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EM pulse

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

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Inside this Issue

A View from the Top

Daniel Elliott MD, FACEP, FAAEM

Greetings from Indiana ACEP,

As I'm writing this message, we appear to be coming out of this latest Covid-19 surge and I hope this finds you getting back to a little bit of normalcy. As your newest President, I want to start off by highlighting what INACEP and ACEP have been doing for you as members over the past couple months. At this moment, we are finishing up an eventful legislative session that shows that we are well positioned for the future. We worked this session with the Indiana Physician Council on SB 239 (Healthcare Advertising Transparency). This legislation will lay out better requirements for who can call themselves a doctor and the need to display credentials to patients in advertising material.

We are also working to lay the groundwork for the next session and likely additional battles yet to come with regard to scope of practice and reimbursements as the legislature promises to take a hard look at healthcare costs and ways to cut costs. We continue to work to be at the table for these discussions and work to represent Emergency Physicians.

We are also working to lay the groundwork for the next session and likely additional battles yet to come with regard to scope of practice and reimbursements as the legislature promises to take a hard look at healthcare costs and ways to cut costs. We continue to work to be at the table for these discussions and work to represent Emergency Physicians.

Back here in Indiana, our local chapter has been continuing to look for ways to support our members. We have brought back our in-person Annual Conference this April 20th and are excited for the event and to be together as a group again.

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We have brought back our in-person Annual Conference this April 20th and are excited for the event and to be together as a group again.

We have also been adding new members to our Board who are already working at the national level to represent Emergency Physicians as a part of an ACEP Committee. We look forward to getting new ideas from these members and insight about how to grow our chapter and better serve our members.

Finally, I hope that all members feel they are represented by our Board and leadership team and know that they are always welcome to reach out with any issues they encounter, no matter how small. I hope to continue to be your voice and I appreciate the opportunity to represent you all!

--Dan Elliott

Welcome New IEMPAC Chair

Nicholas Sansone DO, FACEP

IEMPAC -- Why Should You Contribute?

My name is Nick Sansone, I'm a practicing emergency physician in Lafayette Indiana, a partner in a small democratic physician group, and I'm thrilled to take over for Dr. Burke as the new Chairman of Indiana Emergency Medicine Political Action Committee (IEMPAC). IEMPAC is an integral part of the lobbying efforts of the Indiana Chapter of American College of Emergency Physicians. IEMPAC is the vehicle that allows your voice to be heard in the state government. Simply put, IEMPAC promotes pro-emergency medicine legislation to our state representatives. Donated funds are used to support pro-emergency medicine legislators' campaigns and to lobby lawmakers.

IEMPAC provides Indiana's Emergency Physicians the ability to make recommendations and support the politicians who care about our profession and support our positions. Law makers are not emergency physicians, they benefit and need IEMPAC's support and advice on what laws will be right for our patients and our profession.

The shifting role of emergency medicine and the changing focus of the healthcare system make IEMPAC more vital than ever. It remains the only way for our collective voice to be heard in the legislature. In the past, the General Assembly has listened to Indiana emergency physicians on a number of important issues including opioid prescribing, the INSPECT program, Physician Ordered Scope of Treatment (POST) issues, and most recently the scope of practice for non-physician providers. These are only a few issues where IEMPAC was able to have an impact. Some of these topics, including the scope of practice of non-physician providers continue to be areas where we need to have a voice. The non-physician providers organizations can be quite aggressive when they lobby. Healthcare monopolies are expanding quickly through Indiana and threatening patient's choices of physicians, while increasing their costs. Our input is imperative, effects change and must be heard to protect our patients and profession.

The access we have been able to gain to legislators was helped by our regular contributions to them. Similar to previous years, the next year's session of the Indiana General Assembly could be career changing for Indiana's emergency physicians. We must continue to promote and protect our specialty. Please consider a contribution to IEMPAC today. As our previous chairman has stated, "you should think of your contribution as malpractice insurance". It's a necessary cost to avoid the risk of letting new laws pass without a say that could negatively if not detrimentally affect your career and your patients.

