

EMpulse

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



**The 2017
INACEP Annual
Conference
will be
held at the
Marriott North
Indianapolis Hotel
April 26-27, 2017**

**Look for
registration
information
in this issue**

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The Prescription Opioid Crisis in America

by John Rice MD, FACEP (INACEP Board Member)

One of the preeminent topics in Emergency Medicine is the prescription pain medication abuse crisis and its evolution and causes. To put this into perspective consider the following. The estimated number of prescriptions filled for opioid substances increased from 174 million in 2000 to 257 million in 2009 [1]. The USA consumes 80% of the world's opioids and 99% of the world's hydrocodone [2], yet only makes up 5% of the world's population. In 2010, enough opioids were sold to medicate every American adult with a typical dose of 5 mg hydrocodone every 4 hours for one month [3].

The death rate from opioid overdose in 2008 was four times higher than in 1999. In the same time period there was a fourfold increase in sales of opioids in the US. While mortality is one aspect of opioid harm; according to the CDC for every one death from oral analgesics there are 10 treatment admissions for abuse, 32 emergency room visits for misuse or abuse, 130 people who are dependent, and 825 who use the drugs recreationally [4].

So how did we get to this point? In the 1990s pain and its under-treatment were widely reported in the medical literature and media to be an international health crisis. The Joint Commission reported that 76 million Americans suffer from chronic, acute, or post-surgical pain [5]. The World Health Organization, which had always had concern for proper treatment of acute and cancer pain, now was emphasizing the importance of treating chronic pain as well [6]. In 1992, the Agency for Healthcare Quality Research (AHQR), a USA Government quality-improvement agency, issued a two-part guideline declaring that half of surgical patients do not receive adequate analgesia, and that concerns by health care providers of addiction to opioids are largely unfounded [7, 8]. The problem was that the AHQR had no good data to back this assertion.

In 2001, the Joint Commission on Accreditation of Health Care Organizations, with its release of pain management standards for the accreditation of healthcare organizations, had the largest practical impact on the treatment of pain in the USA [1]. What were previously labeled clinical guidelines effectively became practice mandates and changed provider and hospital behavior. Continuously documenting pain in the hope of heightening the awareness of pain was the cornerstone of the anti-pain movement. The Veteran's Health Administration (VHA), the USA's largest integrated health system, became among the first major health organizations to buy into this. The VHA adopted the 'fifth vital sign' term and in 1998 enacted a strategy to make sure pain is assessed on all patients using the 0–10 scale [9]. When the Joint Commission released its standards, it distributed educational materials developed by Purdue

"...for every one death from oral analgesics there are 10 treatment admissions for abuse, 32 emergency room visits for misuse or abuse, 130 people who are dependent, and 825 who use the drugs recreationally."



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Jennifer Walthall, MD, MPH Secretary – Family and Social Services Administration



Jennifer Walthall, M.D., M.P.H. was appointed as Secretary of the Family and Social Services Administration by Governor Eric J. Holcomb effective January 9, 2017. Prior to this appointment, she served as the Deputy State Health Commissioner and Director for Health Outcomes at the Indiana State Department of Health. Dr. Walthall is currently an Associate Professor of Emergency Medicine and Pediatrics at Indiana University School of Medicine. She also serves as the Division Chief for Pediatric Emergency Medicine and was the Program Director for the Emergency Medicine and Pediatrics Residency from 2007-2015.

Dr. Walthall works clinically in the Riley Hospital for Children Emergency Department. She earned her undergraduate degree from the University of Houston Honors College and her Master in Public Health at the Richard Fairbanks School of Public Health at Indiana University. She earned her Medical Doctorate at Indiana University School of Medicine and is board certified in Emergency Medicine and Pediatrics.

The Family and Social Services Administration (FSSA) was established by the General Assembly in 1991 to consolidate and better integrate the delivery of human services by state government. FSSA is led by the Secretary who is appointed by the Governor and is a member of the Governor's cabinet.

