FLORIDA COLLEGE OF EMERGENCY PHYSICIANS

EMpulse

FALL 2015

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EMpulse

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Features

Steven Kailes, MD, FACEP
FCEP PRESIDENT

A MESSAGE FROM FCEP'S NEW PRESIDENT

Every ending is also a beginning. In this past year, we have completed building a new center for FCEP, in conjunction with the Florida Emergency Medicine Foundation. This new Emergency Medicine Learning and Resource Center will be the home for the College and the Foundation. More importantly, the Center will be a site for continuing education offerings, simulation training, and webinars. There is a small museum-like display for items important to and influential in the advancement of emergency medicine and the delivery of emergency care to the people of Florida and our country.

The Foundation has its roots within the College and has afforded us opportunities to extend our scope and reach. This non-profit organization is funded by grants and contributions. It allows us to build partnerships and provide accredited continuing education programs for thousands of emergency physicians, nurses, allied health professionals, and first responders throughout Florida.

Moving forward, one of my goals is to complete a new strategic plan to guide the future direction and offerings from our College. We want to ensure we are prepared to successfully navigate our threats and our opportunities. There are many dedicated members helping to complete this task, and we welcome your comments.

Another goal involves you. I want to increase our engagement with our members and increase our total membership. We know we must provide value to you. I believe we already do provide value, but perhaps we can do more. What do you want? Our annual conference registration is free for members. We are constantly working to protect your reimbursement against unfair payment practices and misleading information put out by insurers, hospitals, plaintiff attorneys, and government institutions. We keep a constant vigil for statutes, policies, and governmental rules, which have a positive or negative impact on you whether or not the consequences are intentional. We work tirelessly for better liability protections against unwarranted malpractice claims. We produce numerous accredited educational courses. We launched a leadership academy to mentor those of you who have an interest in guiding the future of your specialty. We provide expanded networking opportunities, as well as being liaisons with other state and national leaders and organizations, relevant to your practice. Through ACEP, we are also expanding and enhancing our 9-1-1 legislative advocacy network to help us engage federal legislators with our specialty.

As I look to the coming year, I see a great deal of promise for what your College will be doing to add value for you, your practice, and the patients for whom you chose a life of service. By the time you read this, we'll have launched our own written board review course. An incredible effort has been undertaken to ensure this is a quality program meeting the needs of our members and is both affordable and convenient.

All that we do is accomplished via the efforts of our devoted core staff and a cadre of emergency physicians who volunteer their time and resources to help our specialty. What is all of this worth? Did you know the price of your ACEP/FCEP dues accounts for less than 0.5% of the average emergency physician's annual salary? IF every emergency physician would join ACEP/FCEP and give to our advocacy efforts, we would have one of the, if not THE, most influential medical organizations in the country. The return on investment would be tremendous.

Finally, as I said earlier, every ending is a beginning. We just returned from our annual Symposium by the Sea at the Omni Resort in Amelia Island. This was a wonderful event in which great CME offerings were available, and there were challenging resident case presentations and simulation "wars." Furthermore, families and friends had time to enjoy good company and many fun activities together. In beginning this new year, I'm looking forward to the next Symposium in Naples. Yet, there is much to do before then. I hope to see you or speak with you soon. Together, we'll strive to provide the value you deserve for your support.

Daniel Brennan, MD, FACEP
MEDICAL ECONOMICS COMMITTEE CHAIR

MEDICAL ECONOMICS - BILLING AND CODING - CONTINUED

The last quarter's Medical Economics column discussed the basics of EM billing and coding, particularly the components of the Evaluation and Management CPT codes 99281-22985 which make up the bulk of our services and revenue. The documentation of the history, the physical examination, and the medical decision making (MDM) factor in the E&M code billed, and the complexity of the MDM most often drives the overall proper level. (All 3 must support the level billed; with a complete H/PE the MDM will be the limiting element). MDM complexity is defined by CMS as straightforward, low, moderate, or high-complexity. MDM in turn has 3 sub-components: (A) the number of diagnosis and treatment options, (B) the complexity of data reviewed, and (C) the risk of morbidity. The overall MDM complexity is the highest level supported by at least 2 of the 3 MDM components. CMS has published guidelines (1995 and 1997) which stratify and provide terms for the various levels of complexity of the subcomponents but provide little direction to coders.

The Marshfield clinic tool has been used by coders, intermediaries, and auditors to attempt to quantify MDM assignment and make coding more objective and reliable. First Coast Service Options, the Florida CMS intermediary, has developed an interactive E/M coding worksheet which closely mirrors the Marshfield clinic tool and CMS Documentation Guidelines terminology: (http://medicare.fcso.com/EM/165590.asp#PopUp_Guidelines).

(A) Number of Diagnosis or Management options – coding tools recognize new patients and new problems requiring a diagnostic workup are more complex. In EM, most of our patients present with new problems (to the examiner) and frequently require a workup. On the FCSO worksheet this would fit the "extensive" level – "new problem to examiner – diagnostic procedure(s) ordered." Interestingly, ACEP and FL experience has shown some payors attempting to ignore diagnostics done in the ED when determining this element – contrary to the seemingly clear-cut CMS FL intermediary's published tool. Inexplicably somehow referring patients out for follow up testing is more complex than actually ordering, interpreting, and acting upon test results during an ED stay?

(B) Amount and/or complexity of data reviewed. The audit tool tallies points for laboratory tests, radiology tests, and other diagnostic tests (e.g, ABG, EKG) – ordered or reviewed (1 point each maximum for lab/ Xray / other). A point is also assigned for decisions to obtain old medical records or history from someone other than the patient. Two points are assigned for discussing the case with another provider or review of old medical records or for direct visualization and independent interpretation of an image or tracing. Four points or more correlates to an "extensive" level in the FCSO / Marshfield clinic tools.

(C) Risk of complications, morbidity, mortality – The CMS Documentation Guidelines provides a "Table of Risk" that provide many examples of presenting problems, diagnostic procedures, and management options that correlate with minimal, low, moderate, and high risk. Many are not directly applicable to EM, but many common EM presenting problems are provided as high-risk examples (acute MI, multiple trauma, PE, acute neuro changes (Seizure, TIA). In terms of diagnostic procedures cardiac stress tests, contrasted CV imaging, and LP are moderate risk examples, while CV imaging studies in patients with CV risk factors are listed as high risk. In terms of management options, parenteral controlled substances and DNR decisions are listed as high risk examples.

After the elements (A), (B), and (C) are determined, the MDM complexity is the highest level at least 2 of the 3 elements supports. For example, a new patient with a new problem being worked up in the ED with labs, Xrays, and a consultation would code as high complexity MDM: (A) = new problem with workup = extensive; (B) lab 1 point + Xray 1 point + discussion with another provider 2 points = 4 points = extensive (likely additional complexity would be involved in reviewing old records, obtaining history from family/EMS etc, independent visualization of images or tracings (EKG, monitor….). In this example, regardless of risk assignment (C), the number of diagnosis and management options and the amount and complexity of data alone support high complexity MDM, and if a comprehensive History and PE are documented a 99285 code is supported. Likewise, straightforward MDM would correlate to 99281, Low complexity MDM to 99282, and moderate complexity 99283 or 99284. All presuming the corresponding History and PE elements support the MDM level; if not the encounter would be down-coded to the lowest level all 3 (H/PE/MDM) support.

(A) Number of Diagnoses or Management options	(B) Amount and/or complexity of data to be reviewed	(C) Risk of complications and/or morbidity or mortality	Type of Medical Decision Making
Minimal (≤ 1)	Minimal or None (≤ 1)	Minimal	**Straightforward**
Limited (2)	Limited (2)	Low	**Low complexity**
Multiple (3)	Moderate (3)	Moderate	**Moderate complexity**
Extensive (≥4)	Extensive (≥4)	High	**High complexity**

Florida College of Emergency Physicians
Annual Calendar 2015 - 2016

DATE	EVENT	TIME	LOCATION
July 31 - August 2, 2015	FMA Annual Meeting		Disney's Yacht & Beach Club Orlando
August 6-9, 2015	Symposium by the Sea		Omni Amelia Island
August 6, 2015	Membership & Professional Development Cmte Meeting	8:00 am - 9:00 am	Symposium by the Sea Amelia Island
August 6, 2015	Academic Affairs Cmte Meeting	9:00 am - 10:00 am	Symposium by the Sea Amelia Island
August 6, 2015	Medical Economics Cmte Meeting	10:00 am - 11:00 am	Symposium by the Sea Amelia Island
August 6, 2015	Government Affairs Cmte Meeting	11:00 am - 12:00 pm	Symposium by the Sea Amelia Island
August 6, 2015	FCEP Board of Directors Meeting	2:00 pm - 4:30 pm	Symposium by the Sea Amelia Island
August 7, 2015	EMS Trauma Cmte Meeting	8:00 am - 9:00 am	Symposium by the Sea Amelia Island
August 7, 2015	Pediatric EM Cmte Meeting	9:00 am - 10:00 am	Symposium by the Sea Amelia Island
August 7, 2015	FEMF Board of Directors Meeting	10:30 am - 12:30 pm	Symposium by the Sea Amelia Island
August 8, 2015	EMRAF Meeting	12:30 pm - 1:30 pm	Symposium by the Sea Amelia Island
August 8, 2015	Medical Student Forum	12:30 pm - 1:30 pm	Symposium by the Sea Amelia Island
August 31 - Sept 3, 2015	Written Board Review Course		Rosen Plaza Hotel, Orlando, FL
September 22, 2015	FCEP Board Conference Call	11:00 am - 12:00 pm	
September 29-30, 2015	Resident Career Day		
October 20, 2015	Counselor Call to Review Resolution	11:00 am - 12:00 pm	
October 24-25, 2015	ACEP Council Meeting		Boston, MA
November 11, 2015	FCEP Committee Meetings		FCEP Offices
November 12, 2015	FCEP/FEMF Board Meeting		FCEP Offices
December 15, 2015	FCEP Board Conference Call	11:00 am - 12:00 pm	
January 12, 2016	FL Legislative Regular Session Convenes		Tallahhassee, FL
January 18 - 20, 2016	EM Days 2016		Tallahhassee, FL
January 19, 2016	FCEP Board Meeting		Tallahhassee, FL
February 9, 2016	FCEP Board Conference Call	11:00 am - 12:00 pm	
February 17, 2016	FCEP Committee Meetings		FCEP Offices
March 8, 2016	FCEP Board Conference Call	11:00 am - 12:00 pm	
April 20-21, 2016	FCEP/FEMF Board and Committee Meetings		FCEP Offices
May 1-4, 2016	EDPMA 2016		Las Vegas, NV
May 10-14, 2016	SAEM 2016		Sheraton New Orleans Hotel
May 15-18, 2016	ACEP Legislative/Advocacy & Leadership		Grand Hyatt, Washington, DC
May 24, 2016	FCEP Board Conference Call	11:00 am - 12:00 pm	
June 21, 2016	FCEP Board Conference Call	11:00 am - 12:00 pm	
July 11 - 16, 2016	CLINCON 2016		Double Tree by Hilton, ORL, FL
July 19, 2016	FCEP Board Conference Call	11:00 am - 12:00 pm	
August 4-7, 2016	Symposium by the Seas 2016		Naples Grande Beach Resort
October 15-18, 2016	ACEP 2016		Las Vegas, NV

