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# Empire State EPIC



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# PRESIDENT'S MESSAGE



**Brahim Ardolic, MD FACEP**  
Chair, Department of Emergency Medicine  
Vice President, Department of Research  
Staten Island University Hospital

In July, I had the pleasure of attending the New York ACEP Scientific Assembly. Over that time, I saw some really interesting poster and oral research presentations, listened to some amazing high level content from some of the greatest speakers that emergency medicine has to offer and just as importantly, I was able to spend time with my peers while learning about what they do and who they are. Perhaps my favorite moments outside of lecture were the airway stories told at fireside. I heard a story about watching your loved one die when you are the physician that is relied upon in those situations. I heard about a physician who dealt with a stalker and was more worried about their shifts and training than about their personal welfare. I learned about a very sad case that we all laugh at to get through the day. I heard about bizarre social customs that lead to truly hilarious clashes of culture. I also heard about a two hour resuscitation where a perimortem c-section lead to first a live child, and then miraculously a live neurologically intact mother. This then lead to a good cry two months later when the patient came in for a wound check.

This event, which we had for the second time this year is very interesting in what it does and how it does it. Sitting in a half circle are wide eyed first year residents, somewhat cynical senior residents and junior attendings who often feel they have seen everything, and crusty, sometimes way too cranky, senior attendings who have seen and processed many cases, sometimes at the expense of their own personal well being. One of the interesting things about this event isn't just the event but the storytelling that continues afterwards. As I was listening to these stories, I was marveling at the range of ages that still have interest in these common stories. I was also considering why this practice is important, and how much the stories have changed since I was a first year resident.

***"Many people do things that are just as important, but no one does anything more important than what you do."***

New York trains by far the most Emergency Medicine residents in the country. We have a disproportionate responsibility to demonstrate to our trainees the importance of their own wellness. In the last few years, this has become very topical due to multiple suicides in residents in New York. This is obviously important, but wellness is so much bigger than that. I personally know many emergency department docs who are in no way suicidal but consider themselves very unwell. They will usually call it burnout, bad work-life balance, or may not even be able to describe why they hate what we do. How do we show our trainees ways to confront these realities and prepare for them?

When I trained, the stories were either of the horror story of the terrible case or the "hilarious" case that is often far from funny when you take a step back. One of the most remarkable things about today's stories is

that the stories are about the teller. The feelings of anger or pain are clear in the telling. Sometimes crying or expletives enter the narrative and that is OK. This is

a safe place. This raises the question though, why aren't we doing this in groups of five or six. It can't be good to wait until the next one of these in three months!!

So the final question is why is it helpful? I think the answer is very clear. The telling is clearly cathartic to the speaker but that isn't the whole story. It is just as valuable for the person who quietly sits. In short, we have all experienced some version of every one of these stories. For me, it allows me to reflect upon my case that was so similar. For the first year resident, it reminds them that it's OK to feel terrible two years from now when they have the same case. These common experiences remind us that we are not alone. We have all been there. It will get better. You will continue to improve, partly by making mistakes. Some people will have bad outcomes no matter what you do. You will see people

doing horrible things to each other. It's OK. Society needs you partly because all these things are true.

What we do is important. When you move away from that basic and true premise, it's the first step toward burnout. The value of stories is to help you remember that all of us get these obstacles and blind spots that hide that basic truth. We are this society's safety net. What could be more important than that? Many people do things that are just as important, but no one does anything more important than what you do.

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# SOUND ROUNDS



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 Jacobs School of Medicine and Biomedical Sciences

## Painless Vaginal Bleeding in the First Trimester Pregnant Patient



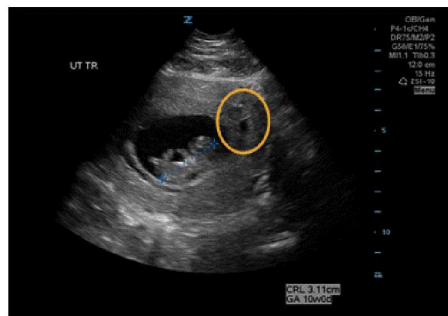
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### Case

A 36 year old female, G4P3, presented to the emergency department with vaginal bleeding for one day. The patient reported being approximately eight weeks pregnant and denied additional medical problems. She had nausea, mild abdominal cramping and painless vaginal bleeding with a small amount of clots. The patient's vital signs were stable with heart rate of 82 bpm, blood pressure 124/82mmHg, respirations of 16 breaths per minute and SpO2 100% on room air. She was afebrile with a temperature of 36.7C. The physical exam revealed a soft abdomen with mild right upper quadrant tenderness without Murphy's sign. The cervical os was closed without active bleeding and no cervical motion tenderness was noted during the pelvic examination. Point of care ultrasound (POCUS) of the gallbladder and pelvis were performed. POCUS of the gallbladder was negative for cholelithiasis. Transabdominal ultrasound of the uterus revealed a single intrauterine pregnancy with estimated gestational age of 10 weeks. The fetal heart rate was tachycardic at 189 bpm. A crescent-shaped, anechoic region outside the gestational sac consistent with a subchorionic hemorrhage was visualized (Figure 1). The ovaries appeared normal and no free fluid was identified in the pelvis.



**Figure 1.** Transabdominal ultrasound of the uterus. Intrauterine pregnancy of approximately 10 weeks gestation with subchorionic hemorrhage.

### Discussion

Vaginal bleeding and pelvic pain account for many emergency department visits among pregnant patients. Vaginal bleeding is common in pregnancy, particularly during the first two trimesters. The differential diagnosis for vaginal bleeding in the pregnant patient is broad. It is important to consider subchorionic hemorrhage as a cause of bleeding, as this is the most common sonographic abnormality in pregnancy with

a live embryo.<sup>1</sup> Transabdominal pelvic ultrasound is a non-invasive diagnostic modality to quickly evaluate the underlying structures in the abdomen and pelvis. Emergent causes of pain and bleeding, such as ectopic pregnancy, threatened abortion and hemorrhagic ovarian cyst and torsion should immediately be ruled out prior to further evaluation of additional causes of vaginal bleeding.

Subchorionic hemorrhage is a common finding in first trimester pregnant patients with vaginal bleeding, occurring in approximately 20% of these patients.<sup>2</sup> Identification of subchorionic hemorrhage is important since this increases the risk of fetal demise, particularly with larger hemorrhage.<sup>3</sup> For those who carry until delivery, there is increased risk for pregnancy related complications, such as premature rupture of membranes, pre-term delivery and placental abruption.<sup>4,5</sup>

Women diagnosed with subchorionic hemorrhage should have urgent obstetrics follow up and should be instructed to avoid tampon use, sexual intercourse and strenuous activity until further notice. Mimics of subchorionic hemorrhage include chorioamniotic fusion, vanishing twin gestation, intrauterine mass and slow flow within the peri-gestational veins.<sup>6</sup>

### Indications for Ultrasound

Pregnancy with any of the following:

- Pelvic pain
- Abdominal pain
- Vaginal bleeding
- Trauma

### Technique

- Encourage patient to have a full bladder, if possible.
- Place the patient in the supine position.
- Use a phased array or curvilinear probe. You may need an endocavitary transducer if an obvious intrauterine pregnancy is not identified transabdominally.
- Scan the transabdominal pelvis in the transverse and sagittal planes.
- Assess for an intrauterine or ectopic pregnancy and identify any free fluid in the pelvis.
- If an intrauterine pregnancy is identified, evaluate for fetal heart rate, fetal movement, irregularity in shape or position of the gestational sac, uterine wall and placental abnormality.

# SOUND ROUNDS

- Sonographic findings most consistent with subchorionic hemorrhage are a retro-placental, hypoechoic region, located between the decidual layer of the endometrium and the chorionic membrane.
- Increasing size of subchorionic hemorrhage is associated with increased risk of fetal demise.
- Shape and echogenicity are variable and change with age of hematoma.

	Size	Definition
Subchorionic Hemorrhage	Small	<1/3 the circumference of the gestational sac
	Medium	1/3 to 1/2 the circumference of the gestational sac
	Large	>1/2 the circumference of the gestational sac

**Table 1.** Definition of small, medium and large subchorionic hemorrhage.

- Be sure to scan through the entire gestational sac to ensure visualization of potential subchorionic hemorrhage.
- Follow the principles of ALARA (as low as reasonably achievable). Use low energy modalities when performing sonography of the

developing fetus unless it is medically necessary. Avoid the use of Doppler, if feasible.

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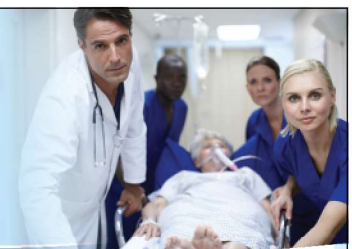
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**Keith E. Grams, MD FACEP**  
Chair of Emergency Medicine  
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## The Stages of (Data) Grief

Data is a part of our life. It seems that emergency medicine has led the House of Medicine in the data process. Often the emergency department is the service that was initially measured and followed – medicine’s data spearhead. We seem to have more metrics than we know what to do with, and juggling all of these can be a bit challenging. Thankfully over time, we have quickly become the leaders in this number juggling game.

For many initiatives in medicine if you can’t measure it, you can’t improve it. An inability to measure only propagates a world of subjective anecdotes. Although it can be cumbersome to obtain, data is critical to departmental operational improvements and progressing patient care. But data can be a little scary. It is truly objective, unblinded, and potentially shocking. Data can present discoveries that we would rather had stay undiscovered. Ultimately, when we and our teams are initially displayed new data – especially if the findings are not edifying – we can see various “colorful” reactions.

These reactions progress through several stages as we accept and incorporate the findings into practice. I find it a little humorous (and perhaps a little disappointing at times) that we still continue to do this repeatedly. Each individual may move through the stages at different rates, though the destination lies in universal acknowledgment.

Having actionable and accurate data is crucial to moving through these stages. Too often we are presented with data that is only rough draft material, with no one having reviewed and verified the details. We have fantastic teams that will pick apart any aberrancies. I would suggest that ensuring accurate and verifiable data is crucial to the introductory presentation. Displaying inaccurate data – at the expense of a speedy implementation – only results in a delay and may permanently derail the attempt. Our

team will spend more time disagreeing with the data, with an inability to achieve the intended outcome. It is well worth additional effort to ensure that the initial data is impeccable, thereby taking away most of the arguments and allowing progression through the required stages.

