New York American College of Emergency Physicians

ADVANCING EMERGENCY CARE

Empire State EPIC

VOL 33-01:15

EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE

PRESIDENT'S MESSAGE

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

It is that time again for me; time for me to take the ABEM ConCert examination and I have had the pleasure of beginning to study. As I do so, I realized how the depth and breadth of our expected knowledge base in Emergency Medicine has exploded. We need to know complex disease entities and their presentations as well as the rapid expansion of medications, treatments, and side effects. The amount of information seems endless. Not to mention we have expanded our specialty into Hyperbarics, Wound Care, Emergency Medical Systems, Disaster Medicine, Pediatrics, Toxicology, Wilderness Medicine, Critical Care Medicine, Research and Sports Medicine to name only a few. In essence, wherever we are needed, we go and are adept at learning along the way. The learning is essentially non-stop and daily. It is nothing short of impressive.

We just completed another wonderful Scientific Assembly with a record breaking attendance. I want to thank the Education Committee and our Executive Team for all of the hard work to bring this meeting to us. The Scientific Assembly is a great example of our breadth of knowledge as well as the expansion of our knowledge base by many wonderful physicians. Dr. Cantor brought to us a wide selection of pediatric knowledge; Dr. Weingart, the best of critical care and trauma management; and Dr. Hoffman, everything we wanted to know about drugs of abuse, antibiotics and our favorite subject: pain management. I want to offer many thanks to our speakers for their time and willingness to share their knowledge. Plus my thanks to them for helping me to study!

Similarly our annual award winners represent our best and brightest with widely varied offerings to our specialty. Dr. Isabel Barata, recipient of the Advancing Emergency Care Award, has tirelessly taught students and physicians the art of pediatric emergency care and has served our specialty in many ways in order to advance pediatric emergency medicine. Dr. Lynne Richardson, also a recipient of an Advancing Emergency Care Award, has served our specialty in the areas of public health, health care disparity work, advancing women in medicine and service to ACEP in many functions. Dr. Joel Bartfield, recipient of the Physician of the Year Award, has not only served New York ACEP as a past president and chair of our education committee but most importantly has accepted the daunting but rewarding task of educating residents by serving as a residency director and now an Associate Dean of Graduate Medical Education. He is an exemplary physician, leader, and friend. I want to congratulate all of our award winners.

Rather than seeing studying for the ConCert as a chore, I see it as an opportunity to learn and enjoy our specialty. We have much to be proud of. And frankly, many more miles to go and places to explore.

Enjoy your summer.

2015 Lifelong Learning and Self-Assessment Course

Friday, September 18, 2015

8:00 am - 1:00 pm

Icahn School of Medicine at Mount Sinai

Fee:* Member - $199

Non-Member - $275

**includes on-site testing, excludes ABEM exam fee*

INSIDE THIS ISSUE

SOUND ROUNDS

Ultrasound Evaluation for Pyloric Stenosis

Guest Author:
Mary Emborsky
DO
Women and Children's Hospital of Buffalo
Division of Emergency Medicine

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

Indication:

- Vomiting in an infant less than 3 months.
- Infant with hypochloremia, hypokalemia and metabolic alkalosis.

Technique:

- Use a high-frequency linear transducer (5-10MHz).
- The infant should be in the supine or lateral decubitus position.
- In the transverse view, follow the superior wall of the stomach towards the liver. The pylorus has a target-like appearance in cross section.
- Measure the wall thickness of the pylorus in both longitudinal and transverse planes.
- A pyloric channel length >14mm is diagnostic of pyloric stenosis (Figures 1 and 2).
- A transverse diameter >11 mm and muscle wall width >3 mm is diagnostic of pyloric stenosis (Figure 3).
- Fluid in the stomach antrum will not advance through the pylorus if stenosis is present (Figure 4).

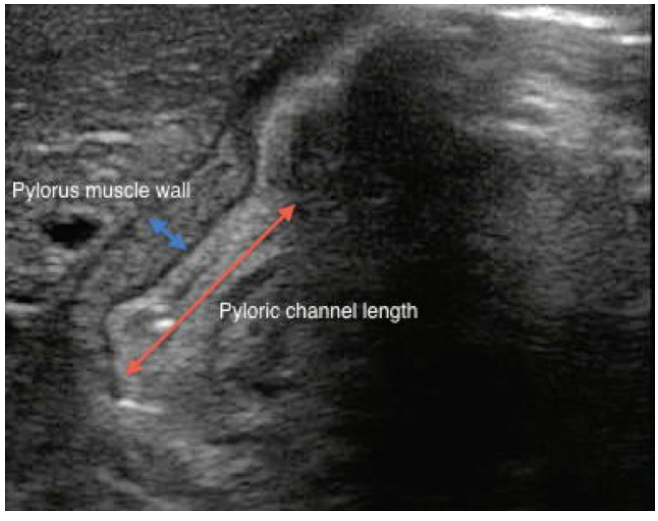


Figure 1: *Longitudinal view of pyloric stenosis. Longitudinal measurement of the pyloric channel (red arrow) and pyloric muscle wall (blue arrow).*

Figure 2: *Longitudinal view of the pylorus.*

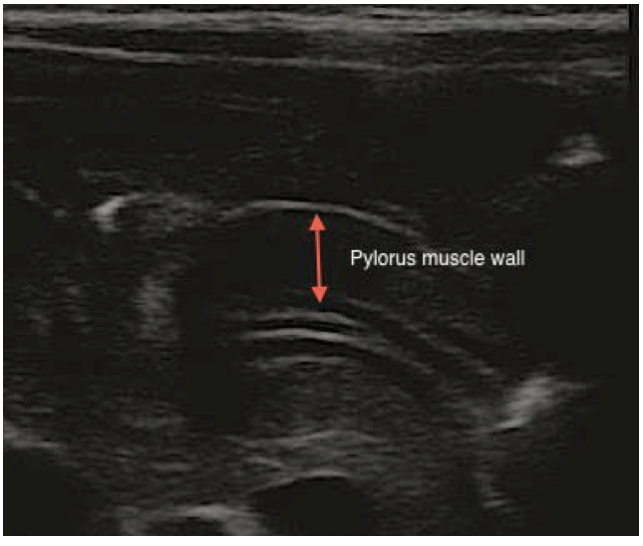


Figure 3. *Longitudinal view of pyloric stenosis. A thickened muscle wall is visualized (red arrow).*

SOUND ROUNDS

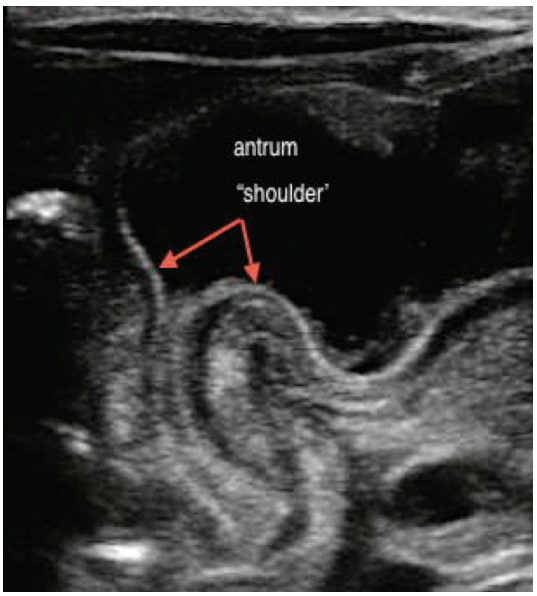


Figure 4. *Longitudinal view of the pyloric channel with a fluid-filled stomach. Stomach antrum and "shoulders" of the pylorus.*

Tips:

- Position infant in the right lateral decubitus.
- Give child 1oz to drink prior to or during the exam. The fluid-filled stomach will improve visualization of the antrum.
- Have parents hold the child in their lap and have a toy for them to play with during the exam.
- Use warm gel, sucrose solution and a pacifier.

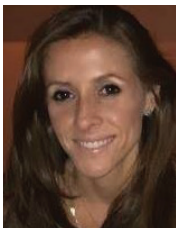
Pitfalls and Limitations:

- Intraluminal bowel gas can often obscure ultrasound findings and make the examination difficult.
- Crying infants.
- Ultrasound of an empty stomach may be difficult.
- A stomach that is too full may require the ultrasound exam to be performed in the left lateral decubitus position or require nasogastric decompression.
- The pylorus will be displaced if the stomach is distended.
- Reexamination in a few days may be necessary, as pyloric stenosis is an evolving process.

TOXICOLOGY

Discontinuing Long Term Use of Benzodiazepines and Opioids

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



Guest Author:
Ellen M. Menocal
MD
Resident, Long Island Jewish Medical Center

In an era of increasing prescription drug abuse, and in a country where approximately 5% of national health expenditures are due to adverse drug reactions ($37-50 billion/year), physicians more than ever require significant conscientiousness when prescribing medications with the potential for dependence (Bain). There have been many safeguards put into place to heighten patient safety during the medication prescribing phase, however, most physicians today are inadequately trained in safely discontinuing medications for their patients. In particular, there does not appear to be a standardized method for "de-prescribing" medications such as benzodiazepines and opioids, which, if discontinued abruptly could result in significant adverse drug reactions and withdrawals.

The medication discontinuing process should be undertaken with consideration for the medication pharmacokinetics, as well as the patient's age and comorbid conditions (Bain). One should consider that clinical manifestation after discontinuing therapy includes withdrawals, exacerbation of the underlying condition, or the development of new symptoms. Symptoms of benzodiazepine withdrawal, in particular, include agitation, anxiety, confusion, delirium, insomnia, and seizures.

In general, many long term medications should be tapered over the course of days to weeks to avoid withdrawal events. Consideration should be made for pharmacokinetics, pharmacodynamics, dose, and duration of use. Additionally, one must consider age-related differences in drug distribution, metabolism, and clearance (Curran). Some of the earlier studies on benzodiazepines provide some pharmacologic insight as to taper strategy, such as a study done by Busto et al., in which it was shown that patients on short-acting benzos may develop withdrawal symptoms earlier than those on long-acting benzos (Busto). Another study by Rickels et al., demonstrated several predictors of withdrawal severity and inability to discontinue use of benzodiazepines, including: higher daily dose/ higher plasma level, shorter half-life, longer duration of daily therapy, and a more rapid rate of taper (particularly in the final 50% of the taper) (Rickels). However, taper rate often cannot be predicted according to pharmacokinetics alone because of altered receptor binding and post receptor changes (Bain). Furthermore, patient variables often play a large part in the success of treatment, including the diagnosis of panic disorder, high pre-taper levels of anxiety/ depression, concomitant substance abuse, and higher personality psychopathology (Rickels). In fact, one could see how easily non-pharmacologic variables could confound "withdrawal" symptoms when performing a study. It could be very difficult to distinguish true withdrawal from a simple relapse of the initial anxiety that has resurfaced in the absence of medication (Schweizer).

Given that so much of the information regarding benzodiazepine withdrawal and dependence comes from studies of patients with current or previous psychiatric illness, and that so many different factors play a role in a patient's ability to discontinue certain chronic medications, it has been extremely difficult to generate a standardized regimen for benzo de-prescribing (Schweizer). This is probably a large reason for the paucity of prospective studies and randomized controlled trials looking to systematically elucidate the optimal dosing regimen for safe taper with minimal adverse reactions. All of these things severely limit our ability to develop a formal standardized methodology to discontinuing medication.

