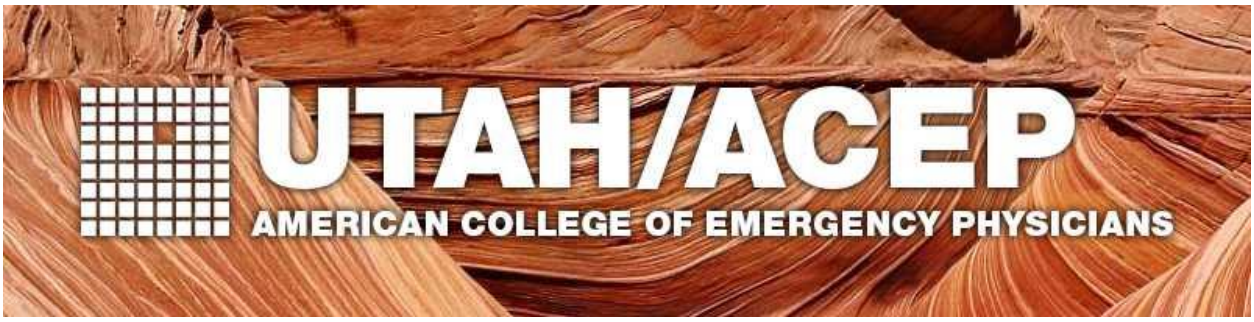
A Newsletter for the Members of the Utah Chapter - Fall 2022



In this edition:

News from ACEP:

Newsletter prepared by Alison Smith, MD, MPH, FACEP, UCEP President

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Improving Care Coordination for Patients in Custody and Dispelling the Myth of "Jail Clearance"

by Sean Slack, DO

A revolution in the way we treat arrested persons being taken to jail is underway in Utah. Historically, arrested persons have been brought to the ED by law enforcement officers for "medical clearance." EM physicians were often expected to fill out a detailed form that

accompanied an arrested person to jail in the care of police officers who then had access to their private patient information. It was unclear what rights an arrested patient had to refuse care or certain aspects of an evaluation in the ED when brought in by law enforcement. Over the past year, a UCEP task force has been working with leaders from law enforcement agencies around the state to find solutions to better care for these and other vulnerable patients in various stages of the penal system.

Early success was seen in Utah County with implementing new procedures such as eliminating forms, allowing patients who demonstrate clear decision-making capacity to refuse testing or evaluation, and doing warm handoff by phone or fax to improve communication with jail medical staff and protect patient confidentiality. Other groups around Utah, including Utah Emergency Physicians and EDs staffed by EPIC, have also recently gone live with a similar process in Salt Lake County. While challenges remain, we've made good strides to improve our communication with the jail medical team and ultimately improve patient care. Importantly, we have reiterated that we are available to provide medical screening exams for patients based on EMTALA but that we do not perform "jail clearance". This inherently decreases liability for emergency physicians, who are often working with limited information and/or dealing with patient unwillingness to cooperate or be forthcoming with information that could affect their care in the presence of police officers.

For many emergency physicians, it is challenging to understand why some patients end up in the ED and others at jail. Those that are referred back to the ED from the jail intake process can often have nebulous problems. Some will check in with a triage chief complaint of "jail clearance" after an alleged drug ingestion or motor vehicle accident, or the patient will report that they are having chest pain or are suicidal. Others may syncopize or have a seizure during arrest without a documented history of syncope or seizures.

To better understand the process of jail intake, a group of Salt Lake City-based emergency physicians went to the Salt Lake County Jail recently to have a tour and comprehensive review of the booking protocols, on-site medical coverage and facilities, and overview of medical and psychiatric physician coverage and access to follow-up care. We came away quite impressed with all the jail is capable of doing for patients.

So why are some patients turned away while others are accepted at jail intake? It's really all about risk and cost. If a patient steps across the jail intake line, i.e., is accepted to jail, the jail is then responsible for any costs that may arise for that patient. If they are denied (told to go to the ED for "jail clearance"), the cost remains with the patient or the agency that has arrested the patient (e.g., the Salt Lake police department, Utah Highway Patrol, etc). Before the patient is even booked into jail, they are screened by a jail RN who uses their clinical judgment as well as an array of protocols to determine whether a patient is accepted into the jail or turned away. From there, it is up to the arresting officer to release the patient or, in many cases, bring them to an emergency department for evaluation.

