New York American College of Emergency Physicians

Celebrating 50 Years of Advancing Emergency Care in New York State

Play

Empire State EPIC

VOL 40-01:22

EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE

PRESIDENT'S MESSAGE

Nicole Berwald, MD FACEP
Associate Medical Director
Staten Island Univeristy Hopsital

Call to Action

I want to open my first President's Message by thanking Dr. Grams, our Immediate Past-President and all those that came before him for their hard work and dedication to New York ACEP. And thank you, our membership, for your engagement and contributions. We have a lot of work ahead of us as we embark on New York ACEP's 50th year. To accomplish our goals, we need you on our journey to make a difference for the emergency physicians and patients of New York State.

In my opinion there are several burning issues that I hope to engage you on, as we work with other medical specialty societies to create the most favorable landscape for emergency medicine.

Violence in our workspace is not a new concept. Gun violence and other threats have impacted many emergency departments across the country, and New York State is no exception. It is past time we become more vocal in our stance against acts of violence committed on Emergency Department (ED) staff. New York ACEP is committed to working with our legislators and regulators on proposals aimed to improve safety in healthcare settings.

A second charged issue on the national scene that has not spared us here in New York State, is scope of practice for nurse practitioners and physician assistants. For those familiar with the outcomes of the 2022 legislative session, we are behind the eight-ball and must pursue legislation that supports the safest, highest quality emergency care. Aligned with out parent organization[1], New York ACEP supports the physician lead team. There is a clear call to action for us to support our specialty and to develop a comprehensive understanding of what the current legislation and potential future changes mean to Emergency Medicine. I believe all emergency department patients should have their care overseen by a board-certified Emergency Physician. With several bills getting traction in Albany this past session, New York ACEP leadership is redoubling our efforts to educate legislators and the public on safe emergency care, for I fear within the current climate, the public may learn through failures in the system.

Additionally, we continue to face issues around reimbursement and fair compensation for the hard work we all do every day. As you may know, New York State has had a no surprise billing law since 2014 that has worked well, but with the initiation of the federal no surprises act, New York's law had to be reconciled with the new federal law. New York ACEP met with the Division of Financial Services regarding improvements to the regulations, as well as our legislators to advocate for fair arbitration for our specialty as well as increasing the Medicaid reimbursement for rates comparable with our neighboring states. We are likely to see continued pressure from insurers to try to drive down reimbursements as well as bad behavior around the prudent layperson standard. New York ACEP remains highly engaged on this issue and we need your help advocating for fair payment processes.

I urge you to read the Albany Update located at the end of this edition of EPIC. As we come off a somewhat disappointing legislative session, I am more energized than ever to work on behalf of emergency medicine and all of you, our members, to ensure the safest and most beneficial practice environment for both our patients and physicians.

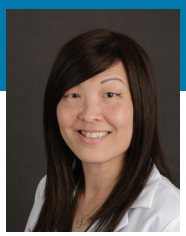
I do not write this in despair or to paint a bleak picture, but to motivate you as I and the New York ACEP leadership team are to engage on all levels to help drive the changes we need. I invite you engage in our committees and events as I think you will find them very rewarding both personally and professionally. Along the way we will provide information to enable you to take our message on the road yourselves. At New York ACEP we have a variety of venues to have your voice heard with opportunities to participate through advocacy, education, research, professional development and to provide input on our evolving practice environment

I am excited to be here with you. If ever there was a time for our voice to be heard, it is now.

Reference

1. https://www.acep.org/patient-care/policy-statements/guidelines-regarding-the-role-of-physician-assistants-and-nurse-practitioners-in-the-emergency-department/

SOUND ROUNDS



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Using Doppler to Distinguish Doppelgangers in Soft Tissue Swelling

Case Presentation

A 71-year-old female with past medical history of bicuspid aortic valve, status post open aortic valve replacement with bovine prosthesis eight weeks ago at an outside hospital, currently on apixaban, presented to the emergency department (ED) with increasing right sided chest wall mass and associated burning pain. Her surgery was complicated by a right sided hemothorax requiring chest tube placement and transfusion of six units of pRBCs while in the ICU. At discharge, she had a small area of swelling over the right chest wall next to the incision, which was thought to be a cyst or post-operative seroma. While visiting family, she noticed increased pain and swelling, which prompted her to present to our ED. She denied numbness, cough, fever, chills, palpitations, abdominal pain, nausea or vomiting.

On presentation, she was awake and in no acute distress. Her vital signs were blood pressure of 155/104 mmHg, heart rate of 68 beats/minute, respiratory rate of 18 breaths/minute, oxygen saturation of 95% on room air and a temperature of 98.6°F. Physical exam demonstrated a well healing midline sternotomy incision without dehiscence, purulence, erythema or edema. There was considerable swelling over the right chest wall in the right superior parasternal region, measuring approximately 12 cm x 10 cm without overlying skin changes. She had normal sensation over the lesion. The swelling was firm to palpation without tenderness.

Point-of-care ultrasound (POCUS) showed an extra-thoracic subcutaneous cystic structure with heterogenous echogenic contents (Figure 1), which was thought to be a possible hematoma or infected cyst. However, using color flow Doppler mode to further characterize the structure, the Emergency Medicine physicians identified bidirectional turbulent color flow or the "yin-yang" sign (Figure 2). Cardiac Surgery was immediately contacted and a CT chest with contrast identified the fluid collection as a pseudoaneurysm arising from the right internal mammary artery. The patient underwent successful embolization of the pseudoaneurysm by interventional radiology and was discharged home a few days later without any further complications.

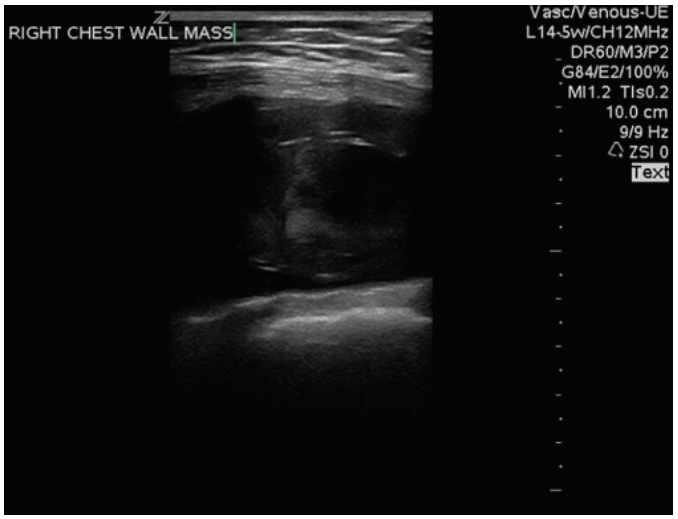

Figure 1. B-mode ultrasound image of the chest wall mass obtained with a linear transducer.

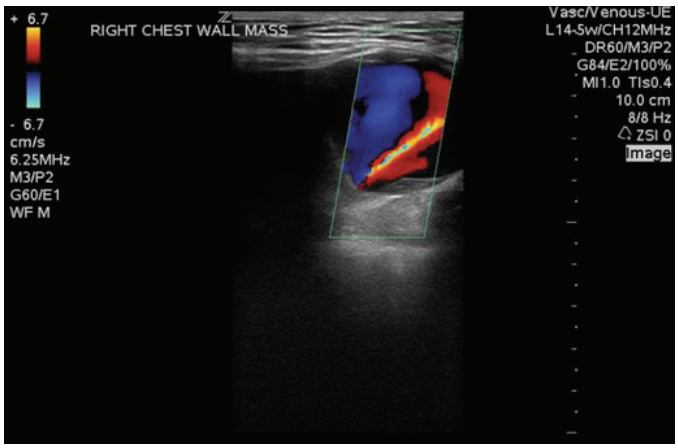

Figure 2. Color flow Doppler ultrasound of the chest wall mass identifying a pseudoaneurysm.

Discussion

Vascular injuries are an important consideration and diagnosis in the ED. Iatrogenic causes account for about one-third of all arterial injuries. Percutaneous procedures, sheath/stent placement and fibrinolytic therapy can all cause or contribute to vascular injury.[1] Vascular pathology is more readily considered and easily identified when there are findings such as rapidly expanding swelling or palpable pulsations on physical examination. However, it is important to always consider possible vascular pathology whenever evaluating for any skin and soft tissue complaint, as the aforementioned physical exam findings may not be present, as seen in our case. Skin and soft tissue complaints are very common ED presentations with a wide variety of causes such as cellulitis, abscess, cysts, lymphadenopathy and vascular pathology. POCUS is often used to identify if there is a fluid-filled structure that may require needle aspiration or incision and drainage. However, inadvertent entry and iatrogenic injury to any vascular structure may lead to serious bleeding complications. The Doppler functions of POCUS is an extremely useful tool in assisting with proper identification and management. In our case, the swelling and pain originally thought to be a persistent post-operative seroma was easily and quickly identified as a pseudoaneurysm, leading to expedited definitive care and avoiding further potential iatrogenic injury.

One of the most common presentations of suspected vascular injury is penetrating trauma. Indeed, 3% of all vascular injuries are caused by trauma such as stab wounds, gunshot wounds or penetrating debris from blasts.[2] For patients who present with hemodynamic instability or signs of vascular compromise (e.g. pulselessness, pallor, neurologic deficits), surgical exploration and repair is often the next required step after initial resuscitation. In the stable patient, angiography is often the imaging modality of choice and regarded as the gold standard.[1] However, given the potential radiation exposure, necessity of contrast agents, long duration and potential delays in obtaining CT and MR imaging, it is reasonable that ultrasound be strongly considered as an imaging modality in vascular injury patients. Fry et al. found, when compared to angiography, ultrasound had a specificity and sensitivity of 100%.[3] In penetrating gunshot wounds of the lower limbs, Montorfano et al. found 100% sensitivity and specificity of Doppler ultrasound for vascular injuries.[4]

Indications

- Skin and soft tissue swelling
- Mass
- Pain

Technique

- Use the linear high frequency probe
- Image in two planes, transverse and sagittal
- Use color flow Doppler mode to identify the presence of absence of blood flow
- Add pulsed wave Doppler mode to differentiate arterial versus venous blood flow

Pitfalls and Limitations

In soft tissue and vascular POCUS studies, high frequency linear transducers are used due to the higher resolution and lower penetration required for superficial structures.[5] As in all ultrasound imaging, it is important to visualize the structure of interest in both transverse and longitudinal planes. Additionally, color flow Doppler can assist in visualization of blood flow within the vessel.

While the utility of ultrasound for vascular injury has been successfully proven in many studies, it does unfortunately have shortcomings. For example, large hematomas, small pseudoaneurysms, bone, casts, burns, subcutaneous air, body habitus or large open wounds can present challenges for visualization of possible injury.[5] Additionally, many of these studies were performed with trained sonographers. Much of the diagnostic utility of ultrasound is user dependent.[6] As mentioned previously, specificity can be as high as 100% but have also been reported as low as 86%.[6]

Conclusion

Using POCUS with color flow Doppler mode to quickly and efficiently evaluate skin and soft tissue complaints is an easy and essential skill when treating patients in the ED and particularly helpful in identifying vascular injuries. Regardless of varying specificities and user experience, with diligent practice, the ED provider can quickly use POCUS to determine whether it is safe to enter any fluid-filled structure and avoid iatrogenic injury.

