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Urgent Care Association of America
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Also in this issue



# An Urgent Care Approach to Complications and Conditions of Pregnancy

## Part 2

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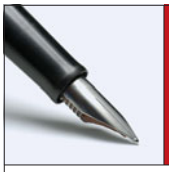
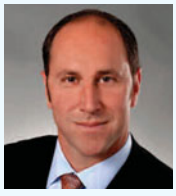


## LETTER FROM THE EDITOR-IN-CHIEF

# What's In a Test? The Psychology of Patient Expectations



The impact of patient expectations and pressures on high utilization rates in this country is a subject of significant discussion but surprisingly little study. A literature review produces scant evidence of scientific inquiry in this area. And yet, most clinicians would say that patient expectations are perhaps an even stronger motivation for utilization than fear of malpractice suits. In an ever-competitive, service-oriented industry like urgent care, this can only be exaggerated. So, what are the underpinnings of patient expectations when it comes to testing? Why are our patients so willing to dismiss the evidence or tilt the decision-making scales in favor of testing? Are there clues in the data that might help reinvent the way we manage patient expectations, or would that be futile, given the vulnerability and irrationality of the human mind?

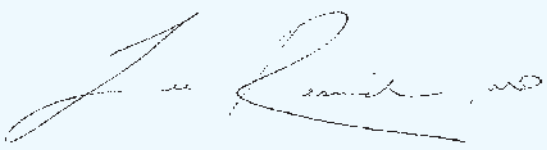
In researching this column, I came across a fascinating study about why our patients are so enamored with testing and convinced of its potential virtues that they ignore any rational discussion to encourage otherwise. Done by researchers at the University of Maastricht, The Netherlands, it involved 224 family practice patients who were questioned about their expectations for testing regardless of the purpose of their visit. A full 26% expected testing regardless of the physician's recommendation. Why? Some of the participants felt that testing was indicated for certain conditions, such as recurrent disease. Others felt that tests were necessary and effective for providing a "certainty of good health." The impact of the media and other social influences was noted, as was the general "appreciation" for the physician who takes an "active policy" in clinical decision-making and testing.

I found that last rationale to be of most interest. It is not lost on me that many of the avoidable "bad outcomes" in medicine are due to tests not ordered and interventions not made. It should be obvious to anyone why patients may feel driven to ensure that they are not victims of these avoidable mistakes. Conversely, little public outcry is ever heard about the risks of over-testing and over-utilization. That topic has been discussed at length within clinical circles but appreciation of the risks has hardly trickled down to patients. It is no wonder, then, that "active" testing is viewed as a favorable physician trait, while conservative approaches are viewed with skepticism.

As a practical clinical matter, the testing paradox is a common daily encounter that creates significant anxiety in both patients and clinicians. The anxiety is only amplified in a brief urgent care encounter between two strangers. Most of my "test heavy" colleagues are deemed "excellent" clinicians and admired by their patients, even when the evidence says otherwise. The productivity demands of the day do not leave room for lengthy conversations with every patient about false-positives and positive predictive values. A real "risk-benefit" analysis is a complex calculation that requires a near instantaneous evaluation of the existing evidence, personal fund of knowledge, and fund of experience. While imperfect, it is what we urgent care providers spend 7 years educating ourselves to do, and years of practice perfecting. Culling that down into 2 or 3 sentences in the hopes of convincing a patient is almost always fruitless.

I have found only one practical way to manage the competing expectations from patients about testing within the scope of daily practice. I present the evidence and "experience-based" case for the direction I would like to take without ignoring a patient's own expectations. With about 80% of patients, a careful review of my clinical decision-making that also addresses any concerns they have expressed or anticipated works. At the end of my clinical decision-making recap, I ask every patient 2 questions: "Does that make sense to you?" and "Does it adequately address the concerns you came in with today?" While most of my colleagues prefer the "don't ask don't tell" approach, I find that most patients are already comfortable with my explanation, and those who are not are worth identifying BEFORE they leave the office. This strategy gives me the opportunity to negotiate a direction that is still clinically reasonable with individual patients while avoiding unnecessary testing for the majority.

Managing patient expectations in a productivity- and service-oriented environment like urgent care remains a daunting challenge, but application of a disciplined, systematic approach can ease some of the burden. Anticipating patient concerns and agendas is a useful way to ensure that you have a fair opportunity to negotiate a clinically reasonable approach to each individual's care without the need for "knee-jerk" testing. ■



Lee A. Resnick, MD
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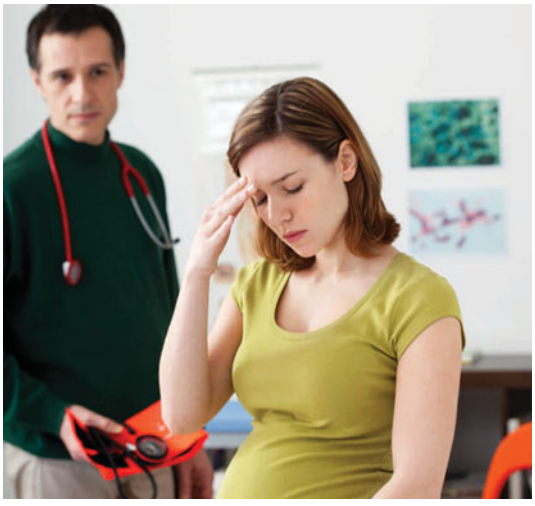

CLINICAL

## 9 An Urgent Care Approach to Complications and Conditions of Pregnancy Part 2

From pregnancy confirmation to the evaluation of bleeding, urgent care centers are often the initial location for management of obstetric-related issues. Careful use of evidence-based guidelines is the key to successful outcomes.

*David N. Jackson, MD, FACOG and Petar Planinic, MD, FACOG*

PRACTICE MANAGEMENT

## 22 Market-Driven, Performance-Based Physician Compensation in Urgent Care

Determining compensation for urgent care physicians is a challenge, particularly given the current health care environment. This article provides guidelines for achieving fair compensation based on reliable metrics and objectivity.

*Richard M. Cameron, MHSA, CMPE and Rick E. Weymier, MBA, FACMPE*

CASE REPORT

## 27 Paraphimosis

Most cases of paraphimosis can be managed in the urgent care setting and prompt treatment is necessary to avoid complications.

*Mohamed A. Fayed, MD*

### IN THE NEXT ISSUE OF *JUCM*

*Over the past 2 decades, multiple studies have shown that when used appropriately, tissue adhesives can produce cosmetic results similar to sutures in treatment of wounds. Next month's cover story looks at advantages and disadvantages of cyanoacrylate for wound closure. Included to help the urgent care provider is information on factors that should influence choice of a wound closure method and proper application of adhesive, as well as tips for troubleshooting and coding for this sutureless method of repairing simple lacerations.*

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

**Affiliations**
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# *JUCM* CONTRIBUTORS


Our series on common pregnancy-related issues in urgent care concludes with this month's cover story, by David N. Jackson, MD, FACOG, and Petar Planinic, MD, FACOG. In it, they provide evidence-based guidelines for management of bleeding in pregnancy, ectopic gestation, trauma in pregnancy, acute abdominal pain in pregnancy, and chronic illness and common medications in pregnancy, including anxiety and depression, asthma, cold symptoms, epilepsy, influenza, preeclampsia and eclampsia, and thyroid disease.

Dr. Jackson is a Professor of Maternal-Fetal Medicine at the University of Nevada, School of Medicine, Las Vegas, Nevada. Dr. Planinic is Assistant Professor of Obstetrics and Gynecology at the University of Nevada, School of Medicine, Las Vegas, Nevada.

Prompt diagnosis and treatment are key to preventing serious sequelae of paraphimosis, as is illustrated in this month's case report. Presented by Mohamed A. Fayed, MD, it details the findings in and clinical pathway for a 29-year-old male with a new sex partner and penile swelling and irritation.

Dr. Fayed is an Assistant Professor at Wright State University/Dayton VA Medical Center, and an urgent care physician at Hometown Urgent Care, both in Dayton, OH.


Authors Richard M. Cameron, MHSA, and Rick E. Weymier, MBA, FACMPE, provide practical advice on the factors that go into determining physician compensation in this month's practice management article. Compensation is a sensitive issue and a challenge but using the guidelines offered here, urgent care providers can approach it with caution, reliable metrics, and objectivity.

Mr. Cameron is Managing Director, Navigant Healthcare, Chicago, Illinois. Mr. Weymier is Chief Administrative Officer, Arlington Orthopedic Associates, Arlington, Texas.

**Also in this issue:**

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses how urgent care providers can help improve safety on the road by becoming involved in federally mandated exams for commercial vehicle drivers. The only requirement to perform such exams is to be a licensed MD, DO, DC, NP, or PA.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for preventive medicine and preventive medicine counseling.

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

## To Submit an Article to *JUCM*

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

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing. The information you provide should be of practical use to our readers, who have come to practice in an urgent care setting from a variety of clinical backgrounds. Your article should take their perspective into account by considering several key issues, such as: What immediate management is indicated? What labs or diagnostics are required? What are the next steps; with whom should the patient follow up? Who should be admitted or referred to the emergency room? Imagine yourself in the reader's shoes and ensure your article includes the answers to questions you'd be asking.

Please send tables, graphs, sidebars (boxes) and digital or film pictures whenever possible. Digital images should be a minimum of 300 dpi. Our readers appreciate well-chosen graphics that add practical value to an article. We prefer that you submit graphics that are original to you, such as x-rays taken as part of your practice. If you wish to use graphics that have previously appeared elsewhere—in print or on the Internet—you must let the editor know. She can write the previous publisher for permission to reuse the material in JUCM. There is no guarantee, however, that the permission will be granted and, if it is not, we cannot reprint the graphics.

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.

## To Subscribe to *JUCM*

***JUCM*** is distributed on a complimentary basis to medical practitioners—physicians, physician assistants, and nurse practitioners—working in urgent care practice settings in the United States. To subscribe, log on to *www.jucm.com* and click on "Subscription."

