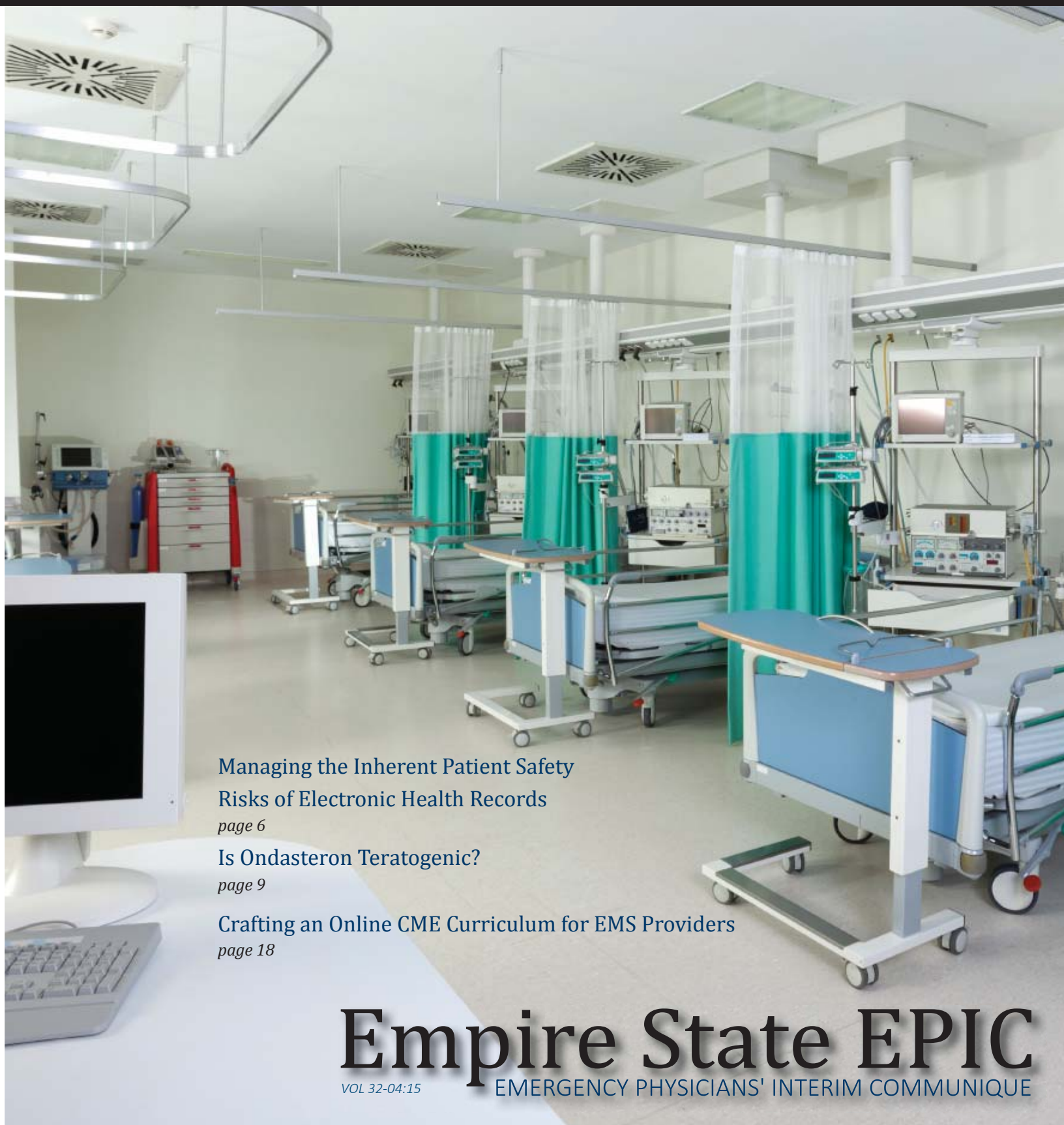
New York American College of Emergency Physicians

ADVANCING EMERGENCY CARE



Empire State EPIC

VOL 32-04:15

EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE

President's Message

Gratitude

Louise A. Prince
MD FACEP
Associate Professor, Emergency Medicine
SUNY Upstate Medical University

At 6 AM July 7, you will find me sitting quietly on the dock behind the Sagamore on Lake George enjoying the serenity and peace offered by that beautiful resort especially in the early morning hours before the rest of the vacationers and boaters awaken. This year New York ACEP will host the 2015 Scientific Assembly at the Sagamore from July 7-9. Please join us. Our membership and their families are so fortunate to have the opportunity to visit and enjoy such a fantastic resort in such a beautiful location. I know my family and I have for many years. I am personally grateful.

As I thought about this upcoming meeting, I realized how simply grateful I am for the wonderful vocation I have been given in medicine that provides for my family. Without it, we would not be headed to the Sagamore for another year. I am also incredibly grateful for the work of the entire education committee, especially Kaushal Shah and Penny Lema, who put in so much time to bring us such a great educational program every year. (Has anyone ever filled out a CME application – point made.) All of our committee chairs, committee members, as well as our board of directors are volunteers. They give freely of their time to help make our New York ACEP programs and initiatives effective. Volunteers. They all deserve our thanks. In addition, did you know that our office in Webster which runs our entire organization including putting together this great meeting, is staffed by two (2) people? Yes, two (2). JoAnne Tarantelli, our executive director and Timothy Pistor, our Program Coordinator. They do the work of 10 people for which we should be grateful. Without them, our chapter would not be successful.

Perhaps now you are picking up on the theme of this presidential message. Gratitude. I think it would be fair to say that in many of our emergency departments, gratitude has taken a back seat. A great example would be focusing on patient complaints and failing to acknowledge compliments. Complaining among staff about hospital administration, each other, and about the patients has become part of our daily mantra. How many emails do we get on a daily basis from physicians from other services complaining about the care we rendered to a patient in the emergency department? When was the last time you received an email saying "nice job." "You saved the patient's life." I save every thank you note from patients, holding onto them like gold. They are a bright light in an often too critical world.

Gratitude can be and has been described as personality strength. It is an ability to be acutely aware of the good things that happen to you and never take them for granted. A grateful individual is able to express heartfelt thanks and appreciation to others. Individuals who exhibit and express the most gratitude are happier, healthier, and have more energy. In a sense, they are more joyful. Could we not use some of this drug in our emergency departments, our homes, and our personal and social lives?

It may seem daunting or even saccharine to try, but I bet we would be happier if we did try. Here are some simple ideas:

1. Every night sit back for one minute and inventory what you should be grateful for today. (You are alive; your family is healthy; you can walk; you have gas for your car; money in your checking account; a job. Dig deep. Your patients from today may have none of the above).
2. Take the next minute to remember what did not go well. An interaction that could have been better. A missed chance to express gratitude. Resolve to do better the next time.
3. Express gratitude. Thank the patients for being there whether you feel that way or not. They are your source of employment.
4. Thank the staff at the end of the shift. Or even at the end of difficult patient encounters. Try saying "good job" more often.
5. Send a thank you note or a compliment to a colleague regarding good patient care or a difficult diagnosis they made.
6. Look for the silver lining – what is right – in a situation, not what is wrong. The cup is half full, not half empty. Maybe there is an opportunity that you are missing.
7. Practice gratitude with your family, friends, and co workers. When you hear complaining, challenge them to find that silver lining. Or at a minimum, do not buy in and complain too. Be an example.

I heard a speaker at ACEP ask whether you prefer to work your shift with "Tigger or Eor"? I think we universally would say Tigger. An Eor simply drags us down making for a long, long shift. It takes a long time and hard work to develop that positive personality so desperately needed in our world, so let's get working on it. Let's encourage each other to as well. Our work environment is stressful and emotionally difficult on a good day; we need to be a light in the darkness.

Sound Rounds
Practical Applications for the Emergency Physician

Ultrasound for Confirmation of Endotracheal Tube Placement

Penelope C. Lema
MD RDMS FACEP
Director, Emergency Ultrasound Fellowship
Assistant Professor, University of Buffalo
Department of Emergency Medicine

Guest Authors
Eitan Dickman, MD RDMS FACEP
Vice Chairman, Medical Director,
Emergency Ultrasound Division Director
Department of Emergency Medicine
Maimonides Medical Center, Brooklyn, NY

Eric H. Chou, MD
Emergency Medicine Resident
Department of Emergency Medicine
Maimonides Medical Center, Brooklyn, NY

Indications

- Monitoring intubation process
- Endotracheal intubation confirmation
- Identification of possible main stem intubation

Technique

Tracheal Ultrasound

- Use a high-frequency linear transducer. A curvilinear transducer can also be used if a linear transducer is not available.
- Place the ultrasound transducer transversely on the anterior neck just superior to the suprasternal notch. (Figure 1A)
- The position of the trachea can be verified with identification of a hyperechoic air-mucosa (A-M) interface with reverberation artifact posteriorly (comet-tail artifact). (Figure 1B)
- Tracheal intubation is confirmed if only one A-M interface with comet-tail artifact is observed. (Figure 2A)
- The esophagus is usually collapsed. Esophageal intubation is identified if two A-M interfaces with comet-tail artifacts are noted, also referred to as the "double tract" sign. (Figure 2B)

Lung Ultrasound

- Place a high-frequency linear transducer on each hemithorax in the mid-axillary line in the 4th or 5th intercostal space, with the probe marker pointing cephalad. A curvilinear transducer can also be used if a linear transducer is not available or if the patient has a large body habitus.
- Identify the hyperechoic ribs with posterior shadowing. The pleural line can be seen as a thin hyperechoic line between the two ribs and deep to the soft tissue of the chest wall. (Figure 3)
- During normal respiration and ventilation, sliding of the pleural line should be noted. Assess both lungs for lung sliding after intubation.
- M-mode can be used to further assess pleural movement. After positioning the M-mode spike over the chest wall soft tissue and pleura, the superficial layers will display a horizontal pattern of lines, while the area deep to the pleural line appears "granular." This is also known as the "seashore sign," and indicates lung sliding in that hemithorax. (Figure 4A)
- The presence of bilateral lung sliding can be used as ultrasonographic confirmation of proper endotracheal tube placement. Unilateral absence of lung sliding should prompt further evaluation for possible main stem intubation or other lung pathologies. (Figure 4B)

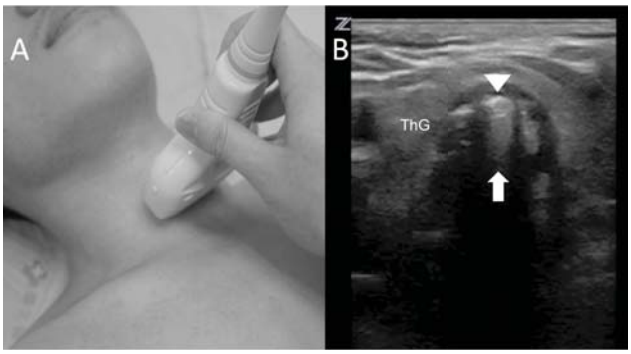


Figure 1. *(A) Placement of a linear ultrasound transducer in a transverse orientation on the anterior neck just superior to the suprasternal notch. (B) Ultrasonographic image of normal trachea. The sonogram shows the trachea, thyroid gland, A–M interface (arrowhead), and the comet-tail artifact (arrow). ThG= thyroid gland*

