Patient Safety Rounds

Louise A. Prince, MD FACEP, Associate Professor, Emergency Medicine, SUNY Upstate Medical University; Nancy E. Page, MS RN PCNS-BC, Director of the Department of Emergency Medicine Patient Safety and Quality, SUNY Upstate Medical University

"Building a Culture of Safety" has become one of the highest priority topics in medicine since the publication of the Institute of Medicine Report: *To Err is Human: Building a Safer Health System* more than a decade ago. This provocative report suggested that between 44,000 and 98,000 deaths occur each year related to medical error. Instituted safety processes usually fall into the categories of "pre-occurrence" or "post occurrence" in relationship to the safety event. One of the popular "post occurrence" processes that has been adopted by hospitals is root cause analysis (RCA). This is a method of event review undertaken after serious safety events that attempts to uncover system issues amenable to change to prevent event recurrence. While other "pre-occurrence" processes focus on preventing the event from ever reaching the patient. An example of a well utilized "pre-occurrence" process would be the pre operative check list and "time out" procedure. Both the root cause review process and pre-procedure check lists were created after patient harm had occurred in various settings.

Two areas remain problematic in the above mentioned system. The first is that "near misses" occur every day, are picked up by clinicians and others and errors are prevented that do not result in patient harm. These near misses are rarely reported and often simply forgotten in the busy work environment. Secondly, despite attempts to build cultures that focus on system errors and subsequent systems improvements, there is an overall continued reluctance to report events due to fear of reprisal such as job discontinuation or legal action. Both of these issues make it essential to create an environment of anonymous reporting with continuous staff involvement to discover more unreported events or "near misses."

An approach to improving patient safety that has been shown to be extremely effective is an exercise known as Patient Safety Rounds (PSRs). This approach has been described in multiple sources including the Joint Commission Journal on Quality and Safety in 2003,[1] the Institute for Healthcare Improvement in 2004,[2] the BMC Health Services Research in 2005[3] and by AHRQ in 2008.[4] The rounds serve three purposes. First, is bringing senior hospital leadership to the frontline in order to visualize safety issues more accurately. Second, the rounds serve as an educational tool with the direct patient care staff participating. Rounds are an excellent time to update staff on safety improvements that have occurred like the purchase of "smart" IV pumps with drug libraries. Third, by enacting change after issues are identified by staff on rounds, there is a recognition that leadership is committed to a culture of safety and the importance of making meaningful changes based on staff input.

Patient Safety Rounds (PSRs) occur in our emergency department at least once a month. It has been very beneficial to rotate the rounds to different shifts to broaden participation and to have an accurate perception of safety issues that occur around the clock. Membership of the PSRs group should include hospital and departmental nursing administrative staff, senior physician staff from the department, departmental quality/patient safety officers, and representation from pharmacy, laboratory, radiology, and even patients and families. Conversations should occur with all levels of employees assigned to different functions. For example, rounds at our institution have included housekeeping, technicians, clerks, LPNs, RNs, resident and attending physicians, any other staff available plus patients themselves. Standard open-ended questions emphasizing patient quality and safety, plus a blame free environment, are essential. Asking "who is the next patient who might be harmed" is one open ended question that could begin rounds.

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president's MESSAGE

Joel M. Bartfield, MD FACEP, DIO and Associate Dean for Graduate Medical Education, Albany Medical Center

Annual Meeting Report

As presented July 6 at The Sagamore Resort

On behalf of the Board of Directors and leadership of New York ACEP, I would like to welcome everybody here this afternoon. This has been a terrific meeting so far and I'm pleased to tell you we have over 200 registrants. This may well be the largest Scientific Assembly we have ever had. I would like to extend a special welcome to Shauneen McNally from Weingarten, Reid and McNally, our lobbyists. I would also like to recognize Dr. Sandra Schneider, President of national ACEP. Sandra is a New York ACEP member and a member of our Board of Directors. I also welcome Dr. Andrew Sama, Vice President of ACEP and candidate for President Elect. Dr. Sama is a New York ACEP member, member of the New York Board of Directors and former President of New York ACEP. A warm welcome to Dr. Michael Gerardi, a member of the national ACEP Board of Directors and candidate for re-election and Dr. John Rogers, member of the Emergency Medicine Foundation Board of Trustees and candidate for the national ACEP Board of Directors. Finally I'd like to recognize and give my sincere thanks on behalf of the New York ACEP Board of Directors to our Executive Director, JoAnne Tarantelli and our office staff, Timothy Pistor and Betsy Hawes.

2010-11 has been a very successful and productive year for New York ACEP. Membership has grown by 101 members to 2,149. This makes us the second-largest chapter in the country, second only to California. Since we are such a large chapter, we are very well represented on a national level at the Council meeting, which immediately precedes the Scientific Assembly this year in San Francisco. New York has a total of 21 councillors this year. As many of you probably know, New York has the largest number of training programs in emergency medicine in the country. We have a total of 22 allopathic and two osteopathic programs.

This has allowed us to keep our dues fixed for fifteen years and . . . only minimal increases in our registration costs for our educational offerings.

Due to superb fiscal management through the efforts of our Board of Directors and Executive Director, New York ACEP continues to flourish and add to our member equity. For over a decade, we have been able to annually increase our total assets. This has allowed us to keep our dues fixed for fifteen years and to have only minimal increases in our registration costs for our educational offerings. We have also been able to largely underwrite our resident members' registration costs for our educational programs. New York ACEP also has reserves available should we need to offset a budget shortfall, respond to any unforeseen expenses, or rally to fight political battles that would benefit our members and our patients.

Most of the work that we do is done by a very robust committee structure. I would like to briefly outline some of the accomplishments of our committees over the last program year, but before I do I would like the chairs of all of our committees to please stand and be recognized. All committee members please stand and be recognized as well.

The Education Committee, under the direction of chair, Dr. Louise Prince, is responsible for all of New York ACEP's educational offerings. In addition to organizing this superb conference, the Education Committee organizes our annual ED Director Forum and LLSA Review Courses. The Committee is currently working to create a web-based LLSA offering.

The Emergency Medicine Resident Committee is responsible for development of programming specific to our resident members and for creating a resident network within New York State. All training programs in the state have representatives on this very important committee. Under the direction of chair Dr. Julian Jakubowski, vice chair Dr. Mary Mulcare and Board liaison, Dr. Christopher Doty, the EMRC developed the educational content for this year's Medical Student Symposium and Resident Career Day. They also worked with the Professional Development Committee on our June 8 Networking Event.

Under the direction Dr. Daniel Murphy, Government Affairs helps to advance New York ACEP's legislative priorities. These include access to care, tort reform, fair payment to emergency physicians and Medicaid reimbursement. Government Affairs also worked with the Board of Directors to promote young physician attendance at this year's New York ACEP Lobby Day, which resulted in participation of thirty-four New York ACEP physicians meeting with our legislative leaders. Through the efforts of Government Affairs and the Board of Directors, New York ACEP had the largest state attendance at this year's national ACEP Leadership and Advocacy conference in Washington, DC in May.

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The Times, They Are a Changin'. Or Are They?

Christopher I. Doty, MD FACEP,
Program Director & Assistant Professor,
Department of Emergency Medicine,
SUNY Downstate Medical Center &
Kings County Hospital Center

Are doctors susceptible to our society's ills? Do we suffer with biases as doctors? Is medicine a bastion against the inequities of our culture and society? It does not seem so. It has been 101 years since the inception of international women's day, yet the gender gap seems to persist in regard to compensation in the fields of business, journalism, healthcare, and entertainment and probably many more. It is not apparent at first glance. The Dean of Harvard and the president of the University of Pennsylvania are women. The presidents of Brown University and Princeton University are female too. The chancellor of Germany and the president of Argentina are female and eight out of 22 of Obama's cabinet posts are filled by women. We even have had women as our last two presidents of ACEP. So what am I talking about?

There is still a huge gender gap in the business world and several studies have shown this. Women make up about 52% of the U.S. workforce but do not garner the top jobs nearly as often. About a third of MBAs graduating today are women but just 3% of Fortune 500 CEO's and 15 % of the board directors of those companies are women.

Likewise, women are entering the medical field more frequently, yet a recent study shows they are earning less. An article in *Health Affairs* by Lo Sasso showed that there was a gender-based pay gap of almost $17,000 for physicians graduating from residency in New York State. This gap has grown from $3,600 just nine years ago. Granted, the literature on this topic is confusing and the differences in pay may have many confounding variables. In the past, women have been more likely to choose primary care fields rather than subspecialty practices. This could account for lower incomes. However, this disparity between primary care and specialty as a career choice for women is no longer true.

Women also are more likely to work part-time or choose work schedules that are conducive to raising children. In the Lo Sasso study, the proportion of women working less than 40 hours per week was higher. However, when considering only women working 40 or more hours per week was analyzed separately, the difference in salary persisted. Differences in productivity have been postulated as a cause of salary disparity, but the data is not consistent and does not look at patient-oriented outcomes. Therefore difference in productivity can not be treated as strong evidence for cause of the pay disparity.

By looking at starting salaries directly out of residency, many of these confounding variables are eliminated. Lo Sasso shows that the gender gap in pay is not explained by: specialty choice, practice setting, or work hours.

A recent study by Medscape showed that across all specialties, male physicians earn about 41% more than female doctors. In primary care, men earn 21% more than their female counterparts. The pay gap between male and female emergency medicine physicians was somewhat narrower than for physicians overall. Male emergency medicine physicians reported median compensation of $263,000 as compared with $217,975 median earnings for women. *EPMonthly*, a monthly print and online journal, also published a recent study with similar findings.

So after everything is said and done, the reasons are not clear for the gap. Perhaps women don't negotiate as often as men. This has been shown in the business fields.

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Times Are a Changin'.

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Maybe women are not looking for the larger paycheck men are. The *EPMonthly* survey found that women are more likely than men to consider schedule as one of the three most important considerations in choosing a job. Perhaps not surprisingly, men are more likely to consider salary as one of the three most important considerations. It is probably too simplistic to believe this is the whole story. There are probably several gender-specific traits that are also at play in these findings.

Regardless of cause, it is important for women in medicine to consider these findings when looking at a job offer or negotiating a raise. We must be aware that the bias exists. There is also some literature to suggest that it takes about a third of the members of a group to be female in order to change the culture of the group and avert subconscious bias. While a little less than 20% of practicing emergency medicine physicians are women, over 25% of residency applicants are female. Moreover, over 37% of present EMRA members are female; so perhaps a change is on the horizon. ■

Congratulations!

It is with great pleasure that the New York American College of Emergency Physicians Board of Directors announces the recipients of 2011 awards presented at the New York ACEP Annual Meeting Wednesday, July 6 at The Sagamore Resort on Lake George.

NEAL E. FLOMENBAUM, MD FACEP, Emergency Physician-In-Chief at New York Presbyterian-New York Weill Cornell Center was awarded the *2011 Advancing Emergency Care Award*. This award was created to recognize a New York ACEP member for a significant contribution in advancing emergency care in New York State. Contributions considered included: Patient Care (improved delivery modes, quality care improvement, cost containment); EMS (organization, service, public education, disaster plan); Education (new or improved teaching methods, publication(s), education programs, evaluation mechanisms); Research or major contribution to a New York ACEP priority objective. The award was first presented in 2008.