To briefly evaluate the evidence that is available regarding safe tapering protocols, one is left with a series of seemingly random dosing protocols and their outcomes. One 2003 study by Curran et al. evaluated chronic benzodiazepine users >65 years old and compared sleep and withdrawal reactions in a nine week versus 12 week taper vs continuous treatment (Curran). The taper schedules varied depending on benzodiazpine and baseline dose, but doses were decreased by roughly 25% every two weeks. It was unclear how this taper schedule was created and what evidence it was based upon, however there appeared to be no differences in withdrawal symptoms between those who stayed on benzodiazepines and those who were de-prescribed. In fact, only those who stayed on benzodiazepines had increased sleep problems and anxiety.

Another study looking at chronic elderly benzodiazepine users tapered off benzodiazepines over five weeks (25% of original dose reduced per week x three weeks, then 12.5% of original dose reduced per week x last two weeks) did not find much difference in experimental versus control group withdrawal symptoms (Habraken). There was an extremely high dropout rate, however, and the focus of the study was more about cognitive improvement and sleep than actual withdrawal symptoms. Again, it was not clear why this particular time period for taper was chosen.

The taper studies available appear to be very mixed, and seemingly randomly assign taper schedules without solid evidence for doing so. A recent meta-analysis from 2014 looking at 10 different withdrawal studies found mixed results in terms of which age groups do better with de-prescribing (Gould). The studies were also varied in that different adjuncts to pure tapering were applied in several instances, confusing pure medication effects with that of behavioral therapy and psychological counseling. The meta-analysis did not discuss tapering strategies or dosing.

TOXICOLOGY

Another study showed that a 25% dose reduction per week taper of benzodiazepines with short and long half-lives produced withdrawal symptoms in 90% of patients (Schweizer). Most reactions were described as mild-moderate, but the article did not describe which patients had severe reactions, or what those reactions were. Overall, a comparable amount of patients in each group was unable to achieve a drug-free state (32% of long t ½ and 42% of short t ½).

Many other similar studies evaluate benzodiazepine de-prescribing, but each with different foci, and with many utilizing extra adjuncts to attenuate withdrawal. A combination of medication de-prescribing with cognitive behavioral therapy may be more effective than pure drug taper alone (Morin).

Opiates are another pharmacologic class of interest when it comes to de-prescribing, particularly due to the high instance of prescription medication dependence leading to illicit drug use in the United States. Similar to benzodiazepines, there appears to be no research-based opioid taper guidelines in the literature and there is a wide variation in the guidelines that do exist (Parran).

In general, similar principals apply in all instances of de-prescribing medications with potential for dependence: one must aim to minimize or eliminate symptoms associated with withdrawal, hopefully decreasing chances of a possible relapse (Fishbain). Opioid dependence poses a particular challenge in that it is known to be a chronic relapsing disorder with genetic, drug-induced, and environmental factors.

Studies have found that because of all of the different factors at play in opioid dependence, complete abstinence only works for a small number of people with stable living conditions and adequate social support (Van den Brink). In fact, agonist maintenance treatment is now considered first line for the treatment of opioid dependence. In order to understand the therapeutic processes of medications targeted at controlling the different physiologic phases of opiate use, one must understand the four phases, which all involve different neurotransmitters taking effect on different parts of the brain. For example, phase one involves the mu-opioid receptors, in which dopamine plays a role in reinforcing drug abuse in the ventral tegmental area and nucleus accumbens. In the second phase, or conditioned responses and drug craving, there is a role for dopamine, corticotrophin-releasing hormone, and glutamate, and in the third phase of detox and withdrawal, glutamate and norepinephrine are critical. The fourth phase, which is relapse, involves several different areas of the brain which are affected by norepinephrine, CTRH, GABA, and glutamate.

Most strategies for opioid de-prescribing therefore focus on targeting the areas of the brain involved in the four phases of dependence. One may block the reward process, by replacing illicit drugs with other less harmful or addictive compounds, prevent or reduce hyperactivity in the stress axis, or aim to restore balance amongst the different regions of the brain. Abstinence, alone, which is comprised of a detox phase and relapse prevention, has been problematic in that patients will most likely inevitably relapse, and also in that it places patients at much greater risk for overdosing if they do resume use because of reduced tolerance that naturally occurred during the period of nonuse. A similar effect can occur with extended use of naltrexone, which results in "super-sensitivity" of the mu-opioid receptors and increased risk of overdose.

Most of the literature regarding opioid taper, therefore, involves crisis intervention with naloxone, abrupt discontinuation of the opioid followed by alpha two agonist therapy (clonidine/lofexidine) to reduce withdrawal symptoms, or agonist maintenance treatment with methadone or buprenorphine. Several Cochrane reviews seem to indicate most efficacy with replacing illicit short acting opioids with the long-acting opioid agonist, methadone, which should theoretically be subsequently tapered and discontinued. Buprenorphine is often preferred because of quicker resolution of withdrawal symptoms compared to methadone, (Van den Brink), with added benefits of less sedation, less respiratory depression, and less hypotension, which come along with it being a partial agonist, and having mixed agonist/antagonist properties (Becker). However, buprenorphine may be suboptimal in patients on higher dosages of heroin and it also may provide inadequate agonist, or "good high" effects, which may trigger craving for opiates more so than methadone.

Several studies evaluate different taper schedules based on replacement therapies, with taper length ranging from seven days, to 36, with mixed results. One study stated that a seven day taper of buprenorphine was just as effective as a 28 day taper at one and three month follow up, whereas another study found that longer taper duration was more successful. Just as with benzodiazepines studies, there is still no absolute consensus as to best taper strategy, and patients will likely require individualized regimens to help maintain them in the long run.

References

1. Bain, Kevin T., Holly M. Holmes, Mark H. Beers, Vittorio Maio, Steven M. Handler, and Stephen G. Pauker. "Discontinuing Medications: A Novel Approach for Revising the Prescribing Stage of the Medication-Use Process." Journal of the American Geriatrics Society 56.10 (2008): 1946-952. Web.
2. Busto, Usoa, et al. "Withdrawal reaction after long-term therapeutic use of benzodiazepines." New England Journal of Medicine 315.14 (1986): 854-859.
3. Habraken, H., et al. "Gradual withdrawal from benzodiazepines in residents of homes for the elderly: experience and suggestions for future research." European journal of clinical pharmacology 51.5 (1997): 355-358.
4. H. V. Curran, R. Collins, S. Fletcher, S. C. Y. Kee, B. Woods And S. Iliffe (2003). Older adults and withdrawal from benzodiaze pine hypnotics in general practice: effects on cognitive function, sleep, mood and quality of life. Psychological Medicine, , pp 1223-1237. doi:10.1017/S0033291703008213.
5. Fishbain, David A., et al. "Opiate detoxification protocols: a clinical manual." Annals of clinical psychiatry 5.1 (1993): 53-65.
6. Gould, Rebecca L., et al. "Interventions for reducing benzodiazepine use in older people: meta-analysis of randomised controlled trials." The British Journal of Psychiatry 204.2 (2014): 98-107.
7. Morin, Charles M., et al. "Randomized clinical trial of supervised tapering and cognitive behav ior therapy to facilitate benzodiazepine discon tinuation in older adults with chronic insomnia." (2014).
8. Parran, Leslie, and Carol Pederson. "Develop ment of an opioid-taper algorithm for hemato poietic cell transplant recipients." Oncology nursing forum. Vol. 27. No. 6. 2000.
9. Rickels, Karl, et al. "Pharmacologic strate gies for discontinuing benzodiazepine treat ment." Journal of clinical psychopharmacology 19.6 (1999): 12S-16S.
10. Van den Brink, W., and C. Haasen. "Ev idenced-based treatment of opioid-dependent patients." Canadian journal of psychiatry. Revue canadienne de psychiatrie 51.10 (2006): 635-646.

ASK THE EXPERTS

Developing Leaders in Emergency Medicine

Robert M. Bramante
MD RDMS FACEP
Director, Emergency Ultrasound
Co-Director, Clinical Decision Unit
Good Samaritan Hospital Medical Center
Progressive Emergency Physicians, PLLC

Vincent P. Verdile
MD FACEP
Dean, Albany Medical College
Executive Vice President, Health Affairs
Albany Medical Center

I had the distinct pleasure of sitting down and speaking with Dr. Vincent Verdile recently during the New York ACEP Scientific Assembly at the beautiful Sagamore Resort. Dr. Verdile is a past president of New York ACEP and Executive Vice President for Health Affairs, Executive Medical Director and Dean at Albany Medical College. Dr. Verdile is the 17th dean of Albany Medical College, and the seventh-longest tenured dean of a United States medical college. He received the 2013 John Marx Leadership Award from the Society of Academic Emergency Medicine (SAEM).

We focused our talk on the development of emergency medicine leaders in the departmental, hospital, local and national level in the ever changing healthcare environment. Dr. Verdile was both interesting and with his experience, very insightful on how to progress from clinician to leadership roles.

As the healthcare environment is changing and new challenges and opportunities arise what qualities or training do you feel physicians need to be successful leaders in their facilities and in their regional/national chapters?

I think emergency physicians are the most optimally prepared to face the future of whatever healthcare reform is, given the nature of our work and how we fit into the health care delivery system. We are clear thinkers under fire, so we can make decisions when we do not have all the resources before us. We are probably at the forefront of understanding the problems in today's health care system for the underserved and underinsured populations. We see the impact of health care disparities, the variability and dysfunctionality of the current health care system and the implications these have on health outcomes. The way we practice medicine gives us, probably, the best vantage point from which to make decisions on where to energize ourselves and improve the system.

Having said that, I think managing and leading in the healthcare environment today requires a fair amount of business sense. Anytime an opportunity arises to do formal course work that helps develop business knowledge, including how health care is financed, should be seized upon. We will be facing questions like how do you prepare for value based purchasing (VBP)? There are two components or dimensions to VBP; one is the population health/disease prevention piece, which we as emergency physicians will own part of. In our literature, there are many studies about patient recidivism, ED over utilization, and putting in place programs that will redirect these patients to better venues. The second piece of VBP is working on the dysfunction and disequilibrium of how health care is delivered today. There are two roles for us, first we can participate on the disease management side, and second, step into the breach of how one re-engineers the healthcare delivery system to make it more functional and equitable.

I always send people who are stepping up into clinical leadership roles at our institution to any one of a variety of leadership programs. There are great forums where aspiring young leaders can gain insights from physician or business leaders from different segments of the health care industry whether hospital based or medical school based. There are several programs for new chairs and clinical chiefs that are quite valuable. Many of these courses have in-person learning, then projects you work on at your own institution. These courses are outstanding because they bring learning opportunities through topics such as contract negotiations, developing budgets and human resource issues.

I do not think you need a MBA to be a leader in the healthcare industry these days. Many physicians do go out and get one, but I do not have a MBA. I really believe it is important to understand the revenue cycle component of our business, the costs associated with delivering health care and where the opportunities are to improve performance. A MBA is not necessary to become proficient in the business of emergency medicine.

I am a big advocate of best practices. I really enjoy reading about other health systems that have embraced disease prevention and population health management. Some have already gone into the business of health insurance planning and value based purchasing. These are the types of organizations we can learn from. We can look to our emergency department colleagues at places like that and say, "Tell me what you are doing or how you are doing things to improve quality, reduce costs and improve the patient experience." The key is, what are the best practices and how do we learn from those. While there are opportunities to learn from best practices without taking formal courses, there are also some very good courses offered at these leading institutions. These courses are best practices forums where people who have been successful come in and present how they did it and what mistakes they made. That information is invaluable. Every scenario, hospital system, and group is different so it will never be one size fits all but at least there is a funda-

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

ASK THE EXPERTS

mental understanding of where others are and how they got there.