New Protocol:

1. Stable Patient- if a patient has a non-revealing work-up, that is, if no emergency medical condition is identified, and the patient would be discharged home under normal circumstances, the patient is discharged in police custody with good return precautions.
2. Watcher Patient- If a patient has an injury or illness that needs further evaluation, we can now call directly to one of the jail RN's to review the case and understand

their capacity for further management (i.e., IV antibiotics). We can relay pertinent information verbally as well as in our discharge paperwork.
3. Admission - If a patient is determined to have a medical issue that requires further hospital evaluation or admission, the patient/arrestee will be admitted to the hospital just as a normal patient would be.

There is more work to be done but these changes have already proved beneficial to patients, physicians, and law enforcement. We have been able to more efficiently address concerns from the jail and ensure the patient gets the right care in the right location at the right time.

Lastly, this work has exemplified the power of UCEP and the importance of working together as a specialty. It has been a privilege to work with many emergency physicians from around the state and in other groups locally to help solve these problems on a unified front.

A Brief Overview of Current Abortion Laws and Policies in Utah

By Ellie Gilbertson, MD

In a historic ruling by the Supreme Court this June, Roe v Wade was overturned in *Dobbs vs Jackson Women's Health Organization*, thereby denouncing abortion as a right outlined in the Constitution. Here in Utah, SB174 immediately went to effect as a trigger law - banning abortions in Utah except when the maternal life is at risk, or in the case of reported rape/incest. However, an injunction went to effect shortly thereafter putting a temporary hold on this law. Given all of these steps, our current situation in Utah is that abortion is legal and available for patients <18wks gestation as long as the aforementioned injunction is in effect (so, unchanged from prior).

Managing non-viable pregnancies in the ED has also therefore not changed; mifepristone and/or misoprostol are still the agents of choice. These options are also used for medication-assisted abortions for viable ongoing pregnancies (again, before 18 weeks, just as before). Interestingly, these medications are often available online for purchase from other countries, however, there is no way to ensure contents or ingredients. Therefore, providing endorsement for this option to patients is not recommended, but they are options that we should be aware of in the ED in case we are asked.

It's important to note that none of the recent changes in state law impact Emergency Contraception (like Plan B). Unlike mifepristone and misoprostol, which work by mimicking prostaglandins and inhibiting progesterone (respectively) in order to potentiate uterine shedding, Plan B has no direct effect on the uterus. Instead, Plan B prevents ovulation, and as such is in no way affected by recent legislation. This agent is most commonly Levonorgestrel; however, Ulipristal Acetate (aka Ella) is effective for a longer period of time following unprotected sex (up to 120 hours). It is oftentimes a more potent/effective alternative than Levonorgestrel especially in patients with elevated BMI.

As of now, contraception (both emergency and non-emergency) is untouched by current legislation. However, many vendors are beginning to limit the number of Plan B pills that a single customer can buy in an attempt to circumvent people stockpiling these medications in anticipation of future legislation. Placement of an IUD remains the most effective

emergency contraceptive method after sex, but this is obviously outside the scope of an ED provider.

Regarding changes that we may see in the ED, there exists the likelihood that we may see an increase in the number of patients who are seeking early pregnancy termination resources given the fragility of the injunction and the unknown future direction our state will take. It is expected that if the injunction is denied and SB174 is passed, we can expect to see an increase in post-medical abortions with misoprostol obtained from overseas in addition to possible complications from illegal procedural abortions. Because of EMTALA, we can of course continue to legally provide emergent care to patients who present with any of these complaints no matter what the legal state du jour may be. Our documentation should continue to be protected by HIPAA.

Finally, it may be helpful to educate your patients that if they are planning to proceed with a pregnancy termination, the state of Utah requires that the patient in question take three steps: 1) complete this information module from the Health Dept website, 2) obtain informed consent from a licensed provider (MD, DO, RN, LCSW) and 3) wait 72 hours prior to the procedure. A useful resource for our patients in the current era may be found at www.abortionfinder.org, which will assist a woman in finding a geographically close location to obtain pregnancy termination in addition to copious amounts of other information based on an estimated gestational age.

