Volume 26, Issue 3 **Summer 2017**

EMpulse

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

The 2018 INACEP Annual Conference will be held at:

The Ritz Charles

Date:

April 25 & 26, 2018

Look for a brochure late this fall.

(This date was listed incorrectly in the previous *EMpulse* newsletter)

Inside this Issue

A View from the Top

Gina Huhnke, MD, FACEP (INACEP President)

Looks like it is shaping up to be a busy year for the INACEP chapter Board members. Our most recent meeting focused on denial of payments from third party payers for Emergency Services. As most of you are probably aware, Anthem recently sent a letter to all Emergency Department directors in the state of Indiana stating that effective September 1, 2017 payment for patient services rendered that were deemed secondary to non-emergent conditions would be subject to review and possible denial. Similar letters were sent in the states of Missouri, Kentucky, and Georgia. The letter also asked that Emergency Physicians educate our patients on appropriate levels of care.

First, I would like to remind everyone that EMTALA legislation remains in place which mandates that we provide all patients presenting to our Emergency Departments with a medical screening examination. In order to thoroughly screen our patients for emergent conditions, we often perform ancillary tests to supplement our diagnostic abilities and ensure safe patient discharge. At my location of employment, there have already been payment denials for negative abdominal CT examinations. While Anthem states this process simply represents a more aggressive stance on their longstanding general benefit policy, there remains doubt that Emergency Services will be reimbursed for certain diagnoses, particularly for discharged patients.

> ***The value of Emergency Medical services cannot be defined as a presenting symptomatic complaint or final diagnosis.***

Second, ACEP has championed health care reform on a national level in the past which supports payment for services rendered for symptoms thought to represent a possible emergency by a "prudent layperson". ACEP supports the "prudent

continued on page 10

The practice management data you need, from the medical billing company you can trust.

With CIPROMS business analytics, your emergency medicine practice has the data you need to ...

- Negotiate with insurance companies based on members' payment history
- Track and report quality data to government and commercial payers
- Negotiate with hospitals using your payer and patient payment history
- Create physician compensation packages based on work performed
- Determine areas for provider documentation improvement
- Reconcile to hospital census logs ... and reduce lost charges and revenue

CIPROMS Medical Billing | Experience Integrity Advocacy

3600 Woodview Trace, Suite 400, Indianapolis, IN 46268 | 317.870.0480 | www.ciproms.com

Legislative Update

by Lou Belch, Lobbyist for INACEP

There has been little legislative activity this summer. Interim Study Committees began meeting the second week of August. Here is the provision from the Legislative Council directing the health topics this summer:

THE INTERIM STUDY COMMITTEE ON PUBLIC HEALTH, BEHAVIORAL HEALTH, AND HUMAN SERVICES

The committee is charged with studying the following topics:

(A) Shortage of health care providers in Indiana. *(Source: SB 538-2017, SECTION 1.) (Introduced Version)*

(B) Goals, benchmarks, and plans to reduce the incidence of diabetes in Indiana, improving diabetes care, and controlling complications associated with diabetes. *(Source: HEA 1642-2017, SECTION 1.)*

(C) Potential improvements to the INSPECT program under IC 35-48-7. *(Source: SEA 408-2017, SECTION 3.)*

(D) Changes needed in state law and policy to respond to changes in federal law on health care.
(Source: Letter-Sen. Lanane; Rep. Pelath.)

While there are not topics of interest to INACEP to be studied, INACEP will monitor the Committee meetings to ensure that no other items make it on to the agenda.

Rep. Cindy Kirchhofer, the Chair of the House Public Health Committee has put together some informal working groups on three issues that will have some impact on emergency medicine. They are:

1. INSPECT and integration into the EHR. INACEP lobbyists attended the first meeting of the work group. The State is exploring options that will allow all prescribers to be integrated in the next 3 years. This would be done at no expense to the prescriber. The first tier of providers will likely be hospital employed or affiliated physicians. Then they would move to more office-based physicians followed by non-physician prescribers.

Additional topics for further discussion include:

- Mandatory query prior to prescribing
- Real time transmission to pharmacies of prescription dispensed
- Inclusion of pain contract
- Inclusion of drug related criminal history

Future dates have not been set.

