

EM **pulse**

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



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A View from the Top



Christian Ross, MD, FACEP (INACEP President)

There is a lot happening in the world of INACEP! Since I know you don't have all day, let's get down to it. Here are the top four items on the table for us:

1) Southeastrans – By now, your departments have undoubtedly been affected by Southeastrans. For those not aware, the FSSA signed a contract with a transportation company, Southeastrans, to coordinate all Medicaid transfers. This would be all well and good, but unfortunately their policies haven't been very ED (or patient) friendly. One example would be the three hours they have to pick up patients for transport. That's obviously a long time to wait in the ED and can really clog up a department, especially in smaller departments or those in need of multiple transfers. Additionally, EMS agencies have to qualify and register to receive Medicaid transport business. This has been a huge burden for some EMS transport agencies and led to many not participating with Southeastrans at all. Reliability of services for outpatients is also an issue. I personally have cared for multiple patients who are in the ED solely because of missed appointments due to transport issues. Some even have missed dialysis appointments! As a result of these mishaps, the INACEP board of directors met with the FSSA in June and relayed our concerns. Since then, there has been a massive influx of complaints and concerns coming from patients, other healthcare organizations and even local media. In response to these concerns, the FSSA issued a stay in the requirement to use Southeastrans to help iron out the kinks. This stay, however, ends on Sept 30th. After that date, all Medicaid transfers will be through Southeastrans. Regardless of the outcome here, rest assured that INACEP will continue the fight to ensure fair, safe and timely transport of our patients.

2) Medicaid Managed Care Services – With increasing efforts over the past year and a half, INACEP has led the fight against unfair payment policies from state Medicaid managed services programs. For those of you not in the know, both MDWise and MHS developed policies to pay based on discharge diagnoses rather than work completed in the ED. Under these systems, they will only pay for a level 4 or 5 chart if the discharge diagnosis matches an ICD 10 code on their "auto-pay" list. If it doesn't, you'd have to submit an appeal for it to be considered for pay at an appropriate level. In practice, this generates a huge cost to groups in generating tens of thousands of appeals. Even worse, MHS/MDWise are not equipped properly to process the massive number of appeals, thus making the whole situation a sunk cost to the hard-working EM groups around the state. Fortunately, however, we have made some progress stopping this unfair practice! After multiple meetings and phone calls with INACEP, MHS has officially stopped this policy and will revert back to the previous process of paying claims submitted. So...one down (MHS), and one to go (MDWise). To continue the fight, the INACEP board of directors met with the FSSA (who oversee the contracts for these companies within the state) and asked them to join us in opposing this practice. We have a follow up meeting soon that will hopefully get us closer to making MDWise accountable for their actions as well. More to come here.

Legislative Update

by Lou Belch, Lobbyist for INACEP

The Indiana Emergency Medical Political Action Committee (IEMPAC) has made political contributions for the 2018 election cycle. IEMPAC supports candidates who are supportive of physician issues and particularly emergency medicine related issues. The candidates receiving support are:

Rep Ron Bacon (R-Chandler)	Rep. Bob Behning (R-Indy)	Speaker Brian Bosma (R-Indy)
Rep. Martin Carbaugh (R-Ft. Wayne)	Rep. Steve Davisson (R-Salem)	Rep. Dave Frizzell (R-Indy)
Rep. Cindy Kirchhofer (R-Beech Grove)	Rep. Don Lehe (R-Brookston)	Rep. Denny Zent (R-Angola)
Rep. Cindy Ziemke (R-Batesville)	Rep. Pat Bauer (D-South Bend)	Rep. Greg Porter (D-Indy)
Rep Robin Shackelford (D-Indy)	Sen. Vaneta Becker (R-Evansville)	Sen. Rod Bray (R-Martinsville)
Sen. Liz Brown (R-Ft. Wayne)	Sen. Ed Charbonneau (R-Valparaiso)	Sen. Mike Crider (R-Greenfield)
Sen. Ron Grooms (R-Jeffersonville)	Sen. Randy Head (R-Logansport)	Sen Jean Leising (R-Oldenburg)
Sen. Mark Messmer (R-Jasper)	Sen. Ryan Mishler (R-Bremen)	Sen. John Ruckelshaus (R-Indy)
Sen Jean Breaux (D-Indianapolis)	Sen. Frank Mrvan (D-Hammond)	Sen. Mark Stoops (D-Bloomington)

