Volume 27, Issue 1 **Spring 2018**

EMpulse

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

The 2018 Indiana ACEP Conference will be held at:

The Ritz Charles
Carmel

April 25 & 26, 2018

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Inside this Issue

A View from the Top - Happy 50th ACEP

Gina Huhnke, MD, FACEP (INACEP President)

Hard to believe that this year marks the 50th anniversary of ACEP. I have only had the privilege of witnessing half of that transformation but testify to the fact that a lot has changed in my tenure. Members of the same specialties who rely on us today to care for their patients once berated the pioneers of Emergency Medicine for abandoning lucrative private practices and venturing into an unknown territory. Thanks to those adventurous warriors, the specialty of Emergency Medicine has become the backbone and safety net of America's healthcare system today. Emergency Medicine physicians are experts in the arts of triage, resuscitation, recognition, and navigation of every imaginable illness and injury. Mark your calendars for the INACEP Annual Conference in April and Scientific Assembly in September to join us in the celebration.

On the home front, INACEP members have been fighting for Indiana EM physicians and their patients. INACEP members recently joined members of the Indiana Legislature and Senate Health Committee to discuss important issues ranging from ways to combat the opioid epidemic to third party payer denials. The meeting was well-received and helped shape the minds of our decision makers in Indiana.

EM physicians across the country have done a commendable job caring for the high volume of acutely ill patients during this record-breaking influenza season by being flexible and innovative with their resources. Thank you for caring for anyone, anytime, anywhere.

Here are a few important updates regarding activities from INACEP:

1. The integration of INSPECT data into EMR will be funded by State funds with a plan to be incorporated in the next three years. Many EDs are adopting opioid prescribing policies. Opioid resources are available at: www.acep.org/opioids or the Indiana State Department of Health: www.in.gov/isdh

2. Third Party payer denials for ED visits are on the rise. INACEP has addressed some of these issues with local insurance providers. Help us demand fair coverage for our patients. If you have a personal story to share regarding a payer denial which violates prudent layperson definition please help wage the fight against dangerous policies by logging on to: www.faircoverage.org

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Legislative Update

by Lou Belch, Lobbyist for INACEP

As this article is being written the General Assembly has reached the half way point. Starting February 12, the Senate will begin hearing House bills and the House, Senate bills. Understand that the legislative process is fluid, so what is written here is only accurate on the day it is written. The INACEP Board is updated frequently during the session and will act in the best interest of emergency medicine.

The bills being tracked that are of interest to INACEP are:

SB 208: The bill prohibits hospitals from denying staff or admitting privileges to a physician solely for not participating in maintenance of certification. It also prohibits insurance companies from denying payment or participation in a network solely for failure to participate in maintenance of certification. The bill has passed the Senate and is awaiting further action in the House.

SB 221: Beginning 1-1-19 providers who provider services to a patient in the ED of a hospital or pain management clinic must query INSPECT prior to prescribing an opioid or a benzodiazepine to a patient. Other practice settings will begin on January 1, 2020 and January 1, 2021. This will only take place if the INSPECT program is interoperable with the electronic health record. The bill has passed the Senate and is awaiting further action in the House.

SB 225 requires holders of CSRs to obtain 2 hours of continuing medical education in the area of opioid prescribing prior to renewal of the CSR. This will expire July 1, 2026. The bill has passed the Senate and is awaiting further action in the House.

HB 1119: Amends the Physician Order for Scope of Treatment (POST) law to clarify that the form does not need to be fully completed in order to honor the Orders that are completed. (If the patient only completes the DNR section, and it is signed by the physician, it is enforceable even if they have made no other decision.) The bill also creates a hierarchy for consent if the patient is unable to express their own wishes. Lindsay Weaver MD, FACEP testified in support of the bill in the House Public Health Committee. The bill has passed the House and is awaiting further action in the Senate.

