DECEMBER 2012
VOLUME 7, NUMBER 2

JUCM™

THE JOURNAL OF URGENT CARE MEDICINE®

www.jucm.com The Official Publication of the UCAOA and UCCOP

Also in this issue

16 Case Report
An Old Condition Presents New Challenges

21 Practice Management
Making the Most of Locum Tenens in Your Urgent Care

Evaluation and Management of Pain (Part 1): Acute Pain

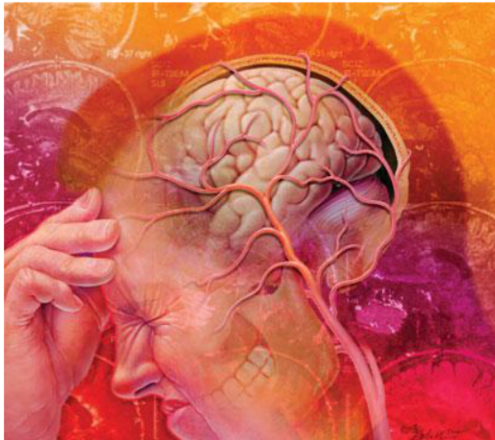
A BRAVEHEART PUBLICATION

JUCM™

The Official Publication of the UCAOA and UCCOP

December 2012

VOLUME 7, NUMBER 2



CLINICAL

9 Evaluation and Management of Pain (Part 1): Acute Pain

Urgent care providers have a clinical, legal, and moral obligation to provide appropriate treatment for patients with pain. The first article in a two-part series addresses strategies for managing acute pain.

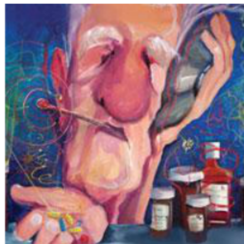
Tracey Q. Davidoff, MD

CASE REPORT

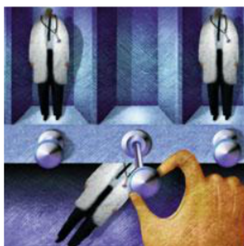
16 An Old Condition Presents New Challenges

Acute rheumatic fever is not common but it does still occur, underscoring the need for head-to-toe examination in patients with vague symptoms that seem unconnected.

Heather Varley, PA-C, and William Gluckman, DO, MBA, FACEP



PRACTICE MANAGEMENT



21 Making the Most of Locum Tenens in Your Urgent Care

Despite the best staff planning, urgent care centers sometimes need to turn to locum tenens firms to fill the "bench." Understanding the challenges these firms face is one key to success.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

Venous thromboembolism (VTE) is a major healthcare problem in the United States, particularly in the elderly. Between 2002 and 2006, the prevalence increased by 33.1% and the trend likely will continue, given the aging of the population. Next month's cover story reviews management of VTE in the urgent care setting, with a focus on clinical evaluation that incorporates pretest probability tools and judicious use of diagnostic tests. Included are a review of risk factors for and pathophysiology of VTE and recommendations on use of the Wells prediction rule for probability of deep venous thrombosis and for D-Dimer testing. Recommendations for inpatient and outpatient treatment, anticoagulation therapy, and long-term management of VTE also are provided.

DEPARTMENTS

25 Insights in Images: Clinical Challenge
29 Health Law
31 Abstracts in Urgent Care
35 Coding Q&A
40 Developing Data

CLASSIFIEDS

37 Career Opportunities

JUCM EDITOR-IN-CHIEF

Lee A. Resnick, MD
Chief Medical and Operating Officer
WellStreet Urgent Care
President, Institute of Urgent Care Medicine
Assistant Clinical Professor, Case Western Reserve University
Department of Family Medicine

JUCM EDITORIAL BOARD

Alan A. Ayers, MBA, MAcc
Concentra Urgent Care

Tom Charland
Merchant Medicine LLC

Richard Colgan, MD
University of Maryland School of Medicine

Jeffrey P. Collins, MD, MA
Harvard Medical School
Massachusetts General Hospital

Tracey Quail Davidoff, MD
Accelcare Medical Urgent Care

Kent Erickson, MD, PhD, DABFM
Unlimited Patient Care Center, PLLC

Thomas E. Gibbons, MD, MBA, FACEP
Doctors Care

William Gluckman, DO, MBA, FACEP, CPE, CPC
FastER Urgent Care

David Gollogly, MBChB, FCUCP (New Zealand)
College of Urgent Care Physicians

Wendy Graae, MD, FAAP
PM Pediatrics

Nahum Kovalski, BSc, MDCM
Terem Emergency Medical Centers

Peter Lamelas, MD, MBA, FACEP, FAAEP
MD Now Urgent Care Medical Centers, Inc.

