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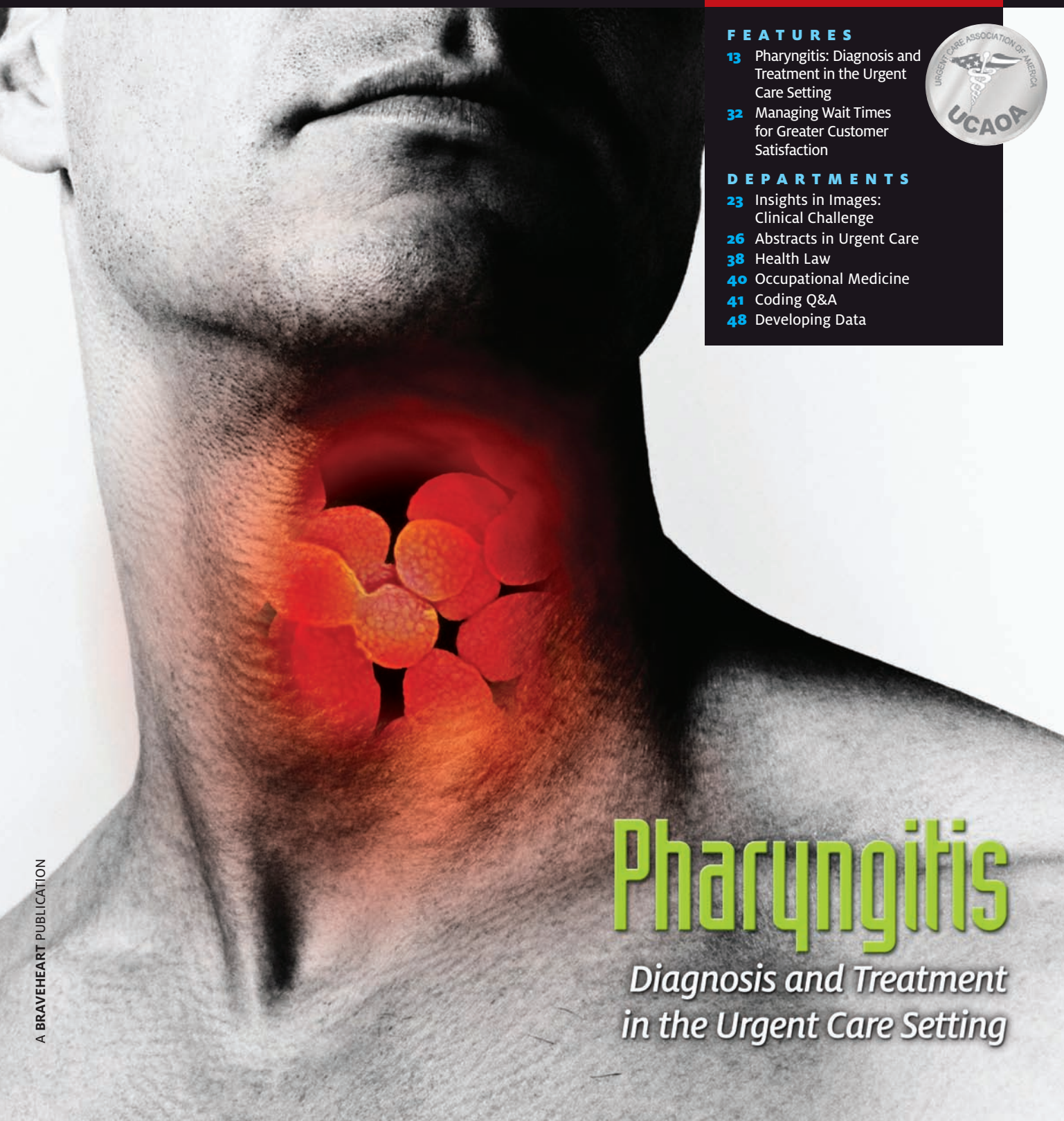
IN THIS ISSUE



Pharyngitis

Diagnosis and Treatment in the Urgent Care Setting

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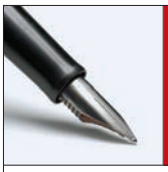

UCAOA in the News

UCAOA has been a busy organization of late.

The announcement of an alliance with the Joint Commission is big news, indeed. We recognize that this news may not be welcomed by all, but are confident that most of your preconceptions will *not* be validated by the process.

I think we all can agree on the goals of an urgent care accreditation program:

- First and foremost, it should be "urgent care focused." And it *must* represent the specific and unique nature of the urgent care delivery model.
- It should not be unduly burdensome. The preparation for any accreditation is an important exercise that indeed takes time, but should not be unreasonable or contain elements that prove to be meaningless.
- It should be strictly voluntary.
- It should, of course, be a reproducible way to protect patient safety. That is the ultimate goal of any accreditation process.
- It should, therefore, reflect an urgent care center's effort on behalf of patient safety, and be meaningful to the public, as such.
- It should further represent this same commitment to third-party and government payors, and be recognized accordingly.
- Perhaps most importantly, it must be nationally recognized. The Joint Commission is, without argument, the gold standard for healthcare accreditation.
- Finally, accreditation should elevate the entire industry, representing its commitment to a higher standard of care on behalf of our patients. This commitment communicates to the world that we are serious about self-regulation and willing to open our doors to outside scrutiny of the highest level.

The decision by UCAOA to collaborate with the Joint Commission was based on three years of critical evaluation at the board, committee, and executive level. We have sought the input of our members, listened to your concerns, and we have represented those concerns in our negotiations with the Joint Commission.

The level of collaboration by the Joint Commission to create unique urgent care standards is unprecedented, and reflects its commitment to a more flexible and realistic process. We are confident that our shared goals will be met and our shared fears will be allayed.

Within days of this announcement, the national media responded. Most notably, *The Wall Street Journal* specifically identified our alliance with the Joint Commission as the reason for its interest in highlighting urgent care in its August 6 edition.

At least one large payor confirmed our expectation that upgrading our accreditation process would resonate with healthcare insurers. Troy Brennan, the chief medical officer of Aetna, highlighted the decision as an important step for payor contracting with urgent care facilities. A standard, nationally recognized accreditation can make the difficult process of contracting as an urgent care with multiple payors a little easier.

Additional efforts are underway to uniquely identify and certify urgent care clinics offering an extended scope/level of services that should help them be more distinguishable to the general public and payors alike.

Combined, these efforts form the most important step to date toward appropriate recognition of urgent care services as a critical part of the healthcare delivery system.

We know you will have additional questions, and we welcome your input. We have set up a special forum, as noted in the From the Executive Director's column this month (page 8). Further, we encourage you to attend September's conference in Memphis, where there will be ample opportunity for face-to-face discussion.

In addition, this fall's conference is packed with some of our best clinical and business content to date. Details on the conference are available at *www.ucaoa.org*.

See you there. ■

Lee A. Resnick, MD
Editor-in-Chief
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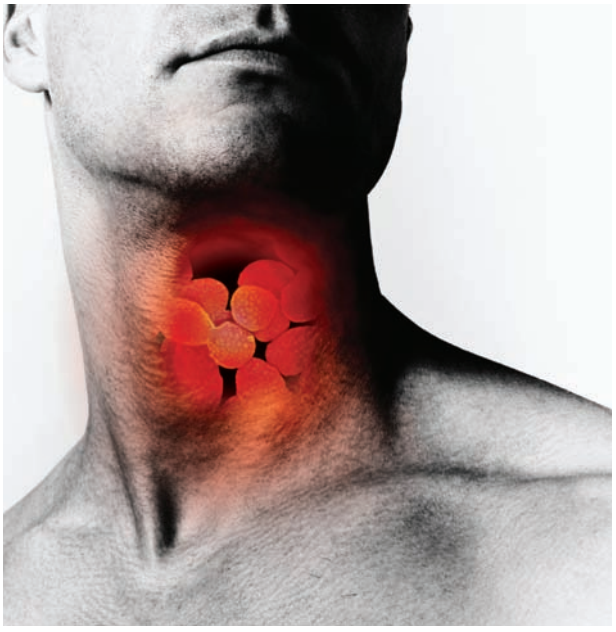


CLINICAL

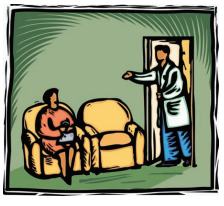
13 Pharyngitis: Diagnosis and Treatment in the Urgent Care Setting

"Sore throat" is a complaint heard commonly in urgent care. Adequate analgesia and judicious use of antibiotics can lead to high patient satisfaction without adding to the problem of resistance.

By William Gluckman, DO and Jessica Kay, PharmD

PRACTICE MANAGEMENT

32 Managing Wait Times for Greater Customer Satisfaction



Time spent in the waiting room may be inevitable for many patients, but it can also sour them on returning to your practice and lead to bad word-of-mouth. Efficient flow from sign-in to sign-out can make for a better experience for the patient, staff, and practitioner.

By Alan A. Ayers, MBA, MAcc

***In the next issue of* JUCM:** *Understanding classification, in addition to familiarity with treatment options, can enable the urgent care clinician to treat most patients presenting with epistaxis on site.*

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Mission Statement

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

JUCM CONTRIBUTORS

Chances are, you've either encountered a patient with the generic complaint of "sore throat" recently or will in the very near future. And within the scope of those encounters, you're bound to get involved in more than one discussion about antibiotics—often with a patient who insists he absolutely must leave your office with a prescription, whether your advanced education, years of experience, and clinical judgment agree or not.


Often, that prescription will be warranted; other times, not so much. And therein lays the problem, which is one of the subjects addressed in Pharyngitis: Diagnosis and Treatment in the Urgent Care Setting (page 13) by **William Gluckman, DO** and **Jessica Kay, PharmD**.

Dr. Gluckman has contributed to *JUCM* in the past, as co-author of an article on urinary tract infections (*JUCM*, October 2007) and on an ongoing basis as a member of our Editorial Board. He is associate medical director of emergency services and associate EMS medical director at St. Joseph's Regional Medical Center in Paterson NJ, assistant professor of surgery at New Jersey Medical School, and medical director of the New Jersey State Police Homeland Security Section's Urban Search and Rescue team. He is also a partner and medical director of Lifesaving Associates, LLC in Watchung, NJ, and a member of UCAOA.

Dr. Kay is currently the clinical pharmacist in the emergency department at St. Joseph's Regional Medical Center. She received her doctorate degree in pharmacy from St. John's University and completed her general residency at the Northport VAMC.

This issue also looks at another topic that may sometimes breed conflict between patient and provider or staff: time spent in the waiting room. True, it is an unavoidable fact that patients have to wait sometimes, but Managing Wait Times for Greater Customer Satisfaction (page 33) by Alan A. Ayers, MBA, MAcc analyzes ways to address the cause in order to minimize negative impact on the patient's visit and the practice in general.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews abstracts of new articles on vasopressin in cardiac arrest, the balance between playground safety and a child's need for physical activity, the use of absorbable sutures in pediatric patients, and other relevant topics in Abstracts in Urgent Care.

John Shufeldt, MD, JD, MBA, FACEP continues his summation of bankruptcy issues as they apply to an urgent care owner in Health Law.

Frank Leone, MBA, MPH looks at the fear factor in occupational health sales—and how to use a customer's concerns to your advantage in Occupational Medicine.

David Stern, MD, CPC addresses questions about applying discount fees; reimbursement related to change or removal of surgical dressing; and some of the intricacies of the S9088 code in Coding Q & A.

We'd like to hear from you, so if you have a thought about an article you read here—be it a challenge to one of our author's conclusions, a general reaction to how we're doing, or an idea for a future article, please send an e-mail to our editor-in-chief, **Lee A. Resnick, MD**, at *editor@jucm.com*.

In Memoriam

We're sorry to report that Allan F. Moore, MD passed away July 24, 2008 from injuries he suffered in a traffic accident 12 days earlier. His wife, Dr. Rebekah Gee, was injured in the crash.

Dr. Moore co-authored our June 2008 cover article, Diabetic Emergencies in the Urgent Care Setting. He was a fellow in endocrinology and an internist at Massachusetts General Hospital, as well as a researcher on the subject of diabetes complications and disease prevention at Mass General and the University of Pennsylvania School of Medicine.

Dr. Moore, who was 31-years-old, is survived by his wife, his brother, and his parents. ■

To Submit an Article to *JUCM*

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

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

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

Before submitting, we recommend reading "Instructions for Authors," available at *www.jucm.com*.

The Big Announcement

LOU ELLEN HORWITZ, MA

I've been waiting over a year to get to tell this story. It was July 12, 2007, on a Thursday. I had been invited to observe a Joint Commission survey of four urgent care centers. This particular survey was what is called an "unannounced survey," which meant that the center had very little notice—about 20 minutes—that we were coming.

The surveyor and I walked in, told the registrar who we were, and were shown into the back of the clinic where we met the clinic manager, Sara. She welcomed us warmly, offered us coffee, invited us to her office and gestured for us to sit. She seemed calm and collected—cool as a cucumber.

I didn't believe it for a minute.

Then I looked into her eyes and I saw something totally unexpected. She was about to spend two solid days with a Joint Commission surveyor and *she couldn't wait*. She believed in her gut that her clinics were ready—and she was right.

Back to the Beginning

A year earlier, UCAOA had approached both The Joint Commission and the Accreditation Association for Ambulatory Health Care to talk about how our accreditation programs could potentially work together. We had a solid, urgent care-focused accreditation program of our own, but it didn't have the national recognition it needed to be valuable; they had the national recognition, but perhaps not the urgent care industry expertise. Maybe we could work better together than apart.

Over time, it became clear that The Joint Commission was our best choice for collaboration. They were strongly interested in working with us, and flexible enough to incorporate urgent care-specific resources into their existing Ambulatory Care Accreditation.

Over the next two years, UCAOA members and staff worked with The Joint Commission on several committees and initiatives as we developed our plans for collaboration. We announced our formal collaboration on July 10.

The executive director of Ambulatory Care Accreditation Programs, Michael Kulczycki, is our primary liaison. We know there are still a lot of questions about the collaboration, so I asked him to "sit down" with me for this column.

"We are reviewing the 2009 ambulatory care standards to identify which standards are applicable to urgent care centers."

Lou Ellen Horwitz: Michael, a concern we have heard already that you can address is that The Joint Commission is an "800 pound gorilla" unable to relate its standards to the smaller practitioner—in the words of one member, that you will "mistake my clinic for a hospital."

Michael Kulczycki: Granted, The Joint Commission is first known for its hospital accreditation. But our Ambulatory Care Accreditation Program has been active for nearly 40 years, now accrediting over 1,600 organizations. The Ambulatory Programs cover settings as small as a single specialty practice, and of course, urgent care centers. We use ambulatory professionals for surveyors, have distinct ambulatory care standards, and have ambulatory-dedicated staff in our Standards Interpretation Group (SIG). UCAOA members will even have a dedicated account representative.

