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EM pulse

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SAVE THE DATE

INACEP

ANNUAL EMERGENCY MEDICINE CONFERENCE

APRIL 11, 2024

downtown Indianapolis

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A View from the Top

Lindsay Zimmerman MD, FACEP

Hello members of Indiana ACEP! Thank you for joining me on my journey as Indiana chapter president of ACEP. My name is Lindsay Zimmerman and I am an emergency medicine physician that lives in Indianapolis. I work with Vituity at several sites around Indiana, including Ascension Health and Henry Community Health systems. I am honored by the opportunity to serve you this year and am looking forward to working with you in the pursuit of advancing the interests of emergency medicine. We are pleased to see the efforts put forth by INACEP and other groups to pay off in the recent passage of SB 400.

This law states that "a hospital with an emergency department must have at least one (1) physician on site and on duty who is responsible for the emergency department at all times the emergency department is open." We are proud to be the first state in the country to pass this type of legislation and are acutely aware of the responsibility and attention this brings. I am gratified to see the results of our hard work. I have included below the testimony that was written to ask for the removal of the critical access hospital exception that was initially in the bill but removed after we went to the statehouse this past year to advocate on behalf of emergency medicine physicians and our patients.

> My name is Dr. Lindsay Zimmerman. I am an emergency physician and the current vice president of the Indiana chapter of the American College of Emergency Physicians. I work in urban, suburban, rural and critical access emergency departments across Indiana. I am here today speaking on behalf of our organization and on behalf of those patients we are privileged to serve. As emergency physicians, we are pleased to note that our high level of professional training and our credentials are recognized in Senate Bill 400. Emergency medicine physicians are highly qualified in all aspects of resuscitative care, and we believe that every patient coming to the emergency department should have access to an onsite physician. We are therefore deeply concerned about the exception of the requirement for onsite physicians for critical access hospitals. Critical access hospitals have fewer services available in their communities and rely upon urgent or emergent transfers of their sickest patients to hospitals that have higher levels of care. When patients come to these emergency departments, often the only physician in the hospital, is the one in the emergency department. Nonphysician providers of care do not have the same level of qualifications or requirements of training as physicians. While valued members of the healthcare team, they are not intended to replace physicians, as their training does not approach that of physicians when it comes to the resuscitation of the critically ill or injured. If a patient needs a breathing tube inserted in their airway because they aren't breathing properly- I have been trained to do that and have demonstrated proficiency to anesthesiologists. If a pregnant patient comes in with an imminent delivery, I have been

(Continued on Page 8)

Legislative Update

by Lou Belch, The Corydon Group

Health care costs were a significant issue this session, with both the House and Senate Republican caucuses making the issue a priority. The bills were primarily directed at hospitals; time will tell the impact on the physician providers. Below we will provide updates on a few new laws that will potentially have an impact on emergency physicians.

SEA 7 (PL 165) prohibits non-compete clauses in primary care physician contracts between an employer and the physician. It also allows physicians who are subject to non-competes to have the contract not enforceable if: the employer terminates the physician without cause, the physician terminates the employment for cause or the contract has termed and all conditions have been satisfied. This applies to contracts executed after July 1, 2023.

SEA 400 (PL 190) has significant provisions regarding heath care. The provision of most interest was initiated by INACEP. It requires a hospital to have a physician on site and primarily responsible for the emergency department any time the department is open. This is the first law of this kind in the nation.

HEA 1001 (PL 201) the state budget. In the final hours of the session, a provision was added to increase the physician fee schedule in the Medicaid program to 100% of Medicare. This is the highest Indiana may pay physicians pursuant to federal law.

HEA 1006 (PL 205) deals with mental health issues. The bill changes the way emergency detentions and civil commitments are handled. This is a very complicated legal process. The Indiana Hospital Association and their counsel are providing guidance to their member hospitals. Emergency physicians should engage with their specific hospitals to determine how this will be handled. It may be different county by county (depending on the presence of a mental health court.).