ANDREW S. JAGODA, MD FACEP Chair, Department of Emergency Medicine at Mount Sinai School of Medicine was awarded the *2011 Physician of the Year Award*. The award is conferred in recognition of contributions to the advancement of emergency medicine in New York State. Recipients demonstrate outstanding dedication and commitment to the improvement of quality patient care and the advancement of emergency medicine in New York through clinical, research, educational and/or administrative activities. The achievements of the recipient have enhanced the state's health care system and advanced the profession of emergency medicine. The award was first presented in 1994. ■

Each year New York ACEP honors individuals for contributions to the advancement of emergency care. Award nominations are now being accepted for the 2012. **Deadline: January 1, 2012.**

Advancing Emergency Care
Leadership in Government Award
National Leadership Award
Physician of the Year

For more information on these awards, visit **www.nyacep.org**

Networking for Physicians

Kevin P. O'Connor MD FACEP, Chair,
Department of Emergency Medicine,
Arnot Ogden Medical Center

"The way of the world is meeting people through other people" is a quote from the author Robert Kerrigan.

"It's not what you know but who you know that makes the difference" is very evident when searching for the ideal job. In medicine, knowledge and education are naturally important, but having connections to help get your foot in the door definitely helps.

Networking is defined as sharing information and services among individuals and groups having a common interest *or* forming business connections and contacts through informal social meetings.

The word 'network' got its origin circa 1560 and meant a 'net-like arrangement of threads, wires, etc.' In 1947, 'network' was used to refer to interconnected groups of people. The actual term 'networking' did not become popular until the 1980s.

Networking used to require a fair amount skill. Schmoozers were skilled in the art of ingratiating small talk and were noted to be highly successful in their businesses. Unfortunately, not all people possess this skill. Now, thanks to the internet, it has become easier to connect with even more people in a fraction of the time. In addition to shaking hands and exchanging contact information at meetings or parties, you can now network from the comfort of your own home.

Here are some tips for young physicians interested in networking that could help to start or advance your career in emergency medicine.

- Join local, state and national organizations.
- Make yourself visible in these organizations by volunteering to be on committees.
- Define your goals.
- Be genuine when building relationships.
- Keep in touch with the people that you meet (e-mail makes this easy).

Author Andrea Santiago offers the following tips:

Start early. Medical school and residency is a great time to begin.

Attend meetings when possible.

Never stop networking – Even if you have a great job. Make networking a part of your regular routine. Try chatting with people about their professions and their contacts. The best time to network is when you're gainfully employed – you'll come across as confident and successful which will make you more interesting and attractive from a professional standpoint. Networking is much like dating – you're more attractive when you're "taken"!

Assume each person you meet is a valuable connection. In other words, don't underestimate someone's networkability, even if he or she is not in the healthcare industry! You never know, a new acquaintance you meet at a party could have a friend/sister/dad/cousin who is the CEO of a hospital or pharmaceutical company.

Combine "inter-net-working" with face-to-face personal networking. Yes, you read it here first - I've coined a new phrase: "internetworking," to describe online networking using the worldwide web. Do not limit yourself to one method of networking – the more methods you utilize, the more successful you will be. Networking is a game of numbers.

When networking online, be sure to use reputable sites and obey the rules.

Get out and about. The more places you go, events you attend, and people you meet, the more successful you will be!

Here are some opportunities that emergency physicians and residents can network in person:

- Join ACEP's Young Physician Section. It is a great networking resource for young physicians starting their careers.
- Attend New York ACEP's Networking events which are held two to three times a year. It is a great opportunity to hear a great talk for about thirty minutes and then have valuable time networking with the speaker and other physicians over refreshments. They are usually held at New York-Presbyterian Hospital.
- Join a New York ACEP committee to become connected with prominent New York physicians. You can review these committees at www.nyacep.org.

I highly recommend face-to face networking whenever possible. However, with our busy lifestyles, there is also the option of networking on the 'net'.

Social networking online began in the 1980s. However, it wasn't until the last ten years that social networking became popular. The benefits of social networking are endless. Social networking makes it possible to meet lots of new people with similar interests more easily and in a short amount of time. Social networks also are a great educational resource and provide us a forum to share our opinions and views.

Facebook and Twitter are by far the most well known networking sites. Most organizations and even other networking sites now have a Facebook page. Just enter any group or topic of interest related to emergency medicine into search box and you will get countless hits. New York ACEP now has a Facebook page. Here you can keep abreast of what is happening in your organization. Watch for continual improvement in this site over the next year.

There are many online professional networks designed for physicians, residents, and medical students today.

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New York ACEP ~ a year in review
Accomplishments and New Programs

Communications
- Published four issues of the *Empire State EPIC* averaging 32 pages and exceeded budgeted advertising income
- Went "social" and created a New York ACEP fan page on Facebook.
- When newsworthy, continued to publish electronic news to members on months that *EPIC* not published.
- Kept the membership informed through the internet of legislative and regulatory issues, New York ACEP accomplishments and continuing education opportunities.

Education
- Planned and developed educational content and promote attendance for ED Director Forum, Scientific Assembly and LLSA Review Course.
- Created promotional copy for publishing on National ACEP LLSA Resource Center on their website.
- Continue to work with National ACEP to meet requirements for ACCME.
- Negotiated Sagamore contracts for 2012 and 2013.
- Negotiated VeoMed contract for the 2011 Resident Career Day and Resident Research Forum; and 2012 Medical Student Symposium.

EMS
- Developed a policy approved by the Board of Directors for Medical Direction of EMS in New York State.
- Prepared Interfacilty Transport Checklist.
- Designed meeting schedule and formatted to facilitate Medical Director collaboration.

Emergency Medicine Residents
- Planned and developed educational content for resident education programs and the Medical Student Symposium.
- Promoted attendance for Residents Career Day, Resident Research Forum and Medical Student Symposium through website, e-mail communications, Facebook and *EPIC*.

Government Affairs
- Created legislature educational brochure featuring New York ACEP legislative priorities: Access to Care, Tort Reform, Fair Payment to Emergency Physicians and Medicaid Reimbursement.
- Initiated beginning of session mail communication with all New York legislators.
- Supported and promoted young physician attendance at New York ACEP Lobby Day by encouraging board members to bring a resident member resulting in participation of 34 physicians.
- Promoted attendance at National ACEP Leadership and Advocacy Conference achieving largest state attendance in 2011.
- Provided emergency medicine input to the Department of Insurance on the Affordable Care Act Department Bill #55.

ITLS
- Coordinated the training of 640 providers and instructors.

Industry Opportunities
- Continue to promote exhibit and support opportunities for ED Director Forum.
- Promoted advertising in both the *Empire State EPIC* and Online Career Catalog to recruiters, hospital, manufacturers through e-mail communications, phone calls and mailings.
- Career Day Job Fair: Promote participation from hospitals and recruiters.
- Residency Fair at the Medical Student Symposium: Promoted participation from 12 residency programs.

Organizational Viability
- Organized and executed successful strategic planning meeting.
- Research viable locations for new office space.
- Negotiated five-year contract for office space, implemented seamless move into new space with no interruption in service to members.
- Began the process of moving toward a paperless office.

Political Action
- Promoted PAC contributions through the development of focused ad campaigns to four different markets.
- Worked with VeoMed to secure and direct video interviews for use in promoting the PAC.
- Implemented two marketing campaigns to attendings and residents.

Practice Management
- Continued to serve as a member resource for practice questions.
- Continued to add new practice resources to the website.
- Corresponded with the DOH to address changes in Stroke CME.
- Addressed New York State Department of Health eligibility criteria for coverage of the treatment of an emergency medical condition (Form DOH-4471, Certification of Treatment of an Emergency Medical Condition).
- Sent letter to DOH on ambulance transfer of PCR to the ED.

Professional Development
- Supported planning, marketing and promotion of the networking events.
- Continued to promote Open Table Networking Dinner during Assembly.
- Membership grew to 2,149 members.

Research
- Worked with the Research Committee to develop and promote Resident Research Forum.
- Continue to work with Research Committee to promote submission for research abstracts for oral and poster presentations during the Scientific Assembly. ■

Congratulations to our newly elected board members:

Brahim Ardolic, MD FACEP
Jeremy T. Cushman, MD FACEP
Penelope C. Lema, MD RDMS FACEP
David H. Newman, MD FACEP

resident representative appointed by President
Mary R. Mulcare, MD

empire state EPIC

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NEWS STAFF
JoAnne Tarantelli, *Executive Director*
Betsy Hawes, *Communication & Marketing*

Networking for Physicians

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One of my personal favorites is **LinkedIn**. I like it because it is professional, easy to use and invite your friends, and it discourages contacting people you do not know, unless you are introduced by a mutual contact. There are over 1.5 million healthcare professionals you can choose to connect with on this site.

I recently signed up for three physician-specific professional websites.

Sermo: Sermo is an online community for U.S. physicians only. Sermo is a place for physicians to post observations and questions about clinical issues and to hear other doctors' opinions It also offers CME, job opportunities, links to other medical websites, has surveys that pay honorariums and contains loads of forums ranging from practice management to healthcare reform. Sermo's site states that it has 112,000 physician members across 68 specialties.

Ozmosis: Ozmosis is another network for "verified U.S. physicians" only. While it seems to have many similar features to Sermo, it does not seem to be as large or established. Ozmosis was cofounded by a physician, and the site is touted as the most "trusted physician network" and one designed exclusively "by physicians for physicians." It allows you to ask questions, post Journal Club items, present or participate in Cases or Virtual Grand Rounds.

DoctorsHangout: Unlike Sermo and Ozmosis, this site is available to physicians anywhere in the world. You will find many interesting images and videos and have a chance to interact with many of our international colleagues.

There are, of course, many more networking sites available that are just a few clicks away. I encourage all physicians, young and old, to get started. Networking is not only fun but can boost your career and status amongst your peers.

Peter Drucker was quoted as saying, "More business decisions occur over lunch and dinner than at any other time, yet no MBA courses are given on the subject." ■

Albany Update

Weingarten, Reid & McNally, New York ACEP Legislative & Regulatory Representatives

Introduction

The New York State Legislature adjourned Friday, June 24 at 10:00 pm. It was a historic Legislative Session culminating with the passage of a bill legalizing gay marriage. Governor Cuomo was successful in convincing the Republican Senate and Democratic Assembly to pass virtually all of his priorities including an on-time, balanced State Budget with no tax increases, the first ever cap on local property taxes and an ethics reform bill that creates an independent body empowered to investigate both the executive and legislative branches and requires public disclosure of outside income by lawmakers.

The State Budget was a disappointment for organized medicine. Despite an unprecedented grass roots effort by New York ACEP members to achieve passage of the Medical Reform Taskforce (MRT) proposal to cap non-economic damages at $250,000, the cap was not included in the final budget deal. In a letter to Governor Cuomo, New York ACEP expressed deep concerns about the failure to include the cap in this year's State Budget, and urged the Governor to re-engage the Legislature on the enactment of the cap this year.

New York ACEP was able to work to **defeat a number of regressive liability measures** including bills to create a date of discovery rule for the statute of limitations, expand wrongful death damages, eliminate the limitations on contingency fees, and others.

