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. 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.) The potential impairment that may occur without...
REGISTER TODAY

Advanced Pediatric Emergency Medicine Assembly

March 8-10, 2016 | Disney’s Yacht & Beach Club Resorts | Lake Buena Vista, Fl.

www.acep.org/pemassembly | 800-798-1822, Ext 5

REGISTER WITH PROMO CODE PEM16PS TO SAVE $100

BE READY — Turn challenging pediatric emergencies into rewarding ones.

Receive clinical updates that offer the latest scientific advances
Gain new skills in our Pre-Conference courses - including procedures and ultrasound labs and Building Blocks of Pediatric EM
Learn from the most respected names in pediatric emergency medicine
Discover products and services for pediatric EM in our exhibit hall

ACEP STAFF

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE
dwilkerson@acep.org

DIRECTOR, MEMBER COMMUNICATIONS AND MARKETING
Nancy Calaway
ncalaway@acep.org

ASSOCIATE EXECUTIVE DIRECTOR, MEMBERSHIP AND EDUCATION DIVISION
Robert Heard, MBA, CAE
rheard@acep.org

COMMUNICATIONS MANAGER
Dianna Hunt
dhunt@acep.org

PUBLISHING STAFF

EXECUTIVE EDITOR/PUBLISHER
Lisa Donnie
lidonne@wiley.com

ASSOCIATE DIRECTOR, ADVERTISING SALES
Steve Jezzard
sjezzard@wiley.com

ADVERTISING STAFF

DISPLAY ADVERTISING
Michael Lamattina
mlamattina@wiley.com
(781) 388-9548

CLASSIFIED ADVERTISING
Kevin Dunn
kdunn@cunnaaso.com
ckucera@cunnaaso.com
Cunningham and Associates (2011) 767-4170

EDITORIAL ADVISORY BOARD

James G. Adams, MD, FACEP
Debra G. Perina, MD, FACEP
Richard M. Cantor, MD, FACEP
L. Anthony Cirillo, MD, FACEP
Marco Coppola, DO, FACEP
Jordan Celetes, MD
Jeremy Samuel Faust, MD, MS, MA
Jonathan M. Glauser, MD, MBA, FACEP
Michael A. Granovsky, MD, FACEP
Sarah Hoper, MD, JD
Linda L. Lawrence, MD, FACEP
Frank LoVecchio, DO, FACEP
Catherine A. Marco, MD, FACEP
Ricardo Martinez, MD, FACEP
Howard K. Mell, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Mark S. Rosenberg, DO, MBA, FACEP
Sandra M. Schneider, MD, FACEP
Jeremiah Schuur, MD, MHS, FACEP
David M. Siegel, MD, JD, FACEP
Michael D. Smith, MD, MBA, FACEP
Robert C. Solomon, MD, FACEP
Annalise Sorrentino, MD, FACEP
Jennifer U’Hommedieu Starkus, MD, JD
Peter Viccellio, MD, FACEP
Rade B. Vulmir, MD, JD, FACEP
Scott D. Weinert, MD, FACEP

INFORMATION FOR SUBSCRIBERS

Subscriptions are free for members of ACEP and SEMPA. Free access is also available online at www.acepnow.com. Paid subscriptions are available to all others for $223/3year individual. To initiate a paid subscription, email cs-journals@wiley.com or call (800) 835 6770. ACEP Now (ISSN: 2333-258X print; 2333-2603 digital) is published monthly on behalf of the American College of Emergency Physicians by Wiley Subscription Services, Inc., a Wiley Company, 111 River Street, Hoboken, NJ, and additional offices. Postmaster: Send address changes to ACEP Now, American College of Emergency Physicians, P.O. Box 619911, Dallas, Texas 75261-9911. Readers can email address changes and correspondence to acepnow@acep.org. Printed in the United States by Cadmus(Cenveo), Lancaster, PA. Copyright © 2015 American College of Emergency Physicians. All rights reserved. No part of this publication may be reproduced, stored, or transmitted in any form or by any means and without the prior permission in writing from the copyright holder. ACEP Now, an official publication of the American College of Emergency Physicians, provides indispensable content that can be used in daily practice. Written primarily by the physician for the physician, ACEP Now is the most effective means to communicate our messages, including practice-changing tips, regulatory updates, and the most up-to-date information on healthcare reform. Each issue also provides material exclusive to the members of the American College of Emergency Physicians. The ideas and opinions expressed in ACEP Now do not necessarily reflect those of the American College of Emergency Physicians or the Publisher. The American College of Emergency Physicians and Wiley will not assume responsibility for damages, loss, or claims of and kind arising from or related to the information contained in this publication, including any claims related to the products, drugs, or services mentioned herein. The views and opinions expressed do not necessarily reflect those of the Publisher, the American College of Emergency Physicians, or the Editors, neither does the publication of advertisements constitute any endorsement by the Publisher, the American College of the Emergency Physicians, or the Editors of the products advertised.
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 near-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.