I think many emergency physicians do learn leadership in a trial by fire way. It is the nature of who we are and the nature of our work. Throw us in the middle of it and we can figure it out. In administration, even though the stakes are high in dealing with issues like budget management and human resources issues of the emergency department, it is not usually a life or death matter. You can make a mistake or have a variance and then work on it. It is not like working clinically in the emergency department.

What is the best way for motivated individuals to advance within their groups and in state/national organizations?

I will say that from an organizational standpoint, ACEP has lots of pathways to leadership through sections, interest groups, committees, etc. where one can just raise their hand and start to get involved. Getting in on the ground floor with ACEP activities is always a good start. My first activity was with the Pennsylvania ACEP Scientific Assembly. I got involved helping at a resident level recruiting speakers, and before I knew it, I was on the Board of Directors. It is easy to work your way up if you are willing to put in the time. ACEP is very welcoming of young people who want to learn and get involved. Once you are involved with ACEP activities you will find there are many people who love being mentors. I have met many people through New York ACEP and National ACEP that I have viewed as mentors or that I have mentored. I think it is a matter of putting your hand up and taking the time to get involved. Life is busy. We all have work, family, and our spirituality and it is important to seek a balance. If you aspire to be involved in a leadership role getting involved at the ground floor in the emergency medicine organizations really does help to develop skills needed to run meetings, drive consensus and make decisions. These are things you can then apply to your business and personal life.

Over the next 5 years what should "rising stars" focus on to best serve the emergency medicine community?

If you aspire to be in a leadership role in the house of medicine or in healthcare policy, you need to gain experience. If you have those aspirations, the more diversified you are in your portfolio of things you participate in, the more knowledge and experience you gain. Each one of these activities becomes the foundation by which you lead or make decisions. I look back on my emergency medicine career, and I think every one of the roles I played from chief resident, to junior faculty, to ED director and all the different roles along the way with ACEP were all helpful to my career.

You can also opt out anywhere along the pathway to a leadership position and it does not mean what you have accomplished or experienced has been wasted. You have already attained the skills and knowledge that you can use in any facet of your life. I think if people in any field aspire to leadership roles, the more involved you are, the more exposure you have and the more decisions you have to make on your own the better you will be and the faster you will rise. Every organization I have been involved with embraces those individuals who say they are ready to get involved. I tell junior faculty all the time, regardless of your specialty training in medicine you should volunteer in the medical school, on hospital committees, or your local town council. These all get you exposure, you meet interesting people and you build your CV for your future. They are all great experiences.

ETHICS

Who is to Decide? Surrogate Decision Making in the ED

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

An 85 year-old woman presents to the Emergency Department in respiratory distress after being placed on CPAP by EMS and is transitioned to BiPAP. She is requiring intubation medically, but she is obtunded and lacks decision making capacity. She has two sons, both of whom claim to share the health care proxy. One wants her to have everything done. The other insists that that is not what she would have wanted. What do you do?

Surrogate decision making provides a mechanism to respect the patient's autonomy when they do not have the decision making capacity to express a choice themselves. It also can provide a way to decide what is best for a patient when they never had decision making capacity. New York has an act that became law in 2010 called the Family Health Care Decision Act (FHCDA) that guides us on who to choose as a surrogate if the court has not appointed a guardian or if the patient has not selected a health care proxy (see table 1).[1]

The hierarchy appoints the spouse or domestic partner first, unless there is a legal separation. Since New York became a no-fault divorce state in 2011, separation has become less common, but estrangement still generally voids the surrogate. When New York legalized same-sex marriage in 2013, this supported the role of a same-sex spouse to be the first surrogate. The role of the domestic partner is still important to consider, as this may include persons who share a dwelling or children together.

When the US Supreme Court upheld same-sex marriage in 2015, the ruling may impact health care surrogate decision making in other states as well, many of which had previously deferred to an adult child or parent rather than a same-sex partner.

Admittedly, there are some challenges with surrogate decision making. One third of surrogates experience stress, guilt, or doubt about their decision. Conflicts of interest, perceived or real, such as desire for inheritances or social security checks, may impact purity of the decision. If there is evidence of conflict of interest, then a physician can pursue an invalidation of a proxy by the courts, but this is a rare and slow event. Ultimately, the majority of patients prefer that their families make decisions together with physicians. In one study, 53% said this, while 30% said that they would prefer families make their own decisions, and 3% would prefer the courts make the decision. It is our job, therefore, as physicians to steer the decision-making process. We should give a recommendation, even though 40% of surrogates prefer we do not. We should aim for consensus by having family meetings and rely upon our social work colleagues to support us in figuring out who to have involved.

In the case above, the woman was actually intubated in the ED prior to the sons' arrival. A family meeting was had with them when they arrived at the ICU. It was determined that the son's claim that intubation was not what the patient would have wanted was based on a conversation he had recently with her. The other son's preference to have everything done, he confessed, was based on his selfish desire to not let her die. The patient's brother and sister-in-law helped persuade him to let her go as she would have wanted and consensus was reached.

References

1. Karmel, Jonathan. "Family Health Care Decisions Act (FHCDA) for EMS." NYSDOH. 2010.

Table 1

Family Health Care Decision Act of NY (2010) Hierarchy
Spouse or domestic partner
Adult child
Parent
Adult sibling
Close friend

New York ACEP
2015-16 Board of Directors

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

2015-16 Directors

Nicole Berwald, MD FACEP
Staten Island University Hospital
718.226.8620

Mathew Foley, MD FACEP
SUNY Downstate Medical Center
718.270.8296

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

William F. Paolo, Jr., MD FACEP
SUNY Upstate Medical University
315.464.4363

Jeffrey S. Rabrich, DO FACEP
Mount Sinai St. Luke's-Roosevelt Hospital Center
212.523.5827

Christopher C. Raio, MD MBA FACEP
Good Samaritan Hospital Medical Center
COMOTC.OYMф

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

Todd L. Slesinger, MD FACEP FCCM FCCP
Aventura Hospital & Medical Center

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

Nicole A. Yuzuk, DO
Beth Israel Medical Center
resident representative

New York
American College of Emergency Physicians

SCIENTIFIC ASSEMBLY HIGHLIGHTS

Record Attendance

The 2015 Scientific Assembly at the Sagamore Resort featured expert faculty members, Richard M. Cantor, MD FAAP FACEP; Robert S. Hoffman, MD FAACT FACMT FRCP Edin FEAPCCT and Scott D. Weingart, MD RDMS FACEP who wowed 300 emergency physicians from around the state. Forty-three companies participated through exhibits and support.

Awards

Each year New York ACEP honors individuals for significant contributions to the advancement of emergency care. New York ACEP members, Isabel Barata, MD FACP FAAP FACEP, North Shore University Hospital and Lynne Richardson, MD FACEP, Mount Sinai Hospital were presented with the 2015 Advancing Emergency Care Award. Joel Bartfield, MD FACEP, Albany Medical Center was presented with the Physician of the Year Award. For more information on these awards, visit http://nyacep.org/about-new-york-acep/awards.

New Speaker Forum

Congratulations to Eric Steinberg, DO, Staten Island University Hospital, recipient of the award for best presentation for *A Refined Approach to PEA Arrest.*

To review winning research, visit http://nyacep.org/research-abstracts-winners.

SCIENTIFIC ASSEMBLY HIGHLIGHTS

Research Forum Winners

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

Oral Presentation

- Sonography in Cardiac Arrest, Real-Time Assessment and Evaluation With Sonography
  Christopher Raio, MD FACEP, North Shore University Hospital
- Ultrasound Identification of Successful Endotrachal Tube Placement By Paramedics and Residents
  Michael O'Brien, MD, University at Buffalo

Poster Presentations

- 30-Minute Target For Fluid Bolus Administration Following The Identification Of Severe Sepsis And Septic Shock
  Daniel Leisman, BS, North Shore University Hospital
- Characteristics Of Patients Offered Rapid HIV Testing In The Emergency Department And Barriers To Testing
  Suzanne Bentley, MD MPH FACEP, Elmhurst Hospital/Icahn School of Medicine at Mount Sinai
- Minor Head Trauma, Clinical Decision Making Rules, And Head CTs; The Experience At A Large Urban Trauma Center *Valerie Lou, MD, University of Rochester Medical Center*
- Is Faculty Knowledge The Most Common Cause Of 72-Hour Returns In The Emergency Department?
  Jean E. Sun, MD, Mount Sinai Hospital
- Simplifying Sepsis - Adherence To A 3-Hour Bundle Saves Lives, Time, and Money
  Benjamin Wie, BA, North Shore University Hospital

Leadership Elected

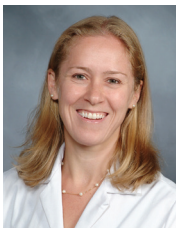
Congratulations are extended to board member Stuart G. Kessler, MD FACEP, Elmhurst Hospital Center elected to serve a second term on the New York ACEP Board of Directors. Newly elected directors include; Mathew Foley, MD FACEP, SUNY Downstate/Kings County Hospital; William F. Paolo, Jr., MD FACEP, SUNY Upstate Medical University and Jeffrey S. Rabrich, DO FACEP, Mount Sinai St. Luke's. Justin Fuehrer, DO, Long Island Jewish Medical Center was appointed resident representative to the Board of Directors by President Louise A. Prince, MD FACEP.

SUNY Buffalo Reins Supreme in Resident Volleyball Tournament

Seven residency programs competed for bragging rights in the Scientific Assembly volleyball tournament.

EDUCATION

Feedback: An Area for Improvement with a New Type of Sandwich



Mary R. Mulcare
MD
Assistant Program Director, Emergency Medicine
NewYork-Presbyterian Hospital
Assistant Attending Physician, Weill Cornell Medical Center
Assistant Professor of Clinical Medicine, Weill Cornell Medical College

Feedback is a critical part of medical education at all levels. As described by Jack Ende: "Without feedback, mistakes go uncorrected, good performance is not reinforced, and clinical competence is achieved empirically or, not at all."[1] In a 2004 survey done of medical students and residents, 96% wanted constructive feedback, 90% wanted it in a timely fashion, and 86% wanted to give ideas first. Of those surveyed, only 31% received helpful feedback and 21% had received recent feedback.[2] There is evidence in 2015, that we (medical educators) are still not achieving desired benchmarks. On the annual national ACGME Resident Survey,[3] feedback was an area that the EM residents expressed less satisfaction relative to other aspects of their training experience. Why is this? And how do we fix it?

There are several factors and people at play: the transmitter (teacher/attending/senior resident), the receiver (learner/resident/medical student), and the interpersonal relationship of the two. The transmitter may be uncomfortable giving feedback. There are palpable social pressures of not wanting to be seen as the "bad guy", worrying about hurting the receiver's feelings, or being concerned about misinterpretation of the point at hand. This is likewise true for peer feedback.

Feedback also may be more prevalent than perceived by the learner. There are times when the teacher thinks that they are reflecting and instructing on recent happenings, and the learner is not recognizing it as such. There may be a role for being as transparent as saying, "If you're willing, I am going to give you some feedback".

