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Out of Network Crisis

It was with a sense of sadness and yes, anger, that I read the New York Times article, http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?ref=health, discussing the issue of mounting patient bills after out of network medical care is rendered to patients with insurance, especially as it portrayed emergency medicine. The patients who came forward to tell their stories are right. Yes, you heard me, right. They should not have to receive a medical bill for the majority of their care even though they have insurance and have dutifully paid the premiums. This will happen to all of us if we access out of network care and I fear it will happen with increasing frequency due to the health exchanges set up by the ACA. The portrayal of the physicians as the cause of the crisis was unfortunate and fell quite short of the real story.

Our specialty of emergency medicine is there for our patients 24 hours a day, 7 days a week, 365 days a year. We take care of anyone who comes to our door despite holidays, weekends and whether they are in pain, dying, abusive, intoxicated, angry, dangerous, or infectious. That is what emergency medicine physicians and providers simply do and have agreed to do for their careers. We are frankly proud of our calling. Over the last 50 years as our specialty has grown and established itself, we have only asked for fair and just compensation for the care we are rendering; 24/7/365. When that is not possible, our physicians are forced to remain outside insurance networks. The patients are then caught in the middle, needing care, having insurance, but still finding themselves with large medical bills. Balanced billing of the patient occurs when the physician rendering the service does not have a negotiated contract with the patient’s insurance company. After the insurance company renders payment for what they consider the “usual and customary fee” the patient is billed the balance.

In 2008, major medical insurers in New York were found by then Attorney General Cuomo to be using an unfair “usual and customary fee” schedule for reimbursing out of network physicians weighted in the insurers’ favor. They were prosecuted and fined. Mr. Cuomo had an independent fee schedule data base created based on region, specialty, and diagnosis/treatment codes called Fair Health. It is a decent start to settling the issue and creating just and fair payment. Many physicians would be satisfied to even receive 80% of the designated payment. Interestingly, the insurers do not agree as they fought strongly against its use as New York created legislation to regulate out of network services this past year.

This past year, New York ACEP became aware of legislation to regulate out of network services, including billing, reimbursement and consumer disclosure for health care services provided to patients by out of network health care providers. Emergency medicine was initially going to be left to negotiate every disputed payment through an Independent Dispute Resolution (IDR) process. Due to many meetings with the Department of Financial Services (DFS), key legislators, and your advocacy, New York ACEP was successful in getting an exemption from the IDR process when the amount billed is under $600 after any applicable patient cost sharing and it does not exceed 120% of the Usual and Customary Cost for the specific CPT code. This Usual and Customary Cost was defined as 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty in the same geographic area as reported by a not for profit entity. The Department of Financial Services (DFS) has confirmed that at this point in time, Fair Health is the only entity that meets the criteria for the not for profit entity. They have also confirmed that the IDR must make a determination within 30 days of receipt of the dispute.

Currently there is no prohibition on balance billing for emergency services. When a patient receives emergency services from a provider who is not in their network, the health plan must ensure that the patient receives no greater out of pocket costs than they would have incurred with a participating health care provider. The details of this aspect of the legislation remain to be clarified by DFS in the upcoming regulations.

DFS has met in July with stakeholders including New York ACEP to discuss the development of state regulations for the IDR process. New York ACEP met again with DFS in October and November to share further concerns including the batching of claims and the cost of the IDR process (efforts to keep the cost reasonable and specified by regulation). The draft regulations are to be shared with all parties including New York ACEP for input and comment prior to publication in the State Register. After publication in the state register, there will be a 45 day public comment period before the regulation will become effective.

In addition to the regulations, there

Louise A. Prince  
MD FACEP  
Associate Professor, Emergency Medicine, SUNY Upstate Medical University

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will be a "guidance document" with further explanation and guidance on the legislation. New York ACEP will also provide input to the DFS concerning that document.

DFS is currently issuing a Request for Proposal (RFP) for the IDR entity. The law requires that the IDR must use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process.

New York ACEP leadership as mentioned above has met multiple times with the DFS to share the concerns of our membership. We have provided them with many examples from other states including California and Illinois. We are now focused on getting as much clarification and benefit for our membership in the regulations as they become apparent.

We also realize that following the implementation of these regulations, the effect on Emergency Medicine across the state must be monitored closely. We plan to put together a group of strategic advisors to assist in our response to the effect of the regulations. I want to assure you that we are concerned and have also heard your concerns.

I think our best response is always to advocate for our patients. They deserve access to medical care 24/7/365. We should be there for them. To make that possible, we also should receive fair and just payment for our services to keep our doors open and our providers working.

We proudly cared for the victims of 9/11, the Boston Marathon, the flooding of New York’s east coast due to hurricane Sandy, flu outbreaks, the D68 respiratory virus, and now possibly even the Ebola virus. We stand in the breech as the safety net for our health system around the clock. Let’s keep our eye on the ball.

*To the Editor:
Re "Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not" ("Paying Till It Hurts" series, Sept. 29):

With sadness, I read the Out of Network Emergency Care article. Patients are right. They should not have large bills for medical care when they have health insurance.

Emergency Medicine physicians care for all patients who come to our door 24/7/365, when they are in pain, dying, intoxicated, abusive, or infectious. We only ask for fair compensation. When that is not possible, physicians are forced to remain outside of insurance networks. There is an answer.

The independent not for profit organization, Fair Health, created by Governor Cuomo when serving as Attorney General, sets compensation rates which Emergency Physicians are willing to accept. Are the insurers? Why isn't Fair Health being used? It is time for patients to ask this as well.

Emergency Physicians cared for patients of 9/11, the Boston Marathon bombing, Hurricane Sandy, and we will be on the front line for future events. Creating an adversarial relationship between physicians and patients does not ensure patients receive needed care. We encourage all parties, including insurers, to make sure patients have 24/7/365 access to care.

Louise A. Prince, MD FACEP
President, New York American College of Emergency Physicians

Dr. Prince’s letter to the editor was not selected for publication.*
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Sound Rounds
Practical Applications for the Emergency Physician
Basic Echocardiography

Indications
• Chest Pain
• Undifferentiated shortness of breath
• Syncope
• Hypotension

Technique
• Use a low frequency phased array probe
• The usual convention in all emergency ultrasound applications is to maintain the ultrasound monitor indicator on the left of the image displayed (Figure 1). This is opposite to the cardiology convention where the indicator appears on the right side of the screen. The location of this indicator must be noted, as images may appear flipped on the screen.

Parasternal Long (PSL) View
• Place probe at approximately 4th intercostal space on anterior chest wall with probe marker pointing towards the patient’s left hip (Figures 2a, 2b)

Parasternal Short (PSS) View
• After finding PSL view, take the probe and turn it 90° clockwise with probe marker pointing towards the patient’s right hip (Figures 3a, 3b)
Apical 4-chamber (A4C) View

- Place probe just inferior and slightly lateral to left nipple with the probe marker pointing towards the patient’s right side. (Figures 4a, 4b)
- Angle the probe up into the patient’s chest, viewing the heart through the apex.
- Gentle pressure should be applied to visualize the heart through the anterior chest rib spaces.

Subxiphoid (Subcostal) View

- Place probe underneath the xiphoid process with the marker pointing towards the patient’s right side. (Figures 5a, 5b)
- Gentle pressure should be applied and the probe angled up into the chest. Use the liver as an acoustic window.

Pericardial effusion

- Subxiphoid view is the most sensitive for a pericardial effusion seen inferiorly between the right ventricle and liver (Figure 6a)
- The descending aorta (DA) is used as a landmark in PSL view: a pericardial effusion appears anechoic above the DA; pleural effusions appear anechoic below the DA (Figure 6b)
- Tamponade is a large effusion seen on echo with diastolic collapse of the RV and RA free walls (Figure 6c)

Ejection Fraction

- Assessment of left ventricular (LV) ejection fraction is obtained qualitatively by visualizing wall motion or squeeze on all 4 cardiac views.
- Ejection fraction (EF) is classified as normal >50%, moderately depressed 30-50% or severely depressed <30%.
- An example of severely depressed EF is found in dilated cardiomyopathy where the LV is dilated and hypokinetic (Figure 7)
Aortic root

- The parasternal long view is the best for assessment of the thoracic aortic root.
- The aortic root diameter is determined by using the “leading edge” technique by measuring the outside wall-to-inside wall (Figure 8a). A normal root is < 4cm and a measurement above this indicates a thoracic aortic aneurysm (Figure 8b).

Right Ventricular Strain (RV:LV ratio):

- The apical 4-chamber view allows for comparison of relative chamber sizes. A RV:LV ratio of 0.6:1.0 is considered normal. Anything greater than or equal to 1:1 is considered significant and indicative of right ventricular strain (Figure 9).

Tips

- For the subxiphoid view, make sure to apply enough pressure, flatten the probe to angle up into the chest and increase the depth control on the machine.
- If the A4C view is difficult to obtain, turn the patient in the left lateral decubitus position.
- If an effusion is suspected, always get a subxiphoid view to confirm its presence.

Pitfalls and Limitations

- Mistaking an epicardial fat pad for a pericardial effusion. A fat pad will normally be seen on a SX or PSL view above the RV as a hypoechoic area that possesses some echoes within it (Figure 10), unlike a pericardial effusion, which is entirely anechoic (Figures 6a, b, c).
- Mistaking a pleural effusion for a pericardial effusion. On a PSL view, an anechoic fluid collection appearing above the descending aorta is in the pericardium and fluid below the descending aorta is located in the pleural cavity (Figure 6b).
- Pathology may be incorrectly identified if probe positioning is not correct. For example, the sonographer may mistake a dilated RV for a normal LV if the probe is flipped.
- Incorrectly measuring the thoracic root. Remember to practice the “leading edge” technique and be generous with your measurement.
- It is not always possible to obtain all four cardiac views on every patient. Perform as many views as possible to gather the information you need.

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Expanding Ketamine’s Usage in the ED

Despite being broadly discussed in social media, seasoned emergency physicians are reluctant to embrace ketamine for all its wonderful indications. The most likely reason for this is that, historically, this drug has been stymied by 40 year old research with broad and incorrect conclusions which permeated our profession and lead to a skepticism of ketamine. Journal headlines read like this: “Ketamine is contraindicated in cranioencephal trauma--fact or fiction?” Based predominantly on dog and rat models, these misconceptions of adverse effects and contraindications have lead to a general fear of the drug and ultimately limited its use. Fortunately, through social media, thought leaders in our field have been bringing research to the forefront and translating it for us in order to fight dogma with evidence.

