Illinois EPIC
Emergency Physicians Interim Communique

Illinois College of Emergency Physicians
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2011 - Issue 1
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PRESIDENT'S LETTER

Exercise Your Right to Be Heard: Take Action

Dino P. Rumoro, DO, FACEP

Pictures from Egypt and Libya fill our television screens and newspapers. We watch as regular people exercise their natural right to be heard after years of repression. Having their opinion heard is as foreign a concept as the lands they come from.

The people we read about are trying to create a democratic process where democracy does not exist. While we witness history being made, we lose sight of the fact that we already have the power to be heard. Others have lost their lives for us to have that right. Yet, we forget what a great privilege we have, which is clearly evident from low voter turnout and apparent apathy when it comes to contacting our elected officials to express our opinions. In short, we take our own freedoms for granted.

I am proud to say, though, that the members of ICEP are alive and well and exercising their right to be heard! As you know, the governor of Illinois recently signed into law HB 5085, commonly referred to as the "Out-of-Network" law. Under this new legislation, hospital-based physicians who care for out-of-network patients are reimbursed at a rate considered "fair and reasonable" by the very insurance companies who crafted this bill.

ICEP fought this legislation in a collaborative effort with other hospital-based physician groups but did not have our promised changes incorporated into the bill before it was signed into law. Fortunately, through continued efforts, ICEP and partners were invited to the Illinois Senate chamber to ask the Insurance Committee to consider a trailer bill that would right the wrongs of HB 5085.

Following physician testimony, Senator William Haine, the committee chairman, clearly vocalized an unexpected proclamation to the Department of Insurance that they (paraphrase) "must fix the mess they created." With that, the testimony ended and we were instructed to work on a solution to be presented back to the committee — a clear positive outcome in our attempt to correct poor legislation. But the real victory was the effort put forth by our members.

Responding to an ICEP action alert the day before the testimony, one of our members made an appointment to meet with Senator Bill Brady, a member of the Insurance Committee. During this meeting, he had the opportunity to exercise his right to be heard and spoke openly about his thoughts regarding HB 5085. Another member showed up at the testimony to provide support and to witness, firsthand, the politics involved with the new legislation.

In these situations, there are often other members who write to their elected officials and call their offices to support ICEP initiatives. All of these members are the real key to initiating change. To all of those who helped turn the tide of HB 5085, thank you. I don't think any of us know what the final solution will entail but at least we can rest assured that our voice has been heard. The hard work of our Board of Directors, officers, Government Affairs Committee, executive director and our individual members made this change possible.

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E-Voting: What Members Need to Know About 2011 Ballots

ICEP ballots to elect Board of Directors members and vote on Bylaws Amendments will be conducted electronically in 2011. Here's an overview of how the process will work:

- All members with an email address registered with ICEP/ACEP will receive an email the morning of March 28 with instructions for voting and links to all websites.
- Members who do not have an email address registered, or who have requested a paper ballot, will receive their ballot by mail with a postage-paid envelope to return it to ICEP.
- If you would like to request a paper ballot, please contact Kate Blackwelder at 630-495-6400, ext. 205, or kateb@icep.org.
- Members will be given a direct link in the email to take them to the online voting platform. To log in, they will use their ACEP Member number (beginning with A) and their last name (as registered with ACEP).

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A Reprieve for Tort Reform?

With Future of Health Care Reform Bill Uncertain, Members Urged to Contact Legislators About National Tort Reform

George Hossfeld, MD, FACEP

Could it be that we jumped the gun in reporting the death of federal tort reform efforts with the passage of "Obamacare"?

With the House passing the repeal bill and the general dissatisfaction of the public with the bill, there may yet be a chance for meaningful national tort reform. The President even said as much in the 2011 State of the Union Address, as did Senator Paul Ryan (R-Wisconsin) in the Republication response. It's enough to make a trial lawyer get dyspepsia.

Make no mistake about it: with more dollars to put in politicians' pockets than nearly any other group, the lawyers' lobby is going to be activated full bore to prevent it. They have too much skin in the game to lose, and unlike most physicians who abhor politics and are just too busy being doctors, they are business savvy and politically involved.

They will fight this tooth and nail, invoking the plight of "the little guy." That would be the same "little guy" that they feel no problem with exploiting by taking one-third plus costs out of judgments, mind you.

A note, a call, a visit, an email to your legislators right about now, will help to remind them that it's votes, not dollars, that ultimately determine their employment.

It's easiest done by investing 10 minutes and going to the web sites where you will be linked to Senator Mark Kirk, R-IL (http://www.kirk.senate.gov/contact_form.cfm) and Senator Dick Durbin, D-IL (http://www.dickdurbin.com/contact). Your U.S. Representative is just as easily contacted at https://writerep.house.gov/writerep/welcome.shtml.

Cutting and pasting the same message to each is a painless way to do it. You want to jog their memories that you miss no occasion to remind your patients of the issue daily. Mentioning the heavy cost of defensive medicine, the early retirement of physicians, and personal stories of litigation abuse make your communication all the more memorable.

It's a bit of a long shot right now, but not out of the question. Even if Obamacare is not totally repealed, which seems likely, the White House will be forced to make concessions to Republicans — and tort reform is an obvious one that both sides can get behind without upsetting a big part of the electorate.

A federal tort reform law would be a huge relief to those of us in states with lawyer-friendly statutes. It's a marathon, not a sprint, to change the system.