Provided below is a summary of pertinent bills that passed both houses. Legislation is transmitted to the Governor for signature or veto in "batches" on a biweekly basis. The Governor has 10 days from the date of transmission by the Legislature to sign or veto a bill. Also provided is an update of issues that New York ACEP is working on.

Update on Legislation Passed by Both Houses

Affordable Care Act (ACA) Compliance Bill (S5800 Seward/A8460 Stevenson)

Patient Cost-Sharing in Emergency Departments

A bill was introduced at the request of the State Insurance Department to bring New York State law into compliance with the provisions of the federal ACA. The ACA does not preempt state laws that meet or exceed protections in the federal law. However, state laws that do not meet or exceed the ACA protections must be amended for compliance. **This bill was signed by the Governor, Chapter 219 of the Laws of 2011.**

The ACA compliance bill contains provisions relating to patient cost-sharing imposed by health insurance plans in emergency departments for non-participating providers. The State Insurance Department advises that these provisions do not change the way that a "non-participating" doctor can bill a patient. The ACA imposes separate rules for Health Maintenance Organizations (HMOs) and indemnity plans as described below.

Specifically, the ACA provides that for HMOs that cover emergency services, the health plan must provide coverage regardless of the participating status of the provider at the in-network cost sharing level for patients. The ACA does not permit the HMO to bill a patient for the excess amount of the non-participating providers' charges. Under current Department of Health rules, if the plan and the non-participating provider cannot agree on the charges, the HMO must make the non-participating provider whole.

For indemnity plans, the ACA requires coverage regardless of the participating status of the provider at the in-network cost sharing level for patients just as it does for HMOs. However, the plan can bill the patient for the excess of the amount a non-participating provider charges which is the greater of:

- the amount the plan pays the participating provider;
- the amount the plan pays the non-participating providers (without a reduction for patient co-pays or other patient cost-sharing); or
- the amount paid under Medicare.

Again, the Insurance Department asserts that these rules are imposed on the plans, not the providers, and that there is no change in what doctors can bill patients.

Definition of Emergency Condition

The ACA compliance bill amends the definition of emergency condition in existing state law to delete the requirement that the "onset of the condition must be sudden." This provision was interpreted by the State Insurance Department as more restrictive than the ACA.

In addition, the bill conforms to the ACA by inserting the term "acute" before the term "symptom" in the definition of emergency condition. After discussions between WRM and counsel at the State Insurance Department, the Department stated that the term "acute" includes the exacerbation of a current or chronic condition. It does not mean that the underlying disease or condition must be acute. The State Insurance Department is awaiting federal regulations on this issue. If a federal interpretation arises that causes the new State law to be more restrictive there will be adjustments made to address this through a circular letter and ultimately another change to the law.

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Albany Update

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Office of Inspector General (OMIG) Reform (S3184-A Little/A5686-A Gottfried)

This legislation which New York ACEP supports would provide transparency and due process for Medicaid providers who are audited by the Office of the Medicaid Inspector General (OMIG). This bill has not yet been transmitted to the Governor. Importantly, this bill would:

(1) prohibit the recovery of Medicaid funds for overpayments not less than 60 days following the issuance of a final audit report or notice of final agency action;

(2) prohibit audits or reviews by OMIG on claims that were the subject of a previous audit within the last three years except where there is new information or good cause to believe that the prior audit was erroneous;

(3) require OMIG to apply the laws, regulations, policies, etc. of the appropriate agency that were in place at the time the claim arose or conduct took place;

(4) prohibit recoveries by OMIG based on administrative or technical defects without intent to falsify or defraud in connection with Medicaid claims, and give providers an opportunity to correct the defect and resubmit the claim within 30 days;

(5) require OMIG to furnish to providers at audit exit conferences any draft audit findings and a detailed written explanation of the extrapolation method; and

(6) give providers 60 days to submit to the OMIG a satisfactory compliance program if they are found not to have one.

Concussion Management Awareness (S3953-B Hannon/A8194 Nolan)

This bill requires the Commissioner of the State Education Department (SED), in conjunction with the Commissioner of the State Department of Health (DOH), to promulgate rules and regulations relating to students who suffer mild traumatic brain injuries (concussions) in school sponsored or related activities. As of this writing, this bill has not yet been transmitted to the Governor.

The commissioners must consider comments from stakeholders including parents, teachers, students, school administrators, school athletic trainers, medical and health professionals and athletic associations in developing the regulations.

The regulations must include requirements that 1) all coaches, physical education teachers, nurses and athletic trainers in the schools complete a course on a biennial basis on recognizing the symptoms and proper monitoring and medical treatment of concussions; 2) information developed by DOH and SED must be part of any parent permission or consent form and posted on the DOH and SED websites; 3) any student believed to have a concussion must be immediately removed from athletic activity; and 4) a return to physical activity must be authorized by a licensed physician. School districts are authorized, at their discretion, to establish a concussion management team.

911 Calls, Alcohol/Drug Use (S4454-B DeFransico/A2603-C Gottfried)

Legislation passed both houses to encourage a witness or a victim of a drug or alcohol overdose to call 911 or seek emergency assistance to save the life of the overdose victim. The bill protects the victim or witness from arrest, charge, prosecution and conviction for drug possession, drug paraphernalia possession, and certain alcohol related offenses. The bill does not provide protections for drug trafficking or interference with law enforcement protocols to secure the scene of an overdose. This bill was signed by the Governor, Chapter 154 of the Laws of 2011.

State Emergency Medical Advisory Committee (S4621-A Young/ A7311-A Gabryszak)

This bill increases the number of members on the state emergency medical advisory committee from twenty-nine to thirty-one members. It also specifies that twenty-three members shall be physicians appointed by the Commissioner of Health including one nominated by each regional emergency medical services council, an additional physician from the City of New York, one pediatrician, one trauma surgeon, one psychiatrist and a chairperson appointed by the Commissioner. As of this writing, this bill has not yet been transmitted to the Governor.

OTHER ISSUES OF INTEREST

Balance Billing

For several years, New York ACEP has aggressively fought a campaign by the health insurance industry to enact, either by regulation or legislation, a proposal to limit reimbursement for out-of-network emergency care. In the past, proposals have ranged from an outright ban on balance billing to the imposition of default rates on providers of emergency care. This year, legislation was under discussion in the State Health and Insurance Departments to impose penalties on out-of-network emergency providers charging "unconscionably high" fees, similar to the Price Gouging Law.

At this time, the State Insurance Department has not submitted a proposal to the Legislature. New York ACEP and WRM will continue to work proactively to defeat detrimental proposals.

Hospital Crowding

New York ACEP has worked for a number of years with officials at the New York State Department of Health to find solutions to hospital crowding. Efforts have included surveys conducted by New York ACEP, the introduction of legislation in the Senate and Assembly, member participation in a DOH Task Force and the development of a white paper.

Last year, the Department announced that it will be using data collected through the Health Emergency Response Data System (HERDS) to identify a sample of hospitals to complete a comprehensive survey on the issue of crowding. New York State DOH said in a letter to all hospital CEOs that "Emergency Department (ED) overcrowding is a hospital wide problem and demands the priority attention of hospital administration as well as the hospital's medical staff and nursing personnel." Unfortunately, the survey was put on hold due to budget issues.

Physician Collective Bargaining Passes Senate, Stalls in Assembly (S3186 Hannon/A2474 Canestrari)

Legislation to allow independently practicing physicians to collectively negotiate participation terms with health insurers passed the Senate by a bipartisan vote of 43-19. The legislation was fiercely opposed by the health insurers and the business community. This is the first time that this bill has passed either house of the Legislature. The bill ultimately died in the Assembly Ways and Means Committee where concerns were raised about its impact on the State's public health insurance programs. ■

Nonconvulsive seizures in patients presenting with altered mental status: An evidence-based review.

Zehtabchi S, Abdel Baki SG, Malhotra S, Grant AC., Department of Emergency Medicine, State University of New York, Downstate Medical Center, Brooklyn, NY, USA.; Epilepsy Behav. 2011 Jul 22.

Definitive diagnosis of nonconvulsive seizures (NCS) can be made only by electroencephalography, and delay in diagnosis can increase morbidity, resource utilization, and length of hospitalization. We performed an evidence-based literature review to estimate the prevalence of NCS in patients with altered mental status (AMS) of unknown cause. PUBMED, EMBASE, the Cochrane Library, and other resources were searched for studies that included AMS and seizure as topics. The resulting 276 articles were screened for predetermined inclusion and exclusion criteria, leaving 5 studies enrolling 478 patients for review. The prevalence of NCS in patients with AMS ranged from 8 to 30% (overall prevalence of 21.5%, 95% CI: 18-25%), suggesting that the prevalence of NCS is sufficiently high to consider routine use of urgent electroencephalography in such patients. However, methodological weaknesses limit the generalizability of the results. A large, prospective study enrolling and screening for NCS in all patients who present with acute AMS is needed.

Hemoglobin A1c As a Screen for Previously Undiagnosed Prediabetes and Diabetes in an Acute-Care Setting.

Silverman RA, Thakker U, Ellman T, Wong I, Smith K, Ito K, Graff K., Department of Emergency Medicine, Long Island Jewish Medical Center, North Shore-Long Island Jewish Healthcare System, Long Island, New York; Diabetes Care 2011 Jul 20.

OBJECTIVE: Hemoglobin A(1c) (HbA(1c)) is recommended for identifying diabetes and prediabetes. Because HbA(1c) does not fluctuate with recent eating or acute illness, it can be measured in a variety of clinical settings. Although outpatient studies identified HbA(1c)-screening cutoff values for diabetes and prediabetes, HbA(1c)-screening thresholds have not been determined for acute-care settings. Using follow-up fasting blood glucose (FBG) and the 2-h oral glucose tolerance test (OGTT) as the criterion gold standard, we determined optimal HbA(1c)-screening cutoffs for undiagnosed dysglycemia in the emergency-department setting.

RESEARCH DESIGN & METHODS: This was a prospective observational study of adults aged ‚â•18 years with no known history of hyperglycemia presenting to an emergency department with acute illness. Outpatient FBS and 2-h OGTT were performed after recovery from the acute illness, resulting in diagnostic categorizations of prediabetes, diabetes, and dysglycemia (prediabetes or diabetes). Optimal cutoffs were determined and performance data identified for cut points.

RESULTS: A total of 618 patients were included, with a mean age of 49.7 (¬±14.9) years and mean HbA(1c) of 5.68% (¬±0.86). On the basis of an OGTT, the prevalence of previously undiagnosed prediabetes and diabetes was 31.9 and 10.5%, respectively. The optimal HbA(1c)-screening cutoff for prediabetes was 5.7% (area under the curve [AUC] = 0.659, sensitivity = 55%, and specificity = 71%), for dysglycemia 5.8% (AUC = 0.717, sensitivity = 57%, and specificity = 79%), and for diabetes 6.0% (AUC = 0.868, sensitivity = 77%, and specificity = 87%).

CONCLUSIONS: We identified HbA(1c) cut points to screen for prediabetes and diabetes in an emergency-department adult population. The values coincide with published outpatient study findings and suggest that an emergency-department visit provides an opportunity for HbA(1c)-based dysglycemia screening.

