

JUCM™

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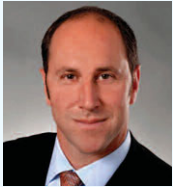
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A New Era for Urgent Care



Spring is here. It's time to shake off the cobwebs of winter and take a fresh look toward the future. With clear eyes, and a little more daylight, our focus is more acute, and our visionary juices start flowing. The Urgent Care Association of America has always been a forward-thinking organization, trying to be a step ahead in a dynamic healthcare arena. Over the last seven years, UCAOA membership has grown sharply, proffering strength of purpose, voice, and financial resources.

As stewards of the industry, we have used our strength to give voice and credibility to our specialty within the healthcare delivery system. And as leaders of the discipline, we have launched specialty development initiatives that have given us legitimacy within the house of medicine. We have tried to represent the industry with respect and inclusion, across all the core competencies, and with an unwavering belief that good governance will protect the future of the discipline and the interests of our members.

With one eye toward the future and one eye mindful of the past, we now stand at the threshold of in a new era for urgent care, one in which we can confidently represent our discipline both as an industry within the healthcare system and as a recognized specialty of medicine, separately but cooperatively.

To that end, for more than three years, the UCAOA Board of Directors has considered the establishment of a physician college to represent the interests of practitioners and advance the specialty with a singular resolve. Behind the scenes, considerable effort has been made to ensure that an independent physician college effectively represents the needs of the discipline, free of special interests and respectful of the advancements made to date.

In the coming months, we will be introducing you to this new organization. Developed in collaboration with UCAOA to provide a focused physician voice on matters affecting the specialty, the new physician college aims to provide a clearer distinction between the discipline of urgent care medicine and the urgent care industry. While there will always be overlap and mutual interests, we feel—and many of you have told us you agree—that the two should be represented separately. We must, however, ensure that such representation is free of conflict and self-interest, as well as be accountable, transparent, and truly democratic.

The founding Board has drafted bylaws reflecting the impor-

tance of good governance, first emphasized by the founders of UCAOA, as the foundation of accountable representation by a non-profit organization. In particular, board term limits and transparency of financial information will be hallmarks. In addition, we feel it is very important that all voting board members receive no compensation for their board-related duties and provide full disclosure of all potential conflicts of interest.

We look forward to the participation of urgent care physicians from around the world in establishing the college as an important center for medical education and research, and, of course, we depend on strength in numbers to adequately support our mutual interests and vision for the future of urgent care medicine.

Thanks to the foundational efforts of UCAOA, the discipline is well-positioned for a bright future. Specialty development initiatives, such as our three existing fellowship programs, modeled on Accreditation Council for Graduate Medical Education standards, will be expanded and refined as we move forward. Clinical education and policy initiatives will be expanded. Quality and outcomes-based research will be supported.

In addition, the new physician college will partner with UCAOA to contribute expertise and support to *JUCM*, *The Journal of Urgent Care Medicine*, the only peer-reviewed journal in our discipline. Public health and patient education programs will be advanced. And, finally, it will continue to advocate for the specialty of urgent care medicine as a distinctly important part of the healthcare delivery system.

Together, we can make a difference. We look forward to introducing you to this new organization soon and hope you will join us in support of our mission to “foster quality, value, and advancement in the clinical practice of urgent care medicine through research, education, and advocacy for its physicians and patients.” ■

Lee A. Resnick, MD
Editor-in-Chief

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CLINICAL

9 Burns: Their Evaluation and Treatment in Urgent Care

Burns can result not just from heat but also cold, chemicals, electricity, or radiation. Most burn injuries can be handled in an outpatient setting—if they are classified accurately, treated appropriately, and referred to a regional burn center when indicated. These insights will help.

By Tracey Quail Davidoff, MD

PRACTICE MANAGEMENT

23 Enhancing Profits with Immigration Physicals

Documenting physical exams, vaccinations, and lab tests required for residency or citizenship in the US can be a lucrative, cash-only business for urgent care centers, and because physicals are scheduled, they can level flows in patient volume. Here's how it works.

Alan A. Ayers, MBA, MAcc



HEALTH LAW

31 Malpractice Insurance: A Primer for Urgent Care Providers



Confused about which type and how much malpractice insurance you need? Join the club. Here, a lawyer who is also a doctor offers plain-English answers to common questions.

By John Shufeldt, MD, JD, MBA, FACEP

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IN THE NEXT ISSUE OF JUCM

Anaphylaxis is a medical emergency that requires rapid and aggressive treatment. But both diagnosis and treatment can be challenging. Here's how to do both for the most common type of anaphylaxis: Type 1, immediate hypersensitivity reaction.

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Mission Statement

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

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

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Burn injuries that are appropriate for urgent care can be challenging to correctly diagnose and treat. Due to variable skin thicknesses and variation in exposures, burns may have multiple areas of varying depths. This can make classification difficult. In addition, it may take several days or even weeks before the extent of injury is fully developed, which may require subsequent revision of the initial diagnosis and treatment plan.



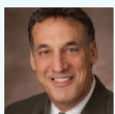
These are just a few of the issues **Tracey Quail Davidoff, MD** addresses in her cover story: Burns: Their Evaluation and Treatment in Urgent Care. Dr. Davidoff reviews the most common types of burn injuries, discusses burn classification and assessment, differentiates superficial partial-thickness burns from deep partial-thickness and full-thickness burns, and offers recommendations for pain and wound management.

Board-certified in internal medicine, Dr. Davidoff is a staff physician at Excelcare Medical Urgent Care and Urgent Care by Lifetime Health, both in Rochester, New York.

Urgent care is a growth industry in high gear, with most centers expected to expand in 2011, as our Developing Data column this month makes clear. One way to grow your business is by offering ancillary services such as immigration physicals, which many urgent care operators have discovered can significantly boost profits through a cash-only service. **Alan A. Ayers, MBA, MAcc** explains what is involved in becoming a “civil surgeon,” what immigration physicals entail, how this scheduled service can improve scheduling, and what to charge.



Mr. Ayers is Content Advisor to the Urgent Care Association of America and Vice President of Strategy & Execution with Dallas, Texas-based Concentra Urgent Care. He last wrote about ancillary services in urgent care in the February 2008 issue of JUCM in an article titled *Boosting Revenue by Working Harder—or Smarter?* The issue is archived on the JUCM website. If you haven't read it, it's well worth a look.



The possibility of being sued for malpractice, while certainly not pleasant, is not something that should be causing you sleepless nights. “It is, in the end, a cost of doing business,” **John Shufeldt, MD, JD, MBA, FACEP** says.

In his Health Law column this month, Dr. Shufeldt tackles one of medicine's most confusing, stress-inducing, yet important topics: malpractice insurance. His primer for urgent care clinicians, written in plain English, explains the types of coverage, extended-reporting endorsements (which you may know as “tail” coverage), gaps in coverage, discovery clauses, deductibles, policy limits, and settlement of claims.

This issue marks the first since JUCM's inception without



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Harris Fleming manning the helm as editor. Mr. Fleming and Dr. Lee Resnick created *JUCM* from scratch. Developing the look of the journal, deciding what articles and columns to offer, recruiting authors—few editors have the intellectual rigor, creative dynamism, and unflagging energy to bring an undertaking of this magnitude to life. That Mr. Fleming had been doing it since 2006 with grace, humor, civility, and warmth is a testament to his achievement. His legacy is a journal in which we can all take a great deal of pride. ■

Also in this issue:

Nahum Kovalski, BSc, MDCM identifies new abstracts relevant to urgent care clinicians, including important studies on pediatric sinusitis, skin testing for β -lactam reactions, inaccurate medication lists obtained in ED triage, a new drug approval for head lice, and steroids for children with CAP, among other topics.

David Stern, MD, CPC discusses medical necessity in E/M coding, the first installment in a multipart series on this important topic. ■

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. If you would like to subscribe, please log on to www.jucm.com and click on “Free Subscription.”

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FROM THE EXECUTIVE DIRECTOR

Announcing the First Certification Program for Urgent Care Management

■ LOU ELLEN HORWITZ, MA

It's time for Announcement Number Three of 2011. January saw the launch of our new website for patients and the public (www.urgentcarecenter.org). February brought the results of our revealing new Benchmarking Survey. And last month we were able to launch our newest initiative: the Urgent Care Management Certificate (UCMC) program.

The UCMC program is, first, an educational program and, second, a certificate program. Its 40-hour curriculum is designed to build and improve proficiency in all the core skills required to manage an urgent care center successfully, and to acknowledge excellence with UCAOA-endorsed certification.

The curriculum was designed, tweaked, tested, and evaluated by our staff, board, and faculty, as well as your urgent care peers, over the past 17 months. We are thrilled to see their work finally come to fruition. We are equally happy that a mechanism now exists for recognizing all the hard-working managers and administrators in our field. Lastly, we hope that UCMC will provide an opportunity for professional advancement for your newer staff, and we encourage you to support their efforts.

To that end, we have established a special website where you can find full details about the UCMC program and apply: www.ucaoa.org/ucmc. The program accepts credit for some past coursework, and we will help you track your progress and quiz results. (Yes, there are tests!) When you are done, we will be pleased to recognize your achievement.

Have questions? If you will be in Chicago this month, come

to the Information Session we're having on Wednesday, May 11, at 4:30 pm. If you are not able to attend the convention, please visit the UCAOA website (www.ucaoa.org/ucmc), call us (877-698-2262), or send us an email (ucmc@ucaoa.org).

What a Long, Wonderful Trip It Has Been

While thinking about this announcement and the others that are coming in the next few months, I've been reflecting on the extended time horizons of our projects, now that we have been

around for a little while. Combined with the announcement in Dr. Resnick's column this month, you can see that there are, and have been, many long-

term projects percolating in the background of our industry that are just coming to fruition. I wonder whether many of you are starting to notice a similar phenomenon in your centers:

In the early days, it seemed like you had a new project starting about every five minutes. Everything was new! Getting your organization off the ground and your doors open was an accomplishment in itself, and things moved very quickly after that.

Over years of operation, though, something changes. You begin to tackle more complex projects with higher stakes that require more stakeholder input. Such ambitious initiatives require more testing, involvement, re-invention, re-testing, and thinking through. That instant gratification from your early years is hard to give up!

Yet when the time finally comes to shatter the figurative champagne bottle against the prow of your ship, and you look back to the day when you first drew up the plans, you are in awe of how long it has been. It is then that you really begin to appreciate the building process, and all those who helped you to build, grow, and achieve success. ■



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



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BURNS

Their Evaluation and Treatment in Urgent Care

Urgent message: Most burn injuries can be handled in an outpatient setting—if they are classified accurately, treated appropriately, and referred to a regional burn center when indicated.

TRACEY QUAIL DAVIDOFF, MD

Introduction

A “burn” is defined as a traumatic, thermal injury to the skin and deeper structures. Some or all of the cells of the skin can be destroyed not only by heat but also by cold, chemicals, electricity, or radiation.

Burns are the third-leading cause of accidental death in the United States, and more than 1 million burn injuries are incurred in the US each year (Table 1). Burns are most common in males 18-35 years of age. Recent advances in burn care have dramatically decreased mortality to fewer than 10% of patients admitted to burn units. Mortality is twofold greater in women.

The most common type of burn in children is from a scald injury, caused, for example, by bath water that is too hot or boiling liquid from a pot on a stove.

In adults, the most common cause of burns is from direct flame or contact with a hot solid object such as a



stove or oven. Hot liquids and steam also account for a fair amount of burns in adults.

Types of Burns

Four types of burns are commonly seen in the urgent care center: thermal, chemical, electrical, and radiation.

Tracey Quail Davidoff is a staff physician at Excelcare Medical Urgent Care and Urgent Care by Lifetime Health, both in Rochester, New York. She is board-certified in internal medicine and worked for 18 years as an emergency physician before switching to urgent care 4 years ago.

Table 1. How Common Are Burn Injuries?

