

JUCM™

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IN THIS ISSUE

FEATURES

- 11** Management of Patients Presenting with Symptoms of Vulvovaginitis
- 19** Bouncebacks: The Case of an 18-Year-Old Male with Hand Pain
- 30** UCAOA Benchmarking Survey: Addressing the Data Drought



DEPARTMENTS

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

Vulvovaginitis

EVALUATION AND MANAGEMENT

HOW CAN YOU MISS?



Achieve Proven Otitis Externa Cures with the #1 Otic Drop Among ENTs and Pediatricians.^{1,2}

Based on 2 clinical trials, CIPRODEX® Otic demonstrated clinical cures in 87% and 94% of per protocol evaluable acute otitis externa (AOE) patients. And, among culture positive patients, clinical cures were 86% and 92% per protocol for CIPRODEX® Otic.¹



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Please see adjacent page for prescribing information.

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CIPRODEX® Otic is indicated in patients 6 months and older for acute otitis externa due to *Staphylococcus aureus* and *Pseudomonas aeruginosa*. CIPRODEX® Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections. CIPRODEX® Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Serious acute hypersensitivity reactions may require immediate emergency treatment. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. Most commonly reported adverse reactions in clinical trials in AOE patients: pruritus (1.5%), ear debris (0.6%), superimposed ear infection (0.6%), ear congestion (0.4%), ear pain (0.4%) and erythema (0.4%).



(ciprofloxacin 0.3% and dexamethasone 0.1%)

STERILE OTIC SUSPENSION

DESCRIPTION

CIPRODEX® (ciprofloxacin 0.3% and dexamethasone 0.1%) Sterile Otic Suspension contains the synthetic broad-spectrum antibacterial agent, ciprofloxacin hydrochloride, combined with the anti-inflammatory corticosteroid, dexamethasone, in a sterile, preserved suspension for otic use. Each mL of CIPRODEX® Otic contains ciprofloxacin hydrochloride (equivalent to 3 mg ciprofloxacin base), 1 mg dexamethasone, and 0.1 mg benzalkonium chloride as a preservative. The inactive ingredients are boric acid, sodium chloride, hydroxyethyl cellulose, tyloxapol, acetic acid, sodium acetate, edetate disodium, and purified water. Sodium hydroxide or hydrochloric acid may be added for adjustment of pH.

Ciprofloxacin, a fluoroquinolone is available as the monohydrochloride monohydrate salt of 1-cyclopoly-6-fluoro-1,4-dihydro-4-oxo-7-(1-piperazinyl)-3-quinolincarboxylic acid. The empirical formula is C₁₇H₁₄FN₃O₂·HCl·H₂O. Dexamethasone, 9-fluoro-11(beta),17,21-trihydroxy-16(alpha)-methylpregna-1,4-diene-3,20-dione, is an anti-inflammatory corticosteroid. The empirical formula is C₂₂H₂₉F₅O₅.

CLINICAL PHARMACOLOGY

Pharmacokinetics: Following a single bilateral 4-drop (total dose = 0.28 mL, 0.84 mg ciprofloxacin, 0.28 mg dexamethasone) topical otic dose of CIPRODEX® Otic to pediatric patients after tympanostomy tube insertion, measurable plasma concentrations of ciprofloxacin and dexamethasone were observed at 6 hours following administration in 2 of 9 patients and 5 of 9 patients, respectively.

Mean ± SD peak plasma concentrations of ciprofloxacin were 1.39 ± 0.880 ng/mL (n=9). Peak plasma concentrations ranged from 0.543 ng/mL to 3.45 ng/mL and were on average approximately 0.1% of peak plasma concentrations achieved with an oral dose of 250-mg [8]. Peak plasma concentrations of ciprofloxacin were observed within 15 minutes to 2 hours post dose application. Mean ± SD peak plasma concentrations of dexamethasone were 1.14 ± 1.54 ng/mL (n=9). Peak plasma concentrations ranged from 0.15 ng/mL to 5.10 ng/mL and were on average approximately 14% of peak concentrations reported in the literature following an oral 0.5-mg tablet dose [9]. Peak plasma concentrations of dexamethasone were observed within 15 minutes to 2 hours post dose application. Dexamethasone has been added to aid in the resolution of the inflammatory response accompanying bacterial infection (such as otitis media in pediatric patients with AOM with tympanostomy tubes).

Microbiology: Ciprofloxacin has *in vitro* activity against a wide range of gram-positive and gram-negative microorganisms. The bactericidal action of ciprofloxacin results from interference with the enzyme, DNA gyrase, which is needed for the synthesis of bacterial DNA. Cross-resistance has been observed between ciprofloxacin and other fluoroquinolones. There is generally no cross-resistance between ciprofloxacin and other classes of antibacterial agents such as beta-lactams or aminoglycosides.

Ciprofloxacin has been shown to be active against most isolates of the following microorganisms, both *in vitro* and clinically in otic infections as described in the **INDICATIONS AND USAGE** section.

Aerobic and facultative gram-positive microorganisms: *Staphylococcus aureus*, *Streptococcus pneumoniae*. **Aerobic and facultative gram-negative microorganisms:** *Haemophilus influenzae*, *Moraxella catarrhalis*, *Pseudomonas aeruginosa*.

INDICATIONS AND USAGE: CIPRODEX® Otic is indicated for the treatment of infections caused by susceptible isolates of the designated microorganisms in the specific conditions listed below: **Acute Otitis Media** in pediatric patients (age 6 months and older) with tympanostomy tubes due to *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *Pseudomonas aeruginosa*. **Acute Otitis Externa** in pediatric (age 6 months and older), adult and elderly patients due to *Staphylococcus aureus* and *Pseudomonas aeruginosa*.

CONTRAINDICATIONS

CIPRODEX® Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections.

WARNINGS

FOR OTIC USE ONLY (This product is not approved for ophthalmic use.) NOT FOR INJECTION

CIPRODEX® Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Serious acute hypersensitivity reactions may require immediate emergency treatment.

PRECAUTIONS

General: As with other antibacterial preparations, use of this product may result in overgrowth of nonsusceptible organisms, including yeast and fungi. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. If otitis media persists after a full course of therapy, or if two or more episodes of otitis media occur within six months, further evaluation is recommended to exclude an underlying condition such as cholesteatoma, foreign body, or a tumor. The systemic administration of quinolones, including ciprofloxacin at doses much higher than given or absorbed by the otic route, has led to lesions or erosions of the cartilage in weight-bearing joints and other signs of arthropathy in immature animals of various species. Guinea pigs dosed in the middle ear with CIPRODEX® Otic for one month exhibited no drug-related structural or functional changes of the cochlear hair cells and no lesions in the ossicles. CIPRODEX® Otic was also shown to lack dermal sensitizing potential in the guinea pig when tested according to the method of Buehler. No signs of local irritation were found when CIPRODEX® Otic was applied topically in the rabbit eye. **Information for Patients:** For otic use only. (This product is not approved for use in the eye.) Warm the bottle in your hand for one to two minutes prior to use and shake well immediately before using. Avoid contaminating the tip with material from the ear, fingers, or other sources. Protect from light. If rash or allergic reaction occurs, discontinue use immediately and contact your physician. It is very important to use the ear drops for as long as the doctor has instructed, even if the symptoms improve. Discard unused portion after therapy is completed. **Acute Otitis Media in pediatric patients with tympanostomy tubes:** Prior to administration of CIPRODEX® Otic in patients (6 months and older) with acute otitis media through tympanostomy tubes, the solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear (see **DOSAGE AND ADMINISTRATION**). **Acute Otitis Externa:** Prior to administration of CIPRODEX® Otic in patients with acute otitis externa, the solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear (see **DOSAGE AND ADMINISTRATION**).

Drug Interactions: Specific drug interaction studies have not been conducted with CIPRODEX® Otic. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term carcinogenicity studies in mice and rats have been completed for ciprofloxacin. After daily oral doses of 750 mg/kg (mice) and 250 mg/kg (rats) were administered for up to 2 years, there was no evidence that ciprofloxacin had any carcinogenic or tumorigenic effects in these species. No long term studies of CIPRODEX® Otic have been performed to evaluate carcinogenic potential. Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin, and the test results are listed below: *Salmonella/Microsome Test (Negative)*, *E. coli* DNA Repair Assay (Negative), *Mouse Lymphoma Cell Forward Mutation Assay (Positive)*, *Chinese Hamster V79 Cell HGprt Test (Negative)*, *Syrian Hamster Embryo Cell Transformation Assay (Negative)*, *Saccharomyces cerevisiae Point Mutation Assay (Negative)*, *Saccharomyces cerevisiae Mitotic Crossover and Gene Conversion Assay (Negative)*, *Rat Hepatocyte DNA Repair Assay (Positive)*. Thus, 2 of the 8 tests were positive, but results of the following 3 *in vivo* test systems gave negative results: *Rat Hepatocyte DNA Repair Assay*, *Micronucleus Test (Mice)*, *Dominant Lethal Test (Mice)*. Fertility studies performed in rats at oral doses of ciprofloxacin up to 100 mg/kg/day revealed no evidence of impairment. This would be over 100 times the maximum recommended clinical dose of ototopical ciprofloxacin based upon body surface area, assuming total absorption of ciprofloxacin from the ear of a patient treated with CIPRODEX® Otic twice per day according to label directions. Long term studies have not been performed to evaluate the carcinogenic potential of topical otic dexamethasone. Dexamethasone has been tested for *in vitro* and *in vivo* genotoxic potential and shown to be positive in the following assays: chromosomal aberrations, sister-chromatid exchange in human lymphocytes and micronuclei and sister-chromatid exchanges in mouse bone marrow. However, the Ames/Salmonella assay, both with and without S9 mix, did not show any increase in His+ revertants. The effect of dexamethasone on fertility has not been investigated following topical otic application. However, the lowest toxic dose of dexamethasone identified following topical dermal application was 1.802 mg/kg in a 26-week study in male rats and resulted in changes to the testes, epididymis, sperm duct, prostate, seminal vesicle, Cowper's gland and accessory glands. The relevance of this study for short term topical otic use is unknown.

Pregnancy

Teratogenic Effects. Pregnancy Category C: Reproduction studies have been performed in rats and mice using oral doses of up to 100 mg/kg and IV doses up to 30 mg/kg and have revealed no evidence of harm to the fetus as a result of ciprofloxacin. In rabbits, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion, but teratogenicity was observed at either dose. After intravenous administration of doses up to 20 mg/kg, no maternal toxicity was produced in the rabbit, and no embryotoxicity or teratogenicity was observed. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Animal reproduction studies have not been conducted with CIPRODEX® Otic. No adequate and well controlled studies have been performed in pregnant women. Caution should be exercised when CIPRODEX® Otic is used by a pregnant woman.

Nursing Mothers: Ciprofloxacin and corticosteroids, as a class, appear in milk following oral administration. Dexamethasone in breast milk could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical otic administration of ciprofloxacin or dexamethasone could result in sufficient systemic absorption to produce detectable quantities in human milk. Because of the potential for unwanted effects in nursing infants, 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 safety and efficacy of CIPRODEX® Otic have been established in pediatric patients 6 months and older (937 patients) in adequate and well-controlled clinical trials. Although no data are available on patients less than age 6 months, there are no known safety concerns or differences in the disease process in this population that would preclude use of this product. (See **DOSAGE AND ADMINISTRATION**). No clinically relevant changes in hearing function were observed in 69 pediatric patients (age 4 to 12 years) treated with CIPRODEX® Otic and tested for audiometric parameters.

ADVERSE REACTIONS

In Phases II and III clinical trials, a total of 937 patients were treated with CIPRODEX® Otic. This included 400 patients with acute otitis media with tympanostomy tubes and 537 patients with acute otitis externa. The reported treatment-related adverse events are listed below:

Acute Otitis Media in pediatric patients with tympanostomy tubes: The following treatment-related adverse events occurred in 0.5% or more of the patients with non-intact tympanic membranes.

Adverse Event	Incidence (N=400)
Ear discomfort	3.0%
Ear pain	2.3%
Ear precipitate (residue)	0.5%
Irritability	0.5%
Taste perversion	0.5%

The following treatment-related adverse events were each reported in a single patient: tympanostomy tube blockage; ear pruritus; tinnitus; oral moniliasis; crying; dizziness; and erythema. **Acute Otitis Externa:** The following treatment-related adverse events occurred in 0.4% or more of the patients with intact tympanic membranes.

Adverse Event	Incidence (N=537)
Ear pruritus	1.5%
Ear debris	0.6%
Superimposed ear infection	0.6%
Ear congestion	0.4%
Ear pain	0.4%
Erythema	0.4%

The following treatment-related adverse events were each reported in a single patient: ear discomfort; decreased hearing; and ear disorder (tingling).