FSSA is a health care and social service funding agency. Ninety-four percent (94%) of the agency's total budget is paid to thousands of service providers ranging from major medical centers to a physical therapist working with a child or adult with a developmental disability. The six care divisions in FSSA administer services to over one million Hoosiers. The mission of FSSA is to develop, finance and compassionately administer programs to provide healthcare and other social services to Hoosiers in need in order to enable them to achieve healthy, self-sufficient and productive lives.

Division of Family Resources (DFR) – Receives applications and approves eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP), Cash Assistance (TANF) and childcare; implementing a modernized application process using internet, document imaging and call-in services. DFR operates in all 92 counties and administers the childcare licensing and inspection program.

Office of Medicaid Policy and Planning (OMPP) – Administers Medicaid programs including the managed care system for Hoosier Healthwise (HHW) participants. OMPP performs medical review of Medicaid disability claims.

Division of Disability and Rehabilitative Services (DDRS) – Manages the delivery of services to children and adults with developmental disabilities. DDRS oversees the First Steps rehabilitation program for children from birth to age three.

Division of Mental Health and Addiction (DMHA) – Supports network of mental health care providers. DMHA operates six psychiatric hospitals and funds addiction prevention and treatment programs.

Division of Aging – Funds long-term care through Medicaid programs. The Division of Aging supports the development and utilization of alternatives to nursing home care, as well as coordinates and funds services through network of Area Agencies on Aging.

Office of Early Childhood and Out-of-School Learning (OECOSL) – Oversees early care and education and out-of-school time programs.

Upcoming Events

Leadership and Advocacy Conference
Washington DC

March 12—15, 2017

INACEP Annual Conference
Indianapolis

April 26 & 27, 2017

EMS Medical Directors Conference
Indianapolis

April 28, 2017

ACEP Scientific Assembly
Washington DC

October 29—November 1, 2017

New INACEP Members

Medical Students

Samuel Barnett

Greta Braun

Brice Brookshire

Kimberly Day

Christian Duncheon

Benjamin Hancock

Janette Magallanes

Thomas Sublett

Andrew Zabel

Residents

Lexie Dore MD

New Members

Justin Ritonya MD

Anna Bona MD

Seth Langsam MD

A Tale of Two Emergency Rooms

by Jonathan Steinhofer, M.D., FACEP

I have the fortunate opportunity to work in a mid-sized independent and democratic emergency medicine group in Indiana. It has been the only job I've held since graduating residency five years ago, and the only thing outside of academic emergency medicine which I've known. Our group has the unique opportunity of staffing a variety of hospitals, and as a partner I have had the ability to travel to all of them. We contract with not only an extremely busy level II trauma center seeing about 65,000 patients a year with an admit rate of 30%, but also rural sites that see fewer than 10,000 patients per year and may often see horse and buggies pull up to the entrance. Our contracts include very urban ER's seeing the indigent and homeless, to stand-alone sites still trying to figure out what exactly their role is in emergency medicine. The following are a few anecdotes I've taken away from my short career, in hopes to convey 1.) the importance of training today's residents to be able to handle things on their own without 10 subspecialists on the next floor, and 2.) praise in our specialty for being able to handle a variety of situations that would cause most others to run for the hills.

I had been out of residency for about a year when this story happened. I was working at one of our smaller sites, and by

smaller sites I mean after 6 pm I am the only physician in the entire hospital if that paints the picture for you. It had been a steady night when the charge nurse got off the phone to tell me that there was a delivery upstairs and the obstetrician wasn't going to make it in time. I'm sure my face showed pure terror when she said this, as the last time I had delivered a baby was 3 years prior, under the guidance of an OB resident. As I begrudgingly walked up the stairs and entered the room I heard the sounds of labor in full progress. The screams, the moaning, the bodily fluids hitting the floor, all reminding me why I didn't go into obstetrics in the first place. As I reverted back to my training, trying to remember what to put where, what to pull when and where to cut what, the delivery, in all, was fairly un-eventful. Shortly thereafter the OB walks in and says, very nonchalantly, 'thanks for filling in' and walks out, not realizing that I had sweat soaked through my entire set of scrubs in nervousness. Feeling empowered, I went back to the emergency, wondering what he would have said if I asked him to now go take care of my septic elderly nursing home patient that needed a central line.

continued on page 7



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Legislative Update

by Lou Belch, Lobbyist for INACEP

As this update is being written, the General Assembly has been in session for 3 days. The universe of bills that will be filed is unknown at this point. Governor Holcomb has just been inaugurated. For these reasons, much of this update regarding 2017 legislation is speculative. INACEP lobbyists and leadership will be reviewing legislation as it is filed and commenting as needed.

