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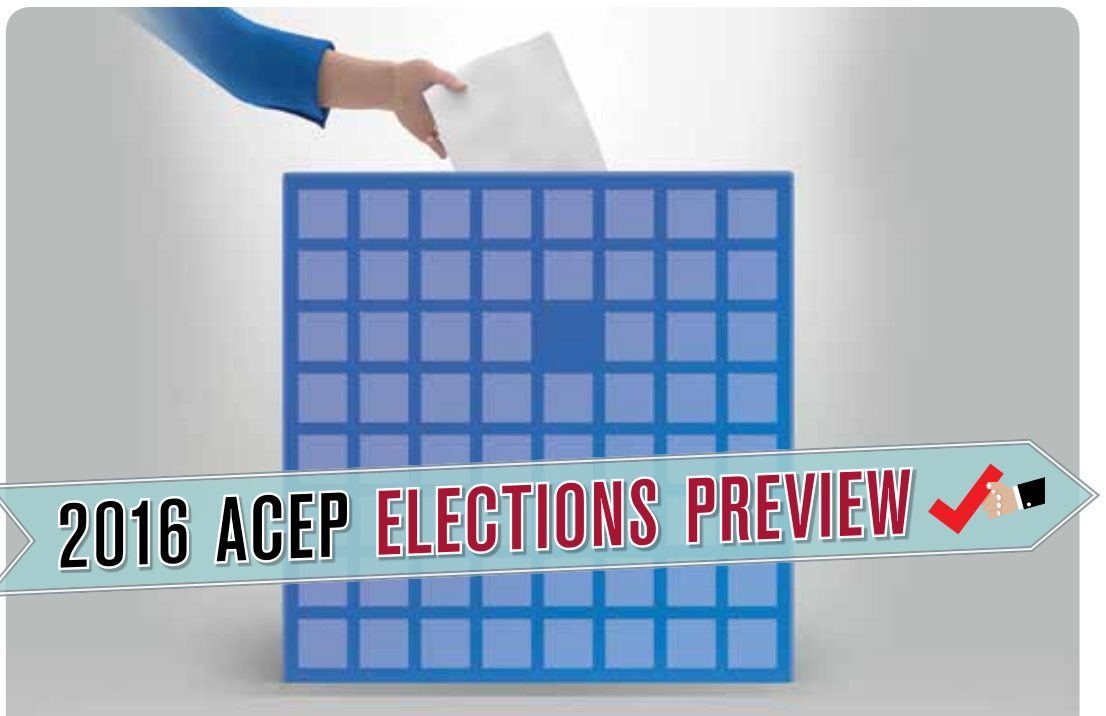

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MEET THE ACEP BOARD OF DIRECTORS CANDIDATES

ACEP Board candidates describe the unique traits, skills, and experience that would make them effective members

At its meeting in April, the ACEP Board of Directors was advised of the slate of candidates created by the Council Nominating Committee for four available seats on the Board. Board members are elected by the ACEP Council and serve three-year terms, with a limit of two consecutive terms. *ACEP Now* has provided the background information and statements of the two incumbents and five new candidates for the ACEP Board positions.

CONTINUED *on page 9*

Upheavals in the Payment Landscape

A detailed analysis of today's payer system

by JOHN G. HOLSTEIN

The composition, demographics, and disposition of today's emergency department patients are changing as quickly as the landscape itself, and this is changing how patients pay for EM services. Let's see if we can connect the dots and get a better sense of the big picture using some of the most current industry information and data.

Patient Experience Is Key

First and most important, in an article in *Medscape*, Nancy Melville documents the results from two European studies showing that "difficult" patients are frequently misdiagnosed.[1] This is obviously most important for its medical-legal implications as well as its impact on patient experience. Wang and colleagues recently reported two significant findings based on the Centers for Medicare & Medicaid Services (CMS) five-star hospital rating system:[2]

1. The number of stars was inversely associated with the risk-adjusted mortality rate.

2. Hospitals with higher CMS star ratings were also associated with lower adjusted readmission rates, with five-star hospitals having the lowest readmission rate at 18.7 percent.

The take-home message for emergency physicians is, of course, to first stay totally focused on clinical issues. But it's also important to be cognizant of the constantly building impact of patient experience-of-care issues and metrics. This is commonly a challenge, with some very sick or injured patients not being particularly open, nor receptive, to your best clinical intentions and

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Statins: The New Aspirin for Coronary Patients?
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NEWS FROM THE COLLEGE

UPDATES AND ALERTS FROM ACEP

ACEP Issues Public Censure

THE BOARD OF DIRECTORS OF ACEP issued on June 22, 2016, a public censure of Peter Rosen, MD, FACEP, for violation of ACEP's Expert Witness Guidelines for the Specialty of Emergency Medicine and the Code of Ethics for Emergency Physicians.

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

ACEP has a process for reviewing complaints of ethical violations or other misconduct. The complete process can be found online at www.acep.org/ethicalcomplaints. The following is a summary of procedures:

- A complaint of ethical violations or other misconduct may be initiated by an ACEP member, chapter, committee, or section.
- The ACEP Executive Director reviews the complaint and determines whether it is frivolous or refers it for review by the Bylaws and/or Ethics Committees or subcommittees, or refers it to be more appropriately addressed through judicial or administrative avenues.
- The respondent is provided with a copy of the complaint, along with any attachments, and given 30 days to respond along with evidence in his or her defense.
- The Committees, or their subcommittees, will consider whether the alleged action violated ACEP Bylaws or the Code of Ethics, which includes ACEP's Expert Witness Guidelines. If they determine that a violation has occurred, they will then consider whether the alleged conduct warrants private censure, public censure, suspension, or expulsion from ACEP.
- The Board of Directors then receives the recommendation of the appropriate committee, the complaint, and response, and at a meeting of the Board, votes to determine whether disciplinary action is warranted. The respondent is notified of the decision and may either request a hearing or accept the Board's decision.
- At the hearing, the complainant and respondent each may be represented by counsel or any other person of their choice. The Board will then render a decision based on the hearing and provide written notice of its decision, along with its basis, to the respondent.

Possible Disciplinary Actions:

- Censure
  - Private Censure: A private letter of censure informs a member that his or her conduct does not conform with the College's ethical standards; the contents are not disclosed, but the fact that such a letter has been issued will be disclosed.
  - Public Censure: A public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards.
- Suspension from ACEP membership shall be for a period of 12 months, after which the suspended member can be reinstated.
- Expulsion from ACEP membership shall be for a period of five years, after which the expelled member may petition for readmission to membership.

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EMERGENCY MEDICINE NEWS BITES

THIS JUST IN

by ANNALISE SORRENTINO, MD, *pediatric emergency medicine division, University of Alabama at Birmingham School of Medicine*

Uber Partners with Hackensack University Medical Center to Provide Patient Rides

Uber goes medical? New Jersey's Hackensack University Medical Center, where 10,000 patients undergo same-day treatments and some have to wait up to eight hours for a ride home, is partnering with Uber to provide transportation. Fares will be based on the patient's financial needs. There's an app for that.

Unauthorized Filming for *NY Med* Results in $2.2 Million Settlement

Wondering about the price of fame? According to the U.S. Office for Civil Rights, it's $2.2 million if you don't ask permission first. New York–Presbyterian Hospital settled the case after disclosing the protected health information of two patients without obtaining authorization while filming the ABC series *NY Med*. Lesson learned? HIPAA always wins.

CDC Panel Recommends Against Using FluMist Vaccine

After reviewing previous seasons' data, the CDC is recommending FluMist not be used this season due to suboptimal effectiveness. Pediatricians will be highly affected, as a third of pediatric flu immunizations are intranasal. Let's hope there are enough shots to go around, or we could be looking at a rough winter.

by ERIC J. MORLEY, MD, MS, *department of emergency medicine, Stony Brook Medicine in New York*

Single GME Update: Successes, Challenges, and a Possible Solution

Thirty percent of American Osteopathic Association (AOA) programs have applied to be or already are ACGME-accredited. One-hundred percent that applied for osteopathic recognition received it. Understanding the different language used by the AOA and ACGME may be a challenge. The Single Application System (SAS) Application Assistance Program provided by the AOA may be a useful resource for programs currently seeking ACGME accreditation.

Obama's Health Law Wrongly Repaying Funds to Insurers, Judge Says

Insurers are required to offer discounts to low-income consumers under the Affordable Care Act. A 2014 House of Representatives lawsuit was filed to block the government from reimbursing insurers for these payments. The courts recently sided with the House, but a stay will allow for an appeal before any changes go into effect.

Study: Dying in Hospital 7x More Expensive than Dying at Home

A claims data analysis from Arcadia Healthcare Solutions showed that dying in the hospital was seven times more expensive than dying at home. The average cost for medical care in the last month of life was $4,760 for those who died at home and $32,379 for those who died in the hospital.

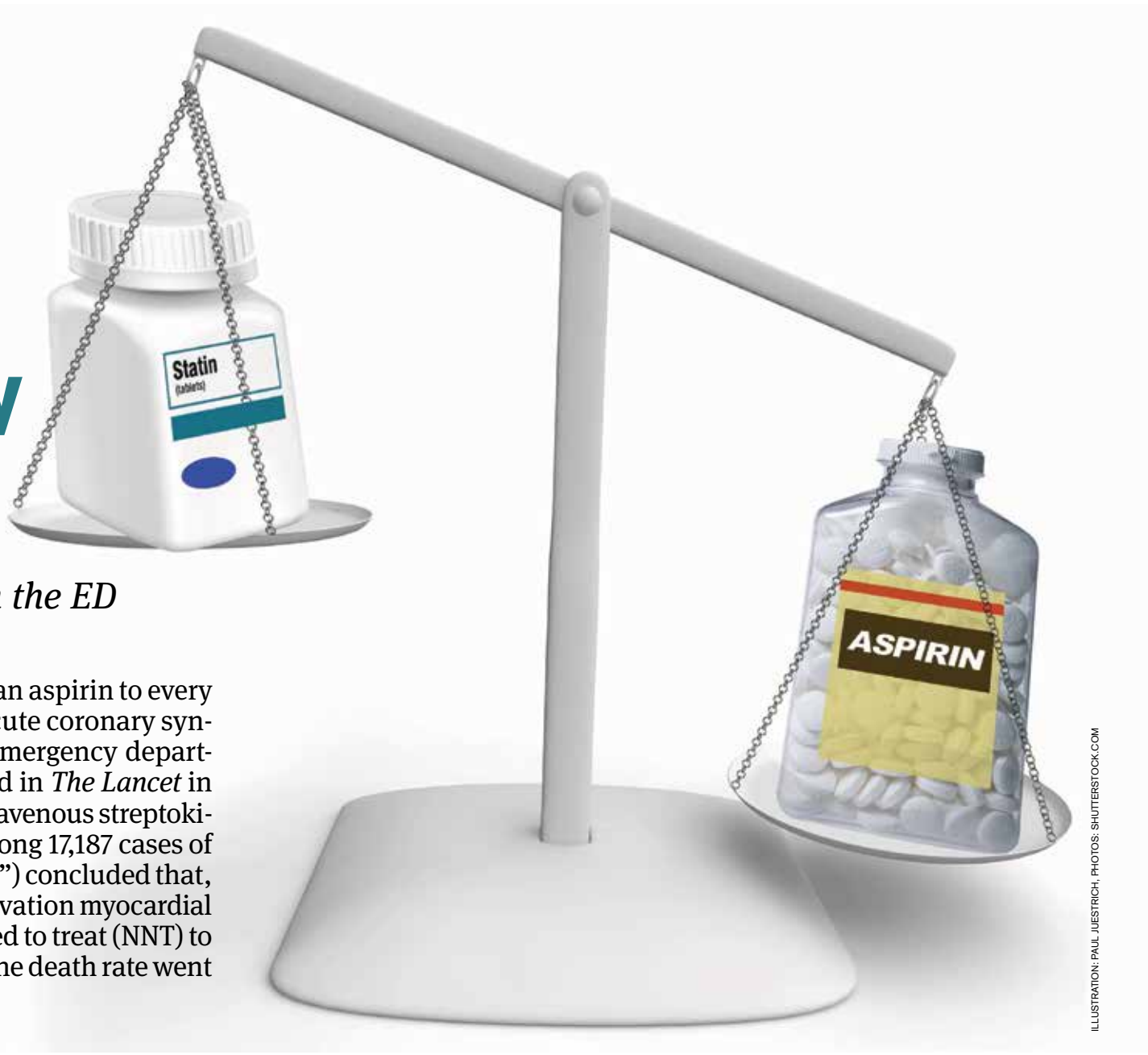
"UNCONVENTIONAL WISDOM"

Statins: The New Aspirin for Coronary Patients?

Every suspected ACS patient should get a statin in the ED

BY W. RICHARD BUKATA, MD

For decades, we've been giving an aspirin to every patient suspected of having acute coronary syndrome (ACS) who enters the emergency department. The ISIS-2 trial published in *The Lancet* in August 1988 ("Randomised trial of intravenous streptokinase, oral aspirin, both, or neither among 17,187 cases of suspected acute myocardial Infarction") concluded that, of patients ultimately having an ST elevation myocardial infarction 9STEMI), the number needed to treat (NNT) to prevent one death at 30 days was 42. The death rate went from 11.8 percent to 9.4 percent. →



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STATINS CONTINUED

However, there are a couple things to consider about ISIS-2: First, chest pain patients with a STEMI represent a very small fraction of the suspected ACS patients presenting to the emergency department. Second, the death rate from STEMI is now about 5 percent, much lower than in 1988. Despite these two factors that would substantially mitigate the efficacy of aspirin in chest pain patients, we still give it to everyone who has chest pain suspected to be ACS.

Nobody argues with giving aspirin even when the vast majority who get it will likely receive no benefit. One aspirin may help a very small percentage of suspected ACS patients and isn't going to hurt anyone—a no-brainer.

In many ways, however, the case for giving high-dose statins to potential ACS patients may be potentially stronger than that for aspirin.

