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The Official Voice of Emergency Medicine



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## PLUS



**THE END OF  
THE RAINBOW  
DO YOUR TOYS  
OWN YOU?**  
SEE PAGE 12



**AIRWAY  
KOVACS' SIGN  
AND OVERHAND  
RIGHTWARD  
TURN**  
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# M&A

**CONSOLIDATION IS CHANGING THE  
EMERGENCY MEDICINE LANDSCAPE—BUT WILL  
THE TREND CONTINUE?**

CONSOLIDATION IN THE HEALTH CARE MARKET isn't a new trend, but the frenzy of mergers and acquisitions in the emergency medicine space make this a top concern for practicing emergency physicians and EM administrators. Over the next few months, *ACEP Now* will feature a series of articles exploring the effects—both positive and negative—that consolidation may have on emergency medicine.

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## TRICKS OF THE TRADE

# A Backhanded Approach to Tendon Lacerations

*Emergency department  
management of extensor  
tendon lacerations*

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

The hand is an intricate structure that provides us with the dexterity needed for our everyday lives. Unfortunately, we see many patients in the emergency department who take this functionality for granted until they lose all or part of it. The attention spent on flexor tendon injuries is pervasive throughout the literature, whereas the more common extensor tendon injuries have not garnered as much attention.<sup>1</sup> As emergency physicians, we have the opportunity to decrease the amount of impairment that patients sustain from these extensor tendon injuries by providing them with the appropriate treatment that they deserve.

Diagnosing an extensor tendon injury takes a thorough physical exam, with time spent by the provider to isolate each joint and test the range of motion against resistance. (See "Management of Extensor Tendon Injuries" for more on the exam.)<sup>2</sup> The potential impairment that may occur without

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improving experience  
of care **SEE PAGE 16**

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# NEWS FROM THE COLLEGE



ACEP's 2015-2016 Board of Directors.

## ACEP15 ROUNDUP

*New leadership, high attendance  
highlight Boston meeting*

Near-record attendance at ACEP15 in Boston brought new leadership, new faces, and healthy contributions to ACEP's advocacy program and the Emergency Medicine Foundation (EMF).

Attendance at the conference matched the record attendance at ACEP14 in Chicago, although final numbers are still being determined.

A new President-Elect and four members of the Board of Directors were elected by the ACEP Council, which also elected its new leadership. Contributions to the National Emergency Medicine Political Action Committee (NEMPAC) and the EMF also pushed closer to the goals set for the year.

### LEADERSHIP

Incoming President Jay Kaplan, MD, FACEP, took the reins of ACEP in Boston as Rebecca Parker, MD, FACEP, was elected President-Elect.

Dr. Kaplan is director of the patient experience for CEP America in Emeryville, California, and a practicing clinician in the emergency department at Marin General Hospital in Greenbrae, California.



Council Speaker James M. Cusick, MD, FACEP (left), and Vice Speaker Col. (ret.) John McManus, MD, MBA, MCR, FACEP (right).

Dr. Parker, who had served as Board Chair, is an attending emergency physician with Vista Health in Waukegan, Illinois. She is senior vice president of Envision Healthcare and president of Team Parker LLC, a consulting group. She is also a clinical assistant professor at the Texas Tech University Health Sciences Center at El Paso department of emergency medicine.

The Council reelected two Board members and voted in two new members. Vidor Friedman, MD, FACEP, and William Jaquis, MD, FACEP, were reelected. Christopher S. Kang, MD, FACEP, FAWM, and Mark Rosenberg, DO, MBA, FACEP, were also elected to the Board.

James M. Cusick, MD, FACEP, was elected Council Speaker, and Col. (ret.) John McManus, MD, MBA, MCR, FACEP, was elected Vice Speaker. ☉



### THE NATIONAL EMERGENCY MEDICINE POLITICAL ACTION COMMITTEE (NEMPAC)

drew nearly \$300,000 in donations during the Council Challenge Oct. 24-25, in Boston. Combined with the thousands of dollars in donations from ACEP members across the country, NEMPAC is on the way toward its \$1 million goal set for 2015.

ACEP members in seven emergency medicine group practices were recognized for outstanding support: CEP America, EmCare, Emergency Medicine Physicians (EMP), Eastside Emergency Physicians (EEP), Florida Emergency Physicians (FEP), Medical Emergency Professionals (MEP), and Wake Emergency Physicians (WEPPA).

NEMPAC advances ACEP's legislative agenda and broadens ACEP's visibility in Congress. It is the fourth largest physician specialty PAC.



### THE EMERGENCY MEDICINE FOUNDATION (EMF)

surpassed its goal for the year with a special Council Challenge at ACEP15 in Boston. The challenge drew \$210,000 in contributions, surpassing the \$200,000 goal for the year.

The average contribution approached the recommended "Wilcox" level of \$500, with record numbers of contributors stepping up to become major donors and 1972 Club members.

EMF is continuing its Pave the Way for the Future of Emergency Medicine campaign, giving members an opportunity to help build the future of the specialty by donating a personalized brick paver at ACEP's new headquarters, now under construction.

## ACEP15 LEADERSHIP AWARD WINNERS

*Please join ACEP in congratulating the 2015 recipients of the College's most prestigious awards.*

### OUTSTANDING CONTRIBUTION IN RESEARCH AWARDS

- Clifton W. Callaway, MD, PhD, FACEP
- Daniel W. Spaite, MD, FACEP

### HONORARY MEMBERSHIP AWARDS

- Marilyn Bromley, RN
- Virginia Kennedy Palys, JD
- W. Calvin Chaney, JD, CAE

### OUTSTANDING CONTRIBUTION IN EMS AWARD

- James V. Dunford Jr., MD, FACEP

### JOHN G. WIEGENSTEIN LEADERSHIP AWARD

- Angela F. Gardner, MD, FACEP

### OUTSTANDING CONTRIBUTION IN EDUCATION AWARD

- Mel Herbert, MD, FACEP

### COUNCIL MERITORIOUS SERVICE AWARD

- Andrew I. Bern, MD, FACEP

### JOHN A. RUPKE LEGACY AWARD

- Stephen V. Cantrill, MD, FACEP

### COLIN C. RORRIE JR., PHD, AWARD FOR EXCELLENCE IN HEALTH POLICY

- James C. Mitchiner, MD, MPH, FACEP

### JAMES D. MILLS OUTSTANDING CONTRIBUTION TO EMERGENCY MEDICINE AWARD

- Robert W. Strauss, MD, FACEP

### DISASTER MEDICAL SCIENCES AWARD

- Carl H. Schultz, MD, FACEP

### WHAT ARE YOU THINKING?

SEND EMAIL TO [ACEPNOW@ACEP.ORG](mailto:ACEPNOW@ACEP.ORG); LETTERS TO ACEP NOW, P.O. BOX 619911, DALLAS, TX 75261-9911; AND FAXES TO 972-580-2816, ATTENTION ACEP NOW.

# Is MERS Coming to an ED Near You?

The 3I tool helps you identify and react to patients who might have Middle East respiratory syndrome

by KRISTI L. KOENIG, MD, FACEP, FIFEM

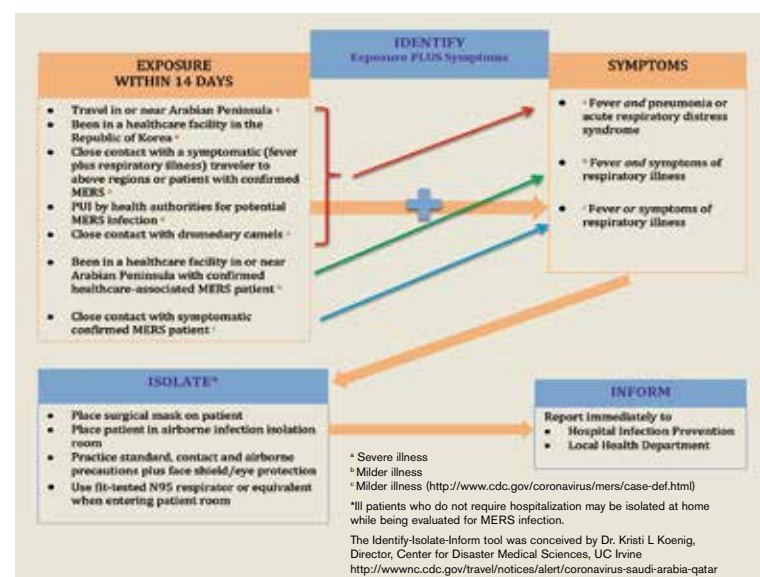
Initially described in Saudi Arabia in September 2012, Middle East respiratory syndrome (MERS) has been reported in at least 26 countries. Between Oct. 26 and Nov. 1, 2015, the National International Health Regulations Focal Point for the Kingdom of Saudi Arabia notified WHO of seven additional cases of MERS coronavirus infection, including one death. As of November 1, 2015, the World Health Organization reported 1,618 cases globally, with at least 579 deaths. The majority of cases have been reported from Saudi Arabia. No sustained human-to-human transmission has been reported to date.

The vast majority of MERS cases outside of the Arabian Peninsula have been in travelers to the region, including two unlinked cases in Indiana and Florida in May 2014 in patients believed to have been infected while they functioned as health care workers in Saudi Arabia. Both patients were hospitalized and recovered.

Nevertheless, as evidenced by reports from Saudi Arabia, disease transmission is occurring within health care facilities, and clinicians are at particularly high risk of contracting MERS from their infected patients. With global travel opportunities, it is essential to assess for risk of exposure to transmissible infectious diseases for all patients presenting to the emergency department. The modified Identify, Isolate, Inform (3I) tool (right) is intended for use in management of patients under investigation for MERS. The algorithm was developed with input from the ACEP Ebola Expert Panel and guidance from the Centers for Disease Control and Prevention.

Visit [www.acepnow.com/?p=7675](http://www.acepnow.com/?p=7675) to learn more about MERS and the 3I tool. ☺

**DR. KOENIG** is director of the University of California, Irvine Center for Disaster Medical Sciences and professor of emergency medicine and public health at the UC Irvine School of Medicine.



This 3I tool helps emergency departments evaluate and manage patients under investigation (PUIs) for MERS coronavirus.

## ACEP Annual Financial Report for the 2014–2015 Fiscal Year

by JOHN J. ROGERS, MD, CPE, FACEP

ACEP is a membership organization. As such, members have a right to know its financial status. The following is a fair and accurate representation of the sta-

tus of the College for the 2014–2015 fiscal year (July 1, 2014, through June 30, 2015). This is the first time this data has been published.

Membership continues to grow. As of June 30, 2015, the College had 34,049 members, of whom 21,083 were active (regular) and 10,261

were candidate members. This represents a 2.9 percent overall increase, with a 1.4 percent growth in active and 7.8 percent growth in candidate members.

The majority of the College's assets are in cash and investments. Current liabilities are mainly deferred revenue. Equity then stands as \$16,956,000, which has grown by \$1,121,000 since the previous fiscal year. This buildup in equity will allow the College to reinvest in its members. It will be applied to the new headquarters, which will give the ACEP staff the space it requires and provide areas for meetings that otherwise would need to be held off-site. Our finances will also allow us to further develop other benefits for our members such as our qualified clinical data registry, CEDR, and explore a national electronic network that will enhance care coordination, promote qual-

ity care, and help control health care costs.