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# Moving Forward With UCAOA

NATHAN NEWMAN, MD, FAAFP

The coming months will be a challenging yet key time to truly understand how the Affordable Care Act will specifically affect urgent care and what the opportunities are for urgent care providers. That will be true whether you own or work in a 1- or 2-center owned urgent care or a corporate-owned multisite urgent care organization. How will the insurance exchanges, which open October 1st, operate and how will that affect you as a provider and as an employer? Should you participate and how do you do that? Are there differences between the private- and government-owned exchanges? What do the 30 million-plus newly insured patients mean to you and your center? What's up with the SGR? If it's replaced, will we get a full dose of Accountable Care Organizations (ACOs), bundled payments, or value-based programs? Who are the players? What's the risk of participating—or not?

UCAOA is launching a series of tools and resources to help you and your team answer these and other questions and navigate the eventual change. Our HealthCare Reform Educational Resource Program is operational. The first articles and tools became available in August and we'll continue rolling them out as the ACA is more fully implemented.

The Fall Conference in Glendale, AZ, is not like previous such events! We have dedicated a convenient one-day track to take urgent care organization representatives through all aspects of health care reform. We are bringing in DGA Partners—a consulting firm experienced in navigating health care reform—as our personal guide! I am sure you will come away with a better understanding of ACA and how your organization can make the most of the opportunities it represents. It is a unique opportunity to learn everything you NEED to know about health care reform and how it may affect urgent care. Check out the schedule and register at www.ucaoa.org/fall.

The variety of this year's Fall Conference offers an opportunity to spend one day focusing on clinical skills, and a second day increasing your understanding of how important it is to improve patient experience and capture repeat visits. This is a can't-miss event for you, your leadership, and your managers!

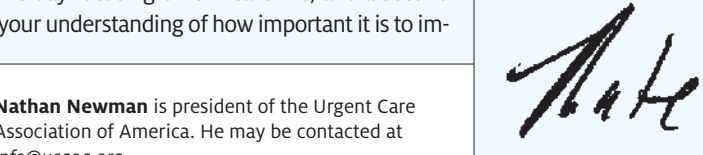
Our Board of Directors recently approved a reorganized and enhanced committee structure to ensure efficiency and collaboration within UCAOA and with external agencies and organizations. This new organizational infrastructure will meet the needs of our growing and dynamic industry, association, members, and centers and support ongoing focused projects—and YOU are the key to its success. The newly revised Member Engagement Committee will help recruit, identify, and match members who want use their interests and talents at the committee level to improve the urgent care industry. A call for volunteers has been distributed and all are invited to submit their names for consideration. To apply, please send a note to our CEO at jray@ucaoa.org.

We have also engaged a health care association consulting group in Washington, DC—Summit Health—to advance our "urgent care message" to our legislators and Capitol Hill advisors. We want to advocate for CMS to more formally recognize urgent care centers as a site of service and to influence federal policies and initiatives to support the delivery of health care services by urgent care centers.

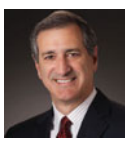
Finally, Reputations Partners, a renowned public relations firm that has worked with many national medical organizations, has begun working with us to design internal and external marketing programs to enhance our urgent care message by updating our website and communications with the general public, patients, vendors and other physicians and medical organizations.

Many teams at UCAOA are focused on delivering great urgent care industry information for you. I look forward to seeing you at our Fall Conference. Register today while there is still space available.

Thanks for your support. ■



Nathan Newman, MD, FAAFP
President, Urgent Care Association of America



**Nathan Newman** is president of the Urgent Care Association of America. He may be contacted at *info@ucaoa.org.*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# An Urgent Care Approach to Complications and Conditions of Pregnancy

# Part 2

**Urgent message:** From pregnancy confirmation to the evaluation of bleeding, urgent care centers are often the initial location for management of obstetric-related issues. Careful use of evidence-based guidelines is the key to successful outcomes.

DAVID N. JACKSON, MD, FACOG and PETAR PLANINIC, MD, FACOG

## Introduction

Urgent care providers are called upon to manage a variety of complaints in pregnancy. Some conditions can be managed at the urgent care center whereas others require stabilization and transport to a center with expert obstetrical capabilities. In all situations, practitioners should consider that a gestational age of fetal viability (many centers now use 23 to 24 weeks) is best served with referral for continuous fetal monitoring if there is bleeding, trauma, significant hypertension, relative hypoxemia ($O_2$ saturation less than 95% for pregnant women), or contractions. Part 2 of this two-part series will discuss:

- Bleeding in pregnancy
- Ectopic gestation
- Trauma and pregnancy
- Acute abdominal pain in pregnancy

**Dr. Jackson** is Professor of Maternal-Fetal Medicine at the University of Nevada, School of Medicine, Las Vegas, Nevada. **Dr. Planinic** is Assistant Professor of Obstetrics and Gynecology at the University of Nevada, School of Medicine, Las Vegas, Nevada.

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

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

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- One tube. One time.
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### PRODUCT APPLICATION[2]

- 10-minute treatment
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## INDICATION

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

## ADJUNCTIVE MEASURES

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

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

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

## IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

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

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

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

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

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

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

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

Sklice® (ivermectin) Lotion, 0.5%

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**Brief Summary of Prescribing Information**

## 1 INDICATIONS AND USAGE

### 1.1 Indication

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

### 1.2 Adjunctive Measures

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

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

## 2 DOSAGE AND ADMINISTRATION

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

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

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

Avoid contact with eyes.

## 4 CONTRAINDICATIONS

None.

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Ingestion in Pediatric Patients

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

## 6 ADVERSE REACTIONS

### 6.1 Clinical Trials Experience

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

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

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

Pregnancy Category C

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

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

Human Data

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

Animal Data

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

### 8.3 Nursing Mothers

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

### 8.4 Pediatric Use

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

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

### 8.5 Geriatric Use

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

## 10 OVERDOSAGE

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

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

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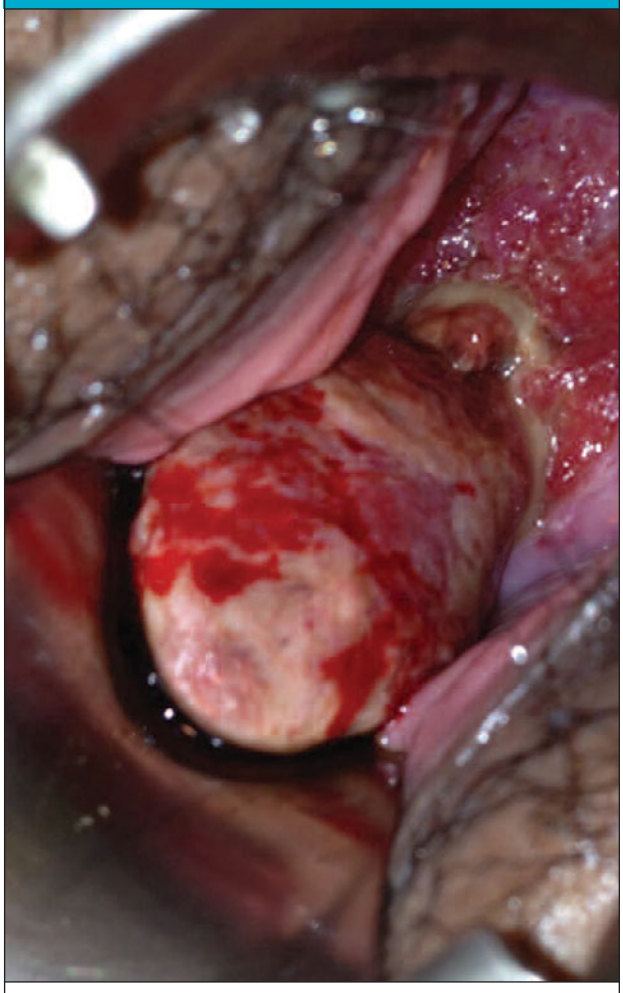
**Figure 1. Bleeding endocervical polyp with inflammation**



Patient was 12 weeks' pregnant with a normal intrauterine gestation.

*Image courtesy of Dr. Arthur Tayengco.*

- Chronic illness and common medications (anxiety and depression, asthma, cold symptoms, epilepsy, influenza, preeclampsia and eclampsia, thyroid disease)
- Bleeding

## Bleeding in Pregnancy

Bleeding in the first trimester is frequent, occurring in 20% to 40% of all pregnancies. Differential diagnosis includes implantation bleeding, threatened to complete abortion, ectopic pregnancy, molar pregnancy, and non-pregnancy sources such as uterine, cervical or vaginal lesions (including inflammation or polyps) (**Figure 1**).

Evaluation of vaginal bleeding should follow a systematic process. History of last menses and sexual activity determines the possibility of pregnancy. Be prepared for potential denial answers regarding pregnancy, ranging from "We've been 'careful'," to "My boyfriend told me he was sterile." A simple rule would be that every reproductive-age woman with new-onset abnormal vaginal bleeding should be offered evaluation for pregnancy. History should especially include the duration and quality of last menses. If menses are regular, ovulation is predicted on day 14 from the first day of the last menstrual period (LMP). Contraception use should be documented, as well as the quantity and quality of current bleeding (including clots or passage of tissue). The passage of tissue suggests incomplete to complete abortion.

Bleeding that occurs "early" in the cycle, (approximately 18-26 days from the LMP), suggests the possibility of implantation bleeding. It is one of the earliest signs of an intrauterine pregnancy. Implantation bleeding occurs 6 to 12 days post-conception and typically presents as spotting, occasionally with cramping.

The pain that occurs with bleeding gives a clinical suggestion as to pregnancy location. Crampy midline or uterine pain suggests intrauterine gestation with threatened abortion. Discrete lateral pain suggests ectopic gestation, ovarian torsion, or degenerating leiomyomata. Shoulder pain suggests intra-abdominal bleeding.