<p>Burn injuries receiving medical treatment: 450,000 Includes visits to hospital emergency departments, hospital outpatient clinics, freestanding urgent care centers, and private physician offices.</p>	
<p>Fire and burn deaths per year: 3,500 Includes deaths from residential fires, motor vehicle and plane crashes, and contact with electricity, chemicals, or hot liquids and substances.</p>	
<p>Hospitalizations for burn injury: 45,000 About 55% of burn patients were admitted to 125 hospitals with specialized facilities for burn care, a percentage that has increased steadily in recent decades.</p>	
<p>Statistics on admission to burn centers, 2000-2009</p> <ul style="list-style-type: none"> • Survival rate: 94.8% • Gender: 70% male, 30% female • Ethnicity: 63% white, 17% African American, 14% Hispanic, 6% other • Admission cause: 42% fire, 31% scald, 9% contact, 4% electrical, 3% chemical, 11% other • Place of occurrence: 66% home, 10% occupational, 8% highway/street, 16% other 	
<p>Adapted from the American Burn Association Burn Incidence Fact Sheet. Available at www.ameriburn.org.</p>	

Thermal burns

Thermal burns occur from heat, either as a direct flame, contact with a solid object, steam, or hot liquids such as water or oils. The depth of injury is related to the contact temperature, duration of contact, and the thickness of the skin. Treatment and prognosis are related to the depth of the burn.

Chemical burns

Injury from chemicals is caused by a wide range of caustic reactions, including alteration of pH (eg, from acid or alkali burns), disruption of cellular membranes, and direct toxic effects on the metabolic processes of cells. Some examples include wet cement, hydrofluoric acid in tire cleaner, gasoline, phenols, and hydrocarbons.

The nature of the agent, as well as the length of contact, contribute to injury severity. This information is essential to the proper evaluation and care of chemical burns. For example, contact with acid generally produces tissue coagulation, whereas alkaline burns generate colliquation necrosis.

Systemic absorption of the burn-causing chemical is also a concern in chemical exposures. As a rule, for most chemical burns, exposure and reaction should be limited by dilution. This is accomplished by continuous irrigation of the burn with tap water or saline.

Most chemical exposures occur in the workplace or are household-related. Typically, the packaging of the chemical is brought in with the patient. If information

regarding the chemical is not available, quickly searching the Internet or contacting your local poison control center may be helpful in determining the proper course of action.

Once the chemical has been eradicated, the resulting burn is treated in the same fashion as a thermal burn.

Electrical burns

Electrical energy is transformed into thermal energy as the current passes through human tissue. This causes cell damage and death. The magnitude of the injury depends on the pathway of current, resistance to current, and the

strength and duration of current flow.

After an electric shock, patients may have electrical “entrance” and “exit” wounds. These usually occur on the hands, feet, or skull, or on oral mucous membranes, especially in children.

Electrical burns are usually painless white, gray, or yellow depressions in the skin. They can be deceiving, however, as a small wound may represent serious underlying injury to subcutaneous structures. Compartment syndromes may occur.

Patients with serious electrical burns are at risk for rhabdomyolysis, renal failure, and cardiac conduction abnormalities. For this reason, evaluation in the hospital for any patient with an electric shock injury is warranted.

Radiation burns

The most common form of radiation burn is exposure to ultraviolet light, or sunburn. Higher amounts of radiation can cause deep internal burns; ultimately, alteration of DNA can cause cancer. Sunburn is generally treated as a first-degree, superficial, thermal burn. More serious radiation burns are beyond the scope of this article.


Evaluation

The initial approach to any burn patient should start with the ABCs. Concerns about burns to the upper airway, smoke inhalation (Table 2), and poisoning from toxic gases from burning plastics such as cyanide should always be considered. Hot and burned clothing should be re-

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Initial U.S. Approval: 1999

INDICATIONS AND USAGE

MOXEZA™ Solution is a topical fluoroquinolone anti-infective indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms: *Aerococcus viridans**, *Corynebacterium macginleyi**, *Enterococcus faecalis**, *Micrococcus luteus**, *Staphylococcus arlettae**, *Staphylococcus aureus*, *Staphylococcus capitis*, *Staphylococcus epidermidis*, *Staphylococcus haemolyticus*, *Staphylococcus hominis*, *Staphylococcus saprophyticus**, *Staphylococcus warneri**, *Streptococcus mitis**, *Streptococcus pneumoniae*, *Streptococcus parasanguinis**, *Escherichia coli**, *Haemophilus influenzae*, *Klebsiella pneumoniae**, *Propionibacterium acnes*, *Chlamydia trachomatis**
*Efficacy for this organism was studied in fewer than 10 infections.

DOSAGE AND ADMINISTRATION

Instill 1 drop in the affected eye(s) 2 times daily for 7 days.

DOSAGE FORMS AND STRENGTHS

4 mL bottle filled with 3 mL sterile ophthalmic solution of moxifloxacin hydrochloride, 0.5% as base.

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

- Topical ophthalmic use only.
- Hypersensitivity and anaphylaxis have been reported with systemic use of moxifloxacin.
- Prolonged use may result in overgrowth of non-susceptible organisms, including fungi.
- Patients should not wear contact lenses if they have signs or symptoms of bacterial conjunctivitis.

ADVERSE REACTIONS

The most common adverse reactions reported in 1-2% of patients were eye irritation, pyrexia, and conjunctivitis.

To report SUSPECTED ADVERSE REACTIONS, contact Alcon Laboratories, Inc. or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Reference:

1. MOXEZA™ Solution package insert.

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Table 2. Common Signs of Significant Smoke Inhalation Injury

- Persistent cough, stridor, or wheezing
- Hoarseness
- Deep facial or circumferential neck burns
- Nares with inflammation or singed hair
- Carbonaceous sputum or burnt matter in the mouth or nose
- Blistering or edema of the oropharynx
- Depressed mental status, including evidence of drug or alcohol use
- Respiratory distress
- Hypoxia or hypercapnia

moved. Other injuries should be assessed. If any doubt exists as to the severity of burns or injury, or if respiratory status is in question, EMS should be called and the patient transferred to the nearest hospital.

Carboxyhemoglobin levels should also be obtained for any patient with suspected smoke inhalation; such patients should be maintained on 100% oxygen until levels can be determined.

Flash burns, such as those that might be caused by a gas grill or oven pilot light, often harm the face but rarely involve the airway, unlike severe burns from prolonged heat exposure associated with smoke inhalation.

Fluid resuscitation should also be instituted as soon as possible with any moderate burns, as fluid losses and shifts may be massive. Although usually not a concern in most urgent care centers, rural areas or areas that may have a long transport time to the hospital may see patients who require fluid resuscitation in the urgent care center. Crystalloid, such as normal saline or lactated ringers, is preferred. Calculation of amounts of fluid is beyond the scope of this article but can be found in most emergency medicine textbooks (see *Resources* on page 20).

Burns are often associated with other injuries, such as are seen in motor vehicle crashes, blast injuries, falls from heights, and assaults. Clinicians should maintain a high index of suspicion to rule out associated injuries.

Major traumas, such as long-bone fractures and injuries of abuse or neglect, need to be considered in the evaluation of the burn patient.

Burn Classification and Treatment

The purpose of classifying burns is to determine the best form of treatment and the prognosis, as well as whether evaluation and/or transfer to a burn center is warranted. Due to variable skin thicknesses and variation in exposures, burns may have multiple areas of varying depths, which may make classification difficult (Tables 3 and 4).

Furthermore, it may be several days or even weeks before the extent of injury has fully developed. Thin skin on the forearms, medial thighs, perineum, and ears may sustain deeper injuries than initially predicted. Also, children under 5 and adults over 50 years of age may have thinner skin and therefore more serious injuries than expected.

Figure 1. Superficial Burn



Superficial burn due to sunburn.

Traditionally, burns were classified into three degrees, but a newer, more widely accepted classification system based on depth of injury is now used to determine prognosis and disposition of the burn patient.

Superficial burns

Superficial burns involve only the epidermal layer of skin. They do not blister but are very painful, dry, and red, and will blanch with pressure. The classic superficial burn is sunburn (**Figure 1**). Redness is apparent within two hours of burning and is maximal within 12 hours. In two to three days, the redness and pain begin to subside; on day 4 or 5, the epithelium peels away from the newly healed epidermis.

Superficial burns heal without scarring. Treatment is designed to improve comfort and is not required for actual healing. Topical treatment may include aloe, cool compresses with water, nonfat milk, or Burow's solution. NSAIDs such as ibuprofen or naproxen may decrease pain and inflammation. Severe cases may respond to prednisone 1 mg/kg/day for three days. Narcotic pain medication may also be of benefit.

"Sun poisoning" is a syndrome of severe widespread sunburn associated with nausea, vomiting, and dizziness. IV fluids may be required in these cases. Local anesthetic containing topical preparations should be avoided; they are generally ineffective and may cause sensitization to the ingredients. Patients should be instructed to avoid sun exposure for three weeks. Patients should be



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Table 3. Burn Classification

Burn Type	Minor	Moderate	Major
Criteria	<ul style="list-style-type: none"> • <10% TBSA* in adults • <5% TBSA in children or elderly patients • <2% full-thickness burns 	<ul style="list-style-type: none"> • 10%-20% TBSA in adults • 5%-10% TBSA in children • 2%-5% full-thickness burns • High-voltage injury • Suspected inhalation injury • Circumferential burn • Medical problem predisposing to infection 	<ul style="list-style-type: none"> • >20% TBSA in adults • >10% TBSA in children • >5% full-thickness burns • High-voltage burns • Known inhalation injury • Any significant burns to face, eyes, ears, genitalia, or joints • Significant associated injuries (major fracture or other major trauma)
Disposition	Outpatient	Admit to hospital	Admit to burn center

*TBSA = total body surface area

Table 4. Burn Assessment

Degree	Depth	Cause	Appearance	Sensation	Healing Time
First	Superficial	<ul style="list-style-type: none"> • Ultraviolet exposure (sunburn) • Very short flash 	<ul style="list-style-type: none"> • Dry, red • Blanching with pressure 	Painful	3-6 days
Second	Superficial, partial thickness	<ul style="list-style-type: none"> • Scald (spill or splash) • Short flash 	<ul style="list-style-type: none"> • Blisters • Moist, red, or weeping • Blanching with pressure 	Painful to temperature and air	7-20 days
Second	Deep partial thickness	<ul style="list-style-type: none"> • Scald (spill) • Flame • Oil • Grease 	<ul style="list-style-type: none"> • Blisters (easily unroofed) • Wet or waxy dry • Variable color (patchy to cheesy white or red) • No blanching with pressure 	Perceptive of pressure only	>21 days
Third	Full thickness	<ul style="list-style-type: none"> • Scald (immersion) • Flame • Steam • Oil • Grease • Chemical • Electrical 	<ul style="list-style-type: none"> • Waxy white, to leathery gray, to charred and black • Dry and inelastic • No blanching with pressure 	Deep pressure only	Never if >2% TBSA*
Fourth	Muscle and bone	<ul style="list-style-type: none"> • Prolonged contact with flame, steam, or electrical • Immersion in oil, grease, or chemical 	<ul style="list-style-type: none"> • No skin remaining • Charred, black, or mummified appearance 	Insensate	Never

*TBSA = total body surface area.
Adapted from American Burn Association criteria. Available at www.ameriburn.org.

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Figure 2. Superficial partial-thickness burn



Superficial partial-thickness burn due to hot liquid. Note the loose tissue on the upper margin due to the break of blister. This can be carefully debrided with tissue scissors to facilitate cleaning and dressing changes. The tissue beneath the blister is healthy and pink.

Figure 3. Deep partial-thickness burn.



Deep superficial-thickness burn several days after injury. Hot liquid such as grease was spilled on the dorsum of the hand. Note the red leathery tissue beneath the broken blister. Although there is a fair amount of redness surrounding the burn, this represents inflammation, not infection.

Figure 4: Mixed-thickness burn.



Mixed-thickness burn consisting of superficial partial-thickness and deep partial-thickness burns due to recent injury. This patient touched a hot object, such as an oven or baking pan. The lower portion shows a recently broken blister with healthy tissue beneath. The upper portion is deeper, with red leathery tissue beneath.

questioned about the use of photosensitizing drugs such as tetracyclines, thiazides, sulfonamides, phenothiazines, sulfonylureas, griseofulvin, vitamin B6, and NSAIDs.

Figure 5. Full-thickness burn.



Full-thickness burn after 8 days. Note the hypertrophic tissue at the margins as the wound granulates inward.

Partial-thickness burns

Partial-thickness burns can be divided into superficial and deep (**Figures 2, 3, and 4**). Superficial partial-thickness burns form blisters within 24 hours of injury between the epidermis and dermis. They are painful, red,

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may be weeping, and will blanch with pressure. They generally heal in seven to 21 days. If blisters break, a layer of fibrous exudate and debris may accumulate on the surface, which may cause bacterial colonization and delayed healing. Scarring is unusual, but skin changes may take months to dissipate. Pigment changes may occur. There is typically no functional impairment.