— George Hossfeld, MD, FACEP
Department of Emergency Medicine
University of Illinois-Chicago

Quick Clicks: Contact Legislators Online

Senator Mark Kirk (R-IL)
www.kirk.senate.gov/contact_form.cfm

Senator Dick Durbin (D-IL)
www.dickdurbin.com/contact

Find Your U.S. House Representative
https://writerep.house.gov/writerep/welcome.shtml

E-Voting: What Members Need to Know About 2011 Ballots

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- If you do not receive an email with voting instructions by March 28, 2011, please contact Kate Blackwelder for assistance. Your email server may block ICEP.org emails as spam.
- As an added protection to ensure you receive the email, consider adding kateb@icep.org to your email Safe Senders List.
- If you have trouble logging in to the voting website, you may contact Kate Blackwelder for assistance during regular business hours of 8:30 AM - 4:30 PM Monday through Friday. (You may vote online at any time, but assistance is only available during ICEP business hours.)
- The voting platform will be open from midnight March 28 until 11:59 PM April 27.
- The online voting platform will allow you to submit your vote only one time. After you have voted, you may log in again but you will receive a message that your vote has already been received.
- After you have submitted your vote, you may print a voting report for your records.
- The online voting program automatically tallies the winners of each election and sends certified results to ICEP. The results of the election will be announced at the Spring Symposium on Thursday, May 12 at Northwestern Memorial.

Illinois EPIC

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2011 Spring Symposium Looks at Diverse Clinical Populations, Health Care Reform

Two nationally recognized speakers, plus the winner of last year's NEXT Forum, are on the agenda for the 2011 Spring Symposium, with clinical topics that focus on the aging population, syncope in young adults, and the impact of the recently passed health care reform on the practice of emergency medicine.

Sandra Schneider, MD, FACEP

Diane Birnbaumer, MD, FACEP

Tarlan Hedayati, MD, FACEP

The Spring Symposium and Annual Business Meeting is scheduled for Thursday, May 12 at Northwestern Memorial Hospital.

ACEP President Sandra Schneider, MD, FACEP, of New York, will analyze the impact of the Patient Protection and Affordable Care Act of 2010 and other health care reform issues that affect emergency medicine. Dr. Schneider will also outline ACEP's 2011 goals and activities.

Diane Birnbaumer, MD, FACEP, of California, will identify best practices for providing optimal care for elderly patients, examining the population's unique challenges: comorbidities, poly-pharmacy, the diminished availability of primary care, and more.

Tarlan Hedayati, MD, FACEP, winner of the 2010 NEXT Forum, will review lethal causes of syncope in young adults, discussing recommendations for ED work-up, diagnosis, and management of these otherwise healthy-appearing patients.

The annual Statewide Research Showcase will spotlight cutting-edge emergency medicine research conducted by Illinois investigators. Oral presentations will be given during a morning session, and research posters will be on display in the exhibit area.

The New Exceptional Teachers (NEXT) Great Speaker Forum, now in its third year, will also be presented as part of the Spring Symposium. The NEXT Forum will be held from 1:20 PM to 4:00 PM. Invited lecturers will present a 15-minute PowerPoint presentation on an emergency medicine topic of their choice. Presentations will be judged by an expert panel, and the winning speaker will be offered a lecture spot at ICEP's 2012 Spring Symposium events. Spring Symposium attendees are encouraged to stay to watch this special educational event to support their colleagues while earning extra CME hours.

If you would like to be considered for the NEXT Forum or the Statewide Research Showcase, submission forms are available at ICEP.org in the Research section.

To register for the Symposium or view the full course brochure, visit ICEP.org. You may also register by calling 630-495-6400, ext. 200.

Governor Signs Out-of-Network Legislation; ICEP, Coalition Continue Opposition Efforts

Despite the tremendous opposition voiced by ICEP members and members of other Illinois medical specialty societies over the past months in efforts to secure a veto, the out-of-network bill, HB 5085, was approved by Governor Pat Quinn on February 14.

The bill will not take effect until June 1, 2011, which will give the General Assembly time to address the concerns raised by physician groups including ICEP, ISMS, and the coalition of hospital-based specialties.

A hearing was held on March 1 by the Senate Insurance Committee on the out-of-network issue. ICEP Government Affairs Committee Chair Mark E. Cichon, DO, FACEP and Dino Rumoro, DO, FACEP testified before the Committee to urge an amendment to HB 5085.

ICEP and the coalition continue to work on alternate language for the trailer bill, SB 72, that will be acceptable as a compromise by all parties and the legislative sponsors. SB 72, introduced by Sen. William Haine (D-Alton), Chair of the Senate Insurance Committee, addresses the adjudication of insurance claims submitted by non-contracted hospital-based physicians.

Under the bill, the insurer would be required to pay the billed charges within 30 days, negotiate agreed charges with the physician, or file for arbitration. If the insurer fails to file for arbitration within 45 days of the EOB, then the insurer is responsible for paying the billed charge minus co-pays and/or deductibles.

ICEP has already voiced concerns with SB 72, primarily that insurers will drag out paying the claims and the physicians will be greatly delayed in getting paid for services they already provided. ICEP has suggested alternate language such as the de minimis clause.

Reimbursement, Coding Updated for 2011

Michael A. Granovsky, MD, FACEP
Member, ACEP Coding and Nomenclature Advisory Committee; President, Medical Reimbursement Systems (MRSI)

The Centers for Medicare and Medicaid Services (CMS) issued the Medicare Physician Fee Schedule Final Rule Nov. 2, 2010, which implements aspects of the Patient Protection and Affordable Care Act of 2010, as well as the Health Care and Education Reconciliation Act.

The 2011 Medicare Physician Fee Schedule final rule also updates payment rates for physician services beginning with dates of service Jan. 1, 2011 and contains a significant decrease in physician rates with a Medicare Conversion Factor (Medicare's Reimbursement per RVU) of $25.5217 — a 30% cut to current rates.