DOSAGE AND ADMINISTRATION

CIPRODEX® OTIC SHOULD BE SHAKEN WELL IMMEDIATELY BEFORE USE

CIPRODEX® Otic contains 3 mg/mL (3000 µg/mL) ciprofloxacin and 1 mg/mL dexamethasone.

Acute Otitis Media in pediatric patients with tympanostomy tubes: The recommended dosage regimen for the treatment of acute otitis media in pediatric patients (age 6 months and older) through tympanostomy tubes is: Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed. **Acute Otitis Externa:** The recommended dosage regimen for the treatment of acute otitis externa is: For patients (age 6 months and older): Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed.

HOW SUPPLIED

CIPRODEX® (ciprofloxacin 0.3% and dexamethasone 0.1%) Sterile Otic Suspension is supplied as follows: 5 mL fill and 7.5 mL fill in a DROP-TAINER® system. The DROP-TAINER® system consists of a natural polyethylene bottle and natural plug, with a white polypropylene closure. Tamper evidence is provided with a shrink band around the closure and neck area of the package. NDC 0065-8533-01, 5 mL fill; NDC 0065-8533-02, 7.5 mL fill. **Storage:** Store at controlled room temperature, 15°C to 30°C (59°F to 86°F). Avoid freezing. Protect from light.

Clinical Studies: In a randomized, multicenter, controlled clinical trial, CIPRODEX® Otic dosed 2 times per day for 7 days demonstrated clinical cures in the per protocol analysis in 86% of AOMT patients compared to 79% for ofloxacin solution, 0.3%, dosed 2 times per day for 10 days. Among culture positive patients, clinical cures were 90% for CIPRODEX® Otic compared to 79% for ofloxacin solution, 0.3%. Microbiological eradication rates for these patients in the same clinical trial were 91% for CIPRODEX® Otic compared to 82% for ofloxacin solution, 0.3%. In 2 randomized multicenter, controlled clinical trials, CIPRODEX® Otic dosed 2 times per day for 7 days demonstrated clinical cures in 87% and 94% of per protocol evaluable AOE patients, respectively, compared to 84% and 89%, respectively, for otic suspension containing neomycin 0.35%, polymyxin B 10,000 IU/mL, and hydrocortisone 1.0% (neo/poly/HC). Among culture positive patients clinical cures were 86% and 92% for CIPRODEX® Otic compared to 84% and 89%, respectively, for neo/poly/HC. Microbiological eradication rates for these patients in the same clinical trials were 86% and 92% for CIPRODEX® Otic compared to 85% and 85%, respectively, for neo/poly/HC.

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U.S. Patent Nos. 4,844,902; 6,284,804; 6,359,016

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Afraid you missed something?

The screenshot shows the homepage of **JUCM** (The Journal of Urgent Care Medicine). The top navigation bar includes links for Home, Urgent Care Authors, Free Subscription, Urgent Care News, Urgent Care Directory, Urgent Care Job Search, Advertising Info, and About Us. A sidebar on the left features links for **How Can You Miss It?**, **PRACTICE VELOCITY®**, **xpress** (with phone number 877.281.8024), **DocuTAP** (with "Learn More" link), and **FindCare** (with "Where Patients Come To You!"). The main content area contains a brief description of the journal, a "Past Issues Archive" button, and a thumbnail of the May 2009 issue cover. Below this are sections for "From the Editor-in-Chief", "From the Executive Director", "Commentary", "Quality of Care", "Clinical" (with a link to "Importance of Antibiotic Misuse in the Urgent Care Setting"), "Insights in Images", "Clinical Challenges", and "Departments".

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LETTER FROM THE EDITOR-IN-CHIEF

UCAOA: A Vision for the Future



The UCAOA National Conference, held last month in Daytona Beach, FL, was an important milestone in the organizational evolution of UCAOA: The elections conducted at the meeting marked the second rotation of board seats since our founding in 2004, and the first board election of a new president.

It is critical to the success of our organization to have a rotating leadership at the board and officer levels. Our bylaws guarantee this to ensure that we adhere to the principles of a member voting organization with strictly democratic governance.

As the new president, I want to express sincere thanks to Bill Meadows, MD for his visionary leadership during our first three years. Additional gratitude should be extended to all of our founding board members.

There is, of course, no time to celebrate our past achievements, as they simply represent a mandate for taking it to the next level. Success breeds expectations of even greater future success.

Looking ahead, I would like to outline what I see as the strategic vision of UCAOA for the next three years:

- Training
 - Target resident recruitment/program expansion.
 - Continue to refine core competencies.
 - Establish training program accreditation.
 - Develop nurse practitioner and physician assistant programs.
- Continuing Education
 - Establish new programs for developing competencies in key areas, both clinical and practice management.
- Convention
 - Build on tremendous past success with new, value-added benefits for new and experienced practitioners, owners and operators.
 - Expand clinical content.
- Benchmarking
 - Augment and formalize benchmarking efforts to present the most authoritative and relevant data in our industry; significant investment will be made to this end.
- Accreditation
 - Work toward creating a powerful and universally accepted tool for identifying industry standards.
- Quality Assurance

- Invest in research to study outcomes, best practices, customer service initiatives and risk management tools.
- Member Recruitment
 - Realize the power of numbers—the more people we represent, the louder our voice.
- Original Research
 - Encourage original research in the field. This is critical to identifying urgent care as legitimate in the house of medicine.
- *JUCM*
 - Drive submissions from within the urgent care community. Please submit. We can help; contact me at editor@jucm.com.
- Organizational Management
 - Continue to build a reliable and accountable corporate and management structure.
- Association Leadership and Thought Leader Recruitment
 - Groom the next association leaders.
 - Augment our internal leadership through the counsel of thought leaders in specialty development, healthcare services research, etc.

Putting the You in UCAOA

Without the involvement of every one of our members, we will not succeed. The critical initiatives presented here form the backbone that supports the success we have had and hope to achieve. If you've read this far, that means you!

If you would like to get involved with these efforts but are unsure where to begin, e-mail me (lresnick@ucaoa.org) or our executive director, Lou Ellen Horwitz (lhorwitz@ucaoa.org); we can help.

Lee A. Resnick, MD
Editor-in-Chief
JUCM, The Journal of Urgent Care Medicine
President, UCAOA

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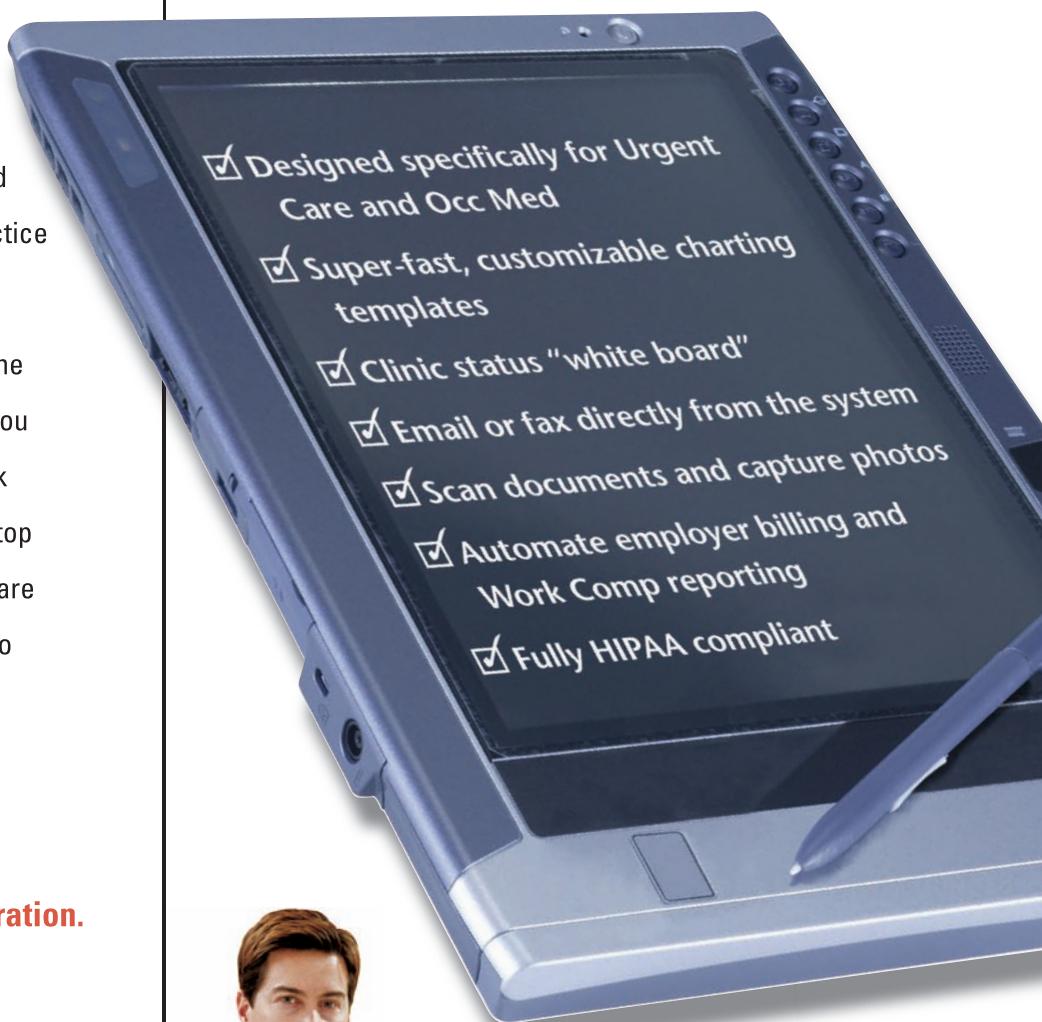
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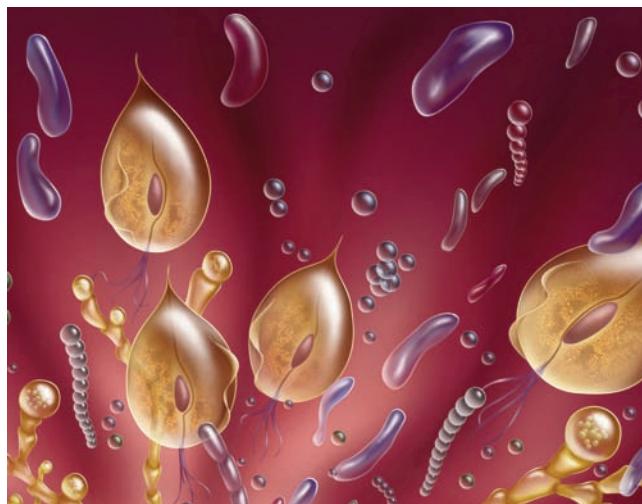
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June 2007

VOLUME 1, NUMBER 8



CLINICAL

11 Management of Patients Presenting with Symptoms of Vulvovaginitis

Approximately 10 million office visits are attributed to vulvovaginitis annually in the U.S. Are you prepared to evaluate and treat appropriately?

By James Tiongson, MD, Samuel Keim, MD, and Peter Rosen, MD

BOUNCEBACKS

19 The Case of an 18-Year-Old Male with Hand Pain

Not all diagnoses are obvious at first glance. What was missed in the initial examination and treatment of this patient with an injury of suspicious origin?

By Michael B. Weinstock, MD and Ryan Longstreh, MD, FACEP

INDUSTRY NEWS

30 Addressing the Data Drought



The first UCAOA Benchmarking Survey confirmed that urgent care practitioners are hungry for data on how and what their colleagues are doing. The second report of the Benchmarking Committee moves one step closer to filling that void.

By J. Dale Key

9

From the Executive Director

DEPARTMENTS

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

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Mission Statement

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

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JUCM CONTRIBUTORS



We have a trio of authors from the Department of Emergency Medicine at the University of Arizona College of Medicine to thank for our lead clinical article (Management of Patients Presenting with Symptoms of Vulvovaginitis, page 11) this month: **James Tiongson, MD** is a resident; **Samuel Keim, MD**, whose clinical practice includes work in both the ED and urgent care settings, is associate head and residency director of the department; and **Peter Rosen, MD**, is clinical professor and a member of the *JUCM* Advisory Board.

In addition, we're pleased to be able to publish an overview of the second annual report of the UCAOA Survey Committee, led by chair **J. Dale Key**, who authored the article (page 30). Mr. Key has spent the bulk of his career gathering expertise in healthcare management, and is administrator of Medac, a four-location urgent care and occupational health practice in Wilmington, N.C.

