



CMS Outpatient Quality Reporting Program: How Does Your ED Measure Up?

Gary S. Rudolph, MD FACEP, Senior Associate Chairman, Department of Emergency Medicine, North Shore University Hospital

The Centers for Medicare & Medicaid Services (CMS) has implemented a number of programs aimed at improving the quality of care, one of which is the Hospital Outpatient Quality Reporting (OQR) Program. The Hospital OQR Program is modeled on the Hospital Inpatient Quality Reporting (IQR) Program which includes emergency department (ED) specific performance data on Acute Myocardial Infarction (AMI), Pneumonia, Stroke and ED Throughput measures for patients admitted to the hospital. The outpatient measure sets focus on the patients that are discharged or transferred to another facility for inpatient care. Data collection began with the AMI measures in 2008. This article will summarize the current outpatient measures that are specific to ED patient care and the currently available benchmarking data.

CMS gives hospitals a financial incentive to encourage adoption and reporting of evidence-based care practices. Hospitals paid under the outpatient prospective payment system (OPPS) that meet administrative, data collection, submission, validation, and reporting requirements are eligible to receive an annual payment update (APU) which is similar to a cost of living adjustment that is added to their payment rate. OPPS hospitals that do not meet these requirements are subject to a two percent reduction

in their APU. The data submitted for the Hospital OQR Program are used by CMS to calculate hospital outpatient process scores, which are posted on the “Hospital Compare” web site, www.hospitalcompare.hhs.gov. This web site enables the public to compare the performance of their local hospitals on these outpatient quality measures. In addition, the web site has data posted on inpatient quality measures, patient safety and infection control, disease specific mortality and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) patient satisfaction.

To comply with current requirements, hospitals must submit data for 23 quality measures: 14 clinical performance measures; seven Imaging Efficiency Measures; and two Web-based Structural Measures. Fourteen of the 23 measures are ED specific. These measures are summarized on the table (see page 17):

Data collection on five of the current six ED measures related to AMI began in 2008:

OP-1, Median Time to Fibrinolysis, and OP-2, Fibrinolytic Therapy Received Within 30 Minutes applies to all patients > 18 years of age who had a principal diagnosis of AMI who received fibrinolytic therapy and were subsequently transferred to another facility for inpatient care.

OP-3, Median Time to Transfer to Another Facility for Acute Coronary Intervention includes all patients who are transferred to another hospital for acute coronary intervention who did not receive fibrinolytic therapy.

OP-4, Aspirin at Arrival and OP-5, Median Time to ECG, include all patients who had a diagnosis of AMI or “probable cardiac chest pain” who were subsequently transferred to another facility for inpatient care.

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I am honored and eager to be President of New York ACEP for the next two years. Since my principal role has been in the realm of lobbying and government affairs, in this issue I will use this space to describe some recent and noteworthy achievements of your Government Affairs Committee and the New York Emergency Medicine Political Action Committee (NYEMPAC).

The 2012 State legislative session ended on time and in a smooth and orderly fashion in late June. As you likely know, Governor Andrew Cuomo has changed the operating procedure and decorum of the Assembly and Senate over the last 18 months and your NYEMPAC is contributing and your Government Affairs Committee is advocating accordingly.

Two major New York ACEP achievements occurred in Albany in 2012. They were a five-day emergency department exemption in the new I-STOP legislation and the successful defeat of the Nurse Practitioner Independent Practice Bill. Unfortunately, we may have suffered a defeat as well, with the passage of Observation Services by Hospitals which modifies New York State Department of Health (DOH) regulations for observation services.

THE WINS

1. New York ACEP achieved a Five-Day Exemption from **Prescription Drug Reform (I-STOP) Legislation S.7637, Lanza/ A.10623, Cusick**: This bill enhances the State Prescription Monitoring Program (PMP) to require more frequent pharmacy reporting. It also requires that health care prescribers consult the PMP for all schedule II, III and IV controlled substances with some exemptions - **including prescriptions written for a five-day supply or less in emergency departments as advocated for by New York ACEP**.

The bill also requires all prescriptions to be transmitted electronically by December 2014, updates the State's controlled substance schedules, expands the duties and membership of the workgroup established under the Prescription Pain Medication Awareness Program, and requires the Department of Health to establish a safe drug disposal program.

Without the intense and direct lobbying by your Government Affairs Committee, this exemption would never have happened. While New York ACEP membership acknowledges and experiences firsthand the prescription drug abuse epidemic and supports reasonable and efficient controls and surveillance, the PMP is simply not ready for prime time. It is slow, awkward, and not current. We could not risk emergency department operations slowing to a standstill. The timely assessments and outcomes of all emergency department patients would have been placed at risk. We are proud of this achievement and will work collaboratively to enhance education, appropriate referrals and surveillance of this important and growing problem.

2. New York ACEP and other partners in medicine defeated the **Nurse Practitioner Independent Practice Bill-A.5308A, Gottfried/ S.3289A, Young**. As a result of your grass roots efforts and advocacy in Albany throughout the session, this legislation which passed in the Assembly was defeated in the State Senate. If enacted the legislation would have eliminated the requirement for a written collaborative agreement and practice protocols between nurse practitioners (NPs) and physicians. Your efforts together with the support of all the major specialty societies and MSSNY lead to the Senate rejecting passage of this legislation in the final days of session.

THE DEFEAT

A.10518-A, Rules (Gottfried)/ S.7031-A, Hannon: This bill makes changes to recently enacted Department of Health regulations related to observation services in hospitals, pursuant to requirements set forth by the federal government. The original DOH regulations, which have been in effect since January 2012 and to which New York ACEP contributed to aggressively, specified that Observation Services be provided in a separate and discrete geographic unit that is also staffed separately and managed directly by each hospital's department of emergency medicine. **New York ACEP strongly opposed this legislation which eliminates the original regulations and will advocate that the Governor veto the bill once it is on his desk.**

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Inpatient Boarding in the ED – How to Tell the Story and Make it Personal

Keith E. Grams, MD FACEP,
Chief of Emergency Medicine,
Rochester General Health System

We have been talking about emergency department crowding for years, perhaps decades. Yet despite years of discussion, an increasing body of literature documenting deleterious affects, the 2006 Institute of Medicine's Committee report, and specific episodes of harm at each hospital, the problem only appears to be getting worse.

The addition of emergency department (ED) time intervals to the 2012 CMS core measures have already served as a mixed blessing. While the ultimate goal is greater hospital involvement, we have already seen a myriad of responses in the short term. Unfortunately, some institutions still possess the primal instinct of "ED blame" and continue to look to the ED alone to solve the issue – "It's alright as long as the chaos is contained in the ED." While some institutions already display upper level reasoning with a fundamental realization - ED crowding is caused by ED boarding, which is caused by hospital crowding. These progressive systems have realized that the patient in the ED waiting room is the hospital's patient, not merely the EDs. Since the patient belongs to the hospital, hospital resources and solutions are necessary to deliver care. While these two scenarios – "primal instinct" versus "crowding wisdom" - represent the extremes, most of us oscillate somewhere along the spectrum.

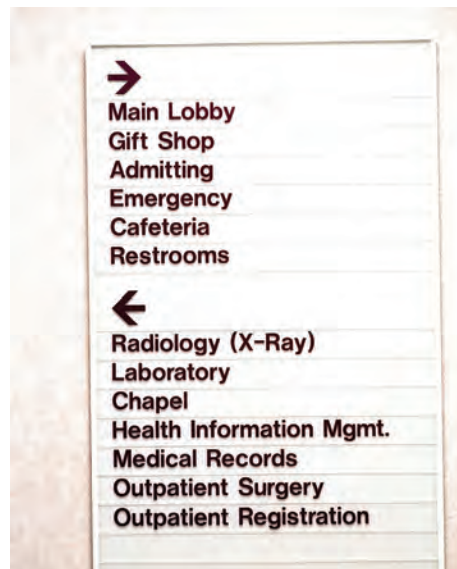
While we work toward the future we are faced with the present cold, hard fact – it is basically up to each ED to

shape its own fate. Each ED must present a compelling argument to drive institutional change. Serving on the frontlines, we are intimately aware of this challenge, having worked on it for years. During the process, we have experienced varying responses and generally only mediocre improvements. Potential barriers to success primarily include institutional willingness to hear the issue, the ability to understand the problem's magnitude, and the overall institutional need to balance system priorities (sometimes we fall low on the totem pole). In efforts to compete on an institutional level, we need to proclaim the "ED crowding story" in a manner that will require action. Given continual change that occurs within healthcare, this can be an imposing task. I would like to suggest a pragmatic approach comprised of two main components; 1) outline the problem to ensure awareness and understanding, and 2) develop a way to measure the problem in efforts to relate to system priorities.

Outline the Problem

Generally speaking, the majority of our institutions do not have a true understanding of ED crowding and how it directly relates to patient care. In some ways this may be our own fault. Arguably, the emergency department team is comprised of the most flexible members of the hospital community. Given system constraints, the ED team often provides amazing care in unbelievable circumstances. When this chaos is internally controlled, the rest of the organization may not be aware that this chaos even occurs.

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ultrasound sound rounds

Practical point-of-care
ultrasound applications for the
emergency physician

Penelope C. Lema, MD RDMS FACEP,
Director, Emergency Ultrasound Education,
Assistant Professor, University of
Rochester Medical Center



Ultrasound Evaluation of Increased Intracranial Pressure

Indications

- Suspicion of increased intracranial pressure
- Papilledema
- Head injury
- Altered mental status

Technique

- Use an individually packaged water soluble gel as an acoustic medium.
- Place a linear transducer in transverse plane over the patient's closed eyelid.
- Scan through eye with the patient looking forward with eyes closed.
- Scan eye also in the sagittal plane.

Normal eye:

- Identify the anechoic chambers, posterior lens and hypochoic optic nerve posteriorly. *Figure 1.*

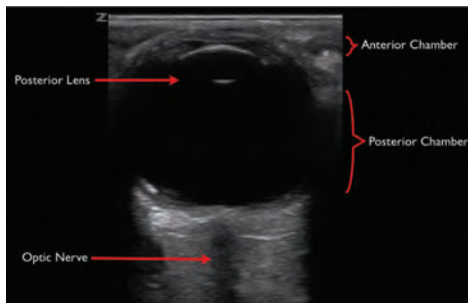


Figure 1. Ultrasound of the normal eye. Note: The anterior chamber is collapsed in this patient.

Axial (anterior) measurement of the optic nerve sheath diameter:

- Measure 3mm posteriorly from the optic disc to determine the location for the transverse diameter measurement of the hypochoic optic nerve sheath diameter. *Figure 2.*
- Measure the transverse diameter of the optic nerve 3mm posterior to the optic disc. *Figure 3.*
- The axial approach to measure the optic nerve sheath diameter (ONSD) using the linear transducer may be a falsely enlarged measurement of the optic nerve due to shadow artifacts from the lens and optic disc.
- An ONSD >5mm suggests increased intracranial pressure.
- The ONSD should be similarly elevated in both eyes.

3 x 5

"Remember a 3 x 5 index card to recall the ONSD ultrasound measurements. 3mm posterior to the optic nerve and ONSD >5mm is abnormal." Scott D. Weingart, MD RDMS FACEP, 2012 New York ACEP Scientific Assembly.



Figure 2. Axial measurement of ONSD. Start with a measurement 3mm posteriorly from the optic disc.



Figure 3. Measurement of the ONSD in a patient with increased intracranial pressure. Measure the transverse diameter of the hypochoic linear optic nerve 3mm posterior to the optic disc.

