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Emergency Medicine
Staten Island, NY

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Another Great Year

Having just returned from another phenomenal New York ACEP Scientific Assembly and seeing so many of you, I was able to reflect on a pretty amazing past year. As I have said in my newsletter articles, and as I can attest to by the many who serve on the Board, Committees and attended the Scientific Assembly, this is NYour ACEP. Testament to that is a list of accomplishments New York ACEP achieved since a year ago. Here are just a few highlights:

This past year held a host of record-shattering events including a Medical Student Symposium, Resident Career Day, Resident Research Conference, ED Director Forum and the Scientific Assembly in beautiful Lake George.

Our Professional Development Committee has been up to lots of great stuff, particularly as it relates to incorporating wellness activities at all of our New York ACEP events and I am grateful for their efforts to keep us all human, when we often face the inhumane.

The Education Committee has been unstoppable, with not only events like the Scientific Assembly, but also having received TWO national ACEP grants: one to Advance Wellness in Emergency Medicine, and the second for our OWL or Opportunities for Women in Leadership program and I am grateful to the amazing women leaders that put that application together and are serving as mentors.

The EMS Committee has been providing input on Stroke Regulations as they are both written and enacted while our Emergency Medicine Residents Committee has been busy with a new Graduation with Distinction Award Program for EM Residency graduates who have met specific (and significant) achievements during their residency in specific areas of specialization. We look forward to that program launching later this fall.

In addition to identifying the nearly 70 abstracts for presentation at this Scientific Assembly, the Research Committee is also poised to announce a fabulous Research Awards program for both young and seasoned researchers alike.

The Practice Management Committee has been developing position statements and best practices for everything from Medication Assisted Treatment in the Emergency Department (ED) to nursing staffing ratios in collaboration with other organizations.

I hopefully need not remind you that the practice of medicine in New York is still under attack from legislators in Albany. Thanks to the tremendous efforts of our Government Affairs Committee, our staff, our lobbyists at Reid, McNally, & Savage, as well as you calling your legislators, we were able to pull off some pretty outstanding victories this past year. A few big highlights include:

- Helped pass legislation to eliminate non-medical exemptions for required childhood vaccinations.
- Defeated a State Budget proposal to eliminate State Medicaid Payments for certain Ambulance Services – which could have left swaths of the state without ambulances.

“Friends, this is not the first year, and it will not be the last, that our representatives try to legislate the practice of medicine. So for every Action Alert or dollar you give to the New York Emergency Medicine Political Action Committee, you are helping yourself practice the science and art of medicine, so I thank you for what you have done, and ask you to keep it up”

Jeremy T. Cushman, MD MS FACEP
Associate Professor and Chief
Division of Prehospital Medicine
University of Rochester
Integration of TEE in an ED Resuscitation

Case
A 78 year old male with a history of hypertension, meningioma, renal tumor status post resection, oral cancer status post radiation therapy, immune thrombocytopenia and splenectomy presented to the Emergency Department (ED) after a fall in the shower prior to arrival. The patient had complaints of fever, cough and malaise for three days. The patient did not endorse any pain except at the site of a scalp contusion and laceration. The patient denied loss of consciousness. He was not on any blood thinners.

ED Course
On arrival, his vital signs were 106/55, 109 with temperature of 38.4°C. His initial physical examination was non-contributory, except for a 3 cm laceration over his left eyebrow and dried blood on his face. He had a non-tender midline c-spine with full range of motion of the neck, clear lungs and non-tender chest wall. On cardiac examination, he was sinus tachycardic without murmur or rub, the abdomen was soft, non-tender without guarding or rebound, cranial nerves were intact and the patient was moving all his extremities. He was noted to be slightly confused and perseverating, but awake, alert, oriented to person, place, time and situation.

A bedside eFAST ultrasound was negative for free fluid in the peritoneum and no pneumothorax was identified. Hospital protocol for sepsis was initiated and initial trauma work up included a CT head, CT c-spine, CT chest, CT abdomen and pelvis, IV antibiotics, IV fluids and rectal acetaminophen.

After returning from CT, the patient’s heart rate was 150. He was found with atrial flutter with 2:1 block. The family confirmed he had missed his daily metoprolol. A beta blocker was administered in the ED.

The patient was found lethargic with agonal breathing after the CT. He stopped responding to verbal and physical stimuli. His blood pressure was undetectable with a thready pulse. He was intubated due to impending respiratory failure and became bradycardic, then pulseless. Advanced Cardiac Life Support (ACLS) and CPR was initiated. Return of spontaneous circulation (ROSC) was achieved after one ampule of epinephrine 1:10,000 and calcium chloride. Norepinephrine was initiated to maintain blood pressure.

Our departmental RESCUE transesophageal echocardiography (Rapid Evaluation for Shock and Cardiac arrest Using Emergent TEE) protocol was initiated. Point-of-care TEE was performed intra-arrest in the ED to evaluate the chest compression vector, quality of compression, pulse check periods and to evaluate for possible cardiac or aortic pathology. The views that were evaluated were the mid-esophageal four chamber, mid-esophageal long axis, mid-esophageal bicaval and transgastric short axis (Table 1). This was followed by a sweep of the aorta first in zero degrees and later in 90 degrees. The additional views obtained in the sweeps include descending aorta short axis, aortic arch long axis, mid esophageal ascending aorta short axis, mid esophageal AV short axis, mid esophageal RV inflow-outflow, ascending aorta long axis, upper esophageal aortic arch short axis and descending aorta long axis.

TEE showed appropriate CPR vector and compression quality. Pulse check periods were minimized. Other causes of cardiac arrest such as cardiac tamponade, intracardiac thrombus, right ventricular strain, fine ventricular fibrillation and aortic dissection were ruled out. TEE was used to identify a vegetation on the tricuspid valve, presumed to be the source of sepsis leading to the cardiac arrest. Subsequent blood cultures were positive and revealed Haemophilus non-influenzae bacteremia as the source of septic shock.

Discussion
Out of hospital cardiac arrest is a leading cause of death among adults in the United States. Every year approximately 400,000 patients suffer from a cardiac arrest and 91% of these patients will ultimately expire from this event. Survival for out-of-hospital cardiac arrest with good neurologic status has been approximately 7% over the past 30 years. In comparison, in-hospital cardiac arrest survival to discharge is approximately 17%. In both cases, rates of survival to discharge are poor. No significant improvement in survival has occurred despite updates to our approach to treat cardiac arrest with ACLS. Improved outcomes will require a different approach to resuscitation of patients in cardiac arrest. This will likely require enhanced hemodynamic monitoring that will be used to guide resuscitative efforts.

The use of ultrasound in recent years has enhanced the clinician’s ability to provide critical care to patients. Rapid diagnosis and ultrasound-guided resuscitation have been proven to be useful in the delivery of appropriate care to the critically ill patient. Transthoracic
<table>
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<tr>
<th>TEE View</th>
<th>Equivalent TTE View</th>
<th>Assessments</th>
<th>TEE Image</th>
<th>TEE Simbionix® Simulator Image</th>
</tr>
</thead>
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| Mid-esophageal 4 chamber view | Apical 4 chamber  | • Pericardial effusion  
• RV function  
• MV & TV function | ![TEE Image](image1) | ![Simulator Image](image2) |
| Mid-esophageal long axis view  | PSL axis          | • Pericardial effusion  
• Aortic & RV function  
• CPR effectiveness | ![TEE Image](image3) | ![Simulator Image](image4) |
| Mid-esophageal bicaval view    |                   | • Central venous lines  
• Guidewire placement  
• Procedural guidance  
• Intravascular volume assessment | ![TEE Image](image5) | ![Simulator Image](image6) |
| Transgastric short axis view   | PSS axis          | • RV strain  
• LV function during ROSC | ![TEE Image](image7) | ![Simulator Image](image8) |

Abbreviations: LV=left ventricle; MV=mitral valve; PSL=parasternal long; PSS=parasternal short; ROSC=return of spontaneous circulation; RV=right ventricle; TEE=transesophageal echocardiography; TTE=transthoracic echocardiography; TV=tricuspid valve

**Table 1.** The four basic TEE views and assessment for pathology.
echocardiography (TTE) has been proven useful in evaluating both peri-arrest and intra-arrest patients. The ability to rapidly and accurately diagnose the cause of cardiac arrest provides the clinician an opportunity to deliver definitive treatment. The presence of a pericardial effusion or right ventricular strain on TTE provides the clinician with an opportunity to address the etiology of the arrest. Identifying cardiac standstill on the other hand, implies futility in continuing a prolonged resuscitative effort and allows resources to be re-allocated.

Although TTE may be highly useful to a clinician, there are several physical and logistical limitations to TTE that affect its usefulness. Limited sonographic acoustic windows may impair the ability to adequately assess cardiac function. In addition, prolonged breaks during CPR to allow for assessment of cardiac function hinders the resuscitative effort. The consequences of prolonged breaks in CPR cannot be overstated. Brief interruptions have been shown to reduce perfusion pressure rapidly. This often requires up to one minute of compressions to restore the perfusion pressure to its level prior to the break.

TEE offers the benefit of imaging superior to that obtained from TTE without limitations of impaired acoustic windows or pauses in CPR. From its position in the esophagus directly adjacent to the heart, the close proximity of the TEE probe allows the examiner to consistently obtain high quality image resolution. In addition, the TEE probe can be left in place during CPR to provide real-time, continuous monitoring of cardiac function without interrupting compressions. This allows for ongoing assessment of CPR quality. Improper positioning of CPR compressions may be identified by TEE images demonstrating LVOT compression. Compressions can be immediately repositioned leading to improvement in perfusion. In addition, TEE has been shown to identify fine ventricular fibrillation during pulse checks when the monitor shows asystole. This leads to a different treatment algorithm and may have a significant impact on the course of the resuscitation.

The ability of TEE to provide feedback on CPR performance in real time and potentially identify the etiology of the cardiac arrest make it an ideal tool for the clinician.

**Technique**

The TEE examination will begin immediately after probe insertion during the manual compression phase and will consist of:

1. A **focused examination** to identify the etiology of the cardiac arrest
2. **Chest compression quality** assessment and continuous monitoring throughout the code
3. **Rhythm analysis** during pulse check by real time TEE imaging

The first task of the TEE examination will be to conduct a focused examination during the manual compression phase. The focused examination has two components: A basic and advanced evaluation. The basic evaluation consists of four views to evaluate the presence of pericardial effusion, RV strain, gross valvular abnormalities and obvious wall motion abnormalities (Table 1).

We have developed a RESCUE protocol with an advanced component, which consists of eight additional views to evaluate the ascending aorta, descending aorta and aortic arch for dissection (Table 2). In addition, these views will also assess the main, right and left pulmonary artery for pulmonary emboli.

The second task of the TEE exam will be to **assess CPR quality**. Throughout the resuscitation, the mid-esophageal long axis is used to monitor effectiveness of compressions. Effective CPR will demonstrate adequate LV compression. Ineffective CPR will demonstrate poor LV compression of the LVOT / aortic valve area.

The third task to the TEE exam will be to visually evaluate the heart for organized activity during pulse checks. This will assist in rhythm analysis by identifying organized activity or fine ventricular fibrillation. If discordance between the cardiac monitor and TEE image occur, the findings obtained from TEE can be utilized. Therefore, if the monitor shows asystole, but real-time imaging shows fine ventricular fibrillation, the rhythm should be identified as v-fib and not asystole.

<table>
<thead>
<tr>
<th>TEE View</th>
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<tbody>
<tr>
<td>Mid-esophageal descending aorta short axis</td>
<td>• Assess descending aorta for dissection</td>
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<td>Upper esophageal aortic arch long axis</td>
<td>• Assess aortic arch for dissection</td>
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<tr>
<td>Upper esophageal aortic arch short axis</td>
<td>• Assess the aortic arch for dissection</td>
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<tr>
<td>• Directly visualize the pulmonary artery for massive pulmonary emboli</td>
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<tr>
<td>Mid-esophageal AV short axis</td>
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<td>• Assess overall RV function</td>
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<tr>
<td>• Evaluate tricuspid and pulmonic valve function</td>
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<tr>
<td>• Identify clot in transit</td>
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<td>• Identify pulmonary emboli in the main pulmonary artery</td>
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<tr>
<td>Mid-esophageal ascending aorta long axis</td>
<td>• Assess ascending aorta for an aneurysm or dissection</td>
</tr>
<tr>
<td>Upper esophageal aortic arch short axis</td>
<td>• Assess the aortic arch for dissection</td>
</tr>
<tr>
<td>• Identify pulmonary emboli in the main pulmonary artery</td>
<td></td>
</tr>
<tr>
<td>Mid-esophageal descending aorta long axis</td>
<td>• Assess the aortic arch for dissection</td>
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**Abbreviations:** RV = Right ventricular

*Table 2. Eight advanced TEE views and assessment for pathology.*
Risks

Transesophageal echocardiography is a non-invasive and minimal risk procedure. While significant complications may occur, a significant volume to data indicates that the incidence of these events is extremely low and the procedure is well tolerated. The potential risks of the procedure include dental trauma, oropharyngeal mucosal bleeding, esophageal mucosal bleeding, esophageal perforation, gastric perforation, cardiac dysrhythmias and respiratory distress. Although several of the previously listed complications may lead to significant patient morbidity, several large studies have documented that the incidence of these events is extremely rare.

References

Conquering the Chaos: The Key to Unlocking Your Best Possible Life

In 1995 Dr. Daniel Goldman shared his book “Emotional Intelligence: Why it Can Matter More than IQ”, with the country. His work enhanced the discussion on how low Emotional Intelligence can ruin all aspects of your life. Emotional Intelligence (EI), is equated to Emotional Quotient (EQ), which is the ability to understand your own emotions, those of others and knowing how to manage them effectively. Research has shown that high performers consistently have higher EI competency than low or even average performers do. EI has a more significant impact on success, then does IQ. Research indicates that IQ is fixed by the end of the teenage years. Even learning more facts does not increase your IQ. Fortunately, EI is learnable and measurable. Having strong EI will help you improve decision-making, performance and enhance your overall quality of your life – professionally and personally. EI is the single most significant predictor of success and excellence in life.

