

EMpulse

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



May 3 & 4, 2012

will mark
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Annual Post
Graduate Course
in Emergency
Medicine
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Inside this Issue...

View From the Top.....	1
INACEP Member Candidate for Congress.....	2
A Win In Washington State ..	4
Future of EMS Certification Levels in IN	5
Painful, Swollen Cyanotic Leg: A Case Study	6
Uncivil Liberties	9
INACEP Board Nominations	9
IU Health North Hospital ..	10
Legislative Update	11
2012 Conference Update	11
Fournier's Gangrene: Case Study.....	12
EMS/Trauma Updates	13
INACEP IT Updates.....	13
Reimbursement Update....	13

A View from the Top: Indiana's Health Exchange

Tony Steele MD, FACEP (INACEP President)

The issues and debates around healthcare occupy the spotlight of our political figures, media, physician and patient advocacy groups, and our kitchen tables. Since this is our professional workplace and our own personal family's health, we cannot

overestimate how critical the decisions that are made will change us. Given that the United States spends 16% and rising of our gross domestic product on healthcare, the decisions our elected leaders and unelected administrators make will affect our economy and the financial stability of our country. The upcoming Supreme Court case ruling over the constitutionality of the individual mandate requiring the purchase of health care insurance as a part of the Affordable Care Act (ACA) will be a sentinel moment in healthcare. The verdict of this case is due sometime this summer and will alter the trajectory and implementation of the ACA. However the case is decided, healthcare will be a major issue in November's national elections and the results of this election will alter how our country pays and delivers healthcare. The current cost escalation is unsustainable. How we react to the current and looming crisis will be in a large part shaped by our next elected leaders.

At a state level, there are vastly different approaches to the ACA. Some states are

aggressively preparing to implement the ACA and some are going beyond to extend additional governmental coverage. Others are not moving forward at all counting on either the ruling of the Supreme Court to strike down the ACA or that public opinion

"... increasing Medicaid enrollment and the expansion of the Healthy Indiana Program (HIP) from the current number of 950,000 to an increase somewhere between 500,000 - 1.5 million. The financial requirements needed to support this large influx of patients are staggering."

and the overwhelming requirements of Act will make it difficult for the federal government to pursue. The Washington Post reported in mid-December that with many states unwilling or unable to get the insurance exchanges operational by the ACA deadline of Jan 1, 2014, pressure is reverting to the federal government to do the job.

Indiana has taken a more moderate course. Governor Mitch Daniels has signed an executive order to establish and operate a state Health Exchange should it remain in place at the federal level. The completion of the Exchange requires legislative action to be enacted. What Health Exchange looks like and its requirements is still very much a fluid situation.

The financial impact of the ACA and Health Exchange is overwhelming. It is estimated that 25% of the Indiana's population will be eligible for coverage under the ACA by 2014. Hoosiers under 133% of the poverty level are now Medicaid eligible. The expansion occurs for those between 133% and a 400% of the poverty level. Estimated state costs are about

INACEP Member Candidate for Congress

Indianapolis emergency physician John P. McGoff, MD, FACEP, is running for Indiana's 5th Congressional District. Dr. McGoff is a lifelong Hoosier. While in high school, he volunteered in the Wishard Hospital emergency department, and reaffirmed his ambition to become a physician.

At the age of twenty, Dr. McGoff graduated from Indiana University with a degree in biology and then matriculated to the IU School of Medicine. Upon completion of medical school in 1984, he performed his post-graduate residency in Emergency Medicine at Thomas Jefferson University in Philadelphia. While working there, he met his wife Karen. They have been married for over 26 years and have a 15-year-old daughter. After finishing his emergency medicine residency in 1987, where he served as Chief Resident, Dr. McGoff returned to Indianapolis and began working in the emergency department at Community Hospital. He served as chairman of the department for many years, as well as on the Board of Directors.

Dr. McGoff has been very active in organized medicine. He is currently an Alternate Trustee for the Indiana State Medical Association. He is past President of both the Indianapolis Medical Society, as well as the Indiana Chapter of ACEP.

During his second year of medical school, he joined the Medical Officer Training Corps with the Indiana National Guard. He has continued serving in the National Guard for over twenty-nine years and holds the rank of Brigadier General. He is currently the Chief of Staff for Indiana and oversees nearly 2,000 airmen. Prior to his promotion in 2010, he held the position of Air National Guard Assistant to the United States Air Force Surgeon General at European Headquarters. He is a decorated Iraq War Veteran and has logged over 600 hours of flight time in many aircrafts, including the F-4 and F-16 fighters. He is an Air War College Graduate and his decorations include the Meritorious



Service Medal with an Oak Leaf Cluster, Air Force Commendation Medal, Iraqi Campaign Medal, Air Force Outstanding Unit Award and many others.

In addition to his roles as a physician and military officer, Dr. McGoff remains an active member of the community in many other ways. He has served on a variety of national, state and local boards, including national ACEP's Reimbursement and Practice Management committees, Marion County Forensic Science Commission, Indiana Organ Procurement Organization, and the Indiana Brain Injury Leadership Board to name just a few.

He is a long time activist in Republican politics in Marion County, starting as a precinct committeemen, ward chairman,

and alternate delegate for the Republican National Convention on two occasions. In 1996, he was elected Marion County Coroner and served two terms. In 2004, he served Governor Mitch Daniels as a healthcare policy advisor for his campaign, and as a member of the Indiana Department of Health Transition Team following Daniels' victory. In May 2008, he won over 45% of the vote in the 5th Congressional District Republican Primary becoming the closest challenger in history and nearly unseating a fourteen-term incumbent. Dr. McGoff is running again for Congress in Indiana's 5th District.