Again, please note that none of these bills are law yet. There are still 6 weeks left of the legislative session and things could change. *EMpulse* will publish a final action by the legislature in the next issue.

Conference Update

by Chris Ross, INACEP Vice President & Education Director

The 2018 INACEP conference will be here sooner than you think, and …it's going to be awesome! The first day will feature Howie Mell doing a live podcast, Jen Walthall trailblazing a path of intervention for the opioid crisis in Indiana and Ed Leap unveiling the "physician satisfaction score" amongst many other exciting topics. We'll follow up on the second day with Houston-native Casey Patrick giving a first-hand account of EMS activities during a hurricane. The second day will then close with a repeat performance of the well-received US skills lab. Between "MacGuyvering in the ED" and discussing "broken-hearted" kids, I promise you'll be entertained!

This year's conference will also pilot several changes in an effort to keep you on your toes. First, most of the lectures will only be a half hour in length. This has been successful at the national ACEP conference, so we thought we would give it a shot. Second, the lectures will only be available online. In an effort to cut costs and be eco-friendly, we will no longer be printing off or distributing handbooks or thumb-drives. Access will be available for attendees via our website, inacep.org.

I hope to see you all at the Ritz Carlton in Carmel on April 25-26th. Registration is online at inacep.org. Again, it will be open to all levels of training including RNs, APPs or really anyone interested in Emergency Medicine. It should be a great time!

2018 Conference Agenda

Day 1 – Wednesday, April 25

7:00 - 8:00am	***Registration***
8:00 – 8:30am	***Broken Hearted . . . Child with Repaired Congenital Heart Disease*** • Elizabeth Weinstein MD, FACEP
8:30 - 9:00am	***EM "Macguyvering"*** • Joshua Mugele MD
9:00 - 10:00am	***Swimming in Quicksand; What Emergency Physicians Can Learn from Fighter Pilots, Marines, and the Architect of Shock and Awe*** • Howard Mell MD, FACEP
10:00 -10:15am	***Break***
10:15-10:45am	***Advances in Emergency Psychiatric Care*** • Paul Kivela MD, FACEP
10:45-11:45am	***Emergency Medicine and the Opiate Epidemic . . .*** • Jennifer Walthall MD, FACEP
11:45-12:15pm	***EMS Updates Andrew Stevens MD***
12:15-1:30pm	***Lunch – Annual Meeting***
1:30 - 2:00pm	***What's Your Physician Satisfaction Score?*** • Edwin Leap MD, FACEP
2:00 - 2:20pm	***Break***
2:20 - 2:50pm	***"So What?' Live" - An ACEP Podcast*** • Howard Mell MD, FACEP
2:50 - 3:20pm	***Trends in Emergency Medicine*** • Paul Kivela MD, FACEP
3:20 - 3:40pm	***Break***
3:40 - 4:10pm	***Evidence-Based Practice Changers*** • Bart Besinger MD, FACEP
4:10 - 4:40pm	***Impacting EM through Quality Feedback*** • Joseph Turner MD, FACEP
4:40 - 5:10pm	***Critical Access Survival Tips*** • Edwin Leap MD, FACEP

Day 2 – Thursday, April 26

7:00 - 8:00am	***Community Medicine Breakfast and Case Sharing***
8:00 - 8:30am	***Dying to Lose – Complications of Bariatric Surgery*** • Joseph Martinez MD,FACEP
8:30 - 9:00am	***My Patient with Abdominal Pain Has a Normal CT*** • Joseph Martinez MD, FACEP
9:00 - 10:00am	***Useful Without My Tools – My Hurricane Harvey Experience*** • Casey Patrick MD
10:00-10:30am	***Unconscious Bias in Your Workplace*** • Katie Pettit MD
10:30-10:45am	***Break***
10:45-12:15pm	***Ultrasound Guided Nerve Blocks*** • Robert Blankenship MD, FACEP & Bart Brown MD, FACEP

REGISTRATION FORM

WE ARE GOING PAPERLESS

Although you can use this form to register by check, we highly recommend registering online to make it easier for you to download conference materials. (We will have electrical plugs for computers at event.)