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1. Gaitini D, Razi NB, Ghersin E, Ofer A, et al. Sonographic Evaluation of Vascular Injuries. *J Ultrasound in Med*. 2008;27:95-107.
2. Martín TA. Traumatismos vasculares periféricos. *Rev Med Univ Navarra* 2005;492:24-31.
3. Bergstein JM, Blair JF, Edwards J, et al. Pitfalls in the use of color-flow duplex ultrasound for screening of suspected arterial injuries in penetrated extremities. *J Trauma* 1992;33:395-402.
4. Montorfano MA, Montorfano LM, Perez Quirante F, et al. The FAST D protocol: a simple method to rule out traumatic vascular injuries of the lower extremities. *J Crit Ultrasound*. 2017;9:8.
5. Montorfano L, Sarkissyan M, Wolfers M, et al. POCUS and POCDUS: essential tools for the evaluation and management of carotid artery pseudoaneurysms after a gunshot wound. *Ultrasound J*. 2020;12:35.
6. Davison BD, Polak JF. Arterial injuries: a sonographic approach. *Radiol Clin North Am*. 2004;42(2):383-396.

PRACTICE MANAGEMENT

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New York ACEP 2021 ED Director Forum Highlights - Part II

New York ACEP held its 2021 ED Director Forum virtually Friday May 7, 2021.

Litigation and medical malpractice, as well as the stress associated with these occurrences and ways to avoid being sued were topics at the forum. Here are highlights from last year's forum. The summary is presented in bulleted format.

The content of this summary is provided for informational purposes only and is not legal advice. You should consult an attorney if you have legal questions that relate to specific litigation and medical malpractice. New York ACEP does not recommend or endorse any specific actions, procedures, opinions or information contained herein.

The ABCs of OPMC and NPDB: From Reports to Investigations

Colleen McMahon ESQ and Alex Bateman ESQ

OPMC: Office of Professional Medical Conduct; NPDB: National Practitioner Data Bank

From the Hospital Perspective

What should you do if you have a physician who you think may possibly have committed misconduct?

Applying IRAC method during investigations

I-Issues and Investigation

- Identify the possible misconduct issues-for example: failure to escalate, failure to communicate, breach of hospital policies, jeopardy to patient health and wellbeing, failure to respond, etc.

R-Rules and Regulations

- Identify if there are hospital or state rules and regulations that have been violated-for example: EMTALA, HIPPA, Hospital Bylaws/Rules and Regulations, etc.

A-Application and Analysis

- Review documents including medical records, training materials that the physician would have taken (on-boarding), root cause analysis, review of interviews with witnesses, etc.

C-Conclusion and Corrective Actions

- Once the investigation is complete, determine the corrective action that will be applied to the physician-for example: verbal warning, written warning, letter of reprimand, suspension, termination, etc.

Who Participates in the Hospital Investigation?

Several individuals may participate in the investigation including Medical Directors, Departmental Chairs or Directors, Quality Assurance, Human Resources, Compliance, Security, Inside/Outside Counsel

What Hospital Policies and Procedures are in Play?

Policies and Procedures related to Department, Human Resources, Compliance, Quality, Medical Staff Bylaws/Rules and Regulations, etc.

What are the Legal and Regulatory Considerations?

Federal and state laws (HCQIA, Title VII, Title IX), ACGME, Joint Commission Standards, AMA Code of Ethics, Reporting obligations to OPMC and NPDB, etc.

What are the Investigators' Responsibilities?

- Interview ALL parties, including the complainant(s), the subject of the complaint and all witnesses
- Review all documentation
- Assess credibility and motives
- Review and consider prior acts and disciplinary actions
- Document all your findings
- Determine reporting needs

Ways to Promote Professional Behavior (PROACTIVE)

- Communicate expectations and ensure consistency
- Model behavior
- Require accountability
- Educate and and train
- Hold Ongoing and Focused Professional Practice Evaluations (OPPE/FPPE)
- Counsel and mentor
- Document every investigation (HR, Quality, Credentialing, Compliance, etc.)

Responding to Unprofessional Behavior (REACTIVE)

- Investigate first, document second, decide action third
- Remove from on-call schedule
- Issue verbal warning
- Issue letter of reprimand/warning
- Issue conditional letter of re-appointment
- Create last chance agreement
- Report to licensing and healthcare oversight agencies (OPMC, NPDB, OPD)
- Professional peer review
  - Probation/proctoring
  - Mandatory training and course work
  - Prospective (pre-treatment) case reviews
  - Reduction or modification of clinical privileges
  - Summary suspension
  - Suspension
  - Termination
  - Recommendation against re-appointment

When is a Report Required to OPMC?

NY Public Health Law 2803e(1)(a)-SHORT VERSION-Examples

Denial, suspension, restriction, or termination curtailment of privileges, training, employment, association, or certification of completion of training due to any of the following reasons: mental/physical impairment, incompetence, malpractice, misconduct, impairment of patient safety or welfare. Reporting is also necessary when a physician resigns from medical staff or withdraws an application to the medical staff in order to avoid imposition of disciplinary measures.

Under NYS law, all reports to OPMC must be made within 30 days. The hospitals must report incidents of possible misconduct but only OPMC can determine if professional misconduct is substantiated and only OPMC may take action on a physician's license.

When is a Report Required to the NPDB?

A hospital must query the NPDB as part of credentialing and privileging a physician (for example, when a physician is an initial appointment or reappointment to the medical staff).

Hospitals must report malpractice payments, a professional review action adversely affecting clinical privileges for more than 30 days that adversely affected or could affect patient safety, or surrender of clinical privileges while the physician is under an investigation relating to possible incompetence or improper professional conduct. There are a broad range of categories of misconduct. Some examples include:

- Abusive conduct towards staff, patient abuse, sexual misconduct, conduct evidencing ethical or moral unfitness, disruptive conduct, etc.

The Fall-out of Disruptive and Unprofessional Behavior

- Medical errors and near misses
  - ○ Medical malpractice
  - ○ Violation of EMTALA
  - ○ Distraction of staff from patient care, increased staff and patient anxiety, decreased engagement, poor communication among teams
  - ○ Joint Commission (2008): 70% of sentinel events trace back to poor communication
- Sexual workplace harassment and retaliation
  - ○ Employer liability under federal law
  - ○ Personal liability and for leaders as "aiders" and "abettors"
  - ○ Negative publicity
  - ○ Poor morale and staff turn-over
  - ○ Economic impacts from litigation, settlements, attorney's fees

From the Physician Perspective

Communication is critical among and between physicians, teams, nursing staff, patients and administration. Things may escalate to Human Resources, OPMC, NPDB, etc. when sometimes they don't have to escalate if there is appropriate communication. In the ED, work can be very stressful but communication is key. Lack of good communication leads to complaints, malpractice claims, reporting to agencies and other fall-outs.

If the physician understands the seriousness of the investigation early on, they can prepare for the interview and focus on the issues that will be raised. This may affect the outcome of the investigation. Take these investigations serious. Get counsel if needed to assist with these matters. Sometimes, having counsel may assist in what type of corrective action is issued and what is reported.

What Happens After a Physician is Reported to OPMC?

Investigation: OPMC will do their own investigation. OPMC has the ability to discipline the physician and can revoke a physician's license. An OPMC investigation will include requests (subpoenas) for medical records, hospital documentation, quality files, HR files, credentialing files, compliance reports, interviews with witnesses and an interview with the physician in question. OPMC may take months to complete an investigation.

Documentation Request: By the time OPMC requests information from the physician, they have already obtained all the needed information from the hospital. They will also ask the physician for his own office records (if that applies). When OPMC requests documentation, it is critical that the information sent to them is complete and accurate. The physician will have to attest (certification) will need to be completed. In the age of electronic records, this is a difficult challenge. Identifying the correct fields and notes to print.

Interview: A physician does not have to agree to be interviewed by OPMC. However, agreeing to interview with them is the right thing to do. The reason is because OPMC receives approximately 5,000-8,000 complaints per year. The vast majority of these are resolved, closed out and no action is taken. Usually during the interview, OPMC is convinced there was no misconduct. Very rare would counsel recommend not appearing for an interview. Usually this would happen when there is a very severe allegation or serious conviction. Another example might be if the physician would not handle him/her self well. Instead, counsel would draft a written statement instead. In the best-case scenario, there is a peer-to-peer interview.

Outcome: Internally, the investigator would then meet with an investigatory committee. This process is confidential and not reported to the public. After the investigatory committee, OPMC may resolve the issue and no action is given. On the other hand, an administrative warning may be given to the physician. This is not a disciplinary action. It is confidential and not public. If OPMC finds there was some type of professional misconduct, counsels will negotiate and attempt to settle (consent agreement). Corrective action may range from a censure and reprimand (minor action) to revocation of license (major action). In between, it may be probation, license suspension, monitoring, CME education, etc. Settlement agreement with OPMC is public and reportable to boards.

Administrative Hearing: If the matter cannot be settled, then there will be an administrative hearing. If the charges of misconduct are voted unanimously, then the charges will be public but the hearing will not be public. If the physician prevails, there is no public notification of that decision yet the charges still exist publicly. The hearing panel will have three members (one lay person and two physicians-one of which should be in the same field as the charged physician). There will also be an administrative judge. After the hearing, the physician may appeal the decision.

This entire process needs to be taken seriously. OPMC may also issue fines in addition to disciplinary sanctions.

If a physician is convicted of a crime, that is professional misconduct and will lead to an OPMC proceeding even if the crime was unrelated to the practice of medicine. This includes larceny, driving while intoxicated, etc.

There are about 48 different types of professional misconduct including failure to provide medical records, failure to respond to OPMC requests, etc.

DON'T LET OPMC NOTICES GET LOST IN THE MAIL WITH YOUR OTHER UNIMPORTANT MAIL! PAY ATTENTION AND RESPOND. TAKE THESE INQUIRIES SERIOUSLY. EVERY PHYSICIAN MUST UPDATE THEIR PHYSICIAN PROFILES! Also, I-STOP needs to be followed. DON'T WRITE PRESCRIPTIONS FOR FRIENDS OR FAMILIES. You need a medical record.

Panel Discussion

New York ACEP hosted a panel discussion during the 2021 ED Director Forum. The panel consisted of defense and plaintiff attorneys and an ED physician with experience in ED administration.

PRACTICE MANAGEMENT

Below is the selection of questions posed.

1. Question on OPMC interview: At the interview with OPMC, do only doctor in your specialty present or are they from various speacialties?

Answer: Not always. It is more likely to be of the same specialty if the complaint is heavy on the medical side.

2. Question on OPMC interview at the interview with OPMC, do you recommend going with someone?

Answer: Do not go to the interview alone. It is not transcribed. Always have an attorney with you.

3. Question on license revoking for alcohol/drug use: Is it true OPMC can't take your license away if you have a drug or alcohol problem?

Answer: False. If there is a reason to suspect that a physician was under the influence, it can be by itself grounds for loosing his/her license. CPH (Committee For Physician Health) via Medical Society of the State of New York works with OPMC and physicians (CPH provides non-disciplinary, confidential assistance to physicians, residents, medical students and physician assistants experiencing problems from stress and difficult adjustment, emotional, substance abuse and other psychiatric disorders, including psychiatric problems that may arise as a result of medical illness). Appropriate use and dealing with CPH will place an OPMC inquiry on hold while the physician is dealing with drug/alcohol/etc. issues. If the physician deals with these issues productively, it has influence on how OPMC cases are resolved.

4. Question on M&M case reviews: Should physicians be present or involved in discussion at the M&M?

Answer: OPMC is entitled to all notes, including M&M sessions, unless it is specifically attorney-client privileged. OPMC is obligated by law to maintain confidentiality of that information.

5. Question on how to avoid a complaint to OPMC

- Communicate
- Be nice
- Do not refuse hospital investigations - don't be belligerent. Participate in the investigation.

EDUCATION

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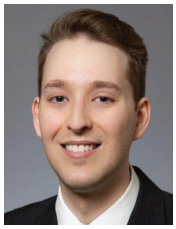

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Guest Author
Danielle Langan, DO
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Docendo Discimus - By Teaching We Learn

If a medical school education is like drinking from a firehose, then residency training is like being thrown down the Niagara. Rather than holding your breath and treading water, great attending physicians can be a life vest to help you capitalize on your adventure. Certain qualities and teaching styles of faculty stand out as effective and make shifts feel meaningful. Every patient encounter can be a learning opportunity and great preceptors allow that potential to be realized.