Statins have long been known to have other effects besides lowering LDL cholesterol. These pleiotropic effects include decreasing platelet adhesion, inhibiting thrombosis, improving endothelial function, decreasing inflammation, and stabilizing plaque. The fundamental question is whether these pleiotropic effects (and others that may be unknown) can acutely benefit ACS patients.

THE CASE FOR EARLY STATINS

Below are some studies that indirectly support the idea that statins should be given to every suspected ACS patient in the emergency department. Unfortunately, as of yet, there is no study that hits the nail directly on the head regarding the benefits of statins given in the emergency department, but there are many that suggest that there may be a benefit.

Unfortunately, as of yet, there is no study that hits the nail directly on the head regarding the benefits of statins given in the emergency department, but there are many that suggest that there may be a benefit.

Saab FA, Eagle KA, Kline-Rogers E, et al. Comparison of outcomes in acute coronary syndrome in patients receiving statins within 24 hours of onset versus at later times. *Am J Cardiol.* 2004;94(9):1166-1168.

This large study by Saab et al looked at 1,639 statin-naive ACS patients who received statins within 24 hours of admission and found that inpatient mortality wasn't significantly lower (1.64 percent versus 2.26 percent) compared with those who received them later than 24 hours after admission. There were, however, substantial differences in other outcomes:

- Inpatient pulmonary edema (6.9 percent versus 15.8 percent; NNT = 11)
- Cardiogenic shock (2.2 percent versus 7.3 percent; NNT = 20)
- Atrial flutter or fibrillation (5.2 percent versus 9.0 percent; NNT = 21)
- Major bleeding (4.9 percent versus 10.4 percent; NNT = 18)
- The composite outcome of death-reinfarction-stroke (7.0 percent versus 10.4 percent; NNT = 29)
- The six-month composite outcome of death-myocardial infarction (MI)-stroke-rehospitalization (32.8 percent versus 38.3 percent; NNT = 18)

Ferrières J, Cambou JP, Guéret P, et al. Effect of early initiation of statins on survival in patients with acute myocardial infarction (the Usic 2000 Registry). *Am J Cardiol.* 2005;95(4):486-489.

In a nonrandomized registry study of 2,210 acute myocardial infarction (AMI) statin-naive patients receiving statins within 48 hours of admission, there was a hazard ratio of 0.57 for a one-year prognosis for cardiovascular deaths and/or recurrent MIs.

Lenderink T, Boersma, E, Gitt AK, et al. Patients using statin treatment within 24 hours after admission for ST-elevation acute coronary syndromes had lower mortality than non-users: a report from the first Euro Heart Survey on acute coronary syndromes. *Eur Hear J.* 2006;27(15):1799-1804.

There isn't much I can add here—just reading the title gives you the results.

Fonarow GC, Wright RS, Spencer FA, et al. Effect of statin use within the first 24 hours of admission for acute myocardial infarction on early morbidity and mortality. *Am J Cardiol.* 2005;96(5):611-616.

This registry analysis (174,635 AMI patients from 1,230 hospitals) found numbers that were too good to be true. Patients started on early statins had an in-hospital mortality of 4 percent; the rate was 5.3 percent in patients already taking them and 15.4 percent in those not treated with statins. Although I'm trying to make the case for early statins, even I can't believe the results of this study.

The problem with all of these studies is that none of them indicated that statins were given in the emergency department. Statins within 24 hours and within 48 hours were beneficial. It would seem that the earlier they are given, the better, but we don't know for sure.

What about randomized controlled trials? A meta-analysis of 12 trials involving more than 13,000 patients concluded, "Early statin therapy in ACS patients had no statistical effect on virtually any of multiple outcome measures, including the primary combined endpoint." But what's early? Studies looking at initiation of statins at seven to 14 days are irrelevant to our question.

EARLY STATINS AND PCI

Not convinced yet? Here's more positive news about the value of early statins. It focuses on their use in patients having a percutaneous coronary intervention (PCI).

Chan AW, Bhatt DL, Chew DP, et al. Early and sustained survival benefit associated with statin therapy at the time of percutaneous coronary intervention. *Circulation.* 2002;105(6):691-696.

The Chan et al study included 5,052 patients not having ACS who had a PCI. About a thousand were treated with a statin at the time of their PCI and had greater comorbidities. Statin therapy was associated with a mortality reduction at 30 days (0.8 percent versus 1.5 percent; hazard ratio, 0.53; $P = 0.048$) and at six months (2.4 percent versus 3.6 percent; hazard ratio, 0.67; $P = 0.046$). And these patients weren't even having MIs. (PCIs have been known to bump troponins by 5 to 40 percent [periprocedural MIs], suggesting that some leakage occurs during the process even in elective PCIs.)

Patti G, Pasceri V, Colonna G, et al. Atorvastatin pretreatment improves outcomes in patients with acute coronary syndromes undergoing early percutaneous intervention: results of the ARMYDA-ACS randomized trial. *J Am Coll Cardiol.* 2007;49(12):1272-1278.

Here's another provocative paper where the title tells the tale. This was a randomized controlled trial of 171 patients demonstrating that non-STEMI (NSTEMI) patients getting high-dose atorvastatin (80 mg) 12 hours prior to a PCI had a decrease in the 30-day composite outcome of death, MI, or unplanned revascularization (5 percent versus 17 percent, mostly due to a reduction in MIs [5 percent versus 15 percent]).

Benjo AM, El-Hayek GE, Messerli F, et al. High dose statin loading prior to percutaneous coronary intervention decreases cardiovascular events: a meta-analysis of randomized controlled trials. *Cath Cardiovasc Interv.* 2015;85(1):53-60.

Finally, here's a meta-analysis of 14 studies of statin-naive patients with stable angina, NSTEMIs, or mixed indications. Curiously, STEMIs weren't included because it was felt that the short time between drug administration in the emergency department and the PCI would be insufficient to note a drug effect—just the effect we're looking for!

Only one of the studies was ED-based and involved only 171 patients, comparing 80 mg versus 10 mg of atorvastatin. The ED study had an extraordinarily low rate of major adverse cardiac events, and so the difference between high- and low-dose statins didn't achieve statistical significance. However, the rate was substantially lower in the high-dose statin group (5.8 percent versus 10.6 percent). It's hard to conceive that such an underpowered study would be performed. But it suggests that high-dose statins are beneficial (and this perhaps could have been proven if the study was adequately powered).

Here's the result of the meta-analysis: Statin loading was associated with a reduction in the combined endpoint of death, spontaneous MI, and target vessel revascularization (odds ratio, 0.59; 95 percent CI, 0.38–0.92, $P = 0.02$), but this benefit was observed only in the subgroup of patients undergoing PCI for NSTE-ACS (odds ratio, 0.18; $P = 0.0005$).

Well, isn't an NSTEMI an AMI? Even though there are prior studies suggesting value of statin loading in non-AMI patients, I'm happy with the conclusion of this paper. Although often a trap, a pathophysiologic argument would suggest that if statins work in NSTEMIs, why would they *not* work in STEMIs?

So here are the options: Wait 10 years for the definitive randomized controlled trial demonstrating that all suspected ACS patients be given a single high-dose statin in the emergency department and potentially allow 10 years' worth of patients to receive no benefit, or begin now based on the evidence presented above. No one will be hurt if you do give a single dose of statins—some ACS patients will likely be helped.

So be courageous and take this article to the cardiology committee at your hospital and tell them that you want to do this. Like giving aspirin, it's also a no-brainer.

DR. BUKATA is the executive editor of *Emergency Medical Abstracts* and a clinical professor of emergency medicine at the Keck School of Medicine of USC in Los Angeles.

THE DAY I ALMOST QUIT

Better communication with leadership leads to more opportunities

BY HALA SABRY, DO, MBA

As I entered the physicians' parking lot, I rehearsed the conversation I was dreading. This was the day I would quit my job. It was my first job out of residency, and I loved my coworkers, but I had to quit. I was frustrated and dissatisfied after being overlooked for a directorship. It was time to move on, wasn't it?

OVERLOOKED?

I started medical school with high hopes of advocating for physicians and patients while contributing to my field through administration. Choosing emergency medicine as a specialty came naturally. The pathology, pace, and intensity spoke to me, but I was well aware of some of its challenges.

I made a conscious effort to expand my residency training beyond medicine and took advantage of leadership opportunities. As a new attending physician, I assertively took on labor-intensive projects from my medical director in hopes of furthering my career. I spent my days off in meetings and was involved with medical societies. As the lone full-time female in my group, I took pride in my work.

When I found out I was pregnant, I was immediately afraid of having to choose between this career I had nurtured and the family I was ready to start. For 20 weeks, I wondered whether I would be judged by the size of my belly or by the dedication I maintained while pregnant.

When I finally made the announcement, I found myself promising a short maternity leave and reassuring my partners that I would maintain my hours. I worked until 38 weeks and had my C-section the following week. I returned from my maternity leave when my daughter was five weeks old, hoping to prove that my loyalty had not wavered. While on maternity leave, a new male partner was promoted to a position that I thought would be mine. My involvement in administration not only had prepared me for this role, but I believed I was "next in line." I wondered whether it was being a woman or becoming a mother that caused me to lose this opportunity. Feeling shocked and confused, I concluded that if I wanted to advance, I would need to start elsewhere.

Then, the negative voice in my head got me thinking that maybe there was another reason I was overlooked. Perhaps I wasn't an effective leader, or I was missing a key element required for advancement. Maybe I didn't deserve the promotion.

That voice was still with me later as I sat in my medical director's office. I decided to take a chance and stray from my rehearsed goodbye. I asked, "Why was I not considered for the director's role?"

CREATING A NEW CULTURE

A confused expression stared back at me. Following a brief pause, he answered that he wasn't aware of my interest. He assumed that as a new parent I wouldn't want the added responsibilities. He assured me that there were no doubts about my performance. The rest of the conversation was one we should have had much earlier in my career. After discussing my goals, we developed a plan and within the year I found myself in a director's role.

Reflecting on this experience made me realize that I looked for validation from my superiors and *expected* to be promoted on the basis of my merits, as opposed to directly expressing my interest. I didn't have a designated mentor to seek advice from, and had few colleagues whose lives looked like mine.

More recently, I've connected with other physician mothers and have learned that many of us suffer from those same negative thoughts that make us feel that our qualifications and interests are ignored. We feel isolated and in competition with other female physicians rather than connecting based on our shared experiences.

In hopes of changing this culture, I started an online support network called Physician Moms Group (PMG), https://mypmg.com/. In less than two years, PMG has grown to 60,000 members! The group has served as a resource of mentorship, professional development, clinical education, and social support. The group celebrates both similarities and differences, applauds each other's successes, and shares solutions for problems that are commonly faced at some point in the personal lives and careers of female physicians. It also serves as a forum for female physicians to advocate for themselves as a whole. PMG has made me a better physician, mother, and leader.

I now know that I was overlooked because of faulty communication. It has been three years since that conversation with my director, and I have since expanded my leadership role as well as my family (with twins). Although I'm extremely happy, I still struggle with being the best mom, wife, physician, and coworker that I can be—which I now realize is the norm of a working parent. Having PMG as an outlet has made me feel like I do have it all (although maybe not all at once). I know I have support every step of the way.

In less than two years, PMG has grown to 60,000 members! The group has served as a resource of mentorship, professional development, clinical education, and social support.

DR. SABRY is the founder of Physician Moms Group, a professional and social network for physicians who are mothers, and is a practicing emergency medicine physician at St. Joseph Health—St. Mary's Medical Center in Apple Valley, California.

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Pearls From the Sept. Issue

In 434 hip fractures, the fascia iliaca block was associated with less use of opiates, shorter LOS and decreased mortality.

In a study of 186 TIA pts. carotid ultrasound plus head CT were more likely to predict a 30-day stroke than the ABCD2 score.

In a non-random comparison of ant. epistaxis treatments, silver nitrate cautery was associated with the highest success rate.

Of 959 ED pts > 65, the 30-day return rate was 15%. Predictors = COPD, cognitive issues, prior ED visit, care needed < an hour.

In 452 cases of aneurysmal SAH, a neg CT occurred in 4%. On rereading by a neuroradiologist, half of the 4% were positive.

6 studies found an age-adjusted d-dimer vs a fixed d-dimer in Wells “PE unlikely” pts. reduced the need for CTA by 5%.

Of 282, 183 pts. with witnessed arrests, 30-day neuro outcomes were best when all pts. had at least 33 min. of EMS resus.

In a RCT of 193 pts with lat. ankle sprains, 6-mo. outcomes were comparable between taping, semi-rigid vs lace-up support.

A sys. rev. of 8 studies found that splinting of peds. buckle wrist fractures was safe and effective compared to casting.

In a RCT of 196 pts direct laryngoscopy & video laryngoscopy (C-MAC) were comparable re first pass success & intub. speed.

A study of nurses found increased DM in night shift workers vs day (HR 1.6) (but not in rotating shifts).

A Can. before & after ED study of a commercial CPOE system found increased wait times, LOS, LWBS, admit times (63 minutes).

...And This List Covers Less Than Half of the 30 Papers in the September Issue of EMA.

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ABEM RESPONDS

AMA Opposes Mandatory ABMS Recertification Exams

What does AMA Resolution 309 mean for emergency physicians?

BY ACEP LEADERSHIP

THE AMERICAN MEDICAL ASSOCIATION (AMA) met in June in Chicago at the AMA House of Delegates Meeting to discuss a number of resolutions affecting physicians, and certainly one of the most interesting was Resolution 309: Continuing Medical Education Pathway for Recertification. The resolution, which passed, directs the AMA to "call for the immediate end of any mandatory, recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process" as part of its maintenance of certification (MOC) process.

What this resolution will mean for physicians and other medical associations is yet to be seen, however. ACEP leadership recently spoke with Barry N. Heller, MD, immediate past president of the American Board of Emergency Medicine (ABEM), to get a clearer view. An edited transcript of our conversation follows.

BARRY N. HELLER, MD, is immediate past president of the American Board of Emergency Medicine, and has been a member of its Board of Directors since 2008.

ACEP: In light of the recently adopted AMA House of Delegates resolution calling for abolishing "high stakes" examinations, what changes do you see taking place with the MOC process?