Derivation of the Uncontrolled Donation after Circulatory Determination of Death Protocol for New York City.

Wall SP, Kaufman BJ, Gilbert AJ, Yushkov Y, Goldstein M, Rivera JE, O'Hara D, Lerner H, Sabeta M, Torres M, Smith CL, Hedrington Z, Selck F, Munjal KG, Machado M, Montella S, Pressman M, Teperman LW, Dubler NN, Goldfrank LR; for the NYC, UDCDD Study Group; Am J Transplant. 2011 Jul;11(7):1417-1426.

Evidence from Europe suggests establishing out-of-hospital, uncontrolled donation after circulatory determination of death (UDCDD) protocols has potential to substantially increase organ availability. The study objective was to derive an out-of-hospital UDCDD protocol that would be acceptable to New York City (NYC) residents. Participatory action research and the SEED-SCALE process for social change guided protocol development in NYC from July 2007 to September 2010. A coalition of government officials, subject experts and communities necessary to achieve support was formed. Authorized NY State and NYC government officials and their legal representatives collaboratively investigated how the program could be implemented under current law and regulations. Community stakeholders (secular and religious organizations) were engaged in town hall style meetings. Ethnographic data (meeting minutes, field notes, quantitative surveys) were collected and posted in a collaborative internet environment. Data were analyzed

using an iterative coding scheme to discern themes, theoretical constructs and a summary narrative to guide protocol development. A clinically appropriate, ethically sound UDCDD protocol for out-of-hospital settings has been derived. This program is likely to be accepted by NYC residents since the protocol was derived through partnership with government officials, subject experts and community participants.

Financial impact of emergency department crowding.

Foley M, Kifaieh N, Mallon WK., Kings County Hospital Center, Brooklyn, NY; West J Emerg Med. 2011 May;12(2):192-7.

OBJECTIVE: The economic benefits of reducing emergency department (ED) crowding are potentially substantial as they may decrease hospital length of stay. Hospital administrators and public officials may therefore be motivated to implement crowding protocols. We sought to identify a potential cost of ED crowding by evaluating the contribution of excess ED length of stay (LOS) to overall hospital length of stay.

METHODS: We performed a retrospective review of administrative data of adult patients from two urban hospitals (one county and one university) in Brooklyn, New York from 2006-2007. Data was provided by each facility. Extrapolating from prior research (Krochmal and Riley, 2005), we determined the increase in total hospital LOS due to extended ED lengths of stay, and applied cost and charge analyses for the two separate facilities.

RESULTS: We determined that 6,205 (5.0%) admitted adult patients from the county facility and 3,017 (3.4%) patients from the university facility were held in the ED greater than one day over a one-year period. From prior research, it has been estimated that each of these patient's total hospital length of stay was increased on average by 11.7% (0.61 days at the county facility, and 0.71 days at the university facility). The increased charges over one year at the county facility due to the extended ED LOS was therefore approximately $9.8 million, while the increased costs at the university facility were approximately $3.9 million.

CONCLUSION: Based on extrapolations from Krochmal and Riley applied to two New York urban hospitals, the county hospital could potentially save $9.8 million in charges and the university hospital $3.9 million in costs per year if they eliminate ED boarding of adult admitted patients by improving movement to the inpatient setting.

A randomized trial of a multicomponent cessation strategy for emergency department smokers.

Bernstein SL, Bijur P, Cooperman N, Jearld S, Arnsten JH, Moadel A, Gallagher EJ., Montefiore Medical Center, Albert Einstein College of Medicine, Albert Einstein Cancer Center, Bronx, New York; Acad Emerg Med. 2011 Jun;18(6):575-83.

OBJECTIVES: The objective was to determine the efficacy of an emergency department (ED)-based smoking cessation intervention.

METHODS: This study was a randomized trial conducted from January 2006 to September 2007 at an urban ED that treats 90,000 adults per year. Discharged adults who smoked at least 10 cigarettes per day were randomized to 1) usual care, receiving a smoking cessation brochure; or 2) enhanced care, receiving the brochure, a motivational interview (MI), nicotine patches, and a phone call at 3 days. Interventions were performed by a peer educator trained in tobacco treatment. Blinded follow-up was performed at 3 months. Results: A total of 338 subjects were enrolled, mean (¬±SD) age was 40.2(¬±12.0) years, 51.8% were female, and 56.5% were either self-pay or Medicaid. Demographic and clinical variables were comparable between groups. Enhanced and usual care arms showed similar cessation rates at 3 months (14.7% vs. 13.2%, respectively). The proportion of subjects making a quit attempt (69.2% vs. 66.5%) and decrease in daily cigarette use (five vs. one; all p 0.05) were also similar. In logistic modeling, factors associated with quitting included any tobacco-related International Classification of Diseases, ninth revision (ICD-9), code for the ED visit (odds ratio [OR]= 3.42, 95% confidence interval [CI]=1.61 to 7.26) or subject belief that the ED visit was tobacco-related (OR= 2.47, 95% CI,=1.17 to 5.21). Conversely, subjects who reported having a preexisting tobacco-related illness were less likely to quit (OR,= 0.22, 95% CI,= 0.10 to 0.50).

CONCLUSIONS: The primary endpoint was negative, reflecting a higher-than-expected quit rate in the control group. Subjects whose ED visit was tobacco-related, based either on physician diagnosis or subject perception, were more than twice as likely to quit. These data suggest that even low-intensity screening and referral may prompt substantial numbers of ED smokers to quit or attempt to quit.

Discriminative accuracy of novel and traditional biomarkers in children with suspected appendicitis adjusted for duration of abdominal pain.

Kharbanda AB, Cosme Y, Liu K, Spitalnik SL, Dayan PS.; Acad Emerg Med. 2011 Jun;18(6):567-74.

ABSTRACT OBJECTIVES: The objective was to assess the accuracy of novel and traditional biomarkers in patients with suspected appendicitis as a function of duration of symptoms.

METHODS: This was a prospective cohort study, conducted in a tertiary care emergency department (ED). The authors enrolled children 3 to 18, years old with acute abdominal pain of less than 96 hours and measured serum levels of interleukin-6 (IL-6), interleukin-8 (IL-8), C-reactive protein (CRP), white blood cell (WBC) count, and absolute neutrophil count (ANC). Final diagnosis was determined by histopathology or telephone follow-up. Trends in biomarker levels were examined based on duration of abdominal pain. The accuracy of biomarkers was assessed with receiver operating characteristic (ROC) curves. Optimal cut-points and test performance characteristics were calculated for each biomarker.

RESULTS: Of 280 patients enrolled, the median age was 11.3 years (interquartile range [IQR] = 8.6 to 14.8), 57% were male, and 33% had appendicitis. Median IL-6, median CRP, mean WBC count, and mean ANC differed significantly ($p<0.001$) between patients with non-perforated appendicitis and those without appendicitis; median IL-8 levels did not differ between groups. In non-perforated appendicitis, median IL-6, WBC, and ANC levels were maximal at less than 24 hours of pain, while CRP peaked between 24 and 48 hours. In perforated appendicitis, median IL-8 levels were highest by 24 hours, WBC count and IL-6 by 24 to 48 hours, and CRP after 48 hours of pain. The WBC count appeared to be the most useful marker to predict appendicitis in those with fewer than 24 or more than 48 hours of pain, while CRP was the most useful in those with 24 to 48 hours of pain.

CONCLUSIONS: In this population, the serum levels and accuracy of novel and traditional biomarkers varies in relation to duration of abdominal pain. IL-6 shows promise as a novel biomarker to identify children with appendicitis.

Yield of head CT in the alcohol-intoxicated patient in the emergency department.

Godbout BJ, Lee J, Newman DH, Bodle EE, Shah K., Department of Emergency Medicine, St. Luke's Roosevelt Hospital Center; Emerg Radiol. 2011 Jun 8.

We aimed to determine the yield of positive head computed tomography (CT) findings among suspected alcohol-intoxicated patients presenting to the emergency department (ED). Our secondary aim was to determine if elderly intoxicated patients were more likely to have an intracranial injury. We identified patients suspected of alcohol intoxication who underwent CT scanning in the ED over a 4-year period. Pre-determined data elements including demographics, diagnosis, and disposition were extracted using a pre-formatted data sheet by blinded abstractors. "Positive" CT was defined as evidence of any type of intracranial hemorrhage. A total of 2,671 subjects with suspected alcohol intoxication and a head CT were identified. Fifty out of the 2,671 (1.9%) had a positive CT. Among CT scans of elderly (>60 years of age) subjects, 15/555 (2.7%, 95% CI =1.4-4.1%) were positive compared with 35/2,116 (1.7%, 95% CI=1.1-2.2%) among those <60 years of age (p=0.11). The yield of positive head CT among alcohol-intoxicated patients was low, at 1.9%. An age cutoff of 60 years in this population did not predict a significantly higher positive rate.

Factors associated with delays to emergency care for bowel obstruction.

Hwang U, Aufses AH Jr, Bickell NA., Department of Emergency Medicine, Mount Sinai School of Medicine; Am J Surg. 2011 Jul;202(1):1-7.

BACKGROUND: Our objective was to determine factors associated with delays to first treatment for emergency department (ED) patients diagnosed with small-bowel obstruction (SBO).

METHODS: This was a retrospective study of ED patients with SBO. Data were collected from medical records, administrative databases, and staffing schedules at an urban, tertiary care medical center from June 1, 2001, to November 30, 2002. Patient-related characteristics and processes of ED and hospital care were evaluated. Outcomes studied were time to first treatment (nasogastric tube or surgery) and risk of surgical resection.

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Patient Safety Rounds

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Providing examples of prior issues that were raised and resolved can improve participation (i.e. equipment concerns, patient identification, patient acuity and staffing match, medication errors, drug side effects, etc). Staff should be encouraged to be open and to recall events since the last rounds occurred. Rounds facilitators can demonstrate a sense of openness by sharing some of their own near misses or actual errors while caring for patients. The information gathered from the PSRs at our facility is recorded by the patient safety officer for the department. Following rounds, the staff is provided with communication as to the results of the interventions made based on information from the PSRs. Closing the loop with safety suggestions creates a learning environment where members of the staff are comfortable bringing concerns forward and develop confidence that the system is listening.

As our department enhanced the dedication to patient safety and quality, PSRs were initiated. Initially, as the physician safety quality officer, I had reservations but was encouraged by our departmental patient safety director, a nurse by training, on the importance of these rounds and their success in the pediatric inpatient units. After the first exercise, the importance of the rounds became obvious. Members of the staff were much more inclined to discuss issues and eagerly recalled "near misses" that had occurred in the weeks prior but had no patient harm. Staff also was able to interact with senior leadership including hospital, nursing, and physicians coming to the front lines to talk to staff while they were working and taking suggestions seriously. Many safety and quality issues have been identified for which change has occurred. Examples include:

1. Paper print out of lab results were hand retrieved off a printer hopefully to make their way to the right patient's chart. Errors arose when results were placed on the wrong clip board. *Resolution:* stop the print process, force providers to look up results on the computer to prevent wrong patient events.
2. A drop down list of prescriptions included Motrin oral solution which was situated right below Morphine Oral solution. A wrong drug was selected for a child, the mother called the emergency department questioning the prescription on return home, and an error was prevented. *Resolution:* Remove oral morphine solution from the drop down list; it is rarely prescribed and if needed can be on a separate prescription.
3. A delay in obtaining drugs for STEMI patients from an automated drug dispenser because drugs were being selected one by one. *Resolution:* STEMI kit created in PYXIS, so drawers for nitroglycerin, heparin, Plavix, and aspirin open up sequentially for the patient.

