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EMpulse

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

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50th Annual INACEP Emergency Medicine Conference

April 20, 2022

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A View from the Top

Tyler Johnson DO, FACEP

I have had the honor of serving as INACEP president for a little over 6 months. We are definitely in a time of change in emergency medicine. This is not just because of COVID-19 but also because of the skew in the balance between medicine and business. Some changes are good and necessary but others do not appear to be positive. We have likely all felt a little unsettled over the past few years.

I have had the opportunity to talk with leaders in insurance, billing, healthcare policy, emergency medical services, and health systems. Like many of you I tend to focus on communication and connecting with individuals. I have enjoyed creating relationships and engaging with legislators. Genuine relationships make our job easier when it comes time to champion good ideas or crush bad ones.

One of the things we have noticed during engagements with insurers, due process discussions, promoting physician autonomy, and finding appropriate balance for scope of practice is that all these at some point affects almost all of us. While ACEP is working at the federal level, we are supporting those efforts engaging our Indiana US representatives and senators. We are also looking for local solutions at the state level and are very active with our state legislators.

We would like you to get actively involved with INACEP going forward. There are many ways you can help and that could be joining the board, supporting a project or legislative engagement.

I want to challenge you personally to help. I have learned that getting involved helps give you a voice or gives you a new perspective on why things happen the way they do.

Listening to all the people we meet with it is clear that emergency medicine is very much held in high regard. You bring a lot of respect and experience -- not just because of your job alone but also with the commitment you bring. It is also clear that legislators and community leaders want to hear from you. We are looking to increase engagement as current events have rightfully encouraged physical separation and virtual events. Sometimes that is reasonable, but in general, we like to be in the presence of others when possible. Most of you are pretty cool and fun to be around! So, we hope to be able to have in person events. We also have had good engagement with some of the virtual meetings so we will likely incorporate more technology moving forward. We want anyone with interest or concerns to reach out to me or any of our board members so we can be an effective voice for you. We would like you to get actively involved with

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Council 2021 – Summary of Events

by Chris Ross MD, FACEP (Ex Officio Board Member)

2021 ACEP council was back in session and in person this year! It was great to see everyone, mingle as appropriate and enjoy the comradery. The session was very productive with 82 resolutions on the docket and a hotly contested BOD election.

Here are some highlights from the weekend:

- Our own JT Finnell was reelected to the BOD (of course) on the first ballot. Way to go JT! All of us here at INACEP are excited to see what JT can accomplish with another three years.
- Gillian Schmitz took the reins as ACEP president. She stands to be a unifying presence for the college and will undoubtedly serve us well during her tenure. Christopher Kang was elected as president-elect to take over after Gillian's term ends.
- The council is looking to be more transparent in its members and leadership with regards to conflicts of interest. Two resolutions were passed (18 and 19) which will require more robust disclosures of conflicts of interest for councilors, alternate councilors and those seeking leadership positions with ACEP.
- Diversity was emphasized. Two resolutions (21 and 22) both highlighted work to be accomplished by ACEP to encourage diversity within ACEP and it's educational offerings.
- Working to help the rural sites was also a priority. Both resolutions 34 and 35 targeted rural and critical access hospitals as particular sites of need. They both task ACEP with trying to find ways to improve reimbursement and staffing at these sites. Resolution 64 and 65 addressed breaking down barriers to get ABEM/AOBEM certified/eligible physicians as staff and leaders in those departments.
- Several resolutions pushed the college to act aggressively on scope of practice issues and bad payor issues we all face.
- A handful of more complicated topics were sent to the Board of Directors to review further. These included: Due process, physician pay ratio, FMLA issues, and rights of detained/incarcerated individuals.

Overall, ACEP council session 2021 was a success. ACEP staff did a great job bringing us all together under still difficult circumstances. I also want to thank our wonderful new Executive Director, Cindy Kirchhofer, who kept us entertained, well fed and on task. Again, with 82 resolutions to go through, we had quite the task but ended up with lots of great guidance for ACEP going forward. I look forward to seeing ACEP leadership putting those recommendations into action over the coming year.