LEH: I also want to add to your answer that as part of our collaboration, we are reviewing the 2009 ambulatory care standards to identify which standards specifically are applicable to urgent care centers, making the process even more tailored. This will take our committees some time, but by this September we'll have our first urgent care-specific resource,

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

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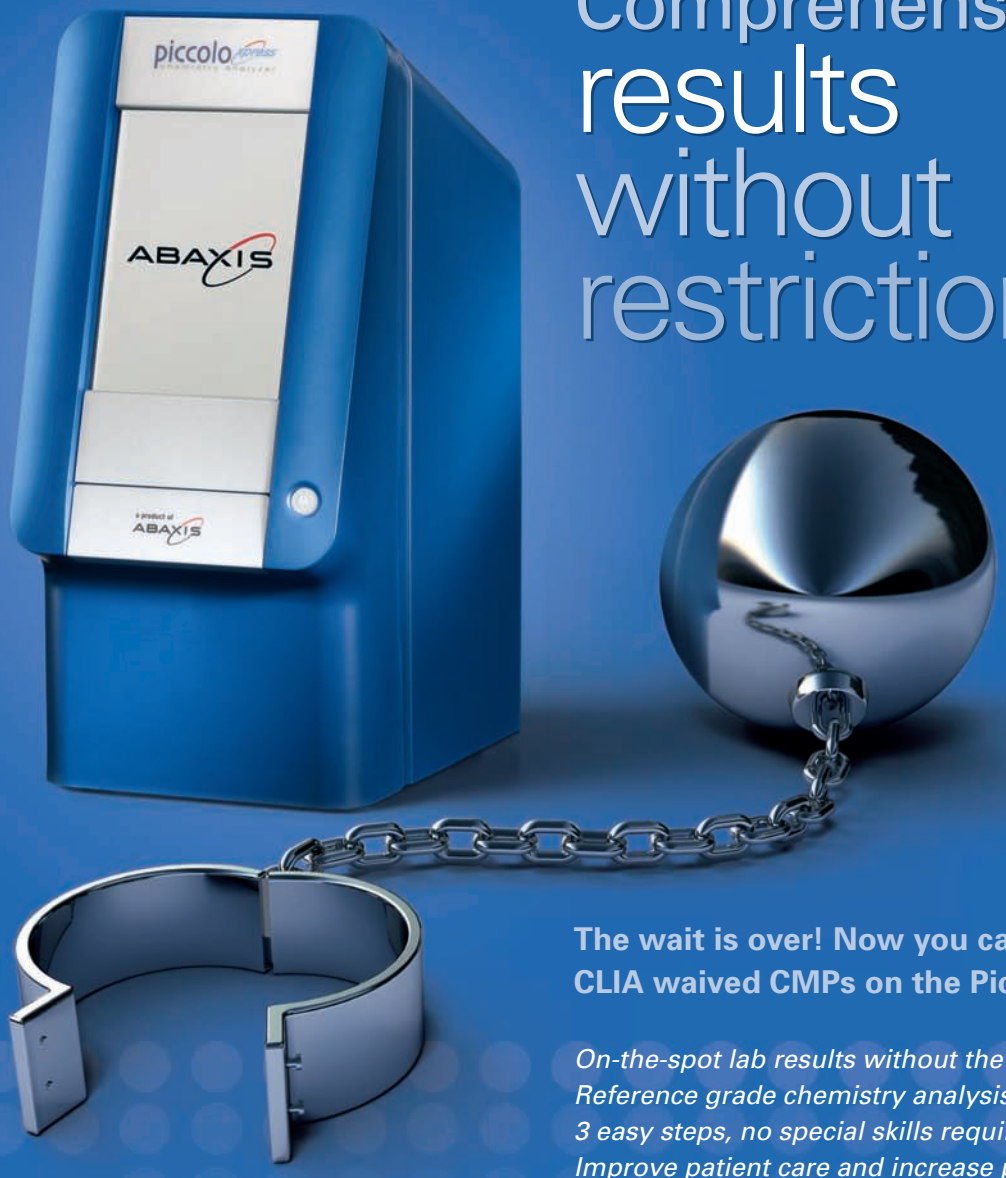

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a new Accreditation Handbook.

Can you tell us about the survey itself? Most of our members have probably never been through any kind of accreditation survey.

MK: A Joint Commission survey is designed to review compliance with national, consensus-based standards, and to provide centers with education and consultation about their overall efforts to provide quality patient care.

The survey process is "open book." There are no secrets. The standards and elements of performance (EPs) which define compliance with the standards are all provided "up front." They are the same standards and EPs the surveyors use in the evaluation.

Organizations also receive a detailed agenda of the survey visit that outlines, hour by hour, the purpose of each time slot on the agenda, which staff will be involved, and any additional resources the center should have available, so they know what to expect.

"The surveyors themselves are all ambulatory care professionals with a minimum of five years of ambulatory practice experience."

"Patient tracers" are the main component of the survey process, accounting for 60% of the survey time. The surveyor selects incoming patient charts as a "roadmap" through the clinic, then observes those patients (with their permission) throughout their visits. The surveyor uses those observations to help evaluate the organization. During the patient tracers, surveyors also talk to staff about their role (e.g., intake, delivery of care, education of patient, discharge, etc.), but do not focus on the details of any one standard. In many cases, these interactions help to "connect the dots" for staff as to why they need to use two patient identifiers, etc.

Surveyors are not looking, despite "urban legend," for dust bunnies in the corner of the rooms. They are simply using the evaluation tools (patient tracers, dialogue with staff, discussions with patients) to assess compliance with applicable standards, and providing suggestions for achieving future compliance.

The surveyors themselves are all ambulatory care professionals with a minimum of five years of ambulatory practice experience. More than three quarters of the surveyors are physicians, and they are all employees, dedicating one quarter or one-half of their time only to Joint Commission surveys. This means they typically visit 50 to 100 ambulatory centers each year, and can bring those "good practices" they see across the country to your centers as part of the survey process.

I recently spoke with a provider who, like the "Sara" in your story, was actually looking forward to her upcoming survey. She said, "The survey process is not a punitive one. It helps me focus on the areas where our organization needs additional attention and assistance."

LEH: For first timers this may all still seem overwhelming. What resources do you provide to help centers prepare for their first survey?

MK: We have many resources to assist organizations new to accreditation:

First, Ambulatory Program staff are available to describe the accreditation process, timelines and costs, and provide electronic access to the accreditation application.

Once centers apply, account representatives specially assigned to UCAOA members assist with the application itself, coordinate survey dates, and provide access to our extranet, Joint Commission Connect.

Our Standards Interpretation Group is available to answer questions about whether a standard applies, if a policy or action is in compliance, and how to maintain compliance over time.

Ambulatory Advisor is our complimentary quarterly newsletter.

The Joint Commission website, *www.jointcommission.org*, has resources about the accreditation process, patient safety issues, and more.

Joint Commission Resources, *www.jcrinc.com*, provides live education and print publications about the accreditation process.

We have also set up a special website for UCAOA members—*www.jointcommission.org/urgentcare*.

I know there are probably many other questions that we don't have room for here. We invite everyone to visit the online forum dedicated to *Accreditation Q&A*. Go to *www.ucaoa.org* and click on the Forums button. It's easy, free, and we have several center leaders who have already been through the Joint Commission process available to answer questions.

We are excited about our collaboration with the Joint Commission, but we know there is still work to do in simplifying the application process for urgent care centers, so we will be focusing on that for the next several months. We will keep you updated on our progress, and look forward to congratulating the first centers to be accredited. ■

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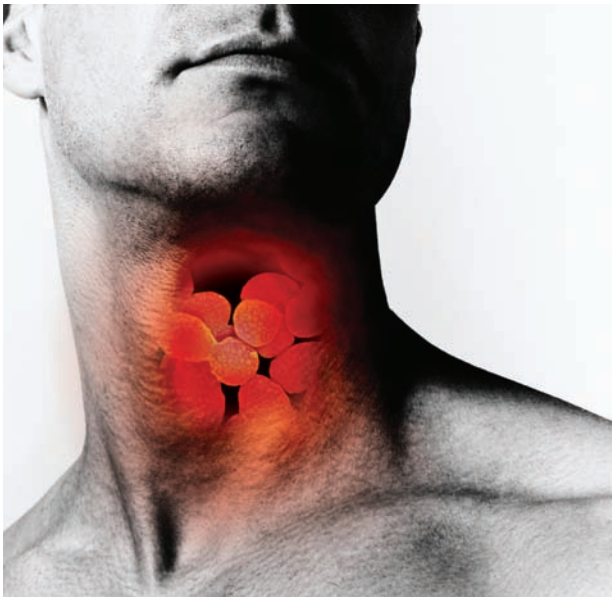
Pharyngitis:
Diagnosis and Treatment in the Urgent Care Setting

Urgent message: Sore throat is a complaint commonly encountered in urgent care. Proper evaluation and understanding and use of appropriate antibiotics will foster better patient care and understanding while limiting antibiotic resistance.

William Gluckman, DO, MBA, FACEP and Jessica Kay, PharmD

Introduction

Pharyngitis refers to the inflammation or irritation of the pharynx, including the tonsils, and can have many etiologies, including a variety of infections, cancer, allergic reactions, gastroesophageal reflux, or toxic inhalations and ingestions. This article will discuss the infectious causes of pharyngitis, the evaluation methods and evidence-based management.



Epidemiology

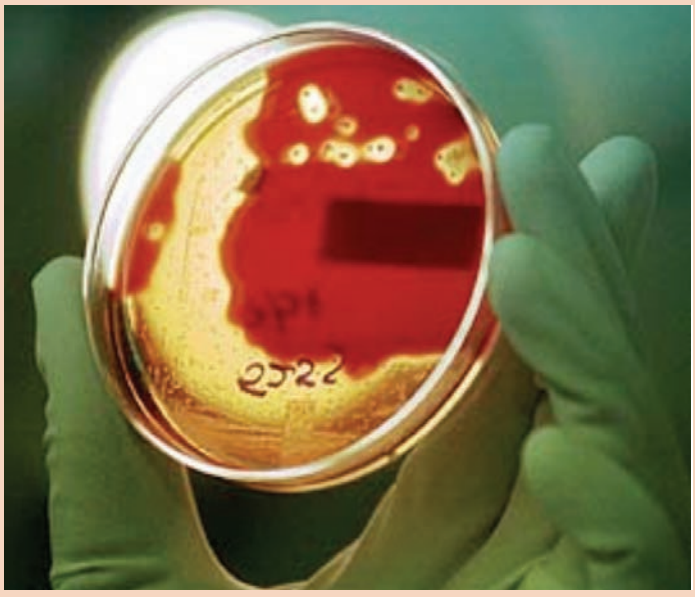
Pharyngitis is a common presenting complaint in urgent care centers, as well as in other outpatient settings. In 2005, 1.2% of all visits to ambulatory care centers and emergency departments were for the complaint of pharyngitis; of those patients, 79% were seen in primary care offices.[1]

Approximately 90% of all infectious pharyngitis cases in adults, and 80% in children, are caused by viruses. A small percentage of cases are idiopathic in nature. The most common bacterial agents include Group A beta hemolytic *streptococcus* (GAS), Groups C, G, and F *streptococcus*, A *haemolyticum*, M *pneumoniae*, C *pneumoniae*, C *diphtheriae*, and N *gonorrhea*.

Some of the common viruses include rhinovirus, coronavirus, coxsackie A, influenza, and herpes. Cytomegalovirus (CMV) and Epstein-Barr virus (EBV) are causes of mononucleosis.

GAS infection (**Figure 1**) is the most common bacterial cause and follows a seasonal predilection. It is most commonly seen in the winter and early spring. Though adults often suffer from GAS infection, it is most prevalent among

Figure 1.



Group A Beta Hemolytic Strep. Hemolysis of the red blood cells from sheep blood agar yields a characteristic clear area.

Figure 2.

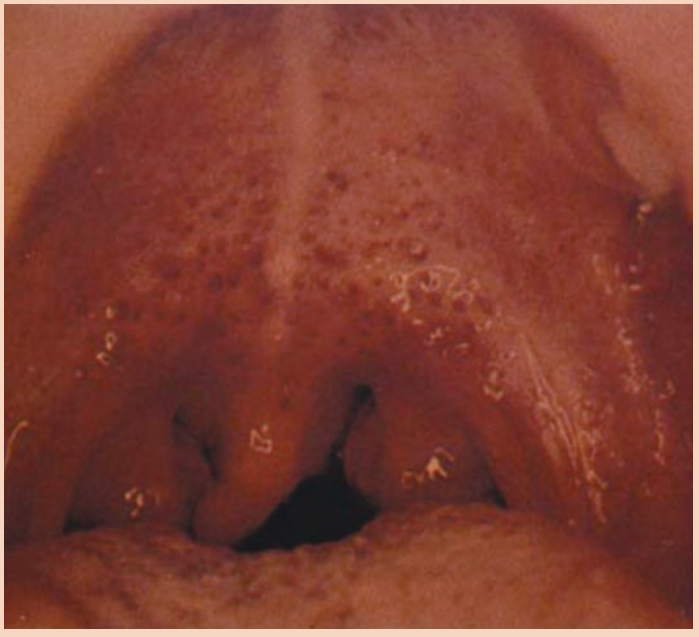


Figure 2. Palatal petechiae in GAS pharyngitis.

children between 5 and 15 years old.

Diagnosis

Characteristically, GAS pharyngitis presents with a complaint of acute fever and chills, sore throat, odynophagia, and painful lymphadenopathy in the neck. Headache and nausea/vomiting and abdominal pain also occur and are more common in children. The pharynx will almost universally be erythematous and may or may not have tonsillar exudates. Approximately 10% of cases will have palatal petechiae (**Figure 2**).

Scarlet fever can occur in the face of GAS infection and produces an erythematous, sandpaper-like rash that begins on the trunk and spreads to the extremities but spares the palms and soles. A "strawberry tongue" may also be present. Tender anterior cervical adenopathy is also common.

However, physical exam findings, overall, are not specific in making a diagnosis of GAS pharyngitis. The presence of tonsillar exudates does not increase the likelihood that GAS is the causative agent; in fact, as noted above, the majority of cases are caused by viruses which also often produce exudates.

Several investigators have developed clinical prediction rules to help determine if the causative agent is GAS, and thus aid in the decision of whether or not to prescribe antibiotics.

Centor looked at presence of tonsilar exudate, swollen or tender anterior cervical nodes, fever history, and absence of cough.[2] He found a positive predictive value of only 56% when all four of these were present.

The McIsaac score evaluated similar signs and symptoms and assigned scores based on age and these criteria.[3,4] Both were both found to be relatively equivalent.[5]

Rapid antigen detection testing (RADT) for GAS is commonly performed in urgent care and other similar settings, and has a high degree of sensitivity (80% to 90%) and specificity (≥ 95%),[6,7] making this a valuable tool—the urgent care practitioner. Infectious Diseases Society of America (IDSA) guidelines support the use of RADT in all suspected cases of GAS and, because of the high specificity, negative

results do not warrant follow-up throat culture to confirm a true vs. false negative result.

In children and adolescents, a culture is suggested unless the clinician has shown that the RADT has demonstrated comparable results to cultures in that specific practice.

