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EMpulse

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Inside this Issue

A View from the Top

Bart Brown, MD, FACEP (INACEP President)

I am grateful for the opportunity to serve as INACEP president and I look forward to a busy and productive year. I have heard from many of you already, and I welcome your input, ideas, and concerns. I am a Hoosier native and I live in Zionsville with my family (wife Kristy, son Quinn, and daughter Hannah).

I'd like to thank the past President, Chris Ross, for his leadership addressing numerous legislative issues, fighting unfair reimbursement practices, and leading the campaign for JT Finnell's election to national ACEP BOD. Below I will highlight the key issues we are currently working on including in the current plan of action.

Legislative Issues

Nationally, Out of Network (Surprise Billing) legislation has been a hot topic with bills progressing through House and Senate committees. This legislation would have drastic effects on our specialty, reimbursement, and ability to care for patients. ACEP has been actively lobbying with other stakeholders to include independent dispute resolution in current bills to ensure a fair playing field with insurers. Contact your legislators during the August recess and keep an eye out for updates and action alerts through Engaged e-mails.

We are working hard to advocate for our specialty and provide value to our members. Feel free to contact us with any concerns and encourage your departments to work towards 100% ACEP membership.

Locally we continue to work with legislators and other medical organizations to anticipate and prepare for upcoming legislative issues. Our lobbyist, Lou Belch, is an experienced and talented resource advocating on our behalf. I will continue to use Engaged to keep members aware of pertinent issues and improve our grassroots network to rapidly respond to legislative issues. Consider donating to IEMPAC, as these funds build important alliances with legislators. Last year there was an unprecedented physician response and presence at the statehouse. Let's build on that momentum as this will be a busy and pivotal legislative year for our specialty.

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Using Magnetic Resonance Venography to Diagnose an Isolated Pelvic Vein Thrombus After Negative Lower Extremity Ultrasound

By Mary Blaha, DO, PGY-2, Indiana University Emergency Medicine Residency

Overview

A 47 year-old male with a history of membranous glomerulonephritis status-post renal transplant, chronic kidney disease (CKD), and multiple prior deep venous thrombosis (DVTs) not currently anticoagulated presented to the emergency department (ED) with right lower extremity swelling and pain for one week. He also complained of intermittent right-sided abdominal pain and lower right flank pain. He denied fever, urinary symptoms, chest pain, shortness of breath, and any other symptoms.

Findings and Workup

Physical exam: The patient's vital signs were within normal limits. The patient was well appearing and was in no acute distress. Physical exam was remarkable for significant swelling and mild erythema localized to the proximal right thigh with intact distal pulses and no calf tenderness.

Labs: Labs were remarkable only for CKD.

Imaging: An ultrasound of the right lower extremity was negative for DVT. Given persistent high suspicion for DVT, MRV of the right lower extremity was obtained and showed a long segment of thrombus in the right proximal external iliac and right common iliac vein.

Management

The patient was stable, so initial management included basic labs and an ultrasound of the right lower extremity to look for DVT. The ultrasound was negative, but because there remained a high suspicion for DVT, venography was the next step to look for a more proximal thrombus. The patient had CKD and a renal transplant, so MRV of the right lower extremity was preferred over CT. MRV showed a long segment of thrombus in the right proximal external iliac and right common iliac vein. He was started on a heparin drip and was admitted to the hospitalist team for further management. While inpatient, vascular surgery and interventional radiology were consulted. The patient underwent balloon angioplasty, catheter-directed thrombolysis, and mechanical thrombectomy of the DVT. Upon discharge, the patient was sent home on lovenox for seven days as a bridge to warfarin for long-term anticoagulation.