An example of this concept is taking an ordinary patient encounter and exploring how a routine scenario could present differently. Being challenged with hypothetical variations to a patient's presentation leads to deeper insight into the problem at hand. A great teacher may have the team consider a routine patient with chest pain- a frequent diagnosis- and brainstorm how the approach would be different if there was X in the history or Y in the work-up. This pattern of critical thinking prompts a broader consideration of alternative differentials and management pathways. These methods expand the patient encounter to deepen the learner's understanding of the case and encourage reflection about how a routine presentation could be more complex.

Likewise, having the team run through potential patient responses to a treatment strategy can have a similar effect. For example, asking "what would the team's next steps be?" after assessing patient response to a given therapy can facilitate thought and learning. These questions can serve as a review of routine methodical treatment pathways, but more importantly this foresight may lead to broader appreciation of the root problem. It prompts re-examination of the goals of treatment, especially in relation to what is being treated and why.

An effective teacher may have a less assertive approach to team management in order to foster a stronger learning experience. A good preceptor prevents a resident from making any mistakes. A great preceptor, however, can maintain a safe environment for a resident to make his or her own mistakes. This allows greater resident growth, akin to nurturing a growth versus fixed mindset. The attending physician may know a better approach to managing a given patient or performing a procedure. However, when the residents are allowed to form their own decision-making processes, including failed pathways, it creates an environment of trust and support to enhance knowledge translation. The preceptor can guide the resident in the proper direction using non-judgmental language to facilitate formative conversation. A supportive environment can then allow the learner to explore and learn through experiences that could be improved upon without compromising patient care.

The most crucial element of being a great teacher revolves around how the attending approaches the relationship with the team. An optimal approach emphasizes teamwork and open communication without a rigid hierarchy in which residents feel micromanaged. When the attending and resident physician work in tandem, the resident can gain a sense of ownership over patient care. The learner can then explore his or her own approach to patient management without feelings of insecurity. This type of relationship is essential in the start of residency as new interns develop their skills as well as styles of patient care. By the end of training, resident physicians will then feel better prepared for when they no longer have an attending readily available for guidance.

The word doctor is derived from the Latin verb "docere", meaning to teach. Teaching is a fundamental aspect of being a physician. Above are a few examples of the many habits that make certain attendings truly stand out as excellent educators, thereby guiding their residents as they negotiate their way down the Niagara. Taking advantage of every patient encounter can certainly be a challenge. Going through management and treatment options may at times be frustrating and require patience, but when teachers prioritize their role as an educator, it never goes unnoticed. The impact of being mindful in the approach to teaching medical trainees will perpetuate a cycle of positivity that inspires future generations of physicians to not only practice excellent medicine, but to teach excellent medicine.

SCIENTIFIC ASSEMBLY HIGHLIGHTS

The 2022 Scientific Assembly at the Sagamore Resort featured expert faculty members: Robert Hoffman, MD FAAT FRCP Edin FEAP-CCT; Sophia D. Lin, MD; Evie Marcolini, MD FACEP FCCM; Amal Mattu, MD FACEP and Gillian Schmitz, MD FACEP who wowed 300 emergency physicians from around the state. Twenty-five 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, Laura Iavicoli, MD FACEP was presented with the 2022 Advancing Emergency Care Award. Michael A. Redlener, MD FAEMS was presented the Michael G. Guttenberg Outstanding Contribution t EMS Award; Andy Jagoda, MD FACEP was presented the National Leadership Award; Brahim Ardolic, MD FACEP was presented with the Physician of the Year Award and Richard M. Cantor, MD FACEP was presendted the Edward Gilmore Lifetime Achievement Award

For more information on these awards, visit New York ACEP's website.

Leadership Elected

Congratulations are extended to the newly elected Board members: Robert Bramnate, DO FACEP, Good Samaritan Hosital Center; Penelop C. Lema, MD FACEP, NewYork Presbyterian Columbia; Laura Melville, MD, NewYork-Presbyterian Brooklyn and Joshua Moskowitz, MD MBA MPH FACEP, Jacobi/Montefiore Medical Center.

New Speaker Forum

Congratulations to Joel Park, MD MS FACEP NewYork-Presbyterian Weill Cornell, recipient of the award for best presentation for *Machine Learning and Artificial Intelligence in Medicine.*

Research Forum Winners

Tuesday's program included the Research Forum featuring oral and poster presentations. Congratulations to the following research pre[illegible]r category.

Oral Presentation

- Comparing Oral Ibuprofen and Acetaminophen to Either Medication Alone for Managing Acute Pain in Pediatric Emergency Department
  Aidin Masoudi, MD, Maimonides Medical Center

Poster Presentations

- Randomized Double-blind Trial Comparing 3 Doses of Oral Ibuprofen for Management of Acute Pain in Adult Emergency Department Patients
  Aidin Masoudi, MD, Maimonides Medical Center
- IPASS as a Handoff Tool Between Emergency Medical Services and ED Triage Nurses
  Tess Studholme, BSN RN, Maimonides Medical Center
- Risk Stratification of Older Adults Who Present to the Emergency Department With Syncope: The FAINT Score
  Marc Probst, MD MS FACEP, Mount Sinai Medical Center
- Development of a Novel Rapid Outpatient Strategy for TIA and Minor Stroke Patients
  Bernard Chang, MD PhD FACEP, Columbia University Medical Center

Mount Sinai took the Crown in the 5th Annual Resident Volleyball Challenge

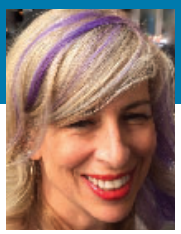
Nine residency programs competed for bragging rights in the Scientific Assembly volleyball tournament.

SCIENTIFIC ASSEMBLY HIGHLIGHTS

Residency Volleyball Challenge
July 7, 2022
Sagamore Resort on Lake George

2022 Volleyball Champions
Staten Island University Hospital

RESEARCH



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Chair, New York ACEP Research Committee

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Guest Author
Courtney Marie Cora Jones, PhD MPH
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How Medical Preprints are Changing the Publishing Landscape

Preprints in clinical research are a relatively new phenomenon, but preprints have existed in the basic sciences for decades and are accepted practice. It is important to note the term preprint is often as an umbrella term to describe an "open access" version of a scholarly work that is accessible to anyone via the internet free of charge. Generally, preprints are nascent research which has been organized into a manuscript format but has not yet undergone peer review. Sometimes these preprints represent incomplete or partial research while others are completed projects pending publication in a peer-reviewed journal. Usually, these manuscripts are uploaded to a large server and made directly available to the scientific community and lay public immediately with no review or minimal review looking for libelous or defamatory information.[1] However, the term preprint may also be used to describe an open access version of a research paper that has been published in a journal via the traditional publication process and is housed on an institutional or external server. Open access options remove the paywall behind which most published research resides and makes research more accessible, however, they often come with large up-front fees to make up for lost revenue to journals.

The first preprint server came online in 1991, arXiv, which publishes preprints in the fields of math and physics.[2] Several other preprint servers emerged in the field of biology and other basic sciences, but it was not until 2016 that large backers began to fund the preprint universe such as Elsevier, the Gates Foundation, Kaiser and the Alfred P Sloan foundation.[2] Shortly thereafter preprints came to the medical sciences in 2019 with the preprint server medRxiv, owned and operated by Cold Spring Harbor Laboratories and in partnership with BMJ. The COVID pandemic came right on the heels of medRxiv and the number of preprint articles skyrocketed due to the acute need to disseminate information about COVID-19 risk factors, treatment and prognosis. Less than six months into the COVID-19 pandemic, over 3,000 preprint articles were submitted by May 2020.[3] Preprints became extremely important during the pandemic in disseminating scientific and medical knowledge quickly and efficiently as situations changed almost daily. This was far faster than possible through the traditional peer review process. However, people started to notice a high rate of retraction and brought up concerns about the quality of research being disseminated to the public.[4] There has been evidence preprint articles led to public support of dubious medical treatments for COVID-19 such as ivermectin and hydroxychloroquine.[5] More recent developments include the ability to discover and cite medRxiv preprints in PubMed and some institutions, such as our own, are considering requiring faculty to submit articles to institutional or external preprint servers. With this growing phenomenon within medical research, it seems reasonable to discuss some of the merits and possible concerns surrounding preprints.

Preprints' rise in popularity seems to stem from several strong beneficial characteristics. Reporting results and data via the traditional publication process can be a slow and cumbersome process due to publisher formatting requirements, peer review backlogs, timeline to publication after article acceptance and author publication fees to provide an open access format for their research. The improved rapidity of publication via preprint servers as opposed to traditional journals is quite clear.

Publication bias is also well documented with studies showing null or negative findings less frequently accepted by many journals. During the COVID pandemic when preprint articles in medicine soared, fewer than 6% of those articles eventually went on to publication.[6] This would seem to suggest preprint publications are filling an important niche in scientific research by providing a home for unpublished but completed research. Proponents of preprints argue open access servers increase accessibility of research and leads to a more egalitarian landscape for reporting research and may generate greater interest in research by the lay public including patients, caregivers and the media.[7] While many traditional journals offer an open access option, this often comes with large fees charged to the author. While this option addresses accessibility issues for the lay public and patients by removing the paywall, it presents an equity concern for researchers. The open access option is often associated with large fees that are simply unaffordable to faculty and trainees without large grants. Nature journals recently announced an open access option for the shocking sticker price of $11,250 – nearly 20% the average salary of an EM resident. Additionally, even faculty and trainees at prestigious universities have difficulty accessing articles if their institution does not have full access to a specific journal. We will share one personal example from our work. The University of Rochester, where we both work, does not have access to the journal *Prehospital Emergency Care* necessitating frequent interlibrary loan requests for our collaborative EMS research. There are other more research specific benefits to consider as well. Some argue preprints offer up an extra layer of quality check by allowing informal peer review, quite literally, by peers in a public forum.

RESEARCH

Preprints also allow for early researchers to "stake a claim," on the research area by getting their results out more rapidly than through traditional publication. This may also allow for less duplication of efforts as researchers can have a clearer idea of the present landscape of a research topic, especially on topics that are rapidly evolving such as COVID-19.