Opioid/Heroin

Sen. Jim Merritt (R-Indianapolis) will be introducing a multi-bill package that will have an emphasis on treatment for individuals suffering from substance abuse disorder.

Other legislators will be introducing bills that impact how physicians prescribe opioids. The Governor has announced, as part of his legislative agenda, that he is seeking a seven-day limit on these drugs. We are not sure if there are any exemptions. Further, there may be a bill that requires a mandatory INSPECT search before a prescription, of any length, can be written.

Scope Of Practice

There are expected to be a number of bills that modify the scopes of practice of non-physicians. This would include advanced practice nurses, physician assistants, CRNAs, and pharmacists.

Insurance Issues

Several members of the House of Representatives have been meeting with interested parties to understand insurance issues. INACEP lobbyists were contacted by the House Insurance Committee Chair, Rep. Martin Carbaugh (R-Ft. Wayne). He wanted to better understand the issue of balance billing by out-of-network providers practicing at in-network facilities. At press time, we don't believe he will be introducing legislation. He likely will want to work on this next summer to see if a workable solution can be reached.

Rep. Donna Schaibley (R-Carmel) is working on legislation that places some restrictions on prior authorization. She believes health care providers are facing increased administrative burdens.

HIP 2.0 Waiver Update

On January 5, 2017, the Medicaid Advisory Council held a special meeting to provide an update of the new components of the HIP 2.0 reauthorization waiver. Medicaid Director, Joe Moser, made it clear that given its past success, the general structure of HIP 2.0 would remain the same. The draft of the waiver extension application was released on December 31, 2016 to begin the 30-day public comment period., which ended at 5:00pm January 20, 2016

The waiver application seeks to build on the existing consumer incentives within HIP 2.0. The managed care entities (MCEs)

will have more flexibility to create programs that offer member incentives consistent with the commercial market. These programs will be required to focus on four priority areas:

1. Tobacco cessation
2. Substance use disorder (SUD) treatment
3. Chronic disease management
4. Employment related incentive programs

When examining the expansion population, it was observed that 48.3% of members smoked. This high rate of smoking cost the state an additional \$589M per year in health care costs. The smoking cessation benefit was increased, but was not widely used among participants. Under the waiver application, a member who is identified as a smoker has one year to take advantage of the smoking cessation services provided under HIP 2.0. Failure to do so will cause a 1% surcharge of additional POWER account contributions. Smokers will be identified by their health screenings and diagnosis codes. The state will partner with the MCEs to develop an education campaign to inform members of the smoking cessation benefits under HIP 2.0. Previously, MCEs were able to develop their own incentive programs but the waiver application seeks to make them more consistent and standardized across different plans.

The current opioid epidemic has put a focus on substance abuse treatment. The SUD initiative will provide benefits to all Medicaid members, not just HIP 2.0. There will be an estimated \$55M increase in federal funding to address substance use. The SUD benefit will include:

- Reimbursement for short-term residential treatment facilities for up to 30 days
- Expansion of inpatient detoxification services
- Residential treatment services
- Addiction recovery management services

There are additional proposed new changes in the waiver application, such as limited chiropractic benefits for HIP Plus members. They will have a limited spinal manipulation benefit that allows up to six visits per member per benefit period. In addition, there will be the reestablishment of open enrollment. Upon reauthorization, users would be required to supply their paperwork within the open enrollment period. If they miss the deadline, there is a six-month lockout period. Members will have a fixed 12-month plan choice once they choose the MCE provider. The HIP Link program, which helps low income Hoosiers pay for their employer sponsored health insurance, will now have the option of additional family member coverage. If a HIP Link enrollee has a family member in the household that is eligible for Medicaid, they will be covered under HIP.