That's all for now! If you have any questions about council or are interesting in getting further involved in INACEP or ACEP council, feel free to email me at ctross@gmail.com. Take care!

Congratulations To Dr. JT Finnell

John T. Finnell, MD, FACEP, FACMI, was re-elected at the national ACEP council meeting in Boston to ACEP's Board of Directors. Congratulations to Dr. Finnell and thank you for your contribution and dedication to ACEP.

American College of Emergency Physicians®

WELCOME NEW INACEP MEMBERS

Resident Members

Oludemilade Akinrotimi, MD
Alex Gutierrez, MD
Matthew Peacock, MD
Theresa Spech, MD

Fellow

Yae Sul Jeong

Medical Students

Wesley Aaron Borman
Connor Bunch
Alexander Close
Will Collier
Monica Ann Feustel
Nathan Gerick
Harrison Paul Goldenberg
Lindsey Haut
Sarah Hopfer
Livia Hopper
Colton Houchin
David Huston
Dominik Adam Kowalczyk
Jasmin Millon
Sidney Joseph Zion Nathan
Jori Faith Ozolin
Adrian Alain Palmer
Alexander Mark Shrum
Kevin Walters

UPCOMING EVENTS

50th Annual INAECP Conference

April 20, 2022

NCAA Hall of Champions, Indianapolis

ACEP Member Physician: $200
Non-ACEP Physician:; $230
PA/RN/LPN/APRN/Paramedic: 140
Resident/Medical Student: $10

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Publication dates are:
Feb. 20, May 15, Aug. 15 and Nov. 15
(approximately).

Mail: Indiana ACEP,
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Indianapolis, IN 46217

Email: cindy@inacep.org

Case Study: Pediatric Pain

by Nicole Carpp, M.D. and Nicholas Pettit D.O., Ph.D.

Overview

A 7-year-old female with no known chronic medical problems presented to the ED for evaluation of bilateral leg pain. She was accompanied by her parents, both of whom had immigrated to the US several years ago and had limited English proficiency. With the aid of a video interpreter, she reported several days of bilateral knee and thigh pain, worse with ambulation, without known injury. These episodes had occurred several times previously. As they had spontaneously resolved in the past, she had never been seen for this before the day of presentation. ROS was notable for rhinorrhea and subjective fevers, but she denied cough, rashes, or bruising. There was no known family hx of malignancy or anemia.

Findings and Workup

Vital Signs: BP:118/67, HR=96, RR=16, SpO2=97%, Temp=99.5°F.

Physical Exam Pertinent Findings: Thin appearing female in moderate acute distress secondary to pain. Non-toxic appearing. Cardiovascular exam with mild tachycardia, no murmurs. Lungs were clear to auscultation. She had reproducible tenderness over the bilateral knees and distal femurs without edema, erythema, or warmth. Her gait was antalgic, but she was able to bear weight on her lower extremities. No rashes or petechia were noted.

Initial Workup: Given ibuprofen 10mg/kg and acetaminophen 15mg/kg while labs and imaging were obtained. BMP was unremarkable. CBC notable for a neutrophilic leukocytosis to 18.3, anemia with a Hgb=8.6, platelets=387, with a peripheral smear notable for sickle cells. CRP was elevated at 1.8; ESR was unremarkable at 7. X-rays of the bilateral knees, femurs, and pelvis were normal. COVID-19 testing was negative.

Given her leukocytosis and sickled cells, there was concern for vaso-occlusive crisis versus acute infectious etiologies. Blood cultures were obtained, she was given a dose of ceftriaxone and bolus of normal saline, and a chest x-ray was obtained and unremarkable. Her pain was slightly improved after the initial NSAID's, so a dose of fentanyl was given with good analgesia.

Management

The patient and her parents were updated with the findings and concern for previously undiagnosed sickle cell disease. They confirmed no family history of sickle cell disease and noted that the patient had never previously had a CBC drawn. The case was discussed with the on-call Hematologist at the local pediatric referral center who recommended obtaining a hemoglobin electrophoresis for confirmation of the diagnosis and accepted the patient in transfer. She was admitted to the Hematology service overnight for pain control and observation.