Coronal (lateral) measurement of the optic nerve sheath diameter:

- Some literature supports the coronal approach for a more accurate measurement of the ONSD.
- Place a covered endocavitary probe with gel at the lateral canthus of the patient's eye. If possible, the patient should be instructed to look laterally. *Figure 4.*
- The optic nerve appears as a circular hypochoic structure posterior to the eye. *Figure 5a.*
- Measure the ONSD. *Figure 5b.*

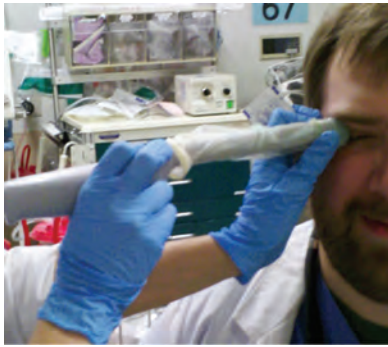
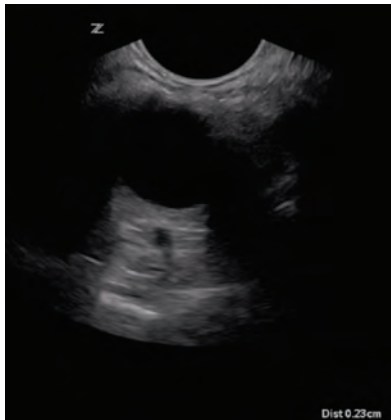


Figure 4 (left). Coronal measurement of the optic nerve. The endocavitary probe is placed at the lateral canthus of the eye. Note: The patient should be in the supine position.

Figures 5a and 5b (below). Coronal measurement of the ONSD. The optic nerve appears as a circular, hypoechoic structure.

Tips

- Place your pinky on the patient’s nasal bridge or temporal area during the ultrasound scan to prevent additional pressure on the eye.
- Do not perform an ultrasound scan when globe rupture is suspected.
- Ultrasound gel from bottles are not recommended on the eye due to potential bacterial contamination.



- Decrease the power output on the ultrasound machine to 25-50% (ALARA).
- Adjust the depth and gain to optimize your image.

Thanks to Scott Weingart, MD RDMS FACEP, Mount Sinai School of Medicine Department of Emergency Medicine for permission to use his quote and Justin Dewillers, MD, University of Rochester Department of Emergency Medicine for his participation as a model for the coronal approach to the ONSD. ■

OUTSTANDING EM OPPORTUNITIES

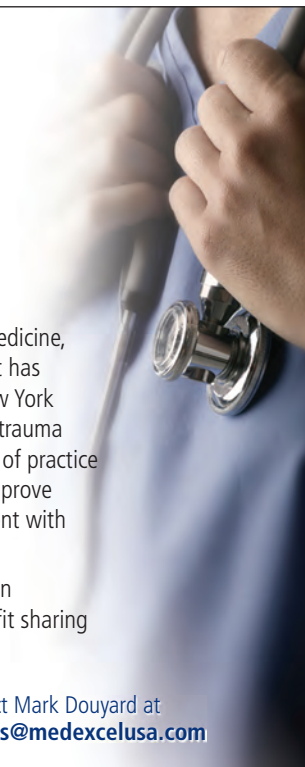
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2012 Scientific Assembly Highlights

Record Attendance

The 2012 Scientific Assembly at The Sagamore Resort on Lake George was attended by over 225 emergency physicians from around the state. Forty-six companies participated through exhibits and support.

Research Forum Winners

Monday'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 (*Read abstracts starting on page 13*):

Oral Presentation

- *Measuring the Impact of Bedside Cardiac Testing in the Emergency Department on Patient Flow and Test Utilization*, Bethany Byrd, DO; Bess Tortolani, MD; Amisha Parekh, MD; Paris Ayana Datillo, RN; Joseph J Bove, MD; Robert H Birkhahn, MD – New York Methodist Hospital

Poster Presentations

- *Obesity and Seatbelt Use: A Fatal Relationship*, Dietrich Jehle, MD FACEP; Joseph Consiglio; Jenna Karagianis, MD; Gabrielle Jehle – SUNY at Buffalo
- *Renal Colic in Pediatric Emergency Medicine*, Anita Datta, MD RDMS; Omar Corujo, MD; Will Apterbach, MD; Gregg Rusczyk, MD; Sanjey Gupta, MD; Marie Romney, MD RDMS; Michael Radeos, MD; Kruti Joshi, MPH; Penelope Chun Lema, MD RDMS – New York Hospital Queens
- *Are ED Visitors Willing to Engage In Political Advocacy to Support Poison Control Centers?* David C Lee, MD FACEP; Jessica S Mounessa, BS; Nina Kohn, MS; Sandra De Cicco, MD; Megan McCullough, BA; Andrew Loftus, BS; Alvin Lomibao, BS; Karen Tenner, BS; Andrew E Sama, MD; Mary F Ward, RN - North Shore University Hospital
- *Bedside Reduced Lead Electroencephalography Can Be Used to Make the Diagnosis of Nonconvulsive Status Epilepticus in the Emergency Department*, Jay Brenner, MD FACEP; P. Kent; Susan Wojcik, PhD; William Grant, EdD – SUNY Upstate Medical University

Leadership Elected

Congratulations are extended to newly elected officers and board members for 2012-2013 program year:



President:
Daniel G. Murphy,
MD MBA FACEP



President-Elect:
Louise A. Prince,
MD FACEP



Secretary-Treasurer:
Brahim Ardolic,
MD FACEP

Board Members:

Jay M. Brenner, MD FACEP
Keith E. Grams, MD FACEP
Sanjey Gupta, MD FACEP
Stuart G. Kessler, MD FACEP

Susan Cheng, MD was appointed resident representative to the Board of Directors by President Daniel G. Murphy, MD MBA FACEP.



Joel M. Bartfield, MD FACEP (left) accepts president's plaque from incoming president, Daniel G. Murphy, MD MBA FACEP



Advancing Emergency Care Award

Scott D. Weingart, MD RDMS FACEP, (pictured above between Drs. Stuart Kessler and Kaushal Shah) Associate Professor, Director of Emergency Critical Care, Department of Emergency Medicine, Mount Sinai School of Medicine & Elmhurst Hospital Center was awarded the 2012 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. Below is an excerpt from the presentation at the annual meeting.

If there is anyone who deserves recognition for advancing emergency medicine care by New York ACEP, it is Scott Weingart. He has been a tireless advocate of EM's role in critical care and for physician/resident education. This is evidenced by his yearly Critical Care Conference with over 450 attendees, his podcast which is downloaded over 100,000 times per month, and his prolific lecturing in New York State, nationally and internationally. He has a "cult" following among residents for his engaging teaching style and high-yield learning points. Scott is also heading up two major quality initiatives in New York: STOP SEPSIS Collaboration and NYC Project Hypothermia. Scott serves on a number of committees not only within ACEP but also represents emergency medicine in a number of non-EM arenas, such as the Society for Critical Care Medicine, Neurological Care Society, CDC and the FDNY.

Each year New York ACEP honors individuals for contributions to the advancement of emergency care. For more information on these awards, visit www.nyacep.org.

Celebrating 40 Years of Advancing Emergency Care

Bartfield's Annual Meeting Address

The following is an excerpt from outgoing president, Joel M. Bartfield, MD FACEP message at the 2012 annual meeting.

"On behalf of the New York ACEP Board of Directors and leadership, I would like to welcome you to New York ACEP's 40th birthday party. This organization has thrived through the dedication and hard work of many people. We are privileged today to have with us a decade of past presidents. I would like to extend a special welcome to our past presidents, Drs. Gerry Brogan, Jerry Balentine, Ted Gaeta, Andy Sama and Sam Bosco.

We would certainly not be anywhere close to where we are today without the incredible dedication and hard work over the last 25 years of our executive director, JoAnne Tarantelli. We also are fortunate to have a hardworking and dedicated office staff. Our thanks go to Timothy Pistor and Betsy Hawes.

I would also like to recognize two New York ACEP members who have become leaders in national ACEP, Dr. Sandy Schneider, ACEP Immediate Past President and Dr. Andy Sama, President-Elect. We also welcome two other national ACEP Board of Directors members: Dr. Alex Rosenau and Dr. Andrew Bern. Finally, I'd like to welcome Bob Reid and Marcy Savage from Weingarten, Reid and McNally, our lobbyists in Albany.

It has been my honor and pleasure to serve as your president for the last two years. In a few minutes my term will officially end and I will turn the reigns over to Dr. Dan Murphy. Anyone who knows Dan, knows that New York ACEP will be in very capable hands. I know New York ACEP will continue to flourish under Dan's leadership and the support of the Board of Directors and Executive Director.

2011-12 has been a very successful and productive year for New York ACEP. Due to superb fiscal management, we continue to add to our assets which allow us to act quickly and effectively to protect our members and our patients in an ever-changing political climate.

Membership continues to grow ~ over 2,200 strong making New York the second-largest chapter in the country. New York

also has more training programs in emergency medicine than any other state in the country. Through the efforts of our Emergency Medicine Residents Committee and resident focused programming by our Education and Research Committees, we maintain a very close alliance with these future leaders in emergency medicine.

Most of the work we do is attributable to our robust committee structure. You are the people that continue to grow this organization and ultimately benefit emergency care in the state of New York. Consider joining a New York ACEP committee and help to make a difference in your profession and the health of New Yorkers.

The cornerstone conference of the Education Committee, the New York ACEP Scientific Assembly continues to present high-quality educational content to an ever growing number of registrants. Other endeavors include the Assembly WebApp launched at this meeting and the development of future online LLSA course offerings.

The Research Forum which opened our Scientific Assembly is made possible through the combined efforts of our Research and Education Committees.

Our newsletter continues to grow in both quality and scope. New feature columns were added this year focusing on Ultrasound, Emergencies in Pediatrics and Toxicology. The EPIC stands out as one of the highest quality newsletters of any chapter in the country.

Our Government Affairs Committee continues to advocate for our members and our patients. Thank you for respond-

ing to the Action Alerts. With the help of Weingarten, Reid and McNally we have been able to accomplish much in an ever-changing political environment. This year we successfully advocated for a New York State Department of Health policy on observation medicine and have secured a five-day exemption for emergency physicians in the I-STOP legislation.

The EMS Committee helped coordinate and train close to 600 ITLS providers and instructors and revised the ITLS policy and procedure manual this past year and advised the state legislature as they worked on revisions to the New York State public health law.

The Practice Management Committee has been responsive to many individual member inquiries throughout the year. The committee transcends many aspects of emergency medicine from day-to-day operations to reimbursement to legislative issues. The committee is often called upon to reach out to the Department of Health as we advocate for emergency care in New York State.

Our Professional Development Committee has helped to grow our membership to the present number of 2,267.

We are very proud of all the New York ACEP has accomplished. I know that those of you who are members of committees and leaders share my enthusiasm and pride in this organization. Help New York ACEP to continue to be the leader in advocating for quality emergency care in New York State. Once again, I thank all of you for allowing me the opportunity to represent you these past two years." ■



Have a toxicology question?
Email it to Dr. Lee at nyacep@nyacep.org for possible inclusion in the next issue of the EPIC.



David C. Lee, MD FACEP, Research Director, Associate Professor, Department of Emergency Medicine, Hofstra North Shore-LIJ School of Medicine brings this feature column to the EPIC.

Potential Adverse Effects of Rapid Intravenous Digoxin

Mark Su, MD FACEP, Director, Fellowship in Medical Toxicology, North Shore University Hospital, Department of Emergency Medicine

Question: Are there any adverse effects of rapid intravenous digoxin administration?

