It just got easier for emergency physicians to obtain medical licenses in multiple states.

For decades, most state medical boards have tried to improve and simplify their medical licensing process, including developing a universal license application and improving the sharing of information among medical boards. However, the Holy Grail of medical regulation, a portable interstate license, remained elusive. The barriers to this interstate license were numerous. Mostly, medical boards were concerned about losing their autonomy over regulating medicine and supervising the care provided by physicians in their own state. As anyone who has applied to multiple states for licensure can attest, each state has slightly different requirements and processes toward granting licensure. A federal medical license covering all the states was not con-
Exertional heat stroke (EHS) is a hyperthermic and hypermetabolic crisis that creates an immediate cascade of CNS and other serious complications. If core body temperatures remain elevated, EHS has been shown to cause long-term neurologic damage and death. 1-3

Learn the signs. Diagnose in time. Visit www.fightthefireinside.com

Exertional heat stroke (EHS) is a hyperthermic and hypermetabolic crisis that creates an immediate cascade of CNS and other serious complications. If core body temperatures remain elevated, EHS has been shown to cause long-term neurologic damage and death.¹⁻³

Learn the signs. Diagnose in time. Visit www.fightthefireinside.com

References:
ACEP Announces Board, Council Candidates for October 2017 Election

At its meeting in April, the ACEP Board of Directors was advised by ACEP Council Speaker James M. Cusick, MD, FACEP, of the slate of candidates created by the Council Nominating Committee for four available seats on the Board. The Board of Directors provides day-to-day management and direction to ACEP and serves as its policy-making body. Board members are elected by the ACEP Council and serve three-year terms, with a limit of two consecutive terms. The President-elect also will be chosen by the Council and ultimately serve as ACEP President beginning in October 2018.

For the October 2017 election in Washington, D.C., there are two incumbents and five new candidates on the Board of Directors ballot:

- Stephen Anderson, MD, FACEP (incumbent, Washington)
- Kathleen Clem, MD, FACEP (AAWEP Section)
- J.T. Finnell, MD, FACEP (Indiana)
- Alison Haddock, MD, FACEP (Texas)
- Jon Mark Hrishon, MD, FACEP (incumbent, Maryland)

For the President-elect position, four current Board members announced their candidacy:

- Vidor Friedman, MD, FACEP
- Hans House, MD, FACEP
- William Jaquis, MD, FACEP
- John Rogers, MD, FACEP

Council Vice Speaker John McManus, MD, FACEP (Government Services), was unopposed in his bid for the Council Speaker position. There are three nominees for the Council Vice Speaker position:

- Sabina Braithwaite, MD, FACEP (Michigan)
- Andrea Green, MD, FACEP (Texas)
- Gary Katz, MD, FACEP (Ohio)

CONTINUED on page 5

BEGIN YOUR JOURNEY WITH PHASE I

November 13-17 • Omni Park West • Dallas, Texas

Are You Currently a Director or Aspiring To Be One?

Join us for ACEP’s ED Director’s Academy, to hear from veteran practitioners and management experts offering you tried-and-true solutions to dealing with difficult staffing issues, creating patient satisfaction, and preventing errors and malpractice. Learn why so many see this as the must-attend conference for ED directors and those aspiring to become director.

Approved for AAMC PRA Category 1 Credit™

Visit www.acep.org/edda or call 800-798-1822, ext. 5

**Begin Your Journey with Phase I**
Remember to Be Grateful

It was my second shift in the SNICU. She was my third elderly female status post a devastating cerebrovascular accident. My third room overflowing with loved ones, tear-streaked faces, and a palpable fear of the unknown. My third goals-of-care discussion. My words flowed smoother as I talked the family through the transition of goals from treatment to comfort. They had reached a “do not resuscitate” decision but were still considering goals of care. Two hours before morning rounds, the patient’s prognosis was confirmed by repeat imaging—cerebral edema and uncal herniation. We revisited her end-of-life wishes and her family requested a transition of goals of care to comfort measures. The third time that shift, I entered comfort care orders.

Two SNICU weeks later, in somewhat of a zombie state, I found it lying open on the table in our workroom. It was handwritten and addressed to two physicians and two nursing staff. To my surprise, I was one of those physicians. My first “thank you” card, from the family of that patient (see Figure 1). “Thank you for the wonderful care provided.... We greatly appreciate your kind and honest interactions with us. We were impressed by the kindness and professionalism of your team.” I felt so good, so satisfied that I met their needs. I was proud of our workroom. It was handwritten and addressed to Dr. Gende and colleagues.

Figure 1: A handwritten thank you note addressed to Dr. Gende and colleagues.

Their expression of gratitude had me reflecting on my own gratitude and the role it plays in my well-being and experiences as a physician. In our fast-paced emergency medicine world filled with high rates of burnout, RVUs, and throughput times, we are bombarded by patient satisfaction scores—but what about our satisfaction? Expressions of gratitude offer a path to resiliency by helping us find reasons to appreciate our daily lives and interactions. After this experience, I bought a journal decorated with bees to hold my gratitude list. I named it “Bee Thankful.” When I’m winding down from a shift, I pause and reflect on things from that day for which I am grateful. I breathe deeply and feel a sense of satisfaction when I write them on the page. My gratitude list reminds me of the positive interactions and opportunities my career offers and provides motivation to start the next day. Our experiences tax us as ever-giving and dedicated physicians, but the simple act of giving thanks can add to our health and vitality. May we all “Bee Thankful” and stay well.

—Alecia Gende, DO
Iowa City, Iowa

Comments on Censure

I would like to compliment Dr. Sullivan and the Ethics Committee on their censure of Dr. Rosen. I have practiced emergency medicine for 38 years and had one malpractice case early in my career—about 1984. The expert witness arraigned against me was Dr. Rosen. You have no idea how disheartening that was to a young physician starting out. At the time, rumor had it that he commonly did this sort of work. Luckily, my expert was Greg Henry, and it eventually settled out of court. Dr. Rosen’s deposition against me was very harsh and judgmental.

—Richard C. Frederick, MD

Thus, I am heartened to hear him finally called on the carpet, albeit 33 years late.

Dr. Peter Rosen remains one of the finest fathers of emergency medicine, who elevated the profession from the basements of hospitals to full and equal academic standings, has written countless books and publications, and trained hundreds of emergency medicine residents. His legacy will live on forever in the millions of patients he cared for, the patients his residents saved, and the patients that his residents’ residents will continue to care for.

I remember making monthly payments to buy the Rosen textbook when I was a medical student. When I was face-to-face with the legendary man, he insisted on being called Peter. It wasn’t just me. Medical students, nurses, paramedics, and colleagues all call him Peter. Peter is a humble man, lives a modest life, and is one of the most generous people I have ever met. I think he spends half his earnings on buying meals for students, residents, and friends. For a man who is constantly busy with...
WASHINGTON UPDATE

by ASHLEY BOOTH NORSE, MD, FACEP

The Affordable Care Act (ACA) reform legislation approved by the U.S. House of Representatives on May 4, 2017, by the narrow margin of 217 to 213 is expected to cause millions of Americans to lose their health insurance, make it much easier to eliminate essential health benefits and protections for people with preexisting conditions, and create instability for these protections in employer-sponsored health plans. Accordingly, ACEP’s Public Affairs team, working in conjunction with the Federal Government Affairs Committee and the Board of Directors, has shifted its focus to the Senate, where the fate of the American Health Care Act (AHCA) is much less certain.

Initial reactions by Republican senators have not been favorable to the AHCA, and not surprisingly, Democrats are unified in their opposition. Senate Majority Leader Mitch McConnell (R-KY) has the unenviable task of trying to craft a bill that can only lose the support of two Republicans from within a caucus of varying ideological beliefs about the ACA, its value to Americans, and whether it needs improvement or outright repeal. If Republicans fail to produce a plan that can be approved in the Senate and still have enough support to be passed in the House again within the next couple of months, the effort to modify the ACA, at least using the favorable procedural rules of budget reconciliation, will likely die.