She was discharged home the following day on folate supplements, hydroxyurea, and PRN oxycodone for pain crises. Her hemoglobin electrophoresis ultimately confirmed the diagnosis of Sickle Cell Beta Zero Thalassemia. She has since established with the outpatient Hematology clinic and has been started on penicillin prophylaxis for functional asplenia.

Discussion

Pediatric extremity pain is a common ED presenting complaint. While many are post-traumatic injuries or the result of benign conditions such as transient synovitis or growing pains, the differential does also include several emergent conditions such as non-accidental trauma, osteomyelitis, septic arthritis, leukemic infiltration, and primary bony malignancies. In this case, we present an unusual presentation of a frequently encountered complication of sickle cell disease. Although this patient had been seen by several clinicians in the past, she never underwent a newborn screen and had never had a CBC drawn prior to the day of presentation. This, in addition to other barriers to care including immigration to the US and limited English proficiency, likely contributed to the delayed diagnosis of her underlying sickle cell disease. Her blood cultures were ultimately negative, and her pain was felt to be secondary to a vaso-occlusive crisis.

While pain crises are the most common ED diagnosis in patients with sickle cell disease, clinicians must also consider associated complications including splenic sequestration crisis, aplastic crisis, cholecystitis, acute chest syndrome, stroke, priapism, and musculoskeletal complications including avascular necrosis and osteomyelitis. Across all age groups, infection is the leading cause of death and patients presenting with fever should have cultures drawn, receive a dose of empiric antibiotics, and a detailed history and physical should guide search for infectious sources.

Conclusion

Consider a broad differential including undiagnosed chronic conditions in vulnerable patients.

REFERENCES

Tintinalli's emergency medicine: A comprehensive study guide (Eighth edition.). New York: McGraw-Hill Education. 2019.

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From The National ACEP

A Checklist to Help You Negotiate the Best Employment Contract

Employment contracts are complex and often difficult to navigate. This checklist is designed to help you consider all the right questions when reviewing any employment contract you receive:
https://www.acep.org/life-as-a-physician/career-center/negotiating-the-best-employment-contract/

Due Process

- Does the group require you to agree to waive your medical staff protections/rights as part of signing a contract to work with the group at a site?
- Does the group provide due process for "internal" company concerns?
- Are all physicians on a medical staff, including emergency physicians, being afforded the same due process rights?

Billing Transparency

- Will you receive timely feedback on any performance-based measures used to determine compensation?
- Is the compensation fair and equitable (does it take into account your experience, clinical and administrative services you may provide, the added value of your participation in the practice, market conditions, etc.)?
- Will you receive a semi-annual report that itemizes all billings and collections done in your name, regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law?
- Do you have the right to audit such billings, at any time without retribution?
- Is there transparency in revenue and expenses associated with the practice, including management services?

Restrictive Covenant

- Does the contract restrict your opportunities to moonlight or have a second job?
- Does it require you to seek written permission before, for example, volunteering to provide care at the local marathon?
- Is there a non-compete clause that restricts where you can work after you leave?
- Is the restrictive covenant written in a vague way so that you cannot readily determine how much it limits your prospects? (ie: "cannot work within a 5-mile radius of any hospital contracted by your group")

Force Majeure

- Is your employer automatically released if an "act of nature" that prevents the employer from paying you? (This is becoming more common in physician contracts.)
- If a force majeure clause is included as a basis for termination, does it provide the same notice period as other terminations?

Family Leave

- Is FMLA available? (it may not be available with small groups)
- Beyond FMLA, are you offered paid leave?
- If no paid leave, are there alternatives such as low-interest loans? Are you able to "bank" paid sick leave for paternal leave?

Termination Provisions

- In which circumstances can the employer or employee terminate the contract?
- Does the employer have the ability to terminate the contract without cause? And if so, do you have the same ability?
- Are there protections in this instance – period of notice, severance pay?
- Are the grounds specified as sufficient for "for cause" termination objective and reasonable (as opposed to "moral turpitude" or other such nebulous terms)?
- Do you have the ability to terminate 'for cause" in certain reasonable instances?
- Can the employer terminate the contract before the employee begins working?
- Is there a force majeure clause, which absolves one or both parties of some or all of their obligations in the event of a catastrophic event (e.g. pandemic)?

