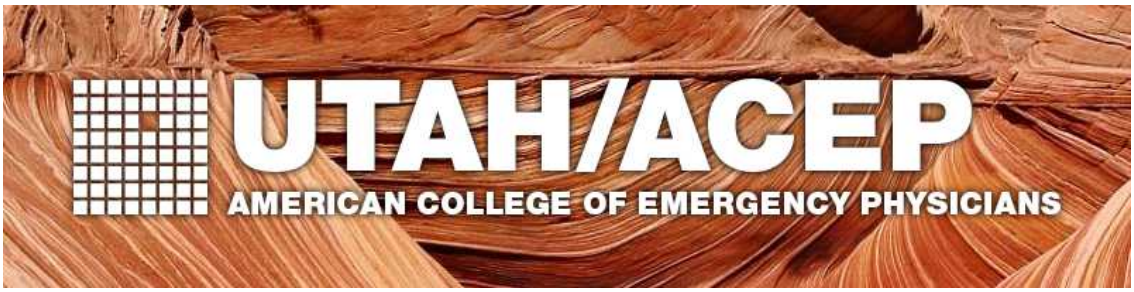
A Newsletter for the Members of the Utah Chapter

Fall 2017



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President's Message
John Dayton, MD, FACEP

Utah ACEP Summit and My Gratitude for You

Thank you to the Emergency Physicians who attended the 3rd Annual Utah ACEP Summit. The conference was attended by our colleagues representing 28 hospitals and 10 separate practice groups. We enjoyed both national and local experts, an LLSA review, 6 free CME hours, and networking.

Dr. Howie Mell, Chair of ACEP's Public Relations Committee, creator of the "So What?" Podcast, and EM:RAP and #FOAMed contributor, gave two keynote lectures. The first lecture was about handling difficult cases and the second was "24 Tweets on 12 Cases." The difficult cases lecture featured using the **OODA loop** first popularized by US Air Force Colonel John Boyd. OODA stands for Observe, Orient, Decide, and Act. The lecture is available as a **Podcast** under the title "*SO THERE: Special Edition 'Swimming in Quicksand*'" and dated

September 22nd, 2017.

Dr. Rob Bryan, from Utah Emergency Physicians, spoke about both ketamine use for pain management and addressed hypotension associated with intubation. Dr. Brian Shiozawa, a leader for both St. Marks and EPIC, and state Senator for Utah's 8th Senate District, spoke about Medicaid expansion, marijuana legislation, proposed balanced billing bans, and other healthcare legislation in Utah. Dr. Robert Stephen led the patient safety LLSA.

Mark your calendars for the 4th Annual Utah ACEP Summit that will be held on Wednesday morning, September 26th, 2018, at the Officer's Club on the University of Utah Campus. This event will be held in conjunction with the University of Utah's Emergency Medicine Resident Conference. It will feature great speakers, important topics, LLSA review, free CME, networking and catered meals.

On a personal note, this is my last message as Utah ACEP President. Thank you for all you do for our patients and each other. It has been an honor to lobby for our patients and profession at both Utah's Capitol and in Washington, DC. I wish that we just had to worry about taking good care of our patients, and that others would take care of us, but this is not the case. It is important that we get to know our elected leaders and offer our expertise for legislation they are evaluating. We need to speak to them about concerns we have related to our patients and the changing nature of the practice of medicine. Thank you, particularly, to everyone who contacted their legislator regarding the proposed balanced billing legislation earlier this year. Your calls and concerns resonated with them and your advocacy blocked a horrible piece of legislation that would have taken away our negotiating powers and forced us to accept whatever insurers were willing to pay. These issues won't go away, but we can continue to fight them together!

Ibogaine: A Potentially Deadly Detoxification Method

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As the number of people dependent on opioid substances increases, so does the number of people using novel and alternative methods for detoxification. Ibogaine is one such substance recently reported in the medical and toxicological literature.

Ibogaine is a naturally occurring dissociative psychoactive substance that is derived from the roots of the *Tabernanthe Iboga*, a shrub native to Western Africa. Interestingly, users describe their hallucinations as more intense and vivid with their eyes closed, contrary to most other psychedelic substances. Ibogaine is scheduled as a Class I substance in the United States; however, this does not stop those who wish to use the unproven therapy for detoxification from obtaining it through illicit means such as online purchases or through international adventures such as visits to Mexico, where several ibogaine treatment facilities exist.