There is a newer model for delivering feedback, devised from the older sandwich model, which addresses some of these issues. The traditional sandwich model followed a pattern of praise – criticism – praise when delivering feedback, with all the verbal communication being in the domain of the transmitter. In the newer iteration, Ask-Tell-Ask (ATA)[4] engages the receiver in the feedback process by asking an initial question, allowing for brief self-reflection and helping direct the teacher based on the learner's response. The "Tell" is delivering the teacher's observations, being as specific with observed behaviors as possible. Then the final "Ask" is a question to assess the learner's understanding and plans for improvement.

In conducting workshops for the faculty and EM residents to introduce the ATA method, we observed that the residents had a greater ease adapting to this model than the faculty members. Whether this is due to years of experience leading the faculty to be more fixed in their ways, or that the residents, in addition to being relatively new to medical education, prefer to deliver feedback in the manner in which they would like to receive, is yet to be determined. Regardless, this model was easy to understand, used in practice settings, and hopefully will translate to increased comfort and the frequency with which feedback is given. We look forward to extending this model to our PA, NP and RN residencies in the near future.

References:

1. Ende J. Feedback in Clinical Medical Education. JAMA 1983;250:777-81.
2. Schultz KW, et al. Medical students' and residents' preferred site characteritics and preceptor behaviours for learning in the ambulatory setting: a cross-sectional survey. BMC Med Educ 2004;4:12.
3. ACGME Resident Survey. July 14, 2015, at www.acgme.org.
4. Luyba Konopasek, MD. Presentation to faculty at NewYork-Presbyterian Hospital, based on work yet to be published.

NEW YORK STATE OF MIND

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

The Association Between Medicolegal And Professional Concerns And Chest Pain Admission Rates.

Brooker JA, Hastings JW, Major-Monfried H, Maron CP, Winkel M, Wijeratne HR, Fleischman W, Weingart S, Newman DH; The Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Acad Emerg Med. 2015 Jul;22(7):883-6.

OBJECTIVES: For patients in whom acute coronary syndrome (ACS) is a concern, disposition decisions are complex and multifactorial and have traditionally been a source of considerable variation. An important factor in disposition decisions for these patients may be physician-perceived medicolegal risk and related professional concerns. The study aim was to determine, at the point of care, how much less frequently physicians report that they would admit possible ACS patients if there was either zero or a defined medicolegal risk.

METHODS: This was a point-of-care emergency physician survey. Research assistants approached physicians at or immediately following the moment of disposition decisions for patients who were being admitted for ACS. The primary outcome measures were the proportion of physicians reporting that patients would not have been admitted if medicolegal issues were of no concern and the proportion of physicians reporting that patients would not have been admitted if there was an "acceptable miss rate" of 1% to 2% for ACS patients.

RESULTS: During the 3-month study period, 576 patients were admitted to an inpatient unit or to the ED observation protocol. Physicians were approached in 271 cases, and 259 surveys were completed. When presented with hypothetical zero medicolegal risk, physicians answered that they would not have admitted the patients in 30% of cases. With a hypothetical 1% to 2% acceptable miss rate, physicians indicated that they would not have admitted the patients in 29% of the cases.

CONCLUSIONS: ED medicolegal and professional concerns may substantially increase admissions for possible ACS. An acceptable miss rate or a zero medicolegal risk environment could potentially lead to a major reduction in admissions that physicians feel to be clinically unnecessary.

The Ultrasound-Only Central Venous Catheter Placement And Confirmation Procedure.

Saul T, Doctor M, Kaban NL, Avitabile NC, Siadecki SD, Lewiss RE; Department of Emergency Medicine, Division of Emergency Ultrasound, Mount Sinai-St Luke's Hospital, Mount Sinai-Roosevelt Hospital, New York; J Ultrasound Med. 2015 Jul;34(7):1301-6.

The placement of a central venous catheter remains an important intervention in the care of critically ill patients in the emergency department. We propose an ultrasound-first protocol for 3 aspects of central venous catheter placement above the diaphragm: dynamic procedural guidance, evaluation for pneumothorax, and confirmation of the catheter tip location.

Saline Flush Test: Can Bedside Sonography Replace Conventional Radiography For Confirmation Of Above-The-Diaphragm Central Venous Catheter Placement?

Gekle R, Dubensky L, Haddad S, Bramante R, Cirilli A, Catlin T, Patel G, D'Amore J, Slesinger TL, Raio C, Modayil V, Nelson M; Department of Emergency Medicine, North Shore University Hospital, Manhasset, New York ; J Ultrasound Med. 2015 Jul;34(7):1295-9.

OBJECTIVES: Resuscitation often requires rapid vascular access via central venous catheters. Chest radiography is the reference standard to confirm central venous catheter placement and exclude complications. However, radiographs are often untimely. The purpose of this study was to determine whether dynamic sonographic visualization of a saline flush in the right side of the heart after central venous catheter placement could serve as a more rapid confirmatory study for above-the-diaphragm catheter placement.

METHODS: A consecutive prospective enrollment study was conducted in the emergency departments of 2 major tertiary care centers. Adult patients of the study investigators who required an above-the-diaphragm central venous catheter were enrolled during the study period. Patients had a catheter placed with sonographic guidance. After placement of the catheter, thoracic sonography was performed. The times for visualization of the saline flush in the right ventricle and sonographic exclusion of ipsilateral pneumothorax were recorded. Chest radiography was performed per standard practice.

RESULTS: Eighty-one patients were enrolled; 13 were excluded. The mean catheter confirmation time by sonography was 8.80 minutes (95% confidence interval, 7.46-10.14 minutes). The mean catheter confirmation time by chest radiograph availability for viewing was 45.78 minutes (95% confidence interval, 37.03-54.54 minutes). Mean sonographic confirmation occurred 36.98 minutes sooner than radiography ($P < .001$). No discrepancy existed between sonographic and radiographic confirmation.

CONCLUSIONS: Confirmation of central venous catheter placement by dynamic sonographic visualization of a saline flush with exclusion of pneumothorax is an accurate, safe, and more efficient method than confirmation by chest radiography. It allows the central line to be used immediately, expediting patient care.

The Baseline Diameter Of The Inferior Vena Cava Measured By Sonography Increases With Age In Normovolemic Children.

Kathuria N, Ng L, Saul T, Lewiss RE; Department of Emergency Medicine, Mount Sinai St Luke's-Roosevelt Hospital Center, New York; J Ultrasound Med. 2015 Jun;34(6):1091-6.

OBJECTIVES: To evaluate normative sonographic measurements of the inferior

NEW YORK STATE OF MIND

vena cava (IVC) diameter in healthy pediatric patients.

METHODS: We performed a prospective observational study of a convenience sample of healthy patients between the ages of 0 and 22 years presenting to a pediatric emergency department. Exclusion criteria included abnormal vital signs, pregnancy, or illnesses thought to influence volume status. During quiet respiration, the maximum and minimum IVC diameters were measured in the sagittal plane distal to the hepatic vein-IVC junction. As second measurements, the maximum diameters of the IVC and aorta were measured in the transverse plane distal to the insertion of the left renal vein into the IVC.

RESULTS: From February 2013 through April 2014, 63 children (51% female; mean age, 11 years) were enrolled. There were 20 children in each age group of 2 to 7, 7 to 12, and 12 to 22 years. The correlations between IVC and aortic diameters as a function of age were calculated using the Spearman rank correlation coefficient. The correlation coefficients were all statistically significant ($P < .001$): sagittal maximum IVC diameter (0.81), sagittal minimum IVC diameter (0.79), transverse maximum IVC diameter (0.79), and transverse maximum aortic diameter (0.81).

CONCLUSIONS: This pilot study of sonographic measurements of the IVC diameter in normovolemic children suggests a statistically significant positive correlation between age and IVC diameter. Future studies should focus on multicenter enrollment, children in the youngest age group, and the development of normative growth curves for the IVC by age, sex, and body mass index.

Stroke Education In An Emergency Department Waiting Room: A Comparison Of Methods.

Chan YF, Richardson LD, Nagurka R, Hao K, Zaets SB, Brimacombe MB, Bentley S, Levine SR; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Health Promot Perspect. 2015 Mar 29;5(1):34-41.

BACKGROUND: Since the emergency department (ED) waiting room hosts a large, captive audience of patients and visitors, it may be an ideal location for conducting focused stroke education. The aim of this study was to assess the effectiveness of various stroke education methods.

METHODS: Patients and visitors of an urban ED waiting room were randomized into one of the following groups: video, brochure, one-to-one teaching, combination of these three methods, or control group. We administered a 13-question multiple-choice test to assess stroke knowledge prior to, immediately after, and at 1 month post-education to patients and visitors in the ED waiting room.

RESULTS: Of 4 groups receiving education, all significantly improved their test scores immediately post intervention (test scores 9.4±2.5-10.3±2.0, $P<0.01$). At 1 month, the combination group retained the most knowledge (9.4±2.4) exceeding pre-intervention and control scores (both 6.7±2.6, $P<0.01$).

CONCLUSION: Among the various stroke education methods delivered in the ED waiting room, the combination method resulted in the highest knowledge retention at 1-month post intervention.

Rapid Diagnosis Of Nonconvulsive Status Epilepticus Using Reduced-Lead Electroencephalography.

Brenner JM, Kent P, Wojcik SM, Grant W; State University of New York Upstate Medical University, Departments of Emergency Medicine and Neurology, Syracuse; West J Emerg Med. 2015 May;16(3):442-6.

INTRODUCTION: Electroencephalography (EEG) is indicated for diagnosing nonconvulsive status epilepticus (NCSE) in a patient who has altered level of consciousness 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 emergency department (ED) at all times. Patients presenting to the ED with altered mental status and known history of seizure or a witnessed seizure having a standard EEG were eligible for this study. The emergency 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 emergency physician ordered a standard 23-lead EEG, which would be interpreted by the neurologist on call to read EEGs. We compared the epileptologist's interpretation of the reduced montage EEG to the results of the 23-lead EEG, which was considered the gold standard for detecting seizures.

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

CONCLUSION: The results are consistent with prior studies which have shown that 8-48% of patients who have had a motor seizure continue to have nonconvulsive seizure activity on EEG. This study suggests that a bedside reduced-montage EEG can be used to make the diagnosis of NCSE in the ED. Further study will be conducted to see if this technology can be applied to the inpatient neurological intensive care unit setting.

Racial Differences In Opiate Administration For Pain Relief At An Academic Emergency Department.

Dickason RM, Chauhan V, Mor A, Ibler E, Kuehnle S, Mahoney D, Armbrecht E, Dalawari P; New York Hospital Queens, Department of Emergency Medicine, Flushing; West J Emerg Med. 2015 May;16(3):372-80.

INTRODUCTION: The decision to treat pain in the emergency department (ED) is a complex, idiosyncratic process. Prior studies have shown that EDs undertreat pain. Several studies demonstrate an association between analgesia administration and race. This is the first Midwest single institution study to address the question of race and analgesia, in addition to examining the effects of both patient and physician characteristics on race-based disparities in analgesia administration.

METHODS: This was a retrospective chart review of patients presenting to an urban academic ED with an isolated diagnosis of back pain, migraine, or long bone fracture (LBF) from January 1, 2007 to December 31, 2011. Demographic and medication administration information was collected from patient charts by trained data collectors blinded to the hypothesis of the study. The primary outcome was the proportion of African-Americans who received analgesia and opiates, as compared to Caucasians, using Pearson's chi-squared test. We developed a multiple logistic regression model to identify which physician and patient characteristics correlated with increased opiate administration.