Joel Stern, MD, FACEP
FCEP VICE PRESIDENT
GOVERNMENT AFFAIRS COMMITTEE CO-CHAIR

GOVERNMENT AFFAIRS UPDATE

The Florida College of Emergency Physicians Government Affairs committee met on August 6, 2015, in beautiful Amelia Island, in conjunction with Symposium by the Sea. The main topic of discussion once again was proposed legislation regarding out of network billing for emergency services. The onerous bills introduced this past session were not passed, thanks in large part to opposition from us and other interested parties, including the Florida Medical Association. We have been informed that these bills, or something similar, will again be on the agenda in 2016. With this in mind, it will once again be our top priority. The previous wording of these bills not only prohibits balanced billing for out of network providers, it also allows insurance companies to reimburse at whatever rate they choose, without any regard for charges. This would clearly result in massive financial losses for all emergency medicine practices, and make adequate staffing and treatment of our patients substandard at best. In addition, on call specialty consultants would be further discouraged from taking call for Emergency Departments, even more than they are now. This is not sustainable for Physicians, and not fair for our patients. Insurance companies would be the only winners here. It is imperative that we unite to fight this grave threat to our specialty. We are planning on an all-out campaign for the coming legislative session to prevent these bills from passing in their current form. We will be providing education to legislators over the summer and fall in preparation for our annual trip to Tallahassee for EM Days.

Speaking of EM Days, we will be meeting in Tallahassee, January 18-20, for the early session in 2016. Dr. Sanjay Pattani will be the program chair for the coming event. Stay tuned for more details to come.

The Government Affairs Committee also discussed some issues occurring at the Federal level which are impacting our problems in Florida. The "Greatest of Three" rule in the Affordable Care Act, contains language eerily similar to the out of network legislation being proposed in our state. Our feeling is that this is the basis for the insurance companies lobbying efforts at the state level. A recommendation was made to the FCEP Board to request further federal lobbying by ACEP on this important issue.

Finally, we convened a meeting of our PAC Board. Donations have been less than in previous years, and we are currently in need of funding for the upcoming session. Going forward, EMPulse will be listing an honor roll of all FCEP PAC donors. I am asking all FCEP members to donate to our PAC this year. This can be done on our website, or by calling the office. Payments can be one-time, or recurring monthly via credit card. Please note that we do not receive any funds from NEMPAC, and member dues are not used for political donations. We actually have two PACs. Physicians for Emergency Care (PEC), is for individual donors, and Emergency Care for Florida (ECF) is for Corporate entities such as Group Practices or other businesses. Please consider a one-time or monthly recurring donation prior to the end of this year to help fund our current legislative agenda.

Thank you for your support.

Emergency Care for Florida Donors

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Physicians for Emergency Care Donors

Dr. Joel Stern
Dr. Kristin McCabe –Kline
Dr. Damian Caraballo
Dr. Steven Kailes
Todd S. Link

René Mack, MD
Symposium by the Sea 2015 Program Chair

2015 SYMPOSIUM BY THE SEA WRAP-UP

If you were not able to attend SBS 2015, you missed a great conference! The location at the Omni Ameila Island was unique and offered a variety of opportunities to connect with family and colleagues. The committee meetings and Board of Director's meeting were filled with new ideas of how we can continue serving you! Some of the highlights of the conference were the SimWars, Resident CPC and the Research Sections awards, and the great lectures.

5th Annual SimWars

The chair of the SimWars, Dr. Ademola Adewale, and the FCEP staff produced another exciting event. There was representation from every emergency medicine residency program in Florida which made the competition even more intense. With the help of guest judges, Dr. Dagan Dalton, Dr. Kristin McCabe-Kline, and Dr. Carmen Martinez as well as audience participation, the **Winner of SBS SimWars 2015 is:** Florida Hospital Emergency Medicine Residency Program!

7th Annual Symposium Research Poster Presentation

Medical students, residents and fellows from schools and programs around the state submitted their research posters and were judged within their category. We were all very impressed with the high quality of Emergency Medicine centered research taking place in Florida. Dr. Adrian Tyndall, Chair of this program, along with our special guest judges Dr. Jay Kaplan - ACEP President and Dr. Rebecca Parker were pleased to give the following awards.

Outstanding Medical Student:
Jayike Nwokolo, MS-2 UF Gainesville

Outstanding Resident Poster:
Amanda Stone, MD, Orlando Health

Outstanding Fellow Poster:
Ayanna Baker, MD, Orlando Health

Florida Resident Case Presentation Competition (CPC)

The Resident CPC has been a staple at SBS for many years. Every year, the residents throughout the state exchange difficult cases with each other, and a representative from opposing programs takes us on a mental exercise to determine the true diagnosis. This year was no exception and all residents did a remarkable job! Dr. Jennifer Jackson, CPC Chair, along with a group of great judges, Dr. Jay Kaplan - ACEP President, Dr. Kristin McCabe-Kline, Dr. David Seaberg, Dr. Jay Rao, and Dr. Paul Kivela made the following determinations for the resident categories.

Best Presenter:
Dr. Kevin Chin, EM-2 – Orlando Health

Best Discussant:
Dr. Mary Jo Lightfoot, EM-3 – Florida Hospital

Best Overall Program:
University of South Florida

A few years ago, based on your reviews, we implemented a second educational track, which runs parallel to the Resident CPC. This alternate track allows us to provide you with additional CME as well as concise updates on topics relevant to our practice. Like previous years, this format was a hit! The faculty and attendees reported this as one of the most successful years so the bar has been raised for the years to come.

One of the great things about SBS is that although we strive to provide dynamic and informative sessions, we also focus on providing entertainment for the entire family. A special "Thank you" to Duva Sawko and EMPros for hosting the annual Casino Night which provided a great mix of family and adult entertainment! The exhibit hall participants and our sponsors again have shown their support for our organization and specialty in full force. They were able to sponsor several drawings and auctions that were a great success!

Thank you for your support of FCEP, and we look forward to seeing you at **SBS 2016 at the Naples Grand Beach Resort, August 3-7, 2016**.

Jami Johnson, PharmD, Clinical Toxicology/Emergency Medicine Fellow
Florida/USVI Poison Information Center – Jacksonville

TRICK OR TREAT? WHAT WE KNOW ABOUT HALLOWEEN SADISM

Halloween Sadism, a term coined by Richard Trubo in 1974[1], refers to the practice of giving children contaminated treats during trick-or-treating. Joel Best, professor of Sociology and Criminal Justice at the University of Delaware, has published multiple thorough literature and media reviews regarding the subject and has found no reports of a child being killed or substantially injured by a contaminated treat[2]. Below is a review of published deaths attributed to Halloween Sadism:

History Surrounding Incident2	Actual Cause of Death2
5 y/o M- ingestion of heroin-laced Halloween candy	Ingestion of heroin found in a relative's home
8 y/o M- ingestion of cyanide-laced Halloween candy	Ingestion of cyanide-laced candy supplied by the child's father in order to collect on a life insurance policy (father later executed)
2 y/o M- ingestion of Halloween candy	Police concluded death due to natural causes
7 y/o F- collapsed and died while trick-or-treating	Child died of known cardiomyopathy
4 y/o F- ingestion of Halloween candy	Child died of streptococcal infection

The only pertinent finding following a comprehensive search of the medical literature involved a healthy 14 year old male that presented to the emergency department four hours after ingestion of a cupcake purchased from a gas station on Halloween. He complained of abdominal pain, dizziness, and generalized weakness. The patient's clinical status declined and he experienced a generalized, tonic-clonic seizure as well as signs of anticholinergic toxicity. The Food and Drug Administration was contacted and initiated an investigation into possible malicious tampering while law enforcement officials were sent to the gas station to confiscate the remaining cupcakes. After an in-depth analysis was performed, procainamide was found in the child's serum. The child eventually admitted to ingestion of the medication after poor report card results[3].

Despite the fact that minimal documentation of Halloween Sadism exists in the medical literature, it is still feared by many parents and caregivers. In order to ease anxiety, hospitals and urgent care facilities across the county offer free radiological examination of candy bags. Cappelle[4] performed a study to determine the frequency of radiopaque items found in screenings of Halloween candy and to determine the frequency of items missed. A total of 454 bags of candy were screened, with no radiopaque items found. To determine the frequency of missing a small item, a needle was stuck into an apple in one bag presenting to each of the participating centers, which was discovered by all but one facility. In a commentary published by Calvanese[5], he concluded that the potential annual cost of free radiography, just in the Reno-Sparks area (in 1986) was between $800,000- $1,400,000.

Although Halloween Sadism has largely been 'debunked,' this author is still not deeming Halloween a safe holiday. It is no surprise that, on a night with millions of children roaming the streets, the odds of a child being struck by a vehicle are almost four times higher than other nights[6]. An analysis of pediatric holiday-related injuries found that, among eight holidays, Halloween ranked fourth in the number of injuries, behind Labor Day, Memorial Day, and Independence Day[7].
However, if you do have any questions about a potential poisoning or would like assistance managing a toxic patient, please contact your poison center toll-free at 1-800-222-1222.
Trick or Treat!