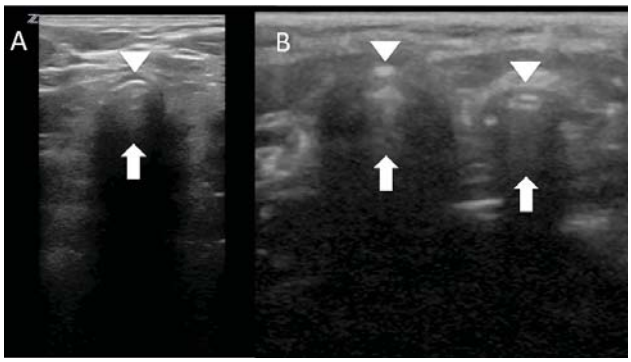


Figure 2. *(A) Ultrasonographic image of tracheal intubation. Only one A–M interface (arrowhead) with comet-tail artifact (arrow) and posterior shadowing is observed. (B) Ultrasonographic image of esophageal intubation. Two A–M interfaces (arrowheads) with comet-tail artifacts (arrow) and posterior shadowing are observed. This is also referred to as the "double tract" sign.*

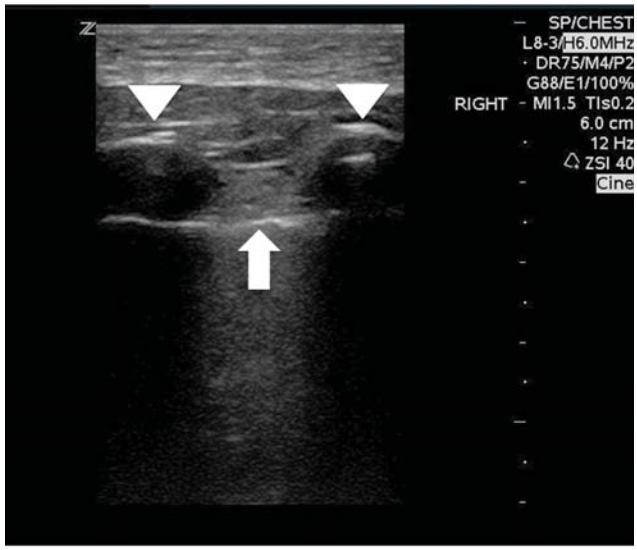
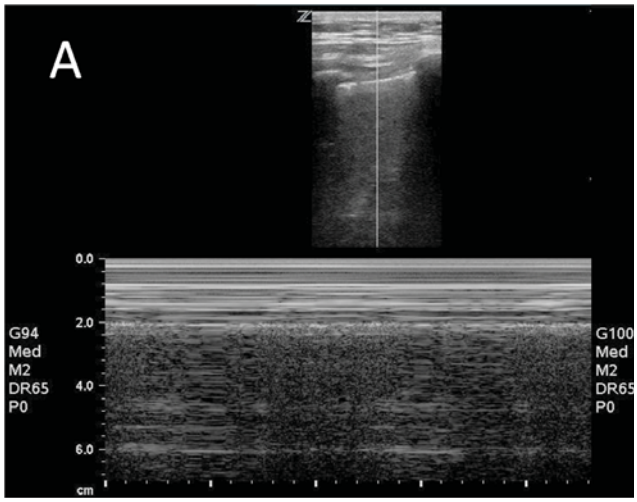


Figure 3. *Longitudinal scan over an intercostal space, demonstrating the pleural line (arrow) and ribs (arrowhead).*



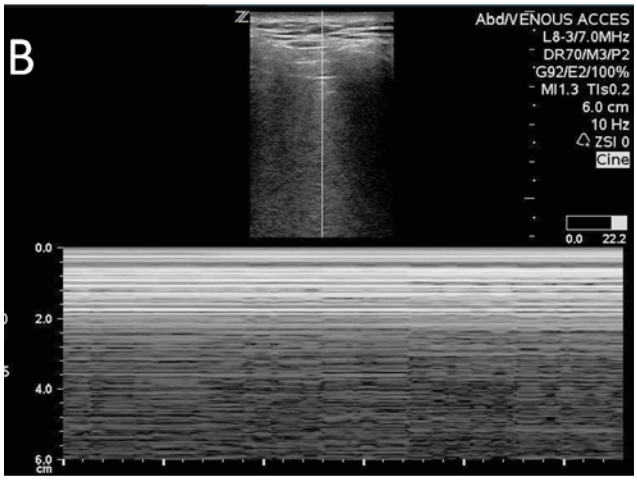


Figure 4. *(A) M-mode demonstrating normal lung sliding, also known as the seashore sign. (B) Absence of lung sliding represented with M-mode as a succession of horizontal lines. This pattern is referred to as the stratosphere sign.*

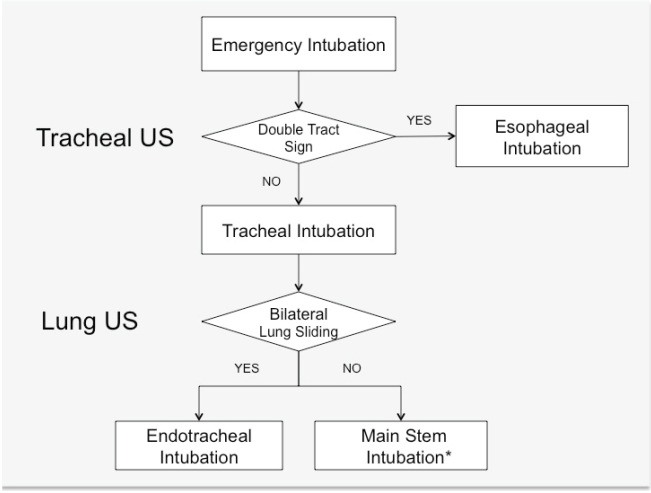


Figure 5. *Algorithm of airway ultrasound for post-intubation confirmation. (US = ultrasound); *Absence of lung sliding may suggest other lung pathologies, such as pneumothorax, pneumonia, pleural disease or malignancy.*

Tips

- Use tracheal ultrasound to identify esophageal intubation, and lung ultrasound to exclude main stem intubation. (Figure 5)
- Sonographically identify the trachea before intubation
- For detection of esophageal intubation, real-time tracheal ultrasound during intubation is superior to post-intubation static confirmation.
- For detection of a "double tract" sign, fan the probe in a cephalad and caudad orientation in order to distinguish a single comet-tail from double comet-tails, especially the overlapping of two comet-tails.
- B-mode imaging is usually sufficient to visualize pleural sliding; an M-mode still image can be used to document the pleural movement.

Pitfalls and Limitations

- Trachea landmarks may be difficult to identify in patients with neck trauma, an anterior neck mass or large body habitus.
- The esophagus is usually posterior-lateral to the trachea. However, the position of the esophagus can be immediately posterior to the trachea. It would be difficult for the sonographer to identify the "double tract" sign in these cases.
- Esophageal intubation can be mimicked by anatomical artifacts such as thyroid gland calcifications.
- Static assessment after intubation is less accurate than real time dynamic imaging for detection of esophageal intubation
- Absence of lung sliding does not always indicate main stem intubation. Other potential lung pathologies should be considered, including pneumothorax, pneumonia, pleural disease or malignancy.

Managing the Inherent Patient Safety Risks of Electronic Health Records

Gary S. Rudolph
MD FACEP
Vice President
Emergency Medicine Service Line
North Shore-LIJ Medical Group

Health information technology (Health IT) systems have the potential to reduce medical errors through their ability to access important medical history data, provide clinical decision support tools, and facilitate communication among providers and between providers and patients, but they are also capable of causing unexpected mistakes. The adoption of Health IT systems such as electronic health records (EHR) and computerized physician order entry (CPOE) does not guarantee an increase in patient safety. In fact, Health IT can be a contributing factor to adverse events, such as medication errors resulting from poor user interface design, failing to detect life threatening illnesses because of unclear information displays, and delays in treatment because of the loss of data. Adverse events, such as these, have led to serious injuries and death.

The Joint Commission just released Sentinel Event Alert (Issue #54) "Safe Use of Health Information Technology". The alert categorizes a variety of IT related patient safety issues and recommends strategies to reduce the risk of occurrence. An analysis of sentinel event reports received by The Joint Commission between January 1, 2010 and June 30, 2013 identified 120 sentinel events that were Health IT-related. Factors contributing to the 120 events were placed into categories corresponding to eight "socio-technical dimensions" necessary to consider for safe and effective Health IT described by Sittig and Singh. Listed by order of frequency, factors potentially leading to Health IT sentinel events involved the following dimensions:

1. Human-computer interface (33 percent) – ergonomics and usability issues resulting in data-related errors (mismatched, wrong, missing or delayed data)
2. Workflow and communication (24 percent) – issues relating to Health IT support of communication and teamwork
3. Clinical content (23 percent) – design or data issues relating to clinical content or decision support
4. Internal organizational policies, procedures and culture (6 percent)
5. People (6 percent) – training and failure to follow established processes
6. Hardware and software (6 percent) – software design issues and other hardware/software problems
7. External factors (1 percent) – vendor and other external issues
8. System measurement and monitoring (1 percent)

Sentinel Event Alert #54 suggests actions that center on the three crucial areas of safety culture, process improvement and leadership.

1. Safety Culture

Create and maintain an organizational-wide culture of safety, high reliability and effective change management, with these characteristics:

- *A collective mindfulness* focused on identifying, reporting, analyzing and reducing health IT-related hazardous conditions, close calls and errors. This information should be shared within the organization, preferably at early stages, before a patient is harmed. IT-related adverse events should also be reported externally, to organizations such as patient safety organizations (PSOs), The Joint Commission through its Sentinel Event policy and procedures, the FDA, and/or the Veterans Administration's National Center for Patient Safety to contribute to aggregate data collection, and to facilitate the identification of risks and hazards not readily apparent to any single organization.
- *Comprehensive systematic analysis* of each adverse event causing patient harm to determine if Health IT contributed to the event in any way. If so, consider the eight dimensions outlined above to determine how Health IT contributed to the event and identify strategies to prevent a similar event from recurring. Gather as much information as possible, as soon as possible, from individuals involved with the event, as well as from IT staff members and vendors/developers who can provide necessary technical information and address system faults.
- *Shared involvement and responsibility* for the safety of Health IT among the health care organization, clinicians and vendors/developers. Clearly define and document the roles and responsibilities of all.

2. Process Improvement

Develop a proactive, methodical approach to Health IT process improvement that includes assessing patient safety risks. Use the SAFER Guides for EHRs checklists, Failure Mode and Effects Analysis, or a similar method to identify potential system failures before they occur.

Recommended areas of focus include the following:

Make Health IT hardware and software safe and free from malfunctions:

- Back up data and applications and have redundant hardware systems.
- Create, make available and regularly review Health IT downtime and reactivation policies.
- Use standardized coded data elements to record allergies, problem lists and diagnostic test results.
- Create evidence-based standard order sets (approved by the organization), clinical guidelines and charting templates available for common conditions, procedures and services.
- Before going live after implementation, conduct extensive testing on hardware, software and system-to-system interfaces involving frontline staff end-users, to assure data are not lost or incorrectly entered, displayed or transmitted. Assign responsibility for this testing, as well as for ongoing monitoring and maintenance of the system's performance and safety.
- Ensure that embedded clinical content, including pharmacy dictionaries and medication libraries, is correctly loaded and regularly reviewed, particularly when changes are made

to related systems. Assign responsibility for the ongoing management of this content.

