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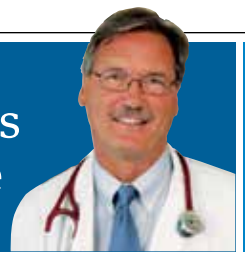

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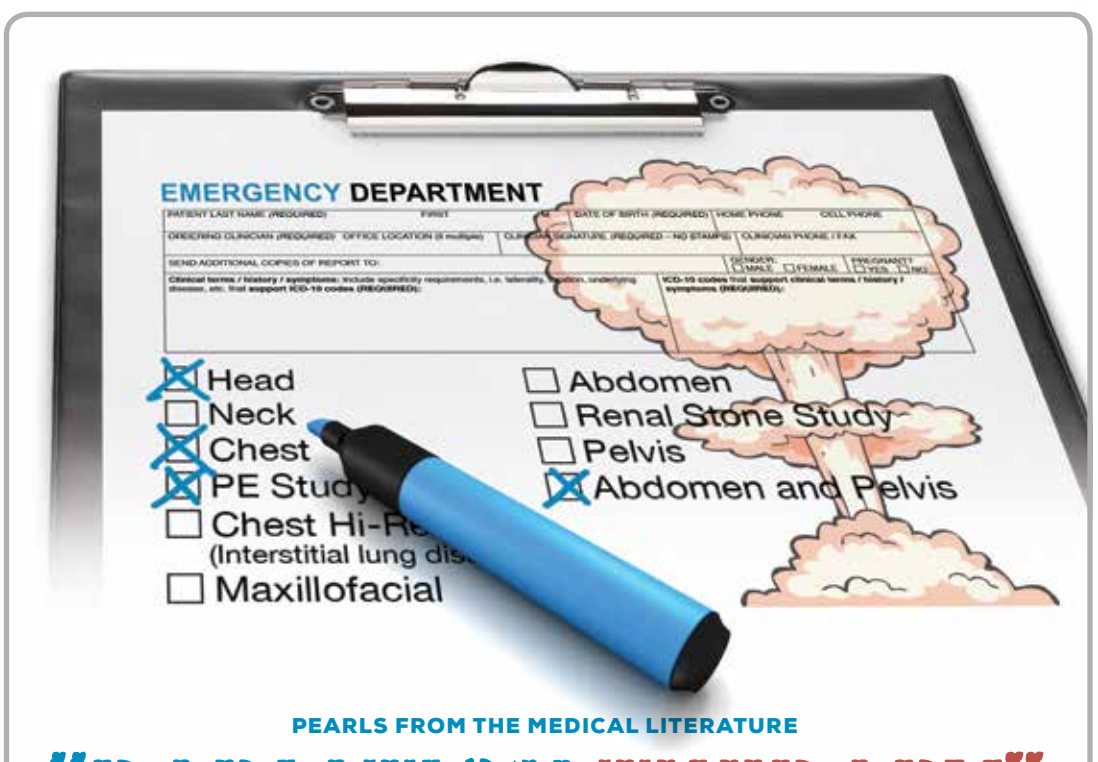

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PEARLS FROM THE MEDICAL LITERATURE

"RADIATION THERAPY" IN THE EMERGENCY DEPARTMENT

Growing use of CT scans is not supported by evidence-based medicine

by RYAN PATRICK RADECKI, MD, MS

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Can you remember the last time you worked a shift in the emergency department and ordered zero computed tomography (CT) scans? Can you even imagine a time in history when the number of CT scans to rule out pulmonary embolism ordered was compiled in a monthly total rather than a daily report? There was, indeed, a time when it was not so common to parade a CT about town in such innovations as mobile stroke units.

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ACEP Takes the Hill at the Legislative Advocacy Conference

Highlights from the 2016 meeting in Washington D.C.

by L. ANTHONY CIRILLO, MD, FACEP

ACEP physicians took to Washington, D.C., and Capitol Hill at the 2016 Legislative Advocacy Conference May 15-18. This year featured record-breaking attendance with more than 600 participants, including 200 first-timers. Having that many newcomers attend the meeting is a great sign that more emergency physicians understand the importance of effective advocacy. After last year's breakthrough on repeal of the flawed sustainable growth rate and the passage of Medicare and Chip Reauthorization Act (MACRA), this year's conference took on a more "forward-looking" tone with a focus on creating a better future for emergency medicine in a rapidly changing health care delivery landscape.

SUNDAY FUN DAY

Although the official ACEP conference program started on May 16, the Emergency Medicine Residents' Association (EMRA) and the ACEP Young Physician Section took the lead with their half-day "Health Policy Primer" educational program on Sunday afternoon. This program is designed to warm up residents, students, and those younger physicians who are attending the meeting for the first time so they get the most out of the experience, especially from the Capitol Hill visits. After an overview and introduction to the program by EMRA President Ramnik "Ricky" Dhaliwal, MD, his brother Jamie Dhaliwal, MD, discussed the basics of health policy and the "alphabet

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PERIODICAL

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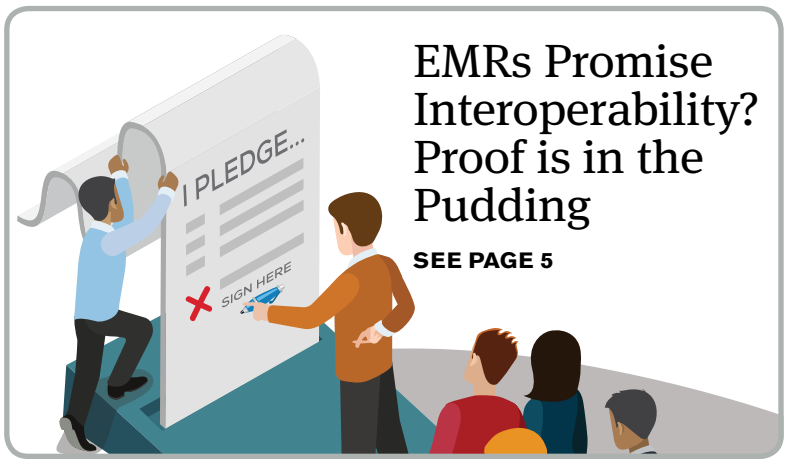

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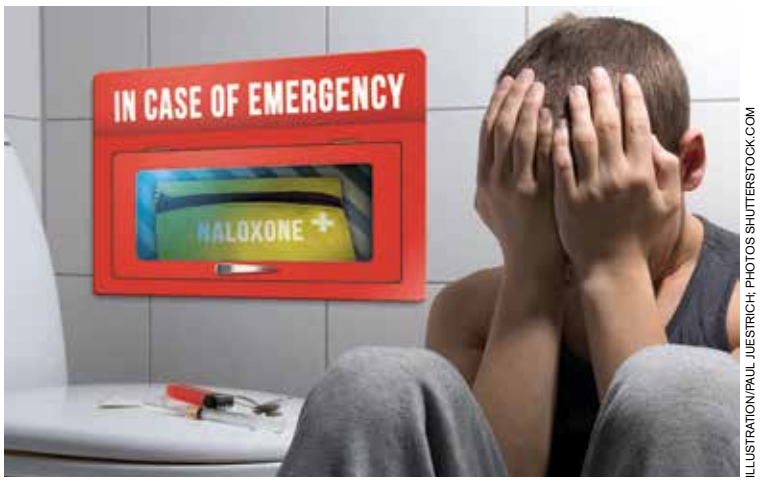

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The Controversy Over Naloxone Distribution to Patients

While naloxone can save lives, giving it to patients and families raises ethical issues that need to be explored

by CATHERINE A. MARCO, MD, FACEP; JOHN E. JESUS, MD, FACEP; JOEL M. GEIDERMAN, MD, FACEP; AND EILEEN F. BAKER, MD, FACEP

The article "Naloxone Distribution Strategies Needed in Emergency Departments" by Samuels et al (*ACEP Now*, March 2016) addresses the important and controversial topic of direct naloxone distribution to patients who may have an addiction to opioids. The authors recommend naloxone for patients who use heroin, exceed 100 mg of morphine equivalents daily, have opioid abuse/dependency, or have had an opioid overdose. They recommend that staff training, program monitoring, and feedback should be data driven and provided on a regular basis.

The problem of opioid addiction and related morbidity and mortality is one of increasing significance in the United States. Particularly in the ED environment, we frequently treat patients for opioid addiction and complications, including drug-seeking behavior, accidental or intentional overdose, and trauma attributable to opioid use, which may include significant morbidity and mortality.

The administration of naloxone by first responders has undoubtedly reduced deaths from opioid overdose for many years. Some also advocate for availability of naloxone to patients, family, and friends who may witness an overdose and its immediate effects. Immediate administration of naloxone can be lifesaving in such circumstances.

The effects of widespread naloxone availability to laypersons are unknown. Some question whether widespread availability might enable substance abuse by creating a false sense of security and by diverting attention and resources from addiction treatment. While naloxone clearly can be a lifesaving intervention for an opioid overdose, it is possible that its availability, in fact, increases opioid use and addiction.

We concur that a lifesaving medication such as naloxone should be made available to patients at risk of opioid overdose. It should, however, be recognized by prescribers that naloxone is only a treatment for acute overdose and does not address the larger problem of addiction and high-risk behavior.

We recommend scientific research to study the consequences of naloxone distribution. Widespread use of a therapeutic agent should be embraced based on sound scientific evidence of its efficacy to patients.

While naloxone clearly can be a lifesaving intervention for an opioid overdose, it is possible that its availability, in fact, increases opioid use and addiction.

We also recommend societal resources to offer treatment for opioid addiction, including making inpatient and outpatient treatment available to all patients who are in need of treatment, regardless of gender, age, income, education level or ability to pay. ⊕

DR. MARCO is professor of emergency medicine at Wright State University Boonshoft School of Medicine in Dayton, Ohio.
DR. JESUS is an attending physician at Augusta Health in Fishersville, Virginia.
DR. GEIDERMAN is a professor of emergency medicine and emergency department co-chairman at Cedars-Sinai in Los Angeles.
DR. BAKER is assistant professor of emergency medicine at the University of Toledo College of Medicine and Life Sciences in Ohio.

WHAT ARE YOU THINKING?

SEND EMAIL TO ACEPNOW@ACEP.ORG; LETTERS TO *ACEP NOW*, P.O. BOX 619911, DALLAS, TX 75261-9911; AND FAXES TO 972-580-2816, ATTENTION *ACEP NOW*.

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Caucasian, Middle-Aged, Christian, Heterosexual Male

Perspectives from a place of relative safety

by KEVIN M. KLAUER, DO, EJD, FACEP

I recently attended ACEP's Diversity Summit, spearheaded by ACEP President-Elect Rebecca Parker, MD, FACEP, as part of the diversity initiative that will be a key part of her presidency. Professionally, thank you Dr. Parker for your vision and leadership, and personally, I thank you for your invitation to the Diversity Summit. I learned a few things about myself, and more importantly, I learned about others.

In one of the early activities for attendees at the summit, we were asked to tell the others in our small group of three why we believed we were invited to attend. It was clear to me why others were present, as they were representing diverse groups of the College, but why me? I noted that I suspect Dr. Parker asked me because she knows I am sensitive to the issues of cultural diversity and have always tried to express my open support. However, one of my group members said, that's not why you are here—you are here because hearing the message from someone who doesn't need to tell it is powerful. In other words, no one is surprised to hear a woman advocate for gender equality or an African-American speak to the need for racial equality, but when the issue becomes important to those who are not directly in the line of fire and there's a realization that we are all negatively impacted by bias and insensitivity, it becomes everyone's issue.

We will never all be alike and nor would we want to be. There are many characteristics that make us diverse. Unfortunately, society tends to focus on obvious and easily detectable differences (eg, gender, ethnicity, religion, and sexual orientation). We may never know the countless ways each of us differs from the next. Those differences may be a source of intrigue, but not admonishment or judgment.

It's good to be confident and comfortable in one's own skin, but being comfortable in your skin shouldn't imply that your skin is the standard one size that should fit all. Quite the contrary, if we enjoy being who we are, free from bias and persecution, we should ensure others enjoy that same basic human right.

I'm a Caucasian, middle-aged, Christian, heterosexual male. I'm not what people think of when they hear the word "diverse." The summit taught me a thing or two about myself. Yes, if we focus on gender, race, etc., my demographic lacks diversity. However, when we consider the entire person, the diversity among all of us is exponential. In one summit exercise, random characteristics were called out by the facilitator and those with that characteristic were to briefly stand. "Were you a cheerleader?" Two women and one man stood. I was standing. You have no idea how

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uncomfortable and embarrassed I felt (or maybe you do). I felt the immediate impulse to explain why I chose that path in college (I'll save that story for another day). But I shouldn't have to explain this to anyone. Nonetheless, I felt the social pressure to explain why I was different. Epiphany: If I felt self-conscious about my insignificant differences being exposed for one minute, then what must others feel about their ethnicity, religion, gender, etc. when made to feel the same way? Regardless of what the characteristic was, each of us was eventually called out and publicly isolated. This was an uncommon situation for someone of my demographic background.

Due to my background, I speak from a position of relative safety. That safety can create complacency with respect to our pursuit of equality and cultural sensitivity.

People who think diversity and cultural sensitivity is a special interest may think so because they are somewhat removed from the impact it may have on others' daily lives.

Is there oppression? It seems like a harsh term, but yes. I have heard too many stories of those changing their behavior to conform or shield themselves from scrutiny. In my opinion, that is oppression.

Shift in Perception

Wow, my eyes are wide open. My culturally diverse friends have become conditioned to accept what others may assume no longer takes place. When you conform or cloak/disguise yourself to hide from social bias and criticism, you must lose a big piece of who you are. Further, once you have decided to acquiesce, those on the outside hear nothing and see normalcy, but distance and resentment may grow on the inside. Silence harbors further division.

Cultural sensitivity is not a cliché, it's not a special interest and it's not something that "those people talk about." Ignorance is no longer an excuse and silence is no longer acceptable. We collectively own this issue.

If I were homosexual, African-American, Hispanic, or in any other minority group, I believe I would feel angry if I were treated differently because of what I am and not who I am.