Revenue for the fiscal year was more than \$33 million, with the majority coming from three activities: dues, ACEP14, and *Annals of Emergency Medicine*. When looking at expenses by line of service, the majority is spent on education and member services. For the year, the net income was \$1,973,000, of which 60 percent went to equity and 40 percent to staff bonuses.

In short, the College is strong financially, membership and equity continue to grow, and we have sufficient funds for high-cost projects that will be a significant benefit to our members. ☺

**DR. ROGERS** is ACEP's current Vice President and its immediate past Secretary-Treasurer.

Did you know that emergency physicians have the second highest rate of burnout (just 1% less than critical care physicians) and that burnout has been shown to negatively affect patient care?\*

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\* Medscape Emergency Medicine Physician Lifestyle Report 2015 - [www.medscape.com/features/slideshow/lifestyle/2015/emergency-medicine#1](http://www.medscape.com/features/slideshow/lifestyle/2015/emergency-medicine#1)

BALANCE SHEET	
Assets	
Cash, Equivalents, Investments	\$27,812,000
Fixed Assets	\$6,776,000
Line of Credit	\$0
Deposits	\$12,000
Other	\$2,757,000
<b>TOTAL ASSETS</b>	<b>\$37,357,000</b>
Liabilities	
Accounts Payable and Accruals	\$4,075,000
Due to Chapters	\$2,390,000
Deferred Revenue	\$13,936,000
<b>Total Liabilities</b>	<b>\$20,401,000</b>
Member Equity	\$16,956,000
<b>TOTAL LIABILITIES AND EQUITY</b>	<b>\$37,357,000</b>

INCOME STATEMENT	
Revenue	
Dues and Membership	\$12,812,000
Products	\$14,044,000
Other	\$6,473,000
<b>TOTAL REVENUE</b>	<b>\$33,329,000</b>
Expenses and Losses	
Education and Membership	\$16,875,000
Public Affairs	\$5,862,000
Policy and Administration	\$5,621,000
Leadership	\$2,998,000
<b>TOTAL EXPENSES</b>	<b>\$31,356,000</b>
<b>Net From Operations</b>	<b>\$1,973,000</b>
Bonus Award	\$758,000
Contribution to Equity	\$1,215,000
Unrealized Gain or Loss	-\$93,000
<b>Net Change in Equity</b>	<b>\$1,122,000</b>

## M&amp;A | CONTINUED FROM PAGE 1

To start the discussion, *ACEP Now* editorial board member **Ricardo Martinez, MD, FACEP**, chief medical officer for North Highland Worldwide Consulting and assistant professor of emergency medicine at Emory University in Atlanta, recently sat down with **Jeff Swearingen**, managing director and cofounder of Edgemont Capital Partners in New York City, to explore some of the forces driving mergers and acquisitions in emergency medicine. *Next month, we'll highlight some of the mergers and acquisitions topics discussed at the ACEP15 Council Town Hall meeting held Oct. 25, 2015, in Boston.*

**RM: We're seeing a lot of activity and tremendous interest in mergers and acquisitions in emergency medicine. What do you see as the main driving forces behind this?**

**JS:** First and foremost, there's a lot of mergers and acquisitions activity throughout health care right now. There is consolidation happening in all four of the main hospital-based specialties: emergency medicine, anesthesia, hospitalist medicine, and radiology. Anesthesia is even more active than emergency medicine in terms of the number of transactions at the moment, if you can believe that. Consolidation is resulting from different types of provider organizations jockeying for position and negotiating leverage as people look to negotiate a larger share of a bundled payment that may be bundled across both the facility and the provider in the future. I think the second reason for consolidation is access to capital. Many of the consolidators that are driving mergers and acquisitions in emergency medicine have far greater access to both debt and equity capital than even a midsized regional group might have. Investment in information technology and other capabilities will be important going forward, especially the ability to capture data beyond just the three hours in the emergency room episode of care. Emergency physicians in the future may be able to capture data via call center follow-up with patients to make sure that they're following their discharge instructions and that they're making follow-up appointments with their office-based providers. Envision, the EmCare business, also owns the large ambulance company American Medical Response, and they are using the trained paramedics to make follow-up house calls to patients discharged from their EmCare-staffed emergency rooms. They're doing this on a test basis in some markets, as I understand it. Envision is using those resources to try to reduce readmission cases. That is just one example of what may be required of emergency medicine providers in the future. To meet these potential requirements, groups will need expertise beyond emergency medicine, information technology resources, and access to capital to make those types of investments.

**RM: What do you see as some of the biggest challenges for these organizations as they begin to merge different entities together?**

**JS:** I'll be the first to tell you, having worked on mergers and acquisitions for 20 years, that there's absolutely a challenge to making mergers and acquisitions work. Many physicians, whether it's in emergency medicine or any other specialty, are used to owning their own practice. If they merge with a large organization, it's critical that the culture of hard work, high clinical



standards, and feeling a sense of ownership and pride in their practice continues to be fostered and supported. We have seen mergers and acquisitions go quite well for several of the groups we've represented, but we've also seen where there were some stumbles. At the end of the day, both of those parties have to live up to the plan under which the transaction was entered into in order to make it work.

**RM: We've watched the valuations and the multiples rise pretty quickly over the last few years. Do you see this as a temporary situation?**


**JS:** I'll say this: From a relative basis, valuations are higher now than they have been at any point in the last five years, maybe even the last 10 or more years. Part of that is driven by the fact that, for the most part, capital markets are doing very well right now. The large consolidators have access to plenty of debt and equity capital at a relatively low cost. Part of that is because of the scarcity value [the economic factor that increases an item's relative price based more upon its relatively low supply] of some of the really high-quality groups. In the last year or two, we've seen several very large transactions in emergency medicine, like Premier Physician Services and Emergency Medical Associates of New Jersey. With those very large groups, there's scarcity value. My general perspective is that if you're a seller, valuations are very attractive right now.

**RM: We're seeing this move to consolidate in a lot of industries. Many of the benefits are back-office benefits: administrative benefits, billing and coding, tracking data, etc. As these types of services become more cloud-based, do you see some undoing of the need to consolidate?**

**JS:** I certainly believe there's always going to be a position and presence in the market for independent groups. That being said, what is going to be increasingly important for those groups to maintain their independence is the ability to access low-cost, high-quality back-office services and be able to access, via information technology, the quality metrics, the data analytics that they need to demonstrate their value in the marketplace. If independent groups are determined to stay independent, they absolutely need to be focused on how to best access those capabilities and services.

**RM: In the next five years, where should emergency physicians be looking to maximize their role in the value chain that's emerging?**

**JS:** It comes back to the importance of being able to measure your impact on a patient's health and affect outcomes beyond the episode within the four walls of the emergency room. That could be measured by increased data gathering and quality metrics within the acute episode of care in the emergency room as well as by the ability to reach that patient and the patient's follow-up physicians to affect care as [the patients] return to their homes. ☛



Have you been having thoughts about killing yourself?

What does that have to do with my sprained knee?

# MADNESS, MANDATE, or Misunderstanding

## Universal suicide screening: saving lives or wasting time?

BY SANDRA M. SCHNEIDER, MD, FACEP

In 2013, more than 41,000 individuals died of suicide in the United States, and while that number has been declining, suicide remains the second leading cause of death among teenagers and young adults. It is the tenth leading cause of death for all ages.<sup>1</sup> These deaths often leave family, friends, and health professionals with guilt, searching for missed clues and interventions that might have prevented the untimely, tragic death. Recently, many emergency departments have started screening all patients for suicide risk. This practice is not only unnecessary but may not be successful and places additional burden on emergency staff.

Many emergency department managers and hospital administrators falsely believe The Joint Commission requires screening all emergency patients for suicide risk. In actuality, The Joint Commission National Patient Safety Goal (NPSG)

15.01.01 states, "Identify patients at risk for suicide." The NPSG also includes a note that states, "This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals." The elements of performance for NPSG 15.01.01 are:

1. Conduct a risk assessment that identifies specific individual characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the individual's immediate safety needs and most appropriate setting for treatment.

3. When an individual at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.<sup>2</sup>

The NPSG goes on to clarify in the FAQ section that screening should occur for "any patient who has a primary diagnosis or primary complaint of an emotional or behavioral disorder."<sup>2</sup> The Emergency Nurses Association (ENA) states in its "Clinical Practice Guideline: Suicide Risk Assessment" developed in 2012, "The Joint Commission [NPSG] requires facilities to 'Conduct a risk assessment that identifies specific patient characteristics and

**For the emergency department, 20 percent visited for mental health issues; 35 percent, for other reasons. However, it is not clear that patients who commit suicide would screen positive 12 months earlier during a routine health visit.**

environmental features that may increase or decrease the risk for suicide."<sup>3</sup> That statement may be interpreted to mean that all patients need to be screened for suicide ideation. However, later in that document, the ENA clarifies that screening is only required for patients seeking mental health care. Therefore, there is no requirement to screen all emergency department patients for suicide risk.

One argument for universal screening is the fact that many patients who later commit suicide are seen in the ED in the weeks and months prior to an attempt. In fact, in a recent retrospective study on a large patient

population in the United States, 38 percent of patients who attempted suicide had a health care visit in the week prior to their attempt; 95 percent had a health care encounter in the year prior.<sup>4</sup> Of those visits, primary care and emergency department visits were most common. In a similar study looking at suicide deaths, 80 percent of patients had contact with some type of health care provider within the year prior to their suicide.<sup>5</sup> Again, primary care and emergency visits were most common. Approximately 25 percent visited their primary care provider within that year for mental health issues; 65 percent, for other reasons. For the emergency department, 20 percent visited for mental health issues; 35 percent, for other reasons. However, it is not clear that patients who commit suicide would screen positive 12 months earlier during a routine health visit. The same study also examined visits within the prior four weeks.<sup>5</sup> The percent who visited their primary care provider was 8 percent for mental health issues, 0.7 percent for chemical dependence, and 21 percent for other reasons. In contrast, except for patients with chemical dependency, patients were less likely to visit the ED, with 7.5 percent going to the ED for mental health, 1.4 percent for chemical dependency, and 12.8 percent for other reasons.

While these numbers may give some credence to screening in the ED, it is important to note that patients who commit suicide are more likely to visit primary care providers than the ED. This fact is important since the U.S. Preventive Services Task Force does not recommend screening for suicidality in primary care practices.<sup>6</sup> The data would suggest EDs should not routinely screen for suicidality as well.