Make the use of Health IT by clinicians, staff and patients safe and appropriate:

- Configure the IT system to ensure the clear display of accurate patient identity information on all screens and printouts at each step of the clinical workflow.
- Limit the number of patient records that can be displayed on the same computer at the same time to one, unless all subsequent patient records are opened as "read only" and are clearly differentiated to the user.
- Have the capability to track orders in the organization's EHR system.
- Provide clinicians with the capability to override computer-generated clinical interventions when necessary. Configure systems to allow clinicians to easily correct accidental clicks, typos or drop-down choices.
- Maximize use of the EHR to order medications, diagnostic tests and procedures.
- Provide training, testing and support for clinical EHR users, particularly in relation to the capabilities and limitations of the system. Have users demonstrate competence before they can access the system and ensure prompt attention to problems encountered by users.
- Establish order sets for common medications and diagnostic testing.
- Maintain clinical oversight when order entry, medication reconciliation or documentation tasks are delegated.
- Provide patients access to their electronic records via portals, particularly for review of history and test results. While encouraging patient engagement and activation, portal access also enables patients to review their records for accuracy.

Use Health IT to monitor and improve safety:

- Monitor key EHR safety metrics via dashboards. Metrics can include help desk use, system uptime and downtime, alert overrides, number of EHR-related legal claims, and the percentage of prescriptions entered through CPOE.
- Engage clinicians and vendors in ongoing optimization and decision making regarding the safe use of EHRs.
- Consider using ongoing safety assessment tools for EHRs in operation to assure their safe performance.

3. Leadership

Enlist multidisciplinary representation providing leadership and oversight to Health IT planning, implementation and evaluation.

- Examine workflow processes and procedures for risks and inefficiencies and resolve these issues prior to any technology implementation.
- Involve frontline Health IT users in system planning, design, selection, modification and potential hazard identification.
- Choose and optimize systems with interfaces that easily align with and support the cognitive work of clinicians, organizational safety goals, and related technologies.
- Continually improve the ability of organizational Health IT systems to reliably and accurately exchange data with each other and with external systems, particularly in regard to the ability to send and receive critical information.
- Make modifications to the Health IT system in a controlled manner.
- Monitor the system's effectiveness according to metrics established by the organization.

In summary: Enhancement of the current functionality and safety of EHRs requires ongoing monitoring, data collection and analysis, and multidisciplinary evaluation of patient safety risks/events to identify the potential involvement of system issues. The actions, outlined above, related to the crucial areas of safety culture, process improvement and leadership provide a framework for continuing improvement efforts.

References

1. Sentinel Event Alert 54: Safe use of health information technology: www.jointcommission.org/sea_issue_54
2. Sittig DF and Singh H: A new sociotechnical model for studying health information technology in complex adaptive healthcare systems. BMJ Quality and Safety, 2010;19 (Supplement 3):i68-i74
3. SAFER Guides http://www.healthit.gov/safer/

A Winning Combination
Cutting-Edge Education at the beautiful Sagamore Resort

New York American College of Emergency Physicians

SCIENTIFIC ASSEMBLY

July 7-9, 2015

TUESDAY JULY 7

11:00 am-12:15 pm	Board of Directors Meeting
12:30-5:00 pm	Registration
12:30-1:30 pm	Research Forum: Poster Presentations
1:40-3:10 pm	Research Forum: Oral Research
2:30-6:30 pm	Exhibits Open
3:10-3:30 pm	Break and Exhibits
3:30-4:30 pm	**New Speakers Forum, Best Practices in Emergency Medicine**
4:30-5:30 pm	**Update on Drugs of Absue/ New Uses of Old Drugs**
5:30-6:30 pm	Exhibits and Networking Reception

WEDNESDAY JULY 8

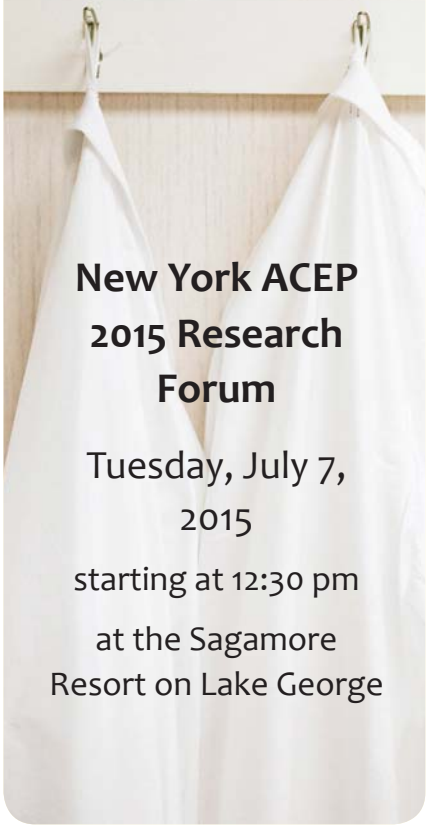
7:30-12:00 pm	Registration
7:30-8:00 am	Exhibits and Continental Breakfast
7:30-11:00 am	Exhibits
8:00-9:00 am	**Why ACLS Was Not Built of ED Docs - The New Cardiac Arrest**
9:00- 10:00 am	**The Cyanotic Child**
10:00-10:30 am	Break and Exhibits
10:30-11:30 am	**Updates in Trauma and Critical Care**
11:30-12:30 pm	**Pain Management for ED Physicians (Update on Opiods: What's the Menu and How to Apply)**
12:45-1:45 pm	New York ACEP Annual Meeting and Legislative update
1:45-2:15 pm	New York ACEP Committee Meetings

THURSDAY JULY 9

7:00-8:00 am	Board of Directors Meeting
8:00-9:00 am	**Infectious Diseases: Antibiotics/Trends**
9:00-10:00 am	**The Best of Pediatric Emergency Literature**
10:00-10:15 am	Break
10:15-11:15 am	**Post-Intubation Sedation**
11:15 am-12:15 pm	**Mistakes You Don't Want to Make with Your Pediatric Patients**

featuring

Poster and Oral Research



New York ACEP 2015 Research Forum

Tuesday, July 7, 2015

starting at 12:30 pm

at the Sagamore Resort on Lake George

Empire State EPIC
EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE
of the New York American College of Emergency Physicians

EMPIRE STATE EPIC is the newsletter of the New York American College of Emergency Physicians (New York ACEP). The opinions expressed in this newsletter are not necessarily those of New York ACEP. New York ACEP makes a good faith effort to ascertain that contributors are experts in their field. Readers are advised that the statements and opinions expressed by the author are those of the author and New York ACEP is not responsible for, and expressly disclaims all liability for, damages of any kind arising out of use of, reference to, reliance on, or performance based on information or statements contained in this newsletter.

NEWS STAFF
JoAnne Tarantelli, Executive Director
New York American College of Emergency Physicians
1130 Crosspointe Lane, Suite 10B
Webster, NY 14580-2986
p (585) 872-2417, f (585) 872-2419, www.nyacep.org

Toxicology

Is Ondasteron Teratogenic?

David C. Lee
MD FACEP
Research Director, Associate Professor
Department of Emergency Medicine
Hofstra North Shore-LIJ School of Medicine

Guest Author
Sabrina Rahman, MD
Emergency Medicine Resident
Department of Emergency Medicine
Long Island Jewish Medical Center
New Hyde Park, NY

An estimated 80% of all pregnancies are complicated by nausea and vomiting in pregnancy (NVP),[1] of which 10-15% require pharmacologic intervention.[2,3] Ondasteron (Zofran®) is a serotonin 5-HT3 receptor antagonist that is commonly prescribed off-label for nausea and vomiting in pregnancy and hyperemesis gravidum. Between 2008 and 2013 there was rise in conflicting literature regarding cardiovascular teratogenicity secondary to early fetal exposure to ondasteron. Despite the debate, in that same five year period the monthly prescription rate of ondasteron by healthcare professions more than doubled, from 50,000 prescriptions a month in 2008 to 110,000 in 2013.[4]

In February 2013, in one of the largest studies to date, Pasternak et al retrospectively analyzed data from the Danish Birth Registry and National Prescription Register. Each of the 1970 fetal exposures to ondasteron from 2004 to 2011 was matched to an unexposed historical cohort to investigate whether ondansetron exposure during pregnancy was associated with an increased risk of adverse fetal outcomes, defined as spontaneous abortion, stillbirth, any major birth defect, preterm delivery, low birth weight, or small size for gestational age. Based on the cohort study, the authors concluded ondasteron was not associated with increased malformation rates when used in the first ten weeks of gestation.[5] However, in August of the same year, Anderson et al utilized the same Danish Birth Registry and National Prescription Register across a broader period from 1997 to 2010, identified 1,248 exposed infants, and found a major malformation risk of 1.3 (95% CI 1.0–1.7) and a congenital heart malformation risk of 2.0 (95% CI 1.3–3.1).[6] The following year, Danielsson et al retrospectively analyzed the much larger Swedish Medical Birth Register and Swedish Register of Prescribed Drugs and made adjustments for year of delivery, maternal age, parity, smoking exposure and pre-pregnancy BMI. Of the 1,349 infants with first term exposure to ondasteron, 17 infants were reported to have septal defects including 13 ventricular septum defects, one atrial septum defect, and three infants with both ventricular and atrial septum defects.[7] Three infants were noted to have hypospadias and no infants had cleft palate but one infant had cleft lip. The authors of the study concluded the risk of a cardiovascular defect, particularly that of a septum defect were in fact increased and statistically significant (OR = 1.62, 95% CI 1.04–2.14, and RR 2.05, 95% CI 1.19–3.28, respective) and recommended the use of other pharmacological agents.

There were several limitations to these often referenced studies. All three utilized national prescription registries which at best indicate ondasteron was prescribed but cannot attest to medication compliance or frequency of compliance. Statistically the confidence intervals of both the Anderson and Danielsson studies were close to the null value, suggesting that the difference between cohorts were only weakly statistically significant. Finally, while there are several proposed mechanisms of teratogenicity, including studies that suggest the non-innervated embryonic heart may be more susceptible than the adult heart to QT prolonging drugs during organogenesis and ultimately result in congenital cardiac arrhythmia[8] and animal studies that demonstrate dose dependent teratogenicity and ventricular septal defects with QT prolonging medication,[9] there are no studies that conclusively establish a causation between early fetal exposure to ondasteron and cardiovascular malformation. In light of these limitations and the contradictatory evidence, it is difficult to disregard ondasteron in the management of nausea and vomiting in pregnancy.

References

1. Clark, S.M., Costantine, M.M., and Hankins, G.D. Review of NVP and HG and early pharmacotherapeutic intervention. Obstet Gynecol Int. 2012; 2012: 252676.

2. Niebyl JR. Nausea and vomiting in pregnancy. N Engl J Med 2010;363:1544-50. 2. Lacroix R, Eason E, Melzack R. Nausea and vomiting during pregnancy: a prospective study of its frequency, intensity, and patterns of change. Am J Obstet Gynecol 2000;182:931-7. 3.

