

HEALTH CARE FROM 38K FEET:  
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# ACEP Now

The Official Voice of Emergency Medicine

JANUARY 2014

Volume 33 Number 1

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## PLUS



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Should end-of-life care begin in the ED?

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[www.acepnow.com](http://www.acepnow.com)

## Dr. Klauer's First and Last Editor's Column for ACEP Now

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### ACEP NOW EXCLUSIVE!

# ACA Roundtable Discussion

5 of the most vocal emergency medicine voices speak out on the Affordable Care Act

by BRYN NELSON, PHD

### INTRODUCTION

With some of its most hotly contested provisions now taking effect, the Affordable Care Act (ACA)—or Obamacare, as both backers and detractors now call it—has been the object of admiration and animosity, of optimism and consternation. Hailed by some as the most significant health-care reform in a half century, it has been roundly scorned by others as an ill-advised debacle.

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## CMS Clarifies Use of Pain Posters in the ED

CMS Response to South Carolina Hospital Association Goes Far Beyond Region 4

On Jan. 18, 2013, the South Carolina Hospital Association requested an opinion from its CMS Regional Office regarding the use of “pain posters” (Prescribing Pain Medication in the Emergency Department) that were developed for posting in emergency department waiting rooms and treatment areas. Despite the fact that these posters were well intentioned and proposed to deter inappropriate

CONTINUED on page 22

## LASH NEWS FLASH NEWS FLASH NEWS FLASH NEWS

### ACEP 2014 REPORT CARD TO BE RELEASED JANUARY 16!

Is your state one of the 21 states to receive an F for Access to Emergency Care?

- Four states received an A for Quality and Patient Safety Environment, while 10 received an F. Where does your state stand?

- Plus, after a grade of C- in 2009, what is the U.S. National Grade in 2014?

Find out on January 16 by logging on to [www.emreportcard.org](http://www.emreportcard.org) at 11 a.m. EST. And read the February issue of ACEP Now for continued coverage!



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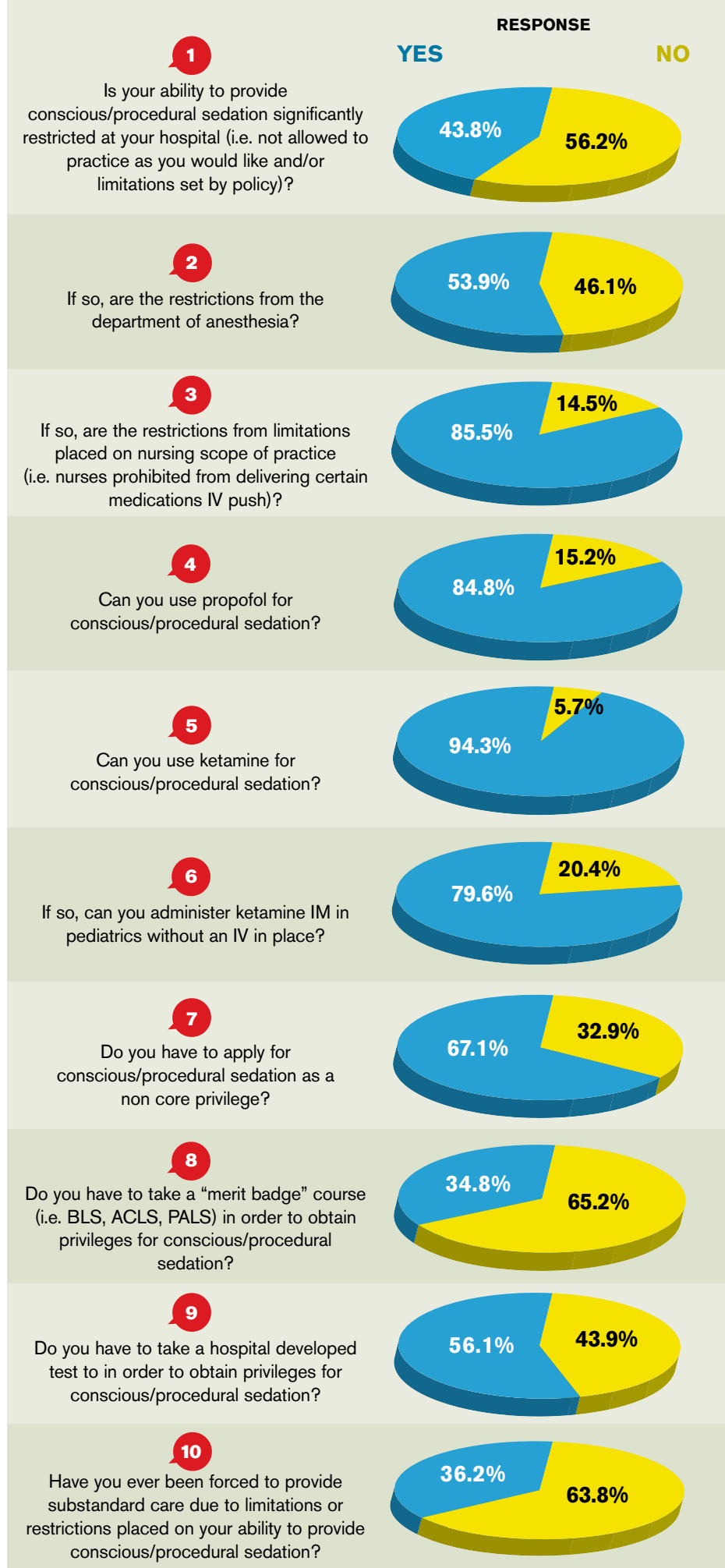
PERIODICAL



## ACEP Council Speaks Out

ACEP Councillors were surveyed about the use of conscious sedation/procedural sedation. In next month's issue, we'll look at what these results mean for emergency physicians.

### JANUARY 2014 ACEP NOW COUNCIL SURVEY



# ACEP Now

The Official Voice of Emergency Medicine

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# THE BREAK ROOM

## Thoughts? Complaints?



**W**hen all the charts are out of the rack and you can finally catch your breath, it's time to take a break. Then, and only then, can you fully consider the frustrations of the day and tomorrow's solutions—as well as vent about what makes you insane and be thankful for what maintains your sanity as an emergency physician.

You can complain at work, but who would listen? You can complain at home, but they might not understand. You can internalize it all, but you'll probably develop irritable bowel syndrome.

It's time to come to "The Break Room." Hang up your lab coat and stethoscope. Pull up a chair, and grab a cup of coffee. It's time to talk about what frustrates you the most.

Who will listen? Who will understand? We, your colleagues, will.

"The Break Room" is as close to

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a "Letters to the Editor" column as we are going to have. You have a thought? Share it. You got a gripe?

Bear it!

We're here to listen. Let the conversation begin! Letters, e-mails, phone calls, and carrier pigeons are all welcome. ☺

## NEW ACEP TEXT



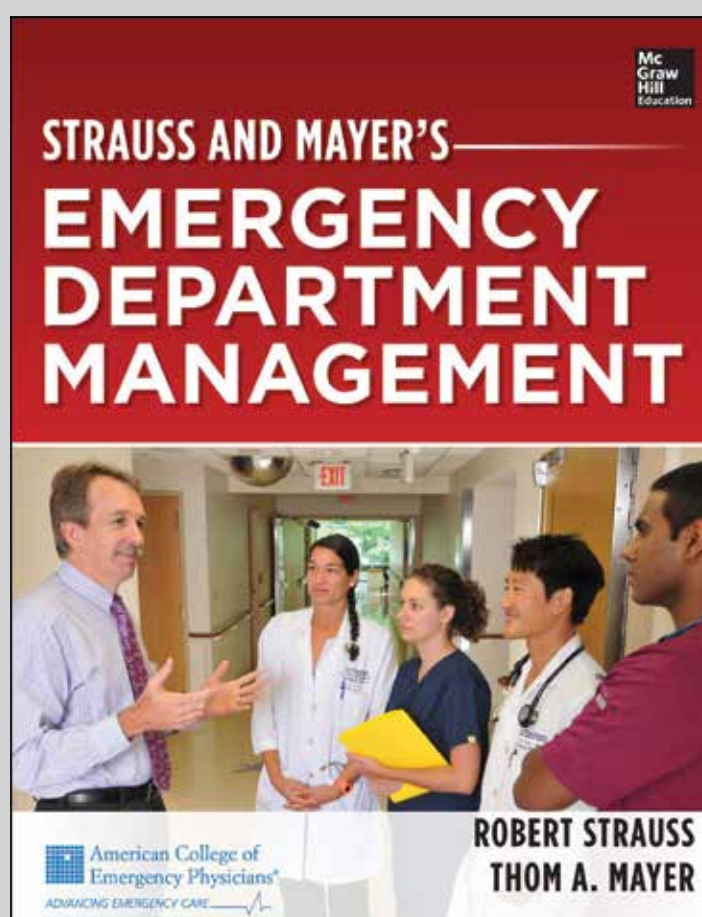
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**A**CEP is accepting nominations through Friday, Feb. 14 for the 2014 Awards Program, which annually honors those who have distinguished themselves through leadership and excellence in emergency medicine. All members are eligible in one or more categories, and a nomination form must be completed for each nomination. Nominations must be accompanied by a current curriculum vitae. If you would like to nominate an individual for an award, contact Mary Ellen Fletcher at 800-798-1822, ext. 3145, for a nomination form. The awards brochure and nomination form also are available on the ACEP website at [www.acep.org/awardnomination](http://www.acep.org/awardnomination).

The awards and their criteria:

## John G. Wiegenstein Leadership Award

Must be an active, life, or honorary member of ACEP and a past or current member of the Board of Directors or officer of the Council; must possess personal leadership attributes and serve as a role model for ACEP members; and must have made an outstanding contribution to ACEP by significantly helping to achieve ACEP's purposes and objectives. Recipients of this award are ineligible to receive awards in other categories of the Awards Program.

## James D. Mills Outstanding Contribution to Emergency Medicine Award

Must be an active, life, or honorary member of ACEP and must have made a significant contribution to emergency medicine through a variety of avenues, including ACEP committee service. Recipients of this award are ineligible to receive awards in other categories of the Awards Program.

## Colin C. Rorrie, Jr., PhD, Award for Excellence in Health Policy

Must be a person of distinction who has made an outstanding contribution to medical health policy or the development or support of legislation and/or regulations that enhance access to emergency medicine, must have shown exemplary performance as an administrator in medicine and health care, or must have made outstanding contributions to organized medicine.

## Award for Outstanding Contribution in Education

Must be a member of ACEP and must have made an outstanding contribution to academic emergency medicine through areas such as development of teaching tools and resident education.

## Honorary Membership Award

Must be an individual who has made an outstanding contribution to ACEP by significantly helping to achieve one or more of the College's purposes and objectives or must have served as a role model for ACEP members with personal attributes such as inspiration, innovation, and consensus building. Candidates for honorary membership cannot be eligible for other categories of College membership.

## John A. Rupke Legacy Award

Must be a member of ACEP for more than 25 years with sustained contributions either in local, state, or national emergency medicine communities as a consensus builder, with humanitarianism, and as an advocate for the profession. The member must also have demonstrated exceptional commitment of time and dedication to emergency medicine and to improving the care of emergency patients. Previous recipients of the Wiegenstein or Mills awards are not eligible to receive this award.

## Disaster Medical Sciences Award

Must have made outstanding contributions to the field of disaster medicine of national or international significance. This includes outstanding contributions to the development, promotion, maturation, education, or humanitarian mission of disaster medicine on a state, national, or international level. Individuals eligible for nomination may include non-members of ACEP and non-physicians. The award may be given posthumously. ☺

## Award for Outstanding Contribution in Research

Must be a member of ACEP and must have made an outstanding contribution to research in emergency medicine as demonstrated through accomplishments, such as outstanding research and publication of original research.

## Award for Outstanding Contribution in EMS

Must be a physician who has been an ACEP member for at least five years, a non-member physician with at least 10 years of EMS activity, or a non-physician with at least 10 years of EMS activity and must have made an outstanding contribution in the area of EMS of national significance and/or an outstanding contribution to the development, promotion, maturation, or education of EMS on a state or national level.

## Council Meritorious Service Award

Must be an active, life, or honorary member of ACEP and a past or current Councillor who has served for at least three years and must have contributed to the Council through Steering Committee membership, Reference Committee participation, participation on other Council committees, resolution development and debate, longevity as a Councillor, or service as a Council officer.



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## FROM THE EDITOR



**KEVIN M. KLAUER, DO, EJD, FACEP**, is director of the Center for Emergency Medical Education (CEME) and chief medical officer for Emergency Medicine Physicians, Ltd., Canton, Ohio; on the Board of Directors for Physicians Specialty Limited Risk Retention Group; and assistant clinical professor at Michigan State University College of Osteopathic Medicine.

# At Your Service

**THIS “FROM THE EDITOR” IS A LANDMARK ARTICLE** because this will be my first and last “From the Editor” column. If I have something worthy of your time and interest, I’ll bring it to you. I will not write for the sake of writing or speak solely to be heard. I have a message, but that message will be delivered collectively by our Editorial Advisory Board, columnists, and writers. I will find the news that is important to you and strive to make certain it is delivered in a way you find interesting and relevant.

The ownership of this publication has officially changed hands. This is not my publication. This isn’t ACEP’s publication. This is *your* publication. ACEP has heard your concerns and is willing to make the changes necessary to bring you back to the table.

You will see a different editorial approach. I have always believed that our publication should be written by emergency physicians for emergency physicians, and with rare exception, that is exactly what you’ll get. Nothing chaps my hide more than a non-emergency physician writing about the practice of emergency medicine. If you haven’t worked a shift, quite honestly, your viewpoint on emergency medicine issues probably isn’t worth my time. When our colleagues possess the expertise, they will be asked to write, and when a topic of interest arises requiring outside expertise, others will be invited into the circle.

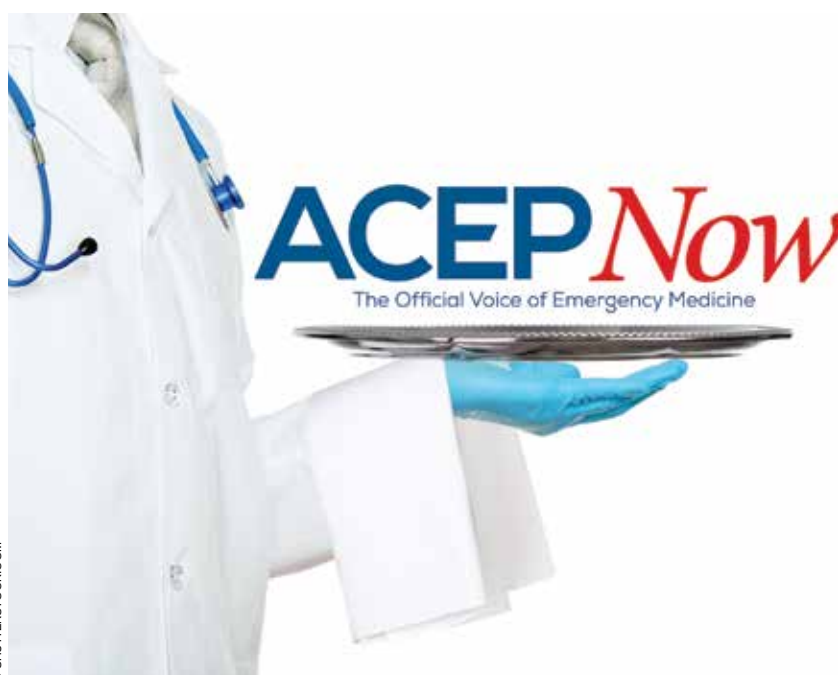
When asked to take this post, medical editor in chief of *ACEP News*, I thought long and hard about what this publication has meant to our specialty in the past and, more important, what it should mean in the future. The first decision was clear: the kind of change required to meet the expectations of the readership and the ACEP leadership required a name change and much more.

It’s time for meaningful discussion and respectful debate, and the place to do it is here and Now. *ACEP News* is being retired to make way for a new publication with a new mission, purpose, and direction.

*ACEP Now* will bring relevance to your doorstep every month, providing a forum for meaningful and respectful debate on “our” issues. *ACEP Now*, The Official Voice of Emergency Medicine, is about what you want to know and need to know, not what others want and think you need to know.

Turn the page, and let’s make history together!

At your service...



The first decision was clear: the kind of change required to meet the expectations of the readership and the ACEP leadership required a name change and much more.



**SCOTT D. WEINGART, MD, FCCM**, is an ED intensivist. This column is a distillation of the best material from the EMCrit Blog and Podcast (<http://emcrit.org>).

**JOHN MICHAEL GUTHRIE, MD**, is a resident in emergency medicine at the Icahn School of Medicine at Mount Sinai.

# Blakemore Placement for Massive Upper GI Bleeding from Esophageal Varices

by SCOTT D. WEINGART, MD, FCCM, AND JOHN MICHAEL GUTHRIE, MD



## RESUSCITATION PEARLS

Become a master of logistics. At the beginning of your shift, check that all of your crucial equipment is stocked and working.

- Master resuscitators trust their gut. Your gut or intuition is really the subconscious result of preparation. Studying and rehearsing critical scenarios in your head result in the right answer just coming to you in the moment. This is described in the cognitive psychology literature as System 1 processing—you must hone yours to a scalpel's edge.
- Resuscitators use checklists. Using a checklist provides cognitive offloading. The mental energy that would be spent trying to remember every step of a complicated procedure, such as intubation, can be focused on solving novel problems and evaluating the big picture.
- Resuscitators prepare for the worst scenario. Better to have it and not need it than need it and not have it.
- There are only two reasons to call a consult: a consultant has a bed you want or can do a procedure you cannot.
- For all critical procedures, remember: slow is smooth, and smooth is fast. With your adrenaline surging, moving fast equals moving sloppy. Focusing on moving slowly and smoothly will result in precise, efficient execution of procedural tasks.

### Case

A 58-year-old male patient presents to the triage area of your ED with the complaint of coffee ground emesis. He has end-stage liver disease from HCV cirrhosis and is on the liver-transplant list. His blood pressure is 105/70, his heart rate is 105, and his abdomen is large and distended. Despite the patient's slightly abnormal vitals, you feel in your gut that this patient is really sick and will decompensate quickly if not aggressively managed. Your first priority is to protect his airway, so you quickly review your intubation checklist ([emcrit.org/airway](http://emcrit.org/airway)) and set up for the tube.