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.

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. Spalte, 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 L. Bern, MD, FACEP

JOHN A. RUPKE LEGACY AWARD

• Stephen V. Contriol, 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; LETTERS TO ACEPNOW, P.O. BOX 619911, DALLAS, TX 75261-9911; AND FAXES TO 972-580-2816, ATTENTION ACEPNOW.

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 tens of 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.
A

MERS Coming to an ED Near You?  

The 31 tool helps you identify and react to patients who might have Middle East respiratory syndrome  

by KRISTI L. KOENIG, MD, FACEP, FIFEM  

I

nitially 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 (31 tool) 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 to learn more about MERS and the 31 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.  

A

CEP Annual Financial Report for the 2014–2015 Fiscal Year  

by JOHN J. ROGERS, MD, CPE, FACEP  

A

CEP 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 status 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 29 percent overall increase, with a 14 percent growth in active and 15 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 $1,210,000 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 quality care, and help control health care costs.  

Revenue for the fiscal year was more than $31 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.
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.
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. This is the tenth leading cause of death for all ages. These deaths often leave family, friends, and health professionals with guilt, searching for missed chances 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.

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.” 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 environmental features that may increase or decrease the risk for suicide.’” This 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. 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. 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. 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 25 percent going to the ED for mental health, 14 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. The data would suggest EDs should not routinely screen for suicidal- ity 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 harm yourself in the past? Has something very stressful happened to you in the past few weeks?). 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-positi...
Screening positive has significant implications for emergency physicians and staff. Should all patients who screen positive be cleared by psychiatrists? 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 itself 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.1 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 referrals system before universal screening of all patients in the emergency department can be embraced.

References

The Official Voice of Emergency Medicine

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

The 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 conversations when a person has 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). 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 about discharge planning and providing written materials and information on other support resources.1 A Suicide Prevention Resource Center publication also focused on patient follow-up needs subsequent to a suicide attempt and discharge from ED.2 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

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 responsive- ness 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.

References

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 Exam 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.

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 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.

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.

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.

What is your favorite aspect of ABEM, especially as it impacts other organizations?

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.

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.
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. “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 ED’s opportunity to bend the curve on the amount of time patients spent in the ED for emergency care. The measure was implemented in 2012, and the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission required management by ED leaders and hospital administrators.”

The EDBA initiated collection of the performance measure in 2012. Unlike CMS, which reports all EDs as one group, the EDBA 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 2 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, increasedbuffeting for those waiting for service, unpleasant treatment environments, ambulance diversion, and poor patient outcomes. The cascade then leads to 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

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

ADDITIONAL READING

How to Perform Ultrasound-Guided Subclavian Vein Cannulation

Part 1: The supraclavicular approach

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.\(^5\)\(^,\)\(^6\) 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.\(^5\)\(^,\)\(^6\)

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.\(^3\)\(^,\)\(^4\) 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.\(^2\)\(^,\)\(^6\)

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 needle technique.

Anatomy

The SCV runs from lateral to medi- al 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.\(^1\)\(^,\)\(^2\) 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 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-
like the classic ultrasound-guided IV 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 habitus and probe size). Slowly advance the needle location (this angle will depend on patient body

**Summary**

The supravacular approach to ultrasound-guided SCV cannulation may be ideal in certain scenarios and safer than the landmark-based SCV central line placement.2,3 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**


**Figure 3.**

(A) In a transverse plane on the neck, locate the thyroid, IJV, and carotid artery (CA) deep to the sternocleido-mastoid (SCM) muscle. (B) Slide the transducer down the IJV into the supravacular fossa until the subclavian vein (SCV) is visualized.

**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.
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 pleasurably. 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 than 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 60, 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.

Some people find it easiest to boost their savings rate by “saving their raises.” Every year you get a raise, you automatically save a percentage of it, without even having to think about it. This behavioral tendency, combined with the convenience of cards, means that we generally spend more than using credit cards. So if you aren’t saving much of your income 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.