You may recall in April we introduced *Bouncebacks*, a semimonthly feature that recounts actual cases in which patients were seen, discharged, and then "bounced back" for further evaluation and treatment. June sees the second



installment contributed by **Michael B. Weinstock, MD**, and **Ryan Longstreth, MD, FACEP**, who are also the co-authors, along with Gregory L. Henry, MD, FACEP, of the book *Bouncebacks! Emergency Department Cases: ED Returns* (2006, Anadem Publishing, www.anadem.com). Drs. Weinstock and Longstreth work together at Mt. Carmel St. Ann's Emergency Department in Columbus, OH as attending physicians. Dr. Weinstock is also clinical assistant professor of emergency medicine at The Ohio State University College of Medicine and has authored *The Resident's Guide to Ambulatory Care*, the sixth edition of which is due out later this year.

Several other regular contributors appear here fresh off speaking engagements at the UCAOA's Urgent Care National Conference in Daytona Beach, FL last month. We're grateful to **Frank Leone, MBA, MPH**; **John Shufeldt, MD, JD, MBA, FACEP**; and **David Stern, MD, CPC**, for their dual support of *JUCM* and UCAOA, as well as to **Nahum Kovalski, BSc, MDCM** for contributing so generously to the Abstracts in Urgent Care and Insights in Images departments.

JUCM was also well represented at the conference by our editor-in-chief, Lee Resnick, MD, who officially took office as the new president of the association. As he pointed out in Daytona Beach, we want this journal to reflect the perspective of as many readers as possible; be part of it by submitting an article. It's probably simpler than you think. Send an e-mail to editor@jucm.com and we'll discuss! ■



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.

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FROM THE EXECUTIVE DIRECTOR

The Crow and the Pitcher

■ LOU ELLEN HORWITZ, MA

"A thirsty crow found a pitcher with some water in it, but so little was there that, try as she might, she could not reach it with her beak, and it seemed as though she would die of thirst within sight of the remedy.

At last, she hit upon a clever plan.

She began dropping pebbles into the pitcher, and with each pebble the water rose a little higher until at last it reached the brim, and the knowing bird was enabled to quench her thirst."

Moral: *Necessity is the mother of invention.*

This Aesop fable may be familiar to many of you. Also familiar may be the feeling that the crow is having; many of you have asked us, why is there virtually no data about urgent care centers out there?

Regularly, I get calls like this:

"We are working on a business plan to open a center..."

"We are considering investing in a new startup center..."

"We are trying to restructure the staffing for our center..."

They all start differently, but they all end the same: *"...and I've been searching the Internet for hours and can't find anything on urgent care. I did find your site, however, and thought I'd call...."*

These folks are all staring into the pitcher in the fable.

As you may know, for the past two years UCAOA has conducted informal annual surveys of our constituents, asking questions ranging from basic demographics to billing and staffing. This has been our way of dropping rocks into the pitcher, to help raise the water level a bit.

This month, *JUCM* reports the results of the latest survey (page 30).

While we appreciate all of the contributions and work that



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goes into our current survey method, we also realize that it is in its infancy and currently cannot be reliably translated into national trends in urgent care—which is what the industry sorely needs.

The UCAOA Board of Directors has made this a priority for the coming years, and significant resources have been allocated toward using proven outside researchers to develop and execute a survey program that will incorporate the rigor and breadth we are all looking for.

One other problem with our benchmarking survey is that it only comes out once each year. The developing of detailed questions, gathering of responses, etc., take a lot of time and effort by the Benchmarking Committee members—all volunteers—so right now once a year is all that is possible. However, the committee has come up with a new survey medium, called QuickPolls, that will provide a way for UCAOA members and website visitors to get regular snapshots of information on an ongoing basis.

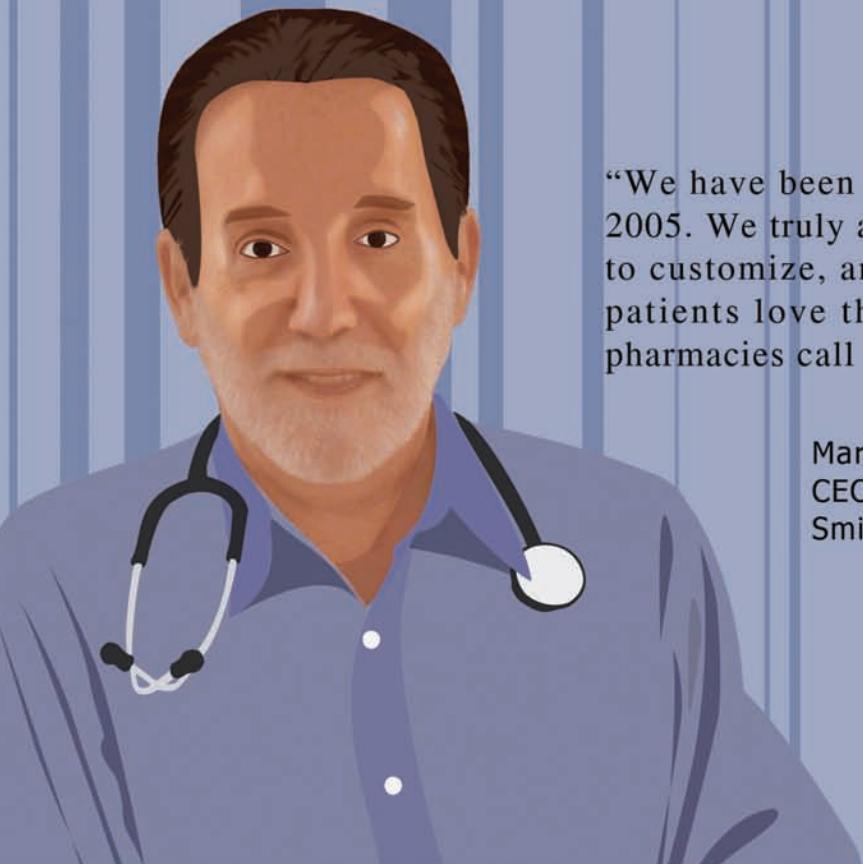
UCAOA's new QuickPolls allow us to collect and share data with you more often. While they are not scientifically rigorous, QuickPolls will elicit anecdotal data on a variety of topics to let you see what's happening in other practices across the country. These polls will ask one multiple-choice question and instantly share the results to date when you vote.

We plan to update the QuickPolls area at least once a month. However, the critical element in the success of the QuickPolls will be input—the more participants in the polls, the better the results.

The polls should take no more than 30 seconds to respond to, so we hope that you will add a reminder to your calendar to visit the website at least monthly to contribute to the current QuickPoll.

If you have questions you'd like to see asked in a future QuickPoll, e-mail me and we'll add them into the lineup for a future poll. (Bear in mind that all questions must be multiple choice.)

But for now, sit back and take a long cool drink of information from our survey report—we hope it will start some dialogue in your practice and be a refresher for you as you head into the summer. ■



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Management of Patients Presenting with symptoms of **Vulvovaginitis**

Urgent message: As the cause of approximately 10 million office visits in the United States annually, vulvovaginitis remains a common but important complaint seen in the urgent care setting.

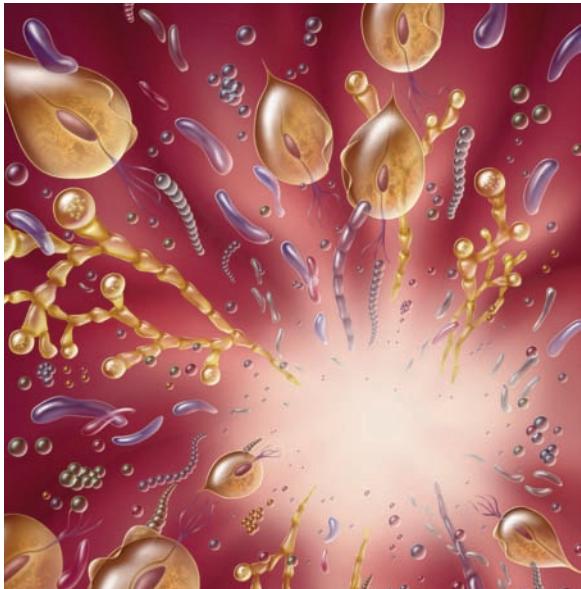
Jansen Tiongson, MD, Samuel Keim, MD, and Peter Rosen, MD

Introduction

Although numerous etiologies account for vulvovaginitis, the vast majority of cases are due to bacterial vaginosis (BV), trichomoniasis, and vulvovaginal candidiasis (VVC). BV causes 40% to 50% of all cases, while candidiasis and trichomoniasis account for 20% to 25% and 15%-20%, respectively.¹ Other notable causes, such as atrophic/contact vaginitis and sexually transmitted diseases, are beyond the scope of this review. This article presents a review of practical concepts of evaluation and management along with supportive data from current literature about the three main causes.

Pathophysiology

The moist vaginal environment promotes the growth of various organisms. However, a balance between different



organisms ordinarily prevents the growth of pathogens.

Lactobacillus, the predominant bacteria found in the vagina, produces glycogen that is broken down to form lactic and acetic acids, thus favoring the growth of normal flora over pathogens by maintaining a pH of 4-5.

Normal flora produce normal vaginal secretions that range from being watery thin to a whitish thick discharge. The disruption of the normal balance in the microflora of the vagina leads to the symptomology ascribed to vulvovaginitis.

Women often present with varying signs and symptoms, including vaginal discharge, malodor, irritation, and itch. Often, urgent care physicians can narrow down the differential diagnosis (**Table 1**) based on the descriptions provided by patients. Systemic illnesses, antibiotic use, diet, immunosuppression, and sexual practices can disrupt the normal

TABLE 1.
Clinical Elements of Vulvovaginitis

Clinical Elements		Bacterial Vaginosis	Trichomoniasis	Vulvovaginal Candidiasis
Symptoms	Vaginal malodor	+	+/-	-
	Vaginal discharge	Thin, gray, homogenous	Green-yellow	White, curd-like
	Vulvar irritation	+/-	+	+
	Dyspareunia	-	+	-
Signs	Vulvar erythema	-	+/-	+/-
	Bubbles in vaginal fluid	+	+/-	-
	Strawberry cervix	-	+/-	+/-
Microscopy	Saline wet amount			
	Clue cells	+	-	-
	Motile protozoa	-	+	-
	KOH test			
	Pseudohyphae	-	-	+
	Whiff test	+	+/-	-
	pH	> 4.5	> 4.5	< 4.5

TABLE 2.
Questions to Ask

Color of discharge	Hygiene practice
Amount of discharge	Oral contraceptive/ IUD use
Duration of symptoms	Recent antibiotics
Association with menses	Pregnancy status
History of STDs	Other medical history
Current and previous partners	

balance in the vaginal flora, and often precipitate vulvovaginitis.

Table 2 outlines the general questions to ask during a history and physical examination, while **Table 3** lists laboratory tests most helpful to diagnose the specific etiology of vulvovaginitis. **Table 4** describes how to per-

form the wet preparation and 10% potassium hydroxide (KOH) tests. Note that the wet mount is 80%-90% sensitive for diagnosing BV, 62% for trichomoniasis, and 22% for VVC.⁵

Bacterial Vaginosis

Epidemiology

Bacterial vaginosis, caused by the overgrowth of *Gardnerella vaginalis*, *Mycoplasma hominis*, and other pathogenic bacteria with deprivation of *Lactobacillus*, affects nearly 5% of college women and 60% of those with sexually transmitted diseases. There is an increased prevalence among divorced women over the age of 30.¹ Many risk factors predispose a patient to BV. For example, an increased number of sexual partners in the prior three months, along with a history of STDs, compound the risk of developing BV.³

Furthermore, habits such as vaginal douching at least

once a week are associated with increased risk, suggesting that daily habits play an important role in the development of BV. Oral contraceptives and IUDs not only diminish the risk of pregnancy but provide protective factors against BV.^{2,3} BV occurs more often in black Caribbean women and among women of lower socioeconomic status.⁴

Presentation and Diagnosis

The diagnosis of BV has been classically defined by Amsel's clinical criteria (**Table 5**). Amsel's criteria include both clinical signs and symptoms and laboratory findings. These criteria have been shown to be 92% sensitive in diagnosing BV. Vaginal pH has the highest sensitivity while a positive whiff test is most specific, although a false positive can be seen with trichomoniasis.⁵

Anderson, et al report that the presence of a malodorous vaginal discharge indicates high likelihood of BV, while its absence essentially rules out the diagnosis. Furthermore, moderate- to copious thin gray homogeneous discharge increases the likelihood ratio (LR) from 4.1 to 14, while normal-to-mild whitish discharge lowers the LR of BV to 0.11.

The study also points out the following percentages of having BV per symptomatology:

- 64% with thin gray homogenous vaginal discharge
- 53% changes in discharge compared to normal
- 32% pruritus

Finally, the absence or scant presence of *Lactobacillus* in addition to the presence of clue cells under microscopy raises the likelihood of BV, while normal levels of the normal flora significantly drop the LR to 0.02¹ (**Table 1**).