Complications

GAS pharyngitis may lead to one or more complications:

- Suppurative complications:
  - Peritonsillar abscess (quinsy)
  - Retropharyngeal abscess
  - Cervical lymphadenitis
- Non-suppurative complications:
  - Scarlet fever
  - Rheumatic fever
  - Acute post-streptococcal glomerulonephritis (APSGN)

Pitfalls

One common mistake when evaluating the patient complaining of a sore throat is to not examine the throat fully. A peritonsillar abscess will often present with the same symptoms; however, a careful examination of the pharynx will reveal a swelling medial to the tonsil and deviation of the uvula to the unaffected side. These patients also tend to have trismus and often appear toxic.

Treatment

The goals of treatment of pharyngitis are to limit the suppurative and non-suppurative complications and decrease the duration of clinical signs and symptoms. Improving patient comfort and decreasing the incidence of adverse drug reactions are also important.

Early antibiotic treatment of streptococcal pharyngitis may lead to earlier resolution of symptoms and shorten the course of illness by about one day, but can increase risk of resistance and recurrence and may decrease immune response.

It is thought that patients no longer transmit GAS pharyngitis after 24 hours of antibiotic treatment. Microbiological elimination with antibiotics usually occurs within 48 to 72 hours.[8,9]

Table 1. Dosing for Pharyngitis

Drug	Adult Dosage	Pediatric Dosage	Duration
Penicillin VK	250 mg 3 times daily or 4 times daily or 500mg twice daily	50 mg/kg/day divided in 3 doses	10 days
Penicillin benzathine	1.2 million units intramuscularly	0.6 million units for under 27 kg (50,000 units/kg)	1 dose
Erythromycin ethylsuccinate	40 mg/kg/day divided 2-4 times daily (max:1 g/day)	Same as adults	10 days
First-generation cephalosporin (e.g., cephalexin)	Varies with agent; 250 mg to 500 mg 4 times daily	Varies with agent; 25 mg/kg/day to 50 mg/kg/day divided in 4 doses	10 days

Although early treatment decreases the risk of transmission, data suggest that therapy may be delayed for two to three days (up to a maximum of nine days) after the onset of symptoms and still prevent the occurrence of complications. This approach is particularly useful in patients with frequent, recurring, mild-to-moderate infections.

Linder in 2005 reported that 53% of children with sore throat received antibiotics. Antimicrobial therapy should be limited to those who have clinical and epidemiologic features of GAS pharyngitis with a positive laboratory test.[10] The authors agree with the IDSA that recommended treatment should be based on clinical criteria and positive rapid streptococcal antigen test (RSAT) or culture results in order to diagnose GAS.

Clinical decision rules have been shown to decrease antibiotic prescription writing. These recommendations are of importance to prevent the inappropriate use of antibiotic therapy.

Pharmacologic Therapy

Analgesics

Systemic analgesics/antipyretics are recommended for pain relief. Acetaminophen is preferred due to concerns over NSAIDs increasing the risk for developing necrotizing fasciitis/toxic shock syndrome, which has been associated with GAS infections. Topical analgesics such as viscous lidocaine and lozenges, along with other non-pharmacologic supportive care such as rest, fluids, and salt water gargles may resolve symptoms up to one to two days faster.[9]

The value of good analgesia should not be underestimated. Patients seek care mostly to make them feel better—i.e., pain relief. Many will ask for antibiotic prescriptions thinking that this is the best and fastest route to resolution of the problem. Urgent care providers can send patients home without an antibiotic when it isn't needed and still achieve high levels of patient satisfaction if the patient's pain is addressed adequately.

Antibiotics

Antibiotic therapy has been the mainstay treatment for GAS pharyngitis. The primary treatment options consist of penicillins (primary treatment), cephalosporins, macrolides, and clindamycin (**Table 1**).

In patients allergic to penicillins, a macrolide should be used. A first-generation cephalosporin may be used if the penicillin reaction is a non-IgE mediated hypersensitivity reaction.

- **Penicillins**—Interfere with bacterial cell wall synthesis by inhibiting the formation of peptidoglycan crosslinks during active multiplication, causing cell wall death and resultant bactericidal activity against susceptible bacteria. Penicillins are currently recommended as the antimicrobial agent of choice for the treatment of GAS pharyngitis.

This recommendation is based upon its acceptable safety and efficacy in eradicating infection, its narrow spectrum of activity, and its economical cost.[6] Although surprisingly in 2001 Kaplan showed resistance rates for benzathine penicillin G IM and oral penicillin V to be 37% and 35%, respectively, in pediatric patients, it remains the recommended treatment.[11] Usual duration of therapy to prevent further systemic complications is 10 days. Gastrointestinal issues and rash are the most common side effects.

Benzathine penicillin G—Patients who may not be willing or able to comply with a 10-day course of therapy may be given a single dose of benzathine penicillin G 1.2 million units IM.

Though amoxicillin has a more extended spectrum of coverage for pathogens than penicillin VK,

There is no substitute for Tussionex®

Recent FDA Action[1]

As of March 31, 2008, manufacturers were mandated by the FDA to cease shipment of unapproved hydrocodone antitussives

- **The only FDA-approved 12-hour Rx syrup antitussive**
- **Still available in pharmacies**
- **There is no AB-rated generic equivalent to TUSSIONEX®**

INDICATION AND IMPORTANT SAFETY INFORMATION

TUSSIONEX® is indicated for the relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older. Each 5 mL of TUSSIONEX® contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate.

TUSSIONEX® is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression, and in the presence of known allergy or sensitivity to hydrocodone or chlorpheniramine. The most common adverse reactions associated with TUSSIONEX® are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks such as driving or operating machinery. TUSSIONEX® should not be taken with alcohol or other CNS depressants. TUSSIONEX® is dosed at 5 mL every 12 hours in patients 12 years of age and older, and at 2.5 mL every 12 hours in patients 6-11 years of age. Overdose with TUSSIONEX® has been associated with fatal respiratory depression. Patients should be advised to measure TUSSIONEX® with an accurate measuring device. A household teaspoon is not an accurate measuring device. As with any other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.

Please see full Prescribing Information on reverse.

Reference: 1. US Food and Drug Administration. FDA takes action to stop marketing of unapproved hydrocodone products [press release]. Available at: http://www.fda.gov. Accessed June 6, 2008.

UCB Medical Affairs Department: 1-800-477-7877

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12 Tussionex® CIII Pennkinetic®
(hydrocodone polistirex/ chlorpheniramine polistirex)
Extended-Release Suspension

Cough relieved. Rest assured.™

Tussionex® Pennkinetic®

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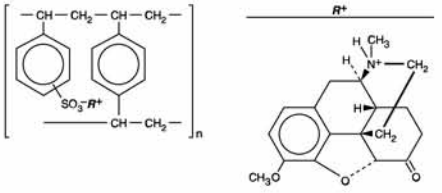
Rev. 01/2008 1E
TU1186-0308 1E

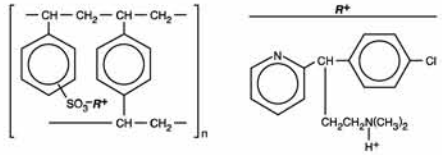
(hydrocodone polistirex and chlorpheniramine polistirex)
Extended-Release Suspension

DESCRIPTION: Each teaspoonful (5 mL) of TUSSIONEX Pennkinetic Extended-Release Suspension contains hydrocodone polistirex equivalent to 10 mg of hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg of chlorpheniramine maleate. TUSSIONEX Pennkinetic Extended-Release Suspension provides up to 12-hour relief per dose. Hydrocodone is a centrally-acting narcotic antitussive. Chlorpheniramine is an antihistamine. TUSSIONEX Pennkinetic Extended-Release Suspension is for oral use only.

Hydrocodone Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 4,5α-epoxy-3-methoxy-17-methylmorphinan-6-one.



Chlorpheniramine Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 2-[p-chloro-α-[2-(dimethylamino)ethyl]-benzyl]pyridine.



Inactive Ingredients: Ascorbic acid, D&C Yellow No. 10, ethylcellulose, FD&C Yellow No. 6, flavor, high fructose corn syrup, methylparaben, polyethylene glycol 3350, polysorbate 80, pregelatinized starch, propylene glycol, propylparaben, purified water, sucrose, vegetable oil, xanthan gum.

CLINICAL PHARMACOLOGY: Hydrocodone is a semisynthetic narcotic antitussive and analgesic with multiple actions qualitatively similar to those of codeine. The precise mechanism of action of hydrocodone and other opiates is not known; however, hydrocodone is believed to act directly on the cough center. In excessive doses, hydrocodone, like other opium derivatives, will depress respiration. The effects of hydrocodone in therapeutic doses on the cardiovascular system are insignificant. Hydrocodone can produce miosis, euphoria, and physical and psychological dependence.

Chlorpheniramine is an antihistamine drug (H_1 receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

Hydrocodone release from TUSSIONEX Pennkinetic Extended-Release Suspension is controlled by the Pennkinetic System, an extended-release drug delivery system, which combines an ion-exchange polymer matrix with a diffusion rate-limiting permeable coating. Chlorpheniramine release is prolonged by use of an ion-exchange polymer system.

Following multiple dosing with TUSSIONEX Pennkinetic Extended-Release Suspension, hydrocodone mean (S.D.) peak plasma concentrations of 22.8 (5.9) ng/mL occurred at 3.4 hours. Chlorpheniramine mean (S.D.) peak plasma concentrations of 58.4 (14.7) ng/mL occurred at 6.3 hours following multiple dosing. Peak plasma levels obtained with an immediate-release syrup occurred at approximately 1.5 hours for hydrocodone and 2.8 hours for chlorpheniramine. The plasma half-lives of hydrocodone and chlorpheniramine have been reported to be approximately 4 and 16 hours, respectively.

INDICATIONS AND USAGE: TUSSIONEX Pennkinetic Extended-Release Suspension is indicated for relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older.

CONTRAINDICATIONS: TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in patients with a known allergy or sensitivity to hydrocodone or chlorpheniramine.

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression.

WARNINGS: Respiratory Depression: As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension produces dose-related respiratory depression by directly acting on brain stem respiratory centers. Hydrocodone affects the center that controls respiratory rhythm and may produce irregular and periodic breathing. Caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively and in patients with pulmonary disease, or whenever ventilatory function is depressed. If respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride and other supportive measures when indicated (see OVERDOSAGE).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions, which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Obstructive Bowel Disease: Chronic use of narcotics may result in obstructive bowel disease especially in patients with underlying intestinal motility disorder.

Pediatric Use: The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS).

In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Caution should be exercised when administering TUSSIONEX Pennkinetic Extended-Release Suspension to pediatric patients 6 years of age and older. Overdose or concomitant administration of TUSSIONEX Pennkinetic Extended-Release Suspension with other respiratory depressants may increase the risk of respiratory depression in pediatric patients. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

PRECAUTIONS: General: Caution is advised when prescribing this drug to patients with narrow-angle glaucoma, asthma, or prostatic hypertrophy.

Special Risk Patients: As with any narcotic agent, TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy, or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

Information for Patients: As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension may produce marked drowsiness and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly. TUSSIONEX Pennkinetic Extended-Release Suspension must not be diluted with fluids or mixed with other drugs as this may alter the resin-binding and change the absorption rate, possibly increasing the toxicity.

Patients should be advised to measure TUSSIONEX Pennkinetic Extended-Release Suspension with an accurate measuring device. A household teaspoon is not an accurate measuring device and could lead to overdosage, especially when a half a teaspoon is measured. A pharmacist can recommend an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

Keep out of the reach of children.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively, and in patients with pulmonary disease.

Drug Interactions: Patients receiving narcotics, antihistaminics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with TUSSIONEX Pennkinetic Extended-Release Suspension may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone.

The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity, mutagenicity, and reproductive studies have not been conducted with TUSSIONEX Pennkinetic Extended-Release Suspension.

Pregnancy: Teratogenic Effects – Pregnancy Category C
Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. TUSSIONEX Pennkinetic Extended-Release Suspension should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: As with all narcotics, administration of TUSSIONEX Pennkinetic Extended-Release Suspension to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from TUSSIONEX Pennkinetic Extended-Release Suspension, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS and ADVERSE REACTIONS, Respiratory, Thoracic and Mediastinal Disorders).

TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in pediatric patients 6 years of age and older (see WARNINGS, Pediatric Use).

Geriatric Use: Clinical studies of TUSSIONEX 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. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

ADVERSE REACTIONS: Gastrointestinal Disorders: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of TUSSIONEX Pennkinetic Extended-Release Suspension may produce constipation.

General Disorders and Administration Site Conditions: Death

Nervous System Disorders: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, euphoria, dizziness, psychic dependence, mood changes.

Renal and Urinary Disorders: Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

Respiratory, Thoracic and Mediastinal Disorders: Dryness of the pharynx, occasional tightness of the chest, and respiratory depression (see CONTRAINDICATIONS).

TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE). Use of TUSSIONEX Pennkinetic Extended-Release Suspension in children less than 6 years of age has been associated with fatal respiratory depression. Overdose with TUSSIONEX Pennkinetic Extended-Release Suspension in children 6 years of age and older, in adolescents, and in adults has been associated with fatal respiratory depression.

Skin and Subcutaneous Tissue Disorders: Rash, pruritus.

DRUG ABUSE AND DEPENDENCE: TUSSIONEX Pennkinetic Extended-Release Suspension is a Schedule III narcotic. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, TUSSIONEX Pennkinetic Extended-Release Suspension should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when TUSSIONEX Pennkinetic Extended-Release Suspension is used for a short time for the treatment of cough. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, assumes clinically significant proportions only after several weeks of continued oral narcotic use, although some mild degree of physical dependence may develop after a few days of narcotic therapy.

OVERDOSAGE: Signs and Symptoms: Serious overdosage with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. Although miosis is characteristic of narcotic overdose, mydriasis may occur in terminal narcosis or severe hypoxia. In severe overdosage apnea, circulatory collapse, cardiac arrest and death may occur. The manifestations of chlorpheniramine overdosage may vary from central nervous system depression to stimulation.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride is a specific antidote for respiratory depression which may result from overdosage or unusual sensitivity to narcotics including hydrocodone. Therefore, an appropriate dose of naloxone hydrochloride should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of hydrocodone in this formulation may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. For further information, see full prescribing information for naloxone hydrochloride. An antagonist should not be administered in the absence of clinically significant respiratory depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric emptying may be useful in removing unabsorbed drug.

DOSAGE AND ADMINISTRATION: *It is important that TUSSIONEX is measured with an accurate measuring device* (see PRECAUTIONS, Information for Patients). A household teaspoon is not an accurate measuring device and could lead to overdosage, especially when half a teaspoon is to be measured. It is strongly recommended that an accurate measuring device be used. A pharmacist can provide an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

Adults and Children 12 Years and Older: 5 mL (1 teaspoonful) every 12 hours; do not exceed 10 mL (2 teaspoonfuls) in 24 hours.

Children 6-11 Years of Age: 2.5 mL (1/2 teaspoonful) every 12 hours; do not exceed 5 mL (1 teaspoonful) in 24 hours.