If you would like to support Dr. McGoff's campaign and see another emergency physician serve in Congress, you can go to his website at www.drjohnmcgoff.com. You can help in a number of ways by hosting a coffee or fundraiser, making phone calls, walking your neighborhood or making a donation. This district is overwhelmingly Republican and the primary is most important. It will be held on Tuesday, May 8th. The 5th District includes all of Grant, Hamilton, Madison, Tipton and parts of Boone, Blackford, Howard, and Marion counties.

Mark your calendars now!

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A View From The Top *(continued from page 1)*

\$1.5 billion for the years 2014 to 2020. During most of this time (2014-2017) the federal government picks up a large majority of the costs. The budget impact to the state could explode after 2017 and will put significant pressure on the legislature to cut costs. \$690 million of the \$1.5 billion expense is attributed to physician fees. This includes the state estimating increasing the physician fee schedule to 80% of Medicare. Where the fee schedule actually lands cannot be overemphasized. No doubt this will be an area under significant scrutiny as the legislature takes up action to actually implement the Exchange. This is an area where we as a specialty will need to have a seat at the table to voice the needs of appropriate funding to maintain quality of care for our state's residents.

The Health Exchange is a sentinel process for the states and the ACA. It is required to begin operations on Jan 1, 2014. The Exchange is to allow comparisons of insurance policy offerings on price, coverage, and quality. It also determines eligibility for Medicaid and for federal subsidies or tax credits to help offset premiums.

According to the data the Indiana state government uses for its projections, there will be dramatic shifts in how our population is covered. Today's estimations are that there currently are about 875,000 uninsured. The 2019 projection is for that number to actually drop to between 300,000 and 525,000. This decrease includes some who will opt out of the health insurance market and instead pay the penalty for not being insured, as well as undocumented residents. The burgeoning governmental public expense occurs with increasing Medicaid enrollment and the expansion of the Healthy Indiana Program (HIP) from the current number of 950,000 to an increase somewhere between 500,000 - 1.5 million. The financial requirements needed to support this large influx of patients are staggering.

There is no standard federal Health Exchange model for an individual state. In a surprise decision, the Obama administration announced in mid-December that specific features for essential health benefits beyond previously defined broad categories would not be federally determined but left up to each state to decide what is appropriate for its Exchanges. Indiana is currently evaluating several options. Seema Varma is the state healthcare reform leader. I met with her as part of the state's medical society presidents about Indiana's health exchange future.

One model would view the health exchange as a facilitator of insurance. This model, dubbed the "Farmer's Market" model, would not influence the market in any meaningful way. Customer choices are maximized. The external health insurance market is not altered. Those eligible would mainly be those eligible for tax credits. Operation costs for the exchange would be less. Advantages include the more insurance players and competition, more choice and less insurance market dis-

ruption. Disadvantages include attracting individuals who are high risk or subsidized and there may be difficulty in attracting plans to participate.

On the other end of the spectrum, another model is the "Active Purchaser" or "Massachusetts model". The exchange would be a bulk negotiator and purchaser of insurance policies. The external health insurance market would be unavailable as an insurer could not offer a policy outside the exchange. High participation is required at a higher operation cost. Advantages to this model include lower insurance costs. Disadvantages include a decreased number of insurers and limited choices of plans. Fewer insurers may ultimately lead to increased costs and decreased ability for providers to negotiate rates.

In the middle is an "Evaluator Model" that would rate plans and identify "top tier" choices and act as a market catalyst. The external market would continue but the choices inside and outside the Exchange would be leveled. Operational costs would fall between the other two choices. Advantages include insurance competition based on the Exchange defined criteria, preserving insurance choices, and influence on the external insurance market to price variation. Disadvantages would include the Exchange rating various plans and protests from those ratings.

Which one or combination of these Exchange options and benefits covered will work best, is still very much on the table. I would encourage you to become familiar with the direction of the discussion. I also encourage contributions to the Indiana ACEP PAC. We need the resource to represent our specialty to our state legislators. Contributions to INEMPAC can be made through the Indiana ACEP office at 630 N. Range Line Rd, Suite D., Carmel, IN 46032. Please contact INACEP for further information at 317-846-2977 or email Sue at indianaacepsue@sbcglobal.net.

A Win in Washington State

As reported in the last issue of EM Pulse, Washington state attempted to enact a controversial "three ER visit limit" for Medicaid enrollees. More than 700 diagnoses were classified as "non-emergent" including chest pain, abdominal pain, miscarriage, and breathing problems. The Washington chapter of ACEP, with the financial help of National ACEP, vigorously opposed this and the measure implementing the rule was ruled invalid. However, the state is now proposing to stop paying for any non-emergency care based on a somewhat scaled back list of about 500 diagnoses classified as non-emergent. The Washington chapter continues to lead the effort to oppose the new proposal, which is currently scheduled to be implemented in April.

The Future of EMS Certification Levels in Indiana

*Sara Brown MD, FACEP —
INACEP ES/Trauma
Committee co-chair,
PEP Regional EMS
Medical Director*

Over the last ten to fifteen years multiple federal agencies and national associations have been working together to ultimately create a national scope of practice model. The authority to define the scope of practice for EMS actually lies within each state which has previously allowed quite varied and heterogeneous practice levels of prehospital providers across state lines. This variability is problematic in multiple regards including national certifications, reciprocity of professionals moving from one state to another, reimbursement by insurance agencies, and education of our prehospital providers. The time has come for Indiana to decide whether to change our certification levels to align with the national recommendations which would help alleviate many of these issues and move toward a national standard for EMS education, certification, and scope of practice. These changes would require quite in-depth updating of rules at the state level and would likely take at least two years to achieve.