It's unconscionable to cast a disparaging look or make a negative comment about persons with disabilities. So, please help me understand why other non-choices in life easily lead to judgment from others. I did not choose to be a male, Caucasian, or heterosexual. I just am. It's not subject to debate, nor a basis for challenge, because I also just happen not to be something else. This is what I am, but not entirely who I am.

We Can Do Better

Trying to really consider how others may feel, I would suggest that when it comes to cultural sensitivity, let's not be "color blind." This concept has always bothered me. Being blind to someone's skin color doesn't demonstrate compassion and acceptance; rather it condones ignoring a very important aspect of who that person is. Acceptance is all-inclusive and not a selective process.

My perspective of another is not impacted by their sexual orientation, and they certainly shouldn't feel social pressure to publicly declare their sexuality, as if this information is a secret kept from society. Hiding or suppressing one's identity due to societal pressure doesn't make them more like everyone else. One attendee at the summit noted that heterosexuals do not have to declare their sexuality to others. Why then is there social pressure for homosexuals to disclose such intimate details?

Ask yourself this question: "Have I ever been surprised by someone's race, ethnicity, faith, or sexual orientation?"

CONTINUED *on page 4*

ACEP HOSTS DIVERSITY SUMMIT, MAKES CASE FOR CHANGE

WITH AN EYE TO THE FUTURE of emergency medicine, ACEP hosted a Diversity and Inclusion Summit in April to promote and facilitate diversity and inclusion and cultural sensitivity within the 35,000-member organization.

Led by President-Elect Rebecca B. Parker, MD, FACEP, the daylong Summit included more than two dozen ACEP members and staff who represent a variety of communities (age, gender, religion, race/color, and LGBT). These participants also brought special knowledge, research, publication, or leadership in diversity and within EM.

Women comprise more than half the population and minority groups comprise roughly 38% of the U.S. population today. Most of the largest American cities and some of the largest and fastest growing states have populations in which minorities are collectively the majority or will be in the near future. By contrast, the leadership of organized medicine and the EM workforce falls well below these averages—a fact that ACEP is working to change.

The primary objectives for the Summit included:

- **Provide environmental data that are important to the specialty of EM.**
- **Create a safe space to share stories, create dialogue, new ideas, and awareness.**
- **Capture results and identify areas of focus that will influence a two- to three-year Diversity and Inclusion Strategic Plan for ACEP.**

Most of the Summit participants will remain as members of a new Diversity and Inclusion Expert Panel that will serve Dr. Parker and future ACEP presidents as topical experts and champions for years to come. Additionally, Dr. Parker is creating a Diversity and Inclusion Task Force to begin work this summer on strategies and tactics for ACEP to begin to implement at ACEP16.

"ACEP and its Board knows this is the beginning of a journey; a journey of cultural change to transform our organization that will span numerous years," states Dr. Parker. "We are excited to begin the journey and encourage everyone to join us."

A NEW SPIN | CONTINUED FROM PAGE 3

If the answer is yes, and I suspect we all would answer yes, this should expose the fact that we probably all have some internal biases. It's not wrong; it's reality. What we do with those biases, a choice, is the standard by which we should all be judged. Recognizing our own internal biases allows us to build the necessary barriers between the subconscious and the conscious so that those biases, whatever their origin, do not define our actions, and ultimately, how we treat others. I believe this is a part of personal growth, and we owe this to each other, our patients, and ourselves.

Ignorance is no longer an excuse and silence is no longer acceptable. We collectively own this issue.

I know life and society are too complex to expect everyone to just get along. In fact, you can dislike as many and whomever you choose, but I challenge you to make certain you have a justifiable and rational reason for doing so.

I'm not a social activist. I'm a sensitive realist. How can I accept inequality for others and remain silent if I would not tolerate inequality and insensitivity toward my family or me?

Recognizing our tendency toward bias is the first step. Make a conscious decision to control those biases and not let them define you. There are many faces of emergency medicine, embracing our diversity makes us all stronger, while closing our minds limits our personal and collective growth as a specialty.

DR. KLAUER is the chief medical officer–emergency medicine and chief risk officer for TeamHealth as well as the executive director of the TeamHealth Patient Safety Organization. He is an assistant clinical professor at Michigan State University College of Osteopathic Medicine and medical editor in chief of *ACEP Now*.

PUT YOURSELF TO THE TEST

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LATEST RESEARCH

Non-Operative Management Effective in Severe Splenic Injury

by DAVID DOUGLAS *(Reuters Health)*

In patients with high-grade splenic injury, non-operative management (NOM) can be as effective as immediate splenectomy (IS), according to Wisconsin-based researchers.

In an April 22 online paper in the *Journal of the American College of Surgeons*, John E. Scarborough, MD, and colleagues at the University of Wisconsin School of Medicine and Public Health in Madison noted that such an approach has become standard in those with low-grade injury. However, routine use in patients with grade IV or V blunt splenic injury remains controversial.

To investigate further, the team examined data from 2013 and 2014 on more than 2,700 patients with such injury in about half of whom NOM was attempted. Using propensity-matching techniques, they identified and compared outcomes in 758 NOM and 758 IS patients. In-hospital mortality was 10.0% in the NOM group, not significantly different from the 11.5% in the IS group. However, the IS group had a significantly higher incidence of infectious complications (21.4% versus 16.9%, P=0.02).

Of the 1,489 patients from the overall study sample in whom NOM was attempted, 299 (20.1%) ultimately required splenectomy. The NOM failure rate was 17.8% in grade IV splenic injury and 29.0% with grade V injury.

Among early predictors of failed NOM were early blood transfusion requirement and grade V injury.

Splenic artery embolization (SAE) was associated with a decreased risk of NOM failure. The failure rate in initial NOM patients who underwent SAE was 11.0% compared to 21.4% in those patients who did not. Although failed NOM patients had a longer median hospital stay than IS patients (13 versus 10 days), their in-hospital mortality was significantly lower (6.4% versus 16.4%).

Overall, the researchers concluded, "NOM is as effective as IS for hemodynamically stable adult patients with grade IV or V blunt splenic injury. The delay in operative intervention that results from failed attempts at NOM does not adversely impact the outcomes of patients who ultimately require splenectomy."

Commenting on the findings by email, Andrew L. Warshaw, MD, told Reuters Health, "Non-operative management of splenic fractures in hemodynamically stable patients is widely accepted. What is being tested here is the extension of the practice from lesser degrees of injury to the more severe grades IV–V, which are more likely to be in unstable patients who may also have other significant visceral injuries."

Dr. Warshaw, who is surgeon-in-chief emeritus at Massachusetts General Hospital in Boston, concluded, "The key to successful application of this approach lies in careful selection of the patients to be treated in this manner."

The authors reported no funding or disclosures.

DON'T GET BITTEN BY ZIKA DOCUMENTATION

Breaking the code for documenting Zika

BY MICHAEL GRANOVSKY, MD, FACEP

CPT codes are updated annually, typically on Jan. 1, and describe the cognitive and procedural care provided by emergency physicians. ICD diagnosis codes are also updated annually, but rather than on a calendar-year cycle, new codes become effective on Oct. 1.

While ICD-10 diagnosis codes are important for coding and billing purposes to communicate the necessity of the care provided, the codes also fill a critical role in facilitating epidemiologic tracking. The World Health Organization has been using ICD-10 codes to track disease and injuries for years. When a novel disease such as Zika virus becomes clinically important, a key component of tracking the disease is to develop, approve, and release an ICD-10 diagnosis code that facilitates disease incidence calculations and the identification of patient-specific details.

Currently, there is no specified ICD-10 code for Zika, and until there is a specific code available, the ICD-10 code A92.8 (other specified mosquito-borne viral fevers) may be reported. This less-specific code is not very effective for tracking the spread of Zika. There is a proposed code (A92.5) for the 2016 ICD-10 annual release. However, it cannot be used until it is officially released in October.

Patients with suspected Zika may present with symptoms such as fever, maculopapular rash, arthralgia, conjunctivitis, headache, and myalgia, which should be reported when the disease is not confirmed. For example, if a patient presents with myalgia, headache, and arthralgia, the clinician may suspect Zika, but it is not confirmed. The diagnosis of M79.1 (myalgia), R51 (headache), and M25.50 (arthralgia, unspecified) would be reported. Reporting Zika would not be appropriate.

On the other hand, if the patient is formally diagnosed with Zika, then A92.8 (other specified mosquito-borne viral fevers) should be reported until such time as a formal Zika diagnostic code is available.

Helpful ICD 10 Signs and Symptoms Codes

R50.9: Fever, unspecified
R21: Rash and other nonspecific skin eruption
M79.1: Myalgia
M25.5*: Arthralgia (*use code for specific joint when appropriate)
R51: Headache
G61.0: Guillain-Barre syndrome
Q02: Microcephaly

WHAT ABOUT PREGNANCY?

Diagnosis reporting for illnesses associated with pregnancy adds another layer of complexity. For patients diagnosed with Zika during pregnancy, providers should report O98.5X (other viral diseases complicating pregnancy, childbirth, and the puerperium). The final digit indicates the trimester (1 for first, 2 for second, 3 for third). For example, a patient who is six weeks' pregnant is treated for fever, myalgia, and headache and reports recent travel to Brazil. A complete evaluation is performed. The patient is diagnosed with Zika. The ICD-10 diagnosis codes of O98.511 (other viral diseases complicating pregnancy, first trimester) and A92.8 (other specified mosquito-borne viral fevers) would be reported.

Consider these additional ICD-10 codes for other flaviviruses:

- **A90:** Dengue fever
- **A91:** Dengue hemorrhagic fever
- **A92.0:** Chikungunya virus disease

Documenting the signs and symptoms that brought the patient to the ED helps to support the medical necessity of the care provided. This fall, we will have a specific Zika code that can be used to track the spread of the virus through submitted claims data.

DR. GRANOVSKY is president of LogixHealth, a national ED coding and billing company, and chair of the ACEP Reimbursement Committee.

The Proof Is in the Pudding

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Hope and skepticism for the pledge of health care information technology interoperability

BY JON MARK HIRSHON, MD, MPH, PHD, FACEP

The English origins of the pudding proverb date back to the early 14th century. The tasting of an item was meant in the general sense to test or try something—to know how good a food item was, you had to taste it. The first version specifically using pudding was in 1605 from William Camden's Remaines of a Greater Worke, Concerning Britaine. *His version was,"All the proofe of a pudding, is in the eating." Of course, back then pudding was not a sweet dessert but likely a savory sausage of meat and seasonings. If not cooked properly, it could have been fatal.*

On Feb. 29, 2016, the Department of Health and Human Services (HHS) announced that multiple major health information technology (IT) developers, providing more than 90 percent of U.S. electronic health records (EHRs), have pledged to improve interoperability of their EHR systems. Many other stakeholders, such as hospital systems and professional organizations, have also signed the pledge. HHS Secretary Sylvia Mathews Burwell announced this wonderful pledge during the Healthcare Information and Management Systems Society convention in Las Vegas.

Great, wonderful, exciting ...

The three main points of the pledge are:

1) **Consumer Access:** To help consumers easily and securely access their electronic health information, direct it to any desired location, learn how their information can be shared and used, and be assured that this information will be effectively and safely used to benefit their health and that of their community.

2) **No Information Blocking:** To help providers share individuals' health information for care with other providers and their patients whenever permitted by law, and not block electronic health information (defined as knowingly and unreasonably interfering with information sharing).

3) **Standards:** To implement federally recognized national interoperability standards, policies, guidance, and practices for electronic health information, and adopt best practices including those related to privacy and security.[1]

Awesome!

However, before we taste this flavorful treat, let me simply state that the proof is in the pudding. Why my dose of healthy skepticism? How about vendor resistance, high fees for data exchange, lack of vendor incentives, and multiple EHR technical variations and challenges, to name just a few reasons?

Let's look at some of the potential challenges in improving health IT interoperability. What about vendor resistance? If the data are locked into their system, they can charge high exchange fees. If their business model is based on information management and data exchange, why would they give away potential profit? Aside from governmental pressure and consumer demand, what is their incentive? How will it benefit their shareholders?

> Why would they give away potential profit? Aside from governmental pressure and consumer demand, what is their incentive? How will it benefit their shareholders?

Additionally, let's not minimize the technical and structural challenges in developing health IT interoperability. These potential obstacles are significant, especially considering the hundreds of different EHRs. Some of these challenges include insufficient interoperability standards, variation in state privacy rules and laws, problems with accurately matching patient medical records, significant costs, lack of trust between vendors, and data security concerns.

Hmm, maybe this sausage doesn't smell so good ...

The three main components of the health IT interoperability pledge are to help patients access their personal health information, to help providers deliver better care through information exchange, and to prompt the government to improve interoperability standards and policies. While consumer demand and government weight can potentially produce some movement, what leverage do individual providers have?

To be sure, there are some health IT developers that are working to improve access to medical records for providers despite the challenges. In Maryland, there is the nonprofit Chesapeake Regional Information System for our Patients (CRISP), which has implemented a statewide health information exchange. As a provider, I can access a patient's medical records from my computer in the emergency department and look at medical record documents such as discharge summaries, laboratory and imaging results, and prescription information from other providers. Upcoming enhancements will include actual image exchange. In Washington and Oregon, there is the Emergency Department Information Exchange (EDIE) by Collective Medical Technologies, which is a private, for-profit corporation. Again, this system allows for real-time access in the emergency department to medical records from many participating health care institutions.

Both of these models are add-on systems to regular EHRs from the major health IT developers. Both have required substantial infrastructure development and investment from private and public partners. They are works in progress but have substantially positively affected the ability of emergency providers to deliver care in the states where they have been deployed. But, as stated, they are not the core health system EHRs.

It would be great to see this pledge fulfill its promise. Obtaining the most recent CT angiogram from an outside hospital on a patient presenting with chest pain can save time and money and reduce patient exposure to ionizing radiation. True health IT interoperability is critically needed to improve our ability to efficiently and effectively deliver modern care.

I just hope my colleagues and I don't end up septic in the ED after eating this savory morsel.

Reference

1. HHS announces major commitments from healthcare industry to make electronic health records work better for patients and providers. US Department of Health and Human Services Website. Available at: www.hhs.gov/about/news/2016/02/29/hhs-announces-major-commitments-healthcare-industry-make-electronic-health-records-work-better.html. Accessed April 15, 2016.