Despite the facts, suicide screening is taking place in a number of emergency departments, often done by the triage nurse. Suicide screening tools are embedded in some electronic medical records. There is no "best practice" screening tool. Many use a four-question tool (Are you here because you tried to hurt yourself? In the past week, have you been having thoughts about killing yourself? Have you ever tried to hurt yourself in the past? Has something very stressful happened to you in the past few weeks?).<sup>7</sup> Any single positive answer is considered a positive screen. A recent study of this tool in an emergency department setting demonstrated a very high false-posi-

tive rate, though it did appear to be successful in identifying individuals who had suicidal ideation. Overall, nearly 42 percent of all patients screened positive, but with secondary screening, only 1.5 percent were true positives. Among adolescents, 51 percent screened positive, but only 5 percent were true positives. Although the numbers screened were low, all patients with mental health complaints screened positive, but none of them were determined to be suicidal.<sup>8</sup> Other tools developed since then and currently under development now may have better sensitivity and specificity and may be better accepted by providers.<sup>9</sup>

Screening positive has significant implications for emergency physicians and staff. Should all patients who screen positive be cleared by psychiatry? Should all patients who are discharged receive referral to mental health resources? Should patients who screen positive, particularly those screening positive for more than one question, have 1:1 observation, at least until they can be assessed by the emergency physician? What are the legal implications of sending home patients with positive screens, particularly if they, sometime in the future, attempt or complete a suicide? All of these issues remain unclear.

Mental health treatment is not universally successful. Successful suicides during inpatient mental health treatment are not uncommon. More important, suicide risk is highest in the first few weeks after discharge from a mental health facility. Inpatient treatment it-

self has been questioned. David J. Knesper, MD, of the department of psychiatry at the University of Michigan in Ann Arbor, noted "there is no evidence that psychiatric hospitalization prevents suicide" in the immediate postdischarge period.<sup>10</sup> The stress that led to the patient's decompensation is often still present in the community, with the addition of the stigma of being in a mental health facility.

There is no necessity for universal screening, though screening of "high-risk" populations is a recommendation of The Joint Commission. Current screening tools are imperfect, and referral options for inpatient and outpatient assessment are not able to absorb a large influx of false positives. Treatment, once available, has limitations. Screening is potentially valuable in high-risk patients. Suicide is an important and serious public health problem. We need better screening tools and better

referral systems before universal screening of all patients in the emergency department can be embraced. ☛

## References

1. Suicide facts. Suicide Awareness Voices of Education website. Available at: [www.save.org/index.cfm?fuseaction=home.viewPage&page\\_id=705D5DF4-055B-F1EC-3F66462866FCB4E6](http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=705D5DF4-055B-F1EC-3F66462866FCB4E6). Accessed Oct. 16, 2015.
2. Suicide risk reduction FAQs. The Joint Commission website. Available at: [www.jointcommission.org/standards\\_information/jcfaqdetails.aspx?StandardsFaqlid=166&ProgramId=47](http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqlid=166&ProgramId=47). Accessed Oct. 16, 2015.
3. Brim C, Lindauer C, Halpern J, et al. Clinical practice guideline: suicide risk assessment. Emergency Nurses Association website. Available at: <https://www.ena.org/practice-research/research/CPG/Documents/SuicideRiskAssessmentCPG.pdf>. Accessed Oct. 16, 2015.
4. Ahmedani BK, Stewart C, Simon GE, et al. Racial/ethnic differences in health care visits made before suicide attempt across the United States. *Med Care*. 2015;53:430-435.
5. Ahmedani BK, Simon GE, Stewart C, et al. Health care contacts in the year before suicide death. *J Gen Intern Med*. 2014;29:870-877.
6. LeFevre ML, US Preventive Services Task Force. Screening for suicide risk in adolescents, adults, and older adults in primary care: US Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2014;160:719-726.
7. Davis KN. Detecting suicide risk in adolescents and adults in an emergency department: a pilot study. Illinois Wesleyan University website. Available at: <http://digitalcommons.iwu.edu/jwprc/2004/oral-pres8/2/>. Accessed Oct. 16, 2015.
8. Folse VN, Eich KN, Hall AM, et al. Detecting suicide risk in adolescents and adults in an emergency department: a pilot study. *J Psychosoc Nurs Ment Health Serv*. 2006;44:22-29.
9. Betz ME, Arias SA, Miller M, et al. Change in emergency department providers' beliefs and practices after use of new protocols for suicidal patients. *Psychiatr Serv*. 2015;66:625-631.
10. Knesper DJ, American Association of Suicidology, Suicide Prevention Resource Center. *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or a psychiatry inpatient unit*. 2010. Newton, MA: Education Development Center, Inc.

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# TOUGH Conversations

Resources for discussing a suicide attempt in the family with children | BY MELISSA MCHARG

**T**he Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC), located at the Denver and Salt Lake City Veterans Affairs medical centers, offers clinicians and communities educational resources to help navigate the rare but critical instances when a person with suicidal ideation or behavior arrives at the emergency department for care. A small working group in MIRECC's education core, led by Douglas Gray, MD, a child and adolescent psychiatrist, created the "How to Talk to a Child About a Suicide Attempt in Your Family" booklet and video (available online at [www.mirecc.va.gov/visn19/talk2kids/index.asp](http://www.mirecc.va.gov/visn19/talk2kids/index.asp)). The group aims to arm emergency medical personnel with professionally developed resources to support suicidal patients and their families.

This educational resource was developed to support parents or caregivers who have recently experienced a suicide attempt by a family member and for professionals who provide crisis and immediate follow-up care for suicidal individuals. While the first priority in a mental health emergency is to stabilize and ensure patient safety, suicidal individuals and their family members also have critical needs for immediate follow-up care.

When faced with this situation, providers must manage multiple challenges such as limited staff time and resources while balancing these realities with the need to address patient and family needs and concerns. A large-scale survey conducted via the National Alliance on Mental Illness highlighted specific areas where family needs could be best met by emergency departments, including communicating better about discharge planning and providing written materials and information on other support resources.<sup>1</sup> A Suicide Prevention Resource Center publication also focused on patient follow-up needs subsequent to a suicide attempt and dis-



The "How to Talk to a Child About a Suicide Attempt in Your Family" booklet and video can help emergency physicians with tough conversations with families in the ED.

charge from ED.<sup>2</sup> Among the recommendations for better continuity of care were positive family involvement and caring emergency physician-patient interactions.

The "How to Talk to a Child" booklet and video supply emergency physicians with a readily available resource that helps meet the most common needs expressed by family members. The booklet and video are available in Spanish and English and may be downloaded or ordered at no cost. The booklet features a full-color visual presentation that focuses on tools for speaking with three developmental groups (preschool, school age, and teenager), with tips for responding to concerns and challenges unique to each group.

## THE BOOKLET:

- Offers tips for parents/caregivers on introducing concepts related to depression, hopelessness, self-directed violence, and suicidality
- Builds understanding of why it is important to speak to children about difficult and traumatic topics, what to share, how much to share, and when

- Addresses mental illness and potentially co-occurring conditions such as substance use
- Promotes elements of resiliency and building resilient coping skills in children and families
- Familiarizes parents/caregivers with developmental concepts that increase their capacity to recognize behaviors that may follow traumatic events, with suggestions for how to support each developmental stage following such an event
- Provides information on recognizing signs of emotional or mental distress that may necessitate intervention by a mental health professional

## THE VIDEO OFFERS THE BENEFITS ABOVE, PLUS:

- Visual demonstration of principles in motion, with professional actors as well as graphic presentations of key approaches and takeaway concepts
- Illustration of how a suicide-related conversation might unfold, showing how open-ended inquiries and responsiveness to children's individual concerns guide the course of the interaction

For more information about the Rocky Mountain MIRECC mission and to learn more about other educational resources available to clinicians, visit [www.mirecc.va.gov/visn19](http://www.mirecc.va.gov/visn19). ☛

## References

1. Cerel J, Currier GW, Conwell Y. Consumer and family experiences in the emergency department following a suicide attempt. *J Psychiatr Pract*. 2006;12:341-347.
2. Knesper DJ, American Association of Suicidology, Suicide Prevention Resource Center. *Continuity of Care for Suicide Prevention and Research*. Newton, MA: Education Development Center, Inc. 2010.

**MELISSA MCHARG** is a program specialist at Rocky Mountain MIRECC.

# A Convener of Emergency Medicine

## President **Dr. Barry Heller** on the ABEM's role as a supportive hub for the emergency medicine community

*The American Board of Emergency Medicine's (ABEM) improvements to its Maintenance of Certification (MOC) program may not grab national headlines, but the board has taken a methodical and diplomate-focused approach to the evolution of MOC, spearheaded by leaders who are also active members of the field of emergency medicine.*

*ABEM President Barry N. Heller, MD, a practicing emergency physician and assistant clinical professor of medicine at UCLA David Geffen School of Medicine, brings a passion for the specialty to his work at the organization. Elected President in August, Dr. Heller is no stranger to the ABEM. He has been a member of the Board of Directors since July 2008 and has served on the Executive Committee since 2012.*

*He recently shared with ACEP Now his objectives for his presidency and his vision for the future of the organization.*

### What are your goals during your term as ABEM President?

**Dr. Heller:** First and foremost, I want to continue ABEM's commitment to delivering the best possible physician assessment for initial and continuous certification. ABEM multiple-choice question examinations focus on complex cognitive skills such as clinical synthesis and diagnostic processing, not purely fact recall. This emphasis carries over into the design of the In-training Examination and the ConCert (Continuous Certification) Examination. After nearly a decade of development and the commitment of substantial financial resources, ABEM recently introduced the Enhanced Oral Certification Examination (eOral) format. The eOral format creates a more authentic experience to the current oral examination. The amount of effort the ABEM Board, its hundreds of volunteers, and ABEM staff have expended on this project has been herculean. The psychometric rigor of the process and the enthusiasm with which the eOral format has been received have been very encouraging.

I also want to explore ways to increase the value of ABEM's MOC program to our diplomates. When you examine the cost and time commitment emergency physicians spend in MOC, it's fairly modest. The annualized cost of MOC is \$265, which is about \$5 per week. ABEM has kept the cost of the Lifelong Learning and Self-Assessment (LLSA) activity fixed for the past four years and the ConCert Examination unchanged for the past three years. ABEM's participation in the Physician Quality Reporting System (PQRS) MOC bonus program through the Centers for Medicare & Medicaid Services added nearly \$4 million in available revenue for emergency physicians. ABEM also provides low-cost CME opportunities with the LLSA through ACEP and the American Academy of Emergency Medicine (AAEM). All of the revenue from the CME activity goes to ACEP and AAEM as the accredited CME providers.

I recognize that the MOC program is not perfect. We, the ABEM Board of Directors, are continually looking for ways to improve the value, relevance, cost, and meaning to our diplomates. As one prong of this approach, we are watchful of changes made by other boards to their MOC programs. For example, we are closely watching how the American Board of Anesthesiology is changing from an every-10-year exam to weekly online quizzes. If this pilot is successful, we could see how this approach might be applied in the ABEM MOC program.

"I also want to explore ways to increase the value of ABEM's MOC program to our diplomates. When you examine the cost and time commitment emergency physicians spend in MOC, it's fairly modest."



Dr. Heller speaking at ACEP15 in Boston.