Discussion

Isolated pelvic vein thrombosis, which is usually defined as a clot anywhere from the external iliac vein to the inferior vena cava, is a relatively rare diagnosis and it is uncommon even in patients with a proven symptomatic pulmonary embolism (PE). Less than 1% of all DVTs in non-pregnant patients are isolated to the pelvic veins. Isolated pelvic vein thrombosis is somewhat difficult to diagnose with standard lower extremity ultrasound. One study found that in patients diagnosed with PE, nearly a quarter had an isolated pelvic thrombosis that was not seen on lower extremity ultrasound. When DVT is highly likely but initial lower extremity ultrasound is negative, venography such as MRV can be used to make the diagnosis of an isolated pelvic thrombus. Case studies show that patients with pelvic thrombosis may complain of abdominal pain in addition to or instead of leg pain. Treatment for pelvic thrombosis is somewhat different than that of an isolated lower extremity DVT. While patients with isolated lower extremity DVT can usually be discharged home from the ED with anticoagulation, patients with pelvic thrombosis are usually admitted to the hospital for more invasive treatment options. Treatments include systemic anticoagulation, catheter-directed thrombolysis, mechanical thrombectomy, inferior vena cava filter, balloon dilation, and stenting. It is important that patients with pelvic vein thrombosis are admitted to the hospital for treatment to prevent complications such as PE and symptoms of post-thrombotic syndrome including leg pain, swelling, venous ulcerations, and loss of mobility.

Conclusion

Isolated pelvic vein thrombosis is a relatively rare diagnosis and it is difficult to diagnose with standard lower extremity ultrasound. If high suspicion for DVT remains but initial ultrasound is negative, consider further imagining such MRV. Patients with pelvic vein thrombosis should be admitted to the hospital for treatment.

REFERENCES:

Dronkers CEA, Sramek A, Huisman MV, Klok FA. Accurate diagnosis of iliac vein thrombosis in pregnancy with magnetic resonance direct thrombus imaging (MRDTI). BMJ Case Reports. 2016;2016.

Björgell O, Nilsson P, Nilsson A, Lorén I, Florén CH, Lindgärde F. Isolated iliac vein thrombosis. J Ultrasound Med. 1998;17:671–673.

Stern JB, Abehsera M, Grenet D, Friard S, Couderc LJ, Scherrer A, Stern M. Detection of Pelvic Vein Thrombosis by Magnetic Resonance Angiography in Patients With Acute Pulmonary Embolism and Normal Lower Limb Compression Ultrasonography. Chest. 2002;122(1):115-21.

Gary T, Steidl K, Belaj K, Hafner F, Froehlich H, Deutschmann H, Pilger E, Brodmann M. Unusual deep vein thrombosis sites: magnetic resonance venography in patients with negative compression ultrasound and symptomatic pulmonary embolism. Phelbology. 2014;29(1):25-9.

Aroke D, Kadia BM, Dimala CA, Bechem NN, Ngek LT, Choukem SP. Right iliac vein thrombosis mimicking acute appendicitis in pregnancy: a case report. BMC Res Notes. 2017;10(1):11.

Goktay AY, Senturk C. Endovascular Treatment of Thrombosis and Embolism. Adv Exp Med Biol. 2017;906:195-213.

Watson L, Broderick C, Armon MP. Thrombolysis for acute deep vein thrombosis. Cochrane Database of Systemic Reviews. 2016;11.

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Keep an eye out on Facebook, Twitter, Engaged and brochures by mail for additional information and registration information.

Procedural impotence

by Tyler Johnson, DO, FACEP (INACEP Secretary/Treasurer)

It is 2 am and a patient is brought in to your community emergency department triage with a complaint of distended abdomen. You start perusing the chart and see the patient has metastatic cancer with hepatic metastasis. They have presented a few times over the last few months for pain control and nausea related to treatments but get most of their care at the ivory tower down the road. You see the patient and immediately notice a rotund distended abdomen in a nontoxic patient that is seemingly uncomfortable. The patients labs are mostly unremarkable with normal coagulation studies. A CT of the abdomen and pelvis reveals multiple hepatic lesions and a large tense ascites. You decide the patient may benefit from paracentesis to relieve their discomfort. You immediately take a deep breath and sigh knowing there is no physician at your facility willing to do a paracentesis and a transfer down the road is required. Sometimes this is an easy transfer. But other times it will takes days for a bed to open up for this patient that needs this urgent procedure.

How often do you find that you are presented with a patient that could benefit from a procedure that you cannot or will not do in the emergency department. Paracentesis is a common one but there is likely a long list of things that we could or should be able to do for our patients.

Sit down and make a list of procedures that maybe you should do but currently you do not do. It will be different for each physician but could include procedures such as peritonsillar abscess drainage, central line placement, dialysis catheter line placement, peripheral nerve blocks, bedside ultrasound, fracture and dislocation reduction.

