Driving in and around the cities that make up the Dallas–Fort Worth (DFW) metroplex, I get the sense that something is in process that could have dire consequences for our specialty. Freestanding “emergency rooms,” both hospital- and physician/investor-owned, are multiplying at an alarming rate, and this is happening all over the state. Texas is, of course, the first state to legitimate and regulate physician/investor-owned freestanding emergency facilities, and there is a good chance this phenomenon will spread nationally. Certainly, the number of hospital-owned freestandings is increasing in other states, but thus far, physician/investor development has dominated the market only in Texas. Is the proliferation of physician/investor-owned freestanding emergency facilities good or bad for emergency medicine?

There is a certain irony in my sense of alarm about this because I was, at one time, considered a pioneer in the development of freestanding “minor emergency centers” in DFW in the late 1970s and throughout the 1980s. Though I sold these facilities long ago, those same

Choose the Right Pain Med for Your Patient

Analgesic options to consider instead of opioids

by JAMES DUCHARME, MD, CM, FRCP

CONTINUED on page 5

Should You Try to Prevent Febrile Seizures?

SEE PAGE 21

CONTINUED on page 4
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Faculty Teaching Award
Deadline: April 13

Each year, ACEP sponsors faculty teaching awards to honor outstanding educators in emergency medicine. These awards are designed to support emergency medicine faculty in their efforts to achieve academic advancement as well as to support the continued academic development of the specialty.

The awards recognize superior teaching activities, including didactic lectures, clinical instruction, and the development of innovative educational programs, as well as endorsement by faculty, residents, and students. Nominations are due April 13, 2015, and can be e-mailed to academicaffairs@acep.org.

While the documentation required for these awards is extensive, the process is designed to mimic the procedure used by university promotion and tenure committees in their tenure deliberations. Recipients of these awards will receive national recognition that can be used to document their teaching excellence.

The National Emergency Medicine Faculty Teaching Award recognizes an emergency physician educator at the instructor, assistant professor, or professor level. The National Emergency Medicine Junior Faculty Teaching Award recognizes an emergency physician educator at the instructor or assistant professor level. This award is recommended for applicants between three and seven years postresidency.

For more information and to download the nomination form, go to www.acep.org/teachingaward.

Abstracts for the 2015 ACEP Research Forum Due April 24

Next month, ACEP will accept abstracts for the 2015 Research Forum. The deadline is April 24, 2015.

The Research Forum will be held Oct. 26–27 in conjunction with ACEP15 in Boston. Abstracts should represent original research that has not been published or presented at a national scientific meeting. Case reports or subject reviews are not considered original research. Abstracts presented at an international or regional meeting are eligible for submission. Authors must include the following sub-sections, consistent in style with those appearing in Annals of Emergency Medicine: title, study objectives, methods (include design, setting, and type of participants), results, and conclusion. Abstracts should be written in complete sentences using grammatically correct English. Spell out all abbreviations on first usage. Abstracts are limited to 3,000 characters, not including spaces. Accepted abstracts will be published as received; no copy editing will be performed. Illustrations are discouraged; however, small tables may be accepted. Figures and photos must be black-and-white and at least 300 dpi. Authors should not be identified in any way on the page containing the abstract.

The Emergency Medicine Foundation will present the Excellence in Research Award to an investigator based on the abstract, presentation, discussion, and subsequent publication of research manuscript, as well as the Best Presentation by a Young Investigator Award.

Abstracts will be peer reviewed. Those judged scientifically valid and that contain important information that will ultimately affect patient care will be accepted. In March, instructions for submitting abstracts will be available on ACEP’s website at www.acep.org/rf.

Four awards will be given to outstanding abstracts. The Emergency Medicine Foundation will present the Excellence in Research Award (Best Paper) to an investigator based on the abstract, presentation, discussion, and subsequent publication of research manuscript, as well as the Best Presentation by a Young Investigator Award. Investigators at the associate professor level or below with fewer than five years of faculty appointment may request their abstracts be considered for review in the young investigator category.

The ACEP Research Committee will present the Best Medical Student Paper Award to a medical student who is the primary investigator of an outstanding abstract presentation and the Best Resident Paper Award to a resident who is the primary investigator of an outstanding abstract presentation.

All four awards will be presented at the 2015 ACEP Research Forum.
What alarms me is that, at a time when the health care system is crying out for less duplication of services and greater efficiency in the use of expensive resources, the boom in physician/investor-owned freestandings appears to be moving the needle the other way.

17 practices, now referred to as “convenience care clinics,” are still in business and have since been joined by dozens of others, mostly physician/investor owned. While operating these clinics, I simultaneously staffed several hospital-based emergency departments in the same catchment areas and was able to conclusively prove that the presence of convenience clinics has no impact on either ED volume or payer mix—but I suspect not so for these freestanding emergency rooms. These facilities take paying emergency patients out of the hospital-based ED, and this logically has to have a negative impact on volume and payer mix. This, in turn, has to make it harder for both the hospital-based facility and its emergency physician staff to meet their unfunded EMTALA-bound hospital-based ED safety net.

Physician/investor-owned freestanding emergency facilities typically involve an investment of $1.5 million to $3 million. The facilities’ ability to charge and collect a hospital-level facility fee as well as use the 992... CPT emergency department professional service codes enables them to break even at about a dozen patients per day. They are required to see all comers, but they are disproportionately located in areas of the metroplex unlikely to have significant numbers of underinsured or uninsured people. To use the word “emergency” in their name, these facilities must operate 24/7 to comply with Texas law. Twelve patients a day is one every two hours. Given the sheer number of these facilities being built, I suspect that many of them may not reach or far exceed this number of visits. From a health care system perspective, this seems an extremely inefficient use of capital, expensive and rapidly obsolete equipment, and emergency physician manpower. In addition, these facilities can’t but worsen the already near-critical emergency physician shortage.

There is a kind of “tragedy of the commons” at work here, where everyone is acting logically and according to their own self-interest but the end result is likely to be detrimental to all. Hospitals do only that which is in their strategic interest, but physicians/investors are free to plunk one of these down at every major intersection in the nicer parts of town. What alarms me is that, at a time when the health care system is crying out for less duplication of services and greater efficiency in the use of expensive resources, the boom in physician/investor-owned freestandings appears to be moving the needle the other way. So it would be helpful to know what factors are driving this phenomenon.

Angel investors learn early on that you can’t make a market for goods or services; you can only discern it and meet its needs. The two markets in play here would seem to be paying hospital-based ED emergency patients and hospital-based emergency physicians. My theory about why the number of physician/investor-owned freestanding facilities is exploding in Texas is that hospital-based EDs have done a poor job of serving their paying patients and their emergency physicians. By any parameter you can name—physical plant, ambience, convenience, parking, rapidity of care, speed of ancillary services, availability of specialty backup, etc.—the hospital-based ED is trumped by the freestanding. All too often, the hospital treats its emergency physicians as commodities and gives them no say in issues like nurse/tech staffing levels, which electronic health record (EHR) will be used, and most other aspects of the operation of their practice. The tensions and pathos of hospital-based emergency medicine practice are psychologically draining, and constantly having to beg for specialty backup is exhausting and degrading in the extreme. What emergency physician of an age wouldn’t prefer the kind of white-glove practice that goes on in the typical freestanding? The stress and workload are a fraction of that of hospital-based practice; the pay is equivalent; you get to choose how you will equip and staff your ED, which EHR best suits your practice, and everything else; and the specialists come running when you call. So while the proliferation of these facilities may not be good for the safety net, they are clearly good for ACEP members. This creates a significant dilemma for the ACEP leadership.

On the one hand, ACEP would like to avoid taking a position on the issue of physician/investor-owned freestandings because it has members on both sides of the question, but on the other hand, ACEP has a duty to adopt health care system policies that support the preservation of the safety net within the context of the current dysfunctional payment system. ACEP’s current position sidesteps the issue, but if this phenomenon goes national, it will be forced to address it.

As to the economic consequences of the physician/investor-owned facilities, the libertarian in me says let the invisible hand of the market separate the winners from the losers, and this would all be fine except that our government-designed health care “system” pays for indigent and much of entitlement emergency care (when it pays at all) through cost shifting. Obamacare, for however long it lasts, is of no help in the ED because it leaves many uninsured out of the program, and its deductibles are so high that its beneficiaries are effectively uninsured for all but a medical catastrophe. In most states, Medicaid pays less than the cost of the care of its beneficiaries, so Medicaid expansion will only further compromise the hospital-based ED. Underinsured and uninsured hospital-based ED volume will continue to grow, and losing paying patients to freestandings must inevitably erode the hospital-based ED’s payer mix.