Ketamine is generally accepted as a useful agent for procedural sedation, however, with the increased attention turned to the drug, we are developing a greater understanding of its potential and expanding its usage. This brief review will discuss ketamine safety in head trauma patients and will focus on its value for agitated delirium and as an agent for analgesia.

Ketamine Dosing:

**Induction agent for Intubation:**
Dosing: 1-2mg/kg IV slow push or 4-5mg/kg IM; with half dose repeated PRN

**Analgesia:**
Dosing: 0.2mg/kg IV and infusion at 0.1-0.15mg/kg/hour

**Agitated Delirium:**
Dosing: 5mg/kg IM or 2mg/kg IV/IO

Intubation Induction agent for head trauma patients: Though there does not exist the coup-de-gras article that definitively states that ketamine is safe to use in head trauma patients, a number of articles have been published disputing the conclusions of the original articles from the 1970s, including an excellent systematic review published online in Annals of EM in July 2014. This ultimately seats providers in a grey-area where we know that older literature does not stand to our more modern scientific rigors, nor does it have any newer supportive literature. All that being said, providers should feel quite confident that ketamine will not be deleterious in patients with head trauma (excluding those with a space occupying lesion or CSF obstruction). There is no doubt that ketamine will raise the systolic blood pressure (SBP) and quite possibly the ICP; however, the pressure we care about in head trauma is the cerebral perfusion pressure (CPP). Among trauma patients with low or borderline SBP or elevated ICP, the additional benefits of sympathetic stimulation that ketamine provides may be crucial to mitigate the potential cerebral hypotension and hypoperfusion which can significantly increase morbidity during the peri-intubation period.

Analgesia

Another instance of ketamine’s expanded usage in the emergency department (ED) is for analgesia. Its analgesic properties are well described in the literature, however, it has failed to gain a foothold in clinical practice. Ketamine interacts with NMDA receptors involved in pain pathways and helps reduce the need for opioids. There is very minimal respiratory depression and airway reflexes are preserved. Clinical scenarios where it should be considered are for whom opiates may not be a reasonable choice due to allergy, unfavorable adverse effects of opiates (nausea, hypotension), history of opioid abuse, opiate tolerance, and severe pain. It is even being touted in oncology and palliative care studies to reduce the need for opioids. Providers administering the drug must be familiar with the drugs spectrum of effects, and how it is wiser to start with low doses and titrate to effect, to avoid patients from going to the recreational dosage range (where they might get loopy and take a trip down the “k hole”). As an added benefit for those with co-morbid psychiatric illnesses, ketamine is showing promise as a fast-acting treatment for PTSD (post-traumatic stress disorder) and depression.

Agitated Delirium

You see these patients in the ED. It typically occurs among men with history of psychiatric illness who are active substance abusers. In those with true excited delirium (tachycardic, tachypneic with labs showing severe acidosis), ketamine plays a very nice role as a sedation medication as it acts very rapidly (3-4 minutes), can be given IM and it will not affect the respiratory drive, whereas benzodiazepines have the propensity to depress it, especially if there is significant alcohol in the system as well. Knowing the value of ketamine for agitated or excited delirium syndrome is essential for emergency physicians; it is a high risk medical emergency that affects both the patient and the providers trying to care for the patient, as everyone is at risk for injury. Patients can have fever, mania, be violently aggressive, and intolerant to other de-escalation methods. By using ketamine, in this setting it is essentially procedural sedation for the purpose of caring for the patient, and if the patient ultimately requires intubation, so be it.
**Adverse Effects**

As always, it is important to know the more common and higher risk adverse effects of a medication you are about to administer. In the case of ketamine, the common side-effects (laryngospasm, hypersecretion, and emergence reaction) are easy to manage, however, preparation and anticipation can certainly mitigate worse outcomes. Laryngospasm can occur rarely, and can usually be weathered via briefly performing bag-valve-mask ventilation. Hypersecretion will simply require suctioning. Emergence reactions have been demonstrated to be reduced or mitigated by administering benzodiazepines. A final word of caution about the drug that we must be familiar with are the different concentrations that may be stocked in your ED (either 10mg/ml, 50 mg/ml or 100mg/ml); consequently, never blindly accept a syringe labelled as ketamine without the concentration clearly written on it.

Clearly, further research is needed to examine and maximize ketamine’s potential as a drug. In addition to sedation, analgesia, and agitated delirium, there is an exciting ongoing study of ketamine for use in migraine, depression, PTSD, psychosis, complex regional pain syndrome, stroke, and post-operative delirium. For further information about what’s being discussed now online; search twitter #Ketamine

**References**


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Staffing Etc., a Health Care Services and Staffing company, has an immediate opportunity with the CDC to provide Physicians of any specialty to be Medical Officers for assessment of Ebola exposure risk at John F. Kennedy International Airport and Newark Liberty International Airport. Physicians will provide medical expertise in conducting entry screening procedures that mitigate public health risk from travelers coming from Ebola-affected countries. This service will include assessing travelers’ Ebola exposure risk by using CDC-developed guidance for establishing and identifying risk currently published on CDC Website (www.cdc.gov).

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Staffing Etc. VOL 32-02:14
What’s New with Prehospital Therapeutic Hypothermia?

The treatment of cardiac arrest is a continuum from the event to the ICU, and, ideally, to meaningful recovery. We know now, perhaps more than ever, of the importance of basic life support in facilitating survival. For all of the drugs and advanced procedures we, and our prehospital partners, can provide for patients, it still isn’t clear that anything has as much benefit as good CPR.

Hypothermia has become the standard of care for many cardiac arrest patients who achieve ROSC (return of spontaneous circulation). This is provided in the field, in the emergency department (ED), in the cardiac catheterization laboratory and in the intensive care unit. While I would hesitate to suggest that there is no controversy about cooling patients once they reach the emergency department, there is certainly a wide range of practice patterns regarding prehospital cooling.

Anyone caring for cardiac arrest patients has a vested interest in this topic as what is done in the field necessitates a discussion about whether to continue the same interventions in the ED, in the lab and even in the ICU. If our prehospital partners are cooling patients in the field, do we continue this in our departments? What if cooling is not continued in the catheterization laboratory or on the unit? How do we cool patients in the field - invasively or non-invasively? Is there a target temperature to achieve before patients even arrive at the ED? How fast should prehospital providers cool patients? I would suggest that many of these questions apply to what we do in the ED as well. How then can we provide medical direction for our EMS partners and ensure the best care for these critical patients?

I would suggest that, as with all important questions in medicine, we turn to the literature. In 2013 and 2014 thus far, there have been many important papers published that can help us navigate this varied terrain.

The first one is a randomized clinical trial by Nielsen et al. published in 2013 in the New England Journal of Medicine. The Target Temperature Management (TTM) trial was conducted in 36 ICUs across Europe and Australia. Adult patients were eligible if, among other criteria, they had a GCS less than eight after out-of-hospital arrest of presumed cardiac cause, and had at least 20 consecutive minutes of spontaneous circulation after resuscitation. Patients were excluded if the interval between ROSC and potential enrollment was greater than four hours or if they had an unwitnessed arrest with asystole as the initial finding. The groups had target temperatures of 36° C and 33° C. The intervention time was 36 hours. The primary outcome was all-cause mortality through the end of the trial. There was no significant difference in the primary outcome between groups.

Some have taken the limited finding of no benefit at 33° and extrapolated that prehospital cooling is thus not beneficial. I don’t think we can reasonably draw any such conclusion. Perhaps all this study tells us is that we aren’t sure cooler is better, not that targeted temperature management is useless. The time to initiation was around 25 minutes which may actually suggest that sooner is better and support prehospital initiation.

The other major study is by Kim et al. and published in JAMA earlier this year. This has been a practice-changing study. The study was a randomized trial of adults with ROSC following prehospital cardiac arrest. Intervention patients received up to two liters of 4° C normal saline, pancuronium and diazepam. The saline was infused peripherally. Patients were included regardless of initial rhythm (VF or non-VF). The primary outcomes were survival and neurologic status at discharge. Enrollment was from 2007 through 2012. Of the 688 patients in the intervention group, the average decrease in temperature by the time of ED arrival was 1.20° C to 1.30° C. There were no differences between groups in either of the primary outcomes. The intervention group had higher rates of rearrest in the field, pulmonary edema, and prehospital time.

The results of this study have been used in some systems to stop prehospital cooling. Others have reexamined how they cool patients and changed protocols. Some have commented that even if there was no difference in the intervention, the increase in side effects justified stopping the practice. I think the answer may be much more complicated.

Looking back to the start of the trial enrollment in 2007, and where we are now, much has changed. The CPR guidelines changed in 2010 and management of ROSC patients has evolved. It is difficult to assess particular therapies in the context of an ever-changing landscape. One question this study raises is if cooling is not being started early enough. Perhaps we should be asking our prehospital partners to begin cooling patients during the arrest itself?

Several limitations in the study should be acknowledged and carefully scrutinized. The first is that these patients received intravenous cooling whereas surface cooling is a different modality that cannot be lumped together. Does the fluid bolus harm an already stunned myocardium? In addition, more patients in the intervention group had rearrest. Did this have an effect on ischemia to the brain and subsequent outcomes?

If one looks at the animal studies that preceded the human trials, I think we can reasonably conclude that the earlier the better in terms of cooling, to the point of intra-arrest cooling or very shortly thereafter. In this trial by Kim et al., the interval to reach target temperature was 4.0-5.5 hours in the control group and 3.0-4.2 hours in the intervention group. Maybe we need to cool even earlier?

The use of saline may not be the best method for cooling. Perhaps we need to...
perform similar trials using surface cooling or other techniques that do not increase the intravascular volume significantly and seem to decrease coronary perfusion pressure.

These two articles seem to put the brakes on the hypothermia movement both in the hospital setting and the prehospital setting. I think, however, as particularly related to the second article, a close reading reveals that perhaps a specific method of cooling does not have a definite benefit and may have some harm. This should prompt us to look at other methods, not abandon the intervention altogether.

There have been a number of other articles published in 2013 and 2014 that address the prehospital hypothermia discussion and I would like to comment briefly on just some of them.

A meta-analysis published earlier this year by Hunter et al. looked at combined data from four different randomized trials of prehospital hypothermia and found no difference in outcome. The mean temperature difference was small, -0.8°C to -1.3°C. A similar meta-analysis by Diao et al. came to the same conclusion from all but one of the individual papers used in the Hunter meta-analysis.