The National EMS Scope of Practice Model (<http://www.nhtsa.gov/people/injury/ems/EMSScope.pdf>) was completed in 2007 and defines four levels of EMS providers: Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician, and Paramedic. While a great deal of the education and the practice of Indiana's EMS providers would not change under the new national recommendations there are some significant differences from our current system. One rather significant change would be the removal of the current Indiana Basic Advanced EMT level which allows the initiation of intravenous access. This skill is not included for the new Emergency Medical Technician. If a current Basic Advanced EMT or ambulance service provider were to decide to increase their care level to the new Advanced EMT (allowing them to continue to use their IV skills) there would be quite significant additional training necessary to reach that level due to multiple other new skills required in upgrading from Basic Advanced EMT to the new Advanced EMT. As EMS providers decide which level of care to provide to their community they will need to consider the increased cost of the education as well as the additional supplies necessary for the remainder of the skills at the new Advanced EMT level (nitroglycerine, epinephrine for anaphylaxis, glucagon, D50, inhaled beta agonists, narcotic antagonist, and nitrous oxide). Another rather significant change from the current prehospital care in Indiana involves the use of airways that are NOT intended to be placed into the trachea (Combitube). Currently these are allowed at the Basic EMT level but in the

new scope of practice would only be used by Advanced EMTs or Paramedics. The Emergency Medical Responder level and Paramedic level would be with minimal change in Indiana.

As Indiana wrestles with these issues they will have the option to make no changes, adopt some components of the National EMS Scope of Practice Model, or to accept the entire model. Senate Bill No. 371, authored by Senator Mishler, is currently being reviewed and addresses some of these changes. The status of the bill and its current draft can be reviewed at:

http://www.in.gov/apps/lisa/session/billwatch/billinfo?year=2012&session=1&request=getBill&docno=0371&doctype=SB#atest_info.

As we consider how this would affect our prehospital professionals both positively and negatively we must keep in mind the importance of national standardization of prehospital emergency care. The EMS/Trauma Committee of INACEP will attempt to keep its members apprised of decisions made at the state level and timelines for such changes.



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PAINFUL, SWOLLEN CYANOTIC LEG: A CASE STUDY

by Jeff Harvey MD Indiana University

Patient Overview:

Chief Complaint:

Extremely Painful Left Lower Extremity

The patient is a 63 year white male who presented two days after he began having extreme pain throughout his left lower extremity. The patient said the pain was a gradual onset and had been worsening over the past two days. Additionally, the patient's leg had become discolored over the last 24 hours. He said he had been diagnosed with a "blood clot" in his left lower extremity two weeks prior to the onset of pain, but had not been placed on any anticoagulants.

The patient reported a past medical history of coronary artery disease. He was not currently taking any medications and had no drug allergies. Social history was pertinent for a thirty pack-year smoking history and six to seven alcoholic beverages a day "for years," with his last drink twelve hours before arrival.

Diagnosis and Discussion:

The patient's history and physical exam are consistent with Phlegmasia Cerulea Dolens (PCD). A chart review of the patient's electronic medical record revealed a left lower extremity ultrasound positive for a superficial venous thrombosis two weeks prior to arrival, after which the patient was discharged without anticoagulants. Vascular surgery was consulted and requested a CT angiogram prior to their evaluation. A complete blood count showed a leukocytosis with a WBC of 26,200. Basic metabolic panel and coagulation

studies were within normal limits. The patient was started on full dose heparin and was given dilaudid for management of his pain. CT angiogram revealed thrombus within the left iliac veins extending distally throughout the left lower extremity, gradual loss of contrast in the left popliteal artery and bilateral lower lobe pulmonary emboli. Vascular surgery admitted the patient and performed a complete surgical thrombectomy the following day. The patient was hospitalized for 8 days. Workups for hypercoagulable state and cancer

were both negative. Six days after his initial thrombectomy, the patient developed a subsequent deep vein thrombosis in his left lower extremity. He was taken to the operating room a second time, but his repeat thrombectomy was unsuccessful. Venography showed narrowing his left iliac vein, and a venous stent was placed. The patient was presumed to have May-Thurner syndrome and was sent home on warfarin.

PCD is a rare manifestation of venous thrombosis and is part of a clinical spectrum that also includes phlegmasia alba dolens and venous gangrene. Deep venous thrombosis progresses to total occlusion of the deep venous system and venous drainage from the affected leg is left to the superficial venous system. The superficial venous system is not adequate to handle the large volume of blood being delivered to the leg, resulting in edema, pain and a white appearance of the leg (phlegmasia alba dolens). Further progression of the disease leads to occlusion of the superficial venous system preventing all venous outflow from the leg, resulting in increasing edema, pain and cyanosis. Ultimately, venous outflow and obstruction will impede arterial flow leading to ischemia and gangrene.

PCD is a life threatening and limb threatening disease with an overall mortality of 20-40% and an amputation rate of up to 50% of survivors. PCD can occur at any age, but is more common in the fifth and sixth decades. Risk factors include coagulopathies, surgery, trauma, ulcerative colitis, gastroenteritis, heart failure, IVC filter placement, compression of the left iliac vein by the right iliac artery (May-Thurner syndrome) or compression of the left iliac vein against the pelvic rim by a gravid uterus during the third trimester of pregnancy (Milk Leg syndrome). The most common risk factor is malignancy, which is seen in 20-40% of cases. Ten percent of patients have no risk factors.