Treatment

The World Health Organization recommends metronidazole as the first-line therapy for the treatment of BV (**Table 6**). Metronidazole 500 mg twice daily for seven days has been the common therapy. Some have recommended a one-time 2 g dose of metronidazole. A randomized clinical trial reported in 2000, however, showed that the one-time 2 g regimen is only 75% efficacious compared with the week-long 500 mg regimen, which has an efficacy rate of 85%-90%.

Finally, the alternative dosing of 375 mg three times daily has the same efficiency as the 500 mg dose, with fewer of the gastrointestinal side effects commonly associated with the use of metronidazole.

However, the compliance of a three times vs. twice daily regimen may not be as good.

TABLE 3.
Laboratory Tests to Order

Pregnancy test	KOH wet prep
Nitrazine pH paper	KOH whiff test
Urinalysis	GC/chlamydia DNA probe
Saline wet prep	

TABLE 4.
Performing A Saline and KOH Wet Prep

1. Obtain sample collected from posterior fornix during a speculum examination
2. Test pH of sample via nitrazine strip
3. Place fluid on one slide with saline drop, use 400x power microscopy to look for trichomonads, clue cells, pseudohyphae, lactobacillus, white blood cells
4. Place fluid on another slide and add a drop of 10% KOH. Look for pseudohyphae and perform whiff test for a fishy/amine odor

TABLE 5.
Amsel's Criteria For Diagnosing Bacterial Vaginosis (3 of 4)

- Thin homogenous vaginal discharge
- Vaginal pH higher than 4.5
- Positive whiff test for amine with KOH prep
- Clue cells on saline wet prep (Figure 1)

A similar efficacy can be expected with the 0.75% metronidazole vaginal gel used twice daily. The gel eliminates BV at a rate of 83.7% after a two-week course. Fewer GI symptoms are reported with the use of the gel. A patient's menstruation status does not change the effectiveness of the treatment. The vaginal gel, therefore, is an attractive alternative for treatment of BV.⁶ The oral week-long formulation is still highly recommended in pregnant patients.⁷ Clindamycin 300 mg twice daily for seven days can also be used alternatively for those intolerant of metronidazole.

Special Considerations in Pregnancy

BV has been associated with pre-term labor, premature

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rupture of membranes, spontaneous abortions, chorioamnionitis, post-partum endometritis and post-Caesarean section wound infection. As mentioned above, 500 mg orally twice daily for seven days of metronidazole has been recommended for the treatment of BV in pregnancy. At present, metronidazole is considered safe to use during pregnancy. While there may be a possible association of premature birth and congenital hydrocephalus, a consensus has not been determined to show the link between metronidazole and complications in pregnancy.⁸⁻¹⁰

Vulvovaginal Candidiasis

Epidemiology

As the second most common cause of vulvovaginitis, vulvovaginal candidiasis (VVC) affects nearly every three out of four women sometime during their lifetime. Furthermore, nearly 10% of women will experience repeated attacks without any obvious precipitating factors. Ninety percent of cases are due to *Candida albicans*, but other *Candida* species, such as *glabrata* and *tropicalis*, have been implicated with VVC. Major risk factors in the development of VVC include previous history of VVC, recent utilization of broad-spectrum antibiotics, diabetes mellitus, AIDS, and the use of immunosuppressive therapies.^{11,12}

Presentation and Diagnosis

Much like other causes of vulvovaginitis, VVC patients present with a vaginal discharge, which in candidiasis is often described as cheesy, curd-like, and thick (**Table 1**). The occurrence of such a discharge makes it more likely to be VVC when compared to a watery discharge.

Furthermore, the presence of vulvar itching increases the likelihood of VVC (LR of 1.4-3.3), compared with its absence.

In contrast to trichomoniasis and BV, the presence of malodor decreases the probability of diagnosis of VVC (LR 0.35). Lack of odor is consistent with candidiasis. Also, unlike the other causes of vulvovaginitis, women often can self-diagnose VVC due to its classical symptomatology, which shows the greatest likelihood (LR 3.5) of having VVC based on history alone in studies reviewed.

"No statistical difference exists between cure rates for oral vs. intravaginal topical agents."

Physical examination findings often include an erythematous vulva and vagina and a normal cervix upon speculum examination. The presence of both the erythema and curd-like discharge supports the diagnosis of VVC.¹

With the utilization of wet saline and KOH prep, the diagnosis of VVC can be rapid and accurate under microscopy. The presence of the branching pseudohyphae, along with a normal pH of 4-5 with nitrazine paper, has a sensitivity of 38%-83%. The absence of pseudohyphae on microscopy, therefore, does not exclude the diagnosis. Often, VVC is diagnosed clinically. A Gram's stain and Sabouraud's agar

culture both reach nearly 100% in sensitivity, but the logistic impracticality of these tests often negates their utilization in the urgent care setting.¹³

Treatment

A single dose of oral 150 mg fluconazole is clinically and microbiologically efficacious in the treatment of VVC (**Table 6**). Fluconazole is also the recommended therapy for recurrent attacks in the following regimen: 150 mg every other day for three doses followed by weekly 150 mg doses for six months. This therapy is effective in more than 80% of women who experience recurrent bouts of VVC.¹⁴

Alternatively, numerous intravaginal topical agents are available both over the counter and by prescription. These agents include imidazoles (clotrimazole, miconazole, and terconazole) and nystatin. A recent Cochrane database systematic review study reports that no statistical difference exists between the cure rates when comparing oral versus an intravaginal topical agent. However, the study also notes that oral administration remains the preferred route in non-pregnant women due to safety, cost, and patient treatment preference. Pregnant patients are advised to use the topical agents for seven days rather than oral medication, as the imidazole topical agents have been shown to have a cure rate of 85%-100% in pregnancy while oral drugs such as fluconazole can be associated with GI intolerance, rash, and headache.¹⁵ Despite repeated use in some patients, utilization of fluconazole and the various imidazoles (clotrimazole, miconazole, and ketoconazole), fungal re-

TABLE 6.
Treatment Options for Vulvovaginitis

	First Line (non-pregnant)	Alternatives (non-pregnant)	Recurrent Bouts	Pregnancy
Bacterial Vaginosis	Metronidazole 500 mg BID po 7 days	Metronidazole 375 mg TID po 7 days Metronidazole 0.75% vaginal gel BID 7 days Metronidazole 2 g po x 1 Clindamycin 300 mg twice daily for 7 days	N/A	Metronidazole 500 mg BID po 7 days
Trichomoniasis (remember to treat sexual partners)	Metronidazole 2g po x 1	Metronidazole 500 mg BID po 7 days Tinidazole 2 g po x 1	N/A	Metronidazole 500 mg BID po 7 days
Vulvovaginal Candidiasis	Fluconazole 150 mg po x 1	Miconazole 200mg vaginal suppository qhs x 3d Miconazole 2% vaginal cream qhs x 7 d Butoconazole 2% vaginal cream x 1 Terconazole 80 mg vaginal suppository qhs x 3 d Terconazole 0.4% vaginal cream qhs x 7 d Clotrimazole 2-100 mg tablets intravaginally x 3 days Clotrimazole 1% cream qhs x 14 d	Fluconazole 150 mg every other day po for 1 week, then weekly for 6 months	Any except fluconazole

sistance is rare with only 3.7%-5.7% resistance shown in a study published in 2005.¹⁶ Boric acid suppositories may be as effective oral itraconazole in treating both acute and recurrent disease.¹⁷

Trichomonas Vulvovaginitis

Epidemiology

With nearly 120-180 million women affected annually worldwide, trichomoniasis remains a common cause of vulvovaginitis.^{18,19} Classified as an STD, *Trichomonas vaginalis* typically is a coinfection with other venereal disease, especially gonorrhea and chlamydia.

Laboratory testing for other STDs, therefore, remains part of the recommended workup in vulvovaginitis. Furthermore, its status as an STD increases its occurrence among premenopausal women, with a prevalence of 2.3% and 4% in 18-24-year-olds and 4% in those 25 and older. This disease can go undetected for months, and while the efficacy of treatment remains high, re-infection remains very common.

Unlike other major causes of vulvovaginitis, the prevalence of trichomoniasis seems to be associated with ethnicity: prevalence is highest in blacks (6.9%) and lowest among Caucasians (1.2%).^{20,21}



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TABLE 7.
Comparison of pH vs. Treatment

Etiology	pH	Treatment
Bacterial Vaginosis	> 4.5	Metronidazole
Trichomoniasis	> 4.5	Metronidazole
Vulvovaginal Candidiasis	= 4.5	Fluconazole

Presentation and Diagnosis

Like the other major causes of vulvovaginitis, trichomoniasis often presents with a vaginal discharge (**Table 1**). It is often described as a yellow-gray-green-frothy secretion with an unpleasant odor. Having a yellowish discharge, as opposed to other colors, makes trichomoniasis 14 times more likely to be the diagnosis. Similarly, only 10% will present with frothy discharge. However, a recent study showed that only 42% of infected women presented with the discharge noted above. Other symptoms suggesting trichomoniasis include malodor and symptoms worse after menses. Unfortunately, 50% of women will not present with malodor, but in the cases that do, the whiff test performed under KOH prep can be a false positive.

With regard to physical examination, the most specific sign of trichomoniasis is colpitis macularis, or strawberry cervix. Described as punctuated hemorrhages with occasional vesicles or papules, this finding is rarely detected without colposcopy, and is seen in only 22%-37% of women.¹

Laboratory examinations include pH testing and wet saline/KOH preparations. Speculum samples will present with a pH >4.5 as well as findings of flagellated organisms under a wet saline mount. The sample should be read under a slide within 20 minutes of preparation to avoid deterioration of the protozoa. This method of confirming *Trichomonas* is only 40%-60% sensitive; thus, the absence of the protozoa under microscopy does not necessarily rule out the disease.

More sensitive and specific to diagnosing trichomoniasis is the latex agglutination test. A *Trichomonas* antibody or antigen, attached to latex beads, is mixed with the speculum sample. If the protozoan reacts with the latex bead complex, then an agglutination reaction occurs. Results are available within 10 minutes to an hour. This test is 98.8% sensitive and 92.1% specific compared with a wet mount preparation.

However, the cost and availability of this examination limits its use in the urgent care setting. For better sensitivity and specificity, a XenoStrip-Tv for *T vaginalis* test can be performed. However, this test is limited due to length, and its utilization in the urgent care setting is presently impractical.²²

Treatment

The Centers for Disease Control and Prevention recommends a single dose of 2 g of metronidazole (**Table 6**). Unlike the treatment for BV, this regimen has a greater cure rate—90%-95%—compared with the week-long treatment of either 250 mg TID or 375 mg BID of metronidazole. The use of a single-dose therapy in the treatment of trichomoniasis increases compliance, and still provides cures. Treatment of the partner with the same regimen is recommended, although further research should focus on developing effective partner treatment strategy.¹⁸

Although the association of pre-term labor and premature rupture of membranes is significantly lower than that seen with BV, treatment with metronidazole effectively eliminates such risks during pregnancy in relation to trichomoniasis.²³

Of note, although resistance to metronidazole still remains uncommon, other azoles such as tinidazole and clotrimazole cream when used topically in a seven-day course have been proven to be effective alternatives.²⁴

Summary

Vulvovaginitis is common in the urgent care setting. Affected patients will present with varying degrees of vaginal discharges and odors. After a history and physical examination, adjunctive tests such as wet preparations, microscopy, pH, and whiff tests can easily aid in differentiating between the three main etiologies of vulvovaginitis. Although laboratory tests can confirm the diagnosis, the clinical signs and symptoms are often accurate enough for diagnosis. One simple strategy is shown in **Table 7**.

Special considerations must be taken with pregnant patients. When treated appropriately, vulvovaginitis often resolves without any sequelae in the majority of women. ■

References for this article are available at www.jucm.com.

Bouncebacks

The Case of an 18-Year-Old Male with Hand Pain

Urgent message: A thorough history and physical exam are essential to positive outcomes and risk reduction when managing patients with hand injuries.

Michael B. Weinstock, MD and Ryan Longstreth, MD, FACEP

Bouncebacks, in which we recount scenarios of actual patients who were evaluated in and discharged from an emergency department or urgent care facility and then “bounced back” for further treatment, appears semi-monthly in *JUCM*.

Case presentations on each patient, along with case-by-case risk management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians (ACEP), and discussions by other nationally recognized experts are detailed in the book *Bouncebacks! Emergency Department Cases: ED returns* (2006, Anadem Publishing, www.anadem.com).

The focus of the *JUCM* series will be a two-step process designed to improve patient safety and reduction in legal risk in an urgent care practice:

Step 1

Identify high-risk patients—specifically, patients with the potential for serious medical illness masquerading

as a benign problem—or patients likely to be litigious. Examples include high-risk discharge diagnoses such as chest pain, fever and headache, abdominal pain, upset patients, patients who have issues with billing, a long wait, or unmet expectations, and patients who have bounced back.