The HIP 2.0 waiver application will be submitted no later than January 31, 2017.

Two Emergency Rooms

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My next case took place at our trauma center. It was a very busy evening when we received a medic run with an obtunded patient. In his early 20s, he was found by a family member unresponsive. The medics arrived, attempting to ventilate him with the ambu-bag, as brown gastric contents were spewing out of his mouth. I took one look with the Mac blade and couldn't even see the hypopharynx. When I put the glidescope in all I could see was a sea of black sludge. Remembering that one attending back in residency who told me to always have a bougie in my back pocket, I finagled the five-dollar piece of plastic until I was able to feel tracheal rings, and got the guy intubated as the anesthesiologist walked in trying to take his fiber-optic scope out of its case. The guy was hypotensive and ultimately got a central line. Usually, at any of our facilities, that guy would have been out the door or in the Unit within 30 minutes. Unfortunately, this night our ICU was full and I was stuck managing him for the next two hours. With a bicarb of 3, pH of 6.5, GI bleeding, creatinine of 8, and a potassium of 7, I was managing acid-base disorders, hyperkalemia, transfusing blood, and managing the ventilator. At the time I was probably running around like a chicken with his head cut off, since I also had an emergency room full of other very sick patients. However, after going home and reflecting, I remember telling myself that is exactly the reason I chose emergency medicine.

I highlight these cases not to offend anesthesiologists or obstetricians, as they are obviously great at what they do and have saved me in more than one circumstance. I mention these cases to stress the importance of good emergency medicine training. I write this to stress the importance of board certified EM physicians, not just any warm body with a license (highlighted by the recent events in Ohio which is altogether a topic for another day). I write this to stress the importance of comprehensive training. I think sometimes today our residencies rely very heavily on the idea of specialists available 24/7 - an OB that can come down and deliver a baby anytime, or an ophthalmology resident who won't be upset when I ask them to come look at an eye at 2 am. The number one goal of any emergency medicine residency should be to prepare a resident to practice in a solo covered ED on day one after graduation. Granted, they certainly will not have the experience of a tenured physician. However they need to have the skill set to handle such situations.

Finally, I want to salute all those who choose our specialty. With obvious bias, I believe there is no greater type of medicine to practice. There is nothing more noble than taking care of a CEO with a heart attack one minute, and a homeless man with gangrene the next. No other profession allows for people to truly practice medicine in such an ever more highly subspecialized world.

SAVE THE DATE

The 4th 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 28

Send questions to: indianatrauma@isdh.in.gov



BULLETIN BOARD

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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The **EMPulse** is published 4 times per year. The **2016 Ad Deadlines** are: February 21, May 22, August 21 and January 8, 2017 (subject to change). Publication dates are approximately March 15, June 15, September 15 and January 25, 2017.

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Councillors Representing INACEP at the Council Meeting ACEP Scientific Assembly in Las Vegas



Drs. Sara Brown, John Rice, John Agee, James Shoemaker, Lindsay Weaver, Bart Brown, JT Finnell, Mr. Nick Kestner, Dr. Michael Bishop.

Not shown: Drs. Timothy Burrell, Chris Weaver, Chris Burke, Chris Cannon & Gina Huhnke



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The Opioid Crisis

continued from page 1

Pharma (makers of oxycontin) that minimized opioid risks, especially the risk of addiction, and exaggerated benefits of opioids.

Despite the good intentions to reduce pain-related suffering, these cultural and regulatory shifts have led to these unintended consequences, especially when the 'fifth vital sign' concept is rolled out to settings where the presentation is not acute. This is a key point; they wanted us to treat chronic pain like we treat acute pain.

