Volume 32, Issue 3 **Fall 2023**

EMpulse

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

SAVE THE DATE

INACEP

ANNUAL EMERGENCY MEDICINE CONFERENCE

APRIL 11, 2024

downtown Indianapolis

Inside this Issue

A View from the Top

Lindsay Zimmerman MD, FACEP

Greetings members of Indiana ACEP! Our state delegation to the National Council meeting has just returned from an energizing few days in Pennsylvania. We have included a few highlights from the council meeting in this edition of EMpulse. Please congratulate Dr. Daniel Elliott, our immediate past president on the successful adoption of resolution 42, which resolves that ACEP works with other states to support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments!

I'm so proud to see Indiana be the leading voice on this important scope of practice issue. The resolution was based off the legislation passed this spring in SB400, which was also discussed at the National Conference of State Legislatures this past August in downtown Indianapolis.

Please congratulate Dr. Daniel Elliott, our immediate past president, on the successful adoption of resolution 42, which resolves that ACEP works with other states to support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments.

Aside from the Council events, we are actively working on your behalf on the other issues that our membership has brought forward to our attention. We are currently looking into solutions regarding insurance payment concerns and violence prevention in emergency departments. We are also closely watching national ACEP's response to the sudden collapse of American Physician Partners (APP) as they navigate this new territory and stand ready to help in any way we can as more information comes in. Please see **acep.org/news/acep-newsroom-articles/acep-executive-director-shares-devastating-impact-of-corporatization-in-emergency-medicine** for more information regarding initial steps. We were happy to see ACEP's October 4th filing of a Notice of Appearance in the American Physician Partners bankruptcy case and will continue to watch closely for ways that we can be of assistance as a state chapter. If this has affected you, we want to hear from you! National ACEP said it best- "We will not relent in our push for solutions that protect emergency physicians from becoming collateral damage of corporate profiteering." We couldn't agree more.

As we move into the fall and winter months, please let us know how to best serve you. We are happy to report that each member concern that has been sent to us in the last couple of months has been addressed and we are making progress on multiple fronts. I look forward to providing updates in the next edition. Enjoy the cooler weather!

No "good" time to have a kid - *imho*

by Emily Fitz MD, FACEP

Emily Fitz is an emergency physician with IU Health. She currently works at both Eskenazi and IU Tipton, where she serves as ED medical director. She subspecializes in disaster medicine. She lives in Zionsville with her husband and five children.

I am not sure I believe in "parenting experts." All the training in the world can't prepare you for that moment when it's 2 am and your infant starts to cry. You blearily stumble into their room only to realize that you have entered into the poop-apocalypse. Then, while trying to change your hellion's diaper in the middle of the night while simultaneously cleaning the poo smeared on the crib wall, your child pees into your open mouth. You just can't prepare for something like that. Indeed, that still ranks as one of the lowest points of my life as a mother.

Despite this episode of the Twilight Zone, I have recently found myself in the position of providing parenting advice, or more specifically, guidance on when it is the right time to have a kid. I am the mother of five playful, mischievous, and mostly-cute children, and I have had a child at almost all points of my medical career. Kid right after the first year of residency…check. Starting a new job while 28 weeks pregnant and needing maternity leave almost right away…check. Having a child shortly after taking on a new leadership role within my organization…check. Fast forward through five children while practicing emergency medicine full-time, and I have come to the conclusion that there is no good time to have a kid.

I still remember when I found out I was pregnant with my first. I had only been an intern for 6 months, and the plan had been to wait for kids until after residency. That was the best way to maintain my sanity, learn about emergency medicine, and properly budget within our limited means, right? It was generally assumed that having a baby in residency was a terrible idea, so when I found out I was pregnant, I cried. I had all the thoughts you normally do: how will I accomplish my goals, how can I take care of a baby, how did this happen (of course, we all know how that happened). I reached out to one of my female faculty for advice, and when we met for coffee I was so disappointed when she told me everything was going to be difficult. I left with the impression that she thought I was crazy, and I didn't know what to do. Luckily, I had a routine meeting with my residency program directors shortly after, and when I told them I was pregnant, they both immediately congratulated me. They reminded me that our residency was a family and we would all figure things out together. I remember that as the first time I felt excited about that pregnancy.