Step 2

Review the chart *before* the patient leaves the urgent care clinic. Affirm consistent documentation between the nurse/tech and physician, address all documented complaints in H&P, confirm that the history is accurate, review potentially serious diagnoses, explore abnormal findings, write a progress note explaining the medical decision-making process (if unclear from the H&P), and assure that aftercare instructions are specific and that follow-up is timely and available.

This month's case highlights several patient care and risk management principles.

On the surface, it seems straightforward: An 18-year-old presents with a hand laceration which is repaired,



after which the patient is advised to follow up with a plastic surgeon.

However, a closer look reveals some serious inconsistencies and missed information—not seeing the forest for the trees, as it were.

This case brings the two-step approach into clear resolution. See how many “red flags” you can spot and if you would have done anything differently.

An 18-Year-Old Male with Right Hand Pain

Initial Visit

(Note: The following is the actual documentation of the providers, including punctuation and spelling errors.)

CHIEF COMPLAINT (at 11:02): Right hand pain

Time	Temp	Pulse
11:12	96.6	66
16	110	68

HISTORY OF PRESENT ILLNESS (at 11:20): 18 year old male without a significant PMH presents with complaints that he was messing around with some friends the night before and they were close to a brick wall and a brick was loose and came down and landed on the dorsum of his right hand over the third MCP joint. The injury occurred 15 hours prior to the ED presentation. He complains of edema and redness and a laceration. Also c/o limited movement of the finger with pain with flexion and extension. No c/o fever, chills, night sweats. No allergies. Tetanus unknown.

PAST MEDICAL HISTORY/TRIAGE:

Medication, common allergies: None

PMH: None

PSH: None

EXAM (at 11:23):

General: Alert and oriented, no acute distress

Ext: 1 cm laceration over the third MCP joint on the dorsum and edema and erythema and swelling between the second and fourth metacarpal clear to the base of the metacarpals; even passive ROM of the third MCP causes pain with both flexion and extension

Skin: No red streaks

Neurovasc: Cap refill brisk. Sensation WNL

ORDERS/RESULTS (at 11:58):

XR negative for fracture

PROGRESS NOTES (at 12:45):

Anesthetized with

0.5% Marcaine, prep, drape, thorough irrigation with sterile saline and explored. The extensor tendon was intact, but the tendon sheath was frayed. Cleaned again with 10% betadine solution. Two loose 4-0 ethilon sutures were placed to the skin. Ancef 1 g IM and dT. Wound dressed with polysporin, adaptec and a volar OCL splint.

Diagnosis

Right hand laceration, 15 hours old, with cellulitis.

Disposition

The patient was discharged to home ambulatory at 13:37. Prescription for Keflex. Referral to a plastic surgeon to follow up in a couple of days and return to the ED with worsening symptoms or if unable to get in to see Plastic Surgeon.

Phone call to ED the next day: Patient called the next day (1 day after initial ED presentation) with complaints of swelling of the hand and fingers and pain. Has been taking Advil because he cannot afford Rx. Advised to return to the ED to be checked.

Discussion of Documentation and Risk Management

Issues at Initial Visit

Error 1

Error: Failure to recognize a laceration over the MCP as a likely clenched fist injury (CFI)/“fight bite.” The patient provides a questionable mechanism for his injury (“a loose brick fell out of the wall”).

Intervention: Use open-ended questions to obtain a clear and accurate history. A patient may be hesitant to reveal he/she punched someone in the mouth; once the physician builds rapport, this information may be easier to discover, leading to improved patient care. Use friends and family, as well, to gather a more accurate history.

Teaching point: Don’t take the complaint at face value; if the history and exam don’t make sense, dig deeper.

Error 2

Error: Failure to consider tenosynovitis or deep fascial space infection of the hand. The patient states the injury occurred only 15 hours prior to presentation, and he had already developed erythema of the second through fourth metacarpals, with associated limited finger movement. The physician documented pain with passive flexion and extension of the third MCP,

and an associated frayed tendon sheath.

Intervention: The time frame presented suggests a rapidly progressing infection. Kanavel first described the four cardinal signs of flexor tenosynovitis in 1939: 1) pain on passive extension, 2) tenderness along the flexor tendon, 3) symmetric edema of the involved finger, and 4) flexed resting posture of finger. Early in the course, a patient may not exhibit all four signs; this patient initially had at least two.

Consideration of this condition in the differential will lead to more aggressive management and improved patient outcome.

Teaching point: The clinical picture suggests a deeper infection, given the time frame and physical exam findings. Hand infections are high risk and must be aggressively managed.

Error 3

Error: Primary closure of an infected wound. The patient's laceration and associated cellulitis with a frayed tendon was closed primarily, 15 hours after the injury.

Intervention: All CFI's should be left open, dressed, and splinted in position of function. CFIs have high rates of associated tenosynovitis (22%) and septic arthritis (12%). Subsequently, all CFIs or potential CFIs should be reevaluated in one to two days.

Teaching point: Don't perform primary closure on an infected wound (or CFI).

Error 4

Error: Failure to prescribe the appropriate antibiotic(s). A first-generation cephalosporin is adequate for cellulitis but not for infected CFIs.

Intervention: Most infected CFIs are polymicrobial, requiring both aerobic and anaerobic coverage. *Staphylococcus* and *Streptococcus* are still the two most common causes, but other bacteria, including *Eikenella*, may also be cultured. This patient was prescribed Keflex (cephalexin), inadequate coverage for oral flora; Augmentin (amoxicillin/clavulanic acid) would have been a better choice.

Teaching point: Choose an antibiotic appropriate for the specific type of wound.

Error 5

Error: Failure to address pertinent social issues. The patient called the ED the next day because he could not afford his antibiotics and was forced to return.

Intervention: A good patient disposition includes assurance that the patient can follow through with your

recommendations. An expensive (or even relatively inexpensive in this case) medication is useless if the patient doesn't have the resources to obtain the medicine. Make sure the patient has insurance or financial means to pay for the medicine; if not, explore other ways for treatment to occur.

Teaching point: Make sure the patient has the ability to obtain the medication in a timely manner.

An 18-Year-Old Male with Hand Pain

Return Visit—Five Days Later

Returned five days later with chief complaint of increased hand pain and drainage after his girlfriend kicked his wound. He had not filled his Keflex.

Temperature was 100.3 and he seemed "very uncomfortable," with a grimace on his face.

Had purulent drainage from the wound with extreme pain on range of motion (ROM) of the metacarpophalangeal (MCP) joint and pain along the tendon.

IV Unasyn (ampicillin and sulbactam) was administered and he was admitted to plastics with a tendon sheath infection vs. MCP septic arthritis.

Taken to the OR the next morning and he was found to have a large extensor tendon laceration with exposed joint and pus within the joint space.

Cultured *Eikenella* species and *Strep viridans*, suggesting human bite wound.

Summary of Case and Risk Management Principles

Patients presenting with hand injuries are common in urgent care medicine and are a potentially high-risk group. To ensure patient safety and minimize medical-legal exposure, the urgent care practitioner must obtain an accurate history and perform a thorough physical exam.

Our patient was initially diagnosed with an infected hand laceration; unfortunately, the potential for CFI and deep infection was not considered. His mechanism and physical exam findings were not consistent. Clues on the initial visit indicated that the patient had a potentially serious problem; it is unusual to develop a simple cellulitis within 15 hours of a finger laceration, and the provider noted tendon injury, with significant pain with range of motion.

Cephalexin was prescribed, which is problematic for a couple of reasons:

First, an infected fight bite is most often polymicrobial, requiring more broad-spectrum coverage, and amoxicillin/clavulanic acid (Augmentin) would be a more appropriate choice.

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A TWO-STEP APPROACH TO AVOIDING A BOUNCEBACK

Second, the patient never actually filled the prescription due to lack of financial resources. We must consider social issues when dispositioning patients; in the urgent care environment, we have only one chance to get it right!

Finally, wound care of this patient was inappropriate; an infected wound or CFI is best managed without primary closure, due to concern for potential infectious complications. The patient did return with a deep hand infection that required operative debridement. A quick review of the patient's chart before he left at the initial visit may have avoided this bounceback. ■

Suggested Readings

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ABSTRACTS IN URGENT CARE

On Radiography in Acute Bronchitis, Rehydrating Children with AGE, Declining Antibiotic Scripts in URIs, and Diagnosing Venous Thromboembolism

■ NAHUM KOVALSKI, BSC, MDCM

Each month, Dr. Nahum Kovalski will review 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.

Evaluation of the Utility of Radiography in Acute Bronchiolitis

Key point: Infants with typical bronchiolitis (clinically $O_2\text{sat} > 92\%$ and mild/moderate distress) do not need imaging.

Citation: Schuh S, Lalani A, Allen U, et al. *J Pediatr.* 2007;150: 429-433.

URL: http://sitemaker.umich.edu/emjournalclub/article_database/da.data/1619753/PDF/bronchiolitis_xray_j_pediatrics.pdf

The purpose of this study was to determine the proportion of radiographs inconsistent with bronchiolitis in children with typical presentation of bronchiolitis and to compare rates of intended antibiotic therapy before radiography versus those given antibiotics after radiography.

The authors conducted a prospective cohort study in a pediatric emergency department of 265 infants aged 2 to 23 months with radiographs showing either airway disease only (simple bronchiolitis), airway and airspace disease (complex bronchiolitis), or inconsistent diagnoses (e.g., lobar consolidation).

The rate of inconsistent radiographs was 0.75% (two of 265

cases). A total of 246 children (92.8%) had simple radiographs, and 17 radiographs (6.9%) were complex. To identify one inconsistent and one complex radiograph requires imaging 133 and 15 children, respectively.

Of 148 infants with oxygen saturation $> 92\%$ and a respiratory disease assessment score < 10 of 17 points, 143 (96.6%) had a simple radiograph, compared with 102 of 117 infants (87.2%) with higher scores or lower saturation (odds ratio, 3.9). Seven infants (2.6%) were identified for antibiotics pre-radiography; 39 infants (14.7%) received antibiotics post-radiography.

Infants with typical bronchiolitis do not need imaging because it is almost always consistent with bronchiolitis. Risk of airspace disease appears particularly low in children with saturation higher than 92% and mild to moderate distress. ■

Intravenous Dextrose During Outpatient Rehydration in Pediatric Gastroenteritis

Key point: Patients who received no IV dextrose had 3.9 times the odds of having a return visit with admission than those who received some dextrose.

Citation: Levy JA, Bachur RG. *Acad Emerg Med.* Volume 14, Number 4:324-330 (published online before print February 12, 2007).

URL: <http://www.aemj.org/cgi/content/abstract/14/4/324>

The point of this study was to determine whether the amount



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

ABSTRACTS IN URGENT CARE

of IV dextrose administered is related to a return visit with admission (RVA) in children with acute gastroenteritis (AGE) and dehydration, and to determine which clinical, laboratory, and treatment parameters are associated with an RVA.

The investigators performed a case control study of children aged 6 months to 6 years who presented to an urban ED with AGE and dehydration and who received IV rehydration before discharge from the ED. Cases were defined as those patients who had an RVA within 72 hours of an original visit for ongoing symptoms. Controls were defined as those patients who met inclusion criteria, but who did not have an RVA. The authors studied whether the amount of IV dextrose administered at the initial visit was related to an RVA, as well as which other clinical and treatment parameters were associated with an RVA.

A total of 56 cases and 112 controls were studied. Patients who had an RVA received significantly less IV dextrose (mean: 399 mg/kg vs. 747 mg/kg, $p < 0.001$) than those who did not have an RVA. Patients who received no IV dextrose had 3.9 times greater odds of having a return visit with admission than those who received some dextrose. Controlling for fluid volume, the amount of dextrose administered remained statistically significant by logistic regression; for every 500 mg/kg of IV dextrose administered, the patient was 1.9 times less likely to have an RVA. Patients with length of symptoms less than or equal to one day were more likely to have an RVA than were those with symptom length of two or more days.

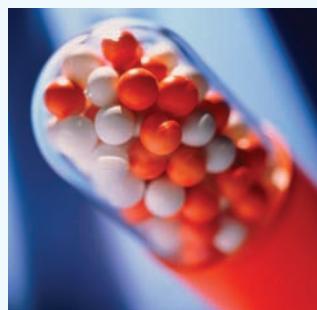
Administration of larger amounts of IV dextrose is associated with fewer return visits requiring admission in children with gastroenteritis and dehydration. ■

Declining Antibiotic Prescriptions for Upper Respiratory Infections, 1993–2004

Key point: Antibiotic prescribing for URIs continues to decrease.