This medicine is contraindicated in children under 6 years of age (see CONTRAINDICATIONS).

HOW SUPPLIED: TUSSIONEX Pennkinetic (hydrocodone polistirex and chlorpheniramine polistirex) Extended-Release Suspension is a gold-colored suspension.

NDC 53014-548-67 473 mL bottle

For Medical Information: Contact: Medical Affairs Department / Phone: (866) 822-0068 / Fax: (770) 970-8859

Storage: Shake well. Dispense in a well-closed container.

Store at 20-25°C (68-77°F); excursions permitted to 15-30°C (59-86°F)
[see USP Controlled Room Temperature].

TUSSIONEX Pennkinetic Extended-Release Suspension
Manufactured for:
UCB, Inc.
Smyrna, GA 30080

Rev. 01/2008 TU1186-0308 1E

its use may increase compliance in children because it is more palatable in the suspension form.

- **Cephalosporins**—Inhibit bacterial cell wall synthesis by binding to one or more of the penicillin-binding proteins, which in turn inhibits the final transpeptidation step of peptidoglycan synthesis in bacterial cell walls, thus inhibiting cell wall biosynthesis.

  Cephalosporins (e.g., cefpodoxime, cefdinir) may be more effective and have better eradication rates after a five-day therapy compared with a 10-day therapy with penicillins.
- **Macrolides**—Bind to the 50s ribosomal subunit, resulting in blockage of transpeptidation, which inhibits RNA-dependent protein synthesis at the chain elongation step.

  Macrolide antibiotics (e.g., erythromycin, clarithromycin, azithromycin) are the drugs of choice in patients who are allergic to penicillin. Newer macrolides such as azithromycin and clarithromycin are as effective as erythromycin and cause fewer gastrointestinal side effects. Cholestatic hepatitis may occur mainly in pregnant adult patients receiving erythromycin estolate.

  Resistance rates are low at approximately <5%.[12]

  Erythromycin estolate and ethylsuccinate are more comparable to oral penicillin for eliminating GAS pharyngitis than erythromycin base or stearate.

  Azithromycin and clarithromycin are safe, require only five days of therapy, and are as effective as both penicillin and erythromycin. These medications should only be used in patients not responding to penicillin or who are unable to tolerate either penicillin or erythromycin.
- **Clindamycin**—Reversibly binds to 50s ribosomal subunits, preventing peptide bond formation, thus inhibiting bacterial protein synthesis. Clindamycin is bacteriostatic or bactericidal, depending on drug concentration, infection site, and organism. It can be used in patients who are penicillin-allergic, and also as an alternative for macrolide resistance. Due to its potential to cause pseudomembranous colitis, it is recommended in patients with multiple, recurrent episodes of GAS pharyngitis or allergies to both penicillins and erythromycins.

In patients with recurrent episodes of GAS pharyngitis, treatment should include β-lactamase-resistant antibiotics against aerobic and anaerobic organisms (**Table 2**). It should consist of clindamycin or amoxicillin-clavulanate due to the high rates or eradication.

Table 2. Antibiotics and Dosing for Recurrent Episodes of Pharyngitis

Drug	Adult Dosage	Pediatric Dosage	Duration
Clindamycin	600 mg orally divided in 2-4 divided doses	20-30 mg/kg/day in 3 divided doses (max:1.8 g/day)	10 days
Amoxicillin-clavulanate	500 mg twice daily	40 mg/kg/day in 3 divided doses	10 days
Penicillin benzathine	1.2 million units intramuscularly for 1 dose	0.6 million units for under 27 kg (50,000 units/kg)	1 dose
Penicillin VK with rifampin	Rifampin: 300 mg PO BID	20 mg/kg/d divided in two equal doses	Last 4 days of treatment with 10 day therapy of penicillin VK

Resistance

Penicillin is currently recommended as first-line therapy. Erythromycin is the recommended alternative in penicillin-allergic patients. First-generation cephalosporins can also be used as an alternative.

Due to increased use of broad-spectrum antibiotics, such as newer macrolides, second- and third-generation cephalosporins, and amoxicillin-clavulanate, problematic increases in resistance among the respiratory pathogens have been seen, and thus their routine or first-line use has not been recommended.

Many cases have been reported in which penicillin failed to eliminate group A *streptococcus* from "GAS carriers."

One study, designed to evaluate the potential of various antibiotics to eliminate Group A *streptococcus*, found that GAS continued to exist regardless of treating it with penicillin.[12] GAS was eliminated when treated with erythromycin or azithromycin.

Cephalothin (a cephalosporin), and clindamycin were more effective in killing GAS than penicillin, but were also less effective than erythromycin or azithromycin. It was concluded that failure to eliminate GAS was due to a lack

of effective penicillin entry into the epithelial cells. Although resistance rates remain higher than with other available treatments, it is still preferred as first-line therapy due to its narrow spectrum of activity and extremely low cost.

Macrolide resistance in the United States is low (<5%) and not widespread, whereas in areas such as Japan and Finland increased resistance remains an issue. However, there have been reports of outbreak of macrolide-resistant GAS pharyngitis in the United States. Resistance may be a concern if these agents are routinely overused. GAS resistance rates to tetracyclines and sulfonamides are high; therefore, use of these agents is no longer recommended.[6,12,13]

Viral Pharyngitis

The use of corticosteroids remains controversial, but has been shown to decrease pain and shorten the duration of symptoms without increasing complications. Corticosteroids (e.g., dexamethasone, prednisone) may be used in patients who are symptomatic and have compromised airways.

In patients with viral pharyngitis, supportive care is recommended. In patients who are immunocompromised, antivirals may have some clinical benefit. In severe cases of herpes simplex pharyngitis and for immunocompromised patients, acyclovir, famciclovir, and valacyclovir are recommended. In CMV infections in immunocompromised patients, foscarnet or ganciclovir is recommended. In patients with oral thrush, antifungals (nystatin, fluconazole) may also be used.

Summary

Differentiation of bacterial pharyngitis from other causes poses some clinical challenges. Through a combination of history, physical exam findings, clinical predictive rules, and rapid strep antigen testing, most cases requiring antibiotic treatment can be identified, and inappropriate antibiotic administration can be avoided.

Penicillin remains the drug of choice in treating GAS pharyngitis, and there continues to be several alternatives for treatment failures due to allergy and resistance. Consideration to maximizing patient comfort with liberal analgesic—along with judicious antibiotic—use will improve patient satisfaction and help decrease antibiotic resistance. ■

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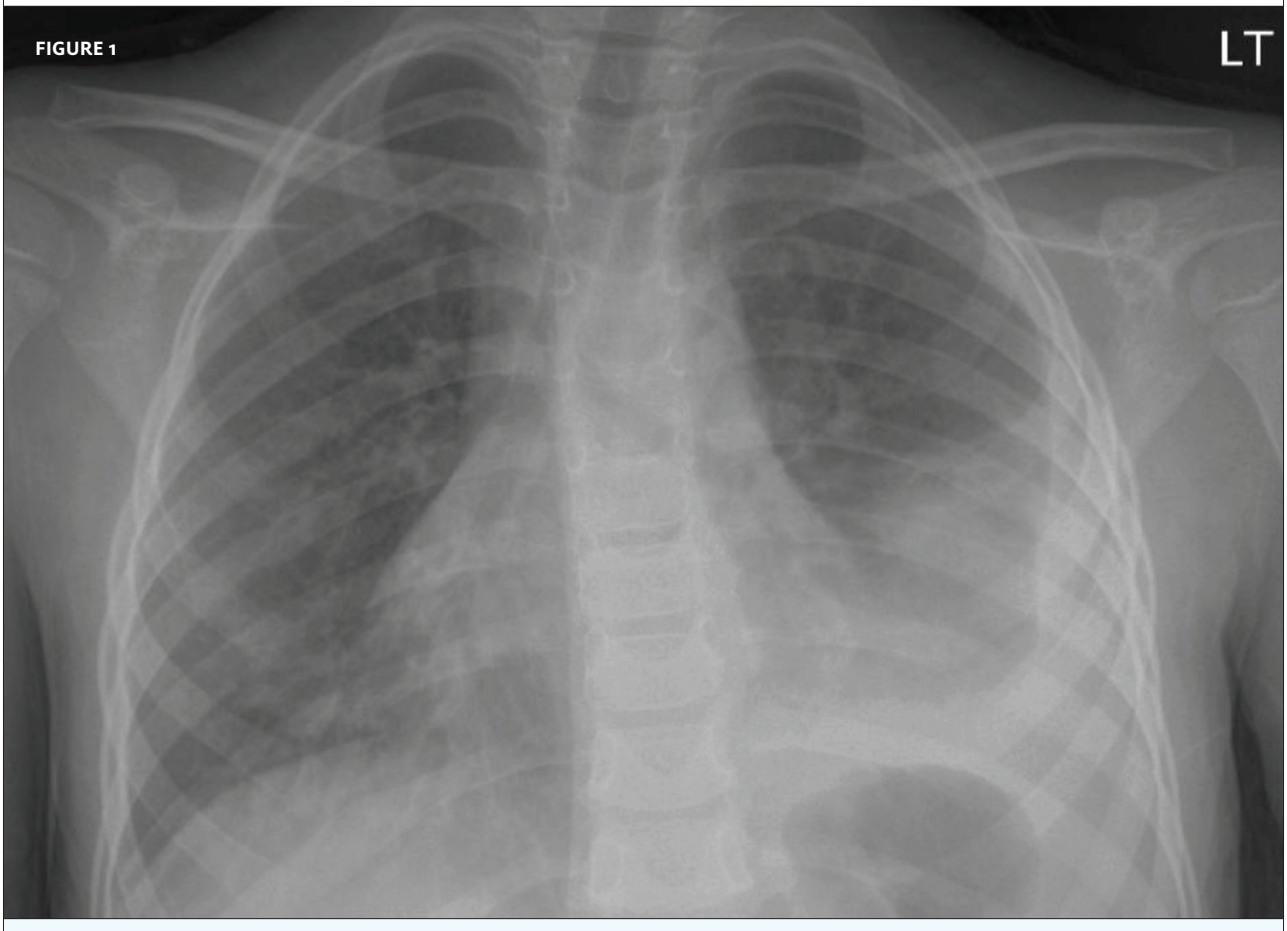
FIGURE 1



The patient is a 7-year-old boy who presents to urgent care at midnight with a four-day history of fever and cough.

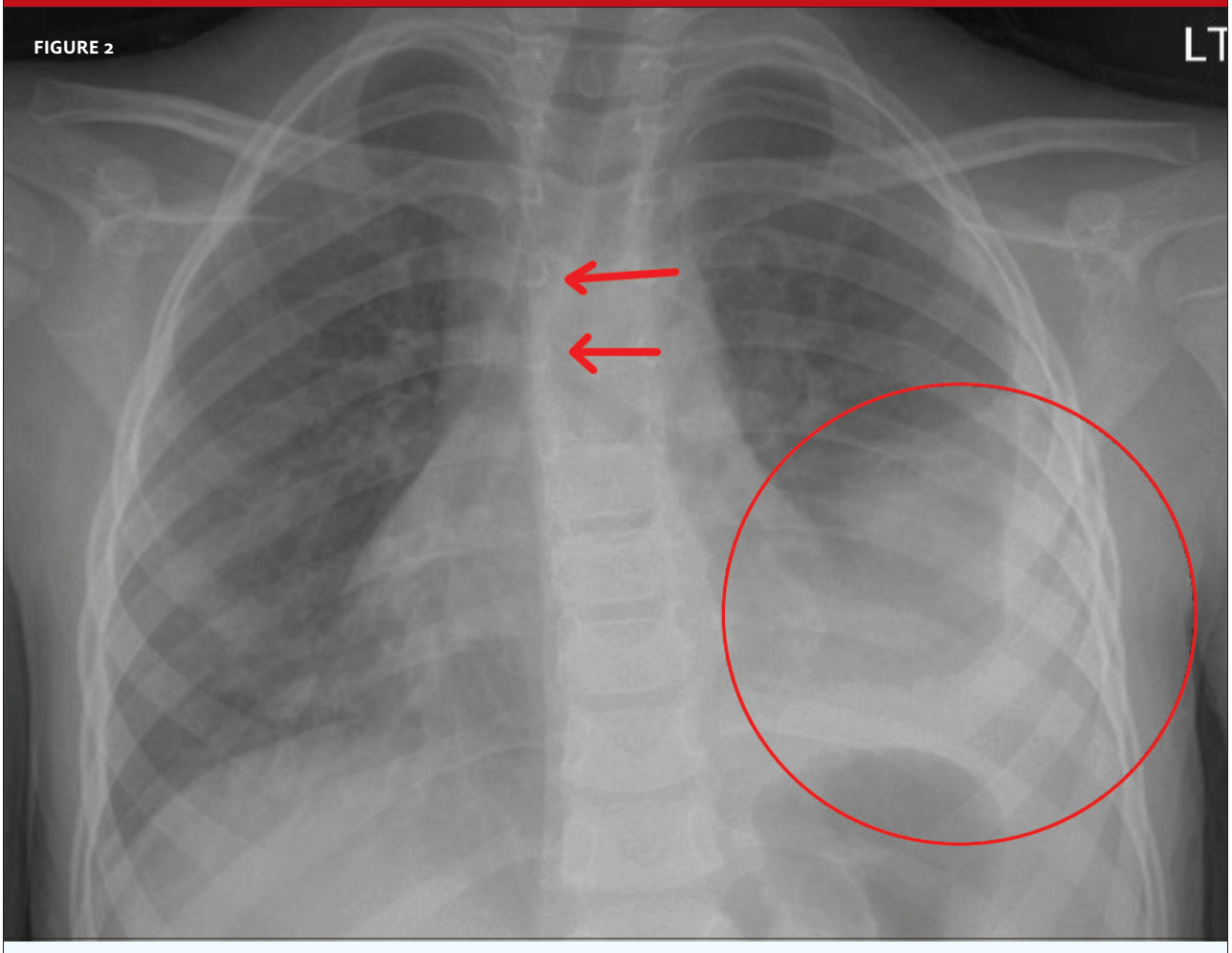
Two days prior, a throat culture administered elsewhere showed nothing suspicious. The parents brought him to urgent care tonight because of increasing chest pain, which began after the visit to the primary care physician.

On exam, you find the child is not in respiratory distress, but has decreased air entry on the left side of his chest. His temperature is 101.3°F, with SAT of 94.

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

THE RESOLUTION

FIGURE 2



The x-ray shows an infiltrate and, likely, a pleural effusion. In addition, note the deviation of the trachea.

This child was sent to the hospital, where he had a pleural tap which returned pus. He was put on IV antibiotics.

It is very likely that this was an aggressive pneumococcal pneumonia that literally developed within the short time after the visit to the primary care doctor.

Had the urgent care physician not identified the infection, there is a good chance that the child would have seriously and quickly deteriorated.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM; the patient was treated by Dr. Eliyahu Sheleg of Terem Immediate Medical Care, Jerusalem, Israel.

