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As I sit to write my first president’s message, I can’t express enough my gratitude at being able to be the President of such a dynamic and storied organization as The New York Chapter of the American College of Emergency Physicians. It does make me reflect on where this chapter and emergency physicians have been and where we are going. I have always believed though that in order to understand where the current road of “Changing the Healthcare Paradigm” and “Bending the Cost Curve” leads, we need to truly understand why we are here.

So why are there emergency physicians. Why did our predecessors feel the need to develop the specialty and why were they successful. You can ask the question in a very internal way as well: What do I actually do for a living and why does society believe it is important. For me, the answer is very basic and pure: We are the last safety net. If the rest of the healthcare system has failed, or the patient has no access to it or the problem is just too acute, we are there to pick up the pieces. We are always there. We try to stop anything bad and preventable from happening. We are the masters of unscheduled care. We stabilize and give the cavalry time to arrive. We make sure that there is a safe place to go to. We take care of every person who comes in, regardless of the time of day, the availability of our resources, or the conditions outside our doors. This is what it means to be a real safety net.

There is another aspect to being the last safety net to our communities. In the last two decades, think of every disaster that has occurred in this country: 9-11, the Colorado shootings, hurricanes Katrina and Sandy, the Boston Bombings and the Orlando shooting just to name a few. These have very few things in common, other than the Emergency Departments (EDs) in these communities were there and their ED docs did what needed to get done. One of us will take care of the next major disaster, we just don’t know which one of us it is, but it will happen. When it does, we will do our best to carry the day until the specialists arrive, just like we have done every other time.

So the next time someone asks you what you do for a living, I want you to say to yourself, if not to them: I save lives for a living. This is true not just when you decompress a tension pneumothorax, but also true when you identify an infection in a brittle diabetic before they get more unstable. It’s also true when you treat that child with moderate to severe croup who had nowhere else to go on Friday night at 11 pm. You are here because your community needs you every day, and some days more than others.

Brahim Ardolic, MD FACEP
Chair, Department of Emergency Medicine
Vice President, Department of Research
Staten Island University Hospital

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The Search for Tanga: Ultrasound-Guided Identification of Small Bowel Obstruction

Guest Author: John DeAngelis, MD
Emergency Ultrasound Fellow
University at Buffalo, Department of Emergency Medicine, Buffalo, NY

Guest Author: David Miles, DO
Emergency Medicine Resident
University at Buffalo, Department of Emergency Medicine, Buffalo, NY

Indications
- Abdominal distention
- Abdominal pain
- Incarcerated or strangulated hernia
- Intractable vomiting
- Constipation

Technique
- Place the patient in the supine position.
- Use a curvilinear or phased array transducer.
- Place the transducer longitudinally with the probe marker directed towards the patient’s head.
- Start by scanning one of the paracolic gutters and sweeping along the course of the flank on each side. Proceed across all quadrants of the abdomen in a systematic fashion. Scan the entire abdomen. This method is described as “mowing the lawn.”
- Rotate the transducer, as needed, to image the bowel in longitudinal view.
- The current accepted sonographic findings consistent with a small bowel obstruction include a fluid-filled small bowel with an outer diameter >2.5 cm. (Figure 1)
- Other findings that are suggestive of a small-bowel obstruction include:
  - Bowel wall thickness >4 mm
  - Prominent and thickened plicae circulares in the jejunum, also known as the “keyboard” sign. (Figure 2)
  - Bowel wall thickness
  - Well-circumscribed fluid collections referred to as the “tanga sign” are often best seen as a triangular shape between loops of small bowel. (Figure 3)
  - There may be increased intestinal contents which consist of fluid and echogenic material within the lumen of the bowel.
  - You may also see increased peristalsis of the dilated segment, as evidenced by a repetitive to-and-fro or whirling motion of bowel contents.

Tips
- Remember that every scan is a “snapshot” and that subsequent scans may show worsening or improvement.
- Ultrasound performed concurrent with the history and physical may expedite the patient’s disposition to definitive care and imaging.
- Rapid identification of SBO with ultrasound may avoid other unnecessary imaging.

Pitfalls and Limitations
- Significant amounts of bowel gas
- Obesity
- Patient positioning
- Operator experience
- Placing an NG tube or re-positioning the patient may resolve some of these issues.
- Partial SBO’s can be difficult to appreciate on a single examination.
- CT imaging may be required to provide other anatomical data such as etiology of bowel obstruction and location of a transition point.

References
Figure 1. Ultrasound of a bowel obstruction. Note the dilated bowel >2.5cm and free fluid (red asterisk).

Figure 2. Dilated bowel with prominent plica circularis (red arrow).

Figure 3. Prominent “tanga sign” between dilated, thickened loops of bowel.

SOUND ROUNDS

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What are the Risks of Hemodialysis for Patients with Acute Overdoses?

Most emergency medicine physicians understand the acute complications of overdoses but may be unclear of the risks of hemodialysis. The main complication for acute hemodialysis is the placement of the central line. Dialysis catheters tend to be larger than central lines used for vascular access. The rates of complications are changing due to improved technology (catheter sizes, use of ultrasound). The acutely poisoned patient is probably sicker but has less co-morbidities than the typical patient that needs to be started on chronic dialysis. Therefore, as with all procedures, risks and benefits should be weighed for considering dialysis.

The major risks are:
- Central line placement
- Hypotension
- Bleeding
- Allergic reactions
- Air embolism
- Dysrhythmias

Central Line Placement
Older studies noted vascular injuries (0-5%) and lung injuries (0-1%). A more recent article published noted a “incidence of accidental arterial puncture (1.2%) and malposition (0.8%), no pneumothorax, and an extremely low rate of repeated attempts (i.e. more than two punctures before successful cannulation) (3.3%). Multiple studies have reported reduced rates of complications with the use of real-time ultrasonography.

Hypotension is a major complication during dialysis. However this is less likely in the overdosed patient because the major objective is to remove the xenobiotic as opposed to the removal of fluid.

Older literature has reported greater rates of complications that may not apply today due to advancements in dialysate and machinery.

- Hypotension — 25 to 55 percent of treatments
- Cramps — 5 to 20 percent
- Nausea and vomiting — 5 to 15 percent
- Headache — 5 percent
- Chest pain — 2 to 5 percent
- Back pain — 2 to 5 percent
- Itching — 5 percent
- Fever and chills — <1 percent

References
EMS Response to Active Shooter Scenes: 
When the Paradigm Becomes Practice

There is no shortage of current events on active shooter, symbiotic attacks, terrorist actions and aggressive deadly behavior incidents. Even without these high threat incidents, first responders are called into action every day to hazards involving violence. New strategies and enhanced training models are specifically engaging EMS and Law Enforcement (LE) to work together to save lives.

EMS Response to Active Shooter Events

The FBI resources generally agree upon the definition of an active shooter situation as “an individual actively engaged in killing or attempting to kill people in a confined and populated area.” Due to the increase in frequency of these events, there is a need to coordinate response from EMS and Law Enforcement. Typically, a standard response for a 911 medical emergency requires the Emergency Medical Technician (EMT) to determine “is the scene safe?” But, what about when the scene isn’t “safe”? Is there then no duty to act?

Most EMS providers are required to challenge the subjectivity of “scene safe” based on subjective assessments, training and personal protective equipment. The modification in practice also comes with a change in EMS lingo - understanding what is “safe” is the first barrier. One could easily conclude that the job of firemen is to respond to fires and EMTs to respond to medical emergencies. Although far more routine, it would not be correct to state that these responses are always “safe” either. What makes a response to a house fire or motor vehicle accident on a busy road a justified risk to safety is training. To mitigate the risks to safety, every EMS system and law enforcement agency should be looking at how they would respond to an incident in their jurisdiction - together. Combined (LE and EMS) training on rescue task force integration, Tactical Emergency Casualty Care (TECC) medical methodologies and basic tactics is essential to saving lives.

Why EMS and Law Enforcement Rescue Task Force Works

The process begins with recognition of the event and the understanding that responders will work towards a common goal: preservation of life. The acronym “THREAT” (Figure 1) was a creation of the Hartford Consensus II outlined in 2013. Through an expert panel, it was expressed that the response goals are indeed shared by EMS and LE, has led to more wide spread education and combined courses.

The medical procedures, previously only taught to EMS, have now been expanded to include the role of Law Enforcement. If we break down the roles of the THREAT response, the continuum of hazard recognition helps to prevent shut-down by initial responding officers after the gun fighting has stopped and subsequently lack of engagement by EMS who may feel they have no role in this high threat environment. There is no question that suppression of the threat in an active shooter is a Law Enforcement job. Previous to teaching the concepts of MARCHE (C-TECC) to both EMS and law enforcement, it was not intuitive for police to expect hemorrhage control as a hazard for them to identify and manage when possible.

As the scene unfolds, the shooting generally only lasts for a few minutes and an overwhelming majority of shooters are lone gunmen (98%) and commit suicide, flee or give up (56.3%). When teaching a combined response plan, it is important that both EMS and law enforcement must embrace the perception that killing all of the bad guys and letting the good guys die, is not a win. When examining principles of responding for initial law enforcement, it is imperative that LE transition quickly when the shooting stops to controlling the bleeding and/or create a hasty plan to escort EMS into the scene. When done as a plan that recognizes the importance of the THREAT mnemonic for ALL responding units, the potential to eliminate loss of life has tremendous promise. At the same time, EMS needs to prepare, on arrival, to form rescue task force teams with the appropriate medical equipment and extrication device to enter the scene when escorted by LE.

As we continue to validate the effectiveness of this type of combined training, we can also examine the medical priorities of current research on active shooter injury patterns and modify medical treatments provided by our initial responders.

Wounding Patterns in Civilian Public Mass Shootings

In recent years, we have learned a lot about wounding patterns from our military conflicts in Iraq and Afghanistan. This combat data has given rise to the military’s Tactical Combat Casualty Care (TCCC) guidelines and those of their civilian counterpart, the Tactical Emergency Casualty Care (TECC) guidelines, that many of us are now familiar with. These guidelines focus on best practice recommendations for point of wounding care directed towards the causes of preventable death. The major cause of preventable death in military engagements is massive hemorrhage from extremity wounds, followed by tension pneumothorax, and airway compromise. These practices are now widely taught in civilian EMS and law enforcement.

Recent national initiatives such as the American College of Surgeons’ (ACS) Hartford Consensus IV and the Department of Homeland Security’s (DHS) Stop the Bleed campaign are placing increased emphasis on teaching hemorrhage control techniques to the public. While there is no doubt these techniques are useful in a wide array of situations, recent evidence suggests...
that injury patterns seen in military conflicts differ from those in civilian public mass shootings (CPMS). It is likely that public campaigns placing so much emphasis strictly on hemorrhage control do not go far enough. The injuries seen in CPMS has implications for how we train our prehospital personnel as well as prepare for such events in the emergency department.