46TH Annual Indiana ACEP Emergency Medicine Conference

Wednesday & Thursday, April 25 & 26, 2018

Name: _____ ACEP # *(if member):* _____

Title/Position: _____ Hospital Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Fax: _____

Your confirmation/receipt will be emailed to you.

2-DAY REGISTRATION

Please check all that apply:

ACEP Member Physician	$325 ❑
Non-ACEP Member Physician	$375 ❑
PA/RN/LPN/NP/Paramedic	$200 ❑
Residents/Interns: *separate form will be sent*	
Medical Student	$20 ❑
Late fee if received after 4/3/18	$25 ❑
TOTAL	_____

Paying by credit card, go to **inacep.org**

1-DAY REGISTRATION

Please check all that apply:

	WEDNESDAY	OR **THURSDAY**
ACEP Member Physician	$200 ❑	$160 ❑
Non-ACEP Member Physician	$230 ❑	$180 ❑
PA/RN/LPN/NP/Paramedic	$140 ❑	$100 ❑
Residents/Interns: *separate form will be sent*		
Medical Student	$10 ❑	$10 ❑
Late fee if received after 4/3/18	$25 ❑	$25 ❑
TOTAL	_____	_____

Paying by credit card, go to **inacep.org**

LOCATION OF CONFERENCE:

Ritz Charles Banquet Facility
12156 N. Meridian St.
Carmel, IN 46032

LODGING: A block of rooms has been reserved at the
Renaissance Indianapolis NORTH Hotel
11925 N. Meridian St.
Carmel, IN 46032

Group rate of $169.00 per night. This hotel is located across the street from the Ritz Charles. To reserve your room please call the Renaissance Hotel call directly at 317-816-0777. Identify the group as American College of Emergency Physicians - Indiana Chapter"

For a list of other hotels in the area, please contact Sue at sue@inacep.org.

PARKING: Free at both Hotel and Banquet Facility

CANCELLATION POLICY:

A full refund will be given, provided cancellation is received by April 3, 2018. A processing fee of $20.00 will be charged for cancellations received after this date. No Shows will be charged full registration amount.

INACEP reserves the right to conduct its courses based on minimum enrollment. Should cancellation be necessary, it will be done not less than 10 days prior to the course date and each registrant will be notified by email or fax and a full refund following. The Indiana Chapter of American College of Emergency Physicians is not responsible for any cost incurred due to cancellation of a program, such as airline or hotel penalties.

Please make your check payable and mail to:
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HOTEL WILL ONLY HOLD ROOMS THROUGH APRIL 3, 2018, SO PLEASE REGISTER EARLY!

Case Report: Cosmetic Outcome of a Scalp Laceration Using the Hair Apposition Technique