Emergency physicians entered 2010 facing a 21.6% decrease to the conversion factor. What followed were a series of small Congressional "patches" that forestalled the severe cuts for only several months at a time, creating great physician uncertainty. On Dec. 19, 2009, the congress passed, via the Department of Defense Appropriations Act, a 2-month freeze to the Medicare physician fee schedule effective from Jan. 1, 2010 through Feb. 28, 2010, thus preserving physician reimbursement at current levels and saving us from the 21% cut.

Two additional patches (the March 2 Temporary Extension Act of 2010 and the April 15 2010 Continuing Extension Act) extended relief from the impending reduction through May 31, 2010. Emergency physicians then received a small increase through the June 25 Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act, which provided for a 2.2 % increase to the conversion factor effective for dates of service June 1, 2010 through Nov. 30, 2010; the conversion factor for services furnished during this time period was $36.8729.

On Dec. 15, President Obama signed a 1-year pay fix into law. The law will eliminate the scheduled deep fee-schedule cut and instead keep Medicare physician fees at their current rate throughout 2011.

Several other factors will impact emergency physician reimbursement for 2011. Adjustments to the Medicare Economic Index (MEI) related to changing the base year from 2000 to 2006 have been updated to reflect changes in prices of goods and services physicians purchase to run their practices and will have a negative impact on emergency medicine of roughly 3%. Practice expense values for 2011 represent year two of a four-year transition to the new practice expense survey data, which will contribute a 0.5% increase to emergency department reimbursement.

Additionally, the timeline for submitting claims to CMS has been significantly shortened. CMS has reduced the maximum time for claim submission from 27 months to 12 months, as mandated by the Patient Protection Act.

Name Change for Physician Quality Program
CMS has changed the name of the PQRI program to "Physician Quality Reporting System" (PQRS) and continues expanding the program and making it more permanent. The new law extends the program through 2014. Payment bonuses to eligible professionals will equal 1% of estimated total allowed fee schedule services for 2011 and .05% for 2012-2014. In 2015, the payment is replaced by a penalty of 1.5% for not meeting the reporting requirements, which increases to 2% for 2016 and beyond.

Significant changes to ED-appropriate measures are not anticipated for 2011. Final measures and specifications (when available) can be viewed at www.cms.gov/pqri. CMS will proceed with developing a "Physician Compare Website," which will provide data on providers who satisfactorily participate in the 2011 PQRS program.

CPT Changes for 2011
The American Medical Association's annual update of the Current Procedural Terminology (CPT) codes and descriptions was also recently released and is effective for dates of service Jan. 1, 2011.

For all new codes mentioned below and their complete descriptions, please log on to: www.acep.org/Content.aspx?id=75242.

Beginning in 2011, emergency physicians will have a new option when reporting the middle day(s) of observation for stays that transcend 3 or more calendar days. This new code set is designated as "subsequent observation care" and is further delineated based on low, moderate, and high complexity as well as escalating documentation requirements.

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News You Can Use from CMS

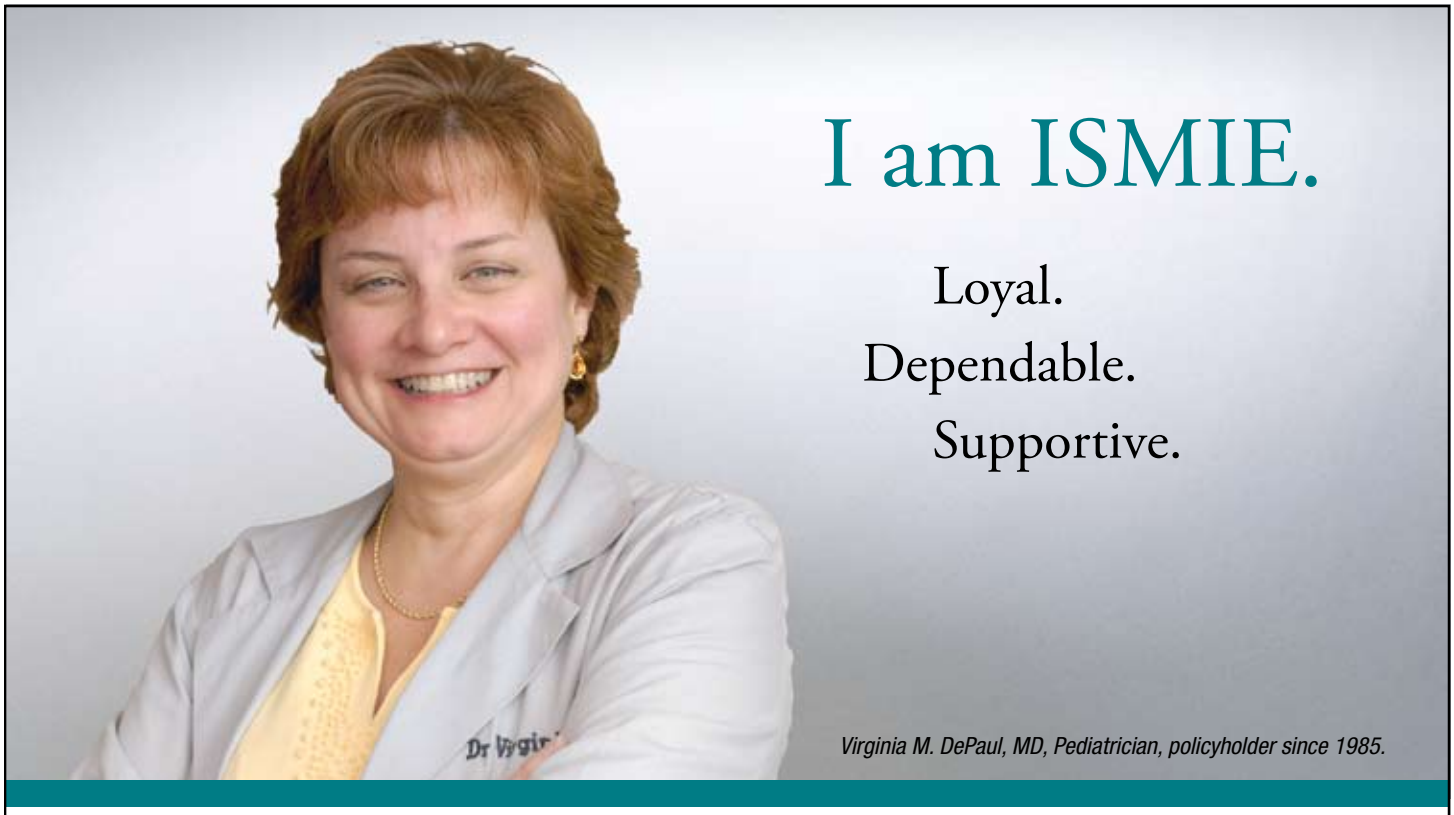
It's a mixed bag of news from CMS, some good, some not so good. Let's start with the beneficial stuff. Back in 2009, CMS published a document called "Hospital Anesthesia Services Interpretive Guidelines." This document had serious negative repercussions on the many emergency physicians (EPs) who utilized Propofol (AKA "milk of amnesia") for procedural sedation in the ED. CMS defined Propofol as a drug for deep sedation only, therefore excluding its use by EPs without the attendance of an anesthesiologist.