There are a multitude of reasons not to do some of these procedures but some are just excuses. Competency, time, or appropriate supplies are all constraints.

The competency dilemma is the toughest part. Many procedures are learned in residency but only done a few times. Some people take interest in certain procedures during their career and take the time to learn them. Many though have not taken the time or haven't had local opportunities to refresh these skills enough to be proficient.

Time is often a cited factor but this is the patient that would likely benefit from your time and expertise the most. Is time restraint just a deflection for laziness? Sure a patient may have to wait or your procedure may get interrupted but that is emergency medicine.

Having the correct supplies available is a much higher level question. It may take hospital involvement to get a modern ultrasound provided or the appropriate catheters for a procedure. Some will question when a dialysis catheter sits on the shelf for a year or years before needing to be used.

It should be pointed out that many times these patients are transferred to see a physician assistant or nurse practitioner to carry out the procedures an emergency physician was not willing to or improperly prepared to do. It should be important to our specialty that we continue to be the Swiss Army knife and duct tape of medicine and the more that emergency physicians can offer their patients safely improves our value and raises the bar for us as a specialty.

Indiana ACEP will be hosting a CME workshop this November on:

Emergency Department Interventions to Address the Opioid Epidemic — Emergency Department Medication Assisted Waiver Training

November 5 – Regenstrief Institute, Indianapolis

Information & registration is available through our website: INACEP.org

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Legislative Update

by Lou Belch, Lobbyist for INACEP

The summer is usually a slow time in the General Assembly and this year is no exception. Interim Study Committees have been appointed and meet in September and October with final reports due by November 1st.

Beginning during the legislative session and continuing every 2 weeks since, Rep. Cindy Krichhoffer (R-Beech Grove), has been convening meetings regarding Medicaid issues with interested parties and Medicaid. Recently they have been discussing emergency department reimbursement issues - how the managed care entities handle prudent layperson and general downcoding issues. Chris Burke MD, FACEP, Chris Ross MD, FACEP and Bart Brown MD, FACEP have been involved in the process.

The goal of the process is to standardize the system among all managed care entities and simplify the process. The Medicaid office is expected to make a proposal by the end of August. INACEP will be meeting with the other interested parties.

Below are the dates and subject matters of the Interim Committee on Public Health:

September 4, 2019

Joint Committee Hearing with Interim Committee on Financial Institutions and Insurance on health care costs:

Time: 9 a.m. – 4 p.m. with a break for lunch. Located in the Senate Chamber.

The National Conference of State Legislatures (NCSL) has agreed to come in and provide an overview of federal vs. state jurisdiction related to health care programs, and update on federal legislation (HELP Committee legislation) and what other states are doing to control health care costs.

FSSA is going to be asked to give an overview on the impact of Indiana's poor health status, social determinants of health and the rate of uninsured on health care costs.

Either the Bowen Center or Lugar Center will be asked to provide an overview on access to health care in rural areas.

IHA will be testifying and hopefully enough of the Lewin Group analysis will be ready

September 19, 2019

Discussion of regulation and practice of pharmacy benefit managers (PBMs).

Time: 9 a.m. – 4 p.m. with a break for lunch. Located in RM 431

October 2, 2019

Discussion of prescription drug pricing and access as well as advantages, disadvantages and feasibility of requiring health care providers to issue prescriptions in an electronic format and by electronic transmission.

Time: 9 a.m. – 4 p.m. with a break for lunch. Located in RM 431

October 16, 2019

Discussion of adoption subsidies and Hospital licensure. Discussion of Authorization of Advanced practice registered nurses (APRN) to operate without a collaborative practice agreement (this topic may be have a very limited discussion).

Time: 9 a.m. – 4 p.m. with a break for lunch. Located in RM 431

October 30, 2019

Hearing to discuss final committee report and any possible legislative recommendations.

Time: TBD Located in RM 431

UPCOMING EVENTS

MAT Course
Indianapolis, IN – November 5, 2019

Scientific Assembly
Denver, CO – October 27–30, 2019

INACEP Annual EM Conference
Carmel, IN – April 22–23, 2020

Leadership & Advocacy Conference
Washington D.C. – April 26–28, 2020

A View from the Top

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Reimbursement Issues

Despite several reversals, payers continue to push new schemes to aggressively and inappropriately downcode patient visits. INACEP has been working with the FSSA, legislators, and payers to create a comprehensive solution to address this. I will keep you updated as we work on this.