3. Anderka M, Mitchell AA, Louik C, Werler MM, Hernández-Diaz S, Rasmussen SA. Medications used to treat nausea and vomiting of pregnancy and the risk of selected birth defects. Birth Defects Res A Clin Mol Teratol 2012;94:22-30.

4. Sales of antiemetics for NVP in the US, 2008-2014. IMS National Prescription Audit from 2008 to 2014.

5. Pasternak B, Svanstrom H, Hviid A. Ondasteron in Pregnancy and Risk of Adverse Fetal Outcomes. New England Journal of Medicine. 2013; 368(9): 814-823.

6. Andersen JT, Jimmenez-Solem E, Andersen NL. Ondansetron Use in Early Pregnancy and the Risk of Congenital Malformations. International Social Pharmacoepidemiology 2013. Abstract 25, Pregnancy session 1. Available at: http:// www.motherisk.org/videos/index.jsp. Accessed April 14 2015.

7. Danielsson B, Wikner BN, and Kallen B. Use of Ondasteron During Pregnancy and Congenital Malformations in the Infant. Reproductive Toxicology 2014; 50: 134-137.

8. Danielsson C, Brask J, Sköld AC, Genead R, Andersson A, Andersson U, et al. Exploration of human, rat, and rabbit embryonic cardiomyocytes suggests K-channel block as common teratogenic mechanism. Cardiovascular Research, 97 (2013): 23–32.

9. Karlsson M, Danielsson B, Nilsson M, Danielsson C, Webster W. New proposals for testing drugs with IKr-blocking activity to determine their teratogenic potential. Current Pharmacologic Design, 13 (2007): 2979–2988.

Ask the Experts

A Candid Reflection on Career Choices

Manish Sharma, DO MBA FACEP
Vice-Chairman, Department of Emergency Medicine
New York Hospital Queens
Assistant Professor, Weill Cornell Medicial College
Associate Director, EMA at New York Hospital Queens

I first met Dr. Schiavone in 2002, when I was a resident on the New York ACEP Emergency Medicine Resident Committee and he was the attending mentor/liaison. He has been an instrumental figure in my career ever since. I am honored to have this opportunity to share the story of his life and career in academic emergency medicine.

Why Emergency Medicine?

Dr. Schiavone remembers being 16 years old and eating at the Huntington Mall. He saw a man drop to the ground. He then heard a girl say, "Daddy, help him." The father responded, "I'm a dermatologist; I don't do that." This not only prompted Dr. Schiavone to become an EMT, but he promised himself that day that if he became a doctor, he wanted to be able to take care of anyone in any situation.

Dr. Schiavone's mentors during his internal medicine training at SUNY Downstate were internists who moonlighted in the emergency department. However, they knew very little about obstetrics, orthopedics and surgery. Even in the early days of emergency medicine as its own specialty, he noted that emergency physicians interacted with all other departments and were often looked upon as leaders.

At one point, Dr. Schiavone considered going into critical care after his internal medicine training but he decided against that pursuit when he realized that the mortality rate for those patients was near 98% at Kings County Hospital at that time.

Deciding that emergency medicine best suited his particular deep interest in a specialty that could help the most people at the times that they were most in need, he chose to enter a second residency at Lincoln Hospital. There Dr. Schiavone met the person he regards as the greatest unsung hero of emergency medicine of all time, Dr. Joel Gernsheimer, whom he feels personifies "giving back to society." Dr. Schiavone's memorable stories about what he learned from Dr. Gernsheimer would take far more than the pages I have for this piece but simply put, he still strives to emulate his first mentor, Dr. Gernsheimer.

Why Academics?

Dr. Schiavone feels that we are all here to serve. He feels there is no better way for him to serve than as an academic emergency medicine physician training others in how to do the same. He has a background in acting and a passion for singing. Those who know him well have had the pleasure of listening to him sing opera and have seen his charismatic presentations. When choosing a career path, he wanted to choose a field where these skills would be beneficial.

Why Stony Brook?

Dr. Schiavone wanted to find an environment where he would feel valued and where he could affect significant change. There were other factors as well.

Dr. Schiavone considered starting his career in Brooklyn, envisioning serving an inner city population. At the first interview in the Bronx, his car was robbed while parked in the ambulance bay and at the second interview, he was offered a salary that was far less than any emergency medicine salaries in New York City. While still searching, a dear and close friend, Dr. Bob Wighton, guided him to Stony Brook. At Stony Brook, he met Dr. David Kreis who interviewed him and took Dr. Schiavone and his wife to dinner in hopes of recruiting him. Dr. Schiavone recalls, "This was the first time someone talked to me like this. He had a vision and he valued what I could offer." After some negotiation, they finally came to an agreement while in the mens' room of the restaurant! Dr. Schiavone remembers his wife asking him why the two of them were smiling while coming out of the bathroom together. He told her, "I just accepted the job at Stony Brook."

As he had promised, Dr. Kreis showed Dr. Schiavone that choosing Stony Brook would give him ample opportunity to develop in leadership and academic roles at the local, regional and national level. When he came to Stony Brook, the Emergency Medicine "Department" was a division of nursing and was staffed by internal medicine residents. In what would become a career-long collaboration and partnership, Dr. Schiavone teamed with Dr. Peter Viccellio (another great mentor) to initiate the Emergency Medicine Residency Program at Stony Brook, followed by establishing Stony Brook's Department of Emergency Medicine – making it the 17th Medical School Department in the United States.

His Advice to Others

- "We are all here to serve so find your niche."
- He advises that you use your abilities to get involved and then engage others to do the same. This involvement can occur at any stage and should continue throughout your career. While local involvement is essential, reaching out to the regional, state, national and global arenas is highly important.

Frederick M. Schiavone
MD FACEP
Vice Dean for Graduate Medical Education
Designated Institutional Official (DIO)
Director of the Center for Clinical Simulation and Patient Safety
Professor of Emergency Medicine
Stony Brook Medicine

Connect with an experienced emergency medicine physician. Read more at this link http://nyacep.org/mentoring

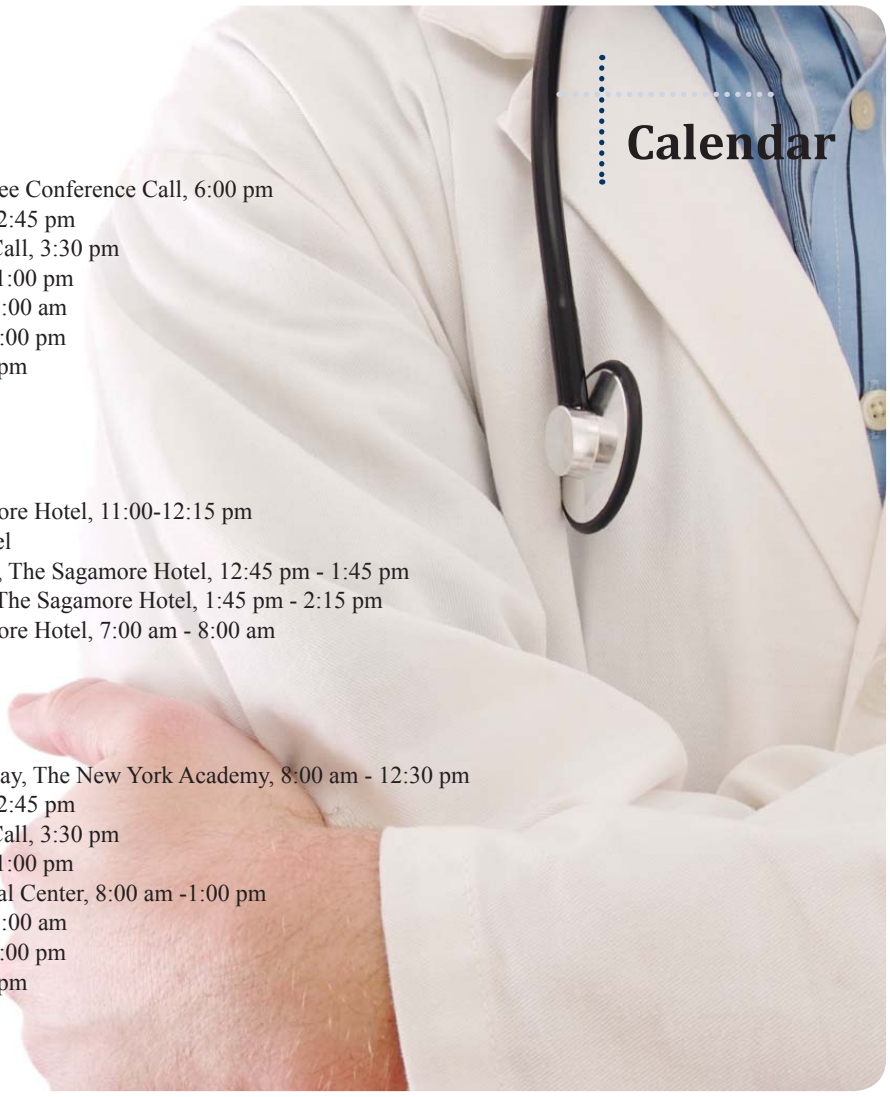
- "One person can change how an organization or institution views an issue."
- Emergency medicine physicians can and should be a tremendous part of the global health initiative.
- Medical students can become engaged and have a voice by joining organizations like the medical student section of the AMA. Once a student has selected a field, choosing organizations like EMRA, ACEP and SAEM is essential in order to maintain focus, obtain mentors and network professionally. These connections – to organizations and to the people in them – are sustainable and important across your entire career.
- "Find a mentor who can guide you. Learn how to be engaged. Find a platform. Be a voice for what is right. And then, become a mentor to others."

Still a practicing critical care emergency department physician, Dr. Frederick Schiavone is the current Vice Dean for Graduate Medical Education in the Stony Brook School of Medicine and is an Assistant Chief Medical Officer and the Medical Director of the Center for Clinical Simulation and Patient Safety at Stony Brook University Hospital. Serving the academic community nationally, he has just started a term as Chair-Elect of the AAMC Group on Resident Affairs, continuing to serve in numerous academic roles during his illustrious career as one of the most respected figures in academic emergency medicine.

He has been the Residency Program Director and Director of Medical Education in the Department of Emergency Medicine. Dr. Schiavone is a graduate of the Harvard Macy Leadership Program and of the AAMC Graduate Medical Education Leadership Development Program. He has received the medical education grant, Enhancing Educational Clinical Transactions, co-sponsored by the AAMC and the New York Academy of Medicine and has also published in several emergency medicine handbooks and as an author of textbook chapters.

Over the course of his career, he has also been able to give back to Italy – as a graduate of the Università di Bologna – by teaching difficult airway and other courses in the Società Italiana di Medicina di Emergenza Urgenza (SIMEU), helping to establish Stony Brook Medicine's international reputation in medical education. He has also been invited several times to be a University at Sea faculty member, teaching emergency medicine to course participants from all over the world.

He believes he is one of the happiest emergency medicine physicians, and attributes his career success and satisfaction to having chosen emergency medicine as a specialty.