It should be noted that none of these events were reported into the hospital's event reporting system, but rather, were discovered on patient safety rounds.

If your emergency department has not yet begun a form of Patient Safety Rounds, it is recommended that a group be pulled together to initiate rounds in your setting. Rounds are relatively simple to conduct. The resources listed at the end of this article provide information on the composition as well as the potential scripted questions. The Institute for Healthcare Improvement website (IHI.org) is an essential resource. After the first exercise, you will find your efforts rewarded by the feedback obtained. Frankel et al [5] reported significant improvement in Safety Attitude Questionnaires and Safety climate scores showing good effect from these rounds. At our institution, there has been a similar positive effect measured by increased reporting of events. As an initial "doubting Thomas" emergency physician, I can now say I believe in the effectiveness and the important role these rounds can play in increasing the quality and safety of care for our patients.

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RESULTS: A total of 193 patients were diagnosed with confirmed intestinal obstruction. Patients with longer times to first treatment arrived during ED clinician hand-offs (adjusted hazard ratio, .40; 95% confidence interval, 0.17-.98). Patients with longer times to surgery consult (ref. first quartile) had greater odds of surgical resection (second quartile adjusted odds ratio, 6.91; 95% confidence interval, 1.85-24.80).

CONCLUSIONS: Remediable ED and hospital factors were associated with longer times to treatment for patients with bowel obstruction.

A content analysis of parents' written communication of needs and expectations for emergency care of their children.

Hoppa EC, Porter SC., Division of Emergency Medicine, Cohen Children's Medical Center of New York/Long Island Jewish Medical Center; Pediatr Emerg Care 2011 Jun;27(6):507-13.

OBJECTIVE: We investigated the potential value of information shared by parents on a written form designed to capture needs and expectations for care to an emergency department (ED) system that values patient-centeredness.

METHODS: We conducted a retrospective content analysis of parent-completed written forms collected during an improvement project focused on parent-provider communication in a pediatric ED. The primary outcome was potential value of the completed forms to a patient-centered ED system, defined as a form that was legible, included observations that mapped to medical problems, and included reasonable parental requests. We analyzed variation in potential value and other form attributes across a priori-defined visit type and acuity. Visit type was validated by a separate, blinded medical record review.

RESULTS: A random stratified sample of 1008 forms was established from 6937 parent-completed forms collected during the 6-month improvement project; 995 of 1008 forms had matching medical records; 922 (92.7%) of 995 forms demonstrated potential value; 990 (99.5%) of 995 forms were legible; 948 (95.3%) of 995 forms included observations that mapped to a medical problem, and 599 (93.3%) of 642 forms contained reasonable parental requests. There was good agreement between the form and medical record for visit type (Œ∫ = 0.62). The potential value of forms did not vary significantly across visit type (88.2%-92.8%) or acuity (88.9%-93.4%).

CONCLUSIONS: Information shared by parents on written forms designed to capture needs and expectations provides potential value to a patient-centered ED

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system. The high level of informational value is consistent across patient type and acuity level.

Comparison of the Diagnostic Characteristics of Two B-Type Natriuretic Peptide Point-of-Care Devices.

Ro R, Thode HC Jr, Taylor M, Gulla J, Tetrault E, Singer AJ., Department of Emergency Medicine, Stony Brook University Medical Center, Stony Brook; J Emerg Med. 2011 May 25.

BACKGROUND: B-type natriuretic peptide (BNP) is used to diagnose heart failure (HF).

OBJECTIVE: To compare the accuracy of two commercially available point-of-care (POC) devices for measuring B-type natriuretic peptide (BNP) in emergency department (ED) patients with suspected heart failure using the central laboratory testing results as the criterion standard.

METHODS: Venous blood samples were collected from adults with suspected heart failure and split into three samples for BNP analysis: central laboratory (Siemens ADIVA Centaur; Siemens, Deerfield, IL), Triage BNP POC device (Biosite, San Diego, CA), and i-STAT BNP POC device (Abbott, East Windsor, NJ). The criterion standard for BNP levels was the central laboratory.

RESULTS: Two hundred fifty patients were enrolled. Mean (SD) age was 70.7 (13.8) years; 200 (80%) were over age 55 years; 146 (58.4%) were male. A final hospital discharge diagnosis of heart failure was made in 108 (42%) patients. The i-STAT system yielded a result within a median of 9 min (interquartile range [IQR] 9-10 min). The Triage device yielded a result within a median of 19 min (IQR 15-22 min); $p < 0.001$. The device failure rate for the central laboratory (8 failures, 3.2%) was significantly higher than that of the i-STAT device (1 failure, 0.4%, $p = 0.04$), but not statistically different than the Triage device (3 failures, 1.2%). Neither the Triage nor the i-STAT were statistically different than the central laboratory result in terms of sensitivity; the i-STAT was less specific than the Triage result ($p = 0.003$). The area under the curve for the Triage device was 0.95 (95% confidence interval [CI] 0.91-0.98), whereas the area under the curve for the i-STAT device was 0.98 (95% CI 0.96-0.99; $p < 0.01$).

CONCLUSIONS: Both POC devices tested were accurate and rarely failed; however, the i-STAT was faster with single use.

Prognostic utility of serum potassium in chronic digoxin toxicity: a case-control study.

Manini AF, Nelson LS, Hoffman RS., Division of Medical Toxicology, Department of Emergency Medicine, Mt Sinai School of Medicine, New York; Am J Cardiovasc Drugs. 2011 Jun 1;11(3):173-8.

OBJECTIVE: In contrast to patients with acute digoxin overdose, the prognostic utility of the serum potassium concentration for patients with chronic digoxin toxicity is unclear. In such patients, we aimed to evaluate the relationship between pre-treatment serum potassium and survival.

METHODS: This was a case-control study at an urban Poison Control Center affiliated with a large urban medical center. We compared the serum potassium concentration between patients with chronic digoxin toxicity resulting in fatality (cases) over a 7-year period (2000-2006) versus survivors (controls) over a 1-year period (2007-2008).

RESULTS: During the study period, there were 13 fatalities (cases) and 13 survivors (controls), of whom seven cases and five controls received appropriately dosed digoxin-specific antibody Fab fragments (Fab). There were no statistically significant differences between cases and controls with respect to serum digoxin concentration, creatinine, age, or sex. Serum potassium elevation pre-Fab was significantly associated with fatality both in mean difference (p 0.03) and using a dichotomous cutoff of 5.0 mEq/L ($p<0.001$), which performed with 92% sensitivity (95% CI 67, 99). In 86% of deaths despite appropriate Fab administration, the clinical presentation included the combination of bradycardia plus hyperkalemia.

CONCLUSION: In these patients with chronic digoxin toxicity, elevated serum potassium was associated with fatality. The combination of bradycardia and hyperkalemia strongly predicted fatality even in cases with appropriate Fab administration.

Prophylactic antibiotics for simple hand lacerations: Time for a clinical trial?

Zehtabchi S, Yadav K, Brothers E, Khan F, Singh S, Wilcoxson RD, Malhotra S., Department of Emergency Medicine, State University of New York, Downstate Medical Center, NY; Injury. 2011 May 20.

BACKGROUND: Simple hand lacerations (not involving bones, tendons, nerves, or vessels) are a common emergency department (ED) complaint. Whilst the practices of irrigation, debridement, foreign body removal, and suture repair are well accepted, the use of prophylactic antibiotics is not. Without evidenced-based guidelines, practice is left to physician preference.

OBJECTIVES: The aim of this study was to assess the need for, and the feasibility to perform, a randomized controlled trial to evaluate the role of prophylactic antibiotics in simple hand lacerations.

METHODS: The study was done in three phases: (1) estimation of the national ED burden of simple hand lacerations and the use of antibiotic prophylaxis; (2) assessment of indications for antibiotic prophylaxis and (3) investigation of patient willingness to enrol in a randomised controlled trial and their preferred outcomes from simple hand lacerations. For Phase 1, we analysed the 2007 National Hospital Ambulatory Medical Care Survey. For Phase 2, we surveyed ED physicians in three urban teaching institutions (two in Brooklyn, NY and one in Washington, DC). For Phase 3, we surveyed ED patients at the same three institutions.

RESULTS: Phase 1: out of 116.8 million ED visits nationally in 2007, 1.8 million (1.6%) were due to simple hand lacerations, of which 1.3 million (71%) required repair. Of those repaired, 27% (95% CI,

19-35%) were prescribed prophylactic antibiotics, most commonly cephalexin (73%). Phase 2: out of 108 providers surveyed, 69 (64%) responded. 16% (95% CI, 9-27%) reported prescribing prophylactic antibiotics routinely, most commonly cephalexin (84%, 95% CI, 67-93%). The degree of contamination was the most important factor (91%, 95% CI, 82-96%) in the physicians' decision to prescribe antibiotics. Phase 3: of the 490 patients surveyed, 64% (95% CI, 60-68%) expressed interest in participating in a study to evaluate the use of prophylactic antibiotics. Their primary concern was prevention of infection (77%, 95% CI, 73-81%).

CONCLUSION: Simple hand lacerations represent a substantial number of ED visits in the United States. Absence of clear guidelines, disparity in physician practice, and patient interest in infection prevention all support performing a prospective randomized controlled trial to establish the role of antibiotic prophylaxis in simple hand lacerations.

Measures of crowding in the emergency department: a systematic review.

Hwang U, McCarthy ML, Aronsky D, Asplin B, Crane PW, Craven CK, Epstein SK, Fee; C, Handel DA, Pines JM, Rathlev NK, Schafermeyer RW, Zwemer FL Jr, Bernstein SL., Department of Emergency Medicine, Mount Sinai School of Medicine (UH), New York; Acad Emerg Med. 2011 May;18(5):527-38.

OBJECTIVES: Despite consensus regarding the conceptual foundation of crowding, and increasing research on factors and outcomes associated with crowding, there is no criterion standard measure of crowding. The objective was to conduct a systematic review of crowding measures and compare them in conceptual foundation and validity.

METHODS: This was a systematic, comprehensive review of four medical and health care citation databases to identify studies related to crowding in the emergency department (ED). Publications that "describe the theory, development, implementation, evaluation, or any other aspect of a 'crowding measurement/definition' instrument (qualitative or quantitative)" were included. A "measurement/definition" instrument is anything that assigns a value to the phenomenon of crowding in the ED. Data collected from papers meeting inclusion criteria were: study design, objective, crowding measure, and evidence of validity. All measures were categorized into five measure types (clinician opinion, input factors, throughput factors, output factors, and multidimensional scales). All measures were then indexed to six validation criteria (clinician opinion, ambulance diversion, left without being seen (LWBS), times to care, forecasting or predictions of future crowding, and other).