A recent study examined autopsy reports from civilian active shooter events in the United States from 2000 to 2013 to determine the prevalence of injury location, probable site of fatal injury, and presence of potentially survivable injury (defined as survival if prehospital care is provided within 10 minutes and trauma center care within 60 minutes of injury). The number of wounds per victim ranged from 1 to 10, with the average being 2.7 wounds. 58% of the injuries were to the head or upper torso, and only 20% of wounds were to the extremities. In analysis of the likely fatal wounds, the majority were due to head and upper torso injuries in 77%, and none were found to be due to major peripheral vascular injury or exsanguinating extremity hemorrhage.iii,iv

These patterns are in direct contrast to those seen in the military data. One of the most likely explanations for this is that our military combatants wear ballistic armor that protects their head and chest. Therefore, we are less likely to see injuries in these areas and more likely to see them in the unprotected extremities. Combat injuries are likely to occur at further distances of 20 to 30 meters, where civilian public mass shootings typically occur at closer range.v

This results in the perpetrator being able to quickly fire multiple shots striking center mass and causing multiple lethal wounds at close range to the head and upper torso.vi,vi

CPMS show a much higher fatality rate than combat injuries. The case fatality rate, or percentage of fatalities among those wounded, is approximately 45% in CPMSvii versus closer to 10% in recent military conflicts.v

Moreover, the rate of potentially survivable injuries is much lower in CPMS at only 7%. And where the majority of potentially survivable injuries in the military are due to exsanguinating hemorrhage (60%) and tension pneumothorax (33%), chest injury with potential pneumothorax accounts for the vast majority (89%) of civilian injuries. In these potentially survivable CPMS injuries, 44% may also have been affected by potential airway compromise.viii

In this review, all of the civilian public mass shooting injuries were due to handguns or shotguns. This paradigm may be changing with the recent use of assault rifles in the San Bernardino and Orlando attacks. While the Orlando attack is too recent and data on the injuries is not yet available, the San Bernardino event showed similar injury patterns to those in previous CPMS. In the San Bernardino shooting, initial first responders encountered 14 fatalities, and treated another 19 injured patients. There were no injuries that required tourniquet use in the field. Many of these patients had chest and abdomen wounds. Field care for these wounds included airway positioning and management techniques, chest seals, and three (3) needle decompressions for tension pneumothorax in the field. 28 patients total were treated in area hospitals including the 19 treated and transported by EMS, all of which survived to hospital discharge.viii

**Implications for First Responders and the Emergency Department**

Based on data from civilian public mass shooting events, training for civilians as well as first responders and EMS should go beyond solely teaching hemorrhage control techniques emphasized by current national initiatives. First responder and layperson training should also teach other aspects of TECC care such as airway and chest wound management, and rapid evacuation to medical care in addition to the hemorrhage control techniques. Programs such as the First Care Provider endorsed by the Committee for TECC address such critical needs.ix

Both hospital and first responder personnel should also be mentally prepared for a high fatality rate near 45% in mass shootings. If triaged appropriately in the field, many of these casualties will not even be transported to the emergency department.

Similarly, emergency departments should prepare for these types of injuries when notified of a civilian mass shooting. Knowing the majority of survivors will likely have head, chest, and torso wounds allows us to prepare our trauma bays with extra chest tubes and thoracotomy trays and to notify neuro- and thoracic surgeons prior to the arrival of the first patient. Given the likelihood of head injuries with potential facial trauma and airway compromise, we should also be prepared for emergent airway management including surgical airways. Having facial and ENT surgeons available in the emergency department may also be beneficial.

### Hartford Consensus - THREAT

- Threat Suppression
- Hemorrhage Control
- Rapid Extrication to safety
- Evaluation by medical providers
- Transport to definitive care


**Figure 1**

**References**


Record Attendance
The 2016 Scientific Assembly at the Sagamore Resort featured expert faculty members, Diane M Birnbaumer, MD FACEP, Robert S Hoffman, MD FAACT FACMT FRCP Edin FEAPCCT and William K Mallon, MD DTMH FACEP FAAEM who wowed nearly 315 emergency physicians from around the state. Forty companies participated through exhibits and support.

Awards
Each year New York ACEP honors individuals for significant contributions to the advancement of emergency care. New York ACEP member, Saadia Akhtar, MD, Mount Sinai Beth Israel was presented with the 2016 Advancing Emergency Care Award. Richard M Cantor, MD FAAP FACEP, SUNY Upstate Medical University was presented with the Physician of the Year Award. The National Leadership Award was presented to G Richard Braen, MD FACEP, University of Buffalo and the Edward W. Gilmore Lifetime Achievement Award was presented to Mark C Henry, MD FACEP, Stony Brook Medicine. For more information on these awards, visit http://nyacep.org/about-new-york-acep/awards.

New Speaker Forum
Congratulations to Akash Bhatnagar, MD, Northwell Health Staten Island University Hospital, recipient of the award for best presentation for Stronger, Better, Faster Management of SVT.

Research Forum Winners
Wednesday’s program began with the Research Forum featuring oral and poster presentations. Congratulations to the following research presenters that took the annual award in their category.

Oral Presentation
- The Use of Emergency Department Diffuse Apneic Oxygenation Versus Usual Care During Rapid Sequence Intubation of Emergency Department Patients: A Randomized Controlled Trial (Preliminary Results of the ENDAO Study)
  Nicholas Caputo, MD - Lincoln Medical and Mental Health Center

Poster Presentations
- The Physiologic Impact of the Apnea Period During Rapid Sequence Intubation of Patients in the Emergency Department
  Anthony Scoccimaro, MD - Lincoln Medical and Mental Health Center
- Feasibility of an Immediate Rapid Reversal of Warfarin Protocol Using a Four-factor Prothrombin Complex Concentrate in the Emergency Department
  Andrea Bianculli - North Shore University Hospital
- Cardiology-driven Observation Protocol Leads to Over-use of Stress Testing Among Patients Younger than 40 Years Presenting to the Emergency Department with Chest Pain
  Ghassan Habib, MD - Queens Hospital Center
- To Study the Use of Interpreter Services Among Adults Presenting to the Emergency Department (ED)
  Nidhi Garg, MD - Long Island Jewish Medical Center
- Emergency Physician Presence At Two Large Outdoor Music Festivals
  Matt Friedman, MD - Maimonides Medical Center

To review winning research, visit http://nyacep.org/research-abstracts-winners.
Leadership Elected

Congratulations are extended to newly elected directors: Nicole Berwald, MD FACEP, Staten Island University Hospital, Sydney E De Angelis, MD FACEP, Brookhaven Memorial Hospital Medical Center, Frank L Dimase, MD FACEP, St. Peter’s Hospital and Laura Melville, MD, New York Methodist Hospital.

Dr. Ardolic presents the President’s plaque to Dr. Prince for her service to New York ACEP.

New Officers

Brahim Ardolic, MD FACEP, Staten Island University Hospital, President
Jeremy T Cushman, MD MS FACEP, University of Rochester, President-elect
Keith E Grams, MD FACEP, Rochester Regional Health, Secretary-Treasurer

Service Recognition

New York ACEP staff member, Timothy Pistor was recognized for 15 years of service to New York ACEP.

Staten Island University Hospital Reins Supreme in Resident Volleyball Tournament

Nine residency programs competed for bragging rights in the Scientific Assembly volleyball tournament.

To review winning research, visit http://nyacep.org/research-abstracts-winners.
New York ACEP 2016 Annual Report

Since it is my last time to give the annual “state of the state” report, not that I want to borrow a phrase from our governor, sit back, order another desert, get a coffee refill, …… it’s going to be a long one.

I struggled with a “theme” for this report. I never like to just real off a list and run. At first I thought “the glass is half full” rather than “half empty” would be a positive way to go considering some of our recent struggles legislatively. But this implies putting spin on bad news. After realizing our accomplishments, I believe the theme is “our glass is full to overflowing” with successes this past year.

Thanks to efforts of our Membership Committee and Board of Directors, we have a record number of members; 2,635 up 166 from last year. We are the second largest ACEP state chapter with California only ahead by 255. Who wants to let California best us? Get out there and recruit members!

We are hosting our most successful Scientific Assembly with over 300 registrants. We continue to grow every year and have had to expand our room block nearly 30%. This year we had the opportunity to take advantage of an ACEP grant to present a lecture on Heart Failure. In addition, we have added a series of wellness events including storytelling, a fun run, and an exhibit display. The volleyball tournament, if anything like last year, will be exciting. Let’s see if the reigning champs from Buffalo can be overthrown. The ED Director Forum in New York City in May exceeded last year’s attendance. Thank you to our education committee and staff for all of the hard work.

We also hosted several events for residents and medical students this past year including Resident Career Day, Resident Research Conference, and the Medical Student Symposium which were all very successful. Thank you to ACEP for underwriting the luncheon at the Resident Career Day.

We awarded three scholarships for residents to attend the ACEP Leadership and Advocacy meeting. We took a large contingent of New York ACEP members to Washington DC to advocate for our specialty. Thank you to all who attended and made this a success.

There were four (4) excellent editions of our newsletter Empire State EPIC which average 32 pages of content. It is one of the most outstanding state publications; the best I would say. Not to mention the morally challenging Presidential Messages this year were a must read. Thank you to all the members who write articles, to the staff who put it together, and to our advertising supporters.

Communicating with other professional societies as well as legislative commissions and regulatory bodies has been a constant effort. We have addressed issues with the Department of Health including rule making for controlled substances in EMS, overcrowding in Emergency Departments (EDs) including providing our own recommendations. We have requested a review of the PALS requirement for emergency physicians and we have commented on the concept of ED initiated Buprenorphine for treatment of opioid addiction. We have worked with MSSNY and other affiliated organizations on issues such as liability reform, opioid educational efforts, and legislated CME requirements. This has created an improved atmosphere of communication with other New York state professional societies.

Lastly, but importantly have been our legislative efforts. We had an enormously successful Lobby Day in Albany this year. Thank you to all who attended. In addition, we had a second lobby day for leadership to meet with focused legislators on active issues affecting emergency medicine.

Our successful inclusion of emergency medicine related language in the Out of Network bill last year has thankfully led to very little need for the Independent Dispute Resolution process for emergency medicine.

We had to fight many legislative battles this year. Our legislators had a very heavy focus on medicine and delivery of health care this year. They presented many pieces of legislation some of which were well intended and with merit, but posed substantial burdens on providers. In particular, the effort to curb opioid abuse and overdose was a major legislative discussion. The initial proposal from the governor’s office not only included physician education but repealed the emergency medicine exemption from ISTOP review for small prescriptions as well as required counseling and consent from each patient for whom we prescribe opioids. In the end, a limit was placed on prescription of opioids for acute pain and a mandate for three (3) hours of CME per registration period was passed. We were successful in obtaining language that will allow professional societies to develop and deliver that CME. The other onerous requirements proposed by the governor were not passed.

After the mandating of E-prescribing, thankfully, legislation was passed to alter the requirement of reporting hand written prescriptions. As long as they are written for exempt reasons, only patient chart documentation is required rather than a lengthy email to the Department of Health (DOH). Although I know you like to email the DOH.

We have narrowly escaped another attempt to worsen our liability climate by changing the onset of the time window for a medical malpractice suit from date of occurrence to date of discovery of the incident. This issue WILL NOT GO AWAY. Knowing that, we have begun to introduce and lay the ground work for EMTALA related liability protection for emergency services. I am proud

Louise A. Prince, MD FACEP
Associate Professor, Emergency Medicine
SUNY Upstate Medical University
New York ACEP Immediate Past President
I want to call everyone’s attention to our action alerts. They are sent out only on extremely important issues and are now very easy to respond to. You will be able to send emails and call your legislators right from the email. If I can do it, so can you. This is beyond important. We must make our voices heard. This is not something that anyone else can do for you! Speak up or suffer the consequences.

I want to take this opportunity to congratulate one of our members, Dr. Lewis Goldfrank. With New York ACEP’s support, he will be receiving the prestigious ACEP James D. Mills Outstanding Contribution to Emergency Medicine Award in October at ACEP16. Congratulations Dr. Goldfrank.

As I end my term as president I want to thank all of the members of our committees, especially the chairpersons who work so hard to complete the work of the committees, Kauhsal Shah, Nicole Berwald, Brahim Ardolic, Keith Grams, Jeff Rabrich, Dave Lee, and Nicole Yuzuk along with the members of the executive committee and board of directors. I believe that all of these individuals exemplify the qualities of servant leaders. They have been tireless listeners, healers, persuaders, and stewards of our resources and profession. They are committed to the health of our professional organization, our colleagues and our patients. Behind every great organization is the executive staff. Ours is exceptional. I will remind you again that we have the second largest chapter in the country.

We need to stand and thank JoAnne Tarantelli and Tim Pistor for their tireless efforts to keep New York ACEP the great organization that it is. Thank You.