The greatest disadvantage of preprint articles is clear. In the absence of a peer review process, there are significant concerns about the quality of research. Prior to COVID preprint articles were less common in medicine. But now, preprints are becoming common practice in clinical research. During COVID preprint servers had minimal screening processes in place before submission and publication of an article. This was demonstrated during the pandemic as we previously noted when many preprints were retracted or the findings were later found to be false resulting in potentially dangerous implications for clinical practice and public health. This process does appear to be changing, with several preprint servers now implementing more stringent processes to prevent publication of articles that appear to be in frank opposition to generally accepted medical axioms.[3] Though it is important to note these are voluntary screenings and not necessarily occurring across the board on all servers especially institutional and personal websites. These screenings also fall far short of a true peer review process meaning new research methods, including new statistical models or complex study designs are unlikely to be vetted by experts. As medical research continues to grow in complexity and "big data" studies become more common, there is a very real concern that in the absence of expert statistical and methodologic review, the validity of large complex studies will be difficult to ascertain. The media or lay public may give more credibility to a study that includes tens of thousands of subjects, even if that study is retrospective, has concerns of bias or uses novel unvalidated statistical methods. And that illustrates, perhaps, one of the most concerning problems with preprint servers; that unverified, unvetted results will be available to those of the public and media who may lack the training and skill to decern meaningful results. This could lead to sensationalizing results that are later found to be faulty or untrue, but there may be far less enthusiasm in publishing a retraction or correction to the story. As Sheldon et al put it, "Under the preprint system, one intrepid journalist trawling the servers can break a story; by the time other reporters have noticed, it's old news, and they can't persuade their editors to publish."[8]

So where does this leave us? Preprints clearly address many of the ongoing problems with publishing peer reviewed research. Proponents envision an egalitarian landscape where researchers can publish results in real time, spend less time and effort on duplicating results and are not beholden to massive publishing houses and their arbitrary rules and fees. This has become such a prominent view that some institutions, including our own, have begun to consider open access policies or guidelines setting expectations that faculty make all their scholarly work accessible to the public while still publishing in traditional journals. Our institutional open access policy was developed by a sub-committee of our Faculty Senate and revised in an iterative process incorporating feedback from faculty, librarians, senior leadership and counsel. The open access policy was approved in 2022 via a formal vote in the Faculty Senate. Many institutions are adopting similar policies and creating and managing their own preprint server as an alternative to the existing preprint servers. The future may look something like this, with every academic institution managing its own open access research platform, and in some ways, own and market the research occurring within its walls. However, it is also clear this same idyllic concept is rife with opportunities for abuse and more broadly for sowing confusion and discord. We all watched the very real consequences of this with both hydroxychloroquine and ivermectin during the COVID-19 pandemic. There is almost no doubt people have suffered as a result of false and misleading information during COVID that came from preprint articles. Regardless, it would appear preprints are here to stay and do offer benefits. We do not see any likely outcome in which we regress from what has now become a well-established practice. However, we as the research community need to be more involved, more vigilant and more forthright about our use of preprint articles. We should be setting guidelines and norms for use, avoiding preprint citations, when possible (or developing a system to identify preprints when we do) and clearly labeling preprint articles as lacking peer review. When media outlets and the public utilize preprint articles for sensational means, we need to be there to educate and denounce the use of these articles in this fashion. As physicians, when patients bring these articles to our attention, we should be compassionately educating them and not rolling our eyes when they "do the research." We are in a unique role as physicians and researchers, to change and mold the use of this new and developing mode of communication to benefit us and our patients and limit harm.

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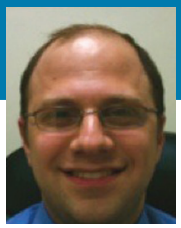
ASK THE EXPERTS



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Chair, Department of Emergency Medicine
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Interviewer
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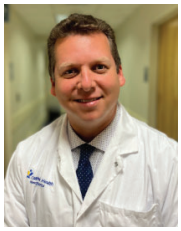

Interviewee
Louis Calderon, BSN RN CEN
Director of Nursing,
Mercy Hospital, Emergency Department

In a little change for the "Ask the Expert" section, I reached outside of our expert population and across the proverbial aisle to get the perspective of our nursing colleagues. As nursing staffing in New York has been upended for a number of reasons which will be mentioned, there is greater importance and need for the critical partnership and collaboration between emergency physicians and emergency nurses in providing safe and effective patient centered care. I had the honor and pleasure of interviewing our facilities Director of Emergency Nursing. Louis Calderon has dedicated his career to the care of the emergent patient in both the prehospital setting and through various emergency department environments. These have ranged from urban to suburban, community to academic sites and general Emergency Departments (EDs) to tertiary care trauma centers. He provides a wide perspective on the current state of emergency nursing and the importance of physician/nurse collaboration and partnership. This partnership in improving care and safety extends beyond the clinical floor interactions and up through the leadership team.

What lead you into emergency nursing and subsequently to ED nursing leadership?

I have always been interested in emergency medicine and emergency nursing. Before becoming a registered nurse, I worked for NYC*EMS for over 10 years. I worked the busy overnight shift in Times Square, before Times Square became Disneyland. While I enjoyed providing pre-hospital care, I always wondered what happened to the patient after I dropped them off at the hospital. Was the care I provided appropriate? What more could I have done? What more did the patient need? This led me to nursing. I started my nursing career working in Manhattan where I learned a lot. I later bought a house on Long Island where I worked for a large level 1 trauma center. I progressed in my nursing career and even worked as a flight nurse on the Suffolk County Police Department aviation unit.

While working as a staff nurse I progressed from staff nurse to triage nurse to nurse preceptor to charge nurse. This led me in my path to leadership. I have served in various leadership roles from both bedside leadership to administrative leadership. I am currently working as Director of Nursing for a mid-size suburban emergency department.

What do you view as the greatest challenges facing emergency nursing over the next 3-5 years?

There are many challenges facing emergency nursing today. The first challenge is staffing. It seems we had a severe nursing shortage about 10 years ago and then, fortunately, we were able to get through it. However, the cycle has returned and we are in another staffing crisis. I do not see this crisis resolving fast enough as there are a number of factors that were not present previously. COVID-19 played a major role as it scared people away from work in the ED. Many staff members quit due to burnout with the emergency department and pandemic pressures while many others left to other areas of nursing. The agency/travel nursing spectrum of staffing is also negatively affecting stable and consistent emergency department staffing. These agencies pay a much higher rate than the hospitals can pay in the long term. This incentive while damaging to consistent staffing is causing nurses to quit their hospital-based jobs to work for the agencies. They sign lucrative contracts both in-state and out-of-state. The staffing fluctuations created by these movement patterns leads to competition and hospitals having to pay these higher agency rates in short term cycles to try to maintain safe staffing.

Another challenge facing emergency nursing is the job itself. Heavy workload, exposure to violence and conflict and high-acuity patients contribute to a very challenging work environment. Obtaining high job satisfaction is a challenge we will face over the next 4-5 years.

How do you feel COVID has changed the emergency department and emergency nursing?

COVID-19 has changed the ED nursing game completely. When we first surged in 2020, the ED quickly became the epicenter for patients with COVID-19 entering the hospital. The ED nurses were forced to adapt to these new, highly-contagious patients while initially not knowing the risk they were facing and potentially bringing home. Policies and procedures were created, new information was disseminated and the ED staff were forced to adapt. Then things changed. Policies were continually revised, procedures changed, new information was disseminated, and the ED staff was forced to adapt yet again. This cycle continues today. Whether it be treatment guidelines, isolations instructions, new mandates or new emerging pathogens, the pace of change and knowledge to be situation ready has vastly increased. The ED staff's process and workflow was continually being redefined as the pandemic bore down on the ED. Staff members were forced to take on new roles and responsibilities they never had before and they did it successfully. The staff in the ED are a special breed of unique individuals. They take on all tasks asked with that "bring-it-on attitude". The ED nurses work with a level of teamwork not seen in other areas of nursing. The COVID-19 pandemic has put that teamwork to the highest test. Emergency department nurses across New York and the nation rose to the occasion and truly shined. In the ED this was probably most evident in our

area during the December 2020/January 2021 surge which primarily lead to the EDs being inundated rather than the entire hospital as we experienced during the initial months of the pandemic.

This rapid change and shift in workflow is having its effect on the ED nurses/staff. COVID-19 has exacerbated a situation that has plagued emergency departments. Overcrowding in the ED and lags in hospital throughput develop into admitted patients boarding in our ED acute beds. Patients are waiting hours in our EDs, increasing the workload for the ED nurses and staff. Boarding patients in the ED presents challenges for the ED and emergency nurses who are now dealing with the ongoing care of seriously ill patients after the acute ED workup and stabilization phase while also trying to keep up with the influx of patients arriving who need emergency care. This is a huge staff dissatisfier and leads to an unhealthy and potentially unsafe work environment. Patients being boarded in the ED rightfully become upset and frustrated, as do their family members. This often leads to both taking their anger out on the ED staff who have little to no control over the boarding crisis. Additionally, it creates a challenge in managing the influx of undifferentiated ED patients who also can grow frustrated with longer turnaround times and less ideal treatment locations within the crowded ED. These issues are known as triggers of workplace violence which is another staff dissatisfier and reason for attrition from emergency medical care employment.

What programs have you seen implemented to retain high quality nurses and recruit new talent?

We recently created an Emergency Nurse Residency Program, following the Emergency Nurses Association (ENA) guidelines. This focuses on new entry-level nurses as they transition into practice. The program incorporates key areas, such as leadership, patient outcomes and professional development. This program is designed to both teach and retain new nurses.

We also implemented steps to retain high quality nurses. We are very strategic during the hiring process and we get current nurses involved to participate in the interview process. We listen to feedback from the staff and use their feedback when selecting nurses to join our team. The goal being to obtain high levels of talent while building up our current staff with goals of increased staff satisfaction and retainment.

Another step we do to retain nurses is to actively work to address workload issues. The goal is to strategically plan and implement technology and workflow solutions to streamline the care process and identify and eliminate bottlenecks to patient care. The key to this is regular observation and communication with all clinical staff.

We also have our nurse manager work to develop positive connections with the staff. This does though, require time and communication. Our leadership team constantly and continually rounds with a purpose to address any issues or concerns in the moment, before they become bigger problems. Often issues that would otherwise fester or seem minor can be identified and brought directly to leadership for resolution. A key part of this process is reporting back to the staff what was identified, solutions implemented and seeking feedback to close the loop.

What actions or behaviors from physicians do you feel have most helped nursing and patient care and which, if any, made care more difficulty?

Building trust between physicians and nurses is really important today. With the patient in the center, the physicians and nurses work on finding a common ground to reach the patient's goal. It starts with understanding each other's role and what value each brings to the patient. That is how to develop trust. When that happens, nurses are proud of the care they can give.

How can emergency physician colleagues best support our ED nursing colleagues?

Emergency physicians can best support their ED nursing colleagues by rounding often and together with the ED nurses. I would like to implement "Lightening Rounds" in the ED where the MD/RN team rounds quickly at each bedside every 4-6 hours. Rounding helps in accomplishing team-based care while also helping with patient experience. The patient now has the perception of cooperation between the physician and nurse. A quick scripted review about the patient's status helps to make the rounds go more quickly, as rounding can often be time-intensive.

In my career I have almost always noticed a great relationship between ED nurses and ED physicians. There are great degrees of collaboration and respect between MDs and RNs. The ED physician needs to be open to listening to the ED nurses and trust the ED nursing assessments when their nursing intuition tells them something is "off" with the patient. Most ED physicians are both respectful of the ED nurses and thankful to have them by their side.

LEADERSHIP & ADVOCACY AWARD WINNER REFLECTIONS

Kessiena Gbenedio, MD, PGY-4
Emergency Medicine
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As a recipient of New York ACEP's Resident Leadership and Advocacy Award, I had the privilege of attending my first ACEP Leadership and Advocacy Conference (LAC), May 1-3, 2022. My excitement was palpable as it also marked my first time visiting the nation's capital and my first in person conference since COVID. LAC provides a terrific professional development opportunity to bring about change, in the realm of healthcare through political activity.

The conference started with a Health Policy Primer designed to give newcomers a sense of the nuances of the current landscape in policy with some historical context. It began to lay the framework I would use when it was time to lobby on the Hill. The value of this work really hit home as Senator Tim Kaine (D-VA) took to the podium to discuss the recent signing into law of the Dr. Lorna Breen Health Care Provider Protection Act, which will provide funding for programs and for research to improve the mental health of health care workers. Dr. Breen was one of my attendings and mentors as a woman in medicine interested in health care leadership and administration; it was a powerful moment to see her legacy continue.

The conference culminated with Lobby Day where emergency medicine physicians from around the country meet with the decision makers that influence our practice. This year's three topics were very apropos in the post-pandemic landscape; the focus was on improving protections and rights for emergency medicine physicians.

- Support for the Workplace Violence Prevention for Health Care and Social Service Workers Act (S.4182)
- Urging introduction of the ER Hero and Patient Safety Act to guarantee due process protections for all emergency physicians
- Calling for hearings to reform the flawed Medicare reimbursement system to ensure fair payments to physicians

The breakout session that resonated with me was when all the conference attendees organized into groups by state. I gathered with residents and attendings from New York to prepare talking points prior to meeting our congressional representatives on Capitol Hill. We each recounted stories of times we witnessed or experienced workplace violence. It became clear just how many of us had been personally impacted by violence in the emergency department and as physician leaders we each felt a duty to ensuring a safe work environment for all our colleagues That afternoon we all went into our meetings on one accord and ready to fiercely advocate not only for our patients but for our specialty.

