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Challenges in Assessing and Treating Insect Bites and Stings

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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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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 88%, 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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LETTER FROM THE EDITOR-IN-CHIEF

It's the Journey, Not Just 'The Win'



Brian Sipe's "Red Right 88." John Elway's "The Drive." Earnest Byner's "The Fumble." Michael Jordan's "The Shot." Jose Mesa's "The Choke." And now, the Cavs' and "The Sweep."

You've just read an abridged version of the History of Cleveland Sports. For those of you who have no interest in sports, fear not; there's an analogy in here somewhere.

Growing up a Cleveland sports fan has been a roller coaster ride of high hopes, heartbreaks, almosts, and near-misses. Not a single championship to our name since the 1964 Browns (and I just missed that one)—the longest-running drought in sports history in cities with at least three professional teams.

And yet, we still cheer. Our teams still battle and the fans still hope for improvement "next year."

Why not just give up? In between the anger and depression stages of my grief, I am reminded of the importance of "the journey" over "the win." (Some might call this the denial and bargaining stages of grief).

Effort, pride, and improvement form the core of this journey. It is here that we come to our analogy: Medicine is a jour-

ney, a perpetual journey of discovery, knowledge, and life-long learning. Urgent care is on a journey of its own, to define and refine a specialty.

There is no end to this journey. There are no "winners," no finish line. It is a process which we pursue because we are driven by pride and the need for continual improvement. "Recognition" and "legitimacy" are fools' gold. Focusing on them minimizes the importance of the journey. My only hope is that we continue to grow, work hard to be better, and find ways to get together and cheer.

There; now I feel better. It all makes sense. I'll live to cheer another day. Go Browns!

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



Call for Articles

The *Journal of Urgent Care Medicine* (JUCM), the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

Please e-mail your idea to JUCM Editor-in-Chief Lee Resnick, MD at editor@jucm.com.

He will be happy to discuss it with you.

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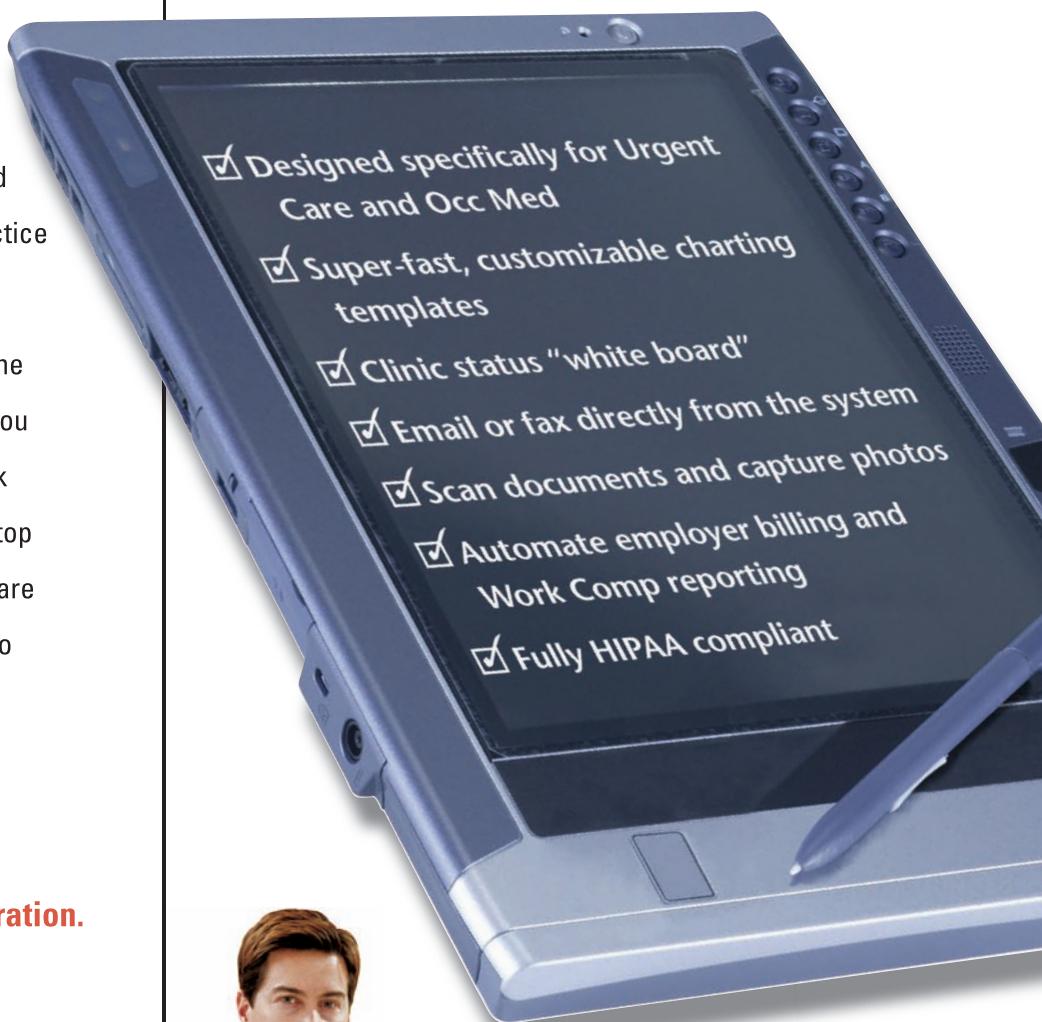
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**CLINICAL****11 Challenges in Assessing and Treating Insect Bites and Stings**

What are the crucial first steps to take when presented with a patient who has suffered a possibly venomous insect bite or sting?

By Kent A. Knauer, MD

ORIGINAL RESEARCH**19 Management of Distal Radial Fractures in Young Patients by Non-Orthopedists in an Urgent Care Center**

Can a relatively common orthopedic injury of childhood be managed with simple splinting without referral to the hospital or an orthopedist?

By Deena R. Zimmerman, MD, MPH, IBCLC, Scott Fields, MD, and Nahum Kovalski, BSc, MDCM

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From the Executive Director

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Case Western Reserve University
Department of Family Medicine
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JUCM

EDITOR-IN-CHIEF

Lee A. Resnick, MD

editor@jucm.com

EDITOR

J. Harris Fleming, Jr.

hfleming@jucm.com

CONTRIBUTING EDITORS

Nahum Kovalski, BSc, MDCM

Frank Leone, MBA, MPH

John Shufeldt, MD, JD, MBA, FACEP

David Stern, MD, CPC

ART DIRECTOR

Tom DePrenda

tdeprenda@jucm.com



2 Split Rock Road, Mahwah NJ 07430

PUBLISHERS

Peter Murphy

pmurphy@braveheart-group.com

(201) 847-1934

Stuart Williams

swilliams@braveheart-group.com

(201) 529-4004

Mission Statement

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

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



JUCM CONTRIBUTORS

In our brief history as a peer-reviewed journal, we have been very fortunate to work with some top-notch physician authors—some more than once, which we find very gratifying.



One such clinician is **Kent Knauer, MD**, who in addition to being a clinician and researcher is director of the Allergy and Asthma Center at University Hospitals in Cleveland, OH. Dr. Knauer authored our lead clinical article, Challenges in Assessing and Treating Insect Bites and Stings (page 11) this month. His previous contribution to *JUCM* discussed evaluation and treatment of patients with urticaria (*JUCM*, December 2006). Dr. Knauer has lectured and written extensively on asthma and other allergic conditions and is a member of the American Academy of Allergy Asthma and Immunology, as well as a fellow of the American College of Allergy, Asthma, and Immunology. He sits on the speaker's bureaus for AstraZeneca, GlaxoSmithKline, Merck, and Pfizer and has received research grants from Meade Johnson, Novartis/ Genentech and GlaxoSmithKline.

An encore of a different sort can be found in another original, peer-reviewed clinical article in this month's issue. A few months

ago, we were pleased and proud to publish our first piece of original research (Emergencies in the Office: Why Are 911 Calls Placed From Family Medicine and Urgent Care Offices?, *JUCM*, January 2007). In this issue we're doing it again, and with an international flair; Management of Distal Radial Fractures in Young Patients by Non-Orthopedists in an Urgent Care Center (page 19), by **Deena R. Zimmerman, MD, MPH, IBCLC, Scott Fields, MD**, and *JUCM* Editorial Board member and regular contributor **Nahum Kovalski, BSc, MDCM** is drawn from research at TEREM Immediate Medical Care in Jerusalem, Israel.

Our other regular contributors, **Frank Leone, MBA, MPH**; **John Shufeldt, MD, JD, MBA, FACEP**; and **David Stern, MD** have been with us right from the start and have everything to do with our identity as a journal by, of, and for the urgent care community.

It's because of them we can say with pride that *JUCM* is only as good as our contributors. If you'd like to find yourself among them by publishing an article, contact our editor-in-chief, **Lee Resnick, MD**. As anyone who met Dr. Resnick at the UCAOA conference in Daytona Beach in May can attest, he is more than happy to discuss the plethora of clinical topics just waiting to be covered in these pages. E-mail him at editor@jucm.com. ■

To Submit an Article to *JUCM*

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

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

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

the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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FROM THE EXECUTIVE DIRECTOR

We Hear You

■ LOU ELLEN HORWITZ, MA



One of my favorite parts of a conference is getting to read the participant evaluations.

I think that all of us—be it through patient satisfaction surveys or course evaluations—like to get feedback on how we are doing. It provides us with a direct link to our “customer” and points us toward a path to follow for planning our next moves.

As you (hopefully) have heard, the 2007 convention was our biggest and best conference yet. According to the evaluations, the conference format, content, keynote speakers, and networking opportunities were all very well done. You also told us about desires for more flexible course choices, more informal networking time, more idea exchange opportunities, and even more advanced courses.

Well, we heard you. By the time you read this, plans will already be underway for our 2008 Urgent Care National Conference. Watch the website and *JUCM* to learn more about this great event as the details unfold.

We Want You

A common question at the convention was, “How can I get involved with UCAOA?”

Let me first say how excited we are about all of the opportunities for participation we have to share with you. One of the benefits and challenges of the rapid growth rate UCAOA is experiencing is the plethora of ideas and initiatives we have. The Board of Directors has the challenge of focusing those ideas on what is most important for UCAOA and the industry, and the staff has the challenge of making them all happen. And that's where you come in.

Dedicated volunteers are at the heart of any successful



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

association. We need your efforts and expertise to help us make things happen, so please consider this a personal invitation to join us in bringing about UCAOA's future and the future of urgent care.

To learn about how you can work with us on our many initiatives, visit the website (www.ucaoa.org) and click on the “Get Involved” link. Or, drop me an e-mail at lhorwitz@ucaoa.org.



Coming Soon

We also hope you'll make plans to join us (or send a colleague) at our upcoming Fall Conference in Chicago, October 26-27.