References:

1. Trubo, R. 1974. Holiday for Sadists. PTA Magazine: 69 (10): 28-29.
2. http://www.udel.edu/soc/faculty/best/site/halloween.html. Accessed 10 August 2015.
3. White S, Grace D, Wilson JM. 2002. The Case of the Slandered Halloween Cupcake. Pediatr Emerg Care 2002; 18(3): 185-88.
4. Cappelle C, Eberly S, Paul RI. Routine Screening of Halloween Candy: Helpful or Hazardous? Ann Emerg Med. 1993;

22(10): 1541-44.
5. Calvanese, J. Should We X-Ray Halloween Candy? AJR. 1986; 147: 854-55.
6. Childhood Pedestrian Deaths During Halloween–United States, 1975-1996. Morbidity and Mortality Weekly Report. 1997;46: 987-90.
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Christine Van Dillen, MD, FACEP
COMMITTEE CHAIR

EMS/TRAUMA Committee Update

All clinical personnel who chose to dedicate their lives to Emergency Medicine do so with the goal of helping people and saving lives. One scenario that always comes to mind (and looks exciting on TV) is resuscitation of a patient whom has suffered from a cardiac arrest. Cardiac arrest resuscitation is something that all EMS agencies continue to strive to perfect, and prognosis remains grim.

On June 30th 2015, the Institute of Medicine published a report, "Strategies to improve Cardiac arrest survival: A Time to Act." In the EMS section of this report they review the current state of affairs of how we respond to cardiac arrest along with the most current literature regarding cardiac arrest outcomes. This is a recommended review that is free and available online. FCEP was recently awarded a Florida state matching grant to purchase simulators to assist with training to improve the quality of compressions our patients receive from EMS providers all around the state.

The Florida Association of EMS Medical Directors recently invited a guest speaker, Brain McNally from the CARES registry, to present to the group the benefits of being part of such a registry. This list included the ability to understand on an ongoing basis the status of each individual agency in comparison to others from around the state, while keeping all information anonymous. This would assist us in breaking down our processes and training to be able to identify areas of needed improvement. FAEMSMD made the decision to recommend to the EMS advisory council that the State of Florida participate in the CARES registry. All steps in the right direction to continue to improve the quality of care we as emergency medicine clinicians can provide to our patients all across the beautiful state of Florida.

Florida Association of EMS Medical Directors (FAEMSMD) update:

- FAEMSMD continues to work on the directive from the department of health (DOH) to accept or develop a set of statewide protocols. FAEMSMD as a group has decided to develop a set of minimum guidelines, not a common statewide mandatory protocol. Dr. Sckeppke asked for EMS agencies from around the state to volunteer model protocols with a goal of approval by the FAEMSMD. Medical Directors submitting the model clinical guidelines (sample protocol) must:
    - Be an EMS Medical Director of an EMS agency licensed in Florida
    - Be a member in good standing of FAEMSMD
    - Agree (in writing or electronically) to update the protocols at least once every 2 years
    - Maintain board certification in a broad based medical specialty
    - Hold an unrestricted license to practice medicine in the State of Florida
    - Ensure that the submitted protocol addresses the topics listed in the recommended guideline of topics to be covered
- Information was presented on the OnStar advanced automated collision network (AACN). The center for disease control has partnered with OnStar to conduct a vehicle telematics initiative to develop evidence-based protocols for the emergency medical community to effectively use automotive telemetry data. The overall goal is to develop procedures that will assist dispatch and emergency medical responders to more accurately and efficiently respond and care for trauma patients after a motor vehicle crash. This data could also determine if a motorist needs care at a trauma center, enabling responders to more quickly identify, diagnose, and treat injuries. OnStar representatives will be attending future FAEMSMD meetings for additional discussion and updates.
- In early July, the National Association of Athletic Trainers (NATA) released an executive summary of recommendations from their Inter-Association Task Force. This reviewed the appropriate care of the spine-injured athlete. This focus stems from the fact that approximately 12,500 new cases of spinal cord injury are reported in the United States each year with 9% percent of these cases stemming from participation in sports and recreational activities.

Their EMS related recommendations include:

- Spinal immobilization of the athlete if there is spinal

cord injury concern (neurological deficits present, mechanism, pain in the spine or alteration in mental status). This recommendation is includes the use of scoop stretchers.
    - Removal of equipment on scene when the appropriately trained personnel are available and the patient is otherwise stable
    - Focus on the appropriate movement of patients with spinal injury (relates to joint training of EMS personnel together with local athletic trainers)

  This executive summary raised controversy with NASEMSO due to the presence of new language that was not present in their original position statement. Prior to full implementation discussion will need to occur through NASEMSO, FAEMSMD, and the FCEP EMS/Trauma committee.
- Our next FAEMSMD and FCEP EMS Trauma meeting is tentatively scheduled one following the other on November 11th, 2015

Department of Health Updates

- A trauma rule workshop was held recently on August 12, 2015. The purpose of this workshop was to solicit expert guidance and public comment in order to revise rules related to the state trauma triage criteria through potential incorporation of the CDC Guidelines for Field Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage, 2011 and rules related to trauma center requirements through the potential adoption of the American College of Surgeons (ACS) Resources for Optimal Care of the Injured Patient 2014 (6th edition) and its' clarifying documents. In this meeting it seemed that most who attended generally felt positive with moving forward with the use of these criteria. There were several points which still needed some attention, these included:
    - The verbiage of bringing patients to highest level of care, specifically differentiating between Level 1 versus Level 2 Trauma centers
    - The lack of specific pediatric criteria
    - The importance of education with this implementation
    - Allowance of paramedic discretion

The remaining time was spent discussing the potential adoption of the ACS Optimal Care of the Injured Patient pamphlet to guide trauma centers on their standards of practice. The newest version: 2014 is available for review online on the ACS website. The new version requires additional registrars to enter a lower number of patients; the old version allowed for 760-1000 per person and the new version requires 500-750 per person, to enable registrars to accommodate additional data fields. There are also new educational requirements and formal CEUs for registrars. Overall this dialogue was also positive. There was discussion that when the current state of Florida guidelines are at a higher standard than this pamphlet, the higher standard should be adopted. Examples include a requirement for nursing CEU's for trauma as well as the requirement for updated ATLS for all emergency medicine and trauma staff working at a trauma center.

- Florida State Statute 381.887: Emergency treatments for suspected opioid overdose is a new Florida statute that was reviewed at our recent FCEP EMS/Trauma meeting. This statute allows emergency responders, including, but not limited to, law enforcement officers, paramedics, and emergency medical technicians, to possess, store, and administer emergency opioid antagonists as clinically indicated. Concerns from our committee include: how medical direction will occur for law enforcement, who will monitor the expiration of these drugs, how storage of drugs will occur, and the needed implementation of training and safety in the use of this drug.
- At the July EMS Advisory Council meeting, representatives from DOH announced that the Surgeon General intends to review and possibly open up all legislation related to health this upcoming legislative session with committee meetings beginning in the October 2015. The intent is to provide updates to these statutes. In light of this announcement the Office of EMS is requesting feedback from professionals in the Emergency Medical services (EMS) industry for suggested areas of change in chapter 401. Please review this document and provide any suggestions to the EMS office or FCEP by emailing Melissa Keahey at mkeahey@emlrc.org.

Education update

- Clincon 2015 this year was a success! There were positive reviews on content with an increase in attendance. This success is due to the hard work of Danielle Dragoo, Felix Marquez, the Clincon programing committee and all of EMLRC staff. Thank you!

Robert L. Levine, MD
Chair Emergency Medicine and Critical Care
The Herbert Wertheim College of Medicine
Florida International University

PASSING OF A GENERATION: RESUSCITATION IN MODERN TIMES

Interest in resuscitation has been evident for thousands of years with references in the bible and other ancient sources. More recently, resuscitative attempts and research extended to methods ranging from tobacco smoke fumigation to application of galvanic current, explored with limited success, during the 18th and 19th centuries. The beginning of the 20th century marked a paradigm shift in the application of scientific inquiry into resuscitation. In short order after epinephrine was isolated in the 1890's, it was applied by George Washington Crile to resuscitate experimental animals from shock and cardiac arrest. Open chest massage and defibrillation followed in the first half of the 20th century. However, the real shift to modern resuscitation occurred at the beginning of the second half of the twentieth century when two groups of investigators working independently at Johns Hopkins developed CPR as we know it today.

Dr. William Kouwenhoven (January 13, 1886 - November 10, 1975), was an electrical engineer born in Brooklyn, NY. He received his B.E. from Brooklyn Polytechnic and his Ph.D. from Karlsruhe Technische Hochschule in Germany in 1913. In 1958 he received a grant from Edison Electric Institute and the NIH to develop a portable defibrillator to resuscitate electric linemen that had been electrocuted. Working with Dr. Kouwenhoven were G. Guy Knickerbocker, a doctoral student and James Jude, M.D., a surgical resident. Dr. Knickerbocker observed a brief rise in a dog's blood pressure when he applied heavy defibrillator paddles to the dog's chest. He discussed this with Dr. Jude, who recognizing the significance of this observation resuscitated a patient in the Operating Room using external cardiac massage. Based on their experience successfully resuscitating dogs with external CPR, the three investigators performed the landmark study published in JAMA in 1960 that demonstrated the efficacy of external chest compression.

While Kouwenhoven, Jude, and Knickerbocker were performing their work on CPR and defibrillation, another Hopkins team was exploring artificial respiration. In the mid-late 1950's, Peter Safar (April 12,1924 – August 2, 2003) working with Lourdes Escarranga and James Elam proved mouth-to-mouth artificial respiration worked better than the respiratory techniques used at that time. Safar, et. al., published their landmark paper in the NEJM in 1958. Working with Kouwenhoven's group, they created CPR as we know it today. In the 1960's, Dr. Joseph Redding (b. May 1921?, d. March 13, 1984) working with Dr. Safar, developed many of the drug regimens used for cardiac arrest completing the early version of ACLS.

Another key figure in the development and refinement of CPR/ACLS was Dr. Max Harry Weil (b. February 9, 1927 d. July 29, 2011). A cardiologist, he realized the importance of monitoring to prevent sudden death after a myocardial infarction, surgery, or serious illness. Dr. Weil, founding president of the Society of Critical Care Medicine, with Drs. Safar and Redding and a few other key physician-scientists were the core founders of SCCM.