Please consider a contribution of a ¼ shift a year but any amount would be helpful and appreciated. Groups may also make a collective contribution if so desired (requires a roster submission). To contribute, please click on the "contribute today" button on the INACEP's IEMPAC webpage or make your check out to IEMPAC and send it to:

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Nick Sansone DO, FACEP

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Case Study: Malaria in a Returning Traveler, an Important COVID Mimic

by Ty Kelly MD/MPH, Luke Schafer MD; Indiana University Emergency Medicine Residency

Overview

A 36-year-old female without significant past medical history presented to the ED with generalized malaise, fever, and chills. She reported that her symptoms had gotten progressively worse for the past three days. She vomited multiple times during the same timeframe. While vomiting, the patient experienced a syncopal episode. She denied any chest pain or shortness of breath. She received two doses of an mRNA-derived COVID vaccine but did not receive a booster vaccination. She reported sick contacts at work positive for COVID. The patient recently returned from a work trip to Benin (West Africa) where she did not take malarial prophylaxis.

Initial Findings and Workup

Vital Signs: BP 125/72, HR 109, RR 18, SpO2 96% on RA , T 102.9˚F

Physical Exam: Non-toxic appearing. Alert and oriented. Cardiac exam revealed tachycardia and normal peripheral perfusion, no murmurs or pulse differentials. No increased work of breathing, lungs CTAB. Abdomen soft and nontender, no hepato-splenomegaly. No jaundice or rashes.

EKG: Sinus tachycardia, LVH, nonspecific T wave changes V3-V4
Initial laboratory studies: WBC 4.7, HGB 12.1, PLT 73, creatinine 1.17, total bilirubin 1.1, LDH 257, COVID negative, peripheral blood smear showed parasites.

Imaging: No acute cardiopulmonary process.

Management: Upon arrival, the patient's symptoms were controlled with Tylenol, Ibuprofen, Zofran and a liter of crystalloid IVF. The physician team initially suspected that the patient's symptoms were due to a viral illness, but sent malaria-specific labs (LDH, haptoglobin, peripheral blood smear) due to the patient's travel history. After the peripheral blood smear showed parasites, the physician team consulted Infectious Disease who admitted the patient for non-severe malaria.

The parasites were ultimately confirmed to be Plasmodium falciparum, and the patient was started on a three-day course of atovaquone-proguanil PO. The patient was discharged the following day and was reported to be symptom-free at time of discharge.

Discussion

Although malaria is not endemic to the United States, emergency medicine physicians need to be able to recognize the clinical signs and symptoms of malaria in returning travelers. Malaria can present similarly to viral URIs and careful attention should be given to gathering a thorough clinical history.

Fever is the hallmark of malarial disease and is frequently accompanied by headache, malaise, nausea and vomiting. Plasmodium falciparum is the malarial species associated with greatest virulence, and in its most severe form, malaria can lead to encephalopathy, seizures, ARDS, DIC and acute renal failure. Amongst returning travelers, median duration until clinical presentation ranges from 11-44 days. Travel to sub-Saharan Africa is associated with the highest relative risk of malarial transmission. Malarial prophylaxis is recommended for those traveling to endemic regions, but unfortunately is not completely effective in preventing disease transmission.

Diagnosis is made with peripheral blood smears which provides visual confirmation of parasites. Diagnosis is also supported by other laboratory findings such as elevated bilirubin, anemia, decreased haptoglobin, thrombocytopenia, and elevated creatinine. Treatment for malaria includes supportive measures in addition to antiparasitic therapy. Antiparasitic treatment modalities include chloroquine, atovaquone, proguanil, artesunate, and quinidine. Severity of illness, region of recent travel, immune compromise, and pregnancy status all affect the preferred antimalarial regimen.

Patients with severe malaria require artesunate IV and ICU admission, but less severe presentations may still benefit from ongoing hospital observation/admission. Given malaria's high morbidity and mortality and infrequency in which it presents in the United States, Infectious Disease consultation is recommended to help formulate the most appropriate plan for individual patients. For emergency physicians without rapid access to Infectious Disease consultation, the Centers for Disease Control and Prevention (CDC) offers a 24/7 hotline ((855) 856-4713) where physicians can speak with the CDC Malaria Branch clinician on call.

Conclusion

Malaria can have a similar clinical presentation to nonspecific viral illnesses. Because patients may not immediately provide a history of recent travel, thorough history-taking is essential to identify this critical diagnosis.

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Legislative Update

by Lou Belch, The Corydon Group

HEA 1001

House Enrolled Act 1001, authored by Rep. Matt Lehman (R-Berne) and sponsored by Sen. Mark Messmer (R-Jasper), deals with vaccines exemptions and employer vaccine mandates. The bill stipulates that a "health care facility that is subject to the federal immunization requirement" is included on the list of exemptions from the COVID-19 immunization requirement.

For the employers that would still fall under the COVID-19 immunization requirements, they can test their employees not more than twice a week. Additionally, if an employee uses immunity from COVID-19 as an exemption, then an employer can only request lab test results for verification every 3 months.