Many national medical specialty groups have issued public statements regarding the decision to overturn Roe v Wade, including ACEP. In this letter, Gillian Schmitz (ACEP president) states “Emergency physicians are bound by oath and law to care for anyone, anytime; as we assess the range of implications this legal decision could have on patient care and safety, our commitment to patients is unwavering and our dedication to leading care teams that provide high quality, objective and evidence-based emergency care will not change.” Regardless of individual practitioner beliefs, the fact remains that as the interface between the outside world and the hospital, changes in legislation such as this one will undoubtedly touch the practice of emergency medicine and thus our daily lives.

Abortion Law in Utah as of August 2022 - Additional Background Information from the Utah Medical Association (UMA)

In *Dobbs v. Jackson Women’s Health Organization*, June 24, 2022, the US Supreme Court overturned Roe v. Wade, which had established in 1973 a qualified right to an abortion under the federal constitution (substantive due process under the 14th Amendment; as modified by Planned Parenthood v. Casey in 1992). The 14th Amendment restricts the ability of states to pass laws that affect individuals’ liberty, so by deciding that the 14th Amendment does not apply to state laws restricting access to an abortion, the Dobbs decision allows states to pass laws restricting that access.

In 2019, the Utah legislature had passed HB 136, banning abortions after 18 weeks of gestation, unless the pregnancy was the result of rape or incest (reported to law enforcement), the pregnancy threatens the life or health of the mother, or the fetus has severe abnormalities. That law was challenged in court and put on hold on the basis that it was more restrictive than allowed by Roe v. Wade. And the case itself was put on hold, pending the outcome of other cases challenging Roe v. Wade.

In 2020, the Utah legislature passed SB 174, a “trigger law.” SB 174 would make it a second-degree felony to induce an abortion, unless one of the exceptions noted above applied. The bill itself said that it would not go into effect unless and until the US Supreme Court overturned Roe v. Wade (as determined by the legislature’s attorneys). When the legislature announced that Dobbs met that criterion, the trigger law briefly (a couple of days) went into effect until a lawsuit was filed and a temporary stay was granted. The lawsuit argues that the trigger law violates the Utah constitution. The court hearing this case granted a temporary injunction for the duration of the case, leaving the trigger law on hold until the case is decided.

With the trigger law on hold and Roe v. Wade overturned, the court that had been considering the 2019 law moved forward and declared that the 2019 law did not violate the US constitution, per Dobbs, so the ban after 18 weeks went into effect in Utah, along with the exceptions mentioned above. This is the current law in Utah.

The lawsuit challenging the trigger law is continuing. Whether the trial court upholds the law or overrules it, that decision will likely be appealed to the Utah Supreme Court. And we will probably not have a final decision on it until the Utah Supreme Court rules on it. If the Court decides the trigger law is valid, it will replace the 18-week ban and become the law in Utah. If the trigger law is found not valid, the 18-week law will continue in effect. Of course, at any point in this process the legislature could make further changes to the law.

Other States. Since states are free to enact their own laws regarding abortion both before and after the Dobbs decision, some states have gone far beyond Utah’s restrictions. Texas law criminalizes aiding and abetting a pregnant woman getting an abortion, even out of state. Several states ban abortion after fertilization and other states are considering granting personhood rights to embryos and fertilized eggs. These laws could potentially ban discarding embryos produced by in vitro fertilization that aren’t implanted, among other significant consequences. Abortion bans or restrictions in some states have fewer exceptions than Utah’s or allow no exceptions to the ban. This has raised serious questions about what care is allowed, for example, for an ectopic pregnancy or a miscarriage, and when. Other states are moving in the opposite direction, putting the right to an abortion in the state constitution or facilitating pregnant women coming to the state for an abortion regardless of the circumstances.

UMA Policy. Under policy adopted in September 2021, UMA opposes legislation restricting “an elective abortion prior to 13-weeks estimated gestational age” and supports legislation reversing restrictions before 13 weeks, as well as supporting exceptions for “medical termination for maternal health complications, fetal anomalies, and non-viability regardless of estimated gestational age.” UMA is working with OB/GYN and pharmacists on clarifying and cleaning up the “trigger” law in case it goes into effect.