Komatsu et al. published a study looking at factors predicting good neurologic outcomes in patients with post-cardiac-arrest syndrome. Therapeutic hypothermia was one of the factors they evaluated. It had a trend toward significance with an OR of 1.64 (0.28-9.52, 95% CI). The only factor that independently predicted good neurologic outcome was time to ROSC.

How do we interpret these findings and, more so, potentially change our clinical practice and the practices of our EMS partners? I would like to make several suggestions.

1. Don’t take my word for it. Please review the studies I have listed and look at the data yourself. My opinion is just that. If you search PubMed for prehospital hypothermia, as a starting point, and then look at papers from 2013 and 2014, you will find a manageable number of articles that you can review.

2. Host a journal club for interested participants. At a minimum, the following professionals should be invited: EMS providers in your area, ED physicians, interventional cardiologists, and cardiac (or general) intensivists. Everyone has a role.

3. Don’t immediately throw out prehospital hypothermia for cardiac arrest.

4. If, however, you are using boluses of chilled saline as described in the Kim et al. article, consider stopping this.

5. Investigate and look for potential practice-changing articles forthcoming about other methods of cooling such as intra-nasal and intra-arrest cooling. (See the references to de Bourmont et al., Lyon et al., and Tommasi et al.)

I think my second point is perhaps the most practical. Find out what everyone involved is thinking. This relates to number three as well. If your EMS partners are cooling patients, and then that stops in the ED or in the ICU, we need to reevaluate the system as a whole.

I hope that you, as I do, remain convinced of the potential of therapeutic hypothermia in the prehospital setting. We just have not established the best way to do this in the context of a systemwide approach from arrest to ICU.

As a CPR instructor for the AHA, I would like to close by pointing out what I started with - - good CPR and basic life support should be our primary goal. If you can help your community develop PAD programs and increase CPR training, you are making a tangible difference. If you can help your EMS agencies develop comprehensive cardiac arrest protocols (perhaps including hypothermia) and train with other agencies, you are making a tangible difference. And if we work together as a healthcare community to prevent cardiac arrest, we are making a tangible difference.

References


Does the Dose of Adenosine Need to be Adjusted in Patients Taking Carbamazepine?

ACLs guidelines state:

“… adenosine does have several important drug interactions. Larger doses may be required for patients with a significant blood level of theophylline, caffeine, or theobromine. The initial dose should be reduced to 3 mg in patients taking dipyridamole or carbamazepine, those with transplanted hearts, or if given by central venous access. Side effects with adenosine are common but transient; flushing, dyspnea, and chest discomfort are the most frequently observed. Adenosine should not be given to patients with asthma. “

No references are provided in the multiple publications referring to this recommendation. The question is what is the basis of this recommendation for an interaction between carbamazepine and adenosine?

The main mechanism of action for carbamazepine is inhibition of voltage-gated sodium channels. However, we know very well that carbamazepine can effect multiple different receptor types and could be considered a very non-selective drug. There is evidence that carbamazepine can block L-type calcium channels. These mostly have effects in the central nervous system. There is some evidence supporting the effect of carbamazepine on adenosine receptors in the brain. Several reports have demonstrated that it may act as an antagonist at adenosine A1 receptors. Application or chronic treatment with carbamazepine induces upregulation of adenosine A1 receptors in astrocytes and rats. In addition, some studies have shown it to be an agonist at adenosine A2 receptors centrally. None of the studies that have demonstrated effects on adenosine have evaluated those specific to cardiac adenosine receptors.

In overdose, carbamazepine is associated with tachycardia due to its anticholinergic effects. In addition, its structural similarity to cyclic antidepressants has led to some similar electrical conduction defects with QRS prolongation due to blockade of cardiac sodium channels. However, in chronic use of carbamazepine the potential cardiac consequences are very different. It appears that the recommendations are based upon the multiple case reports of intermittent high degree atrioventricular blocks in patients chronically using carbamazepine. All of the patients reported had therapeutic levels. Their dysrhythmias (AV block) improved with discontinuation of carbamazepine. The mechanism for this effect is unclear.

The upregulation of adenosine receptors which occurs in the brain sounds like a potential concern for the myocytes. However, the interaction with adenosine seems to be unproven and theoretical. There are no case reports or animal experiments supporting this recommendation that I could find. However, if there is no good evidence then I would encourage a re-evaluation of this recommendation by the American Heart Association or the sponsoring of a study to support this recommendation.

References

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Send letters of introduction and curriculum vitae to Daniel G. Murphy, MD, MBA, FACEP, Chairman, Department of Emergency Medicine, SBH Health System, 4422 Third Avenue, Bronx, NY, 10457 or dmurphy@sbhny.org.

St. Barnabas Hospital has changed its name to SBH Health System. As a leader in the transformation of healthcare, SBH Health System brings you a new model of care that focuses on health and wellness, prevention of illness and caring for the whole you.
Case: Genevieve is a 46-year-old woman who presents to the emergency department with an acute exacerbation of chronic abdominal pain. On physical exam, she is found to have tenderness at McBurney's point, with rebound and guarding. A previous entry in the patient's medical chart reads, “Consider drug-seeking behavior.” The patient is difficult, being hostile to staff and demanding pain medication in a loud voice. The nurse turns to Dr. Ritter, the emergency physician, and asks him, “Do you really want me to line and lab her up?”

Simon et al. uses the definition of the difficult patient to one “who interferes with a physician's attempts to establish a normal therapeutic relationship.” It would be helpful, however, for physicians to move away from the difficult patient paradigm to that of the more neutral model of the difficult patient-physician encounter. In this way, it is the encounter and not the patient that is labeled as “difficult.” The inclusion of the word physician in difficult patient-physician encounter is appropriate because it recognizes that there may be certain physician factors that can also lead to, or at least contribute to, the difficult encounter. The sole emphasis on “the maladaptive behavior” of the patient, with no consideration of physician factors, is a reflection of the outdated paternalistic model of medicine. Contemporary medicine has moved toward a patient-centric model of care, and the concerns of the patient, including the frustrations of the patient towards the “difficult physician,” ought to be duly considered.

Emergency physicians have an ethical duty to care for patients, a duty that extends to difficult patients. The Emergency Medical Treatment and Labor Act (EMTALA) is US law. Emergency physicians are legally bound to provide medical care for all patients, regardless of how pleasant or difficult they may be. Physicians found in violation of EMTALA can expect disciplinary as well as legal action against them.

EMTALA establishes a legal mandate, but emergency physicians should also adhere to the ethical codes established by the American Medical Association and the American College of Emergency Physicians. They both mention that even difficult patients must be treated with compassion and respect. Furthermore, the physician must refrain from denying treatment to a patient because of a judgment based on discrimination. This implies that the physician may not refuse to treat based merely on his or her dislike for the patient.

The duty to care for the patient is balanced with the physician's right to avoid harm. While it is often understood that the physician must avoid harming the patient, it is also true that the physician has the right to avoid harm from the patient. The physician should not need to suffer physical or emotional abuse from the patient. Reconciling the duty to care with the right to avoid harm means that the emergency physician has a duty to care for all, even the patient considered to be difficult, unless the patient is directly threatening the physician either verbally or physically. Therefore, the factors commonly linked to the difficult patient, such as mental illnesses or personality disorders, are not sufficient grounds to terminate the patient-physician relationship.

Iserson's Rapid Ethical Decision-Making Model, a 3-step tool, can help emergency physicians navigate this common ethical dilemma. First, the physician asks himself if there is a precedent case from which a rule can be applied to the new case. In this case, Dr. Ritter is faced with a difficult patient who presents with an acute exacerbation of chronic abdominal pain. Should the nurse obtain an IV catheter to administer pain medication and to facilitate CT imaging with IV contrast? The CT scanner will not only expose the patient to radiation, but it is also a limited resource that must be shared with other patients. Furthermore, the CT imaging will result in a delay in disposition of the patient, meaning the patient’s bed will not be ready for a new patient in the waiting room. In this case, Dr. Ritter can ask himself, “In the previous patient I had taken care of who had a similar history and physical exam—with right lower quadrant tenderness, rebound, and guarding—did I administer pain medication and obtain a CT scan?” When asked in this way, the clinical decision may become obvious: the patient is at risk for acute appendicitis, a condition that indicates pain medication and CT imaging. The emergency physician should seek to apply clinical decision-making tools to aid decision-making in caring for difficult patients, as these tools often consider signs and symptoms as opposed to patient personality.

If, however, there is no precedent case or rule that can reasonably be applied to the situation, Iserson's approach dictates that the physician ask himself whether or not the clinical decision can be delayed. In the case of the difficult patient, this is often appropriate, because the patient-physician relationship may sometimes improve with...
time. In the vignette above, if the patient's physical exam were a bit less worrisome, then Dr. Ritter could potentially order pain medication and carry out serial abdominal examinations. Genevieve may become more pleasant once she is given pain medication, and her physical exam may become more reliable as well. However, delay in decision-making can only be done so long as no harm is expected to come to the patient as a result of it. In the case above, there is enough concern for acute appendicitis that decision-making cannot reasonably be delayed.

The third step of Iserson's method requires the physician to ask himself three questions: (a) The Impartiality Test asks whether or not the physician would accept the clinical decision if he were in the place of the patient, (b) the Universalizability Test asks whether the physician's colleagues would make the same clinical decision in the given scenario, and (c) the Interpersonal Justifiability Test asks whether or not the clinical decision is defensible to others, namely the physician's colleagues, supervisors, and the general public. All three of these questions would give Dr. Ritter clear guidance as to how to proceed: he knows that he would want his right lower quadrant pain taken seriously if he were the patient (Impartiality Test), that another provider would be expected to follow an acute appendicitis protocol if taking care of a similar patient (Universalizability Test), and that he would not have a well-substantiated defense if brought before a court for a missed appendicitis based on that particular patient presentation (Interpersonal Justifiability Test).