Deep partial-thickness burns extend deeper into the dermis, damaging hair follicles and glandular tissues. They are painful to pressure only. Blisters, if present, easily unroof. If absent, the skin may be wet or waxy dry, and may appear cheesy white or red. Blisters do not blanch with pressure. If no infection is present, they should heal without grafting in three to nine days. There is usually hypertrophic scarring, which may cause functional or cosmetic impairment. Grafting may be required in extreme cases.

Full-thickness burns

Full-thickness burns extend through and destroy all layers of the dermis and often injure deeper structures (**Figure 5**). Burn eschar, the dead and denatured dermis, may compromise the viability of a limb or respiratory function if on the torso or neck. A full-thickness burn is anesthetic. It can vary from waxy white to charred and black in color. The skin may appear and feel leathery. The skin is dry and inelastic and does not blanch with pressure. Hair falls out of the follicles easily. Blisters are not present. The full extent of injury may take several days to develop.

After several days, the wound eschar falls away from the underlying tissue, revealing unhealed granulation tissue. The wound heals by secondary intent, leaving contractures and scarring, which may be severe. Skin-grafting surgery is necessary to prevent deformity and facilitate healing. Full spontaneous healing, except in the smallest burns, is not possible without grafting.

Fourth-degree burns are deep and potentially life-threatening. They extend through to fascia, muscle, and/or bone. Amputation or wide excision of deep tissue is required. The procedure itself may be life-threatening and disfiguring.

Immediate Care

Patients presenting with acute burns should have hot or burned clothing, jewelry, and obvious debris removed immediately to prevent further injury and constriction, and to enable accurate assessment.

Burned areas should be cooled using cool water or saline-soaked gauze. For small and moderate-size burns, cooling may minimize the zone of injury and certainly

When to Refer a Patient to a Regional Burn Center

Just as it is important to know what an urgent care center can do to treat burn injuries, it is equally important to recognize what is beyond the scope of urgent care. A burn patient should be referred to a regional burn center under these conditions:

- Partial-thickness burns greater than 10% total body surface area
- Non-minor burns that involve the face, hands, feet, genitalia, perineum, or major joints
- Full-thickness burns
- Electrical burns, including those caused by lightning
- Chemical burns
- Inhalation injury
- Burn injury in patients with pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality (eg, diabetes, immunosuppression, vascular disorders, etc.)
- Children in whom the reliability of the parents is in doubt
- Burn injury in patients who require special social, emotional, or long-term rehabilitative intervention
- Any patients with associated trauma requiring hospitalization

Most regional burn centers have an 800 number to call if there is a question as to whether a patient is appropriate for referral. Some patients may be more appropriate for outpatient follow-up with a burn clinic; these recommendations and arrangements can be made through a regional burn center. It is best to have the phone number of your designated burn center close at hand in case the need to call is urgent.

A directory of US regional care centers—including number of beds, address, phone, fax, email, and the names of and contact information for center directors—is available at this link: www.ameriburn.org/BCRDPublic.pdf. For Canadian regional burn centers, the link is: www.ameriburn.org/CanadaFinalPub.pdf.

reduces pain. Although there is no specific time frame, duration of cooling is generally 15-30 minutes.

Ice and freezing should be avoided, as frostbite, hypothermia, and extension of burn damage can occur. Even with cool water, hypothermia may be a concern if more than 10% of total body surface area is burned.

Pain management

Burns hurt! Adequate pain management is essential and should not be withheld. Parenteral narcotics are often required, sometimes in larger doses than are required for other injuries. It may be helpful to medicate patients before cooling, cleaning, and bandaging are undertaken. Regional anesthesia may be considered. Local injection or topical application of an anesthetic should not be used. Adequate narcotic prescriptions should be



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provided until the patient is able to follow-up. In addition, NSAIDs should be recommended for pain, as their antioxidant, anti-inflammatory, and anti-thromboxane properties may speed healing.

Wound management

All burns should be cleaned by irrigation. Standard recommendations usually include cool saline solution, but recent studies suggest that tap water may be reasonable. Skin disinfectants such as chlorhexidine and povidone/iodine can act as an irritant and inhibit wound healing; as such, they are no longer recommended. Mild soap or antibacterial hand soap may be used, if necessary.

Intact blisters should not be unroofed. In most cases, they should be left in place unless rupture is impending or the blisters are in an area that will likely be traumatized and ruptured (eg, groin, bottom of foot, tip of finger, etc.). Needle aspiration is not recommended due to the increased risk of infection. The skin remaining from broken blisters should be carefully removed.

All partial- and full-thickness burns should have dressings after cleaning. Dressings prevent further trauma and infection, as well as increase patient comfort. Topical antibiotics should be applied to all partial-thickness burns unless the patient is being transferred to a burn center. A thin layer is preferred to copious application.

Traditionally, silver sulfadiazine has been the first-line topical antibiotic. It should not be used on the face or in patients with sulfa allergies, pregnant women, newborns, or breastfeeding mothers.

Bacitracin, triple antibiotics (bacitracin, polymyxin B, neomycin), or polysporin (bacitracin, polymyxin B) may also be used. There are no studies proving the benefit of one over the other. Bacitracin is the least-expensive alternative; it may be preferred for this reason. It has been reported that 7%-13% of Americans are allergic to neomycin¹; avoidance of triple antibiotics may therefore be prudent. Topical antibiotics should be continued until all wound epithelialization is complete.

A layer of non-adherent gauze should be placed over the antibiotic ointment. Loose strips of fine-mesh gauze (as opposed to continuous wrapping) should then be applied to prevent constriction and provide protective padding and splinting of fingers and toes.

Fingers and toes should each be wrapped individually to prevent maceration of tissue when two burnt surfaces are adjacent. Gauze can be held in place with tubular-net gauze or loose wrapping.

Biologic dressings and bismuth-impregnated petroleum gauze are gaining popularity. At present, however,

Resources

While there are numerous resources available for diagnosis and treatment of burn injuries, three texts and one website are especially worthwhile:

- Roberts, JR, Hedges, JR. *Clinical Procedures in Emergency Medicine*, 5th ed. Philadelphia, PA: Saunders; 2009.

Considered one of the best texts on emergency medicine clinical procedures. Chapter 39 is devoted to burn care procedures.

- Tintinalli, JE, Stapczynski J, Ma OJ, et al. *Tintinalli's Emergency Medicine: A Comprehensive Study Guide*, 7th ed. New York, NY: McGraw-Hill; 2010.

With 418 contributors, this is one of most practical and clinically rigorous references for emergency medicine. The chapter on environmental injuries covers thermal burns, chemical burns, electrical injuries, lightning injuries, radiation injuries, and more.

- Buttaravoli, P, *Minor Emergencies: Splinters to Fractures*, 2nd ed. Philadelphia, PA: Mosby Elsevier; 2007.

A quick reference for the hospital or urgent care center, with instructions for handling such common, non-life-threatening emergencies as sunburn, partial-thickness and tar burns, smoke inhalation injury, and more.

- American Burn Association
www.ameriburn.org

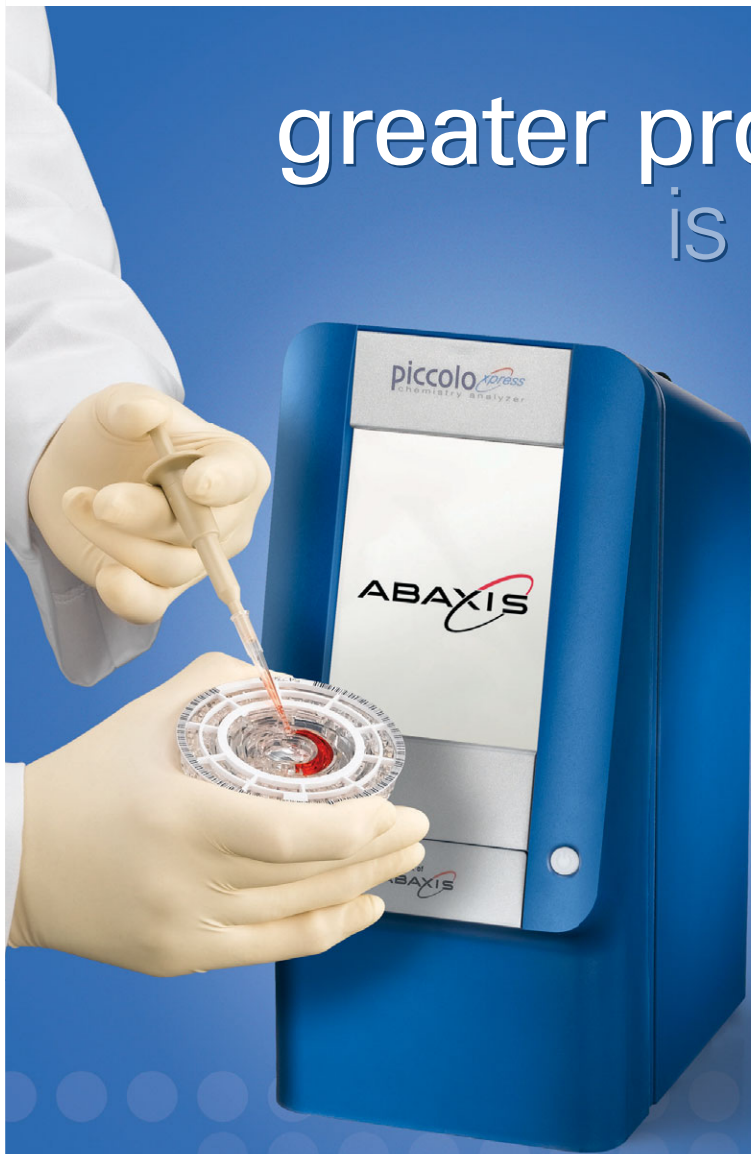
Offers educational materials for providers and patients on electrical, chemical, and non-thermal injuries; wound healing/scar management; burns in the high-risk patient; respiratory/pulmonary injuries and problems associated with burns; rehabilitation/reconstruction; nutrition, infection, and immunology; pain; and psychosocial aspects of burn injury. Includes directories of regional burn centers in the US and Canada.

their use is largely limited to burn centers, where they are used on deeper wounds. They are applied only once and generally do not require changing. These dressings promote lower rates of infection, are more comfortable, require less pain medication, and promote faster healing.

Conversely, biologic and impregnated-gauze dressings are expensive, difficult to apply, and have a narrow time frame for effective application: within six hours of injury. Occasionally, re-application is required if loosening occurs on day 2. The dressing will gradually peel off as wound epithelialization occurs, leaving fresh tissue beneath.

If the wound is deeper than appreciated or if infection occurs, a biologic dressing will be ineffective. In that event, grafting is required.

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Liver Panel Plus	ALB, ALP, ALT, AMY, AST, GGT, TBIL, TP
General Chemistry 6	ALT, AST, BUN, CRE, GGT, GLU
General Chemistry 13	ALB, ALP, ALT, AMY, AST, BUN, Ca, CRE, GGT, GLU, TBIL, TP, UA
Electrolyte Panel	Cl ⁻ , K ⁺ , Na ⁺ , tCO ₂
Kidney Check	BUN, CRE
Renal Function Panel	ALB, BUN, Ca, Cl ⁻ , CRE, GLU, K ⁺ , Na ⁺ , PHOS, tCO ₂
MetLyte 8 Panel	BUN, CK, Cl ⁻ , CRE, GLU, K ⁺ , Na ⁺ , tCO ₂

*Calculated

Hepatic Function Panel	ALB, ALP, ALT, AST, DBIL, TBIL, TP
Basic Metabolic Panel Plus	BUN, Ca, Cl ⁻ , CRE, GLU, K ⁺ , Na ⁺ , tCO ₂ , Mg, Lactate Dehydrogenase

Brands of biologic dressings include Acticoat, Biobrane, and TransCyte. Amniotic membranes and animal products have shown promise as well. None of these dressing alternatives are practical in the urgent care setting at this point but may be useful options in the near future.

Tetanus

Tetanus status should be addressed for any wounds deeper than superficial thickness. In patients who have not received a complete primary immunization, tetanus immune globulin—as well as the primary immunization—should be provided.

Antibiotics

Prophylactic antibiotics in any form are not recommended and have no proven benefit for the prevention of burn infections.

Disposition

All patients who meet the criteria for serious burns

should be transferred to a burn center (see *When to Refer a Patient to a Regional Burn Center* on page 18) .

However, initial difficulties in differentiating superficial partial-thickness burns from deep partial-thickness burns and full-thickness burns, as well as concerns about the unpredictable evolution of injuries, should make consultation with a burn surgeon a precaution to consider. This is especially true if burns are on the face, hands, perineum, or feet, or if burns are on high-risk patients (eg, individuals who are elderly, immunosuppressed, or diabetic).