*Laboratory evaluation for first-trimester bleeding.* Initial lab assessment includes complete blood count (CBC), Type & screen and human chorionic gonadotropin (hCG). Preferentially ordering a quantitative hCG is helpful to begin serial evaluation to determine if a gestation is viable. Rh (D) immune globulin should be given to all Rh-negative pregnant patients who are bleeding, regardless of the etiology or gestational age.[1,2] Rh (D) immunoprophylaxis is currently recommended for women with miscarriage, induced abortion, ectopic pregnancy, and other first-trimester bleeding. Referral by an urgent care provider to obstetrics for treatment with Rh immune globulin based on ACOG guidelines is recommended.[3]

*Physical examination for bleeding in pregnancy.* The maternal physical exam begins with vital signs, looking for tachycardia. Orthostatic changes suggest the need for urgent management of hypovolemia. The maternal abdominal exam should document the presence or absence of peritoneal signs, abdominal distention, rectus rigidity and/or rebound. The fundus of the uterus should be palpable above the symphysis if greater than

**Figure 2. Normal multiparous cervix with leukorrhea and bluish hue of "Chadwick's sign"**

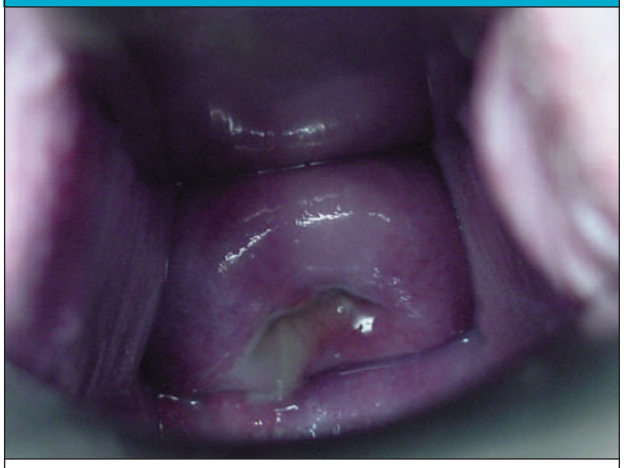


*Image courtesy of Dr. David Jackson*

12 weeks since the last menses. A fetal heartbeat usually cannot be detected until at least 10 weeks of pregnancy by a handheld Doppler. If the patient is overweight, it may be 12 weeks or more before the heartbeat is readily picked up by handheld Doppler.

The external vaginal exam notes the amount of bleeding on the labia and perineum. A speculum exam is mandatory to visualize the entire cervix and vagina. Examples of nonpregnancy bleeding include cervical eversion with friability, cervical infection with inflammation, vaginal and cervical lesions and bleeding tumors such as the bleeding "polyp" seen in **Figure 1**.

Visualize the external os to determine any dilatation and to confirm that the bleeding is originating from within the os. Also determine whether trophoblastic tissue is present (**Figure 2**).

Perform a bimanual exam and gently palpate the uterus and adnexa for size and pain or masses. If an intrauterine pregnancy is confirmed, the following definitions of bleeding in early pregnancy are based upon physical findings:

*Threatened abortion:* Cramping and bleeding without passage of tissue. The cervical os is closed.

*Inevitable abortion:* Cramping and bleeding. The cervical os is open but there is no passage of tissue.

*Incomplete abortion:* Cramping and bleeding with partial passage of tissue. The cervical os may be open or closed.

*Complete abortion:* Bleeding and complete passage of tissue. The cervical os is typically closed.

Spontaneous abortion is often associated with advanced maternal age and/or a history of previous miscarriage. Most spontaneous first-trimester losses are associated with fetal or chromosomal abnormalities.

*Examination of clot or tissues.* One way to determine if a clot contains placental tissue is to suspend the clot in water to look for floating villi. The presence of villi lowers the likelihood of concurrent ectopic pregnancy but it does not prove whether the findings represent a complete or an incomplete spontaneous abortion. *Caution: A "decidual cast" may look like rubbery tissue that has passed. It actually represents decidualized endometrium and correlates with an ectopic pregnancy.*

*Ultrasound evaluation for early pregnancy bleeding.* Transvaginal or transabdominal ultrasound should be considered a standard, not optional, recommendation for emergency and urgent care centers evaluating early pregnancy bleeding.[4] This is especially true when quantitative hCG levels are at least 1500-2000 IU/L. At this "discriminatory level," an intrauterine gestational sac should be visualized. If an intrauterine gestational sac is not seen, work up for ectopic pregnancy must continue. For viable pregnancies, if the gestational sac is 20 mm, a yolk sac should be visualized. If the yolk sac is 5 mm, an embryonic pole should be visualized. If the embryonic pole is 5 mm or greater, an embryonic heart beat should be visualized.

Guidance for centers that currently have to send out β-hCG or that don't have ultrasound machines on-site is problematic. For these centers, it is prudent to suggest immediate transfer for evaluation with ultrasound if the on-site qualitative pregnancy test is positive and the physical exam suggests ectopic gestation.

## Ectopic Pregnancy

Implantation of a developing blastocyst at a site other than the endometrium of the uterine cavity is the most important differential diagnosis an urgent care provider considers in the evaluation of early pregnancy bleeding. Intra-abdominal bleeding from ectopic pregnancy remains a cause of pregnancy-related maternal death in the first trimester. Ectopic gestation occurs in 2% of all pregnancies. The patient should be asked about risk factors including prior tubal surgery, prior ectopic pregnancy, previous salpingitis or pelvic infection, assisted reproduction, infertility history, smoking, and regular vaginal douching.

The most common extrauterine location is the fallopian tube, which accounts for 98% of all ectopic gestations. Symptoms of bleeding, pain or both typically occur 6 to 8 weeks after the LMP. Patients classically present with vague or localized pelvic pain, delayed menses,

and vaginal spotting/bleeding. However, up to 50% of patients may be asymptomatic until tubal rupture occurs. In fact, 10% of patients with ectopic pregnancy have no pain, 21% have no vaginal bleeding, 29% have no tenderness, and 36% have no palpable adnexal mass. Therefore, the modern diagnosis of ectopic pregnancy requires a combination of quantitative assay for hCG and use of high-resolution transvaginal ultrasonography (TVUS). If a true intrauterine sac is identified, the patient should be managed the same as for a threatened abortion and referred for repeat quantitative hCG in 48 to 72 hours. If no intrauterine sac is seen, an ectopic pregnancy should be suspected, especially if hCG is greater than 1500 to 2000 IU/L. This management requires coordination between imaging and lab analysis. Both must be timely and have opportunity to follow up.

### Counseling on First-Trimester Bleeding and Miscarriage

The outcome of ongoing pregnancies with first-trimester threatened abortion is reassuring. Saraswat and colleagues confirmed there is no increase in chromosomal or congenital defects when pregnancies survive early bleeding.[5] However, patients with first-trimester bleeding and ongoing pregnancies are more likely to experience preterm premature rupture of membranes (OR 1.78), preterm delivery (OR 2.05), and intrauterine growth restriction (OR 1.54). To date, there are no prospective interventions that reduce these complications.

*What is the cause of the bleeding?* When miscarriage occurs, patients want to know the etiology. As much as feasible, patients should be reassured that personal issues such as stress, not eating correctly, poor sleep, anxiety, and intercourse do not cause miscarriage. For isolated first trimester loss in which the fetus does not form (anembryonic pregnancy) or does not continue development, chromosomal syndromes are the most likely cause of the loss. If possible, sending products of conception for chromosomal analysis is helpful in future counseling. It is prudent to recommend follow-up counseling with an obstetrical specialist to provide post loss consultation.

### Second- and Third-Trimester Issues: Maternal Positioning

Vena caval obstruction by the uterus decreases preload and can initiate maternal hypotension. Uterine blood flow is not auto-regulated, therefore, a decrease in maternal systolic blood pressure can cause a significant fall in uterine blood flow. A pregnant patient on her back may have sweating, dizziness and hypotension that resolve when she is turned on her side. Prevention begins with positioning all pregnant patients on a rolled-up towel or wedge under the right hip at least 15 degrees. This "left tilt" decreases vena caval obstruction.

### Trauma and Pregnancy Outcome

Trauma complicates 6% to 7% of all pregnancies. Pregnant patients who suffer major trauma will likely bypass an urgent care center, but those with minor trauma may be seen. Data on management of minor trauma in pregnancy are limited and conflicting.[6] Reports indicate that fetal demise or premature births are increased after even minor trauma to a pregnant patient.[7] Monitoring of a viable pregnancy after trauma is typically recommended for 4 to 6 hours. Lab assessment requires CBC, blood type with Rh status, and possibly the Kleihauer-Betke test to determine fetal to maternal bleeding. Any post-trauma patient with symptoms of bleeding, uterine tenderness, contractions, or pain should be referred to a center with obstetrical delivery capabilities for prolonged monitoring and evaluation of possible placental separation (abruption).[8] Patients complaining of unusual falls or seen recurrently for pain should also be screened for abuse and domestic violence.[9]

### Abdominal Pain in Pregnancy

Pain in pregnancy should be categorized as acute or chronic, with or without bleeding, and with or without associated renal or gastrointestinal symptoms. The typical differential includes appendicitis, cholecystitis, fibroid degeneration, adnexal cysts with or without torsion, spontaneous abortion, ectopic pregnancy, amnionitis, and placental abruption. Although rare, ovarian vein thrombosis needs to be considered for acute right-sided pain, especially in postpartum patients.

*Acute appendicitis* is the most common surgical complication of pregnancy. It is often suggested by symptoms that initially are confused with pyelonephritis. Shielding of the inflamed appendix by an enlarged uterus may lead to delayed diagnosis, and appendiceal rupture at the time of surgery is more common during pregnancy.

The primary clinical symptoms of appendicitis in pregnancy include decreased appetite, nausea with vomiting, and fever. The focal abdominal pain location will depend on gestational age, and typically rises with the enlarging uterus. Classic signs such as rebound tenderness and leukocytosis may be delayed or absent. Referral for potential surgery is required as soon as a clinical suspicion of appendicitis is developed.

*Acute cholecystitis* is the second most common surgical complication of pregnancy. Pain is typically upper-right-sided or epigastric. Cholelithiasis is present in 90% of pregnant patients with acute cholecystitis. Elevated white blood cell count, elevated serum amylase, and hyperbilirubinemia are typical. Diagnosis requires ultrasound confirmation. The pregnancy-related differential includes severe preeclampsia, acute fatty liver, and placental abruption. The non-pregnancy differential includes pancreatitis, acute appendicitis, and right-lower-lobe pneumonia. Referral for inpatient observation, conservative intravenous therapy, and potential surgery is required.

