

EMpulse

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



Coming Events

2016 Annual Conference

**May 5–6, 2016
at the Sheraton
City Centre Hotel,
downtown Indy**

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A View from the Top

By James Shoemaker MD, FACEP (INACEP President)



Having recently returned from Boston and ACEP Scientific Assembly 2015 (ACEP15), I can certainly say I am in awe of the greatness of our specialty, emergency Medicine, and the men and women who work tirelessly 24/7/365 to provide evidence-based and cutting-edge Emergency care to our patients every day. This year, I had the distinct privilege to serve as one of our six state Councillors at the ACEP Councillor meeting held October 23rd and 24th. The 2016 INACEP Councillors included Michael Bishop MD FACEP, Timothy Burrell, MD FACEP, JT Finnell, MD FACEP, Jeffrey Nickel, MD FACEP, James Shoemaker Jr., MD FACEP and Chris

Weaver, MD FACEP. The 2016 Alternate Councillors included Robert Blankenship, MD FACEP, Sara Brown, MD FACEP, Geoffrey Hays, MD, Gregory Moore, MD FACEP and Lindsay Weaver, MD. ACEP Scientific Assembly is held annually and begins with the Councillors' meeting comprised of Councillors from every state, who vote on the issues and policies germane to the practice of Emergency medicine. The number of Councillors each state has for representation is based on the number of active state ACEP members. *This makes it so important for every Emergency physician in Indiana to become a member of INACEP!* This year, there were nearly 350 Councillors (not counting the Alternate Councillors!) and each Councillor has a vote on the Resolutions that come before the Council as a whole. The meeting is comprised of some of the brightest minds and individuals in our specialty and I was truly humbled to be part of this important process. Kevin Klauer, MD FACEP was the current ACEP Speaker of the House of Councillors and facilitated an excellent meeting where everyone had an opportunity to speak in favor of or against any resolutions coming before the Council for a vote. Truly, a great democratic process.

Last issue, I shared with you some of the topics that piqued or did not interest the Council. A complete summary of 2015 ACEP Council Resolutions is available on the ACEP website. Some highlights of ACEP15 Resolutions **adopted** by the Council include:

- 1. Res 11 Ethical Violations by non-ACEP members** – will establish ways for ACEP to admonish unethical witness testimony by publishing in an ACEP publication and reporting violations to professional societies and state licensing boards.
- 2. Res 13 ACEP and the Pharmaceutical Industry** – ACEP will evaluate the expanding role and cost for pharmaceuticals affecting the practice of emergency medicine. Stakeholders will be tasked with finding ways to keep costs acceptable and supply available.
- 3. Res 17 Electronic Nicotine Delivery Systems** – ACEP will support legislative and regulatory efforts to control the use of electronic nicotine delivery systems and regulate the toxicity of vapors produced for primary and second hand exposures.
- 4. Res 19 Graduate Medical Education Funding** – ACEP will work with agencies that provide GME funding to ensure eligible institutions receive adequate funding for education and provide transparent records detailing the distribution of funds.

ICD-10 for the Emergency Physician

by J.T. Finnell MD, FACEP (INACEP Board Member)

On October 1st, 2015 – we embarked upon a new era in data standards. It was on this date that CMS mandated that all claims be reported using ICD-10-CM. Standards such as ICD-10 are powerful enablers of technological progress anywhere that variation creates inefficiencies. Without any conscious awareness, we depend on many kinds of standards every day. Weighing yourself in the morning, plugging your plethora of gadgets into electrical outlets, getting cash from an ATM, connecting your laptop to wireless networks at work, home, and the coffee shop – these ordinary activities are almost effortless, in large part because of accepted standards. Just take a look at your local hardware store. All the fittings, connectors required for your home project are possible because of these accepted standards.

There are numerous examples where not having a “standard” created harm. In the early 1900’s, there was a large fire in Boston where local fire departments were not able to connect to the fire hydrants due to the hose not being able to connect to the hydrant. During the rebuilding process, bricks were standardized to help architects and builders make use of a standard brick size and realize these efficiencies in the building process. Standards are also important to healthcare in many areas, from the most basic scientific measurement standards to standards of clinical practice (e.g. guidelines).

ICD-9 was replaced as it was running out of codes for new diseases or conditions. With ICD-10-CM, more diseases and new conditions will have a code that can allow us to more effectively track and monitor diseases within the country and on a worldwide basis. In general, ICD-10-CM supports a much higher level of specificity, which will require us to change our documentation practices to a small extent.

ICD-10-CM stands for the International Classification of Diseases, 10th version, [US] Clinical Modification. ICD-10-CM replaces ICD-9-CM, which has been used for decades in the United States but has become antiquated due to new diseases and advancements in medicine. ICD-10-CM will expand our current diagnostic code set from about 18,000 to over 69,000 codes and will require you to document more details about illnesses and injuries.