Physical Exam

Vital Signs:	BP 104/73, HR 130, RR 20, Temp 36.0 C, SaO2 96% on RA
General:	The patient appeared to be in mild distress.
Cardiovascular:	Tachycardic, no rubs, murmurs or gallops
Respiratory:	Lungs are CTA bilaterally with no rales, rhonchi or wheezes
Abdominal:	Soft, nontender, nondistended with no rebound, guarding or masses
Extremities:	Left lower extremity is edematous and cyanotic throughout. Femoral pulse is 2+, but dorsalis pedis and posterior tibialis pulses are not palpable. Patient has pain with movement of the extremity, but he has FROM both active and passive. Sensation is intact throughout.

PAINFUL, SWOLLEN LEG

continued

Patients with PCD present with the clinical triad of edema, severe pain and cyanosis of the effected limb. The majority of cases of PCD occur in the lower extremities with only 5% occurring in the upper extremities. Left sided involvement is more common than right by a ratio of 3:1. Fifty to 60% of cases of PCD are preceded by phlegmasia alba dolens, and bleb and bullae formation may be present secondary to the massive fluid sequestration. Hemodynamically, patients may present in shock due to volume loss or pulmonary embolus, which is responsible for 30% of deaths from PCD.

Diagnosis of PCD in the emergency department is mainly clinical with the assistance of contrast venography, duplex scan or CT arteriogram. Basic laboratory tests, including complete blood count, coagulation studies and basic metabolic panel, should be obtained. Vascular surgery should be consulted early in the workup of these patients. Treatment in the emergency department includes initiation of full dose heparin, pain control, fluid resuscitation, elevation of the effected limb and close hemodynamic monitoring. Long-term management consists of surgical thrombectomy or conservative medical management with a short course of heparin followed by long-term coagulation with warfarin for six months.

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The **EMPulse** is published 4 times per year. Dates are (approximately) Jan. 25, April 25, July 25 and Oct. 30. Ad deadlines are (approximately) the 5th of each month of the publication date

MAIL TO:

Indiana ACEP

630 N. Rangeline Road, Suite D Carmel, IN 46032
Fax: 317-848-8015
Email: indianaacepsue@sbcglobal.net

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Sue BARNHART Executive Assistant

indianaacepsue@sbcglobal.net
317-846-2977

Uncivil Liberties by Greg Moore MD, FACEP—INACEP board member

I was fortunate this year to attend the ACEP scientific assembly in San Francisco. As always, the new offerings at the ACEP bookstore are carefully perused. I was disturbed and dismayed to see an entry entitled *“Dealing with People You Can’t Stand”* in our professional library. My initial reaction was of a chuckle believing it to be tongue in cheek type humor, but unfortunately it is a real guide to navigating interactions with difficult societal subtypes. Has society at large and our once noble profession deteriorated to the point that we despise those we vowed to serve? It is a sad commentary that such a book is prominent in our professional bookstore offerings. I haven’t read the book. I’m not calling for its condemnation or removal from our bookstore but alarmed by its mere existence. Perhaps we as medical professionals should be modeling civil behavior rather than merely learning how to cope with uncivil acts. I recognize that we are not always civil ourselves being a thirty year survivor of the emergency medicine experience. I recall multiple episodes of blatant physician incivility toward patients and staff and multiple instances where we have been uncivil or downright hostile toward our professional colleagues and vice versa. I worry that this attitude has led to the promulgation of such pseudo-civil entities such as Press-Ganey and their ilk. The effect of the soon to be “Pay For Satisfaction” model of reimbursement forced upon us by the Government and Insurance camps is still unknown. Considering my perception that satisfaction surveys only escalate utilization of services, I can’t imagine that this move is nothing more than a thinly veiled ruse to further cut reimbursement.

Over the past 30 years of my emergency medicine career, I have seen a trend in better behaved physicians. No longer do I have to console or defend a tearful nurse or tech berated by an unruly, abusive colleague or consultant. The threat of civil and sexual harassment suits has done its job. I’d like to believe that as a profession we have become more congenial, but I know better.

As a society, I perceive a general trend toward rudeness, impatience, disrespect for authority, and a general feeling that the rules don’t apply to me, only everyone else. I could only guess at the root cause, latch key kids with no one around to model manners and respect begetting offspring that emulate their

“Has society at large and our once noble profession deteriorated to the point that we despise those we vowed to serve?”

parent’s bad behavior. One only needs to drive down the road, wait in line at a grocery or eat in a restaurant to observe the aforementioned behaviors firsthand. My college aged son has as a required part of his core curriculum a semester course in “Civility.” So we are not alone. I have polled policemen, attorneys and a judge, their observations mirror mine.

In my emergency department we are reimbursed based on Press-Ganey scores and we evaluate an eclectic patient mix with more than its share of actual insured, employed, SUV driving, Starbucks swilling, cellphone talking/texting types. I find them to be the most difficult patient to deal with and satisfy. They are the new “entitlement” type. Educated, prepared with WebMD, and entitled because they actually pay for service. Nothing wrong with that except they often demand services that they don’t require. Doctor, how do you know it’s just sprained until you get an MRI? I try to explain that I’d like to put the ankle in a splint and follow up with orthopedics tomorrow and that in the event we obtain an MRI, the ankle will be placed in a splint and they’ll follow up with orthopedics tomorrow, regardless of the MRI results. They don’t get it. I get a low Press-Ganey score and I take a financial hit. So do I simply order the MRI and add to the rising health care costs in unnecessary services? People don’t seem to care or value our education, training or clinical expertise. We have become merely purveyors of technology on demand for customers that don’t always require that particular technology. I find this notion to be disrespectful of our medical profession. We need to somehow regain control of the practice of medicine.

Perhaps I’m beginning to understand why the guy wrote the book, maybe I’ll order a copy.

