Maryland ACEP www.mdacep.org EPIC Emergency Physician Interim Communique

In this issue - May 2018

Letter from the President

Orlee Panitch, MD, FACEP

I am incredibly honored for the privilege of being the President of Maryland ACEP. It is a privilege to serve with many fine professionals at both the State and National Levels.

I want to take a moment to again recognize Drew White for his two years as President. Drew served during the tumultuous period when pressures on hospitals to comply with our State's Medicare demonstration projects created all sorts of unintended consequences, particularly in the area of EMS diversion time and throughput. With Drew's leadership, Maryland ACEP took a central role in helping the state create new measures of throughput to help our EDs move patients more efficiently. Drew oversaw a strategic planning process that has aligned us to move forward in this constantly changing world. We saw a revitalization of the practice management committee, and multiple behavioral health initiatives.

Let's discuss our strategic plan. With the assistance of a strategic planner, we have been able to hone down our initiatives to the following three:

- *Improve Patient Care Statewide through Advocacy*
- *Promote an Accurate Understanding of the Value and Practice of Emergency Medicine in Maryland*
- *Enhance Membership Value and Engagement.*

Advocacy

I believe advocacy to be one of the most important roles for the College. This is why I became active with ACEP over the past ten years, starting with the initiation of the ACA. We are the experts in acute unscheduled medical care. We must play a very active role in what that medical care looks like in the future, for both our patients and, for ourselves.

To be effective we need to identify the areas that we believe to be critically important to our patients' health, i.e., access to mental health care, improving emergency department throughout and giving patients access to opiate addiction programs.

Identification of these areas has already begun. At this very session we had a very robust public policy committee. The very active trial bar nearly succeeded in passing a bill that would have repealed the requirement that experts only spend up to 20% of their time as expert witnesses. That bill would have benefitted only the trial lawyers. Utilization would increase, patients would be misled by overzealous attorneys and physicians would be subject to frivolous suits. Maryland ACEP, in collaboration with MedChi and other provider stakeholders, proved that we can garner overwhelming bipartisan support to kill this bill. Leveraging from this accomplishment, Maryland ACEP should take the lead and be proactive to create coalitions with our peers to redefine what a medical expert actually is.

We should also continue to pay close attention to Medicaid reimbursement. In Maryland, we enjoyed parity with Medicaid and Medicare several years ago. Over the past few years, the level has eroded, and where we were once at nearly 100% parity, we have diminished to 92% in 2018 with a slight bump up in 2019 to 93%. There is work to be done here.

To be good advocates we must be at the table. If you are not at the table, you are on the menu.We need to be helping make decisions. The Maryland legislature should not be deciding what CME we need to do. We need to sit on key committees like the HSCRC, PDMP, MHA WorkGroups, etc.

We are the experts regarding best practices! This is where our Practice Management Committee and our public policy committees can collaborate. We need to take the lead in making substance abuse treatment more accessible, promoting telemedicine and getting more comprehensive psychiatric care to the people.

We have real work to do. We need to expand on the work we have already done with the media to make sure that we are the *only authority in Maryland on emergency care*.

Promote an Accurate Understanding of the Value and Practice of Emergency Medicine in Maryland

The second initiative ties in closely to the first. This is an election year. The entire legislature, the county governments and the governorship are all up for change. We will have many new legislators that do not know us so, we need to teach them. We need to build a library so we no longer shudder when we hear reports that are clearly inaccurate. We need to have our voice heard in social media forums. To our younger members, here is your initiative. We desperately need your help here. Lastly, we need to adopt feasible goals, schedule and content management plan for *EPIC* publication.

Enhance Membership Value and Engagement

Everyone needs to get something out of their participation with ACEP. This isn't a charity. Participation is not mandatory. For people to give up their time to get involved, there needs to be a value proposition.

We need to give better feedback to our members on our numerous project. We need to effectively let members know what projects are out there and what their contributions are.