2. POST and Hierarchy. There are some technical corrections that need to be made to the POST form. Current law makes it unclear if you must complete the entire form, or if items left blank nullify the entire form. Clarification will be made that items left blank do not nullify the form.

Current Indiana Law does not create a hierarchy of medical decision makers in the event the patient is unable to communicate wishes and has no legal document in place (Power of Attorney, Living Will, etc.). Essentially all family members and friends are on the same level. Lindsay Weaver, MD attended the meeting representing INACEP. Essentially, the proposed law will create a hierarchy. This proposal also will include a provision to allow the provider to bypass a person on the list if the provider believes the person is not acting in the best interest of the patient.

3. Advanced Practice Nurses. Last session the Council of Advanced Practice Nurses sought legislation that would have removed the legal requirement of the "Collaborative Agreement" and 5% chart review. INACEP lobbyists also attended this meeting. No resolution was reached.

While this is not an election year there will be at least one new member of the State Senate when they convene this fall. Sen. Luke Kenley from Noblesville announced he is resigning his seat effective September 30. Sen. Kenley became chairman of the Senate Appropriations Committee in 2009 and assisted with authoring five state budgets. It was announced by Sen. David Long that Sen. Ryan Mishler will be the new chair of the Appropriations Committee. A caucus will be held to select a replacement for Sen. Kenley.

Emergency Doctor-ing in the Age of Tesla

by Chris Ross, INACEP Vice President

Lately, stories about the cost of health care have been dominating the news. Value is a word that's thrown around a lot in those discussions. I like to think my patients feel value from the care I provide, but what does "value" mean to patients? What is "value" to me? In the age of Google and smartphones measuring 0_2 sats, how can we define the role of EPs to ensure our value is felt? Our experience as the front door of healthcare gives us a great view of the problems in the system. With some careful thought and lawmakers behind us, I think we could create valuable changes. Here are my top three value generating ideas:

#1 – Public Reporting Guidelines

How do your patients find your ED? Did they Yelp the reviews to make sure it's a good one? Or maybe they saw a friend check-in yesterday via Facebook? Or, were they savvy enough to check the quality of care at the CMS Hospital Compare websites? Of all the places online comparing doctors and hospitals, I think CMS is most on the right track when it comes to public reporting. I really do. They're trying to gather data to best protect and inform patients. After all, in the day and age of Yelp and Angie's list, that's what people have come to expect. I am behind, in a nonemergent setting, having the ability to go online and look at reviews before you have to make a decision regarding your health care. Heck, give me 5 minutes with my smartphone and I can find the best General Tso's chicken within 5 miles of anywhere. Surely we should be able to have similar information for more important life decisions. Unfortunately, as all of you know, all of the comparison websites in their current state are full of imperfect information. Outcomes and data are difficult to interpret given highly variable clinical settings and patient populations. All of this has the potential to lead the consumer (aka patient) awry.

Hospital comparison gets especially messy when it comes to Emergency Medicine though. For example, reviews of wait times could lead patients to bypass the closest hospital with their heart attack. Simply put, if you have a true emergency, the closest ED is the most appropriate place to go. With the current compare-style websites, there's no indication to the consumer that this is the case. We need to understand how patients are interpreting and using this data to make these websites more valuable and make the data useful. Lastly, there needs to be accountability for any website hosting such information. Every doctor's office begins their phone triage line with "If this is an Emergency, please hang-up and dial 911". Should we do this even when the interaction is just browsing a webpage?

Also, for the record, if you have not read Yelp or Facebook reviews of your ED or hospital I highly recommend it.

#2 – Medical Records

In the age of self-driving cars, turning on my home air conditioner from my smartphone, and family pictures saved on a secure cloud, the difficulty we still have in exchanging medical records is laughable. It's not uncommon for me to work up a patient just to find out that they had the same testing in a different ED less than 24 hours before their arrival. With health care costs at 17% GDP we should be looking at every avenue to save and letting loose this information would make a large impact. Unfortunately, current legalities and HIPAA make it cumbersome.

> ***"With the recent push towards high deductible insurance plans, cost transparency would be of great value. It's tough to make an informed choice as a patient or as a physician caring for patients without knowing the cost involved."***

Privacy is important. I get it. Let's just take a step back to look at a broader picture though. Do you have a Snapchat account? Do you have an Amazon Echo listening to all of your home conversations? More than half of the US population have signed their entire private life away to Facebook, but getting a medlist from a different facility feels like breaking into Fort Knox via fax machine. The idea of giving easier access to providers of personal health information still feels pretty far distant in the future. Here in Indiana, fortunately, we have Careweb to help. Unfortunately, it falls short as not all hospitals participate and those that do don't always share all information.