Education

After a successful 2019 Annual Education Conference, Lauren Stanley has been working hard to plan the 2020 conference. It is guaranteed to offer cutting edge CME from renowned speakers and national and local leaders in Emergency Medicine. In addition to the annual conference, we have received an ACEP Grant to set up *Emergency Department Interventions to Address the Opioid Epidemic-Emergency Department Medication Assisted Waiver Training*. We are excited to be able to offer this new course which will be held on November 5, 2019 at the Regenstrief Institute in Indianapolis. Please go to our website inacep.org for details.

Health Information Exchanges

We have worked with IHIE (Indiana Health Information Exchange) for the ED HIE project. They have conducted hour long interviews from a good representation of Indiana ED clinicians and several EDIE users from different states. They are currently finalizing their analysis and drafting a final presentation we will discuss in the next month. This will be used to identify deficiencies and improve availability and presentation of data in the health information database. We will keep you updated on the progress of this project.

National ACEP Updates

The 2019 ACEP council meeting kicks off in October and INACEP will be well represented. We have 7 councillors and six alternate councillors attending. JT will be attending in his position with the ACEP BOD. INACEP has submitted a resolution concerning "Recognition and Prevention of Dangerous Behavior and Self Harm Promoted by Internet Challenges" and we are cosponsor of another.

I would like to congratulate Jamie Shoemaker, selected as an ACEP Reimbursement and Leadership Fellow. He was also recently selected by the ACEP BODs as the ACEP Alternate Delegate to the AMA/Specialty RVS Update Committee (RUC).

We are working hard to advocate for our specialty and provide value to our members. Feel free to contact us with any concerns and encourage your departments to work towards 100% ACEP membership!

BULLETIN BOARD

Organizations or individuals that want their message to reach emergency physicians in Indiana will find the ***EMpulse*** their number one avenue. The ***EMpulse***, published four times per year, is mailed to members of the Indiana Chapter of the American College of Emergency Physicians. This highly focused group includes emergency physicians, residents and students.

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Publication dates are:
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Hot, Hot, Hot: No Fun in the Sun

by Christine A. Motzkus, MD PhD (Indiana University Medicine Residency)

Overview

We report on an 87 year old gentleman with multiple medical comorbidities including congestive heart failure who was brought in by Emergency Medical Services (EMS) for altered mental status with a possible syncopal episode in the setting of heat related illness. The patient had apparently completed approximately 8 hours of yard work on a day with a high temperature of 31 degrees Celsius. He was found sitting on the ground in his garage by a neighbor who notified his wife. Per EMS, the patient was initially confused upon arrival. Although his body temperature was not obtained, he was noted to be sweaty, flushed, and hot. EMS applied cooling packs and immobilized his C-spine given the unclear history of potential syncope and collapse. The ECG they obtained did not show signs of acute ischemia and they transported the patient to the ED. The patient's confusion progressively improved and by the time of arrival at the ED his mental status had returned to his baseline per his wife.

Findings & Workup

At the time of his emergency department evaluation, the patient had no complaints including no chest pain, palpitations, or shortness of breath. Vital signs at presentation were unremarkable with a temperature of 36.5 Celsius despite suspected elevated body temperature at EMS presentation. Physical exam was largely unremarkable. He had no visible traumatic injury. Heart, lung, and abdomen exams were within normal limits for age. His evaluation also included labs which were only remarkable for a creatinine elevated to 1.65 from a baseline of 1.2, potassium of 3.5, and a lactate of 3.9. His ECG showed a prior left bundle branch block. CT imaging of his head and cervical spine demonstrated age related changes but no acute abnormalities.

Management

The patient was initially managed supportively with administration of a 500mL of lactated ringer's solution and observation in the department. Approximately 2 hours into the patient's emergency department stay, nursing was called to the bedside for seizure-like movements and found the patient to be pulseless. CPR was started immediately, and the initial rhythm was noted to be ventricular fibrillation. Patient received a total of 3 shocks, 1 dose of epinephrine, and 300mg of amiodarone. At no point was return of spontaneous circulation achieved. Family was at the patient's bedside during the code and they elected to cease resuscitation efforts after 10 minutes.