RESULTS: Of the 2,461 patients meeting inclusion criteria, 57% were African-American and 30% Caucasian (n=2136). There was no statistically significant racial difference in the administration of any analgesia (back pain: 86% vs. 86%, p=0.81; migraine: 83% vs. 73%, p=0.09; LBF: 94% vs. 90%, p=0.17), or in opiate administration for migraine or LBF.

NEW YORK STATE OF MIND

African-Americans who presented with back pain were less likely to receive an opiate than Caucasians (50% vs. 72%, p<0.001). Secondary outcomes showed that higher acuity, older age, physician training in emergency medicine, and male physicians were positively associated with opiate administration. Neither race nor gender patient-physician congruency correlated with opiate administration.

CONCLUSION: No race-based disparity in overall analgesia administration was noted for all three conditions: LBF, migraine, and back pain at this institution. A race-based disparity in the likelihood of receiving opiate analgesia for back pain was observed in this ED. The etiology of this is likely multifactorial, but understanding physician and patient characteristics of institutions may help to decrease the disparity by raising awareness of practice patterns and can provide the basis for quality improvement projects.

National Trends in Resource Utilization Associated With ED Visits For Syncope.

Probst MA, Kanzaria HK, Gbedemah M, Richardson LD, Sun BC; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Am J Emerg Med. 2015 Aug;33(8):998-1001.

BACKGROUND: Over the last 20 years, numerous research articles and clinical guidelines aimed at optimizing resource utilization for emergency department (ED) patients presenting with syncope have been published.

HYPOTHESIS: We hypothesized that there would be temporal trends in syncope-related ED visits and associated trends in imaging, hospital admissions, and diagnostic frequencies.

METHODS: The ED component of National Hospital Ambulatory Medical Care Survey was analyzed from 2001 through 2010, comprising more than 358,000 visits (representing an estimated 1.18 billion visits nationally). We selected ED visits with a reason for visit of syncope or fainting and calculated nationally representative weighted estimates for prevalence of such visits and associated rates of advanced imaging utilization and admission. For admitted patients from 2005 to 2010, the most frequent hospital discharge diagnoses were tabulated.

RESULTS: During the study period, there were more than 3,500 actual ED visits (representing 11.9 million visits nationally) related to syncope, representing roughly 1% of all ED visits. Admission rates for syncope patients ranged from 27% to 35% and showed no significant downward trend (P = .1). Advanced imaging rates increased from about 21% to 45% and showed a significant upward trend (P < .001). For admitted patients, the most common hospital discharge diagnosis was the symptomatic diagnosis of "syncope and collapse" (36.4%).

CONCLUSIONS: Despite substantial efforts by medical researchers and professional societies, resource utilization associated with ED visits for syncope appears to have actually increased. There have been no apparent improvements in diagnostic yield for admissions. Novel strategies may be needed to change practice patterns for such patients.

Clinical Risk Factors For In-Hospital Adverse Cardiovascular Events After Acute Drug Overdose.

Manini AF, Hoffman RS, Stimmel B, Vlahov D; Division of Medical Toxicology, Icahn School of Medicine at Mount Sinai, New York; Acad Emerg Med. 2015 May;22(5):499-507.

OBJECTIVES: It was recently demonstrated that adverse cardiovascular events (ACVE) complicate a high proportion of hospitalizations for patients with acute drug overdoses. The aim of this study was to derive independent clinical risk factors for ACVE in patients with acute drug overdoses.

METHODS: This prospective cohort study was conducted over 3 years at two urban university hospitals. Patients were adults with acute drug overdoses enrolled from the ED. In-hospital ACVE was defined as any of myocardial injury, shock, ventricular dysrhythmia, or cardiac arrest.

RESULTS: There were 1,562 patients meeting inclusion/exclusion criteria (mean age, 41.8 years; female, 46%; suicidal, 38%). ACVE occurred in 82 (5.7%) patients (myocardial injury, 61; shock, 37; dysrhythmia, 23; cardiac arrests, 22) and there were 18 (1.2%) deaths. On univariate analysis, ACVE risk increased with age, lower serum bicarbonate, prolonged QTc interval, prior cardiac disease, and altered mental status. In a multivariable model adjusting for these factors as well as patient sex and hospital site, independent predictors were: QTc > 500 msec (3.8% prevalence, odds ratio [OR] = 27.6), bicarbonate < 20 mEq/L (5.4% prevalence, OR = 4.4), and prior cardiac disease (7.1% prevalence, OR = 9.5). The derived prediction rule had 51.6% sensitivity, 93.7% specificity, and 97.1% negative predictive value, while presence of two or more risk factors had 90.9% positive predictive value.

CONCLUSIONS: The authors derived independent clinical risk factors for ACVE in patients with acute drug overdose, which should be validated in future studies as a prediction rule in distinct patient populations and clinical settings.

Emergency Department Bouncebacks: Is Lack of Primary Care Access the Primary Cause?

Moskovitz JB, Ginsberg Z; Department of Emergency Medicine, Hofstra North Shore-LIJ School of Medicine, Hempstead; J Emerg Med. 2015 Jul;49(1):70-77.

BACKGROUND: National emergency department (ED) bounceback rates within 30 days of previous ED discharge have been found to be as high as 26%. We hypothesize that having a primary care physician (PCP) would prevent bouncebacks to the ED because a patient would have a medical resource for follow-up and continued care.

METHODS: We performed a prospective, consecutive, anonymous survey study of adult ED patients at a suburban teaching hospital with 88,000 visits annually, from July 5, 2011 through August 8, 2011. Using chi-squared and Fisher's exact tests, we compared patients with an initial visit to those returning within 30 days of a previous visit to our ED.

RESULTS: We collected 1,084 surveys. Those in the bounceback group were more likely to have no insurance (10.2% vs. 4.4%) or Medicaid (17.7% vs. 10.8%) and less likely to have a PCP (79% vs. 86%). Of those with a PCP, 9% in both groups had seen their PCP that day, 58% (initial visit) and 49% (bouncebacks) could have been seen that day, and 35% & 36%, respectively, within 1 week. Of those with a PCP, 38% of initial visits and 32% of bouncebacks stated they had already seen their physician at least once.

CONCLUSION: Our results suggest that patients who bounce back to the ED might have already contacted their PCP. Although insurance status and the lack thereof predict a higher likelihood to bounce back to the ED, many bouncebacks are insured patients with PCPs able to be seen the same day.

PEDIATRICS

Not Your Ordinary Sore Throat

Denis R. Pauzé
MD FACEP
Vice Chairman Operations
Associate Professor of Emergency Medicine and Pediatrics
Department of Emergency Medicine, Albany Medical Center

History: A 12 year old female presented with nearly 7 days of fever and cough. She saw her pediatrician where a rapid strep was performed and was negative. She was sent to our Emergency Department (ED) with concern for a retropharyngeal abscess. The pediatrician requested an ENT evaluation and lateral x-ray of the neck. Upon arrival to our ED, the patient predominately complained of fever and cough for nearly seven days. She did have a mild sore throat and some difficulty swallowing. She denied chest pain, shortness of breath, headache, abdominal pain or rash.

On review of systems, she admits to several months of nasal congestion and snoring. She had no significant past medical history. Her immunizations were up to date.

Physical Exam: T 37.0 C, BP 129/82, HR 138 RR 24 and O2 sat 95%
She was in no acute distress and was non toxic in appearance.
Her mouth and throat exam revealed an unusual looking oropharyngeal mass (see Figure 1).

Figure 1

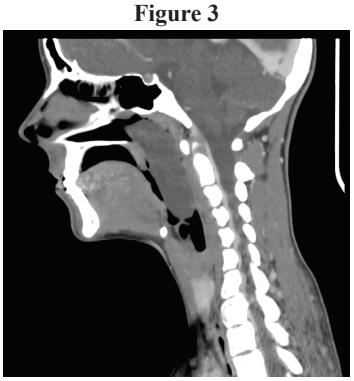
Neck was supple. Lung exam revealed diffuse rhonchi and rales in the left lung. The remainder of her exam was normal.

Assessment, Plan and ED Course: The patient is a 12 year old female here with fever, cough, and mild sore throat. Her exam was significant for an unusual oropharyngeal mass as well as a clinical picture of pneumonia. She was seen and evaluated by ENT who performed a flexible nasopharyngeal laryngoscopy. She was found to have a large left antrochoanal polyp. This was a non friable mass. Her airway was deemed patent. ENT recommended a CT scan of her maxillary sinus and neck.

CT scan revealed: a large polypoid mass extending from the posterior left nasal cavity into the hypopharynx (see Figure 2 and 3). This appears adjacent to an accessory ostium of the left maxillary sinus, which is also nearly completely opacified. The imaging findings are suspicious for a large antrochoanal polyp. This results in moderate obstruction of the nasopharynx and oropharynx. There is also slight mass effect upon the tip of the epiglottis.

Figure 2

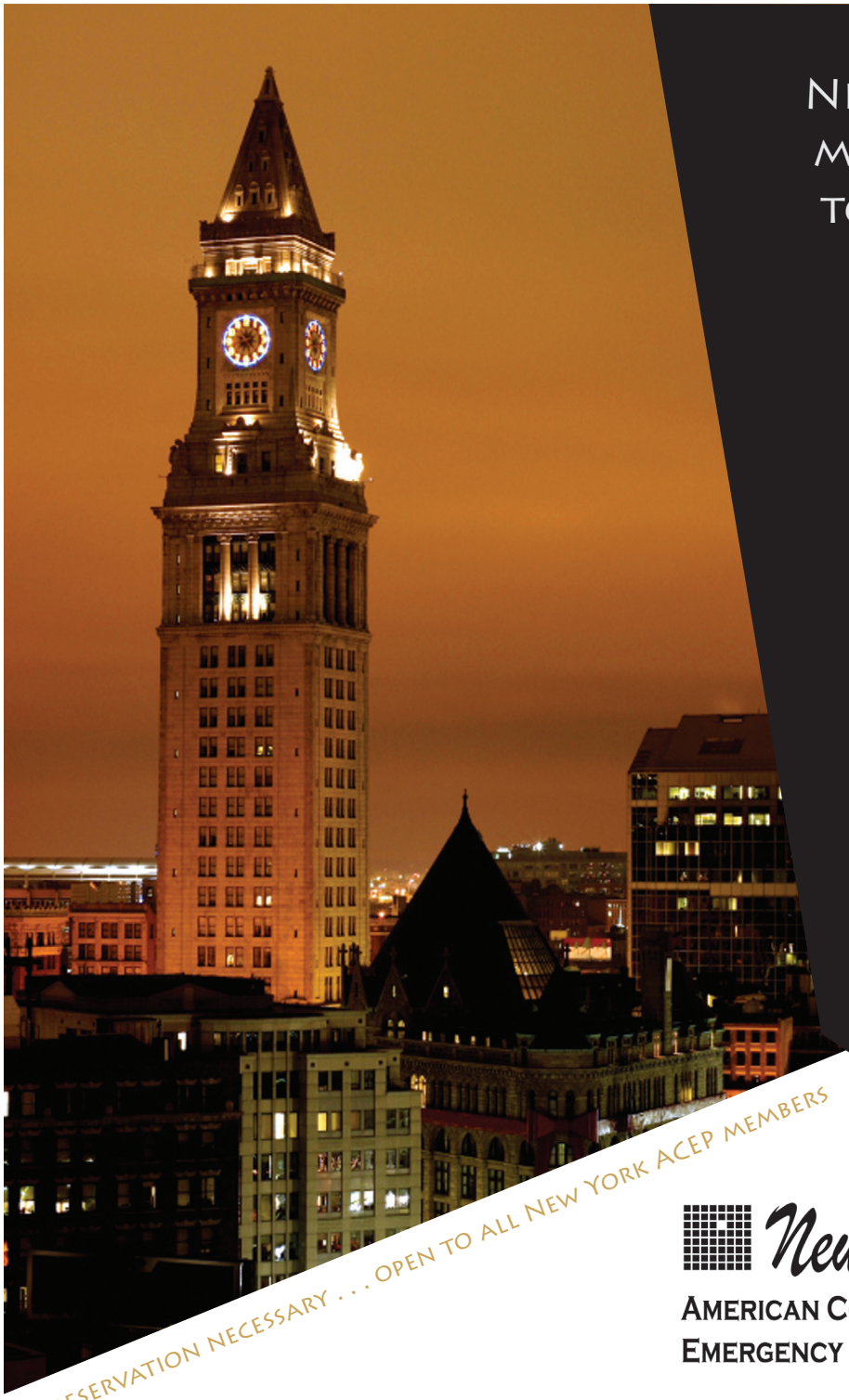
Figure 3



Her chest x-ray revealed a left lingular pneumonia. Her labs were normal. She was treated with antibiotics. ENT recommended outpatient treatment of the antrochoanal polyp. They felt her airway was patent. We had initially thought that due to the impressive CT images as well as the size and location of the polyp, as well as proximity to the epiglottis, she would be taken to the Operating Room within the next 24 hours. ENT stated her airway was stable, and she could follow up in a "few weeks" for operative repair.