On May 24, 2017, the Congressional Budget Office (CBO) released its updated analysis of the AHCA. According to the CBO estimate, the bill would result in 23 million more uninsured Americans over a decade while reducing the national deficit by $119 billion. Medicaid funding would be cut by $819 billion and cover 12 million fewer people. The AHCA repeals $664 billion in taxes and fees expected to cause millions of Americans to lose their health insurance, make it much easier to eliminate essential health benefits, premiums would be 20 percent lower by 2026.

ACEP’s team has been meeting with key senators as they prepare their alternative to stress the importance of emergency medicine as an essential component of the nation’s health care system. Our message has been simple:

Any bill the Senate produces must ensure patients have access to lifesaving emergency care.

We want to constructively work with them to produce a bill that is consistent with ACEP’s Emergency Medicine Health Care Reform Principles (www.acepadvocacy.org/content.aspx?page=issues).

Americans overwhelmingly (95 percent) say health insurance companies should cover emergency medical care, and ACEP agrees with them.

Patients must be able to receive emergency medical care when and where it is needed, without seeking preauthorization or fearing that their insurance company will only cover services based on the final diagnosis and not the presenting symptoms.

In addition to our direct meetings with lawmakers on Capitol Hill, we have also used opportunities provided by NEMPAC to attend fundraisers, sent action alerts from ACEP members, and facilitated member visits with senators back home to share our vision for health care reform. We further intend to supplement these actions through the Leaders Visit program when ACEP President Rebeca Parker, MD, FACEP, travels to Washington, D.C., to meet with key senators in June.

On a related matter, the Trump administration, through the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS), has been placing a great deal of emphasis on state Medicaid waivers. In fact, CMS is actively promoting waivers and has provided guidance to states as to how to go about applying for them. We are working to ensure the federal Prudent Layperson Standard is not eroded through this process and that emergency medicine patients remain protected from predatory practices. Waivers will continue to be the topic of discussion now and for the foreseeable future by ACEP’s Board of Directors, the Federal Government Affairs Committee, the State Legislative/Regulatory Committee, and the Emergency Medicine Action Fund.

THE BREAK ROOM | CONTINUED FROM PAGE 5 publications, he makes time for a meal or a game of tennis with anyone who shows an interest. That’s his soft side. His tough side is a fearless defender of the medical profession and emergency medicine.

I recently visited Peter in his home in Tuscany, and at the age of 80, his body showed wear and tear with ecchymosis to his extremities from being on blood thinners and a slowed gait after several joint replacements. He noticed that I glanced at the row of medications on his windowsill. “Those are keeping me alive,” he said. When I probed about his health, he showed off about his doctors. His urologist was his intern, he trained his cardiologist, and he remembers when his orthopedic surgeon was in residency. I recall that I also treated Peter when he came to the emergency department for an asthma attack. I was a third-year resident and a bit timid to treat my teacher. He said, “I trust you; I trained you well,” and so I did.

Peter no longer sees patients and has not done legal work for several years. But he still reads tens of articles a day from around the world, is the first screening editor for the Journal of Emergency Medicine, continues to write, and still loves teaching. His mind is as sharp as ever.

His residents and I can attest that he did not just teach us the basics of emergency medicine but how to be good human beings and enjoy life as well. He taught us “get your loving at home” when it comes to seeking to be appreciated for a great emergency save, “put your brain in neutral and just do the work” when it comes to avoiding laziness; and “learn from other people’s f** up”s. Peter is an eloquent speaker and adds “toobacco sauce” to the English language.

The recent publications about Dr. Rosen and ACEP by ACEP Now [September 2016] are an unfair representation of who Peter is, what he means to so many emergency physicians across the country, and how much he has contributed to our specialty. He does not deserve the character assassination based on a disputed case of a missed pulmonary embolism that occurred 17 years ago. You can argue the significance of the S1Q3T3 ECG pattern back in 2007, which Peter drilled into his residents, but it will not alter the legacy that Peter leaves to this world and our profession. Peter, get your loving at home—and know your students and residents love you too.

~ Roneet Lev, MD, FACEP
San Diego, California

House passes American Health Care Act — how will it affect emergency medicine?

DR. NORSE is chair of ACEP’s Federal Government Affairs Committee, associate professor in the department of emergency medicine at the University of Florida College of Medicine–Jacksonville, and medical director of the Emergency Medicine Clinical Center.
The 21st Annual
THE NATIONAL
EMERGENCY MEDICINE
BOARD REVIEW COURSE

If You Don’t Pass, You Don’t Pay! | Content Updated for 2017

2017
COURSE
DATES
JULY 24-27, 2017
PLANET HOLLYWOOD
LAS VEGAS, NV
AUG. 11-14, 2017
RENAISSANCE BALTIMORE
HARBORPLACE HOTEL
BALTIMORE, MD
AUG. 28-31, 2017
PLANET HOLLYWOOD
LAS VEGAS, NV

The Course That Has Helped Tens of Thousands of
Emergency Physicians Ace Their ABEM/AOBEM
Certifying and Recertifying Exams.

LIVE COURSE
Get away from all distractions and receive an immersive,
concentrated study at one of our live courses.

SELF-STUDY COURSE
Avoid missing family/work obligations and participate in the
self-study course from the comfort of home.

Learn More Online at EMBoards.com/course
or Call 800-458-4779 (9:00am-4:30pm ET, M-F)

Over 1,700 Participants in 2016 (Over 27,000 Since Inception)
Lumbar puncture is an essential skill for emergency physicians and the gold standard diagnostic procedure allowing for the rapid analysis of cerebrospinal fluid (CSF) to rule out dangerous conditions such as meningitis, subarachnoid hemorrhage, and other neurologic conditions.1 In our busy departments, lumbar puncture failure can be frustrating and time-consuming and cause added stress to clinicians and patients. A successful lumbar puncture demands an intricate knowledge of anatomy, positioning, and technique. Without this experience and knowledge, we are left to rely on anatomical landmarks that can be misleading in more than 30 percent of people requiring the procedure. Obesity is a common challenge we face; it makes landmark acquisition and positioning difficult if not impossible.2 Additional challenges include age-related anatomical changes, such as the calcification of the interspinous ligaments, which can complicate needle insertion, causing deflection of the needle and increased pain.3

As emergency physicians, we have been trained to always have a backup plan and an alternative approach for all procedures. However, if the midline approach fails at a particular level, most physicians will attempt the procedure using the same technique at another level. If this fails, the patient will frequently undergo a fluoroscopically guided or ultrasound-assisted lumbar puncture. This is likely because most emergency physicians have not been trained in an alternative approach to the lumbar puncture.

An alternative method to the traditional lumbar puncture is the paramedian approach. Although scarce in the emergency medicine literature, it has been a successful option that has been performed by anesthesiologists for decades. Advantages of this approach include the larger target of the intralaminar space, avoidance of spinous ligaments, and increased first-attempt success. This procedure does have limitations with obese patients in whom landmarks are not identifiable.4

Paramedian Approach Technique

1. Prepare your lumbar puncture kit. You will use the same equipment, positioning, local anesthetic, and sterile technique as you would for the midline approach. A longer spinal needle may be required since you are approaching the subarachnoid space at an angle.
2. The patient can be positioned in the lateral recumbent or sitting position. Flexing the patient is not necessary using this approach.
3. Identify the L4 spinous process by using the iliac crest as a landmark. Identify the caudal tip of the L4 spinous process and move your finger 1 cm inferior and lateral. Needle insertion will be in a cephalad and medial direction, with the needle angled 10°–15° toward the midline and 10°–15° in the cephalad direction. If contact is made with the lamina, the needle should be adjusted in a cephalad direction so that you are walking up the bone until you enter the subarachnoid space and obtain the CSF. (See Figures 1 and 2.)

