

EMpulse



Official Publication of the Indiana Chapter of American College of Emergency Physicians

Notes

Mark your calendars
for the 2010
INACEP Conference
on March 8 & 9, 2010

The Agenda is nearly set!
Check out page 6 of this
EMpulse for a partial list
of speakers and topics
scheduled for this year.

Watch the website and
your snail mail in early
December for a brochure
and registration form for
this event!

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A View from the Top:

by Gaurav Arora MD, FACEP (President, ACEP)

Greetings!

I hope all of you are keeping healthy amidst the influenza outbreak. If your shop is like mine, volumes are up 20 - 50% and current systems are at a near breaking point. I suspect many of your departments have set daily or monthly visit records last month. Despite working extra hours to handle the volume, my partners, nurses and physician assistants remain upbeat like usual. Once again, I am impressed by the flexibility and dedication of all that work in emergency departments. Keep up the great work!

“This gave several legislators the opportunity to visit a busy local E.D. followed by several extremely effective presentations highlighting issues pertinent to our profession.”

We held a couple of very successful events in September. Our resident’s forum was again very well attended and exposed the current residents to various practice opportunities throughout the state. The panel discussion allowed the residents to explore many employment related questions and review a sample contract. We also hosted a legislative reception in conjunction with the IU Emergency Medicine residency. This gave several legislators the opportunity to visit a busy local E.D. followed by several extremely effective presentations highlighting issues pertinent to our profession. The presentations included vignettes focusing on access to care, crowding and boarding, and the shortage of specialists to cover call. This session was very well received by the legislators and we hope to maintain and further develop this avenue of communication.

I had the opportunity to represent Indiana at the ACEP council meeting in October. For those unfamiliar with the process at this meeting, resolutions were proposed by chapters, and section or individual ACEP members. These resolutions are then debated and voted upon. The resolutions become College policy after they are reviewed and approved by the Board of Directors. Some approved resolutions included supporting the use of appropriate restraint devices in school buses, lobbying to increase the number of EM residency slots, and defining boarding as one who remains in the ED after notification of the need to admit to an inpatient service and ends when the patient leaves the department. A bylaws change to award the Association of Academic Chairs in Emergency Medicine a seat on the Council was adopted. There was also a resolution honoring the late Fred Osborn, an outstanding physician, teacher and gentleman whom many of us knew, and extending sympathy to his wife and sons.

“Some approved resolutions included supporting the use of appropriate restraint devices in school buses [and] lobbying to increase the number of EM residency slots...,”

I was recently involved in a discussion with some of my residency classmates about the value of maintaining our ACEP memberships. It was surprising to hear some of them state they were dropping their membership because of a lack of perceived value.

Continued on page 10

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An Unusual Case of Right Upper Quadrant Pain –



Patient Overview

A 28 yo African American male presents to the Emergency Department with 3 weeks of right upper quadrant pain. He relates it to getting punched in the side during a basketball game around the same time. He had seen his primary care doctor who had ordered a CT scan of his abdomen, which he had with him. Other than the abdominal pain, he reports some shortness of breath for several months. He had actually seen a cardiologist months before and had a stress ECHO, the results of which he reported as normal.

He denies any previous health problems but did have an appendectomy 8 years earlier, does not take any prescribed medication, and does not smoke, drink, or use any illicit drugs. Family history is significant for several relatives with lung cancer.

Exam

VS: BP: 124/80 P:88 RR: 18 sat: 100% on room air

General: Fit adult male, 6'1 and 185 lbs

Neck: no JVD

Chest: Clear to auscultation,
Cardiac: 2/6 systolic murmur heard
best at the left sternal border and apex

Abdomen: No masses, mild tenderness
in the right upper quadrant

Extremities: no edema

Lab studies/Data:

Outside CT scan showing hepatic venous congestion and free fluid surrounding the liver

Bedside cardiac ultrasound was performed which showed a moderate pericardial effusion with RV collapse after which a formal ECHO was ordered. This revealed a large right atrial tumor on the free wall of the atria and an EF of 66%

Chest CT was performed which showed a large effusion, an ill-defined atrial mass, and did not show any metastases.