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On Vasopressin Cardiac Arrest, Playground Injuries, Suturing Children's Faces, Travelers' Diarrhea, and a Boxed Warning for Fluoroquinolones

■ 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.

Vasopressin Not Helpful for Out-of-Hospital Cardiac Arrest

Key point: For now, epinephrine remains the only evidence-based drug option in CPR.

Citation: Gueugniaud P-Y, David J-S, Chanzy E, et al. Vasopressin and epinephrine vs. epinephrine alone in cardiopulmonary resuscitation. *N Engl J Med*. 2008;359:21-30.

The ideal drug regimen for use in CPR is a subject of controversy. Epinephrine is the recommended vasopressor agent, but results of some studies suggest that combining epinephrine with vasopressin may confer additional benefit.

Investigators analyzed data on 2,894 patients in France who experienced out-of-hospital cardiac arrest and were randomized to receive successive injections of 1 mg of epinephrine and either 40 IU of vasopressin or saline placebo. The primary outcome was survival to hospital admission.

The average patient age was about 62, and about three quarters of the events were witnessed. The mean time from collapse to arrival of emergency personnel was seven minutes, and the mean time from collapse to injection of study drug was 21 minutes. Automated external defibrillation was administered to about 80% of patients.

The primary endpoint did not differ significantly between the combination-therapy group and the epinephrine-only group (20.7% vs. 21.3%, respectively). There were also no significant between-group differences in rates of return of spontaneous circulation (28.6% vs. 29.5%), survival to hospital discharge (1.7% vs. 2.3%), or one-year survival (1.3% vs. 2.1%).

This study tested a new drug strategy for out-of-hospital cardiac arrest, which failed to improve upon epinephrine, the agent currently recommended in guidelines.

[Published in *J Watch Cardiol*, July 2, 2008—Harlan M. Krumholz, MD, SM.] ■

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

Children Need to Play... Safely

Key point: Monkey bars cause the most playground injuries.

Citation: Loder RT. The demographics of playground equipment injuries in children. *J Pediatr Surg*. 2008;43:691-699.

Given the risk for obesity, children in the U.S. need to stay active. But they also need to be protected from injury.

The author of this study used the National Electronic Injury Surveillance System (NEISS) database of emergency department visits for 2002–2004 to investigate injuries associated with playground equipment in children younger than 18 years.

The overall incidence of playground equipment injuries peaked in the summer, and the incidence of such injuries at school peaked in the spring and fall.

Based on NEISS data since 1991, the frequency of injuries associated with swings and slides has decreased, but the frequency of injuries caused by monkey bars has not.

It is unlikely active play can be made risk-free, but data such as these can be useful in identifying ways to reduce risk. Par-

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ents, school administrators and others who supervise children should be cautioned to not use these data to reduce children's opportunities to play.

[Published in *J Watch Pediatr and Adolesc Med*, July 2, 2008—William P. Kanto, Jr., MD.] ■

Absorbable Sutures for Repair of Pediatric Facial Lacerations

Key point: Cosmetic outcomes with absorbable sutures are similar to those with nonabsorbable sutures.

Citation: Luck RP, Flood R, Eyal D, et al. Cosmetic outcomes of absorbable versus nonabsorbable sutures in pediatric facial lacerations. *Pediatr Emerg Care*. 2008;24(3):137-142.

Absorbable sutures offer several advantages over nonabsorbable sutures—including ease of use, less skin reactivity, and lower cost—but their use in children has not been well studied. In a prospective, randomized trial, researchers compared the two types of sutures for repair of acute pediatric facial lacerations of 1 cm to 5 cm. Patients were excluded if the lacerations had irregular borders, resulted from mammalian bites, were contaminated, occurred more than eight hours before presentation, or could be repaired with a topical adhesive.

Children 1–18 years of age were randomized to wound closure with either 5–0 or 6–0 fast-absorbing surgical gut or nonabsorbable nylon.

At three-month follow-up, wounds were photographed, and three pediatric emergency physicians who were blinded to group assignment assessed cosmetic appearance (the primary outcome) using a 100 mm continuous cosmesis visual analog scale (VAS; with a score of 100 representing the best scar). A between-group difference of ≥15 mm was defined as being clinically important. Wounds were assessed at five to seven days for infection (defined as requirement for systemic antibiotics) and dehiscence (defined as requirement for additional sutures).

Overall, 23 of 49 patients in the absorbable-suture group and 24 of 39 in the nonabsorbable-suture group completed the study.

At three months, mean VAS scores between the absorbable-suture and nonabsorbable-suture groups differed by only 1.4 mm (92.3 mm and 93.7 mm). Correlation among the blinded observers was good (r=0.42). Two patients, both in the absorbable-suture group, had wound dehiscence. No wound infections occurred.

The data indicate that the two suture strategies are equivalent, at least for highly vascular facial wounds. Absorbable sutures do not require subsequent visits for removal, and fears that they might increase wound inflammation seem to be unfounded.

[Published in *J Watch Emerg Med*, April 25, 2008—Jill M. Baren, MD, MBE, FACEP, FAAP.] ■

Efficacy and Safety of a Vaccine Patch Against Travelers' Diarrhea Caused by Enterotoxigenic *Escherichia* coli

Key point: Protective efficacy of the LT patch was 75%.

Citation: Frech SA, DuPont HL, Bourgeois AL, et al. Use of a patch containing heat-labile toxin from *Escherichia coli* against travellers' diarrhoea: A phase II, randomised, double-blind, placebo-controlled field trial. Lancet. 2008;371:2019-2025.

Enterotoxigenic *Escherichia coli* (ETEC), a major public health problem, is the leading cause of diarrhea among children in developing countries and of travelers' diarrhea. ETEC causes diarrhea via heat-labile enterotoxin (LT) and/or heat-stable enterotoxin (ST). LT is found in two-thirds of cases.

Antibody to LT has been shown to provide protection against ETEC, but LT antigen is too toxic to be administered by the oral, nasal, or parenteral route. Frech and colleagues hypothesized that an LT vaccine applied to the skin would be immunogenic and prevent ETEC diarrhea. In early studies, LT delivered via skin patch produced good immune responses.

The authors examined the safety, immunogenicity, and efficacy of LT transcutaneous immunization against travelers' diarrhea in persons traveling from the United States to Mexico or Guatemala.

Healthy adult travelers with access to one of 14 U.S. regional vaccination centers were eligible. Vaccination was performed in the United States, and surveillance was conducted in Mexico and Guatemala. Participants were stratified by gender and destination city.

Each traveler had patches of either LT or placebo applied on alternate upper arms a minimum of three weeks (first dose) and one week (second dose) before departure. On each occasion, the skin was marked and prepared with a mild abrasive, and the patch was left in place for six hours.

Participants reported to the clinic within 24 hours of arrival in Mexico or Guatemala and returned weekly for blood draws, stool examination, and review of a diary card that recorded adverse events. Ciprofloxacin was given to persons with moderate to severe diarrhea. Stools were examined for LT, LT/ST, or ST by DNA hybridization assay or toxin-specific polymerase chain reaction and were also tested for other stool pathogens by standard laboratory procedures.

An intention-to-treat analysis included 201 subjects who received the first dose of vaccine. Per-protocol analysis was performed on the 170 subjects who also received the second dose and reported for all clinical study-site visits.

The mean duration of stay was 12.4 days (11.8 days for the LT patch group vs. 12.8 days for the placebo group). The vaccine was well tolerated; most adverse events were mild. Upon arrival in and exit from Mexico or Guatemala, titers of IgG and IgA antibodies to LT were significantly higher in the LT patch group than in the

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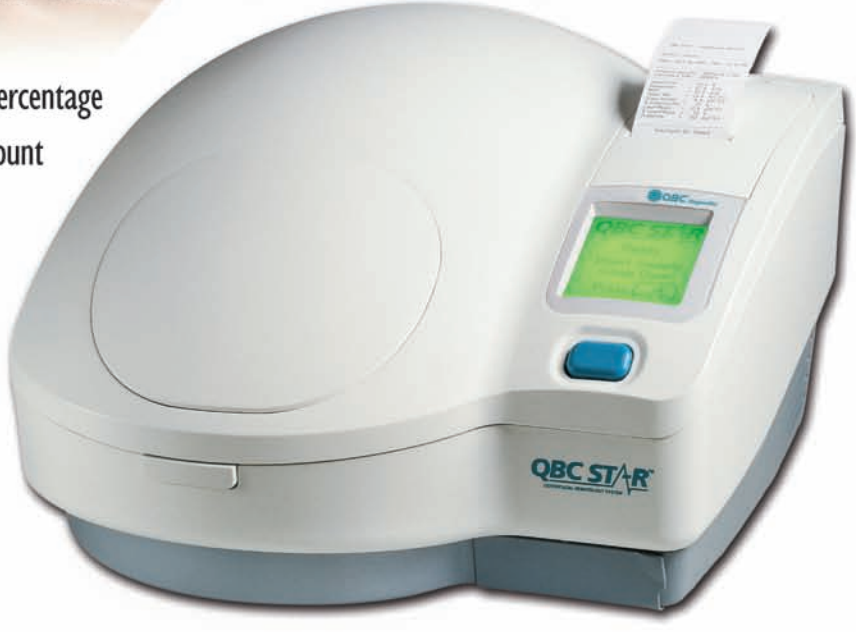

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placebo group; 15% of the LT patch group (nine travelers) and 22% of the placebo group (24 travelers) developed diarrhea (p=.3117).

The rate of moderate-to-severe diarrhea from any cause was higher in the placebo group (21% vs 5%); the protective efficacy of the LT patch was 75% (p=.0070). The number of cases of severe diarrhea was also significantly higher in the placebo group.

Among travelers in whom a pathogen was identified, 11 of 12 persons given placebo and all three persons given LT vaccine had ETEC identified. Persons infected with ETEC who had received the LT patch had significantly fewer stools per episode and diarrhea of shorter duration than placebo recipients.

This study documents that an LT-containing vaccine patch applied to the skin is safe and feasible for the prevention of ETEC diarrhea. The vaccine patch reduced both the rate of occurrence and the severity of ETEC diarrhea, providing a meaningful benefit to recipients. ■

Fluoroquinolone-Related Tendinitis and Tendon Rupture

Key point: A boxed warning must be added to the prescribing information for systemic fluoroquinolones.

Citation: U.S. Food and Drug Administration. Information for healthcare professionals: Fluoroquinolone antimicrobial drugs [ciprofloxacin (marketed as Cipro and generic ciprofloxacin), ciprofloxacin extended-release (marketed as Cipro XR and Proquin XR), gemifloxacin (marketed as Factive), levofloxacin (marketed as Levaquin), moxifloxacin (marketed as Avelox), norfloxacin (marketed as Noroxin), and ofloxacin (marketed as Floxin and generic ofloxacin]).

On July 8, 2008, the FDA announced that the prescribing information for systemic fluoroquinolones must now include a boxed warning regarding the risk for tendinitis and tendon rupture.

The prescribing information for these drugs has long listed tendon-related problems as potential adverse events, but the incidence of these events has not declined, prompting the FDA to require the stronger warning. The manufacturers must also develop and distribute a medication guide for patients.

The risk for tendinitis and tendon rupture is especially increased in patients over 60 years of age, those who are concomitantly taking steroids, and those who have received kidney, heart, or lung transplants.

Patients should be warned of this risk and should be advised to stop taking the fluoroquinolone at the first sign of tendon pain, swelling, or inflammation, to avoid exercise or use of the affected area, and to seek medical advice about switching to a non-fluoroquinolone antimicrobial.

[Published in *J Watch Infect Dis*, July 16, 2008—Lynn L. Estes, PharmD.] ■

Managing Wait Times for Greater Customer Satisfaction

Urgent message: Though patient waits are often unavoidable, understanding—and addressing—the causes can help mitigate negative impact on the patient and the practice.

Alan A. Ayers, MBA, MAcc

The term "urgent care" conveys *immediate* medical attention, so it's no surprise that the greatest determinant of customer satisfaction for an urgent care center is how quickly patients are treated and released. But how does a busy walk-in clinic—which must be prepared to handle any condition while staffing at levels to remain profitable—minimize the negative impact of long waits?

The answer is in identifying the causes of patient waits while working to improve the overall patient experience.

Patient Perceptions of Wait

Concentra Urgent Care recently studied patient attitudes toward wait times at its 324 medical centers in 40 states. The analysis included systems data of total visit times (arrival to departure), wait time from arrival to being seen by a provider, and customer satisfaction scores pertaining to wait. [Disclosure: The author is assistant vice president of product development at Concentra, based in Dallas.]

Although one would expect patient attitudes to be more negative the longer they've waited, the Concentra study revealed that patients have negative attitudes towards *any* wait—even self-reported wait times of 15 minutes or less were frequently rated "too long." In addition, the longer patients waited, the more likely they were to report a time longer than their actual wait.

Perceptions of wait are important because they influence patient attitudes toward every other element of the experience—including the quality of medical care delivered. The Concentra study demonstrated that the

longer a patient waits to see a provider, generally the less satisfied they are with the amount of time the provider spends with them.

Perhaps after an extended wait, patients feel a provider "owes" them more time.

Because some patient wait is unavoidable, a successful practice should understand what factors cause wait time to occur and then manage the patient experience to reduce the negative impact.

Determinants of Wait

Length of stay—also known as throughput or turnaround—refers to the time that passes between a patient's arrival and departure. Intervals spent waiting may be caused by processes including registration, triage, charting and billing; staffing levels, including the number of providers and technicians; the type, number, and acuity of visits; and the layout and capacity of the physical facility.

Knowing total throughput time is a starting place; process improvement involves understanding how patients move through an urgent care center, identifying the steps where waits occur, evaluating the reasons for each wait, eliminating non-value-added activities, and finally, becoming responsive to patient needs.

Identifying Areas for Improvement

The current process is defined using a flowchart that illustrates all the steps a patient passes through.

For example, a patient signs in at the front desk and completes a patient information form; the front desk verifies insurance, enters data into the billing system, and assembles a chart; a medical assistant calls the patient back to the clinical area, records symptoms and takes vitals; and so on.

Once the process is documented, it's possible to identify the steps where patient waits are occurring. **Table 1** provides a sample template that can be attached to the cover of each chart to track the patient's time at various steps. The sample period should be at least one week.

In addition to providing an in-depth understanding of the patient experience from arrival to departure, the flowcharting and time-tracking activity should reveal causes of delays, including task dependencies, duplication of effort, unnecessary steps, and bottlenecks.

Addressing the Causes of Wait Time

Value-added activities are process steps that are necessary to treat the patient and assure that the center gets paid—collecting demographic information, verifying insurance, collecting copays, taking vitals, conducting a history and physical, and documenting findings in a chart cannot be avoided. It is possible, however, to make these activities more efficient.

While process enhancements may improve the overall patient experience, only improvements that target the cause of wait time intervals will reduce length of stay.