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.

<table>
<thead>
<tr>
<th>SAVINGS RATE</th>
<th>YEARS TO FINANCIAL INDEPENDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>Infinite</td>
</tr>
<tr>
<td>5%</td>
<td>65</td>
</tr>
<tr>
<td>10%</td>
<td>50</td>
</tr>
<tr>
<td>15%</td>
<td>42</td>
</tr>
<tr>
<td>20%</td>
<td>36</td>
</tr>
<tr>
<td>30%</td>
<td>27</td>
</tr>
<tr>
<td>40%</td>
<td>21</td>
</tr>
<tr>
<td>50%</td>
<td>16</td>
</tr>
<tr>
<td>60%</td>
<td>12</td>
</tr>
<tr>
<td>70%</td>
<td>8</td>
</tr>
<tr>
<td>80%</td>
<td>5</td>
</tr>
<tr>
<td>90%</td>
<td>3</td>
</tr>
<tr>
<td>100%</td>
<td>0</td>
</tr>
</tbody>
</table>

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 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
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.

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. Kleineit 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). 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. 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. For open injuries, hand surgeons use another classification method where zone I is split up into four different types. 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. For these extensor tendon laceration repairs, you may want to use a roll stitch or dermatoteno-desis, 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. 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 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. 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.

**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. 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.

**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
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.

References

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 adequately 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.1 Instead of waking up the orthopedist at 3 a.m. for someone’s drunken stupor—fuelled flight through a pane of glass, just take matters into your own hands. ø

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

Figure 4. Summary diagram for repair of extensor tendon lacerations.
Kovacs’ Sign and Overhand Rightward Turn

Two pearls when using a hyperangulated video laryngoscope

by RICHARD M. LEVITAN, MD, FACEP

Hyperangulated 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 angle of approach; 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 approximate 70-degree angulation and a side-to-side long-axis dimension exceeding 2 inches (far larger than the diameter of the human trachea).

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!
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. 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. 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.

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.

- **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

Add the authority of Tintinalli’s to your teaching, practice, and study

**TINTINALLI’S EMERGENCY MEDICINE**

A Comprehensive Study Guide

Presented in full color, *Tintinalli’s Emergency Medicine* is the most practical and clinically relevant reference of its kind. It covers virtually every condition for which patients seek emergency department care in a concise and easy-to-read manner. The most widely used textbook in emergency medicine, *Tintinalli’s* is the preferred study guide for in-training and board examinations and recertification.

<table>
<thead>
<tr>
<th>Regular Price</th>
<th>Special ACEP Bookstore price:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$249</td>
<td>$237</td>
</tr>
</tbody>
</table>

Special offer for ACEP members!

Available November 2015

Special member price available at bookstore.acep.org
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.

- **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.**
- **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

---

**Medical College of Wisconsin**

**Academic, VA, and Community Opportunities for MDs, DOs, and APPs**

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 Clinical Educator Path. Our Department is also initiating weekday coverage at the VA ED in Milwaukee. We are recruiting for two faculty.

Additionally, we are actively recruiting for six faculty for our new, freestanding community ED, which opens in July, 2016.

All faculty members could have clinical responsibilities at one or more sites.

We are also seeking PAs and NPs for our new, Froedtert ED 14-bed Clinical Decision Unit.

The Department of Emergency Medicine at MCW is nationally and internationally recognized in Resuscitation Research, Injury Prevention and Control, EMS, Toxicology, Global Health, Ultrasound, Medical Education, and Process Improvement.

Interested applicants should submit a curriculum vitae to Scott A. Spier, MD, Chief Medicine, Curriculum & Process Improvement.

**Contact:** Frank Kaeberlein, MD at frank.kaeberlein@cantonmercy.org.

---

**Ohio - Canton**

Unique opportunity to join an independent, top-quality, democratic, well-established and physician-owned group with an opening for an ABEM or AOBEM BC/BE physician.

Stark County Emergency Physicians staffs a 65,000+ volume ED and a 35,000+ volume Urgent Care. The ED is nationally recognized as the first-ever accredited chest pain center in the US, is a multi-year recipient of the HealthGrades Emergency Medicine Excellence award, and is also a level II Trauma Center and Stroke Center.

Equitable and flexible scheduling. Excellent provider staffing levels. Newly renovated ED. Great work/lifestyle balance. Clearly defined equal-equity partnership track (including equity interest in an independent billing company). Student loan reduction program. Generous benefits include 100% employer-funded retirement plan, BC/CME account, PLI insurance with corporate tail, and HSA-based health insurance.