In closing, we are all here because we were called into the profession of medicine. Emergency Medicine is perhaps one of the noblest specialties as we treat all who come to our door 24/7/365 and we respond to all in need despite time of day or location. I would like to close with a quote from one of my role models, the soon to be Saint Teresa of Kolkata, “Let us touch the dying, the poor, the lonely and the unwanted according to the graces we have received and let us not be ashamed or slow to do the humble work.”

Thank you for the opportunity to serve you.
**Calendar**

**September 2016**
- 8 Practice Management Conference Call, 1:00 pm
- 14 Education Committee Conference Call, 2:45 pm
- 14 Professional Development Conference Call, 3:30 pm
- 15 EMS Committee Conference Call, 2:30 pm
- 21 Government Affairs Conference Call, 11:00 am
- 21 Research Committee Conference Call, 3:00 pm
- 26-27 Strategic Planning Meeting, Mohonk Mountain House
- 27 Board of Directors Meeting, Mohonk Mountain House 1:30 pm – 5:30 pm

**October 2016**
- 5 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 12 Education Committee Conference Call, 2:45 pm
- 12 Professional Development Conference Call, 3:30 pm
- 13 Practice Management Conference Call, 1:00 pm
- 14-15 ACEP Council Meeting, Mandalay Bay Convention Center
- 16 New York ACEP Member Reception, Mandalay Bay Convention Center
- 16-19 ACEP 16, Mandalay Bay Convention Center
- 19 Government Affairs Conference Call, 11:00 am
- 19 Research Committee Conference Call, 3:00 pm
- 20 EMS Committee Conference Call, 2:30 pm
- 28 2016 LLSA Course, 8:00 am -12:30 pm, Mount Sinai Medical Center

**November 2016**
- 2 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 9 Resident Research Conference, 8:30 am - 12:00 pm, Mount Sinai Medical Center
- 9 Education Committee Conference Call, 2:45 pm
- 9 Professional Development Conference Call, 3:30 pm
- 10 Practice Management Conference Call, 1:00 pm
- 16 Government Affairs Conference Call, 11:00 am
- 16 Research Committee Conference Call, 3:00 pm
- 17 EMS Committee Conference Call, 2:30 pm

**December 2016**
- 7 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 8 Practice Management Conference Call, 1:00 pm
- 14 Education Committee Conference Call, 2:45 pm
- 14 Professional Development Conference Call, 3:30 pm
- 15 EMS Committee Conference Call, 2:30 pm
- 21 Government Affairs Conference Call, 11:00 am
- 21 Research Committee Conference Call, 3:00 pm

**Empire State EPIC**

**Empire State EPIC** is the newsletter of the New York American College of Emergency Physicians (New York ACEP). The opinions expressed in this newsletter are not necessarily those of New York ACEP. New York ACEP makes a good faith effort to ascertain that contributors are experts in their field. Readers are advised that the statements and opinions expressed by the author are those of the author and New York ACEP is not responsible for, and expressly disclaims all liability for, damages of any kind arising out of use of, reference to, reliance on, or performance based on information or statements contained in this newsletter.

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Getting Beyond “Scholarly Teaching”:
Medical Education Research & Scholarship

The field of medical education is ripe with opportunities for creativity, innovation, and research. With more outlets and opportunities for publishing medical education research and scholarship than ever before, educators should seek out opportunities to share and distribute their innovations and research findings. A broad definition of medical education research includes “any investigation related to the education of medical professionals, including research related to undergraduate (medical school), graduate (residency), and continuing medical education.” Medical education research focuses on a variety of topics, such as curriculum development and implementation, assessment of novel teaching methods, evaluation of learners or instructors, course evaluation, faculty development initiatives, and use of technology in education.¹

Education research includes elements of basic science (e.g. development of an intervention) and clinical research (e.g. exploring the application). Most medical education studies are not randomized control trials as this study design is often limited by its resource intensive nature (e.g. requires faculty time and structured evaluation strategies), lack of funding, small sample sizes (e.g. a residency or residency class as subjects), and ethical considerations in randomly assigning learners to receive or not receive an educational intervention.²

Education research has been described as a systematic attempt to evaluate different aspects of education to provide answers to specific questions. The basic steps of education research mirror those of other research types.³ Steps for research or developing a scholarly project in education include conducting a thorough literature review to identify existing studies (e.g. is the new study idea truly innovative) and to understand the relevant scholarly environment. Next, a problem statement must be derived to describe the overarching context of the study and convey how it will advance the literature. The study should be undertaken within the context of a specific conceptual framework, defined as the “theory, model or approach that situates the study question within a theoretical context and explains the results.” Once the statement of study intent is finalized, including the formal study question or hypothesis, appropriate study design and methods must be selected. The selected outcomes should strive to go beyond basic outcomes assessing learning confidence and competence and focus on relevant clinical outcomes, when possible.⁴

Research questions in medical education should abide by the “FINER” criteria (feasible, interesting, novel, ethical, relevant) or more simply put, should answer the age old question, “so what?”. Researchers should seek to get beyond pre/post assessments of knowledge study designs and understand and assess changes in skills and knowledge in the larger context of “so what?” such as changes in provider behaviors or patient outcomes. Kirkpatrick laid the groundwork for evaluating the effectiveness of educational training with the following frequently referenced “levels”: Reaction (e.g. learner satisfaction), Learning (e.g. learner attitude, skills), Behavior (e.g. impact on clinical practice), and Results (e.g. change in patient outcomes).⁵

There are multiple facets to medical education scholarship, which include teaching, research, and leadership and administration (e.g. organizing educational activities). Boyer describes four main types: 1) Discovery: “original research” that extends our knowledge and understanding; 2) Integration: to interpret new insights in framework of existing research (e.g. Interprofessional education which often integrates educational insights across disciplines); 3) Application: such as service and citizenship (e.g. a scholarly activity that is tied directly to knowledge such as an approach to a practical question that involves service at local/individual level); 4) Teaching: transmitting knowledge but also transforming it, extending it, and maintaining it.⁶

Fincher and Work stated, “Teaching itself is not scholarship, but
teaching can include the scholarship of application, integration and research. They describe gradual stages on the continuum between teaching and research. “Scholarly teaching” requires the teacher to improve his or her teaching by engaging with the educational literature to design, apply, and evaluate a teaching intervention, submitting his or her work to peer review, and then making use of the results. “The scholarship of teaching,” on the other hand, involves a peer-reviewed and publicly disseminated product that others can use to build on and it advances the whole field rather than just the individual student’s learning. The scholarship of teaching builds on the process of scholarly teaching.

A divide still exists in academic medical education between the “educator” and the “researcher” despite much overlap in objectives and academic pursuits. Medical education research and innovations can take many forms and includes identifying effective teaching methods and valid methods of learner assessment and curricula evaluation. Additionally, studies are required to determine how to best measure the effect of educational interventions, how to prevent cognitive errors, and how to promote and measure effects on patient safety and outcomes.

In the article titled, “Moving Beyond Confidence and Competence: Educational Outcomes Research in Emergency Medicine”, Kessler and Burton describe the need for careful determination of the “important” clinical outcomes for assessment in educational research studies. Medical education studies to date are increasing in frequency and quality assessing critical types of outcomes, such as patient safety metrics, medical error assessment, resource utilization, patient satisfaction, and health care spending. The execution of high quality medical education research requires in-depth knowledge of education theory, research study design and methodology, and understanding of current educational needs, opportunities, and previously published and conducted studies.

Despite adequate methodology and a relevant medical education topic, many education studies are never successfully submitted or accepted for publication. The number one reason medical education research is not published is that it is not submitted for review. Authors may not recognize the value of the project or its innovative nature or they may not know how to organize it into a scholarly work or where to submit it. The top 10 reasons for rejection of submissions include: inappropriate or incomplete statistics; over interpretation of results; inappropriate or suboptimal instrumentation; sample too small or biased; text difficult to follow; insufficient problem statement; inaccurate or inconsistent data reported; inaccurate, inaccurate, or outdated review of the literature; insufficient data presented; and defective tables or figures. In comparison, the main strengths noted in accepted manuscripts were the importance or timeliness of the problem studied, excellence of writing, and soundness of study design. Medical education research with sound research methods, rivaling the rigors of most high-quality clinical studies, and focus on novel emergency medicine content can serve as a resource to further the expertise and research conducted by emergency medicine educators and researchers alike.

References
New York ACEP Practice Management Committee
– How Can it Help Me?

We face all sorts of challenges within emergency medicine, coming from both within and from the outside. The approach to these challenges can be quite varied in each individual emergency department.

The New York ACEP Practice Management Committee is comprised of members across the state and represents a diverse group of physicians – from private to employee, from community to academic. We meet monthly to discuss the various topics that affect the practice of emergency medicine.

Given the issues that we face, it is little surprise that the meeting agenda is quite broad. As the committee has continued to develop, each member has taken on one to two specific topics and work to keep themselves abreast of any local, state, and national developments. We currently review eighteen standing topics (listed below). We also review ad hoc items such as influenza and the current approaches to Zika (our new Ebola equivalent). In addition, several members of the New York ACEP Practice Management Committee also sit on national ACEP committees and provide brief updates on their respective agendas. Commonly we will also review correspondence from members throughout the state that are faced with a current issue.

Approach to avoidable admissions
CMS updates
ED CAHPS
Emergency management
E-prescribing
General ED operations
APP reimbursement
Medicare DSRIP
PALS, ATLS, ACLS, …
Sepsis
ED DOH regulations
Observation unit DOH regulations
Rural ED provider coverage
OPMC changes
PNP (narcotic monitoring)
Psychiatric patient boarding
Stand-alone EDs
Trauma certification

Rarely the issues are black and white, as most fall among the legion of gray hues. In these cases, we have the ability to review how each represented site has chosen to currently address the challenge. Although not a clear answer at times, the discussion can help to provide ideas on how to approach.

If you (or a member of your group) have a question regarding a specific issue, please feel to relay to the PMC via email to nyacep@nyacep.org. We will either review as a group or ask one of our “specialists” to review and provide a response.

Thanks to all who serve on the committee.

Wednesday, November 9, 2016
8:30 am - 1:00 pm

Location
Stern Auditorium
Icahn School of Medicine at Mount Sinai

More information online at www.nyacep.org
Increasing Frequency and Fatality of Poison Control Center Reported Exposures Involving Medication and Multiple Substances: Data From Reports of the American Association of Poison Control Centers 1984-2013.


CONTEXT: Medication use has become increasingly prevalent in the United States, with up trending use of both prescription and over the counter medication. The increasing use and availability of medication may be changing the nature of poisoning fatality.

OBJECTIVE: To evaluate changes in fatal poisoning over time, with respect to fatalities involving one or more medications, using annual reports published by the American Association of Poison Control Centers (AAPCC).

MATERIALS AND METHODS: AAPCC annual reports were reviewed from 1984 to 2013. Data from tables in each annual report titled Number of Substances Involved in Human Exposure Cases and Summary of Fatal Exposures were abstracted. Fatality rates and changes in these rates over time were calculated for exposures to 1, 2, or ≥3 substances. All substances detailed in Summary of Fatal Exposures tables were then coded as medication or non-medication. The percentage of fatalities involving 1, 2, or ≥3 medications was calculated and trended over time. Subset analysis was performed to compare the periods 1984-2005 and 2006-2013 in order to limit confounding from changes in reporting. Secondary analysis linking the number of substances cases were exposed to and the fatality rate was performed for data from 2006-2013.

RESULTS: There were 59,866,357 human exposures and 29,659 fatalities reported from 1984 to 2013. There were 49.5 fatalities per 100,000 exposures. The majority of fatalities (52.2%) involved more than one substance, although multiple substances were involved in only 8.3% of exposures. Fatality rates increased over time and were higher for cases involving multiple substances. Medications were involved in 79.2% of fatalities, a percentage that increased from 70% in the 1980s to nearly 90% after 2010. In recent years, the majority of fatalities have involved multiple medications. For data from 2006-2013 there was a strong association between fatality rate and number of substances involved in an exposure (221 additional fatalities per 100,000 exposures for each additional substance involved in an exposure).