After a successful combined lobbying effort by ACEP, AAEM, and ENA, an exception was granted for Propofol use in the ED by EPs. CMS will now require hospitals to have anesthesia and moderate sedation policies approved by appropriate certifying bodies (including ACEP's), that may be different for the OR and the ED.

On a less cheerful topic, the combination of an 8% reduction in the Medicare Conversion Factor for 2011, along with only small increases in emergency medicine RVUs relative to other specialties, will result in 2-3% decreases in the reimbursed amounts for ED evaluation and management codes 99281-99285.

Also of note, the global period for simple suture repair (which make up the vast majority of ED suturing) has been reduced from 10 days to zero days. That means follow-up visits for wound checks and suture removals can be billed. That will help to make up for the lower reimbursement for the same suturing in 2011. You didn't think it wouldn't come with a downside, did you?

— George Hossfeld, MD, FACEP
Practice Management Committee



As a policyholder, I appreciate that ISMIE Mutual Insurance Company has remained true to its promise to protect Illinois physicians and their practices – in good times and bad. Founded, owned and managed by physician policyholders, ISMIE works to keep our reputations and livelihoods intact.

ISMIE Mutual has continuously insured all specialties throughout Illinois since 1976. Policyholders know they can depend on us to remain committed to them not only as their professional liability insurance company, but also as an advocate and partner.

Depend on ISMIE for your medical liability protection – so you can focus on the reason you became a physician: to provide the best patient care possible.

Not an ISMIE Mutual policyholder and interested in obtaining a comparison quote for your medical liability coverage? Contact our Underwriting Division at 800-782-4767, ext. 3350, or e-mail us at underwriting@ismie.com. Visit our web site at www.ismie.com.

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Simulation Skills Lab Set for 3 Course Dates in 2011

ICEP and NorthShore University HealthSystem will continue to partner to present three Emergent Procedures Simulation Skills Lab courses in 2011 at Evanston Hospital.

The 2011 course dates are:

- Friday, April 29
- Friday, August 12
- Friday, November 4

The inaugural course was held in November 2010 and garnered rave reviews from the 30 participants in attendance.

"What a great experience this was," said course participant Bruce McNulty, MD, of Swedish Covenant Hospital in Chicago. "The facility was great, the faculty was amazing, and the ratio of faculty to students made this truly hands-on in a way I have never experienced before."

The Emergent Procedures program focuses on critical skills for the critical-care environment. The one-day course demonstrates and allows physicians to practice procedures that are seldom performed day-to-day in the emergency department because their clinical presentation is rare.

Among the topics and procedures covered are: Transvenous Pacemakers for symptomatic bradycardia; FAST scan under ultrasound guidance; thoracostomy and chest tube insertion; cricothyrotomy; difficult airway adjuncts; and specialized obstetric and pediatric techniques.

The course provides a maximum of 10 *AMA PRA Category 1 Credits*™ and costs $545 for ICEP/ACEP members or $585 for non-member physicians.

Due to the hands-on nature of the course, space is limited. To reserve your spot, register online at ICEP.org or call 630-495-6400, ext. 200.

PRESIDENT'S LETTER

Take Action, Exercise the Right to Be Heard

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It's never too late to get involved, and not just regarding HB 5085. Soon, you will receive information highlighting potential candidates for the Board of Directors. Take the time to read their statements and exercise your right to be heard by voting for the best candidates. We need to continue to choose current and future leaders of our specialty. The strength of our Board is essential to guarantee a strong slate of officers.

As an ICEP member, you have the privilege and authority to choose your future leaders. As an organization, we are stronger when we act as a unified group and maintain an active role in our own organization. So, please take the time necessary to make well informed choices and exercise your right to be heard.

— Dino P. Rumoro, DO, FACEP
ICEP President

Reimbursement, Coding Updated for 2011

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CPT 2011 will also roll out a more specific set of extremity ultrasound codes replacing code 76880 (Ultrasound, extremity, nonvascular, real time with image documentation) with two new codes that differentiate a complete exam (76881) from a limited ultrasound exam (76882).

CPT also made significant changes to the debridement codes to achieve greater granularity. For 2011, codes 11040 (Debridement; skin, partial thickness) and11041 (Debridement; skin, full thickness) were deleted. Debridement of skin partial or full thickness must now qualify for active wound management, which is less commonly reportable by emergency physicians. New codes may be used to report more substantial debridement involving subcutaneous tissue, and additional codes are available for more extensive debridement procedures.