Melvin Lee, MD, CCFP, RMC
FastMed North Carolina

Sean M. McNeeley, MD
Case Western Reserve University
University Hospitals Medical Group

Patrice Pash, RN, BSN
NMN Consultants

Mark E. Rogers, MD
West Virginia University

Mark R. Salzberg, MD, FACEP
Stat Health Immediate Medical Care, PC

Shailendra K. Saxena, MD, PhD
Creighton University Medical Center

Elisabeth L. Scheufele, MD, MS, FAAP
Massachusetts General Hospital

John Shufeldt, MD, JD, MBA, FACEP
Shufeldt Consulting

Laurel Stoimenoff
Continuum Health Solutions, LLC

Thomas J. Sunshine, MD, FACOG
Doctors Express Cherrydale

Joseph Toscano, MD
San Ramon (CA) Regional Medical Center
Urgent Care Center, Palo Alto (CA) Medical Foundation

Janet Williams, MD, FACEP
Rochester Immediate Care

Mark D. Wright, MD
University of Arizona Medical Center

JUCM ADVISORY BOARD

Michelle H. Biros, MD, MS
University of Minnesota

Kenneth V. Iserson, MD, MBA, FACEP, FAAEM
The University of Arizona

Gary M. Klein, MD, MPH, MBA, CHS-V, FAADM
mEDhealth advisors

Benson S. Munger, PhD
The University of Arizona

Emory Petrack, MD, FAAP
Petrack Consulting, Inc.;
Fairview Hospital
Hillcrest Hospital
Cleveland, OH

Peter Rosen, MD
Harvard Medical School

David Rosenberg, MD, MPH
University Hospitals Medical Practices
Case Western Reserve University
School of Medicine

Martin A. Samuels, MD, DSc (hon), FAAN, MACP
Harvard Medical School

Kurt C. Stange, MD, PhD
Case Western Reserve University

Robin M. Weinick, PhD
RAND

UCAOA BOARD OF DIRECTORS

MarK R. Salzberg, MD, FACEP, President

Nathan "Nate" P. Newman, MD, FAAFP, Vice President

Cindi Lang, RN, MS, Secretary

Laurel Stoimenoff, Treasurer

Jimmy Hoppers, MD, Director

Robert R. Kimball, MD, FCFP, Director

Don Dillahunty, DO, MPH, Director

Roger Hicks, MD, Director

Peter Lamelas, MD, MBA, FACEP, FAAEP, Director

Steve P. Sellars, MBA, Director

William Gluckman, DO, MBA, FACEP, CPE, CPC, Director

JUCM

EDITOR-IN-CHIEF
Lee A. Resnick, MD
editor@jucm.com

EDITOR
Judith Orvos, ELS
jorvos@jucm.com

ASSOCIATE EDITOR, PRACTICE MANAGEMENT
Alan A. Ayers, MBA, MAcc

CONTRIBUTING EDITORS
Nahum Kovalski, BSc, MDCM
John Shufeldt, MD, JD, MBA, FACEP
David Stern, MD, CPC

MANAGER, DIGITAL CONTENT
Brandon Napolitano
bnapolitano@jucm.com

ART DIRECTOR
Tom DePrenda
tdeprenda@jucm.com

120 N. Central Avenue, Ste 1N
Ramsey, NJ 07446

PUBLISHERS
Peter Murphy
pmurphy@braveheart-group.com
(201) 529-4020

Stuart Williams
swilliams@braveheart-group.com
(201) 529-4004

Classified and Recruitment Advertising
Russell Johns Associates, LLC
jucm@russelljohns.com
(800) 237-9851

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 and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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

JUCM (ISSN 1938-002X) printed edition is published monthly except for August for $50.00 by Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey NJ 07446. Periodical postage paid at Mahwah, NJ and at additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey, NJ 07446.