DISCUSSION AND CONCLUSION: Multiple substance exposures have become a greater percentage of cases reported to the AAPCC and have higher fatality rates than single substance exposures. The majority of fatal poisonings reported to the AAPCC between 1984 and 2013 involved medication. The percentage of fatal poisonings involving medication increased over the interval, as did the percentage of fatalities involving more than one medication. Fatalities involving multiple medications are now the most common type of fatal poisoning reported to the AAPCC.

Randomized Trial of Intranasal Fentanyl Versus Intravenous Morphine for Abscess Incision and Drainage.


OBJECTIVES: Abscess incision and drainage (I&D) are painful and distressing procedures in children. Intranasal (IN) fentanyl is an effective analgesic for reducing symptomatic pain associated with fractures and burns but has not been studied for reducing procedural pain during abscess I&D. Our objective was to compare the analgesic efficacy of IN fentanyl with intravenous (IV) morphine for abscess I&D in children.

METHODS: We performed a randomized noninferiority trial in children aged 4 to 18 years undergoing abscess I&D in a pediatric emergency department. Patients received IN fentanyl (2 μg/kg; maximum, 100 μg) or IV morphine (0.1 mg/kg; maximum, 8 mg). The primary outcome, determined independently by blinded assessors, was the Observation-Scale of Behavioral Distress-Revised (OSBD-R). The prestated margin of noninferiority (Δ) was 1.80. Secondary outcomes included self-reported pain, treatment failure, and patient and parental satisfaction.

RESULTS: We enrolled 20 children (median age, 15.4 years), 10 in each group. The difference between total OSBD-R scores was -13.45 (95% confidence interval, -24.24 to -2.67), favoring IN fentanyl. There was less self-reported pain in patients who received IN fentanyl immediately after the procedure. Four patients (40%) receiving IV morphine had treatment failures and required moderate sedation or had the procedure terminated. More patients who received IN fentanyl were satisfied with the analgesic administered compared with those who received IV morphine.

CONCLUSIONS: In a small sample of children aged 4 to 18 years undergoing abscess I&D, IN fentanyl was noninferior, and potentially superior, to IV morphine for reducing procedural pain and distress.

Fetal Alcohol Growth Restriction and Cognitive Impairment.


BACKGROUND: Although both fetal and long-term growth restriction are well documented in fetal alcohol spectrum disorders, effects on pattern of growth trajectory have not been characterized. Furthermore, the degree to which growth trajectories are related to fetal alcohol-related neurocognitive deficits is unknown.

METHODS: Ninety-three heavy drinking pregnant women and 64 controls were recruited at initiation of prenatal care in Cape Town,
South Africa. Small for gestational age (SGA) was defined as birth weight <10th percentile. Length/height, weight, and head circumference were measured at 6.5 and 12 months and 5, 9, and 13 years. Four growth trajectories were identified: SGA with long-term postnatal growth restriction (length/height-for-age <10th percentile through 13 years); SGA with catch-up growth; no SGA or postnatal growth restriction; and late-onset postnatal stunting. IQ was assessed at 5 and 10 years, and learning, memory, and executive function at 10 years.

RESULTS: Children born SGA with postnatal growth restriction were most heavily exposed. Exposure was intermediate for those born SGA with catch-up growth and lowest for those without prenatal or postnatal growth restriction. Effects on neurocognition were strongest in children with both prenatal and long-term growth restriction, more moderate in those with fetal growth restriction and postnatal catch-up, and weakest in those without growth restriction.

CONCLUSIONS: These findings validate the use of growth restriction in the diagnosis of fetal alcohol spectrum disorders and identify growth trajectory as a biomarker of which heavily exposed children are at greatest risk for cognitive developmental deficits.

Academic Dysfunction After a Concussion Among US High School and College Students.


OBJECTIVES: To determine whether concussed students experience greater academic dysfunction than students who sustain other injuries.

METHODS: We conducted a prospective cohort study from September 2013 through January 2015 involving high school and college students who visited 3 emergency departments in the Rochester, New York, area. Using telephone surveys, we compared self-reported academic dysfunction between 70 students with concussions and a comparison group of 108 students with extremity injuries at 1 week and 1 month after injury.

RESULTS: At 1 week after injury, academic dysfunction scores were approximately 16 points higher (b = 16.20; 95% confidence interval = 6.39, 26.00) on a 174-point scale in the concussed group than in the extremity injury group. Although there were no differences overall at 1-month after injury, female students in the concussion group and those with a history of 2 or more prior concussions were more likely to report academic dysfunction.

CONCLUSIONS: Our results showed academic dysfunction among concussed students, especially female students and those with multiple prior concussions, 1 week after their injury. Such effects appeared to largely resolve after 1 month. Our findings support the need for academic adjustments for concussed students.


OBJECTIVE: The objective was to compare agreement between three non-invasive measures of temperature and rectal temperatures and to estimate the sensitivity and specificity of these measures to detect a rectal temperature of 38°C or higher.

METHODS: We conducted a study of the diagnostic accuracy of oral, tympanic membrane (TM) and temporal artery (TA) thermometry to measure fever in an urban emergency department (ED). Data were collected from adult patients who received rectal temperature measurement. Bland-Altman analysis was performed; sensitivity, specificity and 95% CIs were calculated.

RESULTS: 987 patients were enrolled. 36% of the TM and TA readings differed by 0.5°C or more from rectal temperatures, 50% of oral temperatures. TM measures were most precise—the SD of the difference from rectal was 0.4°C TM, and 0.6°C for oral and TA (p<0.001). The sensitivities of a 38°C cutpoint on oral, TM and TA measures to detect a rectal temperature of 38°C or higher were: 37.0%, 68.3% and 71.1%, respectively (oral vs TM and TA p<0.001). The corresponding specificities were 99.4%, 98.2% and 92.3% (oral, TM and TA) with oral specificity significantly higher than the other two methods (p<0.01). TM and TA cutoffs of 37.5°C provided greater than 90% sensitivity to detect fever with specificity of 90% and 72%, respectively.

CONCLUSIONS: None of the non-invasive methods met benchmarks for diagnostic accuracy using the criterion of 38°C to detect rectal temperature of 38°C. A TM cutoff of 37.5°C provides maximum diagnostic accuracy of the three non-invasive measures.

Point-of-Care Ultrasound Integrated Into a Staged Diagnostic Algorithm for Pediatric Appendicitis.


OBJECTIVES: We hypothesized that point-of-care ultrasound (POCUS) is as accurate as radiology-performed ultrasound in evaluating children with clinical concern for appendicitis. As part of a staged approach, we further hypothesized that POCUS could ultimately decrease computed tomography (CT) utilization.

METHODS: This was a prospective, convenience sampling of patients aged 2 to 18 years presenting with abdominal pain to a pediatric emergency department. Those patients with prior abdominal imaging, pregnant, or unable to tolerate the examination were excluded. An algorithm was followed: POCUS was first performed, followed by a radiology-performed ultrasound, and then a CT as necessary. The main outcome measure was the accuracy of the POCUS in diagnosing of appendicitis. This was compared with radiology-performed ultrasound. We also examined whether certain patient or clinical characteristics influenced the performance of POCUS. Lastly, we determined the amount by which CT scans were decreased through this staged algorithm.

RESULTS: Forty patients were enrolled and underwent a POCUS examination. A total of 16 (40%) had pathology-confirmed appendicitis. Point-of-care ultrasound had a sensitivity of 93.8% (95% confidence interval [CI], 69.7%-98.9%) and specificity of 87.5% (95% CI, 67.6%-97.2%). Radiology-performed ultrasound had a sensitivity of 81.25% (95% CI, 54.3%-95.7%) and specificity of 100% (95% CI, 85.6%-100%). The radiology-performed and POCUS examinations had very good agreement (k = 0.83, P < 0.0005). Patient characteristics including body mass index did not have an affect on the POCUS. However, POCUS identified all patients with an Alvarado score higher than 6. Overall, the reduction in CT examinations was 55%.

CONCLUSIONS: In pediatric patients presenting with clinical concern for acute appendicitis, a staged algorithm that incorporates POCUS is accurate and has the potential to decrease CT scan utilization.

Measuring the Transrectal Diameter on Point-of-Care Ultrasound to Diagnose Constipation in Children.
OBJECTIVES: The aim of the study was to determine the test performance characteristics for point-of-care ultrasound in diagnosing constipation, through measuring the transrectal diameter (TRD). We sought to develop a sonographic numeric cutoff value for diagnosing constipation. Secondary objectives included whether certain patient characteristics would affect the TRD measurement and the accuracy of the TRD in comparison with abdominal radiographs.

METHODS: We conducted a prospective, cohort study of pediatric patients between the age of 4 and 17 years, presenting with abdominal pain to a pediatric emergency department. A point-of-care ultrasound was performed with a phased array transducer (5-1 MHz). In addition to a thorough history and physical examination, each patient was administered with the Rome III questionnaire, which served as the criterion standard for the diagnosis of constipation. Radiographs and enema treatments were performed at the discretion of the attending physician. When enemas were administered, a postenema TRD measurement was obtained.

RESULTS: Fifty subjects were “constipated” or “nonconstipated,” as determined by the Rome III questionnaire. A TRD cutoff of 3.8 cm or greater correlated with the diagnoses of constipation (P < 0.001). Ultrasound-diagnosed constipation had a sensitivity of 86% (95% confidence interval, 69%-96%), specificity of 71% (95% CI, 53%-85%), negative predictive value of 0.87 (95% CI, 0.68-0.95), and positive predictive value of 0.70 (95% CI, 0.52-0.84). The TRD measurement was not affected by patient physical characteristics or bladder fullness. In 7 patients, an enema was administered. There was an overall mean (SD) decrease of 1.22 (1.62) cm; this difference was not statistically significant (P = 0.093). Abdominal radiographs were performed in 25 patients. When compared with abdominal radiographs, ultrasound had a higher specificity of 71% (95% CI, 53%-85%), but this difference was not statistically significant. Ultrasound performed similarly to abdominal radiographs with regard to sensitivity 86% (95% CI, 67%-95%), positive predictive value of 0.70 (95% CI, 0.52-0.84), and negative predictive value of 0.87 (0.68-0.95). In 22 of 25 patients who received radiographs, the ultrasound diagnosis was the same as the radiologist read of the radiographs.

CONCLUSIONS: In pediatric patients with abdominal pain, there is a strong correlation of an enlarged TRD with constipation. Our results suggest that point-of-care ultrasound is a useful adjunct for diagnosing constipation and has the potential to replace the use of abdominal radiographs.
teaching hospitals collected between 2009 and 2013. Clinical characteristics of patients with the exposure to SCRs (SRCA subgroup) were compared with those from patients who smoked traditional cannabinoids (marijuana subgroup). Data included demographics, exposure details, vital signs, mental status, and basic chemistries gathered as part of routine clinical care. Study outcomes included altered mental status and cardiotoxicity.

**RESULTS:** Eighty-seven patients reported exposure to any cannabinoid, of whom 17 reported SCRAs (17 cases, 70 controls, mean age 38.9 years, 77 % males, 31 % Hispanic). There were no significant differences between SRCA and marijuana with respect to demographics (age, gender, and race/ethnicity), exposure history (suicidality, misuse, and intent), vital signs, or serum chemistries. Mental status varied between SRCA and marijuana, with agitation significantly more likely in SCRA subgroup (OR = 3.8, CI = 1.2-11.9). Cardiotoxicity was more pronounced in the SCRA subgroup with dysrhythmia significantly more likely (OR = 9.2, CI = 1.0-108).