UCEP Signs on to Co-Sponsor Resolution Regarding Women’s Reproductive Rights for UMA House of Delegates

The UCEP board was recently asked to co-sponsor a resolution for UMA House of Delegates by the UMA Women Physician's Section, Utah American College of Obstetricians and Gynecologists, and the Utah Maternal Fetal Medicine Section regarding women’s reproductive health in Utah. The board discussed at length whether to co-sponsor the resolution and ultimately voted in favor. The resolution was debated on,

amended, and ultimately approved at the UMA annual meeting September 9-10th and reads as follows:

“Whereas the recent rulings by US Supreme Court have severely limited access to abortion in Utah and many states, and

Whereas in their consensus statements, some justices have indicated expanding this to strike down the right to quality contraception and

Whereas other state governors have expressed their support for striking access to contraception services and

Whereas other states have imposed laws allowing civil suit against anyone assisting a pregnant person to receive access to abortion services and

Resolved:

That the Utah Medical Association will use its full capacity to:
Oppose limitations on access to evidence-based reproductive health services, including fertility treatments and contraception.

Protect the sanctity of the patient-physician relationship, including shared decision-making and evidence-based counseling between patients and their physicians regarding all aspects of reproductive healthcare.

Oppose any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare providers and their patients.

Oppose the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, and healthcare providers for providing healthcare of any kind–including comprehensive reproductive health services.

Advocate for legal protections for patients who cross state line to receive reproductive health services, including contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.”

The resolution was also co-sponsored by the American Academy of Family Medicine and the American Academy of Pediatrics.

“988" Suicide & Crisis Hotline Debuts Nationwide

by Alison Smith, MD, MPH, FACEP

The three-digit dialing code 988 has replaced the existing National Suicide Prevention Lifeline as of last month. The number, similar to 911 for emergencies, offers the public easy-to-access lifesaving mental health resources and has been launched throughout the United States. Those who are in a mental health crisis or their families or other loved ones can now immediately text, call, or chat with responders trained in suicide prevention, de-escalation techniques, stabilization, and other crisis strategies. Services are available

24/7/365 in both English and Spanish, along with interpretation services in more than 150 languages.

In Utah, the hotline providing specialized, individualized support for those in crisis or those caring for people experiencing a mental health crisis will be managed and staffed by certified crisis workers at the Huntsman Mental Health Institute. Funding will be via an added tax to monthly cellular phone bills, similar to how 911 is already funded in Utah. The current National Suicide Prevention Lifeline (800-273-8255) will continue to function even after the transition to 988. A toolkit for helping spread the word about the new 988 hotline is also available.

A recent Time magazine article on the new mental health number (August 8/August 15, 2022 issue) states that when a person calls 911, they will be guided through a crisis by trained counselors geographically close to them. This will be enough to mitigate most situations, but when additional help is needed, dispatchers will send a mobile crisis team comprised of mental health experts and peer support counselors. Alternatively, 988 will direct people to stabilization facilities–mental health centers where trained staff can observe and provide additional counseling and support.

The hope is that this will mitigate armed law enforcement responding to mental health emergencies as threats to public safety as well as people in crisis ending up where they currently do: emergency rooms, jail, or in worst case scenarios, morgues when things escalate violently. Law enforcement officers are currently the default responders to almost every mental health situation. A 2015 study showed that the mentally ill were shot by police at a rate of 16 times that of other civilians.

Early data are promising, with one experimental site in New York City demonstrating that having an effective mental health crisis line and responder team of mental health trained professionals was effective in reducing emergency department transport of crisis patients by nearly 30% in 2021.

This is a huge step forward in a country where mental health services have historically been under-funded and under-prioritized. This new crisis line represents the first major investment–$432 million from the federal government–in mental health services in decades. While Congress has passed this initial bolus of funding for mental health resources, such funds are finite, and it will be up to states to find additional money to continue supporting the centers after grants run out.