Contact Frank Kaeberlein, MD at (330)-489-1365 or frank.kaeberlein@cantonmercy.org.

---

**A Great EM Career Hits All the High Notes**

**EMA – The Power of Blue**

Whether it’s a great song or a great EM career, when everything is perfectly aligned, it’s music to your ears. Join a passionate group of physicians and partner with a practice powered by amazing support, technology, benefits and compensation, equitable scheduling, and coaching/mentoring for career development and growth. Empowering you to have a voice in the practice while making healthcare work better.

Explore emergency medicine and urgent care opportunities in NJ, NY, PA, RI, NC and AZ.

Learn more about career opportunities: Call 866.630.8125 or view openings at www.ema.net/careers
the AIDET tool but struggled with a process to validate each individual provider’s performance for feedback purposes. In an early trial, they hired another provider to validate the use of the 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
WE’RE UNITING. YOU’RE WINNING.

COMING TOGETHER TO IMPROVE THE WORLD OF HEALTH CARE.

Schumacher Group and Hospital Physician Partners are joining forces. With our combined clinical services and expertise, we’ll be able to provide more advantages than ever to our providers, hospital partners, and patients.

www.schumachergroup.com | www.hppartners.com

ADVANTAGE: YOU

Schumacher Group
Hospital Physician Partners

6M PATIENTS
5200 PROVIDERS
28 STATES
300 HOSPITALS

North Shore-LIJ
Emergency Medicine

Don’t just join another ED. Join a system of opportunity!

20 Hospitals in Long Island, Queens, Staten Island, Manhattan and Westchester County
Academic, Administrative & Research Settings

Whether you are just starting out as an Emergency Physician or have decades of experience, the North Shore-LIJ Health System has the career opportunity you want today. We can also help you plan for tomorrow with flexible options for scheduling or transferring to different locations as your goals and needs change. So, don’t just plan your next move. Plan your career.

Contact Andria Daily to learn more:
844-4EM-DOCS
EmergencyMedicine@nshs.edu
nslijemphysicians.com

We are an equal opportunity/AE employer: F/M/Disability/Vet

Rutgers, Robert Wood Johnson Medical School
Emergency Physicians (Faculty Positions)

The Department of Emergency Medicine at Rutgers Robert Wood Johnson Medical School is currently recruiting Emergency Physicians to join our growing academic faculty.

Robert Wood Johnson University Hospital serves as the medical school’s primary teaching affiliate. The Hospital is a 580-bed Level 1 Trauma Center and New Jersey’s only Level 2 Pediatric Trauma Center with an annual ED census of greater than 90,000 visits.

The Department has a well-established three-year residency program and an Emergency Ultrasound fellowship. The Department is seeking physicians who can contribute to our clinical, education and research missions. Qualified candidates must be ABEM/ABOEM certified/eligible.

Salary and benefits are competitive and commensurate with experience. Please send a letter of intent and curriculum vitae to: Robert Eisenstein, MD Interim Chairman, Department of Emergency Medicine, Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, MEB 104, New Brunswick, New Jersey, 08901; Email: Robert.Eisenstein@rutgers.edu; Phone: 732-235-8717; Fax: 732-235-7379.

Rutgers, The State University of New Jersey is an Affirmative Action/Equal Opportunity Employer, M/F/D/V

TO PLACE AN AD IN ACEP NOW’S CLASSIFIED ADVERTISING SECTION PLEASE CONTACT:
Kevin Dunn: kdunn@cunnasso.com | Cynthia Kucera: ckucera@cunnasso.com | Phone: 201-767-4170
Aloha

As Hawaii’s oldest and largest ED physician group, we are dedicated to nurturing the next generation of quality emergency physicians and meeting the ever-changing healthcare challenges.