At some point, our society will be forced to face the true cost of caring for the underinsured and indigent patient population, and the explosion of physician/investor-owned freestanding emergency facilities almost guarantees that this time will come sooner rather than later. When that time arrives, I see no alternative but a complete redesign of the system, but so far, no one has produced a single “reform” that’s done anything but make things worse.

DR. HELLSTERN is principal and president of Medical Practice Productivity Consultants, PA and a partner in Hospital Practice Consultants, LLC in Dallas.
colic as well as for severe menstrual cramps. Anticholinergic agents can be effective for both intestinal cramps (hyoscine) and large muscle spasms (benztropine). The indications for the primary use of an opioid in emergency medicine have been refined; there are many fewer indications than before, making their use even more justifiable in these specific instances (eg, extremity fractures, visceral pain, vaso-occlusive crisis).

**PAIN IN THE ED**

In chronic noncancer pain, specific neurotransmitters and nerve channels have been relatively well-established. In neuropathic pain, either a sodium channel (tricyclic) or a calcium channel (Gabapentinoid) blocker serves as first-line therapy, with opioids relegated to third- or fourth-line treatment. In diffuse widespread pain such as fibromyalgia, opioids are not recommended at all, with NSAIDs, tricyclics, or gabapentinoids being the optimal choices.

In managing trauma patients, the last few years have demonstrated that the addition of low-dose (analgesic dose) ketamine serves to decrease the dosing requirements of opioids to control pain. It also serves to block N-methyl-D-aspartate (NMDA) release, thereby decreasing wind-up (pain after discharge and the risk of development of chronic pain). For procedural analgesia, ketamine and nitrous oxide serve as excellent alternatives to opioids. Ketamine, in an analgesic dose (0.2–0.3 mg/kg), seems to lead to less oxygen desaturation and hypoventilation when combined with a sedative than when an opioid, such as fentanyl, is used. The use of “ketofol,” a combination of ketamine and propofol in the same syringe, seems to offer no added value over the titration of an ultrashort-acting sedative such as propofol or methohexital.

Nitrous oxide was widely available in emergency departments 20 to 30 years ago in North America, but it fell out of favor for two reasons: misuse by staff and variable effectiveness in patients. Both of those problems were the result of trying to make use of a 50/50 mixture (nitrous and oxygen). Use of the 70/30 mixture has provided solutions to both problems: the stronger mixture does not lead to euphoria but rather unconsciousness, making it rather evident who might be trying to misuse it.
Analgesic effectiveness is almost 100 percent with the 70/30 mixture, and it is widely used in Australia as a result. It is almost omnipresent in Canadian pediatric EDs as well. Current regulations already in place in the United States for other procedural sedation medications should allow a relatively easy process to reintroduce nitrous oxide into emergency departments. Indications for nitrous oxide’s use rapidly come to mind because of its rapid-on, rapid-off effect. They include catheter placement in cognitively impaired children, casting a pain fracture, and disimpaction, to name a few.

The introduction of IV acetaminophen in the past two years has provided yet another option for acute pain management. In studies to date, 1 g IV of acetaminophen appears to have an analgesic impact almost equivalent to 10 mg morphine. Of course, the same was also said of ketorolac when it was introduced to the market. In Europe, where experience now exceeds three years, IV acetaminophen is used routinely in acute pain management as part of a multi-medication approach.

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The use of regional anesthesia will be discussed in a future article because it, too, can play an important role in pain management of fractures and in procedures.

**AFTER DISCHARGE**

Concern over opioid misuse is at its highest when discharge prescriptions are written. First consideration should be to avoid prescribing the opioid most misused in your community. Each community chooses its opioid. Within a 60-mile radius of where I have worked, patients have told me that “only idiots” abuse any opioid other than “still in the blank.” Heroin, oxycodone, meperidine, hydromorphine, fentanyl, dextromethorphan—they all have been abused, but usually only one is abused in any given community. This is primarily due to control of the drug scene by one gang or another. If opioids do have to be prescribed, limit dosing to three to four days maximum because follow-up for persistent pain is essential.

Newer options that have been promoted include tapentadol and tramadol. The former has turned out to be a very poor analgesic that costs a lot of money, whereas the latter has not gained much favor in the emergency physician community. Neurontin (approved) is not effective, and tramadol does offer valid analgesia in many patients. It might be of value to provide it in the ED to see how helpful it is prior to writing a prescription for it.

The NSAID with the best analgesia/anti-inflammatory/safety profile still is ibuprofen. It is the recommended analgesic of choice for dental pain. For new onset or a flare of chronic sciatica or other neuropathic pain, short-acting opioids will rarely help the patient. A combination of a NSAID with a tricyclic (nortriptyline is less sedating) is probably best. It is important to note that the starting dose of the tricyclic should be 25 mg at bedtime, rapidly titrated over seven to 10 days to at least 75 mg and with follow-up with a primary care provider. Carbamazepine for tic douloureux should be started at 200 mg and titrated up 200 mg every three days to effect, again with follow-up within one week. Initiation of either a tricyclic or a gabapentanoid (gabapentin 300 mg, increasing by 300 mg every three days to effect, or pregabalin 25 mg a day with much slower ramp up due to side effects) for postherpetic neuralgia (PHN) is an excellent option. See Table 1 for more recommendations for treating neuropathic pain.

**SUMMARY**

Many nonopioid options exist, but to use these medications optimally and safely, a much greater understanding of pain mechanisms is required. Opioids have their place but a much smaller one than was seen in the nondiscriminate symptomatic approach era. A

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**Table 1.**

<table>
<thead>
<tr>
<th>AGENT</th>
<th>STARTING DOSE</th>
<th>TITRATION INTERVAL</th>
<th>NEUROPATHIC CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nortriptyline</td>
<td>25 mg hs</td>
<td>Every week (by primary caregiver)</td>
<td>PHN Sciatica</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>300 mg od</td>
<td>Every three days, increase by 300 mg (to bid, then tid before increasing each dose)</td>
<td>Diabetic PHN Sciatica</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>25 mg od</td>
<td>Every one to two weeks (by primary caregiver)</td>
<td>Diabetic Fibromyalgia</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>200 mg od</td>
<td>Every three days, increase by 200 mg (to bid, then tid before increasing each dose)</td>
<td>Trigeminal neuralgia</td>
</tr>
</tbody>
</table>

**Abbreviations:** hs=at bedtime, od=once per day, bid=twice per day, tid=three times per day

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**Brief Script of How to Say No to the Opioid-Seeking Patient**

Here are two variations of a script I use routinely. It is always essential to get two points across to patients:

1. You are willing to help them manage their pain.
2. You know the rules of the game.

Using variants of the below, I can count on one hand the number of times in the past five years the situation degenerated to where the patient was screaming or yelling.

Note that I also assess the patient to ensure there is no new pathology (especially in cancer patients) or acute flare-up of a chronic pain (complex regional pain syndrome and arthritis often have severe flares). These groups do require aggressive pain management in the ED and may well require opioids, but the patients do not get a new prescription unless this is true or unless I discuss the situation with the prescribing doctor, who then agrees. You can also gently say you will check the state drug database to ensure they are receiving their medications solely from their prescribing doctor. In Canada, that makes drug misusers run for the door because false reporting of a controlled Rx is a felony, and as an emergency physician, I am required to call the police if I am aware of a false report and the patient is in the ED—and the patients all know this as well!

**The Patient Encounter**

Hello, Mr./Ms. X.

I am Dr. Y. How can I help you today?

**Patient states need for opioid prescription.**

**OPTION 1:** Mr./Ms. X, I am here to help you in any way I can and to see what exactly might be wrong. With respect to your request for me to renew your prescription of opioid Z, I am unable to do so. We are aware that doctors who prescribe opioids for long-term use advise their patients that only they can prescribe the additional opioids. You would have had to agree to that before your doctor would have started that prescription. Even if you need more pills because of worsening pain and have run out early, you still need to see the doctor who prescribed those medications. Knowing that I am unable to renew that prescription, how else can I help you control your pain today?

**OPTION 2:** Mr./Ms. X, you say that you have run out of your pain pills and your doctor is away. As you know, you have to be responsible and accountable for your medications. If you saw that you were running low, it was up to you to contact your doctor and discuss obtaining more medications. I do know that most doctors caring for people in pain will not allow early refills of their medications. They also request, and get their patients to agree, that only they can prescribe these pain medications. You certainly had that discussion with your doctor. So you can understand that while I am very willing to see how I can help better control your pain today, I cannot prescribe the additional pain pills that you are requesting. How else can I help you?
I have good friends in Liberia. I know the culture, the politics, and the medical system there. Once the news broke in March 2014 that the Ebola virus disease (EVD) epidemic was spreading into Liberia, I knew I had to do something to help. Due to some prior health issues, I couldn’t automatically assume that the best way I could help was to provide on-scene acute medical care.

