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NCAA Conference Center and Hall of Champions

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Inside this Issue

A View from the Top

Daniel Elliott MD, FACEP, FAAEM

Greetings Members!

Over the last 12 months, it has been an honor to serve as President for our state chapter. It has been a whirlwind year with many successes. I have greatly enjoyed learning from all of you. The camaraderie and engagement of members from all over the state on important issues has been critical to advancing our specialty's interests during my time as president. You all all work hard everyday to provide the best possible healthcare to our patients and as such are uniquely positioned to provide insight on challenges and opportunities. We have numerous members working at local, state, and national levels to advance emergency care for Hoosiers. We are also fortunate to have driven and well-trained medical students and residents across this state who are preparing to be the future of our great specialty.

Below are a few things that I'm proud our chapter has accomplished over the past year:

-The successful return of our annual in-person conference and preparation for another exciting edition this April.

-Collaboration with our medical colleagues to work to protect the physician-patient relationship with respect to women's healthcare.

-The re-election of Dr. Finnell to the national Board of Directors at the annual ACEP Council meeting which maintained our status as one of only 3 state chapters to have two or more members on ACEP's national Board of Directors.

-Protecting the physician-led care team for the benefit of patient care by preventing legislation that would allow NPs or PAs to practice medicine without physician supervision.

-Successfully advancing our own legislation which would make us the only state in the country to require 24/7 on-site physician coverage for all emergency departments.

-Support of national ACEP's efforts to ensure proper reimbursement for our services from insurance corporations and work within the state to continue to improve reimbursement from our Medicaid and state-specific payors.

These are just a few of the things we've accomplished this past year. We have many more issues to tackle, especially with regards to ED boarding, mental health, and physician wellness. I know this chapter will flourish next year with Dr. Zimmerman as President and we will continue to work to represent all emergency physicians across the state. Thank you again for your commitment to our chapter. It has been an honor to represent you.

Stay safe and stay well!

SOS - EMS Workforce in Crisis

Eric Yazel, M.D.

Some of you are already acutely aware of this, but for some who aren't, you might want to check on your EMS friends. We are not well. Reimbursement is low, which limits our EMS organizations ability to pay a competitive wage. We have always lost personnel to fire, nursing, and other professions. Now we are losing them to fast food and other non-traditional competitors. Its fair to say the current workforce is at crisis level.

A recent dive into our state data showed only 34% of our certified paramedics responded to 911 calls in 2022. In all parts of Indiana, services are spread thin, scrambling for coverage. A lot of EMS providers work for 3 or 4 services. They will work a 24 hour shift, then immediately report to a shift at another service. Not surprisingly this leads to burnout, physical and mental health issues, and ultimately affects patient care. Depending on what study you read, the average career length for a medic is 5-7 years and only marginally longer for an EMT.

Wow, thanks for the uplifting article right? Well the good news is, this is being addressed from all angles. There are reimbursement improvements that kick in this summer. There is an almost unprecedented level of EMS focused legislation this session. Recruitment is a focus, with scholarships, tuition reimbursements, improved educational opportunities all priorities. Multiple agencies are working on pilot programs and other means to assist with inter-facility transfers, particularly in our rural areas. Mental health is a major priority as well, both the EMS role in behavioral health emergencies and mental health support for the providers themselves. Mobile integrated health (MIH) continues its rapid growth in Indiana and funding opportunities to continue that growth and pathways to sustainability are increasing in turn. This may seem counterintuitive in the face of the previously mentioned workforce shortage. However, MIH appears to be increasing the longevity of our current providers and even bringing some back into the field that had previously left for other opportunities. Not to mention the added benefit of mitigating recurrent ER utilizers and filtering a portion of non-acute runs out of the 911 system. Last, there are several systems piloting new frontiers in EMS, such as prehospital ultrasound, whole blood transfusion in the field, and alternative destination protocols.