Contacting a burn specialist can help with identification of patients who warrant follow-up and ensure appropriate and timely care that can prevent long-term damage. In addition, specialist consultation is a legally prudent course of action; the basis of a malpractice suit, particularly given the unpredictable course of burn injuries, could well be failure to seek specialist advice. ■

Reference

1. Gehrig KA, Warshaw EM. Allergic contact dermatitis to topical antibiotics: Epidemiology, responsible allergens, and management. *J Am Acad Dermatol.* 2008;58(1):1-21.

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Practice Management

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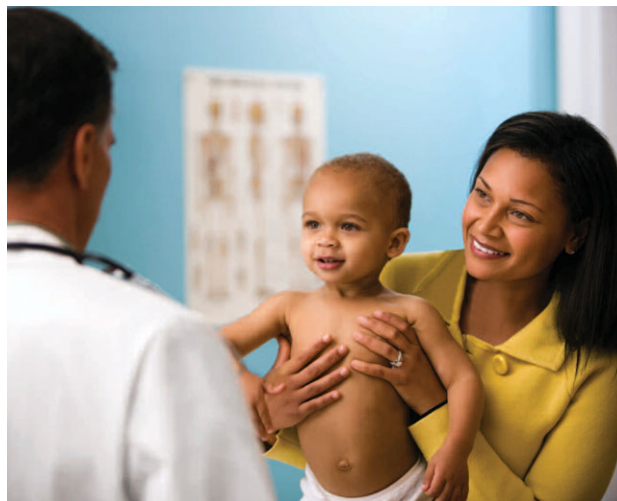
Alan A. Ayers, MBA, MAcc

The success of a new urgent care center in a community requires a change in consumer behavior, with a sufficient number of residents shifting their utilization from emergency departments and primary care physicians.

As such, building sufficient volume to reach breakeven can take a couple of years. But even after volume has stabilized, many urgent care operators find it difficult to grow profits year after year, particularly when faced with rising operating costs and cuts to Medicare and private insurance reimbursement. Once revenue is sufficient to cover such operating costs as salaries, rent, utilities, advertising, and depreciation, each incremental visit contributes directly to the bottom line.

To increase volume and enhance the profitability, many urgent care operators turn to ancillary services. These are generally cash-only services that leverage existing clinic infrastructure but do not entail treating minor injury and illness. The primary advantage of ancillary services is that accepting only cash means no billing or accounts-receivable carrying costs. In addition, ancillary services can be scheduled, flattening the ebb and flow in walk-in volume. Moreover, they can help raise public awareness of a center's services and attract new urgent care patients.

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Alan A. Ayers is Content Advisor for the Urgent Care Association of America and Vice President of Strategy & Execution at Concentra Urgent Care in Dallas, Texas.



A common ancillary service for urgent care providers is “immigration medicine”: documentation of physical exams, vaccinations, and lab tests required by the United States Citizen and Immigration Services (USCIS) for every non-US citizen desiring a change in his/her residency or citizenship status. Immigration physicals require that a physician hold a “civil surgeon” designation, understand the paperwork and examination requirements involved, carry a limited inventory of vaccines, and have access to a clinical reference laboratory.

Table 1. Sample Process Flow and Quality Assurance Checklist for Immigration Physicals	
Chart Creation	
Items below should be assembled into the patient’s chart prior to physician consultation:	
<ul style="list-style-type: none"> • Patient Information Sheet • Medical Questionnaire • Immunization Record (top section) • Physical Form (top section) • Authorization for Laboratory Testing* • Photo Identification 	<ul style="list-style-type: none"> • Pregnancy Form (females over 15 years of age) • Consent for Vaccines • Copy of Previous Immunization Records • Copy of Previous Test Results • Tuberculosis Skin Test (PPD) (or proof of <90 days past) • Results of Chest X-Ray (if <6 months old)
<small>*Effective January 2010, HIV testing is no longer required as part of the USCIS physical screening process. Individuals testing positive for HIV are no longer required to secure a waiver for entry into the US. Testing for syphilis is still required.</small>	
Physician’s Examination	
Items below should be completed in the chart after the physician’s physical examination:	
<ul style="list-style-type: none"> • Civil Surgeon Copy of I-693 Form • Copy of Immunization Record • Copy of Photo Identification 	<ul style="list-style-type: none"> • Copy of Tuberculosis Skin Test (PPD) • Copy of Chest X-Ray (if positive PPD) • Blood Work Results
Patient’s Packet	
Items below should be returned to the patient upon payment and discharge*:	
<ul style="list-style-type: none"> • Provider’s Cover Sheet Letter • Copy of Immunization Record • Photo Identification 	<ul style="list-style-type: none"> • Copy of Tuberculosis Skin Test (PPD) • Copy of Chest X-Ray (if positive PPD) • Copy of Blood Work Results
<small>*Note: Patient does <i>not</i> receive the I-693 Form. This form goes in the sealed the United States Citizen and Immigration Services (USCIS) envelope.</small>	
USCIS Envelope	
Items below should be sealed in the USCIS envelope, which the patient returns to the USCIS*:	
<ul style="list-style-type: none"> • Three Remaining I-693 Form Copies • Original Immunization Record 	<ul style="list-style-type: none"> • Copy of Photo Identification • Copy of Chest X-Ray (if positive PPD)
<small>*Note: Blood work results are <i>not</i> included in the USCIS envelope.</small>	

Civil Surgeon Designation

To practice immigration medicine, a physician first must earn a civil surgeon designation. According to the USCIS website (www.uscis.gov), this entails locating the USCIS District Office serving the provider’s state (a locator by zip code is available on the website) and submitting the following documents:

- A letter to the District Director requesting consideration
- A copy of the provider’s current medical license
- A current CV that shows four years of professional experience (excluding residency)
- Proof of US citizenship or lawful status in the US
- Two signature cards with the provider’s name typed or printed as well as signed

No separate form or application is required. However, there are only a limited number of designated civil surgeons appointed to each geographic area; new applicants will be turned away or waitlisted if there is already a sufficient number in their community. Once designated as a civil surgeon, a provider will be listed on the USCIS website and may begin offering immigration physicals to the general public.

Paperwork and Examination

The purpose of immigration physicals is to assure that individuals seeking citizenship or permanent residency in the US do not have physical or mental conditions that pose a threat to the health, safety, and welfare of

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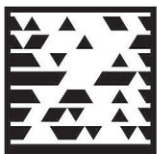
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the nation or lead to exclusion under immigration laws. Although the actual physical exam is not particularly time-consuming for the civil surgeon to conduct, considerable paperwork is involved for front office staff. Flow sheets and checklists can be created to facilitate these transactions and assure that staffers complete the necessary documentation properly (Table 1).

Patients are required to bring several documents to their appointment:

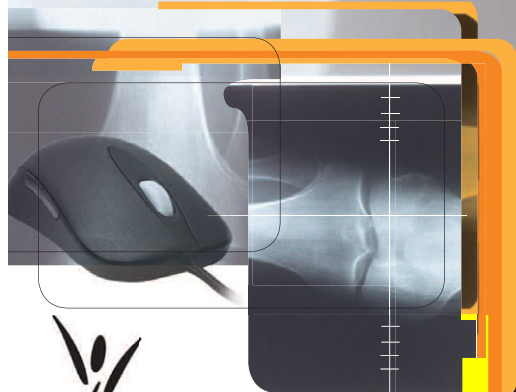
- Patient Information Form
 - Demographics and basic health information
 - Applicable medical records
- USCIS Form I-693: Report of Medical Examination and Vaccination Record
 - Patients should complete the demographics section in advance of the appointment
 - Clinics providing immigration physicals should also keep copies of the forms on-site
- Vaccination records (Table 2), showing proof of vaccination, which includes:
 - Type of vaccination administered
 - Date administered
 - Physician who administered the vaccination
- Copies of previous test results, if applicable:
 - Tuberculosis skin test or chest x-ray
- Photo identification

Once the front-desk staff reviews all materials, they determine which immunizations and tests have been administered and which are needed. When vaccination records are in a foreign language, the patient should provide a certified English translation; otherwise, the record cannot be relied upon and it must be assumed that vaccinations have not been administered. Current USCIS vaccination requirements include:

- Mumps
- Measles
- Rubella
- Polio
- Tetanus and diphtheria toxoids
- Pertussis
- Haemophilus influenzae type B
- Hepatitis B
- Any other vaccine-preventable diseases recommended by the Advisory Committee for Immunization Practices

Necessary vaccinations are administered by the clinic staff or a waiver is sought according to USCIS guidelines, which may be based on age, medical appropriateness, or religious convictions. After the vaccination record is completed, the civil surgeon conducts the physical examination.

Form I-693 specifies examination components, which differ depending on the age of the patient and will include, at minimum, examination of the eyes, ears, nose, throat, extremities, heart, lungs,




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abdomen, lymph nodes, skin, and external genitalia. The Centers for Disease Control and Prevention provide technical instructions for conducting the physical examination that address issues that could exclude an applicant or require further investigation. Such potentially exclusionary issues include physical and mental conditions, communicable diseases, substance abuse, and criminal behavior.

A laboratory test for syphilis is also required as part of the examination requirements. Blood is drawn and sent out by the clinic staff; once results are received, they are documented by the physician on Form I-693. A downloadable form is available at www.uscis.gov/files/form/i-693.pdf.

The completed original Form I-693 with the civil surgeon's signature, a copy of the patient's photo ID, and a chest x-ray (if applicable) are then sealed in an envelope and given to the patient to submit unopened to the USCIS with his/her application for processing.

Revenue Opportunity

Immigration physicals are a cash-only business. They entail checking vaccination records to assure that an applicant is current on all required vaccinations, conducting tests for syphilis and tuberculosis, and conducting a physical exam by an authorized civil surgeon. Fees come from processing the paperwork, conducting the physical exam, and administering necessary tests and immunizations.

USCIS does not have a set or recommended fee schedule for immigration physicals; pricing is up to the individual provider (Table 3). Typically an urgent care center will charge a base fee of \$75-\$150 for the physical and then charge à la carte for vaccinations, tests, or x-rays administered, resulting in a total visit charge of \$250-\$300 or more. To simplify pricing, some practices offer an all-inclusive immigration physical for \$400-\$450 or more, regardless of actual services administered. With moderate volume in a metropolitan area, immigration physicals can easily add \$100,000 or more to an urgent care center's net collections.

When establishing rates, keep in mind that families tend to come for immigration physicals together. A married couple with two children could easily generate \$800-\$1,200 in cash revenue in a single appointment. In addition, applicants with USCIS span the economic spectrum—from engineers with PhDs to day laborers—so price elasticity may be advisable, depending on the applicant profile in a community. To capture new business from patient referrals and generate positive word of mouth in immigrant social circles, pricing must be competitive with rates offered by other immigration medicine providers in the community.

On the other hand, it is important to hold firm on rates once they are set. Members of some non-American cultures are accustomed to bartering and will attempt to "talk down" or engage in other tactics to secure a lower price. When the price is reduced for one sympathetic individual, word may quickly spread that a center's pricing is negotiable and result in an expectation of discounts for all.

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Table 2. Sample Immigration Physical Vaccination Record

Vaccine History Transferred from a Written Record				Date Vaccine Administered by Civil Surgeon MM/DD/YY	Completed Series or Fully Immune (Check if Yes or Include Date of Lab Test if Immune)	Waivers to be Requested from USCIS: <input type="checkbox"/> Blanket <input type="checkbox"/> Not Medically Appropriate		
Vaccine	Dates Received MM/DD/YY					Not Appropriate Age	Contra-indication	Insufficient Time Interval
DT/DTP								
TD								
Polio (OPV/IPV)								
Measles (or MR or MMR)								
Mumps (or MMR)								
Rubella (or MR or MMR)								
Hib								
Hepatitis B								
Varicella								
Pneumococcal								
Influenza								

Likewise, paperwork should never be released to a patient without payment in full. The odds of collecting immigration physical fees after the fact are slim to none. When immigration physicals are promoted as a cash-only service, the onus is on patients to seek reimbursement from an employer, insurer, or other third party.

Marketing of Immigration Physicals

Because the duty to obtain an immigration physical falls on the applicant, individuals requiring the service will generally visit the USCIS website or ask a local congressman’s office, immigration office, friends, family, attorney, or religious leader for advice on where to go. Although urgent care providers are wise to develop relationships with local immigration attorneys, advocacy groups, or places of worship—providing marketing materials for them to display or distribute—most referrals come from word of mouth. Some providers see fairly significant immigration physical volume without any paid marketing at all.