The list above is certainly not a complete recap of all the health legislation, but only the most significant. The Legislative Council met on June 13th to assign topics for the interim. There are several topics, below are just those of most interest to INACEP.

The Interim Study Committee (ISC) on Employment and Labor will study the issue of mobility on professional licenses.

The ISC on Financial Institutions and Insurance will study the issue of “gold cards” for providers who continuously received prior authorization.

The ISC on Public Health, Behavioral Health and Human Services is charged with the following topics:

(A) Study options for child care, including location of child care facilities in businesses or other commercial buildings.

(B) Study the following topics:

(i) The prevalence and impact of mental illness, including major depression disorder, post-traumatic stress disorder, and severe anxiety, among veterans and first responders in Indiana.

(ii) Alternative treatment options for serious mental illness that have been given "breakthrough therapy" status by the United States Food and Drug Administration, including psilocybin for treatment-resistant depression.

(iii) Policies enacted and under consideration in other states that enable access to psilocybin-assisted therapy forveterans, first responders, and others experiencing severe mental illness.

(C) Approval of agreements with private attorneys and private entities when the Child Support Bureau determines that a reasonable contract cannot be entered into with a prosecuting attorney to administer the child support provisions of Title IV-D of the Federal Social Security Act.

INACEP lobbyists will monitor these ISCs and report back to the Board 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.

Improving Organizational Health Literacy

By: Ellen Bloom, Patient Education Manager
Indiana Hemophilia & Thrombosis Center

When we think of health literacy, we often think of personal health literacy—a person's ability to obtain, understand, and act on health information—but in fact, organizational health literacy plays a crucial role in the health of communities. An organization's commitment to providing information and services in a way that is accessible, understandable, and actionable can make an enormous difference in a patient's health. While becoming a health literate organization is a large undertaking, there are many smaller steps that providers can take to make real changes in their interactions with patients and families.

- **Understand the role that fear and anxiety can play.**
  - Even people with high health literacy skills can struggle to understand and act on health information in circumstances where they are afraid, anxious, or overwhelmed.
  - In stressful situations, it's important to speak clearly, use everyday (plain) language, and check for understanding using open-ended questions such as, "What questions do you have?"

- **Explain health information using words that are easy to understand.**
  - For example, talk about high blood pressure, not hypertension. If you do need to use difficult words, jargon, or acronyms, make sure you explain these terms using everyday language.

- **Be clear about health information and health directives.**
  - Use the active (conversational) voice when providing instructions or health information to patients and families. For example, say, "You'll need to schedule a follow up appointment with your primary care doctor," rather than "A follow up appointment with a primary care doctor will be needed." Being clear with directives makes them easier to understand and follow.

- **Think about what happens when a patient walks into your emergency department.**
  - Are the signs they see, the forms they have to fill out, and the procedures they have to follow simple and easy to understand? If not, what can you do to simplify processes as much as possible for your patients?

Want to learn more about communicating clearly using plain language? Check out the CDC's website on health literacy.

Ellen Bloom is the Patient Education Manager at the Indiana Hemophilia & Thrombosis Center in Indianapolis. Ellen works with healthcare professionals to ensure all patient-facing communications are easily understood and help patients achieve better understanding of their medical condition(s) and health management strategies.

Fred Osborn Excellence in Medicine Award
Brian Sloan, MD, FACEP

Dr. Brian Sloan embodied an exemplar academic emergency medicine physician throughout his career via dedicated service to his patients, to his learners and to his profession.

Dr. Sloan graduated in 1989 from Indiana University Bloomington with his Bachelor of Art in History. He returned to Indiana University School of Medicine and graduated in 1997 with his Doctor of Medicine. He stayed to complete his Emergency Medicine Residency at IUSM, graduating in 2000. After residency, he completed a fellowship in Primary Care Sports Medicine at St. Joseph's Regional Medical Center in South Bend, Indiana.