DR. HIRSHON is professor in the departments of emergency medicine and of epidemiology and public health at the University of Maryland School of Medicine in Baltimore.

Planning to Make a Difference in Washington

Dr. Mark Plaster is taking on a 10-year incumbent to fix problems and bring real-world experience to the U.S. House

BY L. ANTHONY CIRILLO, MD, FACEP

Mark Plaster, MD, is not your typical emergency physician and certainly not your typical politician. Born the son of a minister in the Midwest, Dr. Plaster focused on academics and basketball throughout high school so he could land a full-ride basketball scholarship to college, where he met and married his college sweetheart, Rebecca. Dr. Plaster and Rebecca went on to raise three children, who, so far, have given them seven grandchildren.

As an emergency physician, Dr. Plaster has spent most of his life working the night shift in some of our nation's biggest cities. He received his law degree in health law so he could better understand the health care field and the policy and politics behind it. Dr. Plaster started writing for a medical magazine and eventually realized he could produce a magazine himself. He started a publishing company and grew it to produce two national magazines and one international magazine every month, all of which started on a picnic table and a dot-matrix printer in his basement. Today, Emergency Physicians Monthly *is one of the most widely read emergency medicine publications in the industry, and Dr. Plaster's "Night Shift" columns have been compiled into a book of the same title.*

In 2001, with his eldest son preparing to graduate from the U.S. Naval Academy, Dr. Plaster, at the age of 50, volunteered his medical expertise in service to our nation and joined the Navy Reserves. Dr. Plaster became Lt. Commander Plaster and was soon deployed to Iraq, where he led a shock trauma team during the first year of the invasion of Iraq. Upon returning home, he was again called on to serve his nation when he was asked to provide expert advice on an expansive classified report for the President of the United States through the Department of Homeland Security regarding our nation's readiness for a large-scale catastrophic attack on the homeland. Lt. Commander Plaster was again asked to serve, and he returned to Iraq in 2008 to provide humanitarian care for the Iraqi people and train Iraqi medical staffs.

Mark Plaster, MD

In addition to his successes as an emergency physician, veteran, lawyer, and businessman, Dr. Plaster now wants to take on one more challenge: member of Congress. Make no mistake, however, Dr. Plaster isn't a career politician and isn't looking to become one. He just wants to bring his experience to Washington to address the needs of the people of Maryland and the country.

ACEP Now *caught up with Dr. Plaster to talk about taking on the challenge of running for the U.S. House of Representatives in Maryland's 3rd district.*

LAC: What were the biggest motivators for you to run for the House?

MP: In all honesty, I had been thinking about getting involved in politics ever since I graduated from law school in 1989. While I was in law school and then practicing law, I was always interested in how much politics affected the practice of both emergency medicine and law. Although I was interested in politics and potentially running for office, the realities of being a Republican living in a heavily Democratic congressional district kept me from taking the next

What is NEMPAC?

NEMPAC is a critical tool to help ACEP promote our legislative goals and express the concerns of emergency medicine to members of Congress. It is the financial vehicle through which ACEP members can support the election or re-election of federal candidates who share their commitment to emergency medicine. NEMPAC pools smaller donations from individual ACEP members, donating them in one larger and more impressive contribution on behalf of the entire profession.

Under federal law, associations may establish and administer separate segregated funds known as political action committees (PACs) to pool the voluntary contributions of their members. PACs are a legal, transparent, federally monitored means of contributing to candidates. Today, there are more than 4,000 federally registered PACs in the United States.

Why is NEMPAC important to ACEP and to its members?

A NEMPAC's growth in size and presence in Washington, D.C., is increasingly important as Congress continues to address many issues facing emergency medicine, such as Medicare and Medicaid reimbursement; medical liability reform; implementation and/or revisions to the Affordable Care Act; and funding for graduate medical education, trauma care, and EM research, just to name a few. Elected officials are frequently asked to make decisions between competing interests. We must be prepared to support legislators and candidates who understand and advocate for emergency medicine issues.

How does NEMPAC spend the money it receives from contributors?

A All personal contributions received from ACEP members to NEMPAC are considered "hard dollars." NEMPAC uses these hard dollars only for the purpose of making political contributions to US Senate and House candidates, national parties, and other PACs sponsored by federal legislators. NEMPAC does not donate to presidential candidates or to candidates for state or local office.

How does NEMPAC pay for administrative expenses?

A NEMPAC uses a combination of ACEP general operating funds and corporate contributions donated to NEMPAC known as "soft dollars."

Who decides which candidates receive NEMPAC donations?

A NEMPAC donors do. The NEMPAC Board of Trustees, composed of ACEP members, approves a candidate budget for each election cycle. Evaluation criteria are based on the candidate's or member's support of ACEP's legislative priorities. Other factors considered include the member's committee assignment, leadership position, and difficulty of the election campaign. We also rely on the input of ACEP state chapter leadership, individual 911 Network members, and NEMPAC supporters when evaluating open-seat and challenger races.

How can I personally contribute to NEMPAC?

A An ACEP member has several contribution options: 1) Write a personal check; 2) contribute by Visa, MasterCard, or American Express; 3) contribute online at www.acep.org/nempac; or 4) sign up for an installment plan on a monthly, quarterly, or semi-annual basis on a contribution form or online.

Can a group practice make a contribution to NEMPAC?

A There are many options for ACEP members within a group practice and the group collectively to donate to NEMPAC, including payroll deduction. A description of the options is available on the NEMPAC website and by contacting Jeanne Slade, NEMPAC director.

Where can I find additional information about NEMPAC?

A *Visit* ***www.acep.org/nempac*** *or contact Jeanne Slade, NEMPAC director, at jslade@acep.org or 202-728-0610 or* 800-320-0610.

NEMPAC
National Emergency Medicine PAC

step. I figured that, as a practicing emergency physician and a contributor to both *EM Law* and *EP Monthly*, I was doing my part to help the specialty and patients. Things all changed for me in 2003 when I was deployed to Iraq for the first time at the same time as my son who had graduated from the U.S. Naval Academy. As part of a shock trauma team, I witnessed the personal sacrifice of the Marines with whom I served, and my perspective on many things changed. I developed a much deeper and more passionate sense of patriotism. The women and men with whom I served stepped out of their comfort zone and took on the tough challenges. After I returned from my second deployment to Iraq, people started encouraging me to run for office. However, it wasn't until 2014, when Republican Larry Hogan won the governor's race—only the second Republican to hold that seat in nearly 50 years—that I realized it was my turn to take my knowledge, experience, and passion and make a run for the U.S. House.

LAC: What are the key legislative issues that you are focusing on in your campaign?

MP: I believe that we, as a nation, need to rebuild a broad-based economy. As emergency physicians, we really haven't felt the effects of the economic downturn in this country. Patients keep coming to the ED, and our incomes have been pretty stable. But as a small business owner, I have seen how the "baked in" regulation and tax structures in this country have really hindered the growth of small businesses. Because of the unfriendly regulatory environment, new small business start-ups are at the lowest levels since the President Carter years. I also believe that our national security is directly tied to our economic security, which makes it even more critical to fix our economy. The national health care system is also critical to the overall health of the nation and will continue to go through significant transition. Physicians need to develop a better understanding of what patients need and then get involved early on in the process of laws being written rather than reacting to laws passed by Congress and rules promulgated by government agencies.

LAC: How can the house of emergency medicine be more supportive of emergency physicians who are interested in the political arena?

MP: First, I hope that all emergency physicians realize what a tremendous opportunity we have with Joe Heck running for the U.S. Senate. I believe that Joe will win that race and admire the fact that when Joe first ran for the Nevada State Senate, he took on a 20-year incumbent. My race this year is against a 10-year incumbent; I can only hope to have the same success that Joe did in his first race. EM docs also need to know that it does take money to run a campaign. I would hope that every EM doc would make even a small contribution to the campaigns of EM docs that are running for office. The other thing that EM docs need to do is get more involved with organized medicine at the state and national level. Being involved in your state ACEP chapter or national ACEP is a great way to start being more comfortable with understanding politics. EM docs can't be afraid of the political process. For crying out loud, if we can learn medicine, then we can learn the process of how laws are made. You don't have to be a lawyer.

LAC: What do you see as potential solutions to the hyper-partisanship that exists within Congress?

MP: The problem with Congress today is that too many people in Congress are career politicians, including my opponent. My opponent has voted with his party leadership 99.8 percent of the time because he wants to stay in good standing with his party. But that means that he cares more about his political party than he does about making good policy. At the age of 64, I am not running for Congress to have another career. I have plenty of real-world experience, which many members of Congress don't have. I'm running in order to fix problems and, if I can be successful in Congress, would be happy to put myself out of a job.

LAC: How do you believe EM doc candidates like yourself can work more closely with ACEP?

MP: ACEP has real potential for developing political leaders through its advocacy programs. I am embarrassed that I wasn't more involved in ACEP leadership in my career, although as a locum doc and traveling for over 25 years, it was tough for me to get involved. I know that the ACEP Leadership and Advocacy Conference is a great program, and EM docs need to take advantage of that and ACEP's other educational opportunities to understand the issues. In addition to knowing the issues, docs need to get to know the people involved in politics. It isn't enough to just know the issues, you have to reach out to elected officials and make sure your voice is heard.

LAC: How can emergency physicians find out more about your campaign?

MP: The first place to start is on my campaign website, **www.plasterforcongress.com.** There is information about my views on state and national issues on the website. Docs can get a better sense of who I am on a more personal basis by checking out my Facebook page, **www.facebook.com/markplastermd.**

Lastly, if docs want to reach out to me directly, they can email me at either **doc@plasterforcongress.com** or **erdocmark@gmail.com.** If docs want to really just talk about the issues or the campaign, I would also be happy to just talk directly. I can be reached at 302-545-0406.

DR. CIRILLO is director of health policy and legislative advocacy for US Acute Care Solutions/EMP in Canton, Ohio.

LAC16 BY THE NUMBERS

600
more than 600 attendees (a record)

47
states, the District of Columbia and Puerto Rico represented

405
meetings in Capitol Hill offices

94%
of Senate offices were visited

71%
of the House of Representatives' offices were visited

1,200
messages to Congress sent via Phone2Action

$120,000
raised for NEMPAC (a record)

9
fundraising "Dine-Arounds" for Members of Congress

Leadership & Advocacy Conference

2017 Leadership & Advocacy Conference = March 12-15, 2017

soup" of acronyms that are a must to understand the players and programs in D.C. Following Dr. Jamie Dhaliwal, the program consisted of a who's who list of experts, including Mike Granovsky, MD, talking on fair payment and balance billing; Douglas McGee, DO, updating the group on graduate medical education funding; Brendan Carr, MD, presenting payment and delivery reform basics; and Aisha Liferidge, MD, leading a journal club discussion on alternate payment models. The program was capped off by Dr. Ricky Dhaliwal and John Rogers, MD, vice president at ACEP, presenting their views on how emergency physicians can, and should, get more involved in the health policy decision-making process as advocates for patients and our specialty. EMRA also announced the fourth edition of its *Emergency Medicine Advocacy Handbook*, edited by Alison Haddock, MD, and Nathaniel Schlicher, MD. Downloads or hard copies are available at **www.emra.org.**

The social opener of the conference is the National Emergency Medicine Political Action Committee (NEMPAC) VIP reception. All "VIP" level contributors to NEMPAC are invited to the event, which was again held at the Top of the Hay rooftop room in the Hay-Adams hotel. Supporting NEMPAC is the easiest way to support ACEP's advocacy efforts. If you aren't already a NEMPAC contributor, access the NEMPAC website at **www.emergencyphysicianspac.org** or through the ACEP website at **www.acep.org** under the Advocacy tab. In addition to the official Hill visits with members of Congress (MOC), NEMPAC coordinated "Dine Around" dinners, each with MOC. Small groups of EM physicians, 10 to 12 per dinner, attend these fundraising gatherings. These dinners provide quality time with MOC in order to take the "deeper dive" on the issues and challenges that face us every day.

OFFICIAL KICKOFF

The meeting officially kicked off with a welcome from ACEP President Jay A. Kaplan, MD, who got the group all fired up by demonstrating new advocacy technology that is now available to all state chapters. Every attendee was able to email, Facebook, and tweet their MOC to let them know that EM physicians were in D.C. It was a powerful demonstration of how technology can make advocacy easier and more effective. The rest of the day was just as engaging with talks on disruptive innovation, alternative payment models, and ACEP's quality initiatives under MACRA and Merit Based Incentive Payment System (MIPS). Although adjustments to Medicare physician payments under MIPS won't start until 2019, the data collection begins January 2017.

Luncheon speaker Charlie Cook, a nationally recognized political analyst, offered insights into the current election cycle and gave his predictions about the presidential race. Following Mr. Cook's talk was a presentation about good and bad regulations—underscoring the importance of what happens after a law is passed and the regulatory agencies take responsibility for establishing how programs will be operationalized. Closing out the day was a session entitled "State Strategies to Deal with Out of Network/Balance Billing." This rapidly has become the hot topic in EM as many states are considering legislation that would significantly change the rules of billing patients. Dr. Kaplan made this issue a cornerstone of his presidency and his creation of the term "fair coverage" has completely changed the tone and tenor of the discussion with legislators and policymakers. Through the "fair coverage" campaign, ACEP is leading the house of medicine in educating legislators and policymakers on how their constituents, and our patients, are being unfairly treated by insurance companies that are selling insurance policies with exorbitantly high out-of-pocket deductibles. For more information on the campaign, go to **www.faircoverage.org.**

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Speaker Steve Stack, MD, president of AMA, and ACEP member.

WORKING THE HILL

Tuesday morning's program was highlighted by presentations from the two EM physicians who are MOC. Joe Heck, DO, (R-NV), and Raul Ruiz, MD, (D-CA), both challenged attendees to be more active and engaged in health policy and advocacy. Brad Gruehn from the ACEP D.C. office also presented an overview of key issues, which included the following:

1. **The Opiod/Narcotic Issue** – discussing recent CARA (Comprehensive Addiction and Recovery Act) passed in the Senate and the House.
2. **Medical Liability Reform for Emergency Medical Treatment and Labor Act (EMTALA) Services** – ACEP's continued effort to establish federal liability protection for EMTALA mandated care in the ED by EM physicians and on-call specialists.
3. **Mental Health Reform** – asking MOC to pass meaningful reform to give EM the needed resources to provide appropriate care to patients with mental health illnesses.
4. **Improving EMS Delivery of Care** – supporting the Patient Protection Access to Emergency Medications Act of 2016, which would allow for continued administration of controlled substances to patients by EMS under standing orders.