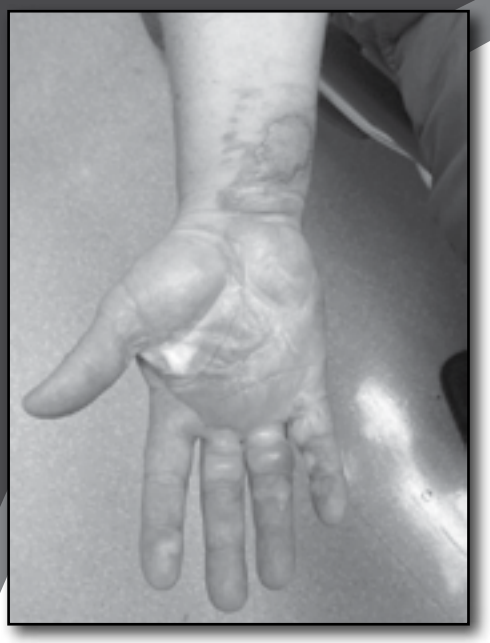
Dr. Jude, born June 7, 1928, died July 2015. After graduating from the University of Minnesota School of Medicine he trained in surgery and thoracic surgery at Johns Hopkins where his laboratory and clinical studies changed the science of resuscitation. Dr. Jude went on to become the Chief of Surgery at the University of Miami and Jackson Memorial Hospital. He taught paramedics, medical students and generations of physicians and laypeople alike how to save lives.

One last giant, not related to cardiac arrest and resuscitation, but rather to critical care, died recently. Dr. Forrest M. Bird, who took us from iron lungs to modern ventilators, died Sunday, August 1st, 2015. In the 1950's and 60's, Dr. Bird, pioneered the development of positive pressure ventilators for adults and children. Bird ventilators were still in use when I trained in critical care. Even stranger, was the persistence of iron-lung ventilators; in Houston I cared for a patient maintained on one of these devices through the 1990's.

Dr. Kouwenhoven passed away in 1975, Dr. Redding in 1984, Dr. Safar in 2003, and Dr. Weil in 2011. With Dr. Jude's passing last month and Dr. Bird this month, we are almost at the end of the generation that changed how we practice medicine, profoundly transforming how we monitor and resuscitate patients from cardiac arrest and shock. Our debt and links to these people runs deep. I had the privilege to train with Drs.

DAUNTING DIAGNOSIS

Karen Estrine, DO, FACEP, FAAEM
EDITOR IN CHIEF



Question:

A 42 year old man presents with the injury shown. What category of injury is this, and how would you treat it?

(Answer on page 21)

Redding and Safar. Dr. Falk trained with Dr. Weil.

With so many people alive today due to the work of these investigators, we've made huge progress in the science of resuscitation and have much to be thankful for. And yet, with resuscitation rates stubbornly remaining as low as they are, today's generation has the opportunity to rethink and reinvent the paradigms that take us to the next level.

References:

NY Times Obituaries
Widepedia and Multiple Internet Sources
JAMA
NEJM

René Mack, MD
COMMITTEE CHAIR

IT'S A NEW SEASON

Symposium by the Sea (SBS) marks a new year for most committees at FCEP, including the Membership and Professional Development committee. The committee meetings that take place at SBS create the template for the year to come and this year is no exception. There are some exciting developments taking place and we need you to make them a success.

The FCEP Leadership Academy is entering its 4th year with 3 promising participants: Drs. Kristine Cottral (Tampa), Cesar Carrelero (Broward) and Gary Lai (Broward). These 3 will attend FCEP meetings, legislative meetings and events as well as national meetings to gain a deeper understanding of the details involved in keeping our specialty in the forefront of medicine. The purpose of the Leadership Academy is to expose the participants to the many areas involved in the continued success and advancement of Emergency Medicine as a practice and a specialty. We look forward to our new class and the advancements they will help to enact within Emergency Medicine. As we usher in a new class we say congratulations to our 2014 Leadership Academy participant, Dr. Danyelle Redden on completing the program. Dr. Redden was an active participant in the Leadership Academy and deepened her involvement in the program by chairing the Human Trafficking Symposium which took place on March 27, 2015. Like other Leadership Academy graduates she plans to continue her involvement by serving on various FCEP and ACEP committees and we look forward to encouraging her endeavors.

Resident and medical student enrichment is another important part of this committee. The SBS Emergency Medicine Resident's Association of Florida (EMRAF) committee meeting allowed the EM residents in Florida to come together and elect their new leadership and set the ground work for their committee for the next year. Stay tuned for all the activities they will be producing in the months to come. Likewise, the medical students also had a great showing and enjoyed round table discussions with many faculty throughout the state. The students continue to show great excitement in Emergency Medicine and we will do our best to foster their interest. The medical student mentorship program is still accepting applications for dedicated mentors who are willing and able to devote a few hours a month so that the medical students in our state receive the most pertinent and updated information to ensure their future success in Emergency Medicine.

In our dynamic committee there is one constant: membership outreach. We continue to strive to make the FCEP and EMLRC available to all eligible emergency medicine practitioners and what we have found it that this is a task that depends heavily on the positive reinforcement and encouragement of current members. Talking with your colleagues and reminding them of the need to stay active in their hardworking professional organization also reminds you of all the reasons that you remain integrated in the emergency medicine community.

These are just some of the activities taking place in our committee and we are always looking for new ways to serve you. If you have ideas for expanding our outreach or new areas for us to focus on, please contact us. I look forward to seeing you at the next committee meetings in November, in our new building!

CODING TIP
ICD-10 – New Concepts

In the new diagnoses code set, there are several new concepts that will require your coders to look for more specifics. These should be documented with your final diagnoses or in your HPI.

- Laterality – Right, Left or Bilateral
- Pregnancy – 1st, 2nd or 3rd Trimester
- Diabetes – Type I or Type II
  - Controlled
  - Uncontrolled or
  - Poorly Controlled (new option)
- Medications – Underdosing (non-compliant)
  - Document why patient is not taking medications as prescribed (example: can't afford)
- Episode of Care (for patients following an injury)
  - Initial (active treatment)
  - Subsequent (after active treatment is complete)
  - Sequela (complication resulting from injury)

Lynn Reedy, CPC, CEDC, Director of Coding Services, CIPROMS South Medical Billing, Tampa Bay Emergency Physicians

J. Adrian Tyndall, MD, MPH
Research Symposium Program Chair

ANNUAL RESEARCH SYMPOSIUM

During the closing moments of Symposium by the Sea, recognition was given to the participants in the research symposium with special awards distributed to outstanding poster presentations. This year, twenty one posters were accepted for presentation at the research symposium with ten medical students, nine residents and two fellows, along with faculty mentors presenting from Orlando Regional Medical Center, the University of South Florida, The University of Central Florida as well as The University of Florida Jacksonville and Gainesville. Poster judges were recruited from amongst the group of special guests, including members of the ACEP Board, who make attendance to Florida's premier Emergency Medicine Conference an annual priority. This year, we were fortunate to have Dr. Jay Kaplan, the President Elect of the American College of Emergency Physicians and Becky Parker, the Chair of the Board of the College enthusiastically serve as honorary judges.

During the Friday evening Wine and Cheese celebration, interactive and dynamic presentations occurred during a moderated poster session where medical students fended off challenges from the judges with crisp and well informed responses, residents and fellows presented material from their longitudinal research projects and even faculty mentors were available to discuss, and in some instances, present in the absence of resident or fellow attendees. All of the work presented were investigator initiated original research projects and the breadth and variety of the clinical projects were substantive - ranging from issues in sepsis, critical care and clinical practice to financial, operational and public health issues in clinical practice.

Judging of the posters were based upon the originality and innovation of the work done, the methodology , the overall impact in terms of the likelihood to change clinical practice, and the mastery of the subject material by the presenter. Winners and runner up prizes were selected from three divisions. Ayanna Baker, an EMS fellow from Orlando Regional Medical Center won the fellow category with her poster entitled End Tidal CO2 is Associated with Survival to Hospital Discharge and Neurological Outcome in Out-of-Hospital Cardiac Arrest Population. Amanda Stone, a resident from Orlando Regional Medical Center swept the resident division with two of her posters: The Effect of an EMS Sepsis Alert on the Management of Patients with Sepsis, and her winning poster, entitled The Value of End Tidal CO2 as a Component of a Pre-hospital Sepsis Alert Notification.

The Student category was exceptionally competitive with several extremely well presented posters in a broad variety of categories. Brandy Dawkins from the University of Florida was the runner up with his presentation of his poster, entitled Scribes in a Free Standing Emergency Department Pay for themselves with increase wRVUs and Improve Throughput. The Winner in the Medical Student Category was Jayike Nwokolo, a second year medical student at the University of Florida. His poster presentation, entitled Impact of Cardiovascular Comorbidities and Outpatient Medications on the Development of Hypotension Following Rapid Sequence Intubation, was one of the most dynamic presentations during the session and truly represented the high quality that was consistent amongst all of the medical students presentations. Congratulations to all the participants for contributing to an excellent research symposium this year and a special thanks to our guest judges from the American College of Emergency Physicians.

Research Symposium participants:
Ayanna Baker, MD, Amanda "Mandi" Stone, MD, Melissa McGuire MD1, Madeline M. Joseph MD1, Phyllis Hendry MD1, Heide N. Valdes MD1, Matthew B. Thomas MD, Laurie Bryant MD, Trent Wilkes, MD, Frank A Marshall MD, Xinwei Liu, Selina Sutchu, Faheem Guirgis, MD, Radim Soucek, MD, Juliana Lefebre, DO, Adam Koby, Jayike Nwokolo, Amanda Horn, Benjamin Banapoor, De-Vaughn Williams, Brandon Burns, Ryan Brown, Ousama Aboushaar, Brody Dawkins.