### Stage 1

The beginning display of the data is often met with the stage one – near complete and utter denial. Since the initial findings are often unfavorable, the team is incredulous. The comments center around: “There is no way we could be performing that poorly.” “You must have measured this wrong.”

When presenting data to a group, especially if the data is not positive, the next group conclusion can be the “corporate salute”. This is my personal favorite as each person looks to their neighbor as the cause for poor performance. Each provider thinking, “It’s definitely not because of me. I take great care of my patients.”

Having actionable data, drilled down to individual performance will help everyone move to the next stage. It will help highlight those that achieve exceptional results, as well as those that have more opportunity for improvement. Some of the team will take longer than others to move through this stage, though accurate data is critical for this stage as well as the next.

### Stage 2

This next stage can be quite individually dependent, though most commonly shows up as anger and frustration. Comments like: “I can’t believe that they’re watching this!” “We take great care of our patient. Why are they bothering me with this?”

Admittedly, all these various initiatives can be quite frustrating. It feels as if we

practice within the fishbowl of medicine. We have many different “metric masters”; CMS, the Department of Health, hospital administration, as well as multiple others. Whether we like it or not, this is emergency medicine in the 21st century. Rather than continue to dispute, I would suggest that we embrace it. Let us demonstrate leading change to the House of Medicine. If a leader contributes to this anger, it will only prolong the stage. The art in moving to an objective is how to shorten this phase for our individual team personalities.

### Stage 3

Having gone through anger, we come to the next stage. This is sometimes a little less apparent on the individual basis. It can generally be observed on the departmental level. I have seen this occur several times at a particular organization I worked for in the past. An initiative was sent out, a goal was set, and then they started evaluating the data. It became quickly apparent that the goal was unobtainable with the current approach. Rather than change the approach we started to see erosion of the data and then the goal. Giving up on a general approach, they chose to focus on certain hours during the day, then certain hours of the day on certain days of the week, then for only certain populations. Rather than figure out a solution that will allow a sustained improvement, they chose to focus on an isolated portion of the data. This only created a limited solution that was not pervasive. No surprise that this bargaining approach did not yield the intended results. We can potentially see this for the individual provider as well. Requesting review of a more limited patient type or presentation. Though this approach would likely be incongruent with the intended goal of overall improvement.

#### Stage 4

Stage four is generally shorter, or perhaps non-existent. There may be a minor depression generated from perceived continued attacking from differing angles. But if we made it through stages 1-3, then we are fairly well equipped to rapidly move through this stage.

#### Stage 5

The final stage is the ultimate destination. The overall acceptance of the initiative and movement to a sustainable solution. We accept the data, along with the changes required, and incorporate them into our practice. Having held on tightly to the flawed approach for fear of change. I also find this a little humorous as once the changes are made, folks will often recall the time prior to the change with disdain.

We spent so much time working through these five stages and anchoring ourselves in mediocrity, we at times forget we're trying to accomplish – improved patient care.

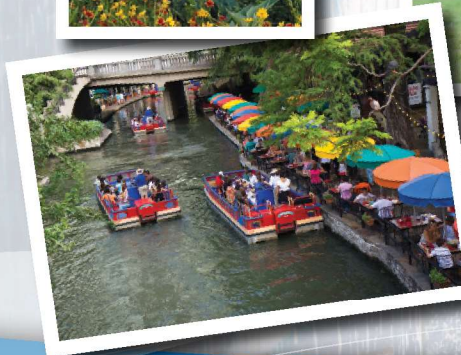
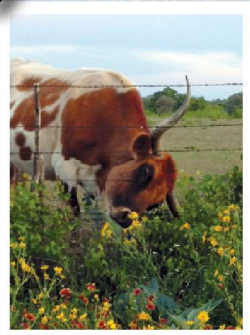
As you have realized, these stages are strikingly similar to the stages of grief proposed by Elisabeth Kübler-Ross in 1969. Obviously they are the same. Though they can be readily apparent as we work toward implementing an initiative. I find it a little comical – and again, also disappointing – that we often follow these stages. At times, I will sit in a meeting and amuse myself by determining at which stage each individual is currently stuck. What can I say, simple things amuse a simple mind. Feel free to try it – you may enjoy it.

#### Wrap Up

As we work to improve our departments we

need to help our team work through their stages as quickly as possible, progressing to the intended acceptance. I believe that the key component is actionable data and establishing a “data dialogue”. This consists of accurate and verifiable data that can be drilled to the individual level as necessary. We need a method to report progress to the team that is rapidly accessible, discernible and synthesized. If it is too complex, it will quickly find the email trash bin and the improvement attempt will be unsuccessful. At times, there will be setbacks. At times, events will not progress as rapidly as one would hope. However, remember that behind each number is a patient. And by improving the “numbers” we reach the ultimate goal – improving patient care.

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# PRACTICE MANAGEMENT



**Barbara J. Gatton, MD**  
 Director of Quality Improvement,  
 Department of Emergency Medicine,  
 NewYork-Presbyterian Brooklyn Methodist Hospital

## Sepsis Update

Are you both tired of hearing about sepsis and still confused about the sepsis measures? You are not alone. Let's break it down.

### Background

Regulation regarding the treatment of severe sepsis and septic shock is intended to standardize and improve care to septic patients. Historically, severe sepsis frequently went unrecognized for hours, until the patients went into shock. In an attempt to have us do better for our patients, catch this earlier and (hopefully) improve outcomes, New York State and CMS created quality measures regarding the treatment of patients with severe sepsis and septic shock.

However, the devil is in the details. Sepsis is complicated and solutions are not "one size fits all." The definition and diagnosis of sepsis is not always clear. There are many reasons for Systemic Inflammatory Response Syndrome (SIRS) other than infection as well as patients who are SIRS negative, but are actually septic. There is concern for doing harm by over treating, while not wanting to miss a single septic patient.

This is an attempt to clarify the muddy waters that are sepsis reporting. Let's start by defining our terms. Table 1 includes CMS definitions, which may not be the same as you understand clinically.

### So What Do You Need To Do?

**ALL Patients with 2 SIRS and possible infection must have a lactate.**

If there is a sign of end organ dysfunction, the patient must have:

- IVF (amount of your choosing. 250mL is fine if you are concerned about renal or cardiac function)
- Blood cultures before antibiotics (ABX)
- Broad spectrum ABX

If the lactate is >4 or the patient is hypotensive (systolic <90, MAP<65, or >than a 40mmHg drop from patient's baseline BP), the patient has criteria for **septic shock** and must have all of the above PLUS:

- 30mL/kg IVF
  - One full set of VS within one hour of COMPLETION of fluid bolus.
  - An additional BP within one hour of completion of IVF bolus.
- For example, if the IVF bolus is initiated at 1314 and is given over 1 hour. There must be a complete set of vital signs as well as another blood pressure taken between 1414 and 1514. A common miss is that the VS are repeated a few minutes before the complete time. Those don't count. It must be done within the one hour window. A full set of VS at 1410 and a repeat BP at 1515 will fail the measure.

**Table 1** CMS and New York State Definitions for Adult Sepsis

SIRS: Systemic Inflammatory Response Syndrome	End Organ Dysfunction	Severe Sepsis	Septic Shock	Bundle
Temp >38 or <36	Lactate >2	2 SIRS + infection + End Organ Dysfunction	Severe Sepsis + Hypotension OR Lactate >4	All or nothing. If you miss one piece of the measure, you fail the entire measure.
HR >90	Creatinine >2			
RR >20	Urine Output <0.5 mL/kg/hr for 2 hr			CMS takes a sample of patients and New York State requires all patients be reported.
WBC >12,000	Bilirubin >2			
Bands >10%	Platelet Count <100,000			
	INR >1.5			
	aPTT >60			
	Hypotension (systolic <90, MAP <65, or drop of >40 mmHg from baseline)			



# PRACTICE MANAGEMENT

- Tissue perfusion reassessment/or volume reassessment

What this means is that if your sign of end organ dysfunction is hypotension, they automatically jump to the septic shock category. Table 2 has what is required to pass the different sepsis bundles.

Certain patients are excluded from the sepsis core measure. These include patients transferred from another facility and patients who are hospice/comfort care only. DNR/DNI is an exclusion for New York State, but NOT for CMS.

There are also a limited number of acceptable reasons to have not gotten blood cultures before antibiotics. Examples are as follows:

“Patient was given antibiotics for infection prior to blood culture and onset of sepsis”

This addresses two issues. The first is that blood cultures were not obtained prior to any antibiotic. For example, the patient is SIRS negative, but requires parenteral treatment for cellulitis due to failed outpatient PO antibiotics. They did not require blood cultures and there is potential harm from obtaining them. The second issue is that it explains why the patient was not on broad spectrum antibiotics. Once the patient has signs of severe sepsis, the antibiotics can be changed to antibiotics that would pass the measure.

“Patient was given prophylactic antibiotics for perioperative procedure prior to blood cultures and onset of sepsis”

This will primarily help patients who are inpatient who develop sepsis after a procedure.

{lab value} is elevated due to {medication or disease}, not acute infection/sepsis”

For example:

“Cr is elevated due to ESRD, not acute infection/sepsis”

“INR is elevated secondary to Coumadin, not infection/sepsis”

“Lactate is elevated secondary to (seizure, GI bleed, ischemia, etc), not infection/sepsis”

These are in quotes because this language has been vetted with CMS. If you prefer other language, you may want to check if it will pass.

## Strategies for Success

The statement “If the lactate is negative, I don’t need to repeat it.” is a myth. That is only true if there is no other sign of end organ dysfunction. If the lactate is 0.34 and the Cr is 2.1, you need a repeat lactate. The list of what counts is long and by the time you realize that one of the other labs is abnormal, the patient is upstairs, and/or you have missed the time window. For practical purposes, all infected patients with 2 SIRS who are being admitted to the hospital should get a repeat lactate.

I recommend building ordersets that include two lactates, one stat and one now + 120min. Ordersets should include all common labs so that clinicians don’t have to use the orderset and add other labs separately. Include two sets of blood cultures. In addition I recommend including IVF. There are a few possible strategies for this. One is to include a 250mL bolus. That will ensure that every patient gets some fluid. For patients in septic shock, you can use weight based calculators for 30mL/kg of IVF, if there is a rounding feature. The other strategy is to build weight based orders in the EMR. Clinicians click on the weight range of the patient under which is an order with the appropriate amount of fluid.