ACEP "Takes the Hill" event closed the conference on Tuesday afternoon. Soapbox Consulting arranged all of the Hill visits on behalf of ACEP. In addition, its Soapbox app provided attendees with information on the meeting visits, background materials for the meetings, and bio details for each MOC.

It was inspiring to walk the Capitol hallways and see how many EM docs are "working the Hill" with MOC and staffers to advocate for appropriate policies and laws that will improve our capacity and capabilities to care for our patients.

The last day of the meeting, "Leadership Day," was about being, or becoming, a more effective leader, not just in Washington, but in your ED, your hospital, your group, and the greater health care community. Attendees heard from and interacted with Dr. Kaplan and President-Elect Rebecca B. Parker, MD, American Medical Association President Steve Stack, MD, and others.

DR. CIRILLO is director of health policy and legislative advocacy for US Acute Care Solutions/EMP in Canton, Ohio.

Showing Up Can Make a Difference: Insights from EMRA members on importance of attending Leadership & Advocacy Conference

by ABBY COSGROVE, MD, AND ALICIA KURTZ, MD

Despite the differences in our backgrounds with politics and government affairs, the Leadership & Advocacy Conference in Washington, D.C., was unlike anything either of us had ever experienced; it was life altering. The quality of speakers, the content of their inspirational and informative messages, and being in the same room as people who truly care about the future of EM convinced us that we wanted a seat at the table. As first-timers, despite our experiences in EMRA, we had very limited knowledge of many of the issues (and the acronyms—oh the acronyms!) affecting our daily practices in the ED.

ONLINE RESOURCE
For complete article, go to June issue on **www.acepnow.com.**

The preparation for ACEP Lobby Day was excellent. With our limited experience lobbying legislators, we were both terrified and excited. Yet, walking through the Senate and House buildings, seeing "Nancy Pelosi" and "John McCain" written on office doors, a surprise showing by Marco Rubio, and meeting with our own federal legislators about issues that truly matter to our patients were almost as exciting as running a successful code or putting in a crash chest tube.

In just a few days, we felt transformed from residents who were somewhat disengaged from the political world around us into doctors who felt empowered to make a difference for our colleagues and patients. We would strongly urge all residents to consider attending the conference next year.

DR. COSGROVE is a member of the EMRA Board of Directors. **DR. KURTZ** is president-elect for EMRA.

ACEP's Health Policy Scholarships

EMF policy research grants aim to encourage policy scholarship in EM

MODERATOR

Stephen Anderson, MD, FACEP, emergency physician in Seattle and a member of the ACEP Board of Directors

PARTICIPANTS

Vidor Friedman, MD, FACEP, emergency physician in Orlando, Florida, and a member of the ACEP Board of Directors

Michelle Lin, MD, MPH, emergency physician at the Icahn School of Medicine at Mt. Sinai in New York City

Sandra Schneider, MD, FACEP, director of EM practice at ACEP

Cynthia Singh, director of the grant program for ACEP and EMF

Arjun Venkatesh, MD, MBA, assistant professor of emergency medicine and a scientist at the Center for Outcomes Research & Evaluation at Yale University School of Medicine in New Haven, Connecticut

National health policy is playing an ever-increasing role in the day-to-day practice of medicine, and it's becoming more important for physician groups to advocate effectively for policies that benefit their physicians and patients. However, many of ACEP's leaders felt that emergency medicine's positions weren't making a big enough impact on policymakers. Several members of the Emergency Medicine Foundation (EMF) Board of Trustees—including Vidor Friedman, MD, FACEP, and Wesley Fields, MD, FACEP—recognized that, in order for emergency medicine to be an effective advocate for the health policy needs of emergency patients, the specialty would need more research and data to back up its ideas. They decided to launch a grant program to support emergency medicine policy scholarship.

The Health Policy Scholar grants are funded by the Emergency Medicine Action Fund (EMAF) and awarded by the EMF. The grant program's long-term goal is to develop a group of emergency physicians who are not only experienced researchers but health policy experts and who can investigate and provide support for policies that will benefit emergency physicians and their patients.

To date, the program has funded two researchers. In 2014, the first EMF/EMAF Health Policy Research Scholar Award was bestowed to Arjun Venkatesh, MD, MBA. In 2015, Michelle Lin, MD, MPH, was the Award recipient. These researchers recently sat down with some of the ACEP leaders and staff who were instrumental in launching this health policy research program to discuss the importance of studying health policy in emergency medicine.

Here is a summary of their conversation.

SA: What exactly is health policy research?

SS: Health policy research, in my mind, is really about how the policies we make to control or conduct our health care affect how health care is provided and what the effect is on the patient. Any time we make a decision about changing the way health care is provided, it can have a profound impact on patients and on the health of our nation.

AV: I totally agree. When I think of health policy research, I think of it as the engine of what we call the evidence-based policy movement. I think a lot of emergency physicians and clinicians are very comfortable with the term "evidence-based medicine." Why don't we use the same scientific rigor to analyze data and inform the policies we make? CMS [the Centers for Medicare & Medicaid Services] is going to rethink how they pay for hip and knee replacements, and they're actually doing a randomized study where certain counties in America are going to be paid differently than other counties. Rather than just set payment policy based on a couple of anecdotes or stories, they're developing a plan and will implement, study, and evaluate it to decide how future payment policy is set across the U.S.

ML: I think of health policy research as investigating the policies that improve the actual delivery of care because if we have the greatest scientific advances but we're not able to implement policies that get those advances to patients in an efficient and equitable way, patients can't be benefited.

SA: Why is it important to do health policy research?

SS: It's vital that we understand the forces that drive health care and their effect on patients and the general population. While an individual experience is important, viewing their effect on health care through too small of a lens gives you too distorted a view of the effect. The effect of the ACA [Patient Protection and Affordable Care Act] on any given individual may be positive or negative. One person may have coverage for the first time, while another may be struggling with a high deductible. The effect of the ACA in terms of its cost will not be understood for years. Understanding the effects and improvements of the provision of care is really the goal of health policy research.

VF: Another reason we need to do health policy research is that policy is created on the basis of anecdotal evidence. One of the great urban myths that we fight in emergency medicine is that family practice and the medical home will cure all of the ills of society. What they do is different fundamentally than what we do in terms of the kind of health care they provide. In emergency medicine, there were very few people studying this, yet we're the target of many, many health policies, most of which are negative for our specialty.

AV: We're at the nexus of the health care system. Just in the same way as when we work a shift, we're the one place that is talking to providers in the hospital and outside the hospital. We see what happens when patients do not have access to effective heath care. We see so much of the cost levers at different places. The same is true on the policy side. So far on the policy side, that's given us a lot of monikers that we don't particularly care for and don't reflect our care, such as the unnecessary ED visit or the costly price tag. The only way to get above the fray when it comes to all of those stories is to have data.

SA: Arjun, you're the first recipient of this scholarship. Can you tell us about your research?

AV: It really helped me to achieve two aims. It was first a way to really embed myself in federal quality measurement policy; I had the opportunity to serve on several national quality forums, technical expert panels, and advisory committees. I had the opportunity to participate as both an emergency clinician as well as a health services researcher in the conversations about how measures get endorsed. At the same time, I also had the chance through our Center for Outcomes Research & Evaluation at Yale to work on several projects for CMS and their development of measures of hospital quality and hospital efficiency. I had completed the Robert Wood Johnson Clinical Scholars Program, so I had great research training. What you need is a little bit of help and support to get your first project up and off the ground. In my year, I had the chance to work with a big national data set that has a lot of detailed clinical and cost data. I studied variation between EDs and the use of observation services and how that variation may impact our measurement of their admission rates as well as their total cost of care.

SA: You're sort of the EM rock star of metrics. What's your vision of where others can expand on your research?

AV: It's a particularly great time for it because of ACEP's launch of CEDR, the Clinical Emergency Data Registry. Now, all of a sudden, you have an infrastructure in place where thousands of EDs around the country are going to be coming into the CEDR to fulfill their quality reporting requirements for CMS. I think that emergency medicine has a lot of opportunity in the coming years to develop the next generation of quality measures. No longer measuring things that are simple process of care, like "Did you do an NIH stroke scale for a patient with a stroke?," but rather getting to the next level. What does a patient-reported outcome measure look like for emergency medicine? Can we develop the science to say that we can effectively measure differences in headache treatment? Can we do a better job of actually measuring cost?

"It's critical that we demonstrate that the EM community is proactive about reducing avoidable health care costs and adding value."

—Michelle Lin, MD, MPH

SA: Michelle, you're the most recent recipient of the scholarship. Tell us about your research.

ML: My primary research interest has been identifying ways to demonstrate and improve the value of emergency care. My EMF Health Policy Scholarship project is to perform a cost-effectiveness analysis of ACEP's *Choosing Wisely* recommendations, with the goal of promoting a greater adoption of these value-based practices. This project allows me to combine methods such as decision analysis and large data base analysis to really understand the downstream financial implications of some of the routine tests and procedures that are performed in the ED. It's critical that we demonstrate that the EM community is proactive about reducing avoidable health care costs and adding value.

SA: How do you think this scholarship will affect your future?

ML: First of all, I'm incredibly fortunate to receive guidance from a stellar team of highly accomplished senior advisers who are really

CONTINUED *on page 10*

invested in helping me finish my project but also helping me flourish as a health policy investigator. Also, I've been exposed to meetings such as the EMAF Board of Governors' calls. For example, I learned about some of the policy priorities of the EM community, and I found that the topic of how emergency medicine is going to fit into alternative payment models came up repeatedly. As a result of those conversations, I've recently submitted another EMF health policy grant in conjunction with my mentor, Jay Schuur, MD, MHS, to study how emergency medicine is going to fit into these payment models. Thank you again to EMF and EMAF for this opportunity.

SA: Armed with specific data, how do we turn policy research into actionable political change?

VF: I think that the more evidence the folks that go to the Hill and fight for emergency medicine have, the more credibility we have in our arguments. We're telling them things they don't necessarily want to hear. It's important. We don't have a health care system; we have a health care paradigm. The biggest driver in the change of that paradigm is all about cost. As much as we want to talk about the quality, quality is assumed. I think that our challenge for the future is to use health policy research to help us tell these stories and help shape future change.

SA: My last question is to Cynthia, who is in charge of grants for ACEP. Where do people look for health policy grants, and who can mentor them?

CS: The EMF also provides a $50,000 health policy grant each year. Many of these recipients have parlayed their EMF research into larger and further-reaching projects. For instance, in 2013, Donna L. Carden, MD, received a health policy grant titled "Implementing an ED to Home Transition Intervention." Based on her work completed with an EMF health policy grant, she was awarded a $1.8 million Patient-Centered Outcomes Research Institute grant. EMF is building a cadre of effective researchers who are improving emergency medicine practice and patient care. In addition to EMF funding, emergency physicians interested in health policy research are encouraged to look at other funds for grants such as through the Agency for Healthcare Research and Quality, the Robert Wood Johnson Foundation, the Commonwealth Fund, and the Kresge Foundation. Networking at ACEP meetings such as Leadership and Advocacy Conference, the Research Forum, and Scientific Assembly can provide direct access with our specialty's best policy researchers.

TIPS FOR BETTER PERFORMANCE

SPECIAL OPs

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

Rocking in Rhode Island

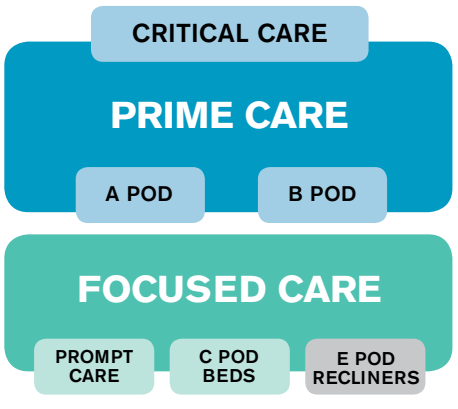
The Brown University model for patient flow

by SHARI WELCH, MD, FACEP

The Rhode Island Hospital emergency department in Providence was built 10 years ago and is one of the busiest teaching hospital emergency departments in the country. Treating more than 100,000 adult patients a year and admitting almost 30 percent of them, the department has such a high acuity that part of its 100-bed ED is dedicated to critical care patients. The Andrew F. Anderson Emergency Center (AEC) is the main teaching site for The Warren Alpert Medical School of Brown University and its many residency programs. It is one of the top-ranked emergency medicine residency programs, and its clinical metrics for sepsis, ST-segment elevation myocardial infarction, pneumonia, and stroke are among the best reported in the country. It is a center for research on medical teams, injury prevention and control, and resuscitation science.

All this aside, the leadership at Rhode Island Hospital—hospital president Peg Van Bree, DrPH, and Brian Zink, MD, chairman of the University Emergency Medicine Foundation—decided that they were not satisfied with the operational metrics for the department. Like most high-volume tertiary teaching hospitals, they struggled with operational metrics like door-to-physician time, length of stay (LOS), and left without being seen (LWBS) rates. After intensely studying their operational data, they learned that lower-acuity patients suffered most in terms of wait times and delays.

Figure 1. The AEC 2.0 model divided the ED into prime care for major medical cases and focused care for limited problems



The leadership team—which includes David C. Portelli, MD, James E. Monti, MD, and Alexis Lawrence, MD, nursing leaders Susan Patterson, RN, and Lindsay McKeever, RN, and advanced practice provider (APP) leader Lisa Murphy, PA—decided that they needed real transformative change. The leadership team decided to stop all committee work on operations and to use the task force model for process improvement recommended by Brent James, MD, of Intermountain Healthcare. They participated in a retreat where they reengineered patient flow and workflow in their department. Armed with a charter and a tight project timeline, the team developed an ambitious change package, named AEC 2.0, involving four big innovations that would go live at once. Using the major care/minor care model that has proven successful in Great Britain, they designated areas in their department as prime care for major medical cases and focused care for patients with limited problems and an expectation of discharge (see Figure 1).