As it turns out, my program directors were absolutely right. I had my oldest son shortly after starting second year. Throughout residency, he was a fixture at lectures and journal clubs, and no one complained. In fact, I believe my son has the distinction of being the first person to vomit on the floor of our (at the time) brand-new county hospital. Numerous co-residents supported me by babysitting, even when they didn't know how to change a diaper, and multiple faculty members gave much-needed advice and shared parenting stories with me. I will be honest and say that having a baby in residency is not easy. There was an absolute lack of sleep, and there were times I didn't see my son for days. More than anything, budgeting for childcare was incredibly difficult on dual-resident incomes. But would I have it any other way? Absolutely not. Having my son during residency helped me to grow as a person, it helped my relationship to grow with my husband, and it allowed me to see the generosity and kindness of my colleagues.

I am not sure how the idea of waiting until after residency to have a child came about. What I do know is that recent studies have shown that women in medicine wait longer than other women to start a family. They also have higher rates of infertility when they finally do choose to try for a baby. I am not sure if it has been studied, but I wouldn't be surprised if male residents and their partners also wait longer before starting a family. Somehow, the idea that having a child in residency is a terrible decision has permeated the medical community and may now be contributing to some of the stress and fertility problems physician families have experienced. This idea led to my panic with my first pregnancy, but it also led me to think that things would be "easier" with any future children. That notion was certainly misguided.

What happens after residency that makes it magically a better time to have a kid? Does it seem like the best idea to have a child right when you start your first job? Sure, you are getting paid more, but don't you want to do well, impress your colleagues, and gain much-needed experience? Aren't you also likely to start paying off large amounts of your student loans? Suddenly, starting a family right then doesn't seem so smart. This was my exact situation during my second pregnancy.

(Cont. pg. 3)

Essentially Essential

By: Eric Yazel MD, FACEP

Dr. Eric Yazel is a graduate of Indiana University with a B.S. in Biology. He has a M.A. in Clinical Physiology from Ball State University. He received his Medical Degree from the University of Louisville and also completed his residency in Emergency Medicine at UofL. He serves as Indiana's Chief EMS Medical Director.

To most of us in Emergency Medicine, the idea of EMS being classified as an 'essential service' seems obvious. However, you might be surprised to learn that only 13 states have given EMS that designation. Indiana is fortunate enough to be one of those 13, but the designation lacks two key components – funding and enforceability that the other states have set in place. Without those two, there is neither the will nor the way to raise the bar for EMS service delivery. So while it may be an essential service in name, it isn't in practice.

The mile high view of EMS as an essential service seems relatively simple and straightforward. But reality is anything but. First, how is the 'provision of EMS services' defined? Does 1 BLS unit for a million citizens and 300 square miles meet the standard? Or does it mean an ambulance on virtually every street corner (what I call the 'Dollar General coverage plan')? Also, Indiana is a very diverse state, both geographically and demographically. So even if minimum coverage standards are set on a basis of square miles or per capita, a one size fits all approach will leave some areas with excess and some spread too thin.

So how does that affect us as Emergency Medicine providers? We see first-hand the effects of an overly burdened system. Response times are lengthening. Longer shifts are leading to fatigued providers and the care issues that coincide with that. Transfers are waiting longer and longer to go to definitive care facilities. All these make our jobs more challenging on a daily basis.

What can we do to help? In the last 18 months, I've visited 68 of the 92 counties. If there is one thing I have noticed (aside from realizing I need a new transmission) is the quality of service is directly related to the level of support provided to them at the federal, state, and most importantly, local level.

Some areas already support EMS as the essential service it is, while EMS in some areas remains an afterthought. And while federal and state agencies can encourage increased support for EMS services, nothing is as effective as engagement at the local level. Get involved with your local EMS agencies. Talk to your elected officials, hospital administrators, etc. Nothing is more effective than a local physician providing concrete examples of what they are seeing out there on a daily basis. Encourage them to support a robust EMS service delivery model and what that can mean for the healthcare continuum in their area. It is an essential service for Emergency Departments across the state, and the citizens we serve.

imho Cont'd from page 2

I had a job lined up after my fellowship, so I thought it would be the perfect time for a second baby. This pregnancy, in my mind, was well-planned and well-thought-out. Then, I suddenly found myself in need of a different job. I was 28 weeks pregnant, and I was the primary breadwinner for my growing family. Once again, I panicked. Do you know how hard it is to look for a job and say in your interview, "By the way, I am 28 weeks pregnant and will need maternity leave 2 months after starting"? You can't hide being 28 weeks pregnant. Luckily, I found a wonderful group to work with, and they were supportive of my job and my family. I was able to take maternity leave and come back, and not one person seemed to begrudge me this.