In 2004, I developed an autoimmune neurological disease and subsequently also developed some significant issues with my eyesight. I stepped down as emergency department medical director, and I’ve made some lifestyle adjustments since then. Despite improvements in my condition, it was an unknown variable whether the intense heat inside the isolation suits and the limited visibility through the goggles or face masks would limit my effectiveness. The last thing I wanted was to become a liability to a medical system that was already in crisis.

To better understand what my options might be, I aggressively started researching the Ebola virus. I also began to study exactly how the epidemic was unfolding. Within weeks, it became clear to me that the overall relief effort was beginning to experience some serious logistical problems. The international community was starting to address the lack of personal protective equipment and medical personnel, but no one seemed to be noticing that there weren’t enough reliable and task-specific vehicles available in the country to transport these resources to where they needed to go. There wasn’t an emergency medical services (EMS) system, and the few ambulances available were either privately owned or in disrepair.

How were people sick with Ebola supposed to get to the new Ebola treatment units (ETUs)? People had to walk, be carried, ride a bicycle or motorbike, or travel in a private vehicle (usually a Toyota Corolla-sized taxi). People sick with Ebola or those transporting their deceased relatives had to pay to travel in these private taxis, and sometimes, to defray the costs, they did so with other passengers aboard. In fact, in December 2014 a taxi driver was arrested for transporting the corpse of someone who had died of EVD.

Focus on Transportation
Like any large humanitarian operation, the problems were legion, but the most salient logistical problems from my perspective were all in the area of transportation. The international community was starting to address the lack of personal protective equipment and medical personnel, but no one seemed to be noticing that there weren’t enough reliable and task-specific vehicles available in the country to transport these resources to where they needed to go. There wasn’t an emergency medical services (EMS) system, and the few ambulances available were either privately owned or in disrepair.

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Early in the epidemic, there weren’t enough hearses or trucks to collect the bodies in the streets or to form the county burial teams that are now in place (see Figure 1). Contact tracers and Ebola awareness teams didn’t have the transportation needed to visit the communities they were being assigned to reach. To make matters worse, Liberia was entering its rainy season, and for the next five months,
For Liberia

the jungle roads were about to become very difficult to navigate even using all-wheel drive a rut, Figure 3).

My friends quickly formed a 501(c)(3) charity, and between our group and another, we collected about $150,000 worth of resources. It was a very eclectic group of donors that rallied around the cause: humanitarians, a Christian ministry, several Muslim Lebanese businessmen, a US pharmacist, a CEO of an international medical corporation, a US/Liberian forestry and mining company, a physician, a physician assistant, and 20 dedicated Liberians all played a part in making things happen. The one common denominator we all shared was the determination to make a difference.

Putting Plans Into Action

Our original intention was to use that money to acquire and refurbish as many old ambulances as we could and to ship them to Liberia as quickly as possible. Within a month, that plan had to change because several countries had recognized Liberia’s transportation problems and started shipping them a large number of service vehicles. We shifted our primary focus from acquiring ambulances to transporting supplies to communities that would be very difficult for the mainline relief organizations to reach.

Our first ambulance shipped to the Liberia Medical & Dental Council (LMDC) in Monrovia. The LMDC thought of a novel way to use it to bring hope and education to communities within the country’s capital city. Its current plan is to use the ambulance to transport Ebola survivors (with lights flashing and siren blaring) directly from the ETUs they are leaving back to their home communities (see Figure 4). We hope that the presence of this impressive rig and the celebration and education that will accompany its arrival in various Liberian communities will advance the relief effort.

The remaining funds were used to purchase and deliver food and sanitation supplies and to bring Ebola awareness campaigns to multiple rural communities we knew probably wouldn’t have been reached until after the rainy season. We hired drivers and all-wheel drive Renault vehicles from a mining company and transported bed linens, rice, buckets with faucets for hand washing, bleach, alcohol, powdered soap, pharmaceuticals, oral rehydration solutions, and personal protective equipment to approximately 25 communities and medical clinics. It took days to reach some of these villages, and they knew what an effort it was for us to make such a trip during the rainy season. They were grateful for the supplies and were eager to learn how to protect themselves during the EVD epidemic.

In closing, I’d like to thank my colleagues in ACEP for all the wisdom and professional encouragement given to me during the planning stages of this adventure. The responses to the queries I posted on the EMS, Disaster, International, and Tactical Medicine mailing lists were invaluable. Emergency physicians, as a group, are the most multitalented individuals I’ve ever worked with. When they volunteer to work during a disaster or a humanitarian crisis, they bring with them not only their medical skills but frequently many other gifts as well. Utilizing those additional talents can sometimes be critical to the overall success of the relief effort.

Whenever possible, a physician volunteer should be vetted and only work in these situations under the aegis of an established relief organization. There are occasions, however, when an individual or a small group of individuals with the proper background, resources, and action plan can achieve operational objectives that the larger relief organizations just can’t. First, do no harm!

DR. BOLLARD is a former ED director and co-founder of the ACEP Tactical Emergency Medicine Section. He currently works as an operational medicine consultant for various EMS, fire, and law enforcement agencies across the country. He resides in Bozeman, Montana.
Bridge the Gap Between School and the ED
An approach to measuring competency in APPs
BY RANDY D. DANIELSEN, PHD, PA-C, DFAAPA

ately, the topic of competency of advanced practice providers (APPs), also known as physician assistants (PAs) and nurse practitioners (NPs), has come up frequently within hospitals and large health care organizations. These groups have been hiring more new APP graduates and want to know how long it will take for them to get up to speed within the institution. Additionally, it is a point of contention within emergency medicine, with some EM groups refusing to take new graduates until they demonstrate the necessary knowledge and skills—a Catch-22 if I’ve heard one. Don’t get me wrong! This is an important issue within a strongly procedure-based specialty in which clinical acumen must remain high. Emergency medicine is also a specialty among APPs that is highly sought (see Figure 1). Nonetheless, APPs seeking to work in emergency medicine must demonstrate they have advanced knowledge and experience in emergency medicine above and beyond that expected of entry-level APPs working in a generalist practice.

Competence is defined not so much as “how long” but rather the achievement of the skill sets needed to practice in an ED. It is a narrow, specific question rather than a broad, philosophical one.

While there are a number of definitions of clinical competency, I prefer Norman’s definition of professional competence: “The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served. Competence builds on a foundation of basic clinical skills, scientific knowledge, and moral development.” He goes on to say that competence has multiple functions: cognitive (using acquired knowledge to solve real-life problems), integrative (using biomedical and psychosocial data in clinical reasoning), relational (communicating effectively with patients and colleagues), and affective/moral (the willingness, patience, and emotional awareness to use these skills judiciously and humanely). I was struck by a final comment that competence is “developmental, impermanent, and context-dependent.” Competence is certainly developmental in the context of lifelong learning. If it is indeed impermanent (temporary, transient, transitory, passing, fleeting), then it must be evaluated frequently. There is no argument that it is context-dependent, whether by level of care, specialty knowledge required, or institution.

Clearly, competence is complex. While the PA and NP professions have developed and published a list of specific skills necessary to be considered competent, which mirror and parallel those of our physician colleagues, the question becomes, “How do we actually demonstrate them?”

Benner developed one of the best-known competency definitions in 1982 with her novice-to-expert model, which applied the Dreyfus Model of Skill Acquisition to nursing. It has been widely used as a tool to determine expertise. Her model describes the five levels of expertise as:

- **Novice**: A beginner with little to no experience. Novices face the inability to use discretionary judgment and require significant supervision.
- **Advanced beginner**: Able to demonstrate marginally acceptable performance based on some real-life experience.
- **Competent**: Has usually been on the job for two to three years. At this level, the clinician has a sense of mastery and the ability to cope with and manage many aspects of patient care.
- **Proficient**: Able to grasp clinical solutions quicker and able to home in on accurate regions of the problem faster.
- **Expert**: No longer relies on analytics to connect to understanding of the problem but has an intuitive grasp and is able to zero in on the all aspects of the problem at hand without any wasteful or unfruitful possibilities.

Benner maintains that knowledge accrues over time in clinical practice and is developed through dialogue in relationship and situational contexts. It should be noted that clinical experience is not the mere passage of time or longevity within a clinical experience but rather the actual level of clinical interaction. The clinician, therefore, may move forward or backward in the model, depending on the situation.
In the Benner model, the novices and advanced beginners would be premedical students and students. You can see variations of this learning curve in different situations, whether it is a new clinician in the ED or an experienced clinician moving to a new practice. Returning to the comment that prompted this article: when is an APP fully competent to see patients? There has been some good research in the last decade that demonstrates APPs have excellent patient care outcomes, even when taking into account the particular clinician level (novice through expert). The reality is that competence is acquired gradually, and even when APPs are far from fully competent, they can still see patients as long as the supervision is commensurate with the need.