An easier, quicker route to exchanging health information may start with giving easier access to patients and caregivers. Instead of charging twenty bucks and waiting a week for medical records to sort through their chart, they could log online at their primary care physician's office to show test results and charts from their ED visit. The value in giving patient's the ability to see their health information and allow them to share with their doctors would be a win-win for everyone.

#3 – Cost Transparency

With the recent push towards high deductible insurance plans, cost transparency would be of great value. It's tough to make an informed choice as a patient or as a physician caring for patients without knowing the cost involved. Think about it yourself for a bit. Do you know how much that CBC and BMP you order cost? What's the difference in price between a formal lab test and a point-of-care test? Would knowing these price differences change the way you practice? I did a little research myself a few years back, and I found a few price tags rather shocking. For instance, a drug screen costs about $450. I'm pretty sure that's around the same price as my first car. Also, for an informed patient knowing the pricing, the cost of something may not be worth the perceived benefit. If we're encouraging patients to take charge of their health and healthcare expenses, then we should give them the tools to do so. Seeing the price tag attached to their care may open up more honest discussion about how best to manage and work up their symptoms. It surely will make things more difficult for us at times, but with healthcare costs so significant it has to be worth at least trying.

With Washington's microscope focused on our health care system and it's cost, now is an ideal time for us front line ED docs to speak up about the tools we need to create value in our current system. What ideas do you have to create value for you and your patients?

Informatics Q&A *(Modified from their article written for the national informatics section newsletter)*

by JT Finnell, MD, MSc, FACEP, FACMI and Todd B. Taylor, MD, FACEP

Protecting Access to Medicare Act of 2014 — Appropriate Use Criteria via Clinical Decision Support for Advanced Diagnostic Imaging Services

Question

Our radiology department called a meeting to discuss a federal mandate to utilize Clinical Decision Support based on the American College of Radiology's Appropriate Use Criteria. Apparently, this is already live in the ambulatory world and may be coming to EDs in the future.

The requirement is to choose a supported indication using computer assisted technology. I have heard EMR implementation of this requirement often fails, due to no logical choice being presented.

The whole thing sounds absurd. Has anybody else caught wind of this or implemented it yet? What steps have you done to mitigate the negative impacts to your ED?

Short Answer

Utilization of "Appropriate Use Criteria (AUC) via Clinical Decision Support (CDS) for Advanced (defined as MRI, CT, NM & PET) Diagnostic Imaging Services" is a "newish" federal statutory requirement created by the "Protecting Access to Medicare Act of 2014" (PAMA) (see references below). Of note, implementation of this requirement has been delayed (originally scheduled for Jan 1, 2017) with an uncertain new date pending further definitions by CMS.

Although the statute explicitly states "applicable setting" includes Emergency Departments, it further states exams for an individual with an emergency medical condition defined under the Emergency Medical Treatment and Active Labor Act (EMTALA) are exempt. This exemption is likely to only be relevant on appeal for payment denial. The EMTALA definition of EMC is a relatively high bar, often only determined retrospectively, and a substantial number of ED patients fail to meet this definition. Put another way, by the time you know a patient has an EMC, most tests will have long been ordered. So from a practical point, you may need to comply with this requirement regardless, except perhaps Level I trauma, cardiac arrest and other critical situations.

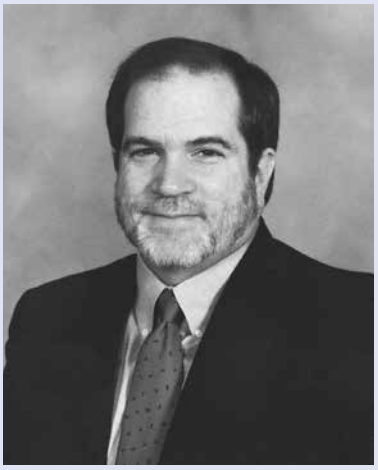
This legislation was part of the annual "SGR fix" in 2014, and in practice, these new requirements may seem onerous (or perhaps just one more "straw for the camel's back"). But in this setting, you take the good with the "bad" (in quotes because many believe these sorts of "innovations" help make healthcare "better"). From a cynical point of view, it probably has more to do with money than care and will be expanded to all imaging eventually.