These are all things that will positively impact EMS care delivery, but they are 'long game' initiatives. How do these things help you on your shift this weekend when you are trying get a sick transfer out at 2am? We have all been there. The short answer is they don't, but there are some things that can help. First is resource utilization, especially on transfers. Remember cardiac monitoring requires paramedic transport. If they need a monitor, they need a monitor, period. But we are seeing transport requests where cardiac monitoring is become more of a de facto box to check on a medical necessity sheet versus truly requiring ALS skills. Remember the downstream effects of pulling a medic from 911 availability in this scenario. Next, be cognizant of diversion. We all have times where the system hammers us, in those scenarios, do what you have to do. But too often its a result of ED boarding and other factors that are hospital administration issues. Allowing that to trickle down to you only lowers their motivation to develop more viable solutions. It also impacts patient care and safety. We have all been presented with that intricately complex medical patient who has never set foot in your facility previously as a result of diversion. Its not in the best interest of you or the patient. If a situation exists we can help advocate for you, please reach out. Last, but definitely not least, be kind. Take a moment and listen to the EMS report. I am always surprised how much can get lost in translation during the triage process. If you see a correctable action, take a minute or two to teach. EMS providers are some of the most eager and enthusiastic learners you will encounter. And if they do a particularly good job with a patient, let them know. The backside chewing to back slap ratio for EMS is pretty grim these days!

There are great challenges across the state, but solutions abound as well. It's an exciting time for EMS, and how we navigate this will determine our path for years to come. In order to reach our potential as Emergency Medicine providers in the state, we need a strong EMS system. It makes our lives easier and it makes for better outcomes in our patients, which is what it's all about.

Legislative Update

by Lou Belch, The Corydon Group

This legislative update is being written just after "halftime" of the legislative session. The House is now considering Senate bills and the Senate is considering House bills. The legislative session must end no later than April 29, 2023. All bills reported on below are subject to change as the process continues.

SB 400, introduced by Sen. Liz Brown (R-Ft. Wayne) contains several issues of interest to health care providers. Of most interest to Indiana ACEP is a provision that requires a hospital with an emergency department to have a physician on site who is primarily responsible for the emergency department. Additional provisions deal with provider credentialing and prior authorization. The bill is currently awaiting further action in the House.

SB 7, introduced by Sen. Justin Busch (R-Ft. Wayne), prohibits physicians from entering into an employment contract that contains a non-compete provision. The bill is currently awaiting further action in the House.

HB 1006, introduced by Rep. Greg Steuerwald (R-Danville), make changes to the civil commitment process including the immediate and emergency detention provisions. INACEP lobbyists are working with the author to ensure that the changes do not adversely impact the practice of emergency medicine. The bill is awaiting further action in the Senate.

HB 1462, introduced by Rep. Ann Vermilion (R-Marion), requires emergency departments of hospitals to annually submit to the department of health annually a plan to address SUD in the ED. The bill is awaiting further action in the Senate.

There are a number of bills that are seeking to address the high cost of hospital care in Indiana. A subset of the discussion is the low reimbursement rates for physicians in Indiana. There may be, by the end of session, provisions that would increase physician reimbursement rates. Also being discussed are tax credits for physicians in independent practices. While it is too early to predict where the discussions will lead, it is a promising development.

Your Indiana ACEP board of directors is monitoring the session and will intervene as necessary.

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.

Here's an easy way to contribute $100 now to IEMPAC
Your voice and your contribution are important

New Members

Acep Regular:
Diane Wallace MD

Medical Student:
Taylor Kowalski

A Breakthrough for Treating Opioid Use Disorder in the ED

Goodbye, X-Waiver!

Lauren Stanley, MD, FACP

A recent legislative change is a breakthrough for emergency physicians treating patients with opioid use disorder (OUD): as of January 2023, the requirement for an X waiver to prescribe buprenorphine has been eliminated. Any provider with a DEA schedule III license can prescribe it. This is a huge step forward in our ability to treat patients with OUD, as medication-assisted treatment (MAT) with medications such as buprenorphine is considered standard of care for treating patients with OUD. A plethora of data show the many benefits of MAT, especially in conjunction with motivational interviewing, counseling, and behavioral therapy. Benefits of MAT include decreased overall mortality, overdose, criminal activity, and infections related to IV drug use (such as HCV and HIV); MAT also increases patients' likelihood of continuing treatment, being employed, and many other positive effects. In short, medication-assisted treatment is an evidence-based intervention that has tremendous potential to help our patients with OUD in the ED.