**CONCLUSIONS:** In the first clinical study comparing the adverse effects of SCRA overdose vs. marijuana controls in an ED population, we found that SCRA overdoses had significantly pronounced neurotoxicity and cardiotoxicity compared with marijuana.

**Utility of Brain Natriuretic Peptide Assay as a Predictor of Short Term Outcomes in Patients Presenting with Syncope to the Emergency Department.**


**BACKGROUND:** Syncope is a common condition that accounts for 3% of emergency department (ED) visits and 1-6% of hospital admissions. Current admissions practices result in marginal diagnostic and therapeutic benefit and consume healthcare resources.

**METHODS:** This prospective cohort study examined the use of brain natriuretic peptide (BNP) test as a predictor of short term serious outcome in 159 patients who presented to ED with syncope between August 2012 and August 2013 in two tertiary teaching medical centers.

**RESULTS:** A total of 41 patients (36%) had serious outcomes within 1 month, 21 of them were in the low BNP group and 20 were in the high BNP group. There was a significantly higher incidence of serious outcomes, myocardial infarction (MI), and life-threatening arrhythmias in the high BNP group. Patients with BNP >250 has an 8.844 fold increase risk of serious outcomes [odds ratio (OR) 8.844, 95% CI: (3.281 to 23.8), P<0.001], a 14.8-fold increase risk of MI [OR =14.8, 95% CI: (1.57 to 139), P=0.011], and a 4.46-fold increase risk of life threatening arrhythmia [OR =4.46, 95% CI: (1.15-18.8), P=0.034]. However, there was no statistically significant difference between the two groups in one month mortality, major bleeding, major cardiac procedures or stroke.

**CONCLUSIONS:** Our study results further validates the ROSE rule and the utility of BNP in risk stratification of syncope patients. This study showed that measuring BNP and adding ROSE rule to the standard evaluation of syncope can sufficiently predict short-term outcomes.

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Tel: (718) 283-6031; fax (718) 635-7274; email: jmarshall@maimonidesmed.org
serious outcomes for patients presenting to ED with syncope.

**Human Factors in the Emergency Department: Is Physician Perception of Time to Intubation and Desaturation Rate Accurate?**


**OBJECTIVE:** The main objective of the present study was to examine the perceived versus actual time to intubation (TTI) as an indication to help determine the situational awareness of Emergency Physicians during rapid sequence intubation and, additionally, to determine the physician’s perception of desaturation events.

**METHODS:** A timed, observation prospective cohort study was conducted. A post-intubation survey was administered to the intubating physician. Each step of the procedure was timed by an observer in order to determine actual TTI. The number of desaturation events was also recorded.

**RESULTS:** One hundred individual intubations were included. The provider perceived TTI was significantly different and underestimated when compared with the actual TTI (23s, 95% confidence interval (CI) 20.4-25.49 vs 45.5s, 95% CI 40.2-50.7, P < 0.001, respectively). Pearson correlation coefficient of perceived TTI to actual TTI was r(2) = 0.39 (95% CI 0.21-0.54, P < 0.001). The provider perceived desaturation rate was also significantly different from actual desaturation rate (13, 95% CI 3-12 vs 23, 95% CI 13-29, P = 0.05, respectively). The overall time to desaturation was 65.1s.

**CONCLUSIONS:** Our findings have shown that provider’s perception of TTI occurs sooner than actually observed. Also, the providers were less aware of desaturation during the procedure.

**Geographic Variation in the Demand for Emergency Care: A Local Population-level Analysis.**


**BACKGROUND:** Geographic variation in healthcare has been traditionally studied in large areas such as hospital referral regions or service areas. These analyses are limited by variation that exists within local communities.

**MATERIALS AND METHODS:** Using a New York claims database, we analyzed variation in emergency department use using 35 million visits from 2008 to 2012 among 4797 Census tracts, a smaller unit than usually studied. Using multivariate analysis, we studied associations between population characteristics and proximity to healthcare with rates of emergency department use. We analyzed how factors associated with emergency department utilization differed among urban, suburban, and rural regions.

**RESULTS:** We found significant geographic variation in emergency department use among Census tracts. Public insurance and unemployment were correlated with high emergency department utilization across all types of regions. We found that race, ethnicity, and poverty were only associated with high emergency department use in urban regions. In suburban and rural regions, a lower proportion of elderly residents and shorter distances to the nearest ED were correlated with high emergency department use.

**CONCLUSIONS:** Significant variation in emergency department use exists locally when studied within small geographic areas. Insurance type is significantly associated with variation in emergency department use across urban, suburban, and rural regions, whereas the significance of other factors depended on urbanicity.

**IMPLICATIONS:** Studying geographic variation at a more granular level can lead to better understanding of local population health, drivers of healthcare utilization, and inform targeted interventions. Given heterogeneity in emergency department use by Census tract, policies directed at shaping acute care utilization must consider these local geographic differences.

**Oligoantimiesis or Inadequate Prescrition of Antiemetics in the Emergency Department: A Local and National Perspective.**


**BACKGROUND:** Nausea and vomiting are common, but prevalence of antiemetic use in ED patients is unknown.

**OBJECTIVES:** We determined the use of antiemetics in emergency department (ED) patients presenting with nausea and vomiting (NV).

**METHODS:** We conducted a retrospective chart review of ED patients presenting to a local ED with NV and analyzed data from the National Hospital Ambulatory Care Survey for similar patients to determine the frequency of administration of antiemetics in the ED.

**RESULTS:** Of 3876 patients presenting to a local ED with NV in 2014, 2637 (68% [95% confidence interval (CI) 67-69%]) received an antiemetic. Of an estimated 11.3 million U.S. ED visits for NV in 2011 (the latest year available), antiemetics were prescribed in 56% (95% CI 53-59%). Females, older patients, and those with vomiting were more likely to receive an antiemetic. Use of antiemetics was associated with reduced admissions in the single institution (odds ratio [OR] 0.62, 95% CI 0.52-0.74), but not in the national database (OR 1.08, 95% CI 0.74-1.60).

**CONCLUSIONS:** Many patients presenting with NV do not receive antiemetics while in the ED. Effort should be made to further study and reduce the phenomenon of undertreatment of nausea or vomiting, coined “oligoantimiesis.”

**Impact of Hurricane Sandy on the Staten Island University Hospital Emergency Department.**


**INTRODUCTION:** On October 29, 2012, Hurricane Sandy touched down in New York City (NYC; New York USA) causing massive destruction, paralyzing the city, and destroying lives. Research has shown that considerable damage and loss of life can be averted in at-risk areas from advanced preparation in communication procedures, evacuation planning, and resource allocation. However, research is limited in describing how natural disasters of this magnitude affect emergency departments (EDs).

**HYPOTHESIS/PROBLEM:** The aim of this study was to identify and describe trends in patient volume and demographics, and types of conditions treated, as a result of Hurricane Sandy at Staten Island University Hospital North (SIUH-N; Staten Island, New York USA) site ED.

**METHODS:** A retrospective chart review of patients presenting to SIUH-N in the days surrounding the storm, October 26, 2012 through November 2, 2012, was completed. Data were compared to the same week of the year prior, October 28, 2011 through November 4, 2011. Daily census, patient age, gender, admission rates, mode of arrival, and diagnoses in the...
days surrounding the storm were observed. 

RESULTS: A significant decline in patient volume was found in all age ranges on the day of landfall (Day 0) with a census of 114; -55% compared to 2011. The daily volume exhibited a precipitous drop on the days preceding the storm followed by a return to usual volumes shortly after. A notably larger percentage of patients were seen for medication refills in 2012; 5.8% versus 0.4% (P<.05). Lacerations and cold exposure also were increased substantially in 2012 at 7.6% versus 2.8% (P<.05) and 3.8% versus 0.0% (P<.05) of patient visits, respectively. A large decline in admissions was observed in the days prior to the storm, with a nadir on Day +1 at five percent (-22%). Review of admitted patients revealed atypical admissions for home care service such as need for supplemental oxygen or ventilator. In addition, a drop in Emergency Medical Services (EMS) utilization was seen on Days 0 and +1. The SIUH-N typically sees 18% of patients arriving via EMS. On Day +1, only two percent of patients arrived by ambulance. 

CONCLUSION: The daily ED census saw a significant decline in the days preceding the storm. In addition, the type of conditions treated varied from baseline, and a considerable drop in hospital admissions was seen. Data such as these presented here can help make predictions for future scenarios. 

A Multicenter Evaluation of Emergency Department Pain Care Across Different Types of Fractures. 


OBJECTIVES: To identify differences in emergency department (ED) pain-care based on the type of fracture sustained and to examine whether fracture type may influence the more aggressive analgesic use previously demonstrated in older patients.

DESIGN: Secondary analysis of retrospective cohort study.

SETTING: Five EDs (four academic, one community) in the United States. 

PARTICIPANTS: Patients (1,664) who presented in January, March, July, and October 2009 with a final diagnosis of fracture (774 long bone [LBF], 890 shorter bone [SBF]).

MEASUREMENTS: Primary-predictor was type of fracture (LBF vs. SBF). Pain-care process outcomes included likelihood of analgesic administration, opioid-dose, and time to first analgesic. General estimating equations were used to control for age, gender, race, baseline pain score, triage acuity, comorbidities and ED crowding. Subgroup analyses were conducted to analyze age-based differences in pain care by fracture type.

RESULTS: A larger proportion of patients with LBF (30%) were older (>65 years old) compared to SBF (13%). Compared with SBF, patients with LBF were associated with greater likelihood of analgesic-administration (OR = 2.03; 95 CI = 1.58 to 2.62; P<0.001) and higher opioid-doses (parameter estimate = 0.268; 95 CI = 0.239 to 0.297; P<0.001). When LBF were examined separately, older-patients had a trend to longer analgesic wait-times (99 [55-163] vs. 76 [35-149] minutes, P=0.057), but no other differences in process outcomes were found.

CONCLUSION: Long bone fractures were associated with more aggressive pain care than SBF. When fracture types were examined separately, older patients did not appear to receive more aggressive pain care. This difference should be accounted for in further research.

Seeing Is Believing: Evaluating a Point-of-Care Ultrasound Curriculum for 1st-Year Medical Students.


PROBLEM: Point-of-care ultrasound has been a novel addition to undergraduate medical education at a few medical schools. The impact is not fully understood, and few rigorous assessments of educational outcomes exist. This study assessed the impact of a point-of-care ultrasound curriculum on image acquisition, interpretation, and student and faculty perceptions of the course.

INTERVENTION: All 142 first-year medical students completed a curriculum on ultrasound physics and instrumentation, cardiac, thoracic, and abdominal imaging. A flipped classroom model of preclass tutorials and tests augmenting live, hands-on scanning sessions was incorporated into the physical examination course. Students and faculty completed surveys on impressions of the curriculum, and all students under-went competency assessments with standardized patients.

OUTCOME: The curriculum was a mandatory part of the physical examination course and was taught by experienced clinician-sonographers as well as faculty who do not routinely perform sonography in their clinical practice.

METHODS: This retrospective cohort analysis was based on HIE CT study records performed between March 2009 and July 2012. The number of CTs performed, the total number of patients receiving CTs, and the hospital locations where CTs were performed for each unique patient were calculated. Using a previously described process established by one of the authors, hospital-specific proprietary CT codes were mapped to the Logical Observation Identifiers Names and Codes (LOINC®) standard terminology for inter-site comparison. The number of locations where there was a repeated CT performed with the same LOINC code was then calculated for each unique patient.

RESULTS: There were 717,231 CTs performed on 349,321 patients. Of these patients, 339,821 had all of their imaging studies performed at a single location, accounting for 668,938 CTs. Of these, 9,500 patients had 48,293 CTs performed at more than one location. Of these, 6,284 patients had 24,978 CTs with the same LOINC code performed at multiple locations. The median time between studies with the same LOINC code was 232 days (range of 0 to 1,227); however, 1,327 were performed within 7 days and 5,000 within 30 days.
CONCLUSIONS: A small proportion (3%) of our cohort had CTs performed at more than one location, however this represents a large number of scans (48,293). A noteworthy portion of these CTs (51.7%) shared the same LOINC code and may represent potentially avoidable studies, especially those done within a short time frame. This represents an addressable issue, and future HIE-based alerts could be utilized to reduce potentially avoidable CT scans.