### What is your vision for ABEM, especially as it impacts other organizations?

**BH:** There are so many challenges facing the specialty and plaguing emergency physicians. I believe that our specialty is made stronger by working in collaboration with the various membership organizations serving our specialty. We all need to find ways to work in harmony with one another and not waste time bickering over differences. When that happens, we lose, the specialty loses, and ultimately, our patients do not get the best that our specialty has to offer. ABEM can serve as a convener of the emergency medicine community, much as we have done with the EM Model Task Force. More recently, we brought together every key EM organization for an MOC summit to explore ways of improving the program and had a similar summit on the issue of board eligibility last fall.

ABEM works to promote its mission to ensure the highest standards in emergency medicine. It has been energizing to collaborate with so many organizations in emergency medicine. For example, ABEM appreciates the opportunity to work with ACEP on the development of clinical quality measures that are relevant and are aligned with the ABEM MOC program. The potential for working with ACEP to participate in the Clinical Emergency Data Registry in order to reduce the reporting requirements for Part IV Practice Improvement activities is quite exciting. If we can build the appropriate interface, reviewing and reacting to one's clinical performance reports would automatically be reported to the ABEM MOC program. This would obviate the need for a separate attestation and aligns with ABEM's desire to lessen the burden of MOC reporting for our diplomates.

### What initially drew you to the specialty of emergency medicine and ABEM, in particular?

**BH:** I was lucky enough to have been in a traditional rotating internship, with one month in obstetrics, neurosurgery, emergency medicine, and so on. I say I was lucky because I think the loss of opportunities to see all these different disciplines significantly complicates the decision to choose a specialty in today's environment. After several months working on different services, I came to the emergency department, and I was amazed at how much I enjoyed the many aspects of emergency medicine that make it so attractive to all of

us. Furthermore, the role models I encountered in the ED, people such as Bob Rothstein, MD, our first emergency department chair [at Harbor-UCLA Medical Center in Torrance, California], made an even bigger impression and convinced me that this specialty was the best match for me.

My initial impression of ABEM was when I took the oral exam; it was a remarkable examination. I was impressed with the sophistication of the examination structure as well as the logistics of its administration. It was clear to me that ABEM was focused on quality, and I wanted to learn more about the Board. I also wanted to give something back to the specialty that had served me so well. I had two great mentors who encouraged me, Howard Bessen, MD, and Bob Hockberger, MD. They are two great leaders in our field, and both served on the ABEM Board of Directors. My connection with ABEM started in earnest when I became an oral examiner. Advancing through the organization has been a professionally rewarding experience.

### Where do you see ABEM heading?

**BH:** As medicine changes, especially in the area of physician quality reporting, ABEM needs to create a relevant, sensible way to help physicians stay current and to assure the public that emergency physicians are doing so. One attribute that I bring to ABEM is the perspective of the community physician. I've been clinically active at the same community hospital for 32 years. ABEM has over 32,000 diplomates, and most of them do not work in a residency program. It is important to remember the challenges that all of our diplomates face in trying to deliver the best care possible and demonstrating their continuing competency and commitment to improvement.

I see ABEM continuing its refinement as the gold standard in certification and applying best practices to every type of physician assessment. The transition from an episodic physician testing organization to one of continuous physician assessment will be ongoing. The most important goal for ABEM is to be true to our mission statement: to ensure the highest standards in the specialty of emergency medicine. I also hope that we can continue to improve our specialty so that, in addition to being the best in our field, we can always end our shifts with the feeling that we have done something useful. By listening to physicians and creating better links with the tremendous organizations supporting our specialty, I think we can achieve our mission. 🧠



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# Bending the Curve

Opportunities to reduce boarding time that will improve the care and service of all emergency patients



by JAMES J. AUGUSTINE, MD, FACEP

A few years ago, emergency department leaders were given a valuable gift. The Joint Commission and then the Centers for Medicare & Medicaid Services (CMS) identified hospitals reducing the boarding of admitted patients as a priority for safety and quality of care. This was an opportunity to bend the curve on the amount of time patients spent in the ED, a curve that had been on an upward trajectory for years in many hospitals. This time interval, referred to in the ED literature as “boarding time,” requires management by ED leaders and hospital administrators. Both groups promoted measures with The Joint Commission that reduced boarding time. They wrote standards that emphasized the importance of ED flow to minimize ED boarding.

Then in 2011, CMS published a set of performance measures that highlighted the ED. “ED-1, Admit Decision Time to ED Departure Time for Admitted Patients” was an important measure. The CMS defined the measure in a positive fashion: median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. The rationale for this measure was the opportunity for emergency physicians to influence behavior by hospital administration and the admitting medical staff of the hospital. As the measure states, “Reducing the time patients remain in the emergency department can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment.”

The measure was implemented in 2012 and was subject to public reporting in 2013. The simple definition and explanatory language became a very complicated process for many hospitals. The challenge was to define “admit decision time.” The Emergency Department Benchmarking Alliance (EDBA) asked its 1,100 ED leaders to describe the time marker that had been implemented in their hospital. The reported definitions included actions by the ED clerk (placing a bed order), the ED charge nurse (contacting the bed coordinator), the admitting physician (writing an admission order), and the emergency physician (changing status to admitted in the ED information system). From the hundreds of answers to this question, it was apparent that there were wide variations in the definition of this time stamp.

The EDBA initiated collection of the performance measure in 2012. Unlike CMS, which reports all EDs as one group, the EDBA reports the measure by cohorts. The median

ED boarding times for the years 2012, 2013, and 2014 are summarized in Table 1. Reporting the data by cohort gives ED leaders a much more precise comparison based on ED volume and patient population served. The highest number is found in adult EDs and those EDs seeing between 80,000 and 100,000 patients per year. These EDs have boarding times of around 160 minutes. The low-volume EDs, seeing fewer than 20,000 patients, have boarding times that average 65 minutes, nearly a 100-minute difference. The boarding time median of 119 minutes in 2012 has been decreased to 112 minutes in 2014.

But in many EDs, and in particular those in the 20,000 to 60,000 cohorts, the boarding time has actually increased over the three years measured. There is clearly an opportunity gifted from CMS and The Joint Commission to allow ED leaders the traction needed to negotiate better hospital flow for admitted patients. More ED physicians and nurses need to engage in the efficient processing of patients needing inpatient services. In most hospitals, this will primarily be focused on patients being admitted to the same hospital, which on average is 17 percent of overall ED volume. But processes will also facilitate the movement of patients to admission units of other hospitals when transfers are necessary, which is about 2 percent of patients in the average ED.

Boarding of inpatients in the ED leads to crowded conditions, lack of patient care areas, insufficient staff to process all ED arrivals, and then a deadly cascade. The cascade will typically include prolonged patient waiting times, increased suffering for those waiting for service, unpleasant treatment environments, ambulance diversion, and poor patient outcomes. The cascade then leads to

## ADDITIONAL READING

- Wiler JL, Welch S, Pines J, et al. Emergency department performance measures update. *Acad Emerg Med.* 2015;22:542-553.
- Rosenau AM, Augustine JJ, Jones S, et al. The growing evidence of the value of emergency care. *Acad Emerg Med.* 2015;22:224-226.



dissatisfied ED staff, frustration, and turnover at all levels. Overwhelmed EDs also lack the capacity to respond to community emergencies and disasters.

The timely processing of patients who are admitted to the hospital or transferred for admission to another hospital improves the overall flow rate of all ED patients. This leads to a culture of timeliness and satisfaction for all patients who arrive for ED service and reduces walkaway rates.

Where have EDs had success in improving admission flow? Primary work is done outside of the ED, with the global recognition that reduced boarding times are associated with reduced overall hospital length of stay, improved quality of care, and closer adherence to established hospital pathways. ED nursing

leadership needs to focus its efforts on the nursing administration to link rapid flow of inpatients to nursing incentives. These may be financial (credit for nurse worked hours going to the inpatient unit rather than the ED), communication enhancement (timesaving patient turnover methods from ED to inpatient nurses), and/or recognition (award programs for competing nursing units).

On the physician side, most EDs now admit the majority of patients to hospitalists or group practices, including resident teams. The emergency physicians have the opportunity to negotiate with those services regarding the elements of improved patient service and pathway compliance. Many admitting physicians want a patient to be completely “worked up” by the time that patient will reach the floor and have the most important therapies started. The emergency physician can offer those elements if the admitting service will provide a timely response to emergency physician calls, a rapid concordance on the need for admission, and the timely delivery of an “order to admit.” The emergency physician also needs to facilitate the work of the admitting physician with an organized and complete history and physical exam on the patient record and transition-of-care communication that is clear and concise.

The work of the emergency physicians and nurses together will lead to a process of effective care and communications and then reduce blocking behaviors by staff in the admitting areas of the hospital.

There are a growing number of sources to use for best practices in the admission process. It is the opportunity to use them to bend the curve of boarding time that will improve the care and service of all ED patients. ➔

**Table 1. Boarding Time in the EDBA Data Survey Through 2014**

ED TYPE	ED BOARDING TIME, MEDIAN MINUTES, 2012	ED BOARDING TIME, MEDIAN MINUTES, 2013	ED BOARDING TIME, MEDIAN MINUTES, 2014
<b>All EDs (N=1,105)</b>	<b>119</b>	<b>115</b>	<b>112</b>
Under 20K	83	73	65
20-40K	80	101	96
40-60K	122	128	124
60-80K	144	131	128
80-100K	161	153	168
Over 100K	161	174	149
Pediatric EDs	97	96	98
Adult EDs	175	161	154

# How to Perform Ultrasound-Guided Subclavian Vein Cannulation

## Part 1: The supraclavicular approach

With the supraclavicular approach, the SCV is often shallow and easily visualized as compared to the infraclavicular approach, making for an ideal site for central venous cannulation.

by CHARMIANE LIEU, MD, GERIN RIVER, MD, DANIEL MANTUANI, MPH, MD, AND ARUN NAGDEV, MD

Central venous catheter placement is an essential procedure in emergency medicine, with the internal jugular vein (IJV) the most commonly accessed site. However, in certain situations such as abnormal neck anatomy, presence of a cervical collar, IJV thrombosis, or active cardiopulmonary resuscitation, the subclavian vein (SCV) may be a better option.<sup>1,2</sup> Also, because of the SCV's fixed position under the clavicle, size variations are less common (unlike the often collapsed IJV noted in patients with severe dehydration or sepsis). Cannulation of the SCV may also improve patient comfort while reducing rates of infection and thrombosis when compared to the IJV and femoral vein.<sup>3,4</sup>

Classically, landmark-based SCV cannulation is performed below the clavicle. In contrast, ultrasound guidance allows cannulation to occur both via the infraclavicular (at the junction of the axillary vein and SCV) and supraclavicular (where the SCV meets the IJV to form the brachiocephalic vein) approaches. When compared to landmark techniques, ultrasound guidance reduces the rates of arterial puncture, pneumothorax, brachial plexus injury, and hematoma formation.<sup>5-8</sup> With the supraclavicular approach, the SCV is often shallow and easily visualized as compared to the infraclavicular approach, making for an ideal site for central venous cannulation.<sup>9,10</sup>

Our two-part series will discuss both the supraclavicular and infraclavicular approaches to ultrasound-guided SCV cannulation. Before attempting either of these more challenging ultrasound-guided SCV cannulations, we recommend novice sonographers obtain comfort with both the ultrasound-guided IJV

or femoral vein cannulation as well as attain proficiency with in-plane needling technique.