They then developed a patient-flow model that played to their strengths and their unique demographics. Rhode Island has unusually high emergency medical services utilization relative to the rest of the country. Forty percent of patients arrive at the AEC by ambulance. Imagine 120 ambulances arriving in your department each day! While the national norm is to bed ambulance patients upon arrival, this department did not have the capacity to immediately bed everyone who arrived by ambulance. Many ambulance patients, in fact, did not need a bed, and the leadership opted to save those beds for the sickest arriving patients. The AEC also has two other unique assets: strong nursing and a robust APP presence with a homegrown emergency medicine APP development program. The APPs have an average of nine years of experience and can function autonomously and efficiently.

The hospital is confident that its nurses know sick when they see it, and so all patients, whether they arrive ambulatory or by ambulance, receive a very rapid nurse assessment taking fewer than three minutes. During this assessment, a chief complaint is obtained, and an Emergency Severity Index (ESI) score is assigned. Vital signs, allergies, and a pain score are recorded. All ESI 1 and 2 patients go to the prime care area, which consists of mirror pods with 16 beds each and a 16-bed critical care area for highly unstable patients, and they are immediately seen by a physician. All patients of low acuity with an ESI of 4 or 5 are sent to a fast-track area, named prompt care, and are seen expeditiously by an APP (see Figure 2).

Half of the nearly 300 patients arriving at the AEC each day have an ESI 3 designation (intermediate acuity). Across the country, we have begun realizing that this is a tricky patient mix and will include some very ill patients with occult medical problems. These ESI 3 patients are typically seen by a physician in triage in fewer than 20 minutes. This physician quickly begins the patient workup and assigns the patient to an appropriate area within the department. If the physician determines the patient is sicker and needs an acute care bed, the patient can be sent to the prime care area, but most patients are sent for treatment in the lower-acuity focused care area and are treated in lounge chairs. The staff rapidly caught on to this new vertical flow model, which is being adopted and adapted to high-volume departments across the country.

Figure 2. Patient flow at the Andrew F. Anderson Emergency Center

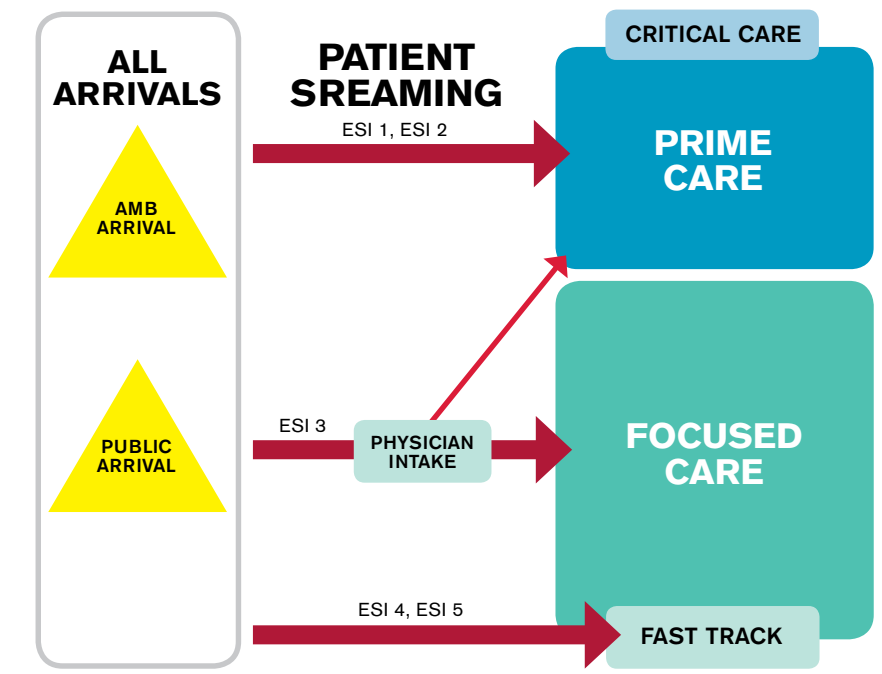


Table 1. Results of the AEC's patient-flow improvement efforts

	BASELINE May-Dec 15	RCT x 4	TO DATE
Volume	287	305	294
Admit Rate	28.15%	31.2%	29.1%
Door to Doc (Median)	52	26 min	22 min
Discharge LOS (Median)	297 min	225 min	228 min
Admit LOS (Median)	428 min	410 min	387 min
LWBS	4.63% (13)	1.64%	1.87%

The leadership team ran four tests of change (rapid cycle testing, or RCT) before going live with the model. Each test of change allowed the team to see the model at work under different conditions. The model was tested with volumes from 284 patients per day (PPD) to 340 PPD, with admission rates of 25 percent to 36 percent and fast-track volumes that varied by 50 percent. The model performed well, and the data were irrefutable.

Table 1 summarizes the remarkable results. The table shows the baseline, the RCT data, and the data-to-date numbers showing consistent improvement for two months. Door-to-doctor median, which began at 52 minutes, was reduced to 22 minutes, and LWBS rates, which were 4.6 percent, were reduced to 1.87 percent.

Their crowning event occurred on April 25, 2016, when the AEC recorded its busiest day ever: The department treated a whopping 364 patients and the door-to-doctor wait time was only 20 minutes.

Most high-volume tertiary and teaching hospitals believe that this type of performance is impossible, but the experience in Rhode Island suggests otherwise. The AEC has been quickly transformed in only 12 weeks from planning through implementation into one of the most operationally efficient teaching hospital EDs in the country. They are rocking in Rhode Island! The Brown University patient-flow model may become the standard for high-volume tertiary teaching emergency departments.

PRACTICAL TIPS FOR THE PRACTICAL DOC

TRICKS OF THE TRADE

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A Bad Day of Fishing Is Better Than a Good Day at Work—Usually

Tips and tricks for removing fishhooks

by WILLIAM TRINH, DO, JUSTIN MCNAMEE, DO, AND TERRY MCGOVERN, DO, MPH

"Foreign body–fishhook." We commonly see these injuries in our emergency departments and think, "This could be a real pain to remove from wherever it may be." Sometimes we need a simpler method, or even a MacGyver-like alternative to make our jobs easier, so our days spent in the trenches are more like our days wetting a line.

The Case

A 35-year-old, right-hand dominant, previously healthy male presents with a fishhook lodged in his right first digit. The injury occurred that morning, the opening day of trout season. His buddy tried meticulously to dislodge the hook to no avail. The patient now presents with finger pain and an inverted smile, and he is anxious to get back to that game of cat and mouse with an elusive nine-pounder that'll win him a $250 gift card for the local tackle shop.

Background

Most fishhooks become embedded in either the hand or face. Unfortunately, some fishhooks will find their way into people's eyes or even intracranially, as described in a case report in 1992.[1,2] Obviously, ophthalmology will need to be consulted for ocular fishhook injuries, but the remaining majority of these occurrences can be dealt with in the emergency department.

Having the patient describe or even draw a picture of the fishhook will help the clinician decide which of the following techniques may be most appropriate for removal. The smaller size and shape of most recreational fishhooks keep them from penetrating deep into the soft tissue. However, commercial hooks and some sport-fishing tackle can be much larger and could very well access deeper neurovascular or bony structures. While not required for these accidents, radiographs can help identify the type of fishhook (eg, single-barbed, multi-barbed, treble), the size of the hook, its orientation within the soft tissue, and proximity to bony structures. Theoretically, using a water bath ultrasound technique, the emergency physician could identify nearby neurovascular structures that could be damaged when attempting to remove the hook. In that case, surgical colleagues should be consulted.[3] Also consider consultation of a specialist when other vital regions (eg, joints, tendons, testicular, urethral, or peritoneal) are involved.

Classically, there are three different techniques that are used to remove embedded fishhooks: pull through, barb sheath, and string yank. There is a simple retrograde technique that is often attempted by the patient in the field prior to arrival. This technique is just as it sounds and is often only successful for very superficial hook injuries. As far as we know, there is only one prospective study that has reported success rates of these different fishhook removal techniques.[1] In 1990, Doser et al evaluated 97 fishhook injuries that occurred in Alaska. They reported the greatest success rate (56/97, 58 percent) with the advance-and-cut technique when compared to all the other approaches. While the success rate was higher, they suggest attempting less traumatic retrograde techniques prior to progressing to advance and cut. Of the 87 injuries that were followed up, none had any complications or subsequent infections, despite the fact that only five patients were placed on prophylactic antibiotics.[1]

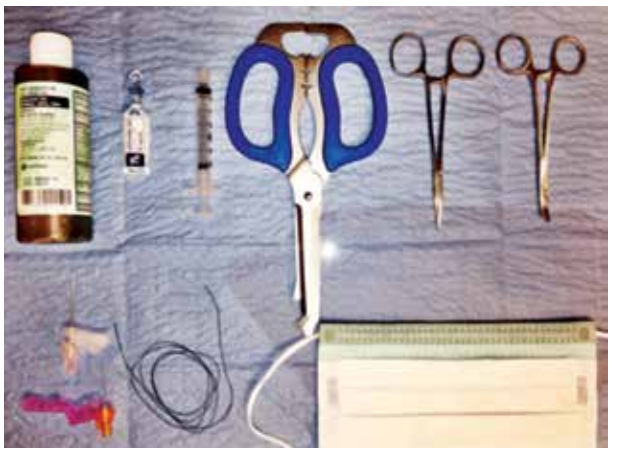

Figure 1. Equipment for fishhook removal.

The discussion of who receives prophylactic antibiotics remains controversial and is left up to the provider. If antibiotics are deemed necessary, doxycycline, trimethoprim-sulfamethoxazole, or fluoroquinolones are preferred for gram-negative coverage of organisms that are commonly found in recreational water-sport injuries. As a general rule of thumb in fishhook accidents, if the hook is embedded superficially, then there is no evidence to support prophylactic antibiotics. However, if the fishhook is embedded deeper or near neurovascular structures, then providers should consider prophylactic antibiotics, depending on the type of exposure (eg, saltwater versus fresh water; see Table 1). Stronger consideration for prophylaxis should also be made if the patient is immunocompromised.[4]

Equipment and Techniques (see Figure 1)[4]

- Povidone-iodine or chlorhexidine solution
- Local anesthetic solution without epinephrine
- 3 mL syringe

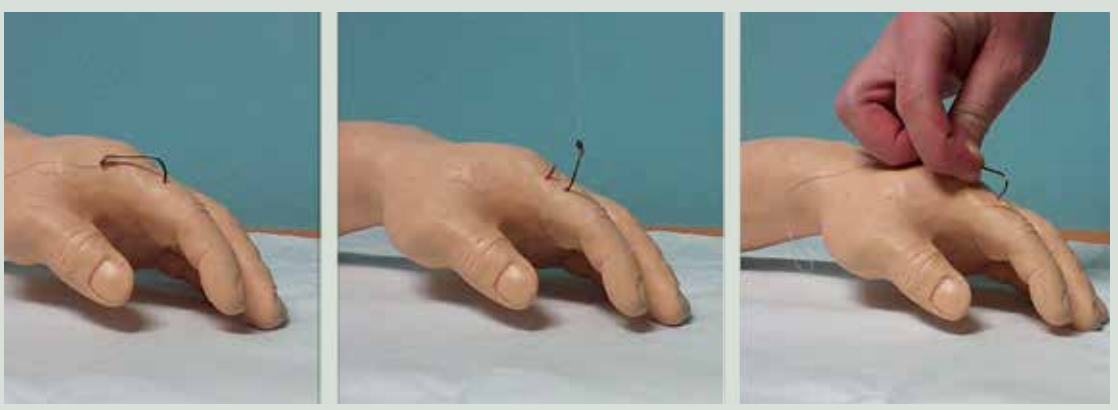

Figure 2. Pull through technique for single-barbed hooks.

Figure 3 . Pull through technique for multi-barbed hooks.

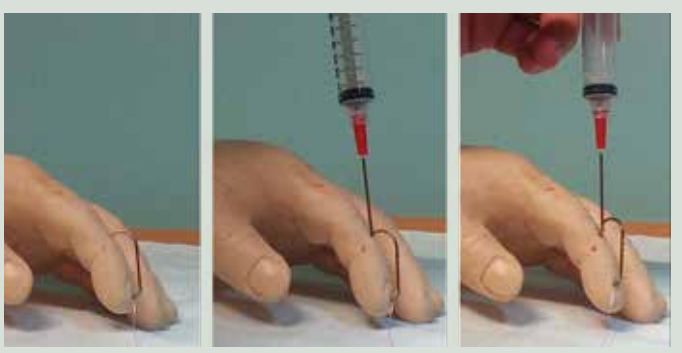

Figure 4. Barb sheath technique.

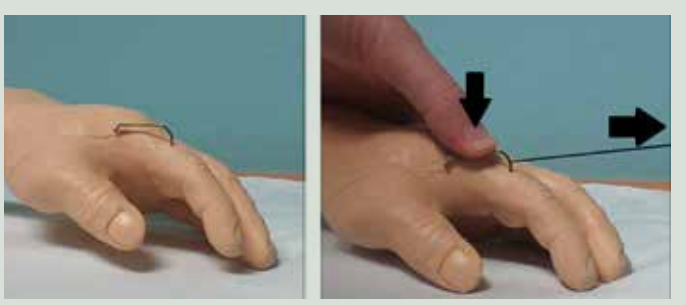

Figure 5. String yank technique.