In 2001, Dr. Sloan joined the emergency medicine faculty at Wishard (Eskenazi) Hospital. Dr. Sloan's career is the embodiment of sacrifice, leadership, communication, teamwork, patience, compassion, and resiliency.

He was a cornerstone in the clinical educational mission of IUSM and the EM Residency Program, serving over two decades as a physician educator and mentor. He was awarded Faculty Teacher of the Year in 2012 by the IU Emergency Medicine Residency.

Dr. Sloan has provided outstanding service to the community by volunteering as a staff physician at the IUSM Student Outreach Clinic, overseeing residents and medical stud and starting the ED Threads Program.

Early in his career, he co-founded the first county hospital Sports Medicine Clinic in conjunction with the Department of Family Medicine focusing on assessing and treating acute musculoskeletal injuries while teaching students, residents, and fellows.

Dr. Sloan worked with Methodist Sport Medicine as a sports medicine physician providing history and physical exams to NFL draft potentials at the NFL Combine annually (2011-2018).

He served as a Safety Team Physician at the Indianapolis Motor Speedway for the Indy Racing League and Indy Lights Series from 1999-2004. He also served as a Fast Car intervention Physician for the US Grand Prix Formula One events. Dr. Sloan's team published "An Analysis of Maximum Vehicle G forces and Brain Injury in Motorsports Crashes" in Medicine and Science in Sports and Exercise in 2006.

In addition, Dr. Sloan has contributed his expertise in the niche of road race medicine. He served as Medical Director of the Indianapolis Life, Mini Marathon (2005-2010), the largest half marathon in the US (13.1 miles; 35,000 runners). During his leadership, he impacted the emergent treatment of life-threatening events at the mini-marathon, such as implementation of an onsite heat stroke protocol to deliver timely critical care and decrease hospital transfer and admission of heat stroke victims. He published this innovative approach and outcomes in an article titled "On-Site Treatment of Exertional Heat Stroke" in the American Journal of Sports Medicine in 2015. More recently, in 2019, he published "A Novel Technique for Ice Water Immersion in Severe Drug Induced Hyperthermia in the Emergency Department" in the Journal of Emergency Medicine, thus disseminating his work through scholarship.

As an innovator and entrepreneur, Dr. Sloan developed a Wound Irrigation Device. In 2015, he applied for a provisional patent, started a company, and a manufacturer. In addition, he secured grant funding through the Indiana Clinical and Translational Sciences Institute (ICTSI) for final prototyping and an animal study in collaboration with Purdue University School of Veterinary Medicine. Data from this study was disseminated in a published article titled, "Comparison between a novel tap water wound irrigation device with sterile saline device in an open traumatic wound animal model" in the journal Trauma in 2019. [Results showed no difference in the reduction of inoculated MRSA in this tap water device relative to a sterile saline system. Switching to tap water irrigation would result in a substantial cost savings (approximately $65,600,000 per year in the United States).]

WELL DESERVED, DR. SLOAN!

Case Study: Benzonatate Toxicity

by Lindsay Zimmerman MD, FACEP

Cardiac arrest in 1 year old

Initial presentation:
1-year-old female child presents via EMS in cardiac arrest. The patient had been playing in some moving boxes in the bathroom next to the mother when the mother heard a thump. Mother looked over and saw patient seizing, which lasted for about 30 seconds and then went limp. EMS arrived on scene and intubated child and gave 9 rounds of epi. Patient was in asystole during most of the resuscitation except for one unclear rhythm which was shocked once. Mother reports a prescription of Tessalon Perles may have spilled in the box the child was playing in with possible overdose. No PMH/PSH.

Physical Exam: Unresponsive child intubated, being bagged, equal pupils still reactive. Bagging easily and equally with CPR in progress. Skin without color change. IO in right proximal humerus.