Background

Digoxin is a cardioactive steroid that has been and is still used for the treatment of various cardiovascular conditions including atrial fibrillation and congestive heart failure. Due to its delayed antidysrhythmic and inotropic effects of at least several hours, one might expect that rapid intravenous administration of digoxin be considered extremely safe. However, according to the package insert of at least one formulation of digoxin:

“Slow infusion of LANOXIN Injection is preferable to bolus administration. Rapid infusion of digitalis glycosides has been shown to cause systemic and coronary arteriolar constriction, which may be clinically undesirable. Caution is thus advised and LANOXIN Injection should probably be administered over a period of 5 minutes or longer.”¹

Evidence for this recommendation appears to originate from animal studies performed in the 1960s – 1970s. In the following study of mongrel dogs, IV digoxin was associated with a significant increase in coronary resistance compared to controls by 10-15 minutes (See Figure 1).² This effect appears to be mediated by coronary alpha receptor stimulation as this vasoconstrictive effect was blunted following alpha blockade (See Figure 2).²

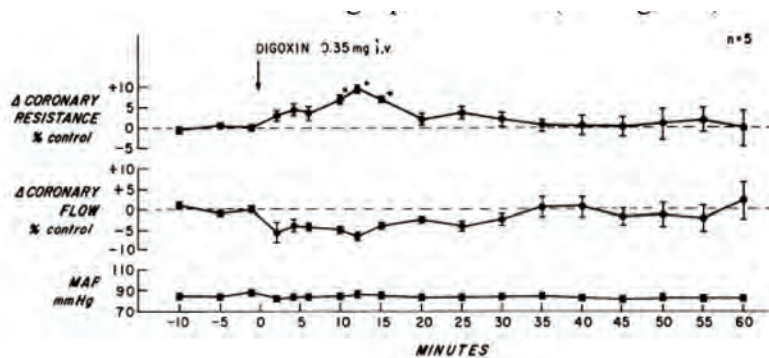


Figure 1

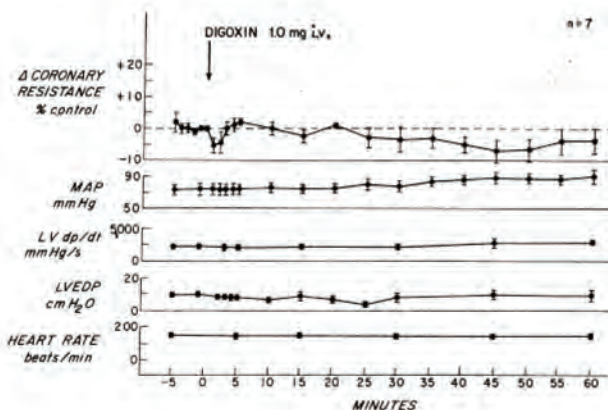


Figure 2

In additional work by one of the same authors, there appeared to be a temporal relationship of increased coronary resistance and CSF digoxin content (Figure 3) leading to the hypothesis that some of these effects may be centrally mediated.³

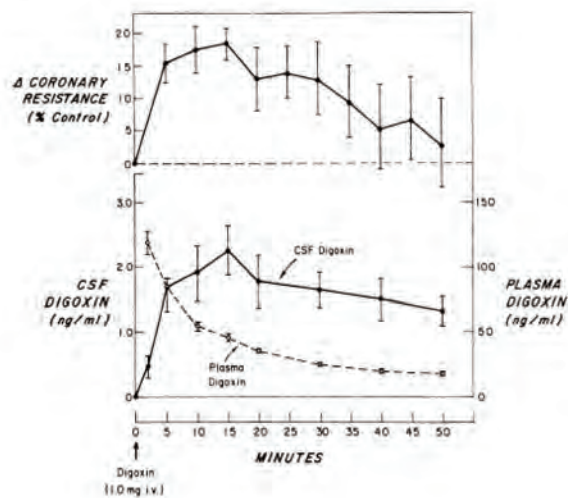


Figure 3

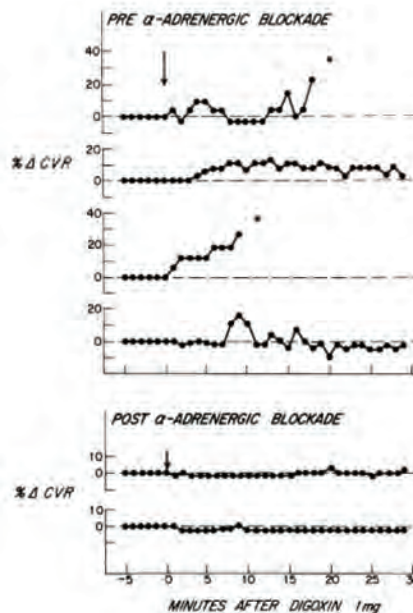


Figure 4

Lastly, in a canine model of induced coronary ischemia, intravenous digoxin was associated with a significant increase in coronary vascular resistance in all four animals.⁴

In clinical practice, adverse effects of ischemic chest pain or worsening heart failure immediately after administration of intravenous digoxin is theoretically possible.⁵ Despite the persistent therapeutic use of digoxin to treat various cardiovascular conditions, this area remains unstudied.

Conclusion

As with most drugs administered via the intravenous route, caution should be taken when administering intravenous digoxin rapidly.

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Albany Update

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

2012: A Very Successful Session for New York ACEP. And More Work to Be Done

The State Senate and Assembly completed their 2012 regular Legislative Session late in the evening of June 21. Legislators returned to their districts to spend the next four months campaigning for the November 6 elections.

This year, several veteran legislators announced their retirement including Senators Owen Johnson (R-Babylon), James Alesi (R-I, Monroe), Thomas Duane (D-W, Manhattan) and Susan Oppenheimer (D-W, Westchester), and three Democratic Assembly members from the Capitol District area, Majority Leader Ron Canestrari, Jack McEneny and Robert Reilly. In addition, there will be a new 63rd Senate seat in the Capitol District under the new district lines that were drawn earlier this year.

There is speculation that the Legislature will return to Albany after the November elections to take up outstanding issues including additional tax credits for businesses and an increase in the minimum wage. Also it has been reported that legislative pay raises could be considered during a special session in November.

The 2012 session was very challenging but successful for New York ACEP. Below we have provided a summary and status of New York ACEP's priority issues.

New York ACEP and Other Partners in Medicine Defeat Nurse Practitioner Independent Practice Bill A.5308A, Gottfried/ S.3289A, Young

As a result of all of the strong grass roots efforts by members locally and advocacy in Albany, New York ACEP was able to defeat legislation to eliminate the requirement for a written collaborative agreement between nurse practitioners (NP) and physicians. Beginning last year, the nurse practitioner association joined by the State nurses union made a major push for this measure through the Governor's Medicaid Redesign Team (MRT) claiming

that NP independence was the solution to the state's healthcare workforce shortage issues. While the MRT approved the measure, New York ACEP and others weighed in with the Governor in strong opposition and unlike most MRT proposals, NP independent practice was not included in the Governor's budget released in January.

New York ACEP then made this legislation a top priority for discussions with legislators during the Albany lobby day in late February, as well as other meetings, action alerts and other activities throughout the session. While the bill was passed by the Assembly in the final days of the session, we defeated it in the State Senate. This could not have happened without all of New York ACEP's efforts. We thank members for all of your assistance with opposing this bill. Unfortunately, despite our success, this issue is not going away. We will continue to work with New York ACEP on strategies and efforts to defeat it in the coming year.

New York ACEP Achieves Five-Day Exemption from Prescription Drug Reform (I-STOP) Legislation S.7637, Lanza/ A.10623, Cusick

A second priority for New York ACEP this session was to work with Governor Cuomo, Attorney General Schneiderman and state legislative leaders to make emergency medicine a part of the solution to the serious controlled substance abuse and diversion problem in New York but to do so in a reasonable way that does not overburden the State's emergency departments and which protects access to pain and other medications for patients who legitimately need them. In early June, New York ACEP was successful in doing both. When the Governor and Legislative Leaders announced a deal on the I-STOP legislation, **New York ACEP was able to get one of the few exemptions from the mandatory consultation of the prescription monitoring program requirement in**

the bill for five-day prescriptions written in emergency departments. This was the result of numerous meetings and local efforts by New York ACEP members. In particular, we would like to thank JoAnne Tarantelli and Drs. Joel Bartfield, Dan Murphy, Sam Bosco and Brahim Ardolic for their extensive efforts in this regard which led to New York ACEP's success.

As further background, the enacted I-STOP legislation enhances the State Prescription Monitoring Program (PMP) to require more frequent pharmacy reporting on controlled substance dispensing. Also it requires that health care prescribers consult the PMP for all schedule II, III and IV controlled substances with a few exemptions as mentioned above. The bill also requires all prescriptions to be transmitted electronically by December 2014, updates the State's controlled substance schedules including making hydrocodone schedule II and scheduling tramadol as a IV, expands the duties and membership of the workgroup established under the Prescription Pain Medication Awareness Program, and requires the Department of Health to establish a safe drug disposal program for controlled substances.

Out-Of-Network Legislation Passes State Senate S.7754, Hannon

On March 7, Ben Lawskey, Superintendent of the Department of Financial Services (DFS), held a press conference to announce the release of a report "**An Unwelcome Surprise. How New Yorkers Are Getting Stuck with Involuntary Medical Bills from Out-of-Network Providers.**" The report focused on medical bills received by consumers from "out-of-network" health care providers who do not participate in the consumer's health insurance plan.

Following the release of the report and in response to the issues identified, DFS quietly circulated drafts of Out of Network legislation to key legislators and interest groups for comments. Weingarten, Reid & McNally was able to gain access to the drafts which we shared with New York ACEP leadership. Upon review, New York ACEP held a series of meetings with the Governor's office including DFS officials, Senate and Assembly Health and Insurance Committee Chairs and key staff to discuss the College's position and concerns with

this issue. The DFS bill was not proposed formally nor introduced in the Legislature. However in the final days of the session, Senate Health Committee Chair Kemp Hannon introduced and passed legislation in this area (S.7754) which was very similar to the DFS bill drafts. Below we have provided a summary of the legislation, which was not introduced or advanced in the Assembly. We will continue to closely monitor this issue for the College.

S.7754 contains a number of provisions including:

Consumer Disclosure

- Requiring insurers to provide consumers a listing of the languages spoken and the insurers affiliation with participating hospitals posted on the insurers web site;
- A description of the method by which an insured may submit a claim for health care services (internet, fax, mail);
- A clear description of the method the insurers use to determine reimbursement for out-of-network services as a percentage of the usual and customary cost for out-of-network services and examples of anticipated out of pocket costs for out-of-network health care services;
- An insurer must disclose whether the provider is an in-network provider or if an out-of-network provider the anticipated costs the insurer will pay for the out-of-network health care service; and
- An insurer must provide in writing and through a website information that allows an insured to determine the anticipated out of pocket cost for out-of-network health care services by zip code based upon what the insurer will pay and the usual and customary cost of a out-of-network health care service.

Usual and Customary Cost Definition

- Usual and Customary cost is defined in the bill as the eightieth percentile of all charges for a particular health care service performed by a provider in the same geographic area as reported and tracked by a benchmarking database maintain by a not-for-profit organization specified by the DFS.

Adequate Network Coverage

- The DFS shall ensure that an insurers network is adequate to meet the health needs of insureds and provide appropriate choice of providers sufficient to render services; and
- With the exception of emergency services, an insurers policy must provide coverage for at least fifty percent of the usual and customary cost of out of network health care services after imposition of any deductible or any permissible benefit maximums;

Appeals

- An insured may appeal a denial of an out-of-network referral by an insurer by submitting a written statement from the insured's attending physician on the basis of lack of appropriate training or experience for in-network providers and recommends out-of-network providers with such; and
- Details the grounds for an external appeal regarding out-of-network referrals.