In addition to our popular Starting a New Urgent Care Center track, we're presenting an updated course on Specialized Coding for Urgent Care, and a brand new program on Urgent Care Center Marketing, covering topics from signage to advertising to building relationships with the media. Visit the website for full details on all of the Fall Conference courses.

In closing, I'd like to welcome our new Board of Directors members. We are so appreciative of the time and effort that all of our Board members share with us on your behalf.

Elected (or re-elected) by their peers at the convention were David Stern, MD, CPC, Lee Resnick, MD, Dan Konow, PA-C, MBA, and Marc Salzberg, MD, FACEP.

We look forward to seeing all of you at an upcoming conference. ■

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Challenges in Assessing and Treating Insect Bites and Stings

Urgent message: When presented with a patient who has experienced an insect bite or sting, the most crucial role for the urgent care clinician is to triage for anaphylaxis, venom toxicity, and local tissue damage.

Kent A. Knauer, MD

Introduction

Now that summer is here, it is likely that urgent care practitioners—especially those practicing in suburban and rural areas—will see an increasing number of patients who have experienced an insect bite or sting.

Though data are scarce, it is accepted that the most common such events leading to an urgent care visit are multiple stings or bites or larger than normal localized swelling—especially worrisome if on the face or neck. Frequently, there is a small puncture wound visible in the central part of the lesion.

It is important to establish whether a stinger is still present in the wound, and whether the swelling indicates an early cellulitis. More crucial, however, is the need to recognize potential severe injury from some uncommon spider bites. Positive identification of a spider is rare; however, in fact, the identity of the



stinging or biting insect is not clear in most cases.

Another area of concern is the potential presence of additional organ involvement such as throat symptoms, possible airway swelling, or a generalized rash. This often occurs in a setting of much patient and/or family alarm.

The worst reactions are truly anaphylactic in nature and require prompt aggressive therapy. Some patients need referral to an allergist for further evaluation and treatment.

The Players: Arthropods

Over 60% of the world's animal species are arthropods. Fortunately, only a small number are venomous and able to cause harm to humans. Among the most common complaints are potentially dangerous stings and bites from arachnids (spiders and scorpions) and *Hymenoptera* species (bees, wasps, and ants).¹ This article excludes a discussion of scorpion stings; a good resource regarding such

**FIGURE 1.****Papular urticaria, usually caused by mosquitoes or chiggers.**

Source: NZ DermNet, www.dermnetnz.org.

events can be found in Amitai's article in *Public Health Review*.²

Occasionally, a patient presents with multiple, even dozens, of small raised lesions—a condition called papular urticaria (**Figure 1**). Often on the legs of young children, these lesions are caused by mosquitoes or chiggers, and although medically harmless, they can cause a few days of intense pruritis and sleepless nights. The treatment includes cool baths and antihistamines, either oral or topical, and topical corticosteroids. Allergic reactions to these insects are rare.

Bite or Sting?

Technically, a bite comes from mouth parts, and a sting from a posterior needle-like structure. Stings are mostly defensive and the venom hurts.

On the other hand, bites are usually meant to kill the victim by various means. Bites from some spiders, therefore, can potentially lead to tissue damage and necrosis.

Only honey bees leave a stinger behind. It should be readily visible on the surface; contrary to popular opinion, it should be removed by any means as soon as possible.

A dark puncture mark at the sting site from other species is not hiding a sting. Most of these creatures sting or bite when attacked or caught, though some sting to defend their nest. Yellow jackets, hornets, and fire ants are the most aggressive, while honey bees and wasps are the least likely to sting. Most spiders bite only when there is a perceived attack.

Bees, Wasps, and Ants

There are three types of reactions to *Hymenoptera* species: a normal skin response, a large local skin reaction, and a systemic or allergic reaction.³

"Normal" Reaction

Initially, the normal reaction consists of pain, pruritis, or intense burning (fire ants) and a small wheal. Dozens of stings can

be inflicted by a swarm of bees, but hundreds of bites can be inflicted by a colony of fire ants within seconds. Bee and wasp stings resolve spontaneously over a few hours.

Unlike bee stings, fire ant lesions develop into sterile vesicles within 24 hours. The pustule may last for several days before rupturing and forming a crust which heals over a period of several days (**Figure 2**). Secondary infection is a possibility in the later stages. Initial treatment is by ice, oral antihistamines, and topical corticosteroids.

Treatment

There is controversy over the use of oral corticosteroids for fire ant bites.⁴

Large Local Reactions

A large local reaction can occur with bee and wasp stings and consists of a swelling that is larger than normal but is limited to the area adjacent to the sting.



The swelling may cross several joints. For example, a bee sting on the back of the hand could swell up to beyond the elbow.

These reactions progress slowly over hours, and can last up to five days or more. They are alarming but not particularly painful except for stretching of the skin, and they may not itch. They are warm but not necessarily red and usually not tender. The lack of tenderness distinguishes them from cellulitis.

Cellulitis as a result of a bee or wasp sting is rare.

Treatment

Large local reactions should be treated with ice, antihistamines, and oral corticosteroids in a burst-and-taper method. They do not require antibiotics. These reactions tend to recur, but usually do not progress to systemic reactions.

Systemic Reactions

Systemic reactions differ in children and adults. In early teens and children, a hive-only reaction may not represent life-threatening anaphylaxis, and has a good prognosis for being outgrown. These children have no related gastrointestinal, cardiovascular, or respiratory symptoms. The hive-only reaction may recur but does not progress.⁵

It is sometimes difficult to determine the presence or absence of other organ system involvement in young children, so when in doubt treat them for anaphylaxis.

Heart rate is always increased in anaphylaxis, whereas vasovagal reactions are associated with bradycardia. A serum tryptase level drawn at the time of the sting can be useful at a later time to decide if the event was truly anaphylactic. Tryptase is a specific marker for mast cell activation and mediator release. Skin testing or radioallergosorbent testing (RAST) for venom is the final determinant for allergic sensitization (**Figure 3**).

In adults, any reaction outside of the immediate sting site is considered anaphylaxis. These include hy-

FIGURE 2.
Fire ant bites. Vesicles form within 24 hours; treatment is symptomatic.



Rosa Codina, John T. Ramey, Richard F. Lockey in *Atlas of Allergic Diseases: Allergic Diseases*. Edited by Phillip L. Lieberman, Michael S. Blaiss. Current Medicine, Inc. 2000.

potension; generalized hives; mouth, tongue, or throat swelling; wheezing or chest tightness; and nausea, vomiting, or diarrhea.

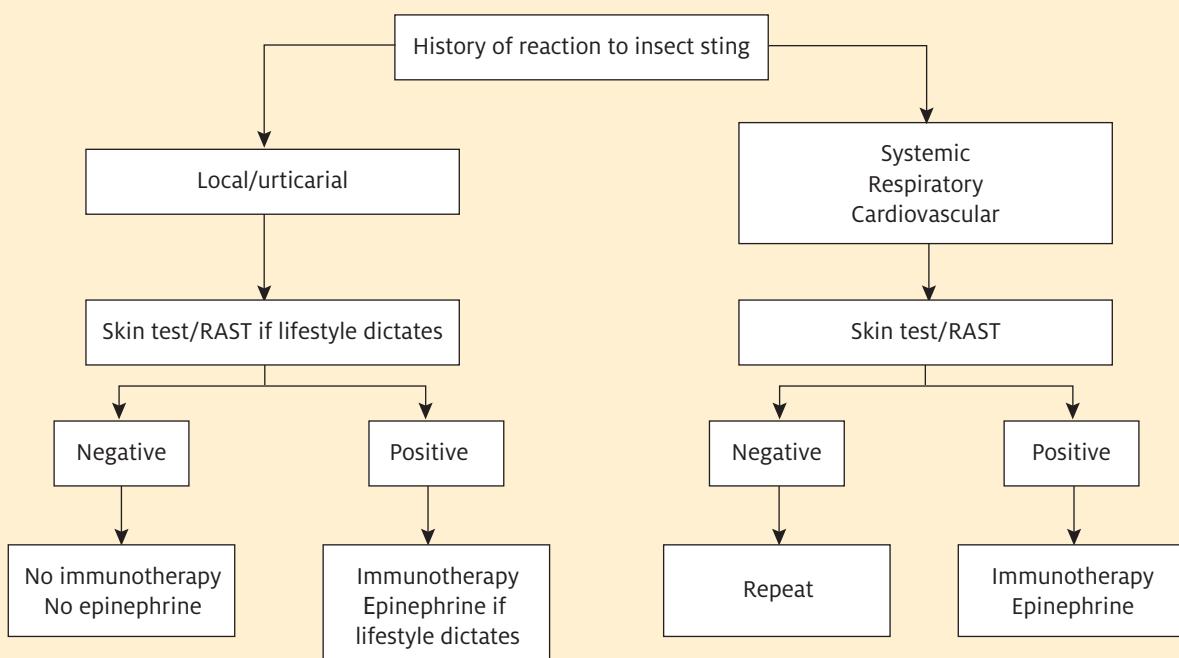
Anaphylaxis is IgE-mediated and can occur on any sting other than the first sting. Typically, the reaction proceeds rapidly from itchy palms to generalized hives and itching and then to other organ involvement, but hypotension and loss of consciousness may be the first symptom. On rare occasions, cardiac arrest may occur and death can result, although this is rare and frequently related to the adverse effects of hypotension on underlying medical conditions such as coronary artery disease.

Treatment

After quick assessment, epinephrine (with dose dependent on age and weight) is the treatment of choice, and may be repeated several times if necessary to maintain airway patency or to maintain blood pres-

**FIGURE 3.**

Algorithm for the evaluation of bee sting reactions in childhood. Presence of antivenom IgE is the primary determinant of long-term management.



sure.⁶ Supplemental oxygen, IV fluids, and parenteral antihistamines and steroids are adjunctive therapies.

A common error is to give IV steroids and/or antihistamines as first-line therapy, presumably out of concern over the safety of epinephrine. Anaphylaxis itself is much more dangerous than epinephrine, and withholding epinephrine for treatment of anaphylaxis can be a fatal mistake. Patients require observation to monitor for secondary late recurrences four to eight hours later. Patients with anaphylaxis need a self-injecting epinephrine device and instructions on when and how to use it.

Allergist referral is recommended for specific venom testing and possible desensitization.

Spiders

Fewer than half of arthropod bites and stings in North America are spider bites. Of these bites, the two species that cause most of the harm are the black widow (*Lactrodectus* species) and the brown recluse (*Loxosceles* species). These bites have potential for both skin and systemic toxicity, but anaphylaxis does not occur.