Citation: Vanderweil SG, Pelletier AJ, Hamedani AG, et al. *Acad Emerg Med*. Volume 14, Number 4:366-369 (published online before print February 12, 2007).

URL: www.aemj.org/cgi/content/abstract/14/4/366



Data were compiled from the National Hospital Ambulatory Medical Care Survey (NHAMCS). URI visits were identified by using ICD-9-CM code 465.9, whereas antibiotics were identified using the National Drug Code Directory class "Antimicrobials."

Approximately 23.4 million ED visits resulted in a diagnosis of URI between 1993 and 2004. Although the proportion of URI diagnoses remained relatively stable, a significant decrease in provision of antibiotic prescriptions for URIs occurred during this 12-year period, from a maximum of 55% in 1993, to a minimum of 35% in 2004. Patients who were prescribed antibiotics were more likely to be white than African American and to have been treated in EDs located in the southern United States.

Antibiotic prescribing for URIs continues to decrease, a favorable trend that suggests that national efforts to reduce inappropriate antibiotic usage are having some success. Nevertheless, the frequency of antibiotic treatment for URI in the ED remains high (35%). ■

Current Diagnosis of Venous Thromboembolism in Primary Care: A Clinical Practice Guideline from the American Academy of Family Physicians and the American College of Physicians

Key point: New evidence and recommendations may aid in early diagnosis of venous thromboembolism.

Citation: Qaseem A, Snow V, Barry P, et al. *Ann Int Med*. 2007; 146(6):454-458.

URL: www.annals.org/cgi/content/full/146/6/454

This guideline summarizes the current approaches for the diagnosis of venous thromboembolism. The importance of early diagnosis to prevent mortality and morbidity associated with venous thromboembolism cannot be overstressed. This field is highly dynamic, however, and new evidence is emerging periodically that may change the recommendations. The purpose of this guideline is to present recommendations based on current evidence to clinicians to aid in the diagnosis of lower extremity deep venous thrombosis and pulmonary embolism.

Recommendations:

- Validated clinical prediction rules should be used to estimate pretest probability of venous thromboembolism (VTE), both deep venous thrombosis (DVT) and pulmonary embolism, and for the basis of interpretation of subsequent tests.
- In appropriately selected patients with low pretest probability of DVT or pulmonary embolism, obtaining a high-sensitivity D-dimer is a reasonable option, and if negative indicates a low likelihood of VTE.
- Ultrasound is recommended for patients with intermediate-to-high pretest probability of DVT in the lower extremities.
- Patients with intermediate or high pretest probability of pulmonary embolism require diagnostic imaging studies. ■



INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

FIGURE 1



The patient is a 15-year-old boy who presents with pain in the wrist 40 minutes after stopping a soccer ball with his hand. There is no snuffbox tenderness.

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 correct reading of the x-ray is: fracture of the ulnar styloid and Salter-Harris Type 1 fracture of the distal radius, with significant displacement of the epiphysis.

Type 1 Salter-Harris fractures are distinguished by complete separation of the growth plate from the metaphysis; such fractures of the distal radius are common, though ulnar involvement is not.

This patient was referred to the hospital for further evaluation and treatment.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM.

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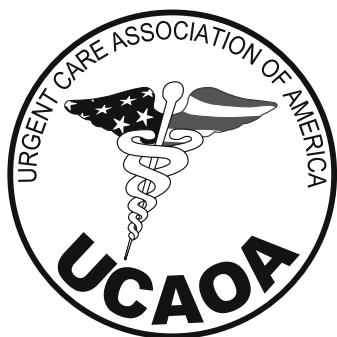
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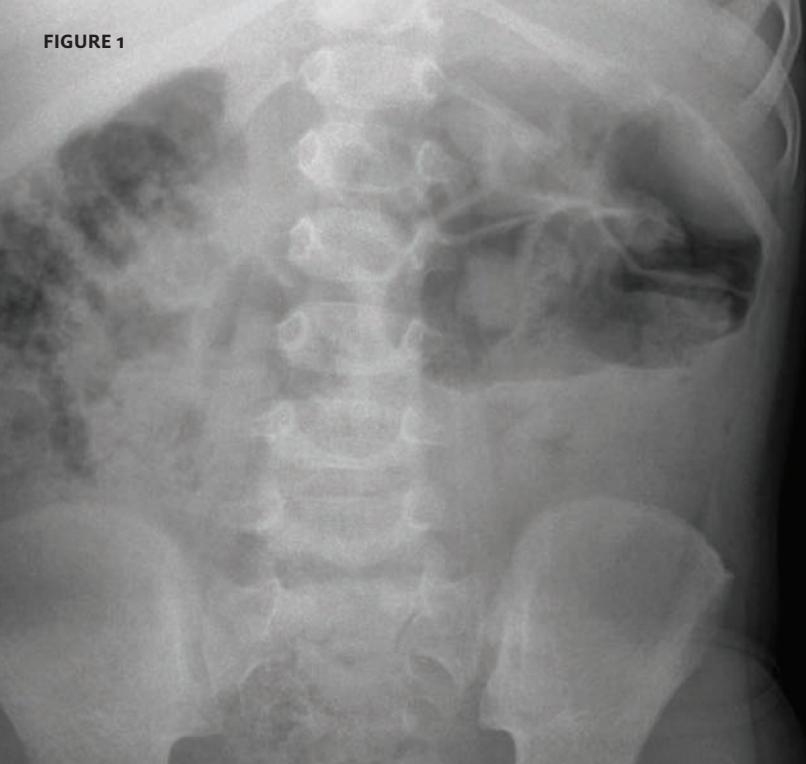
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CLINICAL CHALLENGE: CASE 2

FIGURE 1

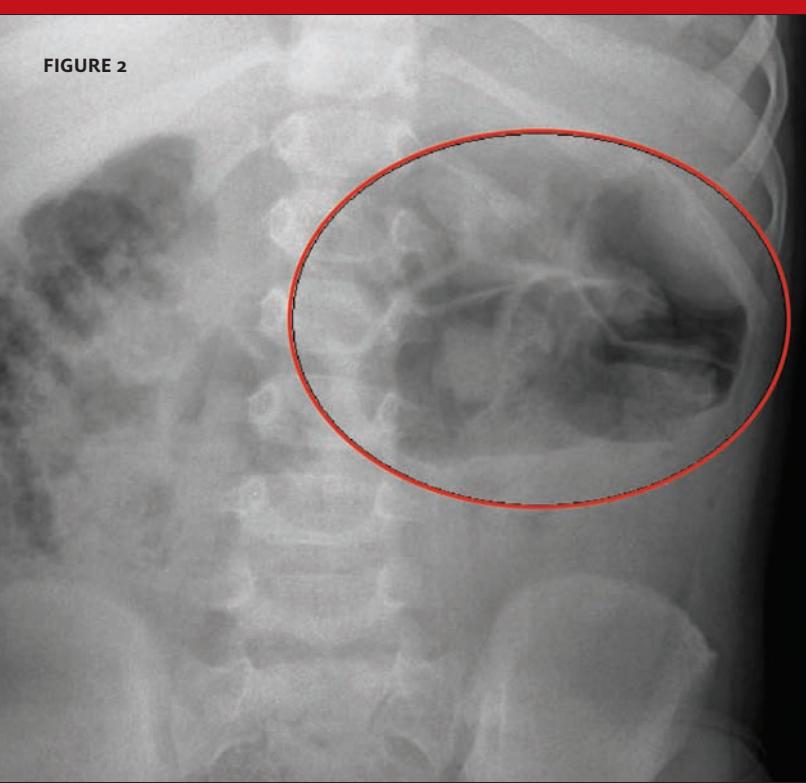


The patient is a young child with three days of constipation with a non-specific history of abdominal pain. On exam, the child was asleep. The abdomen was easily palpable and soft.

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

THE RESOLUTION

FIGURE 2



The finding in the left upper quadrant is a concern. The bowel is dilated and cannot be identified clearly as being the small or large bowel. Also, there is a "loop"-like form to this distended bowel.

This finding is most likely pathological and is consistent with intussusception. With such a finding, even with an asymptomatic child, it is best to refer.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM.

Urgent Care Industry

Addressing the Data Drought

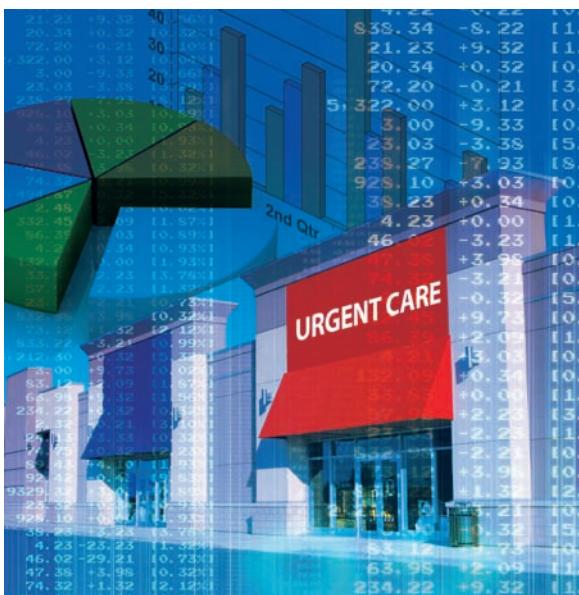
Urgent message: The second UCAOA Benchmarking Survey takes one small step toward filling the information gap in urgent care medicine.

J. Dale Key, UCAOA Benchmarking Committee Chair

Although the practice of urgent care medicine is not a new phenomenon, there is a significant absence of reliable information about the industry.

One first step toward filling that void was initiated last year when the Urgent Care Association of America's Benchmarking Committee released the results of its first-ever benchmarking survey of UCAOA members and others in the industry. Results of this year's survey were released during the UCAOA Annual Convention in Daytona Beach, FL, last month.

Both surveys share the common goal of beginning to gather data in specific areas of interest to urgent care owners, administrators, and practitioners. More rigorous study and surveys of greater depth are a priority for UCAOA and are planned for the upcoming years.



Photos: iStockphoto.com; Digital composite: Tom DePenda

Among the issues covered in the first survey were hours of operation, ownership structure, payor data, per-patient charges, and more.

While UCAOA members are the first to see the results, the association's perspective is that the survey can play a small role in addressing the information needs of the entire urgent care industry.

An Overview

The latest survey was sent to individuals representing 1,200 urgent care practices in the United States, with a response rate of 13.4%. (For purposes of the survey and

this article, a "practice" is defined as the total medical operation, while the word "clinic" will be used to describe a single, individual location; in other words, a practice may consist of any number of clinics under the same practice ownership). Respondents hailed from 40 states, with the majority representing Florida, Michi-

gan, Ohio, Texas, California, Georgia, and Illinois.

One of the important tenets of the committee's strategy is to ask some identical questions from year to year so, over years to come, trend lines might be identified in certain areas.

One of those areas pertains to the corporate structure of the practices (i.e., who owns them?). Results in 2006 indicated that about 47% of the responding practices were "freestanding" and 26% were "hospital-owned." One year later, the free-standing practices continue to pull ahead of the hospital-based practices, moving to 53% while hospitals fell to 23%.

The survey also posed a new question about whether practices were established as for-profit or not-for-profit ventures—and 74% of respondents report that their practices are for-profit. The majority (55%) of responding practices are also "solo" practices, meaning they are a one-site operation. Only 9% claim more than six clinics.

And while those clinics are busy, the average number of patients per clinic among the respondents has actually declined since the 2006 survey, falling to approximately 9,923 per clinic per year from last year's figure of 15,455. The perceived drop-off in patients-per-clinic could be a statistical anomaly grounded in the growth of the industry, however; an increase in the number of clinics that have been in business for a short period of time may be driving down the overall patient per clinic average.

Staffing Models

Of the many questions posed to UCAOA staff, board members, faculty, and forum participants, the most prevalent concern staffing of urgent care practices: How do you decide how many physicians you need? How many mid-levels? In what ratio? This year's survey presented at least a snapshot of how participating practices are staffed, currently.

Distribution

1,200 urgent care practices in the U.S.

Response rate

13.4%

Areas covered

Urgent care structure and organization
Facilities and operations
Patients and staffing
Patient record charting
Financial
Profitability

UCAOA Benchmarking Committee

Trina Danielsen, RN, St. Joseph Urgent Care in Sonoma County, CA
Kevin DiBenedetto, MD, Convenient Care, LLC in Baton Rouge, LA
Lou Ellen Horwitz, MA, UCAOA Executive Director
Cindi Lang, RN, DocNow Urgent Care in Rochester Hills, MI
Dale Key, Medac Health Services, PA in Wilmington, NC

Staffing arrangements with physicians are split almost evenly between two models:

- employed practitioners (50%), and
- a combination of independent contractors (26%) and a mix of employed practitioners and independent contractors (24%).