Disclosure by Physicians and Hospitals for Non Emergency Services

- A physician (or health care provider) must disclose to patients and prospective patients in writing or through an internet website which health care plans and hospitals the physician is a participating provider;
- If the physician does not participate they must, upon request, provide in writing to a patient or prospective patient the amount or estimated amount the physician will bill the patient for health care services or anticipated health care services;
- A physician must provide a patient or prospective patient with the name, mailing address and telephone number of any physician or health care provider of lab, anesthesia, radiology, surgical or pathology services;
- A physician must provide a patient or prospective patient with the name, mailing address and telephone number of any physician whose services will be arranged and or scheduled during the time of pre-admission testing, registration or admission or health care provider of lab, anesthesia, radiology, surgical or pathology services;

- A hospital shall establish and make public a list of the hospital's standard charges for items and services by DRG groups;
- A hospital shall post on their website which plans they participate and the names, addresses, etc. of physicians who will not be billed as part of the hospital charges; and
- A hospital, at pre-admission, out-patient registration or earlier for non-emergent hospital admissions or visits, must provide a patient or prospective patient with the name, mailing address, telephone number of any physician or health care provider of lab, anesthesia, radiology, surgical or pathology services and whether their services will be billed as part of hospital charges.

Emergency Medical Services

- A physician who provided health care shall not charge excessive fees. Under the legislation an independent dispute resolution entity shall decide whether the fee charged by a physician for services rendered is excessive by considering the following factors:
 - whether there is a gross disparity between the fee charged by the physician for services rendered as compared to A) the fees paid by the health care plan to similarly qualified physicians and B) fees paid to the involved physician for the same services rendered by a physician to patients in health care plans in which the physician does not participate;
 - the level of training by a physician;
 - the usual charge for comparable services with regard to patients in health care plans in which the physician does not participate;
 - the circumstances and complexity of the particular case including the time and place of service;
 - individual patient characteristics; and
 - the usual and customary cost of the service.
- A physician will not be paid as the independent dispute resolution entity is considering an appeal; and

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New York State of Mind



This edition of the *New York State of Mind* features the winning oral and poster abstracts chosen at the 2012 Research Forum at the July Scientific Assembly.

Obesity and Seatbelt Use: A Fatal Relationship

Dietrich Jehle, MD FACEP; Joseph Consiglio; Jenna Karagianis, MD; Gabrielle Jehle – SUNY at Buffalo



BACKGROUND: Motor vehicle crashes are a leading cause of mortality in the United States. Although seatbelts significantly reduce the risk of death, a number of subgroups of individuals tend not to wear their seatbelts. A third of the population is now considered to be obese and obese drivers may find it more difficult to buckle up a standard seatbelt.

OBJECTIVES: In this study, we hypothesized that obese drivers were less likely to wear seatbelts than their normal weight counterparts.

METHODS: A retrospective study was conducted on the drivers in severe motor vehicle crashes entered into the FARS (Fatality Analysis Reporting System) database

between 2003 and 2009. This database includes all motor vehicle crashes in United States that resulted in a death within 30 days. The study was limited to drivers (336,913) of passenger vehicles in severe crashes. A number of pre-crash variables were found to be significantly associated with seatbelt use. These were entered into a multivariate logistic regression model using stepwise selection. Drivers were grouped into weight categories based on the World Health Organization definitions of obesity by BMI. Seatbelt use was then examined by BMI, adjusted for 12 pre-crash variables that were significantly associated with seatbelt use.

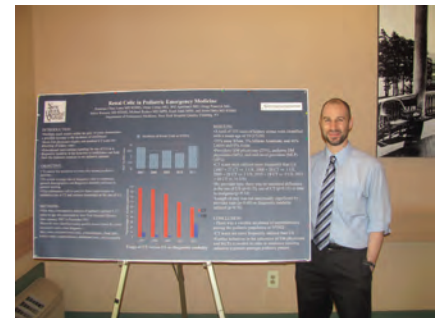
RESULTS: The odds of seatbelt use for normal weight individuals were found to be 67% higher than the odds of seatbelt use in the morbidly obese. The table below displays relationship of seatbelt use between the different weight groups and the morbidly obese. Odds ratios (OR) for each comparison are displayed with the lower and upper 95% confidence limits.

	OR	L CL	U CL
Underweight vs. Morbidly Obese	1.616	1.484	1.784
Normal Wt. vs. Morbidly Obese	1.666	1.538	1.805
Overweight vs. Morbidly Obese	1.596	1.472	1.730
Slightly Obese vs. Morbidly Obese	1.397	1.284	1.520
Moderately Obese vs. Morbidly Obese	1.233	1.120	1.358

CONCLUSION: Seatbelt use is significantly less likely in obese individuals. Automobile manufacturers need to investigate methods of making seatbelt use easier for the obese driver in order to save lives in this population.

Renal Colic in Pediatric Emergency Medicine

Anita Datta, MD RDMS; Omar Corujo, MD; Will Apterbach, MD; Gregg Rusczyk, MD; Sanjay Gupta, MD; Marie Romney, MD RDMS; Michael Radeos, MD; Kruti Joshi, MPH; Penelope Chun Lema, MD RDMS – New York Hospital Queens



INTRODUCTION: Multiple studies performed within the past ten years demonstrate an increasing incidence of urolithiasis. The increased incidence of urolithiasis, combined with the trend towards reducing ionizing radiation exposure among children, make alternate diagnostic modalities such as ultrasonography (US) more desirable.

STUDY OBJECTIVE: The purpose of this study was to assess the incidence of renal colic among pediatric patients in an urban Emergency Department (ED) during the past five years. The pediatric ED at our hospital is separate from the adult ED and is staffed by adult ED physicians, pediatric physicians and midlevel providers (MLPs). We reviewed the patient demographics, length of stay and diagnostic modality utilized in patient workup. This information will be used for future intervention to minimize use of CT and increase knowledge in the use of US.

METHODS: This was a retrospective analysis of medical records of patients ≤ 21 years of age evaluated at NYHQ from January 2007 until December 2011. Records were identified with a search of specific terms within the summary of patient records by chief complaint and diagnosis. A search of key words such as renal colic, ureterolithiasis, flank pain, kidney stone, nephrolithiasis, abdominal pain and hematuria were performed.

RESULTS: We found 153 cases of kidney stones (43% male) among the pediatric population from January 2007 to 2011.

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New York State of Mind

Mean age was 19 (IQR: 17-20); 35% White, 3% African-American, and 62% Asian/Hispanic or other race. Patients were evaluated by 23% ED physicians, 66% pediatric physicians and 10% MLPs. There was no statistically significant increase in the incidence of renal colic patients over the past 5 years, $p=0.11$. CT scans were more utilized than ultrasound for diagnostic workup (2007= 27 vs 3, 2008= 20 vs 1, 2009= 29 vs 1, 2010 24 vs 0, 2011= 24 vs 11). The type of provider (ED attending vs Peds attending vs MLPs) had no significant effect on the use of CT or US ($p=0.65$, $p=0.86$, respectively). There was no difference in length of stay when comparing ultrasound as the only imaging modality compared with non-contrast CT as the only imaging modality ordered.

CONCLUSION: There was no overall increase in renal colic among the pediatric emergency patient population over the past 5 years. Female pediatric patients are slightly more affected than males. CT's have been more frequently utilized in the diagnostic workup compared to US. We plan to use this data to educate health-care providers on the use of ultrasound in patients suspected of having nephrolithiasis in order to minimize the use of CT scans.

Are ED Visitors Willing to Engage In Political Advocacy to Support Poison Control Centers?



David C Lee, MD FACEP; Jessica S Mounessa, BS; Nina Kohn, MS; Sandra De Cicco, MD; Megan McCullough, BA; Andrew Loftus, BS; Alvin Lomibao, BS; Karen Tenner, BS; Andrew E Sama, MD; Mary F Ward, RN - North Shore University Hospital

BACKGROUND: Poison control centers (PCC) throughout the country have been closing due to reduced governmental funding. The closure of PCCs has been associated with a negative impact on the delivery of health care to the communities they service.

OBJECTIVES: Our objective is to determine if visitors in the ED waiting area are interested in engaging in a political advocacy project to support PCC funding. We believe that the visitors in the ED waiting area are a readily accessible cohort motivated to participate in health care policy issues.

METHODS: We performed a prospective, 3-stage survey of adult, English-speaking visitors in a suburban academic ED with 80,000 annual visits. In Stage 1, research interns approached a convenience sample of visitors in the ED waiting area to complete an anonymous nine-question survey on health care issues. Questions were extracted from a national survey (Kaiser Family Foundation/Gallup Poll, 2007). In Stage 2, visitors were offered an informational brochure from the American Association of Poison Control Centers on the importance of poison control centers. In Stage 3, visitors were asked to sign a letter to the Governor of New York State in support of continued funding for poison control centers and to indicate whether they wanted their letter to be sent. Data were analyzed employing descriptive statistics. The chi-square test was used to compare groups (males vs. females who proceeded to Stages 2 and 3). Subjects who did not meet inclusion criteria were excluded from data analyses.

RESULTS: Of 878 eligible subjects approached between June 2010 and October 2011, 563 (64.1%) agreed to complete the survey, 380 (43.3%) agreed to read the brochure, 297 (33.8%) agreed to sign letters of support, and 292 letters (33.3%) were mailed. Of those who agreed to complete the survey, 298 (58.3%) were female; no significant difference existed between the percentage of males and females who proceeded to Stages 2 and 3 of the study. Of

the 545 subjects who reported their ages, 223 (50%) were between 33 and 57 years old (median age: 46).

CONCLUSION: The political advocacy program supporting PCC funding yielded significant participation from eligible visitors. Over one third of visitors approached were willing to send a letter to their governor. The ED waiting area is an effective location to implement a political advocacy program in support of PCCs.

Bedside Reduced Lead Electroencephalography Can Be Used to Make the Diagnosis of Nonconvulsive Status Epilepticus in the Emergency Department



Jay Brenner, MD FACEP; P. Kent; Susan Wojcik, PhD; William Grant, EdD – SUNY Upstate Medical University

OBJECTIVES: Electroencephalography (EEG) is indicated for diagnosing nonconvulsive status epilepticus in a patient who has altered level of consciousness (ALOC) after a motor seizure. A study in a neonatal population found 94% sensitivity and 78% specificity for detection of seizure using a single-lead device. This study aims to show that a reduced montage EEG would detect 90% of seizures detected on standard EEG.

METHODS: A portable Brainmaster EEG device was available in the ED at all times. The indication for enrollment into the study was ALOC with a known history of seizures. The ED physician obtained informed consent from the legally authorized representative (LAR), while an ED technician attached the electrodes to the patient, and a research associate attached the electrodes to the wiring routing to the portable EEG

module. A Board-Certified Epileptologist interpreted the tracings via the Internet. Simultaneously, the ED physician ordered a standard 23-lead EEG, which would be interpreted by the neurologist on-call to read EEGs. The epileptologist's interpretation of the reduced montage EEG was compared to the results of the 23-lead EEG, which was considered the gold standard for detecting seizures.

RESULTS: 12 of 12 patients or 100% had the same findings on reduced montage EEG as standard EEG. 1 of 12 patients or 8% had nonconvulsive seizure activity.

CONCLUSION: The results are consistent with prior studies which have shown that 8-25% of patient who have had a motor seizure continue to have nonconvulsive seizure activity on EEG. This study shows that a bedside reduced-montage EEG can be used to make the diagnosis of nonconvulsive status epilepticus (NCSE) in the emergency department. Further study will be conducted to see if this technology can be applied to the inpatient neurological intensive care unit setting.

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Shellhaas, RA and Clancy, RR. "Characterization of neonatal seizures by conventional EEG and single-channel EEG. *Clinical Neurophysiology*. 2007;118:2156-2161.