Interim Study Committees

The Legislative Council has assigned topics for study this interim. The Interim Study Committee on Public Health, Behavioral Health and Human Services has been charged with studying the following:

- A. Issues related to the use of medical marijuana
- B. The impact that opioid treatment programs have on the neighborhoods and communities in the immediate area of the opioid treatment programs, including the following:
 - a. Consider the effect on the neighborhoods and communities in the immediate area that the opioid treatment programs have on the following:
 - i. Criminal activity, including violent crimes, property crimes, & drug related crimes.
 - ii. Emergency medical services, including the number of calls for assistance, runs provided, and cases of overdoses.
 - iii. The effect on the local economy, including the area property values.
 - iv. The effect on residents' quality of life, including any additional traffic and excessive noises.
 - v. Other direct impacts opioid treatment programs have on the surrounding area.
 - b. Study other states and localities best practices to monitor and regulate opioid treatment programs to reduce negative impacts to the neighborhoods and communities in the immediate area of the opioid treatment programs.

- C. The impact that joining the nurse licensure compact would have on the delivery of nursing services to residents of Indiana, including the following:
 - a. Recent changes made to the nurse licensure compact, including benefits other states have realized from joining the nurse licensure compact.
 - b. The likely changes to access to nursing services in Indiana as a result of adopting the nurse licensure compact, including access to nurses near state borders and in underserved areas.
 - c. Increased employment opportunities that may be gained by Indiana nurses if Indiana enters the nurse licensure compact.
 - d. Issues concerning the oversight and enforcement of standards of practice of nurses by the Indiana state board of nursing and the interstate commission of nurse licensure compact administrators.
- D. Imposing:
 - a. The following as conditions to receive benefits from the federal Supplemental Nutrition Assistance Program:
 - i. Eligibility verification and monitoring;
 - ii. Identity authentication;
 - iii. Prohibition of waivers of work requirements; and
 - iv. Cooperation with child support enforcement activities
 - b. The following as conditions to receive benefits from Medicaid:
 - i. Eligibility verification and monitoring;
 - ii. Identity authentication;
 - iii. Prohibition of waivers of work requirements

The following table lists the members of the study committee:

House	Senate	Lay
Cindy Kirchofer (Chair)	Liz Brown (Vice Chair)	Kevin Burke, MD
Steve Davisson	Vaneta Becker	Richard Feldman, MD
David Frizzell	Ron Grooms	Patricia Miller
Dennis Zent	John Ruckelshaus	Derek Sprunger, MD
Ryan Hatfield	Jean Breaux	
Robin Shackelford	Frank Mrvan	
Vanessa Summers	Mark Stoops	

The Committee is scheduled to meet August 23 and Sept 27 @ 12:30 pm in the House Chamber. INACEP will monitor the committee and report to the members.

A View from the Top

continued from page 1

3) Anthem – I’m sure you all have heard by now that national ACEP filed suit against Anthem regarding their “non-emergent” payment policy. Legal means unfortunately seem like our only recourse at this point. INACEP had met with Anthem during their initial rollout of the policy and were able to delay it some, but we weren’t able to stave it off completely. Furthermore, we’ve been told that it may be ramping up here in Indiana soon. There’s a lot in flux here, so who knows where we’ll end up in the next couple of months. Likely, we’ll have to redouble our efforts in opposition here locally to keep them at bay.