BH: The short answer is that Resolution 309 will have very little impact on the current path of MOC activities. The ABMS, other specialties, and ABEM have been actively exploring innovations in physician learning and assessment since the beginning of MOC and will continue to do so.

Interestingly, groups within the AMA that were well-informed about MOC, including the Emergency Medicine Section, did not support the elimination of recertification examinations, and many emergency physicians spoke in opposition to the resolution.

Resolution 309 will have very little impact on emergency medicine. As you know, ABEM is constantly reviewing its MOC Program. We're no longer requiring diplomates to report participation in patient satisfaction or patient experience of care surveys. We're working with ACEP to provide automatic credit for Improvement in Medical Practice (Part IV) for physicians participating in the Clinical Emergency Data Registry [CEDR]. Finally, in 2017, we'll be incorporating correct answers and explanations to LLSA [Lifelong Learning and Self-Assessment] questions as a part of test feedback. Nearly all of these changes are the direct result of physician suggestions.

The attrition rate of currently certified emergency physicians is only about 1.5 percent per year, and there has been a net annual increase of about 1,200 new ABEM diplomates. I tell you this because despite numerous anecdotal assertions, there's no evidence that the ABEM MOC Program has had a negative effect on the workforce.

ACEP: How long do you believe it would be before changes to MOC would take effect?

BH: It would be difficult to estimate timelines until and unless specific changes are approved. Before ABEM changes from the current ConCert Examination format, we need to carefully study the alternatives. In short, we need to be certain that innovation doesn't outpace rigor.

The ABEM MOC Program already has a significant learning dimension. For the LLSA, 92 percent of physicians report that the activity leads to changes in practice to at least some degree. In a report by Marco et al, more than 90 percent of test takers reported a learning benefit to preparing for and taking the exam.[1]

Before ABEM considers any transition from the ConCert, which is a highly successful, psychometrically proven physician-assessment format, we need to study the alternatives. There are potential upsides to these new processes, but there are aspects that could be better understood.

ACEP: The American Board of Anesthesiology (ABA) has been allowed to pilot an alternative to a continuous certification exam every 10 years. Do you think this is a viable alternative? Why or why not?

BH: It's too early to definitively determine if the ABA approach is the best course for emergency medicine. ABEM is carefully monitoring the ABA program as well as a similar one developed by ABMS called CertLink. Both formats use frequently transmitted questions for physicians to answer that can be delivered via a mobile platform. Before ABEM would adopt CertLink, we would need to be sure that the learning and assessment advantage is better than the current combination of LLSA tests and the ConCert Exam. ConCert is carefully designed to assess complex cognitive skills, such as diagnostic processing, rather than fact recall. Cognitive psychology research demonstrates that tests designed like this have a huge learning dimension. Though physicians don't prefer learning through testing or appreciate the considerable learning impact, learning is a proven and powerful aspect of the ConCert Exam.

What makes certification different from simple CME [continuing medical education] testing is that it includes a summative assessment against an external objective national standard. In ABEM's case, that assessment is accomplished via an examination. In the absence of a physician demonstrating cognitive competencies against a national standard, ABEM would become little more than a CME clearinghouse, and becoming certified, little more than a glorified CME certificate.

ACEP: Is ABEM considering changes to its MOC process, including moving away from the ConCert exam every 10 years? If so, when would such changes occur?

BH: ABEM is open to exploring any improvement to the MOC Program. When the ABA platform was first discussed, physicians would receive a question every week. As the program has been implemented, many physicians are batching the questions and responding every three months. We don't know if, over time, physicians would like even greater spacing for items, such as once per year, or if they'll experience participation fatigue. In addition, these pilot programs must determine how to reach a summative assessment of a physician's performance. The bottom line is that this is a complex issue that requires a more thorough review.

ACEP: Do you think ABMS member boards have a conflict of interest when considering changes that may also reduce their revenue?

BH: Any nonprofit organization must consider the value equation for its stakeholder groups. Speaking for ABEM, revenue has never been a top priority in designing our certification processes, and it seems that we've always had success in balancing that value proposition. It's also unclear at this stage whether changes will positively or negatively affect revenue. If it's best for our diplomates and our patients, we'll find a way to make it work regardless of the financial effect.

ABEM is committed to making certain that ABEM certification is valued by the patient, hospital systems, payers, and physicians. ABEM diplomates can be proud that they have accomplished a milestone that required a significant professional commitment. ABEM is pleased to support a specialty whose physicians have always embraced the notion that a one-time credential at the beginning of their clinical practices is an insufficient testament to their competencies throughout their medical careers.

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2016 ACEP ELECTIONS PREVIEW

CONTINUED FROM PAGE 1

MEET THE ACEP BOARD OF DIRECTORS CANDIDATES

PLATFORM-STATEMENTS

The following members are candidates for Board of Directors. They responded to this question:

Describe your skills, background, knowledge, or unique abilities that will make you an effective Board member.

James J. Augustine, MD, FACEP (Ohio)

Current Professional Positions: chair, National Clinical Governance Board, US Acute Care Solutions, Canton, Ohio; clinical professor, Department of Emergency Medicine, Wright State University, Dayton, Ohio; vice president, Emergency Department Benchmarking Alliance; executive editor, *ED Management*

Internships and Residency: integrated residency in emergency medicine, Wright State University School of Medicine, Dayton, Ohio

Medical Degree: Wright State University School of Medicine, Dayton, Ohio (1983)

Candidate Question Response: Emergency medicine serves as a model of team building and effective management for other elements in our health system. There's an opportunity to bring the collective emergency medicine experience of quality improvement, emergency department performance, team building, and collaboration to the entire American health system. The College has a responsibility to the public, and to our current member physicians, to develop a model for emergency medicine practice that's safe and fulfilling so that emergency physicians can serve a long career. It's my opportunity to continue as a member of the Board of Directors to continue the development of the ACEP Qualified Clinical Data Registry known as CEDR, the Clinical Emergency Department Registry. Other projects will be available through this development process that will serve emergency physicians at the bedside and will offer the ability to improve the delivery of high-quality emergency care.

In my 30 years of practice, I have served in about every form of American emergency department that exists, from isolated critical-access hospitals to academic urban Level I trauma centers, and into the community through EMS. I've been a member of physician group practices that were academic in nature and those that are community-based. It has been a pleasure to participate in graduate medical education throughout my career. Many of my responsibilities have been in leadership positions, at The Joint Commission where I served as chair of the Hospital's Advisory Committee, in the Emergency Department Benchmarking Alliance where I have served for more than 20 years, and in the state of Ohio.

This is the time when we will develop new approaches to patient safety, quality, efficiency, and transparency. My background in data acquisition and analysis in emergency care will contribute to the ongoing decisions that the Board and the College will be making in fulfilling mandates for the American health system. This is essential for the future of our specialty.

John T. Finnell, MD, MSc, FACEP (Indiana)

Current Professional Positions: fellowship program director, Clinical Informatics; chair, American Medical Informatics Association (AMIA) Academic Forum; member, AMIA Board of Directors; member, AMIA Education Committee; senior case examiner reviewer, item writer, and oral examiner, American Board of Emergency Medicine (ABEM); member, ABEM Case Development Panel

Internships and Residency: emergency medicine, UCSF Fresno

Medical Degree: University of Vermont (1991)

Candidate Question Response: We all wear many hats throughout our careers as physicians. My three hats would be emergency physician, educator, and research scientist in biomedical informatics. As an emergency physician, I've been practicing medicine since 1995 after graduating from UCSF Fresno as a chief resident. As an educator, I've found it rewarding to create and innovate within the fields of emergency medicine and, more recently, within clinical informatics. As a research scientist, I continue to explore and innovate with learners from high school to graduate programs. It is these unique attributes that will provide me with the skills to be your next ACEP Board member.

As a practicing emergency physician for more than 20 years, I will bring *judgment* and *courage* to help lead the Board. After graduating from residency, I moved to Saint Paul, Minnesota, to work alongside Bob Knopp and Felix Ankel to create a new emergency medicine residency training program. I was assistant and then associate program director until moving to Indianapolis in 2002. I serve as faculty for Indiana University's emergency medicine residency program, and I work clinically at a Level I trauma and burn facility that serves Marion County residents.

As emergency physicians, we utilize our best judgment every day. Who's sick? Who can be safely sent home? Can I trust this learner with this patient or procedure? In the emergency department, we must have timely access to relevant clinical information on medi-

CONTINUED *on page 10*

cations, allergies, prior visits and hospitalizations, diagnoses, and previous laboratory and radiology data. We must have courage to make the tough calls when the answer isn't always obvious and when there are considerable consequences if the call is wrong.

As an educator, I will provide *relevance* with my expertise in informatics and *mentorship* to help lead the Board. An ACEP Board member needs to have relevant context to offer actionable and on-point advice. ACEP is building CEDR, the Clinical Emergency Data Registry, which will continue to require input from informaticians. My current role on AMIA's Board of Directors would provide ACEP with access to national expertise in this area. If you desire to vote for a Board member who has "seen the movie before" and has a pretty good idea of what's around the next few corners as the practice of medicine changes, I am that candidate.

An often undervalued role for a Board member is that of a mentor. I've been fortunate in my career to have great mentors who have allowed me to grow as a leader and as an educator. I've also been privileged to mentor a number of learners. A great mentor doesn't tell you what needs to be done or how to do it; he or she is primarily a good listener. A great mentor asks you questions and poses challenges designed to help you see problems that you may not have identified, to look further ahead than you may be currently looking, or to encourage a different perspective. ACEP Board members should be good listeners, offering a sounding board to test your ideas and concerns.

As a research scientist, I will bring *wisdom* and *motivation* to help lead the Board. Wisdom is essential to make critical decisions and think strategically about the future. As a research scientist, I've led many projects and have learned many valuable lessons along the way. Scholarship, like the work of your ACEP Board, is hard work. There are many meetings, lots of homework, and times when very difficult, delicate, and challenging decisions must be made.

As your ACEP Board candidate, I will draw upon my judgment, courage, expertise, mentorship, wisdom, and motivation to help your ACEP Board navigate our future together.

Kevin M. Klauer, DO, EJD, FACEP (Ohio)

Current Professional Positions: chief medical officer–emergency medicine, chief risk officer, and executive director–patient safety organization, TeamHealth; medical editor in chief, *ACEP Now*; member, NEMPAC Board of Trustees; member, Advisory Board, Society of Emergency Medicine Physician Assistants (SEMPA); assistant clinical professor, Michigan State University College of Osteopathic Medicine, East Lansing

Internships and Residency: emergency medicine, Louisiana State University, Charity Hospital, New Orleans

Medical Degree: University of Osteopathic Medicine and Health Science, Des Moines, Iowa (1992)

Candidate Question Response: Three skills or attributes critical to the effectiveness of a member of the ACEP Board of Directors are vision, unique knowledge, and collaborative thinking.

Vision

Jonathan Swift said, "Vision is the art of seeing what is invisible to others." I believe that organizations benefit greatly from directors who have individual vision crafted by their unique professional experiences. Sharing of individual vision provides synergy to gain organizational insight and clarity in direction and mission. Vision should be rich in well-informed, relevant experience, with sufficient breadth and depth to provide historical perspectives and generate future insight.

My leadership experience with ACEP began 23 years ago and includes my most recent service as ACEP Council speaker. I have served on nine different national committees (excluding Council committees) for a total of more than 30 years of service (serving on multiple committees simultaneously), and I served as chair on five of those committees for a total of 13 years. In addition, I have served on the NEMPAC (ACEP's political action committee) Board of Trustees for the past six years and served two terms as president of Ohio Chapter ACEP. My experience includes multiple task force appointments, including the current ACEP Diversity Task Force.

My ACEP leadership experience and duration of service, along with a diverse professional background, help to inform and guide my vision. Board members don't think or work in isolation. Their perspectives, combined with a variety of other opinion sources, should be a catalyst to unification of thought and direction for the College.

Unique Knowledge

My professional and educational background would complement the current Board well and is timely with the current challenges facing our College, our specialty, and our members. Although I have considerable experience with leadership, academics/education, and emergency department operations, I want to highlight two important unique knowledge areas for the Board of Directors: legal expertise and patient safety. My legal degree, combined with work in patient safety, provides me with unique perspectives. I have focused on risk management for more than 15 years and have published three risk-management books. In addition, I have developed and currently administer the largest clinical risk-management program in the nation. I have been the executive director of two patient safety organizations (PSOs) listed with the Agency for Healthcare Research and Quality (AHRQ). Thirteen of the 82 current AHRQ-approved PSOs are participating in the national common formats reporting data project, which includes both of the PSOs I have worked with. This project is designed to aggregate national data to identify opportunities to improve patient safety in the US health care delivery system. Complementing patient safety is ACEP's work with the Centers for Medicare & Medicaid Services (CMS) Transforming Clinical Practice Initiative (TCPI) $3 million grant, which includes the Avoiding Unnecessary Imaging Initiative. I serve as co-chair of the initiative, as we use clinical and utilization data to inform and educate our members how to reduce imaging without sacrificing quality. These experiences led to my recent CMS appointment to the MACRA (Medicare Access and CHIP Reauthorization Act) Episode-Based Resource Use Measures Clinical Committee.

Collaborative Thinking

I have always believed that individual opinion serves the greater good by informing others of new perspectives and stimulating further thought to reach a better, more well-informed conclusion than any one individual may reach on their own. Many hands make for light work through collaborative thinking and, quite honestly, better work and outcomes. In representing you as ACEP's representative to ABEM for CME (continuing medical education), LLSA (lifelong learning and self-assessment) and maintenance of certification (MOC) since 2010, ACEP and ABEM have collaborated to provide CME for all LLSA modules, select LLSA articles relevant to current practice, and develop performance-improvement modules to meet the Part 4 MOC requirement.

ACEP Now reflects collaboration between the ACEP staff, the executive director, John Wiley & Sons publishing house, and the *ACEP Now* Editorial Advisory Board to achieve our shared goals of producing a high-quality monthly publication targeting the needs of our members.

Finally, our great work together as a Council reflects perhaps the most impactful but complex example of organizational collaboration. Our deliberative body is of far greater value than the sum of its councillors and component bodies. Listening and learning from one another guides our thinking, which results in well-considered guidance for the Board of Directors.