INACEP Board Nominations

by Timothy Burrell MD, FACEP—INACEP Board Member

Indiana ACEP invites you to get involved! We are taking nominations for directors to serve on the chapter board. This is an opportunity to share ideas, pursue interests, get acquainted with fellow emergency physicians and to lead our chapter as a member of the board of directors. Your voice is needed to help us be successful. The director term is for three years and requires four meetings per year in Indianapolis. Two of the meetings are scheduled to coincide with other IN ACEP events to decrease the amount of travel required. If you or a colleague is interested in being considered for this position, please submit a brief statement of interest and current curriculum vitae to timothy.burrell@dynamicmps.org.

Featuring Indiana Emergency Departments: IU Health North Hospital

by Sean Trivedi MD, FACEP (INACEP Vice-President)

Our second featured emergency department is that of I.U. Health North Hospital in Carmel, Indiana, staffed by a group of physicians and physician assistants of I.U. Health Emergency Medicine. The hospital and emergency department opened their doors in December of 2005. The nearly 190 inpatient bed, full-service hospital and 14 bed emergency department provides a full complement of services to both adult and pediatric patients.

During 2011, the emergency department evaluated and treated over 16,000 patients with a nearly 30% pediatric population and an admission rate approaching 20%. Recent accolades bestowed upon the emergency department include ranking in the 100th percentile for pediatric patient satisfaction and 98th percentile for adult patient satisfaction per NRC Picker.

The physician director at the North Hospital site is Dr. Jack "Skip" Keene, and the nursing manager for emergency services is Ruth Kain, R.N. The other physicians of the group are Drs. Denise Combellick, Amy Duell, Chris Kiefer, Jerry Snow, Chuck Tolan and Sean Trivedi. The group also includes physician assistants Kristin Shields and Lara Tate.

How is your department adapting to the need for an electronic medical record (EMR), and what system do you use? How is your department adapting to the challenges of computerized physician order entry (CPOE)?

Our group currently utilizes Cerner and FirstNet as our electronic medical record. We have been using them since first opening in the winter of 2005 and therefore have six years of experience with the system. The EMR allows for improved documentation and legibility of our patient charts as well as better communication with our inpatient and outpatient colleagues. Physician efficiency with the EMR varies considerably within our group, but few can challenge the assertion that a traditional paper chart is quicker. The department began CPOE in 2011, which has further taxed our physicians and physician assistants. Given the mandate that all medical groups must transition to an EMR and CPOE despite the logical counter-arguments particularly in regard to CPOE, a reasonable solution to return physician efficiency would be to utilize scribes, as noted in the last issue of EMPulse by Dr. Gina Huhnke. We have not leveraged our time in this manner as of yet.

What challenges are your group or your region of the state generally facing?

Many of the concerns of our group are the same as any other emergency department throughout the country. We do enjoy improved access to specialists given our association with the various components of I.U. Health, including I.U. Methodist Hospital, Indiana University Hospital and I.U. Riley Hospital for Children. We face the same increased expectations for quick, efficient and excellent care as other



departments while coping with the increased non-patient care demands placed upon the practicing emergency physician. The increased pressure from national and state entities and the anticipated decreasing financial payments create uncertainty and limit the ability to mobilize additional resources to assist with the ever-increasing demands of emergency medicine today.

What do you enjoy about your group?

I enjoy the supportive nature of my fellow emergency physicians and the excellent care provided by them. The varied training background among them provides a diversity of thought and seeks to improve patient outcomes rather than approaching the same issue in the same manner as can frequently occur. I also enjoy the 24-hour support of our in-house pediatric and adult hospitalists as they add to the cognitive milieu. Our smaller satellite group functions relatively autonomously from the larger I.U. Health Emergency Medicine entity but enjoys the resources and stability of the larger group.

How can ACEP be more helpful to your group?

Continue to champion the field of emergency medicine on a national and local level. Provide further educational/CME opportunities such as ultrasound courses, simulation lab opportunities and LLSA courses in addition to the annual conference.

The Membership Committee of the Indiana ACEP Board of Directors will continue to devote an article in each edition of EMPulse to a feature of one of our state's many emergency departments. If you'd like your ED to be featured in a future issue, please contact me at douglastannas@gmail.com. Thanks!

—Doug Tannas, M.D.

Legislative Update

by Lou Belch, Lobbyist for inACEP

The Indiana General Assembly convened on January 4, 2012. There are several issues being discussed at the Statehouse that are getting significant media attention. We will not spend time discussing those issues in this article; they have been adequately reported in the media.

There are a number of issues that are of interest to Indiana ACEP under consideration at the Statehouse:

SB 52, HIV Testing, changes current law regarding consent for testing. Currently there must be a specific consent for an HIV test. If the bill passes, it will be easier to test for HIV under the general health care consent law. This bill was initiated by INACEP Board member Lindsay Harmon-Hardin, MD.

HB 1114, Physician Ordered Scope of Treatment Forms, was introduced by Rep. Tim Brown, MD. The INACEP Board has voted to support the legislation and has sent a letter to that effect. The bill establishes a process for the execution of a physician order for scope of treatment (POST) form by an individual and the individual's treating physician to indicate treatment the individual would like to have or have withheld under specified circumstances. Requires the state department of health to: (1) develop and distribute the POST form and specifies provisions to be included in the form; and (2) report to the health finance commission

before October 1, 2014, and annually thereafter, concerning the POST form. Allows for the modification or revocation of the POST form. Provides civil and criminal immunity for certain actions taken by a health care provider under an executed POST form.

The issue of regulation of the Spice and Bath Salts is an issue that has gathered a great deal of media attention. The proposal is in two bills, HB 1196 and SB 234. The manufacturers of these drugs continue to change the compounds and make it difficult for law enforcement officers to enforce. These bills seek to make it easier for law enforcement to keep up with changes in chemical compounds.