Ademola Adewale, MD
Medical Director, Florida Hospital Center for Medical Education and Simulation
Assistant Program Director, Florida Hospital EM Residency Program

SYMPOSIUM BY THE SEA SIMWARS 2015: TOPICS IN FLORIDA SUMMER ACCIDENTS AND ILLNESSES

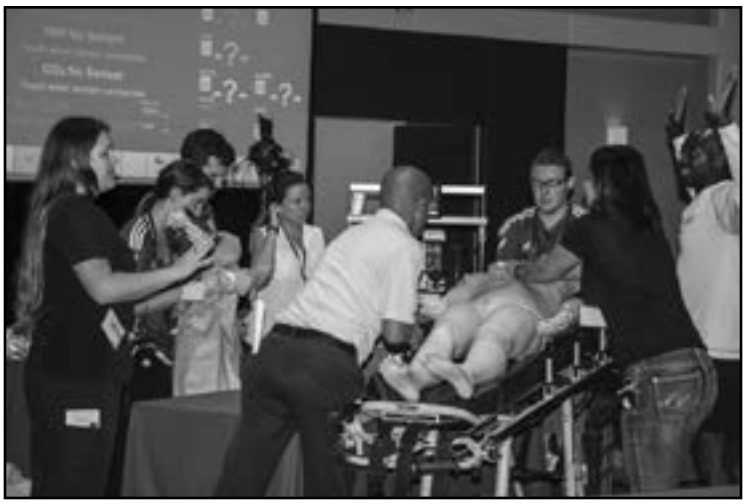
Simulation is now an integral part of medical education. It allows Emergency Medicine educators to evaluate in real time, some of the milestones competencies. Since the inclusion of the SimWars in the Symposium by the Sea program a few years ago, it has rapidly become one of the fan favorites. This year's SimWars was a special one because this was the first time we had the participation of all the seven Emergency Medicine training programs in the state. This, indeed, was a milestone.

The success of the event was due in part to the cumulative effort of the newly formed Simulation Committee which is a sub-section of FCEP's Academic Committee and the supportive staff of the EMLRC. During one of the meetings, the vision to select a theme for this year's competition was determined. For this year, the theme was "Florida Summer Accidents and Illnesses." This explains the plethora of cases that included but was not exclusive of: snake bite, heat stroke, and lightning strike. In addition to these cases, resuscitation, resuscitation, and resuscitation was evident. We believe resuscitation is an art that every Emergency Medicine trainee should master prior to completion of their training.

With vision in hand, the effective execution of that vision became the focus. This year's competition had some logistical challenges with regards to how to make the vision a reality. However, with determination, and the help of our supporters (Laerdal, that provided the SimMan 3G; Simetri, that provided the outstanding moulage that brought our vision to life especially in the case of snake bite to the face; Felix Marquez from the Orlando Medical Institute who provided extraordinary assistance setting up and running the scenarios, and the Audio-Visual team that ensured the seamless flow of the event), this year's event was the best SimWars competition at the Symposium. This in essence will make next year's event a daunting endeavor.

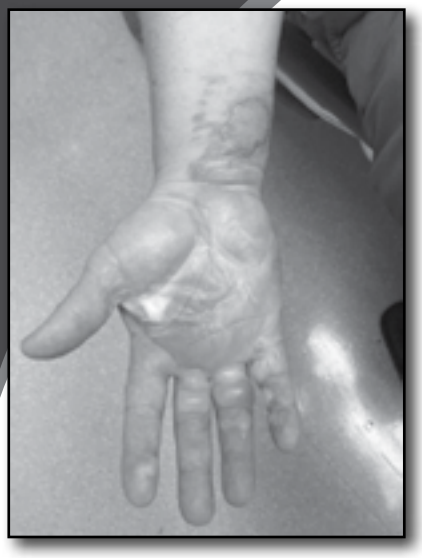
For the first time in the history of the event, an audience response system was utilized. This allows audience participation in judging the first two rounds of the event by using an online audience response system called "ResponseWare." All the audience responses were then projected in real time on the big screen. In all, this was unique in the sense that most of the audience responses were consistent with the judges' votes.

This year's event was fiercely contested at all stages. The teams were equally matched, and were ready to engage in an academic challenge of managing a critically ill patient on a grand stage. They demonstrated their expertise in patient care, professionalism, teamwork and medical knowledge. This year's finalists were the Orlando Regional Medical Center and the Florida Hospital Orlando Residency Programs. The competition was fiercely contested, but Florida Hospital Orlando program edged out Orlando Regional Medical Center program to become the 2015 Symposium by the Sea "SimWars" champion. A big congratulations to the winner, the runner up, and all the programs that participated to make this event a major success. Looking forward to another challenging "SIMWARS" in 2016.



DAUNTING DIAGNOSIS ANSWER

Question on page 15



This is a severe second-degree burn to the patient's dominant hand which appears a couple of days old.

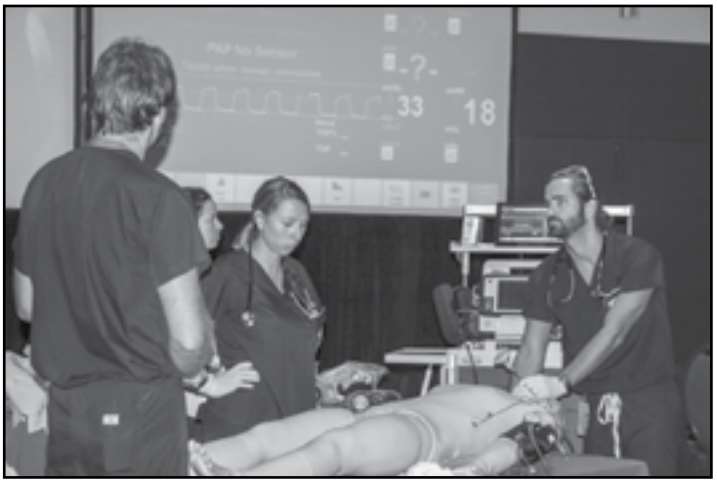
It is characterized as a second-degree burn due to the partial thickness skin damage with blisters.

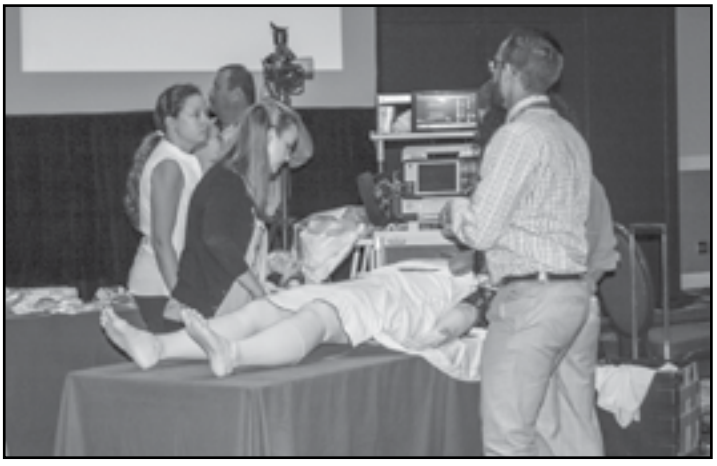
According to the American Society for Surgery of the Hand, initial treatment for this patient would include cleaning the open areas/ trimming dead skin from any open blisters, and leaving intact blisters unbroken.

The patient would require a tetanus shot, pain medications, and possibly antibiotics as the hand can become infected easily, yet antibiotics are not recommended prophylactically, unless obvious infection is present. Silver Sulfadiazine is often recommended as a cream to cover these burns as it is an antibacterial and can be soothing as well for pain. Frequent cleaning, dressing changes will help with wound healing.

As this burn affects the hand, it is at risk for contractures. Hand surgery should be consulted regarding the prevention of contractures and any further needs such as skin grafting.

Patients with severe burns who are at risk for contractures may require extensive therapy and rehabilitation.





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HAPPY TRANSITION FROM ED TO UC

I have practiced Emergency Medicine for approximately 32 years until about 3 years ago when I stepped out of the ER and into Urgent Care.

Towards the end of my EM career, I began to develop a somewhat jaded opinion of some of my fellow human beings, a self-admission about which I am not particularly proud. As I aged in body, mind, and career, I began to wonder where all the nice people were hiding. I cherish my family members, my ER and hospital colleagues, my church friends and my friends at large in the various communities in which I have lived.

Beyond these individuals, it appeared the characteristics of the relatively large number of "other people" that I shared the planet with were reflected by the countless thousands of souls I came across in the ER. Now I know full well that nobody visits the ER as a patient or family member intentionally. I realize that we have the honor and privilege of taking care of patients and their respective family members when they are at their "worst." They are frightened, in pain, worried, apprehensive, waiting too long, etc., etc. Many complain a lot, about non-medical things. Some wear the mantle of entitlement like a new fur coat. Others play games of deceit or bait and switch, and triangulate the ER staff. I always felt that if I could counterbalance a suffering, apprehensive ER patient from a negative space to a midpoint of negative-positive feelings, then I had succeeded in my work. An above the midpoint patient emotional/physical outcome was a bonus! Unfortunately many days I felt like the nameless customer service representative who spends his or her day dealing with complaints and adversities day-in and shift-out trying desperately to achieve customer satisfaction. It wore me down, and it caused me to wonder where the God bequeathed goodness lived in many of my fellow earthlings.

On August 1, 2012 I started working in Urgent Care, and to my amazement and utter delight, I found an unending supply of nice strangers. They come to URGENT CARE!! Urgent Care patients are gracious, grateful, pleasant, they are not very sick, and they pay their medical bills. Aha, what a joy! If the tip of my tongue can be found in my cheek, let's blame it on our chaotic and not always fair-minded medical care delivery system. All patients who visit the 2 Urgent Care Centers in which I work pay their bills. Most are insured and pay relatively small copays. Self-pay patients are given a customary "self-pay discount," which they pay before they are seen.

Some patient care contracts do not require any contribution by the patient such as Workers' Compensation, pre-employment physicals and drug testing. Competitively lower fees are assessed for school and sports physicals in youngsters, and Department of Transportation physicals for those seeking Commercial Driver Licenses. Physicians and physician supervised PA's are employed as providers, and physicians are asked to see all of the Medicare patients because reimbursement is a little higher than if a Medicare patient sees a PA.

The patients are mostly employed and possess medical insurance; there is a plethora of Medicare patients, and the remaining patients are contracted for pre-employment and employment-related issues such as Workers' Comp, and finally self-pay paying patients. By that, I mean, there is payment at the time of service unlike in the ER. There is a skew in the patient demographics towards middle-aged and Medicare-aged patients. There are not many pediatric patients perhaps because Medicaid is not accepted at our facilities. Most of the time the patients have made wise healthcare consumer decisions about seeking care in a lower acuity and ultimately much cheaper venue. They have minor medical and surgical problems which take a relatively brief time to solve. We have X-ray and limited lab capability as we do most of our testing via point of care card testing and urine dip sticks. One of our 2 facilities has the advantage of a full service outpatient Radiology Department located in the same building, and stat advanced imaging studies such as ultrasounds, CT and MRI scans can be obtained during business hours. Our facilities are open 8a-8p with a slight reduction in these hours on weekends and during holidays.