4) National ACEP 2018 – The national ACEP 2018 conference will be kicking off on October 1st in San Diego this year. It’s ACEP’s 50th Anniversary, so it definitely should be a good time. As normal, the weekend prior to the conference will be the ACEP council session. We at INACEP plan to be particularly active at the council session this year. First and foremost, our own JT Finnell will be running for a spot on the national ACEP board of directors. If you know any ACEP members from other states, tell them to let their councillors know to vote for JT! Also, we’re submitting a resolution to support making POST forms more readily available in the EMR and legal across state boundaries. This has sponsorship from the ACEP palliative care committee and hopefully will put us one step closer to better care for our patients regarding end-of-life issues.

As I said, there’s plenty more buzzing around, but those are the heaviest hitters for us right now. I’m sure there will be more to come on all of these in the next EMPulse. Now go save some lives!

— Chris

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Organizations or individuals that want their message to reach emergency physicians in Indiana will find the **EMPulse** their number one avenue. The **EMPulse**, published four times per year, is mailed to members of the Indiana Chapter of the American College of Emergency Physicians. This highly focused group includes emergency physicians, residents and students.

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A Rare Etiology of Hypoxia: *Pulmonary Arteriovenous Malformations*

by Ashley Satorius MD (INACEP Resident Board Member)

Overview

HPI: A 50-year-old female with a history of hypertension, atrial fibrillation, aortic and mitral mechanical valve replacement secondary to rheumatic heart disease on warfarin was admitted to the neurocritical care unit (NCCU) for post-operative management of a subdural hematoma. After surgery, she was noted to be hypoxic with oxygen saturation of ~86-90% on room air. Despite 6L NC oxygen, her oxygen saturation did not improve. She had no history of COPD, asthma or long-standing lung disease, but did smoke 20 years prior. She endorsed exertional dyspnea and denied chest discomfort, cough, hemoptysis, or lower extremity edema.

Exam Findings and Workup

Physical Exam: The patient's vital signs were significant for hypoxia to 86% with normal respiratory rate. The patient was chronically ill appearing with brawny skin changes, nail bed cyanosis and clubbing. Her heart exam revealed a systolic murmur and click, consistent with her prior valve replacement. On lung exam, she was in no respiratory distress and had

faint crackles at her bases, with no wheezes or rhonchi. Her abdomen was soft and non-tender.

Work Up: Her initial chest x-ray showed mild bilateral interstitial opacities with relative peripheral sparing. Given the potential for right-to-left shunt with her unresolving hypoxia, a transthoracic echocardiogram with bubble study was obtained which confirmed presence of shunt at the pulmonary level and also severe right atrium and right ventricle dilatation and poor collapsibility of the inferior vena cava, consistent with cor pulmonale. Follow up Chest CT angiography confirmed the presence of multiple pulmonary arteriovenous malformations (pAVMs) in the right lung and two additional smaller pAVMs at the base of the left lung. Lab work was largely unremarkable.