Certain operational factors, however, may affect how appealing an urgent care facility is to certain immigrant groups. For instance, does the facility offer both

male and female civil surgeons? Some cultures prohibit a patient from seeing a provider of the opposite sex. Is the facility open on Sunday? Some religious groups observe Friday or Saturday as Sabbath holy days. Also, Fridays and Saturdays are workdays for many immigrants. Is the center staff bilingual? If not, is a translator available? If there are large immigrant populations in your community, it may be useful to enlist the assistance of ethnic advocacy groups in providing translation services. Is the facility accessible to a bus line? In urban areas, it is common for recent immigrants to lack reliable transportation.

Even when multiple clinics provide immigration physicals in a community, some applicants in major metropolitan areas have been known to drive three hours or longer to another city if a provider is available with male and female practitioners, Sunday hours, fast turnaround time on documentation, and affordable rates.

Because immigration physicals bring new patients to the urgent care center, they provide an opportunity to educate patients who may not be familiar with the US medical system or know when to choose urgent care for a family’s personal injury and illness needs. Many recent

Table 3. Services Administered, Coding Utilized, and Sample Fees Charged by Patient Age Range^{a,b}

	Tetanus	Physical Examination	DTP	Polio	Hep B	Pneumonia	Hib	MMR ^c	Varicella	PPD ^d	RPR	FLU	Blood Draw ^e
Average Fee	\$29	\$74	\$45	\$25	\$37	\$45	\$120	\$53	\$103	\$34	\$21	\$33	\$15
Birth to 1 Month	—	—	—	—	90744	—	—	—	—	—	—	—	—
2 to 11 Months	—	—	90701	90712	90744	90732	90471	—	—	—	—	—	—
12 to 23 Months	—	99382	90701	90712	90744	90732	90471	90707	90716	—	—	—	—
2 to 6 Years	—	99382 (1–4 yrs)	90701	90712	90744	—	90471	90707	90716	86580	—	—	—
7 to 14 Years	90718	99383 (5–11 yrs)	—	90712	90744	—	—	90707	90716	86580	—	—	—
15 to 17 Years	90718	99374 (12–17 yrs)	—	90712	90744	—	—	90707	90716	86580	86592	—	36415
18 to 19 Years	90718	99385	—	—	90744	—	—	90707	90716	86580	86592	—	36415
20 to 49 Years	90718	99385 (18–39 yrs) 99386 (40–64 yrs)	—	—	—	—	—	90707	90716	86580	86592	—	36415
50 to 64 Years	90718	99386	—	—	—	—	—	—	90716	86580	86592	90658	36415
65 Years and Older	90718	99387	—	—	—	90732	—	—	90716	86580	86592	90658	36415

^aCharges are for illustrative purposes and may be set by the individual provider.
^bThe provider should inquire about the use of birth control and pregnancy status or conduct a pregnancy test if in doubt. Pregnant patients *cannot* receive MMR or varicella. They *must* receive PPD, TD, Hep B, pneumococcal, and flu. If a pregnant patient is positive for HIV or RPR, refer her to the health department for treatment. Paperwork should not be completed until verification of treatment is received.
^cOnly if born after 1956.
^dAll immunizations should be administered on the same day as PPD, except for flu vaccine.
^eTo maximize revenue, all blood work should be drawn and sent out by the urgent care center.

immigrants lack access to basic primary care but nevertheless may have episodic health needs that could be served by urgent care.

In addition, immigration physicals may capture referrals for other ancillary services—eg, travel medicine—especially when parents are inoculated for foreign travel but their US-born children are not. Patients who are satisfied with their immigration physical experience have an incentive to return to the center often and to advise friends and family to do likewise.

Walk-in vs Scheduled Appointments

Although urgent care centers treat illness and injury on a walk-in basis, many centers use scheduled appointments for immigration physicals. The advantage of scheduled appointments is the ability to direct time-consuming physicals to non-peak days and hours. Walk-in clinics typically see declines in visit flow during mid- to late afternoon and mid-week, as well as seasonally during weekend hours. Scheduling physicals in these time slots can result in better utilization of fixed staff and facility investments without adversely affecting overall wait times. If a center lacks a computerized scheduler, a paper appointment book (available at office supply stores) will generally suffice for a single center.

The only limitation is that the times that work best for the center may be inconvenient for applicants. If, for example, a center chooses to perform immigration physicals during peak urgent care times (eg, Saturday mornings), adding additional front office staff and/or providers to avoid extending wait times in the core urgent care business should be considered.

Conclusion

High fixed costs and third-party payer reimbursement in urgent care mean that even after a breakeven volume for patient visits is attained, visits from additional patients can enhance a center’s operating margins. Ancillary services like immigration physicals have been embraced by many urgent care operators as a way to increase profitability through relatively high-priced visits that incur no insurance billing or accounts-receivable carrying costs.

The keys to success are providers who are engaged and willing to seek the civil surgeon designation, keeping the required vaccinations in stock, learning the requirements for conducting an immigration physical exam, and providing a quality patient experience that will attract repeat and new business through word-of-mouth referrals. ■

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Malpractice Insurance: A Primer for Urgent Care Clinicians

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

The possibility of being sued for medical malpractice, while not a pleasant prospect, is not something that should be causing you sleepless nights. Much like flood insurance, malpractice insurance exists for times when an unexpected event occurs and may require some payment for damages. Your goal should simply be to have adequate coverage for those times. And, let's face it, there may be such times. Good providers do get named in malpractice suits. Being sued for malpractice is a cost of doing business.

With this in mind, let's consider what is important to know about malpractice insurance.

The Insurance Contract

Insurance contracts are enforced by the terms of the written policy. Basically, they contain a promise by the insurer to pay or indemnify and to defend all claims covered by the policy against the provider (in insurance-speak: the "insured"). This duty to defend is very broad but not unlimited. For example, in an Arizona case, a malpractice insurer was not required to defend a physician when the plaintiff sought damages for sexual assault since the policy did not cover intentional misconduct.

An insurer may still defend the insured even if the insurer does not believe coverage exists under the policy; the insurer may then seek redress for the coverage issue. For example, if a claim alleges both negligence and intentional misconduct, the insurer is required to defend both; however, if the provider is found liable for both causes of action, the insurer may have no duty to pay damages arising out of the intentional misconduct claim.

Types of Coverage

There are two types of malpractice coverage: claims-made and



occurrence. Claims-made policies provide coverage for claims made against the insured during the policy period. For example, if a provider is notified that he is being sued for malpractice on the day before his policy expires, and the provider in turn notifies the insurance company on the day after the policy expires, the provider may still be covered.

But please review your policy. Some policies require that the claim must be sent to and accepted by the insurer while the policy is in force. In this case, notice to the insured does not constitute the claims trigger. Also, if a plaintiff files a suit against a provider on the last day of coverage but does not serve the summons for 30 days, coverage still exists. However, if the suit is filed after coverage lapses, coverage does not exist even if the event occurred during the policy period.

Claims-made policies are easier for the insurer to price since they allow the carrier to better predict the limits of their liability and thus more accurately predict the premium necessary to cover their exposure. Claims-made policies also provide a prior-acts clause or retroactive date. Depending on the date, this could either include or exclude coverage for prior medical services. The specifics in your policy should be based on what your needs and situation are. Typically, prior coverage is obtained when changing from one claims-made policy to another claims-made policy.



John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*. He may be contacted at JohnShufeldt@shufeldtconsulting.com.

Occurrence policies provide coverage if the event (the “occurrence”) happened during the policy period, regardless of when the claim was filed. Some problems are inherent in these types of policies (especially for the insurer). For example, if treatment extends over a lengthy period of time, it may be difficult to determine when the actual occurrence took place.

Take a provider who is working in an urgent care center and sees a patient on Sunday when Policy A is in place and diagnoses the patient with abdominal pain of unknown etiology. The patient returns on Tuesday when Policy B is in effect and has a ruptured appendix, which results in a malpractice suit. Which policy was in effect at the time of the occurrence? This is something the insurers must determine.

In addition, occurrence policies create significant underwriting challenges secondary to the long tail exposure, which results from their open-ended nature.

Extended-Reporting Endorsements

Extended-reporting endorsements, also known as “tail” coverage, are required when a provider discontinues a claims-made policy and does not have his new insurer assume the prior liability. For example, a provider may be selling his practice or have had claims for which his new insurer does not want to assume any prior liability.

A prior-acts endorsement may be part of the policy or it may be purchased separately. These policies can extend the ability to report claims from past services from one year up to an unlimited period of time. They protect the insured against events that occurred during the reporting period but for which claims were filed after the expiration of the claims-made policy.

Extended-reporting endorsements are typically priced at a multiple of the last year’s premium. The multiple varies by specialty and region of the country but is typically 200%-300% of the mature claims-made policy amount. For example, if an urgent care provider paid \$30,000 per year for his mature policy, a tail coverage policy could cost him up to \$90,000.

Some insurance carriers provide “complimentary” tail coverage if a provider who is retiring has not had any claims. However, free tail coverage for retirement is not available when the policy is written on a clinic as a whole rather than on each individual provider.

Another way to end a claims-made policy without purchasing a tail provision is to purchase “prior-acts” coverage with the subsequent claims-made policy. Prior-acts provisions insure the provider against loss after a specific start date. For example, if a provider has had a claims-made policy for two years and then has to cancel the policy and changes jobs, he can obtain a prior-acts policy for the two preceding years and negate the need for tail coverage. Sometimes, however, a new employer may be loathe to assume prior-acts coverage for the provider’s prior work; in this event, tail coverage must be purchased.

Gaps in Coverage

An incident sparking a malpractice suit may occur during the policy period, but if the claim has not filed until after the policy has expired, the insurer is not obligated to defend it. If the provider does not obtain an extended-reporting endorsement or prior-acts coverage, a gap can occur in his coverage. Such gaps can lead to significant cost issues if the provider allows himself to go completely uncovered. Moreover, once a provider has gaps in his insurance coverage, he becomes much more difficult to insure during subsequent policy periods.

This being the case, be sure to keep copies of your declarations page (“dec sheets”), which prove that you have no gaps in your insurance coverage.

Discovery Clause

When a policy is renewed, an insurance company typically requires an applicant to complete a document itemizing facts or circumstances that have already transpired that might give rise to a claim. If a provider knows of circumstances that may result in a claim and fails to disclose them, he will be accused of fraudulent misrepresentation in the event of a malpractice suit arising from an undeclared but known event.

On the other hand, if a provider does provide full disclosure, the insurer may not cover him against the possibility of a malpractice suit for that particular event. On a positive note, with a claims-made policy, a provider is advised to notify the insurer if he becomes aware of an incident that may give rise to a cause of action. This way, even if the eventual claim is filed after the policy terminates, the claim is usually considered to be made during the policy period.

Deductibles and Policy Limits

You can purchase insurance that either has “first-dollar coverage” (ie, no deductible amount) or that has a deductible amount. Obviously, the higher the deductible amount, the lower the cost of the insurance. The deductible is applied to the cost of the associated court or attorney fees or to the actual dollar amount of any judgment.

“Policy limits” are the amount the insurer is obligated to pay on your behalf. Typically, limits are divided by the amount payable on any one occurrence and the amount paid out during one policy year. For example, a \$1 million/\$3 million policy means that the insurance company will pay up to \$1 million on any one claim and up to \$3 million in any policy year.

Some policies are known as “diminishing-limits” policies. These policies wrap the cost of legal defense into the payout limits. Diminishing-limits policies are of much less benefit to the insured because the defense cost will continually reduce the net amount available to pay damages. Typically, these policies are less expensive than policies that are cost-exclusive.

The determination of appropriate policy limits is essential

to ensure that both the provider and the practice are adequately covered. If the provider is an independent contractor, a judgment in excess of the policy limits could place his personal assets at risk. If the provider is an employee, the practice is typically responsible for covering any judgment that exceeds policy limits.

Settlement of Claims

A malpractice insurance policy often gives the insurer the right to decide whether to settle a claim. The insurer owes a fiduciary duty to the insured to protect his interests. This means that the insurer has an obligation to settle a claim to protect against a judgment exceeding the policy limits. This obligation is a trigger. When the demand is within policy limits, a reasonable insurer would settle the claim, although it is possible that a verdict could exceed policy limits.