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**December 2014**

- 3 Emergency Medicine Resident Committee Conference Call 6:00 pm
- 10 Education Conference Call 1:30 pm
- 10 Professional Development Conference Call 3:30 pm
- 11 Practice Management Conference Call 1:00 pm
- 17 Government Affairs Conference Call 11:00 am
- 17 Research Conference Call 3:00 pm
- 18 EMS Conference Call 2:30 pm

**January 2015**

- 7 Emergency Medicine Resident Committee Conference Call 6:00 pm
- 8 Practice Management Conference Call 1:00 pm
- 14 Education Conference Call 1:30 pm
- 14 Professional Development Conference Call 3:30 pm
- 15 EMS Conference Call 2:30 pm
- 21 Government Affairs Conference Call 11:00 am
- 21 Research Conference Call 3:00 pm

**February 2015**

- 4 Emergency Medicine Resident Committee Conference Call 6:00 pm
- 11 Education Conference Call 1:30 pm
- 11 Professional Development Conference Call 3:30 pm
- 12 Practice Management Conference Call 1:00 pm
- 18 Government Affairs Conference Call 11:00 am
- 18 Research Conference Call 3:00 pm
- 18 Emergency Medicine Resident Committee Conference Call 6:00 pm
- 19 EMS Conference Call 2:30 pm
- 24 Board of Directors Meeting and Lobby Day MSSNY Headquarters, Albany, New York 9:00 am - 4:30 pm
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resident representative
Dr. Rebecca Parker, member of the ACEP Board of Directors, was kind enough to share with me pearls from her experience with ACEP. Dr. Parker offers us advice on how to get involved, stay involved and benefit from participation with ACEP both locally and nationally.

"The Value of Getting Involved with your National Organization"

1. How did you first get involved with ACEP?
   Dr. Parker recounts that as a resident she attended the council meeting in 1996. She was inspired by ACEP and EMRA and ran for vice speaker of EMRA from the floor. She didn’t get elected but came back next spring and was elected to the EMRA Board of Directors. In addition, she was an alternate ACEP councilor representing EMRA. During her involvement with EMRA, Dr. Parker worked on their website. Later when she was running for the Texas Board she used her website experience as part of her platform. Though she did not win that election, the website idea took and she was elected to the Texas ACEP Board the following year.
   Her time as a member of Texas ACEP was fruitful; she found a mentor in Dr. Angela Gardner, was the chair of the Education Committee and was elected to the Texas Board. Dr. Parker later joined the Illinois chapter where she also sat on the Board. In addition she has participated on several national ACEP committees. She is now on the ACEP Board of Directors.

2. How has ACEP affected your career?
   “ACEP has been huge for my career, it’s my home.” Dr. Parker spoke passionately on her experience learning to be a leader from the great leaders in our specialty. She saw their visions, developed her own, and importantly, was exposed to a group that supported each other’s visions for emergency medicine. Through this she reports ACEP has been a resource for her personal and professional development.

3. What has been the greatest benefit you have received from your involvement with ACEP?
   • The people you meet.
   • Professional development and leadership skills.
   • Getting to interact early on with the leaders of our specialty

4. For a new grad who is beginning to pay back loans, and looking to buy a house, and questions why they should spend money on ACEP membership, what would you tell them?
   There are many reasons to join ACEP. It is inherent in the “value” of ACEP; the organization’s advocacy piece keeps dollars in your pocket. Not to forget that ACEP is a place for development in academics and the private practice environment. The people and connections are all pieces of the value.
   Early on there are incentives to young physicians including reduced dues rates for graduates of EM residencies over the first three years. In addition, EM residents, medical students, and those in fellowship training programs are offered one free section membership and additional section memberships at a reduced rate.

5. If someone is a new grad, and wants to know how to get “more involved” with ACEP, what guidance can you offer them?
   “Find your passion and pick the things that interest you.” Dr. Parker recommends getting started locally with your state chapter. Join committees and participate. Parallel your work with ACEP with your other professional goals. For example if you are interested in getting involved in resident education join your chapter’s education committee. For Dr. Parker, attending the coding conference lead to her joining the coding committee and eventually chairing that committee. At the same time the experience she gained with the coding committee helped in her other professional endeavors. Overall, Dr. Parker’s message was clear; it’s best if you follow your interests.

6. Which ACEP committees would you suggest for a new grad looking to join?
   Dr. Parker says starting on the state level with committee work helps prepare you for the national level. “State leadership is a big help to navigate you through”. She also notes that sections are a great place to start on the national level. She advises to attend the section and committee meetings.
   It was a pleasure to sit down and speak with Dr. Parker. We at New York ACEP thank her for her time and advice.

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Ask the Experts

Nicole Berwald
MD FACEP
Associate Chair, Department of Emergency Medicine, Staten Island University Hospital

Rebecca B. Parker
MD FACEP
Chair of the ACEP Board of Director

Connect with an experienced emergency medicine physician. Read more at this link http://nyacep.org/mentoring
Life on the Interview Trail

The countdown started on July 1, the first day of my last year as an emergency medicine resident. Finally I could see the light at the end of the tunnel. All the nights studying at the library and the hours in the hospital paid off. In one year I would no longer be a resident, but an emergency medicine physician. As excited as I was at the prospect of being done, I had one last hurdle to jump, the job interview.

In typical fashion, I set up a list and became organized. The first thing to complete was my CV. I had been updating my old CV from medical school, but this was a whole different ball game. I needed some reference materials, so I emailed the graduated seniors and a few attendings to get copies of their prior CV’s. After getting a good idea about what my CV should entail it was clear, my CV needed a complete makeover. I worked diligently to make changes and once the final product was ready I sent it out for review to my colleagues.

The next thing on my agenda was to meet with our residency director and chairman of the emergency department. Luckily for me, our residency program sets up meetings with all graduating residents to help with career planning. I brought my CV and got valuable feedback to get me started. I also got a lot of advice on how to start my job search. Unlike my colleagues, I decided I was going to look for jobs back home in California. It’s a lot harder to look for a job outside of the state you do your residency in. You’re unfamiliar with the medical groups and hospitals and don’t have that built in network. But as much as I loved living in New York City I wanted to go back home. And with my plan in place I got started on my “job search.”

I started earlier than most of my colleagues because I was looking for a job out of state. I had procured the names of all major medical groups in the area I was looking for. To remain organized I built a spreadsheet with the names of the hospitals and major medical groups in the area where I was looking. Once my CV was ready I started by sending it to all the major groups. Luckily for me I got an interview with a group in California right away. After that I started preparing for “The Interview”.

I spruced up my interviewing techniques by creating a word document filled with responses to possible interview questions. I also had a document for important questions that I would ask them, that way I could make sure I got all the information I needed. Most importantly I asked my attendings for advice and got a ton. Some really stuck with me. 1. Be early! It makes a bad impression if you’re late even if you have a good excuse. 2. Be able to talk about anything you’ve placed on your CV. 3. Be yourself. With these pearls of wisdom in my pocket I was ready.

The week before I left on my first interview one of my attendings told me something that I will always remember, “Interviewing for jobs is completely different than residency. In residency when you interview you are trying to show them how great you are because all you want is for them to choose you. For the first time when you interview for a job the tables are turned. It’s not just about them choosing you it’s also about you choosing them! Once you interviews are over and you have a couple of offers to choose from, you get the choice of where you go.” I had been on a ton of interviews before, for medical school then for residency but this time felt different; for the first time I was interviewing for a job to start my career. With that piece of wisdom in my pocket I boarded my plane to go to my first job interview.

The day of my interview I made sure I was prepared. I had extra copies of my resumes, cover letter and references. I arrived approximately 30 minutes before my interview to ensure I wasn’t late and went over all my answers to possible interview questions. When the time finally came for my interview I was nervous but prepared. I then got my first question, “So tell me about yourself?” I was well prepared for this first question and launched into my five minute description that was well rehearsed, waiting for the next question. But there wasn’t another question. The rest of the interview consisted of them telling me all about their medical group, the hospital and all the benefits of working with them. I continued to ask them questions about their group to get the information I needed and waited for any other questions to come my way. But before I knew it the interview was over.

As I was leaving I remembered what my attending had told me, when you interview for a job it’s about YOU CHOOSING THEM!

My advice for all the residents that are currently in the interviewing process or will be there soon is 1. Be prepared. Even though I may not have needed all the prep work I put in for my first interview, you never know. Making sure I was prepared for any possible outcome helped to relieve some of the stress of that first interview. 2. Ask for support. One of the greatest assets I have as I continue in this process is the support I have from attendings, graduated residents and family. This is a stressful time and having the support really makes your life easier. 3. Make Lists. It really does help keep you organized. The most important list is the ones after the interviews to keep track of the things you liked at each place. That way when you make the choice of which offer to choose from you can compare all the places you interviewed at. 4. Just breathe. Remember that this time, when you interview you’re choosing them. Make sure to get all the information you need when you interview so you can choose a job that’s right for you.
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At first Dr. Larry Geisler had doubts about working in a contract management environment. But when St. Mary Medical Center in Langhorne, PA, made a change to TeamHealth in 2005, Dr. Geisler says everything changed for the better. Patient visits are up. He has far fewer administrative headaches than before. And as Assistant Medical Director, he has plenty of opportunity for professional growth. The best part? His close-knit family and church can count on him for what they need most—his time.

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Antibiotic prophylaxis for ED patients with simple hand lacerations: a feasibility randomized controlled trial.

Berwald N(1), Khan F(2), Zehtabchi S(3); Department of Emergency Medicine, Staten Island University Hospital, Staten Island, NY; Am J Emerg Med. 2014 Jul;32(7):768-71.

BACKGROUND: The benefit of antibiotic prophylaxis for simple hand lacerations (lacerations that do not involve special structures) has not been adequately studied.

OBJECTIVE: To assess the feasibility of a randomized controlled trial to determine the role of antibiotic prophylaxis in emergency department (ED) patients with simple hand lacerations.

METHODS: Randomized, double-blind, placebo-controlled pilot trial in 2 urban academic EDs. Adult (≥18 years old) patients with simple hand lacerations were randomized to cephalaxin, 500 mg; clindamycin, 300 mg; or placebo (every 6 hours for 7 days, all in identical capsules).

OUTCOMES: (1) feasibility determined by the number of patients who agreed to enroll and number of patients who completed follow-up, (2) infection rate (determined by 2 physicians at 10-14 days), (3) satisfaction with wound appearance (measured by a visual analogue scale at 30 days via phone). Medians, quartiles, and percentages with 95% confidence intervals (CI) were used to present data. Groups were compared with Kruskal-Wallis and Fisher exact tests, when appropriate.

RESULTS: Over a 5-month period, 123 patients were approached, and 78 consented to enrollment (63%; 95% CI, 55-71%). Five were lost to follow-up (5/78, 6%; 95% CI, 2%-14%). Only one patient had infection on follow-up for an infection rate of 1% (95% CI, 0.01%-8%). Patient's satisfaction with wound appearance did not differ among the groups.