I left the conference invigorated and determined to continue to build on the relationships formed with legislators and to become more actively involved in the yearlong work it takes to bring about change. I look forward to seeing you next year at the ACEP 2023 Leadership and Advocacy Conference!

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As emergency physicians, we are the only doctors in the United States mandated to care for every patient, at every time. We see threats to patients and to public health – from pandemics to violence – before any other members of the healthcare system. To me, this makes advocacy an integral part of our specialty: for our patients and for our ability to care for them safely. New York ACEP generously enabled me to further my advocacy career by attending ACEP's Leadership and Advocacy Conference (LAC) in Washington, DC, in May 2022.

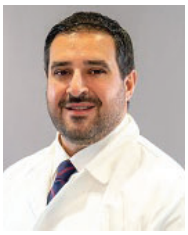
LAC began with experienced emergency physician advocates discussing everything from protecting Medicaid funding for maternal health, to running for office as an emergency physician. The keynote address by Admiral Rachel Levine, Assistant Secretary for Health for the U.S. Department of Health and Human Services, highlighted the role of the US Public Health Service in responding to the COVID-19 pandemic and ways forward for protecting public health over the coming decades. Senator Tim Kaine told the story of the Dr. Lorna Breen Health Care Provider Protection Act, which was signed into law this year. And throughout, emergency physicians came together over shared interests in advocacy and policy.

The final day of the conference gave us the opportunity to meet directly with our Representatives and Senators and their staff. The New York delegation had a productive meeting with Senator Schumer's Legislative Aide, where we discussed the issues of workplace violence in the emergency department and due process protections for physicians and addressed the perennial issue of Medicare payment reform. I also had the opportunity to meet with staff from my own representative's office. The following month, a House bill to address workplace violence in healthcare went to the Judiciary Committee, which my representative chairs; I hope that through our conversations, he will be better informed about its importance.

Earlier in my career, I advised governments around the world on health system strengthening and reform. That work showed me the role of technocratic solutions and data in improving public health. But LAC showed me the power of a clinical story to change policy for the better. The challenges we face in caring for patients every day becomes the fuel we can use to improve the health of our patients and make practice safer for our colleagues. I left LAC energized and better equipped to make meaningful change and I am grateful to New York ACEP for enabling me to attend.

Leadership Elected

Congratulations are extended to the newly elected Board members.



Robert M. Bramante, MD FACEP
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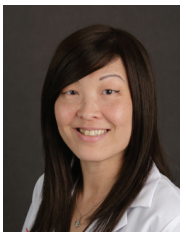

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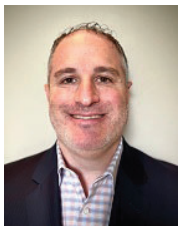

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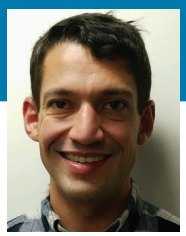
PEDIATRICS



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Pediatric Orthopedic Emergencies

A 5 year old boy with a history of asthma presents after a fall off of playground equipment. The accompanying parent did not see the accident but he was crying afterward and has been holding the left arm adducted across the chest and flexed at the elbow. On inspection you note swelling at the elbow joint. What is the most likely injury? What additional physical exam maneuvers will help guide the management of this patient?

Introduction

Pediatric orthopedic injuries seem to occur in a bimodal distribution, with peaks occurring at the beginning and end of the school year. Therefore, as the end of summer draws near, it is a good time to review one of the most common fractures you can expect to see in young patients: the supracondylar humeral fracture.

The evaluation and management of pediatric fractures can cause understandable anxiety for the general and pediatric emergency medicine practitioner. It is important to recall missed fractures represent a significant source of litigation and there exists a very real potential for lifelong complications from injuries, even those that are well-managed. Nevertheless, most of these patients will do well and caring for them (and their families) can be a rewarding experience.

This article will emphasize general principles in the approach to the pediatric patient with a suspected extremity injury and then cover important points in diagnosis and management of supracondylar fractures relevant to the general and pediatric emergency physician.

General Principles

Start at the Door

As with every patient, the physical exam starts as soon as you lay eyes on the patient, note how they hold their extremity and whether and how they are moving it. In the case of a lower extremity, observe if they are able to ambulate and if so, the degree to which the gait appears affected. Observe their interactions with caregivers and degree of pain and anxiety.

History is Critical

Obtain - as best you can - a thorough history of the trauma. In many instances the actual event was unwitnessed by parents or caregivers. It can be helpful to determine what they actually saw versus how much they are surmising from the circumstances. Attempt to determine the child's position at the time of injury. For example, a fall on an outstretched arm will lead you to suspect a different injury pattern than a fall on a flexed elbow.

The Exam is Everything

The provider may be tempted to, upon observing an obviously fractured extremity from the door, order relevant radiographs and move on to the next patient without conducting a thorough exam. This would be foolhardy. The most-feared complications of pediatric fractures are vascular injury and neurological compromise; these should be assessed in all children with a suspected fracture. Soft tissue injury should be noted, and if overlying the site of known or suspected fracture should be assumed to communicate with the bony fragments until proven otherwise. A full exam of the affected extremity should be undertaken with particular attention paid to the joints above and below. Immobilize the site of suspected injury with one hand while palpating and ranging the rest of the extremity to minimize pain.

While radiographs are commonly ordered for pediatric extremity complaints even in patients with low suspicion for fracture, the savvy clinician will be able to reliably diagnose most fractures based on history and physical exam.

Supracondylar Humeral Fracture

These are some of the most common traumatic fractures seen in children. They occur most commonly in young school-aged children and involve a fracture of the distal humerus. The mechanism is most commonly a fall on an outstretched arm. Diagnosis is often suspected based on mechanism and physical exam and confirmed with radiographs. However, multiple pitfalls in making the diagnosis exist.

Nondisplaced fractures may demonstrate no definite cortical disruption on radiographs, instead the diagnosis is based upon the presence of secondary signs of an elbow joint effusion. Blood from the fracture edges will accumulate in the joint capsule causing swelling and displacement of the fat pads that normally lie posteriorly in the olecranon fossa and anteriorly in along the distal humerus. This may result in a **posterior fat pad or anterior sail** sign on radiograph (figure 1). Ultrasound of the olecranon fossa may also reveal elevation of the posterior fat pad.

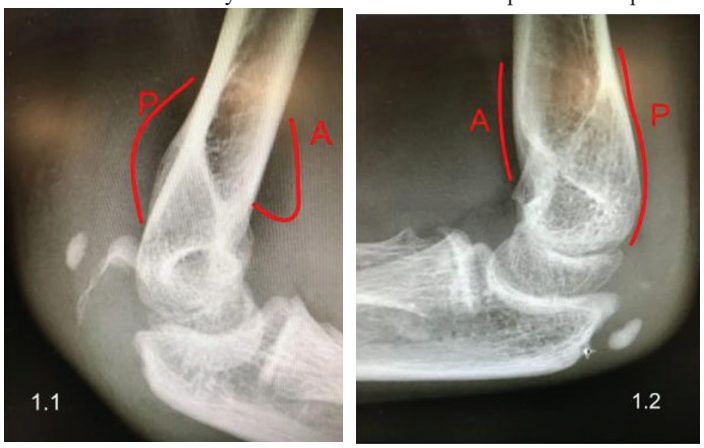

Figure 1 – Anterior and Posterior Fat Pads. Affected (fig 1.1) and unaffected (fig 1.2) elbows of a child with olecranon fracture. Note in fig 1.1 radiolucent fat that has been elevated by the elbow joint effusion outlined by lines (P) and (A). On the unaffected side there is no visible fat posteriorly (P) and a minimal fat pad anteriorly (A) that does not extend far from the anterior humeral border.

PEDIATRICS

In the immature pediatric elbow multiple bony ossification centers develop and fuse during childhood (Table 1). Fracture fragments may be mistaken for ossification centers. It is worthwhile to recall the order and age at which ossification centers develop and make sure one would expect to see them in the patient at hand. If uncertainty exists, it is reasonable to obtain comparison views of the contralateral extremity.

Table 1 - Ossification Centers of the Pediatric Elbow

Ossification Center	Age at Ossification	Age at Fusion
Capitellum	1	12
Radial Head	4	15
Medial Epicondyle	6	17
Trochlea	8	12
Olecranon	10	15
Lateral Epicondyle	12	12

Supracondylar fractures may be classified based on the degree of displacement of the fracture fragments (Table 2). For the emergency physician it is most relevant to determine if the fracture is displaced or non-displaced, as this will have a significant impact on patient counseling and urgency of orthopedic follow-up. Posterior displacement is most common, it may be ascertained by drawing a line parallel to the anterior humerus. In a child > 5 this **anterior humeral line** should bisect the middle third of the capitellum on a lateral radiograph (Figure 2). In younger children the anterior humeral line should cross the capitellum, but the exact relationship may be more variable. If the anterior humeral line crosses anterior to the capitellum, this suggests posterior displacement of the fracture fragment. It is important to ensure a true lateral radiograph is obtained.

Table 2 - Bauman Classification of Supracondylar Fractures

Type I	Nondisplaced	Plaster Immobilization
Type II	Displaced with intact dorsal periosteum	Plaster immobilization or closed reduction and percutaneous pinning
Type III	Complete periosteal disruption, usually displaced in multiple planes	Closed or open reduction, percutaneous pinning

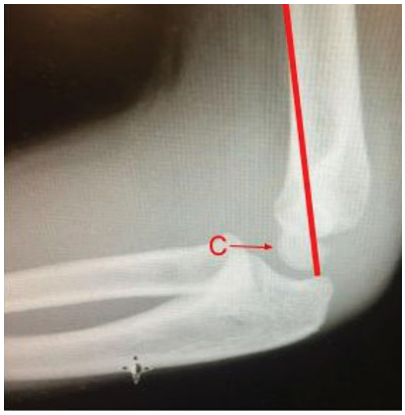

Figure 2 – Nondisplaced supracondylar fracture. Anterior humeral line (A) intersects the capitellum (C) in a 4-year-old child.

Median and radial nerve injuries may occur as a result of supracondylar fractures. Assessment of function should be performed as part of the physical exam. The most commonly injured nerve is the **anterior interosseous** (AIN) branch of the median nerve. Function can be tested by having the child make the OK sign by touching the distal phalanx of the thumb and index finger. The AIN allows flexion at the thumb interphalangeal joint and distal interphalangeal joint of the index finger. If injured, the patient will still be able to oppose the thumb against the index finger but not touch the tips together (Figure 3). Median nerve function can be tested by assessing sensation at the volar index finger. Radial nerve injury can be assessed by having the patient extend at the wrist or give a thumbs-up; inability to perform either suggests radial nerve injury. Presence of neurological compromise should be documented. Most isolated nerve injuries represent a neuropraxia that will resolve without nerve exploration.

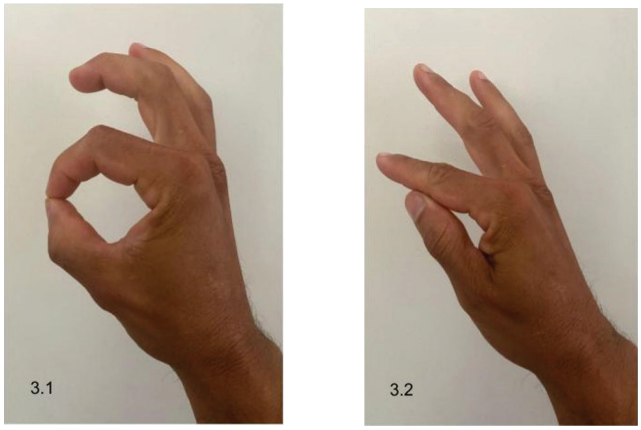

Figure 3 – Test of Anterior Interosseous Nerve (AIN). Normal "OK" sign (fig 3.1) with flexion of thumb and index IP joints. Abnormal (fig 3.2) with absent flexion at IP joints and inability to contact distal tip of thumb and index finger.