Emergency Department course: The patient was brought into the ED in full arrest. Multiple rounds of epinephrine and sodium bicarbonate administered as well as calcium and amiodarone after the patient went into ventricular fibrillation. The child had one shock administered and had ROSC for a brief period, but then lost pulses. Epinephrine and sodium bicarbonate administered again which brought the patient into ventricular tachycardia. The patient was shocked again and achieved ROSC. Labs after ROSC demonstrated pH of 6.8 and lactate >20. She was admitted to ICU, where she was diagnosed with hypoxic ischemic encephalopathy and died two days after presentation.

Discussion: Benzonatate prescriptions have risen significantly in recent years, and the emergency physician should be aware of the dangers of overdose of this drug. Benzonatate acts as a potent voltage-gated sodium channel inhibitor and is structurally related to the para-amin-benzoic acid class of local anesthetic agents (such as procaine or tetracaine). It works by desensitizing pulmonary vagal stretch receptors involved in the cough reflex. Onset of action occurs 15-20 minutes after ingestion and may last for up to 8 hours. Toxicity has been reported in children with a single dose of benzonatate. Overdose due to sodium channel blockade may lead to neurologic and cardiovascular toxicity, manifested by tremors, confusion, seizures, cardiac conduction changes and cardiorespiratory arrest. Benzonatate toxicity is treated with general supportive measures, and agents that reverse sodium blockade or lipid emulsion therapy may be considered. Sodium bicarbonate can be administered at 1-2 meq/kg to counter the effects of sodium channel blocked as demonstrated by widened QRS.

Conclusion: Benzonatate has a narrow therapeutic window and may cause fatal overdose in children younger than 10 years of age even with small amounts of the drug. Patients and caregivers should be educated about the risks of unintentional ingestions in younger children in addition to standard instructions on appropriate administration of the drug. Emergency physicians should be aware of toxicologic risks when prescribing this drug and be familiar with the treatment guidelines of benzonatate overdose.

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Leadership and Advocacy Conference 2023

by Daniel Elliott MD, FACEP, FAAEM

This year's ACEP Leadership and Advocacy Conference (LAC) was held on April 30th to May 2nd in Washington, D.C. and consisted of over 450 emergency physicians from around the country coming together to discuss, strategize, and advocate for solutions to emergency medicine's most pressing issues. Attendees from the Indiana chapter consisted of Drs. Jamie Shoemaker, JT Finnell, Daniel Elliott, Kyle English, William Freudenthal, Anthony Ragusa, and Bryce de Venecia. The conference consisted of 2 days of riveting and eye-opening speakers, from Dr. Dara Kass, on her role at the Department of Health and Human Services to Sen. Maggie Hassan (D-NH) and what our legislators are doing increase access to care for mental health patients.

There were additional speakers and roundtable discussions covering topics including a reimbursement breakdown, post-Dobbs emergency care, as well as a scope of practice update.

The final day of the conference consisted of visits to Capitol Hill to discuss directly with our legislators about topics most concerning to emergency physicians. This year's highlighted topics focused on strengthening protections against ED workplace violence, ongoing boarding crisis in departments across the country, and ensuring annual Medicare payment updates for physicians keep pace with inflation. Our members who attended were able to sit down and discuss these important topics with legislators or their staffers from every Representative and Senator from Indiana, as well as take part in a dinner with Rep. Bucshon (R-IN) where we discussed strategies to combat these issues including his proposed legislation to address inflation-based increase to Medicare rates for physicians every year.

These meetings gave our attendees the opportunity to discuss the day-to-day challenges of working in emergency departments while also highlighting personal stories related to workplace violence and the ED boarding crisis.

During this year's conference, our state chapter was also able to have the podium and highlight our state advocacy success with our recently passed legislation requiring on-site physician staffing in all emergency departments and answer questions from other chapters who hope to pursue similar language.

Overall, ACEP's Leadership and Advocacy Conference was an awesome experience for attendees and another great way to highlight what ACEP and our state chapter are accomplishing on behalf of all our members. All are welcome to partake in future LACs. It is a great way to see this advocacy firsthand!