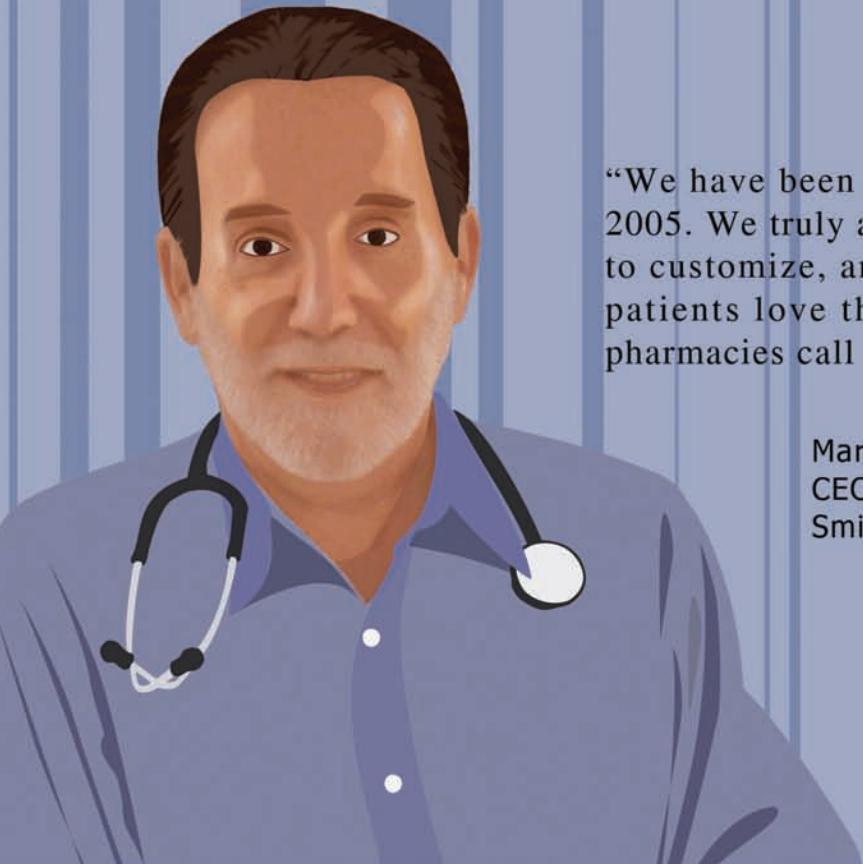
Identification and treatment of these bites is complicated by a lack of proper identification of the spider and delays in seeking medical care. Most patients may be able to determine whether the spider was brown or black, and large or small, but very little beyond that unless the spider was captured in a condition to allow identification.

The instinctive reaction is to run away from spiders. (It is amazing that such a small creature can cause a 150-pound mammal to flee in terror!) Both species are nocturnal, and only bite when trapped against skin in bed linen, clothing, or shoes and boots, or squeezed when a hand reaches blindly under an object.⁷

Initial treatment of a spider bite includes cleansing and application of an ice pack. Parenteral analgesics may be considered. Tetanus prophylaxis is recommended for all significant spider bites. Beyond that, treatment is specific for species and symptoms.

Black Widow Bites

The black widow bite is probably the most important



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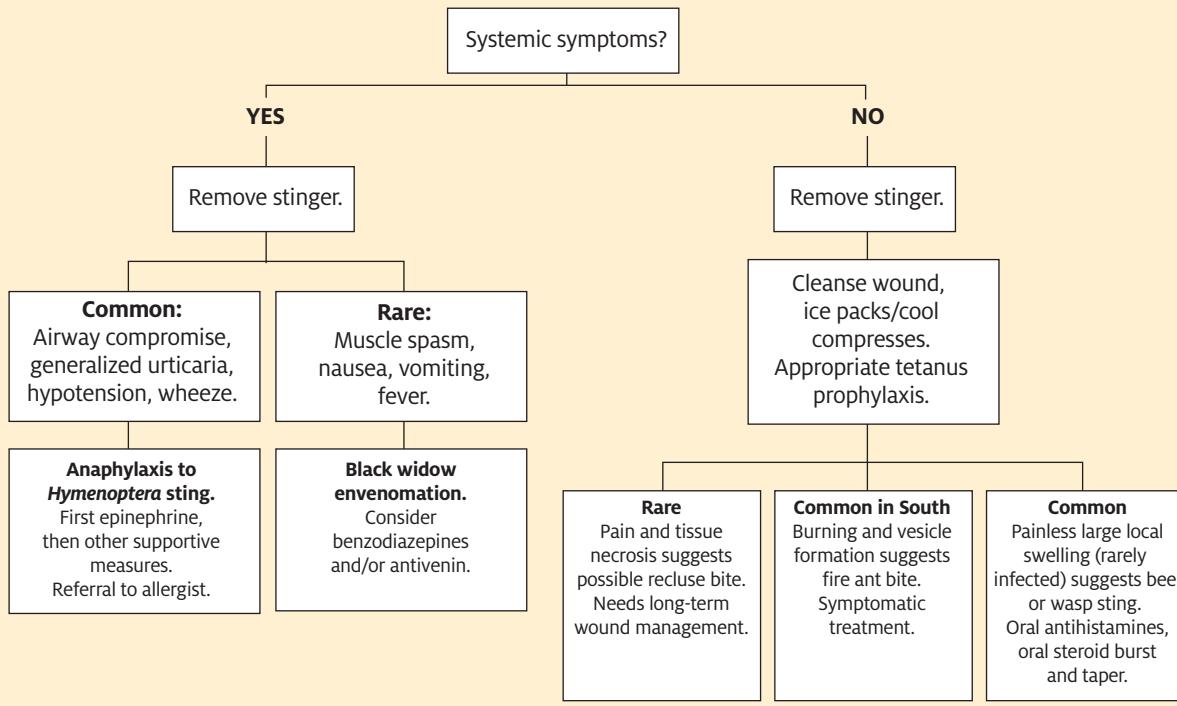


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FIGURE 4.

Algorithm for evaluation of bites and stings in an urgent care clinic.

to identify or consider due to the availability of specific antivenin.

The initial bite is commonly on an extremity, usually painful and shows little or no surrounding inflammation. Systemic reactivity is atypical and rarely full blown. When it does occur, generally 30 minutes to two hours elapse before signs of systemic reactivity. First, muscle spasms occur locally at the site of the wound, and then progress centrally to the abdominal and facial muscles. Joint pain, fever, hypertension, and nausea and vomiting may also occur.

Treatment

Benzodiazepines are recommended for treatment of muscle spasm and rigidity. Antivenin is reserved for patients with severe regional or local systemic toxicity, or who have uncontrolled hypertension, seizures, or arrest. One vial is administered in 100 ml to 250 ml of saline over two hours and may be repeated for refractory symptoms. Antivenin may be effective, espe-

cially in children, up to three days after the bite, but symptoms generally resolve over two to three days. Death from black widow bites is rare.⁸

Recluse Spider Bites

Recluse spider bites are initially painless, but localized inflammation spreads rapidly. The venom causes local tissue damage leading to necrosis and ulceration. Systemic reactivity is rare and delayed up to three to seven days; symptoms may include fever, chills, and a maculopapular rash.

Under the best conditions, ulcers heal over one to eight weeks. Major scarring is expected in roughly one in 10 patients. There are essentially no deaths from recluse spider bites.⁸

Treatment

Antivenin is not available, and systemic manifestations are treated symptomatically. Additional wound care consists of elevation and immobilization of a bitten extremity. The lesion should not be excised, and



the wound should not be injected with corticosteroids, since both of these measures may actually make the outcome worse. Wound care continues with debridement, culture and treatment of infection, and ultimately skin grafting if necessary.

The role of the urgent care physician can be summed up in one word: triage.

Conclusions

Most insect bites and stings need only local wound care and consideration for tetanus immunization. The role of the urgent care physician is to rapidly triage for anaphylaxis, venom toxicity and local tissue damage (**Figure 4**). Try to determine the culprit when possible, and the time since envenomation. Determine if there is a past history of an adverse reaction to a bite or sting. If a stinger is observed on the surface of the skin (left only by honeybees), remove it as soon as possible by any means. Don't waste time searching for a stinger if one is not readily visible.

Signs of anaphylaxis—hypotension, airway com-

promise, generalized urticaria or angioedema, or wheezing—require immediate use of epinephrine. In the case of spider bites, observe for signs of systemic toxicity, particularly painful muscle spasms, which indicate the possible need for antivenin treatment.

Analgesics, antihistamines, corticosteroids, and other symptomatic treatments can be helpful in specific situations.² Epinephrine auto-injectors are prescribed for all patients with anaphylaxis from bee, wasp, or ant stings. Antibiotics are not needed in the majority of cases. Consider consulting with a specialist such as an allergist or surgeon where appropriate.

Recommend avoidance measures such as gloves, long sleeves and pants, and insect repellants. ■

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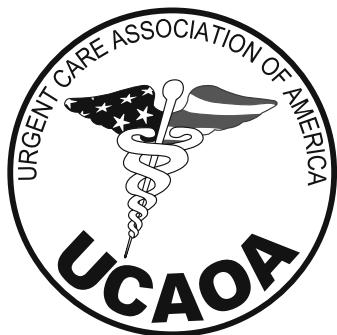
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Original Research

Management of **Distal Radial Fractures** in Young Patients by Non-Orthopedists in an Urgent Care Center

Urgent message: Distal radial fractures in children can often be treated by non-orthopedists without the need for full casting in an urgent care center that can perform simple splinting, thus sparing hospital referral.

Deena R. Zimmerman, MD, MPH, IBCLC, Scott Fields, MD, and Nahum Kovalski, BSc, MDCM

Introduction

Wrist fracture is a common injury in children.¹ Many of these fractures are buckle or torus fractures. Traditionally, treatment for buckle fractures has been short-arm casting for two to four weeks.²

However, questions have been raised as to the need for such treatment. A number of recent studies have indicated that many such fractures may be managed without casting by the use of either elastic bandaging alone³ or splints.⁴⁻⁶ Plaster splints can easily be applied in an urgent care framework, thus sparing the family the need for hospital referral.

For appropriate care to be delivered in an urgent care setting, it is important not only that the treatment is correct, but that the diagnosis is, as well. Clinical evaluation



© Getty.com/Richard Price

alone of the injured wrist is likely to miss 20% of fractures and overall 37%, which indicates that x-ray evaluation is clinically important in wrist fracture care.⁷

The utility of an x-ray evaluation, however, assumes that the initial x-ray assessment to identify the presence and severity of the fracture is accurate even without on-site review by a radiologist or orthopedist. In light of the above, we decided to study our experience in TEREM Emergency Medical Centers in relation to the accuracy of interpretation of wrist x-ray findings in children.