- Wire cutter
- Needle driver
- Hemostat
- 18-gauge needle
- 25-gauge needle
- String, fishing line, or 2-0 silk suture line, at least 50 cm in length
- Safety glasses, goggles, or a face mask with an eye shield for both the provider and patient

Proceed to cleanse the embedded area of debris, apply iodine or chlorhexidine solution, and allow the area to dry. Hooks with more than one point (eg, treble hooks) or lures/bait with more than one hook should have uninvolved points taped or cut off to prevent accidental embedding of uninvolved hooks while removing the embedded hook.[5,6]

Pull through technique for single- and multi-barbed hooks (see Figures 2 and 3). This is a great technique for large-caliber hooks with barb near the surface of the skin in the ears, nasal cartilages, or joints. Once preparation of site is complete, proceed to locate the barb end of the hook and inject 0.5–1 mL of local anesthetic (without epinephrine) over the embedded barb region. Allow a couple of minutes for full anesthetic effect. Proceed by grasping the shaft end of the hook with needle driver and advancing the hook until the last barbed section of the hook is exposed. Grasp the barbed section with a hemostat. If a single-barbed hook (barbed only at the hook tip) is embedded, use wire cutters to cut the hook proximally (toward the shaft end), and with the needle driver, pull back on the shaft and withdraw reverse of the direction of entry. If a multi-barbed hook is embedded or barbs are located on the shaft, advance the hook until the hook and barb are exposed. Grab this end with a hemostat. Use a wire cutter to cut the shaft, and without losing control of hemostat, pull the hook through (advancing toward the direction of entry).[4]

Barb sheath technique (see Figure 4). Normally, this is reserved for small hooks that are not embedded in the nose, in the ears, or near joints, as this is a more technically difficult technique that may cause further damage from blindly inserting an 18-gauge needle to disengage the barb. Firmly grasp the shaft end with the needle driver. Inject 0.5–1 mL of local anesthetic (without epinephrine) along the entry wound site of the fishhook. Insert an 18-gauge needle along the entry site, with the bevel facing toward the barb. Once the core of the needle has engaged the barb, slowly retract both the hook and the needle back out through the entry site.[4]

String yank technique (see Figure 5). This is likely the least painful technique for removing fishhooks. Although effective, this technique cannot be used on hooks embedded in ears, the nose, or joint cavities and is more suited for single hooks that are embedded into stable surfaces such as arms, the back, and the scalp region.[6] Both the patient and the provider should wear eye protection. After cleaning up the area as previously described, loop a string around the bend of the hook. With your nondominant thumb or index finger, depress the shaft of the hook toward the embedded body part until it is parallel to the surface to disengage the hook.

Table 1. Antibiotic Recommendations for Fishhook Injuries

	SUPERFICIAL EMBEDMENT	DEEP EMBEDMENT
Fresh-water exposure	No antibiotics	Fluoroquinolone (*Aeromonas*)*
Saltwater exposure	No antibiotics	Doxycycline (*Vibrio vulnificus*)*
Pediatrics	No antibiotics	TMP-SMX

**If the patient has an allergy to fluoroquinolone or doxycycline, use TMP-SMX as alternative coverage.*

With a quick and firm jerk of the string, using your dominant hand, remove the hook. Local anesthetic is applied similarly to other techniques at the provider's discretion. Many patients do not require an anesthetic, as experienced fishers often perform this procedure in the field.[4]

Case Conclusion

The fishhook is safely removed using the string yank technique. A dry dressing is applied, and the patient's tetanus vaccine is updated. The fishhook was embedded superficially, therefore no prophylactic antibiotics are given. The patient will live to boast the big one next time.

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With minimal barriers to use and the appeal of diagnostic certainty, CT use has spiraled out of control. *Choosing Wisely* implicates excessive use of advanced imaging as low-value care consumers should question. Despite ACEP publishing its own recommendations for avoiding low-value imaging and the known financial and physiologic harms of CT overuse, the literature remains replete with examples of inappropriate use. In even just the past few months, multiple publications have indicted a wide variety of imaging modalities:

Cervical Spine Imaging in Trauma

The ground-level fall is an extraordinarily common presenting mechanism of injury. Some days it seems nearly every single nursing home resident spends their day innovating new ways to evade their caregivers and find their way down to the floor.

These patients frequently arrive fully immobilized in full trauma regalia and undergo CT of the cervical spine for clearance. This single-center review of 760 ground-level fall presentations identified seven fractures—six stable and one unstable.[1] The authors further reviewed each chart individually and suggested only 50 percent of charts supplied sufficient documentation to support appropriateness of imaging according to National Emergency X-Radiography Utilization Study (NEXUS) Low-Risk Criteria or Canadian Cervical-Spine Rule. Conversely, at least 20 percent of charts supplied enough information to judge imaging as definitely inappropriate.

The authors estimate consistent use of validated decision instruments just for ground-level falls could reduce imaging-related costs $12–$31 million annually in the United States.

Pulmonary Embolism

The ACEP Clinical Policy Statement for the evaluation of pulmonary embolism (PE) is clear: In patients with a low pretest probability for suspected PE, the Pulmonary Embolism Rule-Out Criteria (PERC) can be used to exclude the diagnosis based on history and physical alone.[2] This statement is not an endorsement of PERC as a "zero miss" decision instrument but, rather, recognition of the harms relating to long-term anticoagulation and the generally low morbidity and mortality of PE in the setting of preserved normal physiology. The harms are likely understated as the acceptable miss rate used in PERC does not account for the high rates of false positives recognized in patients with low pretest probability for PE. In the interests of protecting patients and decreasing unnecessary CT use, the rate of CT for PE in PERC-negative patients should be nearly zero.

Stojanovska and colleagues present a review of cases from an academic medical center in the Midwest, retrospectively reviewing 602 CT for PE.[3] The overall yield was reported as almost 10 percent, which is sadly unexceptional in the United States. More concerning, almost 20 percent of patients scanned were PERC negative. If a major teaching institution is misusing CT for PE in low-yield and low-value presentations, how will our trainees perform in the future?

Appendicitis in Children

Children, as they say, are our future. If this truism holds, our future is full of solid tumor diagnoses.

The evaluation and treatment of children in the emergency department exhibits some of the widest possible variation. This is to be expected given the gulfs of experience and comfort with pediatric patients. Harms should be avoided when they can be. For example, ultrasound-first strategies for the diagnosis of acute appendicitis are reasonable and widespread. Not every presentation is appropriate to forgo CT, but many uncomplicated presentations can feasibly be addressed first by ultrasound.

This article demonstrates the use of ultrasound deteriorates rapidly with distance from pediatric specialty centers.[4] Comparing a pediatric emergency service at an academic center to a community-based practice still with pediatric emergency coverage, the rate of CT imaging was roughly triple in the community. At the academic center, fewer children with abdominal pain received lab work, and of those receiving lab work, only 10 percent underwent CT. Comparatively, at the community facility, a greater percentage of abdominal pain presentations received blood work, and 28 percent of those underwent CT. The difference boiled down to avoidance of CT by use of ultrasound and by admissions for clinical observation.

Ultrasound or observation-first protocols are widespread and certainly defensible foundations for shared decision making.

Upper Respiratory Infections

Finally, just to complete our comedy of errors, we're also now seeing extensive use of CT for even benign upper respiratory infections (URI). It is reasonable to have a serious debate over the risks, benefits, and diagnostic certainty for illnesses of significant morbidity and mortality, but the common cold?

These authors reviewed the use of CT for emergency department visits coded as URI or lower respiratory tract infections (LRTI).[5] In 2001, only 0.5 percent of patients visiting the emergency department for URI symptoms received a CT, and by 2010, that rate had climbed to 3.6 percent. In 2001, 3.1 percent of LRTI symptom presentations received a CT, and in 2010, this rate had climbed to 12.1 percent. In keeping with classic features of overuse, there was no change in rate of antibiotic prescribing or the rate of hospital admission. Four times as many CT scans with zero benefit.

Undifferentiated Chest Pain

Flipping the channel a bit, this last article concerns not just CT overuse but suggests irresponsible overuse.

Institutions are increasingly adopting HEART score-based algorithms for early discharge. Recent publications call widespread provocative testing into question.[6]

However, the proponents of CT coronary angiograms (CTCA) for patients with low-risk chest pain refuse to fold. Despite the failure of major trials to demonstrate an advantage of CTCA over standard care and impassioned editorials questioning the fundamental insanity of their use, the American Heart Association (AHA) has issued new guidelines for appropriate cardiac imaging.[7,8] Oddly, according to these guidelines, nearly every possible permutation of potential cardiac chest pain

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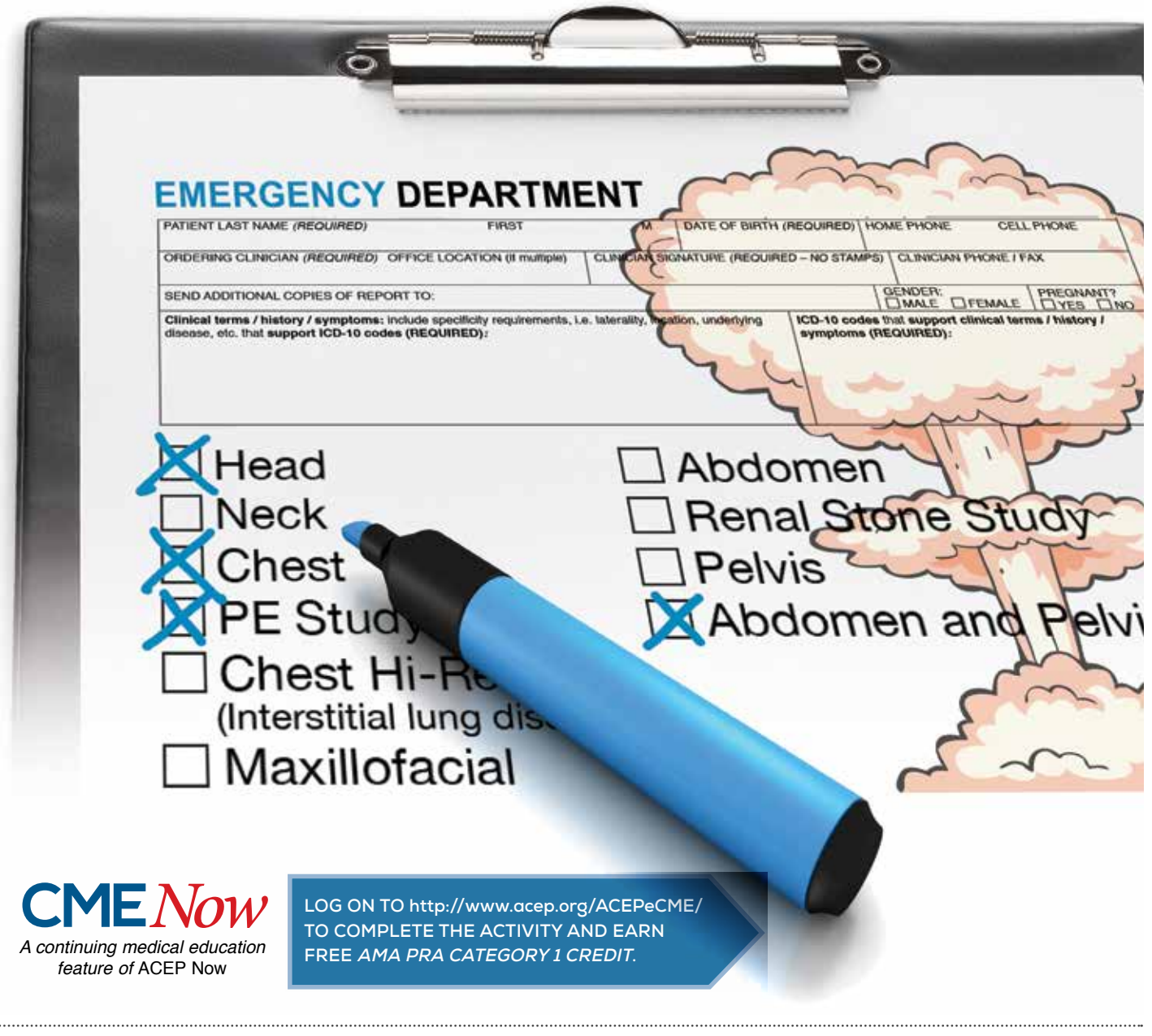

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HARMS SHOULD BE AVOIDED WHEN THEY CAN BE. FOR EXAMPLE, ULTRASOUND-FIRST STRATEGIES FOR THE DIAGNOSIS OF ACUTE APPENDICITIS ARE REASONABLE AND WIDESPREAD. NOT EVERY PRESENTATION IS APPROPRIATE TO FORGO CT, BUT MANY UNCOMPLICATED PRESENTATIONS CAN FEASIBLY BE ADDRESSED FIRST BY ULTRASOUND.

SERVING UP THE BEST EM TWEETS

THE FEED

DR. FAUST is an emergency medicine resident at Mount Sinai Hospital in New York and Elmhurst Hospital Center in Queens. He tweets about #FOAMed and classical music @jeremyfaust.

I'm Now on Twitter—Who Should I Follow?

Deciding what to add to your feed can be daunting, but these tips can get you started

by JEREMY SAMUEL FAUST, MD, MS, MA

Deciding who to follow is one of the holiest decisions one can make on Twitter. After all, it is literally choosing whose ideas you wish to let into your mind. For this reason, many Twitter users, especially new ones, limit the number of accounts they follow to a select few. The question is, what types of Twitter accounts are you interested in? When newbies ask EM Twitter "experts" who to follow, a typical list of well-known names frequently comes up. These lists tend to feature Free Open Access Medical Education (#FOAMed) all-stars. These are usually respected EM providers with a track record of high-quality content both on Twitter and online in general via podcasts or blogs. There's even an account called @FOAMstarter that follows 31 well-known EM Twitter users. New users can simply follow these 31 accounts and be certain that the information appearing in their feeds will be high-quality and high-yield. However, one area that does not receive as much attention is that Twitter is a stellar resource for keeping up with general medical news from the nation's and world's leading health care organizations. The trick is finding accounts that don't merely tweet out banal junk. Personally, I don't need a reminder that it is Arbor Day and that I should plant a tree. That was an actual tweet from the American Heart Association (AHA) account, @American_Heart. The AHA account is basically a digital public relations flack for their various initiatives, which apparently include planting trees on Arbor Day. I'm sure that's very important, but I don't need it in my Twitter feed. Don't believe me? Here's one more "high-yield" doozy from that account: "It's never too late to start eating healthier!" Fortunately, we are not reprinting the JPEG image that accompanied this tweet, which featured a beet with the caption, "Hey girl, my heart beets for you." Now you are free to never follow that account (unless you happen to really like it). You're welcome.

THE QUESTION IS, WHICH LARGE REPUTABLE ORGANIZATIONS ARE USEFUL? HERE ARE A FEW RECOMMENDATIONS.