Ibogaine blocks cardiac potassium channels potentially leading to prolonged QTc and subsequent ventricular tachycardia. Additionally, ibogaine is metabolized through cytochrome P450 complexes and metabolism is affected when used with other medications that share this form of metabolism. There are several case series and reports regarding adverse arrhythmias and cardiac arrests from ingestion of ibogaine.

There is no specific treatment aimed at ibogaine related toxicity, standard treatments for QT prolongation such as correcting electrolyte imbalance, IV magnesium, and anti-bradycardic measures such as isoproterenol or cardiac pacing is recommended. Providers should be aware of the potential use of this substance in patients seeking non-medically approved detoxification methods and evaluate for possible cardiac conduction delay.

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Shredded bark of tabernanthe iboga for consumption. Contains ibogaine.

Treatment of Calcium Channel Blocker Overdose

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The most common cause of drug induced cardiogenic shock is beta-blocker toxicity. While less frequent, calcium channel blockers (CCB) is associated with higher mortality rates and should be considered if the history suggests either intentional drug ingestion or a CCB may be on their medication list in the setting of shock. CCB overdose presents with bradycardia, hypotension and hyperglycemia and must be recognized early and treated aggressively.

The initial step in management should be securing the airway and gastric decontamination with activated charcoal, preferably within 1 hour of ingestion, with a potential benefit after one hour that cannot be excluded based on the current evidence.

Initial therapy specific includes IV fluid resuscitation and IV calcium. Calcium chloride provides more Ca++ per volume than calcium gluconate but usually requires central IV access. Vasopressors, such as norepinepherine or epinephrine, should be started early. However, do not delay administering the mainstay treatment for CCB overdose, hyperinsulinemia euglycemia therapy (HIET), if the patient is not responding well.

The initial dose of insulin is large. Published recommendations are 1 unit/ kg bolus, followed by 0.5-1 unit/kg/hr infusion titrating up by 0.5-1 unit/kg/hr up to 3-5 units/ kg/hr with a goal of HR >50 bpm and systolic BP >100 mm Hg. A hemodynamic response may take 30 minutes. This

high dose can be concerning for inducing hypoglycemia, however, hyperglycemia in the setting of CCB overdose is fairly resistant to insulin. If the serum glucose level does drop quickly after insulin, consider an alternative diagnosis such as beta-blocker or an alpha 2 agonist (e.g. Clonidine) overdose. Monitor glucose and electrolytes carefully, in particular potassium, every 20-30 minutes until stable. Consider a dextrose bolus (D50) and drip (D10) concurrently with HIET if initial glucose is less than 250, or if the patient becomes hypoglycemic.

HIET is recognized as a safe treatment, with very few instances in the literature of hypoglycemia and electrolyte disturbance (hypokalemia) when using HIET for CCB overdose. In addition to monitoring glucose and electrolytes, a baseline bedside echocardiogram can be compared to echo obtained 30-60 minutes after initiation to assess improvement in contractility.

If the patient fails to improve hemodynamically after calcium, vasopressors and early HIET, consider lipid emulsion (Intralipid 20%) therapy or VA-ECMO if your hospital has this capability. If you are considering ECMO, discuss the use of lipid emulsion with the team first as there are case reports of lipid emulsion damaging ECMO circuits.

State Legislative Issues for 2018
by Harry J. Monroe, Jr.
ACEP Director, Chapter and State Relations

Two years after the nearly miraculous successful retreat by the British army from Dunkirk, Prime Minister Winston Churchill remarked on the first actual British victory of the war by declaring, “Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.”

We may be at a similar point in our legislative battles over balance billing and out of network reimbursement. In many states, policymakers that have been considering the issue for multiple sessions will look to address the issue once and for all. Thus, it will be important that we stand ready to engage an issue that continues to pose a threat to our specialty and most importantly, access to care for our patients. Certainly, we want to be paid fairly, but we also want to focus on making sure that insurer practices are not causing patients to delay receiving emergency care out of uncertainty as to what the insurer will pay.

ACEP has developed, and is continuing to refine, resources to help states engaging this issue.

On **our website** you will find numerous documents that will be of help in working on this issue, including talking points, copies of written testimony produced in a number of states, information on why Medicare is not a sound benchmark for determining reimbursement, and many other materials. I would encourage you to take a look.