A Case Study by Mary Whitney, MD

Diagnosis, Disposition, and Discussion

Diagnosis: Right heart failure secondary to pericardial effusion with tamponade – likely caused by a right atrial tumor

The patient was admitted to the cardiology service with a cardiovascular surgery consult. It was decided to take him to the operating room, where his pericardial effusion was drained. His atrial tumor was resected and sent for pathology after which his atrium was reconstructed. The mass was determined to be a moderately differentiated angiosarcoma. He was transferred to the cardiac critical care unit post-op and continues to do well. He is in his second chemotherapy cycle and has no spread of his cancer by PET scan.

Angiosarcomas are relatively rare tumors characterized by rapidly proliferating, usually fairly anaplastic cells of a vascular origin. Most patients who develop angiosarcoma have a grim prognosis as these neoplasms tend to spread quickly locally and have early systemic metastases.

Most angiosarcomas occur in the skin, although they are also known to occur in the breast, liver, spleen, and heart. There has been some association with contrast dyes like Thorotrast, radiotherapy, and arsenic spray used in grape vines.

Due to the malignant nature of this disease, it is important to diagnose early and institute proper treatment. However, these are hard to diagnose without many physical findings until late in the disease. In cases where the angiosarcoma was of cardiac origin most case reports note an associated pericardial effusion. It is therefore important not to forget this on the differential for causes of a pericardial effusion. This case demonstrates an unusual presentation of an extremely rare disease.

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Help Improve Transfers Between Nursing Homes and EDs – by Kevin Terrell, DO, MS

We Need Your Input!

We are seeking your participation in early discussions with key stakeholders that seek ways of improving the quality and safety of transfers between nursing homes and EDs. Our long-term goal is to develop a standardized method for all central Indiana nursing homes, EMS systems, and EDs to communicate during transfers (*in both directions*) between nursing homes and EDs. This may be a universal transfer form or some information technology intervention that facilitates such communication.

These transfers are an incredible source of frustration for ED, EMS, and nursing home providers. All of these groups are generally good providers who are doing their best to provide high quality care; however, the current systems in place to facilitate transfers between nursing homes and EDs are very broken.

As evidence of this, 10% of nursing home residents are transported to EDs without any documentation, and essential information is typically missing in the other 90%.^{1,2} Likewise, residents often return to nursing homes from EDs without any written documentation.³ Communication problems are the most frequently cited barrier to providing care.⁴

However, introducing a standardized transfer form for nursing homes to complete isn't the solution. Studies have shown that when a standardized form is used, documentation of important clinical information increases significantly⁵ and information gaps occurs less often.⁶ However, nursing home personnel complete the forms in less than half of transfers.^{5,6} Even when the forms are used, much of the requested information is still not recorded,⁵⁻⁷ and the exact reason for the ED visit remains either missing or unclear in most cases.⁸ Consequently, solutions to improve quality during transfers of care will involve more than the simple introduction of a transfer form.

Kevin Terrell, DO, MS,

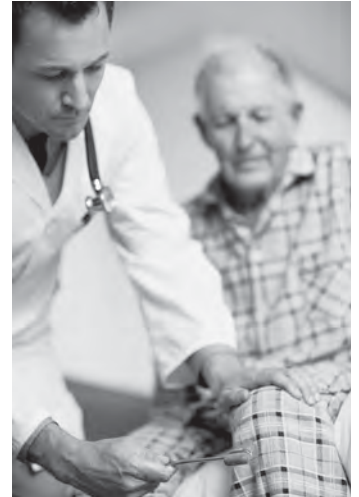
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To date, inpatient and nursing home providers and their respective organizations have taken the lead to try to improve transfers of care from hospitals to nursing homes and in both directions between nursing homes and EDs. As an example of their efforts, the Indiana Chapter of the American Medical Directors Association (AMDA) and the Indiana Chapter of the American College of Physicians (ACP) are joining together for their 2009 annual meetings with transfers of care for nursing home residents as one of the meeting's focal points. (AMDA is the professional association of medical directors, attending physicians, and others practicing in the long term care continuum. ACP is a national organization of internists and is the largest medical-specialty organization and second-largest physician group in the United States.)