Malpractice Insurance

- How is the malpractice policy structured and who is responsible for various premiums?
- Are malpractice insurance limits reasonable?
- Does the policy protect the physician against liability for APPs practicing under their direction?
- Is the policy occurrence-based or claims made?
- What are the provisions for purchasing "tail" coverage?
- Is there a discovery clause?
- Is there a consent to settlement clause?
- What is the group's malpractice claim history over the last 5 years?

Compensation

- What is the base salary? How is it calculated (salary, RVU, quality metrics, patient satisfaction scores)?
- Is there a pay difference between board eligible and board certified?
- Does the salary include bonuses and under what conditions
- Are health, vision, dental, disability covered and are these benefits fixed or subject to change after the contract is signed?
- What other benefits are included?
- What are the retirement contributions?
- Is there profit-sharing?
- What is covered for CME, licensure (state, DEA), board certification expenses, professional society dues?
- Are your moving expenses covered?

Job Description & Obligations

- What are your obligations and are they reasonable?
- Are your clinical hours reasonable?
- Do you have non-clinical obligations (e.g. teaching, research, departmental/committee meetings)?
- Do you have call responsibilities?
- Are you obligated to cover clinical emergencies outside the ED?
- Are you required to obtain and maintain ABEM certification and are you required to maintain medical staff privileges?
- What are your obligations in supervising and signing the charts of APPs providing patient care?

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https://www.acep.org/life-as-a-physician/ACEP-Wellness-and-Assistance-Program/ Career Center

Career Center

For more employment contract & job hunt resources, visit ACEP's Career Center:

https://www.acep.org/life-as-a-physician/career-center

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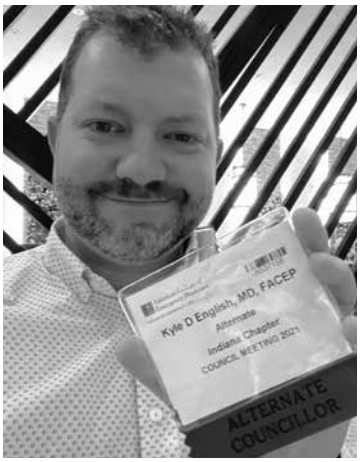
ACEP Council: A First Timer's Guide

by Kyle English, MD, FACEP



ACEP Council. That mysterious place you've only heard of in residency; when you attended ACEP and saw your favorite attendings on Monday only to find out they are "just here for Council" and leaving tomorrow! But what is ACEP Council and why is it important?

I attended ACEP Council in Boston for the first time as an alternate councilor for IN ACEP on Oct 23-24, 2021. It was an incredible experience! On a basic level, ACEP Council is a gathering of representative ACEP members from each state and ACEP chapter to vote on proposed resolutions that will guide ACEP leadership decisions for the foreseeable future. Each state is assigned one councilor position for every 100 ACEP members in the state. Indiana has 6 councilors and I was thrilled to attend as an alternate councilor for this year. Resolutions are proposed throughout the year, discussed prior to and at the Council meetings and then voted on during the Council meetings. The Council follows parliamentary procedure, and ***I was quite impressed at the ability to wrangle 400 Emergency Physicians in a room where I felt all had the opportunity to have their voice heard and ensure their vote was counted***.

Any ACEP member may propose a resolution to be heard at Council. These are arranged into a master guide prior to the Council meetings and posted online. New as of 2020 due to COVID, there is now an 'asynchronous testimony' approximately 2 weeks prior to the actual Council meetings where any ACEP member may post online in support or opposition to any resolution. This has been a great boon to the Council where now any ACEP member can easily read through and have their voice heard on all resolutions. At the Council, the resolutions are split up into 4 'Reference Committees' based on the category of resolution. This year, we had 82 resolutions split into 4 reference committees. On day 1, the reference committees meet and discuss each resolution assigned. Each Councilor attends 1 of the reference committees where they have the opportunity to discuss each resolution in person with a smaller group. These opinions are conglomerated alongside the asynchronous testimony into a reference committee recommendation for each resolution that will be presented to the entire Council on day 2.