When it comes to having a child at the worst possible time, I've done it all. Even when I have had things all planned out, fate has laughed in my face. Five beautiful children later, and I am so thankful I had each of my kids when I did. As I have said, there is no good time to have a kid. There will always be more training, a new job, a recent promotion, or other circumstances to make the timing terribly inconvenient. It is time that we in the medical profession realize this and stop putting our lives on hold for our training. There will always be a job or a new opportunity out there, but we may not always have the chance to start a family or add to our family exactly when we want. If this sounds scary or depressing to you, just remember that if there is no good time to have a kid, it means that any time is a good time to have one!

[1] Bakkensen, J. et al. "Childbearing, infertility, and career trajectories among women in medicine". JAMA Network Open. 2023. 6(7).

Legislative Update

by Lou Belch, The Corydon Group

The 2023 interim has seen significant changes in the Indiana Senate, with more possible. Sen. Chip Perfect, (R-Lawrenceburg) resigned to focus more on his family and business interests. He has been replaced by Sen. Randy Maxwell (R-Gulford). Sen. Jon Ford (R-Terre Haute) resigned to take a position with what is commonly known as the Indiana Coal Council. Greg Goode was selected by caucus to complete the remainder of Sen. Ford's term. Goode is state director for US Senator Todd Young and previously served more than 10 years as executive director of Government Relations and University Communications for Indiana State University. Sen. Jack Sandlin (R-Indianapolis) passed away unexpectedly. The caucus to replace him has not been held at the time of printing this newsletter, but it is set for October 18, 2023. Sen. Eddie Melton (D-Gary) is expected to be elected mayor of Gary in November. As more Senators are expected to announce their retirement, the Senate will look very different after November of 2024.

There have been a few interim meetings of interest since the last EMpulse.

Interim Study Committee on Public Health, Behavioral Health and Human Services

The committee most recently met to discuss behavioral health issues. The focus of the health was on Psilocybin. The FDA has approved its use in some depressions. The DEA has rescheduled from C-1. Indiana does have the ability to move it from Schedule I. The committee has not made any recommendation. They will further consider at their October meeting.

Health Care Cost Task Force

The task force met to hear from providers. Several non-physician providers including:

- Physician Assistants
- EMS
- Nurses
- CRNAs
- Respiratory Care Practitioners
- Physical Therapists

Testified about how an increased role would save the system money.

The task force has not made any recommendations.

Medicaid Oversight Committee

The Medicaid Oversight Committee met to get an overview of the Medicaid Program. During the hearing there was discussion of the implementation of the physician fee schedule increase that was included in HEA 1001 -2023. The General Assembly has raised the Medicaid fee schedule to 100 % of the Medicare fee schedule. It requires approval from CMS. The change is expected to go into effect on January 1, 2024.

INACEP is engaged with ISMA to work with the Office of Medicaid Policy and Planning to address the issue of Medicaid Managed Care downcoding of Emergency Department/Physician claims. Those discussions are ongoing. Legislation may be an option if the discussions do not lead to a satisfactory outcome.

Jamie Shoemaker, MD on your re-election to ACEP's Board of Directors

Jamie Shoemaker MD, Lauren Stanley MD (INACEP President '20-'21), JT Finnell MD (ACEP Board of Directors)

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.

And That's A Wrap! Another Successful Council Meeting in the Books.

by Lindsay Zimmerman MD, FACEP

The National ACEP Council meeting was held in Philadelphia this year on October 7th and 8th and it was quite a productive meeting. Many resolutions were discussed and several were adopted. Of particular pride to our chapter, Indiana submitted resolution 42, which was adopted after an amendment for clarification. Final wording of Amended Resolution 42 (23) is:

Resolved, that ACEP work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further

Resolved, that ACEP continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

Additionally, Indiana recognized the contributions of Dr. William Nice, MD in resolution 56.

Other resolutions that were adopted including a resolution regarding a medical malpractice certificate of merit for emergency medicine physicians, a resolution working to protect physicians in cases of patients leaving the emergency department prior to completion of care, and a resolution for ACEP to work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

After the discussions of resolutions were finished, voting then turned to electing our new officers. Dr. Aisha Terry assumed the role as ACEP's new president. Dr. Alison Haddock from Texas was voted in as the president-elect. Our very own Jamie Shoemaker was re-elected to the ACEP Board of Directors! Other members elected to the ACEP Board of Directors include Dr. Chadd Kraus, Dr. Abhi Mehrota, and Dr. Henry Pitzele. Dr. Melissa Costello moved into the role of the Council Speaker and Dr. Michael McCrea was voted Council Vice Speaker.

Throughout the Council meeting, I found inspiration in the exchange of ideas and the continued enthusiasm for improving emergency medicine and supporting our colleagues. I look forward to the Council meeting next year where we can meet again to continue the important work of advocating for our specialty in an in-person national group setting.