Overall, there isn’t really an increased burden in documentation. Your documentation should make it clear the precise mechanism (i.e. while playing football) and location of injury (i.e. while at school) and the precise anatomical injury (closed left mid-shaft) non-displaced slightly angulated ulnar and radius fracture). The final diagnosis should provide clear-cut anatomical details of the injury and disease status.

Most of the ICD-10-CM documentation changes are within the musculoskeletal section and about 36% of the changes involve documentation of laterality. ICD-10-CM does allow documentation of alcohol, tobacco and drug abuse if it is related to the ED visit. In addition ICD-10-CM allows recording of complications related to a diagnosis, psychosomatic pathology, and signs and symptoms. ICD-10-CM provides the opportunity to provide more precise information to help with health and injury surveillance.

ICD-10-CM codes allow improved support for documentation of severity of illness. Severity of Illness is a term that indicates the acuity of the pathophysiologic changes that have occurred. It provides a basis for evaluating resource

consumption, medical necessity and the patient care provided. Severity of Illness reflects the patient’s level of sickness and disease complications. Sicker patients are more expensive to treat and they utilize more resources, have a higher rate of complications, and have worse outcomes.

ICD-10-CM does not require a “definitive final diagnosis”. Using signs and symptoms such as “chest pain” or “vomiting” as a principal diagnosis is appropriate. You should always strive to document to the highest level of

certainty but there will be times when your highest level of clinical certainty results in an “unspecified” diagnosis.

Examples of acceptable documentation of supporting the principal (final) diagnosis:

- Chest pain with elevated cardiac enzyme (troponin), concern for acute coronary artery syndrome
- Pneumonia etiology unclear
- Dehydration from vomiting with hyponatremia requiring IV therapy

ICD-10-CM supports much more precise anatomic description of the injury or condition. Simply stating “pneumonia” or “ankle sprain” may be inadequate. While many of these descriptors were present in the older system, they are more prominent and enhanced, such as laterality, with ICD-10-CM.

Be sure to document:

- Laterality – Right/Left/or Bilateral
- Arm or Leg – Upper or Lower/Proximal or distal
- Hand – document individual metacarpals
- Foot – document individual metatarsals
- Fingers – specify which fingers are involved, avoid using numbers



Here are some crazy ICD-10 Codes that you may run into:

16. V97.33XD: Sucked into jet engine, subsequent encounter.

Sucked into a jet engine, survived, then sucked in again? First of all, that really, really sucks. Second of all, this patient is obviously Wolverine, and should be detained for imaging and posterity.

(Technically, this means “subsequent encounter with a physician” not “subsequent encounter with a jet engine,” but that’s less dramatic.)

15. W51.XXXA: Accidental striking against or bumped into by another person, sequela.

The “sequela” here implies the kind of human bumper cars that can only happen at a music festival, the subway or possibly an active combat zone. Potentially fatal for agoraphobics. Recommend handling with care.

14. V00.01XD: Pedestrian on foot injured in collision with roller-skater, subsequent encounter.

First, are roller skates even still a thing anymore? I mean, other than how one knows spring has sprung in Central Park? Second, can you call a person on roller skates a pedestrian? Thirdly, if the answers to one and two are “yes,” then these things should be outlawed, because they are obviously dangerous.

13. Y93.D: Activities involved arts and handcrafts.

Camp is a dangerous thing. Hot glue guns and knitting needles definitely wouldn’t be allowed on a plane, yet we habitually allow 7-year-olds to play with them. This is a public health crisis that needs to be addressed.

12. Z99.89: Dependence on enabling machines and devices, not elsewhere classified.

There’s a reason they call it the Crackberry. This is an obsolete joke, but there just isn’t an iPhone pun that can compete with “crackberry.”

11. Y92.146: Swimming-pool of prison as the place of occurrence of the external cause.

There is also a code for “day spa of prison as the place of occurrence.”

10. S10.87XA: Other superficial bite of other specified part of neck, initial encounter.

Alright, people. Let’s call a spade a spade. “Other superficial bite of other specified part of the neck?” This is a hickey. Admit it. Although why anyone would be admitted for that remains a mystery.

9. W55.41XA: Bitten by pig, initial encounter.

First, be sure that the patient is restrained from doing whatever he or she may have done to provoke the pig in the first place. Security should be placed on alert. Also, what was this person doing in a farm setting in the first place? Pigs are not pets.

8. W61.62XD: Struck by duck, subsequent encounter.

Maladies that rhyme should be given immediately priority in the ER. Ducks, like most water fowl, are mean-spirited animals and this case should be treated with the utmost urgency as it is likely to be a serious injury.

7. Z63.1: Problems in relationship with in-laws.

Who doesn’t?

6. W220.2XD: Walked into lamppost, subsequent encounter.

No. No. People. You only get to do this once. ONCE. If a patient is going around whacking into lampposts regularly, there is a deeper problem here, and he should be referred to psych immediately.

5. Y93.D: V91.07XD: Burn due to water-skis on fire, subsequent encounter.

How does this happen? Are water skis even flammable?