Vascular compromise is more challenging. The hand is supplied by rich collateral circulation, so perfusion may be maintained despite an arterial injury. The provider should assess presence of both radial and ulnar pulses by palpation, if non-palpable then it is reasonable to attempt to doppler them. Perfusion should be assessed by making note of the color and temperature of the hand, as well as capillary refill. A warm pink

conitnued on page 22

NEW YORK ACEP
American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Exemplary Commitments to Physician Well-Being Award Nominations Open

This award recognizes Departments and Residency Programs demonstrating exemplary physician well-being through operations, social functions, diversification, equity, education and/or environment.

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Strategizing About Care for Behavioral Health Patients in the Emergency Department

Emergency physicians play a vital role in the initial assessment and management of patients with mental health symptoms. Behavioral complaints such as depression with or without suicidal ideation is commonly evaluated in the Emergency Department (ED). Data from the United States Public Health Service show, annually, nearly 600,000 individuals are evaluated in EDs for suicide attempts, with a population-based annual rate ranging from 163.1 to 173.8 per 100,000.[1,2] The number of patients with suicidal ideation is even larger, accounting for a significant proportion of chief complaints seen across both community and academic EDs.

While patients may come in explicitly expressing some thoughts or intention of self-injury, at times, behavioral complaints may be less apparent. For example, in the ED, depression may manifest in seemingly unrelated somatic complaints, such as unexplained chest pain.[3,4] Work in one previous study of ED patients presenting for acute, unexplained chest and somatic complaints, found approximately 23% met criteria for a major depressive episode.[5] Additionally, unique social and cultural differences among patients presenting to the ED for the manifestation of depression may make the diagnosis of depression symptoms a challenge. Advanced aged patients may also have symptoms of depression potentially misinterpreted as early dementia and vice versa, making the detection of depression in such patients particularly challenging.[6,7]

The evaluation of a patient for behavioral health complaints benefits from emergency clinicians maintaining a flexible and compassionate approach to the patient with a primary focus on safe disposition and appropriate follow-up plan. While many of such patients may be managed safely on an outpatient basis, some patients present with such debilitating symptoms that they warrant hospitalization. A multispecialty collaborative approach with psychiatry is crucial. While some EDs may not have immediate access to behavioral health specialty, discussion of such specialists provides valuable input and may help with coordinating disposition and placement for patients needing inpatient or short stay admissions. Below are some common scenarios and strategies in tackling this complex multi-faceted behavioral crisis in the acute care setting.

"The patient didn't really mention anything about wanting to hurt himself and I didn't want to bring up if he had a specific plan or action, as I worry it may actually give him ideas and potentially encourage him to go through with it."

Past work has found direct questioning about self-injury or thoughts of suicide does not result in an increase in suicidal ideation in patients; on the contrary, for many patients, it is only through direct questioning the emergency clinician is able to assess suicide risk.

This patient is a "frequent flyer" and comes to our ED intoxicated and leaves when sober. He mentioned he wanted to jump off a bridge earlier when he was intoxicated but I thought he was just intoxicated and wanted to sleep."

Individuals with housing instability as well as patients who frequently present to the ED may at times be broadly overlooked or have some of their complaints minimized. There is an increased incidence and prevalence of suicide and depression among vulnerable individuals, particularly those with substance abuse issues; it is important to perform a full assessment and exam of all patients and to re-evaluate when sober to assess whether the behavioral complaints are still present.

"The patient just got diagnosed with metastatic bone cancer and she told us she felt life was over and she wanted to die. I thought it was normal to feel like that after getting such a devastating diagnosis."

Patients with significant personal/life stressors will often present with acute depressive symptoms and at times, even thoughts of self-injury. While taking their unique social context in mind, a thorough psychiatric and safety evaluation should be made by the emergency clinician when seeing these patients, with an emphasis on the safety of the patient.

"I thought he was just making a big gesture or show for attention when he told his girlfriend he was thinking of hurting himself."

Statements of suicide or self-injury, however casual the context or tone, warrant serious investigation and questioning. While not all patients who make such statements ultimately require a psychiatric hospitalization, emergency clinicians should evaluate the patient's ability to maintain safety for themselves as well as others and to involve psychiatry expertise when necessary.

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continued from page 18

hand is well perfused, a cold white one is not. Delayed capillary refill compared to the non-affected extremities suggests impaired perfusion. Any sign of vascular compromise should prompt emergent orthopedic consultation; most cases are due to arterial spasm and improve after reduction, though open vascular exploration may be required.

Volkman's ischemic contracture is a (mostly) historical and feared complication of supracondylar fractures. It results from ischemia and necrosis of the flexor muscles leading to fibrosis and contracture and occurs secondary to untreated forearm compartment syndrome. It is now rarely seen. Compartment syndrome may be seen with any fracture pattern, though is more common in severely displaced fractures, those associated with high energy mechanisms of injury, and concomitant ipsilateral forearm fractures. Compartment syndrome may also occur as a complication of splinting if applied too tightly or if the elbow is immobilized in hyperflexion.

Closed Garland Type I fractures that are not associated with neurovascular compromise can be managed with plaster immobilization and orthopedic follow up for repeat radiographs. The emergency physician may apply a posterior long-arm splint with the forearm held in neutral. In describing management strategies for supracondylar fractures, Gartland suggested the extremity be splinted at 75 - 80 degrees of flexion; modern authors have suggested splinting at 90 degrees of flexion, either way, hyperflexion is to be avoided. Patients have close orthopedic follow-up and cautioned to return if persistent or worsening pain.

Displaced fractures should be managed with emergent orthopedic consultation to assess the need for and timing of operative intervention. Depending on the clinical circumstances and practice environment this may involve phone consultation, emergent ED consultation or transfer to a center with specialty capabilities. Given the association of the fracture vascular injuries and the risk of compartment syndrome, patients are typically admitted. Historically Gartland type III fractures were treated as surgical emergencies with immediate reduction, however some authors have suggested that a delay of up to 12-18 hours may be safe.

Calendar

September 2022

8 Practice Management Conference Call, 1:00 pm
14 Education Committee Conference Call, 2:45 pm
14 Professional Development Conference Call, 3:30 pm
14 Academy of Clinical Educators, Zoom Lecture, 4:30 pm
15 EMS Committee Conference Call, 2:30 pm
16 Board of Directors Conference Call; 11 am - 3:00 pm
21 Government Affairs Conference Call, 11:00 am
21 Emergency Medicine Resident Committee Conference Call, 2:00 pm
21 Research Committee Conference Call, 3:00 pm
29-30 ACEP Council Meeting, San Francisco, CA

October 2022

1 New York ACEP Reception, Hyatt Union Square, San Francisco, 6-7 pm
12 Education Committee Conference Call, 2:45 pm
12 Professional Development Conference Call, 3:30 pm
13 Practice Management Conference Call, 1:00 pm
19 Government Affairs Conference Call, 11:00 am
19 Emergency Medicine Resident Committee Conference Call, 2:00 pm
19 Research Committee Conference Call, 3:00 pm
20 EMS Committee Conference Call, 2:30 pm

November 2022

9 Education Committee Conference Call, 2:45 pm
9 Professional Development Conference Call, 3:30 pm
9 Academy of Clinical Educators Zoom Meeting; 4:30 pm
10 Practice Management Conference Call, 1:00 pm
16 Government Affairs Conference Call, 11:00 am
16 Emergency Medicine Resident Committee Conference Call, 2:00 pm
16 Research Committee Conference Call, 3:00 pm
17 EMS Committee Conference Call, 2:30 pm

December 2022

8 Practice Management Conference Call, 1:00 pm
14 Education Committee Conference Call, 2:45 pm
14 Professional Development Conference Call, 3:30 pm
15 EMS Committee Conference Call, 2:30 pm
16 Board of Directors Conference Call; 12-1:30 pm
21 Government Affairs Conference Call, 11:00 am
21 Emergency Medicine Resident Committee Conference Call, 2:00 pm
21 Research Committee Conference Call, 3:00 pm

NEW YORK STATE OF MIND

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

Patients' Perspectives on Emergency Department COVID-19 Vaccination and Vaccination Messaging Through Randomized Vignettes.

Waxman MJ(1), Ray M(2), Schechter-Perkins EM(3), Faryar K(4), Flynn KC(2), Breen M(2), Wojcik SM(5), Berry F(6), Zheng A(1), Ata A(1), Lerner EB(7), Lyons MS(4), McGinnis S(2); Department of Emergency Medicine, Albany Medical College; Public Health Rep; 2022 Jul-Aug;137(4):774-781.

OBJECTIVES: Emergency departments (EDs) could play an important role in the COVID-19 pandemic response by reaching patients who would otherwise not seek vaccination in the community. Prior to expanding COVID-19 vaccination to the acute care setting, we assessed ED patients' COVID-19 vaccine status, perspectives, and hypothetical receptivity to ED-based vaccination.

METHODS: From January 11 through March 31, 2021, we conducted a multisite (Albany Medical Center, Boston Medical Center, Buffalo General Hospital, University of Cincinnati Medical Center, and Upstate Medical Center), cross-sectional survey of ED patients, with embedded randomization for participants to receive 1 of 4 vignette vaccination messages (simple opt-in message, recommendation by the hospital, community-oriented message, and acknowledgment of vaccine hesitancy). Main outcomes included COVID-19 vaccination status, prior intention to be vaccinated, and receptivity to randomized hypothetical vignette messages.

RESULTS: Of 610 participants, 122 (20.0%) were vaccinated, 234 (38.4%) had prior intent to be vaccinated, 111 (18.2%) were unsure as to prior intent, and 143 (23.4%) had no prior intent to be vaccinated. Vaccine hesitancy (participants who were vaccine unsure or did not intend to receive the vaccine) was associated with the following: age <45 years, female, non-Hispanic Black, no primary health care, and no prior influenza vaccination. Overall, 364 of 565 (64.4%; 95% CI, 60.3%-68.4%) were willing to accept a hypothetical vaccination in the ED. Among participants with prior vaccine hesitancy, a simple opt-in message resulted in the highest acceptance rates to hypothetical vaccination (39.7%; 95% CI, 27.6%-52.8%).

CONCLUSIONS: EDs have appropriate patient populations to initiate COVID-19 vaccination programs as a supplement to community efforts. A simple opt-in approach may offer the best messaging to reach vaccine-hesitant ED patients.

A Multi-Media Digital Intervention To Improve the Sexual and Reproductive Health of Female Adolescent Emergency Department Patients.

Chernick LS(1), Santelli J(2), Stockwell MS(2), Gonzalez A(1), Ehrhardt A(3), Thompson JLP(4)(5), Leu CS(5), Bakken S(6), Westhoff CL(7), Dayan PS(1); Department of Emergency Medicine, Columbia University Medical Center, New York; Acad Emerg Med; 2022 Mar;29(3):308-316.

BACKGROUND: Adolescent females presenting to emergency departments (EDs) inconsistently use contraceptives. We aimed to assess implementation outcomes and potential efficacy of a user-informed, theory-based digital health intervention developed to improve sexual and reproductive health for adolescent females in the ED.

METHODS: We conducted a pilot-randomized controlled trial of sexually active female ED patients age 14-19 years. Participants were randomized to the intervention Dr. Erica (Emergency Room Interventions to improve the Care of Adolescents) or usual care. Dr. Erica consists of an ED-based digital intervention along with three months of personalized and interactive multimedia messaging. We assessed the feasibility, adoption, and fidelity of Dr. Erica among adolescent female users. Initiation of highly effective contraception was the primary efficacy outcome.