EI is your ability to recognize and understand emotions in yourself and others and your ability to use that awareness to manage your behaviors and relationships. EI can be thought of as having two main components - personal competencies and social and competencies. Both can be further broken down into management and awareness domains.

We all have emotions; they are natural. Emotions can be liabilities by impairing what we think, limiting our creativity and negatively affecting our health. However, sometimes emotions can be assets by motivating us, giving us purpose, providing greater insight and positively impacting our health. Being aware of your emotions and knowing how to positively manage them, allows your emotions to be more of an asset.

The first step in mastering EI is understanding your own emotions and how those emotions make you feel physically, mentally or affect the feelings of others. Self-awareness is your ability to accurately perceive your own emotions in the moment and to understand your typical responses to various situations. The most common emotions that we feel are Happiness/Excitement/Joy, Sadness, Anger, Fear, Shame/Guilt, Disgust/Contempt and Surprise. Once you know how to read your own emotions, you can learn how to manage those emotions more effectively.

Self-awareness is basically to just know yourself. You need to be aware of the full range of your feelings and monitor them while not specifically judging them as either good or bad. Throughout the day, you should do a self-check on your own emotions to determine where you are emotionally and ask yourself if you are in your “Control Zone”. If you are not in your personal “Control Zone” where you feel - in control and comfortable, figure out what is pushing you outside of your “Control Zone”. The better you understand why you are outside your “Control Zone” and what is causing it, the better able you will be to keep your emotions in check and prevent them from taking over. Learn how to become aware how your emotions affect you physically; (heart rate, respiratory rate, the tension in your muscles, temperature, the tone of your voice, posture, gestures, etc.). This is very important as you will usually notice physical changes before your brain makes you aware of any specific emotions.

The Key to Self-Awareness is the Ability to Understand Yourself.

Some proven key strategies to help master your own emotional Self-Awareness include:

1. Understanding the role of your emotions in your life.
2. Understanding your personal “Control Zone” – what it feels like to be in it.
3. Control of your irrational thought.
4. Knowing your own emotional triggers – prepare to manage them.
5. Be able to monitor your own emotional response.
6. Knowing what situations are stressful for you – be prepared.
7. Knowing you are able to manage your emotions in the moment.
8. Having mindfulness – understanding yourself and what is going on in the present moment.

Self-management is your ability to use the awareness of your emotions to stay flexible.
and direct your behavior in a positive manner⁶. Our emotions are a primary driver of behaviors which can affect our interactions with others. Once we know how we are feeling, we can then learn to manage our emotions to allow for the best interaction with others. No matter what self-management strategy you choose (and there are many), what matters most is that it works for you. Everyone will have a different strategy that will work for them. For some, controlled breathing works very well: breath in for three seconds, hold for two seconds, breathe out for five seconds, wait for two seconds, then repeat for five more times. Breathing effectively can fully calm you down and makes you feel better. This can give the mind and body a chance to reset and focus and not let your emotions take you in a place you do not want to go.

The Key to Self-Management is Being Flexible and Being Able to Behave in a Positive and Effective Way in Any Situation.

Some proven key strategies to help master your own emotional Self-Management include:⁵,⁶,⁷:
1. Controlled breathing – as above.
2. Counting to 10.
3. Saying a prayer.
4. Taking a pause before you respond.
5. Sleep on it before making a decision.
6. Smiling more.
7. Laughing more.
8. Avoid and squash negative self-talk - keeps you focused on the right stuff.
9. Visualize yourself acting the way you want.
10. Share with someone you trust and feel comfortable with that is not involved in that difficult situation.
11. Take a pause before responding by sipping on a drink.
12. Take a pause before responding by checking the time.
13. Approach every interaction with someone as an encounter where they have something valuable to teach you or you have the opportunity to help them.
14. Develop impulse control.
15. Develop flexibility – ability to adjust your emotions, thoughts and behaviors in order to adapt to any situation.
16. Be open to change – adopt the mantra that the only constant in your life is change.
17. Develop a tolerance for stress.
18. Keep an optimistic attitude.
19. Maybe saying a quiet, under your breath “special word” – in an isolated place. Reacting quickly and without much thought stokes the fire in the emotional brain. When you slow things down and focus on the encounter, it engages your rational brain. You can regain control of yourself and keep your emotions from causing a disaster.⁵,⁶. By giving yourself a little time, it helps you to self-manage by bringing clarity and perspective to the situation. Time also allows you to gain control of your emotions. By laughing and smiling more, your face actually sends signals to your brain that makes it think you are happy.

Social awareness is the skill to actually identify others’ emotions in the moment. Social awareness is looking outward to learn and understand the emotions of others. Social awareness is your ability to accurately pick up on the emotions of others and understand what is really going on with them.⁵,⁶. Being empathetic allows you to identify with other peoples’ emotions. Empathy involves being able to understand what someone else is expressing and an understanding of their point of view.⁵,⁶. We have all heard of the “Golden Rule”, which is to treat others as you would like to be treated. However, being empathetic follows the “Platinum Rule”, which is to treat others as they would like to be treated.

You can build your social awareness skills by observing the body language, facial expressions, posture, gestures, eye contact, touch, tone spoken, space and sub context of others in daily interactions.⁵,⁶. It involves being truly present in the situation and using your own senses – what you see, hear and reading your own emotions, to help you understand more fully what is going on. Being an active listener goes a long way in understanding social awareness. Active listening involves being present and genuinely being in the moment. Good active listening techniques include: focusing your attention, letting the other person finish talking before responding, maintaining good eye contact, confirming an understanding of what is said and being mindful of the nonverbal communications and tone of the person speaking. This is very important as communication is: 67% body language, 30% tone and only 3% the actual spoken words.⁵,⁶. You can improve your social awareness competency by watching others in meetings, observing EI in movies, practicing the art of listening, going people watching, learning to understand different cultures, practicing seeing the entire picture of what is going on and learning how to catch the mood of the room.

The Key to Social Awareness is Focusing on Others, Not Yourself.

Some proven key strategies to help master your own emotional Self-Management include:⁵,⁶,⁷:
1. Greeting people by name.
2. Watching and understanding body language.
3. Understanding that timing is key.
4. Always having a “back pocket” question - to help with conversation.
5. Being truly present.
6. Actively listening to what is said, how it is said, and what is not being said - to understand the hidden message.
7. Being empathetic.
8. Practicing the “Platinum Rule”.

Relationship management is your ability to use your awareness of your own emotions and those of others to manage interactions successfully. Trust is learned over time. Trust is built with open communication, willingness to share, consistency in your words, actions and behaviors. Transparency and openness help people feel valued, respected and truly part of the organization or relationship. Strong EI competency will help you manage conflicts and improve all of your relationships.³,⁴,⁵,⁶. Strong EI can prepare you to prevent inappropriate emotional responses, by recognizing your body’s response to an emotional trigger and either preventing a poor reaction, or to help quickly de-escalating one that has started in order to avoid a crisis and having to deal with the aftermath of a poor emotional response. Strong EI skills can also help influence others and build consensus. Having strong EI skills can also help enhance your team and group dynamics. It can help to motivate and inspire others and can help create a positive environment. Relationship management is about choices. The choices we make create an honest, sincere connection with other. Successfully relationship gives you the skills to make the

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View From the C-Suite

I had the opportunity to interview Dr. Brahim Ardolic, Executive Director of Staten Island University Hospital – Northwell Health, Immediate Past President of New York ACEP and previous Chair of Emergency Medicine at Staten Island University Hospital. We discussed professional development advice for the emergency physician from early career through mid-career and later. We also got a bird’s eye view into life in the C-suite.

INT: What would you recommend for a new grad, 1 to 3 years out, who is looking to get involved but is not sure where his or her interests lie?

BA: I would recommend that you expose yourself to several different things and that you are physically present. One of the mistakes new grads make is that they feel like their opportunities to get involved have to be proscribed. Some of the most important things that I did in my career were offered to me just because I was physically there. Just by being around you will get opportunities. Ask to go to meetings. Ask to see what people do. Sometimes what you think you should be doing and what you really should be doing based on your skill set may be very different things. Just be around. Get a sense of what people do and what they like and don’t like about what they do.

INT: Mentorship seems to be very important in this process. How does someone find and choose the right mentor?

BA: The easiest way to find the right mentor is to find several mentors. Put yourself in a position where you can learn from multiple people. Then you will get the mentorship that can change your life. You will need different mentors for different things. It’s not one person. You should have at least one mentor within your department, you should have one mentor in a completely different location but in a similar department and you can have a mentor who is on the same level as you who is on a totally different path. You can learn a lot from all of these people. The idea that you are going to find this one person who is going to give you everything you need – that doesn’t exist. Also, sometimes you are not going to pick the right person. So try to develop that relationship with multiple people and be flexible as time goes on.

INT: Now let’s talk about the person who is 7 to 10 years out of residency and has been doing as you suggested. How do they get to the next level?

BA: This is the hardest part. Going from being involved to being committed is very difficult. It is important to ask yourself, “Are you in the right environment where you will get the opportunity to move to the next level? Will the place you are working give you the opportunity to move up or, at least jump around until you get to the next level? Do you need to jump somewhere else to get to the next level?” It is also important to ask a mentor, are you as prepared as you think you are to move to the next level? Hopefully you have developed that mentoring group. Ask them what they think. Are there gaps you still have or are you ready to go? If the people around you feel like you are ready and you feel like you are ready, then you need to ask yourself, are the opportunities here? Or, do I need to make a change. Sometimes opportunity is not necessarily in the place that you are currently at.

INT: Can you tell us a little bit about your career? How you climbed the ladder through the various rungs to get to the position you are in now?

BA: I was always attracted to working with people I could learn the most from. I would identify that person and put myself out there and say I would do whatever it took to learn from that person. Early in my career, I was a graduating chief resident. I approached a brand new medical director in the place where I trained and I said, “I want to be exposed to you building a department. What do I have to do?” He gave me some really interesting things to do and some really not great things to do. I was willing to do the not great things to get exposed to the interesting things and to get exposed to him and give me the opportunity to learn what I could from him.

Later I was offered a job that I wasn’t totally prepared for because there was a position that someone needed to fill. I was willing to take a risk on myself. I am a firm believer in taking a risk on yourself if you have a golden opportunity. There is no perfect time to take a job. If you wait for the perfect time to take a job, you are going to be waiting a very long time.

When I took the job as the director at Staten Island, I knew I wasn’t really prepared to run the finance side of a department. But I was willing to learn. So I taught myself accounting. Someone asked me for an ROI and I didn’t know what it was. So I had to learn it.

Going into the Executive Director job, it was really scary because you don’t know what you don’t know, and you don’t know what kind of skills the people around you have in terms of skills you don’t have. But at the same time, if you are smart enough to get into an EM residency, you are smart enough to learn what you need for most of these jobs. You just have to be willing to take that risk on yourself,
you have to be willing to fail, and you have to be willing to learn what you need.

The other thing that really helped in my success is, I have always been a firm believer in the small victory. Whenever I have taken a job, I decided early on, “What do I know I can fix so people see I know what I’m doing?” Analyze what is not going well and what you can improve on. When I went into the Director job at Staten Island, I did some basic math and I figured out there was a giant hole in the finances of the department and I fixed it. That bought me more time to figure out the things I didn’t know how to do. Identifying early wins and things you can fix quickly is critical. This is one of the things I tell everyone going into a new role. For example, if you are going into a new place as a residency director, find what you are going to fix. Are you going to improve the board passing rate? Are you going to improve conference? Are you going to put more into your Chief Residents? If you are going into a quality position, are you going to put together a more forward facing quality program? Are you going to give your doctors more say in the quality process? If you are going to be a new director, are you going to fix your door to doctor time? Are you going to fix your RVUs per doctor? Find a simple thing that you are going to focus on as your first project that is going to show people you know what you’re doing. First impressions for a leader are ridiculously important. These have been the guiding principles for me.

I also feel you should go in with a very high expectation level and be willing to dial it down over time. It is very difficult to increase your expectation level as time goes on. Once people think you are okay with something, it is much harder to say you’re no longer okay with it and it has to get better. It is much better to start off more stringent and relax the rules as time goes on than the other way around.

INT: Can you tell us one or two things that a hospital CEO wishes every emergency physician understood

BA: I think the hospital CEO would love the ED to fully understand how admitting the right person affects the perception and economic outlook of the hospital. STAR rating has become so incredibly important for a hospital. Everyone on the hospital side understands that readmissions are not the ED’s fault. But if the ED works together with the rest of the hospital as a team to find a solution, maybe we can provide better care. Maybe it is better out-patient resources. Maybe it is a short observation stay. If you are able to collaborate with your in-patient peers and understand that we are all in this together, that would be incredibly important.

Another thing is to understand where the ED stands in terms of the total input and output of the hospital. Every ED leader fully understands the input and output of the ED. But I don’t think they always fully understand how that relates to the input and output of the hospital and how the ED fits into that together with other services such as ambulatory surgery, labor and delivery, etc. Understanding the dynamics of that and how it all fits together and how we can work together is absolutely critical.

That said, the ED sees the downstream bad effects of a poorly run hospital more than the other way around.

INT: I presume it is easier for you to see that perspective being an EM physician yourself. I presume not everyone in your seat would see it the same way.

BA: I think it is getting better. Here’s an example. Everyone talks about seven day a week hospitals and people act like they invented bread. I don’t know why this is so shocking for people to understand. “Here’s an idea. Let’s put a doctor here on the weekends so more patients get discharged.” You hear people say this more and more, that we need to have seven day a week hospitals. And in principle that sounds great. But, there are certain things we will never get to by ourselves. Approximately 40% of patients go home with some kind of service. That may be a nursing home, home visits, home oxygen. Those things can’t be delivered on weekends. The reality is, if you could get your weekend discharges to two-thirds of what they are on a weekday, then you have done a really great job and many of the issues that EDs are facing will go away.