Discussion

Heat illness, both exertional and classic, is responsible for nearly 250 deaths annually with spikes in this number during years with significant heat waves. (1) Heat related illness encompasses a spectrum of disease from the mildest forms such as heat edema and heat cramps through to the most severe form, heat stroke. The elderly, due to both physiologic factors and increased likelihood of multiple medical comorbidities, are at particularly high risk of serious complications including death as in this patient. In general, patients with heat related illness including the most severe form, heat stroke, generally have very good outcomes if cooling is achieved within 30 minutes and mental status improves. (3) Lactate has been previously shown to be a useful prognostic indicator. (4) Rapid cooling and frequent monitoring of patients with heat illness including heat stroke is critical to prevent poor outcomes among patients. Cardiac arrhythmias, including ventricular arrhythmias, are the primary cause of death in those succumbing to heat illness. Physicians should make every effort to achieve rapid cooling to relative normothermia, and consider fluid resuscitation and other interventions to correct electrolyte abnormalities and enzyme elevations in patients presenting with heat related illness.

Conclusion

Heat related illness has substantial morbidity and mortality. A high level of suspicion must be maintained in patients with abnormal laboratory values despite normalizing mental status.

REFERENCES

1. Barrow MW and Clark KA. Heat Related Illness. American Family Physician. 1998. 58(3):749-756
2. Gauer R and Meyers BK. Heat Related Illness. American Family Physician. 2019. 99(8):482-489.
3. Hess JJ, Saha S, and Luber G. Summertime acute heat illness in U.S. emergency departments from 2006-2010: Analysis of a Nationally Representative Sample. Environmental Health Perspectives. 2014. 122(11)
4. Alzeer AH, El-Hazmi HAF, Warsy AS, Ansari ZA, Yrkendi MS. Serum Enzymes in Heat Stroke: Prognostic Implication. Clinical Chemistry. 1997. 43(7).

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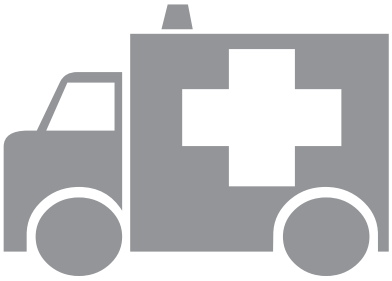
E.T.3 Phone Home?

by Timothy Burrell MD, MBA, FACEP - INACEP Board Member

Actually, these days ET3 stands for Emergency Triage, Treat and Transport which is an innovative 5-year payment model that gives EMS providers new treatment options for Medicare beneficiaries who call 911. The enhanced treatment options are:

- ***Transport to the Emergency Department***, as usual
- ***Transport to an Alternative Destination (AD)***, such as a PCP office, urgent care center or sobriety center
- ***Provide Treatment in Place (TIP)*** by a qualified provider either in-person or via telehealth

The model also seeks to recruit local governments who operate or have authority over 911 dispatches to establish a medical triage line for all calls. The intent of the medical triage line is to screen callers for eligibility to be redirected to the most appropriate place of service prior to ambulance initiation. The triage lines must offer at least one medical clinic option that accepts sliding scale payments.



CMS anticipates approving three waves of EMS participants to capture up to 50% of Medicare fee-for-service emergency ground ambulance transports. EMS participants must partner with non-ED Alternative Destination and Treatment in Place providers to meet model requirements. The combination of non-ED partner services must allow for 24/7 coverage.

The model is funded by the following payments:

1. ***Ambulance transport to Alternative Destination:*** Medicare pays for transportation to destinations previously not listed as a covered destination such as a physician office.
2. ***Treatment in Place:*** Medicare pays for care rendered by a qualified health care practitioner (physician/APP) on the scene.
3. ***Telehealth:*** Medicare pays for care rendered remotely by a qualified health care practitioner. Participants that facilitate telehealth will be paid as an originating site at a rate equivalent to the base BLS ground ambulance rate.
4. ***After-hours:*** Medicare pays qualified health care practitioners that treat individuals in place using telehealth during non-business hours an increased payment rate.
5. ***Quality measures:*** Medicare pays up to an additional 5% based on quality measures performance

Historically, non-emergency transport services have suffered from high fraud, waste and abuse rates and many safeguards were adopted over the years to mitigate this risk. The ET3 model waives many of these safeguards to allow non-emergency transportation to previously disallowed destinations. CMS will continuously monitor ET3 Participants to prevent, identify, and respond to fraud and abuse related to the model, including monitoring for overutilization of services.