JUCM The Journal of Urgent Care Medicine *(www.jucm.com) is published through a partnership between Braveheart Publishing (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).*

JUCM CONTRIBUTORS

Urgent care clinics are filled with patients who are ill or injured, and pain—which is subjective—is a common presenting symptom. But pain scales are subjective and in treating an individual's discomfort, providers must avoid either overtreating or undertreating the problem. Overtreatment can lead to serious morbidity or mortality and potential for addiction, whereas inadequate treatment can leave a patient both uncomfortable and dissatisfied with care. This month's cover story, on effective management of acute pain, reviews strategies for treating discomfort adequately while simultaneously protecting yourself from dissatisfied patients and potential litigation. Included are three case studies that demonstrate application of the principles in common urgent care scenarios.

Dr. Davidoff is an urgent care physician at Accelcare Medical Urgent Care in Rochester, New York, on the CME Committee of the Urgent Care College of Physicians, and a member of the *JUCM* Editorial Board.

In this month's case report, Heather Varley, PA-C, and William Gluckman, DO, MBA, FACEP, remind urgent care providers that conditions that aren't seen in everyday practice still need to be considered to make an accurate diagnosis and reduce adverse outcomes. They review the course and treatment of a patient with a 3-week history of mild-to-moderate sore throat and otherwise unremarkable history. Diagnosis? Acute rheumatic fever, which can have long-term cardiac effects. The message here is to take a detailed history and perform a thorough head-to-toe exam when a patient presents with vague, seemingly unconnected symptoms.

Ms. Varley is a full-time Physician Assistant at and Dr. Gluckman is President & CEO of FastER Urgent Care in Morris Plains, NJ.

Having a "bench" of trusted clinicians who are available to work in your center as the need arises is the best way to avoid issues associated with locum tenens. But when unanticipated events such as provider resignations leave no choice but to use locum tenens providers to fill shifts, there are ways to mitigate the risks. Such strategies are the subject of this month's practice management article, by Alan A. Ayers, MBA, MAcc. Among his recommendations are interviewing locum tenens providers offered by an agency, ensuring that they have prior urgent care experience, making time to orient them to your center, and incentivizing locum tenens providers based on factors such as efficiency and patient satisfaction.

Mr. Ayers is Associate Editor, Practice Management, *JUCM*, Content Advisor, Urgent Care Association of America, and Vice President, Concentra Urgent Care.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, discusses the animus between physicians and lawyers and makes the case for why the two professions need to "get along."

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of risk of burns with OTC topical pain relievers, acellular pertussis vaccine, prevention of falls in the elderly, and imaging for acute cholecystitis.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for medications, supplies, and x-rays.

Our Developing Data end piece this month looks at benefits for clinical staff other than physicians, PAs, and NPs. ■

To Submit an Article to *JUCM*

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

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

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

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 "Subcription."

To Find Urgent Care Job Listings

If you would like to find out about job openings in the field of urgent care, or would like to place a job listing, log on to *www.jucm.com* and click on "Urgent Care Job Search."

Practice Management

Making the Most of Locum Tenens in Your Urgent Care

Urgent message: Despite the best staff planning, urgent care centers sometimes need to turn to locum tenens firms to fill the "bench." Understanding the challenges these firms face is one key to success.

ALAN A. AYERS, MBA, MAcc

Regardless of how aesthetically pleasing an urgent care facility, how convenient its hours, how creative its marketing, or how sophisticated its technology, the ultimate "product" is its clinicians and the solutions they provide for patients' immediate medical problems. Without a provider ready and able to serve the public on a walk-in basis, an urgent care center is incapable of delivering value. So, what happens when an urgent care center is without a provider? It can turn patients away, it can close its doors, or it can fill schedule gaps with locum tenens and temporary clinicians. The need met by locum tenens providers is clear: They enable an urgent care center to sustain operations.

Ideally an urgent care center should be staffed by equity owners and employed clinicians whose personal interests are aligned with the long-term success of the operation. Such providers understand that positive medical outcomes and good patient experiences result in satisfied "customers" who not only return for services themselves, but tell friends and family to do likewise.

When a physician-owner or employed physician is incentivized by productivity and is vested in the financial returns of the practice, he/she focuses on providing clinically effective and cost-efficient care. Locum tenens providers are usually paid hourly for being present in the center and they're typically self-employed, so their personal interest is not to maximize patient satisfaction and center revenue but rather, to minimize the professional liability of an assignment. This lack of interest in the center's success results in:

© Corbis.com

- A narrow focus on treating and discharging based on the immediate presenting medical condition versus developing collaborative relationships with patients because the locum tenens provider likely will not be at the center if/when the patient returns. Patients often complain about this lack of continuity in care.