Measuring the Impact of Bedside Cardiac Testing in the Emergency Department on Patient Flow and Test Utilization



Bethany Byrd, DO; Bess Tortolani, MD; Amisha Parekh, MD; Paris Ayana Datillo, RN; Joseph J Bove, MD; Robert H Birkhahn, MD – New York Methodist Hospital

BACKGROUND: Crowding plagues Emergency Departments (ED) worldwide, specifically in the US, with a reported 23% increase in ED visits from 1997 to 2007. The CDC reports 123.8 million ED visits annually. Chest pain remains the second most common reason for an ED visit, accounting for 5.5 million ED visits in 2007-08. The efficient management of patients who present with chest pain is

crucial. Poor central laboratory turnaround time can result in delays in diagnosis for these patients.

OBJECTIVES: We aim to determine if the use of a point-of-care testing (POCT) pathway will impact the ED length of stay (ED LOS) and hospital length of stay (hospital LOS) of patients who are suspected to have Acute Coronary Syndrome (ACS) in the Emergency Department.

METHODS: This was a prospective observational cohort study that used a randomized schedule that required physicians to use either bedside cardiac POCT testing (Alere Triage Cardiac Panel) or core lab testing (Roche XXXXX). Test availability was randomized by 2-week intervals within 8-week blocks. Two cohorts were created, the first only had bedside POCT available, and the second group who had only central laboratory testing available (CORE cohort). All patients who met eligibility criteria, and were evaluated for ACS in the ED were enrolled in the study. A medical record review and 30-day telephone follow-up was conducted for all patients. Trained reviewers used a standardized data abstraction form.

RESULTS: Of 1554 patients with chest pain, a total of 705 patients had cardiac biomarker testing over a 6-month time period. The mean age of patients was 60.83 years, and 53% were female. The POCT cohort consisted of 288 patients (41%) and the CORE cohort consisted of 417 (59%) patients. In the POCT cohort the mean ED LOS was 7.64 hours, and mean hospital LOS was 64.66 hours. Comparatively, the CORE cohort had a mean ED LOS of 7.41 hours, and a mean hospital LOS of 69.87 hours. Patients with chest pain presenting during the CORE time period were twice as likely to have cardiac testing (95% CI 1.5, 2.4) as patients in the POCT group.

CONCLUSION: Our study was designed to measure the impact of bedside cardiac biomarker testing on a cohort of ED patients presenting with chest pain. Although we were unable to identify a difference in the patient flow parameters of admission and ED LOS and hospital LOS between groups, we did observe a 30% reduction in amount of cardiac testing performed when POCT was the only testing available. Requiring physicians to run their own POCT resulted in fewer patients undergoing cardiac evaluation in the ED. ■

research resources

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New York
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CMS Outpatient Quality Reporting Program

continued from page 1

Benchmarking data for OP-1 through OP-5 are available for Calendar Year 2010 (see image top right).

Beginning in calendar year (CY) 2012, data collection began on a new AMI measure, OP-16, Troponin Results for Emergency Department Acute Myocardial Infarction (AMI) Patients or Chest Pain Patients (with Probable Cardiac Chest Pain) Within 60 Minutes of Arrival. It will be interesting to see how many EDs can meet this timeframe.

There are two Imaging Efficiency measures that are related to ED patient care. Data collection for OP-8, MRI for Low Back Pain, began in 2010. In 2011 a data collection dry run was performed for OP-15.

OP-8, MRI Lumbar Spine for Low Back Pain, calculates the percentage of MRI of the Lumbar Spine studies with a diagnosis of low back pain on the imaging claim and for which the patient did not have prior **claims-based** evidence of antecedent conservative therapy. MRI lumbar spine studies without a diagnosis of low back pain on the claim are not included in the denominator count.

OP-15, Use of Brain CT in the Emergency Department for Atraumatic Headache, calculates the percentage of emergency department (ED) visits for headache with a coincident brain computed tomography (CT) study for Medicare beneficiaries. Claims with secondary diagnosis codes related to lumbar puncture, dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage, complicated or thunder-clap headache, focal neurologic deficit, pregnancy, trauma, HIV, tumor/mass and imaging studies for ED patients admitted to the hospital are excluded from the measure.

Data for both measures are derived from Medicare claims data as opposed to medical record abstraction. This becomes problematic, as no clinical data other than ICD-9 and CPT codes are considered. Submitted claims include an incorrect primary ICD-9 code or fail to include a secondary diagnosis that would exclude the patient from the measure will result in patients being included that do not clinically

CY 2010 National Values	OP-1		OP-2		OP-3b		OP-4		OP-5	
	Median	90th Percentile	Median	90th Percentile	Median	90th Percentile	Median	90th Percentile	Median	90th Percentile
	29 min	13 min	50%	100%	60 min	29 min	98%	100%	8 min	0 min

Source: www.qualitynet.org

fit the measure. This problem came to light after analysis of data from a dry run of the OP-15 measure in 2011 revealed a large number of patients who, on medical record review, had clear indications for head CT were inappropriately included in the measure. Representatives of National ACEP met with CMS and related concerns regarding the measures validity. As a result, CMS postponed public reporting of this measure. "As indicated in the most recent Outpatient Prospective Payment System (OPPS) rule, published November 30, 2011 (CMS) will postpone public reporting of OP-15 in order to allow time for thoughtful refinement of the measure in collaboration with a technical expert panel and stakeholders." www.qualitynet.org.

Collection of ED outpatient throughput measures also began in CY 2012 including:

- OP-18 Median Time from ED Arrival to ED Departure for **Discharged** Patients
- OP-20 Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP-22 ED- Patient Left Without Being Seen

OP-19 *** Transition Record with Specified Elements Received by Discharged Patients, which requires a patient to receive a transition record (discharge summary) at the time of ED discharge including, at a minimum, the following five elements:

1. Major procedures and tests performed during the ED visit AND
2. Principal diagnosis at discharge OR chief complaint AND
3. Patient instructions AND
4. Plan for follow-up care (or statement that none required) including primary physician, other health professional or site designated for follow up care AND
5. List of new medications and changes to continued medications for after discharge including quantity prescribed (or duration) and instructions for each.

This measure has been suspended by CMS effective January 2012 because of concerns raised regarding the current measure specifications, including potential privacy concerns.

Data collection for new Outpatient Pain Management and Stroke Measures began in 2012.

OP-21, ED-Median Time to Pain Management for Long Bone Fracture Time (in minutes) from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department patients with a diagnosis of a (long bone) fracture. Patients seen in a hospital emergency department are eligible to be sampled if they have:

1. A Patient Age on *Outpatient Encounter Date* \geq 2 years, and
2. An *ICD-9-CM Principal Diagnosis Code* for Long Bone Fracture

OP-23, ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival. Patients seen in a Hospital Emergency Department are eligible to be sampled if they have:

1. A Patient Age on *Outpatient Encounter* \geq 18 years, and
2. An *ICD-9-CM Principal Diagnosis Code* for Acute Ischemic or Hemorrhagic Stroke

The list of quality measures that affect emergency medicine will continue to grow. It is important to stay ahead of the curve. Updates to the measures are published on line every six months. They can be reviewed at www.qualitynet.org. Click on the "Hospitals Inpatient" or "Hospitals Outpatient" tab and select "Specifications Manual." To keep your eye on the competition and review your own publicly reported data go to www.hospitalcompare.hhs.gov. I will update you on any new measures and the status of those currently on hold in a future edition of the *EPIC*. ■

Measure Type / No. Measures for Calendar Year (CY) 2013 Payment Determination

Acute Myocardial Infarction

- OP-1 **Median Time to Fibrinolysis ¹**
- OP-2 **Fibrinolytic Therapy Received Within 30 Minutes ¹**
- OP-3 **Median Time to Transfer to Another Facility for Acute Coronary Intervention ¹**
- OP-4 **Aspirin at Arrival ²**
- OP-5 **Median Time to ECG ²**
- OP-16 **Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Within 60 minutes of Arrival ²**

- 1. Measure only applies to AMI population.
- 2. Measure applies to both AMI and Chest Pain population.

Surgical

- OP-6 Timing of Antibiotic Prophylaxis
- OP-7 Prophylactic Antibiotic Selection for Surgical Patients

Imaging Efficiency

- OP-8 * **MRI Lumbar Spine for Low Back Pain**
- OP-9 * Mammography Follow-up Rates
- OP-10 * Abdomen CT—Use of Contrast Material
- OP-11 * Thorax CT—Use of Contrast Material
- OP-13 * Cardiac imaging for preoperative risk assessment for non cardiac low risk surgery
- OP-14 * Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography
- OP-15 ** **Use of Brain CT in the Emergency Department for Atraumatic Headache**

Structural

- OP-12 The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data
- OP-17 Tracking Clinical Results between Visits

ED Throughput

- OP-18 **Median Time from ED Arrival to ED Departure for Discharged ED Patients**
- OP-19 *** **Transition Record with Specified Elements Received by Discharged Patients**
- OP-20 **Door to Diagnostic Evaluation by a Qualified Medical Professional**
- OP-22 **ED- Patient Left Without Being Seen (Numerator/denominator one time per year for the previous year)**

Pain Management

- OP-21 **ED- Median Time to Pain Management for Long Bone Fracture**

Stroke

- OP-23 **ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival**

Bold - ED Specific Measures

*Imaging Measures Data Reported on 2010 Claims in 2012.

**Public reporting postponed

***Suspended by CMS until further notice;

Inpatient Boarding in the ED

continued from page 3

The result is a profound disconnect between daily ED life and what the remaining hospital staff imagine takes place on the ground floor.

During the entire discussion always highlight the fundamental driving force behind your efforts. The explanation must be patient centric. Potential side effects such as an improvement in working conditions, staff morale, and recruiting ability are secondary and should be reserved for other discussions.

Probably the most challenging aspect in outlining the problem is the need to present the issue in a constructive manner. It must be advanced from a problem-solving vantage point, a common ED characteristic. It cannot be presented in a manner that allows the audience to interpret it as merely “whining.” Depending upon your situation, you may consider some of the following methods:

Tell a story – It can be surprising how well a specific example appeals to members of the audience. The majority can relate to a description of a particularly “pungent” example of boarding – we all have one. If necessary, develop a list of examples to reference as the situation requires.

Know the literature – Take the time to perform a literature search and be prepared to provide ample evidence surrounding the deleterious affects of boarding (www.acep.org is a great place to start). While the approach is doubtful to be a primary driving force, it can be a powerful piece. It will also serve as an ample resource in offering potential solutions.

Highlight real or potential patient harm – We all have a specific example where a patient was harmed due to ED crowding. Similar to the telling of a story, outline the contributing factors and details that surrounded the episode. One must use caution with this approach, as it may invite severe criticism and blame at certain institutions. Ensure that you have adequate hospital support before highlighting a safety issue.

Present the extremes – I would offer that most members of the institution do not understand the profound flexibility required on a daily basis. Most EDs use “nontraditional” treatment spaces such as hallways, chairs, recliners, as well as various other

potential solutions. The number of non-traditional treatment spaces relative to the number of ED rooms can be quite sobering. As before, this needs to be presented with a “can-do attitude,” highlighting the ED’s flexibility to meet the need for patient care.

Develop an analogy - Some of the greatest leaps in understanding (especially among nonmedical audience members) can be obtained with the use of an analogy. Greater benefit will be realized if the analogy can be specifically tailored to the audience. Find something that you are comfortable with that can directly relate to your situation. Some suggestions would include using an aircraft carrier, restaurant, grocery store, or manufacturing line. Keep it simple and allow your audience to relate.