Timeline

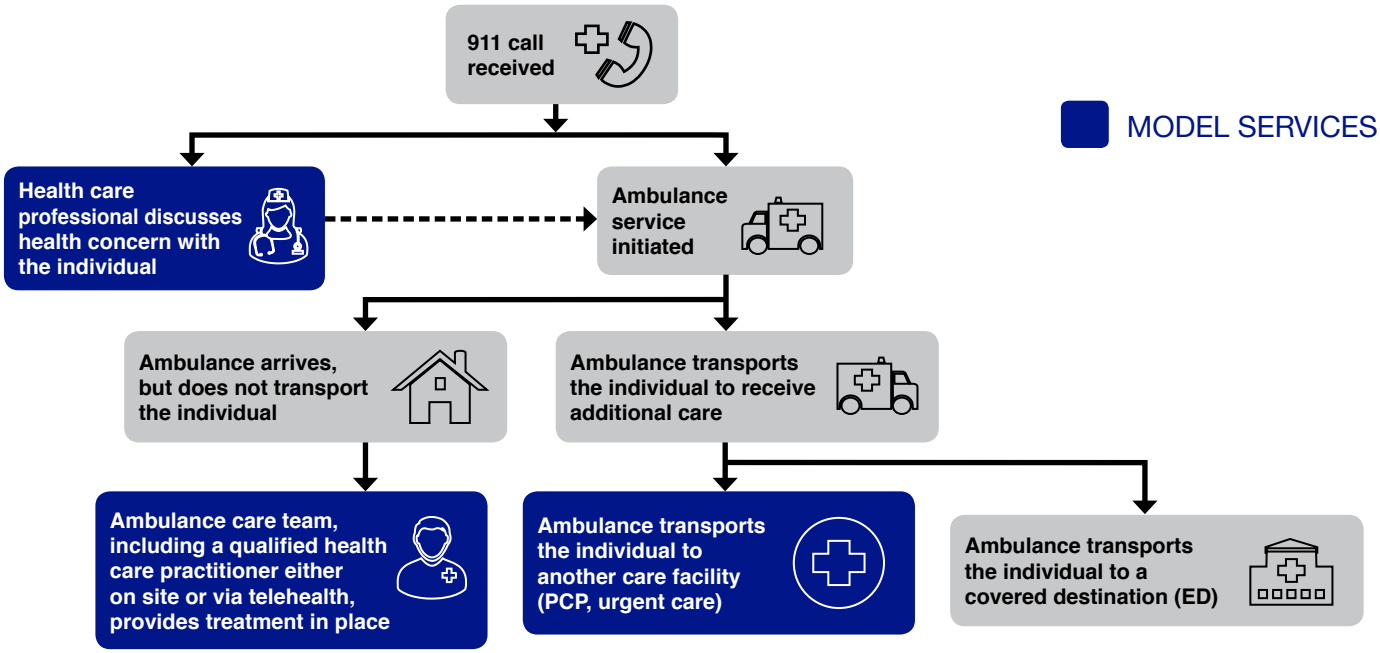
- **September 19, 2019** – Deadline to submit Participant application (https://app1.innovation.cms.gov/ET3/)
- **Fall 2019** – Announce participants (EMS entities)
- **Fall 2019** – Notice of Funding Opportunity (NOFO) release for 911 operators
- **Early 2020** – Award cooperative agreements to 911 line operators

Reference: https://innovation.cms.gov/initiatives/et3/ .

Dr. Burrell is medical director at IBM Watson Health providing advanced analytic, program integrity, medication safety, and quality reporting consulting services to U.S. federal health agencies.

Realigning Incentives for Future State

Individuals get the care they need and enable ambulances to work more efficiently.



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