CONCLUSION: The findings of this pilot study support the feasibility of a randomized, double-blind, controlled trial. The low rate of infection suggests the need of a large sample size for the trial.

The effect of point-of-care ultrasonography on emergency department length of stay and computed tomography utilization in children with suspected appendicitis.

Elikashvili I(1), Tay ET, Tsung JW; Departments of Emergency Medicine and Pediatrics, Divisions of Pediatric Emergency Medicine, Mount Sinai School of Medicine, New York, NY; Acad Emerg Med. 2014 Feb;21(2):163-70.

OBJECTIVES: The role of clinician-performed ultrasonography (US) for suspected appendicitis is unclear. Published data conclude that US has high specificity to rule in the diagnosis of appendicitis, with variable sensitivity to rule it out. Newer data suggest that point-of-care (POC) US may have similar test characteristics. Our objective was to evaluate the effect of POC US in children with suspected appendicitis and its effect on emergency department (ED) length of stay (LOS) and computed tomography (CT) utilization.

METHODS: This was a prospective observational convenience sample of children with suspected appendicitis requiring imaging evaluation that adhered to the Standards for Reporting of Diagnostic Accuracy Studies (STARD) criteria. Outcomes were determined by operative or pathology report in those who had appendicitis, and 3-week phone follow-up in those patients who were nonoperative. Differences in ED LOS were analyzed by one-way analysis of variance (ANOVA) between patients who received dispositions after POC US, radiology US, or CT. Test performance characteristics were calculated for all imaging modalities.

RESULTS: Among 150 enrolled patients, 50 had appendicitis (33.3%). There were no missed cases of appendicitis in discharged patients at 3-week phone follow-up, nor negative laparotomies in those who went to the operating room. Those who had radiography US (n=25) had a significantly decreased mean ED LOS (154 minutes, 95% confidence interval [CI] 115 to 193 minutes) compared with those requiring radiology US (288 minutes, 95% CI=257 to 319 minutes) or CT scan (487 minutes; 95% CI=434 to 540 minutes). Baseline CT rate was 44.2% (95% CI=30.7% to 57.7%) prior to study start and decreased to 27.3% (95% CI=20.1% to 34.4%) during the study. CTs were avoided in four patients with conclusive POC US results and inconclusive radiology US results. The sensitivity, specificity, positive likelihood ratio (LR+), and negative likelihood ratio (LR-) for POC US were: 60% (95% CI=46% to 72%), 94% (95% CI=88% to 97%), 10 (95% CI=4 to 23), and 0.4 (95% CI=0.3 to 0.6). For radiology US they were: 63% (95% CI=48% to 75%), 99% (95% CI=94% to 99%), 94 (95% CI=6 to 1,500), and 0.4 (95% CI=0.3 to 0.6); and for CT they were: 83% (95% CI=58% to 95%), 98% (95% CI=85% to 99%), 45 (95% CI=3 to 707), and 0.2 (95% CI=0.05 to 0.5).

CONCLUSIONS: It may be feasible to reduce ED LOS and avoid CT scan when using POC US to evaluate children with suspected appendicitis. Test characteristics for POC US have high specificity to rule in appendicitis, similar to radiology US. Addition of POC US prior to sequential radiology imaging was safe, without missed cases of appendicitis or negative laparotomies.
Effect of microEEG on clinical management and outcomes of emergency department patients with altered mental status: a randomized controlled trial.


OBJECTIVES: Altered mental status (AMS) is a common presentation in the emergency department (ED). A previous study revealed 78% electroencephalogram (EEG) abnormalities, including nonconvulsive seizure (NCS; 5%), in ED patients with AMS. The objective of this study was to assess the impact of EEG on clinical management and outcomes of ED patients with AMS.

METHODS: This was a randomized controlled trial at two urban teaching hospitals. Adult patients (≥18 years old) with AMS were included. Excluded patients had immediately correctable AMS (e.g., hypoglycemia) or were admitted before enrollment. Patients were randomized to routine care (control) or routine care plus EEG (intervention). Research assistants used a scalp electrode set with a miniature, wireless EEG device (microEEG) to record standard 30-minute EEGs at presentation, and results were reported to the ED attending physician by an off-site epileptologist within 30 minutes. Primary outcomes included changes in ED management (diagnostic, diagnostic work-up, and treatment plan from enrollment to disposition) as determined by surveying the treating physicians. Secondary outcomes were length of ED and hospital stay, intensive care unit (ICU) requirement, and in-hospital mortality.

RESULTS: A total of 149 patients were enrolled (76 control and 73 intervention). Patients in the two groups were comparable at baseline. EEG in the intervention group revealed abnormal findings in 93% (95% confidence interval [CI]=85%-97%), including NCS in 5% (95% CI=2%-13%). Using microEEG was associated with change in diagnostic work-up in 49% (95% CI=38%-60%) of cases and therapeutic plan in 42% (95% CI=31%-53%) of cases immediately after the release of EEG results. Changes in probabilities of differential diagnoses and the secondary outcomes were not statistically significant between the groups.

CONCLUSIONS: An EEG can be obtained in the ED with minimal resources and can affect clinical management of AMS patients.

Classification accuracy of serum Apo A-I and S100B for the diagnosis of mild traumatic brain injury and prediction of abnormal initial head computed tomography scan.


The objective of the current study was to determine the classification accuracy of serum S100B and apolipoprotein (apoA-I) for mild traumatic brain injury (mTBI) and abnormal initial head computed tomography (CT) scan, and to identify ethnic, racial, age, and sex variation in classification accuracy. We performed a prospective, multi-centered study of 787 patients with mTBI who presented to the emergency department within 6 h of injury and 467 controls who presented to the outpatient laboratory for routine blood work. Serum was analyzed for S100B and apoA-I. The outcomes were disease status (mTBI or control) and initial head CT scan. At cutoff values defined by 90% of controls, the specificity for mTBI using S100B (0.899 [95% confidence interval (CI): 0.78-0.92]) was similar to that using apoA-I (0.902 [0.87-0.93]), and the sensitivity using S100B (0.252 [0.22-0.28]) was similar to that using apoA-I (0.249 [0.22-0.28]). The area under the receiver operating characteristic curve (AUC) for the combination of S100B and apoA-I (0.738, 95% CI: 0.71, 0.77), however, was significantly higher than the AUC for S100B alone (0.709, 95% CI: 0.68, 0.74, p=0.001) and higher than the AUC for apoA-I alone (0.645, 95% CI: 0.61, 0.68, p=0.0001). The AUC for prediction of abnormal initial head CT scan using S100B was 0.694 (95% CI: 0.62, 0.77) and not significant for apoA-I. At a S100B cutoff of <0.060 g/L, the sensitivity for abnormal head CT was 98%, and 22.9% of CT scans could have been avoided. There was significant age and race-related variation in the accuracy of S100B for the diagnosis of mTBI. The combined use of serum S100B and apoA-I maximizes classification accuracy for mTBI, but only S100B is needed to classify abnormal head CT scan. Because of significant subgroup variation in classification accuracy, age and race need to be considered when using S100B to classify subjects for mTBI.


BACKGROUND: Methods of defining hospital disaster preparedness are poorly defined in the literature, leaving wide discrepancies between a hospital’s self-reported preparedness and that assessed by an objective reviewer.

OBJECTIVES: This study compared self-reported surge capacity data from individual hospitals, obtained from a previously reported long-distance tabletop drill (LDTT) prior to the 2010 FIFA World Cup tournament in Cape Town, South Africa, with surge capacity data assessed by an on-site survey inspection team.

METHODS: In this prospective, observational study, contact persons used in the prior LDTT assessing hospital disaster preparedness in the lead-up to the 2010 FIFA World Cup made surge capacity assessments (licensed bed capacity plus surge capacity beds) for the respiratory intensive care unit (RICU), neonatal intensive care unit (NICU), medical intensive care unit (MICU), and general medical/surgical beds in each hospital. Following the 2010 World Cup, this data was then re-evaluated by an on-site survey team consisting of two of the authors.

RESULTS: The contact persons for the individual hospitals from the LDTT underestimated their individual hospital’s surge capacity in 86% (95% CI, 46%-99%) of RICUs; 100% (95% CI, 63%-100%) of MICUs; 75% (95% CI, 40%-94%) of NICUs; and 71% (95% CI, 35%-92%) of medical/surgical beds compared with the on-site inspection team.

CONCLUSIONS: The contact persons for the LDTT overwhelmingly underestimated changes in probabilities of differential diagnoses and the secondary outcomes were not statistically significant between the groups.

continued on page 24
North Shore-LIJ is America’s third largest, non-profit, secular health system, with a network of 17 hospitals serving the greater New York metropolitan area. Our Department of Emergency Medicine Services includes the Emergency Departments of five tertiary care teaching hospitals, a children’s hospital, several community hospitals, urgent care centers and our new Freestanding Emergency Department in Greenwich Village.

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surge capacity determined by the on-site inspection team.

Re-evaluating the diagnostic accuracy of the tongue blade test: still useful as a screening tool for mandibular fractures?

Caputo ND(1), Raja A, Shields C, Menke N; Department of Emergency Medicine, Lincoln Medical and Mental Health Center, Bronx: Emerg Med Int 2013 Jul;45(1):8-12.

BACKGROUND: Mandibular fractures are one of the most frequently seen injuries in trauma. In terms of facial trauma, mandible fractures constitute 40%-62% of all facial bone fractures. The tongue blade test (TBT) has been shown to be a sensitive screening tool when compared with plain films. However, recent studies have demonstrated that computed tomography (CT) scan is more sensitive for determining mandible fractures than the traditionally used plain films.

OBJECTIVE: The purpose of the study was to determine the sensitivity and specificity of the TBT as compared with the new gold standard of radiologic imaging, CT scan.

METHODS: Any patient suffering from facial trauma was prospectively enrolled during the study period (August 1, 2010 to April 11, 2012) at a single urban, academic Emergency Department. A TBT was performed by the resident physician and confirmed by the supervising attending. CT facial bones were then obtained for the ultimate diagnosis. Inter-rater reliability was calculated, along with sensitivity, specificity, negative predictive value, and likelihood ratio (-) based on a 2 x 2 contingency table generated.

RESULTS: During the study period, 190 patients were enrolled. Inter-rater reliability was p = 0.96 (95% confidence interval [CI] 0.93-0.99). The following parameters were then calculated based on the contingency table: sensitivity 0.95 (95% CI 0.88-0.98), specificity 0.68 (95% CI 0.57-0.77), negative predictive value 0.92 (95% CI 0.82-0.97), and likelihood ratio (-) 0.07 (95% CI 0.03-0.18).