In addition to ordersets, I recommend templates with mandatory fields for tissue perfusion and/or volume status reassessment. A frequent reason for missing this is that the reassessment was complete, but did not include all of the mandatory components. If these are required fields, that eliminates that problem.

You can build macros and/or templates for the exclusions as well. That is an easy way to help clinicians phrase specific circumstances in a way that meets the CMS standard.

Algorithms are helpful. Keep them close and refer to them frequently. **You too can succeed at Sepsis!!**

Table 2 The Bundles	
Severe Sepsis	Septic Shock
<b>Three Hour Bundle</b>	<b>Three Hour Bundle</b>
Lactate	Lactate
Blood Culture	Blood Culture
IVF (amount at clinician’s discretion)	IVF (amount at clinician’s discretion)
Broad Spectrum Antibiotics	Broad Spectrum Antibiotics
<b>Six Hour Bundle</b>	<b>Six Hour Bundle</b>
Repeat Lactate	Repeat Lactate
	30mL/kg IVF
	Tissue perfusion reassessment/ or volume reassessment
	1 full VS within one hour of COMPLETION of fluid (a common reason for failure is repeating VS before IVF is completed)
	Repeat BP within the same hour
	If persistent hypotension after INITIAL 30mL.kg bolus, must receive vasopressors

# #IAMNYACEP



Abbas Husain, MD FACEP

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Associate Program Director  
Department of Emergency Medicine  
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I am a Canadian transplant academic ED physician who lives and works in the outer boroughs of New York City. My interests include knowledge translation, ED flow, and integrating technology with emergency medicine.

New York ACEP is my virtual neighborhood and academic community that keeps me excited about teaching and learning emergency medicine.



Kartik Shah, MD

Kartik Shah, MD  
Academic Chief Resident  
Department of Emergency Medicine  
Stony Brook University Hospital

I've stayed in New York for my education so far, going to undergraduate college at Cornell, medical school at SUNY Upstate, and now emergency medicine residency at Stony Brook.

New York ACEP has given me a larger perspective on emergency medicine, and by being on the Education Committee, it has given me an opportunity to help my colleagues become better physicians working in a better environment.



## Emergency Medicine Resident Career Day & Job Fair

Wednesday, September 20, 2017 - 8:00 am-12:30 pm

New York Academy of Medicine

7:30 am - Registration

8:00 am - Welcome - Trent She, MD

8:05 am - **Finding Your First Job** - Mary Jo Wagner, MD FACEP

8:40 am - ACEP News - Mary Jo Wagner, MD FACEP

8:55 am - **What You Need to Know About Contracts and Salaries**

David S. Cherkas, MD FACEP

9:10 am - Break

9:25 am - **How to Write a Curriculum Vitae**

Mary Jo Wagner, MD FACEP

10:05 am - **Panel: Reflections on Fellowships and First Jobs**

11:00 am - Job Fair & Lunch

# EDUCATION



**Jared DiBenendetto, MD**  
PGY2, Emergency Medicine, University at Buffalo  
Jacobs School of Medicine and Biomedical Sciences



**Jeffrey J. Thompson, MD FACEP FAAEM**  
Clinical Assistant Professor of Emergency Medicine,  
Associate Program Director, University at Buffalo  
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## Are You Gritty Enough?

In order to match into and succeed in an emergency medicine residency one must persevere through a long and arduous journey of nearly a decade of postsecondary education, numerous standardized tests and a unique variety of intellectual and emotional challenges. In her seminal 2007 article, “*Grit: Perseverance and Passion for Long-Term Goals*”, Angela L. Duckworth stimulated the education community with her research into the non-cognitive factors that allow an individual to overcome challenges such as those encountered in medical education. Dr. Duckworth and colleagues define grit as “perseverance and passion for long-term goals,” and developed a 12-item instrument to measure grit that assesses such qualities as consistency of interest and perseverance of effort.<sup>1</sup>

In the decade since this work first appeared in the psychology literature, Duckworth has gone on to demonstrate that grit is a better predictor of success when compared to other standard metrics of intelligence or academic ability such as GPA or standardized testing scores. In some of the more recent research, she demonstrates the power of grit in a stunning array of contexts, from predicting West Point dropouts to success in national spelling bees.<sup>1</sup> Indeed, the positive impact of a gritty personality appears to be consistent across stages of education and a variety of professions. In other research, so-called grittier individuals tended to achieve greater success despite having lower standardized test scores and class rank.<sup>2</sup> While few would argue that these more traditional means of assessment should be altogether replaced, including a measure of one’s grit may be an additional component of assessing an individual’s personality.

Duckworth’s novel research sent a powerful shockwave through the education community, and in subsequent years, many have attempted to apply this research to a range of subjects. In the medical community, Duckworth’s Grit Scale has had a variety of applications. In the field of general surgery, a specialty where nearly one quarter of all trainees will leave at some point, Buckhart, et al. inquired whether grit could be used as a marker of potential risk for resident attrition.<sup>3</sup> Though this study has several limitations, including a small sample size and a program dropout rate of 2%, it demonstrated that residents with a below-median score on the Grit Scale were more likely to leave or consider leaving their program. Considering burnout, a topic particularly relevant to EM residents, Salles and colleagues demonstrated that

grit scores correlated closely with psychological well-being as measured by the Maslach Burnout Inventory and the Psychological General Well-Being Scale.<sup>4</sup>

Future application and research within medical education may focus on the use of the Grit Scale for student and resident selection or allocation of program resources. For instance, medical schools and residency programs could consider developing rubrics to objectively identify and select grittier individuals based upon the academic and personal achievements reported on their CVs or during interviews. Likewise, grit scores may help identify students and residents at risk for attrition or burnout, and potentially be used to guide the allocation of financial, educational and/or professional resources to prevent such regrettable circumstances. Even more compelling would be determining how to actually instill a sense of grit into our learners in an effort to promote satisfaction and longevity.

Emergency physicians often pride themselves on their diverse interests and their ability to seamlessly task switch. Within this context, then, it may seem difficult to develop a persistent passion for and maintain perseverance in the field of emergency medicine. Furthermore, determining how best to foster this complex psychological trait in trainees creates a unique educational challenge for those in emergency medicine graduate education. However, if Duckworth, Buckhart, and others are correct it has the potential to reduce or eliminate the undesired consequences of practicing in the field with the highest rate of burnout,<sup>5</sup> and may intensify the recent momentum in resident and physician well-being driven by a focus on mindfulness<sup>6</sup> and growth mindset.<sup>7</sup> By further encouraging and fostering these constructive mindsets, educators can inoculate trainees against behaviors leading to burnout and develop the resources needed to persevere through adversity in order to maintain the passion to practice our vocation.

### References

- 1) Duckworth A, Peterson C, Matthews MD, and Kelly DR, Grit: Perseverance and Passion for Long-Term Goals (2007), *Journal of Personality and Social Psychology*, 92(6)1087-1101
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## Calendar

### September 2017

- 6 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 13 Education Committee Conference Call, 2:45 pm
- 13 Professional Development Conference Call, 3:30 pm
- 14 Practice Management Conference Call, 1:00 pm
- 15 LLSA & Patient Safety LLSA, Mount Sinai, 8:00 am - 3:00 pm
- 20 Emergency Medicine Resident Career Day, New York Academy of Medicine, 8:00 am - 12:30 pm
- 20 Government Affairs Conference Call, 11:00 am
- 20 Research Committee Conference Call, 3:00 pm
- 21 EMS Committee Conference Call, 2:30 pm
- 27 New York Emergency Medicine Resident Day of Service

### October 2017

- 3 Board of Directors Meeting, Albany NY, 1:30 pm - 5:30 pm
- 4 Emergency Medicine Resident Committee Call, 2:00 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
- 29 New York ACEP Reception, Marriott Marquis, Washington D.C. 6-7 pm

### November 2017

- 1 Emergency Medicine Resident Committee Call, 2:00 pm
- 8 Resident Research Conference, Mt. Sinai Medical Center, 8:30 am - 12:30 pm
- 8 Education Committee Conference Call, 2:45 pm
- 8 Professional Development Conference Call, 3:30 pm
- 9 Practice Management Conference Call, 1:00 pm
- 15 Government Affairs Conference Call, 11:00 am
- 15 Research Committee Conference Call, 3:00 pm
- 16 EMS Committee Conference Call, 2:30 pm

### December 2017

- 6 Emergency Medicine Resident Committee Call, 2:00 pm
- 13 Education Committee Conference Call, 2:45 pm
- 13 Professional Development Conference Call, 3:30 pm
- 14 Practice Management Conference Call, 1:00 pm
- 20 Government Affairs Conference Call, 11:00 am
- 20 Research Committee Conference Call, 3:00 pm
- 21 EMS Committee Conference Call, 2:30 pm

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**Theodore J. Gaeta, DO MPH FACEP**  
Residency Program Director  
New York-Presbyterian Brooklyn Methodist Hospital

### Factors for Severe Respiratory Depression from Prescription Opioid Overdose.

*Fox LM, Hoffman RS, Vlahov D, Manini AF; Division of Medical Toxicology, Ronald Perelman; Department of Emergency Medicine, New York University School of Medicine; Risk Addiction. 2017 Jun 23.*

**BACKGROUND:** Prescription opioid overdose is a leading cause of injury-related morbidity and mortality in the US. We aimed to identify characteristics associated with clinical severity in emergency department patients with prescription opioid overdose.

**DESIGN:** This was a secondary data analysis of adult prescription opioid overdoses from a large prospective cohort of acute overdoses. We examined elements of a typical emergency department evaluation using a multivariable model to determine which characteristics were associated with clinical severity, specifically severe respiratory depression (SRD).

**SETTING:** This study was conducted at two urban academic emergency departments in New York City, USA.

**PARTICIPANTS:** Adult patients who presented with acute prescription opioid overdose between 2009 and 2013 were included in the current study. We analyzed 307 patients (mean age 44.7, 42% female, 2.0% mortality).