INT: Any final advice for our readers?

BA: One: Find a job that you love doing that you enjoy almost as much as your favorite thing to do in your personal life.

Two: Surround yourself by people that will help you get there. Go work for people that you like working with and that are giving you what you need to get to the next level. At the same time, make sure you are giving them what they need so they can help you and you can help them. It is a two-way street.
New York ACEP gave me the terrific opportunity to attend the ACEP Leadership and Advocacy Conference (LAC) in Washington D.C. recently. I have been involved in the Government Affairs group in New York ACEP and have been to Albany several times now for the New York ACEP Lobby Days. In the past, this has been a great experience and has taught me about the legislative process and how we can impact this to advocate for our patients and our specialty. This is one of the most important aspects of our careers and I feel that these experiences have been one of the most influential aspects of my residency. Attending the LAC conference in D.C. was an opportunity to take these lessons to the national level.

The first couple days of the conference offered an opportunity for lectures both on leadership and policy issues facing emergency medicine. The leadership presentations were especially beneficial as I am very early in my career and I learned many lessons going forward. While I was familiar with the policy issues from New York ACEP, it was interesting to hear how other state chapters have been affected and some of the innovative solutions that have been produced. National ACEP gave us a great framework for presenting these ideas to legislators and how to effectively advocate. Increasing access to mental health care and protecting patients from balanced billing were the two largest topics we were able to cover. We heard frequently at the conference that New York was a model for protecting patients from balanced billing and this was a source of pride for New York ACEP.

We then were able to go to the Hill to advocate for our specialty and patients. New York had a large delegation, showing that our physicians are heavily involved in the specialty. Meeting with the legislative assistants and directors for our State’s senators and representatives was informative and I learned more about how national politics can affect our specialty. We also met with Representative John Katko, which was terrific. At the end of the day I left feeling like ACEP and New York ACEP had helped improve our patients’ care.

I look forward to continuing to advocate for our specialty and patients and cannot thank New York ACEP enough for this opportunity and the many they have given me in the past as well.

As a recipient of New York ACEP’s Resident Leadership and Advocacy Award, I had the privilege of attending my first ACEP Legislative Advocacy Conference (LAC) and Leadership Summit in Washington, D.C., May 5-8, 2019. While I had done advocacy and social justice work at a local, grassroots level (from signing people up to vote at my alma mater UC Berkeley to joining numerous protests, marches and walkouts), I did not understand how advocacy at a national policy level worked. During LAC, we spent a day lobbying two main ACEP causes: 1) ending surprise medical billing, and 2) introducing measures to assist with psychiatric boarding in the Emergency Department (ED).

I was amazed that shortly after our lobby day, bills to address both of these issues were introduced in Congress. This was my first time lobbying in Washington D.C. and I realized the true value of doing this work – it does make a difference. Most legislators are not aware of the issues that we want addressed from a healthcare perspective. They care; it’s just that they have so many issues to deal with. When someone talks to them, shares personal stories and explains the issue and a potential solution, it gets our legislatures to start thinking about the changes we want. This was especially effective because we were backed by a large, reputable organization such as ACEP.

After this conference, I have a much better idea of how change at a national level happens. I appreciate all of those that work year-round in preparation for this conference and to create change in general. I am inspired to continue doing this work!
The Scientific Assembly

“... an exceptional event at a first-rate location.”
If Equipped and Trained: Updates to the Statewide BLS Protocols and the Collaborative ALS Protocols

The New York Statewide Basic Life Support protocols have been updated over the course of the last year. The last comprehensive update to this foundation for New York’s diverse EMS community occurred during the Pataki administration in the 1990s! Since that time the world has drastically changed... and so has medicine.

As the writing group worked on this update, we focused on establishing a document that would facilitate both ongoing development as future updates are needed and medicine advances, as well as how to best guide care across our wonderfully diverse state. New York State’s (NYS) EMS varies from one of the busiest systems in the world to places where there are only a few emergencies each year. We have volunteers and career providers, commercial and municipal agencies, EMS organizations at ski slopes and special event venues, squads that run primarily for college campuses and religious communities, and even park rangers, fire departments, and law enforcement agencies that fulfill a dual role in the provision of EMS. Establishing a single document that outlines practical and effective treatment guidelines for these and many other contexts was a challenging undertaking. The unifying principle that helped fuel the process was the pride each of these groups bring to the professional practice of emergency medical services and the passion all EMS providers share for quality patient care.

Overarching Concepts

The writing group working on the protocol revision was made up of educators, EMS providers, nurses, researchers and doctors. They came from Long Island, New York City and even “Upstate”! Each brought a different perspective to the team. The State Emergency Medical Advisory Committee (SEMAC) previously voted to use the National EMS Scope of Practice Model (NSoPM) promulgated by the National Highway Traffic Safety Administration (NHTSA) as the template for our protocols. The writing group picked up from there. Understanding that the National Scope of Practice Model establishes a minimum skill set for each level, we identified instances in which NYS required something beyond what this model prescribed. For example, NYS allowed naloxone administration at the basic EMT level prior to its addition to the NSoPM.

Points of Discussion

There were several areas of the protocols that led to enthusiastic discussions. Most of these discussions centered around the concepts of scope of practice, protocol and operational implementation. Available resources and medical care needs differ among the diverse regions of the state. To help address this variability we chose to use the term “*if equipped and trained*” in certain parts of the document to allow agencies to provide the care appropriate for their territory, region or community. In effect, the use of this term establishes de facto protocol “options” of which individual regions could govern when and how these treatments and other interventions would be implemented. This empowered the usage of these “options” in the areas that required them without mandating other areas to undertake expensive equipment acquisition or an excessive training burden if there were other effective ways of addressing the need. These decisions would be based on medical and operational considerations under regional program agency authority in conjunction with the regional medical director.

Epinephrine for Anaphylaxis*

There is no doubt that the rapid administration of epinephrine (epi) can be life-saving in cases of anaphylaxis. The operational considerations that are key though, would be where that epi should be carried, how much should be carried and who should be equipped with the medication. Traditionally, BLS personnel have used epinephrine auto-injectors (EAI), but recently there was a program in NYS that taught BLS providers to administer epi via a specialized syringe. This was subsequently expanded by an act of the Commissioner to include the use of a standard syringe. While the delivery of epi via a standard syringe by BLS potentially confers huge cost savings on EMS systems, maintaining the level of training to assure all BLS providers can safely administer medication by syringe may be difficult for some agencies. In addition, it may be unreasonable or unnecessary to implement and maintain BLS syringe epinephrine capabilities in programs that exclusively provide interfacility transfers or work with other rapidly responding personnel with additional resources. For certified first responder (CFR) agencies, equipping personnel with EAI may be a prohibitive expense for very rare implementations. Anaphylaxis deaths following a 911 call are rare.
The incidence of hospitalization from anaphylaxis is about 25 per million and the death rate is less than 1 per million per year (https://www.ncbi.nlm.nih.gov/pubmed?term=24332862). These are the medical and operational factors that need to be considered by agencies, regions and medical directors when making judgments regarding the implementation of “optional” protocol components.

An interesting twist with EAI though – there are bills introduced periodically that require these devices on ambulances or fire apparatus and, in some cases, to be carried by police officers. These well intentioned legislative efforts highlight the importance of New York ACEP’s political advocacy, as these have not led to the legislation of medicine - it would be easy for a law to be written that would unnecessarily burden public safety with a mandate where there was no public health need. This year, bills (S3247/A1024B) were passed to allow police officers to carry EAI. ACEP members suggested that the language within the bill be modified from “must carry” to “may carry” and the change was made by the bill sponsors. This seemingly minor semantic modification prevented significant downstream consequences while still allowing police officers and firefighters in cities of less than 1 million people to possess and administer EAI (for a variety of political reasons, police officers and firefighters in New York City (NYC) are excluded from the bill - sorry NYC!). Assuring that well meaning legislation does not adversely impact the practice of EMS medicine is one important role that ACEP will continue to pursue.

BLS CPAP*

In emergency medicine we have rapidly adopted the use of non-invasive positive pressure ventilation for use in patients who are in respiratory distress. This has led to a decrease in intubation rates and improved patient outcomes in the emergency department. Likewise, we have seen a remarkable effect when this intervention is applied in the EMS setting (traditionally by ALS providers) and now the use of CPAP is an option for the BLS provider as well. However, as with epinephrine, there will be places where training and equipping staff may not make prudent operational sense in the context of the resources available in that community.

Albuterol*

Asthma, and other processes that involve bronchospasm, impacts a large portion of the population. The administration of albuterol by nebulizer is a simple intervention that can make a rapid and drastic difference for a patient in respiratory distress. Some EMS systems allow BLS providers to administer albuterol but chose not to equip BLS-only ambulance units with the medication. The decision whether to carry medications on the responding BLS units is affected by many factors and should be made by the medical director in conjunction with the management of the agency and the REMAC (Regional Emergency Medical Advisory Committee).

Hemostatic Dressings

QuickClot® and Celox® are among the hemostatic agents currently being marketed to EMS and the general public. They may be used by any EMS provider following manufacturers’ guidelines and training. They are not required to be carried by protocol, however regions may choose to compel agencies to carry them.

Updates to the Collaborative ALS Protocols

The Collaborative Protocols have been developing in NYS since 2007. Initially, there was merely a tacit arrangement between several regions in the eastern part of the state. As time passed, more regions across upstate New York joined and the process became more formalized. We now have only four sets of protocols governing advanced life support care in NYS: Suffolk, Nassau, NYC and the Collaborative. Work on the Statewide BLS Protocols has established and strengthened collaboration and communication among all regions and there has been interest in expanding the collaborative group to include the other three regions in a common set of ALS protocols.

The Collaborative Protocols are aptly named; the 15 REMACs that currently participate in this process work together on a “one region - one vote” team. Each REMAC appoints a representative to carry their vote. As the REMAC is responsible for issuing protocols and only physicians can vote at the REMAC, ultimately any vote is conducted by the physician REMAC representatives.

Participants on the Collaborative Committee include EMS providers (including EMS physicians), other physicians, educators, administrators, pharmacists and nurses. This group represents volunteer, municipal, commercial and hospital based EMS, as well as community and academic hospitals. Because the process is truly a collaboration nearly everything is achieved by consensus; the lack of contention speaks to the professionalism, character, and expertise of those who comprise the committee. We both have the pleasure of serving as Co-Chairs of the Collaborative Protocol Committee.

Major ALS Updates

Pain Management

Several additions have been made to the pain management medication formulary although all of these additions are included as “*if equipped and trained” options. In light of the interest in decreasing exposure to opioids these are particularly notable opportunities for agencies and regions to consider implementing these alternatives.

Ketorolac administration for pain has been moved to standing order at a dose of 15mg IV or 30 mg IM. Previously, Ketorolac has been restricted to physician option. In light of the recent paper highlighting efficacy at lower dose, therefore decreasing potential complications, it has been moved to standing orders (https://doi.org/10.1016/j.annemergmed.2016.10.014).

Ibuprofen has been added an option for both antipyresis and for pain management. If it is carried, it must be as a single patient dosing liquid. This is because there is no practical provision for a separate liquid to facilitate the taking of oral medication and multidose containers have little place in the EMS setting.

Acetaminophen has also been added both for fever and pain. Like ibuprofen, if it is carried, it must be as a single patient dosing liquid. Acetaminophen comes in 10ml single dose containers that contain 162.5mg/5ml; these are optimal for use in an EMS environment.

Questions That Remain an Active Part of Our Discussions:

**Pressors:** Dopamine was removed from the Collaborative Protocols in 2014 in part because of the complexity of dosing and administration, as well as rarity of use. Most importantly, it had fallen out of favor as a first-line pressor throughout critical care medicine. Norepinephrine was substituted because of simplicity of administration, ease of dosing, and the Surviving Sepsis Guidelines indicating it was the best first-line pressor. Currently use of any pressor is a rare event across the state and
we will continue to watch for the optimal medications to assure protocols reflect the needs of patient care across the state.

Intubation: Airway management has evolved significantly over the years. An active area of discussion surrounds the practice of endotracheal intubation by the Advanced (AEMT) provider. Previously, the EMT-Intermediate level in NYS included limited endotracheal intubation. Currently, the National EMS Scope of Practice Model includes the use of extraglottic/supraglottic airways (SGA) at the AEMT level but not endotracheal intubation. We will watch the data and assess the impact of endotracheal intubations by AEMTs across the state to help determine the most appropriate methods of airway management at this level. This question will be addressed by the SEMAC and the resulting solutions implemented in the protocols.

Conclusion

Emergency medical care is not static. There must be a process in place to assure updates in care as indicated by relevant scientific evidence, sound clinical judgement and needs across the state.

Our EMS system is governed by Article 30 of the State of New York Public Health Law. Article 30 grants local (regional) control of the development of ALS protocols, yet requires SEMAC approval of those protocols. The collaborative process has allowed us to optimize care and coordinate efforts across much of NYS. Local REMACs may make changes to their formulary based on medication shortage and some local need, if required, to support medical care but must then report these changes to the SEMAC.

In contrast, the BLS protocols have been the responsibility of the State, rather than the regions, and have traditionally existed largely independent of the vary ALS protocols. These two sets of protocols are now coordinated to assist with the care across all levels of providers.

As EMS in New York State continues to grow, we learn from our collective experiences. Our diverse working group allows dedicated and knowledgeable leaders in EMS medicine to continue to shape the development of the practice. Many are connected to national and international groups which allows for insight and perspective from well beyond the borders of NYS. This is an exciting yet challenging time for EMS. Resources are progressively limited and the medicine continually evolves. We intend to meet those challenges and provide the best possible EMS care for the patients in NYS. To that end, we will continue our efforts to improve the process of protocol development seeking input beyond the committee members. Feedback and contributions from field providers is especially vital. Our task is to continually evaluate the dynamic scientific, clinical, practical, fiscal, operational and other factors to provide the best set of guidelines that protect our patients and empower our providers across the entire State of New York. The protocol development is the ongoing effort of a team. Thanks to all for your support.