UMA House of Delegates

by Alison Smith, MD, MPH, FACEP

The 2022 UMA House of Delegates (HOD) took place September 9-10th in Thanksgiving Point, Utah. Resolutions were presented and debated that established policy and will set the UMA stance on vital issues going forward. Debates focused on such issues as women's reproductive rights (including access to abortion care and contraception), newborn home health, gun law stances, collective negotiating, any qualified physician or facility debates, and a host of others. Now that the House has established policy and set its priorities for the year, the UMA Board and Staff work to comply with those policies throughout the year through legislative lobbying, working with the Utah House and Senate, and raising awareness of the issues throughout Utah.

Five Utah emergency physicians (Dr. Jim Antinori, Dr. Alison Smith, Dr. Ben Buchanan, Dr. Shilpa Raju, and Dr. Mark Bair) were present to represent emergency medicine at this year's HOD. Please consider participating in the future to ensure our specialty is well represented and your voice is heard.

Overdose Deaths Rose 30% in 2020 (From UMA/AMA newsletter)

NBC News (7/19) reports, "From 2019 to 2020, the CDC said, the rate of fatal drug overdoses rose by 30% overall, from 21.6 deaths per 100,000 people in 2019 to 28.3 deaths per 100,000 in 2020. Most deaths were due to illicit fentanyl, a powerful synthetic opioid." The data indicate a disparity in outcomes by ethnicity; the death rate among Black Americans "increased most dramatically," by 44%, while for "American Indian and Alaska Native populations, the rate increased by 39%."

Dr. Jim Antinori Named Utah Physician of the Year by the Utah Medical Association

by Alison Smith, MD, MPH, FACEP

Congratulations to Dr. James Antinori, MD. He is **Utah's Doctor of the Year for 2022.** Dr. Antinori received his medical degree from the University of Florida College of Medicine in 1974 and has been practicing emergency medicine full time since 1977. He is Board Certified by the American Board of Emergency Medicine and is an Oral Board Examiner for that organization. He has an appointment as a Clinical Professor of Emergency Medicine with the University of Utah College of Medicine, and is politically active at the local and national levels with the American College of Emergency Physicians (ACEP). He served as a past president of the Utah Chapter of ACEP, and is currently a member of their Board of Directors. He also represents the Utah Chapter on the national ACEP Council. He previously served as medical director of the emergency department at the Veterans Administration Medical Center in Salt Lake City and is still the Chief of Medicine at Mountain West Medical Center in Tooele, Utah. He is one of the founding members of the EPIC physician group and serves on its board of directors. In addition, Dr. Antinori is Chair of the Legislative Committee of the Utah Medical Association and was honored by the UMA with their Distinguished Service Award in 2010 in addition to this latest recognition.

Welcome New UCEP Members!

Angela Aleander, MD
Heidi Jean Arreola
David Barnett, MD, FACEP
Logan Beach
Oscar Bedolla
John Remington Betz
Melissa Brown
Christopher Christiansen
Colton A Clay, MD
Stuti Das, MD

Jacob Galindo, MD
Justin I Hanson, DO
Shiela Jean Heileman
Richard Anthony Jimenez
Zachary Johnson
Lindsay Kadell
Salma Laabi
Jessica Larson
Nicole Lenhares, MD
Joe Robert Lovelace
Michael D Mallory, MD
Tamara Moores, MD
Trenton D Mueller, DO
Zachary Oleskey, MD
Brian Robert Opferman, MD
Robert D Owen, MD
Riley Pence
Steven Salazar
Jaron Ann Santelli, MD
Chad V Stratford, DO
Nathan P Unkefer, MD
Karla Francheska Vazquez-De Jesus, MD
Kajsa Elisabeth Vlasic, MD
Kirsten Young, DO

FROM NATIONAL ACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP Resources & Latest News

There are 58 ACEP Council resolutions up for consideration this year, spanning a wide range of relevant and fascinating topics. Asynchronous testimony is open, so now is your chance to weigh in on these important issues.

ACEP submitted a comprehensive response to the proposed 2023 Physician Fee Schedule, the major annual regulation that impacts Medicare payments for physicians.

Get Ready for the "Once-in-a-generation" CPT Documentation Guideline Changes for ED E/M Codes Coming in 2023.

Land your next EM opportunity with the new emCareers, packed with exciting features for efficient job searching. Check it out!

The comment period is open for the **draft clinical policy related to the management of adult patients presenting to the ED with acute ischemic stroke.** Read the draft and send your comments.