Needle path: skin» superficial fascia » fat » erector spinae muscle » ligamentum flavum » subarachnoid space.

The paramedian approach to the lumbar puncture is a great alternative to the traditional midline approach, and it’s ideal for patients who are difficult to position. Advantages are the larger target of the intralaminar space, avoidance of spinous ligaments, and increased first-attempt success. This procedure does have limitations with obese patients in whom landmarks are not identifiable.

References

Figure 1 (ABOVE): Posterior view of the lumbar spine.
Figure 2 (BELOW): Lateral view of the lumbar spine.

DR. JONES is director of the emergency ultrasound and the emergency ultrasound fellowship at MetroHealth Medical Center and associate professor at Case Western Reserve University School of Medicine, both in Cleveland.

DR. CRESPO is an emergency physician at MetroHealth Medical Center in Cleveland.
sidered an option, as the Federation of State Medical Boards (FSMB) upholds the principle of the 10th Amendment as a core principle that any power not specifically granted to the federal government by the Constitution belongs to the states.

In 2014, FSMB members finally agreed on model legislation to create an interstate compact for medical licensure. Interstate compacts regarding licenses are very common; these compacts impart reciprocity from one state to another from a license held by the home state’s citizen. The best example with which we are all familiar is a driver’s license. If you hold a license to drive in Iowa, you can legally use that license in any other state. Why not do the same for practicing medicine? Thus far, 20 states have signed on to the interstate medical compact and have been developing their processes for providing expedited licenses to physicians from other compact states (see Figure 1).

As of April 3, 2017, seven states (Alabama, Idaho, Iowa, Kansas, West Virginia, Wisconsin, and Wyoming) are ready to issue compact licenses. In fact, the first interstate medical license was issued on April 20, 2017, to a physician from Wisconsin who was seeking a license in Colorado. The 13 other compact states are coming on board soon. Hopefully, more states will pass the compact legislation and join the growing list.

A compact state will grant an expedited license to a physician from another state. This means that the physician can get an additional license by completing a short form and paying $700 plus the license fees for that new state. The verification of training, background, and board certification will come from the home state without additional work by the applicant.

The medical boards at the heart of this compact have some very specific restrictions to allow the expedited license. The greatest barrier for most applicants is that you must live and practice at least 25 percent of the time in one of the current compact states. In addition, applicants must be residency trained, be board-certified, and have no criminal history or problems with previous medical licenses.

For more information or to apply for a compact license, go to www.imlcc.org.
Digitoxin and digoxin are cardiac glycosides that bind to the sodium-potassium-ATPase channel to slow and strengthen the beating of the heart ultimately by increasing vagal tone (decreased conduction through the sinoatrial [SA] and atrioventricular [AV] nodes) and intracellular calcium concentration.

Symptoms
- In overdose, the natural toxin causes nausea, vomiting, weakness, altered mental status, xanthopsia (yellow vision) and seeing halos, cardiac arrhythmias, very slow heart rates, and death.
- Cardioactive glycoside effects on the heart result in a typical pattern called “digeffect.” This consists of a prolonged PR interval, QTc shortening, and a downward-slurred ST segment called “Salvador Dali’s moustache.”
- The classic cardiac toxicity seen with cardioactive steroid poisoning (eg, digitoxin and digoxin) is a slow rhythm.
- Almost any rhythm can be seen with this poisoning (atrial fibrillation, atrial flutter, ventricular tachycardia, ectopy, various blocks, and, of course, the classic ventricular bigeminy), except a rhythm quickly transmitted through the AV node.
- The cardioactive glycosides cause an electrical separation of the atria from the ventricles.
- Definitive therapy for digoxin toxicity (and other closely related cardioactive steroid compounds) is administration of digoxin-specific Fab antibodies.

Facts
- There are other poisonous plants that produce cardioactive steroid toxins. These include oleander (Nerium oleander), yellow oleander (Thevetia peruviana), lily of the valley (Convallaria majalis), plants in the squill family (Urginea maritima and Urginea indica), and ouabain (Strophanthus gratus).
- Some animals produce cardioactive steroids that can act like digoxin and cause toxicity. There is a digoxin-like poison in some species of fireflies. It is called lucibufagin and is found primarily in the Photinus species. Some toads—cane toad (Rhinella marina) and Colorado river toad (Bufo alvarius)—also produce bufadienolides poisonous to humans. Typically, this occurs from “toad licking” or attempts to use dried secretions incorrectly as a sexual enhancer.
- William Withering introduced digitoxin into the Western apothecary in 1785. Vincent van Gogh’s yellow period may have been influenced by digitalis therapy, which at the time was thought to control seizures. Or, it may have been all the absinthe he was drinking.
T elemedicine can be defined as “the remote delivery of health care services and clinical information using telecommunications technology.” While telemedicine has been gaining traction in other medical specialties, namely stroke care and psychiatry, several emergency departments have developed tele-emergency medicine programs and several more have been exploring telemedicine options. A systematic review of the tele-emergency medicine literature in 2015 demonstrated three main categories of applied tele-emergency medicine: telemedicine for general emergency medicine care (eg, a rural hospital would use a tele-emergency medicine program for consultations on their patients), direct-to-patient urgent care offerings, and telemedicine for special patient populations (eg, stroke or trauma care). While many in emergency medicine are familiar with telemedicine use with stroke care, this article highlights three current tele-emergency medicine offerings in the United States that focus on direct-to-patient care or direct-to-provider consultation.

Direct to Patient
New York Presbyterian/Weill Cornell Medicine in New York City has implemented the Emergency Department Telehealth Express Care Service, a direct-to-patient care telemedicine offering. This program aims to quickly see emergency department patients who would typically be seen in low-acuity areas, thus reducing wait times for all ED patients. The length of stay for patients treated via the Express Care offering is 35–40 minutes as opposed to 2.5 hours in the emergency department. The program is currently offered at two emergency departments, Weill Cornell Medical Center and Lower Manhattan Hospital.

The encounter starts with an in-person triage by an ED nurse, followed by a medical screening examination performed by an ED physician assistant or nurse practitioner. The patient is then brought into an examination room with a telehealth video cart (see Figure 1) that is linked to an attending ED physician in an office geographically remote from the emergency department. The patient’s visit finishes with a video consultation and discharge by the attending. The Express Care program is staffed by emergency physicians and is available 16 hours per day, seven days a week. These patients are billed as ED visits because they receive a full triage and an in-person medical screening examination. Since July 2016, the program has had more than 2,000 visits. Patient experience-of-care scores have been in the 99th percentile, and the patients’ ages have ranged from 18 to 99 years old, with approximately 20 percent of these visits from patients older than 60.

Judd Hollander, MD, professor of emergency medicine and associate dean for strategic health initiatives at Sidney Kimmel Medical College of Thomas Jefferson University in Philadelphia, leads his institution’s telehealth offerings. The overall program has had more than 25,000 visits, including on-demand video visits for patients, scheduled video visits, remote second opinions, virtual rounds, and Jefferson Neuroscience Network and remote consults. JeffConnect, its direct-to-patient video-visit program, is currently the only direct-to-patient on-demand video-visit program from an academic center that has 24×7 staffing from physicians in a brick-and-mortar urgent care and emergency department. As for teleemergency education, not only does Jefferson have a telehealth leadership fellowship, it also incorporates telemedicine into its emergency medicine residency training. Its residents work with the telehealth physicians to see ED patients in follow-up using video visits, focusing on both clinical reasoning and communication skills.

Direct to Provider
In 2009, Avera eCARE implemented an emergency care telemedicine program with its service line eEmergency. The eEmergency program serves rural clinicians in the upper Midwest and nationally. With a touch of a button, an ED physician has access to a board-certified emergency physician and an emergency nurse. This program allows peer-to-peer support and consultation, including help with difficult cases such as pediatric trauma, strokes, and cardiac arrest. The cameras enable the eEmergency providers to see and hear the patient at the remote site, and with their peripherals, the eEmergency providers can view an intubation, including the view from the video laryngoscope. Avera eEmergency covers 150 hospitals in 10 states and has consulted on more than 40,000 patients. The eEmergency program has resulted in an estimated cost savings of $29 million and avoidance of more than 4,000 patient transfers.