A seasoned APP with emergency medicine experience will be more likely to hit the ground running, may work at a more rapid pace than a new graduate, and may be able to handle a higher volume of patients.

This is a challenging topic because what we do requires factual knowledge and the consistent, appropriate application of that knowledge. We know how to measure factual knowledge, more or less, but assuredly we don’t know how to measure the latter (possibly the most important part). In my opinion, we need a pragmatic approach to determine whether a clinician is competent and continues to be so.

When recruiting an APP, an emergency department should consider its needs and discuss the feedback. Everyone in the department would know they would be similar. The next question is how to gauge ongoing competence. One method is to do a 360 survey. Such feedback can be a powerful tool for competency evaluation in a rapidly changing and often bewildering emergency medicine clinical environment. Of course, these tools must be used appropriately and intelligently in order to be effective. Here’s how it might work: All coworkers of a particular clinician would be surveyed on the perceived elements of clinical competence, including knowledge, application of knowledge, efficiency, ability to make decisions, and attitude toward patients. Every person in the emergency department could anonymously complete the survey. This would include nurses, techs, other APPs, housekeeping, on-call members of the medical staff—literally everybody, although not all of them will be capable of making some of these determinations. Then the ED director would let the clinician review the feedback. Everyone in the department would know they would be similarly evaluated. This is the most brutal, yet fair and efficient, way to assess competency in its broadest sense. Will all of the opinions be factually substantiated? Not! What better technique do we have, at least for now? But wait! Perhaps competence is not the endgame. Perhaps competence is really a minimum standard. Competence, albeit novice if we use the Benner model, is measured by completion of the PA or NP curriculum (meeting the course objectives) and passage of board/certification exams, just as physician competence is, essentially.

Most, if not all, would agree that mastery is achieved by the acquisition of additional knowledge (certificate of advanced qualifications, advanced certification) coupled with sound practice and experience. Mastery or expertise, some say, is what we should focus on, the achievement of which is quite individual. All clinicians can move toward mastery, but not all will actually achieve it. I suggest that competency is the starting point and mastery (expertise) is achieved by the ongoing commitment to expand clinical knowledge—keeping up with the literature, completing CME programs, learning from fellow clinicians—coupled with an extensive clinical experience in which knowledge is clinically applied with the achievement of the best results feasible within the constraints of the individual patient encounter.

Lastly, once should not determine competence or mastery in a vacuum. Medicine is a team effort, and in the case of an APP, the interaction with the collaborating physician is essential. Table 2 demonstrates the factors needed to achieve success in the APP/physician relationship.

A successful APP/physician team requires trust, communication, curiosity, evidence-based practice guidelines, feedback, and experience. Although state laws vary regarding the extent of practice and level of collaboration for APPs, hospitals and ED groups may set their own standards independently. The goal is, of course, collaboration among competent APPs, physicians, and other health care providers working together to meet the needs of patients and improving patients’ health and outcomes in the emergency department setting.

References

Table 1. APP Minimal Qualifications to Work in Emergency Medicine

<table>
<thead>
<tr>
<th>TO QUALIFY TO WORK IN AN EMERGENCY DEPARTMENT, APPS MUST:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Have graduated from an accredited PA or NP educational program.</td>
<td></td>
</tr>
<tr>
<td>• Comply with licensure and other regulations of the PA/NP practice act in the state in which they practice.</td>
<td></td>
</tr>
<tr>
<td>• Have developed or maintained qualifications through:</td>
<td></td>
</tr>
<tr>
<td>- Ongoing CME in emergency medicine. and/or</td>
<td></td>
</tr>
<tr>
<td>- Graduation from an emergency medicine PA/NP residency or certificate of added qualification program.</td>
<td></td>
</tr>
<tr>
<td>• Have documented experience in emergency medicine as an NP/PA.</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Five Key Success Factors for APP/Physician Relationship

| 1. SHARED PRIORITIES |      |
| 2. FREQUENT AND EFFECTIVE COMMUNICATION |      |
| 3. MUTUAL TRUST AND RESPECT |      |
| 4. PHYSICIAN ACCESSIBILITY AND APPROACHABILITY |      |
| 5. CONSISTENCY OF DELIVERY OF PATIENT CARE |      |

Figure 1. Number of PAs and NPs in Emergency Medicine

- Certified PAs in US
- Certified PAs working in EM
- Certified NPs in US
- Certified NPs working in EM

Sources
1. http://www.saps
2. http://www.aap

FEBRUARY 2015

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11
Be atTENtive to This Dangerous Condition
Recognize and manage pediatric toxic epidermal necrolysis

BY ADEOLA KOSOKO, MD, AND BRENT KAZINY, MD

OBJECTIVES
After reading this article, the emergency care provider should be able to:

• Know when to suspect toxic epidermal necrolysis (TEN) in the pediatric patient.
• Develop a differential diagnosis for the acutely ill febrile child with mucosal change.
• Understand the reasons a pediatric patient would develop TEN.
• Be able to acutely manage the child in whom TEN is suspected.

The Case
A previously healthy, fully immunized five-year-old boy presents to the pediatric emergency department with three days of fever and a progressive rash. Symptoms started with fevers to 104°F, a few “flat red spots” on his cheeks and behind his right ear, and bilateral injected eyes. The next day, he was seen by his primary doctor, who prescribed ofloxacin eyedrops for a presumed infection. That night, he developed crusting at his lips, redness and swelling of his palms and soles, and red patches on his trunk. On the morning of presentation, he had a few episodes of nonbloody, nonbilious emesis and complained of pain with urination and pain with swallowing. He was refusing to open his eyes to receive the prescribed medication.

Upon presentation to the ED, his blood pressure is 116/76, his pulse is 148, his temperature is 104.4°F, his respiratory rate is 21, and his SpO2 is 97 percent.

He is an alert, tearful boy, persistently keeping his eyes closed and clearly uncomfortable. There is left anterior cervical lymphadenopathy without a single large node and full range of motion at the neck. On ocular exam, the patient squeezes his eyelids shut and cries. Mildly edematous eyelids are pried open, and there is scant white/yellow discharge bilaterally. The pupils are equal and reactive to light, with bright red injection of the conjunctiva bilaterally. The lips are cracked and erythematous. There is a strawberry tongue and some desquamation at the buccal surfaces. There is tachycardia but no murmurs, rubs, or gallop with a brisk capillary refill. No respiratory distress is present. Abdominal and genitourinary exams are unremarkable for this circumcised male. There is mild bilateral hand swelling. There is an erythematous macular rash at the bilateral cheeks, chest, and back, as well as palmar erythema.

While in the ED, the patient is given a 40 cc/kg normal saline bolus, morphine, and acetaminophen, which make him more comfortable. He is started on maintenance IV fluids and empirically with a brisk capillary refill. No respiratory distress is present. Abdominal and genitourinary exams are unremarkable for this circumcised male. There is mild bilateral hand swelling. There is an erythematous macular rash at the bilateral cheeks, chest, and back, as well as palmar erythema.

Toxic epidermal necrolysis (TEN), also known as Lyell’s syndrome, is a life-threatening dermatological condition that is frequently induced by a reaction to medications. It is characterized by the detachment of the top layer of skin (the epidermis) from the lower layers of the skin (the dermis) all over the body.

Background and Pathophysiology
Toxic epidermal necrolysis (TEN) is an infrequent medical emergency (0.4-1.3 cases per million per year worldwide) with high mortality. It is characterized by fever and widespread tender involvement of the epi-
Because of its severe nature, patients with TEN require a multidisciplinary team approach of medical and nursing interventions. Early treatment by a skilled team who are familiar with TEN reduces morbidity and mortality.

PEARLS

1. Mucosal involvement often precedes skin involvement for SJS/TEN, and therefore mucosal involvement in an ill child should increase concern for SJS/TEN.

2. The predominant cause of SJS/TEN is a drug. A careful history should be performed because the early discontinuation of the inciting drug can decrease mortality.

3. If there is a concern for SJS/TEN on clinical exam in the ED, the physician should consider early transfer to a burn center because the condition can be rapidly progressing and specialized care is associated with improved outcomes.

4. The greatest difference clinically between erythema multiforme and TEN/SJS is the development of systemic symptoms and the formation of bullae.

What clinical clues suggest the diagnosis of TEN in a child?

• Increased salivation and decreased appetite from oral involvement.
• Painful micturition due to urethral involvement.
• Profuse diarrhea due to enteral involvement.
• Respiratory distress due to involvement of the bronchial epithelium.
• Ocular lesions, which may indicate a higher chance for morbidity due to tearing of the epidermis leading to conjunctival erosions, keratitis, and corneal erosions.

What else should be considered when treating patients diagnosed with TEN?