Monkeypox: Utilize ACEP's monkeypox resources, including the Monkeypox Field Guide and the Monkeypox EM Project.

A proposed regulation issued establishes **conditions of participation for Rural Emergency Hospitals (REHs)**. Read more.

The Wait is Over — The No Surprises Act Final Reg is Out!

- The latest edition of Regs & Eggs highlights some of the major policies and their implications on you as emergency physicians.
- Read ACEP's comprehensive summary of the final rule of the *No Surprises Act* that came out on August 19. See the specific provisions ACEP has been fighting for and how they were incorporated into the rule.
- **Related study:** Insurer QPA calculation may violate No Surprises Act

Advocating for Physician-Led Care Teams

As part of our advocacy to combat dangerous policies allowing non-physicians to practice medicine without physician supervision, ACEP just released another entry in our My Experience Matters video series. This campaign amplifies the voices of members who began their career in another role on the care team. This time, we hear from Ricki Brown-Forestiere, MD, who began her medical career as a physician assistant. She was told her PA training would prepare her to do pretty much everything a physician does, but nothing could have been further from the truth. Hear about it in her Doc Blog. **Related:** Learn more about ACEP's efforts to protect the physician-led care team.

Advocacy at Home Toolkit: Connect with your Legislators

ACEP's Advocacy At Home: August Recess Toolkit can help you set and prepare for local meetings with federal legislators or staff. Share your stories that personalize our calls for policy changes. Find this toolkit and more helpful resources for speaking with media and legislators in ACEP's Media Hub.

Myth BustED: Patients' Rights in the Emergency Department

ACEP recently launched a "Myth BustED" video series to debunk common misconceptions and educate the public about emergency care. In our first video—*Patients' Rights in the Emergency Room*—Dr. Avir Mitra educates patients about laws like EMTALA and the Prudent Layperson Standard that protect access to emergency care. Watch now to see how ACEP is encouraging patients to always seek care when they need it.

ACEP22 Countdown
ACEP Scientific Assembly in San Francisco is around the corner. While you're in trip-planning mode, keep these recent updates in mind:

- **Get Your Bike Helmet Ready! Dr. and Lady Glaucomflecken** are speaking at ACEP22! Don't miss these social media sensations as they share their perspectives about the physician, patient and family experience.
- **Family**: Affordable childcare is available on site, but it does require pre-registration so we can ensure appropriate staffing.
  Flights: ACEP partner TripEasy could help you save money on your flights to the Bay Area.
  Hotels: Many of our convention hotels have recently lowered their rates. If you've already booked, your rate will automatically be adjusted to reflect the new prices

New Bedside Tools for Posterior Circulation Ischemic Stroke, Cancer Complications

- *Dizzy+* is focused on the recognition and treatment of posterior circulation ischemic stroke.
- ImmunoTox is focused on caring for patients who are experiencing adverse events related to cancer immunotherapy.

Introducing the EM Opioid Advisory Network
Receive clinical guidance, discover tools and resources, and get your questions answered through ACEP's EM Opioid Advisory Network. ACEP's new initiative connects emergency physicians combating the opioid crisis with expert advice on managing Opioid Use Disorder patients presenting in the ED, creating a protocol to initiate buprenorphine, and more. The expert panel is here to help ALL emergency health care professionals, free of charge. Learn more.

Accepting ACEP23 Course Proposals
As we start our countdown to ACEP22 in San Francisco, we're already thinking about ACEP23 in Philadelphia! ACEP's Educational Meetings Subcommittee is accepting course proposals for the 2023 Scientific Assembly until Nov 11. Learn more.

Upcoming ACEP Events and Deadlines

Sept. 15: When We Don't Have Workers, We Need to Change the Work
Sept. 19: Last day to give input during ACEP Council Asynchronous Testimony
Sept. 19: GEDs and Patient Safety Innovations
Sept. 22: The Challenge of Rural Emergency Care During the Pandemic and After
Sept. 22: Management of the Well-Appearing Febrile Young Infant: Integrating the AAP Guideline into Practice
Oct. 1-4: ACEP Scientific Assembly in San Francisco
Oct. 17-22: EM Basic Research Skills (EMBRS)
Nov. 11: Last day to submit ACEP23 course proposals

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