### Anatomy

The SCV runs from lateral to medial under the clavicle, just anterior to the subclavian artery (SCA). As it approaches the heart, the SCV is joined by the IJV, forming the brachiocephalic vein. The supraclavicular approach attempts to cannulate the portion of the SCV just lateral to the clavicular head of the sternocleidomastoid muscle.<sup>8</sup> The right SCV is preferred to the left since it forms a straighter angle with the IJV, offering a shorter distance for wire passage into the superior vena cava, avoiding proximity to the thoracic duct, which drains into the left SCV (see Figure 1).

### Procedure

#### Set Up

As with all central venous access, standard sterile technique should be followed to minimize infection (sterile ultrasound probe cover and gel, drapes, etc.). Place the patient in a supine position and the ultrasound machine contralateral to the patient (eg, left side of the patient for right SCV cannulation) to allow for visualization of the screen and needle in a similar line of sight (see Figure 2).

#### Survey Scan

Place a high-frequency linear transducer (eg, 13–6 MHz) on the lateral neck just above the clavicle to locate the IJV and carotid artery (see

### POTENTIAL PITFALLS

- This approach may be more difficult in patients with higher BMI or short necks since it's more difficult to probe and needle into the supraclavicular notch.
- Always clearly visualize the needle tip with the in-plane technique and remember that the SCV is anterior to the SCA.
- For more advanced sonographers, color Doppler can be used to discern between SCV and SCA.

Figure 3A). Slowly trace the IJV caudally (toward the chest) into the supraclavicular fossa until the probe abuts the clavicle (see Figure 3B). While visualizing the most proximal/caudal aspect of the IJV, angle the probe anteriorly to visualize the confluence of the IJV and SCV (see Figure 4). At this proximal location, the SCV lies anterior to the SCA, and the operator should dynamically fan the probe from a posterior to anterior position to identify both vessels.

A clear view of the often shallow and large SCV can make for a relatively simple access site. Unfortunately, variation in vascular anatomy always exists, and in some patients, clear SCV visualization can be difficult.

#### Ultrasound-Guided SCV Cannulation

After clear ultrasonographic visualization of the SCV is obtained, place a small skin wheal just lateral to the ultrasound transducer. Un-

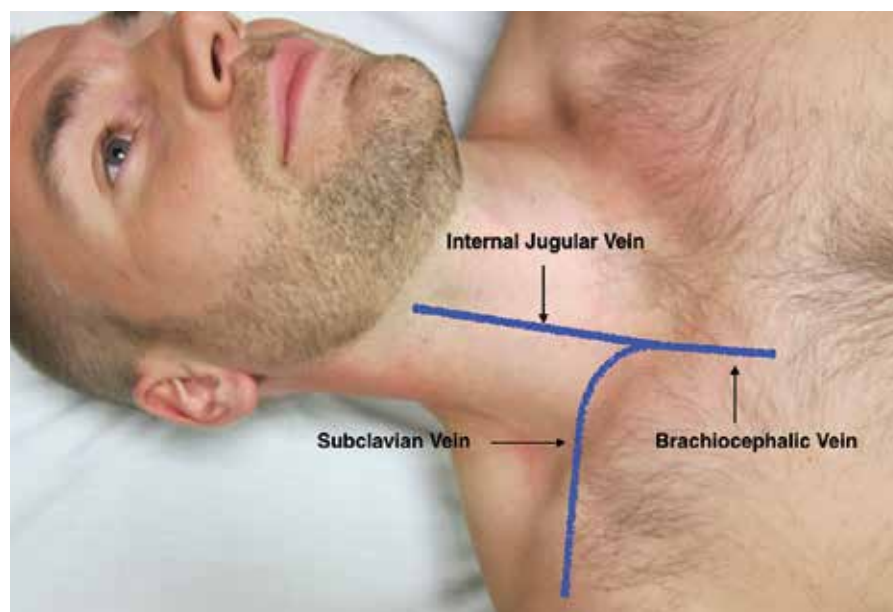


Figure 1. Surface anatomy of the right subclavian vein (SCV). Note the confluence of the SCV and internal jugular vein (IJV) to form the brachiocephalic vein.



Figure 2. For a right SCV cannulation, the operator has placed the ultrasound system on the contralateral side. This ergonomic position allows for direct view of the ultrasound screen and site of needle entry without change in visual axis.

Figure 3.

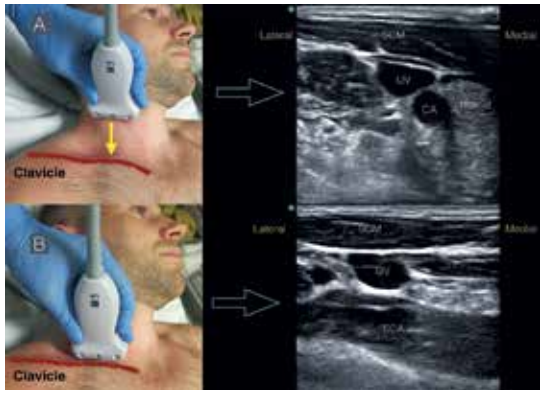


Figure 4.

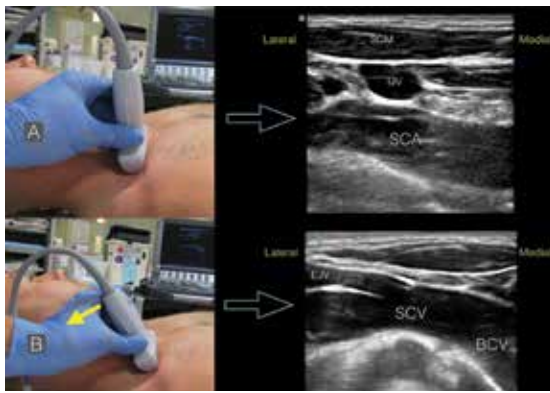


Figure 5.



**Figure 3.** (A) In a transverse plane on the neck, locate the thyroid, IJV, and carotid artery (CA) deep to the sternocleidomastoid (SCM) muscle. (B) Slide the transducer down the IJV into the supraclavicular fossa until the subclavian artery (SCA) is noted.

**Figure 4.** Angle the probe anteriorly (solid yellow arrow) to visualize the SCV as it joins the brachiocephalic vein (BCV). The external jugular vein (EJV) may be seen joining the SCV at this location.

**Figure 5.** An in-plane technique will be used with the needle entering the skin just lateral to the ultrasound transducer. The operator should use the nondominant hand to stabilize the transducer on the patient's neck. SCV; IJV; BCV.

like the classic ultrasound-guided IJV cannulation, SCV cannulation will require the use of in-plane technique (see Figure 5).

Enter the skin just lateral to the transducer at an angle that will intersect the SCV at the desired location (this angle will depend on patient body habitus and probe size). Slowly advance the needle under ultrasound guidance, gently aspirating the syringe for flashback and ensuring that the needle tip is clearly visualized as it transverses soft tissue

and finally enters the SCV. Confirmation of venous access is performed in a similar manner to other central venous cannulation sites (checking for non-pulsatile dark blood, ultrasound-guided visualization of the guidewire, etc.). A postprocedure chest radiograph will determine the location of the catheter tip and identify most pneumothoraces.

### Summary

The supraclavicular approach to ultrasound-guided

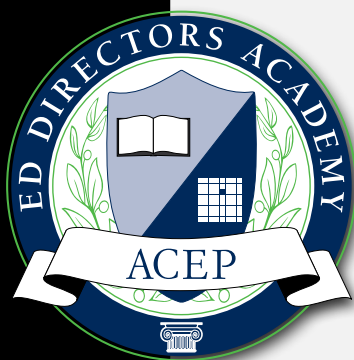
SCV cannulation may be ideal in certain scenarios and safer than the landmark-based SCV central line placement.<sup>2,3,11</sup> We recommend this access site as an alternative for providers comfortable in procedures requiring in-plane needle visualization. Using a pragmatic ultrasound-based approach to central venous cannulation that relies on visualized patient anatomy, operator skill, and the clinical scenario allows emergency physicians to become adept at an often challenging aspect of emergency care. ☺

### References

- Mallin M, Louis H, Madsen T. A novel technique for ultrasound-guided supraclavicular subclavian cannulation. *Am J Emerg Med*. 2010;28:966-969.
- Gorchynski J, Everett WW, Pentheroudakis E. A modified approach to supraclavicular subclavian vein catheter placement: the pocket approach. *Cal J Emerg Med*. 2004;3:50-54.
- Ouriel K. Preventing complications of central venous catheterization. *N Engl J Med*. 2003;348:2684-2686; author reply 2684-2686.
- O'Grady NP, Alexander M, Burns LA, et al. Healthcare Infection Control Practices Advisory Committee (HICPAC): guidelines for the prevention of intravascular catheter-related infections. *Clin Infect Dis*. 2011;52:e162-e193.
- Brass P, Hellmich M, Kolodziej L, et al. Ultrasound guidance versus anatomical landmarks for subclavian or femoral vein catheterization. *Cochrane Database Syst Rev*. 2015;1:CD011447.
- Fragou M, Gravvanis A, Dimitriou V, et al. Real-time ultrasound-guided subclavian vein cannulation versus the landmark method in critical care patients: a prospective randomized study. *Critical Care Med*. 2011;39:1607-1612.
- Lalu MM, Fayad A, Ahmed O, et al. Ultrasound-guided subclavian vein catheterization: a systematic review and meta-analysis. *Crit Care Med*. 2015;43:1498-1507.
- Patrick SP, Tijunelis M, Johnson S, et al. Supraclavicular subclavian vein catheterization: the forgotten central line. *West J Emerg Med*. 2009;10:110-114.
- Gualtieri E, Deppe SA, Sipperly ME, et al. Subclavian venous catheterization: greater success rate for less experienced operators using ultrasound guidance. *Crit Care Med*. 1995;23:692-697.
- Stachura MR, Socransky SJ, Wiss R, et al. A comparison of the supraclavicular and infraclavicular views for imaging the subclavian vein with ultrasound. *Am J Emerg Med*. 2014;32:905-908.
- Parietti J, Mongardon N, Mégarbane B, et al. Intravascular complications of central venous catheterization by insertion site. *N Engl J Med*. 2015;373:1220-1229.



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# Avoiding the Hedonic Treadmill

Steps toward saving may be tough, but you'll thank yourself in the long run

by JAMES M. DAHLE, MD, FACEP

**Q.** *I know you have recommended that attending physicians should be putting about 20 percent of their gross income toward retirement. My spouse and I have found this to be very difficult, both early on and now that we're in our mid careers. I am a bit embarrassed to say this, but I don't see how we could spend much less than we currently do without a dramatic change in our lifestyle. What should we do?*

**A.** Just as the time required to perform a chore seems to expand into the time available, so does our spending naturally expand until it consumes our entire income. For most people, it requires a conscious and sometimes difficult effort to avoid this process. It is also a truism of personal finance that decreasing spending is far more psychologically painful than increasing spending is pleasurable. To make matters worse, many of us find ourselves on the "hedonic treadmill," also known as "hedonic adaptation." As you make more money, your expectations and desires rise in tandem, resulting in no permanent gain in happiness. Thus, you work harder and harder, spending more and more, and then find you are no happier making and spending \$500,000 a year than you were making and spending \$100,000 a year. To make matters worse, the increasingly progressive tax burden on that additional income can further destabilize your finances.