Also, if an employer receives a request for a religious exemption then it must be granted in religious compliance with Title VII of the federal Civil Rights Act of 1964 and the Americans with Disabilities Act. The bill also includes the three provisions that Governor Holcomb stated must be addressed before he would be able to end the public health emergency:

1.Allows FSSA to issue a waiver to claim enhanced federal matching funds for Medicaid.

2.Addressing issues related SNAP in order to participate in federal emergency allotments.

3.Allows the State Health Commissioner is issue standing orders, prescriptions, or protocols to administer or dispense certain vaccines for individuals who are at least 5 years old.

The bill is effective upon passage and has been signed into law by the Governor.

HEA 1153

House Enrolled Act 1153, authored by Rep. Lehman and sponsored by Rep. Phil Boots (R-Crawfordsville), makes changes to worker's compensation. The introduced version of this bill contained provisions that would have impacted physician payment. Those were removed in committee. The issue of physician payment will be a topic of discussion in the 2023 session. IN-ACEP lobbyists will be meeting this summer with other physician organizations to get a jump on this issue.

The 2022 session of the General Assembly ended shortly after midnight on March 8. At the end of the day there was very little that passed that impacts emergency medicine in Indiana.

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Louis M. Belch is President at The Corydon Group where he oversees the strategy and day-to-day operations for all health care clients of the firm. Lou has been a well-known fixture at the Indiana Statehouse since he was named legislative liaison for the Indiana Health Professions Bureau (now the Professional Licensing Agency) in 1989 under Governor Evan Bayh. In 1991 Lou left state government and began lobbying for the Indiana State Medical Association, one of Indiana's most prominent health associations. Since 1997, Lou has been a contract lobbyist specializing in representing health-related clients and has one of the best track records of success of any governmental-affairs professional – having developed and maintained key relationships on both sides of the political aisle for the past three decades.

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ER Preparedness: Pediatric Stroke

Emergency providers play a key role in pediatric stroke diagnosis and management

By Dr. Nihal Bakeer, Pediatric Hematologist-Oncologist
Indiana Hemophilia & Thrombosis Center

Is your emergency department ready to quickly diagnose and treat a pediatric stroke patient?

As an emergency practitioner, take action now. Prepare your team to effectively diagnose and manage stroke in children, before a young stroke patient arrives to your emergency department.

STROKES DO OCCUR IN CHILDREN

The notion that children do not suffer from stroke is a common misconception—even within the broader medical community. And yet, stroke remains among the top 10 causes of death in children. International incidence rates vary widely, from 0.54 to 13 per 100,000 children per year under the age of 18. The incidence rate is as high as 25 per 100,000 newborns, and stroke can even occur in utero.

The consequences of delayed stroke diagnosis and intervention in pediatric patients—including newborns and preemies—can have damaging long-term effects. Infants and children who survive stroke will have more years living with sequelae of brain insult including but not limited to, seizures during critical stages of development, and functional limitations and disabilities including physical, speech, behavioral and/or cognitive.

DIAGNOSING STROKE EARLY

Pediatric stroke diagnosis is often delayed or missed altogether due to lack of awareness, lack of pediatric stroke-ready centers with comprehensive stroke management expertise, and a disproportionately low index of suspicion of disease incidence and prevalence.

It is critical for emergency practitioners to recognize pediatric stroke early and begin treatment during the first hours and days after a stroke to optimize long-term functional outcomes and minimize stroke recurrence. Awareness of, and prompt referral to a neonatal and pediatric comprehensive stroke program can be lifesaving.

Remember the signs of stroke with the acronym BEFAST (Balance, Eyes, Face, Arms, Speech, Time). BEFAST adds gait and visual disturbances to the previous FAST stroke acronym, reducing the percentage of missed stroke patients from 14 to 4.4%. Whereas adult strokes often present with sudden focal neurological deficits summarized in BEFAST, a patient's age and ability to communicate or display focal neurological deficits are important factors in suspecting stroke.

Newborn strokes are often missed at birth and subsequently diagnosed around 4-8 months of age. Neonatal strokes may present as seizures, primary use of just one side of the body, or excessive sleepiness. Furthermore, a fair percentage of childhood strokes are missed because children with stroke may present with headaches, repetitive vomiting, generalized symptoms or seizures mimicking migraines, epilepsy, Todd's paralysis and/or viral illness.