Knowing the patient has a belly full of blood, you place an NG-tube and suck out a liter of clotted blood. Using a small dose of ketamine and a large dose of rocuronium, you perform RSI using video laryngoscopy. Thankfully, there is no aspiration, and the patient's vitals remain stable in the peri-intubation period.

Ten minutes later, however, the patient's blood pressure worsens. He is still bleeding, and his labs show a low hemoglobin level, coagulopathy, and thrombocytopenia. You initiate your hospital's massive transfusion protocol and replace the patient's 18-gauge with a rapid-infusion catheter, a large bore catheter that is placed over a wire inserted through an existing peripheral IV.

You start a ketamine drip, along with octreotide, antibiotics, and tranexamic acid (based solely on evidence extrapolated from the trauma literature). You call GI for endoscopy, but they won't be in for another 45 minutes. Despite receiving 10 units PRBC, 8 units FFP and two packs of platelets through a level-one infuser, the patient continues to bleed, and his blood pressure continues to drop. You know your next step is placing a Blakemore tube, but how do you put one in?

Although most of us know that Blakemore placement is the next step to temporize massive UGIB from esophageal varices, few have ever placed one and their use is not intuitive. It is crucial to rehearse the steps of placing a Blakemore in your mind and ensure you have all the requisite



A VIDEO DEMONSTRATING  
BLAKEMORE PLACEMENT IS AVAILABLE AT:

<http://emcrit.org/procedures/blakemore-tube-placement/>

supplies available in your ED before a sick GI bleeder rolls in.

### Here's your shopping list:

- Sengstaken-Blakemore tube
- Salem Sump gastric tube
- 60 mL Luer-Lok syringe
- 60 mL slip-tip syringe
- 2 Christmas tree to male Luer-Lok converters
- 3 three-way stopcocks
- 3 med lock caps
- Surgilube
- Roller bandage (Kling)
- 1 one-liter bag of crystalloid
- May also need: laryngoscope, Magill forceps, hemostat

### How to place the tube:

1. The patient should be intubated and the head of the bed up at 45 degrees.
2. Test balloons on Blakemore and fully deflate. Mark Salem Sump at the 50-cm mark of the Blakemore with the tip 2 cm above gastric balloon and then 2 cm above esophageal balloon.



A salem sump NG tube is laid next to the Blakemore with its tip just proximal to the gastric balloon. A piece of tape is placed on the NGT at the level of the 50cm mark on the Blakemore. This piece of tape should be marked, "Gastric." The same procedure should be repeated with the tip of the NGT just proximal to the esophageal balloon. This tape should be marked "Esophageal."

3. Insert the Blakemore tube through the mouth just like an OGT. You may need the aid of the laryngoscope and Magill forceps. Make sure the depth-marker numbers face the patient's right side.

4. Stop at 50 cm. Test with slip-tip syringe while auscultating over stomach and lungs. Inflate gastric port

with 50 mL of air.

5. Get a chest X-ray to confirm placement of gastric balloon in stomach.

6. Once confirmed, inflate with additional 200 mL of air (250 mL total).
7. Apply 1 kg of traction using roller bandage and 1 L IV fluid bag hung over an IV pole. Mark the depth at the mouth. The tube will stretch slightly during the next 10 minutes as it warms to body temperature.

8. Insert the Salem Sump until the depth-marked gastric is at 50 cm on the Blakemore. Suction both Blakemore lavage port and Salem Sump. You may need to wash blood clots out of the stomach with sterile water or saline.

9. If bleeding continues, you will need to inflate esophageal balloon:

- 9a. Pull the Salem Sump back until the esoph mark is at the 50 cm point of the Blakemore. Attach a manometer to the second three-way stopcock on the esophageal port of the Blakemore. Inflate to 30 mm Hg. If bleeding continues, inflate to 45 mm Hg.

## HOW TO PLACE A BLAKEMORE



Figure 1. Sengstaken-Blakemore Tube

Figure 2. Christmas tree to male Luer-Lok converter connects Blakemore ports to 3 three-way stopcocks.

Figure 3. Gastric port setup: After placing Blakemore tube, attach Luer-Lok syringe and inflate 50 cc of air. After confirming placement with chest X-ray, inflate an additional 200 cc of air.

Figure 4. Esophageal port setup: Connect one med lock cap to manometer and the other to Luer-Lok syringe. Inflate to 30 mm Hg. If bleeding continues, inflate to 45 mm Hg.

### Conclusion

After you place the Blakemore and inflate the gastric balloon, the bleeding stops and the patient stabilizes. GI arrives and must remove the Blakemore for scope. As soon as it is removed, blood begins gushing into the esophagus. GI is unable to stop the bleeding via EGD, so you are forced to

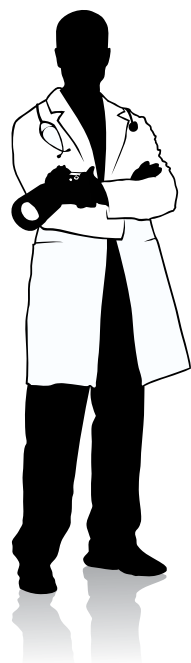
reintroduce the Blakemore. You call IR in, and they take the patient for a TIPS (transjugular intrahepatic portosystemic shunt) procedure, which finally stops the bleeding. Thanks to your efforts, the patient is able to walk out of the hospital after a short ICU stay and eventually has a successful liver transplant. ☺





**ELSBURGH O. CLARKE, MD**, is a practicing emergency medicine physician with Emergency Medicine Physicians (EMP). He has been photographing and documenting emergency medicine since 1978 while he was an emergency medicine resident at LA County/USC.

# A White-Supremacist Patient/Friend



by ELSBURGH CLARKE, MD

Except for the staff giving you a heads-up, you *never* know how your patient encounter will begin or end—either to treat them or, in my case, photograph them. My personality is predictable: I always go in with a smile and a handshake. This approach has allowed me to create some of the most compelling and intense photographs during my 30-plus years in emergency medicine. This instance was no exception.

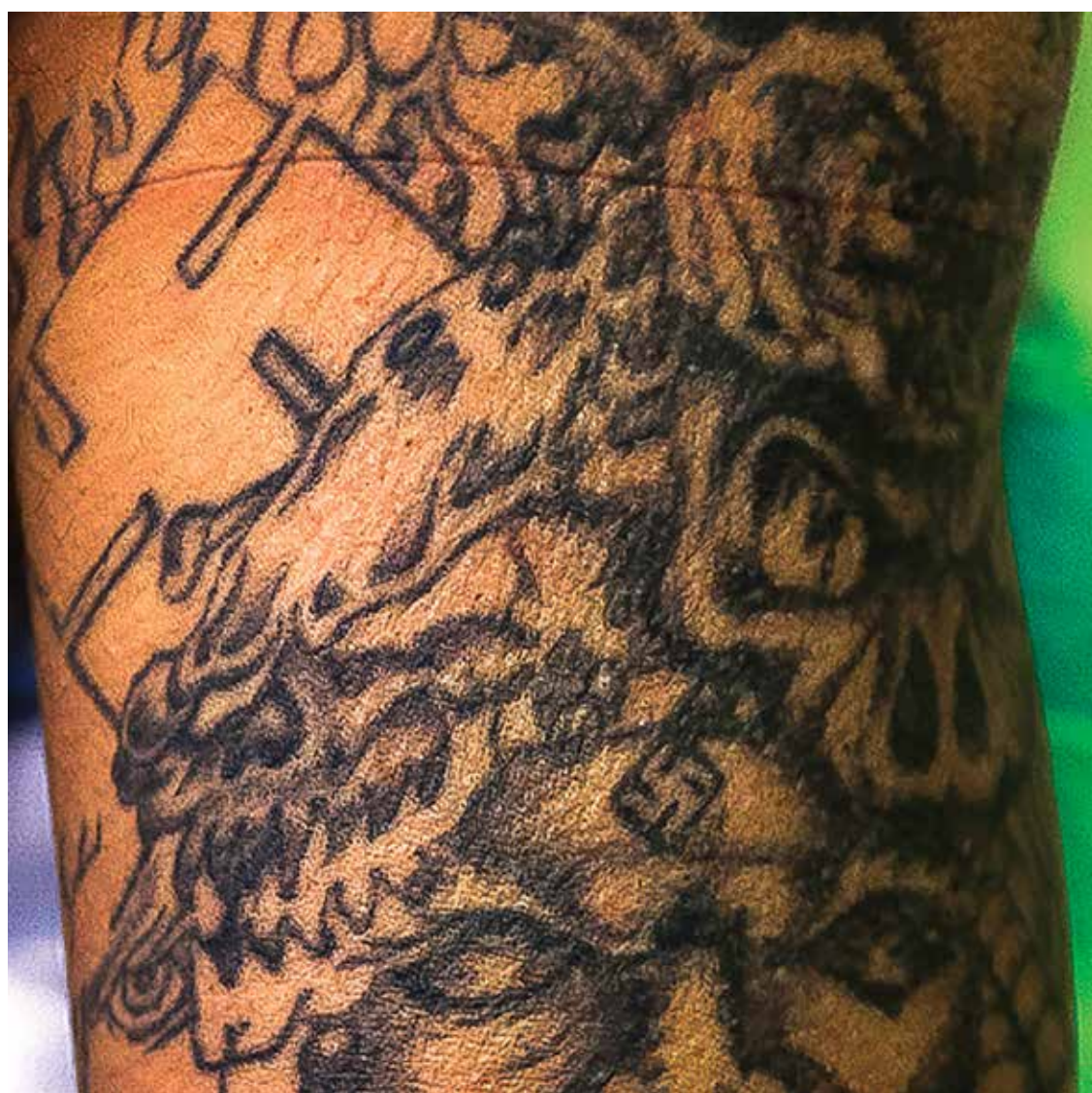
I had no knowledge of my patient's prior prison history. He recently had been released from jail after being incarcerated from 1993 to January 2012. He was in the emergency department for alleged methamphetamine abuse, which he vehemently denied.

Upon my entering the room, he was not overly aggressive. Little did I know that under his gown (which he had on backward with the opening in the front) were tattoos that dilated my pupils as if I had taken atropine! As I shook his hand and introduced myself, I could not help focusing on the "White Pride" tattoo on his chest and the Aryan Brotherhood swastika prison "tats" emblazoned on both arms.

Instantly, my personality and training, as well as my being on the Patient Satisfaction Faculty, went into hyperdrive. "What brings you to the emergency room, my brother?" I asked him.

He looked at me quizzically, paused, and said, "Huh?"

To make a long story short, after I knew he wasn't going to kill me (ie, he is a paraplegic with a left BKA), I sat down by his bedside. After several minutes and my continued smile to show him I had a sincere and genuine interest in his care, we actually became "friends." We actually began to talk "prison stuff." (I had watched *Lockup* and *Gangland*, so I knew the jargon.) His story was amazing and intriguing such that I asked my newly found Aryan Brotherhood friend if he would allow me to take photos of his tattoos. He smiled and said, "Sure."



As a photojournalist and an emergency physician, my smile-and-a-handshake approach, in itself, can begin to break down cultural and racial differences. Does it always work? No. But in my experience as a photojournalist/emergency physi-

cian, while the barriers can be challenging, this technique has allowed me to produce photographs that are captivating and gripping.

Oh, and no staff or physician was hurt during the encounter with my friend! ☺







**RONALD A. HELLSTERN, MD, FACEP**, is principal and president of Medical Practice Productivity Consultants, PA and a partner in Hospital Practice Consultants, LLC in Dallas.

## Independent Contractor Status Explained



*The transition from resident to attending—and through other career transitions—is often filled with mystery and angst about the unknown. Many physicians live by the motto, “Frequently wrong, but never in doubt!” This recurring column will present questions asked by those seeking info, answered by those in the know.*

by RONALD A. HELLSTERN, MD, FACEP

In the bad old days, when emergency medicine was in its infancy and struggling to carve out its niche, practicing as an independent contractor (IC) was nearly universal. The structure was relatively simple to set up and relatively cheap to administer, and most of the physicians worked in more than one emergency department. Then, in the early 1990s, the IRS began auditing EM IC agreements and, in many cases, ruled that the emergency physicians did not meet the IRS IC “20-point test.” A few of these points are that ICs must set their own schedule, supply their own tools, and perform their role however they see fit. The full list is at [www.irs.gov/pub/irs-utl/x-26-07.pdf](http://www.irs.gov/pub/irs-utl/x-26-07.pdf). The IRS has a vested interest in monitoring ICs because ICs don’t pay employment taxes until they distribute compensation and they pay quarterly estimated income tax withholding rather than monthly. This deprives the IRS of a steady flow of employment tax and withholding revenue. Of course, there is also the potential issue of abuse, such as writing off things not truly related to business expenses.

The employer-employee structure didn’t come to predominate until the mid-1990s with the government’s decision to prohibit provider reassignment of their patient fees to the group for IC relationships. This bit of “help” from the government made emergency medicine group-practice management and administration for groups treating their provider members as ICs infinitely more complex and expensive. Physicians in the group now had to have their own bank accounts with full access, and all payments from the government payers generated by each physician could only be deposited in that account. All things considered, the easiest path to compliance was simply to convert the group to employer-employee, and that’s what happened. Just about the time everyone made the transition, ACEP’s lobbying efforts paid off, and in 2003, President George W. Bush signed legislation rescinding the change in reassignment rules, making the IC structure a viable option once again.

Fast-forward to the threshold of 2014 and the full implementation of the Affordable Care Act: we find significant renewed interest in the IC structure. Part-time employees working fewer than 28 hours per week and ICs are exempt from the Act’s

employer mandate (but not the individual mandate). Therefore, many people are being forced to consider the IC model by their employers. So let’s look at some of the distinctions between the two models.

Employers typically pay 50 percent of employees’ Social Security and Medicare taxes (generally about 7.65 percent of gross compensation), whereas ICs must pay both halves, or 15.3 percent. Employers typically provide benefits like personal time off, paid vacations, health insurance, and retirement plans. ICs receive none of these benefits. Primarily because of these two facts, ICs are generally paid a higher hourly wage than employees to make up at least some of the difference.

Employers withhold employees’ estimated federal and state income taxes with each paycheck. ICs must estimate their own withholding obligation and pay it to the government on a quarterly basis. Employees get a W-2 at the end of the year, whereas ICs get a Form 1099.

Employers can dictate employees’ schedules and how they do their jobs. In an IC structure, they aren’t permitted to do either of these things, which can be a real problem for the group practice of emergency medicine.

ICs are their own small businesses contracting with other small businesses to provide their services. They

**Employers can dictate your schedule and how you do your job; in an IC structure they aren’t permitted to do either of these things, which can be a real problem for the group practice of emergency medicine.**

receive a gross sum for their services, out of which they must pay their employment taxes and a quarterly estimated income tax amount, fund whatever benefits they choose for themselves, and, in most cases, buy their own malpractice liability insurance. Depending on the state they are in, they may be able to write off

certain business-related expenses—whether they are individually incorporated or not. In others, it’s best to form a professional association (PA) or professional corporation (PC). A corporate structure is generally essential to maximizing retirement-plan contributions.

But being an IC is not all positive. In an employer-employee structure, the practice only has to have one set of books, one malpractice policy, and one benefits plan, plus file just one tax return. Each IC working for the group, on the other hand, has all of these same expenses individually, making the annual PA/PC carrying cost \$3,000–\$5,000. Also, ICs don’t have the statutory protections afforded most employees, such as due process and overtime pay. In most states, a PA or PC cannot own stock in a non-PA/PC company, making for some difficult ownership issues. Neither can a non-physician spouse own PA or PC stock.

To sum up, being an IC is a viable emergency medicine practice option with its own set of pros and cons. Because it is extremely important to meet the IRS’ IC test criteria, some legal guidance in setting up the structure is essential. The structure also has to work for an IC’s employer(s) because, in general, having both employees and ICs doing the same full-time job is a red flag for an IRS audit. ☛

The following outlines steps to take toward forming a PC.

STEP	CLARIFICATION
1. Seek legal advice from an attorney experienced in professional incorporation.	There are PAs, PCs, SCs, LLCs, PLLCs to choose from depending on the state and the purpose of the entity.
2. You will need a name for the entity and a name search will have to be done to assure that no one else is using that name.	Mine in Texas is Ronald A. Hellstern, MD & Associates, PA
3. You will need to obtain an Employer Identification Number (EIN) from the IRS.	This can now be done online at <a href="http://irs.gov">irs.gov</a> .
4. You will need articles of incorporation.	Entities like LegalZoom.com or BizFilings.com offer professional incorporation packages tailored to your state laws. However, coupling IC status with it adds additional liability and tax complexity issues.
5. In most states you will need proof of licensure and liability insurance to obtain state medical board approval.	Professional corporations are almost always single service providers.
6. You will need corporate by-laws and an operating agreement.	Depending on the purpose this may need to include governance and buy-sell provisions.
7. You will need to arrange for your own benefits.	This probably the most troublesome aspect of being an incorporated IC.



RATIONAL  
APPROACHES FOR  
A NATIONAL  
PROBLEM

# CHRONIC PAIN: THEIR PAIN OR YOURS?



**JIM DUCHARME, MD, CM, FRCP**, is editor in chief of the *Canadian Journal of Emergency Medicine*, clinical professor of medicine at McMaster University, and chief medical officer of McKesson Canada.

## Why Us? The Role of Emergency Physicians in the Care of Chronic Pain

Managing chronic pain is a challenge in the ED. Finding the right balance between too much and too little is key to good patient management.



by JIM DUCHARME, MD, CM, FRCP

The figures are well-established: more than a quarter of people will suffer from chronic pain during their lifetime. It is the disease state with the highest economic impact on society in terms of lost workdays. The average annual family income of patients with chronic pain is less than \$25,000, which is below the poverty line. But why do emergency physicians need to know about chronic pain?