However, Indiana's nursing home providers deliver care on only one side of the nursing home-ED interface. They need Indiana's emergency providers and our organizations to partner with them to identify, develop, and introduce ways to improve the quality of transfers in both directions between nursing homes and EDs.

To accomplish this, we are seeking input from Indiana ACEP's leaders and members. Please contact me if you are interested in joining this early discussion of how to improve the quality of transfers in both directions between Indiana's nursing homes and EDs.



1. Jones JS, Dwyer PR, White LJ, Firman R. Patient transfer from nursing home to emergency department: outcomes and policy implications. *Academic Emergency Medicine*. 1997;4:908-915.
2. Stier PA, Giles BK, Olinger ML, Brizendine EJ, Cordell WH. Do transfer records for extended care facility patients sent to the emergency department contain essential information? [Abstract]. *Ann Emerg Med* 39(1):14-23. 2001;38(4S):S102.
3. Davis MN, Toombs Smith S, Tyler S. Improving transition and communication between acute care and long-term care: A system for better continuity of care. *Annals of Long-Term Care*. 2005;13(5):25-32.
4. Terrell KM, Miller DK. Challenges in transitional care between nursing homes and emergency departments. *J Am Med Dir Assoc*. 2006;7:499-505.
5. Terrell KM, Brizendine EJ, Bean WF, et al. An extended care facility-to-emergency department transfer form improves communication. *Academic Emergency Medicine*. 2005;12(2):114-118.
6. Cwinn M, Cwinn A, Forster AJ, et al. Prevalence of information gaps for seniors transferred from nursing homes to the emergency department [Abstract]. *Academic Emergency Medicine*. 2006;13(5Suppl):S32.
7. Madden C, Garrett J, Busby-Whitehead J. The interface between nursing homes and emergency departments: a community effort to improve transfer of information. *Academic Emergency Medicine*. 1998;5(11):1123-1126.
8. Davis MN, Brumfield VC, Smith ST, Tyler S, Nitschman J. A One-Page Nursing Home to Emergency Room Transfer Form: What a Difference It Can Make During an Emergency! *Annals of Long-Term Care*. 2005;13(11):34-38.



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Legislative Update *by Lou Belch, Indiana ACEP Lobbyist*

The Indiana General Assembly convened for the 2010 session on Tuesday November 17th. That traditionally opens the bill filing season. They next session day is scheduled to be January 5, 2010. The session must end no later than March 14, 2010.

Many are predicting a much shorter session. Legislators are interested in an unusually short and quiet session, as they will want to begin campaigning as soon as possible.

MEDICAID

The Governor has instructed all state agencies to cut their budgets by 10%. During the press conference he did announce that there would be Medicaid cuts, but the physicians would not be cut. The Secretary of Family and Social Services Administration also announced cuts but spared the physicians. Hospital reimbursement will be cut 5% beginning January 1, 2010.

Emergency Physicians continue to have difficulty getting reimbursed by the Medicaid Managed Care Organizations. IN-ACEP leaders are scheduling meetings to continue to work with the Managed Care Plans to find a resolution to the situation.

Assignment of Benefits

Sen. Beverly Gard (*R-Greenfield*) will once again introduce legislation requiring insurance companies to honor assignment of benefit requests from their enrollees. This legislation is supported by IN-ACEP and all physician groups.

EMS Medical Directors

Senator Karen Tallian (*D-Portage*) is introducing a bill that seeks to clarify the role of the medical director in EMS services. IN-ACEP will pursue language that allows the medical director to refuse to direct any pre-hospital personnel. While many believe this to already be the case, Indiana law is silent on the matter.

This article is being written as bills are being filed. INACEP lobbyists will review all legislation introduced and the IN-ACEP board will act as necessary.

