positive predictive value of 15%. Use of this rule in the study sample would have resulted in a 59% reduction in ultrasound testing.

Published in *J Watch Emerg Med.* April 12, 2013 — Katherine Bakes, MD. ■

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

Walgreens Clinics to Start Managing Chronic Conditions

Key point: Walgreens' in-store Take Care Clinics, run by nurse practitioners and physician assistants, will now offer chronic disease management at over 330 locations.

Citation: http://news.walgreens.com/article_display.cfm?article_id=5730

Walgreens' in-store Take Care Clinics, run by nurse practitioners and physician assistants, will now offer chronic disease management at over 330 locations, the company announced on Thursday.

The new services will include diagnosis, treatment, and monitoring for chronic conditions, such as hypertension, diabetes, and hypercholesterolemia. In addition, new preventive health services will be offered; for example, screenings or blood tests may be ordered based on a patient's age, sex, and family history.

The Associated Press notes concern among physicians that such services "can disrupt their relationships with patients and lead to fragmented care." The chief medical officer of the Take Care Clinics counters that the clinics are "filling a niche for patients who need access" to primary care, especially given the growing shortage of primary care doctors and difficulty find-

ing a provider who accepts Medicare or Medicaid. ■

Morning-Sickness Pill Bendectin Back on the Market with a New Name

Key point: The combination of doxylamine succinate and pyridoxine hydrochloride (in the past called Bendectin) has once again been approved to treat nausea and vomiting in pregnancy.

Citation: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm347087.htm

The combination of doxylamine succinate and pyridoxine hydrochloride has once again been approved to treat nausea and vomiting in pregnancy, the FDA has announced. The drug, to be marketed as Diclegis, was previously sold under the name Bendectin.

Bendectin was voluntarily pulled from the market in 1983 over concerns about birth defects; those concerns later proved to be unfounded.

The new approval was based on a randomized trial in which Diclegis outperformed placebo among some 260 pregnant women. In addition, says the FDA, epidemiologic studies show that the drug does not harm the fetus.

Severe sleepiness can occur with Diclegis, so patients should not drive, operate heavy machinery, or perform other activities that require mental alertness while taking the drug.

Clinicians should reassess a patient's continued need for Diclegis as the pregnancy progresses, the FDA advises. ■

Chest Pain: What Happens After the Emergency Department?

Key point: Patients who follow up with cardiologists do best.

Citation: Czarnecki A, Chong A, Lee DS, et al. Association between physician follow-up and outcomes of care after chest pain assessment in high-risk patients. *Circulation*. 2013;127(13):1386-1394.

Researchers examined patterns of follow-up care and outcomes in high-risk patients with chest pain who presented to Ontario emergency departments (EDs) from 2004 to 2010. High risk was defined as having a prior diagnosis of cardiovascular disease, diabetes, or both. The primary outcome was a composite of all-cause death and hospitalization for myocardial infarction within 1 year after the index visit.

Of nearly 57,000 patients, 17% followed up with a cardiologist (with or without a visit to primary care) within 30 days after ED discharge, 57% followed up with a primary care practitioner only, and 25% did not have a visit to a physician recorded. After adjustment for clinical, demographic, and hospital characteristics, the cardiologist group had a significantly lower hazard ratio for the composite outcome (HR, 0.79; P<0.001) than the no–follow-up group and the PCP-only group (HR, 0.85; P<0.001). PCP-only follow-up was significantly beneficial compared to no follow-up (HR, 0.93; P<0.023). Patients seen by cardiologists underwent more testing and received more evidence-based therapies within 100 days after discharge.

Published in *J Watch Emerg Med.* April 19, 2013 — J. Stephen Bohan, MD, MS, FACP, FACEP. ■

Gastrointestinal Complications from NSAID Use in Clinical Practice

Key point: In a PROBE trial of 8067 patients with osteoarthritis, 1.3% using celecoxib experienced GI complications compared with 2.4% using a nonselective NSAID.

Citation: Cryer B, Li C, Simon LS, et al. GI-REASONS: A novel 6-month, prospective, randomized, open-label, blinded endpoint (PROBE) trial. *Am J Gastroenterol*. 2013;108(3):392-400.