Differential diagnosis should include Kawasaki disease, staphylococcal scalded skin syndrome, toxic shock syndrome, disseminated adenovirus infection, infectious conjunctivitis, Reiter’s syndrome, hypersensitivity vasculitis, erythema multiforme, exfoliative conjunctivitis, disseminated herpes infection, and measles.

What immediate threats must be addressed in a patient with TEN?

In the ED, the treatment of the patient with suspected SJS/TEN is akin to that of a patient with severe burns.

What clinical clues suggest the diagnosis of TEN in a child?

What else should be considered when treating patients diagnosed with TEN?

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What immediate threats must be addressed in a patient with TEN?

In the ED, the treatment of the patient with suspected SJS/TEN is akin to that of a patient with severe burns.

Figure 1.

Supraglottic desquamation of lingual surface of epiglottis and vallecula.

Figure 2.

The patient’s trachea appears normal.

Supraglottic desquamation of lingual surface of epiglottis and vallecula.

The patient’s trachea appears normal.

Continuous any identified offending agent early.
• Consider early transfer to a burn unit because these interventions are associated with improved outcomes.
• Early fluid resuscitation is imperative in any patient who appears to be in shock.
• Broad-spectrum antibiotic administration is warranted if the child meets criteria for sepsis or if infectious etiology of symptoms is considered likely; however, routine antibiotic administration is not indicated as in the case of severe burns.
• Manage fluids and electrolytes, provide adequate analgesia, prevent secondary infection, and keep the patient warm.

Other than supportive care, what can be done for a patient with TEN?

Therapeutic measures for TEN remain controversial.
• Most dermatologists at this time do not advocate corticosteroid use.
• Intravenous immunoglobulin (IVIG) is often utilized in treatment protocols, but no randomized controlled trials to date have shown definitive benefit.

Case Resolution

While the patient is on the floor, an echocardiogram is scheduled for the next day to check for potential Kawasaki disease. Infectious disease and dermatology are consulted and scheduled to see the patient the next day. Urology is consulted for placement of a urethral catheter due to lack of urine output and urethral pain. By the eighth hour of hospital admission, the rash has quickly changed quality from macular to bullous and vesicular and has spread to involve the majority of surfaces of his body, including the palms and soles. The patient is transferred to the pediatric ICU with a new oxygen requirement of 0.5 L by nasal cannula and concern for upper airway involvement with TEN.

Shortly after transfer to the pediatric ICU, the patient’s respiratory status worsens. He is taken to the operating room with ENT and anesthesia for elective intubation for airway protection. Upper airway evaluation shows desquamation of the supraglottic structures without tracheal involvement. The patient is diagnosed with TEN secondary to mycoplasma infection based on positive immunoglobulin G and immunoglobulin M titers. The patient receives a three-day course of IVIG with improved outcomes.

The patient’s trachea appears normal.

References

Are You Ready for PQRS Changes?
Successfully navigate the Medicare Physician Quality Reporting System

BY STACIE SCHILLING JONES, MPH

Last fall, the Centers for Medicare & Medicaid Services (CMS) released the 2015 Medicare Physician Fee Schedule Final Rule, which makes significant changes to federal quality reporting requirements and holds physicians to an increasingly high bar. Satisfactory participation in Physician Quality Reporting System (PQRS) becomes especially critical because 2015 marks the official end of PQRS incentive payments as the program transitions to penalties only (see Table 1). The 2015 PQRS reporting year also will determine an additional payment adjustment under the Value Modifier (VM) in 2017, which now applies to all physicians and carries stiffer penalties for large groups.

In order to avoid the PQRS adjustment, CMS requires eligible professionals to report nine measures across three national quality strategy domains, which must also include at least one “cross-cutting” measure:

- Person- and caregiver-centered experience
- Patient safety
- Communication and care coordination
- Community and population health
- Efficiency and cost reduction
- Effective clinical care

Cross-Cutting Measures
This year, CMS also finalized a newly designated list of cross-cutting measures, which represent a core set of measures that CMS feels addresses critical improvement gaps that apply across specialties. The cross-cutting measure for emergency care is PQRS #317: Preventive care and screening: screening for high blood pressure and follow-up documented.

PQRS-CAHPS Required for Groups of 100 or More
CMS has finalized that all groups of 100 or more eligible providers that register to participate in the group practice reporting option, regardless of reporting mechanism the group practice chooses, must select a CMS-certified vendor to administer the PQRS–Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on their behalf (formerly known as Clinician Groups–CAHPS).

2015 PQRS Measure Updates
CMS has retired 50 measures from the PQRS program in 2015, including the following four out of the seven measures from the 2014 emergency care cluster:

- #28: Aspirin for acute myocardial infarction
- #55: 12-lead ECG for syncope
- #56: Community-acquired pneumonia (CAP): vital signs
- #59: CAP: empiric antibiotic

PQRS measures potentially relevant to emergency physicians in 2015 are listed in Table 2. Please review the detailed coding of each measure in the 2015 PQRS Measures Specifications Manual.

Measure-Applicability Validation (MAV) Process
Eligible providers can still satisfy PQRS and avoid the penalty by reporting on fewer than nine measures but would be subject to the MAV process to determine whether they reported on as many measures as are applicable to the eligible professionals’ practices. The MAV process will also allow CMS to determine whether eligible professionals to report the CAHPS for PQRS survey measures.

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Table 1. INCREASING IMPACT OF PQRS PARTICIPATION

<table>
<thead>
<tr>
<th>PQRS</th>
<th>2014 PERFORMANCE YEAR</th>
<th>2015 PERFORMANCE YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional PQRS incentive</td>
<td>+0.5% payment in 2015</td>
<td></td>
</tr>
<tr>
<td>PQRs Maintenance of Certification incentive</td>
<td>+0.5% payment in 2015</td>
<td>— No incentives —</td>
</tr>
<tr>
<td>Total potential PQRS incentives</td>
<td>+1.0% in 2015</td>
<td></td>
</tr>
<tr>
<td>Penalty for failure to satisfy PQRS</td>
<td>-2.0% in 2016</td>
<td>-2.0% in 2017</td>
</tr>
<tr>
<td>Value Modifier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional VM penalty for failure to satisfy PQRS</td>
<td>-2.0% in 2016</td>
<td>-4.0% in 2017</td>
</tr>
<tr>
<td>Total potential penalties</td>
<td>-4.0% in 2016</td>
<td>Up to -6.0% in 2017</td>
</tr>
</tbody>
</table>

Table 2. POTENTIAL MEASURES FOR EMERGENCY CARE

<table>
<thead>
<tr>
<th>MEASURE #</th>
<th>NQS DOMAIN</th>
<th>QUALITY MEASURE TITLE</th>
<th>REPORTING MECHANISM</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS #91</td>
<td>Clinical effectiveness</td>
<td>Acute otitis externa (AOE): topical therapy</td>
<td>Claims, registry</td>
</tr>
<tr>
<td>PQRS #93</td>
<td>Efficiency and cost reduction</td>
<td>Acute otitis externa (AOE): systemic antimicrobial therapy—avoidance of inappropriate use</td>
<td>Claims, registry</td>
</tr>
<tr>
<td>PQRS #187</td>
<td>Clinical effectiveness</td>
<td>Stroke and stroke rehabilitation: thrombolytic therapy (IAP); also known as hospital STK-4</td>
<td>Registry only</td>
</tr>
<tr>
<td>PQRS #254</td>
<td>Clinical effectiveness</td>
<td>Ultrasound determination of pregnancy location for pregnant patients with abdominal pain</td>
<td>Claims, registry</td>
</tr>
<tr>
<td>PQRS #255</td>
<td>Clinical effectiveness</td>
<td>Rh immunoglobulin (Rhogam) for Rh-negative pregnant women at risk of fetal blood exposure</td>
<td>Claims, registry</td>
</tr>
<tr>
<td>PQRS #317</td>
<td>Community-population health</td>
<td>Preventive care and screening: screening for high blood pressure and follow-up documented</td>
<td>Claims, registry</td>
</tr>
<tr>
<td>PQRS #326</td>
<td>Clinical effectiveness</td>
<td>Atrial fibrillation and atrial flutter: chronic anticoagulation therapy; also known as hospital STK-3</td>
<td>Claims, registry</td>
</tr>
</tbody>
</table>

A clinical data registry records information about the health status of patients and the health care they receive in an organized system. Clinical data registries collect uniform data (administrative, clinical, patient-reported, and other data) to evaluate clinical processes and outcomes. Clinical data registries typically focus on patients who share a common reason for needing health care. Registries have emerged as valuable solutions for harnessing the power of information technology to capture statistically relevant, evidence-based data to aid in decisions regarding the most optimal patient care. Information from registries may also be used to compare the performance of health care providers with regard to their patient outcomes.