Calendar

June 2015

3 Emergency Medicine Resident Committee Conference Call, 6:00 pm
10 Education Committee Conference Call, 2:45 pm
10 Professional Development Conference Call, 3:30 pm
11 Practice Management Conference Call, 1:00 pm
17 Government Affairs Conference Call, 11:00 am
17 Research Committee Conference Call, 3:00 pm
18 EMS Committee Conference Call, 2:30 pm

July 2015

7 Board of Directors Meeting, The Sagamore Hotel, 11:00-12:15 pm
7-9 Scientific Assembly, The Sagamore Hotel
8 Annual Meeting and Legislative Update, The Sagamore Hotel, 12:45 pm - 1:45 pm
8 New York ACEP Committee Meetings, The Sagamore Hotel, 1:45 pm - 2:15 pm
9 Board of Directors Meeting, The Sagamore Hotel, 7:00 am - 8:00 am

September 2015

9 Emergency Medicine Resident Career Day, The New York Academy, 8:00 am - 12:30 pm
9 Education Committee Conference Call, 2:45 pm
9 Professional Development Conference Call, 3:30 pm
10 Practice Management Conference Call, 1:00 pm
18 2015 LLSA Course, Mount Sinai Medical Center, 8:00 am -1:00 pm
16 Government Affairs Conference Call, 11:00 am
16 Research Committee Conference Call, 3:00 pm
17 EMS Committee Conference Call, 2:30 pm

Ethics

Assessment of Decision Making-Capacity is Necessary for Refusal of Treatment

Jay M. Brenner
MD FACEP
Medical Director
Upstate University Hospital - Community Campus Emergency Department
Associate Professor
Department of Emergency Medicine
and the Center for Bioethics and Humanities
SUNY Upstate Medical University

ND is a 34 year-old man who presented to the emergency department complaining of abdominal pain and was found to have gallstone pancreatitis. General surgery agreed to admit the patient with Gastroenterology consultation. ND requested to leave and come back in the morning for an ERCP, because he wanted to "sleep in his own bed." The PA covering the general surgery service discussed the risk of necrotizing pancreatitis and discharged the patient Against Medical Advice (AMA). While it is implied that the patient had decision making-capacity, no formal documentation of it being present was made. This may happen every day in every Emergency Department (ED) in New York, but we ought to be mindful of the necessity to assess and document decision making-capacity when patients refuse treatment.

It is well-recognized that physicians tend to only question decision making-capacity when a patient makes a choice with which they disagree. We should be cautious about this bias and pay attention to inconsistent choices even when they are made along with our recommendations. Most hospitals assign the responsibility of determination of decision making-capacity to the attending physician of record. Frequently, psychiatrists can help in a consultation, but ultimately it is up to us as emergency physicians to know how to determine decision making-capacity.

Allow me to review the basic elements of decision making-capacity. Essentially, it boils down to understanding, appreciation, and reasoning.

Understanding requires a patient to acknowledge the diagnosis being made and the treatment being offered. In the case above, ND accepts the physician's diagnosis of gallstone pancreatitis and the plan for ERCP in the morning.

Appreciation means that the patient can verbalize the consequences of not following the physician's recommendation. ND said that he knows that he could possibly die from necrotizing pancreatitis if he went home.

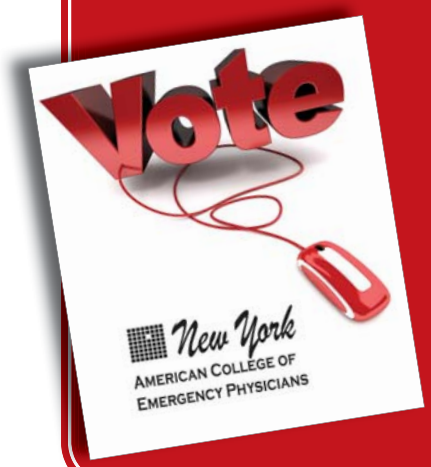
Reasoning can be further broken down into consequential reasoning, comparative reasoning, and logical consistency. ND acknowledged the potential consequences of leaving, but he did not think that they were likely. He reasoned that his bed would be more comfortable than the hospital bed. He intended on returning in the morning for the same test at the same time as if he were going to stay in the hospital. This seems logical.

ND did return the next day as he said he would. The gastroenterologist recommended an MRCP and general surgery admitted the patient. He did not die a terrible death from necrotizing pancreatitis as the PA from the general surgery service warned might happen. He played the odds and won. It is our job as emergency physicians to respect his autonomy to make this risky decision provided that he has the capacity to do so.

Next time, I will review the approach to surrogate decision making when the patient lacks decision making-capacity.

References

Lo, B. Resolving Ethical Dilemmas: A Guide for Clinicians. 2014.



Board of Directors Election

This June, New York ACEP members will receive the 2015 Candidate Profile and proxy. Through this proxy, members will elect four board candidates to serve three-year terms on the New York ACEP Board of Directors.

Members can cast their vote on board positions by proxy no later than July 2. Proxies will be sent by email to all New York ACEP member in June. Members may cast a proxy in person at the New York ACEP Annual Meeting Wednesday, July 8 at 12:45 pm at The Sagamore Resort on Lake George in Bolton Landing.

New York State of Mind

compiled by
Theodore J. Gaeta
DO MPH FACEP
Residency Program Director
New York Methodist Hospital

The Ethics of Physicians' Web Searches for Patients' Information.

Genes N, Appel J; Department of Emergency Medicine, Mount Sinai School of Medicine; J Clin Ethics. 2015 Spring;26(1):68-72.

When physicians search the web for personal information about their patients, others have argued that this undermines patients' trust, and the physician-patient relationship in general. We add that this practice also places other relationships at risk, and could jeopardize a physician's career. Yet there are also reports of web searches that have unambiguously helped in the care of patients, suggesting circumstances in which a routine search of the web could be beneficial. We advance the notion that, just as nonverbal cues and unsolicited information can be useful in clinical decision making, so too can online information from patients. As electronic records grow more voluminous and span more types of data, searching these resources will become a clinical skill, to be used judiciously and with care-just as evaluating the literature is, today. But to proscribe web searches of patients' information altogether is as nonsensical as disregarding findings from physical exams-instead, what's needed are guidelines for when to look and how to evaluate what's uncovered, online.

Redistribution of Emergency Department Patients After Disaster-Related Closures of a Public Versus Private Hospital in New York City.

Lee DC(1), Smith SW(1), Carr BG(2), Goldfrank LR(1), Polsky D(3); Ronald O. Perelman Department of Emergency Medicine, New York University School of Medicine; Disaster Med Public Health Prep. 2015 Mar 17:1-9.

Sudden hospital closures displace patients from usual sources of care and force them to access facilities that lack their prior medical records. For patients with complex needs and for nearby hospitals already strained by high volume, disaster-related hospital closures induce a public health emergency. Our objective was to analyze responses of patients from public versus private emergency departments after closure of their usual hospital after Hurricane Sandy. Using a statewide database of emergency visits, we followed patients with an established pattern of accessing 1 of 2 hospitals that closed after Hurricane Sandy: Bellevue Hospital Center and NYU Langone Medical Center. We determined how these patients redistributed for emergency care after the storm. We found that proximity strongly predicted patient redistribution to nearby open hospitals. However, for patients from the closed public hospital, this redistribution was also influenced by hospital ownership, because patients redistributed to other public hospitals at rates higher than expected by proximity alone. This differential response to hospital closures demonstrates significant differences in how public and private patients respond to changes in health care access during disasters. Public health response must consider these differences to meet the needs of all patients affected by disasters and other public health emergencies.

Implementation of a 24-hour Pharmacy Service with Prospective Medication Review in the Emergency Department.

Sin B, Yee L, Claudio-Saez M, Halim Q, Marshall L, Hayes-Quinn M; Brookdale University Hospital Medical Center, Brooklyn; Hosp Pharm. 2015 Feb;50(2):134-8.

BACKGROUND: It is reported that more than 128 million patients are seen in emergency departments (EDs) annually. Patient overcrowding had been associated with an increased occurrence of medication errors.
PURPOSE: Due to increased patient volume and the need for improved patient safety, a 24-hour pharmacy service was established for our institution's ED. The purpose of the study is to quantify and demonstrate the impact of a 24-hour pharmacy service in an urban ED.
METHODS: This was a retrospective descriptive study conducted at a regional level 1 trauma center. The study period occurred between December 2012 and July 2013. The following variables were quantified and analyzed: number of medication orders reviewed, number of intravenous medications compounded, and number of clinical interventions that were recommended by the ED pharmacy team (EDPT) and accepted by ED clinicians.
RESULTS: A total of 3,779 medication orders were reviewed by the EDPT. Of these orders, 3,482 (92%) were prospectively reviewed. A total of 3,068 (81.2%) and 711 (18.8%) orders were reviewed for the adult and pediatric ED, respectively. During the study period, the EDPT procured 549 intravenous admixtures and conducted 642 clinical interventions. Most of the interventions involved providing drug information for physicians and nurses (45.9%), adjusting drug dosages (21.1%), and recommending antimicrobial therapy (15.1%).
CONCLUSION: The implementation of a 24-hour pharmacy service at our institution was an innovative practice that increased the role of pharmacists in the ED. The EDPT conducted prospective medication review, procured intravenous admixtures from a sterile environment, and provided therapeutic recommendations for the ED interdisciplinary team.

Descriptive Study of Prescriptions for Opioids from a Suburban Academic Emergency Department Before New York's I-STOP Act.

Ung L, Dvorkin R, Sattler S, Yens D; Good Samaritan Hospital Medical Center, West Islip; West J Emerg Med. 2015 Jan;16(1):62-6.

INTRODUCTION: Controlled prescription opioid use is perceived as a national problem attributed to all specialties. Our objective was to provide a descriptive analysis of prescriptions written for controlled opioids from a database of emergency department (ED) visits prior to the enactment of the I-STOP law, which requires New York prescribers to consult the Prescription Monitoring Program (PMP) prior to prescribing Schedule II, III, and IV controlled substances for prescriptions of greater than five days duration.

METHODS: We conducted a retrospective medical record review of patients 21 years of age and older, who presented to the ED between July 1, 2011 - June 30, 2012 and were given a prescription for a controlled opioid. Our primary purpose was to characterize each prescription as to the type of controlled substance, the quantity dispensed, and the duration of the prescription. We also looked at outliers, those patients who received prescriptions for longer than five days.

RESULTS: A total of 9,502 prescriptions were written for opioids out of a total 63,143 prescriptions for 69,500 adult patients. Twenty-six (0.27%) of the prescriptions for controlled opioids were written for greater than five days. Most prescriptions were for five days or less (99.7%, 95% CI [99.6 to 99.8%]).

CONCLUSION: The vast majority of opioid prescriptions in our ED prior to the I-STOP legislature were limited to a five-day or less supply. These new regulations were meant to reduce the ED's contribution to the rise of opioid related morbidity. This study suggests that the emergency physicians' usual prescribing practices were negligibly limited by the new restrictive regulations. The ED may not be primarily contributing to the increase in opioid-related overdoses and death. The effect of the I-STOP regulation on future prescribing patterns in the ED remains to be determined.

Provider Perspectives on the Use of Indwelling Urinary Catheters in Older Adults in Emergency Department Settings: Developing a Novel Clinical Protocol.