New York Statewide Basic Life Support Adult and Pediatric Life Support Treatment Protocols

New York State Collaborative Advanced Life Support Adult and Pediatric Treatment Protocols

President's Message - continued from page 2

There was a bill that would allow Off-Campus Emergency Departments to operate on less than a 24-hour basis. We did not feel something called an Emergency Department should be allowed to operate on banker’s hours and were able to defeat that as well.

Now, how would you like it if when a patient came in to the ED with an over dose, you were required to notify the prescriber of the patient that just overdosed? Sound like fun? I don’t know about you, but most of my overdoses don’t have a “prescriber”…thankfully, we defeated that misguided bill.

Or how about this, you would be required to log in to the Prescription Monitoring Program (PMP) to report the patient, the time, and place of naloxone administration. Every naloxone administration. Yeah, we defeated that legislation as well since it is simply not reasonable or practical to expect of emergency physicians and would further delay us from doing what really matters – sitting down with our substance use disorder patients and identifying options to help them.

No doubt we like the PMP to be able to figure out folks that are narcotic shopping, but let us face it, the interface is awful and I do not need to check it for ten pills of OxyIR after Father Mulcahy falls off the pulpit and breaks his wrist (if I prescribe it at all!). We were again successful in defeating a State Budget proposal that would have eliminated the ED exemption for consulting the PM for controlled substance prescriptions that do not exceed five days.

Friends, this is not the first year, and it will not be the last, that our representatives try to legislate the practice of medicine. So for every Action Alert or dollar you give to the New York Emergency Medicine Political Action Committee, you are helping yourself practice the science and art of medicine, so I thank you for what you have done, and ask you to keep it up.

All of what I have shared is the result of your efforts: The collective wisdom, voice and energy of emergency physicians in New York. I am so thrilled to see so many initiatives being offered by members, and being able to offer NYour ACEP support of them. This speaks to your love of the specialty and your willingness to share your time and talents, and sometimes even your treasures, with the rest of us. So as I look back on the year I would most of all like to say thanks. Thank you for being a New York ACEP member. To my fellow Board members, I am humbled by your commitment and dedication to your patients, your colleagues and this specialty. To all of you that are members of Committees – Education, EMRC, EMS, Government Affairs, Practice Management, Professional Development and Research – I thank you for engaging New York ACEP and making this specialty what you want it to be – without your efforts none of our achievements would be possible. Lastly, you would never know it, but this entire organization runs on the extraordinarily strong backs and broad shoulders of two of the most humble servants to emergency medicine you probably don’t know – Timothy Pistor, and JoAnne Tarantelli – thank you for all you do for New York ACEP and the membership, we are extremely fortunate for your work on our behalf. Here is to another great year ahead!
3 WAYS WE CAN HELP!

1. HIV GUIDELINES ONLINE
   WWW.HIVGUIDELINES.ORG
   Access HIV clinical guidelines for adult and pediatric care, mental health and substance use, pre-exposure prophylaxis and more!

2. CEI LINE
   1.866.637.2342
   Access to a specialist to discuss case-based HIV, HCV, STD, PEP or PrEP patient care.

3. FREE CE ONLINE
   and other educational resources
   WWW.CEITRAINING.ORG
   Earn CE credit at your leisure and stay abreast of HIV, HCV, STD, PEP and PrEP clinical updates.
The 2019 Scientific Assembly at the Sagamore Resort featured expert faculty members: Sally Bogoch, MD; Brenna M. Farmer, MD FACEP; Ken Milne, MD MSc CCFP-EM FCFP FRRMS; Anand Swaminathan, M FACEP and Reuben J. Strayer, MD FACEP MD who wowed 330 emergency physicians from around the state. Thirty-five 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 members, Dara Kass, MD FACEP was presented with the 2019 Advancing Emergency Care Award. Penelope C. Lema, MD FACEP was presented with the Physician of the Year Award. Earlier this year Michael A. Granavsky, MD CPC FACEP received the Outstanding Contribution to Emergency Medicine in New York State and Robert Delagi, MA NREMT-P received the Michael G. Gutenberg Outstanding Contribution to EMS Award. For more information on these awards, visit New York ACEP’s website.

Leadership Elected
Congratulations are extended to the newly elected Board members: Robert Bramnate, DO FACEP, Good Samaritan Hospital Center; Penelope C. Lema, MD FACEP, NewYork-Presbyterian Columbia; Laura Melville, MD, NewYork-Presbyterian Brooklyn and Joshua Moskowitz, MD MBA MPH FACEP, Jacobi/Montefiore Medical Center.

New Speaker Forum
Congratulations to Joel Park, MD MS FACEP NewYork-Presbyterian Weill Cornell, recipient of the award for best presentation for Machine Learning and Artificial Intelligence in Medicine.

Research Forum Winners
Tuesday’s program included the Research Forum featuring oral and poster presentations. Congratulations to the following research presenters who took the annual award in their category.

Oral Presentation
- Comparing Oral Ibuprofen and Acetaminophen to Either Medication Alone for Managing Acute Pain in Pediatric Emergency Department
  Aidin Masoudi, MD, Maimonides Medical Center

Poster Presentations
- Randomized Double-blind Trial Comparing 3 Doses of Oral Ibuprofen for Management of Acute Pain in Adult Emergency Department Patients
  Aidin Masoudi, MD, Maimonides Medical Center
- IPASS as a Handoff Tool Between Emergency Medical Services and ED Triage Nurses
  Tess Studholme, BSN RN, Maimonides Medical Center
- Risk Stratification of Older Adults Who Present to the Emergency Department With Syncope: The FAINT Score
  Marc Probst, MD MS F ACEP, Mount Sinai Medical Center
- Development of a Novel Rapid Outpatient Strategy for TIA and Minor Stroke Patients
  Bernard Chang, MD PhD FACEP, Columbia University Medical Center

Mount Sinai took the Crown in the 5th Annual Resident Volleyball Challenge
Nine residency programs competed for bragging rights in the Scientific Assembly volleyball tournament.
SCIENTIFIC ASSEMBLY HIGHLIGHTS

Residency Volleyball Challenge
July 10, 2019
Sagamore Resort on Lake George

2019 Volleyball Champions
Mount Sinai
From Cali to Long Island: Tales from a Transplanted Resident

Christine Ahn MD is an attending physician and assistant program director at Stony Brook Medicine, in Long Island. She completed her medical school training at University of Southern California, residency at Stony Brook, and now happily resides in the nearby town of Se-tauket with her family. In between driving to practices and feeding her voracious children she dreams of hiking in the mountains and enjoys landscape photography.

I still remember with distinct clarity the shock I felt when opening my match letter over ten years ago. In all honesty, while I was excited about the program itself, my heart sank when I saw that I would be spending the next several years on the other side of the country, away from my friends and family. Having spent most of my life in warm and sunny Southern California, living within an hour’s reach of my well-meaning but overbearing parents and at arm’s reach of delicious tacos in Los Angeles, I could not fathom moving away, but there it was on the paper in front of me.

Two months later, I packed up my belongings and headed to Long Island, where I found an apartment, got myself setup, and dug into the rigors of internship. I am eternally grateful to have been a part of a welcoming class and quickly made friends with my fellow interns. The majority of them had spouses or partners, and most all of them were from New York or neighboring states. But we quickly bonded over our trials and tribulations and were united in our feelings of ineptitude as we were faced with learning how to become a doctor, while learning the ins and outs of a complex hospital system with all its quirks.

However, outside of the hospital, I struggled to find my place in the cultural landscape of Suffolk County. Coming from Los Angeles where Asian Americans abound, moving to Suffolk County was somewhat jarring, even for me. Back home, I was an oddity—coming from a Korean-American household—in that I hardly spoke my parents’ native tongue and had always been somewhat of a cultural nonconformist, compared to my similarly aged Asian peers who acquiesced to the expectations of their families and communities. But even I couldn’t help but notice the difference when I found myself surrounded by a population that was for the most part well-meaning, albeit somewhat lacking in terms of cultural awareness. I found it amusing when people assumed I could speak Chinese, or asked me how to make General Tso’s chicken.

My understanding and awareness of the Long Island culture grew over time, as I learned to appreciate the beauty of the island and I have come to see Long Island as a wonderful place to live, and continue to live here and am happily raising my family here.

The working environment I found during residency was key to my transition in calling Long Island home. While I initially felt trepidation at the idea of going to residency so far from the support of friends and family, that feeling dissipated after the first few months of adjustment. Perhaps if I were in a less supportive program and had not bonded with my peers I would have felt differently, but I was lucky to form friendships with people whom I still consider good friends to this day. In retrospect, I realize that my peers were likely making a point of reaching out to make sure the displaced out-of-towner was as welcome and comfortable as possible. Those simple gestures made a huge difference in my well-being and I have done my best to extend similar to residents and new faculty alike.

In addition to having the opportunity to learn to appreciate and love a completely different cultural and geographic location, another benefit from moving across the country is that I now have professional connections to both sides of the country. There are a handful of greats in emergency medicine situated in various academic institutions nationwide, who are applauded and celebrated and whose words, sayings and explanations become part of the liturgy of our practice. I have had the honor of finding such mentors in California during my medical school training and have since gotten the opportunity to rub elbows with others in the Northeast as well.

Likewise, many of those who I knew and joked around with in medical school have gone on to become amazing clinicians, fellowship directors, company starters and owners and members of residency leadership in California. I had the privilege of spending time with them during their formative years and planting seeds of kinship which have grown and developed in ways I could never have imagined or projected. This has come in handy multiple times in my career and I am grateful I have this resource on the west coast.

The same is true of the many residents and fellows I have had the honor of educating and learning from during my time in the East. Without fail many of them go on to assume academic positions at fine institutions spanning the East and South, assuming leadership roles, and become renown prolific writers and respected leaders in the twitter world and blogosphere. At this stage in my career I am watching the world grow up around me and transform into young leaders of our profession and finding my network field in the East has blossomed and flourished.

Therefore, to those who are starting afresh in a new and unknown land, whether a new resident or attending, I encourage you to lay your fears aside and step outside and enjoy the activities around you, as different as they might be from what you are used to. Push yourself to talk to those around you, listen to their stories, and you will find your time and experiences will benefit you professionally and personally if you allow it.
Emotional Intelligence Plays a Critical Role in Successfully Achieving a Happy, Healthy and Productive Personal and Professional Life⁶,⁷.

So how do you go about improving your own personal EI? The best way is to start by making a plan.

1. Take an EI assessment to determine your baseline level of competence in each of the four domains; Self-awareness; b. Self-management; Social Awareness; d. Relationship Management.
2. Select one Emotional Intelligence domain to work on and determine three tactics to improve that specific EI domain.
3. Start a journal to help guide and track your Emotional Intelligence journey.
4. Seek out and develop relationships with others that seem to have strong levels of success in the specific EI domain you have chosen to personally improve.
5. Make sure to take care of yourself.

Taking Care of Ourselves – Crucial for Strong Emotional Intelligence.

There is a strong relationship between what and how we think and how we feel both physically and emotionally⁴. In order to have the best EI skills, you also need to make sure that you take care of yourself. Some proven key strategies of self-care include:

1. Get adequate, restful sleep every night – THE MOST IMPORTANT.
3. Don’t hold grudges.
4. Check in with yourself throughout the day to be self-aware of your emotions.
5. Quash negative self-talk.
6. Do daily exercise or physical activities.
7. Do something you like doing: (Knit/crochet, listen or perform music, watch or play sports, take a walk, enjoy nature, play with your pets, spend time with your family and friends, etc.)
10. Unplug for at least 15 minutes a day to give your mind a rest, with time to think and avoid distractions.
11. Find a balance in life – work, family/friends, self.
12. Be optimistic – look for the brighter side of situations and life.
13. Maintain a positive attitude – even when faced with adversity.
14. Be Happy – enjoy yourself, others and your life.
15. Find a way to have fun every day.

The Most Important Thing That We Can Do to Help Ourselves is to Ensure Adequate, Restful Sleep.

There are many things we can do to reach that goal: a. try to get into a regular sleep cycle (as often as we can); b. keep the computer out of the bedroom (don’t make your bedroom just another office); c. try to keep the TV out of the bedroom too; d. stop caffeine use in the early afternoon; e. try to wake up to sunshine (when we can); f. sleep in a dark environment, etc.

The next most significant piece of self-care is managing our own stress. Unmanaged stress consumes much of our mental resources. While under stress, many people lose their EI skills, probably at the time they need them the most³.

Just like learning a new sport or a musical instrument, mastery of your own EI will take practice. However, unlike learning the new instrument or a sport; learning to master your own EI will allow you to improve all aspects of your life and truly become your best total self – professionally and personally.

Now it is up to you to embrace your own personal EI journey - good luck and enjoy the ride!

References
The treatment of severe agitation, aggression, and violent behavior in behavioral health patients who present to the emergency department (ED) often requires the intramuscular administration of a sedative. However, administering an intramuscular sedative to an uncooperative patient is associated with the risk of needlestick injuries to both patients and health care providers, and times to onset of sedation range from 15 to 45 minutes. Intranasal absorption is more rapid than intramuscular, with sedatives such as lorazepam reaching peak serum concentrations up to six times faster when administered intranasally. We present the first report of using intranasal lorazepam as a needle-free method of providing rapid and effective sedation to treat severe agitation in a pediatric behavioral health patient presenting to the ED.

Effect of New York State Electronic Prescribing Mandate on Opioid Prescribing Patterns.


BACKGROUND: Drug overdose was the leading cause of injury and death in 2013, with drug misuse and abuse causing approximately 2.5 million emergency department (ED) visits in 2011. The Electronic Prescriptions for Controlled Substances (EPCS) program was created with the goal of decreasing rates of prescription opioid addiction, abuse, diversion, and death by making it more difficult to “doctor-shop” and alter prescriptions.