YOU DON'T WANT TO MISS THIS!

52nd Annual INACEP Emergency Medicine Conference

April 11, 2024
downtown Indanapolis

Leadership and Advocacy Conference

LAC: Residents' Perspective

Bryce de Venecia, MD
Anthony Ragusa, MD

Pictured from left: William Freudenthal, MD, Jamie Shoemaker, MD, Bryce de Venecia, MD, Anthony Ragusa, MD, JTFinnell, MD, Daniel Elliott, MD.

The Leadership and Advocacy Conference gave us resources and reignited our passions to improve our healthcare system for the betterment of our patients and our fellow Emergency Medicine colleagues.

The days leading up to the conference were grueling: Tony was finishing up his time in the Surgical Trauma ICU and Bryce had a string of busy, high acuity shifts. An all too early flight out of Indianapolis (we both prefer the night shift lifestyle) brought us into Washington DC right as the conference was kicking off. We hit the ground running with the Health Policy Primer through ACEP's Young Physician Section. We heard talks given from residents and physicians around the nation covering a variety of issues. Hopefully a representative from Indiana will be providing their voice next year.

The second day, we learned from prominent leaders in EM about a range of topics from leadership tactics, navigating new legislation, and combating the opioid crisis. INACEP's very own Daniel Elliott, MD spoke about the work that went into SB 400, highlighting the successes and concessions to ensure Hoosiers have the access to a physician within the Emergency Department. Later that evening, we were invited to attend a dinner with multiple board members of ACEP and the US Representative from Indiana's 8th district, Larry Bucshon, MD, who was a co-author on a number of bills supported by ACEP. Networking with somebody who has personally advocated on behalf of physicians to policy makers on a national stage was an incredible opportunity.

The first two days were such a valuable learning experience, but the final day was by far our favorite. The last day of the conference brought us to the Capitol where we were able to speak with the Legislative Teams representing Indiana. We informed our Representative and Senators about ED boarding, workplace violence experienced by frontline workers, and the stagnation of physician compensation, encouraging them to support legislation that would confront these issues. Most surprisingly was that very few of those we spoke with even knew of the boarding crisis, so we hope that through sharing our stories and experiences the legislators can better understand the issue and work to rectify it. We invited these legislative teams to the Emergency Departments throughout Indiana, so they can exchange their suits for scrubs and see first hand how much these issues affect our world.

The opportunity to speak with the legislative teams was such an incredible and inspirational opportunity. There are times when our role as Emergency Physicians can seem like we are fighting a constant uphill battle against wait times, overcrowding, and difficult patient encounters, adding stress to an already strenuous job. The discussions we had with our fellow ACEP members and legislative teams gave us renewed vigor to advocate both locally and nationally. We will definitely be attending LAC in the future!

acep Scientific Assembly PHILADELPHIA, PA 23

October 9-12, 2023
Pennsylvania Convention Center
Philadelphia, PA
acep.org/sa/

A View From the Top Continued

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trained by OB/Gyns to deliver the child and stabilize any immediate complications. If a patient presents with fluid in their heart sac that is crushing the heart, I have been trained on the procedure to remove the fluid and prevent the patient from dying.