Mulcare MR, Rosen T, Clark S, Scherban BA, Stern ME, Flomenbaum NE; Department of Medicine, Division of Emergency Medicine, Weill Cornell Medical College, New York; Am J Infect Control. 2015 Feb 5. pii: S0196-6553(14)01378-9.

BACKGROUND: Indwelling urinary catheters (IUCs) are commonly placed in older adult (aged ≥ 65 years) patients in emergency department (ED) settings, often for inappropriate indications. The aim of our qualitative study was to explore ED provider knowledge, attitudes, and practice patterns surrounding use of IUCs in older adult patients in the ED setting, to better guide development of a clinical protocol.

METHODS: We conducted 4 focus groups with 38 participants at a large academic medical center. Each focus group was conducted with a single ED provider type: attending physicians, residents, physician assistants, or nurses. Focus groups used a semistructured format, ranging in duration from 23-33 minutes. The sessions were audiorecorded, fully transcribed, and data were coded and analyzed to identify themes.

RESULTS: Participants reported believing that IUCs are overutilized in ED settings, confirming that IUCs are infrequently removed once placed and often inserted for staff convenience. Participants reported that current clinical decision making about IUC placement varies widely; yet all acknowledged the known risks for patient safety and willingness to adopt a clinical protocol to standardize practice. Focus groups were a critical component for the development of a user-friendly protocol, identifying 10 key elements for successful implementation and 11 potential barriers.

CONCLUSIONS: An evidence-based clinical protocol guiding ED providers in appropriate placement and management of IUCs in older adults would be welcomed.

Emergency Department-triggered Palliative Care in Advanced Cancer: Proof of Concept.

Kistler EA, Sean Morrison R, Richardson LD, Ortiz JM, Grudzen CR; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Acad Emerg Med. 2015 Feb;22(2):237-9.

BACKGROUND: The American College of Emergency Physicians and the American Society of Clinical Oncology recommend early palliative care consultation for patients with advanced, life-limiting illnesses, such as metastatic cancer.

OBJECTIVES: The objectives were to assess the process of early referral from the emergency department (ED) to palliative care for patients with advanced, incurable cancer as part of a randomized controlled trial and to compare the proportion and timing of consultation to a care as usual group.

METHODS: A single-blind randomized controlled trial (ClinicalTrials.gov ID NCT01358110) compared early, ED-based referrals to palliative care for patients admitted with advanced, incurable cancer to physician-driven consultation (i.e., care as usual). Participants had to speak English or Spanish and have no history of palliative care consultation. They were randomized via balanced block randomization to the intervention or control group. Each intervention subject was referred by a research staff member to the palliative care team for consultation. The usual care group received palliative care only if requested by the admitting physician. Analysis was based on intention to treat. A chart review was performed to assess proportion and timing of palliative care consults during the index admission, defined as: 1) completed palliative care consult documented in the chart and 2) days from admission to palliative care consult.

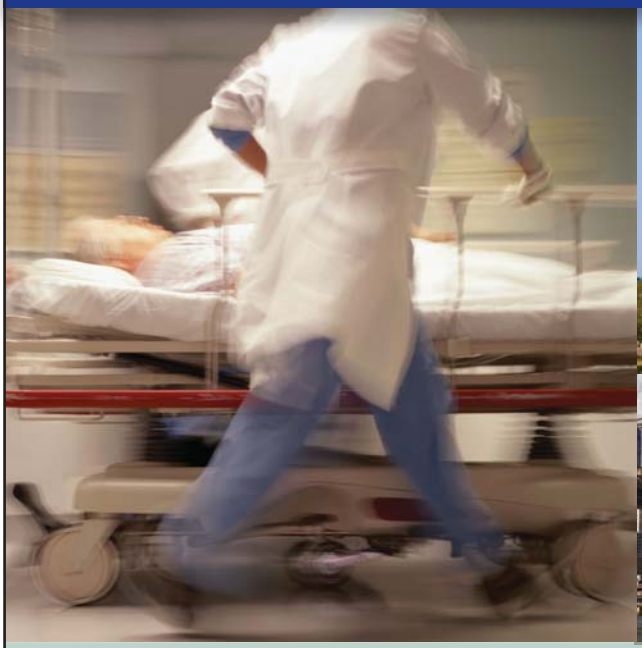
RESULTS: A total of 134 participants were enrolled and randomized. For patients in the intervention group, 88% (60 of 68) had documented palliative care consultations during their index admissions (95% confidence interval [CI] = 80.5 to 95.5), compared to 18% (12 of 66) in the control group (95% CI = 8.8 to 27.5; $p < 0.01$). The 60 intervention patients received palliative care consultations on average 1.48 days from admission (95% CI = 1.19 to 1.76), compared to 2.9 days from admission in the 12 control patients (95% CI = 1.03 to 4.79; $p = 0.15$).

CONCLUSIONS: This study documented a low baseline rate of palliative care

continued on page 16

North Shore LIJ Emergency Medicine

nslijEMPhysicians.com



EMERGENCY MEDICINE OPPORTUNITIES GREATER NYC METROPOLITAN AREA

Exciting things are always happening in Emergency Medicine at North Shore-LIJ, a network of 19 hospitals dedicated to serving the needs of the greater New York metropolitan area. Our system is expanding, opening up new opportunities for Emergency Medicine physicians interested in practicing in a visionary, integrated health system. From upper Westchester to Suffolk County and all areas in between, there's an opportunity that's right for you:

Tertiary Hospitals

- Cohen Children's Medical Center, New Hyde Park
  49,500 annual ED visits
- Lenox Hill Hospital, Manhattan
  56,000 annual ED visits
- Long Island Jewish Medical Center, New Hyde Park
  88,000 annual ED visits
- North Shore University Hospital, Manhasset
  87,000 annual ED visits
- Southside Hospital, Bay Shore
  72,000 annual ED visits
- Staten Island University Hospital
  123,000 annual ED visits

Community Hospitals

- Forest Hills Hospital, Forest Hills
  51,000 annual ED visits
- Franklin Hospital, Valley Stream
  42,000 annual ED visits
- Glen Cove Hospital, Glen Cove
  18,000 annual ED visits
- Huntington Hospital, Huntington
  50,000 annual ED visits
- Phelps Memorial Hospital, Sleepy Hollow
  27,000 annual ED visits
- Plainview Hospital, Plainview
  33,000 annual ED visits
- Syosset Hospital, Syosset
  16,000 annual ED visits

FREESTANDING ED

- Lenox Hill Healthplex, Greenwich Village
  30,000 projected annual ED visits

If you're a BC/BE Emergency Medicine-trained physician or physician leader interested in exploring career opportunities, please contact **Laura Screeney, Office of Physician Recruitment at (888) 685-7545** or **lscreeney@nshs.edu to join our team**. EOE M/F/D/V

continued from page 14

involvement as part of usual care in patients with advanced cancer being admitted from the ED. Early referral to palliative care in the context of a research study significantly increased the likelihood that patients received a consult, thus meriting further investigation of how to generalize this approach.

A Prospective Evaluation of the Contribution of Ambient Temperatures and Transport Times on Infrared Thermometry Readings of Intravenous Fluids Utilized in EMS Patients.

Joslin J, Fisher A, Wojcik S, Cooney DR; Department of Emergency Medicine, State University of New York Upstate Medical University, Syracuse; Int J Emerg Med. 2014 Dec 16;7(1):47

BACKGROUND: During cold weather months in much of the country, the temperatures in which prehospital care is delivered creates the potential for inadvertently cool intravenous fluids to be administered to patients during their transport and care by emergency medical services (EMS). There is some potential for patient harm from unintentional infusion of cool intravenous fluids. Prehospital providers in these cold weather environments are likely using fluids that are well below room temperature when prehospital intravenous fluid (IVF) warming techniques are not being employed. It was hypothesized that cold ambient temperatures during winter months in the study location would lead to the inadvertent infusion of cold intravenous fluids during prehospital patient care.
METHODS: Trained student research assistants obtained three sequential temperature measurements using an infrared thermometer in a convenience sample of intravenous fluid bags connected to patients arriving via EMS during two consecutive winter seasons (2011 to 2013) at our receiving hospital in Syracuse, New York. Intravenous fluids contained in anything other than a standard polyvinyl chloride bag were not measured and were not included in the study. Outdoor temperature was collected by referencing National Weather Service online data at the time of arrival. Official transport times from the scene to the emergency department (ED) and other demographic data was collected from the EMS provider or their patient care record at the time of EMS interaction.
RESULTS: Twenty-three intravenous fluid bag temperatures were collected and analyzed. Outdoor temperature was significantly related to the temperature of the intravenous fluid being administered, $b=0.69$, $t(21)=4.3$, $p<0.001$. Transport time did not predict the measured intravenous fluid temperatures, $b=0.12$, $t(20)=0.55$, $p<0.6$.
CONCLUSIONS: Use of unwarmed intravenous fluid in the prehospital environment during times of cold ambient temperatures can lead to the infusion of cool intravenous fluid and may result in harm to patients. Short transport times do not limit this risk. Emergency departments should not rely on EMS agencies' use of intravenous fluid warming techniques

and should consider replacing EMS intravenous fluids upon ED arrival to ensure patient safety.

Tranexamic Acid for Traumatic Brain Injury: A Systematic Review and Meta-analysis.

Zehtabchi S, Abdel Baki SG, Falzon L, Nishijima DK; Department of Emergency Medicine, State University of New York, Downstate, Medical Center, Brooklyn Am J Emerg Med. 2014 Dec;32(12):1503-9.

OBJECTIVE: The antifibrinolytic agent tranexamic acid (TXA) has demonstrated clinical benefit in trauma patients with severe bleeding, but its effectiveness in patients with traumatic brain injury (TBI) is unclear. We conducted a systematic review to evaluate the following research question: In ED patients with or at risk of intracranial hemorrhage (ICH) secondary to TBI, does TXA compared to placebo improve patients' outcomes?
METHODS: MEDLINE, EMBASE, CINAHL, and other databases were searched for randomized controlled trial (RCT) or quasi-RCT studies that compared the effect of TXA to placebo on outcomes of TBI patients. The main outcomes of interest included mortality, neurologic function, hematoma expansion, and adverse effects. We used "Grading quality of evidence and strength of recommendations" to assess the quality of trials. Two authors independently abstracted data using a data collection form. Results from studies were pooled when appropriate.
RESULTS: Of 1,030 references identified through the search, 2 high-quality RCTs met inclusion criteria. The effect of TXA on mortality had a pooled relative risk of 0.64 (95% confidence interval [CI], 0.41-1.02); on unfavorable functional status, a relative risk of 0.77 (95% CI, 0.59-1.02); and on ICH progression, a relative risk of 0.76 (95% CI, 0.58-0.98). No serious adverse effects (such as thromboembolic events) associated with TXA group were reported in the included trials.
CONCLUSION: Pooled results from the 2 RCTs demonstrated statistically significant reduction in ICH progression with TXA and a nonstatistically significant improvement of clinical outcomes in ED patients with TBI. Further evidence is required to support its routine use in patients with TBI.

Ultrasound-assisted Lumbar Puncture in Pediatric Emergency Medicine.

Kim S, Adler DK; Emergency Department, University of Rochester, Strong Memorial Hospital, Rochester; J Emerg Med. 2014 Jul;47(1):59-64.