4. W55.29XA: Other contact with cow, subsequent encounter.

“Other contact with cow.” OTHER CONTACT WITH COW? There are codes for “bitten by cow” and “kicked by cow.” What else is there?! What, precisely, is the contact with the cow that has necessitated a hospital visit?!

3. W22.02XD: V95.43XS: Spacecraft collision injuring occupant, sequela.

The existence of this type of code does not engender trust in the National Aeronautics and Space Administration. Shouldn’t they have more control over their spacecraft than that? Or are they just careening around in the ether, ping-ponging into one another and injuring occupants/astronauts?

2. W61.12XA: Struck by macaw, initial encounter.

Macaws are endangered—some are extinct in the wild—so if a patient has been struck by a macaw, chances are, it was the patient’s fault. Consider calling the SPCA and/or the police. The macaw needs to be found and treated immediately.

1. R46.1: Bizarre personal appearance.

LADY GAGA, IS THAT YOU? WE LOVE YOUR MEAT SUIT.

- Phalanges – document whether proximal, mid, or distal phalanges
 - Toes – document which toe(s) and joint(s) are involved
 - Face – document whether upper or lower eyelids and lips
 - Pneumonia – specify whether right, left, or bilateral)
 - Abscess/Cellulitis – document the precise anatomic location
- Be specific if the injury is a sprain, which describes damage to a ligament, or strain, which is damage to a tendon or an overstretching overexertion of some part of the musculature. The ICD-9 system did not differentiate between sprains and strains.

ICD-10-CM does make that distinction and allows documentation of the specific tendon, ligament or muscle.

Injuries need to have the how, where (geographic location) and mechanism of the injury.

Document:

- External causes: Fall, assault, accident, or complication from a procedure.
- Activity: Work related, sports, tripped.
- Geographic location: Home, work, boat etc.

Legislative Update

by Lou Belch, Lobbyist for INACEP

The Indiana General Assembly convened on November 17, 2015 to officially open the 2016 Session. They will not reconvene again until January 5, 2016. This is a short session, which must adjourn no later than March 14, 2016.

There are a number of health issues that will be discussed this session, they are summarized below:

Medical Malpractice

Picking up where we left off last session on the medical malpractice debate, the interim study committee on Courts & the Judiciary met three times this summer, partly to discuss the medical malpractice caps and other aspects of the Act. Not surprisingly, the trial lawyers association is pushing for an increase in the overall cap on damages. They argue that the constitutionality of the Act is at risk as there has not been a change in the cap for several years. There is current discussion of increasing the cap from \$1.25M to \$1.65M. The Indiana Hospital Association is willing to come to a compromise on this issue. However, the Indiana State Medical Association has not agreed to an increase. We will likely see a bill filed this session with the cap somewhere around the number mentioned above. Other pieces of the Act that are at play include the number in order to have direct access to the courts and bypass the medical review panel, the provider liability portion of the cap, as well as the percentage of attorney's fees.

Death Certificates

Another piece of legislation that will be filed this session deals with death certificates. Representatives Davisson and Bacon will collaborate on this piece of legislation that will work to speed up the process for obtaining a signature on a death certificate by the physician last in attendance at death. The bill will aim to permit the physician to simply certify that the death did in fact take place, but will not require them to certify as to cause and manner if such factors cannot be determined.

Step Therapy

Senator Crider will be introducing a bill that allows for step therapy override determinations. In many instances, a patient is required to jump through hoops as required by their health plan before being prescribed a medication that works for them. This piece of legislation will allow, under certain circumstances where a physician can determine with some medical certainty that a step will not work for a particular patient, to override that step and jump directly to the medication that the physician knows will work for that patient.

Substance Abuse Task Force Update

The Governor's newly appointed Substance Abuse Task Force has met twice since being formed and will meet for its third and final meeting this week at Notre Dame University. The discussions at the

first two meetings were heavily law enforcement focused. FSSA Medicaid Director Joe Moser has stated that a 1115 waiver is being contemplated. Along these same lines, Speaker Brian Bosma said that a measure requiring a prescription to purchase pseudoephedrine is a top priority for the 2016 legislative session.

Cost Transparency

Representative Schaibley is working to draft legislation that calls for price transparency for patients. Her goal is to require cost estimates to be available to patients upon request within a reasonable timeframe. We will know more details about what she is working on after a work group meeting next week on the topic.

Telehealth

Representative Kirchhofer will carry a piece of legislation regarding telehealth this session. The bill will allow the in-person relationship between patient and provider to be established with a telehealth visit. Of course, this establishment will come with certain requirements but we are not sure what that will look like at the moment.

MMIS Update

MMIS will be replacing Indiana AIM near the beginning of next year. Providers will need to re-register as accounts will not transfer over. This will open early 2016. IHCP bulletins will be put out about twice a month to update providers on this change. The rollout date of February 29th is in discussions. Please note that there will have to be dark out periods. Right now the estimated time frames are as follows: provider enrollment – 45 days, claims filing – 30 days, no adjustments – 15 days. At least 30 days' notice will be given to providers regarding these dark out periods. Provider training for the new system is currently available online.