Non-provider staff consists of an office manager who directs all of the non-clinical activities such as personnel and medical contract management, policy development, billing and coding, payroll, etc. The office manager has a 2 person support staff, there are medical assistants some of whom are moonlighting fire dept. medics and several unique individuals known in the industry as "exceptionalists" who are radiology technicians cross-trained as medical assistants. There is a designated Medical Director among the providers who directs the clinical activities and he works closely with the Office Manager to ensure an efficient and patient-friendly operation of the facilities.

When I begin to feel as though the extraordinary life-saving skills I have learned through the years practicing as an emergency physician are somewhat diminished by the low level of illness acuity displayed in Urgent Care, I remind myself that by seeing such folks in the Urgent Care setting, they are not clogging up the waiting rooms of the area's already over-crowded hospital ER's. Sometimes I lament the fact that my EM background over-qualifies me for working in Urgent Care. Just then a really sick patient comes into the Urgent care like an older person with significant belly pain who thinks they are just constipated, or a patient denying that their cardiac chest pain is just indigestion or GERD. In these cases my EM background stands me in good stead as I am highly trained to distinguish serious illness and injury which requires ER evaluation from those which do not. It can be dangerous for an acute and seriously ill patient to come to Urgent care if the treating physician cannot recognize that the problem needs immediate attention in an ER setting. In addition, so many years of EM work have prepared me to recognize a huge variety of problems brought to my attention by Urgent Care patients. While we have a combination of ER trained and family practice trained physicians working in our facilities, I believe that ER docs have the best background for performing at a high level of confidence and competence in the Urgent Care setting. Finally, I have to reluctantly admit that Urgent care work provides an ideal transition away from the vigors and rigors of high-pressure, fast action, and burdensome stress--rampant nowadays in the ER.

James F. Brown, MD
Emergency Medicine Resident, PGY-III
Kevin Chin, MD
Emergency Medicine Resident, PGY-II
Orlando Health

ANTI-NMDA RECEPTOR ENCEPHALITIS

Case Report

A 13 year-old African-American female presents to the emergency department with two weeks of behavior changes. The mother reports that the patient has become increasingly combative and forgetful. She recounts episodes of strange mouth and hand movements and an episode of staring off with urinary incontinence. The patient also reports intermittent pain and numbness to her left arm. Prior to this episode, she was performing well in the 7th grade and behaved normally. She denied any alcohol or drug use, had no medical history, and was up-to-date on her vaccinations. Eight days prior to this visit, the patient was seen at another ED and had a negative head CT. On exam, the patient has a flat affect and is intermittently uncooperative. She has intermittent lip smacking and choreiform movement of the upper extremity is noted. CBC and BMP are unremarkable. An MRI is performed, which is also unremarkable. A lumbar puncture shows an increased WBC count of 33 with a lymphocytosis.

ED and Hospital Course

The ED resident then called the neurologist and suggested that the patient symptoms were consistent with anti-NMDA receptor encephalitis. The patient was admitted and started on IVIG and high dose steroids. Unfortunately, the patient's mental status declined during her admission. She developed recurrent seizures and became bedridden and nonverbal. On hospital day four, however, the CSF titers for the NMDA antibody came back positive confirming the suspected diagnosis. Due to non-responsiveness to first line therapy, the patient was started on plasmapharesis. She had a prolonged hospital course. Seven months after her initial ED visit, the patient has improved significantly. She is able to walk, talk, and read at her grade level. She is receiving an outpatient regimen of cyclophosphamide and rituximab.

Case Discussion

Anti-NMDA receptor encephalitis is an autoimmune disease with antibodies against the NMDA receptor, a receptor, which has a high concentration in the hippocampus. It was first described in 2005 in four young women with ovarian teratomas and was originally thought to be only a paraneoplastic phenomenon. Today we know that only 38% of all cases are paraneoplastic. It predominantly affects young females. It has prominent psychiatric and motor symptoms. Seizures, chorea, autonomic dysfunction, and altered mental status are commonly seen. CSF will often show a lymphocytosis but can be normal. The California Encephalitis Project cohort suggested a predominance of anti-NMDA receptor encephalitis over viral causes of encephalitis, so the disease may be more common than previously thought. Remember that Ketamine, a drug that we are all familiar with is an antagonist against the NMDA receptors. If someone is acting like they are on Ketamine, and we know they are not, consider anti-NMDA receptor encephalitis.

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Dakota Lane
UF Emergency Medicine, PGY-II

CPC CASE WRITE-UP

The patient is a 25 year old male with a past medical history of asthma who presented with fever for ten days. He reported that his fever reached a max of 40.4C at home which he treated with Tylenol and ibuprofen with no permanent improvement. He also complained of headache, non-productive cough, sore throat, myalgias and abdominal pain. He denied nausea, vomiting, diarrhea, arthralgias and rashes. He stated that he did have a viral illness two weeks prior to the onset of fever but that his symptoms had fully resolved by that time. He further endorsed sick contacts at work and described living in a wooded area. He denied prior substance abuse, surgeries or home medications. The patient initially presented to his PCP two days before his ED presentation with outpatient labs and imaging. He was noted to have a CMP showing hyponatremia and transaminitis. He was negative for EBV and influenza, but a CT abdomen/pelvis was performed secondary to the patient's abdominal pain which showed a fluid collection in the right lower quadrant of the abdomen and splenomegaly. Based on the findings, he was sent to the ED for further evaluation. On presentation to the ED, he was noted to be febrile to 39.9C and was ill-appearing. His physical exam was notable for cervical lymphadenopathy and diffuse abdominal tenderness, more severe in his right lower and left upper quadrants, without rebound or guarding. Labs were repeated which showed a WBC count of 5.2 with 15% bands, an H&H of 8.1/24.5 and platelets of 91. CRP was elevated at 69 while fibrinogen was low at 1.51. The reported transaminitis was confirmed with a result of AST of 791 and ALT of 269. His outpatient lipid panel was notable for high triglycerides with low LDL and HDL. BMP, coagulation factors and urinalysis were unremarkable. An acute hepatitis panel was also negative but the patient was found to be positive for CMV IgM and negative for CMV IgG. A chest x-ray was also negative for acute abnormalities. The CT of his abdomen and pelvis continued to show abnormal free fluid in the right lower quadrant of indeterminate etiology with a normal appendix. In the ED, one additional lab was sent which confirmed the diagnosis.

The additional lab was ferritin which returned markedly elevated at >38,000. The patient's final diagnosis was secondary hemophagocytic lymphohistiocytosis secondary to prior CMV infection. This condition can be primary or secondary, the first type being congenital. The secondary syndrome occurs after systemic infection, immunodeficiency or underlying malignancy. Histiocytes located in the bone marrow attack bone marrow cell lines, leading to uncontrolled proliferation of morphologically benign activated lymphocytes and macrophages. This leads to an increased amount of inflammatory cytokines that can then lead to a cytokine storm. Ultimately, the cytokine storm can lead to multi-organ dysfunction and failure and eventually death. Common triggers are infections which lead to a strong immune response, such as CMV, EBV, Kawasaki's disease and HIV. It can also be triggered by rheumatological conditions or malignancies such as lymphoma or leukemia. Diagnosis is made either by molecular diagnosis of pathologic mutations (in the case of primary HLH) or five out of eight of the following criteria: fever, splenomegaly, pancytopenia, hyperlipidemia, elevated ferritin, low/absent NK cell activity, elevated CD25 activity and hemophagocytosis. Our patient's findings met criteria for the diagnosis of HLH once ferritin was added as an additional confirmatory test, and as he had been positive for CMV IgG, his "viral illness" two weeks prior was the likely trigger. The diagnosis was later confirmed by bone marrow. Treatments for secondary HLH include high dose dexamethasone, which would be the most important initial therapy to initiate in the emergency department to dampen the inflammatory response that can eventually be fatal. Other inpatient treatments include etoposide, cyclosporine, IVIG and methotrexate. The significance of this case to emergency medicine lies in the acuity of the presentation, the possibility of diagnosis in an undifferentiated presentation of fever and inflammatory symptoms, and the potential for death if untreated. In this case, the patient was treated inpatient and did well after eventual transition to PO steroids.

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Christopher Bender, DO - PGY-II
UF Health Jacksonville - Emergency Medicine Residency

I'VE FALLEN AND I CAN'T GET UP…

A 79 y/o female with myasthenia gravis presents to the ED reporting generalized weakness, fatigue, nausea, and then a fall on her way to the bathroom, hitting her head on carpeted floor. She laid on the ground for 30 minutes prior to her daughters' arrival because she was unable to stand. She denies any LOC or pain, and remains A&O in route by EMS.
Upon ROS she admits to increased fatigue, nausea, diarrhea, hoarseness, and SOB for the past 4-5 days. She denies HA, light-headedness, visual changes, CP, vomiting, or bloody stools.

PSH: was significant for hysterectomy.
PMH: arthritis, thyroid disease, myasthenia gravis, and depression.
Current Medications Include:

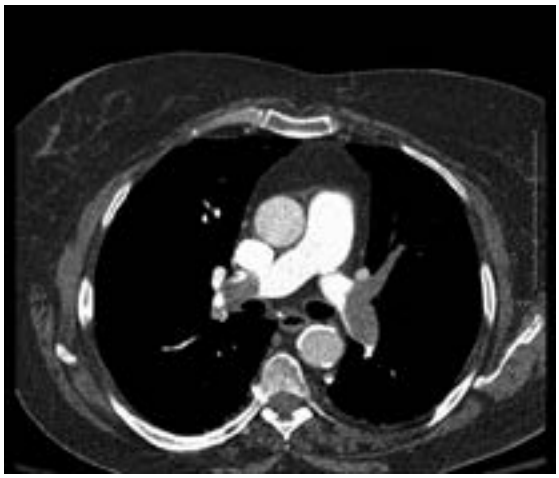
- Duloxetine 60mg daily
- Esomeprazole 40mg daily
- Levothyroxine 90mcg daily
- Mycophenolate 1000mg BID
- Prednisone 15mg daily
- Pyridostigmine 60mg BID

Recent changes to medications include: extra dose of Cellcept yesterday, decreased pyridostigmine from QID to BID because it was making her nauseated.