OBJECTIVE: In this study, we describe the opioid-prescribing patterns of emergency physicians after the introduction of the New York State EPCS mandate.

METHODS: We conducted a retrospective, single-center, descriptive study with a pre-/post-test design. The pre-implementation period used for comparison was April 1-July 31, 2015 and the post-implementation period was April 1-July 31, 2016. All ED discharge prescriptions for opioid medications prior to and after the initiation of New York State EPCS were identified.

RESULTS: During the pre-implementation study period, 22,221 patient visits were identified with 1,366 patients receiving an opioid prescription. During the post-implementation study period, 22,405 patient visits were identified with 642 patients receiving an opioid prescription. This represented an absolute decrease of 724 (53%) opioid prescriptions (p < 0.0001), which is an absolute difference of 2.3% (95% confidence interval 2.0-2.6%).

CONCLUSIONS: There was a significant decline in the overall number of opioid prescriptions after implementation of the New York EPCS mandate.

PROMIS Physical Function 10-Item Short Form for Older Adults in an Emergency Setting.


BACKGROUND: Functional status in older adults predicts hospital use and mortality, and offers insight into independence and quality of life. The Patient-Reported Outcome Measurement Information System (PROMIS) was developed to improve and standardize patient-reported outcomes measurements. The PROMIS Physical Function (PROMIS PF) 10-Item Short Form was not created specifically for older adults. By comparing PROMIS with the Katz Index of Activities of Daily Living (Katz), we evaluated PROMIS for measurement of physical function versus general function in an older adult population seen in the ED.

METHODS: Prospective, convenience sample of ED patients 65 years and older (from 1/1/15 - 6/30/15) who completed Katz and PROMIS PF. Both were compared for scoring distributions and conventional scoring thresholds for severity of impairment (e.g. minimal, moderate, severe). We assessed convergence through Spearman correlations, equivalents of conventional thresholds and ranges of physical function, and item-response frequencies.

RESULTS: A total of 357 completed both function surveys. PROMIS PF and Katz have modest positive correlation (r=.50, p<.01). Mean PROMIS PF scores within Katz scoring ranges for minimal (43, SD=10), moderate (32, SD=7), and severe (24, SD=7) impairment fell within respective PROMIS PF scoring ranges (severe=14-29, moderate=30-39, mild=40-45), indicating convergence. PROMIS identified impairment in 3x as many patients as did Katz, as PROMIS assesses vigorous physical function (e.g. running, heavy lifting) not queried by Katz. However, PROMIS does not assess select ADLs (e.g. feeding, continence).

CONCLUSIONS: There is modest correlation between PROMIS and Katz. PROMIS may better assess physical function than Katz, but is not an adequate replacement for assessment of general functional status in older adults.

The Effect of Pay-for-Performance Compensation Model Implementation on Vaccination Rate: A Systematic Review.

Benabbs R, Shan G, Akindutire O, Mehta N, Sinert R; Department of Emergency Medicine, State University of New York Downstate Medical Center, and Department of Emergency Medicine, Kings County Hospital Center, Brooklyn, New York; Qual Manag Health Care. 2019 Jul/Sep;28(3):155-162.

BACKGROUND AND OBJECTIVES: Pay-for-performance (P4P) is broadly defined as financial incentives to providers for attaining prespecified quality outcomes. Providers, payers, and public officials have worked over the years to develop innovative solutions to rapidly and consistently bring new diagnostic tests and therapies to our patients. P4P has been instituted in various forms over the last 30 years. Vaccines are one of society’s greatest public health innovations and vaccination programs provide a unique opportunity for P4P programs. We attempted to investigate the effect of P4P compensation model implementation on the vaccination rate.
NEW YORK STATE OF MIND

METHODS: Utilizing a systematic review and meta-analysis approach, we searched PubMed, Embase, Scopus, and Web of Science from inception to December 2018.

RESULTS: Nine articles were included with poor to moderate quality. Improvements in vaccination rates after implementation of P4P were statistically significant in eight of nine of studies. However, due to the heterogeneity of the methods used, we could not pool the data.

CONCLUSION: The results of this systematic review indicate that the implementation of P4P programs can increase the vaccination rate. In recent times when it has become increasingly more popular not to vaccinate, implementing P4P becomes even more important if it is shown to be an effective tool in increasing vaccination rates.

Epidemiology of Community-Onset Staphylococcus aureus Bacteremia.

Yarovoy JY, Monte AA, Knepper BC, Young HL; Upstate Medical University, Department of Emergency Medicine, Syracuse, New York; West J Emerg Med. 2019 May;20(3):438-442.

INTRODUCTION: Staphylococcus aureus bacteremia (SAB) is the second-most common cause of community-onset (CO) bacteremia. The incidence of methicillin-resistant S. aureus (MRSA) has recently decreased across much of the United States, and we seek to describe risk factors for CO-MRSA bacteremia, which will aid emergency providers in their choice of empiric antibiotics.

METHODS: This is a retrospective cohort study of all patients with SAB at a 500-bed safety net hospital. The proportion of S. aureus isolates that were MRSA ranged from 32-35% during the study period. Variables of interest included age, comorbid medical conditions, microbiology results, antibiotic administration, duration of bacteremia, duration of hospital admission, suspected source of SAB, and Elixhauser comorbidity score. The primary outcome was to determine risk factors for CO-MRSA bacteremia as compared to methicillin-susceptible S. aureus (MSSA) bacteremia in patients admitted to the hospital through the emergency department.

RESULTS: We identified 135 consecutive patients with CO-SAB. In comparison to those with MSSA bacteremia, patients with MRSA bacteremia were younger (odds ratio [OR] 0.5, 95% confidence interval [CI], 0.4-0.7) with higher Elixhauser comorbidity scores (OR 1.4, 95% CI, 1.1-1.7). Additionally, these patients were more likely to have a history of MRSA infection or colonization (OR 8.9, 95% CI, 2.7-29.7) and intravenous drug use (OR 2.4, 95% CI, 1.0-5.7).

CONCLUSION: SAB continues to be prevalent in our urban community with CO-MRSA accounting for almost one-third of SAB cases. Previous MRSA colonization was the strongest risk factor for current MRSA infection in this cohort of patients with CO-SAB.


BACKGROUND: Asthma hospitalizations are an ambulatory care-sensitive condition; a majority originate in emergency departments (EDs).

OBJECTIVE: Describe trends and predictors of adult asthma hospitalizations originating in EDs.

METHODS: Observational study of ED visits resulting in hospitalization using a nationally representative sample. We tested trend in hospitalization rates from 2006 to 2014 using logistic regression, then assessed the association between hospitalization rates and patient and hospital characteristics using hierarchical multivariable regression accounting for hospital-level clustering.

RESULTS: Total ED asthma visits increased 15% from 2006 to 2014, from 1.06 to 1.22 million, while the likelihood of hospitalization decreased (20.9-18.2%, p < 0.01). Adjusting for increased asthma prevalence, ED visit rates and hospitalization rates decreased by 10 and 21%, respectively. Hospitalization was independently associated with older age, female gender (OR = 1.23, 95% CI 1.20-1.26), higher Charlson score (OR = 1.99, 95% CI 1.97-2.01), Medicaid (OR = 1.05, 95% CI 1.01-1.08) and Medicare (OR = 1.26, 95% CI 1.22-1.31) insurance, and trauma centers (OR = 1.34, 95% CI 1.12-1.60). Hospitalization was less likely for uninsured visits (OR = 0.7, 95% CI 0.67-0.73), lower income areas (OR = 0.89, 95% CI 0.85-0.93), non-metropolitan teaching hospitals (OR = 0.83, 95% CI 0.71-0.96), Midwestern (OR = 0.84, 95% CI 0.69-1.01) or Western regions (OR 0.69, 95% CI 0.56-0.83). Unmeasured hospital-specific effects account for 15.8% of variability in hospital admission rates after adjusting for patient and hospital factors.

CONCLUSIONS: Total asthma ED visits increased, but prevalence-adjusted ED visits, and ED hospitalization rates have declined. Uninsured patients have disproportionately more ED visits but 30% lower odds of hospitalization. Substantial variation implies unmeasured clinical, social and environmental factors accounting for hospital-specific differences in hospitalization.

Clinical Benefit of Hospitalization for Older Adults With Unexplained Syncope: A Propensity-Matched Analysis.


STUDY OBJECTIVE: Many adults with syncope are hospitalized solely for observation and testing. We seek to determine whether hospitalization versus outpatient management for older adults with unexplained syncope is associated with a reduction in post disposition serious adverse events at 30 days.

METHODS: We performed a propensity score analysis using data from a prospective, observational study of older adults with unexplained syncope or near syncope who presented to 11 emergency departments (EDs) in the United States. We enrolled adults (≥60 years) who presented with syncope or near syncope. We excluded patients with a serious diagnosis identified in the ED. Clinical and laboratory data were collected on all patients. The primary outcome was rate of post-ED serious adverse events at 30 days.

RESULTS: We enrolled 2,492 older adults with syncope and no serious ED diagnosis from April 2013 to September 2016. Mean age was 73 years (SD 8.9 years), and 51% were women. The incidence of serious adverse events within 30 days after the index visit was 7.4% for hospitalized patients and 3.19% for discharged patients, representing an unadjusted difference of 4.2% (95% confidence interval 2.38% to 6.02%). After propensity score matching on risk of hospitalization, there was no statistically significant difference in serious adverse events at 30 days between the hospitalized group (4.89%) and the discharged group (2.82%) (risk difference 2.07%; 95% confidence interval -0.24% to 4.38%).
CONCLUSION: In our propensity-matched sample of older adults with unexplained syncope, for those with clinical characteristics similar to that of the discharged cohort, hospitalization was not associated with improvement in 30-day serious adverse event rates.

US Emergency Department Visits and Hospital Discharges Among Uninsured Patients Before and After Implementation of the Affordable Care Act.

Singer AJ, Thode HC Jr, Pines JM; Department of Emergency Medicine, Renaissance School of Medicine, Stony Brook University, Stony Brook, New York; JAMA Netw Open. 2019 Apr 5;2(4):e192662.

IMPORTANCE: The US Patient Protection and Affordable Care Act of 2010 (ACA) was enacted in 2010 with several provisions that targeted reducing numbers of uninsured Americans.

OBJECTIVE: To assess the numbers and proportion of emergency department (ED) visits (2006-2016) and hospital discharges (2006-2016) by uninsured patients, focusing on the 2014 ACA insurance reforms (Medicaid expansion, individual mandate, and private insurance exchanges).

DESIGN, SETTING, AND PARTICIPANTS: Cross-sectional study of visitors to US EDs and patients discharged from US hospitals using National Hospital Ambulatory Care Survey data and Healthcare Cost and Utilization Project data, respectively, from 2006 to 2016. Data analysis took place in February 2019.

MAIN OUTCOMES AND MEASURES: Numbers and proportions of total and uninsured ED visits and hospital discharges. Simple descriptive statistics and interrupted time-series analysis were used to assess changes in uninsured visits over time and after the implementation of insurance provisions in 2014.

RESULTS: There were an estimated 1.4 billion US ED visits from 2006 to 2016 and 405 million hospital discharges from 2006 to 2016. Over the study period, ED visits increased by 2.3 million per year, while hospital discharges decreased from approximately 38 million per year prior to 2009 to approximately 36 million per year after, with no clear decrease after 2013. Proportions of uninsured ED visits were largely unchanged from 2006 (16%) until 2013 (14%) (-0.2 percentage point per year; 95% CI, -0.46 to -0.01 percentage point; P = .11) but then decreased by 2.1 percentage points per year from 2014 to 2016 (95% CI, -4.3 to -1.8 percentage points; P = .003), with uninsured visits composing 8% of the total in 2016. For patients aged 18 to 64 years, uninsured ED visits declined from approximately 20% from 2006 through 2013 to 11% in 2016 (3.1% decrease per year after 2013; 95% CI, -4.3 to -1.8 percentage points; P = .003). The proportion of hospital discharges by uninsured patients remained steady at approximately 6% from 2006 to 2013, then declined to 5% in 2014 and 4% in 2016. Similar changes were seen for patients aged 18 to 64 years, with a decrease in hospital discharges from 10% to 7% over the study period.

CONCLUSIONS AND RELEVANCE: Proportions of ED visits and hospital discharges by uninsured patients decreased considerably after the implementation of the 2014 ACA insurance provisions. Despite these changes, approximately 1 in 10 ED visits and 1 in 20 hospital discharges were made by uninsured individuals in 2014 to 2016. This suggests that continued attention is needed to address the lack of insurance in US hospital visits, particularly among people aged 18 to 64 years who have less access to government-sponsored insurance.

Missed Opportunities: Integrating Palliative Care into the Emergency Department for Older Adults Presenting as Level I Triage Priority from Long-Term Care Facilities.


BACKGROUND: Early integration of palliative care from the emergency department (ED) is an underutilized care modality with potential benefits, but few studies have identified who is appropriate for such care.

OBJECTIVE: Our hypothesis is that patients aged 65 years or older who present to the ED as level I Emergency Severity Index from a long-term care (LTC) facility have high resource utilization and mortality and may benefit from early palliative care involvement.

METHODS: We performed a retrospective chart review of patients aged 65 years or older who arrived in the ED of an academic suburban southeastern level I trauma center from an LTC facility and triaged as level I priority. The ED course, hospital course, and final outcomes were analyzed.

RESULTS: Of the 198 patients studied, 54% were deceased 30 days after discharge, with only 29.8% alive at 12 months. Admitted patients had a median hospital length of stay of 5 days and 73% required intensive care. Formal palliative care intervention was provided in 40.4%, occurring a median of four days into hospitalization and leading to 85% downgrading their advanced directive wishes, and discharge occurring a median of one day later. Few formal palliative care interventions occurred in the ED (9.1%).