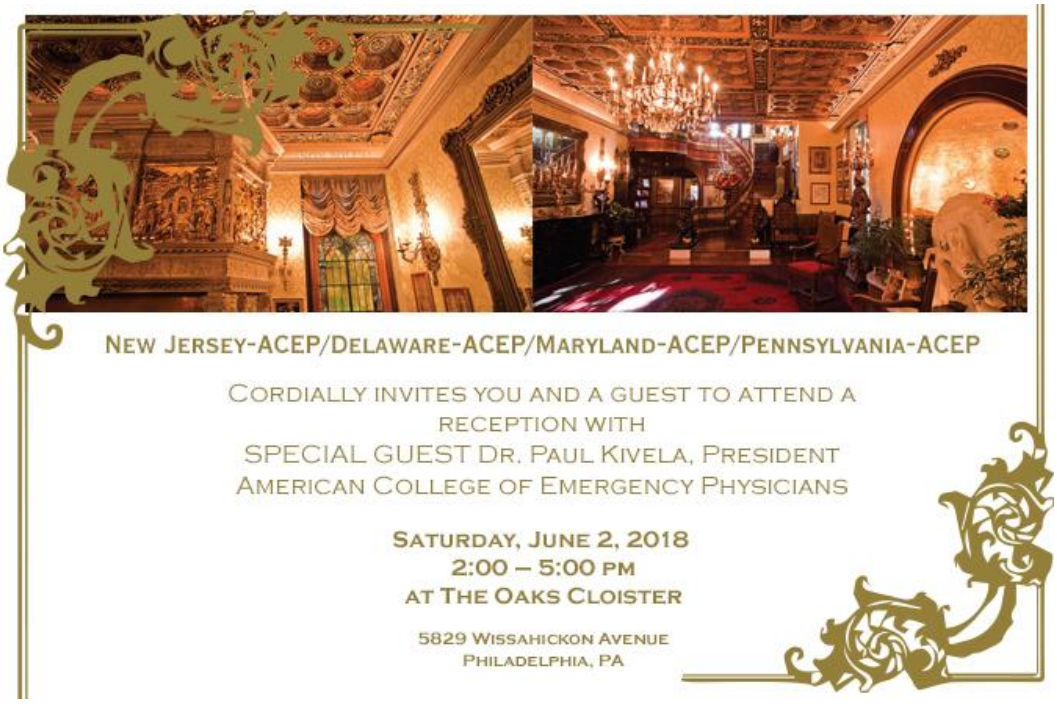
We need benefits that include wellness activities and exclusive career enhancement opportunities. We do a great job of taking care of patients; we need to take better care of ourselves. Physician wellness is critically important to maintain our practices and, to avoid burnout.

We are much stronger when we represent the wonderful diversity we represent; everyone needs a voice.

We need to develop a strategy for engaging and recruiting newly graduated emergency medicine physicians. They [you] are the future; that voice should be the loudest!

We need to leverage social media to share membership advantages and promote dialogue on emergency medicine news and themes.

I'm optimistic. The practice of medicine is changing daily and we have an opportunity to mold it. Please take a part in this process; take an active role in ACEP. Join committees, help us communicate ... help us advocate.



click here for full invitation

EMS Update

Timothy Chizmar, MD, FACEP
MD ACEP EMS Committee Chair

Protocol Updates for 2018

There are a few updates to the Maryland Medical Protocols for EMS Providers that become effective on July 1, 2018. These are a few highlights of important changes. For a full protocol update, please visit www.miemss.org (Hospitals tab) or contact your hospital base station medical director. As a reminder, all Maryland ED base station physicians must complete the annual EMS protocol update at your respective hospitals prior to July 1 every year.

Ketamine

ALS Providers will be able to administer ketamine for patients with excited delirium. Previously, providers were limited to haloperidol or midazolam for management of severely agitated patients. The goal with rapid treatment with ketamine is to promote safety for the patient, EMS providers and law enforcement. Excited delirium patients are at high risk of death and minimizing physical struggle with rapid sedation is a central tenet of management.

ALS providers may administer ketamine 1 mg/kg IV/IO, with max single dose of 100mg, may repeat x1 dose (total dose 200mg IV). Medical consultation is *not* required for 1st or 2nd dose *by IV/IO route*. If there is persistent agitation despite two doses of ketamine, the provider is advised to give a dose of midazolam 2.5mg IV/IO. For the intramuscular route, a dose of ketamine 4mg/kg IM can be given without medical consultation. If there is persistent agitation give midazolam 5mg IM. Medical consult is *required* for an additional dose of ketamine 4mg/kg IM, if necessary.

A medical consultation is required prior to administration of ketamine for children who have not reached their 13th birthday. The recommended dosing in mg/kg is the same as for adult patients.

There is an emphasis on not giving haloperidol or diphenhydramine in EXDS patients, as these medications may prolong QTc or precipitate seizure activity.

ALS providers will also be able to administer "low dose" ketamine, at an initial dose of 0.2 mg/kg IV, slow over 1-2 minutes, max single dose 20mg, for pain management. Intranasal and intramuscular routes with dosing regimens are also contained in the new protocol. The patient would qualify for this protocol, which is an alternative to opioid-based (morphine or fentanyl) pain management, if they have moderate to severe pain.