Physical exam reveals an alert and oriented patient in NAD. HEENT significant only for a small 1cm x 1cm light hematoma on her forehead. Cardiovascular exam reveals a BP of 91/54 and tachycardia at 115 but no m/r/g. Her lungs are clear, oxygenating well on RA, but with a RR of 26. She is guaiac negative with a rectal temp of 97.4F. Neurologically she is grossly intact but with decreased bilateral upper extremity weakness at 4/5.

Imaging: CXR reveals a possible R lobar consolidation. EKG reveals sinus tachycardia with non-specific T wave changes and ST depressions. Labs: unremarkable BMP, CBC with a leukocytosis of 28K with left shift, lactic acid elevation of 3.7 and an elevated Troponin of 0.4, all other labs WNL.

Our initial concern was for myasthenic crisis, however, as results came back this shifted to septic shock and she was treated with 2L NS and IV Ceftriaxone. Despite adequate fluid resuscitation she remained tachycardic, hypotensive, and tachypneic. A repeat troponin was drawn with elevation to 0.88, and repeat EKG was unchanged from the previous. At this point cardiology was consulted and performed a bedside echocardiogram. The echo revealed severe R ventricular dilation, ventricular septal flattening and a dilated R atrium. Pulmonary embolism is now a serious concern and a CTA chest was performed:



With confirmed bilateral PE TPA was administered and the patient was admitted to the MICU for further anticoagulation. During her MICU stay a hormone replacement patch was found on her back and removed. A L popliteal DVT was discovered on US as the likely source of her emboli. She improved hemodynamically and was eventually transitioned to oral anticoagulation.

Discussion:
Pulmonary Embolism can present in a multitude of manners. This particular case was complicated by the patients known endocrine and neurologic comorbidities and even more so the unknown, nondisclosed, information that she was undergoing HRT. So what are some objective ways to hone in on a diagnosis of pulmonary embolism? Often one of the first objective findings is an EKG. The most common findings on EKG are sinus tachycardia (44%) and non-specific ST segment and T wave changes (50%); the classic findings of S1 Q3 T3 are only seen in 20% of cases. A second fast bedside study is the cardiac US to assess for RV dilation, RA dilation, and McConnell's sign (RV dysfunction with akinesia of the mid free wall but normal motion of the apex). McConnnell's sign is 77% sensitive and 94% specific for the dx of PE, competing with the 89-97% specificity of CT diagnosis of PE. Although CT is the gold standard, it is important to realize that this can be the rate limiting step prior to treating a life threatening PE, especially if the patient is not stable enough to undergo CT imaging. Easily accessible bedside testing such as US may support your suspicion of PE and in the correct setting (hemodynamic instability and/or cardiac arrest) may decrease time to thrombolytic therapy.

Roxanne P. Sams, MSN, ARNP- BC, MA

Collaboration is the Key To Successful Emergency Department Turnaround

When confronted with an over-crowded, poorly performing emergency department (ED), many hospitals turn to a capital campaign to upgrade the facility rather than address the underlying cause.

It's all too easy to lay the blame for low patient satisfaction, long wait times and length of stay on an outdated or too small ED. But too few treatment rooms, or an inefficient design of the workspace may not be the real barrier to improving services. It can simply shift the "waiting" from the ED lobby to the treatment room.

What is the answer to turning around a struggling ED? It requires changing the culture and that must start at the very top of the organization. The first step is right alignment of all key stakeholders.

The Executive Leadership Team, including the ED Nursing Director, Chief Nursing Executive and ED Medical Director, must be willing to work collaboratively to steer the ship in a new direction. That requires a open collegial relationship with each other and a commitment to building trust with the ED staff. Visibility is the key. Only by rounding daily on all three shifts and seeing first-hand what is happening on the "front lines" can the leadership team expect to identify the issues and steps needed to lift unexpected barriers.

A 329-bed hospital in Pennsylvania is the perfect example In 2005, the board of directors approved a $13.5 million expansion to address the "woefully inadequate" ED design and processes. But despite a beautiful new facility, the ED continued to be dysfunctional, with long wait times and low patient satisfaction. Looking back, there were several contributing factors to the failed turnaround, including significant turnover among ED leadership and poor staff engagement in the change process.

Three years later, with a new CEO, COO and ED Nursing Director, the hospital embarked on a second ED improvement process. This time the leadership group was totally committed to the project and willing to do what it took to be successful.

The most immediate, critical need was to develop an improved process for moving patients more quickly from the ED waiting area into a treatment room. During a 12-hour "Kaizen" event, a Triage Lean Team comprised of the ED directors, several RNs, ER techs, and Registrars, the ED educator and consultants identified barriers to implementation and the steps required for success, including frequent debriefing "huddles", the visible presence of ED leadership during the roll-out and coaching of staff to accept the changes.

A Joint Practice Committee, co-chaired by the ED Executive Director and Medical Director, with senior leadership representation from the hospital, was also established. The committee met monthly to evaluate baseline metrics and set goals for every step of ED throughput, from lab and radiology turnaround time to inpatient bed assignment and transfer.

A year later, the final benchmarks showed a dramatic improvement. Door-to-room time had gone from an average of 50 minutes to 21 minutes, and door-to-provider time dropped from 72 minutes to 45 minutes. Press Gainey patient satisfaction scores jumped from 73 percent to 83.3 percent. Staff morale was also higher.

Why was this ED turnaround successful when the earlier attempt failed? It required a strong, competent clinical leadership with an open-minded attitude about what needed to be improved and a management culture that held everyone accountable for clearly defined outcomes. The Executive Leadership was willing to come to the table to honestly discuss the issues, set expectations, create a vision and define goals.

Changing long-held practice patterns is not easy, but it can be accomplished. To create change, execute and drive adoption, it is critical to develop a flexible and effective communication strategy based on: 1) Alignment of key stakeholders, 2) Building trust among the staff, 3) Developing effective training, and 4) Monitoring the progress and holding everyone accountable.

Jeffery D. Gilliard, NRP/CCEMTP/FPM, BS
Florida ITLS (FITLS)
State Coordinator/Chapter Coordinator/Affiliate Faculty

SHELFING COOKBOOK PARAMEDICINE

As paramedics, we will be put into a variety of situations and expected to provide quality care to our patients. Some of these situations will be chaotic and not taught step-by-step out of a book. This is why it is crucial to sometimes think out of the box and not be a "cookbook medic."

Paramedics must use their past experience, education, and protocols to implement a workable solution to a problem. Many patients present atypically when compared to textbook descriptions and if you aren't thinking, you could miss the more serious, life threatening problem the patient is having.

Research has shown that paramedics benefit from increasing their practicing of critical thinking, problem solving, and decision making in initial and continuing education. This also includes doing run reviews or run critiques to look back on a call and reflect on how you gathered and processed information and reached the decisions that you did. Mistakes will be made sometimes but the only way to grow and better yourself, is to be able to admit your mistakes and learn from them.

We have to make difficult decisions all the time in this profession, so understanding how and why we make the decisions we make are essential in the decision making process. Having adequate knowledge in anatomy and physiology, having the ability to gather and organize data and form concepts, having the ability to identify and deal with medical ambiguity, having the capability to analyze and compare similar and contrary situations, and the ability to articulate your reasoning and construct arguments are all fundamental elements that contribute to critical thinking.

From an era that grew up with Johnny and Roy from Emergency, each of us has experienced the inevitable call with our name on it. This call no matter how hard we tried to be the super hero, patients died. Some chalked it up to the patient's bad luck and some took these losses very hard. Those who were able to look back and remember their paramedic instructor's wisdom decided to be better.

Even though none of us are perfect and we never will be, to shelf the stigma of "Cookbook Paramedicine" we should all strive for excellence. This goal can be achieved by challenging and educating ourselves throughout our entire career. Be proactive in state & local EMS groups, continuing education, and skills training so that we are continually growing and honing the skills as a paramedic.

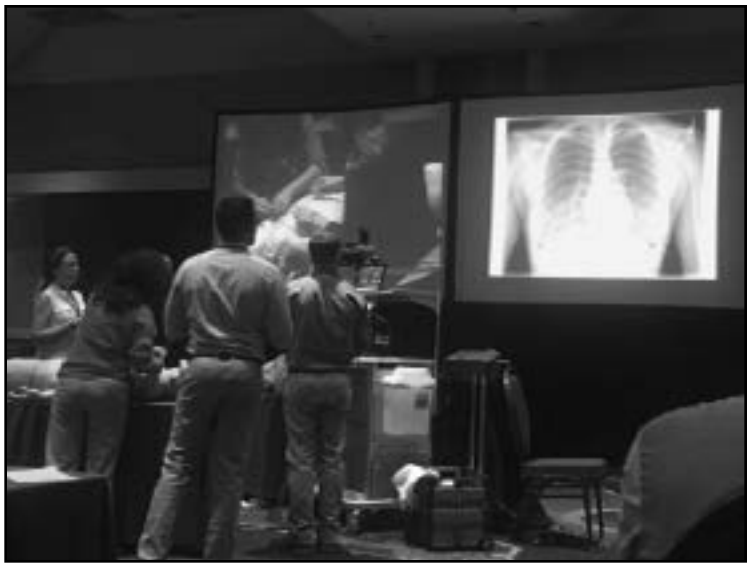
Merisa Kaplan, MD, MPH
Emergency Medicine Resident
Shands at UF Health

THE EMRAF PERSPECTIVE ON SYMPOSIUM BY THE SEA

At this year's Symposium by the Sea conference in Ameila Island, Florida, emergency medicine residents from around the state of Florida got together to participate in the Sim Wars and the CPC competition. This year was the first year that all EM programs, including DO programs, were involved in the Sim Wars. Last year's reigning champs, St Lucie Medical Center, received a first round bye as the other 6 programs competed against one another solving and stabilizing cases, including Wolf Parkinson White syndrome, puffer fish poisoning, and a lightning strike. It was a close race to the finish as both Florida Hospital and ORMC residents showed steady hands and a calm demeanor in the face of crashing patients, artificial animals, and fanatical loved ones. First place ultimately went to the residents at Florida Hospital, led by the senior resident, Dr. Mary Jo Lightfoot.

On Saturday, residents from 6 programs presented cases that appeared in their emergency department for the CPC competition, and in this competition, it's never the bread and butter emergency medicine topics that are seen on a daily basis that get presented. Based on information provided by the initial program, a resident from another program had to come up with a logical method of determining the differential diagnosis and ultimately the final diagnosis for the case. This year, topics included subacute combined degeneration, Lemierre's syndrome, and hemophagocytic lymphohistiocytosis. Best overall went to USF; best case presenter went to Florida Hospital; and best case discussant went to ORMC.