The Future of Telemedicine
As Rahul Sharma, MD, MBA, CPE, FACEP, the emergency medicine physician-in-chief at Weill Cornell Medicine, states, “Patients want high-quality, efficient health care, and most emergency departments and health care systems will have no choice but to incorporate telemedicine in some aspect of emergency care.” Barriers, including state licensure, reimbursement, and credentialing requirements, are actively being reconsidered at the state and federal levels. Research is ongoing regarding the outcomes of telehealth programs in emergency medicine. A telehealth program will most likely be coming soon to an emergency department near you.

References
A 40-year-old woman presented to our emergency department complaining of left hemiparesis and headache. She was awake and oriented, and her vitals were unremarkable except for a blood pressure of 180/100 without a history of hypertension. Past history and medications were negative. No trauma was reported. The optic nerve sheath diameter (ONSD) was measured and showed increased diameter of 0.47 cm bilaterally, demonstrating increased intracranial pressure (see Figure 1). Her level of consciousness decreased dramatically within 30 minutes, and she developed a right-sided gaze. She was intubated and underwent a brain CT showing intracranial hemorrhage in the right basal ganglia with midline shift and intraventricular hemorrhage (see Figure 2). She received a phenytoin loading dose and was taken emergently to the operating room. Fortunately, she survived with an acceptable neurologic outcome.

ONSD can predict increased intracranial pressure effectively. The exact measurement can be achieved by frequent practice. Thus, this approach is being described as an operator-dependent procedure.

Optic Nerve Sheath Diameter

There is no doubt that ultrasonography is a valuable way to evaluate ONSD to determine intracranial pressure, considering that the brain subarachnoid space is continuous with the optic nerve sheath and the pressure should be transmitted.1–4 However, the way to measure the diameter has yet to be determined. Optic nerve color Doppler ultrasonography may clarify this measure and change what was previously approved to evaluate the ONSD. Copetti et al noted that the former measures were not compatible with the real anatomy of the optic nerve and proposed a new measurement that seems to be more reliable.1 There are two points to be considered:

1. According to the route of optic nerve approaching the globe, the oblique hypoechoic shadow running medially represents the exact measure of the optic nerve (see Figure 3).
2. Regarding color Doppler ultrasonography of the central retinal artery, which runs within the dural optic nerve sheath to the globe, the new image compatible with the oblique hypoechoic shadow seems more characteristic of the optic nerve.

Purpose

The evaluation of ONSD via bedside ultrasonography is beneficial in suspected cases of increased intracranial pressure transmission through the optic nerve, which leads to papilledema.

Applicability

There are common situations in which intracranial pressure assessment is necessary, but it is not possible to perform fundoscopy. Some examples include ocular media opacities such as cataract formation, hemorrhage, periorbital swelling (eg, palpebral ecchymosis in trauma patients), fixed gaze, and some infectious respiratory cases that may impose the risk of respiratory transmission.

Indications

Bedside ultrasonography can be performed in cases of suspected increased intracranial pressure (eg, traumatic brain injuries, various types of intracranial hemorrhage, space-occupying lesions, etc.).

Scanning Procedure

To measure the ONSD:
1. Place the patient in the supine position.
2. Apply sufficient amount of sterile (preferably) gel on the closed eyelid.
3. Place a 6–12 MHz linear probe on the superior and lateral margin of the orbit.
4. Angle the probe slightly medially and caudally until the oblique hypoechoic tract of the optic nerve can be visualized with clear margins posterior to the globe.

Pitfalls

Some reported measurements indicating an anechoic image behind the retina were probably artifacts of lamina cribrosa, the mesh-like bony structure for optic nerve fibers’ passage through the sclera, mimicking the

CONTINUED on page 19
Leading the Way for EM Quality

An update on ACEP’s Clinical Emergency Data Registry

by PAWAN GOYAL, MD

As part of its ongoing commitment to assist emergency physicians with providing the highest quality of emergency care, ACEP developed the Clinical Emergency Data Registry (CEDR). This is the first emergency medicine specialty-wide registry at a national level designed to measure and report healthcare quality and outcomes. It also provides data to identify practice patterns, trends, and outcomes in emergency care. CEDR is an evolving registry that will support emergency physicians’ efforts to improve quality and practice in all types of emergency departments even as practice and payment policies change over the coming years. CEDR has re-qualified as a qualified registry by the Centers for Medicare & Medicaid Services (CMS) for 2017 and is waiting for CMS to complete its annual required review of its 2017 Qualified Clinical Data Registry (QCDR) application.

Instead of physicians being mired in an alphabet soup of reporting requirements, CEDR allows for single data capture to fulfill the requirements of multiple programs, making physician quality reporting more efficient. The healthcare environment is transitioning from volume-based to value-based payment for care. The CEDR registry ensures that emergency physicians, rather than other parties (e.g., payers), are identifying what practices work best for whom. CEDR was developed under a sophisticated information technology infrastructure and has been phased in over the past few years in terms of the number of participating emergency departments, scope, and functionality. After a modest pilot project in 2015 with 13 emergency departments, CEDR grew in 2016 to more than 60 emergency departments with nearly 3 million patient records represented in the registry. The 2,500 physicians participating in CEDR last year had their quality data successfully reported to CMS, not only protecting their revenue but providing new insights into the quality of their patient care. Sites participating in CEDR for 2016 received a 1,400 percent return on investment, which is a major success for the program. For 2017, CEDR is anticipating exponential growth, with data for more than 15,000 providers and 20 million patient visits slated to be reported by CEDR to CMS.

In the background, members of ACEP’s CEDR committee, led by Stephen Epstein, MD, MPP, FACEP, have been building a large set of quality measures and methods to collect required data from emergency department patient care records. Dr. Epstein has been the ACEP leader of the development of this registry for seven years. In addition to Dr. Epstein, more than 100 ACEP members have provided guidance to the construction of CEDR through CEDR subcommittees. The CEDR Committee is working hard to create a robust organizational structure to guide the future of this rapidly growing registry. The four subcommittees (research, measures, education, and outreach) have been active in making CEDR a valued partner in physician quality endeavors. Highlights of current subcommittee activities include:

1. Developing a research infrastructure and protocols to allow researchers access to the de-identified CEDR database.
2. Working with the ACEP Quality and Patient Safety Committee, continuing to refine the CEDR measure sets with emergency medicine–relevant reporting measures that can be used across all payers, one of the major advantages of a QCDR like CEDR in quality reporting to CMS.
3. Implementing Maintenance of Certification (MOC) Part IV for our ABEM diplomates. That’s correct: ABEM diplomates will be able to complete their MOC Part IV requirements right from their CEDR dashboard. Beta testing is scheduled to begin for this feature soon, and it will be ready to roll out in late autumn this year.

The CEDR Committee is supported by the new Quality Division within ACEP, which is developing an array of analog and digital programs to assist ACEP members in their practice. The CEDR team wishes to thank the dedicated support of ACEP members who guide CEDR in providing the highest value of reporting for all participants in this quality journey. For more information about CEDR, or if you are interested in participating in the registry, please email CEDR@acep.org.

DR. GOYAL is associate executive director for quality at ACEP.

For more information about CEDR, or if you are interested in participating in the registry, please email CEDR@acep.org.

NEW! Bring the power of PEER assessments to your residency training program!

PEER IX for Residency Programs

Sign up your program, buy memberships for your residents and faculty at a discounted annual fee, then assign and monitor tests to augment your program curriculum.