Conference Update

by David Schlueter MD, FACEP (Education Director)

This year's **Educational and Research Conference (March 8 & 9, 2010)** is shaping up to be an outstanding two days of learning, practice improvement, and intellectual challenge.

Once again, we will be hearing from nationally recognized speakers including ACEP president Angela Gardner, SAEM president elect Jeff Kline, longtime favorite Joe Lex, and the always entertaining and enjoyable Greg Henry. In addition, visiting us for the first time will be Dan Smith speaking on patient satisfaction, Randy Cordle lecturing on pediatrics, and ACEP reimbursement and coding expert Michael Granovsky.

In addition, this year will feature several outstanding local educators speaking on *Updates in the EM literature, Critical Care in the ED, Toxicology and Codes, and Evidence Based CVA Management*. Furthermore, the IU EM academic department will present their cutting edge research and the latest and greatest in Morbidity and Mortality. Lastly, and perhaps most controversial, will be a challenging discussion on health care reform from two different perspectives presented by Greg Henry and Rob Stone.

The inaugural "Fred Osborn Award – Excellence in Emergency Medicine" will be presented at our annual meeting as well, so don't forget to send in your nominations by December 31st.

The Bulletin Board

Organizations or individuals that want their message to reach emergency physicians in Indiana will find the **EMPulse** their number one avenue.

The **EMPulse**, published five times per year, is mailed to members of the

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Mark your Calendars

**2010
Indiana ACEP
Continuing
Education
Conference**

March 8 & 9, 2010

“But I’m not asking for anything heroic to be done.”

The man who spoke these words was standing by his mother’s bedside, wringing his hands, pacing back and forth. He spoke these words next to his mother, my patient, who was still hypotensive and hypoxic despite being on high-dose pressors and receiving maximum ventilatory support. He spoke these words in response to the cardiologist’s apologetic, but frank, refusal to take the patient to the cath lab. Twenty minutes later, despite maximum medical support, the patient died.

Two days later, I had a similarly ill elderly woman. She had only been sick a short time at home prior to her son bringing her in and was rapidly declining in the emergency department. As if reading my mind, her son gave me a wistful look and shook his head. “No, she doesn’t want anything heroic done. Just keep her comfortable.” And so we did. Thirty minutes later, with comfort care and compassionate medical support, she died.

Although illness and death are the business of medicine, addressing end-of-life issues in emergency medicine is an imperfect and often hard to accomplish matter. The chaotic environment of the ED, the lack of established relationships with individual patients and an apparent unwillingness to restrict patient treatment options all thwart even the most willing physician from engaging in frank conversation with a dying patient and/or her family.

According to CMS data, medical care at the end of life consumes 10% to 12% of the total health care budget and 27% of the Medicare budget¹. This statistic has remained unchanged for two decades^{2,3}. Though over-all spending has been static, hospice enrollment among Medicare beneficiaries has more than doubled in the same time period².

National organizations from NIH to ACEP recognize the integral part that emergency physicians play in providing care at the end of life⁴. In the past, the model of palliative care included a near total dichotomy between life-prolonging therapy and end of life or so-called “supportive care.” The latter was offered only when all other “life-preserving” or curative therapies had been exhausted⁵. Newer approaches to palliative care concentrate on offering curative or life-prolonging treatment alongside that which helps with symptom relief and maximizes quality of life. In addition, the newer palliative care model stresses improved physician-patient communication about prognosis and disease progression during the whole of the patient’s disease course. Hospice care itself is still undertaken during the last six months of life.

Nothing Heroic

by Mary Reilly, MD, FACEP

One issue for educators of new emergency physicians is to address the lack of the instruction of palliative medicine skills in the core curriculum of emergency medicine. Such an educational set should take its cues from the National Guidelines for Quality Palliative Care⁶. To assist in the further education of emergency care providers in the arena of palliative care, the National Institutes of Health has sponsored the Education in Palliative and End of Life Care-Emergency Medicine (EPEC-EM) Project. The EPEC-EM project seeks to disseminate a palliative medicine curriculum⁷ and “provide clinicians with palliative care skills tailored for use in the ED”⁵.