Multiple studies have demonstrated the association between nonsteroidal anti-inflammatory drug (NSAID) use and gastrointestinal (GI) complications. Results of these studies might be difficult to apply to clinical practice because of uncontrolled confounding in observational studies or a rigid protocol in randomized trials. Now, to apply the rigor of a randomized, controlled design and reflect the real-life variability of clinical practice, researchers conducted an industry-sponsored, prospective, randomized, open-label, blinded endpoint (PROBE) trial to compare the incidence of GI complications with use of celecoxib versus a nonselective nonsteroidal anti-inflammatory drug (nsNSAID) in 8067 patients with osteoarthritis from 783 clinics in the U.S.

Patients were stratified by *Helicobacter pylori* infection status and randomized to receive either celecoxib or an nsNSAID of the treating physician's choice for 6 months. Patients taking aspirin were excluded. Adjustments in drug doses and the use of gastroprotective agents were allowed. The primary endpoint of clinically significant upper or lower GI complications was determined by a blinded adjudication panel.

More GI complications occurred in the nsNSAID group than in the celecoxib group (2.4% vs. 1.3%; odds ratio, 1.82; 95% confidence interval, 1.31–2.55). The vast majority of complications were occult GI bleeding (44 of 54 in the celecoxib group and 75 of 98 in the nsNSAID group). Upper GI bleeding occurred in only 2 patients — both in the nsNSAID group. Fewer moderate-to-severe abdominal symptoms were reported in the celecoxib versus nsNSAID group (2.3% vs. 3.4%; *P*=0.004). Frequencies of other complications were similar, including cardiovascular events. The dropout rate was approximately 35% in both groups.

Published in *J Watch Gastro* April 5, 2013 — David J. Bjorkman, MD, MSPH (HSA), SM (Epid.) ■

CODING Q&A

Supervising Physician, Physician Rotation, Critical Care

DAVID STERN, MD, CPC

Q. Can a Physician Assistant (PA) bill a claim under a supervising physician even when the supervising physician is not physically present during the patient visit?

A. A PA can render services when the physician is not on site. Incident-to billing (a specific CMS method for billing midlevel services with the physician as rendering provider) would never apply in this case.

Services rendered in this situation should be billed with the PA as the rendering provider. This is an absolute for Medicare and many other payors, and it may be considered fraud to bill with the physician as the rendering provider for services rendered by the PA.

Exception: In certain circumstances a specific (non-Medicare) payor may instruct the physician to bill services that were actually rendered by the PA with the physician as the rendering provider. This was more common in the past, and this instruction is now fairly rare. If the payor does instruct you to bill this way, it would not be fraud to bill the service with the PA as the rendering provider. ■

Q. We use an unassigned physician rotation for patients to have a one-time follow up visit from the ED (emergency department) or urgent care for patients with no primary care provider. How would a family practice physician code this episodic one-time-only follow-up visit since he would not be taking on the patient on a permanent basis? Does it get coded as a new patient E/M level or consult?

A. These visits would be coded with a new E/M, assuming appropriate documentation and medical necessity.

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.

Per CPT guidelines, critical care is the direct delivery by a physician or other qualified health care professional of medical care to a critically ill or critically injured patient.

Of course, it would be coded with an established E/M if either of the two following criteria applied for services rendered within the past 3 years:

- the patient had a face-to-face encounter with the treating "unassigned" physician or;
- the patient had a face-to-face encounter with a physician of the same specialty in the same practice as the treating "unassigned" physician. ■

Q. Are we able to bill critical care code 99291 when the criteria are met? We are a standalone urgent care center and not associated with any hospital.

A. Critical care services, CPT codes 99291, "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes" and add-on code 99292, "...each additional 30 minutes" are usually, but not always, given in a critical care area. However, they can be billed in the outpatient setting. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code.