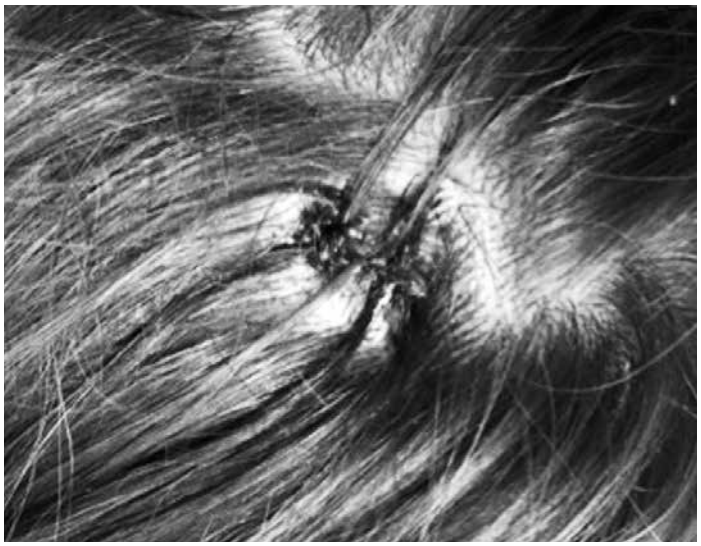
by Brian Sloan, MD, Molly Knecht, MSIII

A 28-year-old patient suffered a 3cm long, 3mm wide laceration to the scalp while enjoying an afternoon out on the lake with her family. After examining the wound and consulting a physician via phone call, it was determined that a trip to the ED and a large hospital bill could be avoided by using a simple wound approximation technique.

Wound pre suture (Figure 1)

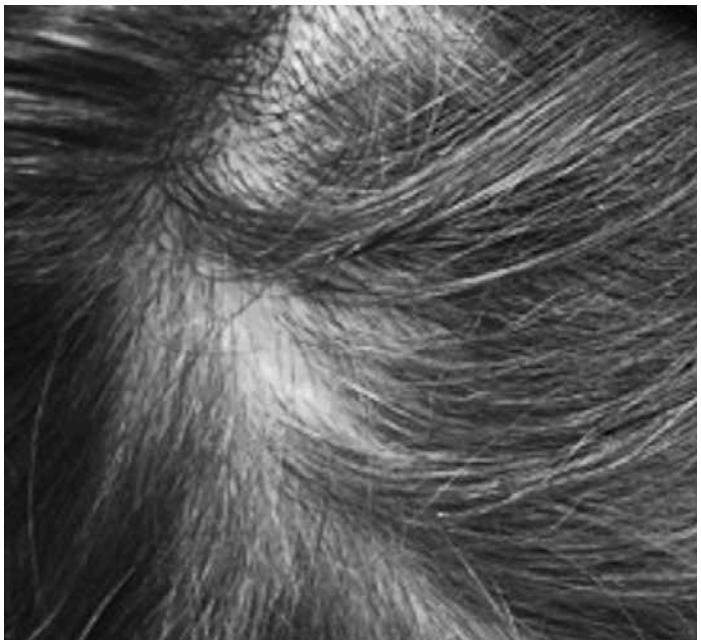
Wound Management

After ensuring that the patient was cognitively intact and that there was no further neurological damage done, proper care was taken to examine and cleanse the wound while separating the hair away from the laceration. Three pieces of hair (about 10-15 strands thick) were gathered on each side of the wound, evenly spaced over the length of the cut. The procedure was initiated by gathering two bundles on opposite sides of the wound, tying one under the other and pulling tightly. While keeping this pulled tight, another knot was performed using the same two pieces. To hold the knot in place, 2-3 drops of store bought super glue (main ingredient: ethyl cyanoacrylate) were placed on the knot. This process was repeated for the next two stitches until both edges of the wound were approximated.



Wound post suture (Figure 2)

This image displays the 3 hair piece stitches after the super glue had dried.



Wound 22 days' post trauma (Figure 3)

The patient's hair had grown out enough, allowing for removal of the glue and attached hair. A visible scar remains but it is apparent that the scalp has healed back together nicely.

Discussion

Lacerations make up approximately 4.4% of all emergency department (ED) visits. Approximately 12 million lacerations are managed in US emergency departments at a cost of $3 billion dollars per year. The hair apposition technique (HAT) is a viable alternative to sutures, staples, wound glue, and healing by secondary intention in appropriate cases.

The main goals of proper wound management include the avoidance of infection, aid in hemostasis, and assistance for the development of a healed scar. Traditionally, after a wound has been properly cared for, including the removal of any foreign debris and cleansed with water and an antibiotic, a small laceration of this size is approximated with staples or sutures. Staples can be an invasive and potentially painful method that meets the desired outcome in an easy and efficient manner. Sutures, on the other hand, require a greater amount of time, skill, and materials to complete, but can be used to eliminate pockets where tissue, fluid, or blood can accumulate when the cut penetrates more deeply. Typically, the material used for staples and sutures will then require an additional visit for their removal.