For example, the first impulse of many urgent care operators is to tackle wait time by applying technology to highly visible

Table 1. Sample Time Tracking Template for Patient Flow

Activity	Start time	Finish time	Total time	Wait time
Patient signs in, provides ID and insurance card, and picks up registration paperwork for completion. Front desk verifies insurance eligibility, copay, and deductible.				
Front desk reviews paperwork, collects copay, and enters patient demographic data in billing system. Front desk assembles chart and passes to the medical assistant for triage.				
Medical assistant calls patient back to the clinical area, records patient's symptoms, takes vitals, and puts the patient in an exam room. Patient chart is placed in the provider's queue.				
Patient is evaluated and treated by the provider. Provider documents chart, marks billing and diagnosis codes on charge ticket, and writes prescriptions.				
Medical assistant provides scripts and discharge instructions to the patient. Patient is escorted to the discharge counter, chart is coded, charges are determined, and balance is collected.				

processes. Installing a self-registration kiosk may reduce the amount of time required for the front desk staff to register a patient, but if patients typically wait 30 minutes to be put in an exam room, reducing registration time from 10 minutes to five minutes may not necessarily reduce *total* wait times. Most likely, the provider isn't sitting in the back waiting for patients to be registered; rather, it's the patients who are waiting for their turn with the doctor.

The most significant bottleneck in urgent care tends to be the medical provider. Thus, activities that focus on improving the efficiency of the provider are likely to have the greatest impact on total wait times.

A time study of the provider's activities should reveal how the provider prioritizes and moves between patients and time spent on charting and documentation, as well as tasks that could be performed by ancillary staff. Although a growing center may not have the resources or infrastructure to add a second provider during busy times, it may be able to utilize a nurse or midlevel provider to better triage patients and manage workflow during busy periods.

When Wait Time is Inevitable

When wait time cannot be eliminated, the urgent care operator should focus on improving patient perceptions by making the wait as pleasant as possible. **Table 2** provides some practical suggestions.

Generally, the longest wait in an urgent care center occurs after completing registration and before being placed in an exam room. Some urgent care operators rightly seek to minimize this wait by rooming patients quickly, following the logic that patients in the waiting room are anxious to move to the back and that a crowded waiting room may turn off prospective patients walking in to the center.

However, compared with the isolation of an exam room, a comfortable and well-equipped waiting room is actually the best place for patients to wait. Instead of "disappearing into to the abyss," patients can gauge wait times by seeing other patients being called to the back and then leaving the center. Having patients assembled in the waiting room also allows the staff to better monitor and communicate wait times.

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Table 2. Five Suggestions for Improving Patient Perceptions of Wait Time

1. Triage and "fast track" patients. Fast tracking means moving patients presenting for routine testing or low-acuity injuries or illness more quickly through the process. By triaging patients immediately after registration, the medical staff can determine the patient's priority for seeing the provider. Low-acuity cases or re-checks may be seen by a mid-level provider or given precedence over a procedure that may tie a physician up for 20 or 30 minutes. When fast tracking is integrated into the provider workflow, the result should be faster average turnaround times for all patients than "first come, first served."

2. Communicate wait times up front and provide frequent updates. Setting expectations for wait time at sign-in puts patients in control and allows them to evaluate their options, including returning at an off-peak time. If expected wait time changes at any time during the patient's wait (for either better or worse), promptly informing patients of the change can reduce their anxiety. Likewise, informing patients at regular intervals (every 15 to 20 minutes) of where they stand in line shows the staff cares about the patient and reduces the possibility the patient will walk out prior to treatment.

3. Let patients choose where to wait. If the wait time from sign-in to seeing a provider exceeds 45 minutes, offer to write down the patient's cell phone or pager number and call the patient within 15 minutes of when the provider will be available. Running errands, shopping, working or even sitting at home is often interpreted by patients as "zero wait time" since the time waiting is spent on the patient's own terms. This practice also reduces crowding in the waiting room.

4. Keep patients comfortable and engaged. Patient attitudes about wait times can be improved if the waiting room is a comfortable, engaging environment. A waiting room should have ample seating, a wide selection of magazines (timely and relevant to the patient base), large-screen television showing talk shows or other "light but entertaining" programming, activities for children such as coloring books or game consoles, refreshments such as water, coffee, or soda, and an easily accessible restroom.

5. Survey patients and act upon suggestions. The best way to understand how to improve the patient experience is to ask patients for advice. Consider implementing a short survey on the comfort of your waiting room, the selection of magazines available, or patient preferences for television channels. Patients not only appreciate being asked for their feedback, but there is no better view into the patient's mind than his or her own words. Such surveys should be administered frequently, whenever there is a question that can benefit from patient input.

next step in a process—to move to the clinical area for treatment. Thus, they are less likely to attribute the cause of their wait to the provider than to factors they can see, such as heavy volume or complicated cases.

By comparison, patients waiting in exam rooms are focused on the arrival of one person—the provider—who they hold responsible for their wait. In an isolated exam room, a patient cannot see other activities that may be the cause of his or her wait.

Regardless, there will still be some wait in the exam room. To reduce feelings of anxiety, many centers have added television with remote control, magazine racks, and windows with blinds that can be opened to the outside. For many visits—particularly involving children—it may also be appropriate to let a family member accompany the patient to the exam room if the patient so desires. The visitor will keep the patient company and when a spouse or parent hears a treatment plan, generally compliance (and thus, medical outcomes) is improved. An extra chair should be available in the exam room for visitors.

Understanding that a provider's capacity will determine initial wait time, some urgent care operators have found ways to shift inevitable waits outside of their centers.

For example, Internet pre-registration and call-ahead scheduling add patients to the workflow when they would normally sign-in. The front desk calls within 15 minutes of when the provider will be ready to see them. The wait time isn't eliminated, but patient perceptions of the wait significantly improve.

One patient who was summoned to the clinic two hours after registering online raved about a "five-minute wait" upon arrival. The actual two-hour, five-minute wait was perceived as minimal because the patient spent that time at home.

Avoid Setting False Expectations

Some urgent care centers advertise "visits in under an hour" or "see a doctor within 15 minutes." While such

promotions may draw attention to a start-up center that is building volume, they also set an expectation for turnaround that, if not met, will disappoint and dissatisfy patients.

Even if turnaround times are not advertised as a guarantee, their presence in an ad will be interpreted as a guarantee by consumers. It is advisable to avoid marketing specific turnaround times; instead, emphasize the core benefits of urgent care: extended hours, walk-in service, no appointments necessary, and faster turnaround than the emergency room.

If patients ask about wait times, be honest—even if it means some patients will balk. Telling a patient who calls ahead there is a "short wait" will lead to disappointment if that patient waits 60 minutes upon arrival. The better solution is to let the patient know if there is an extended wait, then provide options, including returning at an off-peak time or taking the patient's cell phone number and calling when the provider is ready to see them.

Conclusion

Although urgent care centers seek to provide immediate attention to all patients, there are times when it's necessary for patients to wait. Taking a process approach, an urgent care operator can identify the causes of patient wait and seek solutions to improve operational efficiency. When patient waits simply cannot be reduced, the urgent care operator should strive to make the wait as pleasant as possible in order to reduce negative perceptions that may carry over to other elements of the patient experience. ■

Bankruptcy Part Two: Honesty is the Only Policy

JOHN SHUFELDT, MD, JD, MBA, FACEP

In this challenging financial market, in this space (urgent care medicine), should bankruptcy be something with which you are overly concerned?

The answer is an unequivocal, "yes!"

Urgent care ownership is not for the faint of heart or the short of capital. As a friend of mine said, "This business has a lot of moving parts and misfiring on any one of them can cause your business to be upside down very quickly." I have known a number of operators who have gone "tango uniform" by simply not being diligent with health plan contracting and collections. One individual I know was upside down by $1.6 million within 18 months!

Should business be this unforgiving, where a few simple mistakes can lead to financial ruin? Of course it should. After all, Darwinism exists on more levels than simply evolution. It is man's nature to want to improve their lot in life by placing their effort and capital at risk.

Adam Smith realized this back in the 18th century: "It is not by augmenting the capital of the country, but by rendering a greater part of that capital active and productive than would otherwise be so, that the most judicious operations of banking can increase the industry of the country."

When you place capital at risk, one of the potential outcomes is loss of that capital. Let's face it, but for capitalism, bankruptcy laws would probably not exist. As Frank Borman, the ex-CEO of now defunct Eastern Airlines said, "Capitalism without bankruptcy is like Christianity without hell."

So, now that we agree that bankruptcy equals hell, let's figure out how to get out of it with the least amount of burnt flesh!

First and foremost, hire competent council. Bankruptcy law is an extremely complex area of knowledge containing an intertwined body of both substantive law and procedural rules. Just as you would not want me performing brain surgery on you, the debtor does not want a "generalist" attorney representing you in a bankruptcy proceeding. Debtors should not settle for a "discount bankruptcy" attorney or the bankruptcy forms sold at the office supply store.

If a debtor is contemplating bankruptcy, they cannot transfer assets or assume additional debt. Both of these actions can result in suit by the trustee and, more importantly, the transfer of additional debt being denied discharged (i.e., you are stuck with it) during the proceedings.

Nor can the debtor pay off insiders (friends and family) preferentially. Any payments to insiders within 12 months of filing can be set aside as a preferential transfer. A "preferential transfer" (paying off friends and family first) occurs when the debtor moves funds to a creditor before filing, which results in that creditor receiving more than they would have in the liquidation proceeding.

Once hired, competent counsel's advice should be heeded. For example, the Bankruptcy Code allows a debtor to exempt from their monthly income certain expenses that are necessary and reasonable.

Vacations, vacation funds, IRA payments, etc. are *not* considered reasonable. Although what is allowed varies from case to case, the expense, in the eyes of the court, must be reasonable and necessary. Unfortunately, the debtor can simply no longer spend money as they wish and be argumentative with their attorney or the court will not expedite the process.

Now this will sound hard to believe, but some people actually try to pay their attorney with credit cards believing that they will ultimately not have to pay this debt. But some categories of debt cannot be discharged if they are made within a certain period before declaring bankruptcy. If the debtor charges something believing it will never be paid off, it is considered fraud and in some cases can lead to other, more serious charges.

John Shufeldt is the founder of the Shufeldt Law Firm, as well as the chief executive officer of NextCare, Inc., and sits on the Editorial Board of *JUCM*. He may be contacted at *JJS@shufeldtlaw.com*.

Guiding Principles

Two words to be guided by when going through a bankruptcy: Timely and Honest.

The decision to file for a bankruptcy should not be taken lightly. However, once commenced, the debtor must act expeditiously to gather all possible information. The simple fact that they have retained counsel does not relieve them from this duty. Ultimately, how quickly the debtor works to gather the information determines how quickly they will move through the process.

Bankruptcy law is not like criminal law, where the client should only tell the attorney what the attorney needs to know so they do not incriminate themselves. In bankruptcy law, honesty counts. The debtor cannot say they have a few thousand hidden away when they have a few *hundred* thousand. Nor can they even "hide money away." By the time they are in bankruptcy court, the phrase "open kimono" should be very well known to the honest debtor.

This area of the law is like medicine. Much like a doctor who needs to hear everything to make an accurate diagnosis, a bankruptcy attorney needs to understand the entire financial picture to effectively represent the client. At the end of the day, the debtor has to sign the petition for bankruptcy, under the penalty of perjury. They cannot retrospectively claim that, "my attorney was supposed to do that." Courts have denied a discharge to debtors who signed an inaccurate or incomplete petition.

Simply stated, if an individual files for bankruptcy, they are living beyond their means. How they got to this point is actually important. There are many reasons bankruptcy can occur: lost job, illness, lawsuit, divorce, substance abuse, gambling, etc. However, once at this point, counsel needs to have an understanding of how this happened in order to prepare their client for the proceedings. The debtor should not withhold information from their attorney fearing that their counsel will think less of them.

Finally, the debtor should not wait to file until the very last moment. Some debtors, like compulsive gamblers, are waiting for the one big hit to occur which will save them from filing. Ultimately, this never occurs and the debtor becomes further distressed. If the debtor waits too long to file, they may not receive the maximum benefit that filing offers. The time to consider filing is when the debtor first realizes that the debt load is too onerous to handle on their own. At this juncture, the "ostrich approach" will not make the debt go away.

Bankruptcy is a very difficult, time consuming and expensive process which, even at its best, is extremely angst provoking. Competent counsel, timely and honest disclosures, and a proactive approach are the best ways to mitigate the disaster. ■

Fear as a Factor in Occupational Health Sales

FRANK H. LEONE, MBA, MPH

Avoidance, sometimes even more than appeal, appears to be a very real part of decision making at every level. Given sufficient probing, most sales prospects harbor inner fears that can be successfully addressed.

Buyers of occupational health services have two basic motivations: helping their parent company save money, and making their own life easier.

Most occupational health sales presentations emphasize the former: reduce injury/illness incidence and associated lost work time, save the employer money, and everyone is happy.

The second motivating factor is often ignored. Sales professionals often minimize the "me first" factor or ignore it altogether, even though many people are inherently parochial. They are deeply concerned about their own finite time, daily burdens, and professional success.

Understanding a few simple principles, and breaking down those principles into distinct professional and personal factors, may help link the two "basic motivations" identified above.

Principle 1: Assess the potential importance of a prospect's parochial interests during a sales encounter.

Prospects run the gamut of personality types, from those who genuinely place the welfare of their company above all else to those who are card-carrying members of the "me, myself, and I" crowd. Each of these types has its particular priorities:

- **Professional Factors:**
  Save the company money.
  Enhance worker health status.
- **Personal Factors**
  Save the prospect time.
  Save the prospect "hassle."
  Make the prospect look better.

You should be able to assess just where each prospect seems to fall on this continuum, and position your sales approach accordingly.

Principle 2: Use questions to determine where the prospect sits on the "care about my company/care about myself" continuum.

Questions should be crafted to readily identify a pressing problem that can be placed on the table. Typically, the inclination when trying to make a sale may be to ask about purely professional problems (i.e., what is your company's most significant health and safety problem?).

As part of this process, however, it may be helpful to also investigate the personal ramifications of a prospect's professional challenges. Classic questions might include:

- "What activity causes you to lose the most amount of valuable time?"
- "When it comes to workers' compensation costs (or workplace health and safety) what must you personally need to achieve to really be successful?"
- "When it comes to the health and safety of your workforce, what is your worst nightmare? That is, what keeps you up at night?"

Responses to questions such as these serve two purposes.

First, you can usually place the prospect on a pretty reliable place on the "care about my company/care about myself" continuum. If the prospect offers little in response to the preceding questions, they are likely to be on the "best for my company" side of the continuum. Conversely, a prospect that confesses to significant personal challenges is

Continued on page 42

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

CODING Q&A

Of Discounts, Surgical Wound Dressing, and the S9088 Code

DAVID STERN, MD, CPC

Q. For uninsured patients, how much discount should be given—70% off charges? Particularly in California.

A. It would be extremely rare to offer such a big discount to self-pay patients. It would be unadvisable for the following reasons:

- Unless your fee schedule is ridiculously high, you could not operate profitably at these discounts.
- Discounts should be given not for being self-pay, specifically, but for paying in full at time of service.
- You will need to watch out for accepting any fees that are below a Medicare fee schedule, as this may produce legal problems if you are participating in the Medicare program.