Since you can always spend your entire income and then some, the secret to financial independence always lies primarily on the spending side of the equation. As a rule of thumb, financial independence means you have a level of assets that is approximately 25 times your annual spending requirements. The less you spend, the sooner you will become financially independent and the less you will have to save to reach that point, which also means you will need to take less risk with your investments. The easiest way to avoid the hedonic treadmill is to never get on it in the first place. However, for most of us, a conscious effort is required to get off the treadmill or at least limit its effects on our financial lives.

Financial literacy can pay great dividends in this respect. If you have never heard of hedonic adaptation, chances are that you are already on the treadmill. Recognizing this completely natural tendency goes a long way

SAVINGS RATE	YEARS TO FINANCIAL INDEPENDENCE
0%	Infinite
5%	65
10%	50
15%	42
20%	36
30%	27
40%	21
50%	16
60%	12
70%	8
80%	5
90%	3
100%	0

toward fighting it. Understanding the consequences of a low savings rate (ie, out-of-control spending) is also helpful. Saving more money each year not only increases the size of your nest egg, it also reduces the size of the nest egg required to maintain the same lifestyle in retirement. The math behind financial independence is surprisingly simple. You can make a chart with a 0 percent savings rate at one end and a 100 percent savings rate at the other. Then using some simple basic assumptions (ie, 5 percent real investment return and a 4 percent real withdrawal rate) and ignoring the effects of pensions and Social Security, you can determine how long you need to work for any given savings rate.

For example, if you make \$200,000 per year and save 50 percent of your income, then you only need your investments to provide \$100,000 in income, and you can reach that point after about 16 years. But if you only save 10 percent of your income, then you need your investments to provide \$180,000 of income, and it will require 50 years to reach that point. Obviously everyone's financial situation differs, and if someone inherits significant assets early in life, then they have the potential to become financially independent much earlier. But whether you start saving and investing at age 20 or 40, it still takes just as long to reach financial independence, and that amount of time is most dependent on your savings rate.

Now, this chart overstates the case quite a bit, as most retirees will not only have some Social Security but also naturally spend much less in retirement than they

did earlier in life as mortgages are paid off, tax burdens decrease, children leave home and finish their educations, work-related expenses disappear, and the need for life and disability insurance is eliminated. And obviously if you work and save until you're 80, you probably won't need your portfolio to last as long as an early retiree will. But the point of the chart remains the same—increased savings simultaneously increase portfolio size and decrease the need for income from the portfolio.

There are some practical steps that can be taken in order to get off the hedonic treadmill. Everyone has heard about how important it is to live on a budget. What they don't tell you, however, is that living on a budget is really a temporary process. A budget is a training tool, and once you've trained yourself to spend at a sensible level, you can actually quit the physical act of budgeting. Most financially successful people can generally get to that point with a few months or years of careful budgeting. Track your spending by initially writing down every dollar you spend, then make sure you are actually spending your money in accordance with your values. For example, if you find you value vacations with your children and having a nice home the most but discover you are spending a large percentage of your money on education, eating out, and auto payments, then you need to realign your spending with your values. As a typical physician, you can generally buy anything you want but not everything you want. Spend your money on what makes you the happiest.

Some people find it easiest to boost their savings rate by "saving their raises." Every time their income goes up, they simply keep spending the same way they did on a lower income. This technique, however, does not work as well for most emergency physicians, who generally reach peak earnings relatively early in their career.

Studies have shown that spending cash is psychologically more painful than using a debit card, which, in turn, is more painful than using a credit card. This behavioral tendency, combined with the convenience of cards, means that we generally spend more when using credit cards. So if you aren't saving as much as you would like, consider going to a cash-spending plan. Psychological studies also show that our willpower is limited. We are only able to deny ourselves so many times before giving in. However, it turns out it takes the same amount of willpower to decide not to buy a BMW as to avoid buying a latte. Use your limited willpower where you can get the most bang for your buck—on the big-ticket items.

Recognizing the behavioral pitfalls that lead to out-of-control spending can help keep you off the hedonic treadmill. Practicing emergency medicine is far more enjoyable when you do not have to do it for financial reasons. ☺



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# TRICKS OF THE TRADE



**DR. MCGOVERN** is an emergency medicine resident at St. Joseph's Regional Medical Center in Paterson, New Jersey.



**DR. JUSTIN MCNAMEE** is an attending physician at Emergency Medicine Professionals in Ormond Beach, Florida.

Any pain on extension or extension lag at the proximal interphalangeal joint on presentation to the ED should raise your suspicion for potential central slip rupture.

## A BACKHANDED APPROACH TO TENDON LACERATIONS | CONTINUED FROM PAGE 1

proper treatment is reason enough to have a low threshold to treat these patients for a tendon injury if there is any doubt in your mind. Even a small discrepancy in your exam may indicate a partial tendon laceration that can progress to a complete laceration if not treated appropriately. Kleinert and Verdan developed a classification system for extensor tendon lacerations that divides the dorsal part of the hand into eight different zones (see Figure 1).<sup>3</sup> This classification system is used below as a reference point to provide emergency physicians guidance in treating their next extensor tendon injury.

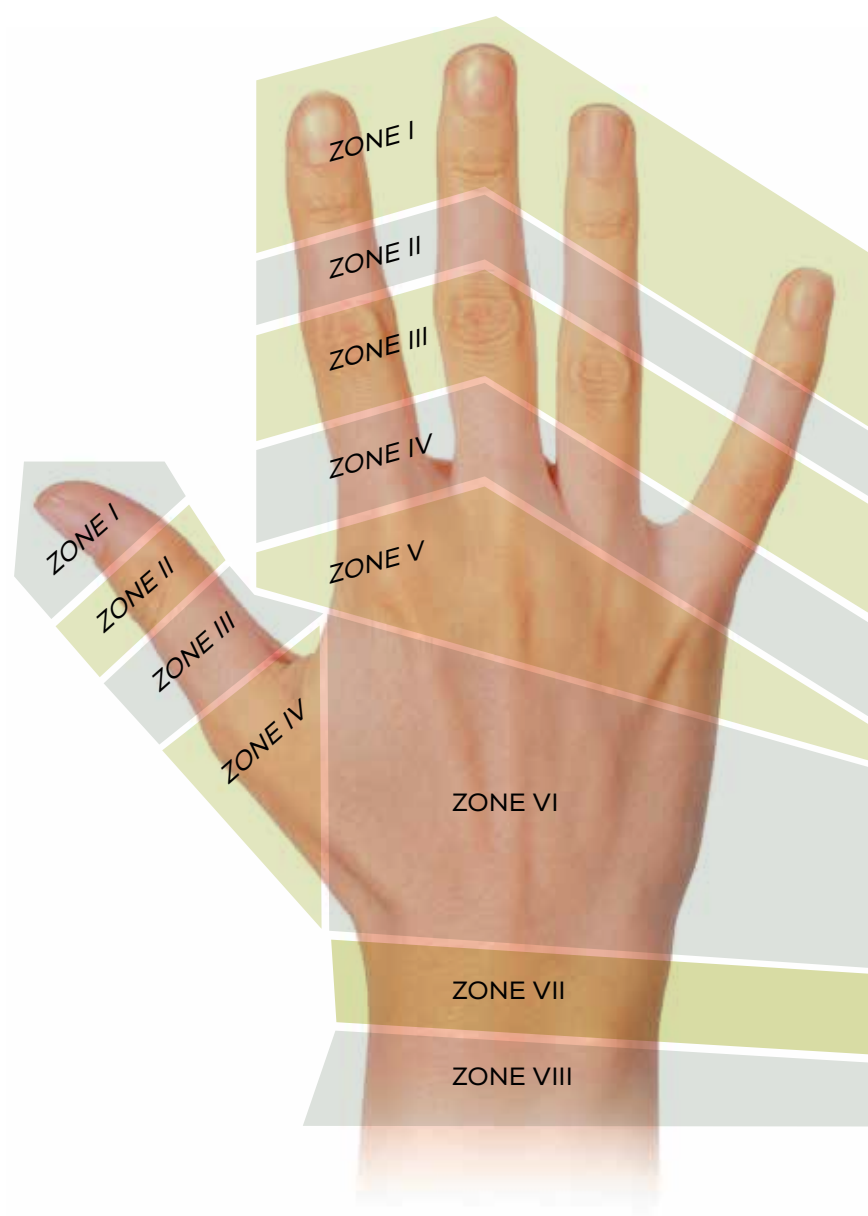
### Extensor Tendon Injuries and Lacerations

**Zone I:** This zone encompasses the distal interphalangeal (DIP) joint and the remaining part of the finger distal to the joint. Most commonly, these injuries are closed and require immobilization in hyperextension of the DIP for six to eight weeks and outpatient follow-up with the hand surgeon.<sup>4</sup> Besides outpatient follow-up with a hand surgeon, patients are truly responsible for how well these injuries will heal because it's been shown that compliance with the splint is the biggest factor affecting successful treatment.<sup>5</sup> For open injuries, hand surgeons use another classification method where zone I is split up into four different types.<sup>2</sup> For our purposes, we will focus on open injuries with an associated tendon injury that you have identified on exam. If the injury results in physical loss of part of the tendon or significant avulsion of the skin, the surgeon will likely need to take the patient to the operating room for a possible graft, and we should cover them with antibiotics in the ED. However, if there is only loss of tendon continuity, we can suture the tendon back together, splint only the DIP in mild hyperextension, and have the patient follow up as an outpatient with the hand surgeon.<sup>6</sup> For these tendon laceration repairs, you may want to use a roll stitch, or dermatotendodesis, that incorporates both the overlying skin and tendon using 4-0 or 5-0 nonabsorbable sutures as detailed in Figure 2.

**Zone II:** This zone consists of the middle phalanx, and closed injuries can be placed in an extension splint for three to four weeks if there is only minimal weakness on extension. However, significant extensor lag will need to be explored by a hand surgeon on an outpatient basis.<sup>8</sup> Open tendon lacerations overlying the middle phalanx can be repaired primarily in the ED using a roll stitch as described above in zone I, splinting the DIP in extension with outpatient follow-up with the hand surgeon.