Materials and Methods

Setting

TEREM Emergency Medical Centers is a privately owned medical services company based in Jerusalem, Israel



that establishes and manages freestanding emergent care clinics. The central clinic is open 24 hours per day, 365 days per year. An orthopedist is on site in this particular clinic for approximately six hours daily. Four other TEREM clinics are open evening and weekend hours but do not have an on-site orthopedist at any time. All five clinics provide digitalized on-site radiology during all operating hours.

Films are read initially by the treating physician. All films undergo review by a radiologist within 24 hours and any "mismatches" between the initial reading and "official" reading are followed up by a senior physician to assure that there is no need for change in care.

Data Source

TEREM uses a proprietary electronic medical record (EMR) system called PARPAR to register, clinically manage, and administer all visits, laboratory tests, and radiological studies. Data captured into PARPAR include the patient's demographic information, the patient's complaint on arrival, the diagnosis, the main procedures done, and the referral decision made. The digital radiological images are stored short term in an online picture archiving and communication system (PACS) and long term in a compressed jpeg format in an online, web-accessible archive. Printed materials, such as the handwritten doctor's chart, are scanned into the system and attached to the matched patient EMR.

A unified "data warehouse" exists for housing the combined data from all TEREM urgent care clinics. A set of web-based forms was developed to allow for the review of individual charts as well as the extraction of summary statistics. For example, a reviewer can request a list of visits by patients of a certain age with a specified diagnosis.

The list of retrieved results representing visits throughout all the TEREM clinics includes web-based links to the matching charts and x-ray reports done during the given visits. Basic statistics can be generated based on combinations of query criteria. In this manner we can easily extract the number of children up to age 15 who had forearm x-rays.

Study Subjects

All children up to age 15 who presented from January 2, 2006 to September 30, 2006 to any TEREM clinic for whom a forearm x-ray was performed.

Data Analysis

Categorical data were compared by chi square analysis. Statistical significance was set at $p < .05$.

Results

During the study period, 883 children had a radiological study of the forearm due to suspected trauma. Of these, 611 (69%) were managed by a non-orthopedist without the real-time involvement of a radiologist or orthopedist. The non-orthopedist diagnosed a distal radial fracture in 253 (41%) of these visits. In 11 (4.3%) of these 253 visits, the radiologist subsequently read the film as normal (i.e., overcall by the non-orthopedist). In 38 (10.6%) of the 358 visits where the non-orthopedist read the film as normal, the radiologist identified a distal radial fracture (i.e., undercall by the non-orthopedist).

The remaining 272 (31%) of the 883 visits were managed by an orthopedist. The orthopedist diagnosed a distal radial fracture in 239 (88%) of the 272 visits. In eight (3.3%) of these 239 visits, the radiologist read the film as normal (i.e., overcall by the orthopedist). In two (6.1%) of the 33 visits where the orthopedist read the film as normal, the radiologist identified a distal radial fracture (i.e., undercall by the orthopedist).

Neither the differences in undercall nor overcall rates between orthopedist and non-orthopedist were statistically significant.

Limitations

As this was a chart-based retrospective study, we do not have the final outcome data for these patients. Such a follow-up study is being planned. However, as the focus of the study is the ability to recognize the fracture and track the disposition of these patients, we do not feel this deters from the conclusion of this study.

Treatment Discussion

The traditional treatment for buckle wrist fractures has been short-arm casting for two to four weeks. However, Walker, et al conducted a survey of 104 pediatric orthopedists and showed wide variety of clinical practice.⁶

The traditional treatment is not without problems.

First of all, typically it requires at least two evaluations by an orthopedist, one at the time of the injury and the second at the time of cast removal. For example, Plint et al² reviewed the experience of treating 309 patients with buckle fractures in the pediatric emergency department of a pediatric hospital. Follow-up data were available for 276 (89%) subjects, all of whom had been referred to the orthopedic service of the same hospital. In fact, two-thirds of these subjects had more than one follow-up visit with an orthopedist and nearly half of these subjects had more than one radiograph obtained.

As none of the children needed further orthopedic interventions, the authors questioned the need for these visits.

Furthermore, the traditional treatment is not without a price:

- Each visit to an orthopedist has a cost to the parents in terms of both time and money.
- Each x-ray is added radiation exposure for the patient.

Casting itself has a risk of complications. In Plint's study quoted above, 32 subjects (12%) had an unplanned ED visit because of cast- or injury-related problems. Of these, 30 (94%) were for wet, damaged, or tight casts; two (6%) were for broken splints. In an additional study, Plint et al demonstrated the improvement in quality of life when children are NOT casted.⁴

Van Borse, et al described use of plaster splints created with the use of simple material such as plaster of paris-impregnated gauze, stockingnette, cast padding, and elastic bandages.⁵ The protocol he,

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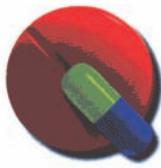
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- diagnosis using radiographs and application of a removable plaster-of-paris volar forearm splint in the emergency department
- one orthopedic office/clinic visit to confirm diagnosis of torus fracture and to provide splinting protocol instructions.

Ultimately, the splint would be discontinued at the discretion of the family. The removable splint would cause less disruption of daily activities. The need for an additional orthopedic visit for repeat radiographs and cast removal would be eliminated, reducing the patient's time lost from school, the parent's time lost from work, and the physician's time and costs.

This type of treatment can easily be performed in an urgent care setting by non-orthopedists. A similar splint is, in fact, done routinely in our clinics. The findings of the current study (that the percentage of overcall and undercall between orthopedists and non-orthopedists is not significantly different) support the contention that such care can be offered in this setting.

When this is coupled with review of all x-rays by a radiologist within 24 hours and call back by a senior physician in the case of any mismatches, a safety net is in place and patients are not placed at risk.

Conclusions

Non-orthopedists can reliably identify and manage trauma cases that are suspicious for fractures of the distal radius. With minimal training, they can appropriately apply splints that can be made of inexpensive, readily available materials. In combination with radiologist review within 24 hours, as well as a call-back follow-up system by a senior physician, initial undercalls will still be managed appropriately. Significant monies can therefore be saved, as management of these cases in an urgent care center is less expensive than direct ED care. ■

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ABSTRACTS IN URGENT CARE

On New Syncope Guidelines, Low Back Pain, MSCT and Pulmonary Embolism, Infants with Bronchiolitis, Macroscopic Hematuria, and More

■ 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.

Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Department with Syncope

Key point: *Syncope is a common presentation to the emergency department. These recommendations help stratify low- versus high-risk patients.*

Citation: Huff JS, Decker WW, Quinn JV, et al. *Ann Emerg Med.* 2007;49:431-444.

American College of Emergency Physicians Issues Guidelines for Treatment of Syncope

Citation: Barclay L. *Medscape News.* April 30, 2007.

URL: <http://www.medscape.com/viewarticle/555843?src=mp>

Syncope accounts for 1% to 1.5% of visits to the ED annually, and up to 6% of hospital admissions. Causes include any process that transiently reduces cerebral perfusion. Difficulties encountered in the ED evaluation of patients with syncope may include missing, inaccurate, or conflicting historical information from observers; lack of memory of the event when patients arrive in the ED; and the often asymptomatic state pa-

tients are in by the time they reach the hospital.

The authors note that applying the level B recommendations of the 2001 American College of Emergency Physicians (ACEP) clinical policy on syncope would identify all patients with cardiac causes of syncope and reduce the admission rate from 57.5% to 28.5%. Those relatively few patients with life-threatening processes (such as dysrhythmias, pulmonary embolism, aortic dissection, subarachnoid hemorrhage, and acute coronary syndromes), and other patients who may benefit from urgent intervention (such as patients with bradycardia or medication-induced orthostatic hypotension), must still be identified.

When the ED evaluation of a patient presenting with syncope does not identify a clear etiology, the emergency clinician must determine which of these patients need additional diagnostic evaluation and monitoring—and in what setting that should take place. Similar to the process of chest pain evaluation, the role of the clinician managing syncope has shifted from an effort to determine a specific diagnosis to that of risk stratification.

Symptoms and complaints of the patient with syncope should be carefully considered after performing a complete history. Other associated symptoms (e.g., cardiac, neurologic, abdominal, or respiratory) may facilitate diagnosis of an underlying medical condition, such as an acute coronary event, aortic dissection, pulmonary embolism, seizure, ectopic pregnancy, or gastrointestinal hemorrhage.



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

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The current update of the 2001 ACEP clinical policy on syncope does not attempt to outline the evaluation of patients presenting with syncope associated with specific diagnoses, but instead attempts to assist the clinician with three critical issues:

- What history and physical examination data help to risk-stratify patients with syncope?
- What diagnostic testing data help to risk-stratify patients with syncope?
- Who should be admitted to the hospital after an episode of syncope of unclear cause? ■

Strategies for Evaluation and Treatment of Acute Low Back Pain

Key point: A more thorough evaluation of back pain is required only in selected patients with 'red flag' findings.

Citation: Barclay L, Lie D. *Medscape News*. April 27, 2007.

URL: <http://www.medscape.com/viewarticle/555790?src=mp>

Evaluation and Treatment of Acute Low Back Pain

Citation: Kinkade S. *Am Fam Physician*. 2007;75:1181-1188.

URL: <http://www.aafp.org/afp/20070415/1181.html>

A review published in the April 15 issue of *American Family Physician* discusses evaluation and treatment of acute low back pain (LBP), including drug treatment and other physical therapies.

Acute low back pain with or without sciatica usually is self-limited and has no serious underlying pathology. For most patients, reassurance, pain medications, and advice to stay active are sufficient. A more thorough evaluation is required in selected patients with "red flags" associated with an increased risk of cauda equina syndrome, cancer, infection, or fracture.

Patients with these red flag findings also require closer follow-up, with urgent referral to a surgeon in some cases. For patients with nonspecific mechanical LBP, imaging can most often be delayed for at least four to six weeks, during which time the pain usually remits to some extent.

Physical examination findings may suggest specific nerve root impingements because of disk herniation at different levels. An L3-L4 disk herniation affecting the L4 nerve root is associated with sensory loss over the medial foot, weakness in knee extension (tested by squat and rise), and reduced patellar reflex.

An L4-L5 disk herniation impinging on the L5 root may be associated with sensory loss over the dorsal foot, and weakness of ankle and great toe dorsiflexion (tested by heel walking).

Signs of L5-S1 disk herniation affecting the S1 root are sensory loss over the lateral foot; weakness of plantar flexion of the ankle and toes (tested by walking on the toes), and reduced or absent Achilles reflex.

Treatments with good underlying evidence of efficacy include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), skeletal muscle relaxants, heat therapy, physical therapy, and advice to stay active. Although spinal manipulative therapy may provide short-term benefits when compared with sham therapy, benefits are limited in comparison with standard treatments. Evidence for the benefit of acupuncture is conflicting, but no benefit has been proven in higher-quality trials. ■

Urine-Specific Gravity and Other Urinary Indices: Inaccurate Tests for Dehydration

Key point: Urinary indices are not useful diagnostic tests to identify the presence of dehydration.