The Effect of Surgical Consult in the Treatment of Abdominal Pain in Older Adults in the ED.


OBJECTIVE: The objective was to determine whether need for surgical consult contributes to delayed or reduced analgesic administration in older adults presenting to the emergency department with abdominal pain. METHODS: Secondary data analyses from a prospective cohort study consisting of adults ≥65 years in age presenting to the emergency department with a chief concern of abdominal pain from November 1, 2012, through October 31, 2014, were performed. Measurements included administration of analgesics, time to administration, type given, and pain score reduction. Covariates for adjusted analyses included age, sex, race/ethnicity, and Emergency Severity Index. RESULTS: A total of 3,522 patients were included, of which 281 (8.7%) received any consult. Consult patients were less likely to receive any analgesic medication (53.0%) compared with nonconsult patients (62.5%) (relative risk = 0.80; 95% confidence interval, 0.70-0.91). However, among those patients receiving analgesic medications, there were no differences in likelihood of receiving an opioid, time to administration, or pain score reduction. When analyzing patients who received a surgical consult (n = 154, 4.4%), these associations were notably stronger. Surgical consult patients had a lower rate of analgesic administration (46.8%) compared with nonconsult patients (62.4%) (relative risk = 0.75; 95% confidence interval, 0.63-0.89). Again, no differences were found in likelihood of receiving any opioid, time to administration, or pain score reduction. CONCLUSION: Need for abdominal surgical consult is associated with decreased administration of analgesics in older patients, possibly indicating a continued need to improve management in this setting. This difference, however, did not impact pain score reductions.

Qualitative Study Exploring Implementation of a Point-of-Care Competency-Based Lumbar Puncture Program Across Institutions.


OBJECTIVE: To explore the factors that facilitated or hindered successful implementation of a multi-centered infant lumbar puncture (LP) competency-based education program that required interns to demonstrate skills readiness on a task trainer before performing their first clinical LP. METHODS: In 2013, investigators conducted a qualitative study utilizing semistructured interviews and focus groups of site directors (SDs) from the International Network for Simulation-Based Pediatric Innovation, Research, and Education (INSPIRE) who were responsible for implementing the LP competency-based education program. Transcripts were analyzed using grounded theory to identify and verify emergent themes and subthemes. RESULTS: Thematic saturation was attained after interviewing 19 SDs in 12 interviews and 3 focus groups. The most significant strategies and barriers were organized into 4 main themes: 1) alignment of different visions to obtain buy-in, 2) balance between providing education versus patient care, 3) acceptance of novel teaching paradigms, and 4) communication logistics. The ability to overcome barriers was influenced by institutional culture on trainee education, patient safety and research; the level of relational coordination between different groups of stakeholders; and the ability of SDs to identify and diversify entrepreneurial strategies. CONCLUSIONS: INSPIRE SDs reveal the challenges of implementing a network-wide competency-based educational initiative that determines interns’ readiness to perform LPs in clinical settings. Strategizing to align the common goals of graduate medical training, patient care and research instructs clinician educators and leaders on how to successfully change educational culture in academic medicine. An Audit of Top Citations Published in Pediatric Emergency Care.


OBJECTIVE: The aim of this study was to identify and compare the 100 articles published in Pediatric Emergency Care (PEC) from its inception in 1985 to date that are most often cited. METHODS: Three online citation indices, Scopus, Web of Science, and Google Scholar, were examined to identify the 100 top cited articles from PEC. Mean citation numbers were used to rank the studies, due to differences in the results among the 3 citation indexes. Median citation number, country of origin, study topic within the field of pediatric emergency medicine, and year of publication were compiled, compared, and analyzed. Those articles that had an outcome with the same mean citation number were listed in the table in alphabetical order according to the last name of the primary author of the publication. RESULTS: Mean citation numbers were used to identify the 100 most often cited articles from PEC. The citation counts ranged from a high of 132 to a low of 42 citations, the median being 55. Research for 84 of the 100 articles was conducted in the United States with no other country contributing more than 3 articles each. The top subjects of these articles (and their frequencies) included infectious disease (12), resuscitation (11), anesthesia (10), and toxicology (9). The number 1 ranked article was graduate medical education (GME) related and evaluated resident training/education, with respect to the field of resuscitation. All articles in the top 100 cited were published between 1985 and 2010. The top publication years included 1997, 2000, and 2001, wherein 9 articles were published in each of those 3 years. Of the top 100 articles cited, 78% were published in 1997 and later. CONCLUSIONS: In reviewing the literature and to our knowledge, this study is the first of its kind in the field of pediatric emergency medicine to determine the influence of articles in a journal by evaluating citation number. It identified the 100 articles with the highest number of citations that were utilized in subsequent journal articles and published in PEC since 1985. The clinical relevance of identifying the most popular article topics cited supports the value to the pediatric emergency medicine readership of emphasizing subjects of core curriculum content for further education. In addition, reviewing the literature using PEC as a source for articles published 10 to 15 years ago can be helpful because these articles may be considered benchmark articles that many authors choose to cite, creating an impact in their more recent publications.
Case: An 8-year-old girl was swinging on the monkey bars when she fell onto her right arm. She is now complaining of pain and swelling to her right elbow. On exam, she appears nervous but with stable vital signs. She is holding her right elbow with her left hand, and is unable to fully extend her right elbow. No deformity or lacerations are noted. You suspect an elbow fracture and order a right elbow x-ray, which shows the following:

The x-ray is reviewed by the radiologist, who reports “no fracture or dislocation, but correlate clinically”. You think you see a posterior fat pad on the x-ray, but you are not sure. You remember reading a paper on using ultrasound to detect occult elbow fractures and decide to perform the procedure.

Discussion: The posterior fat pad in the olecranon fossa of an elbow is elevated in the presence of joint effusion, usually in a setting of an elbow fracture. The presence of a posterior fat pad has high sensitivity for a fracture in the setting of an elbow injury. While an elbow x-ray is the study of choice, occult fractures can often be missed. Ultrasound has been studied for the use of identifying elevated posterior fat pads and lipohemarthrosis in elbow trauma with high sensitivity when compared to x-rays for fractures.

This study may be performed by placing a high-frequency, linear transducer to the posterior aspect of the distal humerus while holding the elbow flexed at 90 degrees (Figure 2). The transverse and longitudinal ultrasound views of the posterior elbow reveals the olecranon fossa between the lateral condyles of the humerus (Figure 3). In the setting of joint effusion or lipohemarthrosis, the posterior fat pad within the olecranon fossa will be elevated above the lateral condyles in both the transverse and longitudinal views (Figure 4). Rabiner, et al studied the accuracy of point-of-care ultrasound of the elbow by pediatric emergency medicine physicians and found that when compared to positive elbow x-ray findings in patients who presented with elbow trauma, a positive elbow ultrasound for an elevated posterior fat pad had a sensitivity of 98%.

In our case patient, an elevated posterior fat pad was identified on ultrasound. She was treated for an occult elbow fracture with the proper orthopedic management.

References:
Looking Through the Lens in Difficult Circumstances

On June 12, 2016, a Sunday, I was sitting on the couch with my family watching the morning news and learned the early information on the Orlando nightclub shooting. Like most others I had the usual thoughts of empathy for the victims, the survivors, and the families who still might not know if their loved ones were okay. But within minutes I had other thoughts: How are the local Emergency Departments (EDs)? Do they have enough staff? ORs? Equipment? What will be the state of their psyches when this is over?

As EM physicians we look through a unique lens, and given my lens, my thoughts progressed to something that felt more selfish; will we be ready when it happens closer to home?

Working on Staten Island and living not too far from the hospital, the emotions that surrounded Hurricane Sandy always rush back when I learn of tragedy. Yet we expect natural disasters; floods, tornadoes, hurricanes are due to happen every year. But I cannot imagine that I will ever get used to gunmen firing into crowds of innocent victims. In recent years, there have been so many events. We have to learn from the experience of prior events. It is relatively standard practice to drill on events, and review our processes. But the onus is on us to make sure we have this information down, know our disaster protocols and have an understanding of how these drills might transfer to a real-life scenario.

Commenting on their response after the Colorado shooting and highlighting the benefit of a mature disaster response plan, Dr. Mark Mayes, the Director for Emergency Services at the Medical Center of Aurora (received 18 patients from the movie theater) remarked that, “Everything was difficult, but what made it manageable were the systems we have in place, the structure we have in place, and the training we have done around crisis management and incident command. We basically have a whole laid-out plan to follow.”

But even with a good plan it might not be that simple. Not all events will be created equal, nor will the state of our EDs when disaster strikes. For instance, my ED and hospital function at full or over capacity on many days. The challenge of rearranging the proverbial “furniture” alone is not without obstacles.

As Dr. Richard Zane, Chair of Emergency Medicine at the University of Colorado School of Medicine (received 23 patients) noted, “Although we prepare for disaster and mass-casualty care, you never prepare for specific events because preparedness is 80% generic ... and you have to accept that the last 20% is going to be enigmatic or variable.”

When looking into other settings, educational institutions for instance, a 3-prong approach of Prevention, Response and Recovery is used. For us the prevention phase is clearly limited. There is no intel that will provide advance notice of these unplanned events.

However, we can focus on response and recovery.

So what can we do? Prepare.

Consider the following and inquire at your institution:

1. Law enforcement presence regionally and in your facility
2. How long does it take to activate your disaster response team?
   a. The who, what and where of the hospital incident command system
   b. Hospital security and threat mitigation
3. Do you have a staffing plan?
   a. Short list of staff willing to come in at a minutes notice
   b. Back up team for relief of the initial providers
4. Consider interdepartmental relationships and knowledge of their escalation plans
   a. Surgeons, OR Staff, Anesthesiologists, Radiology, Psychiatry, Social Work, Transport, Environmental Services/Housekeeping
5. Consider inter-hospital and first responder relationships
   a. Agreements with nearby institutions
   b. Emergent and non-emergent EMS system capacity and communication
6. Plan for existing ED patients
   a. Surge capacity
   b. Alternate areas of care
   c. Ability to rapidly decompress your institution
7. Volume of critical equipment
8. Staging areas
   a. Individuals coming to the hospitals to locate loved ones
   b. Medical liaison/Press
9. Clergy
And lastly, share experiences, success and failures. Publish these for the EM community to see. Having the wisdom of each other’s experience can only broaden our perspectives and enhance the care of our communities.

References
I had the wonderful pleasure of attending the ACEP leadership and advocacy conference from May 15-18 in Washington D.C. I was able to attend thanks to a stipend through the New York ACEP chapter. I have always had an interest in advocacy through the emergency department as the emergency department is known as the safety net of the national health care system. During my stay at the conference I was able to interact with various physicians and get their takes on various challenges and obstacles that they face in the emergency department. On the first day of the conference I attended the Health Policy Primer from EMRA which was an introduction to health policy. During the primer I had the opportunity to listen to great lectures on topics including fair payment and an introduction to payment and delivery reform. Also during the primer there was a journal club which allowed me to interact with fellow residents from various programs all over the country. During the following days I was able to listen to wonderful and insightful lectures by some of the country’s leading experts on issues including payment reforms, utilization of emergency departments and mental health reforms as well. I was also able to hear from the ACEP president Jay Kaplan and AMA Steven Stack who are both wonderful speakers. My favorite part of the conference was the lobbying day.

Along with my fellow conference participate I had the opportunity to go to capitol hill and speak to my local representative and lobby for various topics emergency physicians and patients we encountered are facing. Along with my colleagues I was able to speak to the reps face to face and their representative about topics including opioid abuse, EMTALA and psych boarding in the emergency department and lack of resources for people suffering with mental illness.