*Adnexal torsion* is typically acute and localized to one side of the abdomen. On ultrasound, an adnexal mass without adequate blood flow to the ovaries can be visualized. Complications include peritonitis and preterm labor. Surgical management is indicated for patients with signs of acute abdomen.

*Degenerating leiomyomata* in pregnancy presents as focal, severe, point tenderness. Contractions may be an initial symptom. Imaging is required to confirm the presence of the leiomyomata at the site of a patient's pain.

### Common Medications in Pregnancy

Urgent care centers may make the initial diagnosis of pregnancy. Because urgent care practitioners may be asked by pregnant patients for advice regarding continuing chronic medications, they should be aware of which medications are safe in early gestation. An alphabetized list based on diagnosis is included below and **Table 1** provides a summary on common medications in pregnancy.

*Anxiety and depression.* Initial treatment of anxiety and depression in pregnancy should include expert assessment, psychotherapy, or a combination of psychotherapy and lowest-effective-dose pharmacotherapy. The best medications for anxiety and depression in pregnancy are now controversial, as recent data suggest an increased risk of fetal problems with selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs).

Antidepressants are generally category C drugs; bupropion is category B. Paroxetine exposure during the first trimester has been associated with an increased risk of birth defects.[10] Patients who use SSRIs after the 20th week of pregnancy are 6 times more likely to have persistent pulmonary hypertension.[11]

In general, tricyclic antidepressants have increased risk over SSRIs, MAOIs should not be used during pregnancy, and benzodiazepines should be avoided in the first trimester.

*Warning: Women on antidepressant treatment are 5 times more likely to relapse into major depression during pregnancy if their antidepressant medications are stopped.[12] Referral for cognitive-behavioral and interpersonal supportive therapies that involve the family is critical if a patient's medications are discontinued in pregnancy.*

All antidepressants have been shown to be present in breast milk, but sertraline, paroxetine, and nortryptyline are preferred antidepressant treatments in breastfeeding mothers because they result in the lowest drug levels in infants.

*Asthma.* Along with influenza and bronchitis, asthma is a common urgent care issue.[13] Evaluation and treatment in pregnant patients does not differ significantly from that in non-pregnant patients. Typical regimens are short-acting inhaled beta$_2$-agonists, such as albuterol for rescue therapy, and inhaled steroids for maintenance therapy. Although use of fluticasone use is common in women with asthma who are not pregnant, budesonide and beclomethasone are considered the inhaled steroids of choice during pregnancy according to guidelines from the American Congress of Obstetricians and Gynecologists (ACOG). They are the two medicines that have been most studied during pregnancy.[14]

Urgent care providers managing upper respiratory infections or complicated asthma in pregnancy may be overly concerned about fetal risks associated with chest x-rays. ACOG Guidelines place a limit for maximum elective cumulative fetal dose at 5 rad (1 rad = 1000 mrad =10 mGy = 0.01Gy). A two-view shielded chest x-ray delivers only 0.00007 rad. Therefore, a pregnant patient would have to undergo 71,429 exams to reach

**TABLE 1. Quick Review of Medications in Pregnancy**

| Medication | Potential Effects in Pregnancy |
|---|---|
| *Antibiotics* | |
| Ciprofloxacin | Joint abnormalities |
| Chloramphenicol | Gray baby syndrome; hemolysis in women or fetuses with G6PD deficiency |
| Nitrofurantoin | Hemolysis in women or fetuses with G6PD deficiency |
| Sulfonamides (sulfa drugs) | Jaundice and increased risk of brain damage from kernicterus, particularly when used during the third trimester |
| Streptomycin | Ototoxicity resulting in deafness |
| Tetracycline | Slow bone growth; teeth discoloration; increase cavities in newborn |
| Trimethoprim | Blocking of action of folic acid, a vitamin important in prevention of NTDs; linked to increased incidence of NTDs if used in the first trimester |
| *Antihypertensives* | |
| ACE inhibitors | Maternal hyperkalemia, fetal renal dysplasia with anuria and craniofacial abnormalities, skull ossification defects. ACE inhibitors in the second or third trimester have caused renal dysfunction in a fetus, leading to oligohydramnios from anuria. ACE inhibitors have been associated with pulmonary hypoplasia from oligohydramnios, growth retardation and hypoplasia of the fetal skull. Also risk of maternal hyperkalemia. |
| Alpha methyl dopa (Aldomet) | Coombs positive hemolytic anemia/hepatitis |
| Atenolol (Tenormin) | Risk of IUGR, neonatal bradycardia |
| Hydralazine (apresoline) | Lupus-like syndrome (maternal), maternal tachycardia, neonatal thrombocytopenia |
| Hydrochlorothiazide | Sodium diereses with volume depletion = low maternal electrolytes, neonatal thrombocytopenia |
| Propranolol hydrochloride | Risk for IUGR, neonatal bradycardia |
| *Antiepileptics* | |
| Carbamazepine | Facial defects, NTDs, hypoplastic distal phalanges |
| Phenobarbital | Neonatal coagulopathy, neonatal withdrawal |
| Phenytoin | Facial clefts, nail hypoplasia (distal phalanges), hypertelorism, neonatal coagulopathy, growth and developmental retardation |
| Trimethadione | Developmental retardation, dysmorphic facial features |
| Valproic acid | Facial defects, NTDs |
| *Other* | |
| Isotretinoin (Accutane) | Pregnancy loss, hydrocephalus, other CNS (microcephaly, retina, optic nerve abnormal), craniofacial (microtia, anotia, cleft palate), thymic hypoplasia, conotruncal heart defects |
| Lithium | Possible cardiac anomaly |
| Warfarin (Coumadin) | Anticoagulant. Primary effect is in the axial and appendicular skeleton. Exposure during early pregnancy may result in nasal hypoplasia, stippling of secondary epiphysis, IUGR, and mental retardation. Exposure in late pregnancy may result in CNS bleeding. Elective cesarean to avoid neonatal ICH if mother is on warfarin at delivery. |

CNS = central nervous system; ICH = intracranial hemorrhage; IUGR = intrauterine growth restriction; NTD = neural tube defect

the cumulative 5-rad dose limit.

*Chronic hypertension.* Antihypertensive monotherapy is typically begun when a patient's systolic blood pressure (BP) is greater than 160 mm Hg and/or diastolic BP is greater than 105 mm Hg. If there is risk of maternal end organ damage, we prefer an upper limit of 140/100 to begin therapy. Referral to obstetrics for treatment is appropriate.

*"Cold" symptoms.* Symptomatic relief of rhinitis, sneezing, cough, and throat pain can be attempted

with acetaminophen, pseudoephedrine, nasal spray, and chlorpheniramine. Because of the theoretical risks, recommendations are to avoid oral decongestants in the first trimester unless benefits are balanced by theoretical risks of rare birth defects. [15,16] Any pregnant patient who has an upper respiratory infection that lasts more than 7 days should be evaluated for bacterial infection or influenza.

*Dental care.* Cavities or infection in pregnant patients must be treated. Cephalosporin and penicillin-based antibiotics are safe to use during pregnancy. Local anesthetics and short-term use of opioid analgesics are also appropriate. *Pregnant patients should not be prescribed prolonged antiprostaglandin medications for pain or inflammation because of the fetal renal effects and risk of ductus arteriosus constriction.*

*Epilepsy or status epilepticus.* Many patients have increased seizure frequency in pregnancy because of stopping medications or taking medications at subtherapeutic dosages. Concerns are typically over medication-induced fetal embryopathy. The highest risk is with valproic acid (especially if >1100 mg/day) and poly-drug therapy. Lamotrigine may have the safest fetal profile.[17] Recurrent seizures in a pregnant patient that result in hypoxia may have a greater negative impact than the potential teratogenic effects of antiepileptic drugs. Therefore, monotherapy at the lowest dose needed to control seizures is recommended.

Status epilepticus is treated with diazepam at 1 mg/min, or up to 250 mg of sodium amobarbital, slowly administered IV. Phenytoin and phenobarbital also can be safely used to prevent recurrent non-eclamptic seizures in a pregnant patient. However, IV magnesium sulfate should be immediately used to prevent recurrent seizures associated with eclampsia.

## Influenza Vaccine and Treatment

Along with asthma, influenza is one of the most common respiratory conditions complicating pregnancy.[18] Influenza is more severe in pregnant women than in other populations. Annual vaccination is recommended for all women who will be pregnant during influenza season

(October to May).[19] Pregnant women with influenza are more likely to develop severe illness and to die than the general population. Pregnant women are also more likely to be hospitalized for respiratory illnesses than nonpregnant women, especially during influenza season.[20,21] The diagnosis of influenza is made clinically and confirmed with results from rapid influenza diagnostic tests or reverse transcriptase polymerase chain reaction testing. Typical symptoms of influenza include fever, cough, rhinorrhea, sore throat, headache, shortness of breath and myalgia. Some patients will have vomiting, diarrhea, conjunctivitis, and some have respiratory symptoms without fever.

*"Pregnant women with suspected influenza require immediate empiric treatment with antiviral medications, even if treatment is initiated more than 2 days after symptom onset."*

Pregnant women with suspected influenza require immediate empiric treatment with antiviral medications, even if treatment is initiated more than 2 days after symptom onset.[22] The recent influenza virus outbreaks have been responsive to neuraminidase inhibitors such as oseltamiir and zanamivir. These are Category C drugs in pregnancy. Dosing is oseltamivir 75 mg twice faily for 5 days or zanamivir 10 mg (2 inhalations) for 5 days. For treatment of pregnant women or women up to 2 weeks postpartum with suspected or confirmed influenza, oseltamivir is currently preferred (see CDC recommendations for frequent updates).

Because prevention is better than treatment, all women who are pregnant or will be pregnant during influenza season should be encouraged to receive the inactivated influenza vaccine, regardless of pregnancy trimester.

## Pain Management

Minor pain in pregnant patients can be treated with massage, heat and ice, and acetaminophen. Do not prescribe antiprostaglandin medications as primary agents for pain because of the possible risks of fetal renal impairment or adverse effects on the ductus arteriosus. Pregnant women may get relief from back pain by placing one foot on a stool when standing and placing a pillow between their legs when lying down. Supportive shoes and a pregnancy-based exercise program can be recommended to improve strength and flexibility.