Few physicians among us understand the myriad of pain conditions that fall under the label “chronic pain.” Fewer still recognize the pathologic changes in personality associated with chronic pain as being part of the disease symptom complex, just as peripheral neuropathy is a manifestation of diabetes. Most family physicians are ill-equipped to provide the multidisciplinary care required; most patients cannot afford the paramedical care provided by physiotherapists, psychologists, social workers, etc. Pain management is further complicated by the issues related to opioids—opiophobia, diversion, and addiction—even though only one-third of chronic-pain patients require opioids as part of their care.

The consequence? Chronic-pain patients are poorly understood and poorly treated. As a result of not having their pain properly controlled and not having been taught adequate coping skills, these patients modify their behavior in an attempt to get the physician to provide the necessary care—aberrant behaviour called *pseudoaddiction*. Distinguishing aberrant behavior linked to pseudoaddiction from that associated with true addiction is difficult at best; it may take a pain-medicine expert months to identify the underlying reason for the aberrant behavior. It is almost never possible to do so in an isolated visit to the emergency department.

CONTINUED on page 10

Table 1: Opioid Risk Tool from the Canadian Opioid Guideline

ITEM	MARK EACH BOX THAT APPLIES	ITEM SCORE IF FEMALE	ITEM SCORE IF MALE
<b>Family History of Substance Abuse</b>			
Alcohol	[ ]	1	3
Illegal Drugs	[ ]	2	3
Prescription Drugs	[ ]	4	4
<b>Personal History of Substance</b>			
Alcohol	[ ]	3	3
Illegal Drugs	[ ]	4	4
Prescription Drugs	[ ]	5	5
Age ( mark box if 16-45)	[ ]	1	1
History of Preadolescent Sexual Abuse	[ ]	3	0
<b>Psychological Disease</b>			
Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia	[ ]	2	2
Depression	[ ]	1	1
<b>TOTAL</b>			
<b>Total Score Risk Category</b>			
Low Risk: 0 to 3			
Moderate Risk: 4 to 7			
High Risk: 8 and above			

More information is available at <http://nationalpaincentre.mcmaster.ca/opioid>.  
**Source:** Furlan AD, Reardon R, Wepler C, for the National Opioid Use Guideline Group (NOUGG). Opioids for chronic noncancer pain: a new Canadian practice guideline. CMAJ. 2010;182: 923-930.



The emergency department is the safety net of our system—impoverished patients in pain receiving inadequate (or no) care from a primary-care provider have nowhere else to turn. In the Pain and Emergency Medicine Initiative (PEMI) study involving 18 academic centers across Canada and the United States, 20 percent of patient visits had chronic pain as the *primary* reason for their visit to the emergency department. That is the largest percentage of visits to the emergency department for any one pathology; paradoxically, it is decried by most emergency physicians as a condition that is “not part of emergency medicine.” It is clear the emergency department cannot provide ongoing care to chronic-pain patients any more than it can do so for patients with diabetes. It is equally clear that we must be involved in their care to some degree, just as we are involved to some degree in the care of many patients with a chronic disease—that is the nature of our horizontal specialty. What is our role?

**Caring for patients with chronic pain is part of the ED mandate. Distinguishing them from patients with problems of addiction is difficult, but they are not the same patients and should not be treated similarly.**

#### Acute Flare-up of Chronic Pain

Certain conditions, such as fibromyalgia (FM) or complex regional pain syndrome (CRPS), generate new pain or acute worsening of that pain state. Our role is to first ensure that patients are not suffering from a new acute condition unrelated to their chronic pain condition—the latter does not make them immune to other pathology. Intervening with ketamine in analgesic doses can abort the acute flare-up in CRPS. For patients with FM, reassurance they do not have a new medical problem will usually result in their returning home satisfied, reluctantly accepting that their new pain is, indeed, part of their FM.

#### Acute New Pain Pathology

Patients who take medications for chronic pain (including opioids) require proper pain management just like everyone else when they suffer, for example, an acute fracture. If they already take opioids, they will require their usual daily dose *plus* dosing for their new pain;

often, identifying what their usual PRN dose is will give a starting point for the first dose of opioids in the emergency department, with titration after that. Physicians have to recognize that the doses of opioids required to provide adequate analgesia in chronic-pain patients taking long-term opioids will almost always be higher than the doses we use for patients not taking such opioids.

#### Medication Requests

Patients receiving care from pain physicians require a minimum of two to three *months* to get their pain controlled. Emergency physi-

cians should, therefore, not feel an obligation to provide or initiate a medication for someone's chronic pain during a single emergency department visit, nor should they feel any urgent need to manage that chronic pain in the emergency department. Patients receiving long-term opioids have an agreement or contract with a primary provider wherein only that provider will prescribe their opioids. If patients were to go to their primary provider and say they had “run out” a few days early, the provider would reiterate that the patients are responsible for their medication usage and not renew the prescription until the next scheduled time

interval. In the emergency department, the physician should restate this “single provider” principle and feel very comfortable declining to provide opioids, all the while offering to help patients in any other way possible.

#### Adverse Events or Drug-Drug Interactions

Most emergency physicians are unfamiliar with either the medications prescribed or the (high) doses prescribed for chronic-pain management. While most physicians will not exceed 75 mg of amitriptyline, for example, patients with neuropathic pain

**Request samples at [Xifaxan550.com/samples](http://Xifaxan550.com/samples)**

## Hepatic Encephalopathy: ARE YOUR PATIENTS LIVING ON THIN ICE?

**Overt hepatic encephalopathy (HE) should be considered in any patient with cirrhosis.<sup>1</sup>** Once a cirrhotic patient has developed HE, experts in hepatology recommend maintenance drug therapy to reduce the risk of unpredictable recurrences.<sup>2</sup>

**Treat continuously with a Xifaxan 550 mg pill twice daily**

- 58%** proven reduction in the risk of overt HE breakthrough<sup>3\*</sup>
- 50%** proven reduction in the risk of HE-related hospitalizations<sup>3††</sup>

The most common adverse reactions occurring (≥12% incidence) in the clinical trial with Xifaxan 550 mg were peripheral edema, nausea, dizziness, and fatigue.<sup>3</sup>

**Xifaxan 550**  
rifaximin 550 mg tablets  
Prescribe. Protect. Repeat.

\*Over a 6-month period;  $P < 0.0001$  vs placebo.<sup>3</sup>  
†Over a 6-month period;  $P = 0.0129$  vs placebo.<sup>3</sup>  
††HE-related hospitalization defined as hospitalization directly caused by HE or a hospitalization during which an HE event occurred.<sup>3</sup>

**Indication for XIFAXAN 550 mg**

XIFAXAN® (rifaximin) 550 mg is indicated for reduction in risk of overt hepatic encephalopathy (HE) recurrence in patients ≥18 years of age.

**Important Safety Information About XIFAXAN 550 mg**

XIFAXAN® (rifaximin) 550 mg tablets are contraindicated in patients with a hypersensitivity to rifaximin, any of the rifamycin antimicrobial agents, or any of the components in XIFAXAN. Hypersensitivity reactions have included exfoliative dermatitis, angioneurotic edema, and anaphylaxis.

*Clostridium difficile*-associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including XIFAXAN, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon which may lead to overgrowth of *C. difficile*. If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued.

There is increased systemic exposure in patients with more severe hepatic dysfunction. The clinical trials were limited to patients with MELD scores <25.

Therefore, caution should be exercised when administering XIFAXAN to patients with severe hepatic impairment (Child-Pugh C).

Based on animal data, XIFAXAN may cause fetal harm. Discontinue in nursing mothers after taking into account the importance of the drug to the mother.

The most common adverse reactions occurring in ≥10% of patients and at a higher incidence than placebo in the clinical study were peripheral edema (15%), nausea (14%), dizziness (13%), fatigue (12%), and ascites (11%).

Xifaxan 550 mg is not available for sale outside the U.S.

Xifaxan 550 mg is licensed by Alfa Wassermann S.p.A. to Salix Pharmaceuticals, Inc.

**Please see brief summary on reverse.**

**References:** 1. Starr SP, Raines D. Cirrhosis: diagnosis, management, and prevention. *Am Fam Physician*. 2011;84(12):1353-1359. 2. Khungar V, Poordad F. Management of overt hepatic encephalopathy. *Clin Liver Dis*. 2012;16(1):73-89. 3. Xifaxan [prescribing information]. Raleigh, NC: Salix Pharmaceuticals, Inc.; 2011.

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may require up to 250 mg. Higher than normal dosing carries a higher risk of adverse events. Another example of risk is seen in patients prescribed methadone for pain or addiction. These patients will have a markedly prolonged QT interval from the methadone. Multiple case reports of sudden death have been reported after patients taking methadone were prescribed a fluoroquinolone. It is critical during the emergency visit that we ensure patients will not suffer from such an adverse event.

Why is abnormally high dosing often required when medications are used to manage

pain? For many patients in pain, their nervous system has undergone “plastification” as a result of the pain. Functional MRI often shows multiple areas of the brain with abnormal function. Be it the development of tolerance with opioids or the higher doses of non-opioid medications required to deactivate abnormal synaptic transmissions, patients with chronic pain often require dosing higher than what may be considered therapeutic for other conditions. These higher doses should not lead to suspicion of misuse or drug dependency but should lead to careful evaluation to identify possible adverse effects.

Providing Support

In chronic-pain patients who have been properly screened for addiction risk using the Opioid Risk Tool (see Table 1, p. 9), the risk of addiction for those who are scored at low risk is less than 0.2 percent—60 times *lower* than the general public rate of addiction. When these patients arrive in our emergency departments, they do not know where else to turn. Simply saying “no” is not a solution. Guiding them to support services, advising them of community resources, demonstrating understanding, and educating them on the role of the emergency department in their care are all key roles for emergency phy-

sicians to play. We advise smokers to stop smoking and guide them to programs; we encourage alcoholics to get into detox programs; we advise diabetics about diet, exercise, and community programs—surely, we can do the same for patients with chronic pain.

Higher than normal dosing carries a higher risk of adverse events. Another example of risk is seen in patients prescribed methadone for pain or addiction. These patients will have a markedly prolonged QT interval from the methadone. Multiple case reports of sudden death have been reported after patients taking methadone were prescribed a fluoroquinolone.

Mandate for Care

Caring for patients with chronic pain is part of the emergency department mandate. Distinguishing them from patients with problems of addiction is difficult, but they are not the same patients and should not be treated similarly. They have very different needs because they suffer from very different pathologies. Learning more about chronic pain conditions will allow us to provide the necessary care.

Hands On: Chronic-Pain Management at McKesson Canada

As part of my role within McKesson, I directly oversee the running of nine community-based pain centers where patients with chronic non-cancer pain are treated. Unlike what is commonly thought, only one-third of the patients treated there received opioids as part of their care. The optimal approach to chronic-pain management is a combination of multidisciplinary clinical care, self-management programs to learn proper coping skills, medications, and nerve blocks (the last is effective in roughly 20 percent of all chronic-pain patients). Identifying patients with pain at risk for addiction is a key screening element and part of a 21-page initial evaluation tool completed by patients. In those patients identified as “at risk,” care pathways without opioids or with methadone are explored. Patient agreements are routine and include limiting patients to a single prescriber of opioids, no early renewals, and random urine drug testing (frequency determined by their score on the Opioid Risk Tool). All physicians have to undergo our standard training and be supervised for their first year of practice (provincial regulation) in pain management. ☛



The following is a brief summary; see complete Prescribing Information at [www.Xifaxan550.com](http://www.Xifaxan550.com).

INDICATIONS AND USAGE

To reduce the development of drug-resistant bacteria and maintain the effectiveness of XIFAXAN and other antibacterial drugs, XIFAXAN when used to treat infection should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

Hepatic Encephalopathy

XIFAXAN 550 mg is indicated for reduction in risk of overt hepatic encephalopathy (HE) recurrence in patients ≥ 18 years of age.

In the trials of XIFAXAN for HE, 91% of the patients were using lactulose concomitantly. Differences in the treatment effect of those patients not using lactulose concomitantly could not be assessed.

XIFAXAN has not been studied in patients with MELD (Model for End-Stage Liver Disease) scores > 25, and only 8.6% of patients in the controlled trial had MELD scores over 19. There is increased systemic exposure in patients with more severe hepatic dysfunction [see Warnings and Precautions (5.4), Use in Specific Populations (8.7), Clinical Pharmacology (12.3)].

CONTRAINDICATIONS

Hypersensitivity

XIFAXAN is contraindicated in patients with a hypersensitivity to rifaximin, any of the rifamycin antimicrobial agents, or any of the components in XIFAXAN. Hypersensitivity reactions have included exfoliative dermatitis, angioneurotic edema, and anaphylaxis [see Adverse Reactions (6.2)].

WARNINGS AND PRECAUTIONS

Travelers' Diarrhea Not Caused by *Escherichia coli*

XIFAXAN was not found to be effective in patients with diarrhea complicated by fever and/or blood in the stool or diarrhea due to pathogens other than *Escherichia coli*. Discontinue XIFAXAN if diarrhea symptoms get worse or persist more than 24-48 hours and alternative antibiotic therapy should be considered.

XIFAXAN is not effective in cases of travelers' diarrhea due to *Campylobacter jejuni*. The effectiveness of XIFAXAN in travelers' diarrhea caused by *Shigella* spp. and *Salmonella* spp. has not been proven. XIFAXAN should not be used in patients where *Campylobacter jejuni*, *Shigella* spp., or *Salmonella* spp. may be suspected as causative pathogens.

*Clostridium difficile*-Associated Diarrhea

*Clostridium difficile*-associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including XIFAXAN, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon which may lead to overgrowth of *C. difficile*.

*C. difficile* produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of *C. difficile* cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents.

If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibiotic treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

Development of Drug Resistant Bacteria

Prescribing XIFAXAN for travelers' diarrhea in the absence of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

Severe (Child-Pugh C) Hepatic Impairment

There is increased systemic exposure in patients with severe hepatic impairment. Animal toxicity studies did not achieve systemic exposures that were seen in patients with severe hepatic impairment. The clinical trials were limited to patients with MELD scores <25. Therefore, caution should be exercised when administering XIFAXAN to patients with severe hepatic impairment (Child-Pugh C) [see Use in Specific Populations (8.7), Nonclinical Toxicology (13.2) and Clinical Studies (14.2)].

ADVERSE REACTIONS

Clinical Studies Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Hepatic Encephalopathy

The data described below reflect exposure to XIFAXAN 550 mg in 348 patients, including 265 exposed for 6 months and 202 exposed for more than a year (mean exposure was 364 days). The safety of XIFAXAN 550 mg taken two times a day for reducing the risk of overt hepatic encephalopathy recurrence in adult patients was evaluated in a 6-month placebo-controlled clinical trial (n = 140) and in a long term follow-up

study (n = 280). The population studied had a mean age of 56.26 (range: 21-82) years; approximately 20% of the patients were ≥ 65 years old, 61% were male, 86% were White, and 4% were Black. Ninety-one percent of patients in the trial were taking lactulose concomitantly. All adverse reactions that occurred at an incidence ≥ 5% and at a higher incidence in XIFAXAN 550 mg-treated subjects than in the placebo group in the 6-month trial are provided in Table 2. (These include adverse events that may be attributable to the underlying disease).

Table 1: Adverse Reactions Occurring in ≥ 5% of Patients Receiving XIFAXAN and at a Higher Incidence Than Placebo

MedDRA Preferred Term	Number (%) of Patients	
	XIFAXAN Tablets 550 mg TWICE DAILY N = 140	Placebo N = 159
Edema peripheral	21 (15%)	13 (8%)
Nausea	20 (14%)	21 (13%)
Dizziness	18 (13%)	13 (8%)
Fatigue	17 (12%)	18 (11%)
Ascites	16 (11%)	15 (9%)
Muscle spasms	13 (9%)	11 (7%)
Pruritus	13 (9%)	10 (6%)
Abdominal pain	12 (9%)	13 (8%)
Abdominal distension	11 (8%)	12 (8%)
Anemia	11 (8%)	6 (4%)
Cough	10 (7%)	11 (7%)
Depression	10 (7%)	8 (5%)
Insomnia	10 (7%)	11 (7%)
Nasopharyngitis	10 (7%)	10 (6%)
Abdominal pain upper	9 (6%)	8 (5%)
Arthralgia	9 (6%)	4 (3%)
Back pain	9 (6%)	10 (6%)
Constipation	9 (6%)	10 (6%)
Dyspnea	9 (6%)	7 (4%)
Pyrexia	9 (6%)	5 (3%)
Rash	7 (5%)	6 (4%)

The following adverse reactions, presented by body system, have also been reported in the placebo-controlled clinical trial in greater than 2% but less than 5% of patients taking XIFAXAN 550 mg taken orally two times a day for hepatic encephalopathy. The following includes adverse events occurring at a greater incidence than placebo, regardless of causal relationship to drug exposure.

*Ear and Labyrinth Disorders:* Vertigo

*Gastrointestinal Disorders:* Abdominal pain lower, abdominal tenderness, dry mouth, esophageal variceal bleed, stomach discomfort

*General Disorders and Administration Site Conditions:* Chest pain, generalized edema, influenza like illness, pain NOS

*Infections and Infestations:* Cellulitis, pneumonia, rhinitis, upper respiratory tract infection NOS

*Injury, Poisoning and Procedural Complications:* Contusion, fall, procedural pain

*Investigations:* Weight increased

*Metabolic and Nutritional Disorders:* Anorexia, dehydration, hyperglycemia, hyperkalemia, hypoglycemia, hyponatremia

*Musculoskeletal, Connective Tissue, and Bone Disorders:* Myalgia, pain in extremity

*Nervous System Disorders:* Amnesia, disturbance in attention, hypoesthesia, memory impairment, tremor

*Psychiatric Disorders:* Confusional state

*Respiratory, Thoracic, and Mediastinal Disorders:* Epistaxis

*Vascular Disorders:* Hypotension

Postmarketing Experience

The following adverse reactions have been identified during post approval use of XIFAXAN. Because these reactions are reported voluntarily from a population of unknown size, estimates of frequency cannot be made. These reactions have been chosen for inclusion due to either their seriousness, frequency of reporting or causal connection to XIFAXAN.

*Infections and Infestations*

Cases of *C. difficile*-associated colitis have been reported [see Warnings and Precautions (5.2)].