RESULTS: We enrolled 146 patients; mean (±SD) age was 17.7 (±1.27) years and 87% were hispanic. Dr. Erica demonstrated feasibility, with high rates of consent (84.4%) and follow-up (82.9%). Intervention participants found Dr. Erica acceptable, liking (98.0%, on Likert scale) and recommending (83.7%) the program. A total of 87.5% adopted the program, responding to at least one text; a total of 289 weblinks were clicked. Dr. Erica demonstrated fidelity; few participants opted out (6.9%) and failed to receive texts (1.4%). Contraception was initiated by 24.6% (14/57) in the intervention and 21.9% (14/64) in the control arms (absolute risk difference [ARD] = 2.7%, 95% confidence interval [CI] = -12.4% to 17.8%). Participants receiving Dr. Erica were more likely to choose a method to start in the future (65.9% [27/41]) than controls (30.0% [15/50]); ARD = 35.9%, 95% CI = 16.6% to 55.1%).

CONCLUSIONS: A personalized, interactive digital intervention was feasible to implement, acceptable to female ED patients and demonstrated high fidelity and adoption. This ED-based intervention shows potential to improve contraception decision making.

How Informal Healthcare Providers Improve Uptake of HIV Testing: Qualitative Results From a Randomized Controlled Trial.

Ponticiello M(1)(2), Mwanga-Amumpaire J(3), Tushemereirwe P(3), Nuwagaba G(3), Nansera D(4), King R(5), Muyindike W(4), Sundararajan R(1)(2); Weill Cornell Department of Emergency Medicine, New York; AIDS; 2022 Jul 1;36(8):1161-1169.

OBJECTIVE: Uganda is HIV-endemic with a prevalence of 5.7%. Lack of epidemic control has been attributed to low engagement with HIV testing. Collaborating with informal healthcare providers, such as traditional healers, has been proposed as a strategy to increase testing uptake. We explored acceptability and implementation of an HIV testing program where traditional healers delivered point-of-care testing and counseling to adults of unknown serostatus (clinicaltrials.gov NCT#03718871).

METHODS: This study was conducted in rural, southwestern Uganda. We interviewed participating traditional healers (N=17) and a purposive sample of trial participants (N=107). Healers were practicing within 10km of Mbarara township, and 18+ years old. Participants were 18+ years old; sexually active; had received care from participating healers; self-reported not receiving an HIV test in prior 12months; and not previously diagnosed with HIV infection. Interviews explored perceptions of a healer-delivered HIV testing model and

were analyzed following a content-analysis approach.

RESULTS: Most participants were female individuals (N=68, 55%). Healer-delivered HIV testing overcame structural barriers, such as underlying poverty and rural locations that limited use, as transportation was costly and often prohibitive. Additionally, healers were located in villages and communities, which made services more accessible compared with facility-based testing. Participants also considered healers trustworthy and 'confidential'. These qualities explain some preference for healer-delivered HIV testing, in contrast to 'stigmatizing' biomedical settings.

CONCLUSION: Traditional healer-delivered HIV testing was considered more confidential and easily accessible compared with clinic-based testing. Offering services through traditional healers may improve uptake of HIV testing services in rural, medically pluralistic communities.

Intranasal Ketorolac Versus Intravenous Ketorolac for Treatment of Migraine Headaches in Children: A Randomized Clinical Trial.

Tsze DS(1), Lubell TR(1), Carter RC(1), Chernick LS(1), DePeter KC(1), McLaren SH(1), Kwok MY(1), Roskind CG(1), Gonzalez AE(1), Fan W(2), Babineau SE(3), Friedman BW(4), Dayan PS(1); Department of Emergency Medicine, Division of Pediatric Emergency Medicine, Columbia University College of Physicians and Surgeons, New York; Acad Emerg Med; 2022 Apr;29(4):465-475.

BACKGROUND: Intravenous ketorolac is commonly used for treating migraine headaches in children. However, the prerequisite placement of an intravenous line can be technically challenging, time-consuming, and associated with pain and distress. Intranasal ketorolac may be an effective alternative that is needle-free and easier to administer. We aimed to determine whether intranasal ketorolac is non-inferior to intravenous ketorolac for reducing pain in children with migraine headaches.

METHODS: We conducted a randomized double-blind non-inferiority clinical trial. Children aged 8-17 years with migraine headaches, moderate to severe pain, and requiring parenteral analgesics received intranasal ketorolac (1 mg/kg) or intravenous ketorolac (0.5 mg/kg). Primary outcome was reduction in pain at 60 min after administration measured using the Faces Pain Scale-Revised (scored 0-10). Non-inferiority margin was 2/10. Secondary outcomes included time to onset of clinically meaningful decrease in pain; ancillary emergency department outcomes (e.g. receipt of rescue medications, headache relief, headache freedom, percentage improvement); 24-h follow-up outcomes; functional disability; and adverse events.

RESULTS: Fifty-nine children were enrolled. We analyzed 27 children who received intranasal ketorolac and 29 who received intravenous ketorolac. The difference in mean pain reduction at 60 min between groups was 0.2 (95% CI -0.9, 1.3), with the upper limit of the 95% CI being less than the non-inferiority margin. There were no statistical differences between groups for secondary outcomes.

CONCLUSIONS: Intranasal ketorolac was non-inferior to intravenous ketorolac for reducing migraine headache pain in the emergency department.

Take-Pause: Efficacy of Mindfulness-Based Virtual Reality as an Intervention in the Pediatric Emergency Department.

Butt M(1), Kabariti S(1), Likourezos A(1), Drapkin J(1), Hossain R(1), Brazg J(1), Motov S(1); Department of Emergency Medicine, Maimonides Medical Center, Brooklyn; Acad Emerg Med; 2022 Mar;29(3):270-277.

BACKGROUND: Emergency department (ED) visits are known to be anxiety-ridden and stress-provoking experiences especially in the pediatric population. Distraction techniques have been used as a means to reduce anxiety and stress thereby facilitating care in the ED and making the visit less unpleasant. Our study aimed to evaluate the effectiveness of an active and immersive distraction technique, using a mindfulness-based virtual reality (VR) program (Take-Pause), to alleviate anxiety in pediatric ED patients.

METHODS: A prospective, randomized, single-blinded study, evaluating ED patients aged 13-17 years with a chief complaint of acute pain was conducted. Patients were randomized either to the active distraction intervention (VR group), utilizing the VR headset for 5 min, or to the passive distraction intervention (iPad group), playing on an iPad for 5 min. The primary outcome was a difference in the change in anxiety scores on the Spielberger State-Trait Anxiety Inventory between the two groups. Secondary outcomes included a difference in pain scores, respiratory rate, and heart rate between the groups.

RESULTS: A total of 110 subjects were enrolled. At 15 min, the mean anxiety score for the VR group improved by 10 points versus 6 points in the iPad group ($p < 0.001$; 95% confidence interval = 0.44 to 7.6). There was no statistical significance in the reduction of pain scores ($p = 0.953$) and respiratory rates ($p = 0.776$) between the groups. Patients enrolled in both groups did not experience any adverse effects.

CONCLUSION: Take-Pause, offering an active and immersive distraction technique, is more effective than a passive distraction approach to lower anxiety levels in adolescent ED patients.

Learning Outcomes of High-Fidelity Versus Table-Top Simulation in Undergraduate Emergency Medicine Education: Prospective, Randomized, Crossover-Controlled Study.

Offenbacher J(1), Petti A(1), Xu H(1), Levine M(1), Manyapu M(1), Guha D(1), Quint M(1), Chertoff A(1), Restivo A(1), Friedman BW(1), Silverberg J(1); Albert Einstein College of Medicine, Department of Emergency Medicine at the Jacobi and Montefiore Hospitals, Bronx; West J Emerg Med; 2022 Jan 3;23(1):20-25.

INTRODUCTION: Over the last several decades simulation, in both graduate and undergraduate emergency medicine education, has continued to develop as a leading and highly effective teaching modality. Limited research exists to evaluate the efficacy of low-fidelity (table-top) simulation, as compared to high-fidelity standards, as it relates to medical knowledge learning outcomes. We sought to assess the efficacy of a low-fidelity simulation modality in undergraduate emergency medicine education, based on quantitative medical knowledge learning outcomes.

METHODS: A prospective, randomized, crossover-control study comparing objective medical knowledge learning outcomes between simulation modalities. Analysis was designed to evaluate for the statistical equivalence of learning outcomes between the two cohorts. This was done by compar-

ing a calculated 95% confidence interval (CI) around the mean difference in post-test scores, between experimental and control modalities, to a pre-established equivalence margin.

RESULTS: Primary outcomes evaluating student performance on post-test examinations demonstrated a total cohort CI (95% CI, -0.22 and 0.68). Additional course-subject subgroup analysis demonstrated non-inferior CIs with: Shortness of Breath (95% CI, -0.35 and 1.27); Chest Pain (95% CI, -0.53 and.94); Abdominal Pain (95% CI, -0.88 and 1.17); Cardiovascular Shock (95% CI, -0.04 and 1.29). Secondary outcome analysis was done to evaluate medical knowledge acquisition by comparing the difference in pre and post-test examination between the cohorts. CI of the full cohort ranged from (95% CI, -0.14 and 0.96).

CONCLUSION: The student's performance on quantitative medical-knowledge assessment was equivalent between the high-fidelity control and low-fidelity experimental simulation groups. Analysis of knowledge acquisition between the two groups also demonstrated statistical equivalence.

A Randomized, Placebo-Controlled Study of Intranasal Fentanyl as an Analgesic Adjunct for Incision and Drainage of Abscess.

Latev A(1), Baer J(1), Sharpe S(1), Gupta C(1), Feliciano C(1), Friedman BW(1); Department of Emergency Medicine, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx; J Emerg Med; 2022 Mar;62(3):291-297.

BACKGROUND: Incision and drainage (I&D) of abscesses is one of the most painful procedures performed in emergency departments (EDs).

OBJECTIVE: We tested the following hypothesis: The addition of intranasal fentanyl to the standard practice of local infiltration with lidocaine would provide better pain control than lidocaine alone for adult ED patients undergoing I&D.

METHODS: This was a randomized, double-blind study. Participants received 2 µg/kg of intranasal fentanyl or a comparable amount of intranasal water in addition to local lidocaine infiltration. The primary outcome, which we assessed immediately after the I&D was completed, was a summary 0-10 pain score for which we asked study subjects to provide a number depicting their entire experience with the procedure.

RESULTS: During a 19-month enrollment period, we screened 176 patients for eligibility and enrolled 49; 25 received placebo and 24 received fentanyl. Baseline characteristics were comparable. Mean (standard deviation) summary pain scores were as follows: fentanyl 6.2 (3.3) and placebo 7.0 (3.2). The 95% confidence interval for a rounded between-group difference of 0.9 was -1.1 to 2.6.

CONCLUSIONS: In this small study, the addition of intranasal fentanyl did not substantially impact the pain scores of ED patients undergoing I&D.

New York
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

New York ACEP 2023 Leadership & Advocacy Award

Nominations

New York ACEP created the Award to promote young physician leadership and to advance political action and advocacy through attendance at the ACEP Legislative Advocacy Conference, April 30-May 2, 2023 in Washington, DC.

Three awards up to $1,000 each will be provided for young physicians and residents to participate in leadership training at the ACEP Legislative Advocacy Conference in Washington DC April 30 - May 2, 2023.

If you know a deserving resident or young physician, consider nominating them. Resident candidates must be in good standing and in an accredited residency program within New York State. Special consideration will be given to resident candidates planning to practice in New York State.

Looking for a few good leaders.
Is there a deserving resident or young physician candidate in your department?

Purpose

To fund young physicians and residents to attend and participate i n leadership training at the ACEP Legislative Advocacy Conference, April 30 - May 2, 2023 at the Grand Hyatt Hotel in Washington D.C.