Short-term opioid use can be beneficial for acute relief. Chronic opioid use creates risk for habituation. Referral for physical therapy assessment and chronic pain management services are essential adjuncts for the opioid-dependent pain patient who subsequently becomes pregnant.

## Preeclampsia and Eclampsia

We have admitted many patients directly from an urgent care center to our obstetrical unit after they have been seen for severe headache in pregnancy. The cerebral and visual disturbances that are typical for preeclampsia may be misdiagnosed as migraine with aura or non-pregnancy CNS pathology. Preeclampsia is new onset of elevated blood pressure and proteinuria (greater than 300 mg in 24 hours or 1+ (30 mg/dL) on at least two random urine dipstick tests after 20 weeks' gestation.

Patients with preeclampsia and impending eclampsia may have severe headache with visual disturbances, epigastric pain, nausea, and emesis. Delay in diagnosis potentially leads to seizures, abruptio placentae, pulmonary edema, aspiration pneumonitis, cardiac failure, intracranial hemorrhage, and transient blindness. Therefore, any pregnant patient over 20 weeks' gestation with hypertension or severe headache should be considered at risk of eclampsia until proven otherwise. Warning: Urgent care providers may also see preeclampsia in patients up to 4 weeks postpartum. Basic screening postpartum also includes analysis of symptoms suggestive of organ-specific vasoconstriction (headache, scotomata, elevated LFT, platelets <100,000, elevated uric acid, and proteinuria >1+ on dipstick or >300 mg in 24 hours).

It is critical to initiate therapy with magnesium sulfate at a 4- to 6-g loading dose over 15 to 20 minutes and 2 g per hour IV maintenance. The ambulance services typically carry these medications.

## Thyroid

Women who are on thyroid hormone replacement may require an increase in their dosage by 30% to 50% during pregnancy. Serum concentrations of free T4 and thyroid stimulating hormone are typically used for monitoring thyroid dosing in pregnancy. Ordering a free T4 is necessary because the increase in thyroid-binding glob-

ulin associated with pregnancy falsely elevates total T4. TSH is typically unaffected by pregnancy after 16 weeks.

## Teratogenic Risks of Common Medications

The fetus is most vulnerable between the 3rd and 8th week after fertilization (5th to 10th week after LMP). Teratogenic drugs taken before the 20th day following conception (5th LMP week) typically have an "all-or-nothing" effect, inducing miscarriage or having no effect at all. **Table 1** provides a quick review of medication effects in pregnancy. ■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# Market-Driven, Performance-Based Physician Compensation in Urgent Care

**Urgent message:** Determining compensation for urgent care physicians is a challenge, particularly given the current health care environment. This article provides guidelines for achieving fair compensation based on reliable metrics and objectivity.

RICHARD M. CAMERON, MHSA, CMPE and RICK E. WEYMIER, MBA, FACMPE

*Editor's Note: This article is based on information presented by the lead author at the 2012 National Urgent Care Convention.*

## Introduction

Physician compensation presents one of the greatest challenges to the success of an urgent care practice because it has an impact on practice culture, physician interelationships, and the ability to attract and retain quality physicians. The current health care environment is not conducive to promoting steady growth, or even maintaining what physicians may perceive as fair compensation for their work effort. Physician compensation is a sensitive issue that must be approached with caution, reliable metrics, and objectivity.

## Urgent Care and Physician Compensation

Urgent care services can be provided in a variety of settings, which have signifiant consequences to the level and quality of care provided today and in the future. These settings include extended hours in both primary care and specialty care offices, and stand-alone outpatient urgent care centers, hospital emergency rooms, and free-standing emergency care centers. Physicians who typically provide these services are in urgent care, family practice, general internal medicine, and emergency medicine. Furthermore, orthopedists , sports medicine physicians and therapists continue to move into this space through the advent of walk-in sports


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injury clinics. Overall trends for urgent care physician compensation indicate an increase in compensation with a 5% change for urgent care physicians and a range of 3% to 6% for the primary care physicians who provided urgent care services between 2011 and 2012, according to Medical Group Management Association – American College of Medical Practice Executives compensation survey results.[1]

With the advent of Accountable Care and the ensuing push to create a Patient-Centered Medical Home system of delivering and coordinating care, along with the projected shortage of primary care physicians (from which the body of urgent care physicians are recruited) and the continuing increase in the number of urgent care centers across the country, we anticipate that there will be significant competition to recruit and retain urgent care physicians. This competition will put increased pressure on physician compensation levels in an era of declining reimbursement. Independent urgent care centers will also need to compete with hospital systems as they continue to incorporate urgent care services into their integrated delivery systems.

It is likely that there will continue to be a space for independent urgent care centers, albeit with a higher level of competition from other specialties and health systems. Urgent care physicians will be held to the same standards of quality, outcomes, and patient satisfaction that will be driven by quality metrics and value-based reimbursement. An effective strategy for growth and success should include pursuit of formal relationships with health systems, independent physician practices, and insurance carriers. Urgent care services need to be considered as part of the continuum of health care services and viewed as complementary and working in partnership within the health care delivery system, particularly as health care reform is implemented.

### Key Tenets in Physician Compensation

The primary goal of every physician compensation formula is to make it representative of the work effort and overall contribution put forth by the physician. This should be balanced by what is fair and equitable, acheivable within the reimbursement and cost structures, and mutually agreed upon by the physicians. A significant ongoing challenge is that reimbursement continues to decline while the overhead cost structure continues to increase, and physicians want to maintain a better-than-average level of compensation.

The environment is constantly changing, thus once a compensation formula is put in place, the organiza-

**Table 1. Key Questions for Physicians to Ask About Compensation**

1. Am I being paid fairly–in relation to internal group equity and external market competitiveness?
2. Is there compensation and performance consistency across the group (have historical/legacy acquisition issues created an uneven playing field)?
3. What are the performance expectations of a full time equivalent physician in each specialty?
4. What is the mission/vision of the group practice and how do these relate to the physician compensation plan?
5. Is my level of productivity appropriate for what I'm being paid?
6. Are incentives or bonuses distributed fairly and adequately measured?

tion cannot expect that formula to remain static nor can the physicians expect that an unmovable baseline has been established. The organization must take the time to carefully assess and evaluate the physician compensation formula on a regular basis because physician productivity, payor mix, physician behavior, and the cost structure all have an impact on compensation. Physician compensation evaluation should be a standard recurring event, reviewed on a regular basis as a part of the annual financial and operating assessment process.

Health care is not totally immune to the cost consideration pressures that other industries have faced, which have caused dramatic shifts in consumer buying patterns and the ways that suppliers of goods and services approach their customers. Although health care remains partially isolated from some of the pressures (as premium rates continue to go up, new technology investments are made and health care organizations retain some price point leverage), this is rapidly changing. It appears as if employers are finally stating that "enough is enough" and it is not a matter of if, but when Medicare reimbursement cuts will take place. If history is true to form, the commercial payors will follow suit shortly thereafter. In fact, some commercial payors are already accelerating the inclusion of higher forms of "value-based" services and outcomes to just maintain current reimbursement levels. The fact of the matter is that the pool of funds available to support physician compensation expectations will be severly constrained and changed in the near future with the expected implementation of additional pay-for-outcomes-based care.

Sustaining a fair compensation plan is not as simple as it appears. The basic formula is that: (1) you provide services; (2) you bill for those services; (3) your business office collects for those services; (4) you pay your overhead; and (5) whatever is left over is available to pay the physician. In reality, physician compensation often causes a great deal of discussion and contentiousness in an attempt to arrive at what will likely be a very short-term solution. Key components of the formula include the age of the physician, the scope of practice, hours desired to work, on-call coverage, full vs. part time work, overhead allocation formulas, vacation time, medical/pregnancy leave, income guarantees, outside directorships and industry benchmarks.

Understanding the Burning Platform–from the physician's perspective–includes addressing the questions listed in **Table 1**.

Payor mix is the largest contributing factor to most private practice physician compensation formulas. Your payor mix will largely determine your ability to create the pool of funds that is available to pay practice expenses and meet physician compensation expectations. In some cases, an affiliation or employment by a health system may result in additional funds subject to the appropriate legal constraints and configurations. Most private practices focus on negotiating with the large insurance carriers. However, an increasing amount of financial responsibility is shifting to the patient and reimbursement levels from government payors will decrease in the future. The organization needs to have the necessary systems in place to demonstrate quality, outcomes, and patient satisfaction in the future in order to take advantage of value-based reimbursement and avoid payment penalty reductions from government payors.

A major devisive force within a practice when coming up with a compensation formula typically ties into each individual physician's payor mix. It is very unusual in a practice for every physician to have the same payor mix profile. Unless the group can collectively agree that all physicians will get paid the same amount for work effort, quality, outcomes and patient satisfaction, payor mix issues will often drive physician behavior in a manner that is destructive to the long-term success of a practice. For example, many physicians will gravitate towards those payors that are the most profitable and will also implement access roadblocks to those payors that offer lower levels of reimbursement or represent a higher hassle factor.

Overhead and other expense allocations are becoming increasingly important variables in determining the physician compensation formula, especially in integrated delivery systems that use a revenue-minus-

expenses formula, even when the physician is on a guaranteed salary. Other areas of contention involve determining which expenses should be direct expenses and which should be indirect and shared by all physicians. One common flaw in many physician compensation formulas is that a highly productive physician actually consumes a higher level of indirect expenses (check in, billing, medical records), yet the cost to that physician is significantly less as a percentage of their compensation than physicians who are producing at an acceptable level, albeit at a lower rate.

## Essential Attributes of Compensation Models

There are many variations of physician practice models that impact physician compensation. The two major forms of practice are private practice and hospital- or health system-employed practice and the other variations include employment in a group practice (such as Kaiser Health Plan). An emerging trend is the movement by major insurance carriers to employ physicians to round out their networks.