**Zone III:** The most well-known closed injury of zone III is perhaps rupture of the central slip, which results in the commonly tested Boutonniere deformity typically two to three weeks after the injury. Any pain on extension or extension lag at the proximal interphalangeal (PIP) joint on presentation to the

Figure 1. Extensor injury zones.<sup>3</sup>



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ED should raise your suspicion for potential central slip rupture. These patients should be placed in a dorsal or volar splint that keeps the PIP in extension while allowing for full range of motion of the DIP.<sup>9</sup> The complexity of the extensor mechanism surrounding the PIP requires the training of an orthopedic surgeon for repair of open lacerations of the tendon. For an extensor tendon laceration identified within the ED, we can suture the overlying laceration, splint the wrist in 30°

of extension, the metacarpophalangeal joint (MCP) in 15° of flexion, and the PIP in the neutral position with outpatient follow-up with a hand surgeon.<sup>10</sup>

**Zone IV:** Once you start to enter zone IV, the tendons become larger and easier to repair. Fortunately, there are not many instances of closed tendon injuries from zone IV and the more proximal zones. For tendon lacerations that are greater than 50 percent of the tendon, we can repair the tendon with the modified Kessler technique detailed below in the suturing technique section.<sup>8</sup> Similar to zone III injuries, these should also be splinted in a volar splint and should follow up with the hand surgeon on an outpatient basis.<sup>10</sup>

**Zone V:** This zone is where we frequently encounter the “fight bites” that patients don’t always willingly admit. With the high possibility of subsequent complications, any open injury in this region should be treated as a fight bite until proven otherwise. After extensive irrigation of the wound, we can suture the tendon if possible. However, leave the skin open for hand surgeons to do a delayed closure in their office. This is in addition to

CONTINUED on page 14

Figure 2. Roll stitch for extensor tendon laceration repair in zones I and II.<sup>7</sup>



REPRINTED WITH PERMISSION FROM J. EMERG MED. 1986;4:217-226.

## Using the modified Bunnell technique and 4-0 nonabsorbable sutures, we can repair these lacerations in the ED. Patients can then be splinted (wrist in 30° of extension, MCP neutral, DIP and PIP joints free) and follow up with a hand surgeon.

placing a splint (wrist in 45° of extension, MCP in 20° of flexion) and starting patients on prophylactic antibiotics, such as Augmentin.<sup>5</sup> If patients aren't going to see the hand surgeon the next day, it may be prudent to have them come back to the ED for a wound check in the next 24 hours.

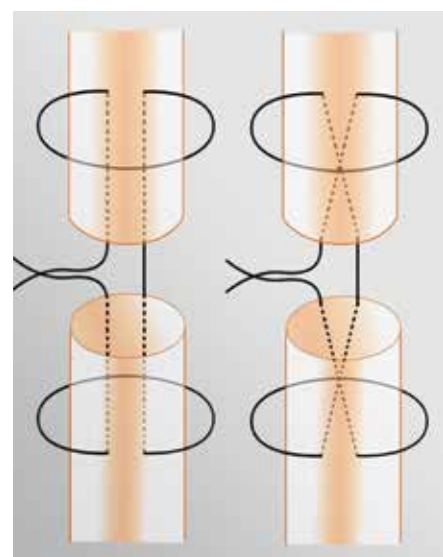
**Zone VI:** This zone encompasses the majority of the dorsum of the hand. The broad, well-defined tendons in this area make it, arguably, the easiest tendon repair we can do in the ED. Using the modified Bunnell technique and 4-0 nonabsorbable sutures, we can repair these lacerations in the ED. Patients can then be splinted (wrist in 30° of extension, MCP neutral, DIP and PIP joints free) and follow up with a hand surgeon.<sup>10</sup>

**Zones VII and VIII:** Once you have an extensor laceration in the wrist or forearm, the musculotendinous junctions and muscle bellies become more involved, which is outside of the scope of what we can repair in the ED. We should repair the overlying skin and put in a volar splint (wrist in 20° of extension, MCP neutral). Our hand surgeon colleagues are going to need to repair these injuries.<sup>10</sup>

### Tendon-Suturing Techniques

As described above, there are a number of different ways to repair tendon lacerations. Typically, the tendon should be repaired with 4-0 or 5-0 nonabsorbable sutures. Two of the more commonly described repairs are the modified Kessler and modified Bunnell stitches. Figure 3 provides a schematic of the repair.

**Figure 3. The modified Kessler (left) and modified Bunnell (right) stitches for tendon repair.<sup>11</sup>**



### Summary

Far too often, we become reliant on our consultants for relatively simple procedures that can be done safely and efficiently in the ED. Figure 4 provides a quick reference for repairing these extensor tendon injuries in the ED; it is assumed that all of these injuries are ad-

equately irrigated and debrided and that the patient's tetanus status is updated. For the majority of these injuries, you can approximate the overlying skin laceration, splint, and have the patient follow up with the hand surgeon in the next couple of days. These injuries can be repaired as late as one week after the initial injury.<sup>9</sup> Instead of waking up the orthopedist at 3 a.m. for someone's drunken stupor-fueled flight through a pane of glass, just take matters into your own hands. 🍷

### References

1. Tuncali D, Yavuz N, Terzioğlu A, et al. The rate of upper-extremity deep-structure injuries through small penetrating lacerations. *Ann Plast Surg*. 2005;55:146-148.
2. Griffin M, Hindocha S, Jordan D, et al. Management of extensor tendon injuries. *Open Orthop J*. 2012;6:36-42.
3. Kleinert HE, Verdan C. Report of the Committee on Tendon Injuries. *J Hand Surg Am*. 1983;8:794-798.
4. Anderson D. Mallet finger—management and patient compliance. *Aust Fam Physician*. 2011;40:47-48.
5. Handoll HH, Vaghela MV. Interventions for treating mallet finger injuries. *Cochrane Database Syst Rev*. 2004;3:CD004574.
6. Carl HD, Forst R, Schaller P. Results of primary extensor tendon repair in relation to the zone of injury and pre-operative outcome estimation. *Arch Orthop Trauma Surg*. 2007;127:115-119.
7. Calabro J, Hoidal CR, Susini LM. Extensor tendon repair in the emergency department. *J Emerg Med*. 1986;4:217-225.
8. Hanz KR, Saint-Cyr M, Semmler MJ, et al. Extensor tendon injuries: acute management and secondary reconstruction. *Plast Reconstr Surg*. 2008;121:109e-120e.
9. Newport ML. Extensor tendon injuries in the hand. *J Am Acad Orthop Surg*. 1997;5:59-66.
10. Chapter 11: Hand. In: Simon RR, Sherman SC, eds. *Emergency Orthopedics*. 6th ed. New York, NY: McGraw-Hill Medical; 2011:207-211.
11. Rosh AJ, Kwon NS, Wilburn JM, et al. Extensor tendon repair. Medscape Web site. Available at: <http://emedicine.medscape.com/article/109111-overview>. Accessed Nov. 16, 2015.

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Visit **ACEPNow.com** to watch videos of the modified Kessler and modified Bunnell stitches.

**Figure 4. Summary diagram for repair of extensor tendon lacerations.**





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# Kovacs' Sign and Overhand Rightward Turn

## Two pearls when using a hyperangulated video laryngoscope

by RICHARD M. LEVITAN, MD, FACEP

**H**yperangulated video laryngoscopes have blade shapes with a curvature more acute than a standard Macintosh blade. Commercial products include the GlideScope, Storz D-Blade, and McGrath X blade. In the course of teaching use of these devices, I have often been told, "I had a great view but had trouble delivering the tube."

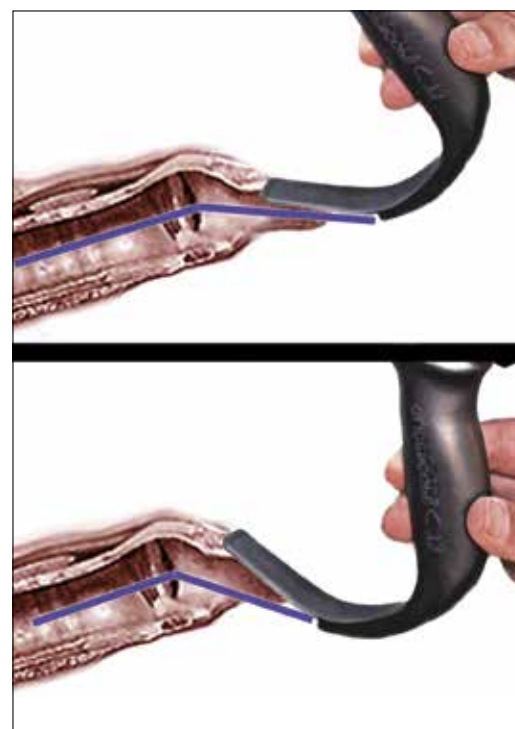
Hyperangulated blades look around the curvature of the tongue very well, but their perspective on the larynx, looking upward at it from the base of the tongue, can lead to difficulty in tube delivery. If the blade is inserted too deeply, the video-imaging element gets very close to the larynx, and the view will be great, but the angle of approach is consequently very extreme. This creates difficulty with tube delivery through three mechanisms. First, it steepens the up angle to the larynx; second, it shortens the tube delivery area (distance from blade tip to larynx); and third, it reduces the area on the screen for observing tube delivery. Operators must be careful that they look in the mouth when inserting a hyperangulated stylet, then carefully observe it coming into view on the monitor. Jamming a rigid hyperangulated stylet into the posterior pharynx (off screen) can cause injury to the soft palate, tonsils, or hypopharynx.

George Kovacs, MD, MHPE, an emergency physician from Halifax, Nova Scotia, and director of the Airway Interventions & Management in Emergencies (AIME) courses, recently showed me a simple way to determine if the angle of approach using a hyperangulated blade is excessive. I have labeled this "Kovacs' sign" and now incorporate it into my instruction with hyperangulated blades (see Figures 1 and 2). If the blade is overinserted, the cricoid ring becomes visible between the vocal cords. This indicates a very steep angle of approach and will likely make tube introduction difficult. Conversely, when the angle of approach is not so steep, the cricoid ring is not seen, there is more room between the blade tip and the larynx, and there will be more space on the inferior aspect of the monitor to observe tube delivery.

The second piece of the puzzle with a hyperangulated video blade is getting the tube to drop into the trachea. One cannot merely advance the stylet, as the curvature used to get around the tongue creates a side-to-side dimension that exceeds the diameter of the human trachea. The trachea is only 15–20 mm in males and 14–16 mm in females. Additionally, if the hyperangulated stylet is simply rotated upward through the cords, the direction the tube and stylet points is upward, while the trachea has a downward inclination. Finally, there are the tracheal rings, which can prevent tube advancement when using a standard asymmetric left-beveled tracheal tube.



**Figure 1 (Left).** Blade positioning and Kovacs' sign. In the upper image (ideal placement), the cricoid ring is not seen. There is more room beneath the posterior larynx on the monitor screen, which is critical for observing tube delivery. In the lower image, the cricoid ring and the internal aspect of the cricothyroid membrane are visible between the vocal cords, indicating over-insertion of the hyperangulated blade and a steep angle of approach.



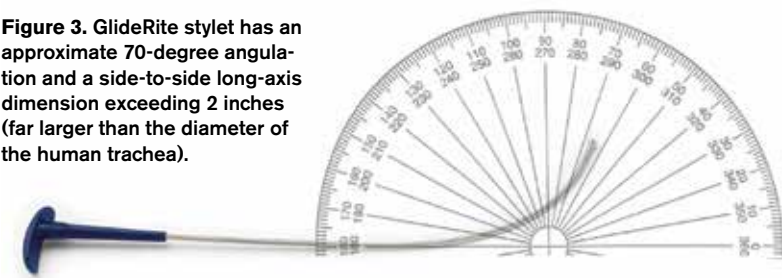
**Figure 2 (Right).** Schematic representation of the angle of approach. The top image shows ideal placement of a hyperangulated blade—in this case, a GlideScope Titanium blade—compared to overinsertion (bottom image). Note that the approach angle is more acute and that there is less room for tube delivery between the blade and the larynx.