CONCLUSIONS: Based on the test characteristics calculated (negative predictive value 0.92, sensitivity 0.95, likelihood ratio -0.07), the TBT is a useful screening tool to determine the need for radiologic imaging.

Diagnosing pulmonary edema: lung ultrasound versus chest radiography.


BACKGROUND: Diagnosing the underlying cause of acute dyspnea can be challenging. Lung ultrasound may help to identify pulmonary edema as a possible cause.

OBJECTIVE: To evaluate the ability of residents to recognize pulmonary edema on lung ultrasound using chest radiographs as a comparison standard.

METHODS: This is a prospective, blinded, observational study of a convenience sample of resident physicians in the Departments of Emergency Medicine (EM), Internal Medicine (IM), and Radiology. Residents were given a tutorial on interpreting pulmonary edema on both chest radiograph and lung ultrasound. They were then shown both ultrasounds and chest radiographs from 20 patients who had presented to the emergency department with dyspnea, 10 with a primary diagnosis of pulmonary edema, and 10 with alternative diagnoses. Cohen’s p values were calculated to describe the strength of the correlation between resident and gold standard interpretations.

RESULTS: Participants included 20 EM, 20 IM, and 20 Radiology residents. The overall agreement with gold standard interpretation of pulmonary edema on lung ultrasound (74%, p = 0.51, 95% confidence interval 0.46-0.55) was superior to chest radiographs (58%, p = 0.25, 95% confidence interval 0.20-0.30) (P < 0.0001). EM residents interpreted lung ultrasounds more accurately than IM residents. Radiology residents interpreted chest radiographs more accurately than did EM and IM residents.

CONCLUSION: Residents were able to more accurately identify pulmonary edema on lung ultrasound than with chest radiograph. Physicians with minimal exposure to lung ultrasound may be able to correctly recognize pulmonary edema on lung ultrasound.

Triage vital signs do not correlate with serum lactate or base deficit, and are less predictive of operative intervention in penetrating trauma patients: a prospective cohort study.


BACKGROUND: Triage vital signs are often used to help determine a trauma patient’s haemodynamic status. Recent studies have demonstrated that these may not be very specific in determining major injury. The purpose of this study was to determine if there is any correlation between triage vital signs, base deficit (BD) and lactate, and to determine the odds of operative intervention in penetrating trauma patients.

METHODS: A prospective observational cohort study was undertaken. Baseline vital signs, BD and lactate were recorded in all patients for whom the trauma team was activated. Pearson correlation and coefficient were calculated. ORs were calculated.

RESULTS: 75 patients were enrolled. Pearson correlations and coefficients calculated for lactate to systolic blood pressure were: -0.052 (p=0.0011, 95% CI -0.225 to 0.228); lactate and HR: 0.23 (p=0.0166, 95% CI -0.211 to 0.242); lactate and RR: 0.23 (p=0.054, 95% CI -0.174 to 0.277). BD to systolic blood pressure were: 0.003 (p=0.00001, 95% CI -0.229 to 0.224); BD and HR: -0.19 (p=0.038, 95% CI -0.399 to 0.038); BD and RR: -0.019 (p=0.0004, 95% CI -0.244 to 0.208). Odds of operative intervention were greater in patients with abnormally high lactate, OR 4.17 (95% CI 1.57 to 11), but not for BD, OR 2.53 (95% CI 0.99 to 6.45), or any of the vital signs.

CONCLUSIONS: Triage vital signs have no correlation to lactate or BD levels in penetrating trauma patients. Odds of operative intervention are greater in patients with abnormally high serum lactate levels, but not in those with abnormal triage vital signs or BD.

Ethics Seminars: A Best-practice Approach to Navigating the Against-Medical-Advice Discharge.

Clark MA(1), Abbott JT, Adyanthaya T; The Department of Emergency Medicine, Mt. Sinai St. Luke’s Mt. Sinai Roosevelt, The Icahn School of Medicine at Mount Sinai, New York, NY; Acad Emerg Med. 2014 Sep;21(9):1050-1057

continued on page 26
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Patients who sign out or choose to leave the emergency department (ED) against medical advice (AMA) present important challenges. The current approach to the complex legal, ethical, and medical challenges that arise when adult patients decline medical care in the ED would benefit from a systematic best-practice strategy to maximize patient care outcomes, minimize legal risk, and reach the optimal ethical standard for this at-risk population. Professional responsibilities generated during an AMA encounter include determination of patient decision-making capacity, balancing protection of patient autonomy with prevention of harm, providing the best alternatives for patients who decline some or all of the proposed plan, negotiating to encourage patients to stay, planning for subsequent care, and documenting what transpired. We present two cases that illustrate key insights into a best-practice approach for emergency physicians (EPs) to address problems arising when patients want or need to leave the ED prior to completion of their care. We propose a practical, systematic framework, ”AIMED” (assess, investigate, mitigate, explain, and document), that can be consistently applied in situations where patients consider leaving or do leave before their evaluations and urgent treatment are complete. Our goal is to maximize patient outcomes, minimize legal risk, and encourage a consistent and ethical approach to these vulnerable patients.

Whole-body computed tomographic scanning leads to better survival as opposed to selective scanning in trauma patients: A systematic review and meta-analysis.

Caputo ND(1), Stahmer C, Lim G, Shah K. Department of Emergency Medicine (N.D.C., C.S.); Lincoln Medical and Mental Health Center, Bronx; and Department of Emergency Medicine (G.L., K.S.), Icahn School of Medicine, Mount Sinai Hospital, New York, New York; J Trauma Acute Care Surg. 2014 Oct;77(4):534-9.

BACKGROUND: Traumatic injury in the United States is the number 1 cause of mortality for patients 1 year to 44 years of age. Studies suggest that early identification of major injury leads to better outcomes for patients. Imaging, such as computed tomography (CT), is routinely used to help determine the presence of major underlying injuries. We review the literature to determine whether whole-body CT (WBCT), a protocol including a noncontrast scan of the brain and neck and a contrast-enhanced scan of the chest, abdomen, and pelvis, detects more clinically significant injuries as opposed to selective scanning as determined by mortality rates.

METHODS: Scientific publications from 1980 to 2013 involving the study of the difference between pan scan and selective scan after trauma were identified. The Preferred Reporting Items for Systematic Reviews and Meta-analyses was used. Publications were categorized by level of evidence. Injury Severity Score (ISS) and pooled odds for mortality rate of patients who received WBCT scan versus those who received selective scans were compared.

RESULTS: Of the 465 publications identified, 7 were included, composing of 25,782 trauma patients who received CT scan following trauma. Of the patients, 52% (n = 13,477) received pan scan and 48% (n = 12,305) received selective scanning. Overall ISS was significantly higher for patients receiving WBCT versus those receiving selective scan (29.7 vs. 26.4, p < 0.001, respectively). Overall mortality rate was significantly lower for WBCT versus selective scanning (16.9; 95% confidence interval [CI], 16.3-17.6 vs. 20.3; 95% CI, 19.6-21.1, p < 0.0002, respectively). Pooled odds ratio for mortality rate was 0.75 (95% CI, 0.7-0.79), favoring WBCT.

CONCLUSION: Despite the WBCT group having significantly higher ISS at baseline compared with the group who received selective scanning, the WBCT group had a lower overall mortality rate and a more favorable pooled odds ratio for trauma patients. This suggests that in terms of overall mortality, WBCT scan is preferable to selective scanning in trauma patients.

Medical utilization of kiosks in the delivery of patient education: a systematic review.


BACKGROUND: The utilization of kiosks has previously been shown to be effective for collecting information, delivering educational modules, and providing access to health information. We discuss a review of current literature for the utilization of kiosks for the delivery of patient education.

METHODS: The criteria for inclusion in this literature review were: (1) study discusses the utilization of kiosks for patient health education; (2) study discusses the use of touch screens for patient health information; (3) published in English. Our review includes searches via MEDLINE databases and Google Scholar for the years 1996-2014.

RESULTS: Overall, 167 articles were screened for final eligibility, and after discarding duplicates and non-eligible studies with abstract. Full-text review of 28 articles was included in the final analysis.

CONCLUSION: The review of available literature demonstrates the effectiveness of touch screen kiosks to educate patients and to improve healthcare, both at a performance and cost advantage over other modes of patient education.

Adolescents’ and young adults’ perspectives on their emergency care.


OBJECTIVES: The aim of this study was to assess the perspectives of adolescents and young adults seen in the emergency department (ED) on the optimal age for transition from a pediatric ED (PED) to an adult ED (AED) as well as the appropriateness of their assigned ED site. Secondary aims were to determine ED physicians’ understanding and assessment of their psychosocial needs, to determine whether subjects had a primary care provider (PCP), as well as to identify resources they felt would improve their ED experience. METHODS: This study used in-person structured interviews on a convenience sample of ED patients aged 15 to 25 years. Data were analyzed with the SPSS for Windows (v15.0) using t tests and uncertainty coefficients.

RESULTS: We interviewed 200 subjects; the mean age was 20.5 (SD, 3) years, 65% were female, and 54% were seen in the PED. The subjects reported a mean age of 18.5 years as optimal for transition to an AED (mode, 18; second peak, 21); only 5% chose an age older than 21 years. The AED subjects more likely felt that their site of care was appropriate (Likert scale, 1-3; 2.5 vs 2.2, P < 0.05). HEADSS (Home, Education/Employment,
Activity, Drugs, Sexuality, Suicide) topics were rarely addressed in both ED sites. The PED subjects more often identified a PCP (87% vs 68%); there was no difference in notifying their PCP (27% vs 19%). The PED subjects more often desired magazines (83% vs 70%) and entertainment videos (61% vs 34%).

CONCLUSIONS: Adolescents and young adults identify the age of 18 years as optimal for transition from a PED to an AED setting. Instituting a standardized HEADSS assessment protocol and offering age-appropriate resources may enhance the emergency experience for this population.

Epidemiology of Nursemaid’s Elbow.

INTRODUCTION: To provide an epidemiological description of radial head subluxation, also known as nursemaid’s elbow, from a database of emergency department visits.

METHODS: We conducted a retrospective medical record review of patients 6 years of age and younger, who presented to the ED between January 1, 2005, and December 31, 2012, and were diagnosed with nursemaid’s elbow. Inclusion criteria consisted of chart information, including date, unique account number, medical record number, weight, age, sex, and arm affected. Exclusion criteria included any charts with missing or incomplete data.