BACKGROUND: Ultrasound-assisted lumbar puncture in the pediatric emergency medicine setting has not been well established, but ultrasound could serve as a valuable tool in this setting.
OBJECTIVE: To assess whether ultrasound increases provider confidence in identifying an insertion point for lumbar puncture.
METHODS: A feasibility study was conducted using a convenience sample of pediatric emergency patients requiring lumbar puncture. Provider confidence in selecting a needle insertion site for lumbar puncture using ultrasound assistance was compared to provider confidence using traditional landmarks alone. A simple technique using a linear probe is described.
RESULTS: Nineteen patients were included in the study, with the primary end point the mean confidence score (based on a five-point Likert scale) in identifying a needle insertion site prior to and after using ultrasound. Using the Wilcoxon signed rank test, the mean confidence score was 2.89 with the landmark procedure alone, and 4.79 with ultrasound assistance, yielding an average score difference of 1.90 (95% confidence interval 1.23 2.56; Wilcoxon $p < 0.001$, paired t-test $p < 0.001$). Thus, compared to the landmark procedure, the use of ultrasound was associated with a significantly higher average confidence score.
CONCLUSION: The use of ultrasound in the pediatric emergency setting can be a valuable adjunct with lumbar puncture.

A Survey of Academic Emergency Medicine Department Chairs on Hiring New Attending Physicians.

Aycock RD, Weizberg M, Hahn B, Weiserbs KF, Ardolic B; Department of Emergency Medicine, Staten Island University Hospital, Staten Island; J Emerg Med. 2014 Jul;47(1):92-8.

BACKGROUND: For graduating emergency medicine (EM) residents, little information exists as to what attributes department chairs are seeking in hiring new attendings.
STUDY OBJECTIVES: To determine which qualities academic EM department chairs are looking for when hiring a new physician directly out of residency or fellowship.
METHODS: An anonymous 15-item Web-based survey was sent to the department chairs of all accredited civilian EM residency programs in March of 2011. The questions assessed the desirability of different candidate attributes and the difficulty in recruiting EM-trained physicians. Respondents were also asked to give the current number of available job openings.
RESULTS: Fifty-five percent of eligible department chairs responded. On a 5-point scale, the most important parts of a candidate's application were the interview (4.8 ± 0.4), another employee's recommendation (4.7 ± 0.5), and the program director's recommendation (4.5 ± 0.7). The single most important attribute possessed by a candidate was identified as "Ability to work in a team," with 58% of respondents listing it as their top choice. Advanced training in ultrasound was listed as the most sought-after fellowship by 55% of the chairs. Overall, department chairs did not have a difficult time in recruiting EM-trained physicians, with 56% of respondents stating that they had no current job openings.
CONCLUSION: How a physician relates to others was consistently rated as the most important part of the candidate's application. However, finding a job in academic EM is difficult, with graduates having limited job prospects.

Crafting an Online CME Curriculum for EMS Providers

Paul Barbara
MD FACEP
Assistant Director
Division of Emergency Medical Services
Staten Island University Hospital

Walking into my swing shift at Staten Island University Hospital, through the ambulance bay doors as always, I sometimes hear "Hey doc, when are you doing another CME lecture?" from crewmembers who are likewise heading back out to the field. I have heard this request commonly, and since my involvement in prehospital medicine arose during residency, I have been tasked with providing Continuing Medical Education to Paramedics and EMT-Basic providers. EMS Medical Direction is a complex field for a physician, where mid-level providers act autonomously but at the same time in conjunction with oversight from a physician. It is not nearly as easy as blessing the twenty-year veteran PA's laceration repair patient prior to discharge. Oversight of prehospital providers involves complex ways of ensuring high-quality care is delivered without you being present on the scene. But as many of us know, you certainly hope they think of your input while treating the patient!

Over my decade of service in academic emergency medicine, I have delivered lectures regularly to medical students, residents, and prehospital providers. Like the rest of you, these lectures become your little niche within the Department. I still get requests for my Mass Casualty Incident tabletop, complete with pinnie vests and job action sheets, as well as the Environmental Emergencies in which each slide has a quote from Jimmy Buffett songs (there are ten quotes in total!). Crafting a live lecture has an appropriate gestational attachment for the writer – it becomes a true reflection of where your intellect blends with your passion. Nothing is more upsetting than having any student pay little attention to you during this education transfer, then yawn as they walk up and ask for their automatic CME completion certificate. What to do, as a "young doc", with the veteran medic who desires attestation of an activity that was not completed? What if your background in EMS is minimal, yet you are the one being asked to give the lecture? Have you ever been uncomfortable because of a student's question that you might not have either the literature citation or experience-based answer to provide? Also, crews work different times as well as personal conflicts as common issues for not attending a given live lecture. What to do with the academically interested, part-time medic who also has family/childcare issues, preventing him/her from attending a live lecture? What about the overnight crews? I'm sure some of you have run into similar situations at your facility.

We were certainly in a moral and occupational dilemma: how can we deliver high-quality, free medical education to a diverse group of individuals? How can we maintain their academic investment in our teaching? The solution, evidently, was where we too often search for ANY answer: "online".

Having been a faculty member of the emergency medicine residency program at Staten Island University Hospital since my arrival in 2010, I saw the various changes in how the didactic curriculum is now delivered. There are many teaching similarities to when I was Academic Chief Resident of my residency program "way back" in 2008. There are many differences as well and I am fortunate to be surrounded by open-minded educators found within our residency program. They have done more than just "flip the classroom" as so many teachers boast, they have also engaged their faculty colleagues in new methods of professional growth. These new methods, most of which include the practice of free online meducation aka FOAM, engaged me to start a CME social media account on twitter (@ SIEMSCME). [Insert collective groan here.] Amazingly, I tweet, re-tweet, and have my share of followers. I did this to engage those learners who desire this type of engagement. More important than the followers, I have been able to hear updates from academic leaders in Emergency Medicine and take these concepts to the prehospital arena. As Dr. Scott Weingart has been famous for bringing "upstairs care -- downstairs"; it has been my goal to extend that concept into "inside care -- outside". I agree there are risks to this type of education but like the rest of us, I have also witnessed a fair share of "landmark" articles in the peer-reviewed literature that have not been ubiquitously useful. There is a middle ground of utility for the free vs. peer reviewed medical education: it is an individual medical providers' determination to credentialing the information available.

Fortunately, I was also able to tap into our residency program's dedicated website, www.statenislandem.com, and start posting CME cases with a corresponding test in January 2014. These scenarios are based on actual cases our residents saw during their EMS rotation and test the current content according to the Regional Emergency Medical Services Council of New York City. The curriculum has been furthermore based on the topics provided by the New York State Department of Health's Paramedic Refresher curriculum outline (NYS DOH Form DOH-4231).

We were even able to create a form allowing online submission of test answers by the medics. By creating an Online EMS CME curriculum, our providers can take their monthly examination at their own leisure. The time-stamping from the online form does identify some curious themes in when the overnight folks take their exams.... We can also attest or deny a level of proficiency based on the student's test scores: it has been difficult to fail people but these workers are responsible for life-saving care for patients in our community. Despite my personal affection for NASA and former Director Eugene Kranz, in this case they had it wrong: failure, unfortunately, is an option. The ability to take the test has been extended beyond the crews who work for Staten Island University Hospital or the North Shore-LIJ Centers For EMS. Anyone who desires NYC REMAC CME credit can take our test online. They will be granted CME credits... so long as they don't get less than 70% on the test.

After the month's exam, we release the test to each taker via email with

explanations and literature sources to explain the answer reasoning. We are also able to provide the "class performance" success percentage on each question to identify which questions perform poorly to the group. Trust me, writing these questions has kick-started personal academic growth for me as well!

As of this document's submission to *Empire State EPIC* we have had over 150 test-takers and have moved many EMS concepts into the forefront of the minds of our prehospital providers. We've been able to introduce new themes as well, pushing newer concepts to what can be loosely described as a stereotypically closed-minded profession. Hot EMS topics such as selective spinal immobilization, apneic oxygenation, proper sedation, tourniquet use, restraint methods and intranasal delivery of medications have all been found in our CME curricula. As EMS medicine evolves, our CME content will move with it to make our providers think.

If you have a concern for delivering regular education pieces to a motley group of individuals who work throughout all hours on the clock, consider implementing an online CME curriculum as an adjunct to your live lectures. The academic buy-in for those who desire to further their education, despite having other obligations, is worthwhile. The onus is on the student to ensure they perform the learning activity. The educator is not required to set up a room or change their schedule to accommodate their entire staff. With the right information technology, a singular person without an overwhelming amount of work can do this efficiently.

If you have any questions about this program, please email me at: pbarbara@nshs.edu.

Albany Update

Reid McNally & Savage

New York ACEP Legislative & Regulatory Representatives

2015-16 Final State Budget

The 2015-16 State Budget passed in the early morning hours of April 1, 2015. The final spending plan totals approximately $142 billion. The proposed State Budget includes a number of provisions of interest to New York ACEP as summarized below.

Regulation of Urgent Care Centers

New York ACEP supported Governor Cuomo's State Budget proposal to regulate urgent care centers. New York ACEP members lobbied for the proposal on the March 10 Lobby Day in Albany. Two action alerts were issued to members to call on the State Legislature to pass the proposal. Unfortunately, **the State Legislature objected to the bill and it was not included in the final plan.**

The Governor's proposal sought authority to:

- define "urgent care" as treatment on an unscheduled basis to patients for acute episodic illness or minor traumas that are not life threatening or potentially disabling;
- prohibit care for conditions that require monitoring and treatment over a prolonged period of time;
- require full accreditation as a condition of using the term "urgent care" or a symbol that implies "urgent care" and
- prohibit signage, advertisements, or symbols that imply that the center is a provider of emergency medical care.

At this time there are no separate bills pending in the State Legislature on urgent care.

Excess Medical Malpractice Program

The final State Budget includes level funding ($127.4 million) for the Excess Medical Malpractice Program. The program is extended until June 30, 2016. In addition, the final bill extends for one year provisions contained in the 2013-14 State Budget to limit eligibility for enrollment in the program to physicians and dentists who were provided coverage from July 1, 2013 to June 30, 2014.

Private Equity Demonstrations

The Legislature **rejected** the Governor's proposal to authorize the establishment of five private equity pilot programs. The proposal would have allowed the Public Health and Health Planning Council (PHHPC) to approve up to five business corporations to operate a hospital or home care agency in affiliation with at least one academic medical institution. Publically traded entities are not eligible to participate in the demonstration program.

Enhanced Reimbursement for Sole Community Hospitals

The final State Budget **includes the Governor's proposal** to provide up to $12 million in enhanced reimbursement for inpatient and outpatient services provided at sole community hospitals. **The Legislature added a new provision** to require the New York State Department of Health to provide 30 days notice on the procedure for making an allocation and intent to distribute funds.

Critical Access Hospitals

The final State Budget includes the Governor's proposal to increase Vital Access Provider (VAP) funding for Critical Access Hospitals from $5 million to $7.5 million. **The Legislature added a new provision** to require the New York State Department of Health to provide 30 days notice on the procedure for making an allocation and intent to distribute funds.

Kings County Capitol Funds: $700 Million

The final State Budget includes $700 million in capital funds for health care facilities in Kings County to be used to stabilize health care delivery.