There are new influenza virus vaccination codes (90664-90668) for 2011 for products that represent a formulation of H1N1 vaccine in the event a new outbreak occurs prior to FDA approval for vaccine products. The codes are available for the facility to report vaccine administration.

In the emergency department setting, it is unlikely that the physician bears the cost of the vaccine, syringe and related supplies so they would be captured on the facility bill, rather than the physician's professional fee.

ICD-9 Diagnosis Codes for 2011

Effective Oct. 1 2010, several ICD-9 diagnosis codes became available that are relevant to emergency medicine. A full listing of ICD-9 additions, deletions, and change may be found at www.cdc.gov/nchs/icd/icd10cm.htm#10update.

Additional resources can be found on the reimbursement section of the ACEP website. The ACEP Coding and Nomenclature Advisory Committee, the ACEP Reimbursement Committee, and ACEP Reimbursement Department staff members David McKenzie, CAE, (dmckenzie@acep.org) and Amy Wynn (awynn@acep.org) are also available to field your questions.

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JOB OPPORTUNITIES

FOR BOARD CERTIFIED EM PHYSICIANS

A new private EM physician group for top ER doctors has partnered with a new hospital on Chicago's south side. Metro South Medical Center, formerly known as St. Francis Hospital in Blue Island, has awarded Emergency Care Physician Services (ECPS) with a 10-year EM physician-staffing contract.

ECPS is a Chicago-based, physician-owned, financially democratic Emergency Medicine group with **Full & Part-Time Positions Available Now for Board Certified EM Physicians.**

The newly renovated Emergency Department facilities of MSMC offer 30 State of the Art Medical Exam Rooms with integrated LCD televisions. 42,000 patients are evaluated annually by double to triple staff coverage, with 43 hours of physician coverage.

Base salary is $190/hr for day shifts, $200/hr for night shifts.
ECPS will provide malpractice insurance.

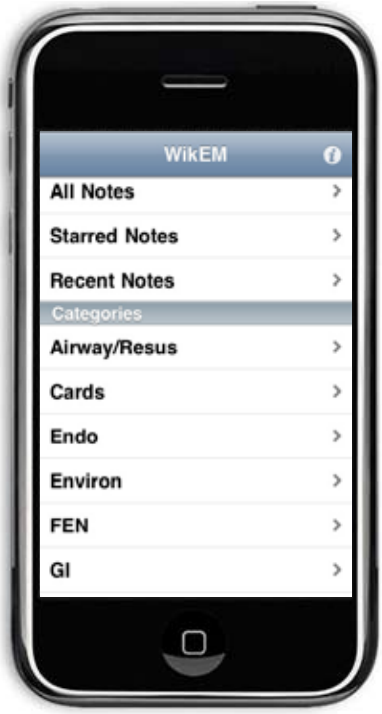
If you are interested in participating in a financially democratic EM physician group, please contact

Seth Guterman, MD FACEP
(773) 255-1236 or **sguterman@ecps.md**

More information can be obtained at **www.ecps.md**

There's an App for That? Ten Useful iPhone Apps for Emergency Medicine

Sam Ko, MD
CAL/ACEP - California Chapter of the American College of Emergency Physicians
President, CAL]EMRA, 2010-2011



Want to really make your iPhone work for you? Sure, it can handle email, contacts, your calendar, and music — but did you know it can help you practice emergency medicine, too? Check out the top 10 apps for EM as discussed by California EM resident Sam Ko, MD.

1. **WikEM –** This app from UCLA Harbor Residency is devoted to the practice of EM. The content includes IV drip concentrations, initial approach to almost every complaint, emergency imaging, and emergency procedures. Very easy to read and concise. **Cost: Free**

2. **Epocrates –** Easy to use app for drugs, pharmacology, pregnancy & lactation safety, and drug cost. A nice bonus is the pill identification tool when your patient tells you, "I take the little pink pill." **Cost: Free**

3. **Medscape –** From creators of WebMD, this app includes nearly every diagnosis and has a clinical, diagnostic, and treatment component. It's sort of like the free version of UpToDate on my iPhone, although probably not as up-to-date. **Cost: Free**

4. **Eye Handbook –** This app is focused for ophthalmologists; however, some EM applicable sections are the Eye Atlas, Testing, and Patient Education. Check out the Movies tab and download the Cheese Cartoon, an excellent distraction when calming pediatric patients or checking for extra-ocular movements. **Cost: Free**

5. **Eponyms –** Remember Takotsubo syndrome, Von Hippel-Lindau disease, or Alder's sign? This app provides a succinct description of various eponyms. A great way to remember everything you forgot from medical school. **Cost: Free**

6. **MedCalc –** It helps you calculate CURB-65 Scores, fluid repletion for burns, glomerular filtration rates (GFR), and even view a dermatome map. When you double tap an equation, it gets

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Illinois Prescription Information Library

P.I.L.

www.ilpmp.org

Have you ever suspected a patient was abusing or misusing prescription medication...

The Illinois Prescription Information Library (PIL), managed by the Prescription Monitoring Program, is a centralized online repository dedicated to preventing the misuse, abuse and diversion of controlled prescription medications.

The PIL Contains:
- Schedules II-V prescription information
- Records viewable for six months and kept on record for two years

Who submits data?
- Retail pharmacies dispensing in Illinois report on a weekly basis.

Who can access the website?
- Physicians
- Pharmacists
- Other Prescribers and Dispensers

How to access the website:
- To access the Illinois Prescription Monitoring website, visit www.ilpmp.org
- Electronic registration forms are provided on the home page.