*General*

Hypersensitivity reactions, including exfoliative dermatitis, rash, angioneurotic edema (swelling of face and tongue and difficulty swallowing), urticaria, flushing, pruritus and anaphylaxis have been reported. These events occurred as early as within 15 minutes of drug administration.

DRUG INTERACTIONS

*In vitro* studies have shown that rifaximin did not inhibit cytochrome P450 isoenzymes 1A2, 2A6, 2B6, 2C9, 2C19, 2D6, 2E1 and CYP3A4 at concentrations ranging from 2 to 200 ng/mL [see Clinical Pharmacology (12.3)]. Rifaximin is not expected to inhibit these enzymes in clinical use.

An *in vitro* study has suggested that rifaximin induces CYP3A4 [see Clinical Pharmacology (12.3)]. However, in patients with normal liver function, rifaximin at the recommended dosing regimen is not expected to induce

CYP3A4. It is unknown whether rifaximin can have a significant effect on the pharmacokinetics of concomitant CYP3A4 substrates in patients with reduced liver function who have elevated rifaximin concentrations.

An *in vitro* study suggested that rifaximin is a substrate of P-glycoprotein. It is unknown whether concomitant drugs that inhibit P-glycoprotein can increase the systemic exposure of rifaximin [see Clinical Pharmacology (12.3)].

USE IN SPECIFIC POPULATIONS

Pregnancy

*Pregnancy Category C*

There are no adequate and well controlled studies in pregnant women. Rifaximin has been shown to be teratogenic in rats and rabbits at doses that caused maternal toxicity. XIFAXAN tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Administration of rifaximin to pregnant rats and rabbits at dose levels that caused reduced body weight gain resulted in eye malformations in both rat and rabbit fetuses. Additional malformations were observed in fetal rabbits that included cleft palate, lumbar scoliosis, brachygnathia, interventricular septal defect, and large atrium.

The fetal rat malformations were observed in a study of pregnant rats administered a high dose that resulted in 16 times the therapeutic dose to diarrheic patients or 1 times the therapeutic dose to patients with hepatic encephalopathy (based upon plasma AUC comparisons). Fetal rabbit malformations were observed from pregnant rabbits administered mid and high doses that resulted in 1 or 2 times the therapeutic dose to diarrheic patients, based upon plasma AUC comparisons.

Post-natal developmental effects were not observed in rat pups from pregnant/lactating female rats dosed during the period from gestation to Day 20 post-partum at the highest dose which resulted in approximately 16 times the human therapeutic dose for travelers' diarrhea (based upon AUCs) or approximately 1 times the AUCs derived from therapeutic doses to patients with hepatic encephalopathy.

Nursing Mothers

It is not known whether rifaximin is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for adverse reactions in nursing infants from XIFAXAN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

The safety and effectiveness of XIFAXAN 200 mg in pediatric patients with travelers' diarrhea less than 12 years of age have not been established. The safety and effectiveness of XIFAXAN 550 mg for HE have not been established in patients < 18 years of age.

Geriatric Use

Clinical studies with rifaximin 200 mg for travelers' diarrhea did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently than younger subjects. In the controlled trial with XIFAXAN 550 mg for hepatic encephalopathy, 19.4% were 65 and over, while 2.3% were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Renal Impairment

The pharmacokinetics of rifaximin in patients with impaired renal function has not been studied.

Hepatic Impairment

Following administration of XIFAXAN 550 mg twice daily to patients with a history of hepatic encephalopathy, the systemic exposure (i.e., AUC<sub>τ</sub>) of rifaximin was about 10-, 13-, and 20-fold higher in those patients with mild (Child-Pugh A), moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment, respectively, compared to that in healthy volunteers. No dosage adjustment is recommended because rifaximin is presumably acting locally. Nonetheless, caution should be exercised when XIFAXAN is administered to patients with severe hepatic impairment [see Warnings and Precautions (5.4), Clinical Pharmacology (12.3), Nonclinical Toxicology (13.2), and Clinical Studies (14.2)].

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## Go Stealth: Your HSA May Be Your Best Retirement Plan

Money can't buy happiness, or so they say, but it sure does help. You've worked way too hard for far too long. Money buys you choices, and financial choices protect your future.

by JAMES M. DAHLE, MD, FACEP

**Question:** *My employer has recently gone to a high-deductible health plan (HDHP), so I became eligible this year to use a health savings account (HSA). What is the best way to use my HSA?*

**Answer:** In 2014, HDHPs must have a minimum deductible of \$1,250 if you're single (\$2,500 family) and a maximum out-of-pocket amount of \$6,350 (\$12,700 family). The plan may offer preventive care for a lower deductible (or none at all) and still qualify. If your only health coverage is a HDHP, then you qualify for an HSA and may contribute up to \$3,300 (\$6,550 family), with a \$1,000 "catch-up" contribution if you're older than 55. Even if

your spouse is covered by a non-HDHP, as long as you are not, you may still use an HSA, and if at least one of your children is also not covered by a non-HDHP, you may contribute the higher family amount.

There are two ways that people use their HSAs. The first is to pay for health care in the year you make the contribution. If you get a CT scan for \$1,000, you use the HSA money to pay for it. Not only do you get to use untaxed dollars to pay your health-

insurance premiums (at least if you're self-employed), you also get to pay for unreimbursed health care using untaxed dollars. If you plan to use your HSA to pay your deductible and other health-related expenses in the near future, you want to invest the money very conservatively, probably in the savings-account option of your HSA.

### HSAs for Long-Term Savings

The second way to use an HSA is as a "Stealth IRA." Many physicians need to save more money for retirement each year than they are allowed to contribute to their available retirement plans. While a taxable investing account is always an

option to save more, an HSA offers three significant advantages over a taxable account as a retirement savings plan. First, just like any other retirement plan, it offers an estate-planning advantage in that you can simply name a beneficiary on the account instead of having those assets go through probate. Second, although asset protection is always state-specific, your state may protect assets in an HSA from your creditors in a lawsuit or bankruptcy proceedings. Last, and most important, an HSA is the only "triple-tax-free" account.

What do I mean by triple-tax-free? Consider your 401K. You get an upfront tax deduction in the year you





make the contribution. It then grows protected from the drag of taxes. Finally, when you pull out the money in retirement, you have to pay taxes on it. I consider that “double-tax-free.” A Roth IRA, into which you contribute after-tax dollars, but then is never taxed again, is also double-tax-free. But an HSA is different. You get the up-front tax deduction, just like a 401K. You get the tax-protected growth, just like a 401K and a Roth IRA. In addition, as long as the money is spent on approved health-care expenditures, it comes out of the account tax-free. Triple-tax-free. There is no minimum income required to contribute or maximum income above which you cannot contribute to an HSA.

#### Advantages of HSAs

Because an HSA is the only triple-tax-free account, unless you’re receiving an employer match on your 401K, the first retirement contributions you make each year should go into your Stealth IRA. An HSA is different from a flexible spending arrangement (FSA) in that there is no “use it or lose it” provision. If you don’t spend your HSA in any given year, it just rolls over to the next year. Because you don’t need to spend this money for decades, it can be invested aggressively like any other retirement account. If you decide you don’t want to spend it on health care for whatever reason, after you turn 65, it becomes just like any other IRA. You can blow it on a boat without having to pay the 20 percent (not 10

percent like most retirement accounts) early-withdrawal penalty, although you’d still owe income tax on the withdrawal. Still, that’s double-tax-free. Most retirees, however, will have some health-care expenses in retirement because medications, Medicare premiums, and long-term-care insurance premiums are all considered eligible expenses. The 20 percent early-withdrawal penalty, as with most retirement accounts, also doesn’t apply if you die or are disabled.

**If you find yourself wanting to save more than you can put into your retirement accounts, consider using your HSA as a Stealth IRA, the only triple-tax-free retirement account.**

There is one other loophole worth knowing about: the IRS doesn’t require you to withdraw the money from the HSA in the same year you incur the health-care expenditure. That means you can leave the money growing tax-free in the HSA and keep a running tally of your qualified health-care expenditures and receipts. Then when you need money to buy that sailboat, even before age 65, you pull it out of the account and report an equal amount of health-care expenditures from prior years on your tax form 8889 for that year. Be sure to keep your receipts in the event of an audit. The requirement is that you incurred the health-care expenditure after opening the HSA, not necessarily in the year you withdrew the money from the account—although it wouldn’t surprise me to see this loophole closed in the future.

HSAs have other advantages over employer-provided retirement accounts: you do not have to use your employer’s suggested HSA, and you can transfer HSA assets to another HSA account once per year. Employer-provided retirement and HSA accounts are notorious for poor investment choices and high costs. Even if you decide to use your employer’s designated HSA to obtain an employer-provided match, you are allowed to then transfer the money to your own preferred HSA immediately afterward, so you’re never stuck in a poor HSA for long. Recommended HSAs with low fees and solid investment options include HSA Bank, Health Savings Administrators, and Alliant Credit Union.

If you find yourself wanting to save more than you can put into your retirement accounts, consider using your HSA as a Stealth IRA, the only triple-tax-free retirement account. ☺



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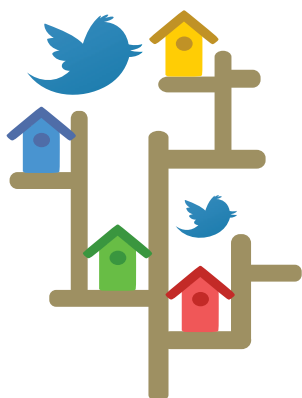
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**JEREMY SAMUEL FAUST MD, MS, MA**, is an emergency medicine resident at Mount Sinai Hospital in New York and Elmhurst Hospital Center in Queens. He tweets about #FOAMed and classical music @jeremyfaust.

# Averting Stroke, TXA Vials, Backboards, and More



by JEREMY SAMUEL FAUST, MD, MS, MA

A Twitter feed is like a sushi-boat restaurant: many options float by, and you take the ones you like, leaving the others for someone else to enjoy. The analogy continues. Sometimes there is more than meets the eye. Only when you delve in can you appreciate the whole experience. Perhaps most important, when enjoying the content, you have to trust the chef.

In this column, I'll share some recent high-impact tweets, along with some commentary, to give you a sense of the depth that can be packed into 140 characters. Many links below are Free Open Access Medical Education (FOAM), while certain articles may be behind paywalls or accessible through your employer accounts.

**1. Amie Hsia, MD (@DCStroke-Doc), neurologist and medical director of the stroke center at MedStar Washington Hospital Center in Washington, DC, tweeted:** “@emlitofnote hit the mark in @JAMA\_current with citing our averted #stroke paper: #tPA-treated does not equal #stroke <http://bit.ly/16GitWt>” There's a lot to unpack here. In this tweet, Dr. Hsia agrees with a letter published in *JAMA* written by Ryan Radecki, MD (@emlitofnote), creator of the Emergency Medicine Literature of Note blog, and she provides the link. In his letter, Dr. Radecki points out that stroke mimics, such as transient ischemic attacks, would have, by definition, resolved without intervention. Patients treated “most expeditiously would be afforded the least opportunity to manifest clinical improvement.” Therefore, we can't know which of the patients in the study had TIAs rather than true strokes, with TIAs likely being over-represented in the cohort. Further, those who received thrombolytics (tPA) and subsequently had profound resolution of symptoms probably were not having strokes at all, as complete resolution of symptoms following tPA is rare, a point made in a paper by Dr. Hsia's research group also referenced and linked in the *JAMA* letter. Dr. Hsia's tweet demonstrates the power of virality of medical information on Twitter. While she has just 80 followers, this particular tweet was re-tweeted to more than 3,000 people. She also



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demonstrated good use of hashtags. Including #stroke and #tPA helped identify these tweets to anyone looking on Twitter for information on these topics.

**2. University of Wisconsin emergency physician and chief flight physician Mike Abernathy, MD (@FLTDOC1), tweeted this beauty:** “...I really like this! ‘Shock Index(SI) = HR/SBP If SI >0.9 Trauma pt at high risk for massive transfusion <http://www.ncbi.nlm.nih.gov/pubmed/21307738>.” This is a great example of using Twitter to reduce the window between research knowledge and clinical application. Sure, the Shock Index (SI) has been discussed in the literature since a landmark paper in *Resuscitation* in 1992, but how many emergency physicians actually use it? The tweet links to a newer paper

(Vandromme et al. 2011 in the *Journal of Trauma*) detailing a new way that the SI can be applied: to identify normotensive patients at risk of requiring massive transfusion. Applying this knowledge might give a trauma team a head start, saving precious seconds and minutes. Additionally, the website and app MDCalc (<http://www.mdcalc.com>) by Graham Walker, MD (@MDCalc), does the SI math for you and alerts you to the meaning of the number you calculate.

**3. Kiwi-turned-Salt Lake City emergency physician Rob Bryant, MD (@RobJBryant13), tweeted:** “TXA vial is tough to open & ironically sharp. If you cut yourself, pour a little on the lac, you'll be fine [pic.twitter.com/ExiGDAnpML](http://pic.twitter.com/ExiGDAnpML).” The picture shows a small glass vial of tranexamic acid with a sharp edge after being

broken off by hand. While the data for tranexamic acid for significant bleeding may still be a work in progress (the CRASH-3 trial is currently under way), a recent *Annals of Emergency Medicine* paper (Zahed et al. September 2013) suggests good outcomes for a usually less severe but certainly common emergency-department problem: epistaxis.

**4. Emergency-medicine resident Lauren Westafer, DO (@LWestafer), tweeted:** “AAEM practice guideline supports droperidol. Hip hip hooray! <http://www.aaem.org/UserFiles/file/Safety-of-Droperidol-Use-in-the-ED.pdf> ... (updated black box summary <http://shortcoatsinem.blogspot.com/2012/12/not-black-boxed-droperidol-as-anti.html> ...)” The newly published American Academy of Emergency Medicine's policy states that the black-box warning on droperidol is unwarranted for doses under 2.5mg IV or IM and that electrocardiograms for such doses are unnecessary for the evaluation of QT interval. The guideline also states that IM doses of up to 10 mg are as safe and effective as the other medications in common use. Dr. Westafer's own summary on her blog, Short Coats in EM (<http://shortcoatsinem.blogspot.com/>), which she started as a medical student, has a great slide deck on the topic, as well.

**5. The University of Nevada School of Medicine Department of Emergency Medicine's website and Twitter account (@LasVegasEM) has been putting out great stuff lately. This post takes a welcome shot at backboards and cervical collars:** “Check out a new post in our FOAM blog. Dogma in EMS: Spinal Immobilization. What are your thoughts?? <http://www.lasvegasemr.com/foam-blog.html> #FOAMed” High-impact point: not only do backboards and c-collars provide no benefit, there may even be harm associated with their use, including respiratory compromise and difficulty with airway management. Other than for ease of transport, backboards should probably be banned! ☘

**DO YOU HAVE ANY FAVORITE TWEETS THAT ACEP NOW READERS SHOULD KNOW ABOUT VIA THE FEED?**

TWEET AT ME @JEREMYFAUST OR E-MAIL TO JSFAUST@GMAIL.COM.



BETTER, SAFER,  
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## COST-EFFECTIVE CARE



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# A Better Approach to Managing Recurrent Renal Colic

## Introducing the Cost-Effective Care Series

Every day, there is increasing pressure from patients, payers, and government to get more value for health care spending. Too often, health care stories cite problems with our current system but don't offer solutions. As practicing physicians, we are committed to first do no harm—and that includes financial harm—but we receive little guidance on specific ways to help fix the many problems in our health care system. In the emergency department, we influence health care costs through the tests, treatments, and hospital admissions we order every day. This series will address common emergency department presentations and identify a diagnostic or treatment strategy that is efficient, safe, evidence-based, and more cost effective than how we frequently deliver care. Some of you may be practicing this way already; others may think we're crazy. Continue the conversation and send us your feedback on social media at @ACEPNow.

by MICHELLE LIN, MD, MPH, AND JEREMIAH SCHUUR, MD, MHS

**“D**octor, EMS just brought a man who is really uncomfortable into bay 4. He looks like he has a kidney stone, and he's had one before. Can I give him some morphine?”

“Sure, put him in for a CT, and I'll see him in a few minutes.”

Every day, emergency departments across the United States care for similar patients. Kidney stones affect one in 11 adults in the United States, and their prevalence has increased 40 percent in the past decade. Renal colic accounts for more than 700,000 emergency-department visits annually, and in 2009, 71 percent of these patients underwent CT examination. Depending on how it's measured, the use of CT for renal colic has increased between three- and tenfold in the last two decades.<sup>1,2</sup>

**Among patients presenting with recurrent acute renal colic, should non-contrast CT of the abdomen be the standard diagnostic approach?**

CT of the abdomen is the preferred diagnostic test to identify kidney stones due to its accuracy, speed, and widespread availability. Sensitivity ranges from 94 percent to 100 percent, while specificity ranges from 92 percent to 100 percent. CT is the test of choice for patients presenting with first-time renal colic or

potentially complicated renal colic (eg, fever, a single kidney, or immunosuppression). Additionally, in patients in whom you suspect a serious alternate cause of their flank pain (eg, dissecting abdominal aortic aneurysm), CT should be performed. However, while CT is useful to detect extra-renal pathology, the rapid increase in CT use has not resulted in an increased incidence of alternate pathologies.

Increasing use of CT is concerning due to radiation exposure, and patients with recurrent renal colic are at particularly high risk of repeat CTs, with a median dose of 7.9 mSv each (20 mSv is the maximum allowable for radiation workers annually, and 100 mSv is associated with carcinogenic effects).

The cost of these CTs adds up to real dollars. In 2012, Medicare reimbursement for non-contrast CT of the abdomen was \$306, while hospital charges ranged from \$35 to \$2,724. In 2009, an estimated 497,000 CTs were performed for the evaluation of renal colic, totaling \$152 million in medical costs (a conservative estimate based on Medicare payments).<sup>3</sup>

**How can we safely evaluate patients with recurrent renal colic in a more cost-effective way than with repeat CTs?**

Urinalysis and bedside renal ultrasound are an effective strategy to confirm recurrent renal colic. Microscopic hematuria is found in 84 percent of patients with kidney stones; however, due to its presence in other diseases, the specificity is 48 percent. Adding ultrasound enhances the yield of urinalysis alone.