A round of applause and congratulations go out to all the programs and residents who participated in the events. After the competitions came to a close, everyone got together to celebrate at the luau where they partied and gambled the night away at the blackjack and poker tables with fake money and good company. It was a fun, relaxing, and intellectually stimulating weekend overall. The residents who participate next year will definitely have some large shoes to fill, but based on this year's topics, next year's conference in Naples promises to be just as interesting and enjoyable.



University of South Florida
Taylor Matthews, MD

Summer is in full swing here at the USF. A recent ultrasound course, taught by our own ultrasound director, Dr. Derr, has been the talk of the town with our critical care colleagues. Our new PGY-1s, in addition to navigating through the EMR, are already proving themselves to be ultrasound pros. They spent July honing in their skills in both ultrasound exams and ultrasound guided procedures.

Symposium by the Sea was particularly exciting this year. Our residents did an incredible job competing in the Resident Case Presentation Competition and SimWars, as well as presenting some cutting edge research posters! Drs. Lefebre and Grammatico brought home the title (and giant trophy!) for the Best Overall Program's Performance in CPC. Dr. Lefebre presented a case of subacute combined degeneration secondary to B12 deficiency from nitrous oxide huffing. Dr. Grammatico solved a case of anti-NMDA receptor encephalitis. Drs. Duss, Kaufman, Lisankie, and Smith battled hard in SimWars, but fell just short of the championship round. Our growing research program was evident with three impressive poster presentations. Dr. Soucek presented his ongoing research, "Management of Atrial Fibrillation and Associated Length of Stay in the ED," Dr. Lefebre presented, "How Many Ultrasound Examinations Are Necessary To Gain Proficiency In Accurately Identifying The Femoral And Popliteal Nerves?," and Drs. Rosenberg and Duss presented, "Change in Incidence of Oxygen Desaturation During RSI after Implementation of an Apneic Oxygenation Protocol." We are incredibly proud of everyone's hard work and their representation of our program.

"Summer" comes to a close. Storm season is in full swing with our daily rains rejuvenating our plush tropical environment. Our new first year residents, Matthew Brooks, Nikki Warren, Robert Farrow, and Justin Burkholder are all settling into their new lives and roles within our family quite well. As they came in and settled in we have been able to hear from a few of our seniors that graduated a few months ago; it is nice to know how well they have been doing. Our new seniors have stepped up to the plate with not only new responsibilities being that much closer to the light at the end of the tunnel (that we are promised is not a train), but with a decrease in the actual number of seniors that means an even greater workload. As a class… as a residency… as a group we say "Bring on tourist season!" To our interns – keep up the strong work. To Dr. Anthony Cruz who took part in his first CPC - great work!

Mt. Sinai Medical Center
Benjamin Abo, DO, EMT-P

Orlando Health
Tory Weatherford, MD

We are thrilled to welcome our new intern class. They have now finished up a great orientation month, and are starting rotations. They have already proven to be a great new addition to the ORMC family in their short time of being here, and we cannot wait to see the many great things they will accomplish.

Orlando Regional Medical Center is happy to announce their success at Symposium by the Sea. This year we came in 2nd place in the Sim Wars competition with Zoe McGowan, Chris Ponder, Blaine Norton and Stacie Miller representing us. James Brown and Kevin Chin also did a wonderful job representing ORMC at the case presentation, with Kevin Chin coming in first place for his part as discussant. Our EMS fellow, Ayanna Walker won the poster presentation for fellows and our 3rd year resident Amanda Stone won the poster presentation for the resident portion. In addition to success with awards, we had the great pleasure of watching James Brown win the poker tournament that occurred at casino night. Overall resident attendance at Symposium by the Sea made for a great weekend, and we couldn't be more proud of our representatives.

ORMC is looking forward to a great fall with many 3rd year residents applying to fellowships and some residents even already applying for jobs! Good luck to these residents in this career changing time.

The emergency medicine residency at St. Lucie Medical center has been keeping busy. On July 1st, we were pleased to welcome the incoming class Dr. Thomas Adams, Dr. Patrick Davison, Dr. Jessica Lacey and Dr. Porscha Roache-Robinson to our residency family. Our program director, Dr. Matese, and assistant program director, Dr. Mathai, attended the Symposium by the Sea conference in Amelia Island. We participated in the Sim wars as defending champions. Our team, Dr. Daniel Hohler, Dr. Kristen Hanrahan, and Dr. Brant Hinchman, lead by chief resident Dr. Rick Carlson, exited in the semifinals in a close contest. Dr. Jason Morris (core faculty), lectured on Flakka at the Symposium. Dr. Weller (new core faculty) also gave a visiting lecture at Mount Sinai's D.O. program on syncope. We are looking forward to the ACOEP conference in Orlando, and with it being only a short two hour drive from our program, it is an added bonus.

St. Lucie Medical Center
Rege Turner, DO

University of Florida,
Gainesville
Merisa Kaplan, MD, MPH

The 2015-2016 academic year has started off without a glitch here in Gainesville. While the PGY-1s are spreading their wings outside the emergency department in off-service rotations, many of the PGY-2s traveled to Amelia Island, Florida in August for this year's Symposium by the Sea Conference to participate in the Sim Wars and CPC Competition. It was a weekend of great weather, interesting lectures, and uncommon diagnoses as residents from around the state presented rare cases that walked into their emergency departments. Diagnostic skills were tested as residents were finally allowed to think of the rare zebras, such as hemophagocytic lymphohistiocytosis, Lemierre's Syndrome, and Vancomycin-induced Cardiovascular Collapse based on a brief HPI, ROS, physical exam, and labs. It was not an easy feat, with many of the practicing EM physicians in the audience noting how grateful they were to no longer be in residency trying to solve these cases.

Now, as summer moves into fall, the PGY-3s are gearing up for a trip to Boston, Massachusetts for this year's ACEP conference—one of the last opportunities the group will have together in residency to learn and have fun. Additionally, some may even be looking at job opportunities, if they have not already found and signed that coveted contract. To those going—live, learn, and have a great time!

Florida Hospital
Jessica Fides Aun, DO

Happy Autumn from Florida Hospital East Orlando! It's that time of year when everyone starts dreaming of Pumpkin Spiced Lattes and the leaves start changing beautiful colors and falling from the trees… okay, maybe not the leaves here in Florida, but you know what I mean. Everyone is settling into their new roles. The new third years are jumping into their new leadership positions with grace and ease, enjoying their time taking the new interns under their wing and running the Emergency Department like champions.

We are so proud of the team of residents that represented our residency at the annual Symposium by the Sea in Amelia, Florida. Our crew placed first in the 4th Annual Sim Wars: Residency Simulation Competition! Representing our team were Alex Drake, MJ Lightfoot, Chasi Skinner, and Jerome Clayton. In addition, our very own MJ Lightfoot won Best Presenter in the Case Presentation Competition! Great job guys!! We hope everyone has a great year!

Here at UF Health Jacksonville, we would love to start by welcoming all of our new interns. Over half of the new class comes from right here in Florida with others coming as far as Lake Erie, Arizona, New York, Virginia and Arkansas. You all survived July and have taken on the physical, intellectual and emotional challenges of intern year here in Jacksonville with astonishing competence and enthusiasm. Congratulations to you all! We would also like to congratulate several of our residents for their fierce battle at Amelia Island at the Symposium by the Sea. Bryant Lambe (PGY-3) and Chris Bender (PGY-2) went head to head with other residencies here in Florida in the resident clinical case presentation competition. Lexie Mannix (PGY-2), Bryant Lame (PGY-3) and myself, Nate Bach (PGY-2) teamed up for the Sim Wars competition. Our new location UF Health North is up and running, giving our 3rd year residents an opportunity to rotate in a new setting seeing patients in Northeastern Florida and Southeast Georgia. Finally, we want to congratulate our very own Dr. Norse, who served as FCEP president over the last year and will be passing the torch on to Dr. Steven Kailes. Dr. Norse was awarded the Martin Gottlieb Advocacy Award for working tirelessly representing our state and our profession. For all your hard work, dedication to our residents and ability to still smile when the going gets tough, we thank you Dr. Norse!

University of Florida, Jacksonville
Nathan Bach, DO

Shanna Howe
Executive Director of Managed Care
Martin Gottlieb & Associates

Managing your Managed Care Contracting Discussions

Negotiating a managed care contract with a third party payer can be complex. Managed care contracts are not one size fits all—while much of the contract terms and language may appear similar at a glance, each payer has their own contract template and each should be treated as unique and given thorough review and consideration.

A duly executed contract is a legal and binding agreement between both parties, so make sure you understand what you are committing to before you sign the contract! Every contract should be reviewed, analyzed and negotiated for what is best for your practice.

Some tips to help you through the process:

- ***Complete an analysis***—Always do an analysis to project what the financial impact will be before you sign. The analysis will help you to determine how much you will need to negotiate with the payer.
- ***Reimbursement methodology***—Rates can be structured several ways: as a percentage of Medicare, based on the payer's fee schedule, carve-out rates, or a flat rate are the most common. Study the reimbursement language carefully—a percentage of a payer's fee schedule based on CMS does not mean a percentage of Medicare, it means a percentage of the payer's fee schedule, which is subject to change!
- ***Bilateral language***—Language that holds the payer harmless, but not the provider, is unilateral and only protects the payer. Where applicable, the language should specify that the payer agrees to hold the provider harmless also.
- ***Understand the term*** —Is the contract for a 1-year term, or longer? Most of the contract terms are based on the "initial term" of the agreement, and you will be bound to the terms of the agreement for the "initial term." If the initial term is more than 1-year, check for annual escalators after the first year, or you are locked-in to those rates for the entire term.
- ***Termination clauses***—Every contract should include termination language, allowing either party to terminate the agreement, with or without cause. Make sure you understand what your termination rights are, and at what point you may terminate your contract and at what point notice is required. Mark your calendar with these important dates!
- ***Amendments***—Material changes to the contract that will affect your terms, reimbursement, and rights, should require your approval before such amendments are made effective. If the amendment will materially change the contract, you'll want more than just a notice from the payer.

Get help from an experienced Managed Care professional when negotiating a contract with a third party payer.

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