Take a picture – In keeping with the adage “you have to see it to believe it,” a picture may provide significant understanding of the issue. Despite all of the above, a visual aid may be necessary in solidifying the point. It can be almost humorous to observe the audience reaction when displaying a typical evening in the ED, as judged by the resultant “floor-to-mandible distance” (i.e. jaw dropping). Despite your best efforts, some will be unable to imagine flexing ED space to meet emergent demands (e.g. CPR in the hallways, STEMI care on the EMS stretcher in an egress corridor until the cath lab is prepped, etc.). A picture, HIPAA complaint of course, may be all that is required.

Know your finances - The financial argument against boarding can be extremely compelling. Although this topic falls outside the scope of this article, take time to learn the various economic pieces and how they can fit together.

While the preceding points help to outline the problem, it is important to develop a way to quantitate the issue as well. Providing means of measurement will result in increased level of understanding for certain audience members. It will also serve as a foundation to measure future changes and to determine their effectiveness.

Measure the problem

We all have seen the multiple metrics used to measure ED efficiency. Most sites have a complex dashboard to monitor operations and to recognize the need for process analysis. If we tried to use these dashboards, the audience eyes would likely

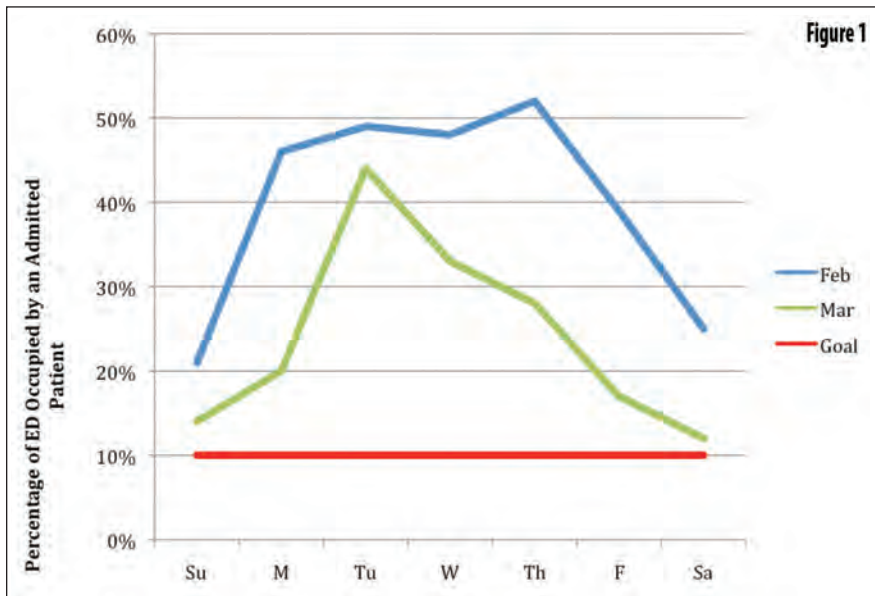
begin to glaze over and we would lose all momentum. The main challenge is to ensure that the presentation is easily understood and followed. Multiple different metrics have been proposed in the literature, but in interests of simplicity I would like to highlight the following. As before, each is dependent upon your department’s ability to collect as well as your audience’s “data maturity” (i.e. Will they be able to understand the data?).

A simple count - This is generally reserved for EDs without an electronic medical record and is relatively easy to implement. This is simply a count of the number of boarders at a certain time of the day. While this is simple to perform, the main drawback is that it does not provide the complete picture. Notably, the exact time of day which to measure is always a source of debate, with constant anecdote that the boarding numbers were higher other points during the day. Though given your level of data extraction ability, a basic count may be your only initial choice to measure boarding.

Number of boarding hours – Some organizations track boarding by simply totaling the number of boarding hours that occur during a time period. In the presence of an electronic medical record this is also one of the simpler metrics to obtain, however can be a bit more esoteric. It is easily tracked and referenced by members of the ED team, though other individuals will likely require a continual frame of reference.

Total boarding impact - Several years ago, the Institute for Healthcare Improvement suggested “wasted bed capacity” as a means to measure ED inpatient boarding. This measurement is somewhat cumbersome and is challenging to explain. We have created a hybrid approach that is more readily understood. “Total Boarding Impact” is simply the number of patient boarding hours divided by the number of ED bed hours available. This generates a single percentage indicating ED bed occupancy and is readily understood, providing for a crisp presentation. By further breakdown, it can be displayed by day of the week; truly demonstrating the specific challenges experienced each day. (see Figure 1).

continued on next page



Total Boarding Impact by day of week – Successive months illustrating the monthly variation. During February, an admitted patient occupied nearly 50% of the ED from Monday through Thursday. Note – the 10% goal was set internally.

Nontraditional treatment space utilization (aka “hallway use”).

The majority of our colleagues have a preconceived notion of how emergency care is delivered, frequently drawing upon their past experience during training days. Some members of the medical staff will even scoff at the idea of providing patient care in “nontraditional” treatment spaces (e.g. hallways, recliners, and waiting room chairs). But given system constraints, this is now commonplace in the ED environment. As a corollary to Total Boarding Impact, it may be beneficial to illustrate the number of patients that received emergency care without occupying an actual ED room. For example, during a particularly challenging week many individuals were quite surprised to learn that 98% of ED treat-and-release patients never received care within the confines of a room. Although crisis numbers of boarding were reported on a daily basis, the extra step in realization never occurred. This data element demonstrated the reality that all ED patients are affected during these extreme times.

Although the above metrics are quite basic, they may significantly increase institutional boarding awareness. The ability to reference baseline data and illustrate

the affects of hospital crowding on ED operations is necessary for understanding. Depending upon your situation, you may also choose to highlight other ED metrics that can be closely associated with ED crowding, such as LWOT, door to provider, ED throughput times, etc. The key is simplicity and to resist the tendency to drown your audience in data.

The Next Steps - High Functioning Organizations

Despite all your efforts, success will be limited by the organization’s approach to ED inpatient boarding. It essentially boils down to, “Who’s patient is in the ED waiting room - The ED’s or the hospital’s?” Organizations that fall in the latter category generally demonstrate some key hospital administrative characteristics.

A surge protocol is present and is implemented at appropriate times

Hospital leadership rounding occurs on patients that boarded in the ED for extended times. The best examples are hospitals in which a senior hospital administrator rounds on any patient boarding in the ED greater than 8-12 hours. This rounding is done the following day.

Hospital leadership rounds in the ED during high-volume times. This provides continual reminders of the underlying issue and practice environment. It also functions to motivate the ED team since they experience direct feedback of hospital administrative involvement.

Nursing leadership involvement during extreme surge. Some sites have required each hospital nurse manager to cover two-hour shifts in the ED. Though not necessarily providing direct patient medical care, these nursing leaders serve as helping hands to meet patient comfort measures, assist with transport, etc. This functions to gain valuable experience and a firsthand reminder how the ED functions during these times.

Putting it all together

Not surprisingly, there is both art and strategy in telling the story. The art is a combination of examples, medical literature, financial data, and metrics during delivery. At each point during our discussions, we must demonstrate a problem solving approach. At no time can our message become confused with “whining.” The strategy component includes a stepwise approach in relaying the key components as well as varying the approach at times. The ability to synthesize the information will take time and dedicated effort.

ED crowding is hurting our patients. We are the ones that will shape our future. It falls as our responsibility to present the issue in an effective manner and gain the needed support for our patients. ■

Well-established private group in Westchester County needs additional staff physicians for contract with excellent community hospital. This facility has a Stroke Center Designation, a new cath lab and a university affiliation. The newly renovated Emergency Department has a Fast Track staffed by Nurse Practitioners and an annual ED volume of 38,000 patient visits. Group is offering competitive compensation package. For more details please contact Daniel Stern at Daniel Stern & Associates 800-438-2476 or sternd@danielstern.com.

Albany Update

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- If the independent dispute resolution entity determines that the fee charged is excessive the independent dispute resolution entity will determine a reasonable fee provided the fee shall not be less than the usual and customary fee for such services.

Changes to Observation Services in Hospitals Bill Passes Both Houses A.10518-A, Rules (Gottfried)/ S.7031-A, Hannon

This bill makes changes to recently enacted Department of Health (NYSDOH) regulations related to observation services in hospitals. New York ACEP strongly supported and championed the NYSDOH regulations to require hospitals to set up separate observation units supervised by emergency physicians. Unfortunately, the regulation was strongly opposed by the state hospital associations and they were successful in getting legislation introduced and passed this session to eliminate most of the requirements in the regulation.

New York ACEP strongly opposed this legislation through a series of meetings, issuing a memo to the full Legislature and a number of action alerts requesting member action. When meeting with the bill sponsors, we requested amendments to the bill to ensure that observation units are emergency physician directed but unfortunately our proposed amendments were not accepted. Despite all of New York ACEP's efforts, the final bill did not mandate emergency physician supervision of observation units nor make such units mandatory. We thank all of the membership for your efforts in opposition to this measure and want to let you know that the fight is not over. The Department of Health still strongly backs our position and their regulation and we will continue to oppose this bill when it comes before the Governor for consideration. Specifically, we will demonstrate that observational units and importantly those supervised by emergency physicians are important to improve patient care and they save hospitals money. We will need member assistance to help make this case by writing to the Governor to ask that he veto the bill once it is on his desk. We are closely monitoring the bill and will notify New York ACEP when it is time to take further action. ■

President's Message

continued from page 2

The Government Affairs Committee had a healthy debate about the legislation. We understood how hospitals might feel they need more leeway in how they handle observation services. We understood how some emergency physicians might feel that formal observation services are not within their bailiwick. In the end, we agreed that emergency medicine needs to be deeply involved in the future of observation medicine, both clinically and administratively. No specialty has the clinical breadth, decision-making capabilities, procedural skills and in-hospital physical presence that we do. The regulation as written would have created more EM jobs.

As of this printing the Bill has not been signed into law and we know that the DOH is opposed to it. A veto by Governor Cuomo is possible but unlikely.

Please get involved with your Government Affairs Committee. Respond to Action Alerts by placing a remarkably simple (and often enjoyable) two-minute phone call to Albany. Please donate regularly to the NYEMPAC.

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Thanks to Weingarten, Reid & McNally, the New York ACEP lobbying firm, with help preparing this report. ■

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PCIA and PCAA in the ED in New York State – Two Laws That Impact How You Provide Care in the ED

*Jon C. Kerr, MD MBA, Emergency Critical Care Fellow, North Shore University Hospital
Todd L Slesinger, MD FACEP FCCM, Director, Fellowship in Critical Care Medicine,
North Shore University Hospital*

Emergency departments across the United States are always in flux. Managing the constant barrage of sick patients, new changes in standards of care and specific nuances to each geographical area are just a handful of the many issues emergency department physicians manage. As a skill inherent to the practice of emergency medicine, emergency department physicians are adept at quickly adapting to changes, adopting new standards and identifying and then instituting state-of-the-art practices. Emergency departments in the state of New York have recently seen two new laws impact the way medicine is practiced therein.

On August 13, 2010 section 2997-c of Chapter 331 of the laws of 2010 of New York State became a law. 180 days later, on February 9, 2011, that law went into effect. Colloquially known as the “Palliative Care Information Act” or “PCIA,” section 2997-c mandates those physicians or nurse practitioners who have primary responsibility for a patient to offer to provide information concerning palliative care to patients with a “terminal illness or condition”. Another new law, Section 2997-d, became a law when, on April 1, 2011, Governor Cuomo signed into law Chapter 59 of the Laws of 2011. This section, known as the “Palliative Care Access Act” or “PCAA” became effective on September 27, 2011. The PCAA legislates that health care facilities, nursing homes and certain types of other care facilities provide appropriate information concerning palliative care and pain management options and facilitate access to palliative care and pain management consultations and services for patients with “advanced life limiting conditions or illnesses.”