Bedside ultrasound by an emergency physician is rapid, safe, and less expensive than CT. Ultrasound is 87 percent sensitive and 82 percent specific for the identification of hydronephrosis, which is present in 69 percent of patients with acute ureteral colic.<sup>4</sup> While ultrasound is less sensitive for the detection of small stones, you don't need to see the stone to make the diagnosis of renal colic. If you choose to perform ultrasound instead of CT, you aren't alone—the American College of Radiology appropriateness criteria rates ultrasound as equivalent to CT of the abdomen for the evaluation of



Hydronephrosis appears on ultrasound as a dilated hypoechoic (black) region in the collecting system of the kidney.

recurrent stones. If your group and emergency department are billing for ultrasounds, the cost of a renal ultrasound based on Medicare rates is \$99, less than a third of the cost of CT.

With basic training, hydronephrosis is easy to identify using ultrasound. In one study, second-year emergency-medicine residents were able to identify hydronephrosis with 96 percent accuracy compared to registered sonographers after 45 minutes of renal ultrasound training (within a larger curriculum).<sup>5</sup> Not all renal colic patients need IV fluids, but hydronephrosis is easier to detect after a 500 cc bolus. A prospective study of urinalysis and ultrasound in 227 patients resulted in discharge of half of patients found to have hydronephrosis and microscopic hematuria.<sup>6</sup> Among those discharged, 81 percent ultimately had kidney stones, and none had adverse outcomes within three months.

### The Bottom Line

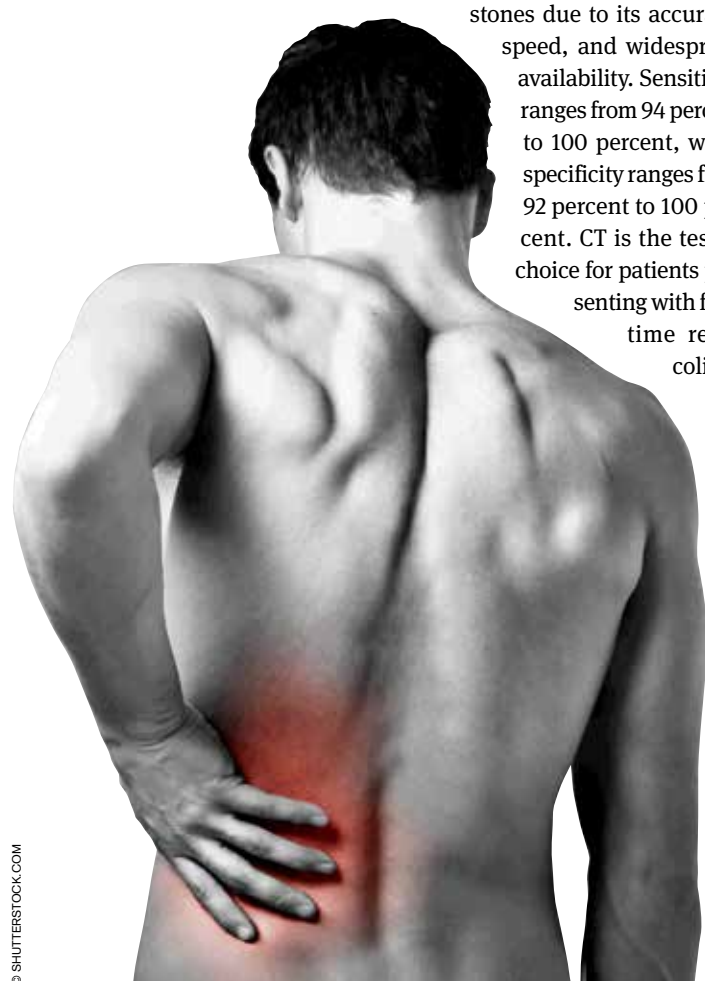
The emergency physician's role in the management of acute renal colic is symptom relief, evaluation for complications such as infection, and consideration of alternate diagnoses. The vast majority of stones pass spontaneously, and CT imaging in the emergency department rarely alters immediate management. One randomized study found that patients with suspected renal colic who undergo delayed outpatient imaging have equivalent outcomes to those who undergo emergency department imaging at four-week follow-up.<sup>7</sup>

So the next time you see a patient writhing in pain, saying, “Doc, it's like my last kidney stone,” think twice before ordering the CT. Pro-

vide pain relief, get a urinalysis, and if you have an ultrasound and know how to identify hydronephrosis, throw on the probe. Hematuria or hydronephrosis on the side of the patient's pain can help confirm your strong clinical suspicion of kidney stone. If your patient has both, it's even more likely. If you have a real suspicion of another serious problem or can't make the patient feel well enough to go home, order a CT. Practicing cost-effective care for patients with recurrent renal colic will reduce your patients' exposure to radiation and can shorten their length of stay, both of which will improve their satisfaction. ☺

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# ACA Roundtable Discussion

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Beyond the rhetoric, what will the complicated and quickly evolving elements of the law actually mean for emergency physicians? How will the fundamental changes impact issues of patient access, health care affordability, and physician reimbursements?

ACEP strongly supports access to quality medical care, especially emergency medical care. Four emergency medicine experts convened by *ACEP NOW* Medical Editor in Chief Kevin Klauer, DO, EJD, FACEP, recently discussed whether the ACA meets that objective and what the new changes might mean for the field.

## PARTICIPANTS



**KEVIN KLAUER, DO, EJD, FACEP**, medical editor in chief of *ACEP NOW* and chief medical officer of Emergency Medicine Physicians



**ALEXANDER ROSENAU, DO, FACEP**, president of ACEP and senior vice chair of emergency medicine for the Lehigh Valley Health Network in Allentown, Pa.



**MICHAEL GRANOVSKY, MD, FACEP**, president of coding for LogixHealth



**TODD TAYLOR, MD, FACEP**, Veteran emergency physician, EMTALA and healthcare IT consultant



**L. ANTHONY CIRILLO, MD, FACEP**, director of health policy and legislative advocacy for Emergency Medicine Physicians



## ACEP NOW EXCLUSIVE!

**Dr. Klauer:** *To jump in, what parts of the ACA are good, and what parts may positively impact emergency medicine?*

**Dr. Taylor:** I think the good news is that there are some aspects that have already taken effect: children can stay on their parents' plan until age 26; the controversial mandate for coverage of contraceptive services; the prohibition of denial for pre-existing conditions for children; prohibition from rescinding coverage; eliminating lifetime limits; regulating annual limits on insurance coverage; and that 80 percent to 85 percent of premium dollars, at least now for large employers, has to be spent on health care services.

The meat of the Act has not yet taken effect. Many of these extend to larger populations in 2014. The biggest is what's called the minimum-coverage provision, otherwise known as the individual mandate. That requires most U.S. citizens and legal residents to maintain insurance coverage for themselves and their dependents, or they have to pay a 1 percent penalty of their total annual income or—at a minimum—\$95.

It expands the pre-existing-condition prohibition to everyone, there are no annual limits on insurance coverage, it ensures coverage for clinical trials, and it adds mental-health and substance-abuse coverage for everyone—although this does not apply to Medicaid or Medicare. It expands prescription coverage. It provides preventative care, which is mostly free. It redefines pregnancy as preventative care, so it must be covered. Of course, that is under the terms of deductibles and coinsurance. And it caps the maximum out-of-pocket expense per individual at \$6,350 a year, or \$12,700 per family.

**Dr. Klauer:** *Tony, anything to add to that?*

**Dr. Cirillo:** I think the fact that there's at least some hope that more people will have insurance coverage—even if that takes another seven or eight years down the road to get fully expanded out—certainly might help us.

The fact that we see so many patients, particularly on the admission side, I think will give us more leverage because the underlying driver for this is still going to be finances and how to pay for care for more people who are getting older and sicker. And I think it will give us more voice because we're going to be a key player in deciding how best to do that.

**Dr. Rosenau:** What we found good is that one of the main goals of the Affordable Care Act—and of course, the word “affordable” remains to be seen—but the ACA is useful because by providing a means of payment, a means of insuring the whole population, we share the burden among more people, and that should eventually lower the cost per person—we're hoping.

**Dr. Klauer:** *Mike, anything else to add on that question? Anything in the ACA you see as really a windfall for emergency medicine?*

“So the jury is out. ... It's going to be a long process that requires a lot of education, and the resources will have to be put there. We also have to be very careful not to create self-rationing or effective lack of insurance due to very high barriers of deductibles.”

—Alexander Rosenau, DO, FACEP

**Dr. Granovsky:** One item that I'll add, and it seems obvious at the surface, is the inclusion of emergency department care, which ACEP advocated and supported, as one of the essential health benefits so that ED care is required to be a covered service. Now the degree to which that coverage ultimately leads to remuneration for our members remains to be seen, but ED care is a defined, covered service as an essential health benefit.

**Dr. Klauer:** *You mentioned, Todd, that there were caps on the out-of-pocket expenses for the insured. If your deductible is \$10,000, are they really capping your expenses at \$6,350? Then your deductible isn't really \$10,000. So what are your comments on that?*

**Dr. Taylor:** One of the impacts of the website [<http://healthcare.gov>] unavailability is that people really haven't gotten all of the information. The maximum out-of-pocket is \$6,350, so you really don't see deductibles above that, but you do see some plans that have a \$6,350 deductible. Beyond that, there's no coinsurance, no co-pays, or anything else because that's the maximum out-of-pocket. The rest of the plans are really just some mathematical derivation of that, and if you really start to delve into them, what you'll see is

that as you get to the lower deductible amounts, the premiums increase to an extent and the coinsurance increases to an extent that essentially you're better off, if you have the resources, to go with a high deductible—say, a \$5,000 to \$6,000 deductible—pay the lower premium, and save that money toward whatever health-care services you may incur.

So one of the impacts of the way this has been structured is that it is forcing first-dollar coverage onto individuals and basically making them self-insure.

What's funny about it is that when you take into account the individual cost from coinsurance and deductibles and then you add in the additional amount of premium you're going to pay for a lower coinsurance or deductible, and you take pregnancy as an example, you just about pay the same amount out-of-pocket regardless of plan. And that amount out-of-pocket is almost the entire cost of the pregnancy.

**Dr. Granovsky:** I'll just add here, related to the out-of-pocket maximum. The out-of-pocket maximum seems like it will apply to co-pays and coinsurance. The patients' premium costs, which are paying for the actual coverage, may in the end actually be layered on top of that. And depending on the way that the insurance product is set up that you purchase, you may be on the hook for prescription drug co-pays in addition to the \$6,350 out-of-pocket maximum.

In fact, I'm in the process of shopping for my own family's health insurance, and the prescription coverage is an area where there's a lot of opportunity for the issuers, the insurance companies, to pass on costs. As an example, a typical plan that I looked at just yesterday was a \$10 co-pay for a generic drug but 40 percent coinsurance for a non-generic drug. The math changes very quickly. That non-generic drug, which happened to be Protonix, was going to be \$100 for a 60-day supply.

**Dr. Klauer:** *So this is for all of you: we've got a system in place, so we do have some form of access to health insurance but not necessarily health care. So is this really just an illusion of coverage to the average citizen, or is there true coverage? In other words, with such high deductibles, are we effectively just adding to the ranks of self-pay patients?*

**Dr. Rosenau:** I don't think it's fair to say it's just an illusion of coverage, but it's like everything else: the devil's in the details. So the jury is out. In order to get to the point where the Affordable Care Act works well for everyone, it's going to be a long process that requires a lot of education, and the resources will have to be put there. We also have to be very careful not to create this self-rationing or effective lack of insurance due to very high barriers of deductibles.

**Dr. Granovsky:** I want to tie back to the very last thing that Kevin said, which is people who are self-pay. Many of the people who are currently self-pay will

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## Pondering the Impact of Policy Cancellations

**Dr. Klauer:** Mike, what is your perspective on the surprise that initially 5 percent, or 15 million people, got their policies canceled? Was that a surprise? What's the impact of that issue? Do you think the federal government knew but were just waiting to see how it played out?

**Dr. Granovsky:** It seems like it was a knowable fact ahead of time because the requirements to grandfather a plan were very, very well vetted. Then secondarily, the essential health benefits were very, very clearly defined. To the extent that an old plan did not have those benefits, it was clear that plan would be canceled.

**Dr. Taylor:** The reason the plans were canceled is the insurance companies chose to not grandfather the plans. It's not because it wasn't allowed. So it's a total—I'm not sure what to call it. It's just another example of stretching the truth. The reason the insurance companies canceled the plans is because they canceled the ones they weren't making money on. It was an excuse to get rid of the dogs, and they're keeping the other ones. So they're not going to come back. That horse is already out of the barn.

**Dr. Klauer:** So the Affordable Care Act gave them the window to do this, and the federal government didn't foresee that there was economic incentive to have this happen. They should have closed this loophole.

**Dr. Taylor:** Exactly.

move into Medicaid products if that state has opted to expand Medicaid. And then the discussion that we're having is very different. Some states do have a shared portal for their Medicaid products and their health insurance exchange commercial plans. But for most states, the Medicaid enrollment process and the Medicaid benefits are very different than the health insurance exchange process. There's very little in the way of co-pays, coinsurance, and patient responsibility if you make less than 138 percent of the federal poverty limit and your state has opted to expand Medicaid.

You would find yourself with new Medicaid coverage when you were previously self-pay, with very little in the way of patient responsibility. Then we've got the health insurance exchange products, where the subsidies run for individuals with adjusted gross income between 138 percent and 400 percent of the federal poverty limit, and that's the process that we've been discussing now. I just wanted to make that distinction.

**Dr. Klauer:** Tony, what are your feelings about whether this is just the illusion of health-care coverage? If people really are not going to want to pay this out-of-pocket expense anyway, they're going to be in the same situation they're in now. What do you think?

**Dr. Cirillo:** Let me give you a real-world example because I'm actually on the Connecticut exchange website right now. If you have a family of four in Connecticut, and I did two adults and two teenage children with an annual income of \$60,000—that's gross income—there are four silver plans that are available through the Connecticut marketplace, the cheapest of which, after a \$520 tax credit, is \$405 a month.

So that's the premium. The max out-of-pocket for the year is \$12,700, and it comes with a \$6,000 deductible. So I would pose to the group: if you're a family of four making \$60,000 a year and you have to shell out \$5,000 a year in premiums and you're on the hook for \$6,000 to start with, are you really going to be able to afford that coverage?

**Dr. Klauer:** So when it comes down to it, this is a shell game. You're still paying \$11,000 before anybody pays one penny of coverage for your family.

**Dr. Cirillo:** That's correct. And your primary-care visits have a \$30 co-pay. As Mike pointed out, there are three concepts that people need to consider when they're looking at this—really four. OK, I'll give you five: What's the premium? What's my deductible? What are my co-pays? My coinsurances? And then, what's the maximum that I'm on the hook for when I get my card?

**Dr. Klauer:** Is there any carve-out in any one of these plans that you're aware of that says, but if this is an emergency, we cover more of this or you don't have to meet the deductible?

**Dr. Taylor:** I've looked at that specifically. So emergency care is included in the deductibles, and it's actually worse because some of the plans require a facility fee of up to \$500. So even if you have a low deductible and reasonable coinsurance, you're going to have that minimum of a facility fee, and that also applies to some plans with regard to hospitalization admission on a per-day basis. You may have to pay up to \$2,000 per day.

**Dr. Klauer:** What you two have said leads me to what I think is an obvious question: If we have people in the insurance pool right now who maybe don't have great plans but they have coverage and now they're going to switch over to this type of system, are we at risk of converting people who were going to be covered patients in the emergency department

to patients who are now effectively uninsured self-pays in the emergency department? Is this negatively impacting our situation in the emergency department based on these plans?

**Dr. Taylor:** We probably don't functionally impact those who are currently uninsured. However, once the employer mandate starts, you're going to see shifts in those plans where I believe we will be creating an underinsurance situation, or what I like to call functionally uninsured, throughout the current insured population. So the scenario that Tony mentioned I believe will expand to a large segment of the popu-

"If the good news about the Affordable Care Act is that in half the states we can look forward to more Medicaid patients, then I think that fairly well summarizes what we can expect for emergency medicine in this initiative."

—Todd Taylor, MD, FACEP

CONTINUED on page 20



## Summarizing the ACA's Shortcomings

**Dr. Klauer:** *So what parts of the ACA are a bust to you?*

**Dr. Granovsky:** The degree of patient economic responsibility in the form of deductibles, co-pays, and coinsurance; loss of individual-physician relationships based on small and restrictive panels; the cancellation of whole swaths of health-insurance plans, in some zip codes as much as 5 percent of the citizens; the lack of messaging to us, as citizens, about the exchange process and how it works. The folks on this call know a lot about this stuff, but nobody else does, and it is complicated. And one specific issue related to IT: the inability to shop and compare without setting up an account [on the health-care exchange].

**Dr. Rosenau:** One of the things that disappointed us about the Affordable Care Act is that during its rollout, it seemed to almost forget that there was an emergency care system or a need for such. And because of the shortage of primary care doctors, we also know that there are many primary care doctors that just don't have a spot open spontaneously to see a patient.

We want those who do get the health insurance coverage to know that coverage does not equal access because if it turns out to be Medicaid rates, a lot of primary care doctors and some specialists may not take those patients. And so it may actually increase the number of people coming to the emergency department. That happened in Massachusetts initially. Depending on how you look at it and what year you look at, there was about a 3 percent to 7 percent increase in emergency room visits to Massachusetts ERs after the law went into effect.



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**Dr. Cirillo:** 1) Despite all of the time, political effort, and money that went into making ACA the law, it is projected that there will still be 31 million uninsured Americans by the year 2020. There were 50 million when the law went into effect in 2010. Seems like we should have gotten more than a 40 percent reduction for "landmark" major health care legislation. Imagine the uproar if when Medicare was passed in 1965, it only covered 40 percent of seniors over the age of 65.