HB 1149, creates a Statewide smoking ban. The bill as introduced would ban smoking in all businesses in the state with the exception of:

- **Gaming floors in racinos, casinos, and OTBs.**
- **Cigar and hookah bars;**
- **Fraternal organizations, social and veteran's clubs.**

The bill likely will have more amendments to expand the exemptions to the ban.

The General Assembly will adjourn by March 14, 2012.

2012 IN ACEP & IUSOM DEM Conference

by Sean Trivedi MD, FACEP (Education Director)

The 40th annual post-graduate course is rapidly approaching. It is set for May 3rd and 4th, 2012 at the Marriott North Indy Hotel. Mark your calendar and request your time off now so that you can attend. Earn nearly 13 AMA Category 1 Credits while catching up with old friends and making new ones.

This year's events include presentations from noted national speakers ACEP President Dr. David Seaberg, SAEM President-Elect Dr. Cherri Hobgood and Vanderbilt Chairman of Emergency Medicine Dr. Corey Slovis. There will be additional presentations from excellent regional and local speakers including Drs. Bart Besinger, Jason Schaffer, James Webley and Elizabeth Weinstein.

Do not miss this opportunity to learn and earn CME while enjoying some time with your fellow Indiana emergency physicians. See the registration form included in this EMPulse edition or download it from our website www.inacep.org. If you have any questions, contact Sue at your Indiana ACEP office directly at indianaacepsue@sbcglobal.net.

Fournier's Gangrene: A Case Study

by Greg Moore MD, FACEP—INACEP board member

A 55 yr. old poorly compliant, diabetic, male patient presented to the ED with a 24 hour history of a low grade fever, vague supra-pubic discomfort, dysuria and a small amount of blood in his terminal urinary stream. He had no nausea, vomiting, cough or dyspnea.

The Past Medical History was remarkable for poorly controlled diabetes and hypertension as well as morbid obesity.

The Physical Exam revealed an obese male who was non-toxic in appearance. Vitals: 99 temp, 113, pulse, BP 158/96, 148 Kg. Chest and heart exam were unremarkable. The abdomen was tender in the supra-pubic area. No erythema or edema was present. The genital exam was unremarkable

Lab work: CBC revealed a leukocytosis of 13,500 with a left shift. CMP revealed normal renal function and electrolytes. The glucose was 315. His urinalysis was positive for 18 WBC's and glycosuria

A CT abdomen was performed and interpreted as, "some mild inflammatory stranding around the left kidney consistent with early pyelonephritis". This selected view is at supra-pubic level.

The patient declined the offer for admission, citing financial concerns, and was given Ceftriaxone intravenously. He was then released home with a prescription for Ciprofloxin and advised to follow up with his primary care provider for re-evaluation.

Unfortunately, also citing financial concerns, the patient failed outpatient follow up as had been advised.

Within 24 hours of his release, he noted increasing supra-pubic pain, continued dysuria and began to develop erythema to his supra-pubic area. This extended to his penis

and scrotum area. All areas became markedly edematous and indurated. Over the next several days this erythema, edema and induration extended unto his abdominal panniculus ultimately progressing to 10 centimeters above his umbilicus. He developed urinary retention and had increasing pain in his scrotum which prompted his return to the ED six days after his initial visit.

On this visit, the patient appeared septic with the following vital signs: temp 96, pulse 120, BP 90/45. He had tense edema, induration and erythema to his abdominal panniculus, penis and scrotum areas. There were several circular necrotic areas on his scrotum. His mental status and cognition were normal as was the remainder of his physical exam.

The lab work revealed a leukocytosis of 14,300 with 46% Bands, vacuolated neutrophils, and toxic granulations. His glucose was 502, BUN 43, Cr 3.3, and sodium 125. Blood cultures were obtained.

He received fluid resuscitation with 2 liters of normal saline, Zosyn and Vancomycin intravenously, and immediate urology consultation. We were unable to pass a foley catheter.

He was transferred to the operating suite for wide debridement and supra-pubic catheter placement.

Tintinalli describes Fournier's Gangrene as a poly-microbial, synergistic, infective necrotizing fasciitis of the perineal, genital, or perianal area. Diabetics and chronic alcoholics are disproportionately affected. Overall mortality is 40%

Emergency physicians are cautioned to maintain a high index of suspicion for this entity when a high risk patient presents with genital pain out of proportion to other findings.



Figure 1. Suprapubic level

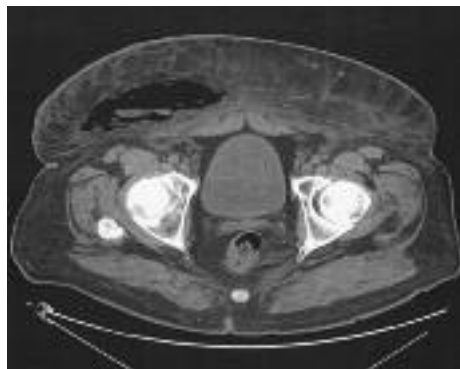


Figure 2. marked inflammatory changes in panniculus with gas formation in soft tissue