Bottom Line

Barring some sort of reversal, everyone will have to comply eventually. Further, this is merely part of a much larger effort to force standardization (reduce variability) in healthcare. Motives include patient safety, cost & fraud reduction via automated "black box" auditing, and efficiency. Untoward "cost" is the unaccounted overhead on providers to comply with mounting data input and compliance which may have the effect of offsetting these objectives (i.e. counterproductive).

1. President Trump signed an Executive Order on January 20th putting a stay on all new regulations. It is unknown if that will apply to this provision.

JT Finnell, MD, MSc, FACEP, FACMI
Clinical Informatics Program Director, Indiana University School of Medicine



Todd B. Taylor, MD, FACEP
Emergency Physician & Independent HIT Consultant
Certified Emergency Medicine, ABEM
Certified Clinical Informatics, ABPM

For more detail, read on . . .

PAMA included a mandate that physicians utilize "appropriate use criteria" via "clinical decision support" for ordering advanced imaging studies such as diagnostic MRI, CT, and nuclear medicine (including PET). Plain X-ray, fluoroscopy, and ultrasound exams are not currently included. The appropriate use criteria requirements also only apply to outpatient settings such as physician offices, hospital outpatient departments (including EDs), ambulatory surgical centers, and any provider-led outpatient setting.

An additional provision has been defined in Rules (42 CFR 414.94) which describes "Provider-led entity" (PLE) which is "a national professional medical specialty society or other organization that is comprised primarily of providers or practitioners who, either within the organization or outside of the organization, predominantly provide direct patient care. Once a PLE is qualified the AUC that are developed or endorsed by the entity would be considered to be specified applicable AUC."

What this means is a PLE (the American College of Radiology is one of a few current certified) can develop evidenced-based criteria which then become appropriate use criteria with regard to Medicare billing and reimbursement. I suppose this is preferable to CMS coming up with their own criteria that may or may not be based in reality.

Speculation

A stated indication has been required for diagnostic tests for a long time in order to get paid. If not included with the order, either the radiologist has to infer it or contact the provider. In more recent years, not just any indication would suffice, especially for high dollar tests. This legislation codifies this process and allows Medicare (and other insurers) to deny payment. This is largely done via "black-box" computer algorithms without human interpretation. You can see why the ACR might want to better define this process. So, as a PLE, the ACR came up with criteria to include definitions of 1) Appropriate care, 2) May Be Appropriate care, 3) Rarely Appropriate care [See: http://www.acc.org/about-acc/press-releases/2013/02/21/14/05/auc-methodology]

So, how do you "force" compliance from ordering providers to impact the downstream effect? Simple, define the appropriate indications for every test, and if the provider does not choose one of them, either refuse to order the test or require consultation. This is where "Clinical Decision Support" (CDS) helps. For each test, simply have a drop down list of "appropriate" indications. However, implementing this is not so simple as it requires accommodation by various EMRs. Ambulatory EMRs are ahead of this "game". Hospital based EMRs are playing catch up. The downside being a pre-defined list does not always account for all scenarios and the "best" indication may not be present.

Just one more example of where hospital EMRs fail to meet the needs of patients and clinicians. Workaround (e.g. 3rd party software) solutions will be forth coming. In fact, the American College of Radiology (ACR) has created a solution for compliance.. See "ACR Select™" [https://www.acr.org/Advocacy/eNews/Archive/2014/20140404-Issue/ACR-Select-Provides-Ordering-Physicians-with-Timely-Access-to-Imaging-Appropriateness-Criteria]

As with many such circumstances, this is largely being driven by payment.