BE PREPARED

Will your emergency team be able to identify pediatric stroke quickly and efficiently? During hyperacute stroke management, your team has a narrow window of opportunity—just 4 to 6 hours—to restore perfusion, limit the dense infarct core and salvage the penumbra—the hypoperfused tissue surrounding the ischemic core.

The American Heart Association/American Stroke Association recommends preparing dedicated stroke teams, units, nurses and emergency protocols to ensure timely delivery of life-saving care. An example of such preparedness is a multidisciplinary, multi-institutional neonatal and pediatric comprehensive stroke program—a joint collaboration between the Indiana Hemophilia Thrombosis Center (IHTC) and St. Vincent Ascension's Peyton Manning Children's Hospital (PMCH) in Indianapolis.

When a child with suspected stroke presents in the emergency department at PMCH, IHTC hematologists and nurse practitioners spring into action to execute a carefully tuned stroke algorithm that calls upon pediatric neurology, pediatric neurosurgery, critical care, neuroradiology and interventional neuroradiology experts from IHTC, PMCH, Northwest Radiology Network and Goodman Campbell Brain and Spine.

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Legislative Update

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Other Important Information

The primary election is **May 3rd**.

While there are 22 contested primaries in the House, we will focus here on the 5 physicians who are on the ballot and one who is not.

Rep. Tim Brown, MD (R-Crawfordsville) is retiring after 28 years in the General Assembly. Dr. Brown has served as Chair of the House Public Health Committee and ultimately Chair of the House Ways and Means Committee. Prior to his retirement from the practice of medicine, he practiced emergency medicine in Crawfordsville.

Rep. Brad Barrett, MD (R- Richmond). Dr. Barrett has just completed his second session as Chairman of the House Public Health Committee. Dr. Barrett has a primary opponent. Dr. Barrett is a retired general surgeon.

Rep. Rita Fleming, MD (D-Jeffersonville). Dr. Fleming is completing her second term.She serves on the House Public Health Committee. She is a retired OB/GYN.

Tyler Johnson, DO (R) is an emergency physician and past president of Indiana ACEP. He practices in Dekalb county and is in a 3 way primary to replace retiring Sen. Dennis Kruse in district 14.

Alex Choi, MD (R) is an anesthesiologist running against the incumbent Sen. JD Ford (D) Indianapolis.

David Welsh, MD a general surgeon and local health officer is running in a 3 way primary to replace retiring Rep. Cindy Ziemke (R-Batesville).

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in.gov/sos/elections/voter-information/

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State-of-the-art hyperacute therapies including systemic and intra-arterial thrombolysis, clot retrieval, and thrombectomy to manage the disease process in carefully selected patients are possible thanks to this team's rapid assessment and prompt intervention.

Patients are then safely transferred to the pediatric ICU or ward for institution of neuroprotective measures to protect the brain and prevent hemorrhagic conversion of the stroke. Together, the entire team makes the best-informed decision about hyperacute, acute and secondary stroke prevention strategies. Thereafter, the patient may undergo an expanded work up as necessary.

It is worth remembering that stroke care does not end with the discharge of the patient. Comprehensive stroke care and rehabilitation must continue after discharge. Some patients may need physical therapy, assistive devices, and orthotics, while others might experience speech and/or cognitive/learning deficits. Thus, continued multidisciplinary follow-up with neurology, rehabilitation medicine and other members of the stroke team is key for long-term success. Ongoing hematology treatment for sickle cell disease, hereditary hemorrhagic telangiectasia (HHT) and thrombosis hemostasis is also crucial.

Children are strong and resilient. With the right combination of provider expertise and caregiver advocacy, these survivors can recover in miraculous ways.

PREVENTION & AWARENESS OF PEDIATRIC STROKE

To diagnose stroke, you should have a high index of suspicion of stroke in at-risk patients. You should also help build awareness to the very real risks of stroke in kids—including hemorrhagic, ischemic and mixed-stroke syndromes. This can help save more children's lives and ensure that survivors live with less morbidity and disability.

Pediatric Stroke Risk Factors:

·Newborns, especially full-term infants

·Congenital heart disease

·Sickle cell anemia

·Trauma

·Children with hereditary or acquired thrombophilic coagulation disorders

·Vasculopathies including hereditary hemorrhagic telangiectasia (HHT), moyamoya, and vasculitis

·Pediatric cancers (especially those receiving brain radiation)

·Autoimmune disorders

·Infections

·Metabolic and genetic disorders

Teens and young adults should also be considered for adult stroke risk factors, such as hypertension, diabetes mellitus, smoking, drug use, hormonal contraception, heart disease and dyslipidemia.