$99 each seat OR LESS

Learn more at acep.org/PEER

PEER IX for Residency Programs

Learn more at acep.org/PEER

The Official Voice of Emergency Medicine

JUNE 2017 ACEPNOW 13
The Case

You’re getting in that first sip of coffee at 7:05 a.m. as your colleague continues his sign-out. “Room 24 is a 38-year-old healthy female with right lower quadrant abdominal pain. Pelvic ultrasound was negative. Labs were normal: no leukocytosis, normal basic metabolic panel and liver function tests. Pregnancy test and urinalysis were negative; she had her tubes tied last year. She’s awaiting a CT to rule out appendicitis,” he says.

“Slam dunk,” you think. Follow up the CT, reassess the patient, and dispose accordingly. No problem.

An hour later, the CT returns: no appendicitis, no inflammatory changes. As you prepare the discharge, a quick skim of the radiology report reveals, “Long segment of thrombus in the right ovarian vein.”

You reassess the patient, and she is still having pain but is feeling better overall after a tiny dose of morphine. Her abdominal exam is reassuring, and her vitals remain normal. You politely advise her that you will get back to her and her husband shortly with the treatment plan.

What on earth do you do about ovarian vein thrombosis?

Background

If you haven’t seen a case of ovarian vein thrombosis (OVT), that’s because it is exceedingly rare, especially in its idiopathic form. The diagnosis was first identified in 1956, published in a case report by Austin. Our colleagues in obstetrics should recognize this condition more readily. They see it in the peripartum period (most commonly postpartum) as well as in patients who have had recent gynecologic (or abdominal) surgery, pelvic inflammatory disease, or gynecologic malignancy. Outside of these conditions, the diagnosis of OVT is considered idiopathic and tends to be picked up incidentally, as in this case. The exact prevalence of idiopathic OVT is uncertain; it is only reported in case series. In one study, investigators uncovered six cases of OVT in the 2.5-year study period. Two of those cases were discovered incidentally.

Presentation

OVT most commonly presents with an acute onset of abdominal or flank pain. Literature suggests that the pain will be on the right side 90 percent of the time, theoretically owed to the right ovarian vein following a longer course with incompetent valves. This laterality makes the condition a mimic of more common etiologies such as acute appendicitis, renal colic, pyelonephritis/urinary tract infection, and inflammatory bowel disease. In the case of peripartum disease, the patient may frequently present with fewer and leukocytosis in a similar manner as endometritis. In postpartum patients, expect a higher frequency in cesarean section patients (1–2 percent) than in those following vaginal delivery (0.05–0.18 percent).

Diagnosis

OVT is at risk of becoming lost in the long differential diagnosis for abdominal and flank pain in the emergency department, especially when fever and/or sepsis physiology are present. Clearly, the emergency physician will be on the lookout for the more common etiologies mentioned above. In this case, the emergency physician was appropriately suspicious for acute appendicitis. Although not useful in idiopathic cases, which will usually be tricky; a careful history may help elucidate some risk factors. Consider OVT in the recent postpartum patient (although endometritis is far more likely), after recent hysterectomy or other gynecologic surgery, or when there is a concern for undiagnosed malignancy. Physical exam findings may reveal fever, tachycardia, abdominal tenderness, and signs of peritonitis, all of which are nonspecific for this condition. A detailed pelvic examination may reveal findings of pelvic inflammatory disease, which may be the cause of OVT, as well as adnexal mass.

The emergency physician may be unlikely to diagnose OVT based on the history and physical examination alone. Fortunately, contrast-enhanced CT scanning of the abdomen and pelvis provides excellent sensitivity (100 percent) and specificity (99 percent) for the condition. It may also be diagnosed on MRI or with pelvic ultrasound but with markedly decreased sensitivity. In this case, pelvic ultrasound with Doppler did not detect OVT or any signs of ovarian vascular congestion or enlargement.

Management

When the patient with OVT presents in overt sepsis, empiric antibiotics, fluids, labs, and appropriate cultures are the mainstay as well as cross-sectional imaging to rule out various causes of intraabdominal pathology. When OVT is detected in this fashion, inpatient management should also include systemic anticoagulation, typically with heparin.

There are no standard or specialty society guidelines for the management of these patients as data are limited. There is a theoretical risk that the patient will develop signs of sepsis, but perhaps the most worrisome complications are inferior vena cava extension and subsequent embolization (ie, pulmonary embolism). Estimates (from all causes of OVT) put the risk for pulmonary embolism at an alarming 25 percent, with an associated mortality of 4 percent. Clearly, this suggests a need for anticoagulation to help reduce this risk. Historically, systemic anticoagulation has been initiated with heparin, followed by bridging to warfarin until a therapeutic international normalized ratio is achieved. The increasing popularity of direct oral anticoagulants offers a potentially useful alternative. However, the efficacy of these drugs for the treatment of OVT has not been studied.

Disposition for these patients will likely depend on patients’ presentation, laboratory and imaging results, symptom control, and provider discretion. Patients with sepsis physiology will require admission and gynecological or surgical evaluation. In patients with an incidental finding whose symptoms are controlled and have a reassuring workup, disposition may depend on the anticoagulation plan and ability to secure follow-up and outpatient referral.

Expert consultation for nonsurgical patients may pose a challenge. Recently delivered patients should be evaluated by their obstetrician. However, in non-peripartum patients without acute gynecologic pathology, a gynecologist may or may not manage the condition. Patients will likely require hematology referral or evaluation for consideration of an underlying hypercoagulable state and to both monitor and determine the duration of anticoagulation.

Case Resolution

The patient’s pain continues to improve with oral acetaminophen. Given her normal vital signs, labs, and otherwise benign CT scan as well as established outpatient follow-up, you make a shared decision with the patient and her husband to manage her OVT in the outpatient setting using a direct oral anticoagulant. You consult hematology over the phone, screen the patient for her bleeding risk on anticoagulation, and provide relevant education. The pharmacy helps start the patient on a 30-day starter kit of rivaroxaban, and you reinforce the importance of early follow-up and to return for worsening symptoms. The patient will see her primary care doctor in one week, with subsequent hematology referral.

References


by S. Tyler Constantine, MD

DR. CONSTANTINE is an EMS fellow and junior faculty at Carolinas Medical Center in Charlotte.
The Maine Thing

Patient flow improvements can increase efficiency even in small emergency departments

by SHARI J. WELCH, MD, FACEP

The emergency department at Houlton Regional Hospital (HRH) in Houlton, Maine, wanted to take its operational performance to the next level. This Critical Access Hospital (CAH) seeing 11,000 visits a year struggled with patient surges. As is the case in many CAHs, HRH was challenged with recruiting new physicians, especially hospitalists, who are so critical to ED flow. (Approximately 25 percent of Americans choose to live in rural areas, while only 10 percent of physicians choose to practice there.) Further, the emergency department has only single coverage, and was easily overwhelmed by one critically ill patient. Finally, HRH struggled to manage the behavioral health burden in its nine-bed emergency department.

CEO Tom Moakler, ED Medical Director Brian Griffin, and Nursing Director Tricia Murray wanted to re-engineer patient flow in their department during peak flow times to improve efficiency. They began with an ambitious change package:

- Redesign intake
- Repurpose triage as a rapid treatment unit (RTU) (low-acuity service line)
- Re-engineer patient flow for high-flow/low-flow times of the day
- Develop a night plan with the hospitalists

Redesign Intake

The emergency department had continued to use traditional nurse triage and booth registration, followed by traditional ED patient flow. This did not serve it well during peak arrival times. The leadership did a number of things that help expedite intake and patient care in the single-covered emergency department.

Traditional triage was replaced with an abbreviated triage and a “pull-to-fill” model to bring the patients, provider, nurses, and registration to the bedside. This takes all of the steps of intake and conducts them in parallel instead of in series, which is inarguably more efficient.