**MEASUREMENTS:** Patient demographics, reported substances ingested, suspected intent for ingesting the substance, vital signs, laboratory data, treatments including antidotes and intubation, and outcome of death were recorded by trained research assistants. Intent was categorized into four mutually exclusive categories: suicide, misuse, therapeutic error, and undetermined. The primary outcome was SRD, defined as administration of either (a) naloxone or (b) endotracheal intubation (ETI).

**RESULTS:** 109 patients suffered SRD with 90 patients receiving naloxone alone, 9 ETI alone, and 10 both naloxone and ETI. The most common opioids were oxycodone (n=124) and methadone (n=116). Mean age was higher in patients with SRD (51.1 vs. 41.1,  $p<0.001$ ). Opioid misuse was associated with SRD in the multivariable analysis

(OR 2.07, 95% CI 1.2-3.6). The unadjusted relative risk of SRD was high for fentanyl (83.3% SRD) and lowest for codeine (3.6% SRD).

**CONCLUSION:** In emergency department patients in the US with prescription opioid overdose, worse clinical severity was associated with opioid misuse, increased with age, and was widely variable depending on the specific opioid medication involved.

### Assessing Coagulation by Rotational Thromboelastometry (ROTEM) in Rivaroxaban-anticoagulated Blood Using Hemostatic Agents.

*Bar J, David A, Khader T, Mulcare M, Tedeschi C; Department of Emergency Medicine, New York-Presbyterian Hospital, New York, New York; Prehosp Disaster Med. 2017; 32(5):1-8.*

**BACKGROUND:** The use of direct oral anticoagulants (DOACs) such as rivaroxaban (Xarelto) is increasingly common. However, therapies for reversing anticoagulation in the event of hemorrhage are limited. This study investigates the ability of hemostatic agents to improve the coagulation of rivaroxaban-anticoagulated blood, as measured by rotational thromboelastometry (ROTEM).

**HYPOTHESIS:** If a chitosan-based hemostatic agent (Celox), which works independently of the clotting cascade, is applied to rivaroxaban-anticoagulated blood, it should improve coagulation by decreasing clotting time (CT), decreasing clot formation time (CFT), and increasing maximum clot firmness (MCF). If a kaolin-based hemostatic agent (QuikClot Combat Gauze), which works primarily by augmenting the clotting cascade upstream of factor Xa (FXa), is applied to rivaroxaban-anticoagulated blood, it will not be effective at improving coagulation.

**METHODS:** Patients (age >18 years; non-pregnant) on rivaroxaban, presenting to the emergency department (ED) at two large, university-based medical centers, were recruited. Subjects (n=8) had blood drawn and analyzed using ROTEM with and without the presence of a kaolin-based and a chitosan-based hemostatic agent. The

percentage of patients whose ROTEM parameters responded to the hemostatic agent and percent changes in coagulation parameters were calculated.

**RESULTS:** Data points analyzed included: CT, CFT and MCF. Of the samples treated with a kaolin-based hemostatic agent, seven (87.5%) showed reductions in CT, eight (100.0%) showed reductions in CFT and six (75.0%) showed increases in MCF. The average percent change in CT, CFT and MCF for all patients was 32.5% (Standard Deviation [SD]: 286; Range: -75.3 to 740.7%); -66.0% (SD: 14.4; Range: -91.4 to -44.1%); and 4.70% (SD: 6.10; Range: -4.8 to 15.1%), respectively. The corresponding median percent changes were -68.1%, -64.0%, and 5.2%. Of samples treated with a chitosan-based agent, six (75.0%) showed reductions in CT, three (37.5%) showed reductions in CFT, and five (62.5%) showed increases in MCF. The average percent changes for CT, CFT, and MCF for all patients were 165.0% (SD: 629; Range: 96.9 to 1718.5%); 139.0% (SD: 174; Range: -83.3 to 348.0%); and -8.38% (SD: 32.7; Range: -88.7 to 10.4%), respectively. The corresponding median percent changes were -53.7%, 141.8%, and 3.0%.

**CONCLUSIONS:** Rotational thromboelastometry detects changes in coagulation parameters caused by hemostatics applied to rivaroxaban-anticoagulated blood. These changes trended in the direction towards improved coagulability, suggesting that kaolin-based and chitosan-based hemostatics may be effective at improving coagulation in these patients.

### Derivation and Validation of The Prehospital Difficult Airway Identification Tool (PreDAIT): A Predictive Model for Difficult Intubation.

*Carlson JN, Hostler D, Guyette FX, Pinchall M, Martin-Gill C.; University at Buffalo, Department of Emergency Medicine, Buffalo; New York West J Emerg Med. 2017 Jun; 18(4):662-672.*

**BACKGROUND:** Endotracheal intubation (ETI) in the prehospital setting poses unique challenges where multiple ETI attempts are associated with adverse patient outcomes.

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Early identification of difficult ETI cases will allow providers to tailor airway-management efforts to minimize complications associated with ETI. We sought to derive and validate a prehospital difficult airway identification tool based on predictors of difficult ETI in other settings.

**METHODS:** We prospectively collected patient and airway data on all airway attempts from 16 Advanced Life Support (ALS) ground emergency medical services (EMS) agencies from January 2011 to October 2014. Cases that required more than two ETI attempts and cases where an alternative airway strategy (e.g. supraglottic airway) was employed after one unsuccessful ETI attempt were categorized as “difficult.” We used a random allocation sequence to split the data into derivation and validation subsets. Using backward elimination, factors with a  $p < 0.1$  were included in the multivariable regression for the derivation cohort and then tested in the validation cohort. We used this model to determine the area under the curve (AUC), and the sensitivity and specificity for each cut point in both the derivation and validation cohorts.

**RESULTS:** We collected data on 1,102 cases with 568 in the derivation set (155 difficult cases; 27%) and 534 in the validation set (135 difficult cases; 25%). Of the collected variables, five factors were predictive of difficult ETI in the derivation model (adjusted odds ratio, 95% confidence interval [CI]): Glasgow coma score [GCS]  $> 3$  (2.15, 1.19-3.88), limited neck movement (2.24, 1.28-3.93), trismus/jaw clenched (2.24, 1.09-4.6), inability to palpate the landmarks of the neck (5.92, 2.77-12.66), and fluid in the airway such as blood or emesis (2.25, 1.51-3.36). This was the most parsimonious model and exhibited good fit (Hosmer-Lemeshow test  $p = 0.167$ ) with an AUC of 0.68 (95% CI [0.64-0.73]). When applied to the validation set, the model had an AUC of 0.63 (0.58-0.68) with high specificity for identifying difficult ETI if  $\geq 2$  factors were present (87.7% (95% CI [84.1-90.8])).

**CONCLUSION:** We have developed a simple tool using five factors that may aid prehospital providers in the identification of difficult ETI.

## Ultrasound vs. Computed Tomography for Severity of Hydronephrosis and Its Importance in Renal Colic.

Leo MM, Langlois BK, Pare JR, Mitchell P,

Linden J, Nelson KP, Amanti C, Carmody KA; New York University School of Medicine, Department of Emergency Medicine, New York, New York; *West J Emerg Med.* 2017 Jun; 18(4):559-568.

**BACKGROUND:** Supporting an “ultrasound-first” approach to evaluating renal colic in the emergency department (ED) remains important for improving patient care and decreasing healthcare costs. Our primary objective was to compare emergency physician (EP) ultrasound to computed tomography (CT) detection of hydronephrosis severity in patients with suspected renal colic. We calculated test characteristics of hydronephrosis on EP-performed ultrasound for detecting ureteral stones or ureteral stone size  $> 5$ mm. We then analyzed the association of hydronephrosis on EP-performed ultrasound, stone size  $> 5$ mm, and proximal stone location with 30-day events.

**METHODS:** This was a prospective observational study of ED patients with suspected renal colic undergoing CT. Subjects had an EP-performed ultrasound evaluating for the severity of hydronephrosis. A chart review and follow-up phone call was performed.

**RESULTS:** We enrolled 302 subjects who had an EP-performed ultrasound. CT and EP ultrasound results were comparable in detecting severity of hydronephrosis ( $\chi^2 = 51.7$ ,  $p < 0.001$ ). Hydronephrosis on EP-performed ultrasound was predictive of a ureteral stone on CT (PPV 88%; LR+ 2.91), but lack of hydronephrosis did not rule it out (NPV 65%). Lack of hydronephrosis on EP-performed ultrasound makes larger stone size  $> 5$ mm less likely (NPV 89%; LR- 0.39). Larger stone size  $> 5$ mm was associated with 30-day events (OR 2.30,  $p = 0.03$ ).

**CONCLUSION:** Using an ultrasound-first approach to detect hydronephrosis may help physicians identify patients with renal colic. The lack of hydronephrosis on ultrasound makes the presence of a larger ureteral stone less likely. Stone size  $> 5$ mm may be a useful predictor of 30-day events.

## Variability in CT Imaging of Blunt Trauma Among ED Physicians, Surgical Residents, and Trauma Surgeons.

James MK, Lee SW, Minneman JA, Moore MD, Klein TR, Robitsek RJ, Barie PS, Schubl SD; Department of Emergency Medicine, Jamaica Hospital Medical Center, Jamaica; *J Surg Res.* 2017 Jun 1; 213:6-15.

**BACKGROUND:** Trauma triage decisions can be influenced by both knowledge and experience. Consequently, there may be substantial variability in computed tomography (CT) scans desired by emergency medicine physicians, surgical chief residents, and attending trauma surgeons. We quantified this difference and studied the effects of each group’s decisions on missed injuries, cost, and radiation exposure.

**METHODS:** All blunt trauma activations at an urban level 1 trauma center were studied over a six month period. Three months into the study, a pan-scan protocol was introduced. Prior to CT imaging, providers separately completed a survey that asked which CT scans were desired for each patient. Based on the completed surveys, hypothetical missed injuries, radiation exposure, and cost were determined.

**RESULTS:** The variability in the number of CT scans desired by each of the three providers and the resulting cost and radiation exposure were not statistically significant. Substantial variability was predominantly seen in the indications for the desired scans, with the difference between proportions ranging from 3.1%-68.7%. Agreement among the three providers was highest for head and c-spine scans (80%-100%) and lowest for maxillary face (57%-80%) and chest scans (52%-74%). Overall, the missed injury rate was similar for all the providers; chief residents missed significantly more major injuries than trauma attending during the pan-scan period ( $P = 0.03$ ).