Q. Using diagnosis code V58.31 (encounter for change or removal of surgical wound dressing), can we bill the following codes?

- **A6407 packing strips**
- **A4209 syringes**
- **A4550 surgical trays**
- **A4322 irrigation**
- **A6245 hydrogel**

A. In general, these supplies are not billed by physician offices, as reimbursement for these codes is bundled into the fee for the actual CPT code of a procedure. These codes are usually billed by facilities (on the UB-04 form), where the relative value units (RVUs) for the procedure CPT codes are included.

In the outpatient physician office setting (i.e., the setting for billing for most urgent care centers), there are several situations that will come into play when considering this issue:

- Recheck of a wound that was sutured (or had an incision and drainage [I&D]) and is still within the global period (usually 10 days) for the procedure. In this case, it would *not* be appropriate to bill any of these codes, as all routine follow-up is included.
- Recheck of a wound that was repaired in another facility. If you did debridement, I&D, or some other procedure, then these codes would be included in the code for the procedure.
- If you used these supplies, but it was not during the global period for a procedure done at your center and it was not part of a procedure, then you may be able to code for these supplies.
- If you used these supplies and all the following criteria apply, then depending on the payor (but never for CMS payors), you may code for these supplies: The visit was during a global period, it was associated with a complication of that procedure, and it was not associated with another billable procedure.

NOTE: Just because you may compliantly code for certain supplies does *not* mean that a payor will actually reimburse for these supplies.

Q. We are an urgent care center in Georgia. Thanks to your lecture at the UCAOA convention, we recently began using code S9088 to group health insurance with great success. Can we bill that code on every visit?

A. If you meet the UCAOA definition of an urgent care center, then it seems appropriate to use the code for all visits. Exceptions might include:

- scheduled visits
- drug screen visits
- visits that do not involve the physician.

Note: Some payors may refuse to pay on the code, and in the future some payors may ask you to reimburse them for the payments. If they do ask for reimbursement, you should see if they are allowed to do this by contract. At the very least, use this interaction as a starting point to educate the payor to the additional expenses and significant value of urgent care cen-

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ters. Then work toward negotiating any parts of the contract that you don't find optimal for your urgent care center.

Q. I just contracted with a major national managed care organization. I asked them if they recognized S9088. The provider representative stated they did not. She suggested that our urgent care use the code 99284 [level 4 emergency department (ED) evaluation and management (E/M) code]. The provider representative stated that all the urgent cares use this code frequently and that the payor would list this code as a "covered" code in our negotiated codes for reimbursement. Our urgent care physicians mentioned to me that this code (99284) is used for ERs only. Could you please shed some light on this issue?

A. It is correct that 99281-99285 are E/M codes for use in emergency departments. In general, these codes should not be used outside of a true emergency department.

Making the issue even more confusing for coders, even in states that allow free-standing EDs, many payors are refusing to pay on ED E/M codes for freestanding emergency departments.

Be careful with accepting any unconventional information that you might receive from a provider representative, as the provider representative may be mistaken. As with the IRS, advice that you get on the phone is often incorrect. Even if the representative told you to code in that fashion, the payor might refuse to reimburse for emergency department E/M codes for services rendered in an urgent care center. Or, worse, a payor that does pay on the code might later require you to refund payments.

Using ED E/M codes in your urgent care, however, may be a compliant use of the code, if the payor specifically states that they will accept these ED codes from your place of service.

Before following this unconventional coding method, I would want the payor to confirm this policy in writing. If the payor does confirm that it will accept ED E/M codes, then you will want to clarify what place of service should be used, as many payors use edit software that will not accept ED E/M codes from POS-11 or POS-20. ■

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

"A salesperson should not minimize or ignore the potential importance of their prospect's personal self-interest."

more likely to be responsive to solutions that help them (i.e., save them time and/or make them look good).

Second, you now know not only that your solution should include an appeal to their self-interest, but you have a good line on what their personal "hot buttons" are. The sales process tends to be all down hill from there.

Principle 3: Include, as appropriate, a "what's in it for them" point in every benefit statement.

Once having detected the relative importance of personal issues, you can craft their benefit statement(s) accordingly:

- *Heavy "company" orientation:* "Our unique computerized focus on return-to-work outcomes provides your company with the best chance to reduce unnecessary costs and enhance the health status of your workers."
- **Company/personal blend**
  "Our approach serves two vital purposes: we emphasis early return-to-work, thus reducing unnecessary lost work time and your workers' compensation related costs, while at the same time allowing you to spend more time addressing other important issues."
- **Heavy personal orientation**
  "Our injury/illness prevention programs focus on early return-to-work and will likely reduce the time that you have to spend on such cases, thus providing you with more time for other matters and making your life a lot easier."

A salesperson should not minimize or ignore the potential importance of their prospect's personal self-interest. Learn to assess the degree of such self-interest, and craft recommendations and benefit statements in accordance with these interests. ■

Career Opportunities

SACRAMENTO, CALIFORNIA URGENT CARE established 1981. Four physician group seeking full-time physician BC/BE in FM/IM/EM. Competitive compensation with possibility of future partnership. EMR (eCW) since 2006. Fax resume to (916) 966-2541.

URGENT CARE IN LAKELAND, FLORIDA SEEKS BE/BC physician. Must be comfortable with pediatrics and minor adult care. Excellent salary, benefit package, and bonuses. Future partnership available. Fax CV to (863) 666-6089.

MAGAN MEDICAL CLINIC IS A 40-PHYSCIAN, multispecialty group serving the east San Gabriel Valley in Southern California for approximately 90 years. Currently we are seeking a full-time, board certified family medicine urgent care physician providing care for adult and pediatric patients. Candidates must be flexible to work both 12 and 8-hour shifts and utilize excellent customer service skills when providing patient care. CVs may be submitted via email to recruit@maganclinic.com or faxed to Human Resources at (626) 251-1550.

Work and Play in the Blue Ridge Mountains of Virginia

Carilion Clinic is searching for an Urgent Care Physician to work at Carilion Roanoke Community Hospital in Roanoke where the ED has been converted to an Urgent Care due to the consolidation of 2 Carilion hospitals located in Roanoke, Virginia. Candidates must be BE/BC in Family Practice, Internal Medicine, or Emergency Medicine with Urgent Care experience preferred. Hours of operation are Sunday - Saturday from 8 AM to 10 PM, anticipating 36,000 visits annually. Flagship ED located within 1 mile for transfers of acute care. Physician Assistants and nursing support 7 days a week. Enjoy working a 36 or 40 hour work-week and every other weekend or 5 out of 10 weekends with days off during the week. Practice with cutting edge technology such as Electronic Medical Records, PACS Imaging and Web-based scheduling.

Roanoke, Virginia, a five-time "All America City", population over 280,000, and one of the top rated small cities in the US. Nestled in the gorgeous Blue Ridge Mountains and close to 500 mile shoreline Smith Mountain Lake.

Carilion Clinic is the largest, not-for-profit integrated health system in southwest Virginia with 7 hospitals, 82 multispecialty clinics, 7 residency and 2 fellowship programs affiliated with the University of Virginia and VCOM, serving 1.5 million throughout the region. The Virginia Tech Carilion School of Medicine is slated to open Fall 2010.

This opportunity offers a salary plus incentive, 10% shift differential 7p-7a, comprehensive benefits package, paid relocation, 20 days paid vacation, paid malpractice, CME days and allowance, and more.

Visit Carilion at **www.carilionclinic.com**

For more information or to submit your CV for consideration, please contact
Andrea Henson, Physician Recruiter at
(540) 224-5241 or **ahenson@carilion.com**

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SEATTLE, WASHINGTON – URGENT CARE Live the good life! As a MultiCare urgent care physician, you will benefit from a flexible, rotational, and "tailor-made" shift schedule with awesome work-life balance. Multispecialty medical group seeks B/C family medicine, IM/Peds or ER physician for a full-and part-time positions. All urgent care clinics are located within 40 minutes of downtown Seattle. Integrated inpatient/outpatient EMR, excellent compensation/benefits, flexible shifts, and system-wide support. Take a look at one of the northwest's most progressive health systems. Year round temperate climate affords outdoor enthusiasts endless recreational opportunities, such as biking, hiking, climbing, skiing, and golfing. For more information call (800) 621-0301; or email your CV to MultiCare Health System Provider Services at blazenewtrails@multicare.org; or fax to (866) 264-2818. Web site: www.multicare.org. Refer to opportunity #513-623. "MultiCareHealth System is a drug-free workplace".

URGENT CARE ARNP OR PA – WESTERN WASHINGTON full-time opening for a nurse practitioner or physician assistant to provide quality healthcare to patients of all ages in one of our urgent care centers located within 40 minutes of downtown Seattle. Experience in urgent care and family practice is preferred. Candidates must be qualified for licensure and certification in Washington State as a PA or NP. You will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. You'll live the northwest lifestyle and experience the best of northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. For more information regarding this opportunity, contact Provider Services at (800) 621-0301 or send your CV to blazenewtrails@multicare.org. Refer to opportunity ID#734-910.

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Email: Lori.Miller@sharp.com

Illinois

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HEALTH SYSTEM

Urgent Care Physician

Gundersen Lutheran Health System, based in La Crosse, Wisconsin is seeking an Urgent Care physician to join our neighboring, Onalaska Clinic. The La Crosse and Onalaska Urgent Care Department consists of 12 physicians which will enable you to lead a balanced lifestyle in a collegial environment. The successful candidate will be BC/BE in Family Medicine, Emergency Medicine, Internal Medicine or related.

Gundersen Lutheran is a large multi-specialty group practice than employs over 440 medical staff and serves a population base of 500,000 through its La Crosse campus and 20+ regional clinics based in Southwest Wisconsin, Southeast Minnesota, and Northeast Iowa.

We will consider full or part time employment. Our physician lead organization emphasizes quality and compassionate care.

Contact: Jon Nevala, Medical Staff Recruitment,
Gundersen Lutheran Health System,
(800) 362-9567, ext. 54224 or email JPNevala@gundluth.org

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Vhi SwiftCare Clinics

SENIOR MEDICAL ADVISOR

Vhi SwiftCare Clinics IRELAND

Since launching in November 2005, as the first community based Urgent Care Service in Ireland, VHI Swiftcare already employs 20 experienced doctors in 3 Urgent Care Clinics in Dublin.

In light of the enormous appetite demonstrated by our patients, the intention is to expand nationally in Ireland growing to at least 60 doctors working out of 8 Vhi SwiftCare Clinics with three new clinics opening in 2008 and four further clinics anticipated within 18 months.

Priorities for the role include

- Overall responsibility for implementing the patient policies, operational processes and clinical protocols which are being molded to govern the running of all the clinics – ensuring optimal clinical governance.
- Close integration with senior management through reporting to the Chief Executive of VHI SwiftCare Clinics who has overall responsibility for the success of the business.
- Mentorship to be provided to the Senior Medical Officer in each clinic regarding their local leadership role – particularly in the areas of service development and risk management.
- Championing the delivery of a platinum standard patient experience, grounded in clinical excellence and superior customer service.
- Clinical leadership of all our doctors and senior nurses.
- Benchmarking best clinical practice through ongoing development of the Urgent Care Concept in Ireland.
- Representation to promote linkages with the broader medical community – Hospitals, A+E Departments, Family Physicians and Medical Specialists.

The ideal candidate will have an innovative approach to her/his role, have a good working knowledge of International Healthcare systems, have practical experience and suitable qualifications at the highest level pertaining to the delivery of Urgent Care/ Acute Care services.

Applicants must have 5 years post-registration experience in Urgent Care / Acute Care or Family Practice with appropriate post-graduate qualifications, current certification in ATLS, ACLS and APLS or equivalent and be eligible for specialist registration with the Medical Council in Ireland.

**American Board Certified Physicians may not be eligible for registration for clinical practice if preferred, but it is envisaged to change within the next 12 months. In the meantime VHI Swiftcare Clinic is eager to fill the position as a Senior Executive role*

Excellent package on offer.

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Centric

www.centrichealth.ie

Northern California

Urgent Care Opportunities

Sutter Health, Sacramento Sierra Region providing services to Greater Sacramento area currently has Urgent Care opportunities in a variety of locations. Full-time and per-diem or supplemental positions are available.

The region offers something for everyone. The central location provides easy access to many of the best attractions Northern CA has to offer: San Francisco, Napa Valley, and Lake Tahoe are all within the immediate area. Enjoy activities such as skiing, camping, and biking or just sit back and relax under the warm California sunshine.

Contact us to learn more about practice opportunities Sutter Health has to offer.

Locations

Sutter Medical Group

- Roseville
- Sacramento

Sutter West Medical Group

- Davis

* Other opportunities available

Sutter Health
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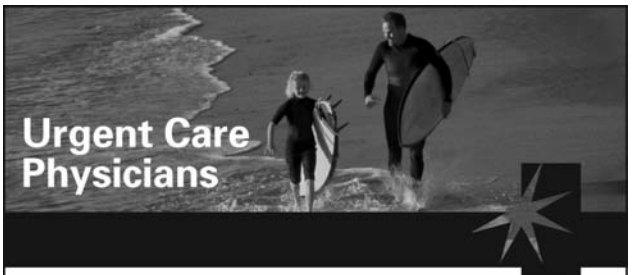
Career Opportunities



Urgent Care Physicians

Get on board with a rapidly expanding group!

Dominican Medical Foundation in Santa Cruz, CA is currently seeking two part-time, experienced Urgent Care Physicians to help launch our new urgent care center which includes lab and radiology. You'll treat patients with acute illnesses, minor trauma and some sports injuries. Join our multi-specialty group of over 30 physicians that takes pride in coordinating the entire family's medical care and focusing on the entire person. We have a varied patient population that will keep you engaged and challenged!

Located on the beautiful coastline of Northern California between San Francisco and Monterey, you and your family will enjoy breathtaking beaches, redwood forests, fresh cuisine and fine wine, and an area rich in history and culture, all in year-round sunny weather that makes this area so desirable.

For more information, please contact and/or send CV to:
Arlene Wong, Physician Recruiter, arlene.wong@chw.edu,
P: (916) 733-5774. F: (916) 859-1612.

Dominican Medical Foundation
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Lexington Clinic
get well connected

Lexington Clinic is seeking a physician to join a very busy **FirstChoice Walk-In Care Center** located in Lexington, Kentucky. Background may include training in Family Medicine, Internal Medicine, Med/Peds, ER, and/or Urgent Care.

Lexington Clinic is large multi-specialty group practice, consisting of primary care physicians, medical surgical specialists, and allied health professionals. With over 150 physicians, 50 physician extenders, and 1000 full-time employees, Lexington Clinic enjoys the reputation of a well-established and highly respected multi-specialty group practice.

Competitive salary guarantee with production driven quarterly bonuses and opportunity for partnership after one year with no buy-in! **Excellent benefits!**

Interested candidates please contact:
Audra Wray, Manager Physician Services and Recruitment
859-258-4135 or e-mail **awray@lexclin.com.**

For more information please visit www.lexingtonclinic.com.