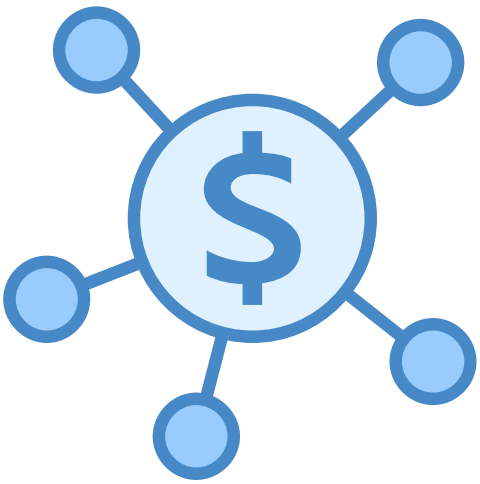
If a baby comes in with a congenital heart defect, I have been trained to recognize the symptoms and how to stabilize the child prior to transfer. If an athlete presents from a game with a collapsed lung, I have been trained to put in a chest tube to restore lung function. If a patient comes in with no pulse, I have been trained in both diagnosing the causes and managing the treatment of cardiac arrest. I have seen these and many other types of emergent presentations that occur at critical access hospitals. These cases are best managed by physicians who have been trained and have demonstrated proficiency in management of these complex problems. When these cases come in, they require significant fund of knowledge and extensive training and often need advanced treatment immediately. In addition, we have recently seen waits of up to ten days for transferring patients to facilities with advanced services during which time those people have their inpatient care provided by the emergency department physician. We cannot place an undue, and frankly unfair, expectation on nonphysician providers to try to provide care for these complex cases without in-person physician backup. If the patients at facilities other than critical access hospitals deserve a physician on site, why don't our fellow Hoosiers in the more rural areas of our state? We ask you to remove this exception so that all patients of Indiana hospitals have the equal opportunity to be seen by an in-person emergency department physician."

I would like to encourage all of us to be aware of the ramifications of this new law. In many rural areas, physicians are hard to find. Seventeen of Indiana's counties do not have a hospital and Hoosiers who live in these communities tend to have limited access to primary care physicians. In a rural hospital setting, I have had the experience of being the only physician in the building when the following scenarios have presented: C1 burst fracture with atlanto-occipital dissociation, prolapsed umbilical cord in a patient 25 weeks pregnant, pulseless hypoglycemic 6 day old baby, and many other cases. At these sites, it can be incredibly intimidating to manage these patients by oneself. And yet, these cases can be some of the most rewarding of an emergency physician's career (and have been for me). As a state with a significant rural population, we would like to highlight the importance of a physician's presence in rural areas and work to find ways to encourage physicians and residents to gain more awareness of the rewards of rural medicine. That might be working a shift or two at a rural site. Maybe it is encouraging medical students to do a rotation at the critical access facility where you already work. It could even be taking a course in advanced procedures that refresh your skills that might have not been used in a while. Although today's focus is on the critical access hospitals we fought for earlier in the year, I would like to thank all members of INACEP for their continued hard work no matter where they work. I look forward to serving you this year. I hope you are having a great summer!

Here's an easy way to contribute $100 now to

IEMPAC

Your voice and your contribution are important



Breaking News

Welcome New Members

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James Harris, MD
Diane Wallace, MD
Michael Lincoln Weber, MD

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Mary K Jones, MD
Caleb James Munson, MD
Grant Parrelli, MD
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Matthias Ebeyer
Annie Elizabeth Graber
Aidan Mark Hannon
Taylor Kowalski
Natalya Marie Meinhart
Charles Ryan
Madison R Sido
Gagandeep Sooch
Margaret Therese Tuckey
Daniel Robert Wright

Thank you to all who made INACEP'S 51st Annual Emergency Medicine Conference a HUGE success!

We were very fortunate to have residents and students in attendance

Indiana is well represented at the national level

James L. Shoemaker, Jr., MD, FACEP, elected to ACEP Board in 2020 and serves as current Secretary-Treasurer

John T. Finnell, MD, FACEP, FACMI elected to ACEP Board in 2018 and 2021 serves as current Vice President

CONGRATULATIONS

Amy Souers, MD
on her successful completion of ACEP's Fellow program and her distinction as a FACEP credentialed member

Dr. Souers is a member of Fort Wayne's Professional Emergency Physicians' team

for more information on ACEP's Fellow Program:
acep.org/acep-membership/membership/join-acep/fellow-status

Breaking News (cont.)

Thank you to our INACEP Conference Partners for your support

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