TRUE PARTNERSHIP OPPORTUNITY

Providence Health Center
- Busy 86,000-volume ED
- Scribe coverage & NP/PA support
- Certified stroke and chest pain center
- BC/BP in Emergency Medicine required

“Providence is a busy hospital where I can see high acuity in a fast-paced environment. Leave work and Waco offers attractive real estate with great schools and the best sports teams in the Big 12 (Sic Em Bears!). I have access to all that I would want in a big city without the hassles of traffic and crowds.”
—Nicholas Steinour, MD
ED Medical Director

Brody School of Medicine

EMERGENCY MEDICINE FACULTY
- Clinician-Educator
- Clinical-Researcher
- Critical Care Medicine
- Pediatric Emergency Medicine
- Ultrasound

The Department of Emergency Medicine at East Carolina University Brody School of Medicine seeks BC/BP emergency physicians and pediatric emergency physicians for tenure or clinical track positions at the rank of assistant professor or above, depending on qualifications. We are expanding our faculty to increase our cadre of clinician-educators and further develop programs in pediatric EM, ultrasound, clinical research, and critical care. Our current faculty members possess diverse interests and expertise leading to extensive state and national-level involvement. The emergency medicine residency is well-established and includes 12 EM and 2 EM/IM residents per year. We treat more than 130,000 patients per year in a state-of-the-art ED at Vidant Medical Center. VMC is a 960+ bed level 1 trauma center and regional referral center. Our tertiary care catchment area includes more than 1.5 million people in eastern North Carolina, many of whom arrive via our integrated mobile critical care and air medical service. Our new children’s ED opened in July 2012, and a new children’s hospital open in June 2013. Greenville, NC is a fast-growing university community located near beautiful North Carolina beaches. Cultural and recreational opportunities are abundant. Compensation is competitive and commensurate with qualifications; excellent fringe benefits are provided. Successful applicants will be board certified or prepared in Emergency Medicine or Pediatrics Emergency Medicine. They will possess outstanding clinical and teaching skills and qualify for appropriate privileges from ECU Physicians and VMC.

Confidential inquiry may be made to:
Theodore Delbridge, MD, MPH
Chair, Department of Emergency Medicine
delbridge@ecu.edu

ECU is an EEO/AA employer and accommodates individuals with disabilities. Applicants must comply with the Immigration Reform and Control Act. Proper documentation of identity and employability required at the time of employment. Current references must be provided upon request.

www.ecu.edu/ecuem/ 252-744-1418
What has your career done for you lately?

As facility medical director, Dr. Karen Kriza relies on TeamHealth to manage the administrative duties associated with operating an efficient emergency room. Thanks to TeamHealth’s support with scheduling, recruiting, insurance negotiations and risk management, Dr. Kriza has more time to focus on her patients and family and enjoy the luxuries of living by the water.

Text CAREERS to 411247 for latest news and info on our job opportunities! Visit teamhealth.com to find the job that’s right for you.

Featured Opportunities:

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>City, State</th>
<th>Volume (annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamilton Medical Center</td>
<td>Dalton, GA</td>
<td>63,000 volume</td>
</tr>
<tr>
<td>Grays Harbor Community Hospital</td>
<td>Aberdeen, WA</td>
<td>36,000 volume</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>Martinsville, VA</td>
<td>42,000 volume</td>
</tr>
<tr>
<td>St. Joseph’s Medical Center</td>
<td>Stockton, CA</td>
<td>65,000 volume</td>
</tr>
<tr>
<td>Northwest Healthcare</td>
<td>Florissant, MO</td>
<td>58,000 volume</td>
</tr>
<tr>
<td>Hilton Head Hospital</td>
<td>Hilton Head, SC</td>
<td>23,000 volume</td>
</tr>
<tr>
<td>WCA Hospital</td>
<td>Jamestown, NY</td>
<td>36,000 volume</td>
</tr>
<tr>
<td>Abruzzo Arrowhead Campus</td>
<td>Glendale, AZ</td>
<td>36,000 volume</td>
</tr>
<tr>
<td>Charleston Area Medical Center General Hospital</td>
<td>Charleston, WV</td>
<td>36,000 volume</td>
</tr>
<tr>
<td>College Station Medical Center</td>
<td>College Station, TX</td>
<td>25,000 volume</td>
</tr>
<tr>
<td>Hillside Hospital</td>
<td>Pulaski, TN</td>
<td>12,000 volume</td>
</tr>
<tr>
<td>Waterbury Hospital</td>
<td>Waterbury, CT</td>
<td>55,000 volume</td>
</tr>
</tbody>
</table>

855.615.0010 | physicianjobs@teamhealth.com | www.teamhealth.com
The best of both worlds – Academic and Community

Mercy Medical Center, an academically affiliated community hospital in downtown Baltimore is looking to add a Board Certified Emergency Physician.

Mercy is a major community teaching affiliate of the University of Maryland School of Medicine, with all medical students, and residents from multiple departments, rotating regularly. The Emergency Department has a long history of educational excellence, providing regular rotations for Emergency Medicine residents, medical students, and residents in other specialties.