**CONCLUSION:** Trauma training and level of training did not have a substantial effect on radiological decisions during the initial trauma assessment. This study sheds light on the growing uniformity among providers with regard to medical decision-making in the initial work-up of trauma.

## Lung Consolidation Locations for Optimal Lung Ultrasound Scanning in Diagnosing Pediatric Pneumonia.

Milliner BHA, Tsung JW; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai; *J Ultrasound Med.* 2017 Jun 6.

**OBJECTIVES:** Lung ultrasound (US) has been shown to be accurate in diagnosing pneumonia in children. Evidence to inform an optimal scanning protocol is limited. Our objective is to describe an optimized lung US

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scanning protocol for pediatric pneumonia based on the anatomic location and transducer orientation.

**METHODS:** We performed a secondary analysis of data and images from two prospective lung US studies for the emergency department diagnosis of pneumonia in children (0-21 years). The anatomic location of each lung consolidation was mapped to one or more of six anatomic zones on the chest, noting the transducer orientation (sagittal or transverse) in which it was identified.

**RESULTS:** Seventy-eight patients were included; 51% were female, and the median age was three years (interquartile range, 1-7 years). Overall, 46.5% (95% CI confidence interval [CI], 37.9%-55.1%) of lung zones with a visible consolidation were posterior; 31.0% (95% CI, 23.0%-39.0%) were anterior; and 22.5% (95% CI, 15.3%-29.1%) were axillary. A total of 54.3% (95% CI, 45.7%-62.9%) of affected lung zones were in the lower lung compared to the upper lung (8.5%; 95% CI, 3.7%-13.3%) and middle lung (37.2%; 95% CI, 28.9%-45.5%). Most lung consolidations were seen in both transducer orientations: 96.2% (95% CI, 92.0%-100%) of patients had a visible consolidation on the transverse view, whereas 85.9% (95% CI, 78.2%-93.6%) had a consolidation on the sagittal view.

**CONCLUSION:** Efficient lung US scanning may start with the posterior, anterior, and then lateral chest zones if no pneumonia is identified. A transverse transducer orientation detects more pneumonia than a sagittal orientation. Omission of either orientation or any lung zone may miss pneumonia.

## Shared Decisionmaking in the Emergency Department: A Guiding Framework for Clinicians.

*Probst MA, Kanzaria HK, Schoenfeld EM, Menchine MD, Breslin M, Walsh C, Melnick ER, Hess EP; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai; Ann Emerg Med. 2017 May 27.*

Shared decision making has been proposed as a method to promote active engagement of patients in emergency care decisions. Despite the recent attention shared decision making has received in the emergency medicine community, including being the topic of the 2016 Academic Emergency Medicine Consensus Conference, misconceptions remain in regard to the precise meaning of the term, the

process, and the conditions under which it is most likely to be valuable. With the help of a patient representative and an interaction designer, we developed a simple framework to illustrate how shared decision making should be approached in clinical practice. We believe it should be the preferred or default approach to decision making, except in clinical situations in which three factors interfere. These three factors are lack of clinical uncertainty or equipoise, patient decision making ability and time, all of which can render shared decision making infeasible. Clinical equipoise refers to scenarios in which there are two or more medically reasonable management options. Patient decision making ability refers to a patient's capacity and willingness to participate in his or her emergency care decisions. Time refers to the acuity of the clinical situation (which may require immediate action) and the time that the clinician has to devote to the shared decision making conversation. In scenarios in which there is only one medically reasonable management option, informed consent is indicated, with compassionate persuasion used as appropriate. If time or patient capacity is lacking, physician-directed decision making will occur. With this framework as the foundation, we discuss the process of shared decision making and how it can be used in practice. Finally, we highlight five common misconceptions in regard to shared decision making in the ED. With an improved understanding of shared decision making, this approach should be used to facilitate the provision of high-quality, patient-centered emergency care.

## Audience Response System Facilitates Prediction of Scores on In-Training Examination.

*Shah KH, Jordan J, Jahmes K, Lisbon DP, Lutfy-Clayton L, Wei G, Winkel G, Santen SA; Icahn School of Medicine at Mt. Sinai, Department of Emergency Medicine; West J Emerg Med. 2017 Apr; 18(3):525-530.*

**BACKGROUND:** Audience response systems (ARS) are increasingly popular; however, their contribution to education is not completely clear. Our study found that scores from review quizzes delivered by an ARS correlate with in-training exam (ITE) scores and are viewed positively by residents. This information may be useful in identifying poor performers early so that targeted educational interventions can be made. The objective was

to determine if scores on review quizzes delivered by an ARS correlate with ITE scores and to obtain participant feedback on use of the ARS for ITE preparation.

**METHODS:** This was a prospective observational study of emergency medicine (EM) residents at six accredited EM residency programs. Subjects included residents who had taken previous ITEs. Subjects participated in bimonthly review sessions using an ARS. Twelve review quizzes were administered, each consisting of 10 multiple-choice questions. After the ITE, subjects completed an attitudinal survey consisting of six Likert-scale items and one "yes/no" item. We used a mixed linear model to analyze the data, accounting for prior 2012 ITE scores and nesting due to institution.

**RESULTS:** Among 192 participants, 135 (70.3%) completed the ITE in both 2012 and 2013; we analyzed their data for the first objective. Results from the mixed linear model indicate that the total mean score on the review quizzes was a significant [ $t(127) = 6.68; p < 0.001$ ] predictor of the 2013 ITE after controlling for the 2012 ITE score. One hundred forty-six (76.0%) participants completed the attitudinal survey; 96% of respondents stated that they would like ARS to be used more often in resident education. Respondents felt the sessions aided in learning (mean 7.7/10), assisted in preparation for the ITE (mean 6.7/10), and helped identify content areas of weakness (mean 7.6/10).

**CONCLUSION:** Our results suggest that scores from review quizzes delivered by an audience response system correlate with in-training exam scores and is viewed positively by residents.

## Clinician-Performed Bedside Ultrasound in Improving Diagnostic Accuracy in Patients Presenting to the ED with Acute Dyspnea.

*Papanagnou D, Secko M, Gullett J, Stone M, Zehtabchi S; The State University of New York, Downstate Medical Center; Department of Emergency Medicine, Brooklyn, New York; West J Emerg Med. 2017 Apr; 18(3):382-389*

**INTRODUCTION:** Diagnosing acute dyspnea is a critical action performed by emergency physicians (EP). It has been shown that ultrasound (US) can be incorporated into the work-up of the dyspneic patient; but there is little data demonstrating its effect on decision-making. We sought to examine the impact of a bedside, clinician-performed

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cardiopulmonary US protocol on the clinical impression of EPs evaluating dyspneic patients, and to measure the change in physician confidence with the leading diagnosis before and after US.

**METHODS:** We conducted a prospective observational study of EPs treating adult patients with undifferentiated dyspnea in an urban academic center, excluding those with a known cause of dyspnea after evaluation. Outcomes: 1) percentage of post-US diagnosis matching final diagnosis; 2) percentage of time US changed providers' leading diagnosis; and 3) change in physicians' confidence with the leading diagnosis before and after US. An US protocol was developed and standardized prior to the study. Providers (senior residents, fellows, attendings) were trained on US (didactics, hands on) prior to enrollment, and were supervised by an US faculty member. After patient evaluation, providers listed likely diagnoses, documenting their confidence level with their leading diagnosis (scale of 1-10). After US, providers revised their lists and their reported confidence level with their leading diagnosis. Proportions are reported as percentages with 95% confidence interval (CI) and continuous variables as medians with quartiles. We used the Wilcoxon signed-rank test and Cohen's kappa statistics

to analyze data.

**RESULTS:** A total of 115 patients were enrolled (median age: 61 [51, 73], 59% female). The most common diagnosis before US was congestive heart failure (CHF) (41%, 95%CI, 32-50%), followed by chronic obstructive pulmonary disease (COPD) and asthma. CHF remained the most common diagnosis after US (46%, 95%CI, 38-55); COPD became less common (pre-US, 22%, 95%CI, 15-30%; post-US, 17%, 95%CI, 11-24%). Post-US clinical diagnosis matched the final diagnosis 63% of the time (95%CI, 53-70%), compared to 69% pre-US (95%CI, 60-76%). Fifty percent of providers changed their leading diagnosis after US (95%CI, 41-59%). Overall confidence of providers' leading diagnosis increased after US (7 [6, 8]) vs. 9 [8, 9], p: 0.001).

**CONCLUSION:** Bedside US did not improve the diagnostic accuracy in physicians treating patients presenting with acute undifferentiated dyspnea. US, however, did improve providers' confidence with their leading diagnosis.

**Ethics in the Pediatric Emergency Department: When Mistakes Happen: An Approach to the Process, Evaluation and Response to Medical Errors.**

*Dreisinger N, Zapolsky N; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai; Pediatr Emerg Care. 2017 Feb; 33(2):128-131.*

The emergency department (ED) is an environment that is conducive to medical errors. The ED is a time-pressured environment where physicians aim to rapidly evaluate and treat patients. Quick thinking and problem-based solutions are often used to assist in evaluation and diagnosis. Error analysis leads to an understanding of the cause of a medical error and is important to prevent future errors. Research suggests mechanisms to prevent medical errors in the pediatric ED, but prevention is not always possible. Transparency about errors is necessary to assure a trusting doctor-patient relationship. Patients want to be informed about all errors, and apologies are hard. Apologizing for a significant medical error that may have caused a complication is even harder. Having a systematic way to go about apologizing makes the process easier, and helps assure that the right information is relayed to the patient and his or her family. This creates an environment of autonomy and shared decision making that is ultimately beneficial to all aspects of patient care.