2) The PPACA does not address the underlying fundamental reason for the "health-care crisis." We, the medical community, spend too much money on things we *can do to patients* rather than what we *should do for people*. Until we as the medical community develop the intestinal fortitude to lead a discussion with this country about what is the "right" thing to do, then we will continue to send 95 year olds to the cardiac cath lab and ICU and spend valuable health care dollars

with questionable results.

3) The offer of health insurance "coverage" in the HIE marketplace at the 60 percent bronze level or even 90 percent platinum level in the marketplace is essentially false advertising. What really matters is what the out-of-pocket maximum is under the plan and how much "real money" individuals and families are going to have to come up with when you add up premiums, deductibles, co-pays, and coinsurances.

4) The PPACA did nothing to address the "hidden" costs of defensive medicine or create any improvement in the medical malpractice arena.

5) Eventually, the IPAB will become the most important aspect of the law. The one critical "itch" that needed to be "scratched" for the U.S. government was the doubling of Medicare expenditures that was projected to occur from 2011 to 2021 due to the aging of the Baby Boomer generation (from \$569 billion to \$980 billion) and that 23 percent

of the federal budget already pays for health care. PPACA will not change that aging demographics, so we know that there will be more people getting older and eventually needing more care. (Last I checked, the one statistic that you can't manipulate is that there is still a 100 percent mortality rate for all individuals.) Eventually, Medicare spending will need to be decreased; the IPAB would just be the most expedient way to do that (although all of the 1 percent and 2 percent bonuses that few will achieve will help).

**Dr. Taylor:** The Affordable Care Act (perhaps more aptly named the "Health Insurance Reform Act") is the biggest economic and social sciences experiment in American history, eclipsing Medicare and Medicaid combined. The ACA's fundamental flaw is that it assumes health insurance coverage will (necessarily) result in access to health care. While ACA may increase the number with insurance coverage, it will functionally decrease health care access, largely due to high out-of-pocket cost (premiums plus deductibles plus coinsurance plus special fees) and due to limited network-provider panels.

The second (perhaps fatal) fundamental flaw of the ACA relates to human behavior by assuming the American public will a) be able to figure it out, b) have the patience to do so, and c) have sufficient incentive to care at all. So while perhaps well-intentioned, the ACA is the illusion of health insurance coverage, resulting in less actual health care, and at a cost of \$2 trillion plus increasing individual costs (also in the trillions). In total, this makes the ACA the biggest boondoggle in America history.



lation, and the ultimate result is that the immediate dollars available for emergency care will decrease and we'll be chasing individuals for their deductibles like we have never seen before.

**Dr. Klauer:** *We have people who, perhaps, have decent plans now who've got to choose one of these new plans. If they elect not to do it or they end up having a high deductible and they come to the emergency department—where, a year ago, their plan would have paid us something—now it's all their burden, and we may not be able to get anything from them. Until they meet their deductible and premium, they're effectively a self-pay to us.*

**Dr. Taylor:** Well, you'll be able to get something from them, but you're going to have to chase it; it's much more difficult. The days of submitting a bill to their insurance plan and getting a check in 30 days I believe will be largely gone, and you'll be chasing this money for months.

**Dr. Granovsky:** In 2003, tax-law changes facilitated the growth of high-deductible health plans, and we had 8 million enrollees in high-deductible health plans in 2010 and 13.5 million in 2012 and over 15 million in 2013. And the experience has shown exactly what both Kevin and Todd are saying. We actually have the experience already: those dollars *are* harder to collect.

**Dr. Klauer:** *That brings me to my next question: How do you think the Affordable Care Act will impact reimbursements, short-term and long-term?*

**Dr. Granovsky:** There is a silver lining, which is the Medicaid expansion for states that opt into that expansion. The typical self-pay collection runs \$15 to \$20 per visit. The typical Medicaid payment for an ED visit to physicians is between \$50 and \$80. And over time, some modeling has shown that you could see a shift of 7 percent to 10 percent of a given ED's patient population moving from self-pay to that state's Medicaid pool. Medicaid doesn't pay quickly, the rates aren't so robust, but nonetheless, you could see a difference of \$50, \$60, \$65 a patient, which for a typical 40,000-visit ED could create \$150,000 in additional revenue.

However, that would all be offset by high-reimbursing patients moving into health insurance exchange products. Our general feeling is that it will trend toward Medicare or close to Medicare rates from what now are much higher rates.

**Dr. Klauer:** *Tony, quick question for you. If Medicaid expansion could almost be a safe harbor in this plan that in some way helps us or protects us, is that going to be a place that we're going to drive emergency care?*

**Dr. Cirillo:** There are 25 states plus the District of Columbia that have opted to expand and 25 that have opted not to. In those states that opt not to,

"The offer of health insurance 'coverage' ... is essentially false advertising. What really matters is what the out-of-pocket maximum is under the plan and how much 'real money' individuals and families are going to have to come up with."

—L. Anthony Cirillo, MD, FACEP

not only are there still going to be people who are more self-pay when they could have been covered by Medicaid, but those hospitals are still going to lose their disproportionate share payments. So I will tell you that the people working in those hospitals are going to continue to see self-pay patients, and their hospitals are going to be put in a more financially challenging position.

I think the other issue is that, remember, there are only two states that pay above Medicare for Medicaid patients, and that's North Dakota and Wyoming. So if you practice there, you're doing OK, but many states pay 25, 30, 40 cents on the Medicare dollar. So although it will be better than nothing, I agree with Mike: the reality is that it's not much better than nothing, and you're still going to have to work so much harder to get that first dollar out of the patients who have these pseudo-insurance cards. I don't see this as being a magic windfall for emergency medicine in any way.

**Dr. Klauer:** *Tony, just for the readers, give us a one- or two-liner defining disproportionate share.*

**Dr. Cirillo:** The Disproportionate Share Program, or DSH, is a program that essentially provides federal dollars to help offset the cost of care provided by hospitals to patients who are self-pay or "indigent." Each state receives a payment annually, and then the states decide how to divvy up those funds among their hospitals by some formula that the feds have created to determine the dollar amount.

**Dr. Granovsky:** To build on that, if you are in a non-Medicaid-expansion state, you are losing, as Tony said, your DSH payment. Those payments support, in part, resident-driven or public-facing free clinics or indigent-care health-care access. So now you didn't expand Medicaid if you're in a Gulf state, let's say Texas, Louisiana, or Mississippi. And the resources, the revenues that the hospital uses to fund its indigent care have now dried up. Where do those patients go? They only have one place left: the front door of the hospital's emergency department.

**Dr. Taylor:** Just to add to that discussion, patients in this gap are exempt from the mandate based upon their income. So you create a situation where you don't provide Medicaid to them and they don't have the individual mandate.

If the good news about the Affordable Care Act is that in half the states we can look forward to more Medicaid patients, then I think that fairly well summarizes what we can expect for emergency medicine in this initiative.

**Dr. Klauer:** *Thank you for that ray of sunshine, Todd. So how will the ACA impact reimbursement—short-term and long-term? Mike?*

**Dr. Granovsky:** Medicaid will expand over time. The Massachusetts experience was that it took three to five years until everybody who could be insured would be insured. The movement into the health insurance exchanges will also take time, and it seems like the federal government is backing off of that by delaying the employer mandate by a year. And I agree with Tony: I think a lot of that will then lead to reconfiguring of the workforce to below the mandated 30-hour cutoff that requires employers to have coverage.

As more and more patients move into the exchanges, we will see ED reimbursement for the higher-end commercial plans driven down closer to Medicare levels.

**Dr. Klauer:** *So is this model sustainable, Tony?*

**Dr. Cirillo:** The answer, to me, is no. The fundamental reasons why we spend money on people haven't changed. So we haven't had any discussion, and I will fault the medical specialty for not doing this. Ten years ago, we could have had a discussion, honestly, with the people whom we refer to as "The Greatest Generation," who understood the concept of self-sacrifice for the greater good. We could have had a discussion about, hey, let's really talk about what people really want for health care as they get older and what should we really tell them about what it's like to go to the cardiac cath lab at 90 and go to the ICU.

**Dr. Klauer:** *So our problem is we still treat health care in this country as a right, but we're funding it as a privilege, and this law doesn't change that.*

## Weighing in on the Individual Mandate

**Dr. Granovsky:** Relating to the individual health mandate, it's actually quite soft. Although the 1 percent or \$95 penalty is in place and a very significant step for us societally, the IRS has been stripped of its usual enforcement mechanisms. If any of the folks on this call owe the IRS \$95, the IRS has very significant items in its toolkit to collect that, including garnishment of wages, liens on property, freezing of bank accounts. And in fact, those three mechanisms of enforcement, or collection of the \$95 penalty, have been removed from the IRS' processes. The main mechanism for recouping an individual-mandate \$95 penalty would be an offset against a future tax refund. It remains to be seen how often folks who fall into that cohort of not purchasing individual insurance would actually have a tax refund that would be available for offsets.

**Dr. Klauer:** So Mike, is it fair to say that the IRS has been given the charge and also the authority to implement the financial aspects of the Affordable Care Act?

**Dr. Granovsky:** Yes, that's correct, although perhaps not all the tools required to do it.

**Dr. Klauer:** Do you think



*they've been given more latitude with this than with standard implementation of the tax system and tax code, or less?*

**Dr. Granovsky:** The IRS has a very narrow and defined role as far as the way they can recoup any penalties.

**Dr. Taylor:** I wanted to ask a question. How much penalty does this group believe would be required to actually force people to purchase insurance?

**Dr. Cirillo:** I'll chime in. I think the penalties on both the individual and the employer side are so unequal to the actual ask to pay for insurance that I don't think they're going to make any difference to people; I think people will accept the penalty. I think Mike's right: the IRS has very limited tools in their toolbox to go get money from individuals.

Even with their subsidies, as Todd said, there's still going to be this \$6,350 for an individual and \$12,700 deductible out-of-

pocket cost for a family, and I don't see that people are going to be able to afford either of those. And the only way you'd actually be able to make them buy insurance is to make the penalty almost as bad, or as painful, as the cost of the insurance.

One of the reasons why the employer mandate was delayed a year is I think the administration was going to see a number of companies opt to take the penalty and drop insurance for their employees.

**Dr. Cirillo:** We treat it as something that we have to do because we have the possibility of doing it. And we stopped being thoughtful and mindful about what we *should* do.

**Dr. Klauer:** Todd?

**Dr. Taylor:** With the Affordable Care Act, we now treat health care as a fundamental right, but we are now funding it as mandate, and I think that's the difference.

**Dr. Klauer:** So do you think it's sustainable, Mike?

**Dr. Granovsky:** Not sustainable under its current form.

**Dr. Klauer:** Todd?

**Dr. Taylor:** OK, I have to explain why it's not sustainable. The idea, under the Affordable Care Act, was to get everybody to contribute into the insurance pool and then spread the risk across the entire pool. The problem is that this scheme does not accomplish that and, in fact, makes it worse.

**Dr. Rosenau:** I'm like the rest of the population: I

have to reserve judgment. I'm not sure. I know that I live by the values that I heard when they first talked about the Affordable Care Act, which was we have 47 million Americans that are uninsured and don't get proper health care because of that. We're living in a divergent system where some people get one level of health care and the other one-sixth, the other 47 million, do not. I would like to see a consistent level of health care be provided to all of our citizens, and I think that we have to find a way to do that in an affordable manner. ☺

**BRYN NELSON, PHD,** is a medical journalist based in Seattle.





opioid drug seeking, concerns about CMS's perspective and compliance issues with EMTALA must have been contemplated. Otherwise, why would such an opinion be requested? In summary, the CMS Chief Medical Officer for the Atlanta Regional office (region 4) responded—to the surprise of many. Dr. Rick Wild responded on behalf of CMS

Region 4 making several observations and providing words of caution, strongly discouraging the use of such postings. In his response, Dr. Wild stated the following (summarized):

- The definition of an “Emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity including severe

pain, psychiatric disturbances, and/or symptoms of substance abuse.

- “Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.”
- “Accordingly, the language regarding, ‘Prescribing Pain Medication in the Emergency Department,’ which

you have provided and any similar language, which the hospital might choose to post in patient waiting rooms or treatment rooms, might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions, thereby violating both the language and the intent of the EMTALA statute and regulations.”

These statements have generated a great deal of debate and discussion. Some say, “Well this is just an opinion.” Others have said, “This only impacts Region 4,” and yet some have said, “We’ll just word ours a little better.”

To help clarify the implications of this statement, I have asked Dr. Wild and CMS to clarify their opinion, which they have done with the written interview responses below.

—Kevin M. Klauer, DO, EJD, FACEP,  
Medical editor in chief, ACEP Now

# NO SHOES, NO SHIRT,

# NO NARCOTICS

## **1 Can you tell us about CMS EMTALA enforcement policy and the CMS Region 4 letter dated Feb. 6, 2013 regarding “Prescribing Pain Medication in the Emergency Department” (in general)?**

CMS is responsible for the enforcement of and issuance of regulations, guidance, and policies pertaining to the Emergency Medical Treatment and Labor Act (EMTALA) (Sec. 1867 of the Social Security Act, 42 U.S.C.1395dd). The CMS Central Office in Baltimore has the overall responsibility for issuing regulations, guidance and policy, and each of the ten (10) CMS regional offices are responsible for the enforcement of the EMTALA law within their areas of jurisdiction and for responding to questions regarding EMTALA enforcement policy. The individual CMS regional offices regularly communicate with CMS Central Office and also conduct regular conferences between the central office and across all the regions to ensure that CMS policies are implemented and enforced in as uniform manner as possible. Each CMS regional office works with their respective state survey agencies and quality improvement organizations (QIOs) in each enforcement investigation and action. EMTALA enforcement is complaint-driven, i.e., investigations occur in response to complaints, which suggest violations of EMTALA. Each case is investigated and decisions are rendered based on the unique facts and circumstances of that case. Each CMS region is responsible for the final determination of whether EMTALA was violated, for issuing notices of termination from the Medicare and Medicaid programs, and for approving plans of correction submitted by hospitals to avoid termination. Additionally, each region refers cases to the HHS Office of the Inspector General (OIG) for consideration of

possible imposition of civil monetary penalties when appropriate.

**a. History of why and when the CMS Region 4 letter regarding “Prescribing Pain Medication in the Emergency Department” was drafted?**

Region 4 was made aware of instances or proposals to post signage in emergency department waiting areas and distribution of informational materials pertaining to “Prescribing Pain Medication.” The Region 4 letter was written in response to an inquiry from a state hospital association regarding these practices and their possible violation of the EMTALA statute and regulations. Subsequently the same issue has been arising in other CMS Regions.

**b. What are the concerns of CMS?**

CMS shares the concerns of public health organizations and the hospital industry about prescription drug abuse and its harmful effects. We understand that hospital EDs face considerable challenges in dealing with individuals seeking pain medication and controlled substances for non-legitimate purposes. We emphasize that it is within the bounds of reasonable professional judgment and discretion for a physician or other licensed healthcare practitioner to provide or withhold opioids and/or other methods of pain control, depending on the specific clinical circumstances of an individual’s presentation.

However, the posting in an ED of signs and/or distribution of brochures emphasizing that certain types of pain medications will not be prescribed appears designed to indiscriminately discourage any individual seeking treatment for pain from remaining in the ED for a medical screening examination or from coming to that ED in the future. Furthermore, such signage or brochures raise questions about whether the hospital would provide stabilizing treatment in cases in which administration of opioids might be clinically appropriate. In summary, hospitals, which employ such signage or disseminate similar brochures, are at risk of being found noncompliant with EMTALA requirements.

The EMTALA statute requires that any individual who comes to the emergency department for a medical condition must be provided an appropriate medical screening examination (not merely a triage exam) by an appropriately credentialed and qualified medical professional to determine whether or not an emergency medical condition exists. It is significant that the statute defines “emergency medical condition” to include symptoms such as severe pain. Additionally, the Medicare provider agreement statute (Section 1866(a)(1)(N)(iii)) requires hospitals to post con-



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**THE REGION 4 RESPONSE REPRESENTS CURRENT NATIONAL CMS POLICY. THIS IS NOT A NEW POLICY, BUT THE APPLICATION OF THE CURRENT LAW, REGULATIONS, AND CMS POLICIES TO THIS PARTICULAR SITUATION.**

spicuously in any emergency department a sign that specifies the rights of individuals under EMTALA with respect to examination and treatment for emergency medical conditions and women in labor. Signs that announce restrictions on treatments, regardless of the facts of an individual’s case, appear to be at odds with the signage hospitals are required by law to post in their EDs.

Further, federal EMTALA regulations (42 CFR 489.24) reiterate and expand upon these statutory requirements. For example, 42 CFR 489.24(d)(4)(iv) states that “Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.” Although certain signs and literature posted and distributed in emergency department waiting areas may be intended to “educate patients,” they nevertheless may have the real or perceived effect of discouraging an individual from remaining for further evaluation, or stabilizing treatment and thus be in violation of EMTALA. It should also be noted that EMTALA is a federal statute, which supersedes state laws, regulations, or municipal ordinances which are in conflict with EMTALA.

In some cases, CMS is asked to pre-approve or endorse specific or “model” language for waiting room signs or handout materials. However, as a matter of policy, CMS does not provide prior approval to any individual hospital’s policies and procedures, nor does it review a hospital’s EMTALA policies and procedures outside the context of a specific investigation of an EMTALA complaint. Each EMTALA case complaint or investigation will be judged based on the particular facts of each case. Certain signs or materials posted or distributed in ED waiting rooms may be determined in the course of such investigation to be inconsistent with the EMTALA signage requirements and/or to have the potential to discourage individuals from remaining in the ED.