The Department sees over 56,000 adult visits annually with an additional 7,500 pediatric patients seen primarily by pediatricians in an adjacent area. 24 to 36 hours of daily PA coverage augments 54 hours of attending physician coverage. A collegial medical staff provides extensive specialty coverage. The department houses a Sexual Assault Forensic Exam program that is the primary referral site for Baltimore City. We share close relationships with nearby Health Care for the Homeless and Baltimore City.

Mercy is ranked by US News and World Report the #2 hospital, and the #1 community hospital, in Maryland. Becker rates it as a Top 100 Hospital. Sponsored by the Sisters of Mercy, we are an independent, fiscally strong hospital, located six blocks north of Baltimore’s Inner Harbor, equidistant between the University of Maryland and Johns Hopkins Hospital.

Salary and benefits are competitive. Mercy is an Equal Employment Opportunity Employer.

Interested candidates should submit their curriculum vitae to Scott A. Spier, MD, Chief Medical Officer, Mercy Medical Center, sspier@mdmercy.com.

Exceptional Emergency Medicine Opportunity
Antelope Valley, California
Antelope Valley Emergency Medical Associates (AVEMA) seeks:
(1) Experienced, board certified Emergency Physician for full-time/part-time work with IC status
(2) PAs or NPs with EM/Acute Care experience
Hourly compensation is among the highest in Southern California.
AVEMA is a stable, independent, democratic group that has staffed the ED for over 40 years.
Antelope Valley Hospital is a public, not for profit hospital in Lancaster, California, with 115,000 ED visits. We have trauma, stroke, STEMI, EDAP, and chest pain center status. Full specialty call panel 24/7. Also: Scribe coverage for all physicians/NPs/PAs, efficient EHR, radiologist real-time reading of all imaging, paid malpractice, housing between shifts, excellent nurses and medical staff.
As the community-training site for the UCLA/OVMC EM residency program, residents are in the ED most days. UCLA faculty appointment is possible for our attendings.
This is an amazing opportunity!
We look forward to hearing from you.
Contact: Thomas Lee, MD, tomlee@ucla.edu
323-642-7127

Texas - Texarkana

Earn up to $450,000 plus partnership opportunity in as little as one year!
Busy, high-acute ED, tort reform, and no state income tax – no wonder our physicians love working at CHRISTUS St. Michael, a beautiful, award-winning hospital with a 33-bed, 60,000-volume ED.
Enjoy scribes and NP/PA support.
Wonderful mid-sized, family-friendly community is an outdoor-lover’s dream.
Emergency Service Partners, L.P. is a respected, Texas-based, 100% physician-owned group.
Contact Ashley Ulbricht today at ashley@eddocs.com for more details, and mention job # 268430-11.

Texas - Houston Vicinity

Gleaming new and expanded emergency department opened in September, just one hour from Houston!
Full-time and PRN openings in Bellville, TX for Family Medicine physicians with Emergency Medicine experience, as well as EM-boarded physicians. As part of the Bryan-based St. Joseph Health System, enjoy excellent specialty backup and easy transfers. Flexible scheduling and paid malpractice.
Work as few as 6 days per month and become a true partner in your practice with Emergency Service Partners, L.P.
Contact Jeff Franklin at jeff@eddocs.com and mention job # 268434-11.

TO PLACE AN AD IN ACEP NOW’S CLASSIFIED ADVERTISING SECTION PLEASE CONTACT:

Kevin Dunn:
kdunn@cunnasso.com

Cynthia Kucera:
ckucera@cunnasso.com
Phone: 201-767-4170

The Official Voice of Emergency Medicine
EPPH joins US Acute Care Solutions.
Welcome trailblazer.

We’re glad you don’t turn away from adventure. That you chose to align with the innovators to secure and grow your territory. As a founding partner of US Acute Care Solutions, we’ll give you the muscle you need to compete, and the resources you need to expand your horizons. You’ll maintain your identity under the security of the powerful group we’re forming together. Physician strong, we will remain majority physician owned. We won’t be traded or sold. We’re not a commodity. We’re US Acute Care Solutions. We own our future.
For epistaxis events, there’s only one right answer: RAPID RHINO product by Smith & Nephew.

- Easy placement
- Lubricated removal
- Anterior and posterior options

Reach for RAPID RHINO Epistaxis Products.

Contact your local sales representative or call 1.800.797.6520.
www.smith-nephew.com/ent
Supporting healthcare professionals for over 150 years.