Eligibility

Young physician candidates must be within their first three years of practice.

Resident candidates must be in good standing in an accredited residency program within New York State. Special consideration will be given to resident candidates planning to practice in New York State.

Award

Maximum reimbursement of $1,000 per recipient. A total of three awards will be given for both categories.

Read more about award requirements, selection criteria and to download a nomination form online at www.nyacep.org

Deadline: Nominations due by **November 15, 2022**

ALBANY UPDATE

Reid, McNally & Savage

New York ACEP Legislative & Regulatory Representatives

It has been a busy Spring and early Summer for New York ACEP with the end of the legislative session, Primary Elections and an Extraordinary Session to address Gun Safety and Reproductive Rights here in Albany. We have detailed information on all these happenings below but first want to thank New York ACEP President Keith Grams, Nicole Berwald, Chair of the Government Affairs Committee, the Board and JoAnne Tarantelli, Executive Director for all her guidance and assistance!

Elections

The primary races for the offices of the Governor, Lieutenant Governor and the Assembly were conducted in June. With Governor Hochul beating out Representative Tom Suozzi and NYC Public Advocate Jumaane Williams to become the Democratic nominee for a full term. In the Lieutenant Governor's race, Antonio Delgado won against Ana María Archilla and Diana Reyna. On the Republican side, Representative Lee Zeldin captured the Republican party nomination.

In the Assembly many incumbents won. Such as Assembly Members Dinowitz (Bronx), Santabarbara (Capital Region) and Glick (Manhattan). Additionally, the candidates endorsed by New York City Mayor Eric Adams did well, as Assembly Members Dickens (Manhattan), Benedetto (Bronx) and Lucas (Brooklyn) won. However, in the Bronx, Assembly Member José Rivera lost to George Alvarez, who was backed by Congressional Members Adriano Espaillat and Ritchie Torres. Upstate, Assembly Member Kevin Cahill was beaten by Sarahana Shrestha, a member of the Mid-Hudson Valley chapter of the Democratic Socialists of America. Also, Assemblymember Tom Abinanti in the 92nd Assembly District's Democratic primary lost to Westchester County Legislator MaryJane Shimsky (D-Dobbs Ferry).

Primaries for the Congressional and Senate primary elections have been moved from June 28 to August 23.

Extraordinary Session

The New York State Legislature finished the 2022 Legislative Session Friday, June 3 and there was an extraordinary session held at the end of June in which the New York State legislature passed a concurrent resolution to solidify the right to abortion access in the State Constitution. They also passed gun safety legislation in response to the United States Supreme Court's decision in *NYSRPA v. Bruen* which changes the concealed carry permitting process and adds specific eligibility requirements, including the taking and passing of firearm training courses for permit applicants. It enables the State to regulate and standardize training for license applicants. The legislation also identifies sensitive locations where it is prohibited to carry a concealed weapon and establishes private property owners must expressly allow a person to possess a firearm, rifle or shotgun on their property. Individuals who carry concealed weapons in sensitive locations or in contravention of the authority of an owner of private property will face criminal penalties. Under the new law the State will have oversight over background checks for firearms, run regular checks on license holders for criminal convictions and create a state-wide license and ammunition database. The legislation also strengthens and clarifies the law relating to the sale of body armor and the safe storage of firearms. The bill will take effect September 1, 2022. An appeals board will be created for those applicants whose license is denied, which will take effect April 1, 2023.

End of Session

During regular session legislators passed a record high of 1,007 individual bills during the less than six-month session.

This year New York ACEP was successful in:

- Increasing (1%) and Restoring (1.5%) Medicaid Rates.
- Defeating the Governor's proposal to restructure the Physician Excess Medical Malpractice Coverage Program to provide payments to carriers in two yearly installments. The budget also provides for a one-year extender of the program.
- Passage of up to $200 million to be awarded to "emergency departments of regional significance."
- Defeating detrimental changes to the Emergency Medical Services program.
- Increasing funding for the Physician Loan Repayment program by 75% to nearly $16 million.
- Defeating legislation to establish independent practice for physician assistants.

Despite strong efforts by New York ACEP working in collaboration with the Medical Society of the State New York (MSSNY) and several physician specialty societies, the final State Budget includes the Governor's proposal to remove the requirement in the State Education law for a nurse practitioner (NP) to engage in a collaborative practice agreement with a physician for the delivery of health care services. While the bill no longer requires a collaborative agreement, MSSNY's interpretation of the bill is that it does not amend or expand the scope of practice of a nurse practitioner as currently provided for in the New York State Education Law.

The budget also included alignment of New York's consumer protection against surprise bills with the Federal No Surprises Act, which took effect January 1 as follows:

- Repeals provisions to exempt emergency service codes under a certain amount from the Independent Dispute Resolution process;
- Disputes must be submitted to the IDR entity within three years of the date the health plan made the original payment on the claim subject to dispute;
- Makes the laws applicable to all provider types not just physicians and hospitals;
- Includes the in-network median rate recognized by the health plan as a factor the IDR entity must consider; and

- Requires health care plans to ensure members are held harmless for surprise bill amounts in excess of in-network cost sharing.

In the early morning hours just prior to the close of the Session, both houses passed "Wrongful Death" legislation (S74-A Hoylman/A6770Weinstein), a regressive liability bill that will expand the possible damages in a wrongful death action and greatly increase New York State's already outrageously high liability insurance premiums. The bill authorizes an award in a wrongful death action to include compensation for grief or anguish, the loss of love or companionship, loss of services and support and the loss of nurture and guidance. New York ACEP is working with MSSNY and other physician specialty societies to urge the Governor to veto this bill. The bill is also opposed by statewide business groups including the New York State Business Council, NFIB, the Greater New York Hospital Association, the Healthcare Association of New York State and others.

Other legislation of interest to New York ACEP is outlined below.

BILLS THAT PASSED BOTH HOUSES

Institutional/Hospitals

Hospital/Health Care Provider Medical Debt Prohibitions (S6522-A Rivera/A7363-Gottfried)

This bill prohibits hospitals licensed under Article 28 of the Public Health Law and health care professionals licensed under Title Eight of the Education Law from placing a lien on a patient's primary residence for medical debt judgements. In addition, it prohibits hospitals and health care professionals from wage garnishment for medical debt judgements.

Informed Consent Provisions Added to Hospital Patient's Bill of Rights (S1172-C Rivera /A9677 Tapia)

This legislation requires general hospitals to ensure the following rights for patients:

- The right to receive all information necessary to give informed consent for any proposed intervention, procedure or treatment including information regarding foreseeable risks and benefits of the proposed intervention, procedure or treatment;
- The right to receive complete information of a patient's condition, prognosis and clinical indications for the proposed intervention, procedure, or treatment;
- The right to be informed of the name, position and functions of any hospital staff including medical students and physicians exempt from New York State licensure who provide face-to-face care or direct observation to a patient;
- The right to receive information related to alternative treatment options, including the risks and benefits of such treatment options that take into account any known preconditions;
- The right to refuse the proposed intervention, procedure or treatment and to be informed of the clinical effects of refusal;
- The right to engage and participate in the process of informed consent, including the patient's right to ask any questions they might have and have them answered satisfactorily as deemed reasonable;
- The right to be informed of any human subjects research that may directly affect a procedure or treatment received by the patient and to provide voluntary written informed consent to participate, should the patient be an appropriate candidate for such research, as determined by the attending physician. Informed consent for such human subjects research shall conform with federal requirements related to protections for human research subjects and any other applicable laws or regulations.

Facility Fees Charged by Hospitals and Health Care Professionals (S2521-A Rivera A3470-C Gottfried)

This bill provides that no hospital, health care system or health care provider may bill or seek payment from a patient for a facility fee that is not covered by the patient's health insurance unless the patient was notified prior to the date of service that such fee would be applicable. If a health care provider enters into a business relationship with a hospital or health care system that will result in the provider's patients being subject to facility fees, the health care provider must notify its patients of the change.

Compliance with Medicare/Medicaid Antimicrobial Stewardship Programs (S7717 Kavanagh/ A8787 Woerner)

This bill clarifies that general hospitals and nursing homes must meet the federal standards for antimicrobial stewardship programs in health care facilities including training requirements for infection prevention and control.

This bill was signed Chapter 83 of the Laws of 2022 on 2/24/2022.

Health Professions

Professional Misconduct and Reproductive Health Care (S9079-B Kaplan/ A9687-B Rosenthal)

This legislation would prohibit professional misconduct charges against health care providers who provide reproductive health care to patients who reside in states where such services are illegal, if the provider is acting within their scope of practice. The provider's license shall not be revoked, suspended or annulled solely on the basis the provider performed such service for a patient who resides in a state where it is illegal.

This bill was signed Chapter 220 of the Laws of 2022 on 6/13/2022.

Legal Protections for Abortion Service Providers (S9077-A Krueger/ A10372-A Rules (Lavine)

This legislation provides judicial protections for abortion providers in New York by providing an exception for extradition by the Governor, stating a police officer shall not arrest a person for performing an abortion, stating that no state or local law enforcement shall cooperate with or provide information to out of state agencies or departments regarding lawful abortions performed in New York State and the courts and county clerks shall not issue subpoenas in connection with out-of-state abortion proceedings which were legally performed in New York State.

This bill was signed Chapter 219 of the Laws of 2022 on 6/13/2022.

Medical Malpractice and Reproductive Health Care (S9080-B Hinchey/ A9718-B Rosenthal)

This legislation prohibits medical malpractice insurance companies from taking any adverse action against a reproductive health care provider who provides legal reproductive health care.

This bill was signed Chapter 221 of the Laws of 2022 on 6/13/2022.

ALBANY UPDATE

Red Flag Law: Extreme Risk Protection Orders (S9113-A Skoufis/ A10502 Cahill)

This bill authorizes specified healthcare professionals including licensed physicians, psychiatrists, psychologists, registered nurses, clinical social workers, clinical nurse specialists, certified nurse practitioners, clinical marriage and family therapists, registered professional nurses, licensed master social workers or licensed mental health counselors, to apply for an extreme risk protection order and it requires police and district attorneys to apply for extreme risk protection orders if there is probable cause that a person poses a threat.

This bill was signed Chapter 208 of the Laws of 2022 on 6/6/2022.

Clinical Peer Reviewer Definition (S8113 Cleare/ A879 Gottfried)

This legislation amends the public health law and insurance law to clarify that a health plan's "clinical peer reviewer" or utilization review agent is not just a physician, as is currently required, but also by board-certified or board eligible in the same or similar specialty as the physician who typically recommends the treatment or manages the condition under review. Also requires all clinical peer reviewers to be licensed or certified in New York State.

Address Confidentiality Program (S9384-A Cleare/ A9818-A Paulin)

Provides address confidentiality to protect reproductive health care services providers, employees, volunteers, patients or immediate family members of reproductive health care services providers.

This bill was signed Chapter 222 of the Laws of 2022 on 6/13/2022.

Physician Assistants under Medicaid Managed Care (S5956-A Rivera/ A6056 Gottfried)

This legislation allows physician assistants to be recognized as primary care providers for those enrolled in Medicaid managed care.

Limiting Liability: First-Response Emergency Vehicles (S8031-A Felder/ A8933-A Eisenstein)

This bill limits the liability of operators and owners of first-response emergency vehicles by providing for a rebuttable presumption the driver of an emergency vehicle involved in exceeding the speed limit, running a red light or driving in a bus lane is not liable for monetary penalties if they provide evidence that at the time of the infraction, the vehicle was involved in a medical emergency call and the operator of the vehicle is a medically trained first responder.

Crisis Training: Emergency Medical Services Personnel and Firefighters (S7144 Sanders/A7686 Frontus)

This bill adds firefighters and emergency medical services personnel to required training for mental health first aid, implicit bias training and naloxone training.

This bill was signed Chapter 185 of the Laws of 2022 on 5/6/2022.

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