DHS Illinois Department of Human Services

Apps for EM: A Review of Ten Useful iPhone Tools

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uploaded to your "Favorites" file for easy access. **Cost: Free**

7. **Radiology 2.0 –** Created by a radiologist and a medical student, this app's subtitle is "One Night in the ED." It has clear CT scan images of small bowel obstruction, aortic injury, appendicitis, and more. You can even quiz yourself by hiding the answers. Once you review the scans, go to the discussion section and read the explanations. **Cost: Free**

8. **Diagnosaurus –** This app is useful when you want to expand your differential list. All entries are organized by symptom, disease, or organ system. For frequently viewed entries, simply click the star in the bottom right hand corner to add to your Favorites. **Cost: $0.99**

9. **PediStat –** When working with critical pediatric patients, it can be difficult to remember drugs dosages, tube sizes, and normal vital signs. Simply plug in the weight, age, length/height, or Broselow Color on the first page. You will now have accurate dosing information to resuscitate your patient. **Cost: $2.99**

10. **EMRA Antibiotic Guide 2011 –** You may have the hard copy version but if you want to unload your pockets, you must download this app. This amazing guide has antibiotic recommendations based upon organism, diagnosis, and organ system. This version also has a dosing calculator to make your life easier! **Cost: $15.99**

All apps mentioned above can be downloaded (and purchased, where applicable) from iTunes.

This article was originally published in the January 2011 of Lifeline, the magazine of the California Chapter of the American College of Emergency Physicians (CAL/ACEP). Reprinted with Permission.

Emergency Medicine Action Fund Announced

Nancy Calaway
ACEP Communications Manager

With changes in the health care system already underway, a new initiative is looking to positively impact the regulations that will be written and implemented under the reform.

The Emergency Medicine Action Fund, launched by ACEP in February, will pool contributions from individual emergency physicians and groups, chapters, and anyone else interested in advancing emergency care to provide financial support for advocacy activities in the regulatory arena.

The Emergency Medicine Action Fund will pursue a regulatory agenda that supports emergency physicians and quality emergency care. For example, evolving practice models and demonstration projects, such as accountable care organizations and bundled payments, are two areas of the Patient Protection and Affordable Care Act where the Action Fund might be able to wield some influence.

Organizations that have been invited to designate representatives to the initial Board of Governors are: American Academy of Emergency Medicine, Association of Academic Chairs of Emergency Medicine, American College of Osteopathic Emergency Physicians, Emergency Department Practice Management Association, Emergency Medicine Residents' Association, and Society for Academic Emergency Medicine.

One of the unique features of the Emergency Medicine Action Fund is that chapters can band together to form coalitions that would be eligible to have a seat on the Board of Governors. Or chapters can organize individuals and groups in their states for collective representation. The first 10 groups of contributors at $100,000 will be granted seats on the Action Fund's Board of Governors.

The Emergency Medicine Action Fund is modeled on a successful initiative by EM groups in California that has raised several million dollars for state advocacy since 2004. Wes Fields, chair of tthat initiative, has been appointed by ACEP President Sandra Schneider, MD, FACEP as the founding chair of the national Action Fund.

CEP America, the nation's largest emergency medical partnership, will be the inaugural donor to the Emergency Medicine Action Fund, pledging $100,000.

NEMPAC, ACEP's National Emergency Medicine Political Action Committee, gives contributions to candidates who have listened to the needs of emergency medicine and made a positive change. However, NEMPAC may be used only to support candidates.

The Action Fund can enhance regulatory advocacy with policy makers to ensure emergency physicians receive fair payment for their services. It can also fund numerous meetings with regulators to help guarantee patients receive the best care, and provide funding for studies to demonstrate the value of emergency medicine.

"With the new Congressional session upon us, it is as important as ever to be active on both the legislative and regulatory fronts," Dr. Schneider said. "We will depend on all of these funds to make our case. This will be the year we ask everyone to dig a little deeper. In these challenging times, we need contributions to both the Action Fund and NEMPAC."

Find out more about the Emergency Medicine Action Fund at www.acep.org/EMActionFund.

How is the Emergency Medicine Action Fund Different from NEMPAC?

	NEMPAC	EM Action Fund
Gives campaign contributions to Congressional candidates	YES	
Funds meetings with regulators and policy makers		YES
Enhances emergency medicine advocacy efforts	YES	YES

March Designated Poison Prevention Month in Illinois: Get Involved with IPC

Year after year, millions of accidental poisonings occur in America — the majority of them affecting children. Last year, the Illinois Poison Center (IPC) handled more than 90,000 exposure and information calls – 52 percent involving children – on everything from household products and cosmetics to medicines and insect bites.

With the IPC's help, approximately 90 percent of poisoning cases are safely and effectively treated at the site of the poisoning, saving an estimated $50 million annually in unnecessary visits to a doctor's office or a hospital emergency department.

Each year, the third week in March is recognized as National Poison Prevention Week.

However, in 2009, Gov. Pat Quinn declared the entire month of March as Illinois Poison Prevention Month in observance of the importance of this vital health awareness initiative.

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Physicians are encouraged to let patients and their families know — during the month of March and every day— that the poison center can be reached 24 hours a day via a toll-free phone number, 1-800-222-1222 .

Quick and Easy Ways to Get Involved:

- Order and distribute IPC Stickers in your emergency department and community.
- Take IPC's free online Poison Prevention Education Course (takes about 15 minutes) and encourage patients and their family members to do the same.
- Order a complimentary packet full of poison prevention information for a patient or for your emergency department.
- More activities and details available on IPC's website at www.illinoispoisoncenter.org/IPPM_2011

This year, the IPC is revealing its new interactive website just in time for Illinois Poison Prevention Month. New and exciting features include: a comprehensive resource library, interactive games, an online store full of educational items, access to free educational and training materials for health care professionals and other educators, and much more. Log on to www.illinoispoisoncenter.org to explore this revamped resource.

If you would like more information about how your emergency department can get involved during Illinois Poison Prevention Month, please contact Veronica Valentin-Redmond, Illinois Poison Center, at 312.906.6139 or email vredmond@ilpoison.org.