Citation: Stiner MJ, Nager AL, Wang VJ. *Ped Emerg Care*. 2007;23(5):298-303.

URL: <http://www.pec-online.com/pt/re/pec/abstract.00006565-200705000-00005.htm;jsessionid=GZ3GyfX3NH9Lj2m-MopshRgvgx65RPpGfRLGp13CNLyGcB325y1!959335381!-949856145!8091!-1>

Urine output, specific gravity, and ketones (urinary indices) are commonly used as an objective means to assess for dehydration and gastroenteritis severity; however, their utility has not been established. The study was designed to evaluate the accuracy of urinary indices as diagnostic tests to identify acute dehydration.

The authors completed a prospective cohort study of 79 subjects ages 3 months to 36 months with gastroenteritis, clinically suspected moderate dehydration, and the need for intravenous rehydration in the emergency department of an urban pediatric hospital.

Urine-specific gravity ($r=-0.06$, $P=0.64$), urine ketones ($r=0.08$, $P=0.52$), and urine output during rehydration ($r=0.01$, $P=0.96$) did not correlate with the initial degree of dehydration present. Clinically useful cutoff values for urine-specific gravity and ketones to increase or decrease the likelihood of dehydration at the time of enrollment could not be identified. ■

Can Multislice CT Alone Reliably Rule Out Pulmonary Embolism? A Prospective Study

Key point: A negative MSCT enables omission of anticoagulation in patients with suspected PE.

Citation: Guilbert JP, Manzur DN, Tarrasa MJT, et al. *E J Rad*. 2007;62:220-226.

URL: [http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T6F-4MVN03J-1&_user=10&_coverDate=05%2F31%2F2007&_rdoc=14&_fmt=summary&_orig=browse&_srch=d&c_info\(%23toc%235029%232007%23999379997%23649-654%23FLA%23display%23Volume\)&_cdi=5029&_sort=d&_do](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T6F-4MVN03J-1&_user=10&_coverDate=05%2F31%2F2007&_rdoc=14&_fmt=summary&_orig=browse&_srch=d&c_info(%23toc%235029%232007%23999379997%23649-654%23FLA%23display%23Volume)&_cdi=5029&_sort=d&_do)

ABSTRACTS IN URGENT CARE

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A total of 383 consecutive patients with suspected acute pulmonary embolism were studied prospectively. Patients underwent multislice computed tomography (MSCT) pulmonary angiography and lower-limb venography, as well as pulmonary scintigraphy and lower-limb ultrasound examination. Patients with negative MSCT results for both pulmonary embolism and venous thrombosis were not administered anticoagulants and were followed up for six months to rule out thromboembolism.

At MSCT, 156 patients were positive for pulmonary embolism, venous thrombosis, or both; 224 were negative; and findings were inconclusive in three. False-negatives included five patients with high probability scintigram and two with venous thrombosis detected at ultrasound. A total of 184 patients with negative MSCT and without anticoagulation were followed up for six months; during that time, just one recurrence of pulmonary embolism was detected.

The negative predictive value of MSCT pulmonary angiography plus lower-limb venography was 95.8% (183/191).

The authors concluded that MSCT is efficacious in diagnosing pulmonary embolism, with negative predictive values reported in the literature ranging from 94% to 100%. This enables omission of anticoagulation in patients with suspected pulmonary embolism after negative MSCT findings without the need for other diagnostic tests. ■

Should Infants with Bronchiolitis Have Chest X-Rays?

Key point: After viewing radiographs, physicians more than quintupled antibiotic use in bronchiolitic patients.

Published in *J Watch Infect Dis* May 2, 2007, <http://infectious-diseases.jwatch.org/cgi/content/full/2007/502/2?q=etoc>

Citation: Schuh S, Lalani A, Allen U, et al. Evaluation of the utility of radiography in acute bronchiolitis. *J Pediatr.* 2007;150: 429-433.

URL: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=17382126&dopt=Abstract

Acute bronchiolitis, characterized by tachypnea, cough, and wheezing, is generally viral. Recommendations for chest radiography vary. Some sources recommend it routinely; others, only in limited situations. Investigators at a Toronto pediatric hospital examined how routine chest radiography influences treatment decisions.

The researchers enrolled 265 infants ages 2 months to 23 months who came to the emergency department with typical presentations of acute bronchiolitis. All were treated with two or three nebulizations of albuterol before undergoing chest radiography. ED physicians were asked both before and

after viewing the radiographs whether hospital admission or antibiotic treatment was planned.

Radiographs were interpreted as simple bronchiolitis (prominent bronchial markings and peribronchial infiltrates, with or without hyperinflation or atelectasis), complex bronchiolitis (airway disease and adjacent airspace disease), or inconsistent with bronchiolitis (lobar consolidation, cardiomegaly, or other incompatible features).

Only two (0.8%) radiographs were read as inconsistent with bronchiolitis, and 17 (6.4%) were classified as complex. Thus, to detect one child with an incompatible chest x-ray or one child with a complex radiograph, 133 children and 16 children, respectively, would have to undergo radiography. ■

Management of Macroscopic Hematuria in the Emergency Department

Key point: In men >60 years, the positive predictive value of macroscopic hematuria for urological malignancy is 22.1%.

Citation: Hicks D, Li C-Y. *Emerg Med J.* 2007;24:385-390.

URL: <http://emj.bmjjournals.org/cgi/content/abstract/24/6/385>

Macroscopic hematuria, which has a variety of causes, is a condition commonly seen in the emergency department. However, most importantly, macroscopic hematuria has a high diagnostic yield for urological malignancy; 30% of patients presenting with painless hematuria are found to have a malignancy.

In men aged >60 years, the positive predictive value of macroscopic hematuria for urological malignancy is 22.1%, and in women of the same age it is 8.3%. In terms of the need for follow-up, a single episode of hematuria is equally as important as recurrent episodes. Baseline investigation in the ED includes full blood count, urea and electrolyte levels, midstream urine dipstick, beta human chorionic gonadotrophin, and formal microscopy, culture and sensitivities.

Treatment of macroscopic hematuria aims at RESP—Resuscitation, Ensuring, Safe, and Prompt. Indications for admission include clot retention, cardiovascular instability, uncontrolled pain, sepsis, acute renal failure, coagulopathy, severe comorbidity, heavy hematuria, or social restrictions. Discharged patients should drink plenty of clear fluids and return for further medical attention if the following occur: clot retention, worsening hematuria despite adequate fluid intake, uncontrolled pain or fever, or inability to cope at home. Follow-up by a urological team should be promptly arranged, ideally within the two-week cancer referral target. ■

Chronic Cough? Consider Pertussis

Key point: At a Tennessee university, 27% of undergraduates with chronic cough had serologic evidence of pertussis.

Citation: Published in *J Watch Infect Dis* April 18, 2007, <http://infectious-diseases.jwatch.org/cgi/content/full/2007/>

Credentialing, Contracting, Coding, Billing/Collection headaches seem to be getting bigger each day?



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Citation: Craig AS, et al. Outbreak of pertussis on a college campus. *Am J Med.* 2007;120:364-368.

URL: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=17398232&dopt=Abstract

Because of waning immunity, adolescents and young adults are at increased risk for pertussis. Presentation is often only a prolonged cough, in which case this diagnosis might not be considered. At Vanderbilt University, an increase in complaints of prolonged cough at the student health service during October and November prompted an epidemiologic investigation.

Thirty-seven students with prolonged cough were prospectively identified over a four-week period; all reported full childhood immunization. Serologic testing revealed evidence of pertussis in 10. These students differed from the 27 without serologic evidence of pertussis only in duration of cough at presentation (38 days vs. 24 days; $P=0.02$) and in total duration of cough (74 days vs. 47 days; $P=0.02$).

Eight of the 10 students with serologic evidence of infection were diagnosed based on a single high pertussis antibody titer. None of the students had a positive nasopharyngeal swab culture or direct fluorescent antibody smear, and only one had a positive PCR result. An e-mail survey sent to a random sample of 500 Vanderbilt undergraduates revealed that 29% had had a cough for >2 weeks during the four-week study period.

This elegantly done study demonstrates the difficulties of recognizing and diagnosing pertussis. All cases were based on serologic evidence—most of them, on a single test. Some of the results could have been false-positive, leading to overestimation of the frequency of pertussis. However, students with positive serologies did have significantly prolonged duration of cough. As the authors note, a booster dose of acellular pertussis vaccine is now recommended for preadolescents, and for adults as part of their routine tetanus/pertussis immunization every 10 years. ■