INACEP will be monitoring all of these issues and comment where necessary this session.

New INACEP Fellows

Following is a list of INACEP members that are receiving their fellowship status at ACEP15. Two of these physicians are current INACEP Board Members—**John Rice MD, FACEP** and **Jonathan Steinhof MD, FACEP**.

The list also includes: Anthony P. Collins MD, FACEP, Mark A. Collins MD, FACEP, Jeanette Hammerstein MD, FACEP, Tyler Johnson DO, FACEP, James Leonard DO, FACEP, Pau Musey MD, FACEP, Frances Russell MD, FACEP, Alicia Sanders MD, FACEP, Richard Walz III MD, FACEP and Ceasar Weston III MD, FACEP.

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Featuring Indiana Emergency Departments: Emergency Medicine of Indiana (EMI)

by Douglas Tannas MD, FACEP

This issue's featured group is Emergency Medicine of Indiana (EMI), located in the northeastern region of the state. EMI providers staff eight EDs, including Lutheran Hospital (Fort Wayne, 39k visits/year), Lutheran Children's Hospital (Fort Wayne, 10k), Dupont Hospital (Fort Wayne, 20k), St. Joseph Hospital (Fort Wayne, 31k), Kosciusko Community Hospital (Warsaw, 23k), Bluffton Regional Medical Center (Bluffton, 10k), Dukes Memorial Hospital (Peru, 11k), and Marion General Hospital (Marion, 45k).

The group is led by Dr. Andy McCanna, president of the group, and Dr. Troy Clouse, vice president. Medical directors include Dr. Matt Sutter (Lutheran, with Dr. McCanna serving as assistant director), Dr. Susan Frayer (Lutheran Children's), Dr. Joe Kosnik (St. Joseph; Dr. Kosnik is also Chief of Staff of the hospital), and Dr. Andy Offerle (Dupont; Dr. Offerle is also Chief of Staff). EMI has 34 full-time physicians and 26 midlevels.

EMS direction and disaster planning questions can be directed to Dr. Matt Sutter at msuttermd@gmail.com or 260-203-9600. Inquiries regarding hiring and recruitment are handled by Dr. Veeran Davy, who can be reached at jvdavy@gmail.com or 260-203-9600.

Drs. Davy and McCanna provided answers to the questions that I ask each group that we feature in EMPulse:

How is your department adapting to the need for an electronic medical record, and what system do you use?

"We have been using McKesson HEC since 2007. The key to how successful it has been is in the orientation process we have with new providers. After doing an extensive half-day training session in the computer lab, we have them do several shifts alongside other providers to get used to the EMR with real patient flow."

How is your department adapting to the challenges of computerized physician order entry?

"We worked with IT to create something called "iforms" that have all of the most common orders ED physicians place. We have a general iform but also several more specific ones for certain conditions such as a STEMI iform, StrokeAlert iform, and Trauma iform. This has made the ordering of multiple items a simple point-and-click activity/pre-clicked order set."



Lutheran Hospital and Lutheran Children's Hospital (Fort Wayne).

What might someone not know about your group/hospital/city?

"We have enjoyed a very stable contract with Lutheran Health Network for over 20 years. We are very active at the hospital level—all partners sit on at least one committee, three of our partners are either current chief of staff or immediate past chief of staff, and one of our partners is going to become the chief medical officer of one of the hospitals starting in early 2016.

In 2014, Lutheran Hospital sent a RFP for their Hospitalist physician service to several hospital based physician staffing groups while also including EMI. We were excited to be included in this process and believe it's a testament to not only our outstanding relationship with Lutheran Health Network but also to our longstanding track record of excellent ED services and patient experience. In spite of stiff competition from large hospital based physician staffing companies, we were awarded the contract and subsequently created a multi-specialty democratic physician group which now provides both ED and Hospitalist services. Our Hospitalist partners at Lutheran Hospital have subsequently started up their service and have rapidly and successfully grown. While challenging and somewhat daunting at the outset, this has been a productive endeavor for all parties involved and is something of which our group is tremendously proud and excited.

The healthcare environment in Fort Wayne allows us to practice big city medicine while enjoying the myriad benefits of a medium-sized city. Fort Wayne has top-rated school systems, a progressive business environment, and has numerous activities for families."

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

"With a national shortage of physicians, specifically emergency medicine physicians, we have seen a decrease in physicians moving to the area. We have seen this impact in other specialties as well in the area. Recruiting efforts, as a result, have had to increase to attract high quality physicians. The democratic model, which we hold so dear, has become rarer in the marketplace. Contract management groups are making it increasingly difficult to compete. This challenge is being faced by other groups like ours."

What do you enjoy about your group?

Dr. John Goodman, DO: "That's easy—camaraderie"



Dr. Bruce Sowers, Dr. Kenneth Lee, PA Heather Raesky, PA Andrea Moll, and a group of the outstanding ED nurses at Lutheran Hospital.