CONCLUSIONS: Elderly patients from LTC facilities presenting with severe acute illness have high mortality and seldom receive early palliative care. Introduction of palliative care has the ability to change the course of treatment in this vulnerable population and should be considered early in the hospitalization and, where available, be initiated in the ED.

Battlefield Acupuncture to Treat Low Back Pain in the Emergency Department.


INTRODUCTION: Battlefield acupuncture (BFA) is an ear acupuncture protocol used by the military for immediate pain relief. This is a pilot feasibility study of BFA as a treatment for acute low back pain (LBP) in the emergency department (ED).

METHODS: Thirty acute LBP patients that presented to ED were randomized to standard care plus BFA or standard care alone. In the BFA group, outcomes were assessed at the time of randomization, five min after intervention, and again within one h after intervention. In the standard care group outcomes were assessed at the time of randomization and again an hour later. Primary outcomes included post-intervention LBP on a 10-point numeric pain rating scale (NRS) and the timed get-up-and-go test (GUGT). t-Test and chi squared tests were used to compare differences between groups demographics to evaluate randomization, and Analysis of Covariance (ANCOVA) was used to assess differences in primary/secondary outcomes.

RESULTS: We randomized 15 patients to BFA plus standard care, and 15 patients to standard care alone. Demographics were similar between groups. Post-intervention LBP NRS
was significantly lower in the BFA group compared with the standard care group (5.2 vs. 6.9, ANCOVA p = 0.04). GUGT was similar between groups (21.3 s vs. 19.0 s, ANCOVA p = 0.327). No adverse events from acupuncture were reported.

**DISCUSSION:** This pilot study demonstrates that BFA is feasible as a therapy for LBP in the ED. Furthermore, our data suggest that BFA may be efficacious to improve LBP symptoms, and thus further efficacy studies are warranted. (Clinicaltrials.gov registration number NCT02399969).

**Development of a Patient Decision Aid for Syncope in the Emergency Department: the SynDA Tool.**


**OBJECTIVES:** The objective was to develop a patient decision aid (DA) to promote shared decision making (SDM) for stable, alert patients who present to the emergency department (ED) with syncope.

**METHODS:** Using input from patients, clinicians, and experts in the field of syncope, health care design, and SDM, we created a prototype of a paper-based DA to engage patients in the disposition decision (admission vs. discharge) after an unremarkable ED evaluation for syncope. In phase one, we conducted one-on-one semistructured exploratory interviews with 10 emergency physicians and 10 ED syncope patients. In phase two, we conducted one-on-one directed interviews with 15 emergency care clinicians, five cardiologists, and 12 ED syncope patients to get detailed feedback on DA content and design. We iteratively modified the aid using feedback from each interviewee until clarity and usability had been optimized.

**RESULTS:** The 11 × 17-inch, paper-based DA, titled SynDA, includes four sections: 1) explanation of syncope, 2) explanation of future risks, 3) personalized 30-day risk estimate, and 4) disposition options. The personalized risk estimate is calculated using a recently published syncope risk-stratification tool. This risk estimate is stated in natural frequency and graphically displayed using a 100-per-cent risk estimate is stated in natural frequency (odds ratio: 1.14 [1.08-1.21], p=0.0001). Groups (lived vs. died) were compared with Man-Whitney-U test. Multivariate analysis was used to measure the association of the independent variables and mortality. The interval likelihood ratios were calculated for all LAC observed values.

**RESULTS:** Out of 226 patients screened, we analyzed 58 patients meeting study criteria (32 MTP, 26 non-MTP). Study characteristics for the MTP and non-MTP groups were similar except age (34.0 vs. 45.85 years, p = 0.015). MTP patients received blood products more expeditiously (41.7 minutes vs. 62.1 minutes, p = 0.10), with more pRBC (5.19 vs 3.08 units, p = 0.05), more FFP (0.19 vs 0.08 units, p < 0.01), and had larger pRBC:FFP ratios (1.90 vs 0.52, p < 0.01). Secondary outcomes did not differ significantly but the MTP group was associated with a trend for decreased hospital length of stay (p = 0.08).

**CONCLUSIONS:** MTP resulted in clinically significant improvements in transfusion times and volumes. Further larger and randomized studies are warranted to validate these findings to optimize MTP protocols.

**Clinical Value of Triage Lactate in Risk Stratifying Trauma Patients Using Interval Likelihood Ratios.**

Baron BJ, Nguyen A, Stefanov D, Shetty A, Zehhtachi S; Department of Emergency Medicine, State University of New York, Downstate Medical Center and Kings County Hospital, Brooklyn, NY; Am J Emerg Med. 2018 May;36(5):784-788.

Emergency physicians face the challenge of rapidly identifying high-risk trauma patients. Lactate (LAC) is widely used as a surrogate of tissue hypoperfusion. However, clinically important values for LAC as a predictor of mortality are not well defined.

**OBJECTIVES:** 1. To assess the value of triage LAC in predicting mortality after trauma. 2. To compute interval likelihood ratios (LR) for LAC.

**METHODS:** Retrospective chart review of trauma patients with a significant injury mechanism that warranted labs at an urban trauma center.

**OUTCOME:** In-hospital mortality. Data are presented as median and quartiles or percentages with 95% confidence intervals. Groups (lived vs. died) were compared with Man-Whitney-U or Fisher’s-exact test. Multivariate analysis was used to measure the association of the independent variables and mortality. The interval likelihood ratios were calculated for all LAC observed values.

**RESULTS:** 10,575 patients; median age: 38 [25-57]; 69% male; 76% blunt; 1.1% [n=119] mortality. LAC was statistically different between groups in univariate (2.3 [1.6,3.0] vs 2.8 [1.6,4.8], p = 0.008) and multivariate analyses (odds ratio: 1.14 [1.08-1.21], p = 0.0001). Interval ratios for LR- ranged from 0.6-1.0. Increasing LAC increased LR+. However, LR+ for LAC reached 5 with LAC>9mmol/L and passed 10 (moderate and conclusive increase in disease probability, respectively) with LAC>18mmol/L.

**CONCLUSIONS:** In a cohort of trauma patients with a wide spectrum of characteristics triage LAC was statistically able to identify patients at high risk of mortality. However, clinically meaningful contribution to decision-making occurred only at LAC>9. LAC was not useful at excluding those with a low risk of mortality.

Chang BP, Wira C, Miller J, Akhter M, Barth BE, Willey J, Nentwich L, Madsen T; Department of Emergency Medicine, Columbia University Medical Center, New York, NY; Acad Emerg Med. 2018 Jan;25(1):54-64.

OBJECTIVE: Ischemic stroke is a leading cause of morbidity and mortality worldwide. While the incidence of ischemic stroke is highest in older populations, incidence of ischemic stroke in adults has been rising particularly rapidly among young (e.g., premenopausal) women. The evaluation and timely diagnosis of ischemic stroke in young women presents a challenging situation in the emergency department, due to a range of sex-specific risk factors and to broad differentials. The goals of this concepts paper are to summarize existing knowledge regarding the evaluation and management of young women with ischemic stroke in the acute setting.

METHODS: A panel of six board-certified emergency physicians, one with fellowship training in stroke and one with training in sex- and sex-based medicine, along with one vascular neurologist were coauthors involved in the paper. Each author used various search strategies (e.g., PubMed, PsycINFO, and Google Scholar) for primary research and reviewed articles related to their section. The references were reviewed and evaluated for relevancy and included based on review by the lead authors.

RESULTS: Estimates on the incidence of ischemic stroke in premenopausal women range from 3.65 to 8.9 per 100,000 in the United States. Several risk factors for ischemic stroke exist for young women including oral contraceptive (OCP) use and migraine with aura. Pregnancy and the postpartum period (up to 12 weeks) is also an important transient state during which risks for both ischemic stroke and cerebral hemorrhage are elevated, accounting for 18% of strokes in women under 35. Current evidence regarding the management of acute ischemic stroke in young women is also summarized including use of thrombolytic agents (e.g., tissue plasminogen activator) in both pregnant and nonpregnant individuals.

CONCLUSION: Unique challenges exist in the evaluation and diagnosis of ischemic stroke in young women. There are still many opportunities for future research aimed at improving detection and treatment of this population.
Having trained in Emergency Medicine (EM) in New York City for nearly four years, I had developed a sense of competence in treating the gamut of common critical illnesses. Earlier this year, that sense of competence was called into question while working at a hospital in Uganda. I recount here the case of a 17-year old girl I had the privilege of treating during my time there. In my attempt to save her, she humbled me and revealed what I now believe to be the essence of being an emergency physician.

She was brought in by her mother for what she could best describe as confusion and unresponsiveness that had started earlier that day and was preceded by a few days of tiredness and weakness. I saw in front of me a scrawny, young girl laying listless in a stretcher, minimally responsive to strong sternal rub. She had labored breathing, rapid pulse, diaphoretic skin and normal pupillary response to light. No vital signs had yet been measured. I immediately requested a blood glucose level and lucky enough, there were supplies available that day. The result on the glucose monitor read: “HI”.

In Uganda, when people see a doctor standing next to a patient, they come crowding over to see what is going on and how they can participate. Amidst the gathered onlookers, one of the nurses checked vitals; the blood pressure was 60 mmHg systolic, the heart rate was 140 bpm, and the pulse oximeter read 90%. Concerned about poor cerebral perfusion, I lowered the head of the bed and propped pillows below her feet. Two intravenous lines would be inserted and she began receiving two 500 cc cartons of normal saline. There were no one liter bags available. After receiving four liters of saline her systolic blood pressure was in the 70s, but still too low for adequate brain perfusion. I made a “dirty” epinephrine drip. Epinephrine and dopamine were the only vasoactive agents available. I drew up 0.5 mg of the code-cart epinephrine and taped over the top of the vial, so that the rest could be saved for use on the next patient, and I injected it into the 500 cc of normal saline. With no infusion pump, I titrated to affect until the mean arterial pressure held steady at 65 mmHg. She was resuscitated.

My suspicion for DKA was high based on history and physical: an obtunded, young, thin patient, with reports of generalized weakness, elevated blood sugar, tachycardia, low blood pressure, and Kussmaul breathing. Although I would have preferred laboratory data to confirm the diagnosis, waiting hours for lab results to return might have meant the difference between life and death, so I bolused 10 units of regular insulin and started an insulin infusion. Although generations of American doctors and nurses before me have been facile at administering infusions based on medication concentrations and (literally) drips in the IV chamber per minute, I had never been taught the concept and resorted to Google for instructions.

Lab results would eventually become available: sodium, chloride and potassium were reported, but not bicarbonate, and I soon would learn that our lab did not have the reagent for that test (also, pH and serum ketones were not available). How would I proceed without knowing her initial anion gap? That question became irrelevant when I learned that repeating the labwork would be impossible due to the cost of 10,000 shillings (or about 2 USD) payable by her family. In Uganda, this patient was diagnosed with “severe DKA” and no additional nuance was possible.

The treatment was to continue IV hydration, continue insulin infusion, observe her, and provide respiratory support (that is, turn her onto her side in case she vomits). That day, trending of the capillary blood glucose was possible, but the resolution of the DKA would be judged solely by the improvement in her mental status. Had her mental status not improved and a CT scan was required, the cost to the family would be a devastating (or more likely, impossible) 300,000 shillings (~ 80 USD). By the end of the night, through some combination of basic medicine and good luck, the patient was conversational — she was well.

There’s nothing profound in pointing out disparities between the practice of medicine in Uganda and the US, but my experience there has taught me the gravity of realizing a patient’s circumstances and working to the best of my capabilities to treat them. In Uganda, I did not have labs, drips or other “basic” technology, at my disposal. I did not have numbers to follow, but I had the same critically ill patients. Having limited resources made me think about what was truly necessary. For this case, we resuscitated her, then we gave her insulin — which is what her body was lacking — and hoped that was enough for her body to heal itself.

The week after this case, I was invited to attend the weekly Emergency Medicine Residency’s (the first EM residency in Uganda) lecture on DKA. Most of what they were taught was from our Western management of DKA, which is highly dependent on laboratory values and fine titrations of medications. It was hard to watch as many of the Ugandan EM residents seemed underwhelmed after quickly realizing that they are unable to perform what is considered standard of care for what is a common emergency department presentation. They were taught in their books to follow anion gaps, electrolytes, as well as titrate medication they do not have. They know nonetheless, they too have the same sick patients; but in their world, in a truly resource limited setting, they will likely have to create their own ways. They not only have to know what I was expected to know, but they must learn to adapt that knowledge to work for them.

My time in Uganda was far in location and in comfort from what I have ever known, and thus rightfully shook my confidence in my skills and my belief of what it means to be a doctor. While the frustrations and difficulties of practicing emergency medicine in the US pale in comparison to those of the doctors in Uganda, the essence of our specialty is that we are continually forced into unfamiliar and difficult circumstances. It is our knowledge base, our compassion, our resourcefulness and our creativity that define our specialty.

I am proud of that.
ED to PICU Transfers: Perspectives from Both Sides of the Elevator Ride

As emergency physicians, I think we can all agree, dealing with consultants can be a challenging experience. Each subspecialty has its own quirks. A particularly picky group of doctors that we have to interact with frequently are the pediatric critical care physicians…and I should know, because I am married to one!

My name is Juan Zequeira, emergency doctor at heart, with a soft spot for pediatrics. Enough so that it pushed me towards completing both point of care ultrasound (POCUS) and pediatrics (PEM) fellowships recently. My wife Veronica is a pediatric intensivist, and for a while during my training, we even worked in the same hospital. The following are examples of cases that we encountered all too frequently.

**Juan:** Let’s start big: WHEN do you call to present your case? Is there such a thing as calling too early?

**Veronica:** I am all for collaboration and patient safety. So, say you need our help with a crashing patient, there is no such thing as too early of a call. However, transfer to the PICU should not happen in lieu of appropriate initial stabilization and a workup conducive to next steps in management. For example, if you are concerned about increased intracranial pressure and your patient might need the operating room STAT, first call neurosurgery before calling us!