Two of the skills paramount to managing the needs of ill patients in the ED is an accurate assessment of their illness and a basic formulation of prognosis⁵. In my experience, emergency physicians readily perform the first assessment but often resist the second and certainly, balk at guiding patients and families based on those assessments. How many patients with stage IV lung cancer and intractable pain are knee-jerk admitted to oncology without an honest discussion of their prognosis or disease trajectory?

Palliative care improves outcomes, as measured by patients’ symptoms and also reduces hospital lengths of stay and therefore overall cost burden. Few other interventions in medicine reduce cost and improve patient satisfaction so readily⁸. The emergency physician with a solid skill set in palliative care will be much more comfortable in identifying a patient’s disease course, making a reasonable prediction of prognosis and providing optimum symptom relief⁹.

Although I could not change the outcome of either case I recounted at the beginning of this article, offering an improved understanding of end of life care would certainly have helped the first son better address his mother’s needs from multiple viewpoints, including not just her physical, but also spiritual, psychological, and social.

1. *JAMA*. 1996;275(24):1907-1914.
2. *Health Aff*. 2001;20(4):188-95.
3. *NEJM*. 1993;328(15): 1092-1096.
4. *Ann Emerg Med*. 2008;52:592.
5. *Ann Emerg Med*. 2009;54(1): 103-105.
6. National Consensus Project for Quality Palliative Care. <http://www.nationalconsensusproject.org>
7. In: Emanuel LL, Quest TE editor. *The Education in Palliative and End of Life Care Project-Emergency Medicine Trainer’s Guide*. 2008
8. *J Palliat Med*. 2007;10:1347-1355.
9. *Ann Emerg Med*. 2009; 54(1): 94-102.

Newly Elected Fellows

Following is a list of Indiana members that have been newly elected Fellows – recognized at the 2009 Convocation Ceremony held at the Scientific Assembly in Boston, MA.

These members are now FACEP!

Nathan Allison MD, FACEP

Sara Ann Brown MD, FACEP

Megan Crittendon MD, FACEP

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A View From The Top *(continued)*

Continued from page 1

Our national ACEP representatives and lobbyists are the only voice we have in Washington D.C.

With the upcoming changes in the health care system it is critical to have a seat at the table. Likewise, the individual state chapters and lobbyists are continually meeting with representatives and discussing issues pertinent to all of our practices.

“With the upcoming changes in the health care system it is critical to have a seat at the table.”

Locally, we are currently spending significant time and effort on issues such as managed Medicaid, assignment of benefits, and workforce shortages. While there are no easy answers, being involved in the discussions and having lawmakers understand issues of emergency departments is crucial. Without our member support, or ACEP, I fear the conditions faced by our specialty would definitely be worse.

Thanks for your time –

I look forward to seeing many of you at our meeting in March!

FRED OSBORN MEMORIAL AWARD: Excellence in Emergency Medicine

The Indiana ACEP board would like to announce the establishment of a new annual award in memory of Dr. Fred Osborn who passed away earlier this year. A tribute to Dr. Osborn appeared in the last EMPulse issue, which briefly reviewed his extensive contributions to the practice of emergency medicine and to his group, hospital, community and the state. The award will be presented annually at the Indiana ACEP Education Conference in March.

The Indiana ACEP board is accepting nominations for consideration. The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state. To nominate a worthy physician, please submit a single typed page detailing the qualifications of a deserving emergency physician whom you know.

The nominated person must be an emergency physician currently practicing in the state of Indiana and be a current member of Indiana ACEP. The person making the nomination however need not be a member of ACEP nor a physician.

All submissions are due by December 31st, 2009 and are to be submitted electronically to indianaacepsue@sbcglobal.net.

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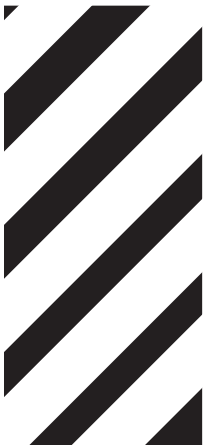
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