Per CPT guidelines, critical care is the direct delivery by a physician or other qualified health care professional of medical care to a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems, such that there is a high probability of imminent or life-threat-

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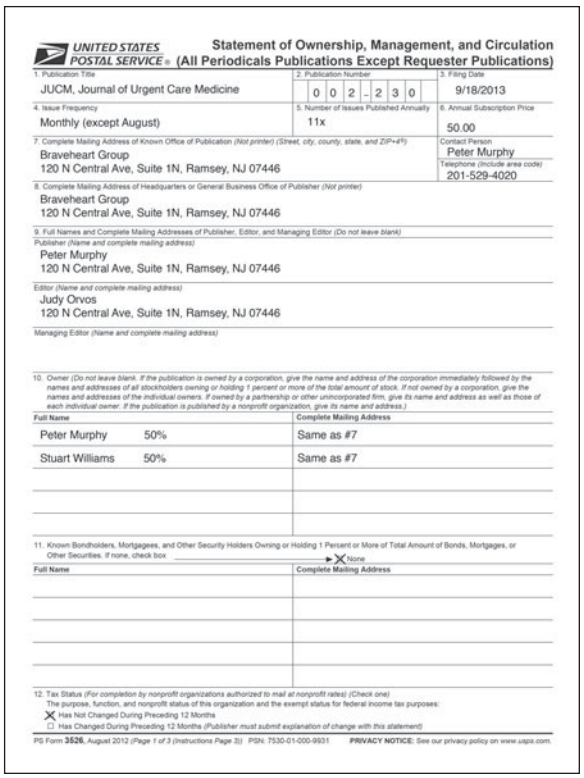

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Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

1. Publication Title	2. Publication Number	3. Filing Date
JUCM, Journal of Urgent Care Medicine	0 0 2 - 2 3 0	9/18/2013
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly (except August)	11x	50.00

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4®)
Braveheart Group
120 N Central Ave, Suite 1N, Ramsey, NJ 07446
Contact Person: Peter Murphy
Telephone (Include area code): 201-529-4020

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer)
Braveheart Group
120 N Central Ave, Suite 1N, Ramsey, NJ 07446

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)
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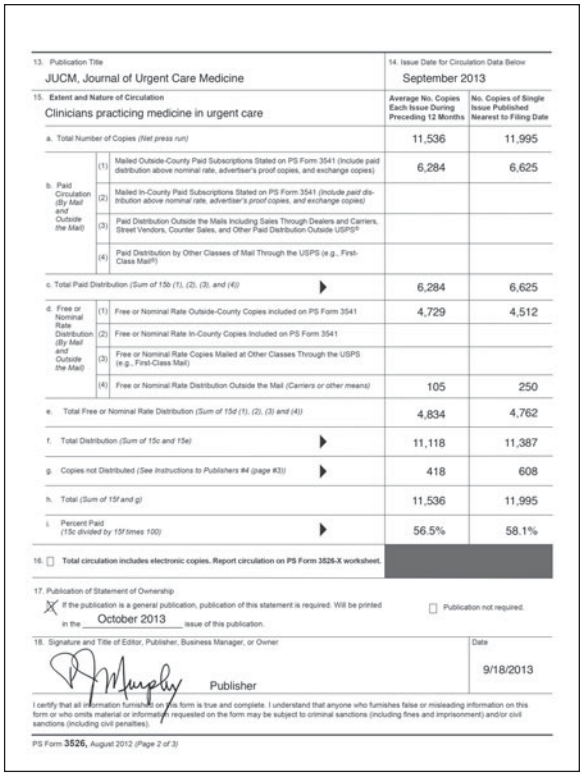

13. Publication Title: JUCM, Journal of Urgent Care Medicine
14. Issue Date for Circulation Data Below: September 2013

15. Extent and Nature of Circulation: Clinicians practicing medicine in urgent care

			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a.		Total Number of Copies (Net press run)	11,536	11,995
b. Paid Circulation (By Mail and Outside the Mail)	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	6,284	6,625
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d. Free or Nominal Rate Distribution (By Mail and Outside the Mail)	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541	4,729	4,512
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e.		Total Free or Nominal Rate Distribution (Sum of 15d (1), (2), (3) and (4))	4,834	4,762
f.		Total Distribution (Sum of 15c and 15e) ▶	11,118	11,387
g.		Copies not Distributed (See Instructions to Publishers #4 (page #3)) ▶	418	608
h.		Total (Sum of 15f and g)	11,536	11,995
i.		Percent Paid (15c divided by 15f times 100) ▶	56.5%	58.1%

16. ☐ Total circulation includes electronic copies. Report circulation on PS Form 3526-X worksheet.

17. Publication of Statement of Ownership
X If the publication is a general publication, publication of this statement is required. Will be printed in the October 2013 issue of this publication. ☐ Publication not required.

18. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher — Date: 9/18/2013

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CODING Q & A

"Time spent in activities where the provider is not immediately available to the patient do not count toward critical care."

ening deterioration in the patient's condition. Critical care also involves high-complexity decision-making to assess, manipulate, and support vital system function(s) or treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

There are certain services that are included in the critical care: the interpretation of cardiac output measurements (93561, 93562), chest X-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic date [99090], gastric intubation (43752, 43753), temporary transcutaneous pacing (92953), ventilator management (94002-94004, 94660, 94662), and vascular access procedures (36000, 36410, 36415, 36591, 36600). Any services performed that are not listed here should be reported separately. Only facilities can report the previously-listed procedures separately.

You would also report codes 99291 and 99292 for the attendance during the transport of critically ill or critically injured patients older than age 24 months to or from a facility or hospital. You are directed to codes 99466 and 99467 for pediatric critical care patient transport.

As with any procedure, documentation must be concise and complete. Along with face-to-face time treating the critically ill or injured patient, time spent engaged in work directly related to the patient's care can be included when calculating the duration for critical care and does not have to be consecutive. For example, when the patient is unable to participate in discussion, time spent on the floor or unit with family members obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment can be reported as critical care, provided that the conversation bears directly on the management of the patient.

Time spent in activities where the provider is not immediately available to the patient do not count toward critical care. Time spent in activities that do not directly contribute to the treatment of the patient cannot be reported as critical care. You also cannot count time spent performing a separately reportable procedure or service. ■

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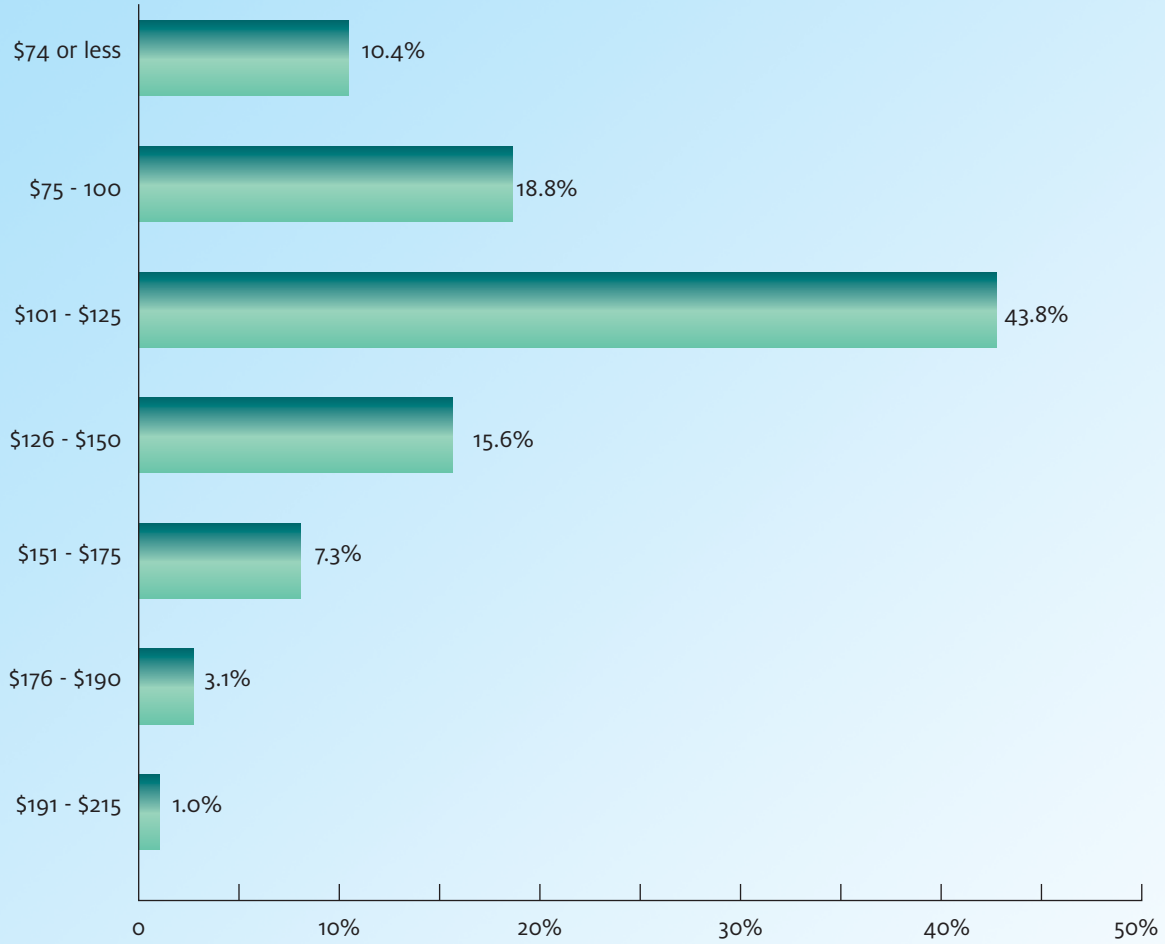
DEVELOPING DATA