**Juan:** Well, let’s say my emergency room is blowing up. We have 15 patients still waiting to be seen, and paramedics rush in with a child in frank respiratory distress. The kid is a well-known asthmatic who always ends up requiring PICU admission.

**Veronica:** Please don’t say, “he is your patient”, because he has been in the PICU before. He may be well known to us, but no intensivist went into this line of work to become a primary care physician.

**Juan:** Fair enough. But his history of severity of illness is pertinent though. So, we start off with the three back-to-back inhaled albuterol and ipratropium treatments, give steroids, start the IV magnesium. Despite this, the kid is still working. We plan on starting him on a high-flow nasal cannula (HFNC). At this point, we know this kid is not going anywhere else than the PICU (at least in our institution).

**Veronica:** Sometimes my unit is also full, and it takes a while for this kid to be admitted to the PICU. If he was in our hands, we would have started him on HFNC earlier. But here we have a patient who needs other treatment modalities but if the initial management was timely and appropriate, we are already ahead of the game.

Sometimes my unit is also full, and it takes a while for this kid to come upstairs. This is where things can get hairy if it’s not clear who’s managing the patient. He needs to keep getting aggressive supportive care while waiting for a bed. If his next treatment doesn’t get started, then we might lose all the progress we made in the initial management.

**Juan:** What about when there is more ambiguity in the diagnosis? Say an infant who comes in tachypneic, retracting everywhere, with rales throughout. May be viral bronchiolitis but wrong time of year. Not really wheezing, gets suctioned with little improvement, keeps on having intermittent desaturations and remains tachypneic. Laboratory studies and a chest x-ray are non-revealing. Sats come up on nasal cannula, but still retracting. So, we figure he’s got to go to a unit and we admit him to the PICU to continue work up and management as the ED is still blowing up.

**Veronica:** Yeah, you know I think that this gets back to some of the risks that occur during transition of care. These kids with respiratory distress can decompensate really quickly. I’ve seen some who get signed out as “possible pneumonia who needs a little oxygen and monitoring” show up a few hour later grunting and needing to get intubated really quickly.

Now kids definitely go south fast once they start to decompensate, and it’s our job to catch them before they get to the steep part of that slope. If they turn the corner really fast does it mean we’re admitting too early? I don’t know. Maybe some of these kids would benefit from positive pressure sooner? Most who decompensate that rapidly are probably not going to avoid intubation though. I guess I would just advocate for early recognition of severe respiratory distress and relaying that information to us while escalating support in a timely fashion.

**Juan:** We talk about premature closure as a common cognitive error in the ED. When we kind of say “oh well, that’s that” and turn around to deal with the next case rather than keeping an open and skeptical mind. Certainly once a disposition has been decided on and a patient is...
admitted, we sort of feel like our job is done and it can be a set-up for that to happen.

Veronica: Yeah, exactly. I mean, we’re talking about critically ill kids, the scenario can change rapidly and it’s important to recognize that and intervene early. If the child needs more aggressive management, start it sooner. Also, it’s important to keep an open mind about the admitting diagnosis, if you don’t know for sure, say so. It makes it easier for me to approach the case with fresh eyes. Kids can get RSV in the middle of summer – yay global warming – but we’re not always used to thinking of it.

Juan: I guess that is a valid point. Patient safety should always come first. Let’s shift gears and talk about patients who might look stable but have high risk of acute deterioration. A very common case is the teenager with insulin-dependent diabetes presenting in ketoacidosis (DKA). Between not so great food choices and poor compliance with regimens, DKA visits make for some ED and PICU frequent flyers. In this particular patient, we get a venous blood gas and point of care electrolytes upon arrival. They reveal a pH of 7.1, potassium of 4.5, glucose 400 and bicarbonate of 4. We get a second IV line, give a 20ml/kg bolus and start an insulin drip. Do I really need to wait for the confirmatory ketones in blood or the full BMP? This seems like another clear-cut case of “I need PICU.”

Veronica: I would not wait for those lab results. Just please don’t give bicarbonate or a huge insulin bolus. Thanks for that second IV line, we are going to need it. Most institutions have algorithms or protocols for management of pediatric DKA. If it is a clear-cut case, just stick to the protocol and the sooner I learn of the patient, the faster I can start ordering those special bags of IV fluids to be ready.

Juan: What is your biggest pet peeve about ED sign-outs?

Veronica: Probably talking to someone who does not know the patient well or has not seen the kid. Something like, “Hey, this patient was endorsed to me to sign out to the PICU for admission. No, I don’t know who’s got to get shipped. And it’s so humbling to see children get so sick from common infections; we’re used to seeing it with the elderly, not healthy athletic kids.

Veronica: That is certainly a great example of how we come together as a team and also a healthcare system to manage the sickest kids that come through those doors. Now it’s my turn to ask, what is your biggest pet peeve when having to call the PICU for a transfer?

Juan: If I would have to pick something, I’d say when the patient’s admission carries conditions that can be outlandish. I mean, is the patient accepted or not? I’m already calling because I’ve identified a problem that needs further inpatient care at the highest level. To name one example, when you ask for an imaging study prior to admission because it “can happen faster from the ED”. But I will say, admitting to PICU is definitely easier than admitting to MICU.

Veronica: Well, tell that to the radiology tech’s overnight! Seriously though, I think it is fair to say we all want to do right by our patients and having a culture of respect, collaboration and effective communication is a step in the right direction towards bridging these gaps.

In conclusion, when you are on that phone call, no matter which side, always take into consideration the other person’s train of thought and surroundings. Think about what is best for the patient above all. Treat each other with respect but do not shy away from questions that could affect the patient’s care and disposition. Do not delay a transfer to a higher level of care if it is warranted, especially if the presenting physician already does not feel comfortable managing this patient or does not have the adequate setting to continue doing so. If you have a genuine question or concern about your patient, presenter or accepting physician, do not be afraid to discuss it in real time. You are both on this patient’s team now. Check your ego and any potential biases at the door when you come in to work. Strive to be effective communicators and team players. It can only lead to better patient care.

And finally, sometimes we work as a well-oiled machine, perfectly in unison doing things “by the book”, yet our patients do not have the desired clinical outcomes. These cases can be the hardest to digest, the ones we take home with us forever. It is somewhat comforting to know that everyone worked together and did their absolute best. A strong interdisciplinary team will learn from these experiences and only become stronger.
Towards a New Open Medical Science

Science, throughout its history, has been defined by the generation of data based upon hypotheses that are then repeatedly tested to confirm the validity of the generated results. As the evidence based medicine (EBM) revolution has evolved since the 1970s to recast medical findings within the empiricism of science, simultaneous advances have been made in the dissemination in the medical literature of these data and discoveries. The rewards of such a movement have been generally evident by the shift in the lexicon of our primary learners and colleagues with concepts such as p-values and number needed to treat invoked when debating the various options for reasonable patient care. The expanded role of empiricism has lead to a revolution of data appraisal in which the cumulative body of knowledge in such entities as the Cochrane Review have supplanted individual studies and anecdotal discussions of the most efficient and parsimonious means of rendering up to date care. This approach has been immensely successful and has become a cornerstone of foundational medical education through its various manifestations in such efforts as morbidity and mortality and journal clubs. However, recently there have been multiple examples of supposed high-level evidence subsequently undermined by downstream findings or the realization that the initial data was incomplete, sometimes intentionally, damaging the credibility of medical empiricism. Though the EBM project has been a boon to science based medical care, it is based upon the expectation that data is transparent and objectively interpretable. However, as it has been currently manifest within the medical literature, it tends to be presented in summarized averages, such as medians, modes, and data sets, which have been distilled into representational statistics. Access to raw data allows for science to work as it should, in a self correcting and critical fashion in which data granularity allows one to assess the validity of the conclusions and to attempt to reproduce the findings in order to validate the external results. There is, inherent in summarized rather than raw data, an individual suspension of incredulity generated by the distillation of data to graphs and statistical comparisons. In order for the EBM mission to be built upon actual evidence and therefore, not upon a house of cards, raw data—that which comprises the actual results of the study in question—must be made available for scrutiny, reanalysis and an understanding of the limitations, in order for medical science to truly rise to the ideal of a complete information revolution of the 70s.

The recognition that publication of original material within the medical literature requires more than just the refinement of data but general access to the raw data that generated the published results has been gaining increasing momentum within the scientific community. The European Union3, World Health Organization4, and National Institutes of Health5, have made data sharing a default position, requiring that one has to opt out if it can be demonstrated why access to raw data would not be possible. This level of oversight has allowed some, but not all, publically funded research to be easily accessible to researchers looking to critically appraise the datasets. However, this affects only a particular subcomponent of medical research (i.e., federally funded) and there is still no general regulatory requirement that other data sets should be accessible to general scrutiny upon publication. To remedy this disparity, particular journals have altered their policies to allow for wider sharing of original trial data. In 2007, Annals of Internal Medicine began requiring data sharing statements6 and in 2013 the BMJ required that published drug and device manufacturers make available patient level data available upon “reasonable request”7. Though these strides are certainly significant and may signify the start of a truly new data revolution in which access to raw datasets becomes the norm, it is still true that this requirement is not universally enforced and easy to avoid by alternative means of funding, publishing within the vast majority of journals that do not require raw data access and claiming data sharing hardships. In order to be a true empirical discipline, medicine needs objective assessment and validation of all data sets regardless of the funding source or journal of publication.

There have been multiple objections raised to a more universally enforced data dissemination requirement throughout the medical literature. It has been claimed that there is a distinction between public and privately funded ownership of data though there is no clear relevant differentiation between their direct applications to patient care regardless of intellectual property rights. There have been proposals that deal directly with the concerns over the copywriting of data and the sharing of raw data sets including the utilization of Creative Commons license that preserve data ownership while serving the public good of data dissemination8. Regardless, it is difficult to discern how intellectual property is a greater ethical virtue than public health as data openness has demonstrable benefits to patient centered care that copyright protection does not preserve. If industry wishes to disseminate their findings both in serving public health and an underlying profit motive then it follows that the prerequisite of the utilization of the literature for both purposes is scientific scrutiny of the published data in order to serve the greater interests of medicine in general. Industry experts have expressed concern that the supposed high cost of research and development would be undermined by access to raw data and proprietary information leading to a decrease in innovation. Regardless of lack of demonstrable truth of this claim, it has been argued that open datasets may actually directly benefit the biopharmaceutical industry through increased efficiency, cost-effectiveness, comparative-effectiveness analysis and reduction of duplication of efforts9. Further objections have been that data sharing may adversely affect patient confidentiality and that the subsequent methods applied to the data set would be inappropriate given the original study design and lead to erroneous conclusions. Reasonably one can conclude that datasets, prior to the public dissemination of their information, should be reliably deidentified, as would be the norm within the institutional review board of most institutions. The secondary analysis of raw data can be problematic and poor conclusions can be drawn from the reinterpretation of the original dataset. However,

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this problem is not unique to an open medical literature and can be seen in current systematic reviews and meta-analysis of compiled published datasets. The objection that the poor interpretation of raw datasets does not argue to continue to shield them for broad scientific scrutiny, rather it argues for a more stringent peer review and critical analysis of studies generated based upon data in any form, primary or secondary. It is not demonstrably true that the potential harm of poor interpretation, one readily amenable to rectification via science, counterbalances the very real benefit that unfinfettered access to raw data would potentially achieve. In order to further aid the process, there have been calls for central repositories of clinical trial data where the study design and results data are stored allowing for the highest fidelity in data interpretation and methodology dissemination12.

Science is a self-correcting discipline that continuously challenges its own assumptions through the generation of experimental data and repeated testing of generated hypotheses. In order for the medical literature to truly be called scientific there must be transparency in all aspects of data in order that interpretation and reproducibility are ultimately preserved. The slow progress of EBM should realize its full potential in data that is immediately available to the researcher, who, working in concert with the established ethical guidelines regarding access to human experimental data, is able to discern the true empirical merit of any medical finding scattered throughout the literature. Until this occurs our medical epoch will be continuously defined by mistrust and general misadventures of hidden data recently represented by the oseltamivir debacle. To move forward, for our profession, our science and our patients, we as a profession need to demand that all data is open data so that we may put this era behind us and get to the work of real science-based patient care.

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Search online for the term “physician suicide” and one is easily bombarded with stark statistics, in addition to words like ‘stigma’ and ‘scourge’ and ‘shame.’ The intertwining of these words with ‘physician burnout’ is even more alarming. The American Foundation for Suicide Prevention, in association with the ACGME, have acknowledged that an estimated 300-400 physicians die by suicide in the United States every year. Compared with the general population, physicians are nearly twice as likely to be afflicted by suicide. Being a physician is not an independent risk factor for suicide and it is generally agreed that suicide is caused by a multitude of risk factors.

Armed with these grim facts, 2018 was the inaugural year for the National Physician Suicide Awareness Day (NPSA Day). The Council for Residency Directors (CORD), with the support of various other national and international organizations, including New York ACEP, chose September 17, 2018 to be the day to “shine a light” on the plight of physician suicide. Using the goal of Vision Zero, NPSA Day was created as a day of reflection for our friends, colleagues and loved ones who have died by suicide. It was also created to call on individuals, residency programs, health care organizations and national groups to make a commitment to break down stigma, increase and open the conversation, decrease the fear of consequences, reach out to colleagues, recognize the warning signs and learn to approach colleagues who may be at risk. The ultimate goal was to shed light on the issue in order to change the culture of medicine to prevent future suicides and to reach an ultimate goal of “zero physician suicides.”

This year, Tuesday, September 17, 2019, will mark the 2nd annual NPSA Day with the newly added theme of hope and recovery.