Discussion and Case Outcome: Antrochoanal polyps are usually benign polyps that arise from the maxillary sinus and pass into the nose. The exact etiology is unknown, but they may be due to inflammation, such as patients with chronic sinusitis or chronic allergies. Endoscopic surgical removal is needed for large polyps.

Our patient was discharged from the ED and had surgery 3 weeks later. She did fine.



New York ACEP members are invited to attend

New York ACEP Reception

Monday, October 26

6:00 - 7:00 PM

Westin Boston Waterfront

Conference Level

Harbor Ballroom I

No reservation necessary . . . open to all New York ACEP members

New York American College of Emergency Physicians

www.nyacep.org

EMS Spinal Immobilization: Changes in Practice

Joseph Bart
DO EMT–P/T
Director, EMS Operations
Division of Emergency Medical Services
University at Buffalo Emergency Medicine

Jeremy T. Cushman
MD MS EMT–P FACEP
Chief, Division of Prehospital Medicine
University of Rochester

Which patients have "back pain" after arriving to your ED on a long spine board? The answer: ALL of them! According to March, et al. in Prehospital Emergency Care in 2002[1] – even healthy, uninjured patients placed on a long spine board will have increased pain and discomfort that challenges the reliability of your physical examination.

Each time you see an alert patient ride by on a long spine board by an arriving EMS unit, you may get angry like we do (insert drama), or perhaps have become resolved to that's the way they have to do it. Either way, let's rejoice together that times have changed and thanks to research, New York State (NYS) EMS will be moving away from the all-or-none concept of spinal immobilization.

The Problem:

Spinal immobilization under the current NYS Basic Life Support (BLS) protocol establishes the expectation that there will be nearly universal use of a long spine board when any type of spinal injury is suspected. The expectation of spinal immobilization is rooted in the belief that it is necessary to immobilize the spine – a tenet of prehospital care promulgated in the 1980's regarding the care of patients injured during motor vehicle accidents. As modern trauma care began to take shape, the continued practice of immobilization was scripted into the everyday practice of EMS. As former paramedics, we can commit to that practice and acknowledge that EMS recognizes trauma very well and takes precautions to minimize unnecessary movement whenever possible. This same practice has evolved into a ritual of placing patients onto a long spine board, often without thought or assessment. For several reasons, this bad practice has been challenged as a matter of national EMS practice.

Most NYS EMT's, when asked on the purpose of the long spine board will tell you – "immobilization, right?" The concept is assuming that we are treating the spine as a long bone injury and immobilizing it from the occiput to the sacrum. We all understand that this just is not the case. What we are seeking is a much simpler concept of spinal motion restriction.

Out With the Old, in With the New:

Spinal immobilization with a long spine board is not a benign process, it very rarely results in its intended goal of "immobilization," and not all patients who sustain trauma require thoracolumbar spinal immobilization to begin with. In a 2013 position paper, NAEMSP recommended the "judicious" use of the long board.[2] This same intent was used to create a new suspected spinal injury protocol for NYS EMS. Other than historical dogma and institutional EMS culture, we can find no evidence-based reason to continue to use the long spine board as it currently exists in practice today. The evidence that does exist regarding the long spine board is overwhelmingly negative.

In January 2015, the State Emergency Medical Advisory Committee (SEMAC) – the EMS physician advisory group for EMS in New York – approved changes to the NYS BLS suspected spinal injury protocol. Together with the Bureau of EMS, the SEMAC constructed a protocol and curriculum update due to roll out later this year. The new protocol will simplify the decisions on spinal immobilization by placing the primary focus on cervical immobilization and spinal motion restriction while eliminating the mandatory use of a long spine board. Importantly, this protocol will affect ALL currently practicing EMS providers, those in training, the curriculum for those who will become EMS providers in the future, and every first receiving facility in the state.

The new protocol (Figure 1) was crafted to allow liberal use of a rigid cervical collar and judicious use of a long spine board. The scheme of the new protocol will remain based on major trauma criteria – more closely mirroring most trauma center activation protocols.

The Difference:

The protocol is based on recognition of trauma patterns and the immobilization of the cervical spine with spinal motion restriction of the remainder of the spinal column. We eliminated the mandatory placement of the patient on a long spine board under any circumstance. We then included language on the shift in practice to enable the NYS EMT to eliminate the use of a long spine board without fear of retribution. We felt this was essential to effectively change practice patterns and convince NYS EMTs that they are indeed doing the right thing.

The bottom line is that we see patients every day arriving on long spine boards that could have safely been assisted to an ambulance stretcher and placed in a position that limits extreme movement of the thoracolumbar spine. Patients who are ambulatory at scenes and would have previously been instructed to lie down or be lowered onto a long spine board should no longer receive such an intervention.

Under this new protocol, you will still see patients arrive on a long spine board. The intent was never to outlaw the practice, but rather to create a protocol that focuses on the true intentions of spinal motion restriction and not the manner in which they are carried to the ambulance. Does the long spine board have a use? Certainly. Prone, uncon-

scious motorcycle wreck in a ditch – we would use a long spine board to extricate that patient 100/100 times; it's likely the best tool for the job. But for the neck pain at a minor mechanism motor vehicle crash that is conscious and able to ambulate? Application of a cervical collar and self-ambulation with assistance to a gurney will provide less spinal motion and greater comfort than placing on a long spine board.

In keeping with this change in EMS practice, emergency departments may need to assist with patient movement once they arrive to the ED in ways we are currently unaccustomed to. We must keep in mind that without the obvious "clue" of a long spine board, that spinal motion restriction prior to a focused ED provider assessment should remain a priority. The traditional transfer of a spinal motion restricted patient on a long spine board will need to be modified through the use of a slide board or similar device to safely transfer a spinal motion restricted patient that is not on a long spine board from an EMS stretcher to an ED bed. Equally important for patients being transferred between facilities, there is no supporting evidence that the use of a long spine board is a necessary practice. Utilization of spinal motion restriction can be safely accomplished without a long spine board during transfers.[2]

There will still be veteran and novice EMTs that will bring you patients on long spine boards. They will hopefully be familiar with the change in protocol, but may be resistant at first. Your respectful correction of the inappropriate use of a long spine board and encouragement for compliance with the updates and their intent to achieve spinal motion restriction without the untoward effects of the long spine board will go a long way.

References:

1. March J, Ausband S, Brown L. Changes in physical examination caused by use of spinal immobilization. Prehosp Emerg Care. 2002;6:421-4
2. National Association of EMS Physicians and American College of Surgeons Committee on Trauma. Position Statement: EMS Spinal Precautions and the Use of the Long Backboard. Prehosp Emerg Care. 2013;17:392-3.

Figure 1
2015 Suspected Spinal Injuries

For patients meeting Adult or Pediatric Major Trauma Criteria (Protocol T-6 or T-7) with a BLUNT mechanism of injury:

1. Spine injury should be suspected.
2. The patient should be placed in a properly fitted cervical collar and spinal movement minimized.

For patients meeting Adult or Pediatric Major Trauma Criteria (Protocol T-6 or T-7) with a PENETRATING mechanism of injury, **OR** for patients **NOT** meeting Adult or Pediatric Major Trauma Criteria with a BLUNT mechanism of injury, **spine injury should be suspected if one or more of the following criteria are present:**

1. Altered mental status – Associated with trauma - for any reason including possible intoxication from alcohol or drugs (GCS<15)
2. Complaint of neck and/or spine pain or tenderness
3. Weakness, tingling or numbness of the trunk or extremities at any time since the injury
4. Deformity of the spine not present prior to the incident
5. Painful distracting injury or circumstances (i.e. anything producing an unreliable physi cal exam)
6. High Risk mechanism of injury associated with unstable spinal injuries that include, but are not limited to:
   - Axial Load (i.e. diving injury, spearing tackle)
   - High Speed motorized vehicle crashes or roll over
   - Pedestrian or bicyclist struck/collision
   - Falls >3feet/5steps or patient's height

If a spine injury is suspected, the patient should be placed in a properly fitting rigid cervical collar, and spinal movement minimized.

Patients without any of the above findings may be transported without the use of a cervical collar or any other means to restrict spinal motion.

Notes:

A long spine board is one of multiple modalities that can be used to minimize spinal movement. Electing not to use a long spine board will not constitute a deviation from the standard of care.

Spinal movement can be minimized by application of a properly fitting rigid cervical collar and securing the patient to the EMS stretcher.

When spinal motion restriction has been initiated and a higher level of care arrives, patients should be reassessed for spinal injury (per this protocol).

When possible, the highest level of care on scene will determine if spinal motion restriction is to be used or discontinued (collar removed, etc.)

Long spine boards do not have a role in transporting patients between facilities.

Getting Involved

Nicole Berwald
MD FACEP
Associate Chair, Department of Emergency Medicine
Staten Island University Hospital

A few years after graduating residency, during my first years as an attending, I recall asking myself: "How can I get involved? During residency it was easy for me to contribute to my department and hospital, as certain aspects of residency training result in academic and administrative projects. Being on my own in the real world was a new experience with many possibilities and opportunities, I just wasn't sure how to get them. With high aspirations but little direction it felt like a complicated endeavor.

At local and national emergency medicine conferences I would watch speakers and leaders from a far, wondering how did they get there, how did they get to take the podium? In full disclosure, that was not and is not my exact objective, but a simpler question with perhaps an equally difficult answer: How do I get involved in a way that is meaningful to me, so I can contribute to the emergency medicine community and feel connected?

Not knowing how to approach this challenge I found myself asking senior emergency medicine faculty at local and national conferences how to get involved. I did the same at my local institution. The results were highly variable. I hadn't realized that this was a loaded question… ask 10 people and you'll get 10 different answers.

The most wonderful part of my experience was finding that the emergency medicine community is nurturing and supportive. The so-called giants of our field want to teach from their experience, and foster the development of junior faculty. So when I asked, "how do I get involved", I had many answers to consider and weigh against each other. However, it was for me to make sense of for myself.