Dr. Bruce Sowers, MD: "I enjoy our group structure and camaraderie we have with each other. I feel like we are all willing to help a fellow co-worker with schedule conflicts when needed. I also enjoy working with each and every one of our midlevels."

Dr. Joe Kosnik, MD: "One of the things I like the most is the variety in clinical practice settings. Between all three sites I feel that we see the complete gamut of clinical presentations in emergency medicine. As a democratic group, I appreciate that we have a high degree of transparency and open lines of communication in regard to running our business."

Dr. Andy McCanna: "I'm fortunate to have joined a group that has a quarter century's long solid relationship with Lutheran Health Network, a democratic structure and physicians who are well trained and passionate about state-of-the-art EM patient care."

I also always ask groups how Indiana ACEP can be more helpful to them. Drs. Davy and McCanna emphasized the need for a continued effort to place control of healthcare in the hands of those who are actually taking care of patients, and mentioned their desire to emphasize to residents the benefits of democratic groups in emergency medicine.

Many thanks to Dr. Veeran Davy, Dr. Andy McCanna, and all the physicians of EMI for being featured in EMPulse! As always, please let any member of the Board of Directors know if there are ways in which your Indiana ACEP chapter can better serve you and your patients. Best wishes for a safe and productive winter season!

If you would like your group to be featured in a future issue, please contact me at: dtannas@iuhealth.org.

As always, please let any member of the Board of Directors know if there is any way in which your Indiana ACEP chapter can better serve you and your patients.



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A View from the Top, *continued*

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5. **Res 27 Reimbursement for Ultrasound performed by Emergency Physicians** – ACEP will work to develop a statement declaring that insurance companies and other payers reimburse emergency physicians for ultrasound studies they perform as separate and identifiable procedures while caring for Emergency patients.
6. **Res 32 Critical Communications for ED Radiology Findings** – ACEP will work with the American College of Radiology to develop a joint best practice guideline for the communication of abnormal findings in a real-time, closed loop manner.
7. **Res 36 (co-authored by Dr. Lindsay Weaver from IN ACEP chapter) Establishing State and National POLST/EOL Registries** – ACEP will support the use of and implementation of POLST programs as a means of honoring our patients' end of life wishes. ACEP will partner with key stakeholders to advocate for and support the creation of state and/or national POLST/EOL database(s) that can be accessed by emergency physicians and EMS responders in times of crisis and uncertainty around a patient's end-of-life care and make this best practice.
8. **Res 38 Patient Satisfaction Scores in Safe Prescribing** – ACEP opposes any non-evidence based financial incentives predicated on patient satisfaction scores. ACEP will work with stakeholders to create a quality measure that is related to safe prescribing of controlled medications. ACEP will encourage the AMA Section Council of Emergency Medicine to support and advocate our position.
9. **Res 42 Prolonged Emergency Department Boarding** – ACEP will seek out and work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. ACEP will work on protocols and education regarding smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services 24/7 and implemen-

tation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of ED boarding as a solution to hospital crowding.

10. **Res 46 Transitioning out of Medical Practice** – ACEP will dedicate member resources towards the study and education of how best to transition out of clinical practice in Emergency Medicine.

This is just a list of ten of the many Resolutions discussed at the ACEP15 Councillor Meeting. It was educational, entertaining, nerve-wracking and exhilarating at the same time. The INACEP Board of Directors will continue to represent IN emergency physicians at the front lines of emergency care. As one issue such as the SGR is laid to rest, another such as AMA RUC RVU adjustments to ED procedures (potentially downward) such as Endotracheal intubation rears its head. Key stakeholders will state our case and we will continue to tow the line for emergency physicians. We will do our best to represent emergency medicine at the Legislative level and to ensure fair compensation for emergency physician work. We will keep you informed along the way.

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For more information contact:
Andy McCanna, MD, FACEP, FAAEM
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Case Report: Sporotrichosis

by David Rayburn, MD, MPH Emergency Medicine-Pediatrics combined Resident, Indiana University School of Medicine.

Overview

HPI: A 32-year-old male presented to the emergency department with a 3-day history of worsening RUE rash. The patient states he first noticed the rash on his right thumb. He described it as painful and itchy and stated that it began spreading up his right upper extremity over the past 2 days. He also states there has been clear fluid draining from the rash as well. The patient works as a landscaper and has never had any similar rashes. He denied any sick contacts. Pt denies sexual activity. His review of systems and past medical history were otherwise negative.

Exam Findings & Workup

Physical Exam: This was a well appearing male with no abnormal vital signs. There was diffuse vesicular rash with

surrounding erythema that was painful to the touch noted on the thumb and dorsum of the right hand with similar patches of vesicular rash on the forearm and elbow. He had FROM in the RUE with no tenderness over the joints. The rest of the exam was benign.