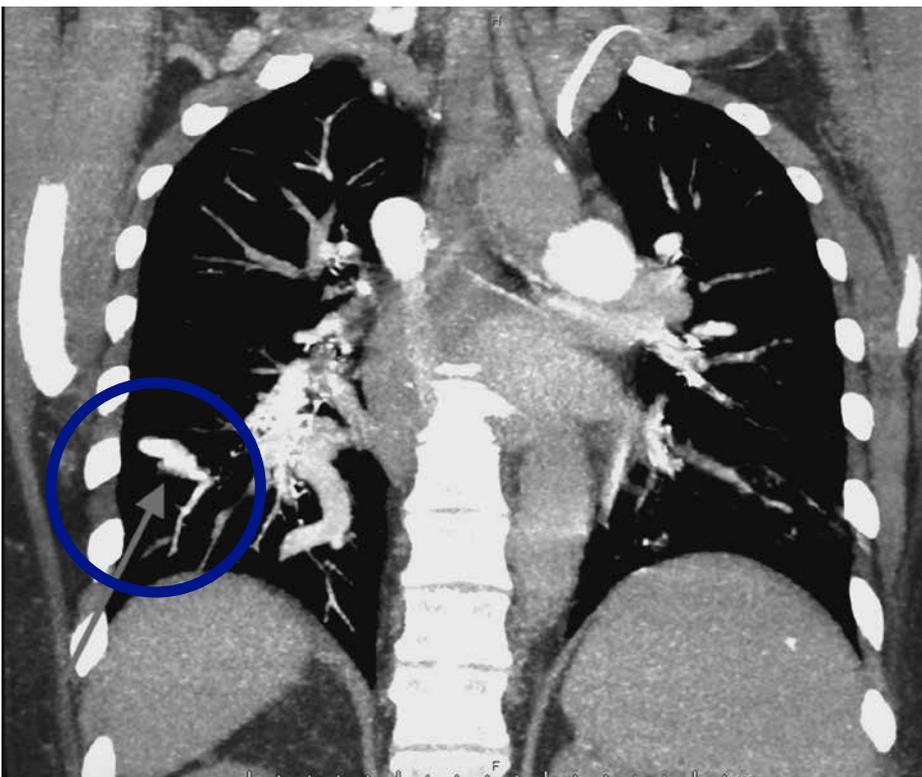
Management

Pulmonology was consulted to assist with management of her pulmonary AVMs. Interventional Radiology was also consulted, but ultimately felt that embolizing her AVMs would result in worsening right heart failure in an already precarious cardiopulmonary patient. When her pulse oximeter

was moved to her ear, she was actually at 100%. Because of the clubbing in her fingers, her readings were not as accurate. She was weaned off nasal cannula and eventually moved out of the NCCU. She unfortunately returned to the ICU several days later when her cor pulmonale worsened her congestive cirrhosis and she became encephalopathic. She was started on standard medical therapy of lactulose and rifampin eventually clearing the ammonia. Pulmonology also suggested starting diuretics to help with fluid balance. Given her existing left-sided heart failure, her cardiopulmonary balance was difficult to maintain and ultimately required conservative medical management by cardiology and pulmonology.

Discussion

A pulmonary arteriovenous malformation (pAVM) is a direct connection between a pulmonary artery and pulmonary vein resulting in a right-to-left shunt. It is a relatively rare diagnosis, and one



Chest CT of patient with arrow indicating the largest pulmonary AV malformation. In total, there were 15-20 pAVMs scattered throughout both lung fields.

we typically will not make in the emergency department. However, it may be an important diagnosis to consider in a middle-aged patient with hypoxia of unknown origin. Pulmonary AVMs have a right-to-left shunt pattern in that additional oxygen therapy will not improve hypoxia. Studies show that only 20-65% of patients will actually be symptomatic, which includes dyspnea, chest pain, epistaxis, or hemoptysis. The patient may also endorse platypnea (worsening dyspnea when upright but improves when recumbent) or orthodeoxia (decrease in oxygen saturation by more than 2% when going from supine to upright). Other physical exam findings may include a bruit heard over the lung fields, clubbing, or nail bed cyanosis, though these are usually rare and late findings. There is also a strong association with hereditary hemorrhagic telangiectasia (HHT) with an estimated 70% of pAVMs also having HHT. Patients may present with stroke symptoms for paradoxical emboli as the risk for stroke in patients with pAVMs is as high as 2.6% - 25%. Polycythemia is a common laboratory abnormality from the chronic hypoxia.

These patients may also have evidence of cor pulmonale and could potentially appear volume overloaded. In late stages, pulmonary hypertension may develop, thus making their management difficult. In the emergency department, resuscitation should focus on airway, breathing and circulation; however, consider adding low-dose diuretics to treat pulmonary hypertension. Diuretics need to be carefully titrated, as patients with pulmonary hypertension are very labile with their fluid status. Work up should include chest x-ray, ECG to evaluate for signs of right-heart strain, bedside echo to evaluate basic contractility, effusion, and signs of right-heart strain, and chest CT angiography with contrast, which typically will show the pAVMs. They should also receive a comprehensive echocardiogram with bubble study to evaluate right-to-left shunt. Given that these patients typically present with undifferentiated hypoxia, they should be admitted with pulmonology consultation. Definitive management is often embolization of the pAVMs with interventional radiology, which usually has good results.