Richmond, Indiana

URGENT CARE

Long standing Emergency Medicine group of 12 - recruiting primary care BC urgent care physician to staff Fast Track at Reid Hospital in Richmond, Indiana. Work 120 hours per month - very flexible schedule! Patient flow averages 2.5 per hour. Patients are triaged from Level II Emergency Department. Work alongside two RNs. Draw area of 150K. Outstanding earning potential with quarterly productivity bonuses, low cost of living. New 233-bed replacement hospital opened September 2008. Three major metro cities within one hour - Indianapolis, Dayton and Cincinnati. Family oriented community with relaxed lifestyle and excellent schools, including private. Outdoor Recreational activities abound including golf, boating, hunting and fishing to name a few. Great place to live and practice medicine.

Email your CV to Amy Koons, Recruiter
Medical Staff Development
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McLeod Health
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McLeod Health, located in Florence, South Carolina is seeking a BC/BE FM, IM, or EM physicians to work in our new urgent care facility. The facility's hours of operation are Monday-Friday, 8:00am-8:00pm and weekends 9:00am-4:00pm. The physicians will work together to develop the work schedule. We offer a competitive salary, comprehensive benefits package, retirement package, 30 days paid time off, malpractice insurance, CME allowance, and a relocation allowance. The urgent care center has cutting-edge technology with a digital x-ray and CT scanner on site. Made up of 10 rooms and 2 procedure rooms we provide our patients with quality service.

Florence, South Carolina offers a wonderful family-oriented life style with great schools, civic events, and sporting events. We are located at the intersection of I-20 and I-95 with a regional airport that is operated by US Air and Delta airlines, making our location easy for travel. In addition, we are 1 hour from the beach, and within 2 hours of Charlotte, North Carolina and Charleston, South Carolina.

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Urgent Care – Layton, Utah

Layton, Utah: Intermountain Healthcare needs BC/BE family physicians to do urgent care work in our InstaCare clinics. Full-time and part-time shifts available.

Shifts are very flexible:

- Weekdays 5 hour or 9 hour shifts.
- Evenings 4 hours (5:00 – 9:00 PM) or
- 8 hours (1:00 – 9:00 PM).
- Weekend shifts are 6 hours.

11 or 12 hour shifts can also be accommodated. Days per week can be variable too.

InstaCare hours:

- 9:00 AM – 9:00 PM on weekdays and
- 9:00 AM – 5:00 PM on weekends.

Physicians will have the ability to make $180k to well over $200k. Employment positions with the Intermountain Medical Group. Intermountain benefits and relocation provided for full-time positions. EOE.

Send/email/fax CV to:
Intermountain Healthcare
Attn: Wilf Rudert, Physician Recruiting
36 S. State Street, 21st Floor,
Salt Lake City, UT 84111
(800) 888-3134,
Fax: (801) 442-2999
Email: PhysicianRecruit@imail.org.
http://intermountain.net/docjobs.

Tampa, Florida

We are looking for enthusiastic physicians to fill full-time and part-time positions at our fast-paced Urgent Care Clinics in the Tampa Bay area.
(no nights or weekend beeper)

Compensation based on experience.

We provide malpractice insurance!

Interested candidates should forward CV to Rosie Watson

Doctor's Walk-In Clinic **(813) 288-0032**

Urgent Care - Bloomington, IL

A Family Medicine Physician is needed for our fast paced Urgent Care at **OSF St. Joseph Medical Center** in Bloomington, Illinois. Come to the fastest growing area offering culture, entertainment, education, community, and stability. Treat walk-in patients using quick diagnostic skills on-site with procedure room, lab, and x-ray. This full-time position includes 8 shifts every 2 weeks and the option to work additional hours.

Please contact: Marie Noeth
OSF Physician Recruitment
Call: (309) 677-8351 or (800) 232-3129 press 8
Fax: (309) 677-8338
marie.k.noeth@osfhealthcare.org
www.osfhealthcare.org

URGENT CARE - SOUTH CAROLINA

From the mountains to the sea and the capital in between, **UCI Medical** offers opportunity and security in a professional setting. With 26 years of successful history, our group comprises over 40 locations throughout **South Carolina**, half with on-site Physical Therapy. Competitve compensation includes malpractice, 401(k), productivity bonus, deferred comp plan, etc.

Inquiries and CV to: kmitchell@UCImedinc.com

Allegiance HEALTH

South Central Michigan

Seeking BE/BC Urgent Care/FP or Emed Physicians minutes from Ann Arbor

Average 5.5 patients/hour. Typical schedule is 2 on 3 off and 3 day weekend. Two weekends a month. Second schedule is: 4-12am with flexibility-equates to 10-8 hour shifts/pay period.

Support staff includes: 3-5 LPN's, Radiologist, Pediatrician, and Registration staff. Procedures: simple sutures, fractures, casts, and those typical of office practice.

For more information contact:
Michelle Spielberg at
(800) 547-1451
Email: mspielberg@sourceonestl.com

MEDPRO Urgent Care Physician

Phoenix, Arizona

Seeking board-certified/board eligible physician in either family medicine or emergency medicine for an urgent care facility located in downtown Phoenix. Join a stimulating practice with a broad variety of patients, and a knowledgeable and supportive staff. **Maricopa Integrated Health System ("MIHS")** provides care to the underserved population of metro Phoenix and includes Maricopa Medical Center, a 450-bed hospital with a Level 1 Trauma and Burn Center which is a major affiliate of the University of Arizona, College of Medicine. The position would include employment through Medical Professional Associates of Arizona, P.C., a 250+ physician multispecialty group exclusively contracted to provide patient care and teaching.

Candidates must have an M.D. or D.O. degree and a valid Arizona license. MedPro offers an outstanding work environment, competitive compensation plan/benefits package including relocation assistance, paid time off, CME allowance with paid time off and paid malpractice insurance.

For consideration please forward CV to:
MedPro, Attn: Provider Recruiting
2929 E. Thomas Road, Phoenix, AZ 85016
Fax (602) 470-5067
E-Mail: practice@medprodoctors.com
EOE

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Urgent Care Opportunities-Washington

Group Health Permanente, the Pacific Northwest's premier multi-specialty group, is currently seeking a BC/BE Emergency Medicine Physician to join our team. Group Health is dedicated to providing innovative and patient-centered care to communities throughout WA.

- Candidates should have a full range of urgent care skills & an interest in working with innovative group
- Affordable housing, highly rates schools & pleasant neighborhoods, an unparalleled place to raise a family
- A flexible schedule, generous benefits and competitive salaries make this an opportunity worth exploring

For additional information or to submit your CV, please contact:

Cayley Crotty – crotty.c@ghc.org
206-448-6519

EOE/AA

www.ghc.org/greatjob GroupHealth

Career Opportunities

WALK-IN MEDICAL CARE

Flagstaff, Arizona, a city boasting four beautiful seasons with the San Francisco peaks and Snowbowl ski resort. Ski in the winter and hike for miles in beautiful Coconino forest lands and trails in the summer. Flagstaff, located in northern Arizona at an elevation of 7,000–feet with a population of 62,000, which does not include worldwide visitors and students from Northern Arizona University, is within an hours drive of the beautiful Grand Canyon and 30 minutes drive to the red rocks of Sedona.

Walk In Medical Care, an urgent care facility located on old Route 66, is seeking full-time family medicine physician to work 12 hours or flexible schedules. Current Arizona State license and ACLS certification, Board-Certification or eligible required. The position is responsible for treatment of walk-in patients using diagnostic skills with on site lab and x-ray. No-call or inpatient care. We offer competitive compensation plus incentive and shifts to meet a providers ever-changing lifestyle.

If you would like to become part of our urgent care team contact Practice Manager:
Carol Lunceford at
luncefordc@walkinmedicalcare.com
(928) 527-1920

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If you are interested in learning more, please submit your CV to:

EMO Medical Care

Soti Lluberes, Physician Recruiter
(877) 692-4665 Ext. 1134
Fax: (973) 740-9895
Email: lluberess@emomedicalcare.com

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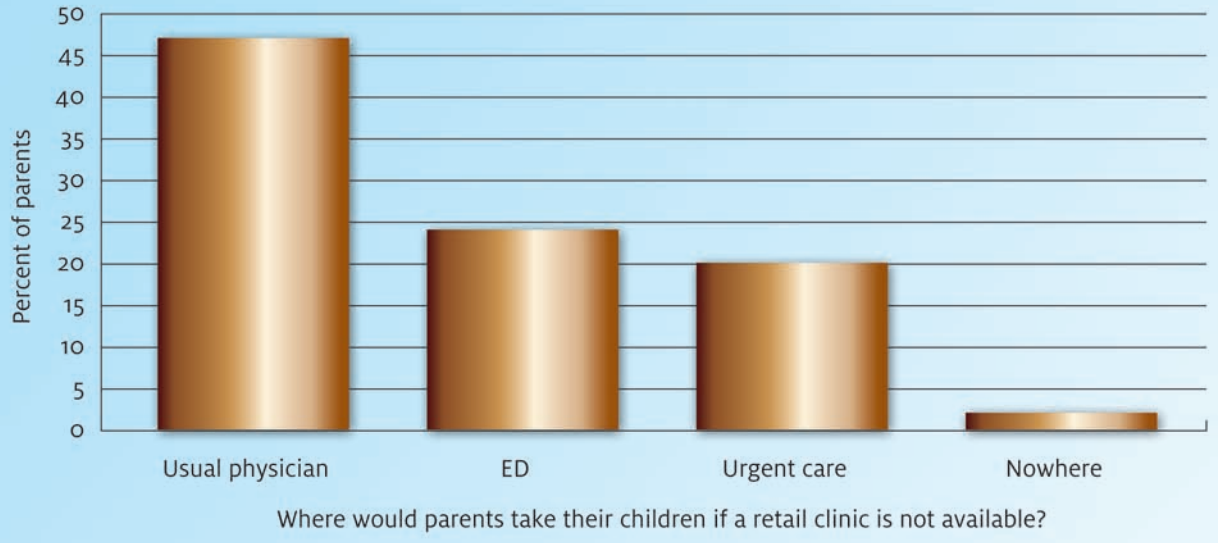
DEVELOPING DATA

As an emerging distinct practice environment, urgent care is in the early stages of building a data set specific to its norms and practices.

In Developing Data, *JUCM* will offer results not only from UCAOA's annual benchmarking surveys, but also from research conducted elsewhere to present an expansive view of the healthcare marketplace in which urgent care seeks to strengthen its presence.

In this issue: What effect does the presence of a retail clinic have on choices parents make—and how likely are they to visit an urgent care clinic when a retail clinic is not nearby?

PARENTS' OPTIONS FOR CHILDREN'S HEALTHCARE



Source: Retail Clinics: An Emerging Source of Health Care for Children. University of Michigan C.S. Mott Children's Hospital National Poll on Children's Health. 2008;4(3). Available at *http://health.med.umich.edu/workfiles/npch/20080811_clinic_report.pdf.*

Results are dependent upon the presence of retail clinics in the respondents' community; just 29% reported having a retail clinic in close proximity, with just one in six parents saying they had taken their child to one. However, one in four of all respondents said they would be likely or very likely to take their children in the future.

Clearly, urgent care offers advantages over other settings: far more facilities across the country compared with retail clinics, quicker and less expensive visits than the ED, and, typically, better off-hour accessibility than pediatric practices. This begs the question: Why didn't more parents say they would take their children to urgent care?

The survey illustrates the need to reach out to the community and to forge healthy relationships with pediatric and primary care physicians.

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

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The UCAC will be present at the **UCAOA 2008 Conference** in Memphis, TN this September. Bring this ad to our booth to be entered into a drawing for a $200 StubHub gift certificate – good for any sporting, theater or concert event.

"Physicians Immediate Care (PIC) is proud to be a founding member of Urgent Care Assurance Company, the only insurer dedicated solely to our industry. PIC received lower premiums on this year's policy and we expect to receive significant profits over time. More importantly, we now have the ability to better control everything from coverage to claim settlements to risk mitigation programs. I invite you to join us as a member-owner and learn what it feels like to be treated as an owner, not a number."
– John Koehler MD, CEO, Physicians Immediate Care

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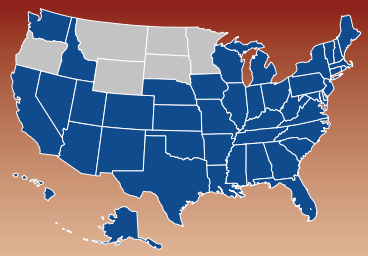

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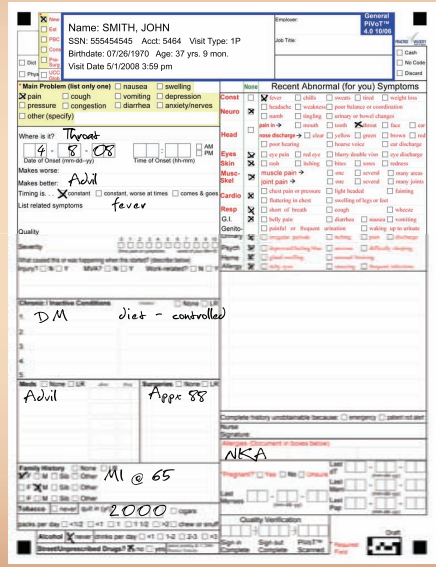

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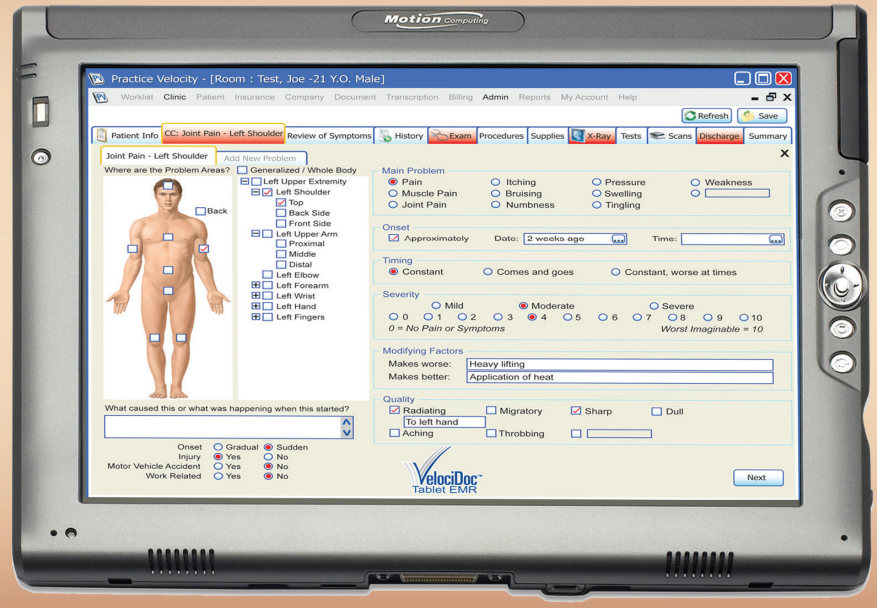

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