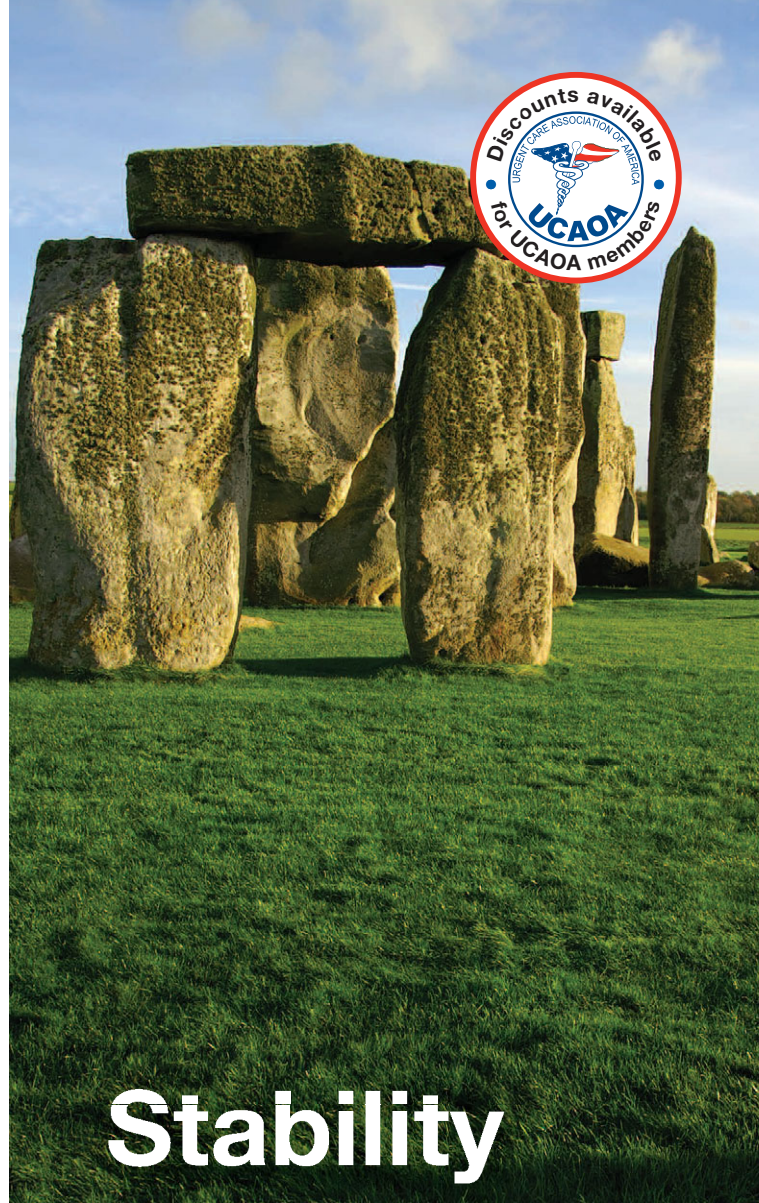
When an insurance company refuses to settle a case and the judgment exceeds the insured's limits, thereby exposing the insured to additional costs, the insured has a potential "bad faith" claim against the insurance company. When this occurs, the plaintiff's attorney may actually indemnify the defendant and then together they would pursue a bad-faith claim against the insurer.

Some malpractice insurance policies contain a clause giving the insured consent rights regarding settlement. This means that the insurer cannot settle a case if the insured refuses to consent to the settlement. When deciding not to settle, however, the insured must consider the possibility that the verdict could exceed his policy limits.

Occasionally, policies with a consent clause also contain a "hammer clause." A hammer clause is a provision stating that if the insured refuses to settle and the verdict is in excess of the proposed settlement amount, the insured is liable to the insurance carrier for the amount paid in excess of the proposed settlement.

Finally, whether a case is settled or lost, any time a payment is made on behalf of a defendant to a plaintiff, the defendant must be reported to the National Practitioner Data Bank (NPDB). I know of some provider groups that are covered under a hospital's high-deductible policy and that have been forced to settle claims for actions for which they did not believe they were culpable. In other words, the providers felt that they were "thrown under the bus" so that the hospital could settle the claim. Consequently, they were reported to the NPDB and ended up with a black mark on their records.

In the end, malpractice insurance is a cost of doing business. A good insurance broker can steer you in the best direction regarding the type and amount of coverage that makes the most sense for you. ■



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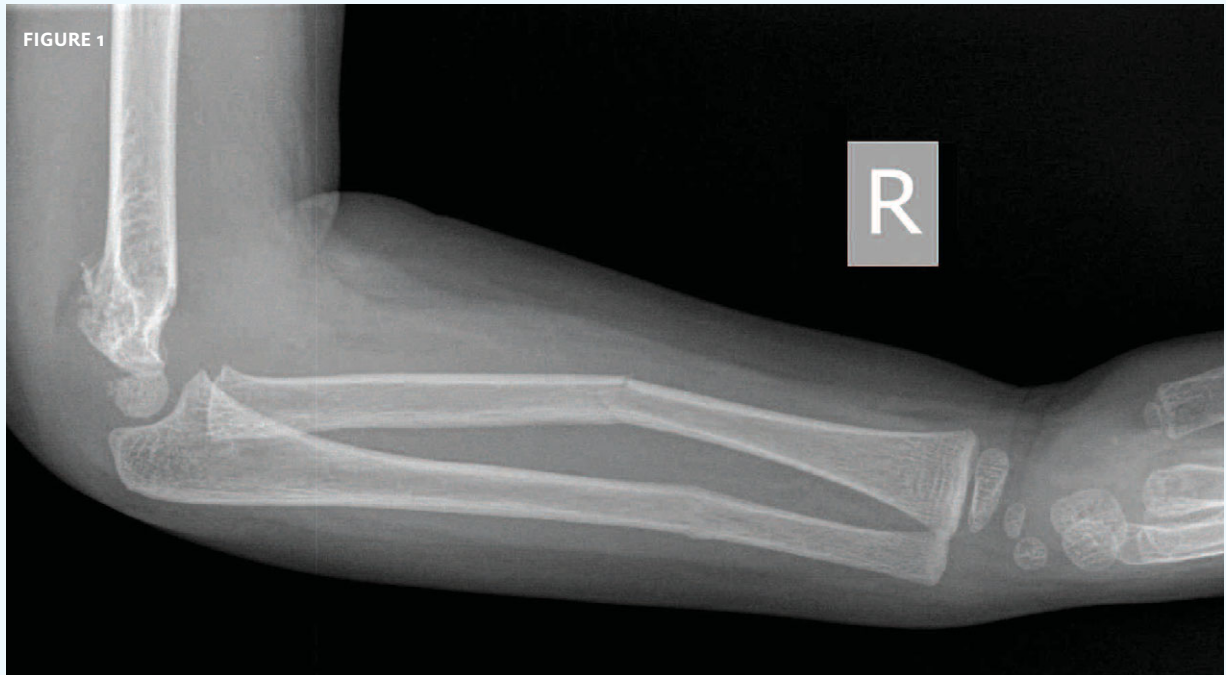
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The patient is an otherwise healthy child, 3.5 years of age, who presents with acute pain in his right lower arm to the elbow. Examination reveals multiple fractures.

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

Resolution of the case is described on the next page.

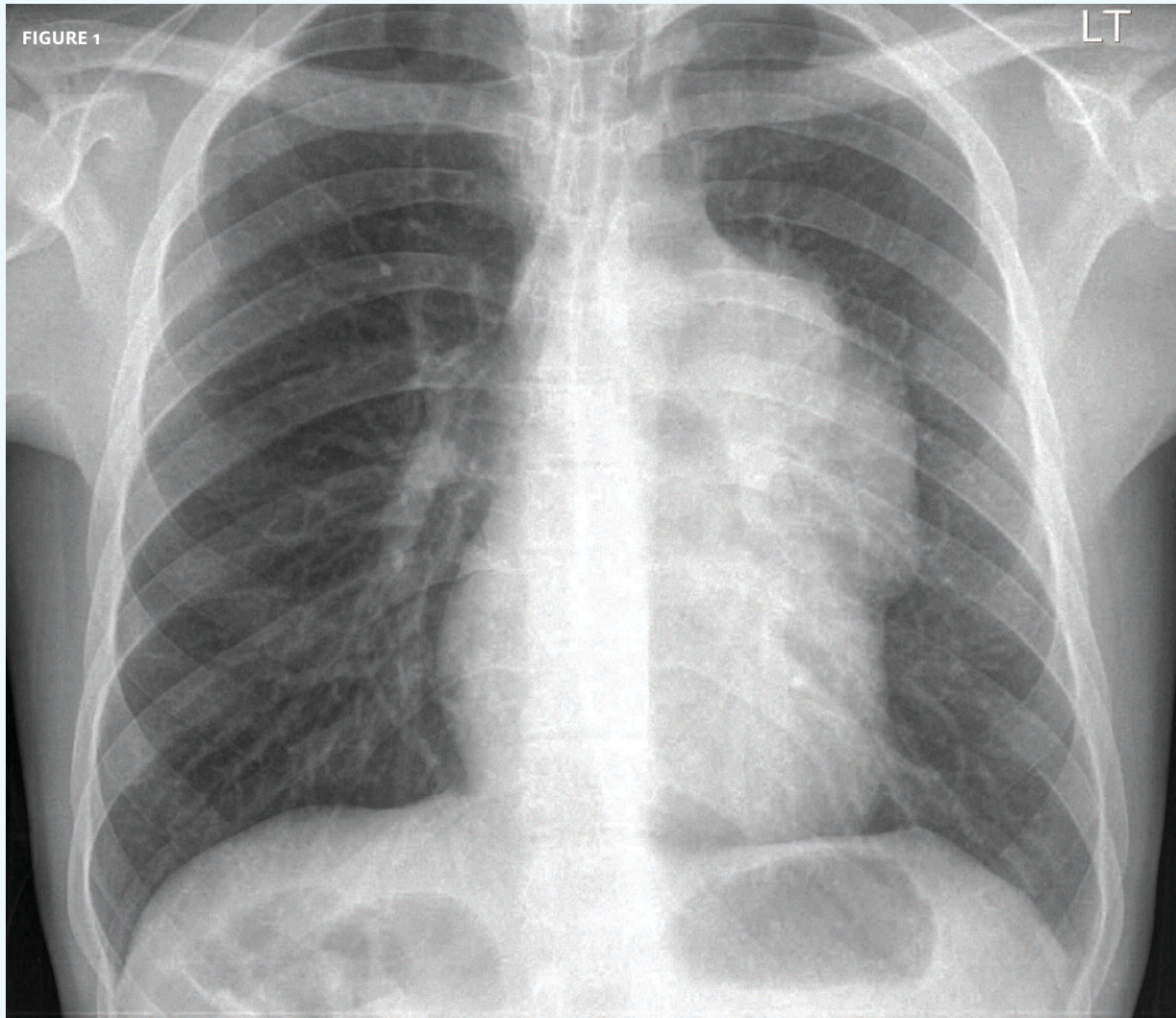
THE RESOLUTION



The patient’s problem list includes trauma and multiple fractures, including the humerus distal (supracondylar) and radius—shaft.

Note that while a supracondylar humerus fracture is evident in this x-ray, it is often occult. In this case, the “anterior humeral line” does not bisect the “capitellum.” This is pathognomonic for supracondylar humerus fracture and requires immediate orthopedic referral. This is an unstable fracture.