Alan Ayers is Content Advisor, Urgent Care Association of America, Associate Editor—Practice Management, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care.

- Risk-aversion (a desire to avoid potential malpractice claims) leading to conservatism in diagnosis and treatment. For example, ordering unnecessary lab tests or imaging studies, refusing to prescribe narcotics, or referring more complex cases to the emergency room. In addition to lost patient revenue, additional services can lead to financial losses on flat-rate insurance contracts.
- Shortcomings in chart documentation leading to under-coding of E/M levels of service, mis-coding of procedures, or omitting procedure and ancillary codes because the locum tenens provider gets his/her hourly rate regardless of the revenue he/she generates.
- Referring patients to specialists who don't need such referrals and not referring patients who actually require specialist care. Referral of patients to specialists the locum tenens provider knows instead of to in-system or in-network providers also is common.
- Extended wait times because locum tenens providers—not incentivized on productivity—may spend more time in patient encounters as a result of unfamiliarity with systems and processes or feel less compelled to keep flow moving.

The better "fit" its candidates, the more satisfied a staffing agency's clients, so partner with the staffing agency by setting clear expectations as to the skills, experience, and personal attributes expected of a locum tenens provider.

Unlike owners and employed clinicians, locum tenens providers are usually disengaged from the culture and management of the center, which can undermine the cohesion of center teams. Friction occurs when the locum tenens provider introduces new ways of doing things or refuses to follow the center's operating procedures. When new clinicians circulate through a center, medical assistants become confused as to medical orders, patient/procedure set-ups, and chart documentation.

The financial bottom line of an urgent care center that relies on locum tenens can suffer—because in addition to these issues with coding and referrals, inefficiency in flow, and lost patient loyalty—locum tenens are often expensive. A center not only pays the provider's hourly wage, but it also incurs agency fees and travel costs.

Locum Tenens and Occupational Medicine

For centers that provide occupational medicine services, additional issues with locum tenens providers can impact relationships with employers who send patients to an urgent care center for workplace injuries, physical exams, and other compliance and prevention services. Temporary clinicians are often:

- Unwilling to or unskilled in communicating with employers in workers' compensation cases, resulting in dissatisfied clients and lost accounts.
- Unwilling or unskilled in selling the center's services to prospective customers (or conducting case reviews with existing customers), resulting in lost sales opportunities.
- Too quick to prescribe medications and/or assign time off/limited duty to injured workers, resulting in reportable workers' compensation cases that raise the cost of claims for employers. Time off from work (as opposed to medical claims) is the primary cost driver in workers' compensation.
- Unfamiliar with Occupational Safety and Health Administration standards or Department of Transportation procedures and forms, resulting in errors that can jeopardize a client's compliance with federal regulations.

Unless a locum tenens provider has specific experience with workers' compensation and employer services, his/her involvement with occupational medicine can result in a longer case duration for workplace injuries and increased risk to employers on compliance services.

Minimizing the Risk of Locum Tenens Providers

The surest way to avoid the issues associated with locum tenens providers is to have a "bench" of trusted clinicians available to work in the center as needs arise on the cen-

ter's schedule. Some centers establish relationships with medical residents or primary care providers willing to "moonlight" at the center—which works particularly well for planned absences including vacation, maternity leave, and continuing medical education. But unanticipated events such as provider resignations and personal and family illness still occur, so when a center has no alternative but to use locum tenens providers to fill shifts, an urgent care operator can mitigate the risks by:

Locum tenens providers are usually disengaged from the culture and management of the center, which can undermine the cohesion of center teams. Friction occurs when the locum tenens provider introduces new ways of doing things.

- Interviewing locums tenens providers put forth by the agency—assessing their comfort level, risk tolerance, and cultural fit—before assigning them to schedule openings.
- Requiring that temporary providers have prior experience working in an urgent care setting and thus grasp the concepts of "consumer-focused health care" such as efficiency, short wait times, and positive bedside manner.
- Limiting the number of providers who circulate through the center by using the same locum tenens provider every time a schedule void arises.
- Documenting operating processes, having detailed written policies and procedures, and creating job aids such as "checklists" and "cheat sheets" to support clinicians in routine tasks.
- Taking time to orient locums tenens providers to the center's culture, processes, and systems by having locums tenens providers "shadow" the center's permanent physicians before working solo.
- Assigning an experienced staff member—such as an RN or LPN—to act as "scribe" to the locum tenens provider, assuming the tasks of chart documentation and processing orders and referrals.
- Conducting chart reviews—focusing on documentation and coding—before submitting insurance claims. Locum tenens providers should be coached on the review findings to improve their documentation going forward.
- Devising temporary employment agreements that go beyond an hourly rate to incentivize locum tenens providers according to their efficiency, productivity, profitability, and patient satisfaction.
- Arranging the center's staffing schedule so that locum tenens providers work solo during the least busy hours or days of the week.