Dextrose 10% (D10)

ALS providers may administer dextrose 10% (D10) to patients of all ages for hypoglycemia, as noted below. In the past, providers may have given D10 or D25 to some pediatric patients. Providers may still administer D50 to adults.

D10 for adults with glucose <70: administer 50 mL boluses of D10 every minute, up to a maximum of 250 mL of D10. Titrate to normal mental status or glucose >90. For persistent hypoglycemia, this dosing regimen may be repeated.

D10 for children 5 years to 18th birthday, glucose <70: administer 2-4 mL/kg of D10

D10 for children 28 days to 4 years, glucose <70: administer 2-4 mL/kg of D10

D10 for children under 28 days, glucose <40: administer 2 mL/kg of D10

For patients without intravenous access, glucagon by the intramuscular (IM) or intranasal (IN) route is another option allowed in protocol.

Stroke Alert

In light of the recent DAWN and DEFUSE 3 trials, which have shown improved functional outcomes for select ischemic stroke patients who are treated with interventional therapy up to 24 hours after last time known normal, our guidance to EMS on the transport of these patients has changed.

EMS will transport all patients with suspected stroke and symptom onset within the past 24 hours to the closest Primary or Comprehensive Stroke Center and indicate "priority one, stroke alert" in their consultation.

While it is appreciated that only select ischemic stroke patients, such as those with suspected large vessel occlusions, will be appropriate for clot retrieval or interventional therapy, this is a judgment that will need to be made in the Emergency Department (not by EMS). At the present time, we will not ask EMS to bypass Primary Stroke Centers in favor of Comprehensive Stroke Centers based on the severity of the suspected stroke, except as noted below.

In Baltimore City, a research protocol will continue, in which acute stroke patients are transported preferentially to a Comprehensive Stroke Center if their Los Angeles Motor Scale (LAMS) score is 4 or greater; this higher score has a higher correlation with large vessel occlusion but it is not a perfect screening tool.

EMS providers are advised to obtain and document a phone number for one or more individuals who have details about the patient and their past medical history on their patient care report.

The Maryland Chapter of the American College of Emergency Physicians wishes to thank our supporters and exhibitors of the 2018 Annual Educational Conference held on April 19, 2018:

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Pediatric EM Update - The Kiddie Corner

Erik Schobitz, MD
MD ACEP Pediatric EM Chair

Hi - I am Erik Schobitz and I am the Pediatric Emergency Medicine committee chairman for Maryland ACEP. We will be writing brief reviews of timely management issues for common pediatric complaints. These will be short, and are not meant as a guideline, rather a quick review to help you care for sick children. We will rely on common sources such as Up To Date, journal review articles, Epocrates, Clinical Management Pathways, etc. for this endeavor. Thank you for reading and for caring for the kids of Maryland.

Pediatric Asthma

Spring has sprung and the pollen is everywhere, so 'tis the season to be wheezin! We wanted to provide a brief review of current evaluation and treatments strategies for pediatric asthma.

A simple way to think of asthma is that it is reversible bronchoconstriction that occurs with increased secretions and underlying inflammation. Some Pediatricians call it recurrent wheezing or Reactive Airway Disease. To those of us who practice in the ED, this nuance doesn't change treatment. Our goal is to improve overall respiratory status by rapid reversal of airflow obstruction with bronchodilators, anticholinergics, and systemic glucocorticoids. For bronchoconstriction: Albuterol should be given at 2.5-5mg via nebulizer every 20-30 minutes x 1 hour. An easy way to accomplish this goal in the busy ED for a sick asthmatic is to start a continuous albuterol nebulizer at 10-15mg/hr x 1 hour. When thinking about how to decide how much, ask yourself "will this patient end up in the PICU"? If you answer "yes", give 15mg, if you think "no", but know you are busy, then getting every 20-30 minute neb treatments will be difficult. Give 10mg over the hour - you can always give more. Remember that the side effects of Albuterol (tachycardia, jitteriness, nausea) are better tolerated in kids than adults so higher doses are not usually a problem for kids with healthy hearts.

We can treat the increased secretions of asthma with ipratropium bromide (atrovent). The dose is 0.25-0.5 mg neb and you can give it up to every 20 minutes for the first hour. Common practice is 0.5-1mg mixed in the 1-hour albuterol nebulizer. There is no proven benefit to continuing atrovent while hospitalized or when you discharge them. Treatment of the underlying inflammation with systemic steroids is key. Dexamethasone 0.6 mg/kg PO x 1 or x 2 - given 2 days apart has been shown to be well tolerated and is equal to a 5 day burst of prednisone. This was well studied by Dr. Faiqa Qureshi at CHKD and has been replicated many times over the ensuing years. As a parent - it's much easier to give one dose at home rather than four to young kids.