1 **The World Health Organization (@WHO).** WHO tweeted out a link to a joint statement by WHO and @UNICEF regarding attacks on medical facilities and personnel in Syria. Earlier in the day, the account tweeted out some important statistics: "#Measles deaths worldwide: 1980: 2,600,000. 2000: 546,800. 2014: 114,900 #VaccinesWork" and a link to the WHO fact sheet on measles.

2 **The Centers for Disease Control and Prevention (@CDCgov).** The CDC's tweeting on the unfolding Zika crisis has been absolutely excellent. As more information has become available, the CDC has tweeted out high-quality information. This account also tends to retweet excellent information from other reputable organizations. Links to influenza surveillance updates are also useful.

3 **The Centers for Medicare & Medicaid Services (@CMSGov).** This account is a "newsy" account that helps me keep up to date with changes in our complicated system. For example, when the newly proposed CMS rule introducing details about the anticipated new Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) was announced in late April, CMS tweeted out information on the new rule with a link to an article by Health & Human Services Secretary Sylvia Burwell (@SecBurwell) that explains how the rule intends to modernize Medicare payments. **The Health Affairs Blog (@Health_Affairs)** also had important takes on these new proposals.

4 On the trendier side, ***The New York Times*** has become an increasingly excellent source for both major health news and smaller interest stories that tend to go viral. The three main accounts worth following are **@NYTHealth, @NYTScience** (less medicine, more environmental, space, etc.), and the **@upshotNYT** (analytical journalism, frequently featuring the superb writing of Aaron Carroll, MD, MS [@AaronECarroll], professor of pediatrics and associate dean for research mentoring at Indiana University School of Medicine in Indianapolis, and others). In addition to their Pulitzer Prize-winning correspondents like Sheri Fink (@SheriFink), *The Times* frequently publishes the informative, thought-provoking, and somehow still humorous writing of Perri Klass, MD (@PerriKlass), professor of journalism and pediatrics at New York University in New York City. When your friends and colleagues ask, "Did you see that piece in *The Times*?" your answer can be, "Yes!"

5 Next, there are **hospital Twitter accounts.** For the most part, hospital accounts are for public relations. That being said, I follow the accounts of any hospital I work at (and any hospital I have ever worked at or am even thinking about working in). Even though most of these tweets are low-yield, it is wise to keep up with what these institutions are doing on a larger scale. Sometimes these Twitter accounts provide better insight than internal emails you might receive on a daily basis.

6 There's one other group of Twitter accounts you should always follow, your colleagues. Any time **a colleague** joins Twitter, follow them. I follow just about any one I know personally from my workplace and many I have met at conferences. It's a polite and low-impact way to say, "I'm interested in what you have to say." And even if you aren't interested, at least each Tweet is capped at 140 characters—not so typical in departmental meetings.

7 Finally, if you are looking for other great accounts, I have two suggestions. First, see **who is getting a lot of retweets** by people already on your feed. If someone you trust keeps retweeting someone you've never heard of, chances are that person might be worth following. Second, you can click on any other account and **see who they follow**. Not surprisingly, the @CDCgov and @WHO follow a lot of highly informative sources.

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

TWEET AT ME @JEREMYFAUST OR EMAIL TO JSFAUST@GMAIL.COM

DR. LEVITAN is an adjunct professor of emergency medicine at Dartmouth College's Geisel School of Medicine in Hanover, New Hampshire, and a visiting professor of emergency medicine at the University of Maryland, Baltimore. He works clinically at critical care access hospitals in rural New Hampshire and teaches cadaveric and fiber-optic airway courses.

Tackling the Omega-Shaped Epiglottis

4 TECHNIQUES FOR MANAGING THIS TRICKY AIRWAY

by RICHARD M. LEVITAN, MD

Curved blade laryngoscopy, whether with a conventional direct blade or video laryngoscope (with a Macintosh design or hyperangulated shape), depends on indirect elevation of the epiglottis. The tip of the blade sits in the vallecula, with the epiglottis lifted upward by pressure on the underlying hyoepiglottic ligament. The epiglottis is positioned between the line of sight (video or direct) and the glottic opening.

In my cadaver lab in Baltimore, as well as in emergency airways, I am increasingly encountering the "omega-shaped epiglottis." A long, curvilinear epiglottis with an omega shape has commonly been reported in children, but I have noticed it is quite common in obese adult patients as well.

An omega-shaped epiglottis creates multiple challenges for intubation. The epiglottis may be difficult to elevate, precluding any sighting of the glottis. Passing a tube or bougie through a long omega-shaped epiglottis is akin to passing a thread through a needle. The operator cannot see if the tip of a tube or bougie is actually going into the glottis.

Difficulties of tube delivery and laryngeal exposure are especially problematic in obese patients. Many of these patients require continuous positive airway pressure before and during induction to maintain oxygenation, and they require a "one and done" approach to intubation to avoid desaturation. They have short safe apnea times and are often difficult to mask ventilate.

Emergency airway providers should anticipate this problem, especially in obese patients, and have a clear plan for tackling the challenge.

TECHNIQUES FOR HANDLING THE OMEGA-SHAPED EPIGLOTTIS INCLUDE:

1 **Using bimanual laryngoscopy.** This changes how the tip of the blade interacts with the hyoepiglottic ligament. This is best done by operators applying their right hand to the neck during direct or video laryngoscopy. Occasionally, assistants are needed to maintain pressure at the proper location because the view can deteriorate when pressure is released.

2 **Using a bougie to "thread the needle"** (see Figure 1). This also allows confirmation of placement within the trachea as the bougie interacts with the tracheal rings.

3 **Lifting the epiglottis directly** with the tip of the curved blade, thereby providing direct exposure to the larynx (see Figure 2). This is best accomplished with a standard geometry Macintosh blade, whether direct or video (eg, GlideScope Titanium Macintosh, McGrath Mac, or Storz C-Mac), as opposed to a hyperangulated video laryngoscope. Hyperangulated blades (standard GlideScope, Storz D blade, McGrath X-blade, and other hyperangulated devices such as King Vision) may not be long enough to reach down and elevate the epiglottis directly.

4 **Using a straight blade direct laryngoscope.** Find the epiglottis, then position the blade in the right side of the mouth, pivot the tip of the blade under the epiglottis, and advance slightly and then lift. Keep the proximal end of the blade in the extreme corner of the mouth (right paraglossal positioning). The small flange of the Miller design does not permit sweeping of the tongue. Moreover, the straight design does not allow pivoting back toward the center. Because of the shape of the dental arch, the straight blade (handle) can only pivot backwards if positioned all the way rightward (right on the right nostril).

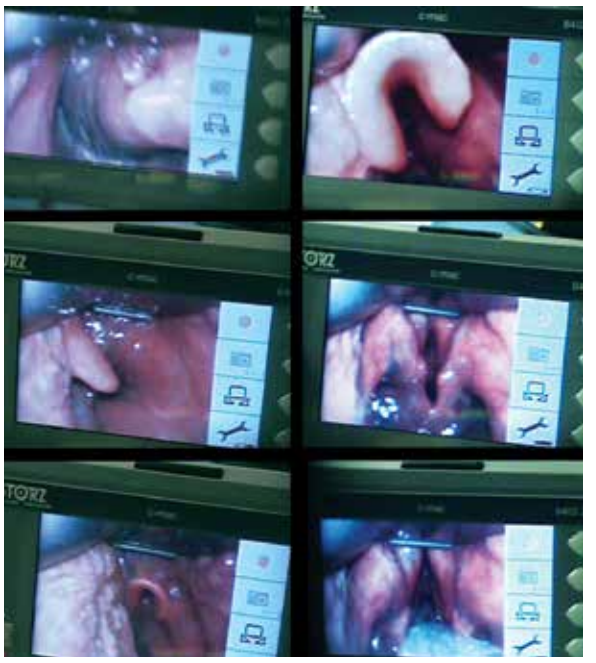

Figure 1. Omega-shaped epiglottis visualized with GlideScope Titanium Macintosh #4 blade. The intubation is accomplished using a styletted tube (straight-to-cuff shape, 35 degrees) and "threading the needle" by carefully passing it through the omega-shaped epiglottis into the glottis. In bottom left image, the cuff is obscuring visualization of the target. In bottom right image, the tube can be seen passing over the posterior cartilages.

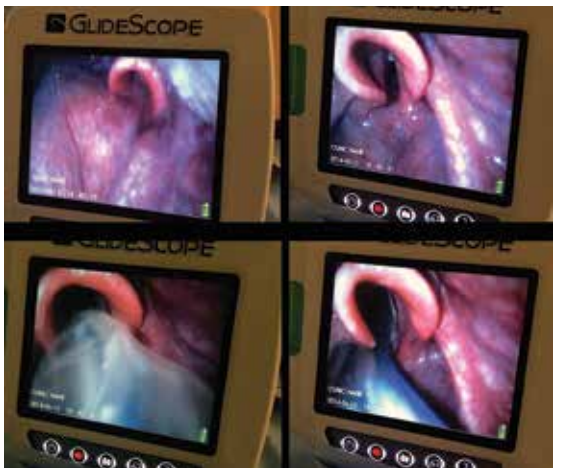

Figure 2. Omega-shaped epiglottis lifted directly by tip of Storz C-Mac blade. An advantage of the Storz C-Mac, GlideScope Titanium Mac, or McGrath Mac blades is that they can be used to lift the epiglottis directly if necessary (ie, using a curved blade like a straight blade). Size #4 Mac blades of these products work best and are recommended for all adult patients. The flange heights of all three of these products are the same in Mac #3 and Mac #4 sizes, and sometimes the extra blade length is necessary. Using a Mac #4 blade on all patients prevents having to switch to a larger size. Always start laryngoscopy holding the blade very lightly (two-finger grip with thumb) and follow down the tongue until the epiglottis is identified. For many patients, you will not need full insertion of the Mac #4, but having it readily available is very helpful.

CODING WIZARD

NAVIGATE THE CPT MAZE, OPTIMIZING YOUR REIMBURSEMENT

Editor's Note: *Cutting through the red tape to make certain that you get paid for every dollar you earn has become more difficult than ever, particularly in our current climate of health care reform and ICD-10 transition. The ACEP Coding and Nomenclature Committee has partnered with* ACEP Now *to provide you with practical, impactful tips to help you navigate through this coding and reimbursement maze.*

Level 5 Caveat

by CARAL EDELBERG, CPC, CPMA, CAC, CCS-P, CHC, AND HAMILTON LEMPERT, MD, FACEP, CEDC

The definition of 99285 includes the concept that the history, physical exam, and medical decision making (key requirements) must be met "within the constraints imposed by the urgency of the patient's clinical condition and/or mental status." This concept is called the acuity caveat and can be very helpful to emergency physicians. For example, consider the limitations we face when patients are unconscious, intubated, altered, under the influence, or needing to be whisked off to the operating room by the trauma team to save their lives. Most Medicare contractors require a description of the patient's urgent condition that prevents satisfying any of these key elements of the 99285 evaluation and management service as well as the physician's thought process through the discussion of risk factors, the differential diagnosis, procedures, diagnostic studies, interventions, and disposition. Make sure to document why the severity of your patient's illness and/or procedures, such as intubation on arrival, preclude or prevent performing a comprehensive history or exam.

Brought to you by the ACEP Coding and Nomenclature Committee.

MS. EDELBERG is chief executive officer of Edelberg & Associates in Dacula, Georgia.
DR. LEMPERT is vice president and medical director, health care financial services, at TeamHealth, based in Knoxville, Tennessee.

ONE MORE REASON NOT TO ORDER AN X-RAY

SOUND ADVICE

DR. NAGDEV is director of emergency ultrasound at Highland Hospital and assistant clinical professor (volunteer) of emergency medicine at the University of California, San Francisco.

Ultrasound-Guided Glenohumeral Joint Evaluation and Aspiration

An approach to evaluating the painful shoulder

by ARUN NAGDEV, MD

Evaluation of the patient with the painful shoulder can be difficult in the emergency department. The septic glenohumeral joint, while less common than infections of the knee and hip (fewer than 10 percent of cases of septic arthritis), can be often difficult to diagnose.[1] Among the myriad musculoskeletal pathologies that can present with a painful shoulder, detection of a septic glenohumeral joint is critical because delay to diagnosis has been shown to allow for irreversible cartilage damage leading to functional impairment. An infected glenohumeral joint can be easily missed because classic signs and symptoms are often not present, plain film imaging does not detect a joint effusion, and classic laboratory tests are insensitive and nonspecific for septic joints.[2] Also, even when a septic glenohumeral joint is suspected clinically, landmark-based aspirations can be unsuccessful. Even in the hands of experienced orthopedic surgeons, the failure rates are up to 30 percent.[3] Point-of-care ultrasound allows for both an accurate method to detect the presence of a glenohumeral joint effusion and also a simplified method for reliable joint aspiration.[4]

PROCEDURE

1. Evaluate the nonaffected glenohumeral joint.

To determine the patient's normal anatomy, obtain clear ultrasound views of the patient's nonaffected/contralateral glenohumeral joint. For simplicity, I recommend evaluation of the posterior glenohumeral joint space (the anterior approach can be more challenging). Place the ultrasound system in front of the patient and palpate the patient's scapular spine to identify basic surface anatomy (see Figure 1). The low-frequency (5 to 1 MHz) curvilinear transducer should be placed parallel to the bed, probe marker pointing to the patient's left and positioned just below the scapular spine. Slowly slide the transducer toward the humeral head. A clear image of the humeral head, glenoid, infraspinatus tendon, and glenohumeral joint space will be obtained on the ultrasound screen (see Figure 2). Gentle passive or active internal and external rotation of the patient's forearm can help novice sonographers recognize the relevant anatomy.

2. Evaluate the affected glenohumeral joint.

Using the same technique as detailed above, examine the affected glenohumeral joint (see Figure 3). A joint effusion will be an anechoic effusion just above the humeral head and under the synovial membrane. Exact measurements of the effusion are not useful, and the patient's clinical evaluation, in conjunction with the ultrasound examination, should help determine the need for synovial fluid analysis.