There are currently 3 medications that are FDA-approved for opioid use disorder: methadone, naltrexone, and buprenorphine. Methadone is a full mu-opioid receptor agonist with a long half-life (24-36 hours), and can only be dispensed from licensed Opioid Treatment Programs approved/accredited by SAMHSA/HHS. Thus, this will be unlikely to be utilized from ED standpoint. Naltrexone is a mu-opioid receptor antagonist that comes in oral and IM forms. Buprenorphine is a partial mu-opioid receptor agonist, which has higher affinity for the mu receptor than other opioids including fentanyl, morphine, hydrocodone, oxycodone, but lower intrinsic receptor activation.

This discussion focuses on buprenorphine, which comes in various forms including sublingual tablets, sublingual films (with quicker onset of action, but more expensive), IV, IM, subcutaneous injection, and transdermal patch. It is commonly formulated with naloxone; it's important to remember, though, that the combination product of buprenorphine/naloxone (brand name Suboxone) contains the naloxone portion to prevent patients from melting it down and injecting it. In its oral forms, there is very little absorption of naloxone. Pregnant patients should receive buprenorphine-only formulations (without naloxone). Buprenorphine (especially the tablets or films) are most convenient for ED induction of MAT, in which the patient is given the first dose/s in the ED and referred for close follow-up (ideally, within several days) to a provider who can manage their long-term treatment.

It is important to keep in mind that giving buprenorphine to a patient who has recently used their opioid of choice (fentanyl, oxycodone, heroin, etc) could precipitate withdrawal. This is because buprenorphine has a higher affinity for mu receptors than these drugs, and will block or displace them from the receptors, precipitating withdrawal. Thus, timing of the first dose is important. Many ED's around the state have protocols for MAT induction with buprenorphine/naloxone. Most protocols require a certain time to have passed since their last ingestion, and/or COWS score (Clinical Opiate Withdrawal Scale) of 12 or more. A first dose of 2-4mg is typically used, followed by a period of observation to assure that the patient's withdrawal symptoms improve. Dose can be titrated to effect; typical initial daily dose is 8-12mg. Patients who are established on buprenorphine are often on 12-16mg/day, up to 32mg per day. Consider working with your community's psychiatry/mental health providers and pharmacists to create a protocol for your ED.

There are many resources available to help with developing a MAT induction plan, such as the SAMHSA Quick Start Guide (and many others available on the SAMHSA website). Check out ACEP's Opioid Use Disorder Resources as well, for ED-specific information.

One frequent counter-argument that is heard regarding buprenorphine is that this medication could become a substitute for whatever opioid a patient had been abusing, and that administering buprenorphine or providing a prescription for it could lead to a patient overdosing on it. On the contrary! Buprenorphine has a ceiling effect in terms of respiratory depression and sedation; unlike full mu-opioid agonists like fentanyl, morphine, hydrocodone, etc, which lead to respiratory depression (or arrest) that is related to the amount ingested, buprenorphine is less likely to cause life-threatening overdose.

Interestingly, although there is a ceiling to the respiratory depression from buprenorphine, there is no ceiling to its analgesic effects. This is important to remember if you are treating a patient who is on buprenorphine (including Suboxone) and has an acutely painful condition, such as a fracture: consider giving them additional or higher doses of buprenorphine in order to treat their acute pain more effectively. You can also administer other opioids such as fentanyl, morphine, or hydromorphone, or consider opioid-sparing options like nerve blocks or ketamine.

A Breakthrough for Treating Opioid Use Disorder (Cont.)