INACEP President Lindsay Zimmerman provides vital information to Council delegates while supporting INACEP's policy positions

Cindy Kirchhofer, INACEP Executive Director, Jamie Shoemaker MD, Timothy Burrell MD and Sara Brown MD ready for Council at 7:30 on Saturday morning!

indiana Council Delegation at work in Philadelphia

L-R
Sara Brown MD
Timothy Burrell MD
Daniel Slubowski MD
Daniel Elliott MD
Lindsay Zimmerman MD
Kyle English MD
Michael Bishop MD
Cindy Kirchhofer
Emily Fitz MD
Lauren Stanley MD
JT Finnell MD
Jamie Shoemaker MD

Case Study: Vision Changes in the ED - Floaters

Chiamara Anokwute MD, Staff MD
Indiana University Emergency Medicine Residency

In collaboration with:
Katie Trammel, MD
Sarah Kennedy, MD

Overview:
Patient A is a 40-year-old male with past medical history notable for surgical reattachment of retinal detachment at 16 years of age and significant bilateral myopia presented to the ED with left eye floaters for 1 hour. He reported "dark, black, smokey web"-like floaters presenting acutely when driving without an inciting event. He denied any flashing of light, loss of vision, or recent head trauma. He also denied any headache. Patient B is a 66-year-old male with past medical history of recent assault to head two days prior, migraines, and hypertension who presents with left eye floaters for 2 days. He reported 1 day of flashing lights in his left visual field and 2 days of increased floaters.

Initial Findings and Workup:
Vital Signs: All vital signs were within normal limits for Patients A and B
Focused Physical Exam: Both patients were nontoxic appearing, alert and oriented.
Patient A had the following eye exam: Intraocular pressure RE: 13, LE: 14. EOM full without pain, diplopia bilaterally, PERRLA. Slit-lamp exam shows reassuring conjunctive a/sclera, cornea without lesions on fluorescein stain, anterior chamber without reactivity, lens clear. Ophthalmologic dilated fundus exam: Few broken weeks rings without vitreous hemorrhage, optic nerve reassuring, macula reassuring. Patient B had the following eye exam: Intraocular pressure 16 mmHg bilaterally. EOM full without pain and without diplopia. Anterior chamber without hypopyon/hyphema on slit lamp exam.

Imaging:
Patient A POCUS: Suggestive of posterior vitreous detachment without significant vitreous hemorrhage.
Patient B POCUS: Findings concerning for vitreous hemorrhage.

Management: The management goal for each patient was to rule out an ophthalmologic pathology that may acutely lead to vision loss. Physical examinations and visual acuities were reassuring. Eye vitals (vision, intraocular pressure, extraocular motion, and pupillary exams) were reassuring. Ophthalmoscopic evaluation in the nondilated eye were challenging and did not yield significant information. Further evaluation with ultrasound for Patient A was inconclusive on the resident physician's interpretation but most consistent with vitreous detachment +/- vitreous hemorrhage. Patient B's ultrasound was concerning for vitreous hemorrhage +/- vitreous detachment on the resident physician's interpretation. Both patients received ophthalmologic consultations in the ED and were ultimately discharged with close follow up one to two days later. Both patient A and B were found to have posterior vitreous hemorrhage. Patient B was believed to have vitreous traction secondary to trauma resulting in visual photopsia.

Discussion:
Although vitreous floaters are often benign (Vitreous syneresis), acute vision change including increase in floaters warrants further investigation. Vitreous syneresis, the contraction of vitreous gel that forms the "floaters" patients describe is an age related process. Floaters may be the presenting finding of Posterior Vitreous Detachment (PVD) (generally benign), Retinal detachment (sight threatening), and Vitreous hemorrhage.1 Thus, warranting emergency ophthalmologic evaluation in the ED. Ocular ultrasounds allows a clinician to gather more information to better determine if a vision threatening etiology is ongoing. Retinal detachment on ultrasound has been described as a cord that mobilizes with eye movements and is attached to the back wall of the eye. This cord can be seen in normal and low gain settings, but evaluation of multiple axes is imperative to not miss a small retinal detachment.