Oneida County Capitol Funds: $300 Million

The final State Budget includes $300 million to create an integrated health care

delivery system in Oneida County.

Capital Restructuring Financing Program (CRFP)

The Governor's proposed budget included $1.2 billion in CRFP funding. The **Legislature modified** the Governor's proposal to require that funds, to the extent practicable, be awarded regionally in proportion to the applications received from the Request for Application (RFA). In addition, the modifications exclude projects receiving funding under the Kings and Oneida County programs from receiving CRFP funding.

Essential Health Care Provider Support Program

The final State Budget includes $355 million for the Essential Health Care Provider Support Program to facilitate health care transformation including mergers, consolidations, and restructuring for health care facilities. The funds can be used to retire debt and for capital and non-capital projects.

Essential health care providers are defined as a "hospital or hospital system that offers health care services within a defined geographic region where such health care services would otherwise be unavailable." Eligible applicants are required to either "fulfill an unmet health care need for acute inpatient, outpatient, or primary or residential health care service" in a community or have experienced a loss from operations in the three preceding years.

Funding for this program is derived from the $400 million bank settlement initiated by the New York State Department of Financial Services (DFS).

Value Based Payments (VBPs)

The Legislature rejected the Governor's proposal to authorize VPBs to Preferred Provider Systems (PPS) under the Delivery System Reform Incentive Program (DSRIP). The Department of Financial Services has taken the position that they can authorize the payment administratively without the need for a State law. Discussions between the Legislature and the Governor's office are expected to continue on this issue.

Out-of-Network Law Effective March 31, 2015

State regulations and a Guidance Document implementing the Out-of-Network (OON) law went into effect **March 31, 2015.** The regulations are the result of the passage of a law last year (Chapter 60 of the Laws of 2014). The law regulates OON health care services including billing, reimbursement and consumer disclosure for services provided to patients by health care providers who do not participate in a patient's health insurance plan.

The law provides for an Independent Dispute Resolution (IDR) process for non-emergency surprise bills and emergency bills when there is a dispute between a physician or uninsured patient and a health plan.

New York ACEP was successful last year in getting an exemption in the law from the IDR process for emergency services when the amount billed is under $600 after any applicable patient cost sharing and it does not exceed 120% of the UCR for specific CPT codes. There is an annual inflation adjustment. Based on our analysis, this exemption will include claims for evaluation, management, and most observation care provided by emergency physicians. This is the only exemption granted to physicians in the law.

For more detailed information, please go to the following documents on the New York State Department of Financial Services' website:

OON Law Guidance http://www.dfs.ny.gov/insurance/ihealth.htm

Summary of Process http://dfs.ny.gov/consumer/hprotection.htm

Description of IDR Process http://dfs.ny.gov/legal/regulations/emergency/np400t.pdf

Pending Legislation

Electronic Prescribing Manate Delayed for One Year

New York ACEP successfully advocated for passage of legislation in both houses to **delay for one year the March 27, 2015** implementation of the e-prescribing mandate that was enacted in 2012 as part of the Internet System for Tracking Over-Prescribing /Prescription Monitoring Program (I-Stop) law. The Governor signed the bill into law.

Date of Discovery S911 (Libous)/ A285 (Weinstein)

Legislation has been reintroduced to change the current statute of limitations for medical, dental and podiatric malpractice from two and half years of the date of the act to a "discovery of injury rule." New York ACEP made our opposition to this bill known to legislators during the March 10, 2015 Lobby Day.

The bill provides that the accrual of an action occurs at the later of either: when one knows or reasonably should have known of the alleged negligent act or omission and knows or reasonably should have known that such negligent act or omission has caused an injury; or within two and half years of the last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the accrual of an action. In no event shall an action be filed more than 10 years after the alleged malpractice.

This bill is currently in the Codes Committee in both houses.

Mandatory Continuing Education (CME) S4348 (Hannon)/A355 (Rosenthal)

Legislation was re-introduced this year to require the completion of three hours of course work developed by the New York State Department of Health and State Education Department (SED) every two years in pain management including ISTOP, DEA requirements for controlled substances, pain management, appropriate prescribing, managing acute pain, palliative medicine, prevention/screening of addiction, responses to abuse and addiction and end of life care.

New York ACEP is opposed to this bill. It was discussed with legislators on March 10 in Albany at the Lobby Day.

The mandate applies to any practitioner who is licensed, registered or certified under Title VIII of the State Education Law and who is registered under the Federal Controlled Substances Act.

The bill provides for an exemption for anyone who can demonstrate that there is no need to complete the course based on the nature, area or specialty of his or her practice or that equivalent course work has been completed.

The bill is on the floor in the Assembly and the Health Committee in the Senate.

The State Legislature is expected to complete its' business for the 2015 State Legislative Session June 17, 2015. Reid, McNally & Savage will continue to work with New York ACEP to represent and advocate for access to quality emergency care and services in New York State.

Education

Global Health & Emergency Medicine: Educational Benefits Beyond Service Abroad

Suzanne Bentley, MD MPH FACEP
Site Director, Emergency Medicine Residency
Elmhurst Hospital Center
Faculty, Arnhold Global Health Institute
Icahn School of Medicine at Mount Sinai

Christie Lech, MD
Chief Resident, Emergency Medicine
Icahn School of Medicine
at Mount Sinai

Alexandra Leader, MD
Pediatric Emergency Medicine and
Global Health Fellow
Eastern Virginia Medical School

Aparna Dandekar, MD
Global Health Teaching Fellow
Icahn School of Medicine
at Mount Sinai

Global emergency medicine (historically called international emergency medicine) is a subset of emergency medicine (EM) focused on the improvement of emergency care in other parts of the world through initiatives in clinical care, medical education, preventative medicine and research. Global EM is one of the fastest growing subspecialties of EM, as evidenced by the increasing number of faculty, trainees, and medical students pursuing international global health (GH) opportunities. Advances in social media brings natural disasters, violence, and health disparities more prominently into the public eye. In addition, increases in overseas travel and immigration quickly carry diseases across borders, making GH increasingly relevant and integral to US-based medical training.

EM residents have expressed a growing interest and engagement in GH and international work. To accommodate the rising interest in GH, many EM residencies offer GH and international opportunities. A 1999 study by Alagappan et al. reported participation in international projects by only 55% of the 113 EM programs followed by a 2002 study by Dey et al. reporting that 86% of EM residents were interested in international health and reported actually ranking residency programs that offered international experience higher. King et al. found in 2012 that 91% of EM programs offered international rotations and 80% of the 111 programs reported graduating residents that had completed an international elective during their EM training at the time of the survey. Similarly, a 2013 survey of the Council of Residency Directors (CORD) shows that 74% of programs had at least one resident who participated in an international elective in the last academic year, comparable to the 2012 study by King et al. Likewise, major EM organizations, including ACEP and SAEM, include specific sections and interest groups dedicated to global EM.

Global EM training certainly strives to improve health care abroad, however, it also serves to improve care locally, as well. From an education standpoint, the benefits of international experiences on resident training are multi-factorial, ranging from increased cultural competency, improved demonstration of cost-aware medicine, increased ability to identify public health threats at an early stage, to an overall strengthening of clinical skills.

Global EM-trained health care providers who serve immigrant populations at home are often better suited to recognize and understand both the physical and psychosocial burdens of disease that this population can have. Moreover, as the world's population becomes increasingly mobile, (e.g. >300 million border-crossings per year in the US alone), knowledge of tropical medicine, parasitology, and epidemiology will be even more paramount to the early detection and treatment of a myriad of communicable and non-communicable diseases locally, as well as abroad.

Health care providers who are accustomed to working in resource-limited environments have been shown to order fewer tests and feel more comfortable making decisions based on their clinical judgment alone. Although not well studied to date, these changes in practice are theorized to result in the provision of more cost-effective and efficient health care. These are just some examples of how GH education gained working in resource-limited settings abroad can positively impact the fields of EM and public health locally, a particularly important consideration as US health care costs and demands continue to rise.

Global EM training imparts innumerable skills across a variety of different arenas and participants in GH education and electives can be expected to develop a unique skill set and knowledge base that they can utilize to instruct their peers at their home institutions. It is important to consider, however, that the future success of global EM education and training requires further objective research in this area to demonstrate benefits to home institutions beyond simple altruism and shared clinical anecdotes.

References

1. King RA, Liu KY, Talley BE, Ginde AA. Availability and potential impact of international rotations in emergency medicine residency programs. J Emerg Med. 2013; Feb; 44(2):499-504.

2. Havryliuk T, Bentley S, Hahn S. Global Health Education in Emergency Medicine Residency Programs. J of Emerg Med. 2014.

3. Alagappan K, Somoza C, Kahoun J, Rennie W. Participation in international EM by U.S. EM residencies. Academic Emergency Medicine. 1999(6):411.

4. Martin IB, Jacquet GA, Levine AC, Douglass K, Pousson A, Dunlop S, Khanna K, Bentley S, Tupesis JP. Global health and emergency care: a postgraduate medical education consensus-based research agenda. Acad Emerg Med. 2013 Dec; 20(12):1233-40.

5. Martin IB, Devos E, Jordan J, Malya R, Tupesis JP, Bentley S, Flemister A, Kapur GB. Global health and emergency care: an undergraduate medical education consensus-based research agenda. Acad Emerg Med. 2013 Dec; 20(12):1224-32.

New York ACEP
2014-15 Officers

President
Louise A. Prince, MD FACEP
SUNY Upstate Medical University
315.464.4363

President-elect
Brahim Ardolic, MD FACEP
Staten Island University Hospital
718.226.9158

Secretary-Treasurer
Jeremy T. Cushman, MD MS FACEP
University of Rochester Medical Center
585.463.2900

Immediate Past President
Daniel G. Murphy, MD MBA FACEP
St. Barnabas Hospital
718.960.6827

Executive Director
JoAnne Tarantelli
New York ACEP
585.872.2417

2014-15 Directors

Nicole Berwald, MD FACEP
Staten Island University Hospital
718.226.8620

Jay M. Brenner, MD FACEP
SUNY Upstate Medical University
315.464.4363

Keith E. Grams, MD FACEP
Rochester General Health System
585.276.3653

Sanjey Gupta, MD FACEP
NSLIJ Franklin Hospital
516.256.6350

Stuart G. Kessler, MD FACEP
Elmhurst Hospital Center
718.334.3050

David C. Lee, MD FACEP
North Shore University Hospital
516.562.1252

Penelope C. Lema, MD RDMS FACEP
University of Buffalo
716.859.1499

David H. Newman, MD FACEP
Mount Sinai Medical Center
212.824.8067

Christopher C. Raio, MD MBA FACEP
North Shore University Hospital
516.562.4049

Gary S. Rudolph, MD FACEP
North Shore University Hospital
526.562.3090

Todd L. Slesinger, MD FACEP
FCCM FCCP
North Shore University Hospital
516.562.3090

Kaushal H. Shah, MD FACEP
Mount Sinai Medical Center
212.824.8068

Anchal Ghai, MD
Staten Island University Hospital
resident representative

New York
American College of Emergency Physicians

New York
American College of
Emergency Physicians

1130 Crosspointe Lane, Suite 10B
Webster, NY 14580-2986

PRSRT STD
U.S. Postage
PAID
Rochester, New York
Permit No. 161