The hair apposition technique (HAT) has been used in wilderness and emergency medicine as a means of approximating wounds and facilitating the healing process in a less invasive, less expensive manner. Although this method has existed as a suitable technique for 15 years, it still remains widely underused. In studies comparing suturing, stapling, and hair apposition, it was found that there are many advantages supporting the use of HAT which include greater patient satisfaction, decreased pain, and improved cosmetic outcomes.

Conclusion

Patients presenting to the ER with linear scalp lacerations and hair length capable of being used for tying are suitable candidates for the use of the hair apposition technique. Increased incorporation of this technique into ED practice has the advantages of increasing patient satisfaction and recovery, while more effectively and efficiently using hospital resources.

REFERENCES

1. Hock MO, Ooi SB Saw Sm, et al. A randomized controlled trial comparing the hair apposition technique with tissue glue to standard suturing in scalp lacerations (HAT study). Ann Emerg Med 2002;40:27-9

2. Ong ME, Coyle D, Lim SH, et al. Cost effectiveness of the hair apposition technique compared with standard suturing in scalp lacerations. Ann Emerg Med 2005;46:237-42

3. Ong ME, Chan HY, Teo J, et al. Hair apposition technique for scalp laceration repair: a randomized controlled trial comparing physicians and nurses (HAT 2 study). Am J Emerg Med 2008;26:433-38

4. Ozturk et al: A retrospective observational study comparing hair apposition technique, suturing and stapling for scalp lacerations. World Journal of Emergency Surgery 2013; 8-27

The Current State of the Opioid Crisis in Indiana

by Lauren Stanley MD FACEP

There is a lot of debate about who is responsible for the opioid crisis in our country, our state, and even our individual communities/hospitals: is it doctors' fault? Is it drug addicts' fault? Is it pharmaceutical companies' fault? In such a contentious topic, every "side" has its own argument for why it is not responsible for the problem, and therefore not responsible for the solution. The concept of "silos" comes to mind: this concept originated in the world of business, and refers to different departments isolating themselves to their own specific niche, avoiding cross-talk, information-sharing, and/or problem-solving with other departments. The concept of silo mentality has been applied to many other industries, including healthcare, and is quite aptly applied to the conversation about the opioid crisis in our country.

In one article from *Forbes* magazine titled "The Silo Mentality: How To Break Down The Barriers," (Gleeson, B. Forbes.com, Oct 2013.) it was written that "It Trickles Down from the Top: The silo mindset does not appear accidentally nor is it a coincidence that most organizations struggle with interdepartmental turf wars. When we take a deeper look at the root cause of these issues, we find that more often than not silos are the result of a conflicted leadership team."

There is a lot of wisdom in this statement, and it can be applied to the opioid "crisis" if one considers "interdepartmental" to mean the interplay between the various players in the situation: physicians, patients, local law enforcement, DEA, mental health providers, pharmaceutical companies, etc. All these parties have contributed to the opioid crisis; we could debate for days about the relative contribution of each party, but does it really matter? In the end, we as physicians should understand and embrace that as leaders of our communities, we should be the first to break down the silo mentality by calling a "truce" and moving forward to the solution part of the debate.

Many of us as emergency physicians probably feel that our individual contribution to the crisis is minimal at most. After all, many of us have already significantly curtailed our opioid prescribing. In my personal practice, it is now unusual to prescribe more than a few scripts for opioids during a typical shift, which is quite different than my practice 5 years ago. However, the crisis is far from over; there is much work to be done, especially now that the limiting of prescribed opioids has created a secondary crisis for illegal opioids including heroin.