## Resident Research Conference

Wednesday, November 8 - 8:30 am - 12:30 pm  
Icahn School of Medicine at Mount Sinai

# 2017





**Matt S. Friedman, MD DABEMS**  
Associate Medical Director of Prehospital Care and  
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**David Lobel, MD FACEP FAEMS**  
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## Mass Gathering and Event Management

At the most recent ACEP Scientific Assembly, Event Medicine was formally recognized as ACEP's newest section. More event organizers are adding or required by local or state DOH regulators to enhance their medical staff, in part to address terrorism concerns. Recent events that have brought international attention to the topic include a bombing at an Ariana Grande concert in Manchester, England, and recreational drug overdoses at multiple music festivals nationwide, which have resulted in scores of fatalities in previously healthy young adults over the last several years. This has created an opportunity for which Emergency Physicians (EPs) are particularly well suited. While this may seem like a great chance to obtain dignitary seats and watch a ball game or concert, there are several core concepts that providers should know before taking on this responsibility. The purpose of this contribution is to offer EPs with an interest in event medicine insight into what kinds of scenarios they may encounter, and some pearls for being prepared for this area of emergency medicine practice.

### Event Specifics

First, while every EMS system is unique, each type of mass gathering has its inherent challenges and risk profile. The number of attendees, potential for extreme weather, geographical barriers and communication difficulties complicate the medical staffing and response. Many cities have a professional sports team, and most host some sort of endurance athletic event such as a marathon or triathlon. These are very different scenarios. The first is a bounded event with seated spectators, the second an unbounded event with scores of active participants spread throughout a city. Predictive models in the mass gathering medicine literature point to a higher patient presentation rate among mobile participants in a bounded area. With the onset of the warm weather, another common scenario where experienced physicians are frequently needed is the outdoor music festival. Linear modeling predicts that for every 10-degree increase in the heat index, there are three more patients per 10,000 patrons. These events are often multi-day events sometimes in urban settings with the amenities of multiple trauma centers and plenty of ICU beds available. However, frequently they are held in remote locations with only 'critical-access' hospitals nearby. When tens of thousands of festival attendees travel to austere locations, the potential for serious illnesses, traumatic injuries and toxicologic emergencies can easily overwhelm local EMS and healthcare resources. There has been an emerging public outcry directed at festival organizers to prevent

compromising emergency services and healthcare resources for local residents. These types of events often require the provision of advanced, intensive medical care on-site, either because of the severity of the illness, or the remote location, and distance to definitive care.

### The Role of the Physician

The role of the physician will change from one type of event to another. In the spectator event scenario, the physician is often a consulting resource for EMS or first aid providers. A separate team physician and athletic trainers will typically be responsible for the professional athletes. Naturally, in the event that there is a seriously or critically ill patient, there is an expectation that the physician will take a more active role. For instance, the National Hockey League mandated that an emergency physician attend and be available at every game to manage the airway or treat an arrhythmia of a critical player after a 2014 episode in which a Dallas Stars player collapsed on the bench and was defibrillated prior to regaining consciousness (he then asked if he could return to the game). In the event of multiple casualties at an event, the physician will certainly be turned to for leadership, medical direction and triage skills. In the larger multi-day events, physicians should expect to provide advanced medical care. Patients may suffer from the effects of the environment, along with intoxicants, as well as complications of their own underlying illnesses or adverse reactions to their daily psychiatric medications which young attendees seem to be prescribed more frequently than in the past. For this kind of an event, the medical director and other physician staff should be involved in the planning with special attention to the staffing and stocking of the medical facility. In the planning phase the event physician should assure that the medical facility be readily recognized, and offer easy access to patrons while still maintaining a direct, unimpeded route of egress. At pugilistic events, such as boxing or mixed martial arts, the physician will be asked to decide when to stop a fight, and determine what injuries require immediate transport to the hospital. In order to care for professional fighters in combat sports in New York State, special credentialing is required by the New York State Athletic Commission.

### Pearls

At the majority of events, the dedicated EMS services will be sufficient to care for the medical needs of the patrons but when you are needed, you will be working in an unfamiliar environment without your usual

set of resources and consulting services compared to the typical ED shift, so be prepared.

- 1. Know Your Equipment:** Critical items, like airway equipment including supraglottic airway devices, AEDs, and lifesaving medications should be checked for function, expiration and location. These items may be placed in obscure locations or locked up, so make sure they are accessible when and where you need them.
- 2. Know Your Staff:** Events may be staffed by EMS, midlevel providers, or first responders. Know who is there to help you, how to find them and what is within their capabilities or scope of practice. If you are responsible for supervising EMS, become familiar with their regional protocols (which will likely differ from your region's), and the equipment and medications that they carry. It is unlikely that the EMS system will have paralytics should the need arise to intubate someone. Thus we recommend bringing your own paralytics for RSI depending on the type of event.
- 3. Know Your Environment:** Large stadiums may be challenging to get around, and you may require access to special areas. You should know the quickest way to get to a critically ill patient, and the most direct route of egress. Working with security/public safety is a must. Be knowledgeable and ensure that the staff is aware of where the closest AEDs are positioned.
- 4. Know Your Priorities:** As the physician, you define the medical priorities. Specifically with regard to cardiac arrest and foreign body airway obstruction, intervention takes priority over movement of the patient. Ensure that the patient is transported to the most appropriate facility should the situation arise, i.e. major trauma to a trauma designated hospital or a patient with acute CVA

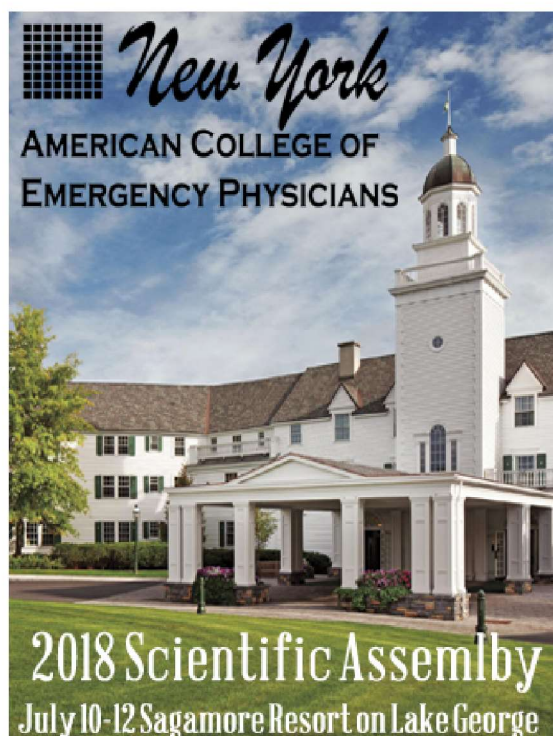
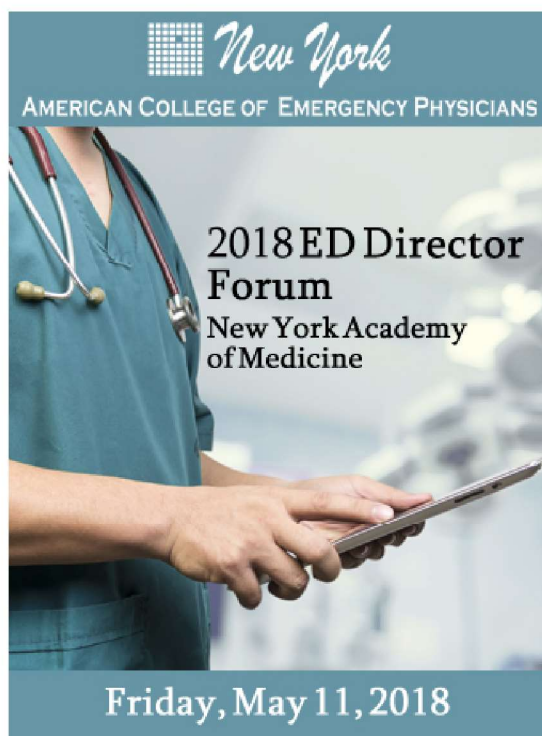
symptoms to a stroke center! Patients should be transported by the proper level of care, while BLS may be appropriate for injuries requiring transport, critical patients should be transported by an ALS capable ambulance and crew.

## Legal Aspects

A contractual agreement specifying your role and liability coverage should be finalized prior to the event. Once you have received compensation of any sort, you cannot claim nor are you entitled to the benefits or protection from liability that a good samaritan status confers. While your services as a consultant may be covered under the liability of the event planner, if you are providing direct medical care you should be certain that your malpractice plan covers such activity. Your hospital may have umbrella coverage that will allow you to practice outside the hospital at no additional cost to them so it is worth inquiring. If not, typically the EMS system can add on an insurance rider to cover physician provided medical care provided by a physician.

Event Medicine is a young and rapidly evolving medical discipline that integrates aspects of emergency medicine, disaster medicine, and public health. It is an exciting area of emergency practice, and the opportunities are increasing rapidly. Emergency physicians should take advantage of this opportunity to have some fun, educate EMS providers and any attendant medical students or residents about key event medicine principles, and to showcase the high quality care that our specialty offers every day.

*About the Author:* Matt S. Friedman, MD is a board certified EMS and Emergency Medicine physician. He completed an EMS fellowship with the Fire Department City of New York (FDNY). He serves as the Lead House Physician for Yankee Stadium, Madison Square Garden and the US Open. Dr. Friedman is the acting medical director for several national annual mass gatherings and music festivals.



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# ASK THE EXPERTS



**Gillian Schmitz, MD FACEP**  
Spectrum Healthcare  
Greater San Antonio Emergency Physicians (GSEP)  
Associate Professor  
Department of Emergency Medicine  
UT Health Science Center

I had the pleasure to meet Gillian Schmitz, MD FACEP at the 2017 New York ACEP Scientific Assembly and speak with her regarding the value of ACEP membership and how to get more involved on a national level.

Dr. Schmitz was elected to the ACEP Board of Directors in 2016. She previously served as the President of the Government Services Chapter, chaired the Young Physician Section and served on the EMRA Board of Directors. She has received the Academy for Women in Academic Emergency Medicine Early Career Faculty Award. Dr. Schmitz helped launch a new residency program at UT San Antonio and currently serves as the Associate Medical Director at Full Spectrum Emergency Room and faculty at the San Antonio Military Medical Center (SAMMC).

## What Initiatives are ACEP Currently Focusing On?

ACEP has been working to protect our patients and urging members of the House and Senate to maintain emergency medical care as an essential health benefit. We have been fighting the insurance companies who are trying to deny payments for “non-emergencies”. Insurance companies in several states have enacted new policies that are unfair and may lead to stiff financial penalties for our patients based on their final diagnosis.