It's also important to ensure that medical staffing agencies understand the center's scope of practice, culture, systems, and patient base. While some agencies have a reputation for getting "warm bodies" into centers, those that "work" for their agency fees ensure that the providers they place are a great "match"—capable of meeting patient needs and functioning on the center team as a "vested" provider. The better "fit" its candidates, the more satisfied a staffing agency's clients, so partner with the staffing agency by setting clear expectations as to the skills, experience, and personal attributes expected of a locum tenens provider. Also avoid "throwing" clinicians "into the fire" by working with the agency to define a clear "on-boarding" or training process.

Develop a Long-Term Staffing Strategy

Urgent care is rapidly growing as an important component of the nation's medical delivery system. Not only do consumers embrace the convenience of extended-hours walk-in service, many find access to a regular primary care physician increasingly limited. But all statistics pointing to a primary care physician shortage in the United States also mean that recruiting physicians to work in urgent care centers is only going to become more difficult in the future. The timeline for replacing or filling a physician opening can already exceed 9 to 12 months depending on a center's geographic location. As an urgent care center sees increased utilization, expands its hours, and opens new locations, the strain on its existing providers will continue to increase. The best defense is business continuity plan that anticipates and addresses physician staffing needs.

Certainly an urgent care center should have a contingency plan to cover planned absences like paid

JUCM's Digital Edition Has a New Look

We've upgraded the digital edition of *JUCM* to give you a better reading experience! We think you're going to like it. Check out the features below and let us know by writing to webmaster@jucm.com

Beautiful reading experience, wherever you are - a beautiful digital edition that looks and feels like a real book, on whichever device you choose.

Searchable and zoomable content - You can use the search function to locate relevant key words or phrases, or click on the page to display a larger view of the publication.

Media-rich environment - You can flip through the digital pages like a real book, watch embedded videos and flash, listen to related audio clips, and click live links to further information.

Ability to add notes and bookmarks - If you see something that you want to highlight or bookmark for future reference, you can do so by using the notes or bookmark options. You can even choose to send typed notes to your email address so your thoughts are never lost.

Ability to view issues on mobile devices - iPad and iPhone users can add an app icon to their home screen for easy access to *JUCM* and launch of our digital editions. The first time you view the publication from an iPad or iPhone, you'll see simple directions for adding the app.

time off, continuing medical education, and pregnancy as well as unplanned absences including personal and family medical leave. In addition, the contingency plan should address variations in center volume due to promotional campaigns (such as back-to-school physicals) and seasonal variations (such as summer injuries, spring allergies, and winter flu).

Long-term factors that affect a center's provider staffing needs include:

- Organic growth of the business through marketing and repeat business
- Addition of new insurance contracts and insurance benefit changes such as reduced co-pays for urgent care
- Changes in scope of practice due to reduced availability of medical services in the community
- Addition of ancillary services like travel medicine or immigration physicals
- Expansion of operating hours
- Addition of new locations

Urgent care operators can avoid being caught off-guard by incorporating provider staffing into all strategic business discussions. Business changes should be planned sufficiently in advance to ensure clinical coverage—whether by full-time, part-time, temporary or locum tenens providers. Otherwise, failure to account for provider staffing can seriously inhibit a center's ability to grow and take advantage of market opportunities.

Conclusion

The "product" of an urgent care center is its clinicians and the services they provide. Successful urgent care centers constantly account for provider staffing—anticipating short- and long-term variations and ensuring a plan to cover all provider shifts. But despite its best efforts to cultivate a "bench" of available providers, a center may still find itself in need of the temporary support provided by locum tenens. Key to success is understanding the typical challenges of utilizing locum tenens providers, working with medical staffing agencies to ensure that temporary providers have the necessary experience and are a good cultural fit, aligning the center and the provider's financial interests, and investing time and resources in training and on-boarding. ■