Conclusion

Pulmonary AVMs should be considered when a patient presents with hypoxia of unknown origin and has right-to-left shunt features. Chest CT angiography will typically find the diagnosis, and may already be in the management plan to evaluate for more common etiologies such as pulmonary embolism. These patients should be admitted with pulmonology consultation, and may need IR embolization.

REFERENCES:

- 1) Santhirapala V et al, Thorax; "Orthodeoxia Orthodeoxia and postural orthostatic tachycardia in patients with pulmonary arteriovenous malformations: a prospective 8-year series. 2014 Nov; 69(11): 1046-7
- 2) Gossage et al, Am J Respir Crit Care Med; "Pulmonary arteriovenous malformations. A state of the art review." 1998 Aug; 158(2):643-61
- 3) Holzer et al, Cardiol Clin; "Pulmonary Arteriovenous Malformations and Risk of Stroke." 2016 May; 34(2):241-6
- 4) Cottin et al, Medicine; "Pulmonary arteriovenous malformations in hereditary hemorrhagic telangiectasia: a series of 126 patients." 2007;86(1):1
- 5) Hanley et al, J Am Coll Radiol; "ACR Appropriateness Criteria Clinically Suspected Pulmonary Arteriovenous Malformation." 2016 Jul;13(7):796-800



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Getting Involved

by Tyler Johnson DO, FACEP—INACEP Board Member

What is your favorite part about practicing Emergency Medicine? Did you have to think about it for more than a second? Was it because there was too little or too much to like?

I am at an interesting point in my career. Six years into practice I am no longer the rookie yet not quite a veteran. The eagerness to meet people where they are at and offer help is still certainly high, but I now find the rare night when I need to fake it. All in all, I definitely think we have the best job on the planet.

I look at the rookie physicians that started in July and realize that I am past the fear of the unknown and the uncertainty of being new. I have a good handle on the department or at least I think I do. I am self-aware enough to know my mistakes but not yet able to see them coming. I am not quite to the point of the doctors in front of me. I am not quite in the league of the men and women who lead our group and hospitals - the experts in emergency medicine in our region. I am fortunate to be in a group that has interest in practice management & hospital administration. They set policy and tend to see the "why" and how things function.

What I have noticed is that there is definitely a difference in attitude of physicians who are actively involved in our specialty outside of seeing patients day to day in the department. Is it because physicians that are more content find themselves seeking more involvement? Or does being involved at a higher level lend itself to a better understanding of the intricacies of practice thus leading to more contentment? It seems getting the behind-the-scenes look leads to a lot less frustration even when practice conditions are not ideal. Being involved at a healthy level, from my observations, helps safe guard from burnout and malcontent.

I would encourage any emergency physician at any point in their career to become involved. There are many options for this. You can get involved at the group, department, hospital, community, state, or national level. Many of these even overlap and each practice setting is unique. An easy way to do this is to identify your colleagues that are involved and ask for guidance. You would be surprised how eager your partners are to bring you along.



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Why Join ACEP?

If you are reading this EMPulse newsletter, you are already an ACEP member in good standing. But perhaps you have a colleague that is unaware of the support ACEP extends to Emergency Physicians, or is on-the-fence about joining. Here are some facts about ACEP that you can (and should) share with them:

1. ACEP's clinical policies are recognized as the standard of care in EM.
2. ACEP led the way to increase accountability within our specialty & tackle unethical expert testimony.
3. ACEP breaks down news each day & delivers compelling, thoughtful articles in various publications to ensure emergency physicians are up-to-date.
4. ACEP eCME, Frontline Podcasts, Scientific Assembly & Education provide the relevant EM educations and more than 900 hours of online CME (more than 70 hours free) for ACEP members.
5. ACEP makes practicing EM easier by creating ways to help you focus on patient care - not paperwork.
6. ACEP developed the first nationwide registry specific to EM - the Clinical Emergency Data Registry (CEDR).
7. ACEP is developing measures that relate specifically to the ED and are accepted by the federal government.
8. ACEP is the ONLY EM organization with a full-time staff in Washington DC, working for you on topics from the opioid crisis to scope of practice issues to unfair insurance practices. ACEP is just in the fight. We're leading it.