Repurpose Triage as an RTU

The former triage area is now the RTU area, which serves as a place to care for low-acuity patients rather than placing them in a traditional bed. In the old flow model, low-acuity patients often suffered long waits and delays because no resources were dedicated to them. This new low-acuity zone cannot support its own provider, but it can have nurses and staff dedicated to the rapid processing of patients. In addition, nurses are empowered to begin standardized, chief complaint–driven order sets. This has long been recognized as a best practice, particularly in single-coverage departments, so that patients are always moving along their patient flow journey.

Re-engineer Flow for High Flow and Low Flow

The leadership also articulated a process for times of the day when all nine beds are full (high flow). During these times, the provider sees new patients in the RTU (one specified chair) until beds are available. Diagnostic testing is started, and patients are managed in the waiting room until treatment spaces open up. Emergency Severity Index 1 and 2 patients are accommodated in the main emergency department by moving less-acute patients out.

Develop a Night Plan with the Hospitalists

Finally, like many rural hospitals, the department struggled with on-call coverage at night. The heavy lifting was being done by the hospitalists, who admitted the majority of patients. However, the hospitalists were working seven days straight and were wearing out quickly. The hospitalists needed to have a few hours on the night shift to get sleep, but the emergency department wanted to get its patients bedded down on the inpatient units. The solution was the implementation of “holding orders,” also known as “bridge orders” or “timed-out orders.”

The before and after data in Table 1 are very impressive. Hats off to the Houlton Regional leaders. When you think you can’t take your emergency department to the next level of operational performance, just remember “The Maine Thing.”

References


Table 1: Houlton Regional Hospital Metrics Before and After Implementing Patient Flow Changes in November 2016

<table>
<thead>
<tr>
<th>Month</th>
<th>Door to Doctor Time (Minutes)</th>
<th>Overall Length of Stay (Hours)</th>
<th>Length of Stay, Admitted (Hours)</th>
<th>Elopement %</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>44</td>
<td>3.6</td>
<td>5.9</td>
<td>3.3</td>
<td>923</td>
</tr>
<tr>
<td>September</td>
<td>43</td>
<td>3.3</td>
<td>5.2</td>
<td>3.4</td>
<td>888</td>
</tr>
<tr>
<td>October</td>
<td>45</td>
<td>3.5</td>
<td>5.3</td>
<td>2.8</td>
<td>858</td>
</tr>
<tr>
<td>November</td>
<td>31</td>
<td>2.7</td>
<td>5.1</td>
<td>1.2</td>
<td>819</td>
</tr>
<tr>
<td>December</td>
<td>32</td>
<td>2.8</td>
<td>5.0</td>
<td>0.5</td>
<td>807</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>31</td>
<td>2.9</td>
<td>6.6</td>
<td>1.3</td>
<td>850</td>
</tr>
<tr>
<td>February</td>
<td>33</td>
<td>2.5</td>
<td>6.1</td>
<td>1.9</td>
<td>765</td>
</tr>
<tr>
<td>March</td>
<td>29</td>
<td>2.6</td>
<td>5.9</td>
<td>1.4</td>
<td>915</td>
</tr>
</tbody>
</table>

ABOVE: CEO Tom Moakler, ED Medical Director Brian Griffin, and Nursing Director Tricia Murray (left to right).
BELOW: Houlton Regional Hospital’s rapid treatment unit area serves as a place to care for low-acuity patients.
these non-emergencies may prove just as challenging. Acute pharyngitis, for example, represents more than 1 million visits annually to US emergency departments. This presenting complaint rarely requires or benefits from antibiotics, yet the desire to provide our patients with at least some token of relief is frequently strong enough to overcome the rationality of antibiotic stewardship. Estimated appropriate prescribing rates for pharyngitis, accounting for group A strep prevalence, are 10 percent to 20 percent, but antibiotics are prescribed in roughly 60 percent of cases.

What alternative might we have to our ill-conceived antibiotic prescriptions? How about systemic steroids?

It follows logically that if pharyngitis is associated with inflammation of the pharynx, perhaps strong anti-inflammatory immunoregulation might prove beneficial. We have seen our otolaryngology colleagues prescribe steroids postoperatively for edema and pain. Should we use them for uncomplicated pharyngitis in our ambulatory population?

Examining Steroid Use for Sore Throat

In this view, the statistically negative result is a feature of inadequate sample size, the lens of their experience and the prior results favoring steroids, the only reliable conclusion is the need for a more robust trial. This leads us to the 2017 publication in JAMA of the Treatment Options without Antibiotics for Sore Throat (TOAST) trial. This trial randomized 366 patients with acute sore throat to either 10 of oral dexamethasone or placebo, was much smaller than expected based on the results from prior trials in which nearly three times as many patients in the dexamethasone group experienced symptomatic relief.\(^\text{1}\) Symptom relief at 48 hours favored dexamethasone by 8.7 percent, a number needed to treat of 12, and almost all the quality-of-life and resource utilization outcomes likewise show small beneficial effects.

Oral dexamethasone is universally inexpensive, and the preponderance of evidence suggests it’s helpful, so why is this potentially controversial? Why were any clinicians taking the opposing viewpoint that this treatment should not be routinely adopted? This is likely because the intervention has likely been downgraded from “harmless” to “mostly harmless.”

The Risks of Steroids

In certain patients, the deleterious effects of systemic steroids are obvious and avoidable. However, we expect most healthy young patients to tolerate short low-dose courses of steroids without ill effects. A recent publication in BMJ, unfortunately, suggests serious adverse outcomes are substantially more common from steroid exposures.\(^\text{2}\)

These authors reviewed a commercial insurance database and a final cohort of more than 1.5 million patients to examine for associations between short-course steroid exposure and sepsis, venous thromboembolism, and fractures. As compared with patients without exposure to steroids, patients prescribed steroids had roughly double the risk for sepsis, a 60 percent increase for venous thromboembolism, and a 25 percent increase for fractures in the five- to 90-day period following exposure. The numbers needed to harm for each of these conditions range from approximately 3,000 for sepsis to 800 for fractures. The harms were not equally distributed across ages, with lower risks for younger patients and increased risks for those older. However, the risks remained substantially increased. These increases in adverse events also held true for short courses and low doses of steroids.

So where does that leave us? Steroids probably do provide some benefit in symptomatic relief of pain from acute pharyngitis but not to the magnitude reflected in earlier trials. At the same time, this treatment is probably not quite as risk-free as previously thought.

**Pearls**

- Steroids probably do provide some benefit in symptomatic relief of pain from acute pharyngitis but not to the magnitude reflected in earlier trials. At the same time, this treatment is probably not quite as risk-free as previously thought.
- Examining Steroid Use for Sore Throat
- Conclusion is the need for a more robust trial.
Take Care of Your Heirs

What you need to know about estate planning

by JAMES M. DAHLE, MD, FACEP

Q. What do I need to know about estate planning before I meet with an estate planning attorney?

A. Estate planning is a chore that most of us put off whenever possible. Not only do physicians usually find it uninteresting, expensive, and even worse, it can force us to face our own mortality. However, it is an important aspect of financial planning and, when done poorly (or not at all), can really cause a mess for heirs.

There are three purposes to estate planning:

• Ensure our minor children, our things, and our money go where we wish them to go at the time of our death.
• Minimize the amount of our assets that have to pass through the expensive, time-consuming, and public process of probate.
• For a select few, estate planning is also done to minimize the amount of estate and inheritance taxes paid at the time of death.

CONTINUED on page 18
A lot of doctors worry about the "death tax"
Taxes
the terms of the trust.

die, the assets are passed in accordance with
cess to the assets at all times and can remove
trust. Since it is revocable, they have full ac-
ones, have their homes, vehicles, and even
FDIC coverage on your assets.
a bank may also allow you to have additional
lic knowledge. Payable-on-death accounts at
cess quickly, inexpensively, and without pub-
understanding. It might take a year or more for
might take a year or more for your heirs to receive what is coming to them.