Vision, unique knowledge, and collaborative thinking are all qualities of an effective Board member. I have vision for the College and our specialty, unique knowledge that will complement the Board's current talents, and a collaborative approach to all that I do.

Debra G. Perina, MD, FACEP (Virginia)

Current Professional Positions: professor, regional quality director, and EMS fellowship director, Department of Emergency Medicine, University of Virginia, Charlottesville; director, Division of Prehospital Care, University of Virginia, Charlottesville

Internships and Residency: emergency medicine, Richland Memorial Hospital/University of South Carolina School of Medicine, Columbia

Medical Degree: West Virginia University School of Medicine, Morgantown (1983)

Candidate Question Response: This is a hard question for me, as I find it difficult to be self-promoting. First and foremost, I strive to be a servant leader. I'm a humble person, preferring to let my actions and work speak for my dedication and effectiveness. A Board member should represent the interests of the membership and stand for the values of the organization. I never forget that I was elected to represent you, our members, and do this to the best of my ability at all times.

Others have described me as an innovative and creative problem-solver. I do approach issues from many angles and will not stop until a solution is found. I'm diligent and persistent until the job is done. I strive to be respectful, transparent, open, and honest in dealing with others, as I think we all would like to be treated this way. I'm dependable: If I make a commitment or say I will do something, I *will* follow through. I have a passion for helping others, which goes to the core of values instilled in me from an early age. Having previously served on several boards, including ABEM's, I have a true working understanding of how a board functions. This definitely helped me hit the ground running during my first term on the ACEP Board. Having been a Board member for the past three years, I'm very familiar with the Board's goals and direction, and I am currently intimately involved with several ongoing projects. This experience will allow me to be an even more effective and productive Board member in service to ACEP going forward.

Due to a genuine interest in helping others, I have spent my entire career building relationships. I'm an active listener, trying to learn what's most important to others to effectively address their needs and desires. This has been especially helpful to achieve win-wins in negotiations, which also promotes collaboration. This is probably one of my greatest strengths. I tend to focus, when possible, on achieving positive results for all involved. This approach allowed me to effectively negotiate with other specialties in the House of Medicine to create the subspecialty of EMS medicine. I have put this approach to work for ACEP, networking with other organizations such as the American College of Surgeons Committee on Trauma, and helping ACEP enter into a new era of cross-organizational cooperation. I am deeply committed to doing all I can to represent you, the members, and continue to further ACEP's mission.

CONTINUED *on page 17*

DOES **YOUR CURIOSITY** KEEP YOU UP AT NIGHT?

It does that to us, too.

CEP America's democratic practice model is designed to encourage your curiosity. We empower our providers to improve the patient experience, rethink work-life balance, and transform their practice.

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actions. Additionally, the entire EM industry continues on its path toward increased commercialization of services: Kutscher reports that in March, HealthEngine offered patients up to $500 for having a preventive colonoscopy.[3]

Next, let's connect a few more dots closer to home. Gooch reports that "74 percent of satisfied patients paid their medical bills in full, compared to 33 percent of their less-satisfied counterparts."[4] This is significant and important news for emergency physicians: Achieving high patient experience-of-care scores adds to the daily constraints and pressures in our emergency departments. This is especially the case in these days of an ever-increasing number of patients who are insured with high-deductible plans and the challenges incumbent on collecting from these patients.

Effects of Medicaid Expansion

With this information as a backdrop, let's examine the changes affecting emergency physicians currently occurring in the industry from Medicaid expansion. As seen in Figure 1, 32 states currently have expanded Medicaid.

What can Medicaid expansion mean for an EM practice? For an emergency department with an annual patient volume of 100,000 patients, the data are as follows:

Figure 1: Current Status of State Medicaid Expansion Decisions

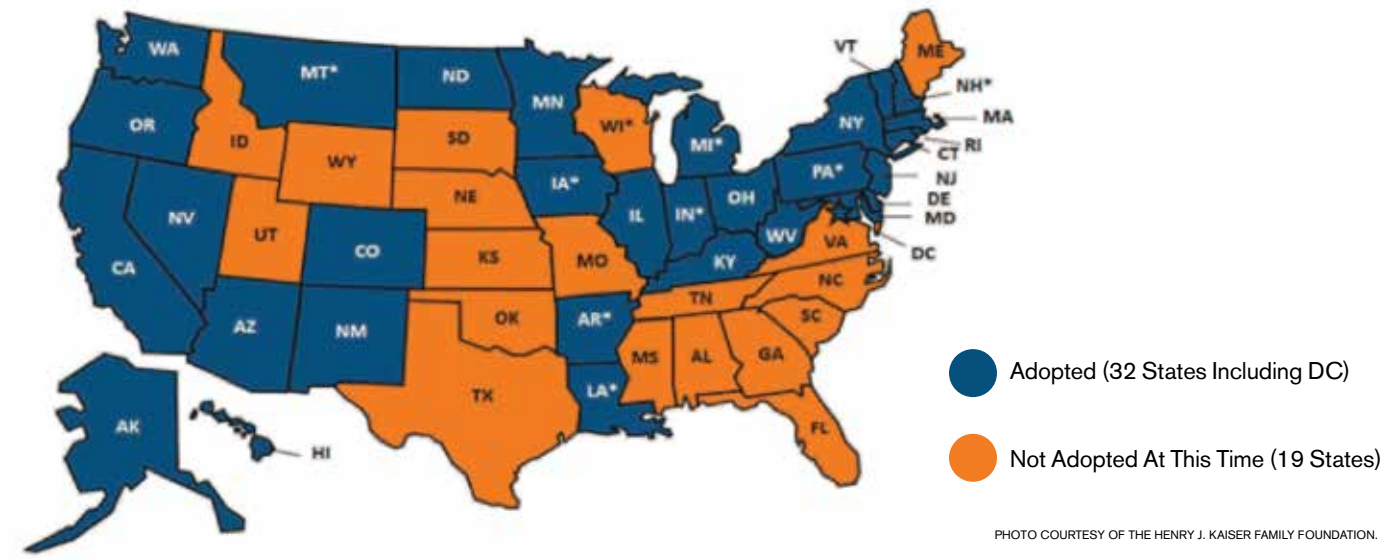

PHOTO COURTESY OF THE HENRY J. KAISER FAMILY FOUNDATION.

Pre–Medicaid Expansion

- 100,000 annual patients
- Self-pay mix: 23 percent (23,000 patients)
- Self-pay cash/visit: $25
- Pre–Medicaid expansion collection revenue: $575,000 annually

Post–Medicaid Expansion

- Self-pay to Medicaid coverage movement of 18 percent (18,000 patients) at $60/visit ($1.08 million)
- Residual self-pay patients 5 percent (5,000 patients) at $12/visit ($60,000)
- Post–Medicaid expansion collection revenue: $1.14 million annually

Bottom Line Impact of Medicaid Expansion

- Total collections pre–Medicaid expansion ($575,000) versus post–Medicaid expansion ($1.14 million)
- Financial impact of Medicaid expansion: +$565,000 collection revenue

Notice the secondary finding of post–Medicaid expansion: Self-pay patient collections can be "less" than your practice's prior self-pay collections. These are most likely your true self-pay patients—your residual self-pay patients who have not been absorbed into a Medicaid plan. Of related importance, however, is that Dussault et al reported early evidence that Medicaid expansion is fulfilling the goal of health insurance providing "peace of mind" by protecting against financial hardship.[5] This certainly bodes well for patient experience-of-care scores.

Examine the Details

When looking at the connected dots thus far, it brings into focus the incredible significance of staying centered on your patient's clinical presentation, coupled with the necessity of being supported by a business partner equipped with the latest analytical tools to efficiently drill down into the patient demographics and propensity-to-pay metrics. It also highlights the absolute necessity that the ED registration staff obtains accurate and current patient demographic information.

Law describes the pertinent industry patient transitions this way: "We've transitioned this business, which used to be a physician-to-carrier relationship, into a physician-to-patient or -consumer relationship."[6] He cites the necessity of developing clear images and metrics of patient and payer personas using various propensity-to-pay and propensity-for-friction metrics as critical today in successfully collecting physician revenue.

At a true nuts-and-bolts level, this involves careful scrutiny of patient information to understand patients' tendencies and proclivities to pay for your services. It culminates in the development of patient protocols and best practices for patient contact and engagement. Butcher additionally describes linking clinical diagnostic data elements to define patient groupings to develop more refined and better care delivery as we migrate toward population health care models.[7]

Why Is This Important?

Patient financial responsibility for medical care continues to rise. The Kaiser Family Foundation reported in 2015 that "since 2010, deductibles for all workers have risen almost three times as fast as premiums and about seven times as fast as wages and inflation."[8] Additionally, the just-released Milliman Medical Index report notes that "the cost of healthcare for a typical American family of four covered by an average employer-sponsored preferred provider organization (PPO) plan is $25,826."[9]

It will be an ongoing challenge to anticipate the dynamics of the continually evolving emergency patient who must first receive quality care, resulting in high experience-of-care scores. Additionally, your business partner must be technically skilled to uncover the metrics that will predict and result in the best financial outcomes for your practice.

The payer industry continues to move toward value-based payment models, and EM continues to face increasing reimbursement challenges and pressures. It has become more important than ever that your patient collection protocols be sharply defined using the best available metrics to legitimately collect the revenue you deserve.

MR. HOLSTEIN is director of development at Zotec Partners.

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#EMRARULES

Highlights of Emergency Medicine Residents' Association initiatives and projects from the organization's president

BY RAMNIK DHALIWAL, MD, JD

IMAGES COURTESY OF EMRA

The mission of the Emergency Medicine Residents' Association (EMRA), founded in 1974, is to be the voice of emergency physicians in training and the future of the specialty. I am happy to report that EMRA is as strong an organization today as it has ever been. The organization's membership exceeds 14,000, including medical students, residents, fellows, and alumni, and it has a close relationship with ACEP that is strengthened by collaboration and mutual respect.

Leadership, Collaboration, and Advocacy

Development of future leaders, advocacy, and collaboration within the specialty of emergency medicine remain key initiatives for EMRA and are crucial components of the newly minted strategic plan, which EMRA's Board approved earlier this year. While the list of ongoing initiatives and projects is long, I am excited to share a few highlights.

This year, the organization revamped its committees and divisions (C&Ds), as they are the drivers of many EMRA projects. Slack, an online, real-time interactive communication system, was used to make EMRA a nimbler and more productive organization and give leaders the ability to collaborate more effectively. In an effort to be more intentional with leadership development efforts, the organization will also be hosting leadership training for each C&D chair and vice chair this October, better preparing them to continue as leaders in the field post-residency.

EMRA is proud to be a diverse organization, and it continues to work to expand diversity within the field of emergency medicine. Earlier this year, ACEP, the Society for Academic Emergency Medicine (SAEM), the American Academy of Emergency Medicine (AAEM), the AAEM Resident and Student Association, the Council of Emergency Medicine Residency Directors (CORD), and EMRA all hosted a joint booth at the Student National Medical Association meeting, representing emergency medicine together as a specialty instead of each individual organization separately. EMRA also sent three members to the ACEP Diversity Summit in February to participate in the dialogue that occurred there.

Collaboration within emergency medicine is important to the organization. EMRA led the collaborative effort for the first EM Day of Service that encouraged residents, attendings, nurses, PAs, EMTs, and others working in emergency medicine to give back to local communities. At least 47 groups participated in the effort last September, impacting at least 463,000 community members.

Finally, EMRA supports advocacy initiatives that affect both members and the field of emergency medicine in general. The organization remains a strong supporter of the Emergency Medicine Action Fund (EMAF), the Emergency Medicine Foundation (EMF), and NEMPAC, contributing $25,000 annually to both EMF and EMAF and maintaining active engagement on the boards of all three organizations. EMRA leaders not only participated in the ACEP Leadership and Advocacy Conference (LAC) but coordinated and facilitated the Health Policy Primer session, which was one of the best-attended ever, with 144 residents present. While in Washington, D.C., for LAC, EMRA's president, immediate past president, and medical student council chair advocated on behalf of medical students to the Association of American Medical Colleges (AAMC) at its headquarters to voice members' concerns regarding a new residency application video pilot program, an effort that ultimately led to CORD and AAMC making changes to the program to ensure this was a true research pilot and that no medical students would be negatively affected by the trial. EMRA remains a member of the working group that will continue to oversee this project.

EMRA Publications and Educational Resources

Since EMRA is an organization made up of trainees, education is paramount. EMRA continues to update and expand its publications and educational resources for its members. This year, it launched EMRA•CAST, a series of podcasts with topics pertinent to EM residents and students. An example is EMpower, which highlights inspiring stories from accomplished EM leaders who have shaped and influenced the specialty. The inaugural EMpower series features Alison Haddock, MD, FACEP, Andy Bern, MD, FACEP, and Steven Stack, MD. Listen to these interviews at www.emra.org/resources/EMRA-CAST/.

EM Resident continues to be a sought-after publication, with most all articles written by members covering clinical, health policy, and residency-related topics. Readership continues to grow even outside of our membership.

EMRA Hangouts was launched with the goal of delivering education and advisement to EMRA members using video- and audio-streaming technology. For EMRA medical student members, EMRA Hangouts increases access and engagement with EM program directors to provide relevant information to help them match in emergency medicine. Each Hangout is posted on emra.org. So far, Christopher I. Doty, MD, FACEP, FAAEM, Brian Levine, MD, FACEP, and J. Scott Wieters, MD, have been featured.

Approximately 75 medical students attend each EMRA Hangout, with even more accessing the recordings asynchronously.

These are just a few of the many things EMRA has been working on as an organization to improve the specialty. With a dedicated membership, strong alumni support, and amazing staff, EMRA continues to exceed its own expectations. The organization believes that the sky is the limit and is truly proud to remain the largest independent resident-run organization in all of medicine.

DR. DHALIWAL is president of EMRA and junior faculty at Hennepin County Medical Center in Minneapolis.