The International Pediatric Stroke Organization (IPSO) is currently working on a position statement, defining what it means for a center to be "ready" to care for a child with stroke, as well as the criteria for a "Comprehensive Pediatric Stroke Center." As your emergency department becomes stroke ready, awareness of local and regional comprehensive pediatric stroke programs to contact is invaluable. Help spread the word. Be prepared. Call for assistance. Thank you for all you do to improve the lives and outcomes of those who seek your care.

Dr. Nihal Bakeer is a pediatric hematologist-oncologist at the Indiana Hemophilia & Thrombosis Center (IHTC) in Indianapolis and co-director of a multidisciplinary, multi-institutional neonatal and pediatric comprehensive stroke program founded and co-directed with pediatric neurologist, Dr. Lisa McGuire—a joint collaboration between IHTC and St. Vincent Ascension's Peyton Manning Children's Hospital (PMCH) in Indianapolis. Dr. Bakeer and IHTC colleagues Drs. Charles Nakar and Kyle Davis are available to discuss stroke with any healthcare team in search of stroke education and preparedness measures. Dr. Bakeer also points to her knowledgeable colleagues on the multidisciplinary stroke team including those from PMCH, Northwest Radiology Network, and Goodman Campbell Brain and Spine.

EM Department earns national award for wellness efforts during COVID-19

by Christina Griffiths
Media Relations Specialist, Indiana University School of Medicine
Jun 30, 2021

INDIANAPOLIS—Indiana University School of Medicine Department of Emergency Medicine has received the 2021 Emergency Medicine Wellness Center of Excellence Award from the American College of Emergency Physicians (ACEP) for work to promote wellness for its faculty, fellows, residents and staff throughout the COVID-19 pandemic. The national award was given to one emergency medicine department in the country for demonstrating an outstanding commitment to developing aspects of wellbeing for emergency physicians.
"When the pandemic started in March 2020, we had to respond quickly and strategically to the crisis as a frontline clinical department," said Julie Welch, MD, vice chair of faculty development. "The Incident Command System leadership team recognized the importance of wellness and incorporated it as a priority from the beginning."

The IU School of Medicine EM department consists of over 155 faculty physicians, five PhD faculty, 16 fellows, 73 residents, 56 advanced practice providers and 30 core administrative staff. Through the school's partnership with Indiana University Health, the department's clinical mission covers 10 emergency departments across the state with over 400,000 patient visits per year.

The Department of Emergency Medicine launched an EM Wellness Taskforce that is comprised of wellness champions from all 10 emergency department sites and provider roles. The taskforce was charged to identify wellness issues facing the frontline EM health care providers and then develop and implement wellness strategies to support the team. To accomplish this, they collaborated across the institution with groups including the IU School of Medicine/IU Health and Wellness Advisory Council (HWAC), the Indiana Clinical and Translational Sciences Institute (CTSI) and the National Alliance for Mental Illness (NAMI) to advocate and build targeted interventions to address wellness concerns.

"We discovered early in the pandemic that our providers needed more necessities for personal safety and wellness, such as on-site scrubs, showers, locker rooms, sleep rooms, and respite spaces to take a break during shifts," Welch said. "We also delivered morale boosters at all 10 of our sites with items like snacks and coffee, notes of gratitude and challenge coins. In addition, the taskforce hosted peer support groups and created a centralized online site for wellness resources such as mental health support and accessible childcare options for working parents struggling with daycare and school closures."

In March 2020, the IUEM Wellness Taskforce began studying wellness across the department utilizing periodic surveys throughout the pandemic. The survey questions focused on COVID-specific questions and validated tools covering personal safety, systems issues, work-life wellness, acute distress symptoms, mental health, well-being, burnout and resiliency. The findings of this study were recently published in BMC Emergency Medicine.

"This award was made possible thanks to the collaborative efforts of everyone in our department. We hope that our study findings and the measures we've implemented in our department will be useful to other departments across the country," said Heather Kelker, MD, lead author of the study and co-chair of the department's IUEM Wellness Taskforce. "Emergency medicine as a medical specialty has one of the highest rates of physician burnout. We want our work to continue to focus on improving wellness here at IU, but also be a model for others."

The department will be presented with an award plaque at the upcoming ACEP national meeting in the fall of 2021.

###

IU School of Medicine is the largest medical school in the U.S. and is annually ranked among the top medical schools in the nation by U.S. News & World Report. The school offers high-quality medical education, access to leading medical research and rich campus life in nine Indiana cities, including rural and urban locations consistently recognized for livability.

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