A similar ratio exists among mid-level providers, with a slight advantage going to employed practitioners at 65%, and independent contractors or mixed splitting the remaining percentage.

Some of the most eagerly anticipated results were the ratios of different levels of staff to each other. For example, responding practices, on average, employ 3.47 physician assistants (PAs) or nurse practitioners (NPs) and 2.37 registered nurses (RNs) for every one physician.

For every RN hour, there are 0.46 hours of clerical staff time, and there are 2.21 radiology

technician hours spent to every PA or NP hour. While these are complex calculations averaged over all responding practices, they will probably not hold true for all practices. Nonetheless, these results can be a good place for practices to start when looking at their own ratios.

Time Spent Per Patient

Another interesting finding concerns time spent per patient by different practice staff; these data show where the time of these individuals is going during a typical patient visit.

Physicians at responding clinics are spending approximately 19 minutes per patient, on average. Nursing assistants claimed the most time, edging out physicians by only one minute, with clerical/registration staff bringing up third with 17 minutes.

The Business of Medicine

Another area of the survey focused on the financial side of urgent care practice. How and when are practices

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ADDRESSING THE DATA DROUGHT

charging their patients? Who's paying for the care? Are urgent care practices profitable?

The results indicate that most practices (60%) charge patients as a part of registration. However, who actually *pays* for the care is much more spread out.

With regard to governmental payors: the majority of respondents reported that Medicare receives only about 10% of their charges, and Medicaid even less.

Private insurance is much more prevalent, with 67% of respondents billing private insurance companies between 30% and 70% of the time. Private pay makes up less than 20% of most practices, with workers compensation accounting for similar levels.

To bill and collect the patient fees, the vast majority (77%) of responding practices currently use in-house staff vs. contracting with outside vendors, to varying levels of success. Only 22% are collecting over 90% of their charges, and fully 41% of practices are collecting 70% or less. About half of the responding practices offer a "prompt" pay discount (generally, no more than 20% off if paid in full at time of service).

The good news is, almost everyone who responded is profitable, or at least breaking even (66% and 20%, respectively). The bad news is, if an urgent care practice is *not* in the black yet, it may take a while according to these results, as 30% of practices responding took longer than one year to reach profitability. Almost 10% made it in less than three months, however, and the results here show that after the first clinic is profitable, the second can reach profitability much more quickly—54% of those made it in less than nine months.

When it comes to reimbursement, only 16% of respondents are being reimbursed using problem-based coding. The moral of that story: Efforts toward more customized reimbursement for urgent care still have a long way to go.

While the same could be said for benchmarking data specific to urgent care medicine, the UCAOA surveys provide the basis for dialogue about how some practices are building on the foundation they have established. Subsequent UCAOA surveys are expected to take that initiative to the next level. ■

Note: The ability to draw broad conclusions from the results of this survey is limited by the small sample size and low response rate. However, as the only available source of data, the benchmarking survey provides unique, early insights into the urgent care field.



Injection Procedures and E/M Codes

■ DAVID STERN, MD, CPC

Q. Can we bill an evaluation and management code along with the code for administration of an intravenous injection?

A. Although it may seem obvious to expect reimbursement in these situations, Medicare waited until 2006 to begin reimbursing physicians for a separate E/M (99201-99205, 99212-99215) when performed at the same time as IV drug administration. The Medicare Claims Processing Manual states, "Medicare will pay for medically necessary office/outpatient visits billed on the same day as a drug administration service with modifier 25 when the modifier indicates that a separately identifiable evaluation and management (E/M) service was performed that meets a higher complexity level of care than a service represented by CPT code 99211....For an E/M service provided on the same day, a different diagnosis is not required."

For example, you should bill an E/M with modifier 25 when a patient comes in for a migraine headache and the physician determines that the best treatment is an intravenous injection of prochlorperazine. Even though there may be only one diagnosis of migraine headache (ICD-9 = 346.00), it still is appropriate to bill both for the therapeutic injection and the physician's evaluation of the patient.

The rationale: It's medically necessary for the provider to evaluate the patient whether the patient is suffering from a migraine headache or some other more serious problem (such as an intracranial hemorrhage, brain tumor, or meningitis).

Q. Don't I need two separate diagnoses to code for the E/M with modifier 25?



David Stern is a partner in Physicians Immediate Care, with nine urgent care centers in Illinois and Oklahoma, and chief executive officer of Practice Velocity (www.practicevelocity.com), a provider of charting, coding and billing software for urgent care. He may be contacted at dstern@practicevelocity.com.

A. A separate diagnosis is not necessary to code for the E/M with modifier 25, according to both Medicare and CPT rules.

Q. Is it appropriate to employ an E/M code for each and every time the patient visits the urgent care center and receives an intravenous injection?

A. Not always. Two examples of situations where it would not be appropriate to code for an E/M:

- The patient calls the physician and reports that the migraine headache has returned and the physician instructs the patient to come into the urgent care center to receive another injection of prochlorperazine.
- If the patient simply returned, received the medication from the nurse, and did not see the physician.

Work values now are included in drug administration codes, so there has to be a truly separate evaluation and management (not merely an evaluation and management incidental to the procedure code) to qualify for reimbursement for an E/M code.

Q. Could we code a 99211 (with modifier 25) for the nursing evaluation? The nurse could document the patient's vital signs and a notation that the patient states that this is a "typical migraine headache." Would this suffice to demonstrate a nursing evaluation and management?

A. Although the documentation noted would be appropriate, coding a 99211 (with modifier 25) would not be appropriate. Medicare does not reimburse for this code (99211) when submitted along with an intravenous injection code. Prior to 2006, many private payors reimbursed for code 99211 when coded on the same day of an injection.

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Vicarious Liability

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

It's 8:15 on Sunday morning. This is the first morning you have actually been able to sleep in since you opened the urgent care center five months ago. Truth be told, you drank a glass (or two) of wine too many last night and are still feeling the effects this morning. However, you don't care; you have the day off and you can slouch around till noon and no one will know or care!

What you don't know is that you are about to get a phone call because the resident manning your urgent care clinic this morning (who also happens to be the boyfriend of your sister) just broke off a needle in a patient's rear end while giving an injection.

Despite your hangover, the term *vicarious liability* springs through the cobwebs of your cortex, as does the famous line from the movie *Animal House*: "My advice to you is to start drinking heavily."

Vicarious liability is derivative responsibility for an agent's or employee's negligence based upon the defendant's employer-employee or principle-agent relationship. The responsibility is imposed when the ability to supervise, control, or direct the conduct of the employee or agent lies with the employee or principle.

Put another way, physicians are liable for their own negligent actions and may be vicariously liable for the negligent actions of their employees which occur in the scope of their employment. Moreover, physicians who join a partnership are vicariously liable for the tortious actions of their partners when the negligent acts are committed within the scope of the partnership.

A physician can be held liable for the negligent or wrongful acts of other individuals if the physician is the employer of the individual and the employee is acting within the course and scope of his or her employment. "Course and scope of employment" is used interchangeably with fur-

thering the purpose of the employer when explaining what employee actions will lead to vicarious employer liability.

If the employee was on the clock, if his actions benefit the employer, if the employee is under the control of the employer, or if an incident occurs at the employer's location or at the authorized time of the work assignment, that will probably be considered to be within the course and scope.

For example, if your medical assistant goes out to mail in her tax return at lunch and runs over a person in the middle of the street, your defense would be that she was not acting under your direction. However, if she was going to the bank to deposit the receipts from the previous day, the aforementioned argument would fail since presumably she was acting on behalf of the business while making the deposit.

Borrowed Servant Doctrine

A physician may also be liable if he or she has the right to control the other professional's work and the manner in which it is performed. This is called the "borrowed servant" doctrine.

The determination is irrespective of whether the physician-employer actually controls the manner in which work is to be performed or simply has the right to control it. This right to control is not based on any one thing, but on a constellation of facts which make up the totality of the circumstances. For example, you may be liable for the negligence of a resident who is working at your urgent care center during a residency-approved rotation even though you never saw nor were consulted on the patient in question.

A physician will also be liable for the negligent acts of other physicians if they are engaged in a joint enterprise or partnership which has never been legally formalized in order to protect the physicians from the imputed liability of his or her partners. Partnerships can be formal when two individuals come together or pursue a common goal.

In the absence of a formal agreement, joint ventures or partnerships may be implied by law when two or more people pursue a business opportunity for profit. For example, if you and a friend from residency open an urgent care center and don't form a business entity which offers you

Continued on page 36.



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.



Using Education as an Occupational Health Marketing Tool

■ FRANK H. LEONE, MBA, MPH

As marketing initiatives become increasingly self-serving, it behooves an urgent care clinic to differentiate itself by "playing the education card."

Why Education?

Many employer decision-makers are still strikingly naïve about the value of a well-integrated, proactive approach to their company's health and safety activities.

Educational information does not come off as self-serving and is perceived as a "kinder and gentler" form of marketing. In our information-saturated world, it is imperative to find a way to stay in front of prospects in an unobtrusive, yet memorable manner. Education can do this.

An urgent care clinic that positions itself as an educator inevitably is also viewed as an expert—an important image to foster.

Live Seminars

Although invariably there is intrinsic value in providing such programs, seminars' value vis-à-vis their opportunity cost is often questionable. Seminars consume scarce financial and human capital—capital that may generate a greater return to an urgent care clinic if expended on other activities, such as direct sales or targeted mailings.

Offering live seminars, however, can be valuable under certain circumstances, such as:

- if your clinic is a recent entrant to the occupational health market
- if your clinic is far from the occupational health market leader and needs attention



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.

- if there is a hot new topic (e.g., a new federal or state regulation).

Should your clinic develop a seminar, remember the following:

- Ask prospective participants what they want to learn about, rather than assume that you know. Educational session topics should be market driven.
- Offer the seminar at a hotel, restaurant, or conference center. We have found that midweek, morning sessions tend to be well attended.

"Providers of occupational health services are, by definition, educators."

- Forget the "if it is free, they will come" maxim. Charge enough to cover expenses and create a perception of value. When I am invited to a "free" investment seminar, I never attend because I assume that the session is little more than a thinly veiled sales pitch. Your clients/prospects are likely to feel the same way.
- Go first class. Find an attractive venue; offer quality food service and recruit knowledgeable, engaging speakers.
- Publicize the event well in advance and through multiple modalities. Use direct mail, e-mail blasts, calls to prime prospects, and even radio spots in appropriate markets. A big turnout makes your program look good; a dismal one has the opposite effect.
- If need be, throw it into fifth gear. If attendance looks disappointing a week out, do something about it.

Emerging Educational Tools

E-mail is a rapid, low-cost mode of communication. Yet,

OCCUPATIONAL MEDICINE

there is a thin line between using e-mail to your advantage and irritating prospects with "spam." Your clinic is less likely to overstep the boundary if your e-mail messages are educational in nature. Prospects are much more likely to open and read e-mail—and to remember the sender (a central marketing principal)—if they feel they will learn something.

Here are some basic rules:

- Your clinic is likely to see greater benefits if you e-mail a brief (i.e., a few sentences) "educational piece" once a week than if you send a lengthy message twice a year. The secret of effective mass communication? Keep it simple and keep repeating it.
- Offer tangible "to do's" (e.g., track consecutive workdays without a reported work injury by posting the number of days in a prominent location) rather than trivial facts or meaningless statistics. Make your prospects want to forward your e-mail to other colleagues within or outside of their company.
- Aggressively build your e-mail address book. Marketing is a numbers game—if you have 1,000 email addresses rather than 500, you reach twice as many people, and it won't cost you any more.

Website Strategies

Many urgent care clinic websites tend to be one-dimensional and inherently fact-based. Use your website as an educational tool; with the right approach, doing so may not even add much additional effort or cost.

For example, our company e-mails a "Tip of the Week" to thousands of occupational health professionals, including urgent care clinics. We have found that maintaining a complete library of those tips, organized by subject (i.e., marketing, financial management, etc.), on our company's website (www.naohp.com) is beneficial both to us and to our customers and prospects; many of them access our website routinely for program management advice and thereby become more familiar with our broader range of services. Your clinic should do the same.

Summary

Providers of occupational health services are, by definition, educators whether they are educating at the employer, individual worker, or coworker level. We are, after all, not selling a hard commodity, but rather an intricate concept: worker health and wellbeing.

The nature of your educational outreach depends on market size, market leadership, program maturity, and consumer preferences. Once your clinic has defined your position in the market, it is advisable to craft education into your broader marketing strategy. ■

HEALTH LAW

some protection (limited liability corporations, limited liability partnerships, professional corporations, etc.) you will both be held liable for each other's negligent actions which occur in the course and scope of your partnership.