RESULTS: There were 1,228 charts that met inclusion criteria. The majority of patients were female (60%). The mean age was 28.6 months (±12.6). The left arm was affected 60% of the time. Most of the included patients were over the 75(th) percentile for weight and more than one quarter were over the 95(th) percentile in each gender.

CONCLUSION: The average age of children presenting with nursemaid’s elbow was 28.6 months. Females were affected more than males, and the left arm was predominately affected. Most patients were above the 75(th) percentile for weight and more than one quarter were over the 95(th) percentile for weight.

Emergency physician awareness of prehospital procedures and medications.


INTRODUCTION: Maintaining patient safety during transition from prehospital to emergency department (ED) care depends on effective handoff communication between providers. We sought to determine emergency physicians’ (EP) knowledge of the care provided by paramedics in terms of both procedures and medications, and whether the use of a verbal report improved physician accuracy.

METHODS: We conducted a 2-phase observational survey of a convenience sample of EPs in an urban, academic ED. In this large ED paramedics have no direct contact with physicians for non-critical patients, giving their report instead to the triage nurse. In Phase 1, paramedics gave verbal report to the triage nurse only. In Phase 2, a research assistant (RA) stationed in triage listened to this report and then repeated it back verbatim to the EPs caring for the patient. The RA then queried the EPs 90 minutes later regarding their patients’ prehospital procedures and medications. We compared the accuracy of these 2 reporting methods.

RESULTS: There were 163 surveys completed in Phase 1 and 116 in Phase 2. The oral report had no effect on EP awareness that the patient had been brought in by ambulance (86% in Phase 1 and 85% in Phase 2.) The oral report did improve EP awareness of prehospital procedures, from 16% in Phase 1 to 45% in Phase 2, OR=4.28 (2.5-7.5). EPs were able to correctly identify all oral medications in 18% of Phase 1 cases and 47% of Phase 2 cases, and all IV medications in 42% of Phase 1 cases and 50% of Phase 2 cases. The verbal report led to a mild improvement in physician awareness of oral medications given, OR=4.0 (1.09-14.5), and no improvement in physician awareness of IV medications given, OR=1.33 (0.15-11.35). Using a composite score of procedures plus oral plus IV medications, physicians had all three categories correct in 15% of Phase 1 and 39% of Phase 2 cases (p<0.0001).

CONCLUSION: EPs in our ED were unaware of many prehospital procedures and medications regardless of the method used to provide this information. The addition of a verbal hand-off report resulted in a modest improvement in overall accuracy.

Adherence to head computed tomography guidelines for mild traumatic brain injury.
Jones LA(1), Morley EJ(2), Grant WD(1), Wojcik SM(1), Paolo WF(1); Department of Emergency Medicine, SUNY Upstate Medical University, Syracuse, New York. (2)Department of Emergency Medicine, Stony Brook University Medical Center, Stony Brook, New York; West J Emerg Med. 2014 Jul;15(4):459-64.

INTRODUCTION: Traumatic brain injury (TBI) is a significant health concern. While 70-90% of TBI cases are considered mild, decision-making regarding imaging can be difficult. This survey aimed to assess whether clinicians’ decision-making was consistent with the most recent American College of Emergency Physicians (ACEP) clinical recommendations regarding indications for a non-contrast head computed tomography (CT) in patients with mild TBI.

METHODS: We surveyed 2 academic emergency medicine departments. Six realistic clinical vignettes were created. The survey software randomly varied 2 factors: age (30, 59, or 61 years old) and presence or absence of visible trauma above the clavicles. A single important question was asked: “Would you perform a non-contrast head CT on this patient?”

RESULTS: Physician decision-making was consistent with the guidelines in only 62.8% of total vignettes. By age group (30, 59, and 61), decision-making was consistent with the guidelines in 66.7%, 47.4%, and 72.7% of cases, respectively. This was a statistically-significant difference when comparing the 59- and 61-year-old age groups. In the setting of presence/absence of trauma above the clavicles, respondents were consistent with the guidelines in 57.1% of cases. Decision-making consistent with the guidelines was significantly better in the absence of trauma above the clavicles.

CONCLUSION: Respondents poorly differentiated the “older” patients from one another, suggesting that respondents either inappropriately apply the guidelines or are unaware of the recommendations in this setting. No particular cause for inconsistency could be determined, and respondents similarly under-scanned and over-scanned in incorrect vignettes. Improved dissemination of the ACEP clinical policy and recommendations is a potential solution to this problem.
Recently my institution opened an off-campus emergency department, commonly referred to as a Free-Standing ED. Months, if not years in planning, the heavy load fell on my Department Chair and our senior leadership team. My role was minimal, but I’d like to share three things I learned going through the process with regards to how EMS can and should interact with a Free-Standing ED as more and more pop up around the state.

Establish a performance-based contract for interfacility ambulance services.

Off-campus emergency department generally have little capacity for boarding and obviously require the transport of any patient requiring inpatient services to an alternate facility. In our case, the new ED was 21 miles and a little more than a half hour away from our main facility in a predominantly rural area. Making sure that the interfacility transport provider could meet the needs of our Free-Standing ED 24/7, and provide all levels of care – BLS, ALS, and Specialty Care Transport (multiple drips and potentially ventilated patients) was critical. Further, we felt it important to have response time expectations (from time of request to time at the facility) of our contract service. We chose 15 minutes for STAT transports (acute stroke, STEMI, multi-system trauma) and 30 minutes for all other transports. This was predicated on two pillars: Patient care and patient flow. From a patient care perspective, for example, we wanted to make sure our walk-in STEMI patient can get to the nearest cardiac catheterization laboratory in a timely manner. From a flow perspective, there are only so many beds and limited staff in this small facility compared to larger area ED’s, so patient throughput is critical to overall ED operations.

An institutional workgroup created a Request for Qualifications for Interfacility Ambulance Transport that included a number of items, but most importantly the qualifications of their personnel and the response time performance expected. Although only in operation since August, 2014, the interfacility operation has worked very smoothly and regular meetings with the contractor assures standardization and improvement of processes to minimize any delays in interfacility transport. Like any new venture, a few hiccups were of course inevitable – such as a baby born in the Free-Standing ED and determining the best means of transporting the mother and baby to the inpatient OB unit at a separate hospital.

Educate EMS on who is, and who is not appropriate to transport to your Free-Standing ED.

OUTSTANDING EM OPPORTUNITIES

⇒ Programs for residents—inquire for details
⇒ Career development/advancement opportunities
⇒ Sites commutable from New York City
⇒ New rates with RVU incentives at most sites

Jeremy T. Cushman
MD MS EMT-P FACEP
Chief, Division of Prehospital Medicine
Associate Professor of Emergency Medicine
University of Rochester
It is extremely important that regular, ongoing communication take place with the EMS agencies that may transport patients to your Free-Standing ED. The New York State Department of Health Bureau of EMS was particularly helpful in this regard, for through this process they recognized that in some cases the Free-Standing ED provided the best possible chance for a patient with a life threatening condition – such as an airway obstruction, or even cardiac arrest – and it was appropriate for EMS to transport there since it is significantly closer than other area ED’s with inpatient capabilities. At the same time, EMS should not be transporting patients that have a high likelihood of requiring inpatient admission. As there are no validated tools that allow EMS to accurately predict this, we encouraged patients with a concerning history suggestive of acute coronary syndrome for example, to preferentially be transported to a facility with inpatient capacity. Similarly, this Free-Standing ED does not have any psychiatric services, so informing EMS of this limitation allows them to route the patient to a more appropriate facility with those resources. On the other hand, patients with an episode of hypoglycemia or injury not meeting major trauma criteria requiring transport to a trauma center are more than welcome. In the end, we provide the information to EMS and allow them to use their best judgment. So far, only a very small fraction of patients transported by EMS to our Free-Standing ED are subsequently transported out for inpatient or subspecialty care.

**Ensure your REMAC evaluates patient care protocols.**

We made sure our REMAC reviewed patient care protocols to make sure there were no changes required as a result of a Free-Standing ED. For example, our facility chose to provide on-line medical direction and met all the requirements set forth by our REMAC as there were no conflicts with existing policy or procedure. We also identified that particularly with our STEMI, acute stroke, and major trauma protocols that all of them indicated transport to designated centers in our area, so no specific protocols had to be modified as EMS should continue to transport patients meeting those criteria to those designated centers (of which our Free-Standing ED is not). We were careful not to “protocolize” the transport of patients to our Free-Standing ED based on simple “ALS” or “BLS” transport criteria as that is a very blunt and nonspecific instrument to determine the patient’s inpatient needs. Rather, we provided information on the resources of the free standing ED (lab, xrays, CT, board certified EM physicians and experienced EM nurses, etc) and encouraged them when in doubt to contact the medical control physician at that facility to discuss the best destination options for the patient.

As the traditional model of Emergency Departments attached to an inpatient hospital begins to change, there will undoubtedly be a learning curve on how EMS can both direct appropriate patients to these facilities, as well as how EMS can facilitate their transport out. As your system may consider a Free-Standing ED, be sure to actively engage your department’s EMS expertise and the surrounding EMS community – it will only better serve your patients – and your staff.
Election/State Budget Update

Activity in Albany has focused on the November elections when all 213 State legislators, Governor Andrew Cuomo, Attorney General Eric Schneiderman and State Comptroller Thomas Dinapoli were up for re-election.

State budget planning at the Capitol has been underway since August and will continue for the remainder of the calendar year. Governor Andrew Cuomo’s 2015-16 proposed State Budget which is scheduled to be released in mid-January is expected to be conservative. In late September, the Director of the Budget, Robert Mega, released the annual “call letter” to state agency heads asking them to submit zero growth budgets for next year. The Governor is committed to keeping overall spending growth to two percent or less over the course of his administration.

Out-of-Network (OON) Law

New York ACEP and Reid, McNally & Savage (RMS) have been working with the Department of Financial Services (DFS) since June of this year on the implementation of the new law to regulate out-of-network health insurance, including billing, reimbursement and consumer disclosure for health care services provided to patients by “out-of-network” providers who do not participate in a patient’s health insurance plan.