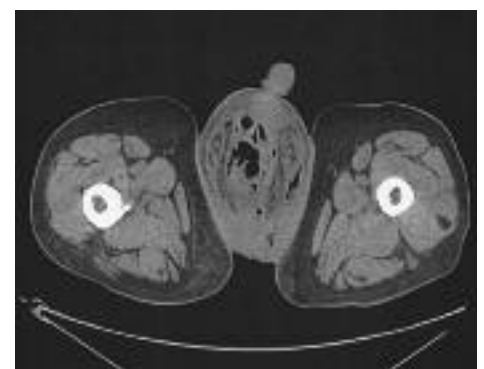


Figure 3. gas in soft tissue of penis and scrotum

INACEP Membership/Public Relations/ IT Committee Update

INDIANAEM – A NEW WEBSITE FOR EM PRACTITIONERS

Indianaem.com is a project website and mobile application being developed to assist Indiana emergency department healthcare providers. The assimilated information is mainly non-clinical and includes elements such as a concise, user-friendly, review of the 4\$ prescription drug programs, relevant, Indiana specific legal issues facing clinicians, low cost follow-up clinic options by county, and legislative matters pertaining to medical practice. There are links to commonly used resources such as the INSPECT program, licensing renewal, INACEP listed jobs, and the IU Department of Emergency Medicine. A variety of transfer center numbers are also listed. Any reasonable announcements pertaining to EM practice may be posted as well. The site is meant to be a virtual and more statewide “three-ring binder”, if you will, for those who remember them.

The project will proceed until July 2012, and if deemed useful, continue thereafter. The administration of the website, ownership and the content are all being considered. Any feedback you have regarding any of these issues is appreciated and considered. Please check it out: www.indianaem.com.

INACEP EMS/Trauma Committee Update

We are developing an email group for EMS Medical Directors in Indiana. Anyone who wishes to participate should contact Dr. Sara Brown at drsnoopy@gmail.com.

Legislation is being supported by INACEP for the execution of a physician order for scope of treatment (POST) form. This would indicate treatment an individual would like to have or have withheld under specific circumstances. The legislation has been drafted by the Indiana Patient Preferences Coalition.

A Trauma Field Triage and Transport Destination Protocol has been submitted by the Indiana State Board of Health and the Indiana Trauma System Advisory Task Force. This protocol has been approved by the Indiana EMS Commission. (http://www.in.gov/dhs/files/Triage_Transport.pdf)

INACEP Reimbursement Committee Update

by Chris Burke MD, FACEP—Reimbursement Committee Chairman

The passing of the Temporary Payroll Tax Cut Continuation Act of 2011 resulted in a temporary reprieve of the 27% SGR cut to the Medicare fee schedule for 2012 and an extension of the fees from 2011. Although the Medicare conversion factor increases slightly (\$33.9764 to \$34.0376) in 2012, Emergency Medicine will experience a -1% update to our overall RVU values in 2012 (due to a minor decrease in the practice expense portion of the RVU formula). Work RVU's remain unchanged. The following is a breakdown of our E+M codes:

Code	2011 Work RVU	2012 Work RVU	2011 Total RVU	2012 Total RVU	2011 Fee	2012 Fee
99281	.45	.45	.61	.60	\$20.13	\$19.71
99282	.88	.88	1.19	1.18	\$39.14	\$38.64
99283	1.34	1.34	1.80	1.77	\$59.28	\$58.06
99284	2.56	2.56	3.40	3.37	\$111.65	\$110.26
99285	3.80	3.80	4.98	4.94	\$163.87	\$161.99
99291	4.50	4.50	6.40	6.38	\$210.26	\$208.68

For those involved with Observation Medicine, the RVU's increased significantly for 2012, as did CPR (5%) and complex abscess drainage (9%). For those staffing urgent care centers, however, the news is not as favorable, as the definition of an “established” patient includes anyone seen by any group member at the facility in the past 3 years (resulting in a significant payment reduction vs. a “new” patient).

Separately, I had received communication that Anthem was going to implement a policy in 2012 that would apply a 50% payment reduction to an E+M service billed with a procedure appended with modifier 25 (most of our ED procedures are also billed with an E+M code, as they are separately identifiable services provided on the same day by the same provider, hence the modifier). Through the efforts of several members of the ACEP Reimbursement Committee, we were successful in arguing that while such a policy may have some merit in an office –type setting, it has none in an Emergency Department, where we don't schedule patients for procedures. We have recently received confirmation from Anthem that his policy will not apply to Emergency Dept. E+M codes.

Lastly, it has come to our attention recently that National Government Services (NGS), who has served as the Indiana Medicare Carrier Director for some time, has potentially lost it's Indiana contract with CMS (currently under appeal). Most feel that NGS has done an excellent job in fulfilling this role, and would hate to see a change made. This could potentially have significant consequences for every Physician in Indiana who is a Medicare provider, requiring everyone to re-enroll with a new carrier (at the very least). Indiana ACEP will be drafting a “letter of support” on behalf of NGS to CMS.

40th Annual Indiana ACEP and IUSM DEM Post Graduate Course in Emergency Medicine Thursday & Friday, May 3 & 4 2012

REGISTRATION FORM

Name: _____ ACEP Membership #(if applicable) _____

Title/Position: _____ Hospital Affiliation: _____

Home Address: _____

City _____ State _____ Zip _____

Home or Office Fax: _____ Email:* _____

*Your receipt/confirmation will be emailed to you. If you do not have an email, it will be faxed.

NEW: I prefer to receive my lecture handbook on **paper** or **flash drive** (check one)
(There will not be electrical outlets for your laptops, so if you choose flash drive please make sure your laptop battery is charged!!!)

Please check one of the following:

- ACEP Member:** \$250 _____
- Physician Non-Member:** \$300 _____
- PA/Nurse/Nurse Practitioner/Paramedic:** \$125 _____
- Intern /Med Student (refund w/attendance):** \$ 20 _____

2

DAY
REGISTRATION

Thursday Morning **Women's Breakfast***: _____ (check if attending)

*The "Women in EM" breakfast is free, but you must preregister for it so we know how many will attend

IUSM Residents and Faculty – separate form will be distributed through Dr. Hunter or Halliday.