The tide now is turning with specialty groups sending petitions to CMS. One petition sent to CMS calls for removal of the pain questions from HCAHPS, the agency's patient satisfaction survey used for determining hospital reimbursement rates. However it is important for all of us to consider how we got to this point. The emphasis on the patient experience and equating a positive patient experience with quality care was in part at the root of this. Many times if we truly want our patients to be healthier and have better outcomes we have to tell our patients things they don't necessarily want to hear—"don't smoke, exercise, lose weight, don't take so many pain pills, etc. etc." Hopefully we (including the regulators, accreditors, organizations etc.) can learn from this tragedy.

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2017 INACEP Conference Update

by Gina Huhnke MD, FACEP (INACEP Vice President & Education Director)

Welcome to 2017. Now that the holidays have passed and your CME funds have been renewed, please make plans to join us at the INACEP educational conference on April 26 & 27 at the Marriott North Indy Hotel (Keystone at the Crossing). The conference will feature many popular speakers including our very own Drs. JT Finnell and Jen Walthall. Joining us from outside the Indianapolis area will be engaging speakers including the always funny and philosophical Dr. Edwin Leap, as well as a variety of eloquent lecturers from around the country.

Day 2 will feature interesting case presentations during breakfast, followed by several lecture topics. Then attendees will be given the opportunity to participate in an interactive, hands-on, ultrasound learning session, focusing on basic and advanced ultrasonographic techniques.

The educational sessions will cover a variety of topics from informatics to EMS, with a focus on both academic and community Emergency Medicine. This conference offers educational opportunities for emergency physicians at any stage of their careers, as well as advanced practice providers and EMS personnel.

Please follow this link to view the full educational brochure and register online: <http://inacep.org/2017-conference>.

The Marriott North Hotel has offered a special room rate for attendees and space is limited, so please register early. See you there!

2017 INACEP Conference Agenda

Wednesday, April 26

- 8:00 a.m.** ***Rethinking the Role of Technology in Healthcare*** by JT Finnell MD, FACEP
- 9:00 a.m.** ***Changing the Opioid Conversation: How Can EM Have a Voice***
by Jennifer Walthall MD, FACEP
- 10:10 a.m.** ***Community EM: It Ain't All Rainbows Unicorns*** by Patrick Fouts III MD, FACEP
- 11:10 a.m.** ***The Emergistan Board of Emergency Medicine Exam Prep: Questions Nobody Asked Us but Should Have***
by Ed Leap MD, FACEP
- 1:30 p.m.** ***How To Kill A Patient With Just Your Prescription Pad***
by Joe Martinez MD, FACEP
- 3:15 p.m.** ***Syncope for the Pit Doc. Just the Zebras!*** by James Webley MD, FACEP
- 4:15 p.m.** ***What's Coming Your Way? Updates on EMS Destination Protocols – Strokes to Mass Casualty Incidents***
by Andrew Stevens MD

Thursday, April 27

- 7:00 a.m.** ***Community Medicine Breakfast and Case Sharing***
- 8:00 a.m.** ***KSI VS RSI - Resuscitate Before You Intubate*** by Ken Butler DO
- 9:00 a.m.** ***Cardiac Ultrasound: How to Confidently Determine the Cause of a "Broken" Heart***
by Robert Blankenship MD, FACEP
- 10:10 a.m.** ***Basic & Advanced Point of Care Ultrasound Workshop***
by Robert Blankenship MD, FACEP & Bart Brown MD, FACEP
- 12:10 p.m.** ***Adjourn***



REGISTRATION FORM



45TH Annual Indiana ACEP Emergency Medicine Conference

Wednesday & Thursday, April 26 & 27, 2017

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Residents/Interns – separate form will be sent	
Medical Student	\$20 <input type="checkbox"/>
Choose one of the following:	
Handbook on paper	<input type="checkbox"/>
Handbook on flash drive	<input type="checkbox"/>
Late Fee – if received after 4/5/17	\$25 <input type="checkbox"/>

TOTAL

If you are paying by credit card, go to inacep.org.

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Late Fee – received after 4/5/17	\$25 <input type="checkbox"/>	\$25 <input type="checkbox"/>

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LOCATION

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CANCELLATION POLICY

A full refund will be given, provided cancellation is received by April 5, 2017. 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.

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**HOTEL WILL ONLY HOLD ROOMS THROUGH
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