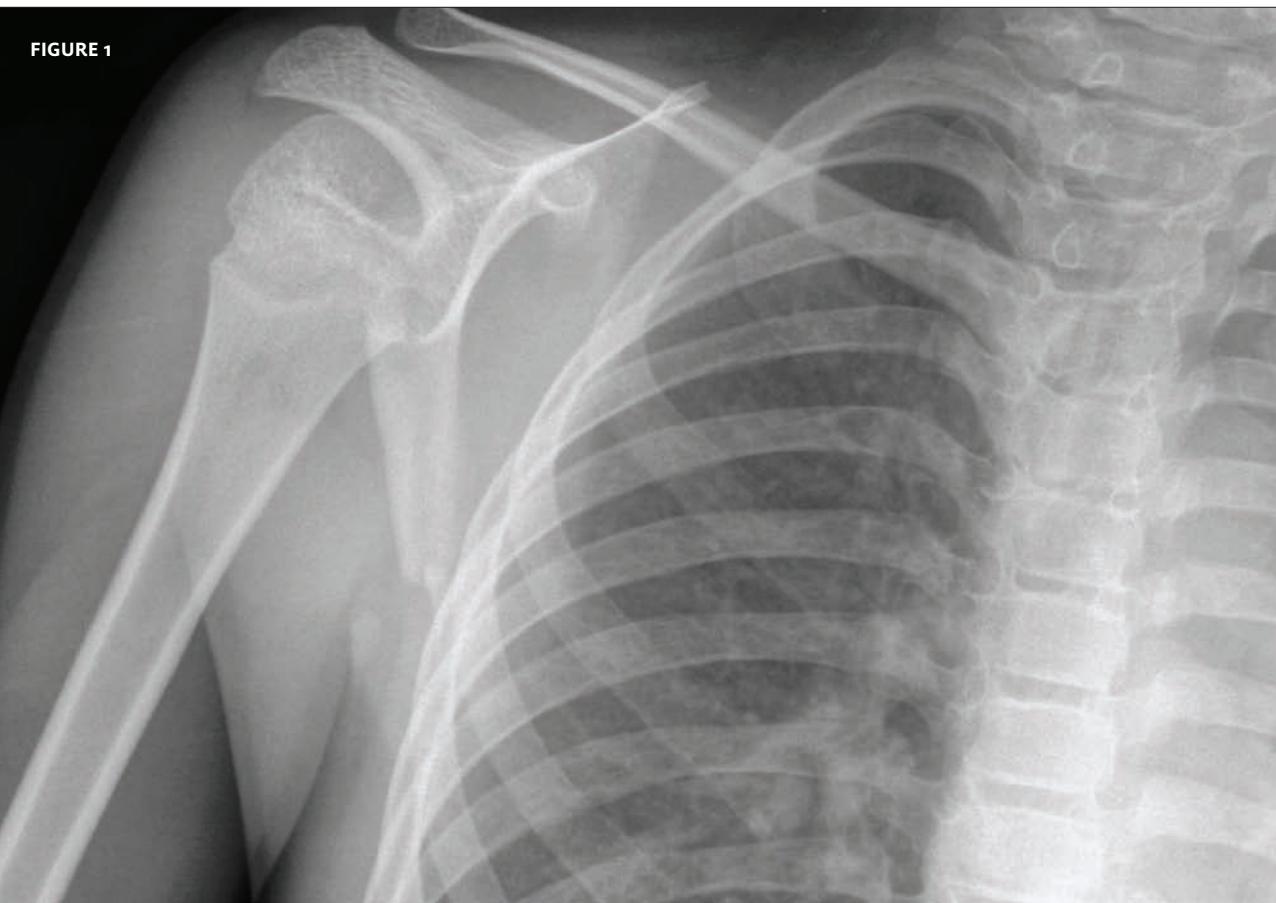
INSIGHTS IN IMAGES

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 9-year-old boy who received a blow to the shoulder from a height of approximately 6 ½ feet. He has limited elevation of the arm due to pain.

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: scapular fracture. The boy was placed in a sling and advised to follow up with an orthopedist the next day.

Due to the nature and location of the injury and the pain the patient was experiencing, a chest x-ray was also taken, but no other injuries were noted.

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



CLINICAL CHALLENGE: CASE 2

FIGURE 1



The patient is an 18-year-old male who jumped or fell from a "short height" but landed hard on his heel. He is able to ambulate, but cannot put any pressure on his heel.

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.

INSIGHTS IN IMAGES: CLINICAL CHALLENGE 2

THE RESOLUTION

FIGURE 2



The image reveals a fracture of the anterior calcaneus.

The patient was placed in a posterior cast splint and advised to follow up with an orthopedist the following day.

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



Readers' Coding Inquiries

■ DAVID STERN, MD, CPC

Q. I had a patient who presented with a hydrofluoric acid burn to the fingertips—right hand worse than left.

First I had to acquire some calcium gluconate gel. I applied this to all of his fingertips for 30 minutes, and it helped a little. I proceeded with a modified bier block with calcium gluconate. I applied a BP cuff tourniquet to his arm, and then injected Ca gluconate intravenously. The blood pressure cuff remained fully inflated for 20 minutes. He remained on an ECG monitor during this procedure. This reduced his swelling and decreased his pain some, but not completely.

I sent him home with his hands in latex gloves holding Ca gluconate paste over all his fingertips, and I will see him again tomorrow.

How would you code this visit?

- Question submitted by Marshall Plotka, MD,
Phoenix Emergency Care

A. This is a great coding conundrum, and a classic case in which correct coding can maximize revenue.

Here are some ideas for coding this visit:

Ca gluconate paste application and dressing: One cannot use the code for treatment of a first-degree burn (16000), as this code is specifically limited to situations in which "no more than local treatment is needed." (Note: If you do perform repeat dressings, you could code future visits with 16000.) The appropriate code in this case, however, is 17999 (unlisted procedure, skin, mucous membrane and subcutaneous tissue).

When billing an "unlisted procedure," make sure that you include documentation of the procedure, time spent, and any difficulties or complications. You could price this code similarly to your fee for 16000.



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.

IV drug push: Code with 90774 (therapeutic, prophylactic, or diagnostic injection—specify substance or drug); intravenous push, single or initial substance/drug).

Ca gluconate IV: Code with J0610 (calcium gluconate, up to 10 ml); code once for each 10 ml or fraction of 10 ml.

Bier block: Code with 64999 (unlisted procedure, nerve). CPT 2007 has been revised to state, "When regional intravenous administration of local anesthetic agent or other medication in the upper or lower extremity is used as the anesthetic for a surgical procedure, report the appropriate anesthesia code. To report a Bier block for pain management, use 64999."

Again, when billing an "unlisted procedure," make sure to include documentation of the procedure, time spent, and any difficulties or complications. Note: Fees across the country seem to range from \$180 to \$230.

E/M: Document and code the appropriate evaluation and management (E/M) code (99201-99215). If more than half of your time involves counseling the patient about the treatment and prognosis, you may consider time as the determining factor in determining the appropriate E/M code.

This is particularly appropriate in the setting of worker compensation claims, as you will need to investigate and document the circumstances of the injury, determine if the patient is predisposed to complications due to factors such as diabetes or smoking, evaluate the viability of the extremity, discuss your findings and recommendations with the workplace, and spend a significant amount of time reviewing the prognosis and treatment of the injury with the patient.

Don't forget to add modifier 25 to the E/M code, as you have performed a procedure along with the E/M code.



CODING Q & A

EKG monitoring: Code with 93040. Make sure that you document your reading(s) and include a sample tracing in the medical record.

Q. We recently saw a patient for severe constipation. The physician performed a manual fecal disimpaction—a time-intensive procedure. I looked for a code to charge out for the procedure, but all I could find was an anesthesia code for the procedure. Is there a code for the actual procedure? I would hate to think the doctor did this for free.

- Question submitted by Jennifer Halloway,
Physicians Immediate Care

A. There is no specific code for a manual fecal disimpaction. The Centers for Medicare & Medicaid Services (CMS) considers the procedure, although sometimes necessary and always quite time-intensive, to be bundled into the evaluation and management code. However, there are codes for much less time-intensive procedures, such as intramuscular injections.

If you want to try creative billing for the procedure (only for payors not directly regulated by CMS), you could code 45999 (unlisted procedure, rectum) along with a doctor's procedure note describing the procedure, difficulties, and time spent. The payor may consider it and pay, but don't hold your breath.

Q. Am I correct in billing with a place of service (POS) 20 for an urgent care setting? I have heard that in Texas we should bill with a POS 11.

- Question submitted by Celeste Ladyman, Valley Urgent Care

A. The answer really depends on the payor that you are billing and how the payor has set you up in its software.

If you are contracted with a managed care organization as an urgent care center, it may require you to use POS 20; claims filed with POS 11 may be rejected.

Payors with whom you have contracted as a family practice may reject claims filed with POS 20.



The key is finding what each payor requires, but there is no blanket answer for any state or even by payor, as there may be many contracts, even for the same payor. What is really frustrating is that sometimes urgent care centers find that they ask the payor which POS to use and the provider representative gives them the wrong answer.

"In most states, NPs should be able to see and bill for new patients."

Q. As a nurse practitioner, I have been seeing Medicare patients for the past year or so and I have never received a Medicare UPIN number. If we are to follow the guidelines set by Medicare, is it legal to bill Medicare for my services since I am a nurse practitioner and am supposedly not allowed to see new patients? They have never explained this to me. Is there a special rule for urgent care?

- Name withheld by request

A. Unless there are specific regulations to the contrary in your state, nurse practitioners should be allowed to see new patients and bill under their own number, but never under the supervising physician number.

An exception occurs when the chart demonstrates that the physician physically examined and designed a treatment plan for the patient. Then the visit may be billed under the physician number. In the situation that you describe, however, there is no compliant method to bill Medicare visits.

Established patients seen under the incident-to requirements of CMS (a very rare occurrence in most urgent care centers) may be billed under the physician number. All other established patient visits (those that do not meet incident-to requirements) should be billed under the nurse practitioner's number.

Note: As of September 30, 2007, National Provider Identifier (NPI) should be used instead of the UPIN to bill for services rendered. ■

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Have a coding question?

Send it to us at editor@jucm.com.
We will compile relevant queries and forward them to Dr. Stern to be addressed in upcoming issues of *JUCM, The Journal of Urgent Care Medicine*.
Please include your name and practice affiliation.



Test the Waters Before Signing an Employment Contract

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

It sounded like a great job. You saw the ad in the back of *JUCM* and contacted the person listed at the bottom. He seemed pleasant enough on the phone and the pay was what you thought was the market rate for the area.

The next day, you drove over for the interview, which consisted of only four questions (the first being "If you were a tree..." and the last being "When can you start?"), toured the center, and signed the employment contract over lunch at the Arby's with the retail clinic inside.

Are you beginning to hear the music from *Jaws*? You should be! If a scenario like this has already happened to you, don't feel badly because you are a member of a large club which most of us have already joined once or twice.

Let's face it; we are victims of our own success. If you have gotten this far in your career, it is fair to say that you are very bright and are used to making critical, even life-and-death decisions at a moment's notice. Thus, consulting a lawyer to read a bunch of words on a contract seems like a waste of hard-earned money. Right?

Let's look at the corollary, though: If you were a lawyer would you trust yourself to diagnose your child's abdominal pain? I rest my case.

Lawyers who have experience reviewing physician contracts are trained to interpret, as a court would, seemingly innocuous language, spot the loopholes and ambiguities, and to know what terms should be included in the contract but aren't.

When a patient shows up with a large fungating mass growing out of the side of his neck with a cigarette dangling from his lips, what is the first thing that goes through your mind (other than please put the cigarette out)? It's probably, "Why on earth did you wait so long?"



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.

It is the same in the legal world. The time to consult an attorney is before you sign or agree to sign anything. This includes letters of intent, an e-mail with a multi-bulleted job description, or anything else which may bind you in the future. Once you have narrowed it down to one or two offers, consult your attorney to help you review the offers and contracts.

Spending Wisely

Let's change paradigms for a moment.

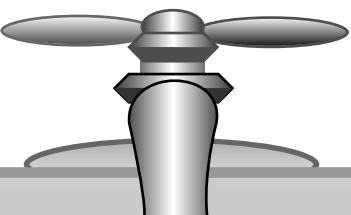
If you were paid by a health plan based upon how much time you spent with the patient, do you think efficiency would matter as much to you? Most attorneys are paid on an hourly rate unless you can find one that will review your contract on a flat rate basis. The time and money spent reviewing a contract is well spent.

However, you do not need an attorney to *negotiate* your contract. The fear, of course, is that your five-page contract negotiation will turn into a protracted AFL-CIO management dispute and that before you know it you will be out thousands of dollars.