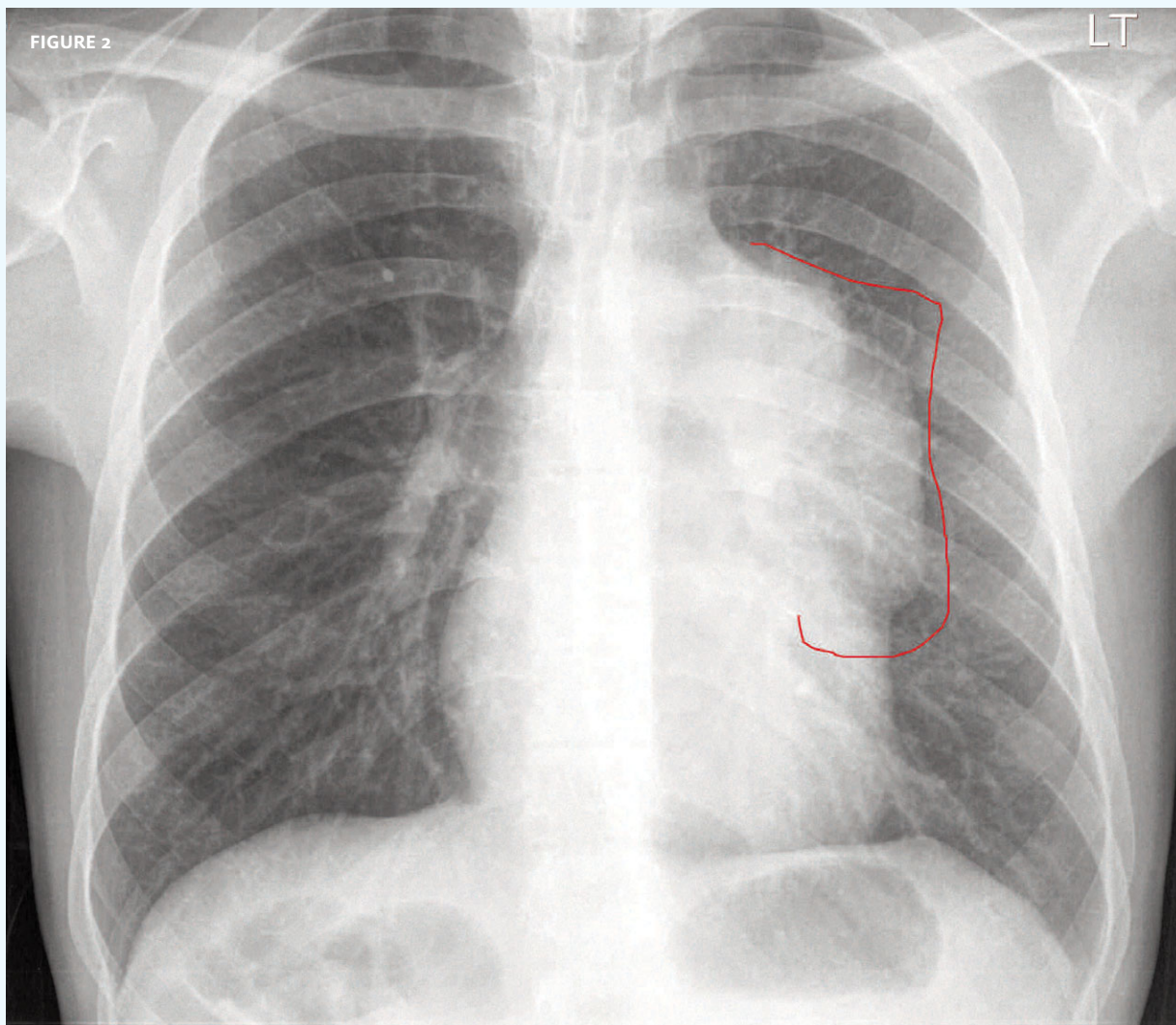
Acknowledgement: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.



The patient is an otherwise healthy 22-year-old male who presents with three weeks of cough. He has already been treated with a macrolide.

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

THE RESOLUTION



The x-ray shows a hilar lesion. The next step is to follow up with a CT scan.

Given the patient's age and unilateral hilar enlargement, the most likely causes are vascular, infectious, bronchogenic cyst, non-Hodgkin's lymphoma (Hodgkin's is usually bilateral), or testicular cancer.

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

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Medical Necessity in E/M Coding

■ DAVID STERN, MD, CPC

Over the next few issues of *JUCM*, we will look at each aspect of E/M documentation from the viewpoint of medical necessity. These columns may be useful as a resource for auditors and urgent care administrators to evaluate issues of medical necessity when auditing charts of urgent care providers for E/M coding.

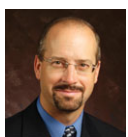
Q. Recently some of my charts were audited and the payor challenged the levels of the evaluation and management (E/M) codes I had used. The payor said that the charts were actually coded correctly, based on the information that was documented on the chart. The auditor, however, challenged what she called the “medical necessity” of the documentation. She claimed that, based on the patients’ chief complaints, many elements of the E/M that were documented were not indicated for each patient. Is this correct?

A. Medical necessity is an area that is being more frequently challenged by auditors. The Centers for Medicare & Medicaid Services (CMS) has noted that physicians should consider medical necessity as the primary issue in E/M coding. ■

Q. What is the definition of medical necessity?

A. AMA (Policy H-320.953[3], *AMA Policy Compendium*) defines medical necessity as:

Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.



David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Dr. Stern speaks frequently at urgent care conferences. He is CEO of Practice Velocity (www.practicevelocity.com), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

CMS (“Medicare Claims Processing,” Pub. 100-04 *CMS Manual System*, Transmittal 178, May 14, 2004) has given the following guidance on medical necessity in relationship to E/M coding:

Medical necessity of a service is the *overarching criterion* for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record. (Italics added.) ■

Q. My charts are going to be reviewed in a Recovery Audit Contractors (RAC) audit. Do RAC audits include reviews of the level of E/M services on physician claims under Medicare Part B?

A. RAC coding reviews currently look at E/M codes that should not be billed because they are already included in the global payment for a procedure. However, RAC reviews do *not* currently involve auditing the actual level of E/M codes. ■

Q. What elements are appropriate for a provider to perform and document in the history of present illness (HPI) for a typical urgent care visit?

A. It is difficult to answer this question in the abstract, so let’s look at a typical urgent care complaint. What elements of the HPI are appropriate for a patient who presents with, for example, a sore throat?

- *Location.* This is recorded by definition in the documentation of sore throat.
- *Quality.* Is the pain merely itching or scratchy, is it burning or sharp, or is it a foreign body sensation? This is important to differentiate probable diagnoses of a viral or bacterial etiology or a foreign body (eg, a bay leaf that was swallowed and has lodged in the throat).
- *Severity.* Sore throats of a rhinovirus etiology are often de-

scribed as milder than sore throats caused by group A streptococci or infectious mononucleosis.

- *Duration.* Sore throats that have been present for several months are much less likely to be caused by group A streptococci than sore throats caused by an ulcer or a tumor.
- *Timing.* In most cases, documenting whether the sore throat is worse in the morning, evening, or at other times of the day is not likely to meet the criteria for medical necessity.
- *Context.* Has the patient been exposed to an individual suffering from influenza, strep throat, or infectious mononucleosis? A positive answer to any of these questions will highly influence the weighting of the differential diagnosis.
- *Modifying factors.* In order for the physician to suggest appropriate symptomatic treatment, it is helpful to know which symptomatic treatments (eg, ibuprofen, acetaminophen, salt water gargles, etc.) the patient has tried and how he/she has responded to these treatments.
- *Associated signs and symptoms.* Significant fevers are associated with an increased likelihood of strep infection. Light-headedness might indicate dehydration. Ear pain

or tooth pain might indicate that the throat pain is referred from another anatomic location.

Thus, almost all elements of the HPI (with the possible exception of timing) meet the criteria for medical necessity, even for a patient presenting with a sore throat—a complaint that is extremely common in urgent care and usually not associated with a poor outcome. Only four of eight elements of the HPI are required for an extended HPI. As such, an extended HPI meets the criteria for medical necessity for the vast majority of urgent care patients. ■

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ABSTRACTS IN URGENT CARE

On Pediatric Sinusitis, Skin Testing for β -Lactam Reactions, Spinosad Approved for Head Lice, Inaccurate Medication Lists, Steroids for Children with CAP, Beclomethasone Rescue for Pediatric Asthma, Zinc for the Common Cold, and Doxylamine and Pyridoxine for Nausea and Vomiting of Pregnancy

■ NAHUM KOVALSKI, BSc, MDCM

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

Complications of Sinusitis in Children

Key point: *Intracranial complications of pediatric sinusitis were more severe than intraorbital complications.*

Citation: Goytia VK, Giannoni CM, Edwards MS. Intraorbital and intracranial extension of sinusitis: Comparative morbidity. *J Pediatr.* 2011;158(3):486-491.

Serious complications of sinusitis occur more often in children than in adults. Prompt diagnosis and treatment are necessary to minimize morbidity and the risk for permanent sequelae or death. In a recent study, investigators reviewed records from a large children's hospital to examine the presentation, course, and severity of two such complications: intraorbital extension (IOE) and intracranial extension (ICE).

The researchers identified 118 children aged 3 months through 18 years who had radiographic evidence of sinusitis and imaging findings of IOE or ICE between 1997 and 2006. Eighty-five children had IOE; among these children, 41 had subperiosteal abscess, 24 had subperiosteal phlegmon, and 20 had orbital cellulitis or orbital abscess. Of the 33 children with ICE, 20 had dural enhancement, 15 had epidural abscess, 16 had subdural empyema, 9 had frontal bone osteomyelitis/Pott's puffy tumor, 4 had brain abscess, and 1 had sinus thrombosis. Some children had more than one finding.



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

Contrast-enhanced computed tomography of the orbit and sinuses was sufficient for medical decision making in IOE, whereas magnetic resonance imaging offered increased sensitivity to identify the location and extent of ICE.

Compared to children with IOE, those with ICE had a longer duration of headache before diagnosis and were more likely to have vomiting; they also had a longer hospital stay and a longer course of intravenous antibiotics. Most of those with ICE were initially treated with cefotaxime, vancomycin, and metronidazole. Until 2002 (when methicillin-resistant *Staphylococcus aureus* became a potential threat), most children with IOE were initially treated with cefuroxime alone or nafcillin plus cefotaxime; since then, the most common regimen has been clindamycin or vancomycin, plus cefotaxime.

Published in *J Watch Infect Dis*, April 6, 2011—Robert S. Baltimore, MD. ■

Skin Testing for β -Lactam Reactions

Key point: *Most childhood rashes following β -lactam treatment are NOT allergic.*

Citation: Caubet JC, Kaiser L, Lemaître B, et al. The role of penicillin in benign skin rashes in childhood: A prospective study based on drug rechallenge. *J Allergy Clin Immunol.* 2011;127(1):218-222.

β -lactam antibiotics are the most commonly prescribed pediatric medication worldwide and are frequently implicated in urticarial or maculopapular reactions that occur more than 1 hour after ingestion. These delayed reactions are likely T-cell mediated.

In a prospective observational study, researchers examined the

cause of non-immediate urticarial or maculopapular reactions that occurred up to 72 hours after β -lactam ingestion in 88 children (age range, 0–16 years) who presented to one emergency department in Switzerland. All patients underwent intradermal and patch skin testing, specific IgE determination (sIgE), viral serology, and oral challenge tests (OCTs).

Only six children had positive OCT reactions; all reactions were mild and similar to presenting rashes. Overall sensitivity, specificity, and negative predictive values of intradermal skin testing for identifying β -lactam allergy were 67%, 92%, and 97%, respectively; skin testing was more accurate for urticarial than maculopapular eruptions. Patch testing and sIgE determinations were not useful. Two-thirds of patients with negative OCTs had positive viral tests (mostly enteroviruses). Of note, three patients (50%) with positive OCTs had positive serology for acute Epstein-Barr virus infection.

Published in *J Watch Pediatr Adolesc Med*, February 23, 2011—David J. Amrol, MD. ■

Spinosad Now FDA Approved for Treating Head Lice

Key point: *In two phase III trials, spinosad was significantly more effective than 1% permethrin.*

Citation: FDA approves head lice treatment for children and adults [press release]. Silver Spring, MD: Food and Drug Administration; Jan 18, 2011. (<http://viajwat.ch/htaUMf>).

Approximately 6-12 million head lice infestations occur in the US each year, most of them among young children. Although various remedies are available, the American Academy of Pediatrics currently recommends topical 1% permethrin as the first-line treatment. Spinosad (Natroba), which received FDA approval on January 18, 2011, for use in patients aged ≥ 4 years, now provides an additional option.

Spinosad has a unique mechanism of action, causing paralysis and death of lice. Like permethrin, this product is a nonprescription topical agent. It is applied to dry hair/scalp, left on for 10 minutes, and then rinsed.

FDA approval was based on two manufacturer-sponsored, phase III, multicenter, randomized trials in which spinosad without nit combing was compared against 1% permethrin with nit combing under home-use conditions; a total of 949 participants from 391 households were involved. Retreatment was administered if live lice were present after 7 days. Among primary patients (the youngest household members with ≥ 3 live lice on day 0), spinosad-treated participants were significantly more likely than permethrin-treated ones to be lice free 14 days after the final treatment (approximately 86% vs 44%).

In addition, most spinosad-treated patients required only one treatment, whereas most permethrin-treated patients required two. Both agents were well tolerated, with no serious adverse events

reported. Rates of eye and scalp irritation—the most common side effects—were similar between groups; application-site erythema occurred less frequently in the spinosad-treated patients.