Another function of a will is to determine who
gets your stuff and your money when you die. If
you die "intestate" (ie, without a will), the probate judge will follow the laws of your par-
ticular state to determine who inherits your es-
tate. Basically, if you don't have a will, the state
will make one for you. Typical intestate rules indicate that your spouse has first claim on
your assets, then your descendants, followed by
your parents, and then your siblings. How-
ever, each state has slightly different rules, and
you should read them before deciding whether
they are in line with your wishes. If they are not, then even if you have no minor
children, you need a will. If your family, de-
sires, and financial situation are very simple,
you may be just fine with an inexpensive will purchased through an online service. As
your assets grow or your family situation becomes
more complicated, a consultation with a quali-
fied estate planning attorney becomes more
and more valuable.
The process of probate involves a judge
reading the will (or following intestate laws in
the absence of a will) and determining who
gets what. This process is public, which re-
veals to the world what you owned. It can also
be expensive, costing as much as 15 percent of
the value of the estate! Finally, it can be time-
consuming. It might take a year or more for
your heirs to receive what is coming to them.

An important aspect of estate planning is
minimizing how much of your assets must
go through probate. This is primarily accom-
plished through beneficiary designations and
secondarily through revocable trusts. Retire-
ment accounts, life insurance policies, an-
uities, and many other types of financial
accounts allow you to name beneficiaries. All
of those assets pass outside of the probate pro-
cess quickly, inexpensively, and without pub-
lc knowledge. Payable-on-death accounts at
a bank may also allow you to have additional
FDIC coverage on your assets.

Revocable trusts are trusts that are used to
pass assets outside of the probate process. Many
wealthy people, particularly elderly
ones, have their homes, vehicles, and even
financial accounts owned by their revocable
trust. Since it is revocable, they have full ac-
cess to the assets at all times and can remove
them from the trust if needed. But when
they die, the assets are passed in accordance with
the terms of the trust.

A lot of doctors worry about the “death tax”
(ie, estate and inheritance taxes). However,
the truth is that under current law, few phy-
sicians will have to worry about estate taxes.
They simply do not earn enough, save
enough, or invest well enough to build their
estate to an amount greater than the federal
exemption amount. In 2017, the federal ex-
emption before the estate tax applies is $5.49
million. As long as the total value of your es-
tate is below that amount at your death, you
will not owe any federal estate tax. The ex-
mption amount is doubled if you are mar-
rried. The exemption amount is also indexed
to inflation under current law, so it should
double every 20 years or so. Unfortunately,
some states have their own estate tax and
often with a lower exemption amount than
the federal law. These states include Con-
necticut, Delaware, Hawaii, Illinois, Iowa,
Kentucky, Maine, Maryland, Massachusetts,
Minnesota, Nebraska, New Jersey, New York,
Oregon, Pennsylvania, Rhode Island, Ver-
mont, Washington, and the District of Co-
mbia, Maine, Massachusetts, New Jersey,
Oregon, and the District of Columbia have
particularly low exemption amounts ($1 mil-
on or less).

If you are fortunate enough to have a fed-
eral estate tax problem or unfortunate enough
to live in a state with a low exemption amount,
it may be worthwhile to address this with some
formal estate planning. The main strategy is
to give away amounts above the estate tax ex-
mption limit prior to death.
This can be done directly by giving away
up to $140,000 per year ($28,000 if you are
married) to anyone you like without using
any of your estate tax exemption. This is a
great way to decrease the size of your estate
to an amount below the exemption limit.
If you have three married children, each with
three married children, that’s 27 people you,
together with your spouse, can give $26,000
per year to ($627,000 total) without any estate
gift tax implications. You can also give mon-
ey to charities through various structures that
may also provide you substantial income tax
deductions. If you are not comfortable giv-
ing assets to your heirs at this time, you can
use an irrevocable trust. The money is then
out of your estate but can only be used by
heirs in accordance with the rules of the trust.
If you expect to owe estate taxes at death, a
consultation with a competent estate plan-
ing attorney in your state could be worth
hundreds of thousands or even millions of
dollars to you.

Be aware that some methods of simplifying
your estate planning can have unforeseen
consequences. For example, placing your chil-
dren’s name on the title of your investment
account or home can keep those assets from
passing through probate. However, they may
also cause the heir to owe a lot more in capital
 gains taxes than they otherwise would due to
the loss of the step up in basis at death.

Estate planning is a process whereby you
can ensure your wishes are met, probate is
avoided, and estate taxes are minimized. Phy-
sicians need a will in place as soon as they
have children or begin to acquire significant
assets. Most will also benefit from scheduling
a visit with an estate planning attorney by the
time they reach mid-career.
optic nerve route, which does not follow the vascular pattern of the central retinal artery on color Doppler.  

Another pitfall is measuring the ill-defined non-clear shadow, probably the previously discussed shadow superimposed on the real ONSD. This can be prevented by carefully angulating the transducer medially and caudally to visualize the oblique ONSD with clear margins. This can be prevented by carefully angulating the transducer medially and caudally to visualize the oblique ONSD with clear margins. However, getting the view of the oblique hypoechoic tract of the optic nerve provides lower normal measures, around 0.35 cm, that need to be validated.

References
IN-HOUSE EMERGENCIES

by BETTY ANN PRICE, BSN, RN

Question: What do I need to know about billing for a consultation on an in-house emergency?

Answer: When you are called to the floor for a code or other emergency, remember to document each of the procedures performed and the services you provide. You may be able to bill for an initial consult if your expertise is required beyond that of the attending service and the attending or other designee has requested your expertise. Be sure to document the name of the person who requested your consultation. A written order for your consult is required. It is important to know whether the patient status is inpatient or outpatient (e.g., observation). Alternatively, more than 30 minutes of time may support critical care when the time claimed is exclusive of separately billable procedures. Otherwise, you may be able to code for subsequent inpatient hospital care, which may be contingent upon whether you are credentialed with admitting privileges. Include in your note participation in CPR, endotracheal intubation, arterial/central venous/intraosseous line insertions, paracentesis, chest tube thoracostomy, etc. Peripheral IV insertion requiring physician skill might be captured with documented medical necessity (e.g., multiple unsuccessful attempts by nursing staff). Brought to you by the ACEP Coding and Nomenclature Committee.

Ms. Price is president and CEO of Professional Reimbursement & Coding Strategies, Inc., and a member of ACEP’s Coding & Nomenclature Advisory Committee.

Emergency Physicians

Einstein Healthcare Network (EHN) in Philadelphia is seeking full-time, board-certified/board-eligible physicians to join our growing regional Emergency Medicine program. We are looking for:

- Attending Physicians
- Associate Residency Program Director
- Medical Student Clerkship Director
- Faculty in the Division of EMS
- Faculty in the Division of Ultrasoundography

Our EM department covers Einstein Medical Center Philadelphia, Einstein Medical Center Elkins Park and Einstein Medical Center Montgomery with over 40 board-certified faculty and over 20 Physician Assistants. EHN has the region’s largest Emergency Medicine Residency Program and is dually accredited by the ACGME-RRC and AOA. The successful candidate would be interested in joining a lively, energetic and committed group of ED physicians providing quality emergency care to our patients and solid evidence-based education to our residents, medical students and PA trainees. We welcome ED physicians interested in being involved in all aspects of Emergency Medicine, including trauma, pediatric care, toxicology, EMS, education, ultrasoundography, research, quality and safety, simulation and observation medicine.

EHN offers a competitive salary, sign-on bonus, relocation assistance, CME allowance, defined benefit pension plan, excellent health insurance and other benefits. Academic appointments are through the Sidney Kimmel Medical School of the Thomas Jefferson University and are commensurate with candidate experience.

Philadelphia is an affordable, walkable, large city with a diverse population and world-class educational institutions, medical facilities, museums, entertainment/sports venues and restaurants. Applicants must be board-certified or board-eligible in Emergency Medicine and have or be eligible for a Pennsylvania medical license.