*Private Practice.* Private practice medical groups operate much like any independent business where the owners of the business assume responsibilty for the management of the business and all the risks associated with running the business. The owners of the private practice retain the freedom to direct the practice as they see fit (within the constraints of health care laws and regulations). There is a significant focus on generating high patient volume, managing overhead costs and taking a major part in governance and management. Many private practices are moving to a higher mix of employed physicians, but the main focus remains on creating a partnership and ownership track. There is a strong belief that if you own part of it, you will work harder to make the organization a success. In addition, private practice often offers the owners access to additional revenue sources such as ancillary services and real estate investments.

*Hospital or Health System Employed.* The number of physicians employed by hospitals has grown by 32% since 2000, raising the number of physicians employed by hospitals to about 212,000.[2] This means that approximately 25% of all physicians are now employed by hospitals. Another study indicated that more than half of practicing physicians were employed by hospitals or integrated delivery systems.[3]

In light of the current market drivers and ongoing implementation of health care reform legislation, it appears that the trend toward a greater percentage of employed physicians will only further accelerate. Under the employed model there is typically some sort of base

### Evaluating Your Compensation Plan

Every compensation plan should be reviewed on a regular basis. It is important for the group to determine if market conditions, reimbursement levels, and increasing expenses allow the current methodology to remain sustainable. This requires a detailed financial and operational analysis of the practice.

An effective starting point to determine if your plan is meeting its intended goals and objectives is to perform a Strengths, Opportunities, Weaknesses and Threats (SWOT) analysis of the compensation formula. Following are some questions that a group can use to perform its own analysis to see where they stand and to help make decisions on whether it is time to change the compensation plan.

**Strengths**

1. Ability to earn better-than-average compensation?
2. Incorporates productivity, resource/expense management and quality into the formula?
3. Cooperative, open and collaborative relationship between administration and physicians?
4. Formula is not overly complex and can be readily modeled against changes in market conditions?

**Opportunities**

1. Adjust formula to allow for some sharing of risk for financial performance?
2. Demonstrate success in achieving high patient satisfaction to influence reimbursement levels?
3. Maintain competitive compensation to allow for continued growth and attraction of high-quality physicians?

**Weaknesses**

1. Minimal downside risk for physicians on guaranteed salary?
2. Substantial rewards possible for poor expense management?
3. Poorer performing physicians have the ability to gain excess compensation from quality and satisfaction components?

**Threats**

1. Difficulty in maintaining compensation pool at desired level due to increasing industry-wide expense structure?
2. Maintaining high revenues and manageable expenses in a primary care based group?
3. Potential for reimbursement backlash if insurance costs continue to increase at an accelerating rate?

**Table 2. Key Questions for Designing Physician Compensation**

1. What are the critical linkages between historical pay, performance, and marketplace positioning for each component of the compensation plan for the health system?
2. How will we measure productivity, performance, and allocation of revenue?
3. How will the plan determine market competitive compensation? And how will performance benchmark to market?
4. How will the plan carry out the organization's objectives?
5. What physician behaviors should the plan reward?
6. How will the plan monitor expense allocation and ensure cost effectiveness?
7. What is expected of a full-time physician?

*"The challenge in designing a physician compensation system is to balance the countervailing forces that have the potential to put significant stress on the organization.*

salary with incentives for productivity, quality, outcomes, patient satisfaction, and participation in committee work or other administrative work. There is a high expectation of standardization and the cost structure is usually managed by a practice management arm of the system. Access to ancillary service revenue is generally very limited or excluded, and there are Stark law limits on how such services can be considered within the physician compensation plans. In most cases, investments in outside entities by employed physicians is highly restricted and often prohibited. This practice model continues to evolve and many industry experts feel that this structure offers the best opportunity to meet the changes occuring in the health care industry. In addition, most of the newest physicians in the marketplace are open to the employment model because it provides a sense of security and a balance between professional and personal life with minimal risks associated with running a business.

Irrespective of the model, the overriding challenge in designing a physician compensation system is to balance the various countervailing forces that have the potential to put significant stress on the organization. The desire to provide physicians with a degree of compensation stability and reward high productivity, quality and outcomes, must be balanced with the need for organizational viability and compliance with federal regulations including fair market value considerations, clinical documentation and appropriate coding.

So what should you do? Start by asking the questions listed in **Table 2**.

## Summary

This article offered a broad overview of the trends and factors that go into determining physician compensation. The following are the recommended core principles that any physician compensation plan or formula should seek to balance:

- Every compensation formula should allow a physician to enjoy personal and professional satisfaction and promote the financial viability of the organization.
- Although physicians want to earn an excellent wage, financial considerations should never get in the way of clinical quality and patient satisfaction with services provided.
- The compensation formula needs to be sensitive to and anticipate changes in the health care industry.
- The compensation formula needs to be flexible and enforceable, and easy to understand, calculate, and implement.
- The compensation formula needs to be structured in such a way that a physician has a chance to earn a reasonable wage.
- Even if the compensation formula includes a base salary or a floor, there needs to be some productivity component of the plan.
- As the health care industry moves toward value-based reimbursement, the formula should reward those who achieve the required goals.
- Direct and indirect costs need to be allocated fairly and individuals should not be insulated from certain costs and overall expense management to the detriment of others in the practice.
- The overall success of the plan design is to ensure that it promotes a level of compensation and aligned incentives that are internally equitable and externally competitive. Without this, a practice will not be able to recruit and retain desired physicians or sustain itself.

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# Case Report

# Paraphimosis

**Urgent message:** Most cases of paraphimosis can be managed in the urgent care setting and prompt treatment is necessary to avoid complications.

MOHAMED A. FAYED, MD

## Overview

An uncircumcised male's penis consists of the penile shaft and glans penis covered by foreskin. At birth, the foreskin and glans penis are fused, which is called physiologic phimosis. Approximately half of uncircumcised males have fully retractable foreskins by age 10 years; by age 17, the foreskins of almost all males are fully retractable.

## Case presentation

A 29-year-old male presents to the urgent care center complaining of penile swelling and irritation (Figures 1 and 2). He reports increased sexual activity in the last 3 months. During this period, he has also had a new sexual partner. He denies any history of sexually transmitted disease (STDs). He also denies any history of diabetes.

## Observation and Findings

Physical examination of the patient reveals the following:

Pulse: 60 bpm
BP: 120/76
Temp: 97.7°F
RR: 12
Cardiac exam: Normal regular heart and rhythm, no murmur.
Lung exam: Clear to auscultation bilaterally
Abdominal exam: Soft and no tenderness
Genital exam: Swollen foreskin, not retractable around the glans penis. The glans penis is pink with no swelling or tenderness.

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## Diagnosis and Treatment

This patient had paraphimosis (Figures1 and 2). His foreskin was not reducible on trial. Therefore, he was sent to the Emergency Room (ER) for immediate reduction and urology consultation

## Discussion

Paraphimosis occurs when the foreskin in an uncircumcised male is retracted behind the glans penis. If it goes unrecognized, it can cause venous and lymphatic congestion and later, blood flow obstruction of the glans penis with potential for permanent damage and gangrene. It is prudent to recognize and treat this condition to prevent penile complications.

**Mohamed Fayed** is an assistant professor at Wright State University/ Dayton VA Medical Center and urgent care physician at Hometown Urgent Care, both in Dayton, Ohio.

**Figure 1.**

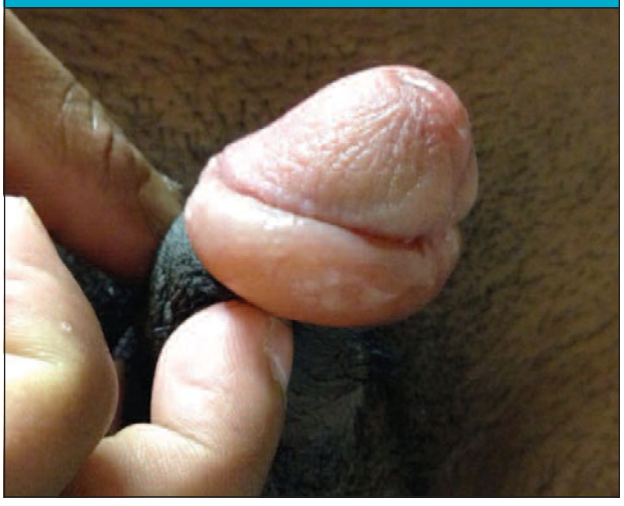

**Figure 2.**

*Early-stage paraphimosis can be managed in the clinic, an urgent care center, or the ER without the need for emergent specialty consultation.*

Paraphimosis is common in elderly patients. It may occur after urinary catheterization or medical examination if the foreskin is not returned to its natural location over the glans, which is termed iatrogenic paraphimosis. One theory regarding the predisposition of elderly men to paraphimosis is decreased frequency of erections from erectile dysfunction.[1] Balanitis at any age is also associated with development of paraphimosis.[2] In the medical literature, paraphimosis has been reported after sexual intercourse and after prolonged erections in erotic dancing.[3-5]

Paraphimosis must be treated promptly to prevent glans ischemia. Patients with this condition can present in different stages and early-stage paraphimosis (minimal changes of the glans penis) can be managed in the clinic, an urgent care center, or the ER without the need for emergent specialty consultation. Many methods for successful paraphimosis reduction have been reported; however, the most commonly used initial maneuver involves manual compression of the distal glans penis or application of ice packs at the glans penis for a few minutes to decrease edema, followed by reduction of the glans penis back through the proximal constricting band of foreskin.[6] In cases of significant edema and pain of the glans penis, adjunctive therapy to reduce the pain is advised, such as penile nerve block, topical analgesic or oral narcotics before penile manipulation.[6] For these patients, emergent referral to an expert also is advisable.