Physicians are naturally a resilient group, having endured years of countless personal and professional challenges; layered into education, training and daily lives as attendings. On its surface, dealing with these challenges in the midst of a career and personal life are just that - life. However, one thing that sets physicians apart from other professions, is that they juggle these complicated emotions with a compulsory stoicism so that they may take care of others. Unfortunately, stoicism carries over into personal lives and into interactions with others. It has been acknowledged that physicians hesitate and avoid discussing experiences with one another, despite how hauntingly similar they may be. These are missed opportunities to share experiences and methods of recovery.

Attendings & Residents: This year, New York ACEP is calling on you to dig a little deeper, be candid and vulnerable with your peers, juniors and medical students; share your untold stories of recovery as they may help others. We ask that this year, you take some time September 17, 2019 to reflect and share at your morning huddles, morning reports and conferences, your own personal stories and help others uncover theirs. We look forward to hearing from you. Use the #NPSAday on Twitter to share your stories!

For more details and ideas on how to get involved, check out CORDEM.org. Be a part of the conversation online by sharing how you participated and by following & tagging @NYACEP @CORDEM #NPSAday on Twitter.
In July, newly minted doctors arrived at teaching hospitals around the country. I knew it was not an exaggeration when I was warned how briskly intern year can pass. I blinked, and now I’m a junior resident, soon to be supervising fresh medical school graduates. I remember how I felt being in their position – timid, yet somehow confident and hungry, yet somehow cautious. Without me even realizing, these sentiments coalesced as I learned how to trust myself.

One of my biggest concerns entering residency was having the right attitude. Everybody tells you to be humble, but what does that really mean? Once you are aware of yourself being humble then are you still humble? One year later it is much clearer why humility is considered such an important trait. Not only does it soften the blows of our own mistakes because we are prepared to make them and learn from them, but it also helps establish a mindset of lifelong learning. The hyperbolic firehose is actually a landslide of information, and what makes intern year horrifying is that this landslide is equipped with phrases including “you don’t know what you don’t know.” Everybody tells you to be humble because this landslide is the norm of intern year, and your humility will eventually be accompanied with confidence when “it” finally clicks.

The greatest challenge of intern year is the pathway to “it” finally clicking. Each resident in my program can attest to different aspects of intern year that made it a difficult adjustment. Just months prior to the start of residency, we were all either traveling or mastering the fine art of lounging. Suddenly, we are introducing ourselves as doctors and being in charge of the patient and their care. We are learning how to manage care, place orders and broaden our medical knowledge until we are faced with our first encounter with a frustrated family member. It is here where we now shift to our first taste of the art of managing expectations in the Emergency Department (ED). It is not a topic that is taught to us in medical school, but managing expectations is arguably as important as patient care, because the patient often cannot discern between the two. A case that stood out for me occurred during my orientation month of residency. A father of three daughters had stage four lung cancer, which was managed at a complex quaternary care center. His daughters knew far more about his cancer care than I did and were very concerned about its nuances that I knew nothing about. It was clear to them that I lacked confidence in allaying their concerns, so I had to ask my senior resident to help. Rather than being saved by my superior, my senior guided me how to speak with confidence to family members in situations like this. Thankfully, the family was pleased with their father’s care in the ED. Throughout the year, I found that I am capable of competence in every aspect of my field as I look at my seniors and realize that they were once where I was.

Then there are the physical requirements -- it also is not taught to us in medical school how to work multiple physically and mentally demanding shifts in a row and then shift our circadian rhythms on demand. There is not a one size fits all strategy on how to recoup in between such shifts and conserve energy, so these strategies only are addressed with experience. Interns eventually process strategies involving developing knowledge, work flow and overall competency under the radar until they realize that they have “it” down.

With every struggle in residency, I looked at twenty other residents and saw that I did not struggle alone. I am thankful that we were able to rely on each other and our seniors to help us learn how to be doctors, but that is integral to the process. Now that intern year is over, the cycle will begin anew. The key is passing on the right attitude so that they grasp “it” while having us to rely on.
The New York State Legislature finished the 2019 Legislative Session in the early morning hours of Friday, June 21. New York ACEP and Reid, McNally & Savage worked throughout the six-month Session on a variety of legislative proposals impacting the practice of emergency medicine and patients. Two lobby days were held, one March 5 which focused on State Budget issues, and one June 4 covering non-budget legislation.

This year, New York ACEP was successful in:

- defeating a State Budget proposal to eliminate the exemption in the emergency department (ED) for consulting the prescription monitoring program (PMP) for controlled substance prescriptions that do not exceed five days;
- defeating a State Budget proposal to eliminate State Medicaid Payments for Medicare Part-B Co-insurance for Ambulance Services;
- defending legislation to require practitioners in the ED to notify a patient’s prescriber when there has been an overdose;
- defending legislation to require all medical practitioners who administer naloxone to report patient information and the time and place of administration to the PMP;
- defeating legislation to allow Hospital Sponsored Off-Campus Emergency Departments to operate on less than a 24-hour basis; and
- passage of legislation to eliminate non-medical exemptions for required childhood vaccinations for school and daycare attendance.

These and other legislative and budget proposals that New York ACEP was active on in the 2019 Legislative Session are discussed below.

KEY BILLS PASSED BOTH HOUSES

Out-of-Network Emergency Hospital Charges Subject to Independent Dispute Resolution (IDR) Process (A264-B Cahill/S3171-A Krueger & A8404 Cahill/S6544-A Krueger)

Legislation passed both houses to subject out-of-network hospital charges for emergency services to the Independent Dispute Resolution process under New York’s Surprise Bill law.

Current law does not allow a health care plan or a hospital to dispute a bill for out-of-network hospital charges for emergency services through the IDR process. However, bills for emergency services provided by physicians in the emergency department are currently eligible for IDR. New York ACEP was successful in ensuring that this legislation does not change existing law with respect to emergency services provided by physicians in hospital emergency departments.

The new provisions for dispute of out-of-network hospital charges for emergency services are as follows:

- If a patient assigns benefits to a non-participating hospital for hospital charges for emergency services, the non-participating hospital may bill the health plan for the services. Upon receipt of the bill, the health plan must pay the non-participating hospital an initial amount, and any subsequent amount determined to be owed.
- The initial payment made to a hospital by a health plan must be at least 25% greater than the amount the health plan would have paid if the hospital had been in network, based on the most recent contract between the health plan and the hospital. The amount paid by the health plan does not prejudice or preclude either party from submitting a dispute to the IDR entity. In addition, it does not preclude the hospital from seeking additional payment from the health plan prior to a decision by the IDR entity.
- If the prior contract between the hospital and health plan expired more than 12 months prior to the payment of the disputed claim, the payment amount must be adjusted based upon the medical consumer price index.
- The provisions above apply only when a health plan and hospital previously had a contract.

These bills have not yet been transmitted to the Governor.

DOH Study Emergency Room Beds (S4699 Ramos/A6832 DenDekker)

New York ACEP is opposed to this bill and has sent a letter to Governor Cuomo urging that it be vetoed. We will meet with the Governor’s Counsel and policy staff as well as DOH to discuss our concerns. The bill requires DOH to study the number of emergency room beds in the State and establish minimum numbers of beds required. The study must include: 1) the current number of emergency beds in the State; 2) the minimum number of emergency beds required to adequately address the needs of patients; 3) the distance patients need to travel to access emergency services, including the maximum distance patients shall be expected to travel to access services; and 4) the number of emergency rooms within a specific area.

This bill could result in an unfunded mandate on hospital emergency departments for the establishment of a “minimum number of beds” which could decrease patient access to care. In addition, it does not take into account complex issues that can lead to ED bed availability, including numerous hospital closures in the State over the past several years, availability of inpatient beds, shortages of qualified emergency providers and staff, the availability of “on-call” specialists such as general surgeons, plastic surgeons and other physician specialists and the availability of emergency medical services transportation.

This bill has not yet been transmitted to the Governor.
Regressive Medical Liability Legislation

Two bills passed the Legislature regarding medical malpractice proceedings. The bills have not yet been transmitted to the Governor for action. New York ACEP worked in a Coalition during the Session with the Medical Society of the State of New York and other physician specialty societies to oppose these bills. We will be joining MSSNY in a meeting with the Governor’s Office to urge him to veto these bills.

Liability Exposure (S6081 Hoylman/A2372 Dinowitz)
- This bill requires a non-settling co-defendant in a tort action to choose whether to reduce their liability exposure by the stated settlement amount or the settling tortfeasor’s equitable share prior to the first opening statements of the trial. This legislation creates the possibility that payouts will exceed an actual jury verdict, which in turn could cause physician medical liability insurance premiums to increase.

Recovery against Third Party Defendant (S6552 Skoufis/A2373 Dinowitz)
- This bill would permit a plaintiff to bypass the defendant he or she sued to collect a judgment from a third-party defendant who or which has been sued by the defendant for contribution or indemnification as a result of the underlying action. If enacted, it will add new costs to the system with absolutely no justification. The bill would allow plaintiffs to collect a judgment from a third party that is not a direct party to the lawsuit in question. The bill would permit this to occur even though the plaintiff had not sued or perhaps could not have sued the third-party defendant in the first instance.

2019-20 STATE BUDGET

Elimination of PMP Exemption in ED Defeated

New York ACEP and contract lobbyists Reid, McNally & Savage, worked to successfully eliminate a proposal from the final budget package to repeal a provision of the original I-STOP law that exempts prescribers from checking the PMP for controlled substance prescriptions written in hospital emergency departments when the dose does not exceed five days.

New York ACEP stressed that emergency physicians highly value the use of the PMP as a tool to prevent inappropriate drug use. Prescribers in the ED who suspect drug seeking behavior frequently consult the PMP and utilize it to avoid prescribing controlled substances to such individuals. However, a mandate to consult the PMP for every patient treated for an overdose would be extremely difficult in the emergency department environment. It would interrupt clinical workflow and impair timeliness and access to patient care. Delegation is often impractical in the ED where a single physician may be working with dozens of different staff on a given day or week.

Furthermore, State and national studies as well as data collected by New York ACEP from 22 hospitals across the State demonstrate that hospital emergency departments are not the source of opioid prescriptions for patients.

Legislature Rejects Governor’s Proposal to Eliminate State Medicaid Payments for Medicare Part-B Co-insurance for Ambulance Services

New York ACEP was successful in defeating the proposed elimination of Medicaid reimbursement for a 20% co-payment for ambulance services for individuals who are “dually eligible” for Medicaid and Medicare. This proposal would have had a crippling effect on ambulance services across the State by seriously diminishing their ability to maintain service levels for elderly and disabled individuals.

Excess Medical Malpractice Program Extended

The final State Budget included the Governor’s proposal to fully fund the Excess Medical Malpractice program through June 30, 2020 at $127.4 million.

Hospital/Emergency Department Medication Assisted-Treatment (MAT)

The final State Budget included the Governor’s proposal to require hospitals to include in their policies and procedures treatment protocols to be utilized by emergency departments for providing medication-assisted-treatment, including buprenorphine, prior to discharge or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department is not feasible.

Across-the-Board Medicaid Cuts

Across-the-board cuts to Medicaid to hospitals and nursing homes proposed by Governor Cuomo were rejected from the final budget deal. However, language is included to give the Governor the option of imposing cuts if there is an unexpected drop in revenue due to tax receipts or federal cuts.

KEY BILLS NOT PASSED BY BOTH HOUSES

Single Payer (S3577 Rivera/A5248 Gottfried)

The New York Health Act which passed the Assembly for the last four years was not voted on in either house this year. Joint Senate and Assembly hearings were held on the bill in Albany. New York ACEP provided written testimony to the Senate and Assembly Health Committees on the bill.

Prescriber Notification of Patient Overdose by Emergency Department Practitioners (S3271 Lanza)

Legislation was defeated that requires “every emergency room or hospital practitioner to consult the PMP registry when treating a patient for a controlled substance overdose and to notify the patient’s prescriber of such overdose.” New York ACEP communicated to the sponsor that while they support the intent of this legislation to work to alleviate the prescription drug misuse and overdose epidemic in the State, the bill as written would be extremely difficult to implement.

The bill died in the Senate Health Committee. The Assembly sponsor from the previous year declined to re-introduce the bill this year.

Requirement for All Medical Practitioners Who Administer Overdose Reversal Agents to Report Patient Information and the Time and Place of Administration (S4482 Harckham/A3741 McDonald)

Legislation was introduced to require all medical practitioners who administer naloxone or other overdose reversal agents to a patient to report to the PMP within 72 hours of administration of the agent the following information: 1) name of patient; 2) address of patient; 3) date of birth of patient; and 4) time and place of administration.
This mandate would interrupt clinical workflow and impair timeliness and access to patient care. Delegation is often impractical in the ED where a single physician may be working with dozens of different staff in a given day or week. Mislabeling patients is a concern because many patients receive naloxone for conditions other than an overdose.

This legislation died in the Assembly Health Committees in both houses.

**Hospital Sponsored Off-Campus Emergency Departments (S1728 Skoufis/A6254 Gottfried)**

Legislation was introduced to allow Off Campus Emergency Departments (OCEDs) to operate less than 24 hours a day, seven days a week, 365 days per year.

New York ACEP’s position is that the current standards for hospital emergency departments should apply to stand-alone emergency departments. All practice environments that provide emergency care should:

- Be available to the public 24 hours a day, seven days a week, 365 days per year;
- Be staffed by appropriately qualified emergency physicians;
- Have adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility;
- Be staffed at all times by a registered nurse (RN) with a minimum requirement of current certification in advanced cardiac life support and pediatric advanced life support; and
- Have policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed (i.e., cath labs, surgery, ICU).

This bill provides an exception to allow hospital-sponsored OCEDs to apply for approval for part-time operation. If approved, an OCED would be allowed to operate for a minimum of 12 hours per day. If a healthcare facility advertises “emergency care” it is expected that they are accessible 24 hours per day. Anything less will be confusing to patients and could hinder access to timely medical treatment.

This bill died on the Senate floor. It was not advanced by the Assembly Health Committee.
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