Overall, I had a wonderful experience participating in the ACEP leadership and advocacy conference. I would definitely recommend it for any attending or resident.

Thank you New York ACEP for allowing me the opportunity to participate in such a wonderful event.

I went in to the Leadership and Advocacy Conference with an open mind and a broad goal to gain a basic understanding of current heath policy issues. This conference was a fantastic learning experience and opportunity to immerse myself in the health policy world for a few days. From the opening health policy primer on day one to spending the day advocating with members of congress and senate on the final day, I felt inspired and excited to be a part of this process. I plan to continue to stay educated and informed in this ever-changing political landscape and hope to become more involved moving forward. I plan to implement many of the ideas provided at this conference to advocate for better patient care within my institution and with county, state, and federal legislators. I would encourage all residents to attend this conference, as we are the future of emergency medicine. The more that we all know and understand as a whole, the better we can advocate for our patients and profession. Lastly, I want to take this opportunity to thank New York ACEP for giving me this opportunity.
I had the distinct pleasure to speak with Dr. Annabella Salvador-Kelly. Dr. Salvador-Kelly is the Associate Medical Director of Northwell Health (former North Shore-LIJ Health System). We focused our talk on the development of leaders in Emergency Medicine.

**What advice would you give to others who would like to get involved in department or hospital leadership early in their career?**

Emergency physicians interact daily with members of the medical staff and administration. Networking with key players within your department and the hospital helps develop relationships that can lead to future opportunities for involvement. Emergency physicians are well positioned to assume leadership roles within healthcare systems.

Many attending physicians start off by taking advantage of opportunities to be involved with residency education or volunteering for projects within their department. There are always opportunities to join hospital committees. Participation in local, regional and national medical societies are also great opportunities to develop skills as a leader.

**How did you become the Associate Medical Director of Northwell Health?**

Dr. Salvador-Kelly completed her Emergency Medicine Residency at NYU/Bellevue Medical Center in 1999. She became an attending physician at North Shore University Hospital and was involved in residency education. She was offered a position within quality management and served as the Director of Performance Improvement for fourteen years.

In 2013, she was named the Associate Chair of the Department of Emergency Medicine at the Long Island Jewish Medical Center. In 2015, she was appointed as the Associate Medical Director of Northwell Health.

**How did you develop your leadership skills?**

Dr. Salvador-Kelly recommended continuing professional development, such as physician leadership development programs. Many hospitals offer programs to top performing physicians to expand their skill set and take on administrative roles within their department and hospital system. These courses can push physicians to learn about topics they may be less comfortable with, such as finance. National ACEP and New York ACEP have great educational offerings for physicians interested in department and hospital leadership roles such as the ED Director forum.

Accessing mentors is also a good way to develop a new skill set. Mentors play an important role in career development. “At each step of your career, it is important to look for mentors and provide mentorship to others.” Physicians with strong networks and mentors enjoy greater career satisfaction.

**How do you maintain a work-life balance?**

Dr. Salvador-Kelly attributes her success to her supportive husband, family and friends. She recommends being fully engaged at work and at home. One of the key factors to maintaining balance is to separate work from family time. Dr. Salvador-Kelly stresses, “When I am home, I am focused on my family.”

**How to Get Ahead in Emergency Medicine Education**

1. Be organized. Effectively manage your time by mastering your own schedule and using prioritized to-do lists.
2. Be accountable. You have to consistent-
Zika Virus: What Do We Need to Know in the Emergency Department?

You are working your shift in the Emergency Department and you click on the next patient to be seen and you see chief complaint of fever and rash in a 27 year old female. You briefly contemplate the vast differential for fever and rash as you get up to go see her. You find the patient in the exam room with her husband as she proceeds to tell you that she and her husband are recently married and returned one week ago from their honeymoon in the Dominican Republic. She states that this morning she woke up feeling achy with pains in her hands and feet and noticed a diffuse rash as well as a fever of 100.5F. Her husband does not have any symptoms but he is concerned because he saw a story on the news about Zika and they are trying to conceive. They both want to be tested for the Zika Virus and ask if you think they have it. How would you proceed?

Zika virus is an arthropod-borne flavivirus transmitted by mosquitoes. The virus is related to other flaviviruses including dengue virus, yellow fever virus, and West Nile virus. The majority of patients who are infected with Zika remain asymptomatic with only 20 percent manifesting symptoms which commonly include low-grade fever, maculopapular rash, arthralgias and conjunctivitis. Zika virus is named after the Ugandan forest where it was first isolated in a rhesus monkey in 1947. The first human cases were detected in 1952 in Uganda and Tanzania. The virus subsequently spread across equatorial Africa and Asia, where it was associated with sporadic infections. The first major recognized outbreak occurred in the Yap Islands of Micronesia in 2007; more than 70 percent of the population ≥3 years of age was infected, resulting in an estimated 5000 infections among the total population of 6700. Another larger outbreak occurred in French Polynesia in 2013 to 2014, which affected about two-thirds of the population, resulting in approximately 32,000 infections. As of July 2016, countries with mosquito borne Zika transmission include most of South America, Mexico and the entire Caribbean. While there are no mosquito borne cases reported yet in the Continental United States, there is concern especially in the southern states as the mosquito that transmits Zika can be found there. Interestingly, regions above 6,500 feet elevation have been excluded from travel warnings as mosquitoes are rarely found at that elevation. Zika is transmitted by the Aedes aegypti mosquito, which lives in tropical regions; however, the Aedes albopictus mosquito, which lives in temperate regions, is also capable of carrying it. While Aedes aegypti are not found in New York State, Aedes albopictus can be and is an aggressive daytime biter. Modes of transmission include:

- Bite of an infected mosquito
- Maternal-fetal transmission
- Sex (including vaginal, anal, and oral sex)

The clinical manifestations of Zika if present can be seen after a 2-14 day incubation period and are usually mild and self-limited with resolution in a couple days to a week. Severe illness requiring hospitalization is rare and the case fatality rate is extremely low. Symptoms commonly include low-grade fever, a maculopapular rash, non-purulent conjunctivitis and arthralgias of smaller joints such as hands and feet. Other symptoms may include myalgias, headache or nausea and diarrhea. To entertain a clinical diagnosis of Zika two or more symptoms should be present in addition to an appropriate exposure history (travel or unprotected intercourse with a person who has traveled to an endemic area). Signs and symptoms in children are similar to adults although myalgias and arthralgias are more difficult to assess and may manifest as a limp. Differential diagnosis includes other arboviruses also found in the same regions such as Dengue, Chikungunya, West Nile, as well as other infections such as Measles, Malaria and Group A Streptococcus which may have a similar appearing rash. There is no specific treatment for Zika virus infection. Management consists of rest and symptomatic treatment, including drinking fluids to prevent dehydration and administration of acetaminophen to relieve fever and pain. Aspirin and other nonsteroidal anti-inflammatory drugs (NSAIDS) should be avoided until dengue infection has been ruled out, to reduce the risk of hemorrhage. Complications of Zika include congenital microcephaly and fetal loss as well as neurologic complications such as Guillian-Barre which has been described during a 2013-2014 French Polynesia outbreak.

Many patient have been presenting to Emergency Departments requesting testing to confirm a diagnosis of Zika and the indications for testing have been evolving over the past six months. The most current recommendations for testing from the New York State Department of Health are as follows:

- Zika virus testing availability to all pregnant women who, during pregnancy, had unprotected vaginal, anal or oral sex with a sex partner who traveled to an area with active mosquito-borne transmission of Zika virus.
- Testing is available regardless of whether the sex partner had symptoms consistent with Zika virus infection.
- Infants with microcephaly or intracranial calcifications born to these non-traveling, pregnant women are also eligible for testing.

Blood transfusion
Organ transplantation
Laboratory exposure
Pregnant women who traveled to an area with active mosquito-borne transmission of Zika virus while pregnant.

Non-pregnant women, men or children who develop (or developed) compatible symptoms during or within 4 weeks of travel to an area with active mosquito-borne transmission of Zika virus.

Persons who traveled to an area with active mosquito-borne transmission of Zika virus and who present with Guillain-Barré syndrome.

Infants with microcephaly or intracranial calcifications born to women who traveled to an area with active mosquito-borne transmission of Zika virus while pregnant.

In order to test a patient, prior authorization is required by the local health department. If you are considering testing a patient, the local health department should be contacted to authorize testing as samples are tested at the New York State Wadsworth Laboratories. There is now limited commercial testing available however it is not as robust as the testing done by the Health Department and both urine and blood samples should be sent.

Now let’s get back to our case. After seeing the patient and discussing her concerns you agree that testing may be indicated and after consulting the local health department, they approve testing for her. As her husband is asymptomatic you inform him that the Department of Health has not approved testing for him. You send off urine and blood samples on your patient and advise her that it will likely be 7-14 days for results but that she shouldn’t worry as most people experience only mild, self-limited symptoms. You recommend fluids and Tylenol and have a discussion with her and her husband regarding sexual transmission of the virus and suggest they use condoms for contraception. The patient asks how long she has to wait before she could try to get pregnant. You inform her that while some studies have shown the virus to be present in semen for up to 90 days, you recommend that she discuss this further with her OB/GYN physician prior to attempting to conceive. The patient is feeling much better after some fluids and Tylenol and you discharge her home.

As of this time there have been no cases of mosquito transmitted Zika in New York State. The New York City Department of Health and Mental Hygiene have recorded approximately 233 cases of Zika however all cases have been reported in returning travelers from endemic areas. Additionally while there is now some commercial testing available, serology testing is not available commercially and both urine and blood should be tested. As such, pregnant women should be tested through the approved Health Department labs, and not commercial laboratories. For more information on Zika you can go to the CDC website at http://www.cdc.gov/zika/.

References:

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The New York State Legislature finished the 2016 Legislative Session in the early morning hours of Saturday, June 18. It was a challenging Session for physicians in general and emergency physicians specifically with proposals to:

- change the statute of limitations for medical, dental and podiatric malpractice from two and half years to a “Date of Discovery (DOD)” law;
- increase the cap on attorney contingency fees for malpractice actions;
- eliminate a provision of the original I-STOP law that exempts prescribers in emergency departments from consulting the Prescription Monitoring Program (PMP) when no more than a five-day supply of a controlled substance is prescribed; and
- require new Continuing Medical Education (CME) requirements for physicians for pain management, addiction, and palliative care.

Many of these issues were resolved in favor of physicians with the defeat of:

- DOD; attorney contingency fees; and efforts to eliminate the exemption to consult the PMP in emergency departments.

The CME mandate passed both houses as part of a comprehensive proposal to address the heroin/opioid crisis put forward by Governor Cuomo. Some concessions for physicians were added to the Governor’s bill by physicians to eliminate mandatory counselling of patients by prescribers and provide for exemptions to CME.

In addition, New York ACEP has worked for the past year on a comprehensive, statewide plan to defend against regressive liability legislation and to inject special liability protection for emergency care providers under the Emergency Medical Treatment and Active Labor Act (EMTALA) into any discussions in the New York State Legislature.

A summary of the EMTALA effort and other legislative proposals of interest to New York ACEP is provided below.

EMTALA Reforms

New York ACEP was already exploring plans for a multi-year, statewide campaign for passage of an EMTALA-related liability reform bill in New York State last year. Quite unexpectedly, the Assembly passed a Date of Discovery bill by a wide margin of 125 to 25 in the closing hours of the 2015 Legislative Session. This led us to significantly accelerate and intensify our efforts to proactively pass EMTALA reform and defensively defeat regressive liability legislation in 2016. These efforts are summarized below.

Milliman Study

New York ACEP commissioned a study by Milliman to perform an actuarial analysis of the impact of EMTALA-related liability reform to increase the standard of evidence from “a preponderance of evidence” to a “clear and convincing standard of evidence” for emergency care.