RESULTS: There were 2,660 papers identified by databases; 46 of these papers met inclusion criteria, were original research studies, and were abstracted by reviewers. A total of 71 unique crowding measures were identified. The least commonly used type of crowding measure was clinician opinion, and the most commonly used were numerical counts (number or percentage) of patients and process times associated with patient care. Many measures had moderate to good correlation with validation criteria.

CONCLUSIONS: Time intervals and patient counts are emerging as the most promising tools for measuring flow and nonflow (i.e., crowding), respectively. Standardized definitions of time intervals (flow) and numerical counts (nonflow) will assist with validation of these metrics across multiple sites and clarify which options emerge as the metrics of choice in this "crowded" field of measures.

Elastic bands on the wrist: a not so "silly" complication.

McIver MA, Gochman RF., Department of Emergency Medicine and Pediatrics, Long Island Jewish Medical Center/Cohen Children's Medical Center of New York, Long Island; Pediatr Emerg Care. 2011 May;27(5):428-9.

The recent popularity of elastic bands on the wrist may put children at risk for acute compartment syndrome. Acute compartment syndrome is a limb-threatening condition characterized by elevated interstitial pressure in a confined fascial compartment. If left untreated, it may result in tissue necrosis, irreversible nerve and muscle injury, and permanent functional impairment. We report a case of a 2 year-old girl with history of a rubber band around her wrist, who presented to the emergency department with a swollen, blue hand suggestive of an impending compartment syndrome. Although this patient ultimately was not diagnosed with acute compartment syndrome, we discuss the importance of prevention, early diagnosis, and prompt treatment of compartment syndrome to prevent permanent disability.

Racial differences in out-of-hospital cardiac arrest survival and treatment.

Wilde ET, Robbins LS, Pressley JC., Columbia University, Mailman School of Public Health, Department of Health Policy and Management ; Emerg Med J. 2011 May 5.

OBJECTIVES: To determine whether there are prehospital differences between blacks and whites experiencing out-of-hospital cardiac arrest and to ascertain which factors are responsible for any such differences.

METHODS: Cohort study of 3869 adult patients (353 blacks and 3516 whites) in the Illinois Prehospital Database with out-of-hospital cardiac arrest as a primary or secondary indication for emergency medical service (EMS) dispatch between 1 January 1996 and 31 December 2004.

RESULTS: Return of spontaneous circulation was lower for black patients (19.8%) than for white patients (26.3%) (unadjusted OR 0.69, 95% CI 0.53 to 0.91). After adjusting for age, sex, prior medical history, prehospital event factors, patient zip code characteristics and EMS agency characteristics, the no difference line was suggestive of a trend, with a CI just transposing 1.0 (adjusted OR 0.71, 95% CI 0.50 to 1.01, p=0.053).

CONCLUSIONS: Blacks were less likely to experience a return of spontaneous circulation than whites, less likely to receive defibrillation or cardiopulmonary resuscitation from EMS and more likely to receive medications from EMS. Differences in underlying health, care prior to the arrival of EMS, and delays in the notification of EMS personnel may contribute to racial disparities in prehospital survival after out-of-hospital cardiac arrest.

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Electrocardiogram and X-ray findings associated with iatrogenic pulmonary venous gas embolism.

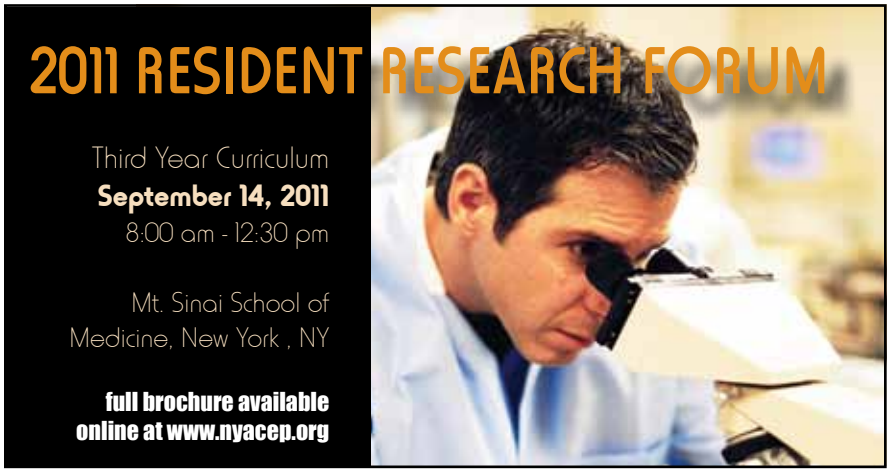
Cooney DR, Kassem J, McCabe J., Department of Emergency Medicine, SUNY Upstate Medical University, Syracuse; Undersea Hyperb Med. 2011 Mar Apr;38(2):101-7.

Iatrogenic venous gas embolism (VGE) has been described in cases of patients with hemodialysis catheters and other thoracic central lines. When VGE is present, it may lead to large gas bubbles in the right heart or pulmonary circulation. We reviewed a case of a 52-year-old male hemodialysis patient who inadvertently received an unknown amount of air through a faulty connection in his line during hemodialysis treatment. The patient was symptomatic with chest pain and was found to have an ECG indicative of acute right heart strain and an unusual bulging of his right mediastinum on X-ray. An emergency consult was called for hyperbaric oxygen therapy (HBO2T) due to the known indications for therapy. The patient had a full recovery after HBO2T and had complete relief of his chest pain after compression. Repeat decubitus chest X-ray and ECG post-HBO2T showed resolution of the mediastinal bulge, and ECG had reverted to the patient's baseline tracing. Iatrogenic pulmonary VGE may be diagnosed with the aid of ECG and X-ray findings when correlated with historical and other clinical elements. HBO2 treatment success may be correlated with reversal of ECG and X-ray findings in patients with clinical improvement.

Using health information exchange to improve public health.

Shapiro JS, Mostashari F, Hripcsak G, Soulakis N, Kuperman G., Department of Emergency Medicine, Mount Sinai Medical Center; Am J Public Health. 2011 Apr;101(4):616-23.

Public health relies on data reported by health care partners, and information technology makes such reporting easier than ever. However, data are often structured according to a variety of different terminologies and formats, making data interfaces complex and costly. As one strategy to address these challenges, health information organizations (HIOs) have been established to allow secure, integrated sharing of clinical information among numerous stakeholders, including clinical partners and public health, through health information exchange (HIE). We give detailed descriptions of 11 typical cases in which HIOs can be used for public health purposes. We believe that HIOs, and HIE in general, can improve the efficiency and quality of public health reporting, facilitate public health investigation, improve emergency response, and enable public health to communicate information to the clinical community. ■



Assembly well attended

The 2011 Scientific Assembly, held at The Sagamore Resort on Lake George, was attended by over 200 emergency physicians from around the state. Forty companies participated through exhibits and support.

Tuesday's program began with the Research Forum featuring oral and poster presentations. Congratulations to the following research presenters that took the annual award in their category:

Oral Presentation

- Anita Datta, MD RDMS, New York Hospital Queens: *Bedside carotid ultrasonography to risk stratify patients with chest pain in the emergency department.*

Poster Presentations

- Sandra Schneider, MD FACEP, University of Rochester: *How we spend our time at work? A community emergency department (ED) experience.*
- Derek R Cooney, MD FACEP, SUNY Upstate Medical University: *Can NEDOCS score be used to predict ambulance offload delay*?
- Muhammad Waseem, MD, Lincoln Medical & Mental Health Center: *Does the Broselow measurement predict the actual patient's weight?*
- Daniel Egan, MD FACEP, St. Luke's Roosevelt Hospital Center: *Emergency Department Technicians: A Novel, Feasible, and Effective Approach to Routine HIV Testing in the Emergency Department.*

Newly elected (and incumbent) board members for 2011-2012 program year are:

- Brahim Ardolic, MD FACEP
- Jeremy T. Cushman, MD FACEP
- Penelope C. Lema, MD RDMS FACEP
- David H. Newman, MD FACEP.

Join us next year Scientific Assembly July 9-11, 2012 ■

New York ACEP Awards Leadership and Advocacy Scholarship Award Recipients

Enesha Cobb, MD, SUNY Health Sciences Center at Brooklyn

Arriving at our first Capitol Hill visit, the energy between the five ACEP members in my group was palpable. My own heart was racing. We had spent the last two days reviewing ACEP's public policy agenda, receiving media training, and practicing presentations…it all was culminating in these meetings with congressional staff and aides.

Over the initial two days of ACEP's 2011 Leadership and Advocacy Conference, we participated in presentations on health policy and political advocacy. The program catered to the wide range of conference attendees, from residents and first-time attendees, to seasoned ACEP leaders. The conference included sessions on macro and micro health care economics, and offered a wide overview of the state of U.S. healthcare.

The media training workshops were practical and effective. We incorporated critical personal stories into conversations about the issues facing emergency physicians (EPs). We delved into the "Just 2%" campaign, which educates the public, government officials, and our colleagues about the costs of emergency care in the U.S. It was even news to many of us that emergency care totals just 2% of all healthcare spending in the U.S.! This directly refutes the myth that emergency department care is the main driver of rising health care costs in the U.S.

Other hot issues include comprehensive medical liability reform, the controversies about the Independent Payment Advisory Board, and defining our role in the Affordable Care Act. After a few practice runs, we were not only prepared to talk to the media, but also to give compelling presentations to the representatives of the House and Senate.

One of the most memorable sessions was a presentation given by Michael Dunn, a veteran political analyst well-versed in the Washington DC political arena. His focus, unlike many of the physicians, concentrated on the political milieu we encounter as we advocate for our specialty. Mr. Dunn laid down the facts in no uncertain terms. There are hundreds of groups lobbying the House and the Senate daily. What will set us apart from the rest? What will get our issues heard and addressed? We must develop relationships with our elected officers to be heard. Whether inviting them to a hosted emergency department tour or to a fundraising event, we must develop relationships with our elected officials to familiarize them with our concerns.

The key to effectiveness is the first hand knowledge each of us holds. We can share personal stories and anecdotes that color our shifts. We live emergency medicine every day and therefore are the best prepared to share our experiences with those who do not.

After meeting with the representatives and aides, it was clear that we as emergency physicians have our work cut out for us. We must educate our peers, friends, families, colleagues, and government representatives if we want our voices heard. I encourage all of you to become involved. Host a representative on a tour of your emergency department, join ACEP's Speakers Bureau, donate a shift, or simply join the New York ACEP 911 Network to respond to immediate action items. Unless we advocate for our patients and specialty, we place both of them at risk. ■

Brian T. Kloss, DO, SUNY Upstate Medical Center, pictured with Sandra Schneider, MD FACEP, national ACEP President

Thank you for having selected me as a 2011 ACEP Leadership and Advocacy Conference Scholarship Award recipient. Due to New York ACEP's generosity, I was able to attend a four day conference in Washington, DC where I learned about political advocacy and had the opportunity to network with other ACEP physician leaders.