Mitigation & Solutions

1. This requirement ONLY applies to "Advanced Diagnostic Imaging Services" defined as MRI, CT, NM & PET). Do not allow it to be expanded to other studies.
2. While it may apply to the ED as a hospital department, EMCs are specifically excluded, and for good reason. Before implementing, hospitals must address the additional administrative overhead and the general lack of functional tools available within the EMR to actually make use of CDS for this purpose safe & effective.
3. One can argue the EMC exclusion along with the types of studies to which this requirement applies, functionally eliminates this requirement for EDs. In the ED context, "Advanced Diagnostic Imaging Services" are never ordered on a patient without a potential serious medical condition (i.e. EMTALA defined EMC). Very different than other OP settings where routine non-emergency "Advanced Diagnostic Imaging Services" are most frequently ordered.
4. This requirement has been delayed until at least summer 2017, and likely to have further delays due to a lack of available suitable technology. Further, on January 20, 2017, the Trump Administration issued a "memorandum to all executive departments and agencies to freeze new or pending regulations — giving the new administration time to review them".

continued on page 11

PROFESSIONAL
MEDICAL BILLING

QUALITY • EXCELLENCE • PROVEN SUCCESS

LINDA PEARCE, PRESIDENT
7619 West Jefferson Blvd. • Fort Wayne, IN 46804
Ph: (260) 407-8003 • Fax: (260) 407-8008
www.profmedbill.com

Ransomware

by Tyler Johnson DO, FACEP (INACEP Board Member)

In May of 2016 I was able to experience firsthand the disruptive nature of a ransomware attack. It occurred at our small community hospital that sees about 18,000 visits a year. We have single physician coverage with 10 hours of physician assistant coverage during the day. I am currently trying to be the medical director. The ransomware attack occurred abruptly on an abnormally busy spring evening.

We had back up procedures and down time procedures in place but I can honestly state that we were not prepared for such an event. There is very little preparation that can occur for nothing working. We lost lab, imaging, dictation, most networked devices, and the electronic medical record. Even the backup and downtime devices in some cases were inflicted. We immediately had to divert many critical cases and were crippled for several days until essentials such as labs and radiology were available. It took weeks to get other systems back online. We documented using pen and paper which is something that is foreign to some of us newer to medicine.

As the hospital tried to fix the disruption we tried to get patient care as standardized as possible but it took some time. We are fortunate to be surrounded by good physician and administrative leadership who were able to keep calm and work through problems to find solutions. Although many of us loath the information technology staff they responded the best way possible, had a data recovery plan and sought outside help when needed. Third party cyber forensic teams were present and even the FBI chimed in.

Our emergency department staff was initially somewhat overwhelmed by the disruption but we were able to quickly transition into our own downtime procedures. This included duplicate paper charts, paper registration, faxing orders and results, and handwritten documentation until a separate voice recognition system was improvised to create paper charts. I was suddenly thankful for the antiquated system I started in at one of our teaching hospitals in residency.

We learned several lessons. First, even though I knew many of the procedures and protocols for downtime, many of our staff did not. Many if not most of the downtime procedures had to be tweaked on the fly. For example our backup dictation system also became affected. It had been previously an analog system over the phone but it had now been computerized. Second, leadership was important. Calm and steady was key. Our CEO did a great job of not being rattled or at least not showing it and that trickled down. Third, emergency medicine physicians still rock at improvising. Lastly, communication is important. There were a lot of meetings, discussions, and on the fly decisions. These were not always communicated the best way possible or quickly. After several days of adjusting it was actually refreshing to improve our work flow and still has changed the way we practice today. We went back to talking to one another rather than writing notes in a computer. Workups and treatment plans were discussed openly and delays we normally see in medication delivery and lab collection improved. Unfortunately, urine was still impossible to collect.

It seemed likely every day we heard the system would be up tomorrow. It took weeks actually nearly a month to restart using the electronic medical record. It took even longer to catch up on billing and entering downtime data into the system.

We were never told if a ransom was paid or not. That was left up to a select few and kept very close to the vest. I do not believe they did but will never truly know. Please, do not pay the ransom.