Workup: The classic form of lymphocutaneous sporotrichosis is a clinical diagnosis based on history and physical exam. The forms that involve the lungs, joints, bones and brain can be determined with culture or histopathology. Culture is the gold standard for diagnosis. Histopathology can be used in other cases where culture media does not grow out the selected fungi.

Diagnosis

Sporotrichosis caused by the fungus *Sporothrix schenckii*.

Management

The presentation of the spreading rash along with the patient's current job made the diagnosis most likely lymphocutaneous sporotrichosis. The gold standard treatment of lymphocutaneous sporotrichosis is antifungal medication. The drug of choice for treatment is itraconazole. The dosing is 100-200mg/day orally and is continued for 2-4 weeks after lesions have resolved. Terbinafine can also be used for treatment. Fluconazole is a second line therapy. The more serious forms of the disease require more potent antifungals like amphotericin B for extended periods of time from 6-8 weeks. This patient was given a prescription for 2 weeks of itraconazole as well as clinic follow up and return precautions for worsening symptoms. Unfortunately, at the time of writing this case report there was no evidence of follow up in the electronic medical record.

Discussion

Sporotrichosis is also referred to as Rose Gardener's disease. It causes a fungal infection that usually affects the skin, but it can also infect the lungs, joints, bones, and brain. The fungus is typically found in soil, hay, moss, and plants and typically causes infection in farmers, gardeners, and agricultural workers. The fungus typically enters the skin through cuts from things such as thorns or barbs. The fungus is not contagious so it cannot be spread from person to person. Recognizing the pattern of the rash as well as risk factors is the key to diagnosis. The treatment regimen involves antifungals, which must be continued for several weeks after the lesions have disappeared.



Figure 1. Patient's left thumb showing cutaneous lesions consistent with lymphocutaneous sporotrichosis.

Conclusion

As we all know a thorough history and physical exam is the key to making the majority of diagnoses. It is important to ask a patient what they do for a living especially when evaluating causes of rash because it can often be the key to determining what caused the rash.

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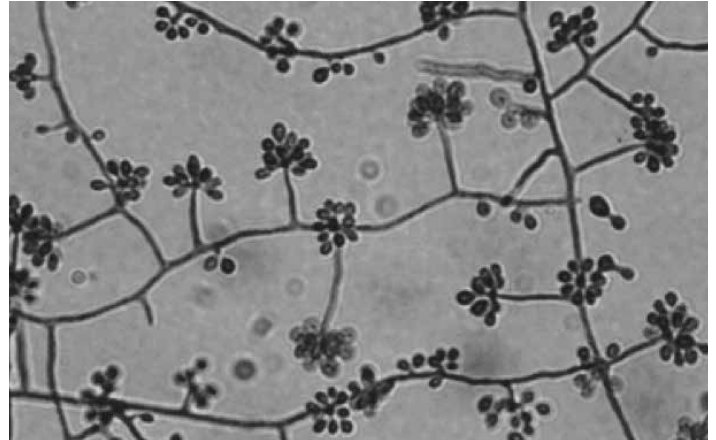


Figure 2. The fungus *Sporothrix schenckii* under light microscope after being grown on Sabouraud agar.

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Many Factors Contributing to the Increase in Emergency Department Visits Nationwide

by John Rice MD, FACEP (INACEP Board Member)

With the Affordable Care Act (ACA) there were initial projections that emergency department visits may go down, possibly substantially. However it has become very clear that emergency rooms are getting busier despite the growth in urgent care centers and efforts on multiple fronts to reduce the number of the emergency department visits. Since the ACA took effect, about 17 million Americans have gotten insurance, either through expanded Medicaid coverage or market-places set up by states and the federal government or other insurance.

A recent study by the American College of Emergency Physicians found increases in the number of people seeking emergency department care. Seventy-five of just over 2000 emergency physicians surveyed stated that they had witnessed increases in the number of patients utilizing the emergency department.

Certainly, part of this increase can be related to the changing demographics of the American population, including an aging population. Also, this increase could be attributed to increased numbers related to substance abuse and the skyrocketing epidemic of obesity, diabetes, and other chronic conditions.

The shortage of primary care physicians has also contributed to the increase in emergency department visits. According to the RAND Corporation, an independent think tank, it is difficult for Medicaid managed care plan patients to get appointments with a primary care provider. The median wait times can be up to two weeks. Further, this think tank found that primary care physicians were sending more of their patients to the emergency room for work ups of serious illness after hours and

on the weekend. A recent national survey showed that 4 out of 5 patients spoke to their healthcare provider before going to the emergency department and were told to go there for the care. The American College of Emergency Physicians president Alex Rosenau said "Emergency visits will increase in large part because more people will have healthcare insurance and therefore will be seeking medical care. But America has severe primary care physician shortages."