(Continued from Page 4)

Another counter-argument against buprenorphine initiation from the ED is that many of us as Emergency Physicians don't have the community-wide support in place to properly treat our patients with OUD, such as readily available counseling/therapy to send patients to after ED discharge. We at Indiana ACEP have heard of mental health resources/services being cut due to hospital budgeting decisions or lack of provider availability. However, it's important to keep in mind that treatment with buprenorphine reduces mortality even without psychosocial treatment. So although the ideal treatment plan includes a specific plan for close follow-up with a mental health provider, lack of follow-up options (or patients' unwillingness to go to a therapist, for example) should not preclude treatment with buprenorphine.

Aside from the clinical question of how we manage patients with OUD at the bedside, treatment of patients with substance use disorder (SUD) has also become a legislative issue. Indiana House Bill 1462 was introduced during this legislative session: among other things, the bill would require every ED to annually submit to the Indiana department of health a plan to initiate interventions with patients who have a substance use related ED visit, and set forth the requirements of a SUD treatment plan. The bill would call for the office of the Secretary of Family and Social Services to require managed care organizations to consider services provided to an individual under a SUD treatment plan as medically necessary. At time of this writing, the current legislative session is still ongoing, and the fate of HB 1462 is still to be determined, but it's safe to say that legislators' attention is tuned into the care of Hoosier patients with SUD. Indiana ACEP is committed to ensuring that any such legislation supports physicians' autonomy in treating patients appropriately, and encourages systems-wide support for that treatment, without creating undue requirements or unrealistic mandates.

Case Study: Recurrent Nausea and Vomiting

By Ty Kelly, M.D./MPH, Indiana University Emergency Medicine Residency and Dallas Peak, M.D, Indiana University Department of Emergency Medicine

Initial Presentation: A 32-year-old female with no significant past medical history presented to the ED for recurrent nausea and vomiting. The patient had been previously evaluated in the ED for similar complaints within the past month, including the day previously where she had a CT scan of the abdomen/pelvis performed which did not demonstrate any acute intrabdominal pathology.

Findings and Workup:

Physical Exam: Nontoxic appearing. Actively vomiting. Dry mucous membranes. Generalized abdominal pain without peritonitis.

EKG: Sinus tachycardia, normal intervals, no ST or T wave abnormalities.

Laboratory studies: CBC, lipase, urinalysis within normal limits. Urine pregnancy test negative. CMP with mild anion gap (15) and decreased bicarbonate (18).

Imaging: No imaging performed.

Management: The patient was given intravenous droperidol and two liters of crystalloid fluids. A BMP was subsequently performed which demonstrated a normal anion gap and bicarbonate. The patient felt much better, reported no ongoing abdominal pain, and was able to easily tolerate PO. Further history from the patient revealed that she had been a daily marijuana user for years and that the patient's symptoms recurred yesterday after using marijuana. The patient was diagnosed with cannabinoid hyperemesis syndrome and was educated on the importance of marijuana cessation.

Discussion: Cannabinoid hyperemesis syndrome (CHS) is a clinical syndrome characterized by intractable nausea/vomiting in the setting of consistent marijuana use. Although there are multiple proposed mechanisms of action, the exact pathophysiology of CHS is poorly understood. Importantly, CHS incidence is increasing across the nation paralleling similar trends in marijuana use. There is a paucity of empiric data to support specific pharmacologic treatment regimens, although case reports suggest that typical and atypical antipsychotic medications, capsaicin cream, and hot showers may have therapeutic benefit. The single most important therapeutic intervention to prevent symptom recurrence, however, is marijuana cessation.

Conclusion: Cannabinoid Hyperemesis Syndrome is increasing in incidence. Obtaining patients' social histories in an open and non-judgmental fashion is crucial to making this diagnosis. Marijuana cessation is the most important therapeutic intervention.

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Fred Osborn Memorial Award

Excellence in Emergency Medicine Nominatons

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 award recipients to date are 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

2022 - Sara Brown MD, FACEP

All submissions are due by April 3, 2023 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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