Day 2 comes and is the big discussion and voting day. The resolutions are presented by the reference committees with a recommendation to either pass or deny the resolution, or alternatively refer the resolution to the ACEP Board of Directors. However, prior to the vote, each resolution can be 'extracted' for further discussion or amendments. After the reference committees present their recommendations, any Councilor may ask for a specific resolution to be extracted. After these extractions, the Council votes on the remainder of agenda as a whole. However, the extracted resolutions are where the majority of time is spent.

Any ACEP member may participate in this discussion, which is an excellent mechanism to ensure all ACEP members have a voice. Discussion of the extracted resolutions happens in accordance with parliamentary procedure. Amendments can be proposed, altered, voted on, new amendments proposed etc. In addition, separate parts of the resolution can be extracted individually for a vote. In a nutshell, this follows a "first in, last out" ideology. Think of it like a "stack" where each new item is added to the stack. Only the top item in the stack can be discussed and voted on, at which time that item is resolved and the underlying item is now discussed. Say a resolution is extracted. If an amendment is proposed, you can then discuss the amendment, but not the resolution. Now say a Councilor proposes a correction to the amendment. Now all must discuss and vote on the correction alone. The correction is voted on, then the amendment can be discussed again. After the amendment is voted on, the Council can then discuss the actual resolution in whole again, with or without the changes from the proposed amendment (based on the voting results). New amendments and corrections can be added to the stack at any time, prompting discussion for that specific amendment. For a given proposal, the Council will move to a vote when there are no further voices to be heard. Anyone may call to a vote during discussion. However, this can only be called for after both a 'for' and 'against' viewpoint is heard. In time, all corrections and amendments are voted on and then the final resolution is voted on. If a resolution is referred to the Board of Directors, the resolution is sent to the ACEP Board of Directors where they review it and return it to Council for a vote the next available session.

In addition to the resolution voting, a very important part of ACEP Council is voting on the ACEP Executive Council Elections. This includes the President Elect, Speaker, Vice Speaker and Board of Director positions. All candidates are given the opportunity to speak, and all Councilors are given the opportunity to hear all the candidates. This was a fantastic experience and a look into the future leaders of our profession and the opportunity to vote on the candidates was extremely rewarding.

All in all, I highly recommend ACEP Council. I am thankful for the opportunity, and I am excited to attend again in the years to come. Representing Indiana was an honor and a fantastic experience. I felt each member had the opportunity for their voice to be heard and their vote counted; I was very impressed!

Legislative Update

by Lou Belch, The Corydon Group

The 2021 Session of the Indiana General Assembly finally concluded on November 15, 2021. Earlier this year the statute was temporarily changed from ending on April 29 to a date in November. The delay in the receipt of census data made it necessary in order to complete legislative redistricting -- which was completed in October.

With the new district maps complete, many legislators have already announced that they will not seek re election in 2022. We will give a complete breakdown in the next issue. Most noteworthy for IN-ACEP members is the announcement the Rep. Tim Brown, MD (R-Crawfordsville) is not seeking re-election. Dr. Brown was elected to the General Assembly in 1994. Upon conclusion of the 2022 Session, he will have served 28 years. Dr. Brown practiced emergency medicine prior to his retirement. He is currently Chair of the Ways and Means Committee. Prior to that position, he was Chair of the House Public Health Committee.

The 2022 Session is a short session. Budget matters are usually not addressed in a short session. Dr. Brown and legislative leaders are actively discussing some tax cuts to be considered next year. As of the writing of this article, it is unclear if the proposal would include expanding the sales tax to included services and lowering the rate. This has long been an interest of Dr. Brown and may get more attention with his announced retirement.

There will also be debate about the inclusion of Indiana in the "Medical Licensing Compact." This would make it easier for physicians to move in and out of the state. This is of interest particularly to border communities.

As expected, there may be further discussion regarding surprise billing. As you recall, Indiana likely does not have a specific law as defined by the "no-surprises act." Last year there was a decision by legislative leaders to not amend Indiana's law until there was federal guidance.