Most Tenured ACEP Staff Member to Retire

Patty Stowe has been a member of the ACEP family for more than 40 years | **BY ACEP STAFF**

ACEP's director of membership and customer service, Patty Stowe, will retire from the College on Sept. 30 after 43 years of service. It is likely no one else will ever match a career at ACEP that spans four decades like that of Ms, Stowe, who played a critical role in ACEP's growth and has an institutional knowledge of ACEP that is unrivaled.

Comments from Colleagues

WITHOUT QUESTION, PATTY STOWE has been *the* most loyal, caring, competent, trustworthy, dedicated member of the ACEP team for most of the life of ACEP! She is the "chapter go-to person"—the one we have placed our trust in to find the answers when we are lost in the bureaucracy of ACEP! Patty, we thank you for your service to us and to our members. "May your troubles be less and your blessings be more, and nothing but happiness come through your door!"

*—**Diane Kay Bollman,** chief executive officer, Michigan College of Emergency Physicians*

PATTY HAS BEEN far more than ACEP's institutional memory over the years—she has engineered myriad ways to ensure our members are supported, engaged, and advocated for. She has always been objective, fair, respectful, and supportive of our members' views during ACEP's unprecedented growth and the challenges such growth faced whether it be dues structures, membership classes, benefits, or fellowship status. Working with her was an honor and a pleasure, and she will be missed.

*—**Jeremy T. Cushman, MD, MS, EMT-P, FACEP,** former Membership Committee chair*

PATTY STOWE EXEMPLIFIES what is great about ACEP. She was a wonderful support to me when I chaired the Membership Committee and before and after I was in that role. She was so helpful. She always had the right answer, and Patty has a great laugh!

*—**Nancy J. Auer, MD, FACEP,** ACEP past president and key voice in the development of fellowship criteria*

PATTY REPRESENTS the best of ACEP staff. She is loyal, understands the needs of the members, and is able to bring members and staff to a place they can work together even when opinions differ. She set the bar for chapter execs. When I was an ACEP newbie, Patty worked with me on several committees. If she hadn't been there, I would have been lost. She has always kept me in line and has done this with respect. I have enjoyed a long ACEP relationship with Patty. I will miss her.

*—**Kathleen Clem, MD, FACEP,** former Membership Committee chair*

ONLY STAFF MEMBER TO HAVE MOVED WITH ACEP FROM MICHIGAN

3 ACEP HEADQUARTERS:
LANSING, MICHIGAN; IRVING, TEXAS (CORPORATE DRIVE); IRVING, TEXAS (ROYAL LANE)

DEPARTMENTS WORKED IN:
SPECIAL RECORDS (REGISTRATIONS, PRODUCT SALES, AND ORGANIZATIONAL FILES—NOW CONSOLIDATED INTO OTHER DEPARTMENTS)

OFFICE SERVICES
(OFFICE FACILITIES, PHONES, REGISTRATIONS, MAILROOM, AND PRINT SHOP)

MEMBERSHIP AND CUSTOMER SERVICE

STAFF LIAISON:
BYLAWS COMMITTEE, MEMBERSHIP COMMITTEE

Mandatory E-Prescribing Is a Dangerous Rx for ED Patients

Policy by well-intentioned legislators results in inconvenience and confusion

BY MICHAEL HELLER, MD, NAYAN PATEL, MD, AND JEREMY ROSE, MD, MPH

Many emergency physicians may be aware that electronic prescribing, where a prescription is sent via the Internet directly to a designated pharmacy, is an alternative to the traditional hard-copy prescriptions used in one form or another by almost all emergency departments. What may come as a surprise, however, is that mandatory electronic prescribing for all patients, including ED patients, is now the law in the state of New York and may well be adopted in other jurisdictions.

Figure 1. Each red mark represents the address of a different pharmacy in New York City.

PHOTO: NAYAN PATEL, MD

As of March 27, 2016, emergency physicians in New York are required to use only electronic prescriptions; paper, fax, and telephone prescriptions are all banned, with both civil penalties and imprisonment specified for noncompliance. Although the law apparently isn't being enforced yet, it's evident that the many pernicious effects, on emergency patients in particular, have received little consideration.

A Prescription for Confusion

Many ED patients may not know the specific pharmacy where they will get their prescription filled. For example, there are 140 pharmacies with the Duane Reade brand alone in Manhattan (which is just one of five boroughs in New York City) and another 47 with the CVS name. As Figure 1 indicates, there are multiple branches of each chain, often in proximity to one another—there are 24 Duane Reade pharmacies on Broadway alone! Moreover, there are 80 Duane Reade pharmacies on a street or avenue with at least one other pharmacy of the same chain. In all, there are a total of 33.6 pharmacies of all types for each square mile of Manhattan.

It's estimated that there are 1.63 million nonresidents in Manhattan every day, including 848,000 visiting vacationers, daytrippers, and students from other countries and states. More than 500 languages are spoken in the city; the potential for confusion with our patients is evident.

Remarkably, the law doesn't allow for the electronic prescription to be filled by any pharmacy except the geographic entity to which it was originally sent. For example, the CVS nearest Mount Sinai Beth Israel on First Avenue and 15th Street couldn't send a patient to the Duane Reade right next door or even reroute a patient or prescription to another CVS a few blocks away. If the particular pharmacy is closed, doesn't stock the formulation, or is simply out of the precise medicine prescribed, the only alternative for the patient is to return to the emergency department for another prescription.

Ironically, the law makes it impossible for the patient to comparison-shop for price or anything else such as availability, formulation, or store hours. Electronic prescribing will likely work well when patients have a long-standing relationship with a particular pharmacy. Unfortunately, this description doesn't apply to many of the ED patients we treat.

There clearly are potential advantages to electronic prescribing, as anyone who's had a prescription forged or a pad stolen can attest to. However, the potential harm to our ED patients, who often don't have an ongoing relationship with a nearby pharmacy and are likely to receive a one-time prescription that needs to be filled quickly for an acute condition, seems to have been ignored.

Electronic prescribing is a reasonable option for both patients and clinicians, particularly in the office or clinic setting. But mandating it for ED providers and patients isn't reasonable; it's a (nonelectronic) prescription for inefficiency and confusion—a textbook example of misguided health policy.

DR. HELLER, DR. PATEL (resident), and **DR. ROSE** are all at Mount Sinai Beth Israel Department of Emergency Medicine and are affiliated with the Icahn School of Medicine at Mount Sinai in New York City.

EM DOCS ON SOCIAL MEDIA

DR. MOODY, founder of the EM Docs Facebook group, is president of the Tennessee College of Emergency Physicians and former emergency department chair for Mountain States Health Alliance.

Virtual Discussions for Real World EM Issues

Triumphs and challenges are easier to share with online colleagues

by K KAY MOODY, DO, MPH

The Facebook group EM Docs, launched in April 2013, was started by a small group of friends and has become a forum to discuss common and uncommon issues and situations that emergency physicians face. It exploded in size and posting volume in October 2015 when it changed the settings to allow current EM Docs group members to invite their colleagues to its discussions. It's empowering to have colleagues come together to share the joys and challenges of emergency medicine. Emergency physicians are fiercely passionate trailblazers with high expectations of themselves and others and are always advocates for patients.

As the EM Docs numbers have grown, the group has shared articles, crowd-sourced difficult cases, encouraged colleagues not to be bullied by attorneys, enjoyed emotional support after pediatric codes and full-moon shifts, laughed at one another's sarcastic dark humor, shared success stories, and sent words of support with virtual pats on the back to say, "I've been there" when a colleague had a rough shift.

The discussions range from absurd and silly to life-changing because EM physicians can see this range on every shift and in their own lives. When a member gets a little out of line, other members declare a "meme war" (ie, they post "too numerous to count" funny captioned photos) until enough comic humor makes everyone forget the controversial post. In this column, I plan to highlight and summarize some of the conversations for those who aren't on Facebook. However, if you want to be included in the conversation, ask a colleague to add you. Chances are someone in your department is on EM Docs. There are currently more than 6,200 of us, representing every state and some countries outside the United States. I'll maintain the privacy of the group, so there won't be personal attribution or details provided in this column. I will, however, summarize the most interesting/impactful posts.

Figure 1. ECG with a complete right coronary artery occlusion that was a STEMI equivalent with Sgarbossa criteria in a symptomatic patient.

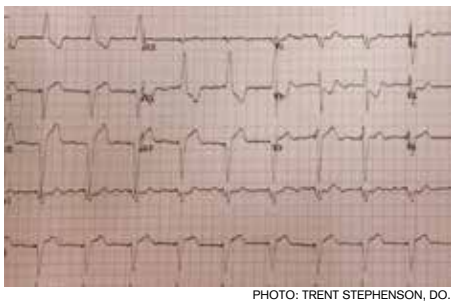

PHOTO: TRENT STEPHENSON, DO.

A Few Helpful Discussions

Sgarbossa criteria: Remember that Sgarbossa criteria applies to paced rhythms as well as left bundle branch block (LBBB). Figure 1 shows an ECG with a paced rhythm that was an ST elevation myocardial infarction (STEMI) equivalent with Sgarbossa criteria in a symptomatic patient. Three criteria are included in Sgarbossa criteria:

- ST elevation ≥1 mm in a lead with a positive QRS complex (ie, concordance): 5 points
- ST depression ≥1 mm in lead V1, V2, or V3: 3 points
- ST elevation ≥5 mm in a lead with a negative (discordant) QRS complex: 2 points

≥3 points = 90 percent specificity of STEMI (sensitivity of 36 percent)

Remember to look at lead I and aVL: An ECG with ST elevations in I and aVL that are cath lab criteria represents a probable occlusion of the diagonal branch of the left anterior descending artery. However, the inclusion of hyperacute T waves in V4 and V5 may indicate the circumflex instead.

Medico-legal: One recently graduated EM Docs member posted about a subpoena from an attorney to be present to testify as a witness in a case with fewer than 48 hours' notice. The doc was scheduled to work and couldn't get coverage. The threat was that the physician would be arrested if they didn't show up for the court date. When the doc turned to the EM Docs group for help, there was a flood of support including written documents that helped the doc file the refusal to appear due to such short notice.

Mental health boarding: In May, there was a post from an EM Docs member with concerns regarding psychiatric boarding. Within hours, there were more than 40 responses reporting length of stays ranging from 16 hours to 30 days for psychiatric patients awaiting an inpatient bed! This information was taken to each congressional and senate visit in every state during the ACEP Leadership and Advocacy Conference. The data from this exchange provided real-world examples for lawmakers that resonated with them, helping ACEP better lobby for improved access and resources for mental health patients presenting to the emergency department.

Crowd-sourcing: When an EM Docs member has a "zebra" and has run out of ideas, they crowd-source the group. Recently, someone mentioned that when a young patient arrived with Wolff-Parkinson-White syndrome (WPW) and a heart rate 180–200, they realized that their hospital didn't have procainamide. Twenty-eight docs responded. Many had also had similar situations. The following week, other EM Docs members had the exact situation, and because so many had mentioned other options, it was fresh in their minds. Other options listed were Valsalva, sedation and cardioversion (the most frequent suggestion), adenosine, and/or amiodarone if the ECG showed narrow complex with a warning to *never* use an atrioventricular nodal blocker in wide complex tachycardia with a history of WPW—especially with an irregular rhythm and changing morphologies. Check with your hospital pharmacy to see if you have procainamide before you need it!

Financial considerations: There are occasional discussions within the group regarding contracts. About 50 percent of responding EM Docs members had an attorney look at their contracts, and many of those who did not wished they had. They shared information on mortgage lenders that offer physician loans, including Wells Fargo (relocation loans for medical student/residents to cover moving expenses with no payment for 60 months), Bank of America (90–95 percent financing on mortgages up to $1.5 million with no required private mortgage insurance [PMI] and a signed contract qualifies the physician before starting their new attending job, student loan debt that is deferred is not calculated into the debt/income ratio), and SunTrust (up to 90–100 percent financing with limits of $750,000 and $1.5 million, respectively, and no PMI requirement). It was noted that MyFedLoan.org has information about public student loan forgiveness programs. Finally, a suggested resource for investing is the personal finance blog The White Coat Investor (WhiteCoatInvestor.com), written by EM physician and *ACEP Now* columnist James Dahle.

MEET THE ACEP BOARD OF DIRECTORS CANDIDATES

CONTINUED FROM PAGE 10

Gillian Schmitz, MD, FACEP (Texas)

Current Professional Positions: associate professor and associate program director, Department of Emergency Medicine, University of Texas Health Science Center at San Antonio; emergency physician, First Choice Emergency Room, San Antonio
Internships and Residency: emergency medicine, University of North Carolina
Medical Degree: Loyola Stritch School of Medicine, Chicago (2004)

Candidate Question Response: My unique background, leadership experience, and skills set will make me an effective leader and Board member. As a member of the Emergency Medicine Residents' Association (EMRA) Board of Directors, I was hooked early in my career on organized medicine and the impact I could make on my patients and my specialty.

National ACEP has always been my true "home" as my family has moved across the country for the military. I have been honored to be a member of several different state chapters, a committee member for the Texas chapter, and president of the Government Services Chapter. Nationally, I have served the College as chair of the Young Physicians Section (YPS), chair of the Academic Affairs Committee, and subcommittee chair for the Medical-Legal Committee and have participated in numerous ACEP task forces.

The Board should reflect the clinical background and diversity of its members. I have had the opportunity to work in emergency departments in the Midwest, the East Coast, and the West Coast and am now in San Antonio. Over the past 10 years, I have primarily worked in academics, but I have also had the experience of working in a military emergency department, a community emergency department in an urban environment, a rural emergency department, a freestanding emergency department, and a small democratic group. *I can represent ACEP members from all different backgrounds and work environments because I have worked in just about every type of emergency department that exists.* I can guide the transition from volume-based care to high-value patient-centered care. I can use my work and life experiences to help improve coordination of care and explore different options for health care delivery.