If patient is not improving, or they are worsening in front of you, there are more adjuncts. Magnesium sulfate 50-75mg/kg a maximum of 2 grams will relax smooth muscles in the lungs. We give this over 20 minutes so you may need to let pharmacy know this when they are preparing the medication. In kids so tight that it's hard to appreciate wheezing, because they were not moving air, you can add IM epinepherine, give an EpiPen JR for kids less than 25 kg, an EpiPen if > 25 kg. You can also treat with SQ terbutaline (dose 0.01mg /kg). If this fails, we are faced with a dilemma. You can add IV solumedrol and IV terbutaline; you should consider High Flow Nasal Cannula Oxygen. This will basically act as non-invasive PEEP. While different institutions have different protocols, 4-5 liters @ a FiO2 of 50% is a reasonable starting point for most patients. You need to titrate to effect quickly, for if this also fails, the patient will require intubation. If you need to intubate - remember they have air trapping so a pressure control strategy with a prolonged expiratory time may be beneficial.

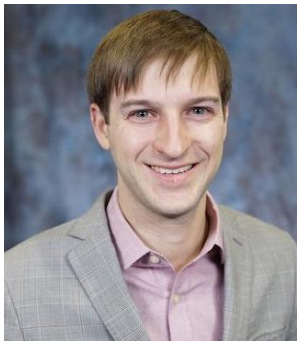
Thanks for your attention and for all the work you do for our region's children!

TOOLS OF THE TRADE

Welcome to the EPIC. We would like to expand our publication to include your experiences starting with a HIPAA compliant section entitled: "Tools of the Trade".

Please send us your interesting, instructive, unusual cases to share in the EPIC. The next issue will be around the 4th of July holiday - we are looking for experiences specific to injuries of the summer- heat stroke, drowning, fireworks, etc.

Articles should be no more than 800 words, sent to info@mdacep.org. Deadline is June 18th for the July edition. We hope to hear from you!



Public Policy Update
Kyle Fischer, MD
MD ACEP Public Policy Committee Chair

It's springtime in Maryland, so that means one thing: the Maryland General Assembly just finished another session of lawmaking. With elections in the near future, this year was filled with near-record levels of drama and excitement. Overall, over 3000 bills were considered, with a sizeable amount relating to health care. Let's recap the session!

The award for most dramatic legislative performance undoubtable goes to Senate Bill 30/HB 1581. Drafted by Senator Ramirez and Delegate Vallario, this bill would have repealed Maryland's "80/20" rule for expert witnesses in medical malpractice cases, essentially legalizing non-practicing, professional plaintiff witnesses. Fortunately, this bill failed at the last minute. In the anxiety provoking final days, the bill passed through both chambers, but with slight differences in the House and Senate. As midnight approached on Sine Die, legislators were not able to resolve the difference, and the bill died when time ran out.

HB 1452/SB 1233 will likely have the biggest direct impact on emergency physicians in Maryland. As originally written, the bill would have required mandatory opioid-related CME for every CDS renewal. MD ACEP generally opposes legislative mandates for CME. However, in the setting of an unprecedented opioid epidemic, this was a bill almsot guaranteed to pass in an election year. We are pleased, however, that we were able to constructively work with Del. Pena-Melnyk to amend the bill to a more palatable form. As passed, the bill only requires two hours of opioid-related CME for *the first* CDS registration or renewal after 2018. Renewals will not require additional CME.

Of course, the number of passed bills is too numerous to relay in a newsletter. Here are some highlights. HB 1092/SB 703 created the

Behavioral Health Crisis Response Grant Program which dedicates $10 million towards community-based crisis response programs. HB 653 / SB 522 mandated that health care providers advise patients of the benefits of and risks of opioid medications when writing a script. Finally, HB 1467/SB 574 created the Sepsis Public Awareness Workgroup. An emergency physician is mandated a position on the workgroup, so please reach out to ACEP if you may be interested in serving in this role.

If you'd like to learn more about this year's session in Annapolis, please to go http://www.mdacep.org/ and click on the "Public Policy" tab for a full recap. As always, don't hesitate to reach out to your Public Policy Committee if there are issues you think we could be helpful with. It's our job to work with our regulators and elected officials to ensure that the policies created in Annapolis address the needs of patients and emergency physicians. We work for you.

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