With the expansion of Medicaid, one could expect the number of visits to go up as well. A Harvard – MIT study (2008) found that after Oregon expanded its Medicaid, those who received the coverage visited the emergency department 40% more than those without insurance, without any improvement in outcomes. In addition, a study by the Colorado Hospital Association found emergency room visits and states that expanded Medicaid under the ACA increased by 5.6% in 2013-2014. That is more rapidly than the 1.8% increase reported by counterparts.

During this time, there has also been an increase in patients with high deductible insurance. There has been a suggestion that patients who have to pay more for their primary care up front will wait until their medical conditions have worsened before they seek care. This may be another reason that patients could end up in the emergency department.

While it is difficult to attribute the increase in emergency department visits solely to the ACA, many other factors point to an increase in the number of emergency department visits, not a decrease, in the coming years.

ICD-10 for the Emergency Physician, *continued*

continued from page 3

Examples:

- Slipping, tripping, stumbling and falls
- Exposure to inanimate mechanical forces
- Accidental non-transport drowning and submersion
- Exposure to electric current, radiation and extreme ambient air temperature and pressure
- Exposure to smoke, fire and flames
- Exposure to forces of nature
- Intentional self-harm

ICD-10-CM clinical documentation can be summarized as encompassing three major clinical presentations in the

emergency department: 1) Injuries and poisoning; 2) infectious diseases and 3) medical conditions.

For injuries, poisonings, musculoskeletal and connective tissue problems, pathologic and osteoporosis injuries; remember the mnemonic: location, location, location.

- Location: Document precise anatomical location
- Location: Laterality – left/right
- Location: Where- geographic location (home, work, car, etc.)
- Why – circumstances/activity surrounding injury underlying osteoporosis, neoplasm etc.
- How – If the injury was related to military, work, recreation, etc.



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EmCare has hundreds of emergency medicine practices serving hospitals, hospital systems and other healthcare organizations nationwide. These hospitals, ranging from some of the highest-volume emergency departments to low volume community facilities, depend on EmCare's physicians and other clinicians to consistently deliver high-quality care.

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Emergency Medicine Openings in Indiana

Community Hospital South:

Indianapolis

- 53K volume ED
- 40 hr phy and 41 hr APP coverage

Daviess Hospital:

Washington

- 13K volume ED
- 7 bed ED and 'quick care' clinic
- APP coverage

Franciscan Healthcare Munster:

Munster

- Brand new Emergency Department
- opening January 2016

Franciscan Rensselaer:

Rensselaer

- 10K volume ED
- 12 hour shifts.
- Located 1 hour from Chicagoland

Franciscan St. Elizabeth:

Crawfordsville

- 18K volume ED
- 24 hr phy and 10 hr APP coverage
- Scribe coverage

Franciscan St. Elizabeth:

Lafayette

- 55K volume ED
- 37 hr phy and 32 hr APP coverage
- Scribe coverage

Kings Daughters:

Madison

- 18K Volume ED
- 12 hour shifts
- APP coverage

Pulaski Memorial:

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- 4800 volume ED.
- 6 ED beds,
- 12 and 24hr shifts.

St. Vincent:

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- 10K volume ED
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Sullivan:

Sullivan

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2016 Conference Update

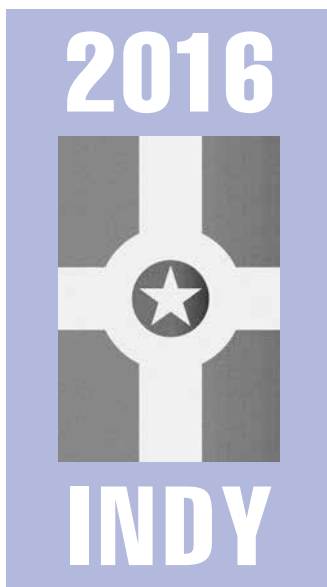
The INACEP Conference for 2016 is shaping up to be a really exciting event. The conference will be held downtown this year at the Sheraton City Centre Hotel. Due to his tremendous popularity at last year's conference we have asked Joe Martinez MD, FACEP, FAAEM to come back again this year—this time lecturing on *"The Geriatric Abdomen"* and *"The Perils Of Shiftwork"*. We were fortunate to get Jay Kaplan MD, FACEP (ACEP president-elect) who will be doing two lectures—*"OB Emergencies"* and *"Nurses are from Venus"*, along with giving us a National ACEP update. Matthew Dawson MD, RDMS, RDCS, a national speaker from Lexington, KY will be addressing *"Upper and Lower Extremity Blocks"* and *"Wearables in Medicine"*. Rounding out day one this year will be a favorite local speaker, Brent Furbie MD, FACMT lecturing on *"Anaphylaxis"* and *"Snake Bites"*.

Day 2 will really be a change from years past. You will choose whether to take a SIMS course in the morning followed by 3 credit hours of

lectures in the afternoon, or the reverse. We will have great local speakers doing the following lectures: Jeffrey Kline MD, FACEP – *"Community Treatment of VTE"*, Elizabeth Weinstein MD, FACEP – *"Pediatric Seizures"*, Andrew Stevens MD – *"Indianapolis SWAT"* and Emily Fitz MD – *"Stump the Professor"*.