With more than 10 years in graduate medical education (GME) leadership, I've led committees and teams whose objectives span across several different emergency medicine organizations. I'm a strong advocate for collaborative work and will promote the skills and strengths we bring as a team. As a national speaker for ACEP, I have learned to effectively communicate, engage my audience, and promote our message to advocate for our specialty and our patients. *I will fight to preserve GME funding and support residency training.*

As an engineer, I was trained to problem-solve. As an emergency physician, I have spent hours on the phone trying to get a patient's medical records and have struggled with the inefficiency of my EMR system. My vision is to create a national information exchange. *We need systems and processes that support our workflow, not disrupt them.* We should be able to access discharge summaries from other hospitals and view recent CT results rather than repeat unnecessary tests, drive up costs, and prolong wait times.

I will support physicians undergoing litigation stress and fight for malpractice reform. As YPS chair and a member of the Medical-Legal Committee, I created a series of podcasts on medical malpractice issues. I created online resources and lectured at ACEP and across the country to educate physicians about preparing for depositions, understanding the lawsuit process, avoiding plaintiff attorney traps, and coping with litigation stress.

ACEP is what energizes me and gives me a sense of purpose. The College has invested so much in me, and *now* is the time for me to give back.

Matthew J. Watson, MD, FACEP (Georgia)

Current Professional Positions: medical director, staff physician, and customer service coordinator, Northside Hospital Forsyth, Cumming, Georgia
Internships and Residency: emergency medicine, Geisinger Medical Center
Medical Degree: Jefferson Medical College, Philadelphia (1998)

Candidate Question Response: I am uniquely qualified to be an effective Board member because my entire career, every stage thus far, has been dedicated to service within and for our College.

I first joined the College as a medical student and later served as a member of the EMRA Board of Directors. I continued my involvement at the state level, serving as president of the Georgia chapter from 2011 to 2013. I have also served on several national College committees and have been active with advocacy at state and national levels. After serving as the chair of the Georgia PAC, I was selected to the NEMPAC Board of Trustees and the Emergency Medicine Action Fund (EMAF) Board of Governors.

Since completing residency, I've been a member of a fully democratic group. I have also been the medical director for a department that has grown from eight to 34 beds in a single hospital system with three clinical campuses and a combined census of more than 170,000 patients. The integration of a cardiac cath lab, stroke center certification, and the country's largest OB center has provided me with leadership opportunities that have enhanced my clinical and administrative expertise. Even with these responsibilities, two-thirds of my time is still spent caring for patients. These experiences allow me to remain a practicing emergency physician and to collaborate with other services to help the emergency department grow and evolve—just as I would do for the College if elected to the Board of Directors.

Improving diversity within our specialty and the House of Medicine is an opportunity and priority for our College—and it starts with our leadership. I'm a member of the generation that has been raised by the College—from medical school to EMRA to state and national service. I represent democratic groups and independent practice. I am an ardent advocate of member involvement and leadership at every level. I am committed to defending the practice and promoting the evolution of emergency medicine.

James M. Williams, DO, MS, FACEP (Texas)

Current Professional Positions: attending emergency medicine physician and member of the Physician Quality Review Board, Covenant Medical Center, Lubbock, Texas; clinical assistant professor, Texas Tech University Health Sciences Center School of Medicine, Lubbock; attending emergency medicine physician, Texas Health Harris Methodist Hospital Southlake, Dallas; advisor, clinical and player development, United States Lacrosse Association
Internships and Residency: general surgery, Brooke Army Medical Center, San Antonio
Medical Degree: Philadelphia College of Osteopathic Medicine (1991)

Candidate Question Response: First, I would like to thank the ACEP Council for the honor of being a candidate for the Board of Directors. Though I know most of the councillors, let me make a few introductory comments for those who may not know me. I'm a husband and a father of three sons: My oldest is attending Colgate University in New York, my middle son will attend Tufts University in Boston, and my youngest is starting eighth grade. If you've seen my postings on the Physician Wellness Facebook page, you know how important wellness is to me. I appreciate how Jay Kaplan and K Kay Moody have highlighted this critical issue that all of us face.

Last year during my candidacy, I mentioned my father, who was the quarterback for the University of Notre Dame's 1949 championship football team. Even if you don't follow Notre Dame, you may have seen the sign players tap as they head for the field. It reads, "Play Like a Champion Today." We have a similar sign in our house for inspiration that we tap every morning going down the steps. When I was in grad school, I asked my dad if he thought there was ever a time in life when you reach a plateau—when everything is steady. He laughed and, of course, said, "Never—you always have to keep reaching and setting new goals." That's one of the reasons I'm seeking your vote for the ACEP Board. I want to lead emergency physicians and our specialty to overcome the challenges we are facing and achieve new goals.

My background includes serving in the US Army in Germany and Bosnia. As a major, I served as a commander, established the first EMT course for medics leading to civilian licensure, and addressed population health issues. I also served as chief of staff of our hospital and worked with physicians across specialties and non-physician groups inside and outside of the hospital. In addition, I served as president of the Texas College of Emergency Physicians, the third largest chapter in the country. This role gave me valuable understanding of how ACEP and its chapters work. I'm involved in research and speak to physicians across the country including groups at national conferences such as SEMPA, ACEP, the American Osteopathic Association (AOA), and American Heart Association (AHA). I understand firsthand your concerns and know the issues. Brahim Ardolic of New York recently complimented me, saying that he judges how well a person will serve on the Board based on how well he campaigns. I hope you'll see my commitment, dedication, and unique skills set that qualifies me for this role and differentiates me from other candidates.

Our president-elect, Becky Parker, is highlighting diversity this year, so I want to address what I would bring to the Board. First is generational diversity. I bridge the baby boomers and Gen Xers and therefore bring a combination of institutional memory of issues and fresh perspectives. Geographically, I am the only candidate and Board member who represents the middle two-thirds of the United States. In addition, I've worked in diverse settings—for example, in Maryland, where a single-payer model exists, and in Texas, where freestanding emergency departments are growing. I also bring the diversity of practice environments. For the past seven years, I've worked for a private independent democratic multispecialty group at a regional referral center in Lubbock, Texas, but I also am a clinical assistant professor at Texas Tech University. I bring business experience through working with corporations as an advisory board member.

How do these skills sets translate into helping you and ACEP? Let me give two examples. I've served on the Public Relations Committee with Steve Anderson, Ryan Stanton, and others for more than 10 years. I've given hundreds of interviews—TV, radio, *The Wall Street Journal*, The Huffington Post, *Women's Health*, to name a few—promoting the value of emergency medicine and advocating for you and our patients.

I've also been active in the state legislature in regard to tort reform. Texas is largely held as the standard as a result of our work in 2003. But make no mistake—we are constantly under attack by trial lawyers. Last year, I mentioned a case in which a New Mexico patient was treated exclusively in Texas but attempted to change the venue to New Mexico, a plaintiff-friendly venue. I was able to help form a coalition of more than 20 organizations that demonstrated how this case would impact patients' access to care. As a result of our work in Texas, New Mexico changed its laws to help ensure patient care.

These are of some of the qualities I bring to the ACEP Board—diversity, unique service and experience, dedication, and commitment—and what differentiates me from the other candidates. I appreciate your consideration and ask for your vote so that I can continue to be an advocate for you and our patients and help ACEP "play like a champion today"!

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.

You Incorporated

Even as an employee, you can still be the boss of your own career

Your job as the CEO of You Inc. is to get as much as you can in exchange for your work and value.

by JAMES M. DAHLE, MD, FACEP

***Q.** It seems that fewer emergency physicians own their own groups. What can I do to increase my income and financial security?*

A. The percentage of emergency physicians who are partners in small democratic groups decreases each year, and it's easy to understand why. Not having to worry about "business stuff" is attractive to many doctors. The growing debt burden for new residency graduates has increased the need for higher initial salaries—perhaps at the cost of lower long-term income. That means that coming up with a financial, or "sweat equity," buy-in for a heavily indebted graduate could also be difficult, especially with the prospect of a small democratic group becoming part of a contract management group (CMG) before the investment could be recouped. In addition, there are now so few small democratic groups that many doctors interested in that model no longer have the option in their desired geographic areas and are faced with the likelihood of being an employee for their entire career.

This puts numerous emergency physicians in the same position that many employees in corporate America have been in for some time. Loyalty to "the company" isn't rewarded in the same way it might have been decades ago. Employees are unlikely to stay in the same location, working for the same employer for their entire career, and then retire with a pension and health care provided by the company.

If a small democratic group isn't in your future, you still stand the best chance to be successful if you think of yourself as an owner: the owner of "You Incorporated." Just like any business owner, you have revenue and expenses. From time to time, you'll negotiate contracts that will increase revenue. And as the chief financial officer of You Inc., you're in charge of reducing expenditures. Taking this attitude should change the way you approach your personal finances.

USE FLEXIBILITY TO YOUR ADVANTAGE

Partially driven by the rapid increase in both investor- and hospital-owned freestanding emergency departments, the number of emergency departments and ED patient visits in the country is increasing at a rate much higher than the increase in emergency physicians coming out of residency. Even before this trend, there were many emergency departments in the country that weren't yet staffed by residency-trained, board-certified emergency physicians. Demand is much higher than supply, and this can work to your advantage.

You may not have the control over your nursing staffing level like you would if you owned your own freestanding emergency department. You may not have the control over physician staffing levels, shift lengths, and the vacation calendar like you might have in a small democratic group. You may not have access to the additional profits that come with a successful business. But you do have something that in some ways can be just as valuable: an in-demand skill set and the potential for an extreme amount of flexibility. Your job as the CEO of You Inc. is to get as much as you can in exchange for your work and value. The more flexible you can be, the higher the rate for which you can exchange your time.

ILLUSTRATION: PAUL JUESTRICH; PHOTOS: SHUTTERSTOCK.COM

There are many situations where hospitals, CMGs, and other employers have difficulty staffing the emergency department. It may be a relatively undesirable town to live in or a difficulty in covering night, weekend, or holiday shifts. (You might be amazed to learn the going hourly rate for covering Christmas Eve in a difficult-to-staff location.) Maybe the emergency department has poor levels of support staff or call coverage. Or perhaps the CMG just acquired the contract and is still scrambling to find doctors interested in working there in the long term.

Whether you relocate your family or simply commute to fill these shifts, they're all opportunities to increase the revenue of You Inc. and gain benefits you might not have as part of a small democratic group. As a "gunslinger" for a CMG or locum tenens company, you can set up your personal finances such that you spend much less than you earn. This will allow you to take sabbaticals lasting weeks or even months, which a partner in a small democratic group could never do. For many docs, this extreme flexibility can more than make up for the inconveniences of not knowing what emergency department you may be working in six months from now.

ADD REVENUE STREAMS

You Inc. should also keep its eyes open for additional revenue streams. By virtue of the fact that most ED shifts don't occur during banking hours, emergency physicians have discovered the value of having multiple weekday mornings off each week. While this time is often used for resting, recovering, and recreating, it can also be profitably used to develop other revenue streams.

This is the time to feed your entrepreneurial streak. You can be an EMS medical director, do medical legal work, consult for insurance companies, or start a business unrelated to medicine. Perhaps you've wanted to become a writer, speaker, or politician. Emergency medicine lends itself to these side pursuits far better than many specialties that are locked into standard clinic or operating room hours. These additional income streams reduce the risk of disability, job loss, contract loss, and other financial catastrophes. After a while, and especially if you keep living expenses down, they may even free you from the need to practice medicine for money at all.

Some revenue streams are more passive than others. An investment in low-cost index mutual funds, for example, requires almost zero additional effort after the initial setup. Publishing a book represents a lot of work up front for writing, editing, publishing, and marketing but eventually reverts to almost completely passive income. Some pursuits, such as real estate investing, are a mix of passive and active income. Many tasks can be outsourced as needed to make them as passive or active as you desire.

Speaking to groups of physicians or consulting for profit lies on the other end of the spectrum, as these are almost entirely active pursuits where you trade your time for money. By diversifying your income, you become less reliant on your employer and are in a much better negotiating position.

You may find it increasingly difficult to own your own practice these days, but that shouldn't stop you from thinking like a business owner. As the owner of You Inc., you can take positive steps to boost profits, income, and flexibility as well as decrease burnout throughout your career.

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.

Change from Below: The Attending's View

Medical students and residents each have things they can teach the other in evidence-based medicine

by JEREMY SAMUEL FAUST, MD, MS, MA

Four years ago, before the term "FOAM" had even been coined, I wrote in *ACEP News* for the very first time as a not-yet-graduated medical student. In that first article, I described how the advent of free open-access medical education provided a powerful new avenue for knowledge sharing in an unusual direction: from student to teacher.

In "Change from Below," I argued that because medical students and residents were more likely to consume podcasts and blogs that advocated for cutting-edge approaches to emergency medicine, the junior member of a team might ever so occasionally be in possession of the most up-to-date knowledge on a particular topic. How, I asked, could that lowest member of the totem pole teach the advanced practice providers and senior clinicians they were training under about the latest in evidence-based medicine (EBM) without being "that guy"?

The answer was for attendings themselves to solicit the latest in EBM from their students and junior residents during shifts by actively inviting the sharing of newly acquired medical knowledge. This approach would allow motivated learners an opportunity to show off their knowledge and would carry the fringe benefit for the attending and other providers of getting free digests on emerging concepts in our field.

The example I used to illustrate the point was the HINTS exam (Head Impulse, Nystagmus, and Test of Skew) for distinguishing between central and peripheral causes of vertigo, a triad of physical exam maneuvers I first learned about on Scott Weingart's EM-Crit podcast (@emcrit).

A year later, I wrote and published an update titled "Change from Below: Update from the Midlevel." By then, I was an illustrious and experienced ... umm ... almost non-intern. Long story short, even by then, I had already discovered that finding EBM was more than just reading some papers and listening to a podcast. It was about combining the knowledge of those helpful resources with clinical acumen and the patient's values. When attempting to answer a clinical question using EBM, it's as EBM guru and host of the podcast Skeptics' Guide to Emergency Medicine Ken Milne (@theSGEM) likes to say: "It depends."

But more important, in that follow-up article, I wrote that adopting evidence-based approaches sometimes led to decreased testing and, occasionally, some commensurate anxiety (in this case, forgoing that MRI to rule out an acute cerebellar stroke when the HINTS exam was reassuring). That meant that sometimes I had to follow up with a patient on the phone—that is, if I wanted to get some anxiety-free sleep later in the week. If I was going to "walk the walk" of EBM, I wrote, I had to "talk the talk." That meant discussing risks and benefits with patients and, occasionally, calling them at home repeatedly after discharging them to check up on them.