Both of these laws apply to emergency physicians and will impact the way we practice, interact with and communicate with our patients. Briefly, the PCIA mandates the attending health practitioner to offer to provide information regarding palliative care to any patient who has a terminal illness or condition. This statement, though ambiguous at first glance, gains clarity with several definitions. The law defines the “attending health practitioner” as the MD or NP “who has primary responsibility for the care and treatment of the patient.”¹ The law further mentions that if there is more than one doctor with primary responsibility, then they each share the burden of providing palliative care information to the patient—unless they all agree on assigning that responsibility to one of them—and document this fact in the patient chart. A terminal illness or condition is defined as “an illness or condition that can reasonably be expected to cause death within six months, whether or not treatment is provided.”² Finally, palliative care describes “health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient’s quality of life, including hospice care...” Essentially when a patient is diagnosed with a terminal illness or condition, the PCIA dictates the attending health care practitioner must offer to provide the patient with information, counseling, and guidance concerning their diagnosis, prognosis, symptom management, pain management and treatment options within the context of palliative care and end-of-life care.

If a patient lacks capacity or is unable to fully understand the implications of a palliative care discussion, the attending health care practitioner should provide the information to someone who has the authority to make health care decisions for the patient. If the health care practitioner decides with another physician that the second physician will accept the responsibility to provide palliative care information to the patient, then this is documented in the chart and the emergency department physician does not have to relay the information to the patient.

Care must be taken to understand that this law does not apply only to primary care practitioners, but rather it delineates primary responsibility to those practitioners who are providing care and treatment to the patient. Thus, although emergency department physicians are not primary care practitioners per se, they are primarily responsible for the care and treatment of a patient while in the emergency department. This is further explained by Karen Lipson, Director of Division of Policy in the Office of Health Systems Management at the New York State Department of Health: “If you are a physician who has primary responsibility for a patient with a terminal illness, working in the State of New York, this law applies to you, whether you are an emergency department physician or a primary care physician or a specialist.”

Section 2997-d or the Palliative Care Access Act (PCAA) adds to the PCIA by ensuring that hospitals and other care facilities as well as physicians are not only providing information and counseling about palliative care but are also facilitating “access to appropriate palliative care

continued on next page

PCIA and PCAA in the ED in New York State

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consultation and services, including associated pain management consultations and services²³—these must be made in parallel with the patient’s needs, preferences and goals of care. Finally, the law applies to patients with “advanced life limiting conditions or illnesses²⁴ and not just the terminally ill patient. Thus, patients with severe dementia, COPD, CHF and other disease states are covered by the PCIA only if their condition is expected to cause death within six months, but they are covered by PCAA if their condition is advanced and life-limiting.

It is important to note that the PCIA requires an offer of palliative care information, and the PCAA requires facilities to provide access to palliative care information and services. The patient or his/her health care decision-maker may decline the information and/or services.

As with *all* public health laws in the state of New York, violations carry a potential civil penalty of up to \$2,000 for

the first infraction. Repeat violators may be charged up to \$5,000 for each violation if the violation occurs within twelve months of the initial violation. Willful violation of any public health law, including the PCIA and PCAA laws, may be punishable by a one year imprisonment term and up to \$10,000 in fines. Furthermore, medical misconduct investigations may be initiated in cases of gross negligence or repeated infractions.

The take home message is that these two laws have the potential to impact how we deliver care and how we talk about delivering care to our patients. Although this may take more time, we can enhance patients’ experiences and enrich their care. For some, they may benefit from a long-needed conversation about their condition, goals for care, treatment options, and palliative care—and that conversation may change the direction of the care provided to them. When asked how emergency department physicians can best harness the potential of these two laws, Lynn Hallarman, Director of Palliative Medicine at Stony

Brook University Medical Center, said, “You don’t realize how much of the patient’s attention you have in the ER. ER doctors have an incredible opportunity to engage patients when they are awake and comparatively well. The ER doctor needs to find words for what you already know. These laws are straightforward, simple and impactful. They develop some language for doctors about how to talk to the patient.” You can use these laws to help initiate appropriate palliative conversations with patients, or in cases where it does not seem appropriate, pass on the responsibility to another provider.

Additional information and other important resources, including resources on communication with patients concerning palliative care and end-of-life issues, can be found at http://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/

Endnotes

- ⁱ Laws of New York 2010. Chapter 331, Section 2997-c.
- ⁱⁱ Ibid.
- ⁱⁱⁱ Laws of New York 2011. Chapter 59, Section 2997-d.
- ^{iv} Ibid. ■



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Vice Chair-Operations at Albany
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Albany Medical Center, bring this
feature column to the EPIC.

Pneumonia, Bandemia and Persistent Hypotension in an Eight Year Old Boy: Clues to an Unlikely Etiology

Lindsay Stokes, MD, PGY3 Emergency Medicine Resident
Kristie Miller, MD, PGY2 Emergency Medicine Resident
Beth Cadigan, MD, Director of Emergency Ultrasound and
Associate Professor of Emergency Medicine at Albany Medical College
Heather Long, MD, Director of Toxicology and Associate Professor
of Emergency Medicine at Albany Medical College
Denis R. Pauze, MD FACEP FAAP, Vice Chair-Operations at
Albany Medical Center

The History

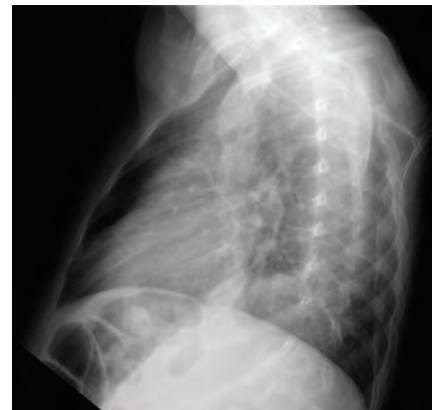
The patient is an 8-year-old male transferred from an outside facility for evaluation of abdominal pain, fever, and a possible “lung mass.” Two days prior to arrival he complained of severe abdominal pain with associated fever. He had no associated nausea, vomiting, or diarrhea. The following day he saw his primary care provider, with additional complaints of cough and rhinorrhea. He was diagnosed with a viral URI and sent home. That evening he awoke from sleep screaming from severe abdominal pain. He was subsequently evaluated at an outside hospital in the middle of the night. Labs were significant for a white blood count of 28 with an associated 30% bandemia. Blood urea nitrogen was 26, creatinine 1.0, and bicarb was 19. A CT of the abdomen and pelvis showed no abnormal abdominal pathology, although lower lung images revealed a left lower lung “mass.” Because of his hypotension, he was treated with a total of 60 cc/kg of normal saline, was given a dose of intravenous ceftriaxone, and subsequently transferred to our facility.

He arrived in the early morning looking tired and somewhat drowsy, but nontoxic. He was able to answer questions appropriately. His initial vital signs revealed a T: 39.4 C, BP: 90/39, HR: 98, RR: 24, O2 Sat: 95% on Room Air. His exam was significant for diminished breath sounds at the left lower base without accessory muscle use. His abdomen was soft and nondistended, with mild diffuse general tenderness. There were no peritoneal signs. Genitalia exam revealed a positive cremaster reflex. Skin was warm without rashes or petechiae. Capillary refill of approximately 3 seconds.

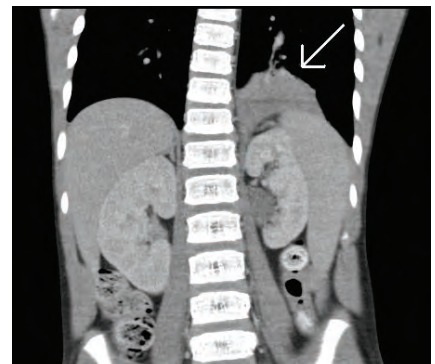
He had a past medical history of ADHD, seasonal allergies, and febrile seizures. Upon further questioning on the family, the patient states that they do recall one episode approximately two weeks prior where he woke up in the middle of the night with complaints of abdominal pain.

Initial ED Course

We sent off a Lactate level which was found to be negative. Chest x-ray performed revealed a presumed round pneumonia (Fig. 1). Previous CT images were reviewed by our pediatric radiologist and confirmed pneumonia as the source



Figures 1 (above) and 2 (below)



of the suspicious looking lung mass (Fig. 2). Vancomycin was additionally added to his antibiotic regimen. Over the next few hours, the patient's blood pressure dropped to 71/40 and 70/31 with heart rates of 87 and 90, respectively. His lowest systolic BP was in the 60's. He was not making urine, was tired, but was answering questions appropriately.

So we have an 8 year old boy with pneumonia, bacteremia, and a negative lactate. He remains hypotensive despite multiple fluid boluses. Why wasn't he tachycardic? What about the abdominal pain? Is this just referred pain from the pneumonia? What would you do next?

What is the Evaluation of the Hypotensive patient with Ultrasound (Dr Beth Cadigan; Director of Ultrasound at AMC)

Although we are quick to apply ultrasound to the unstable trauma patient (FAST), it often takes some of us longer to pursue this tool when working up sick medical patients, particularly those with undifferentiated hypotension or shock. Rapid assessment of the heart and IVC can prove valuable in deciphering these undifferentiated patients.

Using ultrasound to interrogate the pediatric heart may reveal effusion or tamponade and can allow for the qualitative assessment of left ventricular function. Decreased cardiac contractility in the face of hypotension points toward a primary cardiac cause for a child's instability. While precise calculation of ejection fraction has its place, often times a couple second view of the heart will suffice for grossly assessing its functional squeeze, particularly after viewing a reasonable number of normal and abnormal exams. Is the heart dilated with minimal wall movement, or is the heart hyperdynamic with a left ventricle that nearly collapses at the end of systole? The difference between a child with a potential cardiomyopathy and one requiring fluids in the face of sepsis or hypovolemia.

The IVC can also be evaluated to establish volume status. In the subxiphoid area, when viewed in its longitudinal orientation, The IVC should be measured distal to the entry of the hepatic veins (~2 cm down in an adult), can give us a sense of central venous pressure (CVP). In an unvented patient, an IVC that nearly completely



Figure 3

collapses with inspiration is associated with hypovolemia (Fig. 3), while one with no inspiratory collapse suggests against volume depletion and that preload alone is not the answer.

ED Course, continued.

Because of the intermittent severe abdominal pain, abdominal ultrasound was performed and ruled out intussusception. The patient received a further 40ml/kg bolus in the emergency department. He still remained hypotensive, yet his heart rate did not respond to his low blood pressure. EKG revealed a sinus rhythm without evidence of low voltage.

We were subsequently concerned about a cardiac catastrophe as the underlying etiology. Could a myocarditis or cardiomyopathy be causing his symptoms? Pediatric patients with myocarditis can present with various nonspecific symptoms, including abdominal pain, nausea, vomiting or fatigue. The PICU Intensivist was called, as well as Pediatric Cardiology for a stat echo.

Stat echocardiogram done in the ED revealed normal heart function and no significant cardiac abnormalities.

Now we have an 8 year old with pneumonia, leukocytosis, and bacteremia who is persistently hypotensive and unresponsive to fluids. He has a normal lactate and his heart function is normal. There is no obvious abdominal pathology on ultrasound or CT scan. Could this be an unusual infectious disease that can cause relative bradycardia, such as legionella, psittacosis, or typhoid fever? Unlikely. What else could we be missing?

Could the clue be discovered in the patients history?