Published in *J Watch Infect Dis*, February 9, 2011—Lynn L. Estes, PharmD. ■

Medication List Obtained at ED Triage Is Often Inaccurate

Key point: *Lists for 37% of patients at a single emergency department omitted medications or included discontinued medications.*

Citation: Mazer M, Deroos F, Hollander JE, et al. Medication history taking in emergency department triage is inaccurate and incomplete. *Acad Emerg Med*. 2011;18(1):102-104.

The Joint Commission is focusing on medication errors as a major cause of morbidity and mortality. In a prospective, cross-sectional study, researchers evaluated the accuracy of medication lists obtained at triage for 1797 adult patients who presented to a single urban academic emergency department (ED).

Nurses obtained lists from patients at triage as part of usual care. If the patient was unable to provide a list, a prior medication list in the electronic medical record was used, if available. Later during the ED visit, trained research associates administered surveys asking patients to verify all prescription and nonprescription medications that they were taking; 92% completed the survey.

Discrepancies between the initial and later lists were identified for 38% of patients; 28% of initial lists omitted medications, and 10% included medications that the patient was no longer taking.

Published in *J Watch Emerg Med*, February 4, 2011—Diane M. Birnbaumer, MD. ■

Steroids for Children with Community-Acquired Pneumonia?

Key point: *Hospital length of stay was shorter in children who received corticosteroids — but only for those with wheezing.*

Citation: Weiss AK, Hall M, Lee GE, et al. Adjunct corticosteroids in children hospitalized with community-acquired pneumonia. *Pediatrics*. 2011;127(2):e255-e263.

Some data suggest that corticosteroids have an ameliorative effect in adults with community-acquired pneumonia (CAP), presumably because these agents downregulate inflammatory cytokines, resulting in quicker resolution of disease. In a recent retrospective cohort study, researchers examined whether corticosteroids might benefit children with CAP. They analyzed data for 20,703 CAP patients aged 1 - 18 years who were discharged from any of 38 hospitals in 2006 or 2007.

A total of 7234 (35%) patients received adjunctive corticosteroids, but the proportion varied greatly among centers (1%–51%). Across all age groups, length of stay (LOS) was shorter for children who received steroids than for those who did not. The median LOS was

3 days for all children; 10% of steroid recipients and 20% of non-recipients had an LOS >7 days. Among the children who received β -agonists (presumably an indicator of wheezing), LOS was shorter for steroid recipients than for nonrecipients. However, among those who did not receive β -agonists, the LOS was slightly longer for steroid recipients than for nonrecipients

Published in *J Watch Infect Dis*, February 2, 2011—Robert S. Baltimore, MD. ■

Occasional Rescue with Beclomethasone in Children with Controlled Asthma Is a Possible Alternative to Daily Meds

Key point: *In children with mild, controlled asthma, occasional rescue with beclomethasone plus albuterol works better than albuterol alone and doesn't retard linear growth.*

Citation: Martinez FD, Chinchilli VM, Morgan WJ, et al. Use of beclomethasone dipropionate as rescue treatment for children with mild persistent asthma (TREXA): a randomized, double-blind, placebo-controlled trial. *The Lancet*. 2011;377 (9766): 650-657.

Some 300 children with controlled asthma were randomized to one of four groups: “combined” (twice daily beclomethasone; rescue with beclomethasone plus albuterol); “daily” (twice daily beclomethasone; rescue with placebo plus albuterol); “rescue” (twice daily placebo; rescue with beclomethasone plus albuterol); and “placebo” (twice daily placebo; rescue with placebo plus albuterol).

After 44 weeks, the frequencies both of exacerbations and treatment failure were lower in all three treatment groups, compared with the placebo group. However, linear growth was slower in the daily and combined groups than in the rescue and placebo groups.

The authors conclude that their results “suggest that inhaled corticosteroids used as rescue together with albuterol show benefits over rescue albuterol alone and avoids the growth effects associated with use of daily inhaled corticosteroids.” ■

Zinc for the Common Cold

Key point: *Zinc administered within 24 hours of onset of symptoms reduces the duration and severity of the common cold in healthy people. When supplemented for at least 5 months, it reduces cold incidence.*

Citation: Singh M, Das RR. Zinc for the common cold. *Cochrane Database of Systematic Reviews 2011, Issue 2. Art. No.: CD001364. DOI: 10.1002/14651858.CD001364.pub3.*

In an update of a 1999 Cochrane review, the authors examined zinc's efficacy both in shortening the duration of colds and in preventing them. They considered the results of 15 randomized trials, totaling over 1300 participants.

Zinc supplements significantly reduced the severity of cold symptoms as well as the length of illness. Among people taking zinc within 24 hours of the start of symptoms, the risk for still hav-

ing symptoms at the 7-day mark was about half that of those not taking zinc. In preventing colds, zinc supplements taken for at least 5 months conferred a risk for catching a cold that was only two-thirds that of controls.

Zinc's side effects included a bad taste and nausea. ■

Doxylamine and Pyridoxine for Nausea and Vomiting of Pregnancy

Key point: *New combined formulation is effective and well-tolerated*

Citation: Koren G, Clark S, Hankins GD, et al. Effectiveness of delayed-release doxylamine and pyridoxine for nausea and vomiting of pregnancy: A randomized placebo controlled trial. *Am J Obstet Gynecol*. 2010;203(6):571.e1-e7.

Nausea and vomiting of pregnancy (NVP) is common and can be debilitating. The combination of doxylamine succinate and pyridoxine hydrochloride (Bendectin) was voluntarily discontinued in 1983 by the manufacturer because of alleged birth defects in offspring of users. These claims were subsequently shown to be unfounded and the litigations were rejected, but no product has since been FDA-approved for NVP.

Now, investigators have conducted a randomized controlled trial, sponsored by a different manufacturer, to assess efficacy of a new delayed-release formulation of the same two agents (Diclectin). Two-hundred-eighty women with pregnancies of 7-14 weeks' gestation and NVP that was resistant to dietary and lifestyle management were randomized to receive placebo or Diclectin (10 mg of each agent; dosages were escalated as needed). The primary outcome was improvement as measured with a 15-point pregnancy emesis scale to assess symptoms and quality of life.

Diclectin, compared with placebo, was associated with greater improvements in emesis scores (change from baseline, -4.8 vs -3.9; $P=0.006$) and quality of life, with a trend toward fewer missed days of work in the Diclectin group. Substantially more women in the Diclectin group (49% vs 33%, $P=0.009$) asked to continue using their assigned treatment at the end of the 15-day trial period. Adverse events did not differ between groups.

The discontinuation (which was not based on definitive safety concerns) of an effective tool in the battle against nausea and vomiting of pregnancy was followed by a marked rise in hospitalizations for this condition. Taken together with previous findings supporting Diclectin's safety, these data, which offer compelling evidence of the efficacy and tolerability of a new formulation of an old pair of agents, should reassure patients, providers, epidemiologists, litigators, and regulatory agencies alike.

Published in *J Watch Women's Health*, January 6, 2011—Allison Bryant, MD, MPH ■

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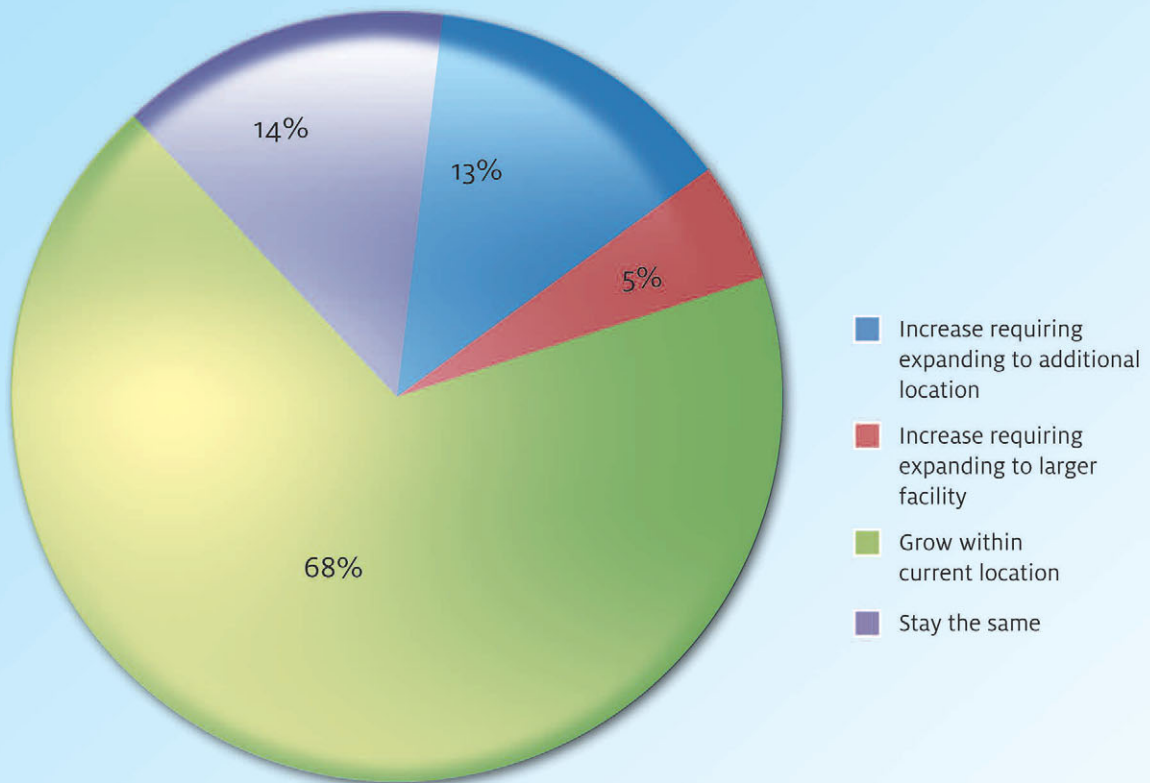


DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we offer a look at data from the 2010 Urgent Care Benchmarking Survey Results. These data are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to “full-fledged urgent care centers,” the qualifications for which included accepting walk-ins during all hours of operation, as well as having a licensed provider on-site, x-ray and labs on-site, the ability to administer IV fluids and perform minor procedures, and being open seven days a week, at least four hours per day.

In this issue: How are urgent care centers expected to grow in 2011?

EXPECTED GROWTH WITHIN NEXT 12 MONTHS



Urgent care is a growth industry in high gear. Fully 86% of urgent care centers expect to grow in some fashion this year, with 18% planning to either add a new site or move to a larger facility. More than two-thirds are planning to acquire additional space at a current location.

Acknowledgment: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at www.ucaoa.org/benchmarking.

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

Certified Urgent Care Centers

The Urgent Care Association of America® congratulates the following centers who were recently presented their Certified Urgent Care designation.

<i>Bethany Bend Urgent Care</i>	Alpharetta, GA
<i>City MD</i>	New York, NY
<i>Emergency Medical Care</i>	New York, NY
<i>Express Medical Care of WNY</i>	Kenmore, NY
<i>Lakes Urgent Care</i>	West Bloomfield, MI
<i>Macomb Prompt Care PLC</i>	Macomb, MI
<i>MidMichigan Urgent Care – Alma</i>	Alma, MI
<i>MidMichigan Urgent Care – Clare</i>	Clare, MI
<i>MidMichigan Urgent Care – Midland</i>	Midland, MI
<i>NextCare Urgent Care – Fettler Park</i>	Dumfries, VA
<i>NextCare Urgent Care – Garrisonville</i>	Stafford, VA
<i>NextCare Urgent Care – Gateway</i>	Fredericksburg, VA
<i>NextCare Urgent Care – Milstead</i>	Woodbridge, VA
<i>NextCare Urgent Care – Plank Road</i>	Fredericksburg, VA
<i>NextCare Urgent Care – White Oak</i>	Fredericksburg, VA
<i>Premier Care Medical of West Islip, PLLC</i>	Lindenhurst, NY
<i>Providence Urgent Care</i>	Columbia, MO
<i>Shawnee Mission Urgent Care</i>	Lenexa, KS
<i>Silver Health Care PC</i>	Silver City, NM
<i>SmartClinic Urgent Care</i>	West Covina, CA
<i>Smoky Mountain Urgent Care</i>	Sevierville, TN
<i>The Family Doctor</i>	Chapel Hill, NC
<i>Urgent Care Manhattan</i>	New York, NY
<i>Watertown Urgent Care</i>	Watertown, NY

For more information on how to become a Certified Urgent Care, visit www.ucaoa.org



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This event is not part of the official 2011 UCAOA Urgent Care Convention

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