ILLUSTRATION: PAUL JUESTRICH; PHOTOS: SHUTTERSTOCK.COM

So now that I'm an academic attending, how do I feel about the "change from below" paradigm that I suggested four years ago as an upstart medical student with a questionable grip on reality? Pretty great, actually. Am I really *that* excited to have my medical students try to teach me something during my hectic shifts? The answer is heck yes!

Long story short, even by then, I had already discovered that finding EBM was more than just reading some papers and listening to a podcast. It was about combining the knowledge of those helpful resources with clinical acumen and the patient's values.

However, there is a caveat. (Of course, there must be a caveat. Otherwise, your protagonist learned nothing, and we wouldn't want that, would we?)

The Caveat

The other day, a mere month or so after graduating residency, my personal arc with HINTS and FOAM came full circle in heroic fashion. Now, my own free podcast (FOAMcast) has become required listening for the incoming interns at the very residency program where I trained. My cohost, Lauren Westafer (@LWestafer), recently recorded an episode in which we briefly discussed the HINTS exam. Neither of us, it turns out, rely on that exam the way we once might have. Why? Because a closer look at the literature reveals that the astoundingly good test characteristics of the HINTS exam that everyone likes to herald have never been shown to be true for emergency medicine providers. The studies we all cite when extolling the virtues of the HINTS exam were actually done by and on neurologists with particular expertise in the subfield of cerebellar strokes and vertigo. Therefore, while Lauren and I both use the HINTS exam as one part of our cerebellar testing in general, neither Lauren nor I feel comfortable relying on that exam alone. That's just not our read of the literature.

However, that's not what a newly minted intern who listens to our show heard recently. The current chief resident texted me after he gave the new interns a lecture about the HINTS exam. One intern raised his hand and said that FOAMcast had said that emergency medicine providers should "never" be doing a HINTS exam. Hey now, that's not what we said—but it illustrated a great point: When junior clinicians read a paper, or equally when they hear a podcast or read a blog, they frequently gloss over important details including the setting and inclusion criteria for studies being discussed. Therefore, they often fail to consider properly whether the research of interest applies to the particular (real) patient in front of them.

A great example of this is the Pulmonary Embolism Rule-Out Criteria (PERC). Most people remember that the PERC rule applies to low pretest probability patients younger than 50 years old. However, can a 16-year-old PERC out? The answer—one most people don't realize—is no. The dataset Kline et al used had 17-year-olds as the youngest patients. This is just one example among countless others.

So starting now as a newly minted attending, when my students and residents teach me new concepts in EBM, I'll be as receptive as anyone to change from below. But the knowledge flow won't be a one-way street. Instead, I'll reply to the latest in EBM by reminding my students and residents about the oldest in EBM: the fundamentals. How was the study designed and performed? In what setting? When? By whom? What types of patients were included and excluded? Were the outcomes patient-centered? When students bring us new answers, we should challenge them with new questions.

In short, I'm absolutely looking forward to having my trainees tell me the latest and greatest of what the emergency medicine literature has to offer. But from there, I'm hoping that, together, we can discuss what these findings actually mean and how to apply them to our living, breathing patients.

"Change from above," "change from below"—those phrases sound too adversarial for me these days. Let's stick with "change things together."

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. MILNE is chief of emergency medicine and chief of staff at South Huron Hospital, Ontario, Canada. He is on the Best Evidence in Emergency Medicine faculty and is creator of the knowledge translation project the Skeptics' Guide to Emergency Medicine (www.TheSGEM.com).

Is Dilute Apple Juice a Viable Substitute for Rehydration?

An apple a day may keep the IV away

CME Now
A new continuing medical education feature of ACEP Now

LOG ON TO http://www.acep.org/ACEPeCME/ TO COMPLETE THE ACTIVITY AND EARN FREE *AMA PRA CATEGORY 1 CREDIT.*

by KEN MILNE, MD

CASE: A 28-month-old boy presents with a three-day history of vomiting and diarrhea. After performing an appropriate history and directed physical examination, you diagnose him with mild gastroenteritis and minimal dehydration. The parents ask if they need to buy an electrolyte maintenance solution or if they could just use some watered-down apple juice to treat his dehydration.

CLINICAL QUESTION: In children diagnosed with mild gastroenteritis who have minimal dehydration, is dilute apple juice followed by preferred fluids an equivalent way to orally rehydrate compared to an electrolyte maintenance solution?

BACKGROUND: Acute gastroenteritis is a common childhood illness in the United States. It's characterized by acute-onset diarrhea with or without nausea, vomiting, fever, and abdominal pain. According to King et al, acute diarrhea results in more than 1.5 million outpatient visits and 200,000 hospitalizations per year.

Children with gastroenteritis are at risk of dehydration. Most cases are mild and self-limited. The Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, and Canadian Paediatric Society (CPS) all recommend oral rehydration solutions (ORS) for mild to moderate dehydration.

CPS has an algorithm for managing acute gastroenteritis in children, located at http://www.cps.ca/documents/position/oral-rehydration-therapy. The emphasis is on ORS followed by an age-appropriate diet after rehydration for those children with mild to moderate dehydration.

REFERENCE: Freedman SB, Willan AR, Boutis K, et al. Effect of dilute apple juice and preferred fluids v. electrolyte maintenance solution on treatment failure among children with mild gastroenteritis: a randomized clinical trial. *JAMA*. 2016;315(18):1966-1974.

- **Population:** Children presenting to the emergency department between 6 months and 5 years of age with three or more episodes of vomiting or diarrhea in the past 24 hours and symptoms for fewer than 96 hours. The children also needed to weigh at least 8 kg and have minimal dehydration on the Clinical Dehydration Scale (CDS).
  - —**Excluded:** Inflammatory bowel disease, celiac disease, diabetes mellitus, inborn errors of metabolism, prematurity with corrected postnatal age less than 30 weeks, bilious vomiting, hematemesis, hematochezia, clinical concern of an acute abdomen, or a need for immediate intravenous rehydration.

- **Intervention:** Half-strength apple juice in the emergency department followed by preferred fluids other than electrolyte maintenance solutions upon discharge. This included milk, juices, half-strength apple juice, or sports beverages that are contraindicated in most guidelines.
- **Comparison:** Apple-flavored, sucralose-sweetened electrolyte maintenance solution in the emergency department and post discharge.
  - —Those who vomited in either group received oral ondansetron.
- **Outcome:**
  - —**Primary outcomes:** Composite measure of treatment failure occurring within seven days.
    1. Hospitalization or IV rehydration
    2. Subsequent unscheduled health care visit (emergency department, urgent care clinic, walk-in clinic, or office)
    3. Protracted symptoms (more than two episodes of vomiting or diarrhea within a 24-hour period occurring more than seven days after enrollment)
    4. Crossover (physician request to administer a solution representing treatment allocation crossover at the index visit)
    5. Three percent or greater weight loss or CDS score of 5 or higher at in-person follow-up
  - **Secondary outcomes:** Frequency of diarrhea and vomiting, percent weight change at 72 to 84 hours, intravenous rehydration at initial visit or a subsequent visit within seven days, hospitalization at initial visit or a subsequent visit.

AUTHORS' CONCLUSIONS: "Among children with mild gastroenteritis and minimal dehydration, initial oral hydration with dilute apple juice followed by their preferred fluids, compared with electrolyte maintenance solution, resulted in fewer treatment failures."

KEY RESULTS: The study enrolled 647 children with a mean age of 28 months. The primary outcome was less treatment failure with half-strength apple juice/preferred fluids versus electrolyte maintenance solution.

- 16.7 percent (95 percent CI, 12.8–21.2) versus 25.0 percent (95 percent CI, 20.4–30.1)
- Difference between groups -8.3 percent (97.5 percent CI, –infinity to -2.0) showing non-inferiority (P<0.001)
- Number needed to treat (NNT) of 12 with half-strength apple juice/preferred fluids to prevent one treatment failure

Secondary outcomes included less IV rehydration in the half-strength apple juice/preferred fluids versus electrolyte solution at index ED visit. No statistical differences were seen in the other secondary outcomes.

- IV rehydration at index ED visit 0.9 percent (95 percent CI, 0.2–2.7) versus 6.8 percent (95 percent CI, 4.3–10.1) (P=0.001)

EBM COMMENTARY

- This was a convenience sample of patients presenting 12 hours per day, six days per week to a single-center tertiary care pediatric hospital. Therefore, the sample of patients included in the study may not be reflective of, or cannot be generalized to, the overall population presenting to the emergency department or other practice locations.
- This study was conduced in Toronto, Ontario, Canada, a high-income country. The results shouldn't be extrapolated to low- and middle-income countries because children in those countries are at a higher risk of gastroenteritis-related complications. Also, the etiology of gastroenteritis can vary in different geographical locations, limiting the generalizability of this study to those children.
- The primary outcome of treatment failure was a composite of a number of different measures that may not all have the same clinical relevance to the caregiver and patient. In this composite outcome, the most statistically significant difference was seen in IV rehydration rates.
- Allocation was concealed in the emergency department but not at home. Documentation informed parents which treatment group their child was allocated to, eliminating blinding. This has the potential to introduce bias into the study. It's hard to know in which direction, if any, the bias would deviate the results.
- This was designed as a non-inferiority study. However, the difference observed was greater than their prespecified non-inferiority margin of 7.5 percent. Thus, they actually demonstrated that dilute apple juice/preferred fluids was superior to the electrolyte maintenance solution.

BOTTOM LINE: In children from high-income countries presenting with mild gastroenteritis and minimal dehydration, oral rehydration with dilute apple juice followed by preferred fluids appears to be a reasonable alternative to electrolyte maintenance solutions.

CASE RESOLUTION: The boy is offered half-strength apple juice and tolerates it well in the emergency department. After a short period of observation, he's discharged home with his caregivers. They are advised to continue his usual dietary patterns, including his preferred fluids to replace losses, and are given detailed instructions on when to return to the emergency department.

Thank you to Dr. Anthony Crocco from www.SketchyEBM.com *for his help with this review. Dr. Crocco is an associate professor at McMaster University and the medical director and division head of pediatric emergency medicine at McMaster Children's Hospital in Hamilton, Ontario, Canada.*

Remember to be skeptical of anything you learn, even if you read it in the Skeptics' Guide to Emergency Medicine.

RESOURCES FOR FURTHER READING

- King CK, Glass R, Bresee JS, et al. Managing acute gastroenteritis among children. *Morbidity and Mortality Weekly Report* website. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5216a1.htm. Accessed Aug. 11, 2016.
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DR. HELMAN is an emergency physician at North York General Hospital in Toronto. He is an assistant professor at the University of Toronto, Division of Emergency Medicine, and the education innovation lead at the Schwartz/Reisman Emergency Medicine Institute. He is the founder and host of Emergency Medicine Cases podcast and website (www.emergencymedicinecases.com).

Anaphylaxis, Anaphylactic Shock, and Kounis Syndrome: Not So Simple

It's important to understand the diagnostic criteria for anaphylaxis in order to initiate time-sensitive lifesaving treatment

by ANTON HELMAN, MD, CCFP(EM), CAC, FCFP

Anaphylaxis is *the* quintessential medical emergency. While the vast majority of anaphylaxis cases are relatively benign, about 1 percent of these patients die from anaphylactic shock quickly—within about five to 30 minutes of onset. Many of these deaths occur because the anaphylaxis was misdiagnosed and/or the treatment of anaphylaxis and anaphylactic shock was inappropriate.

Anaphylaxis is *not* simply an acute onset of an itchy rash with hypotension. To the contrary, up to 20 percent of patients do *not* manifest a rash. Moreover, anaphylaxis can present with isolated hypotension, making the diagnosis even more challenging.

Criteria

In order for time-sensitive lifesaving treatment to be initiated promptly, it's imperative that emergency medicine providers understand the diagnostic criteria for anaphylaxis:

1. Acute illness with skin, mucosal tissues (or both) involvement, *and* at least one of the following:
   - Respiratory compromise
   - Reduced blood pressure or associated symptoms of end-organ dysfunction
2. Two or more of the following that occur rapidly after exposure to a likely antigen:
   - Skin-mucosal tissue involvement
   - Respiratory compromise
   - Reduced blood pressure or associated symptoms of end-organ dysfunction
   - Gastrointestinal symptoms
3. Reduced blood pressure after exposure to a known allergen

Anaphylaxis can present with isolated hypotension, hypotension plus vomiting, or hypotension plus wheezing, without rash. Not recognizing this in a timely manner can lead to misdiagnosis and death.

Epinephrine: Timing, Location, and Dose

All patients who fulfill the criteria for anaphylaxis require epinephrine. Epinephrine is the only drug to show a mortality benefit in the management of anaphylaxis.

Epinephrine should be administered as soon as possible intramuscularly (IM) in the anterolateral thigh. Administering epinephrine IM in the deltoid muscle or subcutaneously is not recommended.

The most common cause of death in anaphylaxis is not giving epinephrine at the right time at the correct dose. The correct dose of epinephrine for the treatment of anaphylaxis is 0.01 mg/kg (to a max of 0.5 mg) IM, repeated after five minutes if there's no clinical improvement. It's common practice to underdose epinephrine in this setting.

The combination of 50 mg of diphenhydramine plus 50 mg of ranitidine compared to diphenhydramine plus placebo as a second-line agent for anaphylaxis was shown in one study to be significantly more likely to result in absence of urticaria at two hours. However, there's a paucity of evidence for the efficacy of steroids in patients with allergic reactions or anaphylaxis, and recent evidence suggests that steroids have little effect on preventing the dreaded biphasic reaction. Nonetheless, steroids are standard care in many jurisdictions. My practice is that if the patient fulfills the diagnostic criteria for anaphylaxis, I give epinephrine *and* steroids.

TAKE-HOME POINTS:

- The number-one cause of death in anaphylaxis is failure to give epinephrine in a timely manner, in the correct location, and in the correct dose.
- There are no contraindications to epinephrine when it comes to severe anaphylaxis.
- Consider anaphylaxis in every patient who presents in shock even if there is no rash present.