What is a CMS Qualified Clinical Data Registry?
The 2012 American Taxpayer Relief Act authorized a new standard for individual eligible professionals to satisfy Physician Quality Reporting System (PQRS) reporting requirements beginning in 2014. This new mechanism recognizes satisfactory participation in a qualified clinical data registry (QCDR) in lieu of reporting traditional PQRS measures to the Centers for Medicare & Medicaid Services (CMS). QCDRs may submit information on both PQRS measures and up to 30 additional non-PQRS specialty-specific measures. Also, QCDRs give a better picture of the overall quality of care provided because they collect and report quality information on patients from all payers, not just Medicare patients.

Why Is ACP Providing a Clinical Data Registry?
ACP’s mission is to promote the highest quality of emergency care. For 2015, CMS has retired four of the five PQRS measures most commonly reported by emergency physicians. Simultaneously, it continues to up the ante by requiring nine measures across three domains, with up to 6 percent of Medicare reimbursements at risk for most emergency physicians.

Can ACP Deliver a Quality Information Technology Solution?
ACP is partnering in the development of a clinical data registry with FIGMD, Inc., a company that specializes in integrating practice management, billing, and coding software as well as electronic health records (EHRs) with registries. FIGMD has developed and maintained registries for the American College of Cardiology, the American Academy of Ophthalmology, and the American Urological Association; has completed integration projects for more than 50 major EHRs; and is capable of working quickly with new practice management, billing, coding, and EHR systems.

Building a Bridge to the Future for PQRS Reporting
The ACP QCDR is being designed to build a bridge for emergency physicians from the claims-based reporting of the past to the electronic clinical quality measures (eCQMs) of the future. During the 2015 pilot of ACP’s Clinical Data Registry, we will continue to focus on collecting quality data codes from claims and administrative data sets and begin testing e-measures for future reporting periods. By building this bridge, we anticipate that most participants should continue to report quality data on ACP’s Clinical Data Registry.
Avoid the Alternative Minimum Tax

by JAMES M. DAHLE, MD, FACEP

**Question.** I end up having to pay thousands in alternative minimum tax (AMT) each year. What is the AMT, and what can I do to avoid paying it?

**A.** The AMT should really be called the alternative maximum tax rather than the minimum tax. Tax law requires you to figure your tax using two separate, parallel tax systems—the regular income tax system and the AMT—and then pay whichever one is higher. The so-called alternative minimum tax on line 45 of your 1040 is really just the difference between what you would owe under the regular tax system and what you would owe under the AMT. If the regular tax bill is higher, that line is zero. If the AMT tax bill is higher, then line 45 is the difference between your tax bills under the two systems.

Historically, the law came into place in 1969 due to political outrage that 155 well-to-do taxpayers were not paying their share of the expenses of our nation thanks to their taking advantage of perfectly legal deductions. In 1982, it became the parallel tax system we know today. In many ways, the AMT is a simpler, better tax system than the regular system, with fewer deductions and brackets. However, until 2012, the exemption and brackets under the AMT were not indexed to inflation, although Congress dutifully “patched” it each year for decades. With time and inflation, many households that would not have been subject to the AMT in 1982 have become subject to it, and now 4–5 percent of taxpayers owe more under the AMT system than the regular system. Because most physicians have top 5 percent incomes, many of them are subject to the AMT.

**How AMT Works**

Having a goal to pay less AMT may be shortsighted. As a general rule, the goal should be to maximize your after-tax income or at least to minimize the total amount of tax paid. For example, the two easiest ways to pay less AMT are to make less money (and thus owe less tax) and to make more money (and thus owe less tax) and to make more money (and thus owe less tax) and to make more money (and thus owe less tax) and to make more money (and thus owe less tax) and to make more money (and thus owe less tax). As a general rule, making less than $250,000 or more than $500,000 will keep you from owing AMT, although there are exceptions.

The AMT system has just two brackets. In 2014, taxable income under $182,500 ($91,250 if married filing separately) is taxed at 26 percent, while taxable income above that amount is taxed at 28 percent. The exemption is also simpler. Instead of getting $3,950 for yourself and each dependent, the taxpayer receives an exemption of $52,800 ($82,100 if married filing jointly). However, this exemption is phased out between taxable incomes of $117,300 and $328,500 ($156,500 and $484,900 if married). The effect of this phase-out is to increase your marginal tax rate within the phase-out range from 28 percent to 35 percent. However, there is often a “sweet spot” above this phase-out range, where your marginal tax rate actually decreases from 35 percent back to 28 percent. If you are in this range, you may actually...
Once you have your tax data plugged into the program, play around with the numbers on the 1040 and Schedule A. See what happens if you make $1,000 more or less. See what happens if you pay your property or state income taxes in December instead of in January.

Table 1. ADVANTAGES OF QCDRs OVER TRADITIONAL PQRS REGISTRY REPORTING

<table>
<thead>
<tr>
<th>TRADITIONAL PQRS REGISTRIES</th>
<th>QCDRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide quality data for Medicare patients only</td>
<td>Provide quality data on patients from all payers</td>
</tr>
<tr>
<td>Limited to PQRS measures</td>
<td>Include PQRS measures, plus up to 30 additional specialty-specific measures</td>
</tr>
<tr>
<td>Require new cross-cutting measures</td>
<td>Do not require cross-cutting measures</td>
</tr>
<tr>
<td>Require groups of 100 or more to report the PQRS– Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey</td>
<td>Do not require CAHPS reporting</td>
</tr>
<tr>
<td>Offer less control over quality measures reported</td>
<td>Offer more meaningful measures to choose from</td>
</tr>
<tr>
<td>Quality measure data collected will be used to calculate the quality composite of the Value Modifier (VM)</td>
<td>CMS will not include first-year QCDR measures in the VM quality composite until such time as CMS has historical data to calculate benchmarks for them; for the 2017 VM, in cases where groups are assessed under the 50 percent option and all eligible professionals report via QCDR in 2015, CMS will classify the group’s quality composite score as average</td>
</tr>
</tbody>
</table>

A QUALITY SOLUTION QCDRs | CONTINUED FROM PAGE 15

be ready to report a mix of administrative and electronic clinical quality measures to CMS for the 2016 reporting period. ACEP’s goal is to have all emergency clinicians reporting eCQMs by the 2017 reporting period, which is when CMS intends to completely eliminate the administrative burden on coders and billers to submit quality data codes should be significantly alleviated.

The key to understanding the AMT and decreasing your AMT tax bill lies in understanding which deductions can be used under both systems and which ones can only be used under the regular tax system. For example, when you have another child, you get another $1,950 exemption under the regular tax system but not under the AMT. You also cannot deduct state and local income taxes, property taxes, child care expenses, or interest earned on certain types of municipal bonds. However, charitable contributions, most mortgage interest, and retirement account contributions can be used under both systems.

The following events can cause you to owe more taxes due to the AMT:
- Having another child
- Moving to a high-tax state
- Paying off your mortgage
- Reducing your tax-deferred retirement account contributions
- Taking the standard deduction
- Increasing your income
- Investing in “private activity” municipal bonds
- Decreasing your charitable contributions

If you wish to reduce your tax bill, you simply need to do the opposite and take advantage of deductions valid under both systems by:
- Increasing retirement contributions
- Giving more to charity
- Paying a lot of mortgage interest
- Avoiding “private activity” municipal bonds
- Deferring income to the new year (making less)

Obviously, giving more to charity and paying more interest on your house may not make you wealthier, even if they lower your tax bill. But if you are doing these things anyway, you might as well maximize the benefits.

Tax Planning

If you really want to get serious about tax planning, either find a good tax strategist (most tax preparers won’t take the time to do this) or learn how to do it yourself with inexpensive tax software, such as Intuit’s TurboTax. Once you have your tax data plugged into the program, play around with the numbers on the 1040 and Schedule A. See what happens if you make $1,000 more or less. See what happens if you pay your property or state income taxes in December instead of in January. Charitable deductions can also be bunched or unbunched as needed to minimize the tax. However, if you find you are in the sweet spot, where additional income is only taxed at 28 percent instead of 35 percent, consider accelerating income (perhaps by doing Roth conversions) or deferring deductions (like charitable contributions) to next year. Remember to pay attention to the total tax bill, not just the AMT.

Tax planning can be complicated, but a better understanding of the tax code will enable you to pay every cent you owe to Uncle Sam without leaving a tip. If you find yourself paying the AMT each year, it is worth taking the time to understand why and what you can do about it.

What Are the Benefits of Participating in a QCDR?

ACEP submitted an application to meet CMS requirements for PQRS and QCDR reporting by the Jan. 31, 2015, deadline for the PQRS 2015 performance year/reporting period. Use of the registry under PQRS and QCDR will minimize or avoid negative financial reimbursement from CMS.