I feel it is now more important than ever for emergency medicine physicians to band together and advocate for themselves and their patients. We must take direct action as individuals, work in groups and meet with our Congressional Leaders, or at a very minimum, contribute to the National Emergency Political Action Committee (NEMPAC). As physicians, we are always focused on the care of our patients and our families. Overall, I do not see enough physician attention focused on the care of our profession, especially in this dramatically changing political climate. For example, many of my resident colleagues are unaware or, and seemingly unconcerned with, the foreseeable cuts coming to Medicare and Medicaid reimbursement rates. It is obvious that once these cuts are implemented, third party payers will follow suit and medical malpractice premiums will rise as trial lawyers advocate for longer statues of limitations and other policies beneficial to themselves. In the background unemployment rates continue to rise, inflation is starting to set in while our government encroaches our national debt limit. More uninsured and underinsured

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Full-Time Emergency Medicine Physician Opportunities

Lutheran Medical Center, Brooklyn, NY

NES HealthCare Group

Lutheran Medical Center is a Level I Trauma Center, Stroke Center, STEMI Center and Hypothermic Center. Luthern Medical Center has cared for the citizens of Brooklyn since 1883.

Physicians Must be BC or BP in Emergency Medicine and Emergency Medicine Residency Trained

Emergency Department Summary:

- Annual Volume of 65,000 Visits
- 15 Full-Time Emergency Medicine Trained Physicians
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- 75 Hours of Physician Coverage Per Day
- Dr. Bonnie Simmons, Chair of Emergency Medicine, is an expert in ED operations, patient flow, customer satisfaction and disaster preparedness.

NES HealthCare Group offers a very competitive compensation package with a monthly incentive bonus.

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Please contact or send your CV to:

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NES HealthCare Group
(800) 394-6376 phone
(631) 265-8875 fax
mevans@neshold.com

Bonnie Simmons, DO FACEP
(718) 630-8383 phone
(718) 630-8653 fax
bsimmons@lmcmc.com

NES HealthCare Group

Networking Event Summary: Job Satisfaction: Mission impossible

Nicole Berwald, MD, Assistant Director, Department of Emergency Medicine, Staten Island University Hospital

On June 8, 2011 New York ACEP held a physician networking event at NewYork Presbyterian Hospital. We were fortunate to have Robert W. Strauss, Jr., MD FACEP, Associate Director of The Christ Hospital, Cincinnati, OH, Adjunct Professor at the University of Cincinnati, Department of Emergency Medicine and the Senior Vice President for Team Health as the speaker. He spoke on a topic central to emergency department physicians' job satisfaction in his lecture titled "**Mission imPossible**".

During this interactive session Dr. Strauss focused on several important aspects of an emergency department physician's career. He started the evening with a how-to discussion on choosing the right job. Factors including location and contracts were central to this discussion. He spoke candidly on the differences between academic and non-academic departments, including the issue of protected time for academic pursuits, opportunities for research and resident education. Details of the physician contract and payment methods were also discussed. Dr. Strauss offered wise words regarding methods of compensation and recommended a brief but dependable practice. He advised four points: That the method be

- **A** Agreeable to all parties
- **S** Simple, and easy to understand
- **M** Measurable, and
- **A** Achievable

Without meeting these key points there is potential for breakdown between the parties (i.e., the physician and their employer). As an adjunct to the topic of compensation, Dr. Strauss reviewed aspects of general medical malpractice insurance plans, comparing claims made and occurrence type insurances. After a round table discussion on these topics it was clear that this offered much food for thought for the junior faculty, as well as points for reflection for the more seasoned clinicians in the group.

Dr. Strauss made it clear that there was no correct answer to the question of the "best" clinical setting. However, he opened our eyes to the pros and cons of practicing emergency medicine in academic and private settings.

Approximately half way through the lecture, prompted by comments and questions from the audience, Dr. Strauss switched gears and offered several techniques on improving day-to-day job satisfaction. Dr. Strauss initiated this portion of the session by prompting the group to consider the following: How do you feel when you walk into the emergency department at the beginning of your shift? The participants, with the help of Dr. Strauss, identified several common threads that contribute to our daily expectations, including: patient volume, crowding, staffing and co-worker characteristics. We were in agreement that these variables significantly impact the emergency department physician's state of mind and personal job satisfaction on a daily basis.

Discussing these factors in more detail, it was clear that some are easier to impact than others. Dr. Strauss then helped us to focus on areas where we can impact our own job satisfaction through an evaluation of the dynamic between ourselves and our co-workers. During this discussion, Dr. Strauss asked the group to characterize a "high functioning team member" or an "A-team" member. Several key personality traits were identified: interested, aware, caring, willing to help, efficient, present, and committed. After acknowledging these ideal traits of the A team, we considered how to address their counterpart, "the B team". Dr. Strauss pointed out a fundamental barrier in converting a B team player to the A team; many B team players do not have insight to their limitations or their impact on their co-workers.

Dr. Strauss then highlighted three basic groups of workers: "Transformers", "Transmitters" and "Terrorists".

Transformers - the ideal A team member, brings others up to meet their standards

Transmitters - go with the flow, follow the mood of the room (may be swayed by Transformer or a Terrorist)

Terrorists – quintessential B team member, brings the group down

It is essential to identify your team members as these individuals can make or break the day in the life of an emergency department physician. Next, Dr. Strauss introduced us to the concept of "The rules of engagement", or simply put, the agreed upon way we will interact with each other. He gave a practical example with regard to the "rules" and asked; "When your relief is late what does this mean?" All agreed that this was a classic B team example of, "my time is more important than your time."

Together we identified other B team behaviors such as "cherry picking charts" and slowing down prematurely towards the end of a shift. In addition we identified aspects of working in the ED that can influence our daily satisfaction, such as unnecessary noise and interruptions.

Now came the critical question: How can we promote change? One method offered by Dr. Strauss was to utilize the feedback process and group discussions. This affords buy-in from the staff, which has greater potential for success than simply setting up rules. This holds true amongst the physician staff as well as initiating change across disciplines. As per Dr. Strauss we must remember to be team members and not "busy docs." It is Dr. Strauss' experience that partnering with members of the care team can lead to joint expectations, better patient care and

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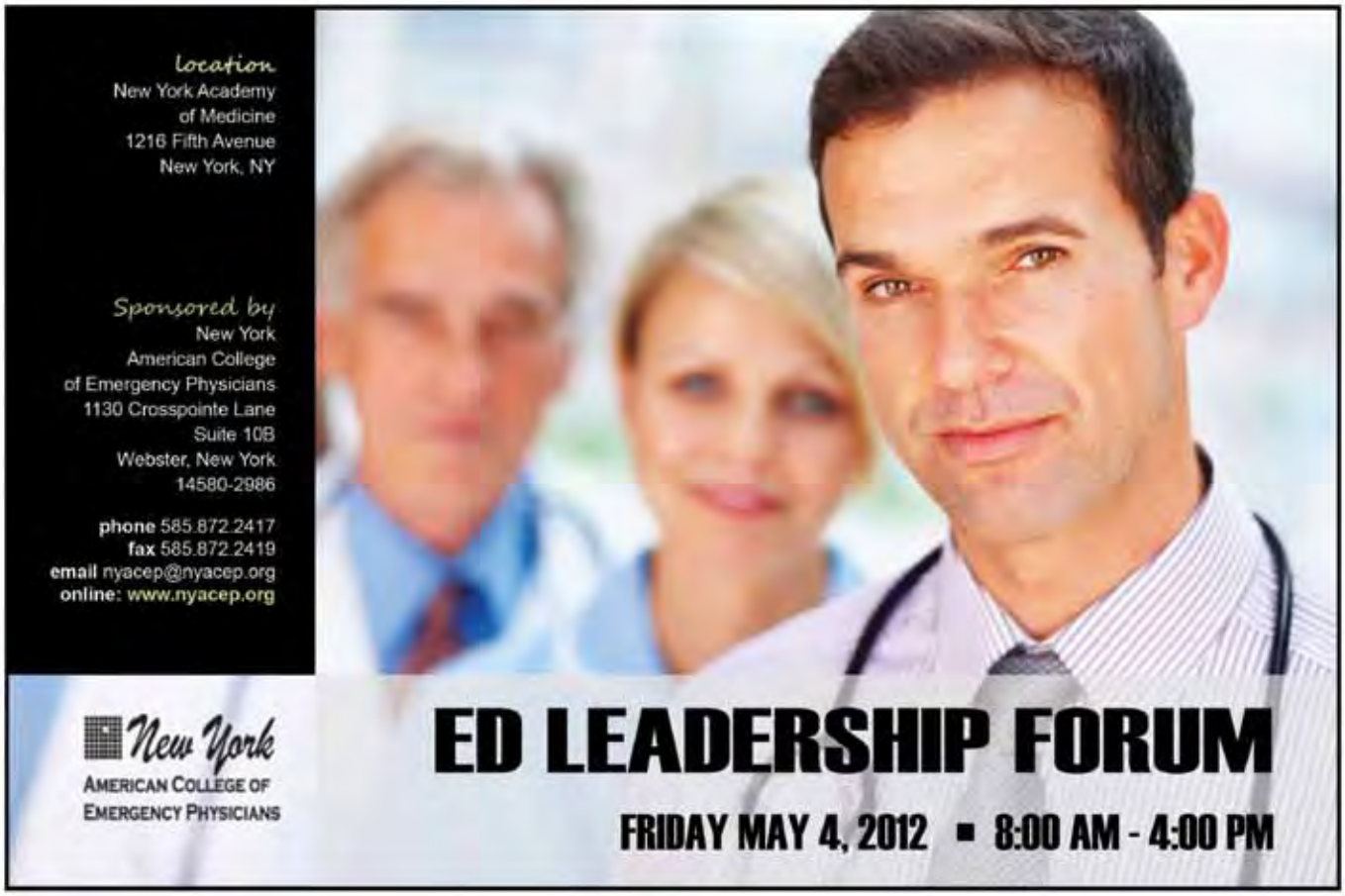

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improved job satisfaction. He has found success in giving positive reinforcement through feedback and offering his gratitude for specific acts.

During the final moments of the evening Dr. Strauss addressed patient satisfaction, and of course patient satisfaction scores. The take home message was to keep your patient informed. Dr. Strauss offered techniques to help achieve this with subtle changes to a usual routine. By using the words "I" and "you" Dr. Strauss has found he can better convey to the patient that his actions are to address their care. For example, when closing the curtain Dr. Strauss suggests stating "I am closing the curtain for "Your" privacy. This allows the patient to identify their care with your actions. In addition Dr. Strauss expressed the importance of keeping the patient informed, noting that some scripting can be helpful. He has found that although scripts can be awkward at first, they become more natural with time. In addition, Dr. Strauss commented on the power of "Yes" whereby you affirm the patients concerns, without implied agreement of the concern. Putting this together he used the example of addressing patients with prolonged wait times. First, he recommends acknowledging and validating the patient's frustration with a simple "Yes", and then proceeding with his script. For example, "Yes, it can be frustrating to wait when your child is in pain."

Throughout the evening, Dr. Strauss shared many valuable pearls from his clinical and administrative experiences. He helped us to realize the necessity in setting high expectations, while offering several tools to meet them. ■

Physician Networking Events are held quarterly. For more information on the next event go online to www.nyacep.org and click CME & Conferences.