**c. What was the process of drafting the Region 4 letter of Feb. 6, 2013, pertaining to “Prescribing Pain Medication in the Emergency Department?”**

The Region 4 response was drafted by me, the CMS Atlanta regional chief medical officer, who is a board certified emergency medicine specialist, in consultation with the federal statutes, regulations, and sub-regulatory guidance and with specific consultation with the CMS central office and other regional offices. The Region 4 response represents current national CMS policy. This is not a new policy, but the application of the current law, regulations, and CMS policies to this particular situation.

or complaint should first receive an appropriate medical screening exam by a properly trained and credentialed qualified medical professional. This exam is not a triage exam but is explicitly tailored to address the particular signs and symptoms of the patient. An appropriate medical screening exam uses all the available resources of the emergency department, which are appropriate to determine whether an emergency medical condition exists. After an appropriate medical screening exam is conducted, it is within the bounds of professional medical judgment and discretion for an appropriately licensed physician or other health care practitioner to provide or to withhold narcotic or other methods of pain control in a particular patient depending on the specific clinical circumstances. It is also left to the judgment of the provider as to how best to give specific patient-centered education, including handouts, policies, and institutional protocols. But again, it is emphasized that patient education should take place after a patient focused medical screening exam is completed and not by posting general policies and procedures or displaying such materials in the waiting area. ☛



**RICHARD E. WILD, MD, JD, MBA, FACEP**, has degrees in business and law and has practiced as a health-care attorney with a large Boston law firm representing hospitals, physicians, skilled nursing facilities, and a major Boston teaching hospital. He was medical director of Medicare’s direct fiscal intermediary in Baltimore and also the CMS (then HCFA) chief medical officer for reimbursement policy during the initial implementation of the Hospital Prospective Payment (DRG) system. He subsequently served on the Medicare Prospective Payment Assessment commission staff (now MEDPAC). He has also served as past president of the Rhode Island ACEP Chapter, alternate delegate to the Council, past national Chair of ACEP’s National Reimbursement Subcommittee of Government Affairs, and member national Government Affairs Committee and NEMPAC Board. Dr. Wild served a three-year term as ACEP’s representative to the AMA CPT-4 Editorial Advisory Board, was one of four ACEP representatives to the Harvard Relative Value study, and participated in ACEP’s national Coding and Nomenclature Committee. He is currently a member of the Georgia Chapter of ACEP and national ACEP. He has also been continuously certified by ABEM since 1985.

**2 Many have reported that this is only a Region 4 opinion and have stated it is only an opinion and not policy and that this is not the position of all CMS regions. Can you speak to that?**

As stated above, this letter was developed in consultation with CMS’s central office, has been shared with all CMS regional offices, and is being followed by CMS regional offices. However, given the frequency with which the issue is now arising and the questions about whether this letter represents CMS policy, CMS may issue a national memorandum on the topic.

**3 Do you see alternatives to ED waiting room patient signage and flyers for chronic opiate needs when patients present to the ED?**

Yes. In accordance with standard accepted medical practices and in accordance with the provisions of EMTALA, every individual who presents to the emergency department for any medical condition



# Compassionate Care in the ED

Emergency physicians can help ensure that patients receive top-quality end-of-life care

by MARK ROSENBERG, DO, MBA, FACEP, FACOEP-D, AND REBECCA PARKER, MD, FACEP

**I**t is 8 p.m. on a Thursday, and you go in to see a 78-year-old woman with pancreatic cancer and a chief complaint of a blocked surgical drain and fever. You walk into the room and see a pleasant elderly woman in no apparent distress, although she is slightly confused. Her anxious son and daughter-in-law are at her bedside. They are insisting that the GI specialist come immediately to the emergency department to see their mother, whom they say is clearly more jaundiced. They also want the blocked surgical drain repositioned. Next week, the patient is going to a large referral hospital for a new Gamma Knife treatment regimen for pancreatic cancer. After your evaluation, you call the GI attending, who states there is nothing to do and, really, this patient should be in hospice care. You agree. What are your next steps?

The emergency department has a unique role in the decisions related to palliative and end-of-life care. In fact, this was addressed by the “Choosing Wisely” campaign, as announced by the ACEP Board of Directors for the American Board of Internal Medicine (ABIM) during the ACEP13 Scientific Assembly. One of the five key “Choosing Wisely” focus points for emergency physicians and emergency departments is to refer appropriate patients to palliative medicine and hospice services: “Don’t delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.” Additionally, the American Board of Emergency Medicine (ABEM) is 1 of 10 spon-

soring boards for the hospice and palliative medicine subspecialty.

Each year, one out of four Medicare dollars is spent by just 5 percent of the beneficiaries in the last year of life, to the tune of \$125 billion.<sup>1</sup> Consider that people die in one of four ways: sudden death, terminal illness, organ failure, or dementia/frailty. In the United States, 6 percent die from sudden death, with the other three categories eligible for palliative or hospice care. The vast majority of people want to die at home, yet only 17 percent do. More than 70 percent of people die in a health-care facility, and most of them are admitted through the emergency department.

The emergency department and the emer-

gency physician clearly play crucial roles in the delivery of palliative and end-of-life care. To clarify, palliative is non-curative symptom management of serious or terminal illness and can be given in conjunction with curative treatment. Hospice care is when curative treatment is no longer beneficial and treatment is to manage symptoms only. The emergency physician, as the team leader, has a tremendous opportunity to aid patients to die in a better way. So where do you start? There are four key elements in the emergency department: identification of patients, having the conversation, symptom management, and the role of hospice.

To achieve this, we need to better understand which patients should receive these services. Consider the following case:

*A 54-year-old male presents to the emergency department with stage-4 lung cancer, a history of metastatic disease to the brain, and a complete white out of the right lung secondary to tumor and effusion. He was identified as needing a palliative consultation by the emergency-department palliative care triage-screening tool. The palliative team, consisting of the emergency physician and palliative registered nurse, saw the patient and family in the exam room. The conversation was started by asking the patient what he thought was going on. His sister answered that he*

was dying. “There is nothing more to be done, but he is so short of breath and uncomfortable,” she said. The patient continued to nod his head in agreement. The palliative team asked if they could partner with the patient and his sister to develop a plan. Together, the palliative team, the patient, and his family developed a plan. This patient was sent in by his doctor for hospital admission; however, during the discussion, it was discovered that one of the patient’s goals was to spend as little time as possible in the hospital. The team agreed that this partnership would manage the patient’s symptoms and notify the hospice case manager to see if he was the right fit to help the patient manage his illness at home with his family. Within four hours, his dyspnea was relieved and he was admitted to inpatient hospice for stabilization. That would give everyone time to prepare so that he could go home for his final days. Two days later, he was home with his family and pet cat.

This is not an unusual case to present to the emergency department. As a matter of fact, this is the type of patient most emergency departments in the country see every day. This emergency department may be unique in that they have hospice/palliative medicine—certified emergency physicians on call 24-7 for palliative consults.

In this case, there are several key elements to a palliative referral, which can be achieved using in-house or community resources. The key elements when considering referral of seriously ill patients are to identify patients who can benefit from palliative intervention, know how to have the conversation, be the best symptom manager, and understand the role of hospice and palliative services.

#### Key Element #1: Identification of Patients

Screening tools have successfully been used in triage for many aspects of emergency-department care. A tool that can easily be adapted for triage screening is a simple yes-or-no question: “Would you be surprised if this patient died within the next six months?” Any patients who have a serious illness with a possible death within six months are candidates for a palliative discussion. This is the critical first step, whether initiated by the emergency physician or the consult.

#### Key Element #2: Having the Conversation

The initial case presentation of the 78-year-old woman with pancreatic cancer illustrates a potential candidate for palliative care and possibly hospice. How do you start the discussion? A shift in demeanor for the emergency physician is required. Take the time to connect with patients and their families. Sit and have a one-on-one intimate conversation; this can be facilitated by the emergency physician or the consult.

The conversation should not be about end-of-life care or do-not-resuscitate orders. The discussion should follow some simple guidelines:

- **Introduction.** Introduce yourself and state the reason for your questions.
- **What’s happening.** Ask patients and their families what they think is going on with their illness. Do they think they are getting better or worse? Simply opening

this dialogue first helps you gather more information and may lead to the quick agreement that a person is dying. To our amazement, many patients or family members say, “I think I am dying,” or “I don’t think I will survive this.”

- **Goals.** The next focus is on exploring patients’ care goals and life goals. This allows you to change the conversation to what you, as a clinician, can do to support patients’ decisions. If they haven’t thought about this, a simple lead-in conversation, such as, “Let’s discuss planning for the worst and hoping for the best,” opens the discussion. Having this type of meeting and discussion is easier than you might imagine.

## Palliative medicine is the newest frontier in EM. ED visits are the logical place and time; a new skill for EPs in 2014 and beyond.

- **Partnering.** Rather than focusing on the traditional “all or none” divisive conversation, this changes the tenor of the conversation to a planning exercise with the emergency physician as a partner. Through this approach, the emergency physician in the initial case was able to guide the family to consider hospice and tone down acute aggressive treatment. However, sometimes this conversation may go nowhere due to reasons beyond your control, such as symptom severity or family members not being present. Remember, it is about patients’ goals—not yours.

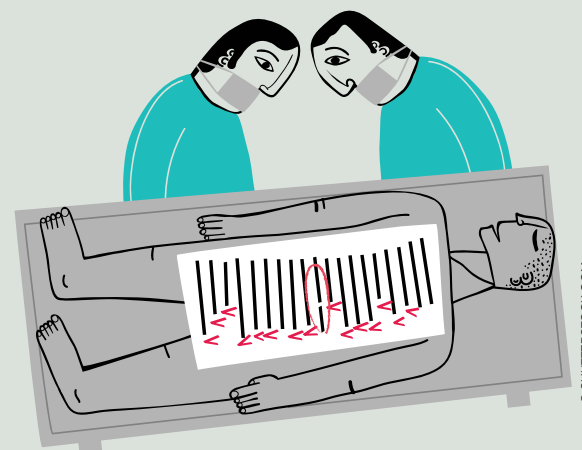
- **Palliative referral.** A referral to your palliative services may be all that is needed so a family meeting can take place at a more appropriate time.

#### Key Element #3: Symptom Management

If patients want everything done, then consider time-limited interventions or therapy. A family meeting to discuss goals of care can be set up for the future.

This is one of the most important areas of palliative medicine in the emergency department and something we do every day. For all patients and families we see, we must be skilled in managing all physical, psychological, and spiritual symptoms, including pain

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## You Can’t Always Get What You Want...

A wide gap exists between what patients want at the end of life and what they get

by SHARI WELCH, MD, FACEP

Many casually mention that a large percentage of Medicare dollars is spent near the end of life for problems that emergency physicians can’t fix. To have a meaningful conversation about end-of-life care and its associated costs, it’s important for every emergency physician to have a firm handle on the data.

An astonishing 32 percent of Medicare spending is in the last two years of life for patients with chronic diseases and is often associated with frequent hospital admissions.<sup>1</sup>

More than 90 million Americans live with at least one chronic illness, and seven out of 10 die from chronic diseases. Among the Medicare population, nine out of 10 deaths are due to nine chronic diseases:

- congestive heart failure
- chronic lung disease
- cancer
- coronary artery disease
- renal failure
- peripheral vascular disease
- diabetes
- chronic liver disease
- dementia

While 70 percent of patients say they prefer to die at home, 70 percent die in a hospital, nursing home, or long-term care facility.<sup>2</sup> Though 80 percent of people say that if they were seriously ill, they would want to have a conversation with their doctor, only 7 percent of patients have had such a conversation.<sup>3</sup>

The number of days spent in the ICU in the last six months of life has been increasing despite patients’ wishes.<sup>4</sup> These numbers point to a

failure of our health care system and a gap between what patients want and what patients get.

Our health care system is backloaded, with more and costlier care provided at the end of life for diseases we cannot cure than provided for keeping people healthy. Seventy-five cents of every health-care dollar is currently being spent on the last six months of a patient’s life.<sup>5</sup> In the past, health insurance and providers have failed to offer preventive care and “wellness” treatment, opting instead for expensive, heroic end-of-life care that may not attend to a patient’s dignity, quality of life, or even autonomy.

There are two things that people fear more than death:<sup>6</sup>

- Suffering with physical pain
- Becoming incapacitated and remaining alive (“becoming a vegetable”)

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and non-pain symptoms. Pain algorithms and guidelines exist, with conversion tables to control and alleviate pain. Other non-pain symptoms, such as dyspnea, nausea and vomiting, diarrhea, delirium, constipation, and anxiety, frequently need management and stabilization. The emergency physician must master this skill and knowledge.

#### Key Element #4: Role of Hospice

A branch of palliative care, hospice is a Medicare benefit that provides patients with terminal illness a complete care program, which includes nursing support, physical therapy, psychological support, and durable medical equipment. Hospice is frequently thought of for those who are terminally ill with cancer, but it is a welcomed adjunct for a son or daughter struggling with a parent with dementia. With the help of hospice, patients can frequently be managed at home instead of in a nursing home. Hospice is a total-care system that is designed for terminally ill patients likely to die within the next six months. It can be provided in any location, including

one's home or a nursing home.

The role of emergency-department palliative care is to support life-sustaining management and alternatives and to allow patients to approach death and dying on their own terms, with comfort and control, while maintaining their dignity. ☺

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### MORE INFORMATION

TO LEARN MORE ABOUT EMERGENCY DEPARTMENT PALLIATIVE CARE, PLEASE SEE ACEP'S PALLIATIVE CARE SECTION AT [WWW.ACEP.ORG/PALLIATIVESECTION](http://WWW.ACEP.ORG/PALLIATIVESECTION).

A toolkit to establish an emergency department palliative care program within your hospital can be found at the Improving Palliative Care in Emergency Medicine (IPAL-EM) website at [www.cape.org/ipal/ipal-em](http://www.cape.org/ipal/ipal-em).



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# ...But Conversation Gets You Pretty Close

The Conversation Project may be a critical bridge in end-of-life discussions

by SHARI WELCH, MD, FACEP

Recent studies have collectively led to a renewed focus on end-of-life preferences, and this discussion is proving increasingly relevant to providers in the emergency department. A study from the University of California San Francisco, published in *Health Affairs*, demonstrates that half of older Americans are seen in the emergency department in the last month of life.<sup>1</sup> Most are admitted to the hospital, and many die there despite what we know about the wishes of older patients with chronic disease.

The Conversation Project in conjunction with The Institute for Healthcare Improvement just launched an initiative to help patients begin this conversation with their health-care providers.

It asks patients to articulate what matters most to them at the end of life. It also asks patients to articulate their wishes through "Where I Stand" scales. These scales acknowledge individual differences in what patients want and expect at the end of life. Using a five-point Likert scale, the material provided

in The Conversation Project packet asks patients to express both how much information they would like to receive and how much care they would want at the end stages of life. Patients can choose "I want to live as long as possible no matter what" or "Quality of life is more important to me than quantity" as the extreme choices along the scale. They can choose "I wouldn't mind being cared for in a nursing facility" versus "Living independently is a huge priority for me."

The material also allows patients to choose how involved they want family members to be and who those involved persons should be. Patients are even encouraged to select a time for the end-of-life discussions and the setting where they would be most comfortable having them (ie, "At the kitchen table," "On a long drive," or "At my place of worship"). It even offers suggestions for scripting that would introduce the subject to family

members and talking points for providers.

The entire packet is written in lay terms and does not require a high level of medical literacy. Finally, the packet helps patients to record these wishes in the documents that are commonly used: the advanced directive, the health-care proxy, and the living will. The Conversation Project packet even clarifies those entities, which often confuse patients and families.

Why should emergency physicians take up the end-of-life banner? One study showed that 96 percent of decedents were admitted through the emergency department in the last 108 days of their lives.<sup>2</sup> Another study noted that 77 percent of patients had their first documented

discussion of end-of-life preferences three days before death, and 82 percent of patients with critical care rendered in the hospital left the hospital without advanced directives being articulated.

There is a performance gap in this important aspect of care. There is a growing body of evidence that suggests when it comes to the end of life, patients "can't

always get what they want." Well, maybe they should, and emergency physicians are best positioned to facilitate these discussions.



**SHARI WELCH, MD, FACEP**, is a practicing emergency physician with Utah Emergency Physicians and a research fellow at the Intermountain Institute for Health Care Delivery Research. She has written numerous articles and three books on ED quality, safety, and efficiency. She is a consultant with Quality Matters Consulting and her expertise is in ED Operations.

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# EMERGENCY AIR

by GRETCHEN HENKEL

**T**hirty minutes into American Airlines Flight 175 from Washington, DC, to Dallas/Fort Worth on October 24, 2013, Rep. Raul Ruiz, MD, MPH (D-CA, 36th District), heard a call for medical help on the plane's public-address intercom. Dr. Ruiz made his way to the front of the plane, where a passenger was lying on the floor. The flight attendants were already attending to a man who had initially collapsed but was now conscious. Another passenger, a firefighter, was also helping.

Dr. Ruiz introduced himself as an emergency physician and began taking the patient's history. The man's companion indicated that he was diabetic, so Dr. Ruiz initially hoped that this would be a simple case of hypoglycemia. But testing with the passenger's glucometer revealed a normal blood glucose level of 122 mg/dL. Further history revealed the man had an internal pacemaker and a history of stroke. "That alerted us to the high risk of serious possibilities," says Dr. Ruiz.

Dr. Ruiz called for an AED (an FAA requirement for all planes with a maximum payload capacity of more than 7,500 pounds and with at least one flight

attendant) so that he could monitor his patient. As they were talking, the man again lost consciousness and became "very pale and diaphoretic," according to Dr. Ruiz. He looked at the others who were helping and said, "I think we need to land this plane."

The pilot agreed with that assessment and, working with air-traffic controllers, quickly agreed to divert the flight to Raleigh-Durham International Airport, where an EMS team would be waiting.

## How Common Are Mid-Air Emergencies?

A *New England Journal of Medicine (NEJM)* review of in-flight medical-emergency calls made between 2008 and 2010 to a ground-based medical communications center found that medical emergencies occurred at a rate of 16 per 1 million passengers, or one medical emergency per 604 flights.<sup>1</sup> The study showed that, while the vast majority of in-flight medical emergencies can be handled with on-board medical equipment and typical providers available, cases where more assistance was needed involved physicians 48.1 percent of the time. Christian Martin-Gill, MD, MPH, assis-

**CONTINUED** on page 28



tant professor of emergency medicine at the University of Pittsburgh School of Medicine in Pittsburgh, Pa, is a co-author of the *NEJM* study. “One of the main reasons we wanted to publish our data was so that health care providers who might be asked to provide assistance would have an idea of the types of medical emergencies they might encounter,” he says. The University of Pittsburgh Medical Center provides medical consultations for 17 commercial airlines, logging approximately one consultation per hour and 8,500 per year. The most frequent in-flight medical emergencies are related to syncope and respiratory and gastrointestinal symptoms.