There was a common theme in almost all of the advice I was given. The most common thread being some version of "show up at the table". You might be asking yourself right now: Which table, and how do I get an invite? That part was not as difficult as I anticipated. Our field is full of true leaders who want to see the next group succeed. My only caution is you might have to show up for something that isn't 100% up your alley. But that's okay. You will get exposure and the opportunity to network. You might even get the chance to take on a project.

For me, the best piece of advice was to do things that truly interested you. Your enjoyment shows through in your work product, and your personal satisfaction will keep you engaged. That will result in longevity and happiness alongside your personal success.

Here is a summary of an approach that can lead to a rewarding experience:

- Seek out conferences/Accept invitations
- Attend meetings
- Introduce yourself
- Get to the table
- Accept projects and make opportunities; There is always work to be done
- Review your commitments, your time, your work-life-balance, your body of work, and finally the consistency of your CV

Volunteer to take on work that will benefit the group. This is true even if it is not your primary area of interest. This will allow you to showcase your work ethic, strengths, and willingness to learn and take on a challenge.

This brings me to what I see as a controversial piece of advice I received several times: "Always say yes". "Always say yes" is true a point. Saying yes can get you in the door, but it is your interest that will keep you engaged. Your desire to participate will shine through in your work product.

I am grateful for the mentors and coaches I have had, as well as those I sidelined at conferences. Their willingness to guide me has been irreplaceable. I am still early in my career, but by the advice outlined above has given me the opportunity to work on committees with inspirational leaders and educators in emergency medicine. I have had the opportunity to chair committees and give back what I have learned.

As a member of the New York ACEP Board of Directors and Chair of the New York ACEP Professional Development Committee I find that I am on the other side of the question, and have been tasked with considering how New York ACEP can help our constituents reach their goals. Navigating a career in emergency medicine, and balancing this with personal goals can be challenging. I have been fortunate and identified colleagues and mentors to help me find my way. If you are in a similar place with questions, and need direction, I offer you the option of the New York ACEP mentoring program (http://www.nyacep.org/mentoring), we want to help you find your way too.

The Rise and Repurposing, of Emergency Medicine

David Newman
MD FACEP
Director of Clinical Research and Associate Professor of Emergency Medicine, Deptartment of Emergency Medicine, Icahn School of Medicine at Mt Sinai

The man held out a piece of paper.

I took it, introduced myself, and delivered my opener: "What brings you to the emergency room, sir?"

I chose this salutation years ago partly for its similarity to that of a 9-1-1 operator. I've always admired "What's your emergency?" for its role-setting efficiency: it is our job to serve—it is your job to have an emergency.

But the man did not. He was requesting medical clearance to drive a taxi for a living. He had no primary doctor and, despite being insured, was unable to arrange an appointment. His job—his family's income—could not begin until he saw a doctor.

Emergency medicine is a growing need. In the U.S. we are seeing more visits, and more visits per capita, and doing more of the health system's work. In a world of healthcare reform, this will only increase. With more insured Americans and a failed infrastructure for primary care that is decades from reconstitution, emergency departments are fast becoming a hub for basic services.

We are asked to screen for HIV, and we should; to arrange for physical therapy, and we should; to order outpatient testing, and we should; to transition patients directly to long term care, hospice, or home care, and we should; to address addiction, and we should; to observe, and we should… the list goes on. And that is a problem, because more visits and more tasks per visit mean crowding, and we are already bursting at the seams and falling out of doorways. Worse yet, the dirty secret about crowding is that people die. A robust body of literature tells us that mortality is higher when Emergency Departments are crowded.

If we accept these tasks without demanding the additional resources necessary to complete them efficiently, our most vulnerable patients will be hurt. It is, to state the obvious, deeply unfair to our neediest and sickest to ask that they bear the burden of expanding the task list of our nation's safety net. It is, after all, there for them.

But here is the conundrum: it would be equally unfair to my budding taxi driver to refuse him a safety net. For him access to healthcare means a sustainable income for his family, and the safety net is all he has. Safety nets do not choose the needy, the needy choose them.

So here is what I propose: we tell the world our story. We are emergency care and safety net providers. We are also, of course, still emergency physicians, resuscitators with the skill set to do much more. But we are capable of overseeing outpatient testing, medical clearances, screening exams, observation, outpatient and long term care, and more. These tasks, traditionally performed by administrative and primary care personnel, can and should be under our domain—but not until we are properly resourced. We need case managers, social workers, palliative care providers, domestic violence specialists, home nursing representatives, administrative schedulers, discharge planners, addiction specialists, and more. With resources we can do this; without them the safety net will be worse off for everyone.

How do we gather these resources? There are untold millions available to help provide safety net resources, but we will have to frame our efforts in a way that we have not in the past. WE are a critical access point. WE are providing care to the underserved. WE are educating the next generation of safety net providers. WE are a medical home for the medically homeless. Emergency medicine has been hesitant to acknowledge these roles, for good reason: we hoped to minimize them. Now that possibility is gone, and there is a new world to embrace. For each of these tasks there are dozens of federal grant programs, hundreds of state initiatives, and thousands of local support mechanisms.

It is time for emergency medicine to rebrand, to embrace our safety net mission by seeking the primary care, underserved care, and safety net funding that is rightly ours, and more importantly our patients'. This means accepting labels like primary care, critical access, and 'hub', labels that will help us harness the resources that will expand our mission—not replace it.

The future is bright. Emergency medicine can rise, lifting and carrying American healthcare even more, and even farther.

New York ACEP Member Guidance on the Implementation of New Out of Network (OON) Law (Chapter 60 of the Laws of 2014)

A new law regulating out-of-network health care services took effect March 31, 2015. Earlier this year, New York ACEP provided members with a comprehensive summary of the OON law and links to the New York State Department of Financial Services' (DFS) website. This summary of the law can be found on New York ACEP's website at www.nyacep.org under Government Affairs (Out of Network Regulations Effective March 31).

New York ACEP continues to receive questions from members concerning the new Independent Dispute Resolution (IDR) process and the impact of the law on billing and reimbursement practices. Provided below is additional information which addresses these questions.

Billing and Reimbursement

There is no prohibition in the law on balance billing a patient for emergency services. There is a prohibition on balance billing for a surprise bill received by a patient for non-emergency services when the patient has an assignment of benefits. The term "surprise bill," as defined in the law, does not include emergency services.

When a health plan receives a bill for emergency services from a non-participating provider, the plan is required to pay an amount that it determines reasonable, less applicable patient cost sharing. Either the health plan or the physician may file a payment dispute with the IDR entity.

The law places responsibility on the health plan to ensure that a patient receives no greater out-of-pocket costs than they would have incurred with a participating health care provider. New York ACEP encourages you to tell patients that they have the right to ask their insurance company to be held harmless.

There is no obligation for an insurance company to pay an out of network health care provider the full amount that is billed under the new law, nor was there such an obligation prior to passage of the OON law. As noted, the health care provider can bill the patient for the balance and the health plan is responsible for holding the patient harmless by either negotiating a different rate with the provider or paying the full amount. Patients with high deductible plans are responsible for paying the provider and the provider can bill the patient.

Independent Dispute Resolution Process

New York ACEP was successful in getting an exemption from the IDR process for particular emergency medicine CPT codes that are less than $600, after any applicable co payment, co-insurance, or deductible, that do not exceed 120% of Usual and Customary Cost (UCR). The $600 exemption will be applied by individual CPT code.

The $600 is subject to annual inflation adjustments. The current threshold for 2015, adjusted for inflation, is $613.50. Please note that the application of the patient cost sharing will increase the dollar amount that triggers an exemption from the IDR process. This exemption will include claims for evaluation, management, and most observation care provided by emergency physicians.

New York ACEP sought this exemption for high volume claims that are reimbursed at modest levels so that physicians would not be in a position of going to arbitration when the cost is higher than the potential benefit of winning an appeal against a health care plan. There was concern that this would provide an incentive for health plans to under reimburse physicians and that the physicians would not have the financial resources to go through the IDR process.

According to the Department of Financial Services (DFS), the cost of the IDR process will range from $225 to $325 per appeal.

UCR is defined as the 80th percentile of all charges for a health service rendered by a provider in the same or similar specialty and provided in the same geographic region as reported by a benchmarking database maintained by a nonprofit organization.

FAIR Health is currently the only entity recognized to calculate UCR. The following CPT codes that meet the exemption criteria: 99281, 99285, 99288, 99291, 99292, 99217, 99220, 99224,99226, and 99234, 99236.

If a health care provider finds a pattern by a health plan of reimbursing well below the usual and customary cost that information should be provided to DFS.

Patient Insurance Information

Patients sometimes do not have their insurance information available when they arrive at an emergency department. If a patient does not have their insurance information at the time of service, providers do not need to wait for insurance information to bill and should bill the patient immediately. A health plan is required to provide at least 120 days for timely filing, both out of and in network. The patient is responsible for the bill in the case of a non participating provider. In the case of participating providers, contracts may vary as to whether the patient is responsible for the bill. In addition, Section 3224-A (g) and (h) of the State Insurance Law allows for providers to ask for reconsideration of the 120 days under certain circumstances.

Patient Assignment of Benefits

Under the current law, a health plan is not required to honor a patient's assignment of benefits for emergency services.

ROCHESTER
REGIONAL HEALTH

PASSIONATE WORK. GREAT REWARDS.

Opportunities for Board-Certified Emergency Medicine Physicians

- Generous sign-on bonus
- Competitive base salary
- Performance-based pay incentives
- Full-time scribe support
- Generous retirement benefits
- Leadership/advancement opportunities
- Credentialed at five system-wide EDs
- Relocation package
- Affordable living throughout the Western New York region

Care for a diverse, mixed-patient population at our five fast-paced, state-of-the-art Emergency Department locations in greater Rochester, Genesee County and the Finger Lakes region.

Apply Today

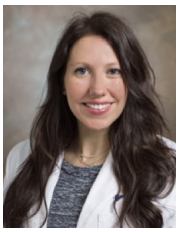
rochesterregionalhealth.org/careers

Forbes | 2015 AMERICA'S BEST EMPLOYERS POWERED BY STATISTA

Connect with us

Rochester Regional Health is an Equal Opportunity/ Affirmative Action Employer. Minority/Female/Disability/Veteran

Understanding the "Choosing Wisely" Campaign: The Future of Cost-Effective Safe Emergency Care is All About Making Good Choices



Jessica M. Cook
MD
Fellow, Yale Center for Medical Simulation
Yale Emergency Medicine

Todd L. Slesinger
MD FACEP FCCM FCCP
Program Director, Emergency Medicine
Aventura Hospital & Medical Center

The "Choosing Wisely" campaign first made headlines in April 2012 through an initiative set forth by the American Board of Internal Medicine Foundation. They recognized a need for better individual patient-centered care and cost effective strategies, two goals often notoriously difficult to achieve harmoniously or simultaneously.

ACEP's 10 recommendations entitled *'Things Patients and Providers Should Question'* was born out of a series of evidence based discussions led by the ACEP Board of Directors, a focused task force and expert consensus. The first five were published in October 2013, and the next five in October 2014. This initiative echoes ACEP's ever-growing commitment to encourage a better style of emergency care. The goal is really quite simple: improve the quality of patient care using a smarter allocation of healthcare resources.

The ordering of unwarranted diagnostic imaging and performance of unnecessary treatments has become a nationwide ED "emergency" that demands immediate attention. The practice of defensive medicine has contributed to the expanding US healthcare debt and evidence suggests that in doing so we may be causing more harm than good to our patients. When we combine evidence-based practice with a patient-physician shared decision making model we can provide quality care at a reduced cost.