Additionally, we have worked hard over the last two years to build relationships with other specialty societies and the AMA, based on shared consensus principles and solutions documents that are included on the website, that have helped us collaborate on these issues. In most states that we have engaged, the national collaboration has helped with building alliances at the state level, with the result that the house of medicine has been largely united in our response to legislation. In addition to fighting off bad legislation, we have looked for opportunities to promote positive legislation on the issue, and model legislation has been developed to that end. In addition, to our collaboration with other specialties, another outside organization, Physicians for Fair Coverage, has been formed and has helped to provide and coordinate resources in this fight.

At the time of this writing, we are also working on developing regional teams of experts that can help provide assistance in terms of legislative interpretation, understanding financial impacts, and advocacy. These should be in place by the time 2018 sessions begin.

We believe that as many as 25 states will see significant efforts by legislatures to address balance billing and out of network legislation this year. If you are facing it in your state, reach out to me **via email** or at 972-550-0911, ext. 3204.

In addition to balance billing and out of network issues, there will be many other important issues to address in the coming year. The prudent layperson standard remains under attack in many places by both Medicaid and commercial payers. The opioid epidemic continues to be a critical public policy concern. Of course, what the federal government does about health care, and how that filters down to the state level, promises to require our attention. This will be a busy year at the state house!

ACEP – You make 50 look good!

As we wind down 2017, we kick off a year-long celebration of ACEP's 50th anniversary starting January 2018. Plan to participate in social media campaigns that highlight the highs, lows and life-changing moments in EM. Get hyped for a historical timeline following the history of our specialty as well as anniversary-themed podcasts. Watch for anniversary editions of ACEP Now and Medicine's Frontline in addition to proclamations from members of Congress and sister medical societies. Don't forget to order copy of our commemorative coffee table book featuring the breath-taking photographs that capture a day in the life of emergency physicians collected by famed photographer Eugene Richards. **Book tickets now to ACEP18** and our blow-out anniversary celebration in San Diego featuring an interactive history museum showcasing the journey of emergency medicine from battlefield to inner city to rural America to every spot in between.

As we enter 2018, we begin the celebration of 50 years of life saving and boundary pushing. Are you on call for 50 more?

Show Your Commitment to High Standards for Clinical Ultrasound

You have the highest standards when it comes to your clinical ultrasound program. Show that commitment to your patients, your hospital, and your payers with ACEP's Clinical Ultrasound Accreditation Program (CUAP). ACEP's **CUAP** is the only accreditation program specifically for the bedside, clinician-performed and interpreted ultrasound. Now also available - accreditation for non-ED clinical settings, including freestanding EDs, urgent care centers and clinics. **Apply Today**!

Ensure safety and efficacy of patient care
Meet ACEP's high standards for point-of-care delivery
Use your own policies or draw from expert-reviewed sample documents

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Geriatric Emergency Department Accreditation Program

ACEP is gearing up to accredit geriatric emergency departments. The **Geriatric Emergency Department Accreditation Program** will be accepting applications after the first of the year. There will be 3 levels of accreditation ranging from a minimal commitment to better elder care to a comprehensive well-rounded robust program. Accreditation shows your patients, your institution and your payers that your ED is ready to provide care to seniors and is a quality program that meets the high standards of the American College of Emergency Physicians. **Find out more**.

Articles of Interest in *Annals of Emergency Medicine*

Sandy Schneider, MD, FACEP
ACEP Associate Executive Director, Practice, Policy and Academic Affairs

ACEP would like to provide you with very brief synopses of the latest articles in *Annals of Emergency Medicine.* Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population. **Read More**

Policy Statements and PREPs Approved by the ACEP Board

The following policy statements and PREPs were approved by the ACEP Board of Directors at their October 2017 meeting.

Policy Statements
Medical Transport Advertising, Marketing, and Brokering – revised

Clinical Emergency Data Registry Quality Measures – new
Mechanical Ventilation – new
Hospital Disaster Physician Privileging – revised
Unsolicited Medical Personnel Volunteering at Disaster Scenes – revised
Sub-dissociative Dose Ketamine for Analgesia – new
Writing Admission and Transition Orders – revised
The Clinical Practice of Emergency Medical Services Medicine – new
The Role of the Physician Medical Director in EMS Leadership – new
State Medical Board Peer Review – new
Pediatric Medication Safety in the Emergency Department – new
Distracted and Impaired Driving – revised

PREPs

Sub-dissociative Dose Ketamine - new
Writing Admission and Transition Orders – new

Welcome New Members

John Hansen
Brandon Nielsen

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