ACEP’s work in the 1990s on this topic led to the “prudent layperson standard” which was written into federal law in the Patient Protection and Affordable Care Act of 2010. The “prudent layperson standard” requires insurance coverage based on the patient’s symptoms, not their final diagnosis. Anyone seeking emergency care suffering from symptoms that appear to be life threatening should not be denied coverage if the final diagnosis does not turn out to be an emergency. ACEP has even considered injunctions and possible legal action. The ACEP Executive Board has been meeting with insurance companies and other stakeholders to protect access to care for our patients. We continue to move the needle regarding our out of network and balanced billing fights. ACEP worked with the AMA to pass a resolution through the AMA House of Delegates to create model legislation on out of network and balanced billing solutions.

ACEP has also been reviewing and responding to recent “research” articles. A *New England Journal of Medicine* article published in November 2016 stated that surprise medical bills occurred in about 22% of all emergency room visits. This study focused on a small percentage of emergency visits and the study group was funded by the insurance industry. A second article was published in *Annals of Emergency Medicine* comparing costs of hospital based and freestanding emergency departments to urgent cares. The methodology is flawed and the cost



**Interviewed By:**  
**Jennifer L. Pugh, MD MBA FACEP**  
Assistant Professor  
UBMD Emergency Medicine  
Associate Chief of Service  
Erie County Medical Center

figures have not been shared with external reviewers for adequate peer review. The cost comparisons are also made by final diagnosis and do not account for patient presentations, acuity or underlying risk factors. Multiple letters to the editor have been sent regarding our concerns for the low standards for health policy research and lack of data transparency.

In 2016, ACEP launched the Clinical Emergency Data Registry (CEDR). CEDR has been approved by the Centers for Medicare and Medicaid Services and allows for single data capture to fulfill the requirements of multiple programs. CEDR will ensure emergency physicians, rather than other parties, are defining quality in emergency medical care.

Finally, ACEP is developing a white paper on best practices for contract transition. ACEP’s primary concern during the controversial transition of the Summa Health contract was for the residents and making sure their needs were being addressed. ACEP has publicized our available resources regarding contract negotiations and transition and we anticipate the publication of our white paper by the Scientific Assembly in October 2017.

## How Can Physicians Get More Involved in ACEP?

Although there is a lot of activity going on at the Board level, the majority of the work of the College is done through our state chapters, committees and sections. There is ample opportunity to get involved. Section memberships are available to all ACEP members. Find something you are interested in and sit in on a meeting. Leadership starts by showing up! Committee members are appointed by the President and require an application process in the spring. Although this may seem daunting, ACEP wants to get young physicians involved and many people are able to get the assignment they request. I remember wanting to get involved in ACEP’s Medical Legal committee. Although I did not initially get appointed, I showed up for a meeting and volunteered on a couple projects, which helped get my foot in the door and allowed me to be added to the committee. Often, you just have to ask to get involved. The state chapters are a great way to learn more about what is going on within your own state. Most state chapters have open board meetings that members can sit in on and listen to the issues. There are generally a number of committees, advocacy opportunities and awards that are available to members.

If you are not sure where to get involved or where to start, feel free to reach out to me or one of the other Board members and we would be happy to discuss specific opportunities and leadership roles within the College. We are a stronger organization having our members engaged and involved.

# ASK THE EXPERTS

## What Are Some Important Things Your Mentors Taught You?

Finding a mentor is one of the most important steps in building a career. ACEP has been incredibly helpful to me in that regard because of the networking and opportunities to meet and develop relationships with several mentors. I cannot even begin to describe the number of doors that have opened for me professionally because of my involvement in ACEP.

I have learned an incredible amount from my mentors. The first and most important thing they have taught me is to have confidence and that you have to put yourself out there. Many physicians are held back by “imposter syndrome” and this pervasive feeling that we are not qualified and someone will figure out we don’t belong there. The reality is that emergency physicians are very well trained for leadership positions. By nature of our personalities and education, we can multi-task really well, we are decisive and we can think on our feet. My mentors have taught me skills of self-promotion, negotiation and mustering confidence (even when I didn’t always feel it), which have been incredibly beneficial in different aspects of my career.

The second lesson I learned from my mentors is public speaking and media training. I used to be terrified of speaking in front of large audiences and now I love it. Public speaking and the ability to clearly communicate are vital for good leadership. It takes practice, but it is a skill that can be learned. I have watched my mentors speak at national meetings and they look like they are having fun on stage. I mimic some of those behaviors, develop my own communication style and keep practicing!

The other important lesson I have learned is to give back. Being a mentor is as equally rewarding as being a mentee. It helps me prevent

burn-out and find satisfaction by helping others. I have gotten 100 times back from ACEP what I have put into it and I find a lot of professional satisfaction in getting others involved.

## How Do You Handle the Challenges of Being a Mother, EM Physician and ACEP Leader?

It’s a personal decision how you chose to balance your time. What works for me may not work for you. I am lucky that I have a very supportive spouse and had a live-in nanny when my children were young. My husband, who is also physician, has cut back on some responsibilities to allow me to pursue my career goals. I have done the same for him in the past and our balance and compromises are what make our relationship such a blessing. Now that my children are a little older, I try to bring them along on some ACEP trips and they love it. I am a firm believer that women can be both leaders and mothers. I have found a balance that works for me practicing in both academic centers and freestanding emergency departments. ACEP gives me additional professional fulfillment and job satisfaction. My husband, kids and hobbies keep me grounded, make me smile every day and remind me where my priorities need to be.

Each day or week is not necessarily “balanced”. Some weeks are complete chaos. But over time, we each learn how to best arrange the mosaic tiles that represents different aspects of our time and lives. I have realized that I am always going to feel busy, but finding contentment in how I spend my time gives me a better sense of balance and wellness. We all juggle a number of balls in the air... we just need to learn which ones are made of glass and which ones are rubber and can bounce a few times.



**2017 New York ACEP  
Lifelong Learning and  
Self Assessment Course  
& Patient Safety LLSA  
Friday, September 15**

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**LLSA Course 8:30 am - 1:00 pm  
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Register online at [www.nyacep.org](http://www.nyacep.org)

# SCIENTIFIC ASSEMBLY HIGHLIGHTS

## Record Attendance

The 2017 Scientific Assembly at the Sagamore Resort featured expert faculty members, Robert S Hoffman, MD FAACT FACMT FRCP Edin FEAPCCT, Richard Levitan, MD FACEP, and Gillian Schmitz, MD FACEP who wowed 320 emergency physicians from around the state. Thirty-six 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, Gary S. Rudolph, MD FACEP and Bruce S. Ushkow, MD MS FACEP were presented with the 2017 Advancing Emergency Care Award. Daniel G. Murphy, MD MBA FACEP was presented with the Physician of the Year Award. The Edward W. Gilmore Lifetime Achievement Award was presented to Lewis R. Goldfrank, MD FACEP.

## SUNY Buffalo Takes Back the Crown in the Third Annual Resident Volleyball Tournament

Seven residency programs competed for bragging rights in the Scientific Assembly Resident Volleyball Tournament.



## 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

- A Prospective Randomized, Double-Dummy Trial Comparing Intravenous Push  
*Jefferson Drapkin, BS, Maimonides Medical Center*

### Poster Presentations

- Chest Compression Interruptions Associated with Utilization of Focused Transthoracic Echocardiography during Cardiopulmonary Resuscitation in the Emergency Department  
*Ralph Monfort, BS, Maimonides Medical Center*
- A Retrospective Analysis of the Respiratory Adjusted Shock Index (RASI) Score to Determine the Presence of Occult Shock in Trauma Patients  
*Nicholas D. Caputo, MD MSc, NYC Health + Hospitals/Lincoln*
- Does Specialty Training And Practice Setting Effect Adherence To The Pecarn Criteria for Pediatric Head Trauma?  
*Mikhail Podlog, DO, Staten Island University Hospital*
- Predictors of Perceived Educational Value in Emergency Medicine Residency Simulation Cases  
*Taylor R. Spencer, MD MPH FACEP, Ellis Hospital*

## Leadership Elected

Congratulations are extended to newly elected Board members; Michael W. Dailey, MD FACEP, Albany Medical Center; Abbas Husain, MD FACEP, Staten Island University Hospital; Sanjey Gupta, MD FACEP, Long Island Jewish Medical Center; Livia Santiago-Rosado, MD FACEP, Nassau University Medical Center.

## New Speaker Forum

Congratulations to Jessica Noonan MD, Albany Medical Center, recipient of the award for best presentation for *Taking Care of the LVAD: It's Not So Bad!*



# SCIENTIFIC ASSEMBLY HIGHLIGHTS



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



## REBOA: Another Resuscitation Tool?

Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) is being introduced into the arena of care for patients with hemorrhagic shock. REBOA is a large vessel occlusion catheter to be used for the temporary occlusion of the aorta and monitoring of blood pressure in the setting of hemorrhagic shock. It will allow for the temporary control of hemorrhage and augmentation of after load until definitive treatment of the cause of shock can be accomplished. REBOA has been used for several years in Europe and is considered a core EM skill in Japan. It has even been used in the pre-hospital setting in Great Britain. REBOA tends to cause less physiological disturbance and have higher rates of technical success than aortic cross clamping. The older versions of the occlusion catheter were complex and required a long complicated insertion procedure. Simplified REBOA devices for use in emergent patient care are now commercially available (ER-REBOA; Prytime Medical Devices, Inc.) cleared by the FDA for use in 2015.

Research on the use of REBOA in acute exsanguinating hemorrhage shows good results but is primarily in animal models and limited to small case series. Survival in the case series increased from <10% in patients receiving routine care to 30-40% in patients where a REBOA device was used.

Indications for use of the catheter include adult patients in PEA arrest <10 minutes secondary to exsanguinating sub-diaphragmatic hemorrhage and patients with severe hypovolemic shock or those in an agonal state due to non-compressible exsanguinating hemorrhage. This would include patients with intra abdominal hemorrhage, pelvic fractures and penetrating injuries to the pelvic or groin area with uncontrolled hemorrhage. The femoral vessels must be visible on ultrasound to allow for safe insertion; alternatively a

cut down would allow safe insertion. The majority of these patients will be the traumatically injured; however, consideration may be given to using them in patients exsanguinating from gastrointestinal hemorrhage, post partum hemorrhage or a ruptured abdominal aortic aneurysm. It is imperative that the insertion of the REBOA not be taken lightly and it should not be placed into patients without the appropriate indication. The complications of the ischemia to the lower half of the body are too high.