Please send curriculum vitae to: Kim Hannan, Physician Recruiter, Einstein Healthcare Network, Recruitment and Placement Center, Phone: 267-421-7435, HannanK@einstein.edu

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

Kevin Dunn: kdunn@cunnasso.com

Cynthia Kucera: ckucera@cunnasso.com

Phone: 201-767-4170

Emergency Medicine Opportunities

Join a physician group with a 97% retention rate

Avera Medical Group is connected to the region’s leading health care system with more than 200 clinics and 33 hospitals covering 60 specialties across South Dakota, Minnesota, Iowa, Nebraska, and North Dakota. Avera Medical Group physicians’ network, consisting of over 850 professionals providing focused patient care. Our patient-centered care structure combines compassion and innovation with the simple goal of creating happier, healthier communities.

“Aviera embodies what physicians represent. Their commitment to excellence has placed them at the forefront of technology. Magdalene Fiddler, M.D.

Opportunities for EM Trained Physicians

- Avera McKennan Hospital, Sioux Falls, SD
- Avera Queen of Peace in Mitchell, SD
- Avera St. Luke’s Hospital in Aberdeen, SD

Opportunity for FM/EM/IM Trained Physicians

- Lakes Regional Healthcare in Spirit Lake, IA

As an Avera Medical Group physician, you’ll be connected to a regional leader in health care. Avera offers:

- A comprehensive network of service lines, allowing physicians to work together to create best practices and deliver consistent care
- Avera eCARE the largest, most comprehensive telehealth network in the nation
- Choice of urban or rural practice settings and great quality of life
- Rural 24-Hr shifts, Urban 12-Hr Shifts

Learn more about physician job opportunities at Avera.org/ careers by selecting Physician Opportunities or call Physician Recruitment at 605-322-7663

EEO/AA Employer M/F/D/V

Phone: 610-227-0400
The Emergency Group, Inc. (TEG) is a growing, independent, democratic group that has been providing emergency services at The Queen’s Medical Center (QMC) in Honolulu, Hawaii since 1973. QMC is the largest and only trauma hospital in the state and cares for more than 65,000 ED patients per year. QMC opened an additional medical center in the community of West Oahu in 2014, which currently sees 30,000 ED patients annually.

Due to the vastly growing community in the West Oahu area, TEG is actively recruiting for EM Physicians BC/BE, EM Physicians with Pediatric Fellowship who are BE/BC and an Ultrasound Director. Physicians will be credentialed at both facilities and will work the majority of the shifts at the West Oahu facility in Ewa Beach, Hawaii.

We offer competitive compensation, benefits, and an opportunity to share in the ownership and profits of the company. Our physicians enjoy working in QMC’s excellent facilities and experience the wonderful surroundings of living in Hawaii.

For more information, visit our website at www.teghi.com. Email your CV to tegrecruiter@gmail.com or call the Operations Manager at 808-597-8799.

MetroHealth Medical Center Correctional Health Program

Seeking ER/FP physician to join MetroHealth Correctional Health Care program serving the Cuyahoga County Correctional Center in beautiful downtown Cleveland.

Join exceptional health care team in the growing specialty of correctional medicine, which encompasses a broad procedural skill set. Comprehensive correctional health program includes full laboratory, pharmacy, digital imaging, ultrasound, and telemedicine services for annual patient census of approximately 30,000.

Consistent with national trends, aging patient population presents with multiple medical/surgical/acute care needs.

Complete range of consultation, emergency medical and surgical services provided by MetroHealth Medical Center, a Level I trauma center.

Qualified candidates should be board certified or board eligible in emergency medicine or family medicine with ER experience. Competitive MetroHealth salary and extensive benefit package.

Send CV and inquiries to ttallman@metrohealth.org. Thomas A Tallman, DO, MMM, FACEP, Medical Director, MetroHealth Correctional Health Program, 216 704 4296.
Physicians (Emergency Medicine)
Openings in Tucson, Arizona

The Southern Arizona VA Health Care System (SAVAHCS) is offering an exceptional opportunity for full-time Emergency Medicine providers to join our winning team.

We are currently seeking skilled physicians holding an active and clear state medical license. Live where the country vacations in the winter. Home of the University of Arizona. This is an exceptional opportunity for experienced Emergency physicians to provide care for Veterans. See acutely ill patients with complex medical problems who have served their country. All backup specialties available, including neurosurgery, ENT and GYN. We offer 10 hour shifts, double and triple coverage. The ED PA sees less acute patients in trage. Our physicians perform clinical duties in the 19-bed Emergency Department which operates 24/7 for the current 26,000 patients seen annually. There are teaching and administrative opportunities available. We offer a competitive salary and generous 401k matching program. A Federal pension is available after only five years of service. Successful candidates must be eligible for a faculty appointment at the University of Arizona. The University of Arizona EM residents and medical students rotate within the department. The physician is required to maintain ACLS/BLS/Imbubation proficiency and certification. Preferred experience: board certified or board eligible in Emergency Medicine. Clinical Contact: Dr. Randall Bennett, MD, FCEP, Emergency Dept. Director, 520-904-3221, or Randall.bennett@va.gov

For detailed information on these positions, go to https://www.usajobs.gov/ and enter the control number 458777500 in the Keyword select to view the announcement and to apply for this position. This is a wonderful opportunity to service those who have served. Applications must identify their current citizenship/Visa status. A current unrestricted medical license in any U.S. state/territory is required. Candidates must apply online by submitting a current CV, with three (3) professional references, and complete the on-line questionnaire. The HR point of contact is David Tweedy, (520) 792-1450, ext. 6213.

The Department of Veterans Affairs is an Equal Opportunity Employer.
The Emergency Medicine Department at Penn State Health Milton S. Hershey Medical Center seeks energetic, highly motivated and talented physicians to join our Penn State Hershey family. Opportunities exist in both teaching and community hospital sites. This is an excellent opportunity from both an academic and a clinical perspective.

As one of Pennsylvania’s busiest Emergency Departments treating over 75,000 patients annually, Hershey Medical Center is a Magnet® healthcare organization and the only Level 1 Adult and Level 1 Pediatric Trauma Center in PA with state-of-the-art resuscitation/trauma bays, incorporated Pediatric Emergency Department and Observation Unit, along with our Life Lion Flight Critical Care and Ground EMS Division.

We offer salaries commensurate with qualifications, sign-on bonus, relocation assistance, physician incentive program and a CME allowance. Our comprehensive benefit package includes health insurance, education assistance, retirement options, on-campus fitness center, day care, credit union and so much more! For your health, Hershey Medical Center is a smoke-free campus.

Applicants must have graduated from an accredited Emergency Medicine Residency Program and be board eligible or board certified by ABEM or AOBEM. We seek candidates with strong interpersonal skills and the ability to work collaboratively within diverse academic and clinical environments. Observation experience is a plus.

For additional information, please contact:
Susan B. Promes, Professor and Chair, Department of Emergency Medicine, c/o Heather Peffley, Physician Recruiter, Penn State Hershey Medical Center, Mail Code A590, P.O. Box 850, 90 Hope Drive, Hershey PA 17033-0850, Email: hpeffley@hmc.psu.edu OR apply online at www.pennstatehersheycareers.com/EDPhysicians

The Penn State Health Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.
We believe in physician ownership.

Physician ownership matters. At US Acute Care Solutions, physician ownership is the key to loving what we do. It empowers us to make a difference in the lives of our patients by keeping clinical decisions in the hands of clinicians. We believe in the high level of ideas and dedication that ownership creates. That’s why every full-time physician in our group becomes an owner. We believe that discovery, camaraderie and the pursuit of excellence don’t end when your residency does. If you’re looking for an exciting home for your career, we believe you’ll find it at USACS. #ownershipmatters

USACS is made up of over 1,900 physician owners and growing.

Own your future now. Visit usacs.com
or call Darrin Grella at 800-828-0898. dgrella@usacs.com