Trust me, no owner wants to talk to a prospective provider's attorney. Learn what you need to know about the changes you are requesting and sit down face to face, if possible, with the manager or owner. You will earn her respect, forge a relationship, and simply elevate yourself in her eyes.

Think of researching a job as akin to taking the history on a 40-year-old mute patient with chronic fatigue syndrome, migraine headache, and fibromyalgia: It is not easy and it is certainly not quick.

At the same time you are looking for the perfect job, you may also be relocating, taking boards, finishing training, etc. It is easy to understand how someone with limited time would focus only on pay rate and time off. Before you interview, though, you should spend considerable time researching the market, the demand for providers, approximate salaries, malpractice rates, managed care penetration, and provider migration.



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HEALTH LAW

Once you have a few potential targets identified, talk to as many people as you can about the group or practice. Pretend you are a patient and "secret shop" them. (One important safety tip however: you may not want to pretend you have an STD for obvious reasons.)

"It is rare that the first contract offered will be the best possible one."

Anyway, during your interview, observe everything you can and ask the tough questions:

- What is the physician turnover rate?
- Why are physicians leaving, if there is turnover?
- What is the group's malpractice history?
- What does the practice do to ensure quality and customer service?
- What electronic medical records system does the group use?
- Does the practice have any pending or past compliance issues?
- Is the practice profitable?
- Are you able to meet with other physicians in the group and spend some time observing the culture? This will also allow you to observe how the office and support staff is treated by the owner/manager.
- What is the reputation of the practice in the medical and lay community?
- Do the physicians and staff seem tense, overworked, or harried?

Once you are done with the interview and have observed everything you can, do not commit either orally or in writing. Thank them for their time and let them know you are seriously considering the offer and will be back to them in a defined time frame. Ask who you should contact if you have additional questions. Use this time to work with your attorney to review the contract and to continue to gather information.

It is rare, except in large groups, that the first contract offered will be the best possible one. In some large groups with many providers, the manager will probably not be in a position to make any substantive contract changes since the provider contracts need to have some degree of continuity.

That said, in those groups the contract has probably been "cleansed" so thoroughly by your predecessors that it is equitable from the start. However, do not rely on others; have it looked at by your attorney as well.

In the next issue, we will review certain clauses which can bite the unwary physician much like the first scene in *Jaws!* ■



Choose Words Carefully in an Occupational Health Sales Call

■ FRANK H. LEONE, MBA, MPH

The art of using the “right” words and avoiding words that tend to harm one’s sales effort is undervalued.

Consider these recommendations:

Use strong, descriptive, positive words. Your choice of words should reflect the image you wish to portray of your urgent care clinic, and the attributes that go along with such an image (e.g., energy, confidence, focus, and warmth).

How about asking your staff to list the 10 words that reflect the most positive things about your clinic and then make a composite of those words? Then emphasize these words when communicating with prospects or clients.

Avoid weak, ambiguous, and negative words. Negative words tend to filter into many sales calls. Avoid words that might be construed as negative, critical, or that suggest lack of confidence in your clinic’s abilities. It is far better to be silent than to introduce a negative.

Use euphemisms to convert negatives to positives. Negative issues can easily be converted to positives, provided you take the time to consider the conversation in advance. For example, “problem,” should become “opportunity.” Or, “your injury rate is too high,” becomes “if we can help bring your injury rate down to historic levels for your industry, it would lower your workers’ comp costs.”

Reflect the word choice of the other party. If “one man’s meat is another man’s poison,” then “one man’s words are another man’s meaningless phrases.”

In short, certain words resonate well with some and other words resonate better with others. Encourage prospects to discuss their needs, wishes, and fears. Listen carefully, taking care to note their choice of words, especially

those they use frequently. Reflect positive words back verbatim and convert negative words into meaningful euphemisms.

Qualify, always qualify. Short of mathematical certitude, nothing is “certain” and the word “never” covers a mighty long time. As a consultant, I wish to project an image of humility and be covered for the inevitable times that I miss something or offer a recommendation that is not necessarily viable. Pepper your written and oral suggestions with phrases such as “in my opinion,” “it seems to me,” and “if I were you I would....” Conversely, avoid such phrases as “you must....”

Keep coming back to your competitive edge. Your most important words are the words that succinctly describe your competitive edge, i.e., what sets your clinic apart. Synthesize each competitive edge down to a word or two and find a way to repeat those words often. Viable, competitive edge words include “experience,” “locations,” and “proven outcomes.” If your program has “the Edge,” don’t be shy about repeating the word/phrases—over and over and over again.

Never promise. Cost savings and return on investment are critical to employer clients and prospects. Therefore, it becomes tempting to “promise” specific savings or a projected return on investment using unrealistically high or arbitrarily developed numbers.

Any statement regarding cost savings or return on investment should be to the point but not so specific that your prospect will have unrealistic expectations or think you are offering a guarantee.

For example, instead of making risky predictions like “we should be able to reduce your costs by 20%” or “we will provide you with a positive return on investment,” simply tell your client, “I am confident that our clinic’s management of your employees’ health will help you reduce unnecessary costs and result in a positive return on investment.” ■



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.



RULES & REGULATORS

News from Federal Health and Medical Agencies

CMS to Make Coverage Determination on CTA

The Centers for Medicare & Medicaid Services (CMS) is considering whether a national coverage determination is warranted for computed tomographic angiography (CTA) to diagnose coronary artery disease.

The agency will also consider coverage with evidence development, it said.

Proponents say the use of cardiac CTA will lead to better health outcomes and a reduction in cardiac catheterization, the current standard for diagnosis of coronary artery disease, according to the CMS. But the agency said it is concerned about the procedure's rapid adoption despite the lack of evidence demonstrating improved patient health outcomes.

The public has until July 13 to submit comments on the agency's national coverage analysis on the use of CT for angiographic study.

CTA is a noninvasive method, using intravenous contrast, to visualize the coronary arteries (or other vessels) using high-resolution, high-speed CT, the agency said. CTA, which includes helical (spiral) CT and multislice CT angiography, has potential uses as a substitute for invasive coronary angiography and for evaluation of chest pain in the urgent care or ED setting. ■

FDA Accepting Comments on Electronic Collection of Adverse Event Forms

The FDA has announced a public comment period on the continuation of a pilot project evaluating the electronic collection of the 3500A form for device adverse events. The project is intended to obtain data from user facilities participating in the Medical Product Safety Network (MedSun).

Additionally, the electronic form will include hospital profile information and several other questions related to the use of medical products. A portion of the MedSun software, called Device Safety Exchange, is a moderated site on which MedSun members may share information with each other.

Written comments must be submitted by Aug. 13. Submit electronic comments on the collection of information to www.fda.gov/dockets/ecomments. ■

Online Database of Bioequivalence Study Guidelines Considered

Information on designing bioequivalence studies for various types of products would be available online under a draft guidance issued by the FDA's Office of Generic Drugs.

To receive approval for an abbreviated new drug application (ANDA), a generic drugmaker must prove that the generic product is absorbed at the same rate as the comparator drug (bioequivalence), according to the FDA.

Currently, drugmakers can submit requests for assistance in bioequivalence study design to the Office of Generic Drugs, and the agency responds to individual companies in written form, according to the guidance.

In addition, the FDA recently published a report detailing many of the scientific issues that impede the development of generic drugs, including the need for improved bioequivalence testing methods. ■

Security Update Part of Fed Agenda

The federal government is getting ready to tighten the HIPAA security rule in the wake of several incidents of compromised patient data involving laptops and other mobile computing devices.

The Centers for Medicare and Medicaid Services expects this month to propose a rule "intended to provide a more prescriptive set of remote security requirements designed to reduce the likelihood of unauthorized uses and disclosures of sensitive health information," according to a notice published in the *Federal Register*.

The notice is the Department of Health and Human Services' semi-annual agenda identifying regulatory actions it intends to take. Deadlines for anticipated action are not always accurate. The regulatory agenda, however, gives a look at what issues are getting attention in the department.

Amendments to the HIPAA security rule are one of at least a dozen upcoming regulatory actions of interest to the healthcare information technology industry.

The complete regulatory agenda in the *Federal Register* is available at gpoaccess.gov/fr/index.html. ■

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."



Carolina's Healthcare System

BC Physicians needed for our expanding network of existing and new Urgent Care facilities throughout the Charlotte, North Carolina area. All facilities are out-patient only, open 8am-8pm, 7 days/week and have no-call. Openings are employed positions with attractive compensation and benefits.

For more information about opportunities, please contact:

Sarah Foster, Physician Recruiter
800-847-5084 • Fax: 704-355-5033
sarah.foster@carolinashalthcare.org
www.carolinashalthcare.org/careers/physicians

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.

OHIO – OUTSTANDING OPPORTUNITY in a unique program! Well-known and respected health system with top academic affiliation seeks family medicine physician—ER/urgent care experience required. Teaching opportunity available in pioneer fellowship program. Competitive salary plus bonus and benefits. Upscale communities in the Cleveland area. Lifestyle opportunity with all the amenities! Contact Linda Jacovino, 800-365-8900, ext. 232; linda.jacovino@comphhealth.com. Ref. #658692

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.

FLORIDA

Excellent Ownership/Partnership opportunities available with a well-established Urgent Care group in Tampa Bay area.

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

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StatClinix Urgent Care, a growing Urgent Care organization in Arizona is seeking experienced Board-Certified UC/FP/ER physicians for current and upcoming Urgent Care Clinics.

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Contact Information:
Mary McGuire at 480-682-4111 or fax CV to 602-926-2628 or email: mary.mcguire@statclinix.com
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HealthServe

Urgent Care Opportunities

HealthServe Medical Group, LLC provides qualified physicians for several Urgent Care facilities located throughout Ohio. We have recently been experiencing rapid expansion and are seeking additional physicians who wish to join us in our growth. We require our physicians to be Board Eligible or Board Certified in the following specialties: Family

Practice, Internal Medicine, Emergency Medicine, or Pediatrics. Physicians must also possess a valid Ohio Medical License as well as a current ACLS Certification. Our physicians enjoy flexible schedules, paid malpractice, and NO CALL COVERAGE. For those that work full time, we offer excellent benefits including health, dental, vision, disability and 401k. Furthermore, we offer a sign on bonus.

Interested physicians, please call or send CV to:

Jillian Oelke
Clinical Recruiter

HealthServe Medical Group, LLC
2939 Kenny Road, Suite 200
Columbus, Ohio 43221
Phone: (614) 442-2431 Ext. 213
Fax: (614) 442-2426
Email: joelke@hserve.com

Memorial

Medical Group[™]

URGENT CARE MEDICAL DIRECTOR South Bend, Indiana

Memorial Medical Group is seeking an experienced **Urgent Care physician** to oversee its three South Bend area "Med-Point", walk-in clinics. This position is responsible for 10 physician FTEs, and consists of approximately 25% administrative time, with the remainder being clinical.