There are many parties at work in our state trying to combat these issues. This includes the local level (whose hospital doesn't have an initiative/committee/project aimed at addressing the opioid problem in their city/county?) all the way up to the state level, including the Indiana State Department of Health. ISDH representatives recently shared some information with the INACEP Board of Directors regarding the opioid crisis in our state. Some data points:

- Of fatal overdoses, 63% were men, 37% were women
- Of fatal overdoses, not surprisingly, 25-34 years old had the highest rate of overdose (state-wide, about 7 deaths per 100,000 population; this was higher, at about 11, in Marion County). Perhaps more surprisingly, 55-64 year-olds had rate of about 3 (state-wide).
- Based on ICD-10 codes used to identify drug overdoses, the rate of opioid-involved overdoses was about 12 per 100,000. The rate was about 4 per 100,000 for heroin. Thus, perhaps surprisingly, heroin isn't accounting for the majority of overdoses.

The opioid crisis has captured the attention of the State Senate, House, and Governor, and there have been multiple bills proposed (and some passed) to address it. You may already be aware of Senate Enrolled Act 226, the law passed in July 2017 that restricts first-time opioid scripts to <7 day supply, and that Governor Holcomb has established a goal for INSPECT to be integrated into our EMRs by 2019. There are bills being discussed during the current legislative session that could also affect us as emergency physicians. A couple examples:

- Senate Bill 221 would require providers to conduct an INSPECT query before any opioid or benzodiazepine is prescribed from the ED
- Senate Bill 225 calls for required CME hours in order for controlled substances registration (CSR) renewal

Whether you support or oppose these proposals, your voice is important. INACEP board members recently met with state legislators to discuss these topics, and it was clear that the legislators are quite interested in understanding the perspectives/opinions of those on the front line – i.e., us! You can educate yourself further on the proposed bills by browsing https://iga.in.gov. (also check out Senate Bill 219). Please consider writing/contacting your representative, becoming more involved in INACEP, or simply becoming a participant in your hospital's opioid committee… this will allow us to be active participants in the solution, not passive subjects of rules/regulations. As emergency physicians, we cannot afford to live in our individual silo; the opioid crisis affects us on a daily basis and we should be leaders in developing a solution.

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A View from the Top

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3. INACEP membership reached 604 for the last calendar year. Thanks to your participation, INACEP will gain an additional councillor seat at Scientific Assembly. While technically still classified as a small chapter, our increased membership gives us a stronger voice.

4. Indiana Information Health Exchange has the capability to share patient records from other institutions. Contact Keith Kelley at: kkelley@ihie.org for more information.

I think this specialty continues to attract physicians with a competitive and warrior-like spirit. Every day we enter the battle searching for the resources needed to provide expert care to our patients. EM physicians across the country have done a commendable job caring for the high volume of acutely ill patients during this record-breaking influenza season by being flexible and innovative with their resources. Thank you for caring for anyone, anytime, anywhere. Take some time to celebrate ACEP's 50th anniversary this year—after flu season of course!

Upcoming Events

INACEP Annual Conference
Indianapolis
April 25 & 26, 2018

5th Annual EMS Medical Directors' Conference
Carmel
April 27, 2018

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

SAVE THE DATE

The 5th Annual EMS Medical Directors' Conference, organized by the IN State Department of Health (ISDH), will be held at our INACEP Conference Hotel on

Friday, April 27, 2018

Send questions to: indianatrauma@isdh.in.gov

Indiana State Department of Health

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

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Happy 50th Anniversary ACEP!
Happy 47th Anniversary Indiana ACEP

Here is a list of our INACEP presidents since our inception:

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2012 Sean Trivedi MD, FACEP
2013 J.T. Finnell MD, FACEP
2014 Sara Brown MD, FACEP
2015 James Shoemaker MD,FACEP
2016 Lindsay Weaver MD, FACEP
2017 Gina Huhnke MD, FACEP

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Mohammad Kadamany MD
Steven Propst MD
Emily Wagner MD

Students

McKenna Frugurson
Anna Harned
Zachariah Slattery
Floyd Timm
Stefani Vande Lune

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