After foreskin reduction, referral to a urologist is important. Urologists can offer other treatment options to prevent recurrence, such as circumcision. Cases of chronic paraphimosis have been reported.[6] In these patients, a mildly constricting irreducible fibrous band of foreskin is present, but glans edema and necrosis are absent. Symptoms only develop with erection. Patients diagnosed with chronic paraphimosis require modified or formal circumcision for treatment.[7] ■

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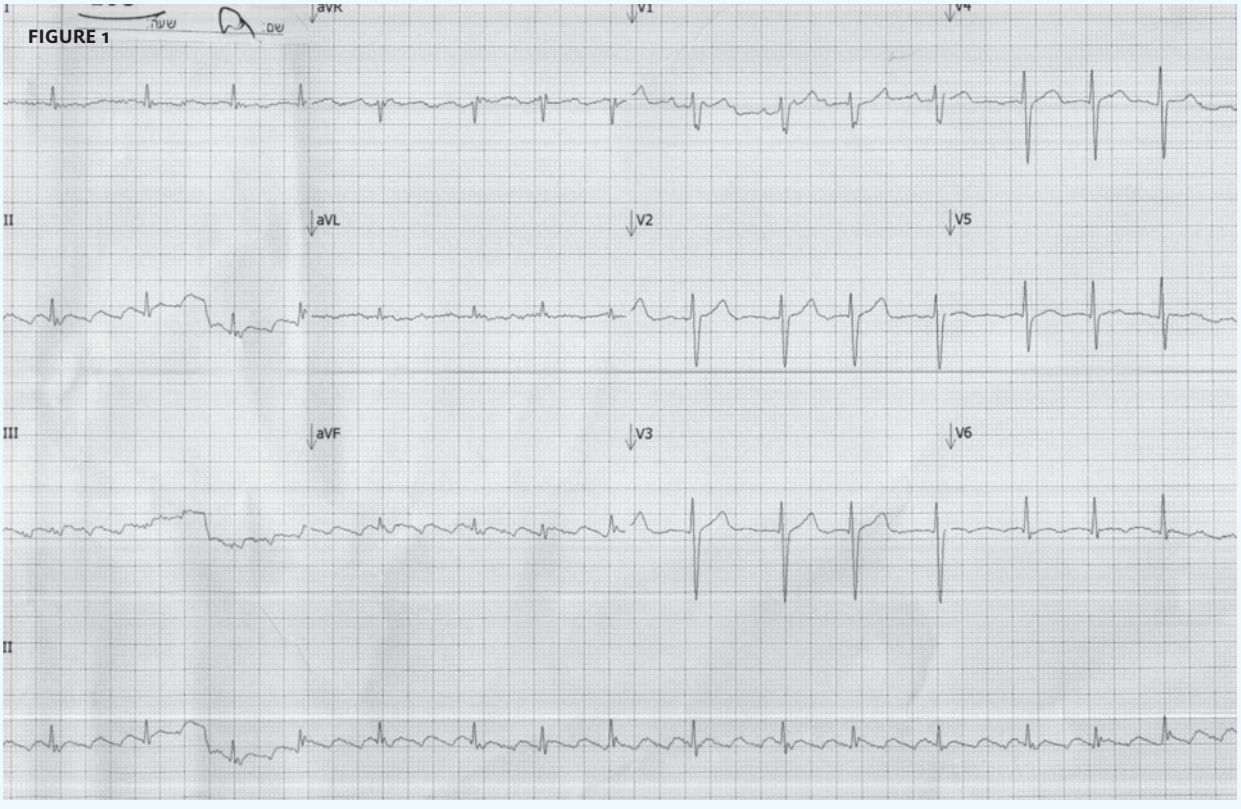
INSIGHTS IN IMAGES

# CLINICAL CHALLENGE

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

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

**FIGURE 1**



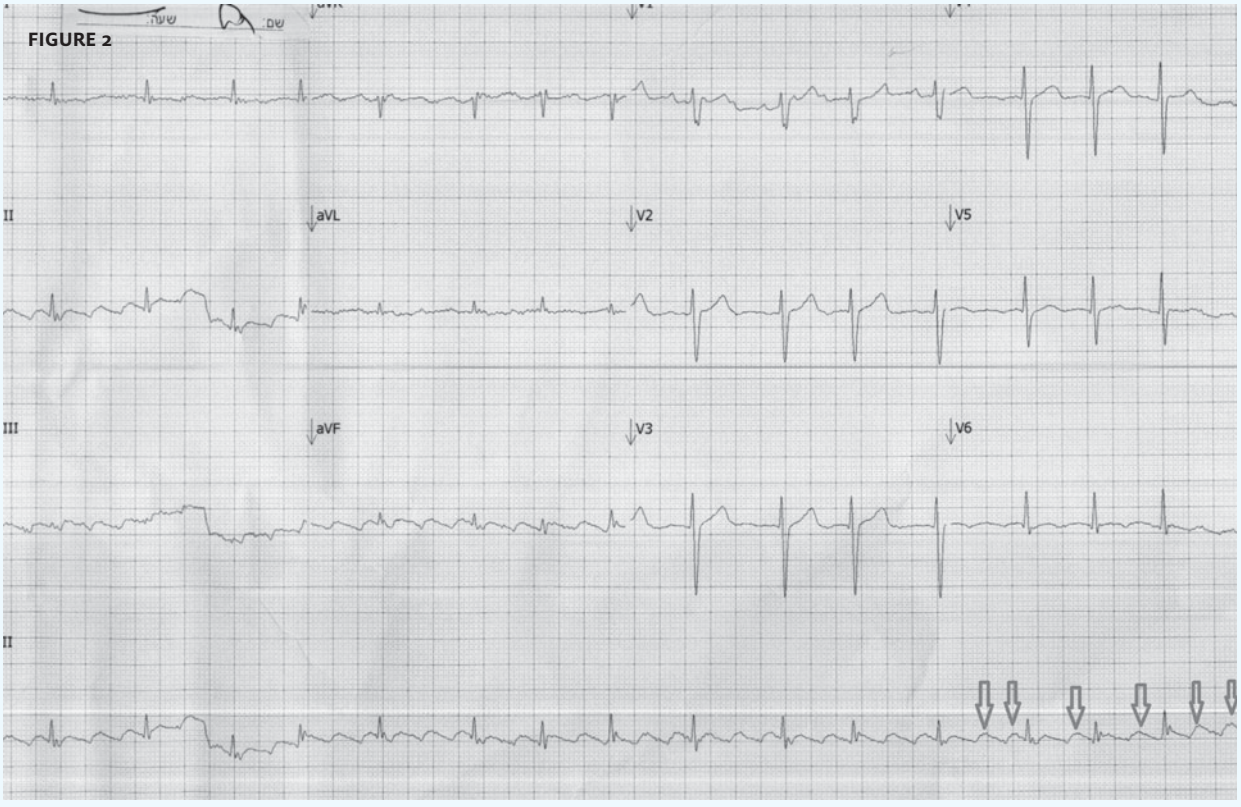

The patient, a 76-year-old male, presented with a complaint of palpitations.

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

Resolution of the case is described on the next page.

## THE RESOLUTION

FIGURE 2




Diagnosis: The electrocardiogram reveals atrial flutter with block. The saw tooth pattern is consistent with atrial flutter at a much higher rate, but due to the block, a much slower ventricular rate.

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



# Commercial Motor Vehicle Medical Examinations — Act Now to Participate!

JOHN SHUFELDT, MD, JD, MBA, FACEP

This is not the call you want to receive. "Dr. Shufeldt, one of urgent care centers your group just purchased was named in a multimillion dollar suit. The allegation is that one of the center's providers performed a DOT physical on a driver who was reportedly overweight, had Type II diabetes, had hypertension and undiagnosed sleep apnea. While driving, he fell asleep, crossed the median and a struck a vehicle carrying a family of four. The truck driver and one teenage child survived. The driver admitted he fell asleep and your center is named, along with the transportation company in a wrongful death suit. By the way, they plan to seek punitive damages."

I breathed a sigh of relief – it was an asset, not a stock purchase. We were immune from any of the award of damages. The previous owners remained on the hook.

I learned a couple things from this one call.

1. When buying clinics, make sure you have an asset purchase or, if the purchase has to be stock for tax reasons, make sure you are completely indemnified.
2. Never, ever take Department of Transportation (DOT) physicals lightly. As a group, the health histories and habits of these patients generally are dismal, yet they are driving huge machines across the country at high speed. One minor issue can lead to significant morbidity and mortality for the driver and many others who happen to be traveling along the same path.

The issue of risk associated with inappropriately completed and approved Commercial Vehicle Exams is becoming appreciated. Fortunately, change is afoot and the urgent care industry is the perfect group to both promote and lead this federally mandated effort.

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By way of background, in 2005 Congress passed the Safe, Accountable, Flexible, Efficient Transportation Equity Act (SAFETEA LU).[1] It established the Medical Review Board (MRB) that advises the Federal Motor Carrier Safety Administration (FMCSA) on medical concerns, including physical qualifications for drivers, medical standards and guidelines, the educational curriculum for medical examiners, and functional tests for drivers w/ disabilities. The MRB also is required to review all FMCSA medical standards and propose new science-based standards and guidelines.

Beginning May 21, 2014, all medical certificates issued to interstate truck and bus drivers must come from medical examiners listed on the National Registry. This rule requires that all medical examiner who conduct commercial motor vehicle exams shall:

- Maintain a valid state license to conduct medical examinations;
- Complete required training on FMCSA's physical qualification standards;
- Pass the FMCSA Medical Examiner Certification Test to demonstrate knowledge of FMCSA's physical qualification standards; and
- Complete refresher training every 5 years and recertification testing every 10 years.

Much of the following information was learned from Larry Earl's excellent overview in the August, 2012 issue of *Med Monthly*. Dr. Earl is medical director of the National Academy of DOT Medical Examiners (ww.nadme.org).

The National Registry of Certified Medical Examiners (National Registry) is a Federal program that promulgates requirements for healthcare professionals who perform physical qualification examinations on interstate commercial motor vehicle

(CMV) drivers who want to be trained and certified in FMCSA physical qualification standards.[2] In order to become a certified medical examiner (ME) and be listed on the National Registry, (https://nationalregistry.fmcsa.dot.gov/NRPublicUI/home.seam) healthcare professionals must complete training and testing on the FMCSA physical qualifications standards and guidelines.[3,4]

FMCSA developed the National Registry of Certified Medical Examiners final rule as part of the agency's commitment to improving the medical oversight of interstate drivers, and preventing commercial vehicle-related crashes, injuries, and fatalities like the one described above. These regulations address four National Transportation Safety Board (NTSB) recommendations on comprehensive training for medical examiners, and tracking of driver medical certificates designed to prevent untoward events.