Scholarship recipients

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Americans are turning to the emergency departments for emergency medical treatment and primary care. The system is strained and we need to advocate for ourselves and the patients we serve.

The entire conference was an excellent experience and I encourage other residents to consider attending. The speakers and the training are top notch and the opportunity to network with other ACEP political advocates was very beneficial. On the eve of the last day we were able to meet with our Congressional Representatives and let our opinions be heard.

Thank you again for the opportunity to attend this year's Leadership and Advocacy Conference and I encourage every emergency medicine physician reading this to get involved. More information can be found on the New York ACEP website at www.nyacep.org, click on events. ■

For more information on scholarships, visit us online at www.nyacep.org and click Awards.

new york acep CALENDAR

september

8 Practice Management Committee Conference Call, 1:00 pm
14 Resident Research Forum, 8:00 am-12:30 pm, Mt. Sinai Medical Center
14 Education Committee Conference Call, 2:00 pm
14 Professional Development Conference Call, 3:00 pm
15 EMS Committee Conference Call, 2:30 pm
19 2011 LLSA Review Course, 8:00 am-1:00 pm, Mt. Sinai Medical Center
21 Government Affairs Conference Call, 11:00 am
21 Research Committee Conference Call, 3:00 pm

october

3 Board of Directors Meeting, 12:30-5:00 pm, Albany Medical Center, Albany, NY
12 Education Committee Conference Call, 2:00 pm
12 Professional Development Conference Call, 3:00 pm
13 Practice Management Committee Conference Call, 1:00 pm
13-14 ACEP Council Meeting, Hilton San Francisco Union Square
14 EMS Committee Conference Call, 2:30 pm
15 New York ACEP Member Reception, 6:00-7:00 pm, Hilton San Francisco Union Square
15-18 National ACEP 2011 Scientific Assembly, San Francisco, CA
19 Government Affairs Conference Call, 11:00 am
19 Research Committee Conference Call, 3:00 pm

november

2 Emergency Medicine Residents Career Day, 7:30 am-2:00 pm, New York Academy of Medicine, New York City
9 Education Committee Conference Call, 2:00 pm
9 Professional Development Conference Call, 3:00 pm
10 Practice Management Committee Conference Call, 1:00 pm
16 Government Affairs Conference Call, 11:00 am
16 Research Committee Conference Call, 3:00 pm
17 EMS Committee Conference Call, 2:30 pm

december

8 Practice Management Committee Conference Call, 1:00 pm
14 Education Committee Conference Call, 2:00 pm
14 Professional Development Conference Call, 3:00 pm
15 EMS Committee Conference Call, 2:30 pm
21 Government Affairs Conference Call, 11:00 am
21 Research Committee Conference Call, 3:00 pm

for the latest calendar, go online to **www.nyacep.org** and click on calendar

classified ADS

Florida Emergency Physicians

The best option for emergency physicians in the Southeast! Florida Emergency Physicians is interviewing BE/BC Emergency Physicians, Physician Assistants and Nurse Practitioners. Our democratic and independently-owned group currently provides care to over 450,000 patients annually at ten Florida hospitals in the Orlando and Tampa area. FEP is excited to announce our affiliation with Florida Hospital Zephyrhills as of October 1, 2010.

We are the largest ED system in the country and we are celebrating our 42nd anniversary as a stable organization. Orlando is a growing and rapidly expanding multi-cultural city, with many attractions, dozens of acclaimed golf courses, famous beaches, and excellent school systems! We are offering a very attractive compensation package, excellent benefits as well as relocation assistance.

Please visit our website at www.floridaemergencyphysicians.com. Immediate opportunities available at our Waterman campus. Contact: Brian A. Nobie MD, FACEP or David Sarkarati DO, FACEP at 800-268-1318. Send CVs by fax to: (407) 875-0244 or E-mail to: syarcheck@psrinc.net

Vice Chair and Associate Director Opportunity, Brooklyn, NY

The Chair of Emergency Medicine at Lutheran Medical Center is seeking a Vice Chair and Associate Director to assist with leadership of the Emergency Department team to achieve our goals of patient safety and overall quality. These positions include clinical shifts as well as administrative duties.

Lutheran's ED is a 66,000 level 1 Trauma Center with a very active stroke center. Candidates must be BC/ EM trained, and have extensive emergency medicine and administrative experience. Very competitive compensation and bonus program.

Contact: Megan Evans, Physician Recruiter, at 1-800-394-6376/mevans@neshold.com. ■

president's message

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Under the direction of Dr. Jeremy Cushman, the EMS Committee has had a very successful year. Some of their accomplishments included: establishing a position statement on qualifications for EMS Medical Directors, collaborating with the Bureau of EMS on a number of issues, collaborating with the Practice Management Committee on a letter to the Commissioner of Health regarding the delivery of PCRs contemporaneously with the patient, and soliciting and appointing an ACEP Member to represent New York ACEP at the State EMS Council.

Practice Management transcends many aspects of emergency medicine from day-to-day operations to reimbursement to legislative issues that affect our abilities to provide care to our patients. Under the direction of Dr. Stuart Kessler, the Practice Management Committee has helped our membership by drafting many letters to the Department of Health advocating for emergency medicine physicians in the State of New York. They have also been responsive to many individual member queries throughout the year.

Under the direction of Dr. Kevin O'Connor, the Professional Development Committee has helped to grow our membership to the present number of 2,149. They have also been active in promoting networking events for our membership and for the professional development of our newest attending physicians in emergency medicine.

Our Research Committee, under the direction of chair, Dr. Theodore Gaeta, and in conjunction with the Education Committee, sponsored the terrific research session which many of you participated in yesterday. This session included superb oral and poster presentations. The Research Committee sponsors the Resident Research Forum and contributes to the newsletter, the *Empire State EPIC*, every issue with a review of the current literature in the New York State of Mind column.

Other accomplishments this year included successfully moving our office from an inadequate, outdated space to a brand-new state-of-the-art facility. The newsletter, the *Empire State EPIC*, was published four times this year, each issue averaging thirty-two pages. Additionally, communications through our newly created New York ACEP Facebook page, and our electronic newsletters have been very successful. Under the direction of Dr. Daniel Murphy, our Political Action Committee's assets are growing. Although we haven't quite reached our goal, I am pleased to say that our total assets have doubled compared to last year at this time. This has certainly put us in a much stronger position when it comes to advocating for our legislative goals in Albany. Our 911 Network has grown and become highly effective under the leadership of Dr. Jay Brenner. New York ACEP also coordinated and trained over six-hundred providers and instructors in Trauma Life Support this year.

I look forward to continued growth and successes in the upcoming year. I would like to encourage everyone present to become more involved in New York ACEP. For those who are not on a committee, please consider joining. Following this meeting there will be round table meetings. I invite you all to attend. I would like to thank you all for giving me the privilege of representing you this year as your president and look forward to continuing to serve New York ACEP and its membership. ■

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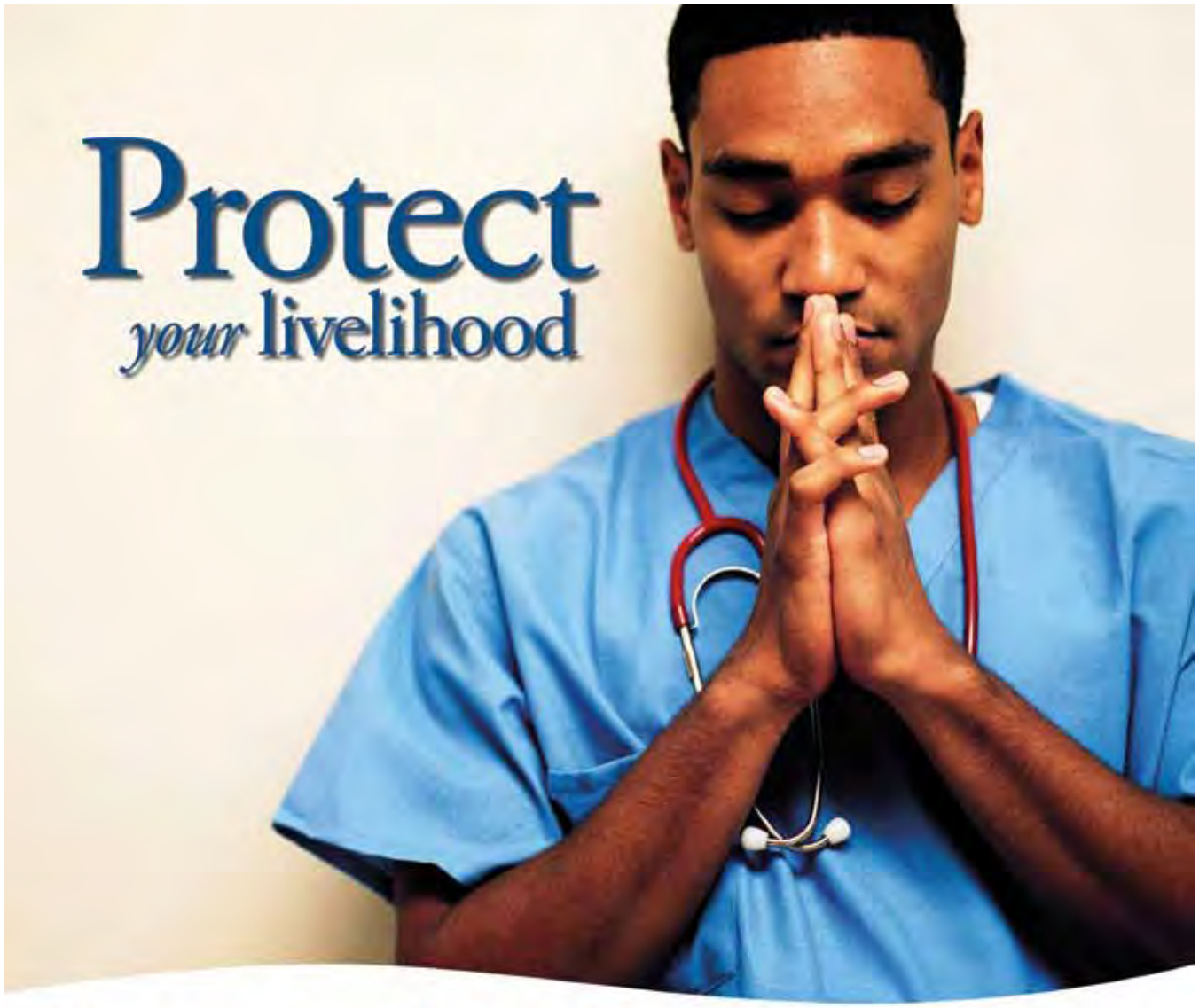

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You have invested a lot to get where you are. Don't stop now. Contribute to New York Emergency Medicine Political Action Committee - your voice in Albany. Make your contribution by going online to **www.nyacep.org.**

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NEW YORK
POLITICAL ACTION COMMITTEE

New York Emergency Medicine Political Action Committee contributes to the election campaigns of candidates for state office who support emergency medicine issues. Governed by a Board of Trustees who direct the organization's contributions, NYEMPAC makes contributions to members of both political parties whose candidates are sensitive to the concerns of emergency physicians and patients seeking emergency care. Read more at www.nyacep.org.