With the transition to a value-based system upon us, in which health service providers are paid based on quality of care, efficiency, patient satisfaction, and outcomes, the QCDR will provide a means for providers to track such parameters from patient encounter information they already document, then adjust practice as necessary to maintain compliance with the highest of standards. PQRS was introduced by CMS to evaluate patient outcomes and quality of care. PQRS registries, and now QCDRs introduced in 2014, are considered key vehicles to automate the reporting of data to qualify for full Medicare Fee-For-Service reimbursement. Private payers are also moving to collect these quality measures to evaluate agreements with providers.

With participation from emergency clinicians nationwide, data from the QCDR will be used to generate regular feedback reports that summarize local practice patterns and treatment outcomes as well as compare an ED’s patterns with those of a number of others across the nation. The reports could also be used to identify process-of-care variables that may correlate with key patient outcomes.

STACIE SCHILLING JONES is director of quality and health information technology in the public affairs division of ACEP in Washington, D.C.

FOR MORE INFORMATION
For more information on ACEP’s PQRS registry reporting options including the clinical data registry option, please visit www.acep.org/quality/pqrs.
TRICKS OF THE TRADE

PRACTICAL TIPS FOR THE PRACTICAL DOC

B3: Bubbling, Bloody, and Blowing Chunks
A novel approach to video laryngoscopy

by TERRANCE MCGOVERN, DO, MPH, AND JUSTIN MCNAMEE, DO

To assist with clearing secretions, video laryngoscopes have been augmented using an inline suction device attached to the blade of the laryngoscope, but the results showed no improvement in time to intubation or increased success rates.

The Case
A 42-year-old female presents to the emergency department after sustaining blunt facial trauma from a high-speed motor vehicle collision. She weighs more than 400 pounds and is back-boarded and collared. Blood is flowing freely from her mouth, and she is unresponsive to painful stimuli and gurgling with each respiration; this patient needs her airway secured five minutes ago. After the newly minted intern gives it a shot by direct laryngoscopy and pulls out with a look that says, “I think I just soiled my pants,” you step in. Using the GlideScope this time, you visualize the epiglottis, but then a splattering of blood hits the lens of your GlideScope and obscures the view. You try again with the same result. Is it time to dust off the #11 blade, or is there an alternative trick of the trade to improve visualization?

Background
In 1944, Bannister and Macbeth described direct laryngoscopy by aligning the pharyngeal, laryngeal, and oral axes to obtain direct visualization of the glottic inlet. Aligning these axes and visualizing the glottic inlet can be easily complicated by difficult airway characteristics (eg, large tongue, short neck, small mandible, bodily fluids in the airway, cervical immobility, facial trauma, edema, or limited mouth opening). Prior to the advent of video laryngoscopy, physicians had limited options to handle these complications before proceeding to a surgical airway. Video laryngoscopy can help circumvent these obstacles and has been shown to improve glottic visualization, especially in difficult airways. The hyperacute angle of the GlideScope can navigate challenging anatomy, and the video display provides a way to supervise novice operators. However, there is no solution for when the video laryngoscope’s view becomes obscured by bodily fluids. Removing the laryngoscope to clean it off wastes time and subjects the patient to another intubation attempt. To assist with clearing secretions, video laryngoscopes have been augmented using an inline suction device attached to the blade of the laryngoscope, but the results showed no improvement in time to intubation or increased success rates. Furthermore, the study did not address the complication of getting the secretions off of the screen to allow for better visualization.

Technique
Attaching IV tubing to a video laryngoscope can help improve visualization during intubation. This novel apparatus will take approximately 20 minutes to assemble, so it should be put together prior to when it is needed. You can assemble it during your next night shift at 3:30 am and store it with your airway supplies. While the example below is applied to the GlideScope, this principle and assembly can also be applied to most other video laryngoscopes (eg, Karl Storz C-MAC).

Equipment Needed
(see Figure 1)
- 10 cc syringe with 18 g blunt-tip needle
- One set of IV tubing
- Scissors

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM
• Tape
• 0-0 silk suture
• Normal saline flush
• GlideScope disposable laryngoscope blade
• One needleless luer lock

Assembly
1. Cut the IV tubing as shown in Figure 2. Cut the distal end of the IV tubing at an oblique angle and fit the luer lock into the oblique opening. This may be take some elbow grease, but it will fit (Figure 3).

2. Use a 10 cc syringe with the 18 g needle as a drill and make the three individual holes as outlined in Figure 4.

3. Fasten the IV tubing to the laryngoscope blade with 0-0 silk with the knot tied on the lateral aspect of the laryngoscope tool.

Utilization
1. The same technique for any GlideScope intubation is used with this apparatus: entering the oropharynx midline, rotating the blade, and visualizing the glottis.

2. If the lens becomes obscured by bodily fluid during the intubation, the operator or assistant can push 5 mL increments of normal saline through the IV tubing to clean the lens (Figure 7). This can be repeated many times as needed to obtain a clear view and intubate the patient (Figure 8).

Patient Selection
This apparatus could arguably be used with any intubation for which you are using video laryngoscopy.

Caution
There may be concern that the additional saline within the oropharynx may put the patient at further risk of aspiration. However, the risk is theoretical and likely the lesser of two evils when considering such time-sensitive airways. While this product may provide improved visualization of the airway on simulated intubations, it has not been approved by the US Food and Drug Administration, and therefore cautious use is recommended at the discretion of the provider.

References
TIPS FOR BETTER PERFORMANCE

SPECIAL OPs

DR. WELCH 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.

How Will Your Next Shift Look?

Know your ED’s patient profile to be prepared for whomever walks through your door

The median ED volume is now approximately 40,000 visits per year (according to the 2012 data set), and the daily dashboard for an emergency department

Do you know the national utilization trends for emergency department services? Do you know what you will be doing to, for, and with your patients? How about what you will need to provide for patients so that you can have those services staffed and available?

In my last column (November 2014), we looked at national trends in the National Hospital Ambulatory Medical Care Survey (NHAMCS) and translated them into a picture of who will come to us in our emergency departments. In this column, I will review recent trend data from the Emergency Department Benchmarking Alliance (EDBA) annual data survey to paint a second vivid picture about the work that we do. From these data trends, we can anticipate the needs of the operational management of your ED.

James J. Augustine, MD, FACEP, vice president of the nonprofit EDBA, believes everyone working in an emergency department should know that department’s dashboard data. The median ED volume is now approximately 40,000 visits per year (according to the 2012 data set), and the daily dashboard for an emergency department is shown in Table 1.

Knowing this data, are you getting upstream of admissions? Are your transporters anticipating 23 trips upstairs with gurneys? Is your fast track optimized in terms of staffing and supplies? Do you open your fast track early enough during the day? Do you have dental supplies and a referral list for low-cost dental providers? Do you alert admitting when an ambulance arrives (because 42 percent of ambulance patients are admitted)?

Next, let’s look at what we will typically do to patients, for them, and with them in Table 2.

Again, are you prepared? Do you have enough imaging staff, particularly on the evening shift? Do you have rapid capability for doing ECGs? Do you have foolproof processes for lab collection, labeling, transportation, and results? Do you have enough IV fluid bags on hand for the day? Are you trying to improve on those critical time intervals (door-to-provider and admission-to-departure times)?

Here are few more interesting facts from the Centers for Disease Control and Prevention and NHAMCS.

The chronic diseases seen most often in the ED are:
• Diabetes (8.6 percent)
• Congestive heart failure (3.1 percent)
• Stroke or cerebrovascular disease (3 percent)

The most commonly admitted disease entities in the ED are:
• Ischemic heart disease
• Chest pain
• Pneumonia
• Psychoses
• Cerebrovascular disease

It is no mystery—the data inform us. Knowing who is coming to the ED, what they will need, and what a typical day will look like in your department, you can be better prepared for what is coming to an ED near you.

---

Table 1.

| 130 | Patients to be seen (although three want to leave) |
| 40  | Will be in fast track |
| 56  | Will need monitors |
| 23  | Will be admitted, representing 26 percent of patients in the main ED |
| 6   | Will have dental problems |
| 25  | Will arrive by EMS |
| 991 | Orders will be entered via computerized provider order entry—this is eight per patient and represents 21 percent of all orders entered in the hospital today |

Table 2.

| 61  | Patients will have an X-ray |
| 26  | Will have a CT scan |
| 34  | Will have an ECG |
| 2.6 | Will be transferred |
| 49  | Will have an IV |
| 80  | Will get lab work |
| 18  | Minutes on average a patient waits to see a provider |
| 119 | Minutes on average it takes to get an admitted patient upstairs |
Should You Try to Prevent Febrile Seizures?

by KEN MILNE, MD

Case
A 2-year-old boy presents to the emergency department via ambulance after a brief tonic-clonic seizure. He has an otherwise healthy, immunized child with no medical history of major illnesses. The distraught parents report he has had a flu-like illness associated with a fever for the last two days. You conduct a good history followed by a directed physical examination. Appropriate testing is done, and the diagnosis of febrile seizure is made.