Please let your colleagues know that they can get more information at acep.org/membercenter. They can join ACEP at acep.org/join. For any member that needs to renew go to acep.org/renew.

Welcome New INACEP Members

New Member:

William Smock MD,
FACEP

Medical Student:

Ian Frink
Megan Hannermann
Jaclyn Jansen
Ilse Jimenez-Segovia
Colton Junod
Danielle Kemp MD
Joseph Lake
Chelsey Miller
Luke Momper
David Mullen
Benjamin Ryan
Sariely Sandoval
Daniel Schloss
Rebecca Tiemens

Emily Tisma
Michael Weber
Jocelyn Young

Resident Member:

Andreia Alexander ND
Mary Blaha DO
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Joann Pearson MD
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Leadership & Advocacy Conference

Washington DC

May 5 – 8, 2019

IMS, INDYCAR Medical Director Bock Dies at 81

Longtime Indianapolis Motor Speedway and INDYCAR Senior Director of Medical Services Dr. Henry Bock, a pioneer in motorsports safety and medical treatment, died May 26 in Indianapolis. He was 81.

Bock, an emergency medicine specialist at IU Health Methodist Hospital and Sidney & Lois Eskenazi Hospital in Indianapolis, served as senior director of medical services at IMS from 1982-2006 and in the same role for INDYCAR since its inaugural race in 1996 through the end of the 2006 season. Bock also worked as a consultant for IMS and INDYCAR after his retirement from both organizations.



Dr. Henry Bock

“Dr. Henry Bock was one of the great leaders in safety for everyone involved in motorsports – drivers, crew members and spectators,” said Tony George, chairman of the board of Hulman & Company, Hulman Motorsports and the Indianapolis Motor Speedway. “His work saved many lives and helped to form the standard for care today, and his selfless dedication to safety and innovation will influence the sport he loved for a very long time.”

Bock was a familiar, trusted specialist to every driver who was cared for at the infield medical center at IMS and at IndyCar Series events throughout the United States. He also worked tirelessly to promote motorsports safety, producing revolutionary advancements in treatment of injured drivers and helping to create state-of-the-art medical facilities at racetracks across North America.

Perhaps the greatest of Bock’s numerous contributions was his work on the development of the Steel and Foam Energy Reduction (SAFER) Barrier, one of the most revolutionary safety advances in motorsports history, which debuted in 2002 at IMS.

Bock began his motorsports medicine career in 1966 when he was a medical student at Indiana University School of Medicine. After graduation from IU in 1968, he served as a medical provider/consultant to the production crew of the motion picture “Winning,” starring Paul Newman and with scenes filmed at IMS.

In 1970, Bock joined the emergency medical staff at Methodist Hospital of Indiana in Indianapolis. He was instrumental in

establishing the LifeLine Air Medical Transport Service at Methodist in 1979.

In the late 1970s, Bock travelled with the United States Auto Club’s Champ Car safety team as an on-track physician and served as an assistant to IMS Medical Director Dr. Thomas Hanna, before succeeding his mentor in 1982.

Bock was a longtime member of the International Council of Motorsports Sciences, an organization of medical professional and scientists dedicated to improving injury prevention and promotion of safety in the motorsports industry.

Bock was recognized by the National Highway Traffic Safety Administration (NHTSA) for his contribution to emergency medical services and was named as the 1998 Indy Racing League Achievement Award winner for his outstanding contributions to driver safety and the success of the series.