In general, a provider is not liable for the negligence of another provider if that other provider is an independent contractor. Typically, independent contractors work on a one-time or on an as-needed basis.

An independent contractor relationship, unlike an employment relationship, does not create vicarious liability. Therefore, physicians are typically not liable for the negligent actions of the independent contractors with whom they contract.

To determine if an independent contractor relationship exists, the courts will look at a number of factors, such as whether the individual has a set schedule, gets paid at regular intervals, whether the services are integral to the business, whether the employer furnishes training material and equipment, and finally, whether or not taxes are deducted and worker's compensation insurance is provided.

Requisite Care

One area where a physician may be liable despite the fact that the relationship is found to be that of an independent contractor is if the contractor was hired without the requisite care required. In other words, liability can attach if the physician did not use reasonable care and discretion in hiring the independent contractor provider. Say the provider you hired to fill in for you during a vacation commits medical negligence; if you didn't check the National Practitioner Data Bank or your state's medical board, you may be directly and not vicariously liable to the plaintiff.

There are ways to mitigate your liability:

- Make sure the business form you choose gives you protection; joint ventures and partnerships are not the vehicles to use when forming a medical practice.
- Know the individuals you are working with. Take the time to adequately screen and train them to ensure they are performing up to the standard of care.
- Urgent care providers, like emergency medicine providers, probably fall under the safe harbor provision under the tax code and therefore can be contracted with as independent contractors.

Finally, if you are working in a hospital or group setting and your job description places you in the realm of having to use "borrowed servants," ask for indemnification for any liability you might incur as the result of derivative negligence of institutional employees.

The practice of medicine is challenging enough without having to worry about the wrongful acts of others. Consult with an attorney to ensure that you are as protected as possible against vicarious liability claims. ■

Career Opportunities

SEATTLE WASHINGTON - Multi-specialty medical group seeks B/C FP, IM/Peds or ER physician for a full-time urgent care position. All Urgent Cares are located within 40 minutes of downtown Seattle. As a MultiCare Medical Group physician, you will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. 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. Please email your CV to MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org. Please refer to opportunity #513-623 "MultiCare Health System is a drug free workplace."

URGENT CARE – Family Practice. Stuart, south-east Florida. Board-Certified/Board-Eligible family practice physician, competitive salary with productivity bonus, malpractice insurance fully covered with great benefits, 401(k) and flexible work schedule. Martin Memorial Health Systems is a not-for-profit, community based healthcare organization comprised of two hospitals, numerous physician practices and ambulatory care clinics throughout Martin and St. Lucie counties on Florida's Treasure Coast. Martin County offers a great quality of life with excellent schools. Visit our website www.mmhs.com and email your CV to jkoerselman@mmhs-fla.org.

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URGENT CARE CENTER – Salem Clinic, P.C., a 40-physician multi-specialty group located in Salem, Oregon, has an opening for a part-time or full-time family practice at our Urgent Care Center. Please forward, email or fax your CV to: Connie Finicle, Salem Clinic, P.C., 2020 Capitol St., NE, Salem, OR 97301. Fax: 503-375-7429 or email: conniefinicle@salemclinic.org.

RAPIDLY GROWING, 1-year old, evening and weekend Urgent Care center is looking for Family Practice, Occupational Emergency Medicine BC/BE physicians, or Pediatric physician willing to see minor adult problems. Urgent Care experience preferred. We have a strong pediatric niche for evening or after-hours care. We are looking for a doctor willing to handle both pediatric as well as adult care, who is used to procedures. Full-and part-time positions available. We offer a competitive salary, good benefits, and bonus's for the high producing physicians. Our facility has on-site blood lab, and X-ray ability. We are located in Lakeland, on the main drag, with easy access to both Tampa and Orlando for those wanting the feel of a medium size town without the hustle and bustle of large cities, yet within a 30-40 minute drive from all the attractions, restaurants and shopping of the larger cities. Fax resumes to 863-644-4992 or call Dr. Parker at 863-646-4000. www.niteowlpediatrics.com.

MT. WEST HEALTH CENTER, P.A. is currently seeking physicians to join practices in El Paso, Texas for Urgent Care Center. Excellent opportunity to work with a large, established private family/urgent care practice in an autonomous manner with other physicians and physician assistants. We offer a competitive salary and benefits package. Please contact Brisa Newberry, MBA. Phone: 915-217-2809; email: brisabn@gmail.com; fax 915-850-0546.

TALLAHASSEE, FLORIDA. ED based Urgent Care Position just opened up. Extremely competitive package totaling \$215K plus and increases to \$275K plus. Includes CME compensation, health insurance for entire family, flex medical account, 401(k) and annual bonus. Basic urgent care including minor fractures, lacerations, URI's, etc. Work 17-18 shifts without taking call! Email CV to goodfriend@pol.net or call 904-234-7433.

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Contact: R. Sandhu, MD
Phone: 813-655-4100
Fax: 813-655-1775
Email: rsandhu@tampabay.rr.com



Contact: Trish O'Brien
The Journal of Urgent Care Medicine
(800) 237-9851 • Fax (727) 445-9380
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Northern California Urgent Care Opportunities



Sutter Medical Group (SMG) is seeking Family Practice physicians to staff an urgent care clinic located on the campus of Sutter Roseville Medical Center. SMG is a large multi-specialty group of over 200 physicians.

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Roseville is located 16 miles northeast of Sacramento. Roseville has excellent schools, and is a family oriented community. Roseville is centrally located only a 1-1/2 hours drive from mountains of Lake Tahoe, and the bay of San Francisco.



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Sacramento Sierra Region

Physician Recruitment
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- Physicians enjoy working in a fast paced practice with on-site x-ray, lab and electronic medical records.
- Excellent opportunity for a BC/BE Family Practice, Urgent Care or Emergency Medicine physician.
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For more information, please call
Timothy Hendrix, MD at (407) 200-2860

Career Opportunities

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 Sarah Foster, Physician Recruiter
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sarah.foster@carolinashealthcare.org
www.carolinashealthcare.org/careers/physicians

Next available issue is September with a closing of August 6th

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- Ladysmith - Urgent Care
- Marshfield - Urgent Care
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 Physician Recruitment, Marshfield Clinic
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 Phone: 800-782-8581, ext. 19781
 Fax: (715) 221-9779
 E-mail: heeg.sandra@marshfieldclinic.org
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For more information contact: Nancy Paul 800-353-6812
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Career Opportunities

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Interested applicants may contact Dr. Fred Tilden, Medical Director of Emergency Services, at **203-694-8278**.

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FOR SALE- northern Virginia. Independent Urgent Care/Family Clinic. Excellent location for full scale Family Practice if desired. Previously retired owner wants to retire for good. Appraised. Send email inquiries to Jakeport@yahoo.com or fax to 703-495-8447. Please include a brief resume.



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DEVELOPING DATA

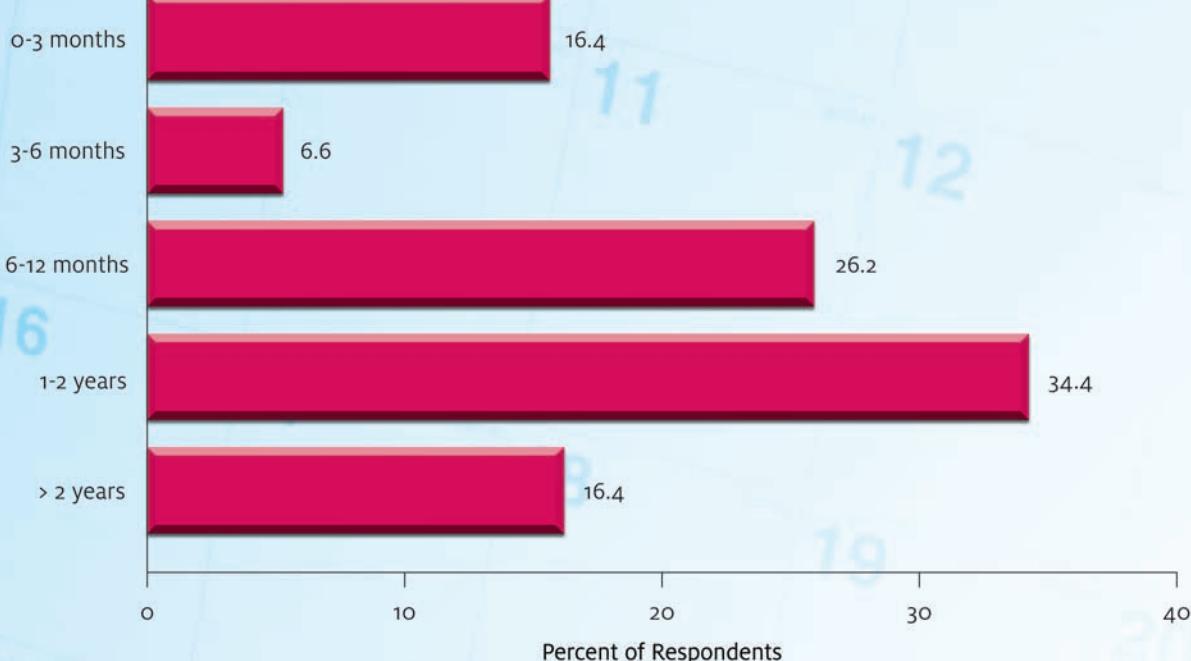
UCAOA's Survey Committee has conducted two annual member surveys, to date, designed to establish benchmarks in an industry for which data have been sorely lacking. Each month in **Developing Data**, we will share one or two tidbits from the second annual survey in an effort to help readers get a sense of what their peers are doing, and what kind of trends are developing as urgent care evolves.

In this issue: If you're planning to purchase an electronic medical record (EMR) system, when do you expect to do so?

At the time of the survey, 23.7% of respondents used only an EMR system for patient charting, while another 28.7% used some combination of methods (dictation only, paper/encounter form only, and paper templates only being the other options).

Come next year and the third benchmarking survey, the data are likely to look considerably different: 70.6% of respondents reported that they are considering purchase of an EMR system, with nearly half expecting to do so within the next 12 months, if not sooner.

EMR SYSTEM PURCHASE TIMETABLE



Areas covered in the UCAOA industry surveys included urgent care structures and organization, services offered, management of facilities and operations, patients and staffing, and financial data. UCAOA members who have ideas for future surveys should e-mail J. Dale Key, UCAOA Survey Committee chair.

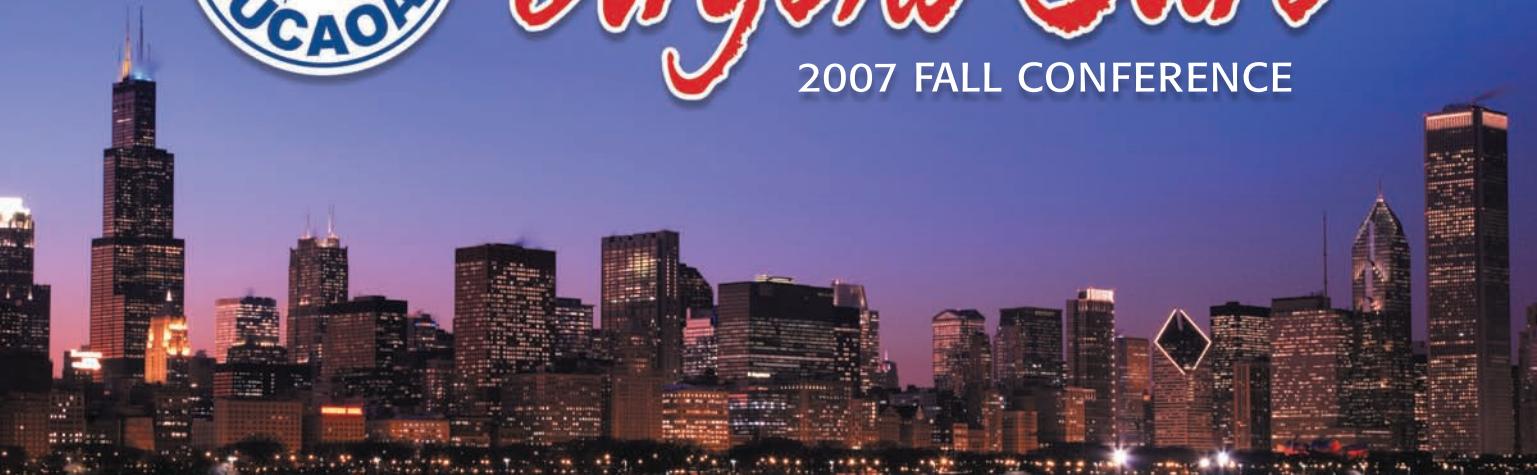
Next month in **Developing Data:**

A look at how some clinics are employing prompt-pay discounts.



Urgent Care

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