A late fee will be charged for any registration received after April 18, 2012. **Late Fee** (after 4/18/12) \$25 _____

NO FULL REFUNDS AFTER April 18, 2012

Please check one of the following:

Thursday or Friday

- ACEP Member:** \$160 _____ \$100 _____
- Physician Non-Member:** \$175 _____ \$135 _____
- PA/Nurse/Nurse Practitioner/Paramedic:** \$ 80 _____ \$ 60 _____
- Intern /Med Student (refund w/attendance):** \$ 10 _____ \$ 10 _____

1

DAY
REGISTRATION

Thursday Morning **Women's Breakfast***: _____ (check if attending)

*The "Women in EM" breakfast is free, but you must preregister for it so we know how many will attend

IUSM Residents and Faculty – separate form will be distributed through Dr. Hunter or Halliday.

A late fee will be charged for any registration received after April 18, 2012. **Late Fee** (after 4/18/12) \$25 _____

NO FULL REFUNDS AFTER April 18, 2012

40th Annual Indiana ACEP and IUSM DEM Post Graduate Course in Emergency Medicine Thursday & Friday, May 3 & 4 2012

INFORMATION

CANCELLATION POLICY:

A full refund will be given, provided cancellation is received by April 18, 2012. A processing fee of \$20.00 will be charged for cancellations received after this date. No Shows will be charged full registration amount.

IACEP reserves the right to conduct its courses based on minimum enrollment. Should cancellation be necessary, it will be done not less than 10 days prior to the course date and each registrant will be notified by telephone with written notification and a full refund following. The Indiana Chapter of the American College of Emergency Physicians is not responsible for any cost incurred due to cancellation of a program, such as airline or hotel penalties.

MAKE YOUR CHECK PAYABLE AND MAIL TO:

Indiana ACEP
630 No. Range Line Rd. Suite D
Carmel, IN 46032

OR FAX TO: 317-848-8015

NO FULL REFUNDS AFTER **April 18, 2012**

HOTEL WILL ONLY HOLD ROOMS THROUGH APRIL 18, 2012, SO REGISTER EARLY!

LOCATION

Marriott Indianapolis NORTH Hotel, (Keystone at the Crossing) on the North side of Indianapolis. This hotel is conveniently close to the Fashion Mall and Keystone at the Crossing and within easy walking distance to theaters, restaurants and popular nightspots.

Address:

Marriott Indianapolis North Hotel
3645 River Crossing Parkway
Indianapolis, IN 46240

PARKING

Convenient parking at the Hotel - **FREE**

LODGING

A block of rooms has been reserved at the Marriott Indianapolis NORTH Hotel for the special rate of \$124.00 single or double occupancy per night. For lodging information, please call Marriott North Indianapolis Hotel directly at: (317) 705-0000. When making your hotel reservations, identify yourself as: "Indiana Chapter of American College of Emergency Physicians"





Indiana Chapter
American College of
Emergency Physicians

630 N. Rangeline Road
Suite D
Carmel, IN 46032

Phone: 317-846-2977
Fax: 317-848-8015
Email: indianaacep@sbcglobal.net

First Class Mail

TeamHealth MidWest Opportunities

Staff Physician opportunities at Schneck Medical Center's 27,000-volume, 16-bed ED in Seymour, IN. Physician must be Board Certified or Prepared in EM or Primary Care with ATLS, ACLS and PALS.

Staff Physician opportunity at Gibson General Hospital's 12,000-volume, newly remodeled, 12-bed ED in Princeton. Must be BC/BP in EM or BC/BE in primary care specialty with ACLS, ATLS, and PALS.

Staff Physician opportunity at Terre Haute Hospital's 23,000-volume, 16-bed ED. Must be BC/BP in EM or BC/BE in a primary care specialty with ACLS, ATLS, and PALS.

TeamHealth Midwest is searching for a Regional Medical Director to join our growing team in Indiana. Interested physicians must be Emergency Medicine Board Certified with leadership experience.

Competitive compensation. Free CME. Professional liability insurance. Competitive compensation. Free CME. Professional liability insurance with tail coverage.

Contact Trisha Miller at
trisha_miller@teamhealth.com
or 855.276.0002

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EMPLOYMENT OPPORTUNITIES

Indiana Emergency Care is a premiere physician owned and operated democratic group, dedicated to providing the best clinical and operational service in its class! IEC recruits top notch physicians looking for long term emergency career opportunities with interest in becoming a partner with IEC. We have 30 board certified emergency medicine physicians on staff and 8 mid-level practitioners that all have been selected by our IEC recruiting team.

We operate five emergency rooms in West-Central Indiana. Our annual patient **volume averages around 117,000 (13,000-35,000 among five campuses)**. IEC shifts are **8-12 hours** with **mid-level practitioner coverage** at two of our busiest sites. **Scribes** are assigned to our providers during most hours at all of our sites.

COMPENSATION :

- \$345,000 Package
- Competitive Sign on Bonus
- \$5,000 of CME
- \$160 per hour
- Partnership Eligibility
- Profit Sharing
- 401K Match
- Two Weeks Paid Vacation
- Health, Vision, Dental, Life Insurance
- Malpractice Insurance (with Tail)

COMMUNITY :

- Home to Big Ten College Purdue University
- Highest ISTEP scores in both public and private school systems
- Low Cost of Living
- Short Drive from Chicago or Indianapolis

CONTACT:

Erika O'Brien, COO-CFO
Phone: 765-446-0170
Email:

Erika.obrien@indianaemergencycare.com