ACEP's contribution to the "Choosing Wisely" strategy identifies a list of important patient care decisions we make every day in the emergency department. Ultimately, by avoiding unnecessary imaging, antibiotics and catheters (intravenous and urinary), we can actually do more by doing less.

The adoption of a more individualized approach to patient care decision making is not unique to ACEP. This initiative has been supported and adopted by over 65 top medical and surgical specialty societies across the nation and is continuously expanding through grants to other organizations that support the "Choosing Wisely" objectives. For more information, please visit their site at:
http://www.choosingwisely.org/clinician-lists/.

Successful healthcare is all about wise choices and decisions. It's time to facilitate an open dialogue to help inform and educate our patients about the recommendations for the care they need and that which is ultimately unnecessary. The translation: appropriate, justified and high quality medical care for millions of Americans.

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

Choosing Wisely®

An initiative of the ABIM Foundation

American College of Emergency Physicians

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Five Things Physicians and Patients Should Question

1 Avoid computed tomography (CT) scans of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules.

Minor head injury is a common reason for visiting an emergency department. The majority of minor head injuries do not lead to injuries such as skull fractures or bleeding in the brain that need to be diagnosed by a CT scan. As CT scans expose patients to ionizing radiation, increasing patients' lifetime risk of cancer, they should only be performed on patients at risk for significant injuries. Physicians can safely identify patients with minor head injury in whom it is safe to not perform an immediate head CT by performing a thorough history and physical examination following evidence-based guidelines. This approach has been proven safe and effective at reducing the use of CT scans in large clinical trials. In children, clinical observation in the emergency department is recommended for some patients with minor head injury prior to deciding whether to perform a CT scan.

2 Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.

Indwelling urinary catheters are placed in patients in the emergency department to assist when patients cannot urinate, to monitor urine output or for patient comfort. Catheter-associated urinary tract infection (CAUTI) is the most common hospital-acquired infection in the U.S., and can be prevented by reducing the use of indwelling urinary catheters. Emergency physicians and nurses should discuss the need for a urinary catheter with a patient and/or their caregivers, as sometimes such catheters can be avoided. Emergency physicians can reduce the use of indwelling urinary catheters by following the Centers for Disease Control and Prevention's evidence-based guidelines for the use of urinary catheters. Indications for a catheter may include: output monitoring for critically ill patients, relief of urinary obstruction, at the time of surgery and end-of-life care. When possible, alternatives to indwelling urinary catheters should be used.

3 Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.

Palliative care is medical care that provides comfort and relief of symptoms for patients who have chronic and/or incurable diseases. Hospice care is palliative care for those patients in the final few months of life. Emergency physicians should engage patients who present to the emergency department with chronic or terminal illnesses, and their families, in conversations about palliative care and hospice services. Early referral from the emergency department to hospice and palliative care services can benefit select patients resulting in both improved quality and quantity of life.

4 Avoid antibiotics and wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.

Skin and soft tissue infections are a frequent reason for visiting an emergency department. Some infections, called abscesses, become walled off and form pus under the skin. Opening and draining an abscess is the appropriate treatment; antibiotics offer no benefit. Even in abscesses caused by Methicillin-resistant *Staphylococcus aureus* (MRSA), appropriately selected antibiotics offer no benefit if the abscess has been adequately drained and the patient has a well-functioning immune system. Additionally, culture of the drainage is not needed as the result will not routinely change treatment.

5 Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in uncomplicated emergency department cases of mild to moderate dehydration in children.

Many children who come to the emergency department with dehydration require fluid replacement. To avoid the pain and potential complications of an IV catheter, it is preferable to give these fluids by mouth. Giving a medication for nausea may allow patients with nausea and vomiting to accept fluid replenishment orally. This strategy can eliminate the need for an IV. It is best to give these medications early during the ED visit, rather than later, in order to allow time for them to work optimally.

Released October 14, 2013

Choosing Wisely®

An initiative of the ABIM Foundation

American College of Emergency Physicians

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Five More Things Physicians and Patients Should Question

6

Avoid CT of the head in asymptomatic adult patients in the emergency department with syncope, insignificant trauma and a normal neurological evaluation.

Syncope (passing out or fainting) or near syncope (lightheadedness or almost passing out) is a common reason for visiting an emergency department and most episodes are not serious. Many tests may be ordered to identify the cause of such episodes. However, diagnostic tests for syncope should not be routinely ordered, and the decision to order any tests should be guided by information obtained from the patient's history or physical examination. CT scans of the brain are frequently ordered for this problem to look for bleeding or strokes, but published research has confirmed that abnormalities are rarely found. CT scans are expensive, and may unnecessarily expose patients to radiation. If a head injury is associated with a syncopal episode (fainting spell), then a CT scan of the brain may be indicated. In addition, if there were symptoms of a stroke (i.e., headache, garbled speech, weakness in one arm or leg, trouble walking or confusion) before or after a syncopal episode, a CT scan may be indicated. However, in the absence of head injury or signs of a stroke, a CT scan of the brain should not be routinely ordered.

7

Avoid CT pulmonary angiography in emergency department patients with a low-pretest probability of pulmonary embolism and either a negative Pulmonary Embolism Rule-Out Criteria (PERC) or a negative D-dimer.

Advances in medical technology have increased the ability to diagnose even small blood clots in the lung. Now, the most commonly used test is known as a CT pulmonary angiogram (CTPA). It is readily available in most hospitals and emergency rooms. However, disadvantages of the CTPA include patient exposure to radiation, the use of dye in the veins that can damage kidneys and high cost.

Studies have demonstrated that certain findings in a patient's medical history put them at very low risk for having a blood clot in the lung. In some cases, a blood test called a D-dimer may be additionally used to screen for the possibility of a clot. If patient historical factors and physical examination findings are negative, along with a negative D-dimer (if the physician chooses to order it), evidence shows that the risk of an undiagnosed blood clot is the same as if the patient had a negative CTPA. Such a strategy saves the risk of radiation, kidney injury and the high cost of a CTPA.

8

Avoid lumbar spine imaging in the emergency department for adults with non-traumatic back pain unless the patient has severe or progressive neurologic deficits or is suspected of having a serious underlying condition (such as vertebral infection, cauda equina syndrome, or cancer with bony metastasis).

Low back pain without trauma is a common presenting complaint in the emergency department (ED). Most of the time, such pain is caused by conditions such as a muscle strain or a bulging disc that cannot be identified on an X-ray or CT scan. When a patient has symptoms or physical findings of a serious or progressive neurological condition, or is suspected of having a serious underlying condition such as cancer or a spinal infection, imaging may be appropriate and may include plain X-rays or advanced imaging (e.g., MRI or CT scan). Diagnostic imaging does not accurately identify the cause of most low back pain and does not improve the time to recovery. The vast majority of cases of back pain in the ED are related to muscle strain or inflammation. As a result, routine imaging of the low back should be avoided in order to reduce ionizing radiation exposure and unnecessary cost.

Released October 24, 2014

9

Avoid prescribing antibiotics in the emergency department for uncomplicated sinusitis.

Sinusitis is a common reason for patients to visit the emergency department. Most patients with acute sinusitis do not require antibiotic treatment, because approximately 98% of acute sinusitis cases are caused by a viral infection and resolve in 10-14 days without treatment. For some patients with sinusitis, antibiotics might be appropriate, such as those patients taking drugs that reduce the effectiveness of the immune system, those with prolonged, severe symptoms, or those with worsening symptoms. Antibiotics can cause many side effects and have potentially severe complications, and these risks usually outweigh the benefits of their use for sinusitis. In addition, inappropriate antibiotic use for sinusitis can contribute to the development of antibiotic-resistant infections and contributes to avoidable health care costs.

10

Avoid ordering CT of the abdomen and pelvis in young otherwise healthy emergency department (ED) patients (age <50) with known histories of kidney stones, or ureterolithiasis, presenting with symptoms consistent with uncomplicated renal colic.

Kidney stones can cause severe pain (called renal colic) and nausea, which can usually be relieved with medication. Most stones pass spontaneously in the urine in a few days, though kidney stones often do recur. CT scans may be needed to diagnose kidney stones, and rule out other problems that may mimic the pain of kidney stones. Many patients in the ED who are less than 50 years old and who have symptoms of recurrent kidney stones do not need a CT scan unless these symptoms persist or worsen, or if there is a fever or a history of severe obstruction with previous stones. CT scans of patients in the ED with symptoms of recurrent kidney stones usually do not change treatment decisions, and the cost and radiation exposure can often be avoided in these cases. Close follow-up by a primary care physician or specialist is necessary.

How This List Was Created (1–5)

The American College of Emergency Physicians (ACEP) developed five *Choosing Wisely*® recommendations through a multi-step process that included input from ACEP members, an expert panel of emergency physicians and the ACEP Board of Directors. In 2012, ACEP appointed a task force to address cost effective emergency care. The Cost Effective Care Task Force conducted a survey that was open to all ACEP members asking for strategies to reduce cost and improve value in emergency medicine. The task force received over 200 individual suggestions, which were grouped into a set of strategies. A technical expert panel, including representatives from all aspects of emergency medicine practice, reviewed and prioritized the recommendations using a modified Delphi technique. The panel prioritized the strategies using multiple rounds of voting based on contribution to cost reduction, benefit to patients and actionability by emergency physicians. A literature review including data on cost was assembled for the highest-rated strategies. Strategies were further refined and a final list of strategies that received majority support of the panelists was created. Five of these were ultimately selected by the Board of Directors to be included in *Choosing Wisely*®.

How this list was Created (6–10)

The entire ACEP membership (30,000+) was surveyed and given an opportunity to provide input on what in their view would be cost effective and improve the quality of patient care. A Delphi panel of emergency physicians was convened and the list was winnowed using the Delphi process to the top twelve. To be included in the top twelve, there must be research to demonstrate cost effectiveness and improvement of patient care if implemented with reason, caution and explanation to the patient. Also of importance was the consideration that the recommendations would be or are also in concert with some of the other specialties participating in the *Choosing Wisely*® campaign.

ACEP's disclosure and conflict of interest policy can be found at www.acep.org.

For more information or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwisely.org.

Calendar

September 2015

2 Emergency Medicine Resident Committee Conference Call, 2:00 pm
9 Emergency Medicine Resident Career Day, New York Academy of Medicine, 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

October 2015

2 Board of Directors Meeting, Albany, NY, 11:00-3:00 pm
7 Emergency Medicine Resident Committee Conference Call, 2:00 pm
14 Education Committee Conference Call, 2:45 pm
14 Professional Development Conference Call, 3:30 pm
15 Practice Management Conference Call, 1:00 pm
21 Government Affairs Conference Call, 11:00 am
21 Research Committee Conference Call, 3:00 pm
22 EMS Committee Conference Call, 2:30 pm
24-25 ACEP Council Meeting, Boston MA
26 New York ACEP Reception, Westin Waterfront, Boston, MA
26-29 ACEP Scientific Assembly, Boston, MA

November 2015

4 Emergency Medicine Resident Committee Conference Call, 2:00 pm
11 Resident Research Conference, Mount Sinai, 7:30 am-12:30 pm
11 Education Committee Conference Call, 2:45 pm
11 Professional Development Conference Call, 3:30 pm
12 Practice Management Conference Call, 1:00 pm
18 Government Affairs Conference Call, 11:00 am
18 Research Committee Conference Call, 3:00 pm
19 EMS Committee Conference Call, 2:30 pm

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