#### A First for Dr. Ruiz

The Flight 175 incident was not the first time that Dr. Ruiz has stepped in to help stabilize a fellow passenger. In 2013 alone, he aided four different people in flight; however, this was the first time he had to recommend that the plane be diverted for an emergency landing. It was also the first time that he received national attention for doing what, he notes, “every emergency medicine physician is trained to do.” Rep. Pete Gallego (D-TX, 23rd District) was on the same flight and tweeted, “Medical emergency on flight from DC to TX. Passenger collapses. @CongressmanRuiz, an MD, on board. Passenger stabilized. Landing in Raleigh.”

#### In Sync

“What was interesting about this experience [on October 24],” says Dr. Ruiz, “is that we were all in sync. I had never met the fireman before, but you know we, as emergency medicine physicians, work so well with EMS and firemen in the field—you can put us any-

## BE PREPARED TO VOLUNTEER

“Even for experienced emergency physicians, there are additional considerations when responding to a medical emergency during a flight,” says Christian Martin-Gill, MD, MPH, assistant professor of emergency medicine at the University of Pittsburgh School of Medicine in Pittsburgh, Pa. Those include issues about altitude physiology, issues regarding operation of the aircraft (such as when and how flights can be diverted), and types and capabilities of medical equipment on board. Flight crews are trained to deal with emergencies. For example, according to

**WHEN THE \*&^% HITS THE TURBOFANS, EPS NEED TO KNOW WHAT THEY ARE LIKELY GETTING INTO AND WHAT RESOURCES ARE AVAILABLE.**

American Airlines spokesperson Matt Miller, all flight attendants are CPR-trained, and the airline was the first to provide AEDs on its aircraft. (American Airlines installed AEDs in 1997, before the FAA requirement in 2004.) As do other commercial airlines, American Airlines crews also have access to 24-7 ground-based expert consultants to guide them—and any volunteer health-care providers on board—through a medical emergency.

The study data published by Dr. Martin-Gill and his emergency medicine colleagues at the University of Pittsburgh ground-based medical communications center revealed the most common types of medical emergencies and also furnished recommendations for traveling physicians or other health care providers who might be called to respond to in-flight medical emergencies.<sup>1</sup>

Dr. Martin-Gill emphasizes that familiarity with required on-board medical equipment can increase providers’ level of comfort if asked to volunteer.

**FOR A LIST OF THE MEDICAL EQUIPMENT AND ITEMS INCLUDED IN THE EMERGENCY MEDICAL KITS,** go to [http://rgl.faa.gov/Regulatory\\_and\\_Guidance\\_Library/rgAdvisoryCircular.nsf/list/AC%20121-33B/\\$FILE/AC121-33B.pdf](http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgAdvisoryCircular.nsf/list/AC%20121-33B/$FILE/AC121-33B.pdf).



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where, and we synchronize. The flight attendants were also very skilled, professional, and helpful. And no one on the plane complained that we had to do an emergency landing. Our focus was on the passenger.”

Dr. Ruiz says valuable lessons can be learned from the actions of the flight attendants, the firefighter, the captain, and passengers in the Flight 175 case. “We can prioritize service and improving the lives of people we serve above all else. When we do that, then we start to find that common ground that’s going to help us work together as a team. That’s what can happen when you put your skills to use for the betterment of your patients,” he says, adding wryly, “I just wish Congress worked that way.”

#### Be Ready and Step Up

Dr. Ruiz and the firefighter sat on either side of the patient until the plane landed. He then relayed the pertinent history to the EMS personnel who met the plane, gave the flight attendants a tally of the emergency supplies that had been depleted, then went back to his seat and fell asleep for the next leg of the flight to Texas.

“It is a commonality of those who work in the emergency field,” notes Dr. Martin-Gill, “that we want to volunteer and assist. Our society looks upon us to help in such situations.”

Based on his experiences, what advice does Dr. Ruiz have for emergency medicine colleagues who find themselves in similar situations? “I don’t think I need to inform my colleagues about the ABCs and whatnot,” he says, “but it’s always good to introduce yourself as an emergency physician. Always think one or two steps ahead of all the possibilities and make sure that you have the equipment nearby that you need or that you may potentially need to help the passenger.” (See sidebar, “Be Prepared to Volunteer,” for a link to the FAA’s



**WE ARE THE MOST PREPARED TO DEAL WITH EMERGENCIES, WHETHER IN THE EMERGENCY DEPARTMENT OR ON A PLANE. AND WHEN WE STEP UP, THEN GOOD THINGS HAPPEN.**

—RAUL RUIZ, MD, MPH

requirements regarding standard emergency medical equipment on commercial airlines.)

“My takeaway lesson to my colleagues,” continues Dr. Ruiz, “is to always heed the call of service. We are the most prepared to deal with emergencies, whether in the emergency department or on a plane. And when we step up, then good things happen.”

**GRETCHEN HENKEL** is a medical journalist based in California.

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# MYTHS

## IN EMERGENCY MEDICINE

Rooted in culture, based on tradition

by KEVIN M. KLAUER, DO,  
EJD, FACEP

I'm always a bit tickled (yes, I said tickled) by the lofty discussions about evidenced-based medicine when much of what is done in medicine and many things we do in emergency medicine have little supporting evidence. It seems that our focus is the evolution of current management and diagnostic strategies and developing research strategies to prove or disprove our hypotheses. Although asking new questions and adding new literature to the world's research database is critical to the evolution of medical practice, what is easier and more critical is questioning what we already do based on evidence that already exists. In other words, we might be asking the right question at the wrong time—or the wrong question altogether.

As much as we claim to be scientists and practice with evidence as our guide, much of the care that is delivered in emergency departments comes from folklore. We have all—present company included—practiced in ways we absolutely believed to be best practice only to find out later that we may have been wrong. Hey, you don't know what you don't know.

There is great value in learning from great educators. However, we can get lost in the “greatness” of our mentors. Many edicts in medical education were taught to those we trust today by those whom they trusted yesterday. Once a learned, respected colleague states a “fact”

with confidence, it often becomes unchallenged evidence and is passed down from one generation to the next. Evidence of my lack of social life, I enjoy using the “hot-tub time machine,” revisiting the land of lost medical questions to see if today's evidence still supports these previously “answered” questions. It is amazing what you can find when you look.

Many edicts in medical education were taught to those we trust today by those whom they trusted yesterday. Once a learned, respected colleague states a “fact” with confidence, it often becomes unchallenged evidence.

Ultimately, there is still great latitude to practice the art of medicine. However, my goal is to challenge many commonly accepted practices that are potentially harmful, are expensive, create operational inefficiency, or simply just don't work.

Prasad et al. published a very interesting article in *JAMA* in January 2012.<sup>1</sup> They reviewed 35 clinical trials published in 2009 that tested established practices. They found that 46 percent of them contradicted current practice. This is evidence that medical reversals are common. Below are six myths worth challenging.

### 1. TRAMADOL OR TRAMACRAP?

I'm no marketing expert, but despite that the name “Tramacrap” or “Ultracrap” would describe this drug perfectly, I doubt we'll see a name change any time soon. Medve et al. published an article 12 years ago that demonstrates this nicely.<sup>2</sup> They assessed the efficacy of tramadol for the treatment of dental pain, and in

the emergency department, this indication is perfectly matched with the drug. Many physicians look for that “tweener” drug that the patient is less familiar with, is not an opioid, and still provides reasonable analgesia. This study identified the following order of efficacy (at eight hours): ibuprofen 400mg, tramadol/APAP 75/650, APAP 650, tramadol 75, and placebo. Further, the onset of action was 17 minutes for tramadol/APAP, 18 minutes for APAP, 34 minutes for ibuprofen, 51 minutes for tramadol, and 66 minutes for placebo.<sup>2</sup> Tramadol does

**CONTINUED** on page 30



not taste great, nor is it less filling.

In addition, this drug does not play well with others. It is known to cause nausea and vomiting and confusion in the elderly, plus it has addictive potential (often referred to as a weak opiate), and creates a nasty overdose picture complicated by grand mal seizures.

## 2. "BANANA BAGS"

This is an expensive practice with little to no return on investment. Although everyone loves to see that yellow hydration solution pumping into the veins of the acutely intoxicated patient, what good are you really achieving? First, what is broken that you are fixing? Many of us have been taught that we must nutritionally replete intoxicated patients with multivitamins, thiamine, folic acid, and perhaps even B12. Even if you believe there is something to be fixed here, let's think this through. How many of us are doing dietary counseling and securing a promise that our patients will eat better and take a daily vitamin before spending the time and money to acutely correct vitamin deficiencies in our intoxicated patients? In other words, if behavior isn't modified, your good intentions are an expensive exercise in futility. More important, we are tilting at drunken windmills. These deficiencies don't routinely exist. In 2008, Li et al. published an article assessing 75 acutely intoxicated patients for vitamin deficiencies (B12, folate, and thiamine).<sup>3</sup> None of the patients had B12 or folate deficiencies, and only 15 percent had thiamine deficiencies (unknown clinical importance).

Hydration is important, but the routine use of multivitamins, thiamine, folic acid, and B12 are not.

## 3. GLUCAGON (GLUCA-GONE) AND ESOPHAGEAL OBSTRUCTIONS

Although many patients will eventually resolve their food bolus obstructions spontaneously, they will still need a non-emergent EGD. Likewise, patients who don't clear them need intervention and, at some point, an EGD. Why not make that point right now? Diagnostic or therapeutic, an urgent/emergent EGD is the most effective treatment. Are other treatments as effective as EGD for these obstructions? No. Let's make glucagon "gluca-gone." Leopard (a spotted surgeon from the United Kingdom) et al. published a systematic review of this topic in 2011.<sup>4</sup> Hyoscine butylbromide was determined to be ineffective. Gas producers (eg, carbonated beverages) worked in 70 percent of cases, but glucagon was no better than placebo (one randomized, controlled trial and two other studies). However, EGD was effective in 93 percent to 100 percent of patients and found pathology in 55 percent to 90 percent of those cases.

## 4. CARDIAC ENZYMES AND SYNCOPÉ

Stop the madness. If the patient has had an AMI resulting in syncope, the history and/or ECG will have already told you. Routinely ordering cardiac enzymes solely for the chief complaint of syncope is a no-yield proposition. Two articles, from 2002 and 2003, respectively, address

this issue. The first, in the *Annals of Emergency Medicine*, reviewed 741 AMI patients.<sup>5</sup> Only 4 percent had a chief complaint of syncope. Even more compelling is the second article, where 2.1 percent of elderly patients presenting to the emergency department for syncope had positive enzymes. However, 100 percent of them had chest pain and ECG changes.<sup>6</sup>

## 5. DILUTION (DELUSIONAL) ANEMIA

Is it physiologically true that when you administer intravenous fluids, the patient can suffer a dilutional anemia, or is this concept delusional? Yes, it is true, but this is a transient physiological phenomenon with very questionable clinical significance. In an article from 1996, euvoletic patients were enrolled in one of three arms: no IV fluids, maintenance IV fluids, and bolus IV fluids.<sup>7</sup> Their blood counts were measured at one, four, and eight hours. The only group showing a difference was the bolus group at one hour. The reduction in hemoglobin and hematocrit were 1.5 and 4.1, respectively. This had resolved by four hours. In an additional study from 1989, it was proved that in healthy individuals who received volume infusions of normal saline equaling 46% of their blood volume, hematocrit dropped by 6% but quickly returned to normal and 60% of the infused volume diffused out of the intravascular space within 20 minutes.<sup>8</sup>

## 6. CEPHALOSPORINS AND PENICILLIN ALLERGIES

Put your worries and fears behind you. The chances of your penicillin-allergic patient actually having a reaction to a cephalosporin are very low. As a matter of fact, the likelihood that a patient reporting a penicillin allergy is actually allergic to penicillin is probably much lower than you may think. Even if the patient is allergic to penicillin, cross-reactivity is unlikely. In a systematic review of 27 articles by Johns Hopkins University and the University of Maryland, the authors reported that less than 10 percent of patients reporting allergies to penicillin actually had such an allergy.<sup>9</sup> The rate of penicillin-related anaphylaxis ranged from 0.004% to 0.015%. Cross-reactivity for patients reporting penicillin allergy was 1% compared with 2.55% in those with proven allergies to penicillin. The structural link between cephalosporins and penicillin is the R1 side chain. Third- and fourth-generation cephalosporins do not have the R1 side chain and thus pose no risk. The first- and second-generation cephalosporins may possess the side chain. It is recommended to avoid the following first- and second-generation agents: cefadroxil, cefatrizine, cephalexin, cephadrine, cefaclor (2nd), and cefprozil (2nd). ☐

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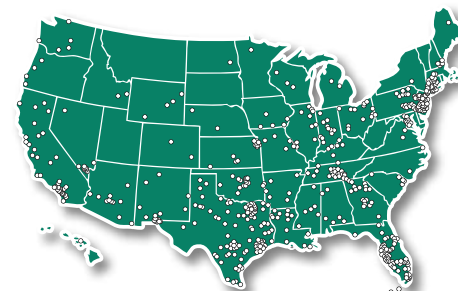
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GHS employs over 11,000 people, including 700+ physicians on staff. Our system includes clinically excellent facilities with 1,358 beds on 6 campuses. We offer 14 residency and fellowship programs and we're home to one of the nation's newest medical schools - University of South Carolina School of Medicine - Greenville.

Greenville, South Carolina is a beautiful place to live and work and the GHS catchment area is 1.3 million people. Greenville is located on the I-85 corridor between Atlanta and Charlotte, and is one of the fastest growing areas in the country. We are ideally situated near beautiful mountains, beaches and lakes. You are able to enjoy a diverse and thriving economy, excellent quality of life and wonderful cultural and educational opportunities.

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# Heartfelt Reunion

A physician and the woman he delivered as a baby 36 years before reunite at ACEP13

by KIMBERLY J. RETZLAFF

**E**very once in a while, life reads a little like a Hollywood script—sweet and surreal, happy ending and all. Picture this: a kind-hearted physician helps deliver a beautiful baby girl for a couple who makes an impression. He never forgets them, although they lose touch over time. Thirty-six years later, that baby girl is grown up and pursuing a career in medicine. She ends up attending a conference where the physician who helped deliver her is speaking. Their reunion is joyous, and both leave with a sense of fulfillment and excitement.

## Serendipitous Meeting

This is the true-life story of Jay Kaplan, MD, FACEP, a member of the ACEP Board of Directors, and Sarah Medeiros, MD, MPH, an emergency medicine resident in Los Angeles. “Dr. Jay,” as he was known by her parents, helped deliver Dr. Medeiros in 1977. In 2009, Manuel Medeiros e-mailed Dr. Kaplan to tell him that his daughter was pursuing a career in medicine. Dr. Kaplan reached out to Dr. Medeiros, but the e-mail was buried in her inbox. Three years later, Dr. Kaplan contacted Mr. Medeiros to see how his daughter’s medical career was progressing and learned that she was a resident in emergency medicine at the University of California, Los Angeles. This prompted Dr. Medeiros to search for and find the lost e-mail, and the two connected and agreed to meet at the ACEP annual meeting in October 2013.





"Though I'd heard the stories, I don't think I ever expected to meet him," Dr. Medeiros said. "But somehow, the fates aligned, and there we were! Dr. Kaplan certainly lived up to the praise. He made the time to meet with me at the ACEP annual conference in Seattle and offered to help me however he could with my upcoming career decisions. The meeting was even more special, as he was able to meet my husband and 4-month-old son."

Dr. Kaplan was equally pleased with the reunion and a bit in awe to witness "the passage of time"—the baby girl he helped deliver years ago was now pursuing a career in the same field that he had enjoyed for so long. "I think that we, as physicians, go into medicine because we want to have purpose in our lives and make a difference," Dr. Kaplan said. "For me, it's like experiencing the generations to watch a child you helped bring into the world now grow up and become a full-fledged contributor and go into medicine for the same reason you did, to help people. There is a sense of fulfillment in that."

#### Life, Family, and Emergency Medicine

Dr. Medeiros chose emergency medicine specifically because of the challenging nature of the specialty. "I love the variety and acuity of emergency medicine—you never know what you're going to get and it keeps you on your toes," she said. "It's one of the few specialties that gives the opportunity for true diagnostic medicine. I also enjoy working with underserved populations; many of these patients



Dr. Medeiros (left) and Dr. Kaplan at ACEP in Seattle; (Inset) Sarah's parents in 1977.

have nowhere else to go."

During their reunion at ACEP13, Drs. Kaplan and Medeiros talked about family and life, but they also talked about the profession of medicine. The meeting was Dr. Medeiros' first time at ACEP, and Dr. Kaplan had been a faculty member at the conference since 1995. Dr. Kaplan's advice was to "look for a job or group that would make me happy," Dr. Medeiros said. "He introduced me to people within his own group, CEP, and talked to me about things that were important to look for in choosing a group."

Dr. Kaplan is an advocate for work-life balance, his presentation topic at ACEP 13. His

**"There are a few times in our lives when we experience the passage of time and when we experience our own mortality, not in a negative way but rather in a positive way. This was one of those times."**

—Jay Kaplan, MD, FACEP

suggestions to Dr. Medeiros were to find a place that is "both a family and a school," he said, a place that can offer a supportive, team environment as well as an opportunity for growth. The other key, he said, is "you have to love what you do. A poet that I have spent some time with once asked of a friend of his, 'Talk to me of exhaustion.' And his friend said, 'The antidote to exhaustion is not necessarily rest; the antidote is wholeheartedness.'"

And so, in true Hollywood fashion, the story ends happily. The resident from California and the experienced physician who helped deliver her are back in touch, both working in emergency medicine and loving it, and both with a sense that the meeting was meant to happen.

"There are a few times in our lives when we experience the passage of time and when we experience our own mortality, not in a negative way but rather in a positive way," Dr. Kaplan said. "This was one of those times." ☺

**KIMBERLY J. RETZLAFF** is a medical journalist based in Denver.

VISIT [ACEPNOW.COM](http://ACEPNOW.COM) TO WATCH A VIDEO OF DRS. KAPLAN AND MEDEIROS MEETING AT ACEP13.



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