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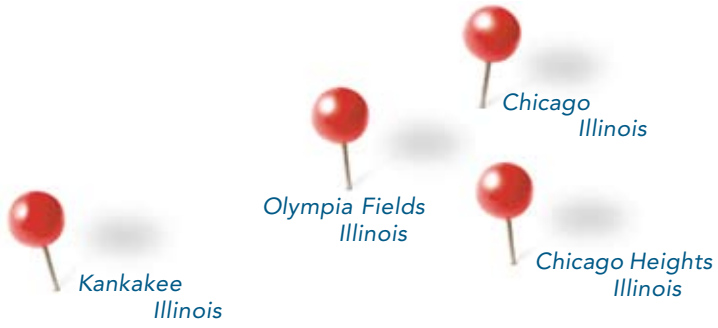

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Fish Poisoning and Envenomation By Marine Organisms In and Around the U.S

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Background[1-4]
Humans can be exposed to various marine toxins through the consumption of certain seafood or via envenomation by certain marine organisms (e.g., some species of jellyfish, sea urchins, and lionfish). The United States has more than 80,000 miles of coastline and activities such as diving, snorkeling, and surfing continue to rise in popularity. As people engage in water sports and activities, the incidence of marine toxin poisonings and envenomations becomes more likely.

Fish Poisoning
Poisonings due to eating certain seafood are more common during the warmer months ("non-R" months: May-August) because warmer conditions favor the growth of toxin producing dinoflaggelates.[2] Larger marine organisms bioconcentrate the toxins in their flesh and sicken humans when they are consumed.

787 poisoning cases associated with seafood consumption were reported to the U.S. Poison Control Centers in 2008.[5] This statistic may be a gross underestimate due to the fact that patients may not call the Poison Control Center; healthcare professionals are not required to report such poisonings; and many milder cases may go undiagnosed.[1]

Most fish poisonings in the U.S. are due to exposure to the following[1-2, 6, 9-10]: Amnesic shellfish; buffalo fish; Ciguatera; neurotoxic shellfish; paralytic shellfish; scombroid; and tetrodotoxin.

Table 1 (see page 14) describes the fish toxins, most common sources, signs and symptoms, and treatment of the poisoned patient.

Stings and Envenomations[3,5,15]
Envenomation by marine organisms is another way humans are exposed to marine toxins. Stingray, jellyfish, and sea urchin stings are the most widespread marine envenomations in the United States. Most commonly, people get stung by the lionfish when attempting to handle these fish in home aquariums. In 2008, United States Poison Control Centers received 2,144 calls regarding aquatic stings and envenomations.

Table 2 (see Page 14) describes four most common marine envenomations: stingray, jellyfish, sea urchin, and lionfish[3,15]

Professional Assistance
Although uncommon, the Illinois Poison Center has been consulted on cases of fish poisonings such as scombroid from restaurant-served mahi mahi, ciguatera from restaurant-served grouper, tetrodotoxin from puffer fish sold as monk fish,

■ CONTINUED ON PAGE 13

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Fish Poisoning and Envenomation By Marine Organisms In and Around the United States

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and Haff disease from buffalo fish caught in the Mississippi river. Additionally, physicians' offices and patients in Illinois have called seeking advice for treatment of various fish stings that took place while on vacation.

Remember, that the Poison Control Center Hotline 1-800-222-1222 is a national number. When dialed the caller is routed to the nearest Poison Center, so in Illinois callers will be directed to the IPC. If in Florida, callers are directed to one of three Regional Poison centers located in that state. Therefore, keep this number handy; it is portable and can provide immediate access to professional help regardless if you are at home, at work, or on vacation.

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■ CONTINUED ON PAGE 14

Table 1: Sources, Symptoms, and Treatment of Fish Toxin Ingestions

	Toxin	Sources	Signs/Symptoms	Onset	Treatment
AMNESIC SHELLFISH [2, 9-10]	Domoic acid	Mussels	N/V/D; headache; dizziness; short term memory loss; labile blood pressure; cardiac dysrhythmias. In severe cases: seizures, paralysis, coma	5 hrs post-ingestion; may range from 15 min to 38 hrs.	Symptomatic/supportive
BUFFALO FISH [2,7-8, 11-12] *(Ictiobus cyprinellus)*	Unidentified	Buffalo fish; possibly crawfish caught in Mississippi River or tributaries	Haff disease, i.e., unexplained rhabdomyolysis accompanied by: muscle tenderness/rigidity, myoglobinuria	6 – 21 hours after ingestion	Supportive. Early hydration is crucial to prevent renal injury.
CIGUATERA [1,2,6,13]	Ciguatoxin	Tropical reef fish: barracuda, grouper. sea bass, snapper, mullet. Particularly, fish caught on reefs in: Florida, Hawaii, Guam, South Pacific Islands, Virgin Islands, Puerto Rico.	*1-6 hours post-ingestion:* N/V/D, abdominal pain, headache. *6-12 hours post-ingestion:* hot-cold sensory reversal, "pins-and-needles" sensation, weakness, itching, dizziness, metallic taste, bradycardia, blurred vision. *>12 hours post-ingestion:* weakness, coordination difficulty, hypotension, possible respiratory complications. Symptoms usually clear completely within 1-4 weeks.	30 min to 30 hrs after ingestion; may last up to 6 hours after onset.	Symptomatic/supportive: fluid and electrolyte replacement; atropine for bradycardia; vasopressors for hypotension; antihistamines for relief of pruritus; benzodiazepines for seizures