3. Aspirate the glenohumeral joint.

I recommend standard sterile precautions for all joint aspirations (sterile probe cover, sterile gloves, etc.). Use the M-mode marker to center the transducer over the space between the glenoid fossa and humeral head. Place a small anesthetic skin wheal at this location. With an 18–21 g, 3.5-inch spinal needle attached to a control syringe, advance the needle tip just parallel to the probe, just under the scapular spine (see Figure 4). The out-of-plane technique does not allow for clear needle visualization but offers a simplified method to enter the glenohumeral joint capsule. While advancing the needle, gently aspirate until synovial fluid is obtained.

SUMMARY

Clinicians should be familiar with a simplified method for the ultrasonographic evaluation of the glenohumeral joint. The presence of a joint effusion on point-of-care ultrasound evaluation in the correct clinical setting will indicate the need for joint aspiration and fluid analysis. The out-of-plane posterior approach to glenohumeral aspiration allows for a simplified method for a safe and efficacious joint aspiration.

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ONLINE RESOURCE

See the online version of this article at **ACEPNow.com** to download a PDF illustrating this procedure.

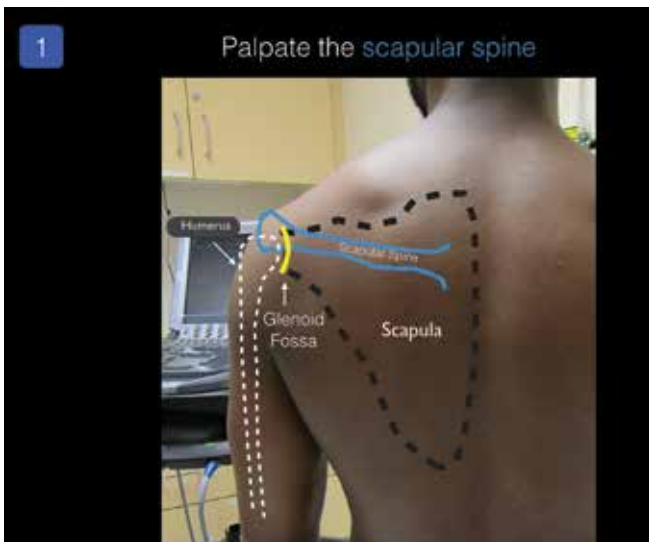

Figure 1. Place the ultrasound system in front of the patient and palpate the patient's scapular spine to identify basic surface anatomy.

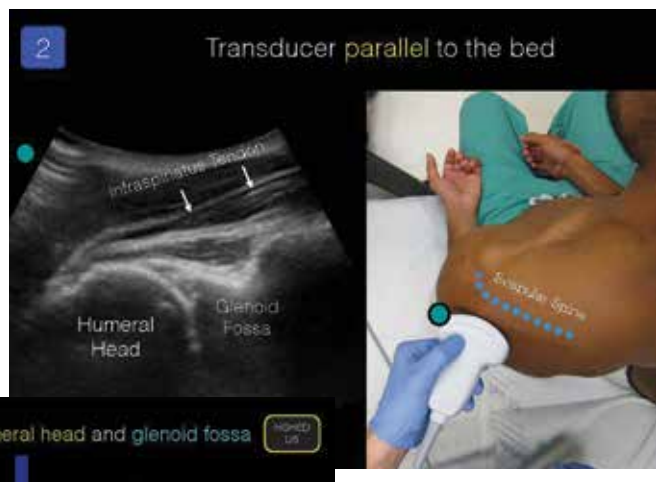

Figure 2. Slowly slide the transducer toward the humeral head. A clear image of the humeral head, glenoid, infraspinatus tendon, and glenohumeral joint space will be obtained on the ultrasound screen.

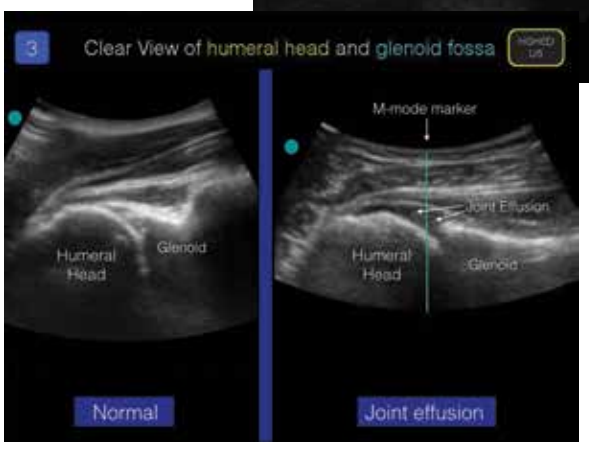

Figure 3. Using the same technique detailed in Figure 2, examine the affected glenohumeral joint.

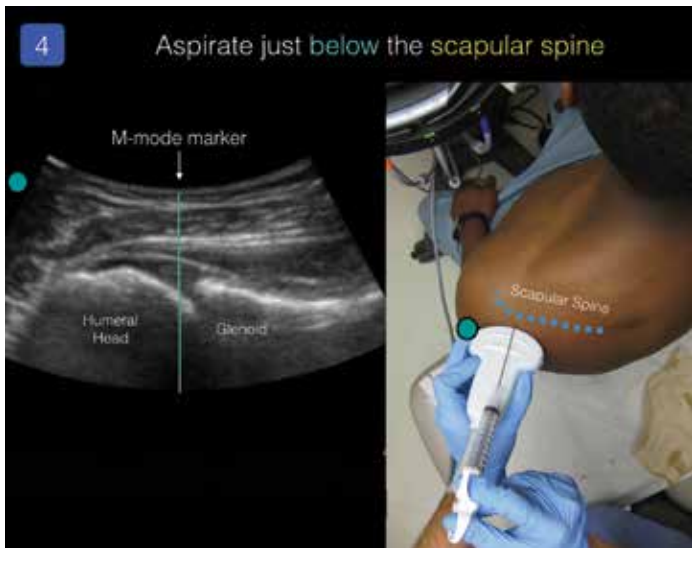

Figure 4. Use the M-mode marker to center the transducer over the space between the glenoid fossa and humeral head. With an 18–21 g, 3.5-inch spinal needle attached to a control syringe, advance the needle tip just parallel to the probe, just under the scapular spine.

PROTECT YOUR POT OF GOLD FROM BAD ADVICE

THE END OF THE RAINBOW

DR. DAHLE is the author of *The White Coat Investor: A Doctor's Guide to Personal Finance and Investing* and blogs at http://whitecoatinvestor.com. He is not a licensed financial adviser, accountant, or attorney and recommends you consult with your own advisers prior to acting on any information you read here.

Investing Wisely Means Taking Taxes Into Consideration

Six ways to reduce your investment-related taxes

by JAMES M. DAHLE, MD, FACEP

Q. ***I like seeing the money my investments are making, but every time tax season rolls around, it seems like a big chunk is going to the IRS. How can I reduce my investment-related tax bill?***

A. There are a number of ways to reduce your investment-related taxes. In fact, it is possible to completely eliminate taxes on your investments. However, prior to doing so, consider what your real goal is. Is it to reduce your tax bill or to maximize your after-tax returns? Of course, as you give it more thought, you'll realize that your goal is to maximize the after-tax returns, and sometimes that involves paying more in taxes than you would pay using other investing techniques. This article will discuss six ways savvy investors reduce their tax bill while boosting their after-tax investment returns.

#1 INVESTING IN RETIREMENT ACCOUNTS

Hands down, there is no doubt that the single best way to decrease your investment-related taxes is to invest in tax-protected accounts such as 401(k)s and Roth IRAs. Too few physicians have gone to the trouble of actually reading the plan documents for their employer-provided retirement plans or, if self-employed, opening an appropriate retirement plan. They also may not be aware that despite their high income, they can still contribute to a personal and spousal Roth IRA—they simply have to do it "through the backdoor" as discussed in a previous *ACEP Now* column. Health savings accounts may be the best investment account you have, a topic also discussed in a previous column. If you have more than one unrelated employer, for example, if you're an emergency physician doing locums on the side, you may also have more than one 401(k).

Investing in retirement accounts has multiple tax-related benefits. With a tax-deferred account, you get an upfront tax break and often an "arbitrage" between your current high tax bracket and a future lower tax bracket. Very few emergency physicians are saving enough money to be in the same tax bracket in retirement as in their peak earnings years. With a tax-free (or Roth) account, all future gains are tax-free. Dividends and capital gains distributions also benefit from tax-deferred or even tax-free treatment, depending on the type of account.

#2 BUYING AND HOLDING TAX-EFFICIENT INVESTMENTS

Another important way to reduce the taxman's take on your investment returns in a nonqualified (ie, taxable) account is to invest in a tax-efficient manner. That means choosing investments such as low-cost, low-turnover stock index mutual funds, where taxable distributions are minimized and those that you do get receive favored tax treatment at the lower-dividend and long-term capital gains tax rates. For example, if you wanted to invest in two mutual funds with similar expected returns but had to put one in your taxable account, look up their tax efficiency on a Website such as Morningstar.com and put the most tax-efficient one in the taxable account. Holding on to your investments for decades rather than frenetically churning them also reduces the tax bill.

#3 USING MUNICIPAL BONDS AND BOND FUNDS

A typical physician who wishes to invest in

bonds in a taxable account should choose municipal bonds, typically using a bond mutual fund to minimize hassle and maximize diversification. Municipal bond yields are federal, and sometimes state, income tax-free. Although municipal bond yields are typically lower than treasury or corporate bond yields, on an after-tax basis, municipal bond yields are often higher for those in the upper tax brackets.

#4 TAX-LOSS HARVESTING

The natural inclination of many investors who own a losing investment is to hold the investment until they get back to even before selling it. However, this is completely wrong. There is rarely any reason to hold on to a losing investment in a taxable account, even if you believe it will come back in value in the near future. It is best to exchange that investment for one that is very similar but, in the words of the IRS, "not substantially identical." This locks in that tax loss while still allowing you to enjoy the future gains of the investment. Professionals call this "tax-loss harvesting." Not only can you use those losses to offset future investment gains, you can deduct up to $3,000 per year against your earned income. If you have more than $3,000 in losses in any given year, they can be carried forward to the next year.

There is rarely any reason to hold on to a losing investment in a taxable account, even if you believe it will come back in value in the near future.

#5 TAKING ADVANTAGE OF DEPRECIATION

Savvy real estate investors know they can lower their tax bill thanks to depreciation. The IRS allows a typical residential investment property to be depreciated over 27.5 years, which means that an amount equal to 3.6 percent of a property's initial value can be taken as a depreciation deduction each year, directly reducing the amount of rental income on which taxes must be paid in that year. Although depreciation must be recaptured when you sell, it is recaptured at 25 percent, which is a rate that is typically lower than a physician's marginal income tax rate. Even better, if you exchange that property for another (instead of simply selling it), that depreciation does not have to be recaptured.

#6 DONATING APPRECIATED SHARES AND THE STEP-UP IN BASIS AT DEATH

If you do have investments, whether mutual funds, individual securities, or investment property, that you have owned for many years and that have appreciated a great deal, you can avoid paying the capital gains taxes on the investments in two ways. The first is to use them instead of cash to make charitable donations. When you give them to charity, you get to deduct the full value of the donation on your taxes but do not have to pay the capital gains taxes due. The charity also does not have to pay the capital gains taxes. So it is a win-win for everyone but the IRS.

The second way is to die. When you die, your heirs receive a "step-up in basis," meaning that the IRS considers the value at which your heirs purchased the investments to be the value on the date of your death rather than the value when you purchased them decades earlier. This can save them so much in taxes that it is generally far better to sell investments with a higher basis (or even borrow against them) and hold on to low-basis investments until death.

Ben Franklin said, "In this world, nothing can be said to be certain except death and taxes." Emergency physicians might not be able to prevent their own deaths, but they can certainly minimize the effects of taxes on their investments through wise investment planning and management, either on their own or in conjunction with a competent, fairly priced advisor.

is deemed appropriate for CTCA, explicitly including even low-risk, troponin-negative patients with Thrombolysis in Myocardial Infarction (TIMI) scores of zero.

Even more damning, the authors of the AHA guidelines also endorse the so-called "triple rule-out" scan for cases in which a "leading diagnosis is problematic or not possible." Considering the various conflicts of interest relating to imaging technology on the writing and rating panels, it's not surprising the default recommendation is "don't think, just scan."

The right thing to do in medicine is rarely the easiest. Avoiding unnecessary admissions and CT scans requires communication and sharing uncertainty with patients, and such efforts require time we rarely have. Incentives—financial, medical-legal, and professional—only rarely align to support the highest-value practice of medicine. Nonetheless, we should continue striving to such ideals.

DR. RADECKI is assistant professor of emergency medicine at The University of Texas Medical School at Houston. He blogs at Emergency Medicine Literature of Note (emlitofnote.com) and can be found on Twitter @emlitofnote.

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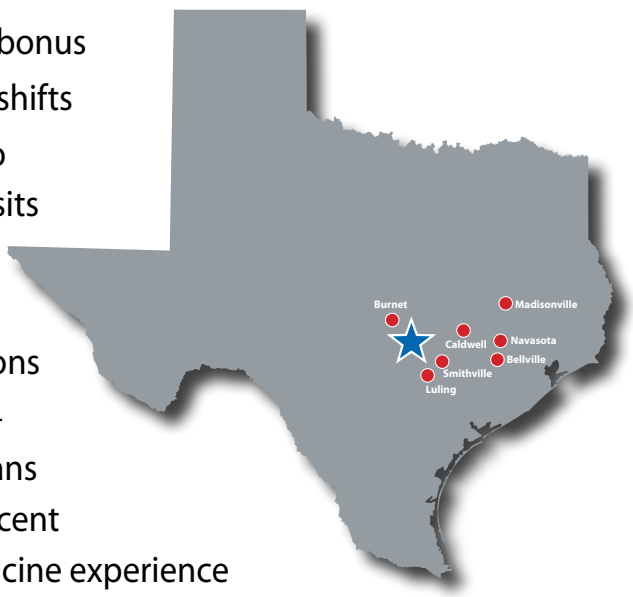

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At US Acute Care Solutions, we whole-heartedly believe that physician ownership empowers us to deliver the best patient care and the best solutions for our hospital partners. Every USACS physician becomes an owner in our group, no buy-in.

To secure a future where patient care is always first, we've aligned with partners who share our vision and passion, becoming one of the largest, fastest growing, physician-owned and led groups in the country. Secure your future and the future of patient care. Ownership matters, join USACS.

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