The study concluded that there would be a material decrease in medical professional liability (MPL) premiums for emergency physicians, other physician specialists working in emergency departments, and hospitals.

Milliman estimates that the decrease in ED physician premiums would range from a low of 10%, central of 16%, and a high of 20%. While the decrease in premiums for non-emergency physicians was low overall, the impact on individual physician specialties was over 5% for cardiovascular and neurologic surgeons. Hospitals would save a low of 0.9%, central of 1.4% and a high of 1.8%. Milliman predicts that total savings for insured hospitals and physicians would be between $16 million and $60 million in total.

Research

RMS worked with New York ACEP to conduct research and create materials including a comprehensive summary of medical liability laws in other states and a study of EMTALA liability reforms either passed or pending in other states and the strategies employed to gain passage.

Development of Legislation

Draft legislation was developed by RMS to provide EMTALA-related liability reform. As noted below, meetings were held with legislators and stakeholders. A decision was made not to introduce the legislation this year after consultation with our legislative supporters who felt that any indication that physicians and/or hospitals were open to negotiation on any medical liability issue would fuel support for passage of a DOD bill. Based on the Senate’s ultimate decision not to pass a DOD bill this year, we think that this advice was well-founded.
A total of 32 legislators were identified, 16 each in the Assembly and Senate who are leaders, emerging leaders, and “marginal” members who are at risk of losing their seats. New York ACEP sought volunteers from the Board of Directors and Government Affairs Committee.

In February New York ACEP hosted a Webinar with the volunteers to inform them of liability issues in the upcoming Legislative Session and to provide information and guidance about how to develop and sustain strong relationships with key legislators to increase the effectiveness of New York ACEP. We will continue to build on these efforts in the future to cultivate a strong government affairs program in Albany and at the local district level.

Meetings with Stakeholders and the New York State Legislature
When the Legislature returned from their break in May to take up non-budget related issues, New York ACEP and RMS arranged a series of meetings and conference calls with legislators, the Health Care Association of New York State (HANYS), and Greater New York Hospital Association (GNYHA).

A Lobby Day was held in Albany May 9 attended by Dr. Brahim Ardolic and Dr. Daniel Murphy to advance the draft EMTA-LA bill. Meetings were held with top staff for the Assembly Speaker Carl Heastie, Senate Majority Leader John Flanagan, Counsel and top program staff to Governor Cuomo, Senator Hannon, Chairman of the Senate Health Committee, staff to Assemblyman Gottfried, Chairman of the Assembly Health Committee, and Assemblyman Kevin Cahill, Chairman of the Assembly Insurance Committee.

The conference calls with HANYS and GNYHA enabled New York ACEP to have preliminary conversations on the value of the proposal. New York ACEP is continuing to work on advancing this legislation over the coming months in preparation for the 2017 Legislative Session.

Key Legislation
Legislation Defeated
Statute of Limitations for Medical, Dental, and Podiatric Malpractice: Date of Discovery (S6596-B DeFrancisco/A10719-A Weinstein)
At the start of the 2016 Legislative Session in January, all 3 leaders, Governor Andrew Cuomo, Senate Majority Leader John Flanagan, and Assembly Speaker Carl Heastie, declared their support for a change in the statute of limitations for medical, dental, and podiatric malpractice from two and half years to a “date of discovery” law. Last year the Assembly passed a DOD bill by a wide margin of 120 to 5.

After much debate, the Republican Senate withdrew their support for the bill, in the waning hours of the 2016 Session. New York ACEP weighed in, in strong opposition to the bill with key members of the State Legislature through meetings and phone calls. In addition, we worked in Coalition with the Medical Society of the State of New York (MSSNY), GNYHA, HANYS, malpractice insurance carriers, and other physician specialty societies to defeat the bill.

Legislation Passed by Both Houses
Opioid/Heroin Package (S8137 Ortt/A10275 Rules and S8139 Murphy/A10727 Rosenthal)
Legislation to require physicians to complete mandatory CME courses in pain management, addiction, and palliative care have been pending for several years in the State Legislature. These proposals were sought by the parents of children who died from opioid overdose.

New York ACEP has worked for the last several years to defeat this legislation. This year, the Legislature agreed to passage of a CME mandate that was put forward by Governor Cuomo as part of a comprehensive proposal to address the heroin/opioid crisis. The bill requires all prescribers in possession of a DEA registration number to complete a 3 hour course every 3 years in addiction, pain management and palliative care beginning on July 1, 2017.

An earlier version of this bill would have eliminated a provision of the original I-STOP law that exempts prescribers in emergency departments from consulting the Prescription Monitoring Program (PMP) when no more than a five-day supply of a controlled substance is prescribed. New York ACEP was able to convince both houses of the Legislature to reject this provision through data provided to the Legislature demonstrating that hospital emergency departments are not the source of opioids for patients. One study found that from 2007 to 2012, the largest percentage drops in opioid-prescribing rates occurred in emergency medicine (-8.9%) and dentistry (-5.7%). The abstract for the study can be found at this link: http://www.ncbi.nlm.nih.gov/pubmed/25896191.

In addition, research published in 2015 by the Annals of Emergency Medicine found that the majority of opioid prescriptions in the Emergency Department had a low pill count and almost exclusively were immediate-release formulations, not the long-acting medications such as methadone, OxyContin, and MS-Contin which are more strongly associated with overdoses. According to the study, “Our data show that opioid prescribing in the ED is done with caution and aligned with short-term use goals-suggesting that emergency physicians generally follow guideline recommendations to limit opioid prescriptions to only 3-5 days and avoid long-acting opioids.” See link: https://www.sciencedaily.com/releases/2015/05/150504130514.htm.

Earlier versions of the Governor’s bill would not have provided for any exemptions to the CME mandate. However, the final bill allows for the New York State Department of Health (NYS DOH) to grant an exemption where a prescriber can demonstrate that the course is not needed; or that they have taken a CME course equivalent to what the State has approved. Provisions of the Governor’s original bill that required physicians to counsel and provide treatment referral for patients when prescribing an opioid were removed from the bill by the Legislature prior to passage.

Other key provisions of the bill would:
- extend from 48 hours to 72 hours the amount of time that an individual who is incapacitated by drugs or alcohol can be held for emergency treatment;
- require insurers to cover inpatient services for the treatment of substance abuse without prior authorization and without the imposition of service denials for the first 14 days of treatment;
- require insurers to cover naloxone;
- require hospitals to provide discharge planning services to connect at-risk patients with treatment options; and
- change the limit on initial prescriptions for an opioid from 30 days to 7 days.

These bills were signed into law by the Governor, Chapter 69 and Chapter 71 of the Laws of 2016.
Reporting of Opioid Overdose Data (S6516A Amedore/ A9251A Rosenthal)

This legislation clarifies that opioid overdoses and deaths must be tracked by the State Department of Health (DOH) and included in an annual report due by October 1st each year and made available on the Department’s website. Such information would have to be provided on a county basis and include data on the dispensing as well as utilization of opioid antagonists, areas of the state that are experiencing particularly high rates of overdoses and ways to determine if services and resources are having a positive impact on reducing overdoses. Current information and data would be required to be provided to each county on a monthly basis to assist in addressing the opioid epidemic.

This bill was signed into law, Chapter 66 of the Laws of 2016.

Electronic Prescribing: Transfer of Prescriptions (S7537-AS Martins/A10488 Schimel)

Legislation strongly supported by New York ACEP amending the mandatory electronic prescribing law which took effect on March 27, 2016 passed both houses. This bill authorizes a pharmacy that is unable to fill an initial electronic prescription to transfer that prescription to another pharmacy at the request of a patient. This bill address circumstances where a pharmacy that receives an initial e-script is unable to immediately fill the script, forcing the patient to return to the prescriber to obtain a new prescription for a different pharmacy.

This bill has not yet been transmitted to the Governor for signature.

Electronic Prescribing: Filing Requirements for Exemptions (S 6779-A Hannon/A9333B Gottfried)

Under existing law, physicians or other prescribers who seek one or more of the exemptions to the e-prescribing mandate must electronically file information with the New York State NYS DOH each time they invoke an exemption. This filing requirement is time consuming and burdensome for prescribers. This legislation replaces the requirement for a filing with NYS DOH to a requirement that the prescriber make a notation in the patient record.

This bill passed both houses. It has not yet been transmitted to the Governor.

Conviction Records of Emergency Medical Technicians (EMTs) and First Responder Applicants (S5524B Bonacic/A3590 Skoufis)

This bill requires the chief officer of an ambulances company or service to search for sex offense conviction records when prospective EMTs and other first responders apply for membership.

This bill passed both houses. It has not yet been transmitted to the Governor.

Hospital Patients’ Bill of Rights: Surprise Bills and CARE Act (S6347B Hannon/ A9188B Gunther)

This bill updates the Patients’ Bill of Rights in a hospital to inform patients that they have a right to:
- be held harmless from “surprise bills” that are not covered by their insurance plan; and
- to designate a caregiver under the CARE Act. The CARE Act which is effective April 23, 2016 requires identification of caregivers while a patient is still in the hospital and includes caregivers in discharge planning, and post-discharge care.

This bill passed both houses. It has not yet been transmitted to the Governor.
The Department of Emergency Medicine at St. Barnabas Hospital is dedicated to our Bronx community and has a strong, well established teaching tradition.

Our inner-city, academic emergency department with over 60 Emergency Medicine residents is seeking dedicated teacher-clinicians to fill the following positions:

- **ED Director of EMS & Emergency Management**
- **ED Director of Quality & Safety**
- **Assistant Director of Research**
- **Director, Pediatric Emergency Department**

These faculty positions include clinical, administrative and teaching responsibilities. St. Barnabas Hospital is the primary teaching hospital of CUNY’s Sophie Davis Medical School, and is also affiliated with Albert Einstein and NYCOM.

Our Pediatric Emergency Department sees over 23,000 patients a year and is open 24 hours a day, providing vital access to crucial services in our diverse community. We are privileged to serve one of New York City’s most challenged communities with high rates of asthma, trauma, diabetes, infectious disease, and other chronic illnesses.

The Pediatric Emergency Department operates as a Section of the Department of Emergency Medicine and also works closely with the Department of Pediatrics and trains both Emergency Medicine and Pediatric Residents. We are home to a 4-year Emergency Medicine residency program with over 60 residents.

The ideal candidate should be Pediatric Emergency Medicine Fellowship trained.

St. Barnabas Hospital is a 461-bed, not-for-profit, nonsectarian, acute care community hospital. We are a NY State-designated Stroke Center, AIDS Center and a busy regional Trauma Center. Our campus is beautiful and our location enables a direct commute from Manhattan, Queens, New Jersey, Long Island, Westchester, Connecticut and the Hudson Valley.

Pursuit of academic and departmental projects is expected. We offer board certified/eligible teachers and leaders who are dedicated to advancing the specialty and practice of emergency medicine and pediatric emergency medicine. Recent residency and fellowship graduates will be considered. We offer career advancement, a competitive salary, and the opportunity to join a Department that is in an exciting phase of growth and improvement: academically, clinically and operationally.

Interested physician candidates should contact Daniel G. Murphy MD, MBA at 718.960.6827 or dmurphy@sbhny.org.

St. Barnabas Hospital has changed its name to SBH Health System. As a leader in the transformation of healthcare, SBH Health System brings you a new model of care that focuses on health and wellness, prevention of illness and caring for the whole you.
Ergentus joins US Acute Care Solutions.
Welcome Denver adventurers.

Strap in, we’re going to stomp this ride. As one of the six founding partner groups of US Acute Care Solutions, you’re joining us in making an epic move that’s dropping the jaws of healthcare onlookers. To the ones who say physician-owned acute care groups can’t compete, we say—watch this. See what happens when you bring passionate, like-minded physician owners together that believe physician ownership creates the best results for patients and hospital partners. We’re USACS and we own the mountain.