Table 1 continued on Page 14 ▶

Table 2: Sources, Symptoms and Treatment of Marine Envenomations

	Common Species	Common Habitats	Symptoms	Treatment
STINGRAY	Dasyatis Americana; Urolophus halleri; a total of 11 different species (7 in the Atlantic Ocean and 4 in the Pacific Ocean) can be found in the U.S. coastal waters.	Southeastern United States; U.S. West coast	Extreme pain (often disproportionate to the appearance of the wound); edema; erythema; cyanosis; petechiae which may progress to ulceration and tissue necrosis. If toxin is absorbed systemically: weakness; N/V/D; headache; vertigo; muscle cramps; hypotension; cardiac dysrhythmias Symptoms peak after 30-90 min and may persist for up to 2 days.	Wound care; oral/parenteral analgesics; elevate extremity to minimize edema; tetanus prophylaxis if necessary; antibiotic therapy may be indicated in some cases Note: Observe patients for 3-4 hours to rule out systemic symptoms
JELLYFISH	Sea nettle (C. quinquecirrha); Lion's mane or hair jelly (C. capillata); Mauve stinger or purple-striped jelly (P. noctiluca); Cabbage head or cannonball jelly (S. meleagris); Thimble jelly (L. unguiculata) causes sea bathers eruption (SBE)	Chesapeake Bay, temperate and tropical waters; Northwest U.S. coast;; Caribbean; Gulf of Mexico, Caribbean; Florida, Caribbean	Usually limited to local severe pain. Note: Although common in the U.S. and Caribbean waters, jellyfish envenomations in these regions are rarely deadly.	If the patient was stung along the US coastline: Apply sea water for 30 seconds; remove the tentacles by gently scraping the area with an edge of a credit card or other blunt straight-edged tool. Note: Vinegar application should be avoided since it may enhance *C. quinquecirrha* and *C. capillata* nematocyst discharge. Hot water is ineffective and may worsen pain.
LIONFISH	Pterois volitan or Pterois lunulata	Home aquariums; coast of Florida to North Carolina. Natural habitat is Indo-Pacific region.	Pain; swelling; numbness; nausea; joint pain	Submersion of the affected part in water as hot as the patient can tolerate for 30-90 minutes; removal of spines; analgesics for pain
SEA URCHIN		Found in oceans all around the world; common in marine aquariums.	Most commonly limited to: local intense burning; edema; erythema	Submersion of the affected part in hot water (105-115°F; 40.6-46.1°C; administration of oral analgesics; radiographic evaluation and foreign body extraction for puncture wounds; tetanus prophylaxis if needed; antibiotic prophylaxis may be indicated in some situations.

Fish Poisoning and Envenomation By Marine Organisms In and Around the United States

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Table 1: Sources, Symptoms, and Treatment of Fish Toxin Ingestions

	Toxin	Sources	Signs/Symptoms	Onset	Treatment
NEUROTOXIC SHELLFISH [1-2,11]	Brevetoxin	Mussels, clams, and oysters caught in the Gulf of Mexico and along the Atlantic coastline of the southern states	GI distress; paresthesias; dysphagia; hot-cold sensory reversal; vertigo; ataxia; malaise; bradycardia; paralysis does not occur. If exposure to toxin is via aerosol route, respiratory irritation, cough, and bronchospasm may occur.	Usually within 3 hours; may range from 15 min to 18 hrs. Duration of symptoms up to 72 hours.	Symptomatic/supportive. Poisoning is rarely fatal.
PARALYTIC SHELLFISH [1-2,6,11]	Saxitoxin (produced by *Gonyalaux spp.* dinoflaggelates)	Fish living in colder waters of the Pacific states and New England. May also concentrate in: mussels, clams, scallops, oysters, cockles, lobsters, crabs.	Numbness/tingling of the lips, tongue, fingertips and possibly the extremities and neck; dizziness; headache; muscle weakness; sensation of floating; N/V/D. In severe cases, muscle paralysis and respiratory arrest can lead to death in 2-25 hours if left untreated.	Usually within 2 hours, but may be 15 minutes to 10 hours post-ingestion	Symptomatic/supportive. Activated charcoal if potentially life-threatening ingestion, the patient is conscious and able to protect the airway, AND the ingestion has been ≤1 hour ago.
SCOMBROID [1-2,6,14]	Histidine ↓ Histamine	Tuna, mackerel, amber jack, skipjack, bonito, mahi mahi, salmon, dolphin fish	Rash; flushing; sweating; diarrhea; vomiting; headache; swelling/burning of the mouth. Symptoms may be more severe in patients on certain medications (e.g., isoniazid, doxycycline)	2 min - 2 hrs following ingestion of spoiled fish	In most cases, symptoms resolve within few hours and no treatment is necessary. Supportive therapy: diphenhydramine; albuterol for bronchospasms; H2 blockers (e.g. cimetidine) if patient is refractory to other therapy; vasopressors (norepinephrine, dopamine); IV fluids if patient is hypotensive/dehydrated
TETRODOTOXIN [1-2,6,14]	Tetrodotoxin (aka TTX)	Puffer fish (fugu), blow fish, horseshoe crab eggs, starfish, Harlequin frog, xanthid crab, some species of newts (e.g., *Taricha granulosa*)	Vomiting; diarrhea; vertigo; dizziness; headache; blurry vision; hypotension; hypothermia; bradycardia; resp. depression/paralysis; paresthesias (particularly perio-oral); generalized weakness in the extremities (with ascending onset); seizures are rare	Minutes to hours. Death may occur within 6-24 hours; prognosis is good if patient survives the first 24 hours.	Symptomatic/supportive: assisted ventilation when needed; vasopressors for hypotension; atropine for bradycardia; hydration; benzodiazepines or phenobarbital for seizures

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April 6, 2011
ICEP EMS Committee Meeting
10:30 AM - 2:30 PM
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April 6, 2011
EMS Forum
1:00 PM - 3:00 PM
ICEP Conference Center
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