New INACEP Members

Medical Students

Nicole Benzoni
Devin Doos
Alexander Doxey
Joshua Garcia
Carl Hurtig
John Jacobs
Michael Kaminski
Alexis Meriweather
Nicole Nemore
Brandon Pearce
Andrea Purpura
Michael Rice
Nathan VanderVinne

Residents

Olubunmi AmakorMD
Christopher Amick MD
William Baldwin MD
Heath Brown MD
Christopher Chestnut MD
David Crow MD
Erin Dancour MD
Rachel Day MD
Thomas Eales DO
Michael Francois MD
Benjamin Grandy DO
Brooke Henderson MD
Christine Huang MD
Stephen McBride MD
Jonathan Pike MD
Justin Smith MD
Kimberly Swartz MD
Aaron Wasserman MD
Kyle Yoder MD

New Members

Stephen Keller MD
Andrea Keyes DO
Heather Prunty MD, FACEP
Bryan Schultz MD
Joseph Stone MD
David Toro MD, FACEP

Fellows

Benjamin Nti MD

Life Members

Alberto Delgado MD

A View from the Top

continued from page 1

layperson" definition of an emergency medical condition as one in which a person who possesses an average knowledge of health and medicine might anticipate serious impairment to their health. Everyone who practices Emergency Medicine realizes that many conditions which present with benign complaints, such as sore throat, can represent a variety of conditions from simple viral illness to airway threatening retropharyngeal abscess. The all important medical screening examination mandated by EMTALA ensures patient safety. The value of Emergency Medical services cannot be defined as a presenting symptomatic complaint or final diagnosis.

Third, the request that Emergency Physicians and providers educate an insurer's patients to seek care at a lower level of care for non-emergent conditions is a responsibility belonging to the insurer prior to the visit to the ED.

In response to this notification letter, INACEP is actively involved in efforts to curb payment denial for Emergency Services. INACEP has already submitted a resolution for consideration at the national ACEP level. Our Board members are active on many committees at the national and state level. Anthem has responded at the state level that children under the age of 14, services provided from the hours of 8pm Saturdays until 8am Mondays, and patients who live more than 15 miles from an urgent care center will be excluded from this denial process. Also a list of ICD 10 diagnoses which will be reviewed for payment has been requested.

INACEP, in partnership with ACEP, ISMA, AMA, IHA and our lobbyists, will continue to advocate for our patients at the state and national level, to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services and to uphold the "prudent layperson" definition of an emergent condition. Thanks for your support. Your feedback is welcome.

Upcoming Events

ACEP Scientific Assembly
Washington DC
October 29 – November 1, 2017

INACEP Annual Conference
Indianapolis
April 25 & 26, 2018

Leadership & Advocacy Conference
Washington DC
May 20 – 23, 2018

Informatics Q&A

continued from page 7

5. If this requirement is to be applied to the ED, ONLY a well-designed functional established CDS should be employed, for example, "ACR Select™" [https://www.acr.org/Advocacy/eNews/Archive/2014/20140404-Issue/ACR-Select-Provides-Ordering-Physicians-with-Timely-Access-to-Imaging-Appropriateness-Criteria]. In general, EMRs are not up to this task and hospitals must be willing to make the financial investment for technology currently only available in third party systems.

REFERENCES

Protecting Access to Medicare Act of 2014" (PAMA)

SEC. 218. QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY DIAGNOSTIC IMAGING AND PROMOTING EVIDENCE-BASED CARE.

Language relate to setting & exceptions. For entire bill: https://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf

(q) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

(1) (D) APPLICABLE SETTING DEFINED.—In this subsection, the term 'applicable setting' means a physician's office, a hospital outpatient department (**including an emergency department**), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

(4)(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

(i) EMERGENCY SERVICES.—An applicable imaging **service ordered for an individual with an emergency medical condition** (as defined in section 1867(e)(1)).

PAMA Brief Summary

Section 218(b) of the Protecting Access to Medicare Act of 2014 amended Title XVIII of the Social Security Act to add section 1834(q) directing CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. In section 1834(q)(1)(B) of the Act, AUC are defined as criteria that are evidence-based (to the extent feasible) and assist professionals who order and furnish applicable imaging services to make the most appropriate treatment decisions for a specific clinical condition.

As previously implemented, SSA Section 1834(e)(1)(B) defines "advanced diagnostic imaging" procedures as diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging procedures, such as positron emission tomography (PET). ADI procedures do not include x-ray, ultrasound, fluoroscopy procedures or diagnostic and screening mammography.

Case Study: Lessons Learned from Implementation of a Radiology Clinical Decision Support System [https://www.acr.org/Annual-Meeting/Program/Abstracts/2015/Informatics/045]

An Intro to Clinical Decision Support for Radiology [http://www.itnonline.com/article/intro-clinical-decision-support-radiology]

EMpulse

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

BOARD OF DIRECTORS AND OFFICERS