Contrasted to Vitreous detachment and hemorrhage, which are observed in higher gain setting. Vitreous detachment will be a thin, linear structure not attached to the back of the eye and crosses the optic nerve. Vitreous hemorrhage will have hyperechoic debris sometimes described as a "snow globe" appearance. Just as with a snow globe, mobilizing the patient's globe by asking them to look in multiple directions will better visualize these findings.2 Retinal detachment is obviously sight threatening as the retina contains our photoreceptor cells that allow for vision. Posterior Vitreous Detachment is associated with the development of a Retinal tear or detachment. One study including over eight thousand adults at a large multicenter comprehensive eye care practice found that 9.4% of patients with acute symptomatic PVD had a retinal tear or detachment on their initial visit. Of those without initial tear or detachment but who were classified as high risk (history of vitreous hemorrhage, lattice degeneration, history of retinal detachment or tear in affected eye), 12.4% had delayed (~6 weeks of initial evaluation) retinal tear or detachment.3 Another study including 7999 eyes found similar results of delayed (majority >6 weeks after initial

Case Study

Cont'd from page 5

evaluation) retinal pathology.4 These retrospective cohort study, admittedly not conducted in an ED, should still evoke a sense of importance to have affected patients who are assessed in the ED followed up by an ophthalmologic provider.

Conclusion:
Floaters are generally a benign process of the vitreous fluid of the eye. However, acute changes warrant evaluation for sight threatening pathology such as retinal detachment. Ultrasound is an excellent tool in evaluation for the ED physician and can help risk stratify the urgency of ophthalmologic follow up when pathology like PVD or vitreous hemorrhage are noted. Neurologic changes such as headache and vision change should be assessed for conjunction with an adequate history including previous eye surgeries, trauma to the head, other genetic pathology involving the eye.

References:

1. Gandhi K, Shyy W, Knight S, Teismann N. Point-of-care ultrasound for the evaluation of non-traumatic visual disturbances in the emergency department: The VIGMO protocol. Am J Emerg Med. 2019 Aug;37(8):1547-1553. doi: 10.1016/j.ajem.2019.04.049. Epub 2019 May 11. PMID: 31130372.

2. Nagdev, A., Riguzzi, C., & Frenkel, O. (2016, November 13). Ocular ultrasound: Retinal detachment and Posterior Vitreous Detachment. ALiEM. https://www.aliem.com/ocular-ultrasound-retinal-detachment-posterior-vitreous-detachment/

3. Seider MI, Conell C, Melles RB. Complications of Acute Posterior Vitreous Detachment. Ophthalmology. 2022 Jan;129(1):67-72. doi: 10.1016/j.ophtha.2021.07.020. Epub 2021 Jul 27. PMID: 34324945.

4. Uhr JH, Obeid A, Wibbelsman TD, Wu CM, Levin HJ, Garrigan H, Spirn MJ, Chiang A, Sivalingam A, Hsu J. Delayed Retinal Breaks and Detachments after Acute Posterior Vitreous Detachment. Ophthalmology. 2020 Apr;127(4):516-522. doi: 10.1016/j.ophtha.2019.10.020. Epub 2019 Oct 23. PMID: 31767432.

Welcome New Medical Students

Evan T. Anderson
Zaid Ahmed Answeri
Ellery L. Day
Vasilios Mihail Katsaitis
Ian Parker
Benjamin Wood Thompson
Kayla Wilson

IN LOVING MEMORY

Stephen R. Miller, MD
1943-2023

Co-founder, Emergency Physicians of Delaware County

INACEP Rising Speaker Series

What: 15 minute presentation (approx. 12 min. presentation with 3 min for questions) on a topic related to Emergency Medicine and/or Emergency Physicians.

Who: Any emergency physician at a PGY-3 level of training or within their first 5 years of clinical practice after graduating from an accredited EM residency program. The physician must be BC/BE in Emergency Medicine.

Each year, INACEP holds a conference focused on the continuing education of emergency physicians. More specifically, the conference presents information relevant to the clinical practice of emergency medicine. We invite speakers from around the state and country to present a wide range of topics. This year, INACEP is searching for dynamic, fresh speakers to elevate the conference content in our inaugural "Rising Speaker Series." Each speaker will present for 15 minutes on a topic of his or her choice. The only stipulation is that the topic be relevant to the practice of emergency medicine.

Four speakers will be chosen by the INACEP board and notified of their opportunity to present at the INACEP state conference!

How:
- Submit a presentation proposal of no more than 250 words
o Describe the topic.
o Describe why it is relevant to Emergency Physicians.
- Submit a current CV

Submission:
- Emily Fitz, INACEP Vice President and education chair: emilyfitz526@gmail.com
- Cindy Kirchhofer, INACEP executive director: cindy@inacep.org.

Timeline:
- November 15, 2023: Proposals Due – Emily Fitz and/or Cindy Kirchhofer (emails above)
- January 12, 2024: Speakers will be notified for acceptance
- April 11, 2024: INACEP Conference

Questions or Concerns:
Emily Fitz or Cindy Kirchhofer, as above

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