Anaphylaxis is not simply an acute onset of an itchy rash with hypotension. To the contrary, up to 20 percent of patients do not manifest a rash. Moreover, anaphylaxis can present with isolated hypotension, making the diagnosis even more challenging.

If you do give steroids, I recommend a single 10 mg dose of dexamethasone in the emergency department, which has the advantage of a long half-life of 53 hours, thus negating the need for prescribing steroids upon discharge.

Some patients who present to the emergency department with anaphylaxis in shock require IV epinephrine. After two IM doses of 0.01 mg/kg (max 0.5 mg) epinephrine five minutes apart, give IV epinephrine:

- Inject 1 mg of epinephrine 1:10,000 into a 1 L bag of normal saline
- Draw up 10 mL from the 1 L bag in a 10 mL syringe

Push dose: 10 mL every two to five minutes (10 mcg)

Dose of epinephrine given via infusion: 1 mL/min (1 mcg/min) and titrate to a maximum of 20 mL/min

Do not underestimate the profound vasodilatory shock that may accompany anaphylactic shock. Aggressive fluid resuscitation is indicated for patients with anaphylactic shock. Consideration may be given to a second vasopressor with alpha properties such as vasopressin.

One of the more common causes of death in anaphylaxis is patients failing to self-administer the epinephrine auto-injector (even if they're carrying it on their person) or not administering it properly. It is, therefore, imperative to take the time to counsel patients before they leave the emergency department: Carry two epinephrine auto-injectors (many patients will require two doses), be sure that the blue end points away and the orange end points to the thigh ("blue to the sky, orange to the thigh"), and hold the auto-injector firmly in place against the thigh for 10 seconds.

Observation Time in Anaphylaxis

Traditionally, patients with anaphylaxis are observed in the emergency department for four to six hours before discharge. However, there's no literature to support this practice. Some experts recommend observing patients until they become asymptomatic regardless of time. It may be prudent to observe patients who are at high risk for severe anaphylaxis for a longer time, including patients taking antihypertensive medications, with an early symptom onset/late treatment initiation, with asthma, and with a past history of severe reactions.

Biphasic reactions in anaphylaxis can occur any time between one hour and seven days after the initial anaphylactic episode in approximately 2 to 5 percent of patients. Recent literature has found that the rate of biphasic reactions may be lower than previously thought, biphasic reactions rarely result in death, and the number needed to treat (NNT) with steroids to prevent one ED relapse visit is 176. However, these studies have included not only patients with true anaphylaxis but also those with simple allergic reactions who did not receive epinephrine. Many of these patients would have gotten better by themselves regardless of medications.

Unfortunately, this means we cannot assume from these studies that steroids play no role in preventing relapses or biphasic reactions in anaphylaxis. Until large validated random controlled trials can show definitively that steroids aren't effective in this respect, it still remains standard care to administer steroids along with epinephrine for patients with true anaphylaxis.

Kounis Syndrome: Anaphylaxis of the Coronary Arteries

A 43-year-old man is brought to the emergency department with an allergic reaction to cloxacillin. He complains of nausea, vomiting, and shortness of breath, along with an itchy rash. He's given 0.5 mg epinephrine IM and

CONTINUED *on page 22*

soon after complains of chest pain. His ECG shows an obvious STEMI (ST elevation myocardial infarction).

Did the epinephrine cause the STEMI? Epinephrine in the correct dose for anaphylaxis generally does not cause coronary ischemia. There are no absolute contraindications to epinephrine in severe anaphylaxis.

The diagnosis in this case is Kounis syndrome: an allergic myocardial infarction, an acute coronary event in the setting of an anaphylactic reaction. When anaphylaxis occurs, chemical mediators induce coronary artery vasospasm as well as platelet activation, which can promote plaque rupture and stent thrombosis.

The management of patients with Kounis syndrome is challenging because you must treat both the allergic and cardiac manifestations of anaphylaxis. Unfortunately, no guidelines exist for the management of patients with acute coronary events in the setting of anaphylaxis. Theoretically, epinephrine may worsen coronary vasospasm and worsen myocardial ischemia. Cardiac catheterization has been used successfully to treat patients with Kounis syndrome.

Notwithstanding, epinephrine should still be given as the initial treatment of choice. In a recent case series, one quarter of patients with Kounis syndrome received epinephrine, and there were no deaths.

Resource from Emergency Medicine Cases Website

Podcast: Episode 78 Anaphylaxis and Anaphylactic Shock – Live from The EM Cases Course (emergencymedicinecases.com/anaphylaxis-anaphylactic-shock/).

A special thanks to Dr. David Carr for his participation in the Emergency Medicine Cases podcast on which this article is based.

RESOURCES FOR FURTHER READING AT:
www.acepnow.com

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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.*

Critical Care: It's All About the Timing

by JASON ADLER, MD, FACEP, AND HAMILTON LEMPERT, MD, FACEP, CEDC

Question: I'm a bit confused about the time requirement for critical care services. There are times when I'm at the patient's bedside for less than 30 minutes, but have been told the time requirements can include more than bedside time. Can you elaborate?

Answer: That's a great question. You're correct in that critical care is a time-based code, 99291 for 30–74 minutes and 99292 for each additional 30 minutes. That includes time at the bedside, record review, documentation time, and historical and treatment conversations with EMS, consultants, and the patient's family (eg, as proxy for the patient).

For the time to count, you should be focused on the care of only that patient and be immediately available to the patient. There are times, however, that the clock is paused; this includes time caring for other patients as well as procedures that are separately billed, such as placing a central line, CPR, intubation, and chest tubes. Teaching physicians should include only the time they *personally* spent caring for the patient and not time spent by a resident. It's also best to specify the total amount of time you spent providing critical care (ie, "50 minutes") rather than using a range such as "30–74 minutes."

For more information, please check the ACEP reimbursement FAQs at https://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues-/-Reimbursement/Critical-Care-FAQ/.

Brought to you by the ACEP Coding and Nomenclature Committee.

DR. ADLER is assistant medical director of the emergency department at MedStar Montgomery Medical Center and chief coding and reimbursement officer for Emergency Medicine Associates in Olney, Maryland. **DR. LEMPERT** is chief medical officer, health care financial services, at TeamHealth, based in Knoxville, Tennessee.

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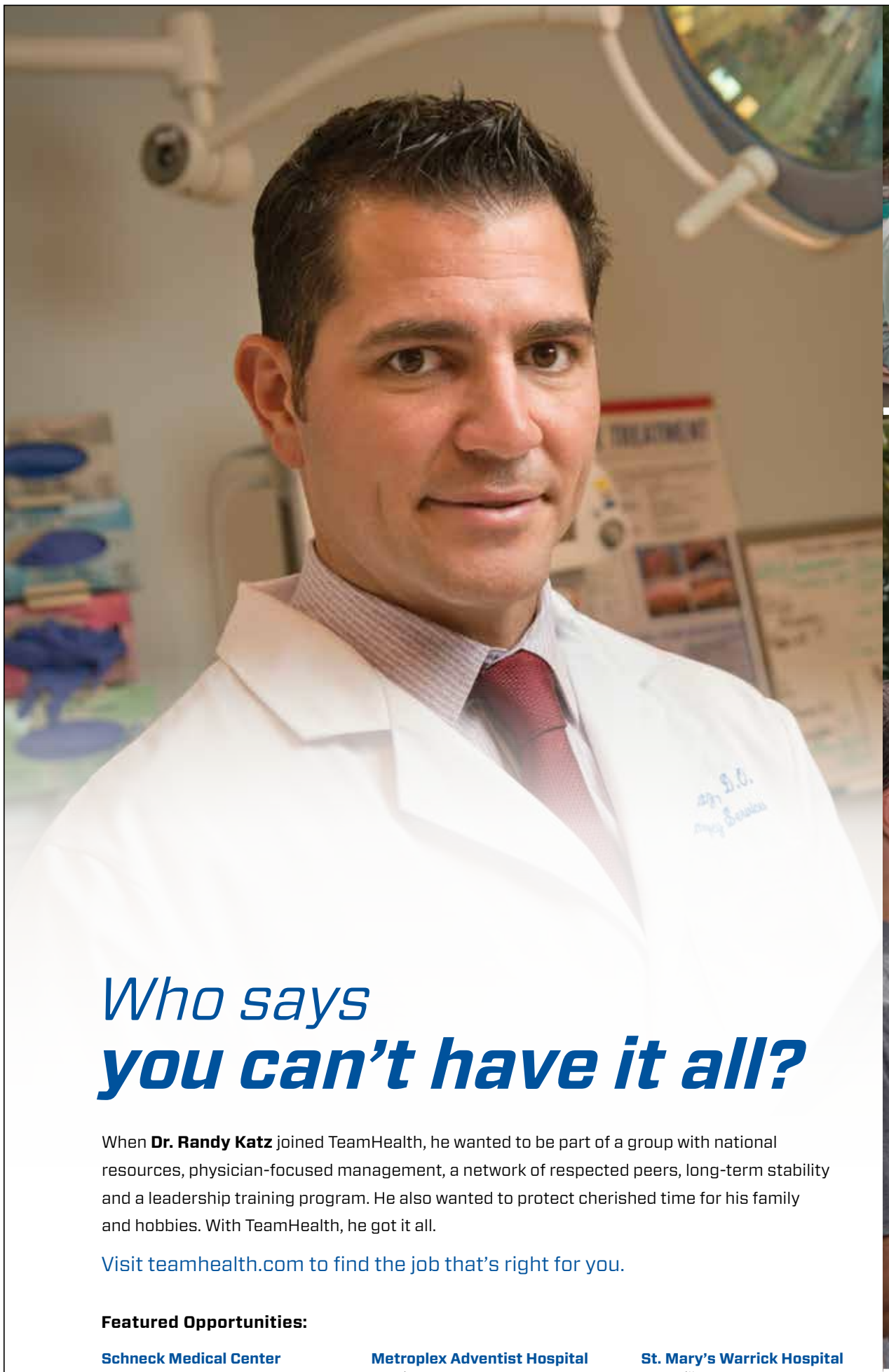

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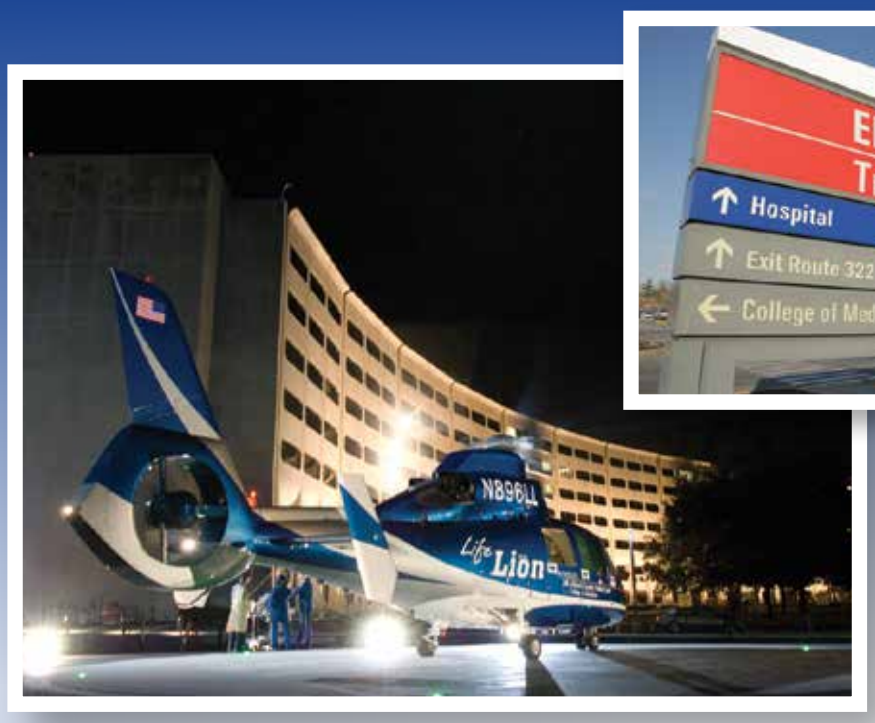

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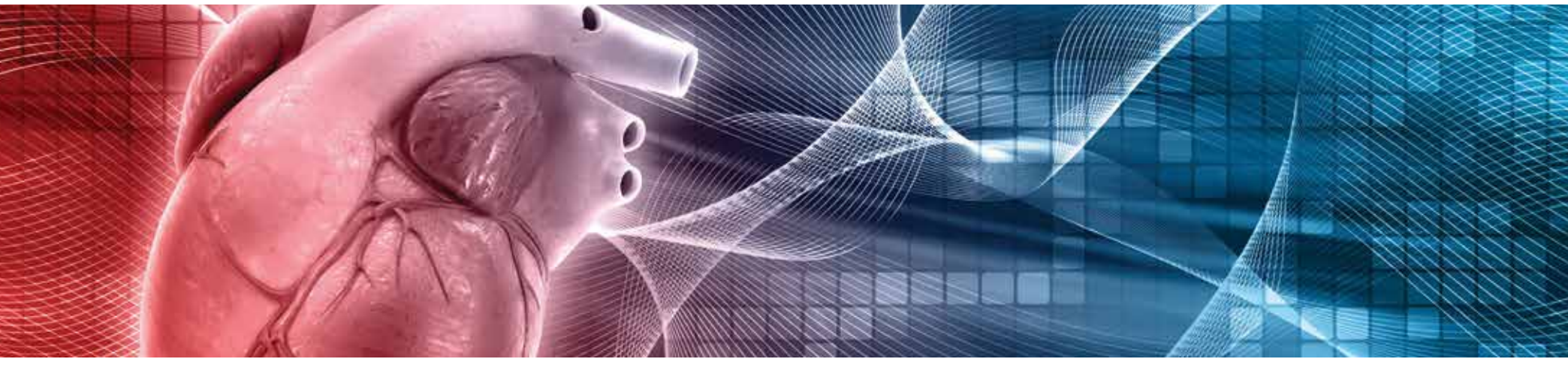

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