Verathon offers the GlideRite stylet to help with tube insertion. It is a rigid stylet with a 70-degree angle and a nifty proximal end, allowing the thumb to pop the stylet up (see Figure 3). A GlideRite stylet exceeds 2 inches in side-to-side dimension; this exceeds the dimensions of the human trachea. Accordingly, it is a tube delivery device (around the tongue and into the larynx), not a tracheal introducer. By partially removing the stylet after insertion through the cords, the tracheal tube can be advanced downward into the trachea. This maneuver, however, doesn't address issues with the inclination of the trachea and the corrugation of the tracheal rings.

An easy maneuver, which can be done gradually by the operator with no assistance, is turning the GlideRite stylet and tube 90 degrees to the right after insertion through the cords (see Figures 4 and 5). The operator should use an overhand grip at the top of the stylet and tube. After insertion through the cords, the tube and stylet are turned rightward, to the corner of the patient's mouth, while making sure the tip is through the larynx. The thumb is then used to slide the tube off the stylet in a series of gradual advancements. By turning the stylet and tube, the tube now points downward, overcoming the inclination problem. Turning 90 degrees also rotates the bevel of the tube upward, which prevents the tube tip from catching on the corrugation of the tracheal rings.

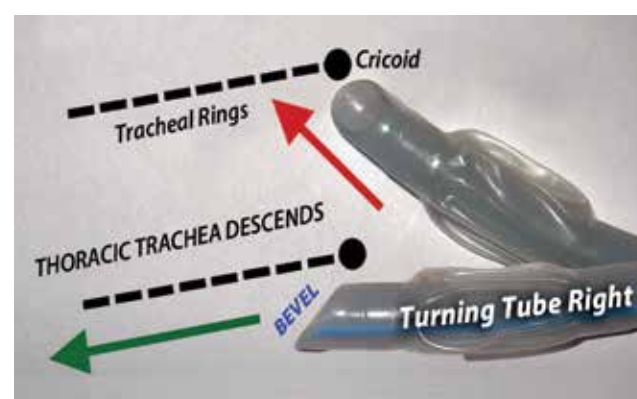
Try the overhand turn and make sure to watch for Kovacs' sign on your next use of a hyperangulated video laryngoscope. These are simple tips that will improve your practice! ☺

**Figure 3.** GlideRite stylet has an approximate 70-degree angulation and a side-to-side long-axis dimension exceeding 2 inches (far larger than the diameter of the human trachea).



**Figure 4.** Right-turn overhand technique for hyperangulated stylet insertion into the trachea. By turning the stylet and tube 90 degrees, the tube angles downward, aligning with the inclination of the trachea. Note that the tube can be advanced in small increments off the stylet using the right hand only as long as an overhand grip is used at the top of the tube and stylet.

**Figure 5.** Turning the tube right improves interaction with trachea rings (corrugation and inclination) with a left-bevel tube. Whenever inserting trachea tubes with a left-bevel tube, if resistance is felt beneath the vocal cords, a gentle rightward turn will solve the problem in most instances.





**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.

# I Heard It Through the 'Grapevine'

Texas hospital finds novel way to improve patient experience using AIDET



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## ACKNOWLEDGE

Warm smile and friendly greeting

## INTRODUCE

"Manage up" yourself and others' competence to the person(s)

## DURATION

Provide others with time expectations

## EXPLANATION

Update the person(s) about what to expect from you and others

## THANK YOU

Thank them for choosing your facility

by SHARI WELCH, MD, FACEP

A number of communication strategies have evolved over the past decade to improve the patient encounter and experience of care. One model that is promoted by the Studer Group, and employed by many health systems, is called the AIDET system.<sup>1</sup> What is AIDET? It is a composite of five behaviors to use in every patient/staff interaction to anticipate, meet, and exceed expectations of patients, coworkers, and visitors. AIDET is used to decrease the anxiety of patients and their families and to improve patient satisfaction.

Baylor Regional Medical Center in Grapevine, Texas, is a 269-bed hospital that sees almost 50,000 emergency department visits. Already performing well in patient satisfaction measures (according to *U.S. News & World Report*, 80 percent of patients would recommend the facility to others), the emergency physician group

committed to the AIDET system to take these measures to the next level.<sup>2</sup> Gordon Aalund, MD, and Dahlia Hassani, MD, presented their novel approach in a poster at the 2015 Innovations in Emergency Department Management conference in Orlando, Florida, February 24–26.<sup>3</sup>

Staff members trained in AIDET are encouraged to use the words "excellent" and "thank you" liberally. Some of the particular habits or behaviors that can promote the AIDET philosophy include:

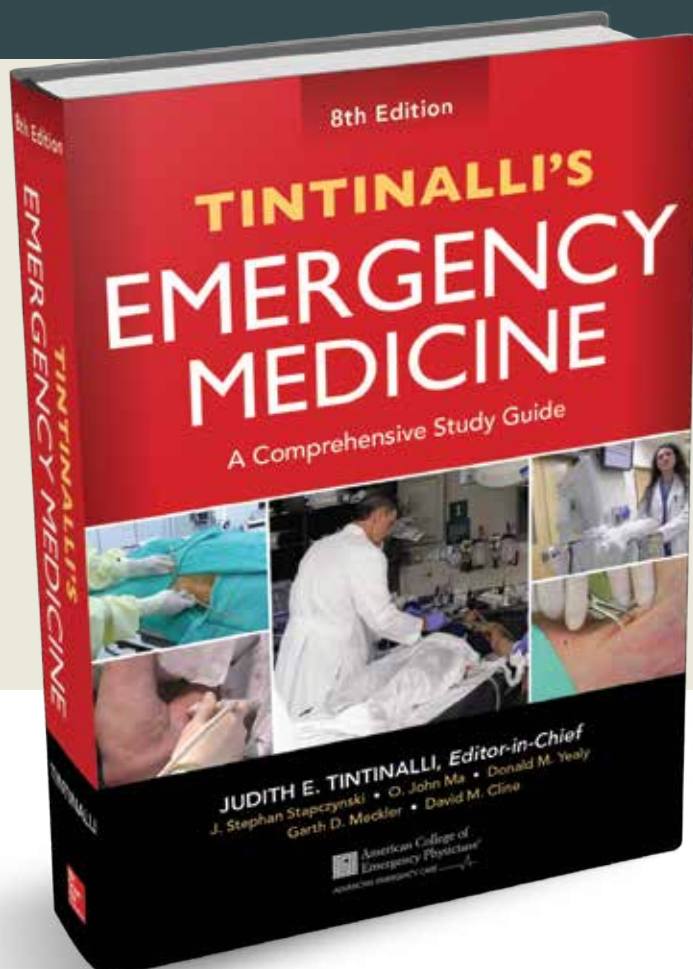
✓ **ACKNOWLEDGE**—Show a positive attitude and put others at ease.

- Anticipate needs.
- Greet the person, provide eye contact, and smile.
- Follow the 10 and 5 Rule: at 10 feet, look up and acknowledge, make eye contact, and smile; at five feet, verbally greet and offer assistance if necessary.

✓ **INTRODUCE**—Give your name and role.

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ABS\_AD\_TEM\_MCHP\_1015

- Name: self, skill set, experience
- Department: coworkers, other departments, physicians

✓ **DURATION**—"How long will this take?"

- Under-promise and over-deliver.
- Give a time expectation that will surely be met and follow up if unable to meet expectations.
- There are two types of time: real and perceived. Understand both.

✓ **EXPLANATION**—"What will you be doing and why?"

- Explain step-by-step what will happen.

Each provider is audited on two to five patients by scribes during an assigned shift ... the [AIDET] tool is used to give performance feedback to the provider.

- Give explanation of purpose, the "why."
- Ask the person if they have any questions or tell them to feel free to ask later.

✓ **THANK YOU**—Let them know you have enjoyed helping or working with them.

- Thank the person for communication and

cooperation or assistance and support.

- Thank the person for giving you an opportunity to help.

The group of emergency physicians in Grapevine has found another way to utilize scribes: as observers of physicians' practices. While there is a growing body of literature demonstrating that scribes in the emergency department can improve efficiency, patient satisfaction, and staff satisfaction, scribes were used in Grapevine to facilitate their AIDET model. The department providers utilized

**CONTINUED** on page 18

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Our Level I Adult ED at Froedtert Hospital is completing an expansion in January 2016. We are recruiting for two faculty to complete our Froedtert coverage in the Clinician/Educator Path. Our Department is also initiating weekday coverage at the VA ED in Milwaukee. We are recruiting for two faculty.

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the AIDET tool but struggled with a process to validate each individual provider's performance for feedback purposes. In an early trial, they used another provider to validate the use of AIDET, but that proved costly and required providers to be available on a shift for which they weren't previously scheduled (not a popular proposition!).

The need to identify another method for monitoring AIDET in practice led to utilization of departmental scribes for the auditing project. All providers receive AIDET training. Scribes are also trained on AIDET and

the use of the AIDET validation tool. Each provider is audited on two to five patients by scribes during an assigned shift. The tool is easily completed by the scribes in the course of the workflow, and the tool is used to give performance feedback to the provider. The feedback is unique in that it is nearly done in real time, which allows physicians to improve in real time. The results are provided routinely with no increased departmental costs. Providers discuss results at departmental meetings. Coaching is tailored for individual providers.


Scribe-implemented AIDET validation was an effective tool to evaluate and improve provider communication. Can you see the possibilities? Scribes have the potential to become partners in emergency department quality and safety initiatives and provide another opportunity to align the goals of the entire health care team. Great job in Grapevine!

**PS:** According to Grapevine Medical Director and Chairman Robert Risch, MD, they have used scribes to help with hand washing and several other lean projects. ☺

**References**

1. Putnam JB Jr, Kennedy J. Teaching physician-patient communication (AIDET) for results in all pillars. Studer Group Web site. Available at: [http://www.studergroupmedia.com/WRIHC/presentations/teaching\\_physician\\_patient\\_communication\\_\(aid-et\)\\_for\\_results\\_in\\_all\\_pillars\\_vanderbilt\\_putnam\\_kennedy\\_0028.pdf](http://www.studergroupmedia.com/WRIHC/presentations/teaching_physician_patient_communication_(aid-et)_for_results_in_all_pillars_vanderbilt_putnam_kennedy_0028.pdf). Accessed Nov. 10, 2015.
2. Baylor Regional Medical Center. *U.S. News & World Report* Web site. Available at: <http://health.usnews.com/best-hospitals/area/tx/baylor-regional-medical-center-6741739/details>. Accessed Nov. 10, 2015.
3. Aalund G. AIDET validation using scribes in the ED. Poster presented at: Innovations in Emergency Department Management conference, Feb. 24–26, 2015; Orlando, Florida.

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