Please look for legislative updates during the Session from IN-ACEP

View from the Top

continued from page 1

INACEP going forward. There are many ways you can help and that could be joining the board, supporting a project or legislative engagement.

I want to challenge you personally to help. I have learned that getting involved helps give you a voice or gives you a new perspective on why things happen the way they do. This often eases some frustrations one way or another. These past few months I have gained a whole new perspective on state legislative advocacy as I take on a new adventure. I have been extremely involved the last 5 years at the statehouse and to a lesser extent the 5 years before that. We have faced scope of practice fights, insurance shenanigans, billing misunderstandings, and covid challenges. I have contributed regularly to the IEMPAC fund and would encourage you to do the same. I have been meeting regularly with legislators to develop relationships and to update them on what you and I face. A legislator recently said he couldn't think of a profession he would trust more than an ER doc right now.

The upcoming legislative session is only a few months away. INACEP is watching as new bills have started to be filed. We are actively discussing the upcoming session with our team and with likeminded organizations. We are participants in the Indiana Physician Coalition (IPC) and have developed good relationships with other specialties through this coalition. The IPC continues to be a good resource. Scope of practice has been a major focus of this group. We need innovative solutions on how to ensure our patients have access to and are getting appropriate safe physician led care. We have been in discussions with our nursing colleagues to see how we can partner to help with many of our mutual challenges such as nursing education, staffing, and longevity in the emergency department.

I recently announced I will be running for Indiana State Senate in District 14. I plan to continue to work with legislators and the INACEP board to help advance emergency medicine in Indiana to better serve Hoosier patients. Due to a conflict of interest concern and the nature of politics, unfortunately, I cannot complete my term as INACEP president.

It is a weird world out there right now. Even if you don't hear it people are grateful for you. I am grateful for you. Thank You

Fred Osborn Memorial Award —
Excellence in Emergency Medicine Nominations

In 2010, the Indiana ACEP board established an annual award in memory of Dr. Fred Osborn who passed away in 2009. Dr. Osborn contributed extensively to the practice of emergency medicine and to his group, hospital, community and the state. As such, an award was established in his memory to be presented annually at the Indiana ACEP Education Conference in the spring.

The Indiana ACEP board is now accepting nominations for this year's consideration. The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state. To nominate a worthy physician, please submit a single typed page detailing the qualifications of a deserving emergency physician whom you know which includes the information included in the template below.

The nominated person must be an emergency physician currently practicing in the state of Indiana and be a current member of Indiana ACEP. The person making the nomination however need not be a member of ACEP nor a physician.

The recipients of the award to date have been as follows:

2010 - Peter Stevenson MD, FACEP of Evansville, IN

2011 - David VanRyn MD, FACEP of Elkhart, IN

2012 - Thomas Madden MD, FACEP of Bloomington, IN

2013 - Thomas Gutwein MD, FACEP of Fort Wayne, IN

2014 - Tom Richardson MD, FACEP of Danville, IN

2015 - Randall Todd MD, FACEP of Indianapolis, IN

2016 - Chris Burke MD, FACEP of Carmel, IN

2017 - John McGoff of Indianapolis, IN

2018 - Thomas Heniff MD, FACEP of Boone CO, IN

2019 - Chris Hartman MD, FACEP of Carmel, IN

2020 - James Jones MD, FACEP of Zionsville, IN

All submissions are due by January 10, 2022 and are to be submitted electronically to cindy@inacep.org.

Nominations for the Fred Osborn Memorial Award – Excellence In Emergency Medicine must include the following information:

Name of Nominating Person _____

Name of Nominee _____

Date of Nomination _____ ***Nominee's Positions of Leadership*** _____

Nominee's Involvement / Contributions to their Group _____

_____

Nominee's Involvement / Contributions to their Hospital _____

_____

Nominee's Involvement / Contributions to their Community _____

_____

Nominee's Involvement / Contributions to their State _____

_____

Additional Comments are accepted. *Please limit submissions to a single, typed page detailing the qualifications of a deserving emergency physician whom you know.* ***Please remember:*** ***The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state.***

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