The SIMS course will include an Ultrasound Station (abdominal, cardiac and vascular access US), a Procedure Station (glidescope, crich, access), a Trauma Station (trauma scenario, work with trauma team), a Pediatric Resuscitation Station (with a peds specialist) and an Adult Resuscitation Station (work on difficult cases, with a critical care team).

Although you will register for the entire program through us, IU will be handling the CME accreditation for the SIMS portion of the program. We will have buses from the hotel that will take you to and from the SIMS location.



Fred Osborn Excellence in EM Award Nominations Opened

In 2010, the Indiana ACEP board established an annual award in memory of Dr. Fred Osborn who passed away in 2009. Dr. Osborn contributed extensively to the practice of emergency medicine and to his group, hospital, community and the state. As such, an award was established in his memory to be presented annually at the Indiana ACEP Education Conference in the spring.

The recipients of the award to date have been as follows:

2010 - Peter Stevenson MD, FACEP of Evansville, IN

2011 - David VanRyn MD, FACEP of Elkhart, IN

2012 - Thomas Madden MD, FACEP of Bloomington, IN

2013—Thomas Gutwein MD, FACEP of Fort Wayne, IN

2014 - Tom Richardson MD, FACEP of Danville, IN

2015 - Randall Todd MD, FACEP of Indianapolis, IN

The Indiana ACEP board is now accepting nominations for this year's 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 which includes the following information:

Your name; The name of the person you are nominating; the days date; Nominee's positions of leadership; Nominee's involvement/contributions to their Group; Nominee's involvement/Contributions to their Hospital; Nominee's involvement/contributions to their Community; Nominee's involvement/contributions to their State; and any additional comments. Please limit submission to a single, typed page.

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 January 10, 2016 and are to be submitted electronically to indianaacepsue@sbcglobal.net.

Please remember: *The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state.*

REGISTRATION FORM FOR:

44rd Annual Indiana ACEP Emergency Medicine Conference Thursday & Friday, May 5 & 6, 2016

Name: _____ ACEP Membership # (if applicable): _____

Title/Position: _____ Hospital Affiliation: _____

Home Address: _____ City: _____ State: _____ Zip: _____

*Email: _____ Fax: _____

*Your confirmation will be emailed to you. If you have no email, it will be faxed.

2-DAY REGISTRATION

Please check one of the following:

ACEP Member \$325 ☐
Non-ACEP Physician \$375 ☐
PA/LPN/NP/Paramedic \$200 ☐
Residents – separate form will be sent
Intern /Med Student \$20 ☐

Choose one:

Handbook on paper ☐
Handbook on flash drive ☐

Choose one:

Friday SIMS lab morning session ☐
Friday SIMS lab afternoon session ☐
Late Fee (if received after 4/4/16) \$25 ☐

TOTAL _____

If paying by credit card, go to **inacep.org**.
Online registration will start in mid-January.

1-DAY REGISTRATION

Please check one of the following:

	THURSDAY	OR	FRIDAY
ACEP Member	\$160 <input type="checkbox"/>		\$200 <input type="checkbox"/>
Non-ACEP Physician	\$185 <input type="checkbox"/>		\$235 <input type="checkbox"/>
PA/LPN/NP/Paramedic	\$100 <input type="checkbox"/>		\$160 <input type="checkbox"/>
Residents – separate form will be sent			
Intern /Med Student	\$10 <input type="checkbox"/>		\$10 <input type="checkbox"/>

Choose one:

Handbook on paper ☐
Handbook on flash drive ☐

If attending Friday only, also choose one of the following:

Friday SIMS lab morning session ☐
Friday SIMS lab afternoon session ☐
Late Fee (if received after 4/4/16) \$25 ☐ \$25 ☐

TOTAL _____

If paying by credit card, go to **inacep.org**.
Online registration will start in mid-January.

LOCATION:

The Sheraton Indianapolis City Centre Hotel, 31 West Ohio St., Indianapolis, IN 46204 (Downtown Indy). This hotel is within easy walking distance to theaters, restaurants and popular nightspots.

LODGING: A block of rooms has been reserved at the **Sheraton Indianapolis City Centre Hotel** for the special rate of \$149 per night. To reserve your room please call the Sheraton directly at **317-635-2000** or **888-627-8186**. Our group is the "American College of Emergency Physicians – Indiana Chapter".

PARKING: Parking at this hotel is offered at a discount rate of \$20 per day.

CANCELLATION POLICY: A full refund will be given, provided cancellation is received by April 4, 2016. A processing fee of \$20 will be charged for cancellations received after this date. **No Shows will be charged full registration amount.**

INACEP 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 email or fax 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 check payable and mail to: **Indiana ACEP, 630 N. Rangeline Rd. Suite D, Carmel, IN 46032**

HOTEL WILL ONLY HOLD ROOMS THROUGH APRIL 4, 2016, SO REGISTER EARLY!



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