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Pam Buckalew
Telephone: (800) 528-8286, ext. 4102
E-mail: pam.buckalew@stratummmed.com

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Email: lrhines@freemanhealth.com, or fax CV to 417-347-9972

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.

- Full-time and half-time opportunities are available.
- Clinic hours of operation
 - › Mon.-Fri. 6 p.m. - 10 p.m.
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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.



Sutter Health
Sacramento Sierra Region

Physician Recruitment
Sutter Health, SSR
800-650-0625
916-454-6645 fax
develops@sutterhealth.org
www.sutterhealth.org



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- 16 centers and rapidly growing with two to four new centers opening in 2007.
- 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.
- Competitive compensation, productivity bonuses, paid vacations, paid CME and malpractice insurance.
- Excellent benefits' package including health, life and Employer matched 403B

For more information, please call
Timothy Hendrix, MD at (407) 200-2860

EMERGENCY MEDICINE/URGENT CARE WISCONSIN

Marshfield Clinic is directed by 700+ physicians practicing in over 80 specialties at 40 locations in central, northern and western Wisconsin. We are seeking BC/BP Family Practice physicians at the following locations:

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- Ladysmith - Urgent Care
- Marshfield - Urgent Care
- Minocqua - Urgent Care
- Park Falls - Emergency Dept./Urgent Care
- Rice Lake - Emergency Dept./Urgent Care

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Please contact: Sandy Heeg,
Physician Recruitment, Marshfield Clinic
1000 N Oak Ave., Marshfield, WI 54499
Phone: 800-782-8581, ext. 19781
Fax: (715) 221-9779
E-mail: heeg.sandra@marshfieldclinic.org
Website: www.marshfieldclinic.org/recruit

Marshfield Clinic is an Affirmative Action/Equal Opportunity employer that values diversity. Minorities, females, individuals with disabilities and veterans are encouraged to apply.
Sorry, not a health professional shortage area.

Career Opportunities

PHYSICIAN MEDEXQUICK URGENT CARE

MidState Medical Center, a state-of-the-art community hospital serving central Connecticut, has an opening for the right physician in our affiliated urgent care facility. MediQuick sees 19,000 patients per year and has a stable, respected nurse and physician staff and offers strong hospital and director support. Work 2-3, 12 hour shifts/week.

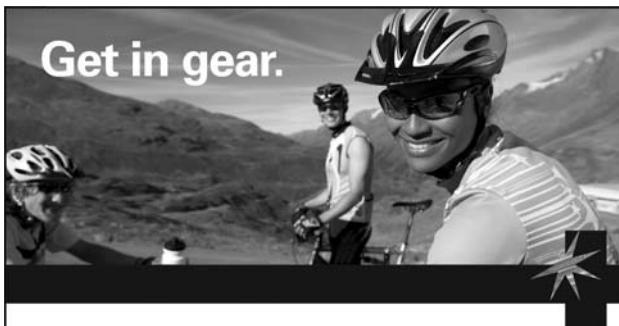
Candidates should be board-certified or Board-Eligible in Internal or Family Medicine.

MidState offers competitive salaries and benefits and is within easy driving distance of Boston, New York City, the mountains, the shoreline and Connecticut's stimulating arts and cultural offerings.

Interested applicants may contact Dr. Fred Tilden, Medical Director of Emergency Services, at 203-694-8278. For more information on MidState Medical Center, and to apply on-line, visit our website at www.midstatemedical.org



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Southern California's leading physician-owned multi-specialty medical group has opportunities for full-time Internal Medicine/Family Practice physicians in our Long Beach and Los Angeles regions. Candidates must be Board Certified, have a current California medical license, DEA current, BLS/ACLS/PALS, suture experience preferred. We are a large, dynamic and well-established group and offer a balanced professional and personal lifestyle, as well as excellent compensation with Partnership Track and benefits.

We have immediate openings for per diem and full-time physicians for a variety of shifts. Our busy Urgent Care Clinic treats patients for anything from a common office visit to an emergency room visit. Our patient population includes children, adults and seniors. We will consider 3rd year/senior residents with letters from residency program chief resident or director approving moonlighting.



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Sdeming@healthcarepartners.com
Reference: ACP
Headquarters is located in Torrance, CA 90502

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FOR SALE- Lansing, Michigan. Busy and very well-established urgent care. Excellent location and reputation. Consistent volume and protocols. Consistent income. Owner would like to retire. Financing is negotiable. Please contact info@redicare.net.

FOR SALE- Urgent Care shares for sale. Has been open for 2 years. Carrollton, Texas. Call 469-222-3630.



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IHA offers a competitive salary and benefit package including:

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Interested individuals may contact:

Arlene Kent, Business Manager
Immediate Health Associates

575 Copeland Mill Road Suite 1D
Westerville, Ohio 43081

Office: 614.794.0481 ext. 100 / Fax: 614.794.3711
akent@ihainc.org



DEVELOPING DATA

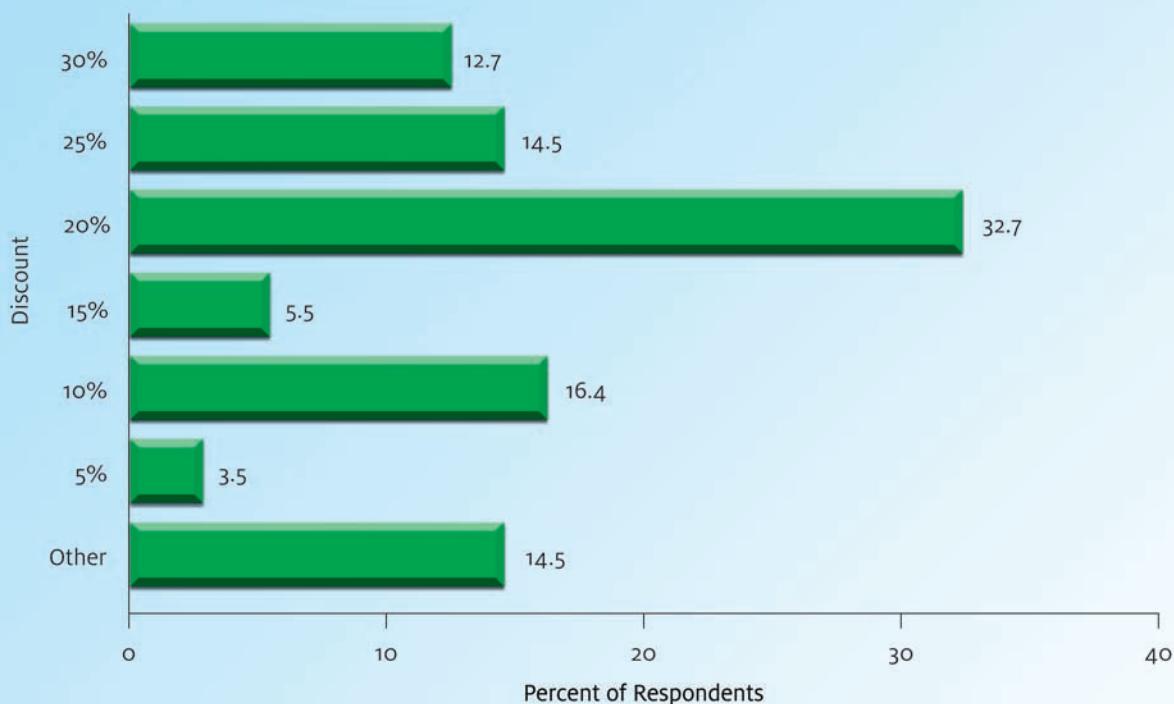
UCAOA's Survey Committee has conducted two annual member surveys, to date, designed to establish benchmarks in an industry for which data have been sorely lacking. Each month in **Developing Data**, we will share one or two tidbits from the second annual survey in an effort to help readers get a sense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

In this issue: How are some clinics employing prompt-pay discounts?

Respondents were split evenly over the question of whether they offer some sort of prompt-pay discount (50.4% do; 49.6% do not). The amount discounted ranged from 5% to 30%, though 14.5% of respondents declined to quantify the percentage by answering "other."

The question of what "prompt pay" really means is open to some interpretation, however; for 83% of respondents, it means immediate payment at the time of service, while 12.9% take a broader view and offer a discount if payment is made within a specified period of time after the patient is billed. The survey did not ask what the range of "specified" time was, however.

PROMPT-PAY DISCOUNTS



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.

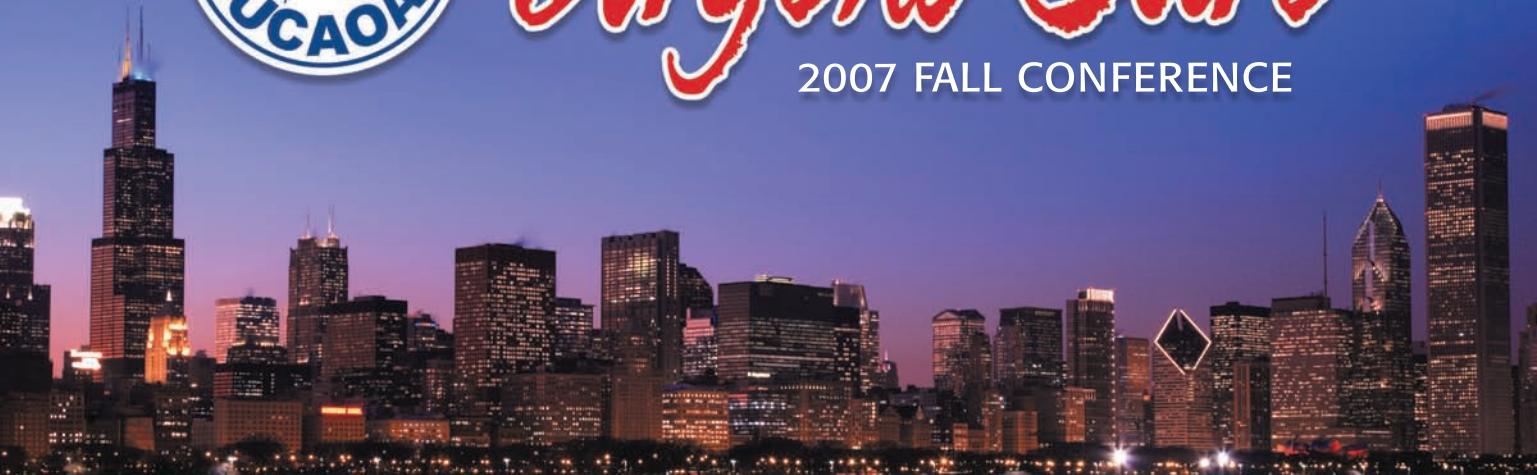
Next in **Developing Data:**

How much time do staff spend with patients?



Urgent Care

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