New York ACEP was successful in getting an exemption in the law from the Independent Dispute Resolution (IDR) process for emergency services when the amount billed is under $600 after any applicable patient cost sharing and it does not exceed 120% of the Usual and Customary Cost (UCC) for the specific CPT code. The dollar amount for the procedure codes that are exempt must be adjusted by the average of the annual average inflation rates for medical care commodities and medical care services components of the consumer price index. UCR is defined as the 80th percentile of all charges for a particular health service performed by a particular provider in the same or similar specialty in the same geographic region as reported by a not-for-profit entity. At this time Fair Health has been confirmed as the only entity that meets the criteria for the not-for-profit entity.

Based on our analysis, the exemption won by New York ACEP will include claims for evaluation, management, and most observation care provided by emergency physicians. This is the only exemption granted to physicians in the new law. There is no prohibition on balance billing for emergency services. The health plan is responsible for ensuring that the patient incurs no greater out-of-pocket costs than they would with a participating provider.

New York ACEP has corresponded (6-27, 8-29, and 10-15) and met with the DFS Deputy Superintendent for Health, Troy Oechsner and his staff (7-30, 10-6) several times this year. Our initial strategy was to focus on development of the DFS regulations for the IDR process to ensure timely and adequate payment to emergency physicians for the services they provide to patients. Over the past four months we have had detailed discussions with DFS on the draft regulations. New York ACEP’s priorities include ensuring that:

• Claims are bundled so that the process is affordable and manageable for emergency physicians who handle an extremely high volume of low to moderate cost claims;
• Physicians do not have to exhaust internal health plan appeals before proceeding to the IDR process with a dispute;
• Emergency physicians receive payment directly from health plans.

In addition, New York ACEP has recommended that the legal responsibility of health plans to ensure that patients are held harmless from greater out-of-pocket costs when the provider is out-of-network is addressed in a DFS guidance document that will be released before the end of the 2014 or early in 2015.

In our discussions with DFS, New York ACEP stressed that there are a number of frequently billed CPT codes for emergency services where the amount billed is relatively modest ($602.28 to $1,024.80) but is in excess of the criteria for an exemption from the IDR process. The IDR process will be meaningless if the physician’s cost of using it exceeds the potential benefit of winning an appeal against an insurance company. We presented the process in the State of California as an alternative. California has a very reasonable complaint fee schedule that allows up to 50 “substantially similar” claims that involve the same or similar services and the same payer for a maximum fee of $600.

New York ACEP is scheduled to meet with Troy Oechsner and other staff at DFS November 14. DFS has concerns that claims can’t be batched because the criteria to be used by the IDR entity must include the “circumstances and complexity of the particular case, including time and place of service” and “level of training, education and experience of the physician.”

In an October 6 meeting with DFS New York ACEP responded that the complexity of the case could be determined by the CPT code. With respect to the education and training of the physician, we noted that data sources such as the CAQ Universal Provider Datasource could be used as a resource. In an October 15, follow-up letter to DFS we pointed out that the “training, education and experience” for all emergency physicians is already prescribed in State regulations (405.19 (b) (2) and 405.19 (d) (1) (a) and (b)).

With respect to the timeframe for IDR decisions, DFS confirms that a determination must be made within 30 days of the receipt of a dispute with no requirement to first exhaust internal appeals of a health plan. They are looking for quick resolution of disputes with no delays or ability by either party to “stop the clock.”

DFS is in agreement with New York ACEP that health care plans should pay providers directly for emergency services. They are considering putting forth legislation in the 2015 Legislative Session to require direct payments to providers.
State regulations on the IDR process will be published in the State register prior to December 31. In addition, a guidance document will be issued on the law by the end of this year or early in 2015. The law is effective April 1, 2015.

New York ACEP will continue to meet with DFS on the development of the guidance document to press for the legal obligation of health plans to “hold patients harmless” from out-of-pocket costs to be included in the document.

New York ACEP’s strategy going forward is to brief key State legislators and staff on the status of implementation issues and seek their assistance and guidance. Meetings will be scheduled in Albany after the November elections to begin the education of the key players.

Outlook for 2015
The State Legislature will return to Albany Tuesday, January 6 for the 2015 Legislative Session. State Budget negotiations will dominate activity for the first 3 months of the year. New York ACEP will hold its annual Advocacy Day Tuesday, February 24, 2015. The turnout for Advocacy Day has been increasing every year.

Mark your calendar now
ED Leadership Forum
Friday, May 1, 2015
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New York ACEP
Young Physician and Resident Leadership and Advocacy Award
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Young physician candidates must be within their first three years of practice. Resident candidates must be in good standing in an accredited residency program within New York State. Special consideration will be given to resident candidates planning to practice in New York State.

Maximum reimbursement of $1,000 per recipient.

To download a nomination form and learn more about award requirements and selection criteria, go to https://nyacep.org/leadership-and-advocacy

2014 New York ACEP Councillors
New York ACEP was represented by 24 councillors at the ACEP Council meeting, October 25-26, 2014 in Chicago, IL.

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Virgil W. Smaltz, MD MPA FACEP
Peter Viscelio, MD FACEP
Nicole Yuzuk, MD, resident representative

2014 Alternate Councillors
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Eric L. Legome, MD FACEP
Joshua Moskovitz, MD MPH FACEP
Katherine M. Nacca, MD
Annabella Salvador-Kelly, MD FACEP

The State Legislature will return to Albany Tuesday, January 6 for the 2015 Legislative Session. State Budget negotiations will dominate activity for the first 3 months of the year. New York ACEP will hold its annual Advocacy Day Tuesday, February 24, 2015. The turnout for Advocacy Day has been increasing every year.
ABEM MOC

Maintenance of Certification® (MOC) was designed by the American Board of Medical Specialties (ABMS) to ensure that physicians are committed to lifelong learning and competency in their specialties.1 ABMS set a required four (4) part framework that ABEM implements and monitors. The MOC process is mandated by ABMS for all EM and EM subspecialty diplomates and is here to stay. It has been driven by governmental policy makers, public demand and private payers who have demanded a reporting and monitoring system for physician continuing education and maintenance of certification.

ABEM MOC is further divided into Four (4) parts which are easily accessible on the ABEM website www.abem.org and I’ve outlined the below to help break it down:

ABEM MOC Part I: Professional Standing (Licensure)
1. Maintain medical licensure in compliance with ABEM Policy on Medical Licensure
2. Provide evidence of licensure to ABEM at the end of your 10-year ABEM MOC cycle.

ABEM MOC Part II: Life Long Learning & Self Assessment (LLSA + CME)
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1. Pass the ConCert examination at least every 10 years

ABEM MOC Part IV : Assessment of Practice Performance (APP)
1. Complete one Practice Improvement (PI) activity in years 1 through 5 of your certification and one PI activity in years 6 through 10 of your certification
2. Complete one Communication/Professionalism (CP) activity in years 1 through 5 of your certification and one CP activity in years 6 through 10 of your certification.

Of these, Part II and Part IV are the most complicated so let’s take a deeper dive into these requirements and what you need to do to meet the requirements.

The LLSA test is published in April of the preceding year and consists of 20 to 30 questions that are developed based on the annual readings. A list of 10 to 15 readings based on the EM Model will be posted on the ABEM website each year.2 The readings are clinically oriented (Review articles, original research, clinical policy statements, special contributions) and taken from a cross-section of journals (AEM, NEJM, JAMA and Annals of EM). You register and take the test on the ABEM website.

Once registered for an LLSA test, you get three tries. (Passing score is 85%) The CME requirements you self report completion and attestation with the possibility of an audit.

The APP (part IV) which seems the most daunting is composed of 2 parts (Practice Improvement [PI] and Communication/Professionalism [CP] activities).3 It is again a self-reporting attestation of completion of these activities which are certified by your ED directors.

A PI activity must include the following four steps:
1. Review patient clinical care data from ten additional patients with the same presentation, disease, or clinical process as the first patient data review.
2. Complete one Communication/Professionalism (CP) activity in years 1 through 5 of your certification and one CP activity in years 6 through 10 of your certification.
3. Develop and implement a plan to improve the practice issue measured in Step #1.
4. After implementing the improvement plan, review patient clinical care data from ten additional patients with the same presentation, disease, or clinical process as the first patient data review.

A CP activity must use an experience of care survey that measures physician behaviors from the three (3) categories listed below:
1. Communications/listening
2. Providing information
3. Showing concern for the patient

To incentivize this, CMS offers an additional 0.5% payment called the PQRS MOC additional reimbursement. You may register on the ABEM site for this after completing one LLSA test, one PI activity, and one CP activity. ABEM will then notify CMS. New grads take note; these requirements kick in the year after you become fully certified (pass your orals)

Another great resource is a talk on ABEM MOC by Dr. Terry Kowalenko. It is available for free online at: bit.ly/ABEM-MOC. Lots of information and FAQ’s are provided at the links in the references. You can also just call ABEM at 517.332.4800 and they will gladly help you navigate through the MOC.

References
The Department of Emergency Medicine of the University of Rochester (URMC) is expanding our faculty group. We are seeking Emergency Medicine and Pediatric Emergency Medicine BC/BE Faculty for positions at our primary academic site, as well as our community affiliates and off-campus emergency department.

Seeking faculty for:
• Academic EM Positions
• Academic Pediatric EM positions
• Community EM positions

The Department of Emergency Medicine includes a highly regarded EM Residency, an active research program, and fellowship programs including Pediatric EM, International Medicine, Research, and Ultrasound. Strong Memorial Hospital (SMH) is the academic medical center and is the regional referral and Level 1 trauma center. It has a full complement of specialist consultant services, as well as ED-based social workers, pharmacists, and child-life specialists. SMH sees over 100,000 patients per year, including 28,000 pediatric patients. The new Golisano Children’s Hospital at Strong is set to open in the summer of 2015. Our multiple community EDs and off-campus ED offer physicians the opportunity to practice in varied settings, experiencing a mix of acuity and patients in both adult and pediatric age groups.

Successful candidates will be dynamic individuals, interested in a diverse Emergency Medicine experience with great potential for career development, promotion, and longevity within our department. Ample opportunity exists to be actively involved in education, administration, and research.

Rochester, New York, located in Upstate New York, offers excellent schools, a low cost of living, and many opportunities both professionally and personally. We have easy access to Canada, including metropolitan Toronto, the Great Lakes, the Finger Lakes and the northeastern United States.

Interested applicants please contact:
Michael Kamali, MD, FACEP
Chair, Department of Emergency Medicine
Michael_Kamali@URMC.Rochester.edu
585-463-2970
Congratulations are extended to new fellows of the American College of Emergency Physicians

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Warm Holiday Wishes

The New York ACEP office will be closed December 22-26 and January 1-2
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