REBOA is contraindicated in patients over 70, cardiac arrest due to causes other than exsanguination, PEA arrest >10 minutes, high proximal traumatic aortic dissection, inability to identify femoral vessels by ultrasound (if unable to perform a cut down quickly), and pre existing terminal illnesses or co-morbidities.

REBOA is inserted into the common femoral artery. It requires an introducer sheath to be inserted first using ultrasound guidance. Prior to insertion, the catheter is hooked up to an arterial pressure monitor and is measured for appropriate length.

The aorta has three zones. Zone I is from the origin of the left subclavian to the celiac artery (for insertion measurement, the xiphoid). Zone II is from the celiac artery to the most caudal renal artery. Zone III is from the most caudal renal artery to the aortic bifurcation (for insertion measurement, just above the umbilicus). The catheter should be inserted and balloon inflated to the aortic zone required for hemorrhage control. Zone I for intra abdominal hemorrhage and Zone III for pelvic or groin hemorrhage. It should never be inflated in Zone II due to potential damage to the arteries coming off of the aorta.

Once inserted to the appropriate length, position is verified by either X-ray or fluoroscopy. The balloon contains contrast material.

The balloon is then inflated to the size mandated by the position and size of the patient. After inflation, arterial pressure should rise quickly and be seen on the pressure monitor. After insertion, the catheter must be secured to prevent dislodgement.

It is imperative that if used, the facility has a procedure for management of these patients. Following insertion, a clear plan of rapid hemorrhage control intervention must be in place. Or, if placed in a facility without the availability of services to provide this level of intervention, a rapid transfer protocol must be in place. Total occlusion time is linked with survival; shorter occlusion time with higher survival. Ideally, the balloon should be deflated within 30 minutes.

Adverse events are multiple. Damage to the femoral vessel includes dissection, perforation, and rupture. Large bore cannulation of the femoral vessel or damage to the vessel or the aorta may lead to ischemia of the limb, arterial thrombosis/embolism and stroke. Parasthesias and paralysis may be seen if the femoral nerve is damaged or in relation to the ischemic time to the lower extremities and to the spinal cord. Large hematomas and infection after cannulation can be seen. But most significantly is the inability to deflate the balloon due to the inability to control hemorrhage or damage to the aorta. Mortality rates are high as mentioned above first of all due to the severity of illness of the patient but also the potential complications. Insertion of a REBOA should be considered only in a life threatening scenario.

The use of REBOA especially for trauma is under active discussion here in the United States. Many centers have acquired the catheter and have educated their staff. Many trauma centers are already incorporating REBOA into their trauma care. In June, a *New York Times* article highlighted its use and featured



two patients who were saved by the use of the catheter. The American College of Surgeons is offering courses in basic endovascular skills for trauma that include REBOA. There will be educational offerings at the ACEP 2017 Scientific Assembly. A quick check of emergency medicine educational web sites and blogs include discussions and videos.

These are our sickest patients with hemorrhage that cannot be controlled with conventional resuscitation. ED thoracotomy has limited indications and very poor survival. It is possible that rapid insertion of REBOA devices may offer a chance of survival to these patients. It is important that we become educated as to its use and the technique for insertion. As its use increases, we will begin to see better statistics regarding its success.

It may be possible that it will enter into our Emergency Medicine practice in the near future if it has not already.

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# ALBANY UPDATE



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

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The New York State Legislature finished the 2017 Legislative Session in the early hours of June 29, 2017. New York ACEP and Reid, McNally and Savage (RMS) worked throughout the six month Session to protect and enhance the practice of emergency medicine. Two lobby days were held, one March 7 focused primarily on State Budget issues, and another May 22 concentrated on a variety of proposals aimed at stemming the opioid crisis. Although it was a very challenging year, New York ACEP was successful in meeting most of their government affairs goals.

## **State Budget Issues**

### **\$20 Million Medicaid Cut for “Avoidable Emergency Visits”**

New York ACEP was successful in defeating a budget proposal put forward by Governor Andrew Cuomo to reduce “avoidable” emergency visits by 25% and cut Medicaid reimbursement by \$20 million.

During the March 7 lobby day, members stressed that many people seeking emergency care have serious or urgent symptoms. In some cases, their final diagnosis may turn out to be non-urgent. However, these visits are not “avoidable.” The State’s Prudent Layperson Standard law, spearheaded by New York ACEP in 1996, requires health insurance companies to provide coverage based on symptoms, not final diagnosis. This law was passed in recognition that anyone with potentially life-threatening symptoms should be treated and stabilized in an emergency department and that the visit should be covered by insurance.

Legislators were persuaded by the fact that many so called “avoidable” visits occur when doctors’ offices are closed and that those hardest hit by this proposal would be underserved people living in rural and urban areas.

## **Extension of Excess Malpractice Program**

The final State Budget includes the Governor’s proposal to extend the Excess Medical Malpractice Program until June 30, 2019 at level funding of \$127.4 million. The Legislature rejected language proposed by the Governor to require physicians to provide evidence that they paid their taxes as a precondition for receiving Excess coverage.

## **Health Care Regulation Modernization Demonstration Program**

The Legislature also rejected the Governor’s proposal to establish a “Health Care Regulation Modernization Demonstration Program” to authorize the Department of Health and other State agencies to waive any current laws, rules or regulations to implement demonstration programs to test and evaluate new models for organizing, financing and delivering health care services that are not currently permissible under statute or regulation.

While fully supporting the concept of modernizing outdated, burdensome laws and rules, New York ACEP objected to this proposal because it provided the Executive Branch with unlimited power to bypass the New York State Legislature and change any State law, rule or regulation. In addition, some of the areas recommended for study in the proposal have been previously considered and rejected by the Legislature including inappropriate expansion of scope of practice for non-physician practitioners.

## **Key Legislation**

### **Requirement for Prescribers to Consult the PMP in Emergency Departments and Mandate for Addiction Specialists in the ED**

Governor Cuomo announced in his annual State of the State Address in January that he planned to put forward amendments to the I-Stop Law, including the elimination of a

provision of the original law that exempts practitioners from consulting the PMP when prescriptions for controlled substances are written in hospital emergency departments for a supply that does not exceed five days.

Information obtained by RMS indicated that a draft Governor’s proposal would eliminate the PMP exemption and require hospitals to have an “addiction professional” available in the emergency department on-site or by telehealth to consult with the attending physician about services provided to a patient who has or is at risk of having a substance use disorder.

New York ACEP lobbied against the elimination of the PMP exemption during the March 7 and the May 22 lobby days. In meetings with legislators and staff, we noted that the PMP exemption was enacted by the Legislature at New York ACEP’s request in recognition of the very busy environment in emergency departments. Unlike other practitioners, emergency physicians don’t have knowledge in advance of the patient’s arrival as to whether a pain medication may be indicated during the visit. In addition, studies show that hospital emergency departments are not the source of opioids for patients and many have taken the lead in addressing inappropriate use.

New York ACEP recommended that if legislation is introduced to eliminate the five day Emergency Department exemption, it should include a requirement for integrating PMP information into patient electronic medical records. Studies show that providing a single point of access for PMP and patient health data would greatly decrease the amount of time and resources required to access information and improve patient care.

While the bill was the subject of intense negotiations between the Governor and both houses of the Legislature during the month of June, it was never introduced. The nego-

tiations on these issues fell apart after strong opposition from many parties including New York ACEP and representatives for the hospital industry.

**Prescriber Notification of Patient Overdose by Emergency Department Practitioners (S2639 Lanza/A1043 Cusick)**

Legislation to require “every emergency room or hospital practitioner to consult the Prescription Monitoring Program (PMP) registry when treating a patient for a controlled substance overdose and to notify the patient’s prescriber of such overdose,” did not pass both houses.

New York ACEP communicated to the sponsors that while we support the intent of this legislation to work to alleviate the prescription drug misuse and overdose epidemic in the State, the bill as written would be extremely difficult to implement. A variety of amendments were discussed with the sponsors of the bills.

It was stressed that communication of this information would be greatly enhanced if PMP information was integrated into patient electronic health records (EHR). Providing a single point of access for PMP and EHR would greatly decrease the amount of time and resources required to access information and improve patient care. This bill passed the Senate and died in the Assembly Health Committee.

**Extending the Independent Dispute Resolution process for Out-of-Network Emergency Services to Hospitals (S4241-A Seward/A7611-A Cahill)**

New York ACEP issued a memo in opposition to legislation that would extend the IDR process for Out-of-Network emergency physician services provided in a hospital and “surprise bills” provided in an ambulatory surgery center to hospital emergency charges. The current IDR process is available to providers, health plans, and patients.

New York ACEP stressed that this legislation would reduce incentives for insurers to contract with hospitals and provide significant leverage to insurance companies to lower reimbursement rates for hospital emergency and other services. This would undermine the State’s emergency health care safety net and result in decreased access to emergency care and services for patients. It comes at a time when hospitals are facing unprecedented threats from Washington for reduced federal aid for Medicaid and the dismantling of the Affordable Care Act. This bill passed the Assembly and died on the Senate floor.

**Date of Discovery (S6800 DeFrancisco/A8516 Weinstein)**

Legislation passed both houses of the Leg-

islature in the closing days of the Session that would change the statute of limitations for medical, dental and podiatric malpractice from two and half years to the later of either: 1) two and a half years from the date an injured patient discovers or should have discovered the negligent failure to diagnose cancer or a malignant tumor; or 2) the date of the last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the accrual of an action. Where an action is based upon the discovery of a foreign object in the body, the action may be commenced within one year of the date of discovery or of the date of discovery of facts which would reasonably lead to such discovery. The bill prohibits a malpractice action from being filed more than seven years after the date of the alleged malpractice.

Senator Hannon, the Chairman of the Senate Health Committee spoke against this legislation on the floor prior to passage and voted against it. Senator DeFrancisco, the Senate sponsor, stated that the bill was limited in scope to failure to diagnose cancer or a malignant tumor.

New York ACEP worked this year and in many previous years to defeat regressive liability legislation. The bill has not yet been transmitted to the Governor.

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**NEW YORK ACEP MEMBERS ARE INVITED TO ATTEND**

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