Question
Will treating with antipyretics prevent a recurrence of a febrile seizure?

Background
“Fever fear” is common in parents and caregivers that a fever alone is not dangerous. According to the American Academy of Pediatrics, “fever, in and of itself, is not known to endanger a generally healthy child. In contrast, fever may actually be beneficial; thus, the real goal of antipyretic therapy is not simply to normalize body temperature but to improve the overall comfort and well-being of the child.”

One of the scariest things that can happen to a child with a fever is to have a seizure. It is a longstanding medical myth that febrile seizures can be prevented with antipyretics.


Authors’ Conclusions: “Antipyretics were ineffective in reducing the recurrence of febrile seizures.”

antipyretic group was 0.9 (95% CI, 0.57-1.43).

EBM Commentary
Treating a fever does not seem to prevent a child from having a febrile seizure. This systematic review identified three randomized controlled trials and combined their data to show that antipyretics have no significant effect in preventing the recurrence of febrile seizures.

There were some major limitations to this systematic review:
1. There was no attempt to search the gray literature. The authors should have contacted experts in the field to find unpublished data. They should have searched for conference abstracts or commented on searching the reference lists of included articles.
2. According to the authors, “no language restrictions were applied, but English abstracts required.” This sounds like a language restriction.
3. There was no risk-of-bias tool used to evaluate the included studies. Without applying a standardized tool, we can only guess as to the risks of bias from the included studies.

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Bottom Line
Antipyretics appear to offer no significant improvement in the recurrence rate of febrile seizures in children.

Case Resolution
The parents are reassured and educated about febrile seizures. You inform them that, unfortunately, treating children with antipyretics does not appear to decrease the risk of febrile seizures. They should focus on their child’s comfort instead of normalizing his temperature.

Thank you to Anthony Crocco, MD, associate professor at McMaster University and medical director and division head of the emergency department at McMaster Children’s Hospital in Hamilton, Ontario, for his help with this review.

Remember to be skeptical of anything you learn, even if you learned it on The Skeptics Guide to Emergency Medicine.

Reference
Detect Cardiac Regional Wall Motion Abnormalities by Point-of-Care Echocardiography

by BRIAN JOHNSON, MD, MPH, EMILY LOVALLO, MD, ORON FRENKEL, MD, AND ARUN NAGDEV, MD

More than 6 million emergency department visits a year in the United States are for chest pain. While there are approximately 1.1 million hospitalizations a year for acute coronary syndrome (ACS) in the United States, only approximately 30 percent of cases are ST-elevation myocardial infarctions. The remaining 70 percent are diagnosed with unstable angina (UA) or non-ST-elevation myocardial infarction (NSTEMI). Risk stratification of chest pain patients with concern for ACS is of high concern in the emergency department. The American Heart Association (AHA) current guidelines recommend prompt management and possibly invasive strategies for patients with UA and NSTEMI who present with high-risk features. Often in the ED setting, chest pain patients have a nondiagnostic electrocardiogram (ECG), and initial cardiac biomarkers can be negative even with significant coronary artery occlusion. Investigation of regional wall motion abnormalities (RWMAs) is a Class I recommendation by the AHA in the hands of trained echocardiogram technicians. The goal is to identify patients with RWMAs likely representing a significant occult coronary artery thrombosis not evident by symptoms, ECG, or initial cardiac biomarkers that could then benefit from an invasive intervention. Previous studies suggest that if a RWMA is present, a large area of myocardium is at risk for death. Initial studies have shown good sensitivity and specificity of the identification of RWMAs for coronary ischemia in the ED setting. Most of these studies were performed by trained ECG technicians or cardiologists. However, several articles recently described emergency physicians of various levels of training being capable of identifying RWMAs.

A case series described three cases in which emergency physicians identified RWMAs in patients with equivocal ECGs; all the cases went to cardiac catheterization partly based on the point-of-care echocardiography (POC echo) detecting RWMA and were found to have significant single-vessel coronary disease requiring intervention.

Clinical Indications for Performing POC Echo for RWMAs

Evaluation for RWMAs should promptly occur when the emergency physician has a high concern for UA or NSTEMI by history and physical examination with an equivocal ECG for cardiac ischemia.

Figure 1.

Appropriate probe positioning and corresponding ultrasound image of A) PLAX, B) PSAX, and C) A4C.

**PROBE SELECTION, TECHNIQUE, AND ECG VIEWS**

**Patient positioning:** The patient should lie supine or be placed in the left lateral decubitus position.

**Probe selection:** The low-frequency phased array transducer (5-1 MHz) is recommended. A curvilinear probe (5-2 MHz) can also be used but may be suboptimal.

**Imaging views:**
- Parasternal long axis (PLAX): Place the transducer on the left chest near the sternum, with the indicator probe pointing to the patient’s right shoulder. Starting at the level of the nipples/areola, slide the probe down the left border of the sternum to find the best acoustic window. Minor rotation (either clockwise or counterclockwise) will allow for a clear PLAX view (see Figure 1A).
- Parasternal short axis (PSAX): After the parasternal long axis is obtained, rotate the probe 90 degrees in a counterclockwise direction until the probe indicator points to the patient’s right hip. Subtle cephalad/caudal movements of the transducer will allow for the best acoustic window (see Figure 1B). The sonographer should move the probe just distal to the mitral valve to the level of the papillary muscles to obtain an ideal view for detecting RWMA.
- Apical four-chamber view (A4C): From the position of the parasternal short/long, slide the transducer laterally along the axis of the heart toward the apex. From this location, angle the beam toward the right scapula (with the probe marker toward the right hip). The goal is to have the transducer footprint at the cardiac apex, with the beam directed through both ventricles and atria. (The ultrasound view will ideally have the intraventricular septum oriented vertically in the center of the screen.) Once again, make subtle movements for the best acoustic window (see Figure 1C). This is often the most difficult view to obtain and generally requires the patient be positioned in the left lateral decubitus position. RWMAs are often evident on parasternal long and short, and the A4C view may not be needed if the other two views are obtained.
Anatomy
For simplicity, the traditional 17-wall motion segment identification on ECG has been condensed into a modified three-area evaluation that corresponds roughly to the major coronary artery perfusion territories of the left ventricle. This is based on American Society of Echocardiography guidelines and cardiac magnetic resonance imaging data of patients with acute coronary ischemia and has been successfully utilized in prior ED studies. Visualization of the left ventricle in PLAX, PSAX, and A4C can roughly display RWMA of the three major coronary arteries: left anterior descending (LAD), circumflex (Cx), and right coronary artery (RCA) (see Figure 2). Thus an anterior RWMA corresponds with an occlusion of the LAD, a lateral RWMA corresponds with an occlusion of the Cx artery, and an inferior RWMA corresponds with an occlusion of the RCA.

Findings
Left ventricular RWMA is described as a hypokinesia, dyskinesis, or akinesis of a segment that corresponds to the 17-wall motion segment identification system. This can be visualized sonographically as a blunting of the typical symmetric myocardial thickening during contraction as compared to other cardiac wall segments. This abnormal movement of the wall segment is highly suspicious for an associated coronary thrombus.

Next Steps in Management
An identified RWMA can often suggest a moderate-sized coronary thrombus in the chest pain patient. While the initiation of invasive strategies based solely on a RWMA remains controversial, cardiologic consultation, consultative echocardiography, and serial biomarker testing may be prudent. Echocardiographic evaluation of RWMA, in conjunction with ECG and a targeted history, can be useful in the risk stratification of the ED chest pain patient.

Corrections, Caveats, and Limitations
When looking for RWMA with POC echo, there are few notable caveats. Novice sonographers may have difficulty obtaining clear views and should not base decisions on suboptimal imaging. Even for the experienced ED sonographer, differentiating between new and old RWMA can be extremely challenging.

Novice sonographers may have difficulty obtaining clear views and should not base decisions on suboptimal imaging. Even for the experienced ED sonographer, differentiating between new and old RWMA can be extremely challenging.
in the ED should be aware of these and other limitations before adjusting clinical care.

Conclusions
While POC echo to identify RWMA cannot supplant patient history, clinical examination, ECGs, and cardiac biomarkers, it can provide a prompt bedside tool to help risk-stratify chest pain patients with a risk for myocardial ischemia. Identification of RWMA may help stratify patients in need of prompt cardiology consultation (and/or comprehensive echocardiography), more frequent serial ECGs, rapid biomarker testing, and in certain cases early cardiac catheterization.

References

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