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 is the Average Per-Visit Reimbursement for Urgent Care Centers?

AVERAGE PER-VISIT REIMBURSEMENT



At a mean of $114.67, average reported reimbursement per visit is significantly lower than the average visit charge ($184.55, as shown in last month's Developing Data column.) It is also just slightly down from the 2010 survey ($118.11) (n=96)

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.

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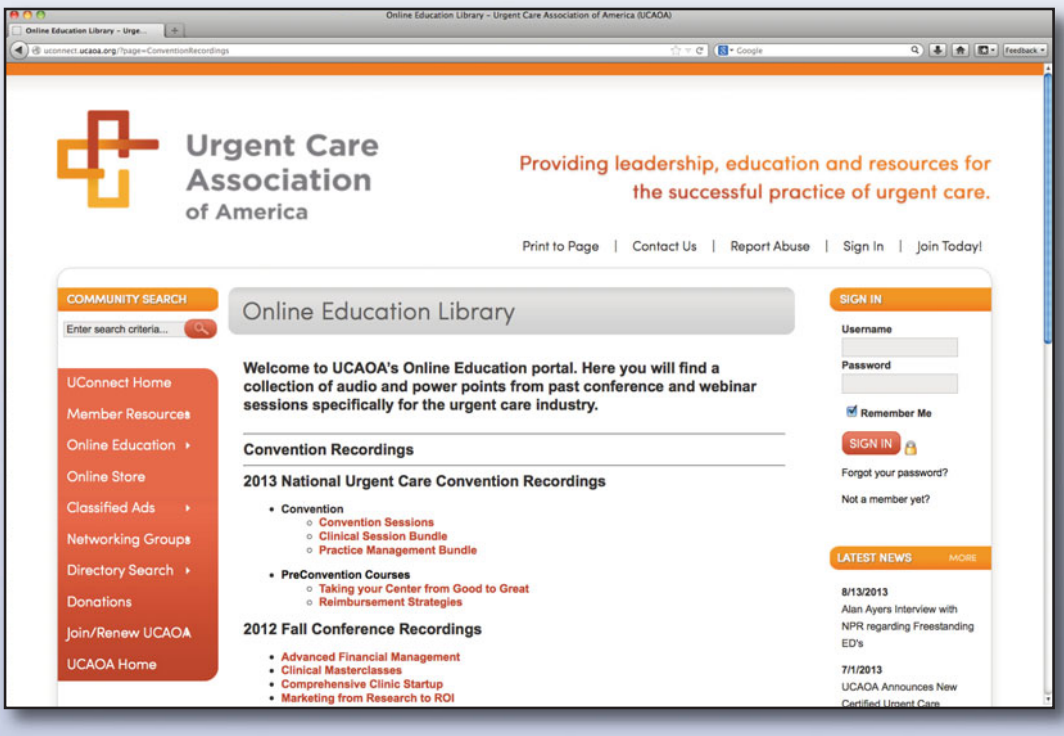

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Tim Johnston is the president and CEO of a multi-site urgent care network in North Carolina. He's also an avid cyclist who participates in races and other events for charity.*

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*This summer Tim Johnston served in Haiti, witnessing how the needs there remain great especially among women and children. In September 2013, Tim participated in Bike for Life, an almost 500-mile ride across North Carolina to raise funds for Sisters of Mercy Urgent Care's medical mission work in Haiti. Practice Velocity was the presenting sponsor for Bike for Life, and proudly supports Tim Johnston and Sisters of Mercy's efforts in Haiti.