PICU Course

After completion of the echo, he was transferred to the PICU. A PICC line was placed in anticipation of pressor use. His blood pressure upon arrival was 68/48 with a heart rate of 82. Additional detailed discussion with the patient's step-mother revealed that he was currently taking Intuniv, Adderall, Focalin, Focalin XR and Clonidine for control of his ADHD, as well as Melatonin for sleep. He had previously taken Clonidine for an extended period of time, but it had been stopped three months prior to this current admission due to improvement in his ADHD symptoms. Clonidine was restarted, however, on his most recent visit to his primary at 1.5 times his prior dose (0.15mg daily) due to resurgence of his symptoms.

He received his first dose of the medication the night before presentation to the hospital.

Clonidine OD in the Pediatric Patient: (Dr. Heather Long; Director of Toxicology at AMC)

The theory was put forth that the patient's persistent hypotension and relative bradycardia could be caused by Clonidine toxicity. His step-mother had the patient's new bottle of Clonidine, the pill count was correct, his previous bottle had been discarded months ago, and his step-mother had administered his medication last night. There was little chance that he had taken more than his 0.15mg dosage. His step-mother also felt that though he had been sick for multiple days, his more acute decline had begun shortly after his medication was given. Could the patient be Clonidine

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Clues to an Unlikely Etiology

continued from page 25

toxic despite having taken no more than the therapeutic dose? Very severe poisonings in children have been reported with clonidine ingestions as small as 0.2 mg. As his vital signs remained unchanged despite fluid administration and antibiotics, we considered that the patient's sepsis like picture in addition to a 50% increase in dosage to a relatively clonidine-naïve patient could have potentiated toxicity. Clinical manifestations of clonidine toxicity in addition to hypotension and bradycardia include CNS depression, respiratory depression and miosis. For these reasons clonidine toxicity may mimic opioid toxicity. Patients with clonidine toxicity can be treated with good supportive care, including airway support, fluid resuscitation and administration of vasopressors if indicated. Animal studies and many human case reports also support a trial of naloxone.

Case Outcome

The patient's Clonidine was held and he was treated with Cefepime for his pneumonia. While he remained hypotensive with relative bradycardia for 10 hrs after his admission, pressors were never started. The next morning the patient had improved significantly and his heart rate and blood pressure returned to 107/82 with a heart rate of 102. He was discharged to the floor where he remained for one day. Blood culture grew out gram negative diplococci *Veillonella* species. His Clonidine was held during his inpatient stay and he was sent home on antibiotics for his pneumonia. On a follow-up call two days after discharge the patient's step-mother said that he had had no recurrence of symptoms and that he was back to his very active self.

We as physicians sometimes have to be "medical detectives." This case illustrates the importance of a taking a good history, including asking about newly started medications. Remember to also ask about herbal supplements, as many patients do not consider herbals as medications. In addition, when things "don't add up" in the pediatric patient, think about a known or unknown tox ingestion.

To submit an article for consideration, email nyacep@nyacep.org. Especially interested in hearing from fellows in Pediatric Emergency Medicine and residents with a special interest in Pediatric Emergency Medicine. ■

Leadership and Advocacy Award

Vincent Roddy, MD, Emergency Medicine Resident, PGY-IV, Mount Sinai School of Medicine, Department of Emergency Medicine

Hello, my name is Vincent Roddy and I am currently in my final year of residency at the Mount Sinai School of Medicine, Department of Emergency Medicine. In May of this year, I had the pleasure of attending the ACEP Leadership and Advocacy Conference. Along with three others from my residency, we came to Washington DC to learn more about the issues that are affecting the practice of emergency medicine nationwide. The conference was increasingly exciting as the Supreme Court decision had yet to be announced regarding the constitutionality of the Affordable Care Act. To say the least, there was much on the agenda and emergency physicians from around the country came to the conference to inform, to be informed, to discuss, and ultimately advocate on behalf of our specialty within the halls of Congress.

Having come to the conference the year before for the first time, I was able to re-connect with a few emergency medicine physicians I had met previously while also meeting and networking with others for the first time. The conference began on a Sunday and lectures covered current issues in health policy as well as Health Economics. The first day truly set the tone of what to expect for the rest of the conference.

The lectures were comprehensive and helped frame why advocacy is important to the health and well-being of our specialty. In addition to the lectures during the first two days of the conference, there were also ACEP and EMRA committee meetings.



This provided residents with a chance to see firsthand what extracurricular opportunities exist within ACEP and EMRA regarding health policy, advocacy, and other relevant topics.

The true highlight for me was during the third day of the conference. There was an advocacy training lecture in anticipation for our Capitol Hill visits later that day. Emergency medicine physicians partitioned by state; once in our groups, we were assigned meeting times with Congressional representatives from our districts and senatorial representatives from our respected States. The lectures, discussions and training we had received during the conference truly showed during our Capital Hill visit. Each member in our group was able to articulate why we felt health reforms were needed and how this would not only benefit our patients, but ultimately the medical system as a whole. The congressional and senatorial representatives seemed receptive. Let us hope that with continued attention to detail and communication with our elected officials, positive change can be achieved within the foreseeable future. I want to thank New York ACEP for awarding me the Resident Leadership and Advocacy award which covered my travel and lodging expenses during the conference. For any, attending, resident, PA, NP or medical student reading this

testimony, I thoroughly recommend attending this conference. The number of attendees has grown per year and the quality of the lectures will leave you in a more informed position regarding advocacy and current issues that may affect our specialty. I definitely plan on attending next year; maybe I'll see you there!

Photo caption: From l to r: Drs. Trevor Pour, Seth Trueger and Vincent Roddy ■

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Regional Health Information Organization

Louise A. Prince MD, FACEP, Associate Professor, Emergency Medicine,
Chief Quality Officer, Upstate University Hospital

It does not take a disaster such as hurricane Katrina for an emergency physician to realize the highly complex and fragmented health information system they work in. It just takes the first patient of the shift with EKG changes that was diverted from the hospital where they usually receive their cardiac care. The EKG changes are troubling; the patient's symptoms are not clearly cardiac in nature. The physician has minimal time to decide whether to embark on a full fledged cardiac evaluation including a stat cardiology consult, or possibly sending the patient to the catheterization laboratory in order not to violate the 90 minute door to balloon time. The mad dash to find an old EKG at the other hospital has commenced. Why is this not easier in this day and age of technology?

Technology is on the way to answering that question. It took a natural disaster causing the displacement of thousands of patients whose medical records, medications, prescriptions, and problem lists were lost or unavailable to providers during hurricane Katrina to awaken the federal government to the serious nature of the problem. In 2004, President George Bush issued an executive order for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care. The goal is for most Americans to have an Electronic Health Record (EHR) by 2014.

In July of 2004, the Department of Health and Human Services released their vision of a health information exchange that endorsed voluntary standards necessary for health information to be shared safely and securely among health care providers. The President's budget in 2005 included \$100 million for demonstration projects. The Health Information Security and Privacy Collaborative began nationally in 2006 resulting in the birth of RHIOs. Currently there are over 190 RHIOs in various stages of development across the country. New York State, under the auspices of the DOH, has established the New York e-health Collaborative; a public/

private partnership with statewide governance. There are now established regional health information exchange organizations throughout New York State. Here in Central New York, it is the HeC (Health e Connections) which provides access to **authorized providers of participant organizations** to a virtual health record via a secure portal **subject to patient consent**. The Central New York RHIO includes multiple hospitals, public health registries, Medicaid providers, long term care facilities, physicians, other healthcare providers, diagnostic centers, and some prescription services. Finally, access to patient health care information in our region is available. Well, that would be a yes and a no.

Currently in New York State, access to this information is patient driven. Patients must give written consent to access their information. When they deny consent, this denies consent even in the case of an emergency. This consent must be obtained separate from the facility's usual and customary consent to treat. If patients are undecided or undeclared, access to their information is limited to cases of emergency. So, for emergency physicians, it is imperative to know the "Break the Glass" consent exceptions. The information for an undeclared or undecided patient may be accessed if: **1.)** There is an imminent life-threatening emergency **and 2.)** The patient cannot consent due to incapacity. **3.)** If the patient's surrogate is present, they must consent (this is considered patient consent and should be indicated as such during RHIO access). Once consent is given, the information can be used for treatment purposes only. There is no filtering of information (for instance HIV status); it is an all or none approach. Access is restricted to minors' information age 10 and older. There is no expiration once consent is given but consent can be revoked. Each organization is provided a report for validation of every case of "break the glass" consent exception declared. The organization must review the cases and insure that this was a necessary access. If the provider is found to be accessing information without consent, their log on

permission will be revoked. If the patient has denied consent for their records to be accessed through the RHIO, a "break the glass" exception cannot be applied.

In 2011, Frisse et al published a study in the Journal of American Medical Informatics Association of 12 emergency departments studied over a 13 month period. In cases in which Health Information Exchange (HIE) data was accessed (6.8% of visits) there was an annual cost savings of \$1.9 million. Hospital admission reductions accounted for 97.6% of total cost reductions. (1) For the example of the abnormal EKG in the new patient presenting to the emergency department, consider the cost reduction of immediate access to prior EKGs and cardiac evaluation studies if this access could avoid a trip to the catheterization laboratory or admission. Cases such as these and the potential reduction of radiation exposure should the availability of prior CT scans, etc, be immediate should prove the value of immediate access to a Health Information Exchange.

To access information in a geographic area, go to the www.nyhealth.org web site for the New York eHealth Collaborative. Currently there are 12 RHIOs available based on geographic areas within New York State that are listed on this site. Click on the one closest to your practice setting to find out if your organization participates and how you can gain access. In general, there is a brief educational session plus the home facility must be a participant and submit each physician name in order for individuals to qualify for access. After completion of access requirements, remember the consent policy briefly stated above. Contact hospital administration for your facility's rules of participation and access.

All physicians share the vision of a national Electronic Health Record (EHR) and the benefits this will have for patient care and safety. For any physician working in a VA facility the incredible value of such a system is easily visible. With such a mobile patient population, the access to all health information available on any patient is imperative for not just cost savings, but good, safe patient care.

(1) Frisse ME, Johnson KB, Nian H, et al. The financial impact of health information exchange on emergency department care. *J Am Med Inform Assoc* (2011). Available online at <http://jamia.bmj.com>. ■

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september

- 12 Resident Research Conference, Mount Sinai School of Medicine, 8:00 am-Noon
- 12 Education Committee Conference Call, 1:30 pm
- 12 Professional Development Conference Call, 3:30 pm
- 13 Practice Management Conference Call, 1:00 pm
- 19 Government Affairs Conference Call, 11:00 am
- 19 Research Committee Conference Call, 3:00 pm
- 20 EMS Committee Conference Call, 2:30 pm
- 24-25 Strategic Planning Meeting, Mohonk Mountain House
- 25 Board Orientation & Board of Directors Meeting, Mohonk Mountain House

October

- 6-7 ACEP Council Meeting, Hyatt Regency at Colorado Convention Center, 8:00 am-5:30 pm
- 8-11 ACEP Scientific Assembly, Colorado Convention Center
- 8 New York ACEP Member Reception, Hyatt Regency at Colorado Convention Center, 6-7:00 pm
- 10 Education Committee Conference Call, 1:30 pm
- 10 Professional Development Conference Call, 3:30 pm
- 11 Practice Management Conference Call, 1:00 pm
- 15 Empire State EPIC articles due (November issue)
- 17 Government Affairs Conference Call, 11:00 am
- 17 Research Committee Conference Call, 3:00 pm
- 18 EMS Committee Conference Call, 2:30 pm
- 22 2012 LLSA Review Course, Mount Sinai School of Medicine, 8:00 am-1:00 pm

november

- 7 Emergency Medicine Residents Career Day and Job Fair, New York Academy of Medicine, 7:30 am-1:30 pm
- 8 Practice Management Conference Call, 1:00 pm
- 14 Education Committee Conference Call, 1:30 pm
- 14 Professional Development Conference Call, 3:30 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

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