Here is the upside for urgent care owners and providers: currently, the only requirement to perform DOT exams is to be a licensed MD, DO, DC, NP or PA. Of the potential 400,000 pool of professionals currently available, the FMCSA estimates that only 40,000 will be needed to serve over 6 million commercial drivers.

Further estimates are that only a fraction of the 40,000 needed will be trained in time for the May, 2014 deadline. If 40,000 providers do get trained, they will on average be performing 150 exams per year. Dr. Earl's estimation, however, is that fewer than 10,000 will be trained by the deadline, which means that on average each provider will be performing 600 exams per year.

Inappropriate medical evaluation and certification of drivers has led to an increase in crashes. In some cases, drivers had documented cases of serious disqualifying conditions which, in the best case, contributed to and at worst, caused these fatal and disabling accidents.[6] Thus, medical examiners need to be educated on the specific physical and mental demands associated with operating commercial vehicles. The standards and guidelines are designed to assist the certified medical examiner in making the individual determination whether a driver should be issued a medical certificate, and in achieving proficiency on the medical protocols necessary to adequately perform the medical examination.

The National Registry final rules address four NTSB recommendations on the requirements of a comprehensive medical oversight program for interstate drivers, which include the following elements:

- Individuals performing medical examinations for drivers are qualified to do so and are educated about occupational issues for drivers;
- A tracking mechanism is established that ensures that every prior application by an individual for medical certification is recorded and reviewed;
- Medical certification regulations are updated periodically to permit trained examiners to clearly determine whether drivers with common medical conditions should be issued a medical certificate; and
- Individuals performing examinations have specific guidance and a readily identifiable source of information for questions on such examinations.

This law also directs FMCSA to remove from the registry the name of any medical examiner who fails to meet or maintain the qualifications and requirements established by the Secretary of Transportation for being listed in the registry and shall accept as valid only medical certificates issued by individuals on the national registry of medical examiners.[7]

After the completion of training, medical examiners are required to provide FMCSA with their state medical license, business address, phone number, and medical examiner training instructor. In addition, the applicant must produce several documents, including a statement that the applicant is capable of and willing to comply with FMCSA requirements; that upon request the provider would produce copies of documents showing evidence of completion of training, state licenses, etc.; and an affirmation that all of the information provided is true. Once the information is complete, the FMCSA issues an approval to take the certification exam, which is a computerized test consisting of 120 multiple-choice questions. Results will be given immediately at the testing site.

In addition to the initial certification test, certified medical examiners are required to complete "refresher" CME training every 5 years and they must recertify by retesting every 10 years in order to remain listed on the registry.

Certified examiners must electronically send a report of DOT exams to the FMCSA and will be required to have an electronic form of communication to receive updates to the DOT medical exam, NRCME training, and changes in FMCSA policy. When an investigation for improper certification occurs, the examiners must produce a copy of the exam within 48 hours upon FMCSA request.

The FMCSA may remove an examiner from the NRCME if he or she certifies a driver who has failed to meet the applicable published standards or makes a false claim that he or she has received the required training.

If you have an interest in pursuing this certification, it is advisable to obtain training early, well before the May, 2014 deadline. This is an area where urgent care can place a stake in the ground and help improve the safety of our roads. ■

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CODING Q&A

# Preventive Medicine, Preventive Medicine Counseling

DAVID STERN, MD, CPC

**Q. How do you code for a Sexually Transmitted Diseases (STD) screening visit in a patient who has no symptoms? Can you use a preventive medicine code (99387-99397) and still receive reimbursement?**

A. You would code based on the service provided. If you performed a physical and collected the specimen to send to the lab, then you would bill the appropriate preventive medicine Evaluation and Management (E/M) code. If the only service you provided was collection of the specimen to send to the lab, then you would only bill CPT code 99000, "Handling and/or conveyance of specimen for transfer from the office to a laboratory." Unfortunately, some insurance companies do not reimburse for this code.

If requirements were met for preventive medicine counseling, you could bill using CPT codes 99401-99404:

Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure);

99401 - Approximately 15 minutes
99402 - Approximately 30 minutes
99403 - Approximately 45 minutes
99404 - Approximately 60 minutes

These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. Risk factor reduction services are used for individuals who do not have a specific illness for which the counseling might otherwise be used as part of treatment.

The ICD-9 codes used should also be related to the reason for the screening. Use diagnosis code V01.6 for "contact with or exposure to a venereal disease," V74.5 for screening for "venereal disease," V73.88 for screening of "other specified chlamydial diseases," or V73.98 for screening of an "unspecified chlamydial diseases."

**Q. When is it appropriate to use 99401-99404 versus 99381-99397? What is the difference?**

A. Preventive medicine services—CPT codes 99381-99397—are typically performed when a patient comes in for a routine preventive examination. Even though you would typically perform counseling services regarding diet, exercise, etc. along with the examination, the purpose of the visit was a routine "check up"—not a visit to treat or follow up on an actual problem.

In the case of the preventive counseling visit—CPT codes 99401-99404—the patient presents to discuss a change in routine or behavior that he or she would like to make. For example, an established patient in overall good health comes to your office to discuss a diet and exercise program. You spend 15 minutes discussing exercise programs, health risks, benefits, etc. This scenario generally does not happen very frequently in the urgent care setting.

**Q. We are not contracted as an urgent care clinic, but meet all of the requirements for an urgent care clinic. Can we get reimbursed if we use the S9088 code?**

A. It is unlikely that any payors will reimburse for S9088 for a clinic that is not contracted as an urgent care center. Even urgent care centers often have trouble receiving reimbursement for S9088, but some are able to add reimbursement to S9088 in negotiations. Getting this added, however, is more likely for centers that can show that they offer higher-acuity services or centers that are always staffed with board-certified emergency medicine physicians.

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

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For immediate consideration, email your CV to Judy Wechter at judith.wechter@readinghealth.org. www.readingdocs.org

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**Interested candidates should contact or forward CV to Andy Jagoda, MD, Professor and Chair at: 212-824-8050 or email: andy.jagoda@mssm.edu**

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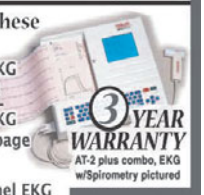


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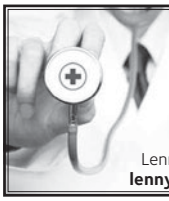

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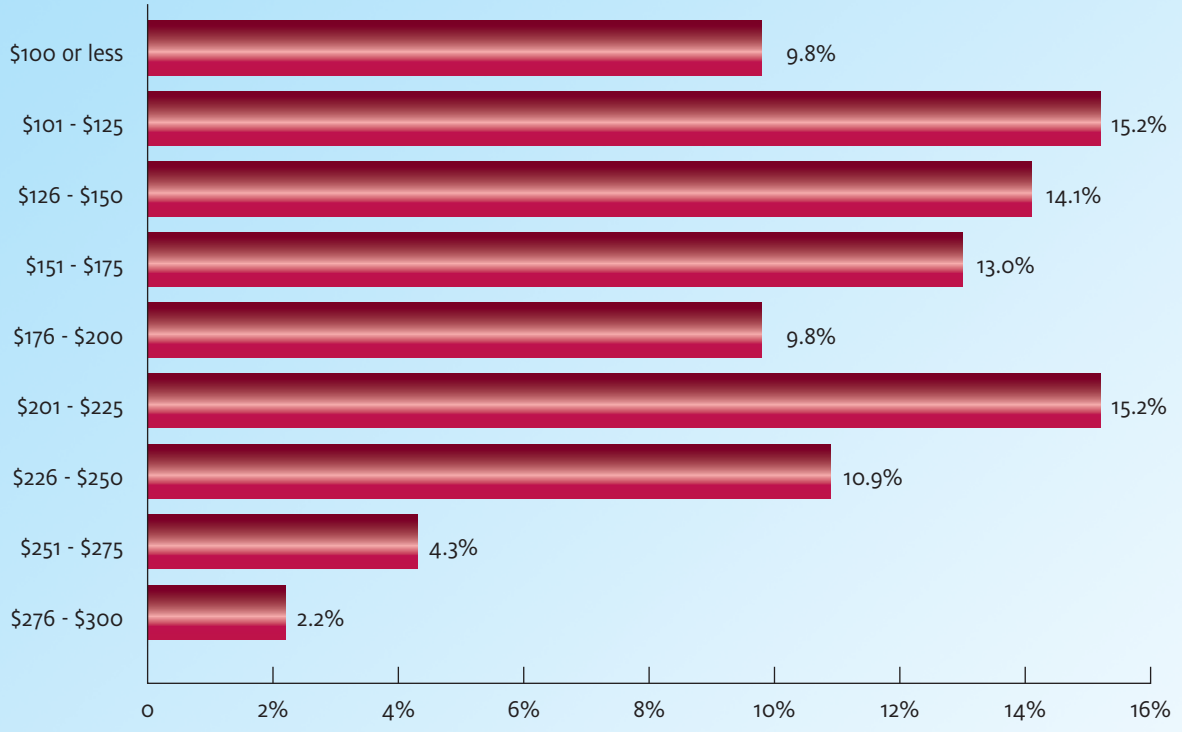
# DEVELOPING DATA

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

*In this issue:* What is the Average Visit Charge for Urgent Care Centers?

## AVERAGE VISIT CHARGE




The average charge for an urgent care visit across all respondents was $184.55 in the 2011 calendar year (n=92). The most recent government data on primary care ("office based") average charges ranges from $199-$145. The average emergency room visit charge for the same time period was $922.*

*Sources:

Machlin S, Chowdhury S. Medical Expenditure Panel Survey: Expenses and Characteristics of Physician Visits in Different Ambulatory Care Settings, 2008. Agency for Healthcare Research and Quality. March 2011. http://meps.ahrq.gov/mepsweb/data_files/publications/st318/stat318.pdf

Davis K, Carper K. Statistical Brief #381: Use and Expenses for Office Based Physician Visits by Specialty: Civilian Noninstitutionalized Population. August 2012 (this study considers pediatrics and other "primary" specialties to be primary care). http://meps.ahrq.gov/mepsweb/data_files/publications/st381/stat381.shtml

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