In 1999, Bock was recognized with the Safety Award from the Championship Drivers Association. In 2004, he received the Herb Porter Award for his contribution to the development of the SAFER Barrier.

Bock also received the Sagamore of the Wabash distinction from Indiana Governor Frank O’Bannon in 2000, a top civilian honor given in the state of Indiana.

A personal quote from John Johnson MD, FACEP :

“I had the pleasure of working with Hank for 2 years in the 70s at Methodist as the residency program was being born. He was the Hawkeye Pierce/ Alan Alda of the ER — extremely knowledgeable and skilled, well liked and respected by staff and patients, and a very common sense approach to patient care. I learned a relaxed approach to emergency medicine that endured my entire career. At the time we both lived in the Knoll condos by the Art Museum on 38th and he loved his Jaguar E-type convertible, especially when it wasn’t having electrical problems.”

Bock is survived by a brother, Bob, and a sister, Marianne.



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Freestanding Emergency Departments: Cost Utilization and Location

by John Rice MD, FACEP (INACEP Board Member)

The number of freestanding emergency departments is increasing in Indiana and throughout the United States. The broad definition of a freestanding emergency department would be a healthcare facility that provides emergency services 24 hours a day but is not located on a hospital campus. These freestanding emergency departments are growing in number quickly, but they do seem to be concentrated geographically in particular areas. How free-standing emergency departments will fit into the delivery of emergency care in the United States and Indiana is not completely clear at this time. In this article I will discuss two major points. First, that freestanding emergency departments may have a useful role but that where they're being placed does not seem to be helpful to the overall delivery of emergency care. Secondly, the idea that freestanding emergency departments will decrease cost of the delivery of care because of their lower overhead is not a certainty.

Emergency department visits have increased and will probably continue to increase. There was a 32% increase in demand for emergency medicine services from 1999 to 2009. There are many reasons for this increase in the demand for emergency care: an aging population, ongoing substance abuse epidemics, the obesity epidemic, to name a few. At the same time this increase was occurring, there was an 11% decrease in the number of emergency departments throughout the country. Many of the departments that closed were in rural areas. It was thought that the Affordable Care Act might decrease utilization of the emergency department because if more people had insurance they would seek care in primary care settings and not in the emergency department. One of the ways coverage was expanded was through Medicaid expansion. Statistics show that there was a 6% increase in the number of emergency department visits in states with expanded Medicaid versus 2% in states that did not extend Medicaid.

Freestanding emergency department proponents assert that freestanding emergency departments will increase access in places where the services don't exist. However, the majority of these freestanding emergency departments are opening up in areas that are urban and are in higher income suburban areas. The areas that could benefit from these freestanding emergency departments are rural areas where small hospitals have been closed. There seems to be a profit motive here in that these freestanding emergency departments can charge emergency department fee schedules, but the overhead is much less in building the facility and staffing it versus a traditional emergency department. Studies have shown that freestanding emergency

departments attract a higher percentage of nonemergent patients. The problem with this is that treating nonemergent patients in an emergency department setting has been shown to drive up the cost of healthcare. One telling study showed that with each additional freestanding emergency department set up within a county in the United States an associated increased expenditure of \$55 per Medicare beneficiary occurred in the same count. So, we have increased access but with increased not decreased cost.

Not all healthcare systems are on the bandwagon to open up the freestanding emergency department. One rationale is that freestanding emergency departments can have costs of up to seven times higher than an urgent care facility according to a major healthcare provider in Indiana.

In summary, two major points that proponents of freestanding emergency departments tout: 1) they will decrease the cost of care and 2) they will increase access in areas that need it, are not certainties. It will require more time and analysis to see how freestanding emergency departments fit into overall emergency healthcare within Indiana and United States. On the other hand, there may be a real opportunity to utilize free standing emergency departments in rural areas where hospitals have closed leaving patients very long distances to traverse to access emergency care.



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