



Implementing a Scribe Program in your Emergency Department- Improving Patient Care (and your life!)

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Over the last several years, there has been increased discussion regarding scribes with implementation in all practice types – from private to academic groups. For those physicians already working with a scribe, you know the benefit this resource can provide. This article is designed for those physician groups that may be considering implementation of a scribe program. We will discuss the purpose and general duties of a scribe, review the potential benefits of a scribe program, and provide some specific information regarding program implementation at three specific hospitals.

What is a scribe?

Turning the page to 2012, the health care delivery system is facing extreme challenges. Providers in all specialty areas are being asked to provide high quality care as rising costs are not being matched by reimbursement rates. As one walks the hospital floors, “efficiency” has become the frequently heard buzzword. Emergency departments (EDs) are experiencing the stress of increasing visits and crowding while also attempting to contain costs, stretching their own operations to run at optimal levels. There are many front-end strategies that have been implemented across the country to give an efficiency

boost to emergency departments such as direct bedding, bedside registration, and kiosk check-in.³ Scribe programs are another option for emergency department physicians looking to not only improve throughput efficiencies but also patient care, cost, and both patient and physician satisfaction.

Classically a “scribe” is an individual who is at some stage of training, progressing toward a career in medicine (often pre-medical students). The role of the scribe is to assist physicians, and frequently nursing and ancillary support staff, in all real-time non-clinical aspects of patient care. It has been stated that 28% of an emergency physician’s time is spent performing clerical duties.² The job description includes documentation of history and physical exams, procedures, lab results, imaging interpretations, consultations, discharge instructions and discussions with medical staff or a patient’s family and friends. The scribe may in some instances act as a chaperone for patient examination, can make phone calls for the assigned physician (we all love those), or get blankets and food for a patient to improve their comfort level. The scribe should step into the role as the non-clinical expeditor in the department; tracking and updating a patient’s progress for the emergency department team and

moving the patient through the process as quickly and effectively as possible. After the scribe team gets accustomed to all emergency department operations they can also be utilized to help with other responsibilities such as the orientation of new physicians and staff, or even electronic medical record (EMR) training and implementation.

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president's MESSAGE



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National ACEP Leadership and Advocacy Conference

Washington, DC

May 20-23, 2012

Omni Shoreham
Hotel

I would like to highlight New York ACEP's recent regulatory accomplishment and some upcoming opportunities to participate in outstanding educational events.

In the January issue of e-news you were notified that New York State adopted regulations for **observation unit operating standards**. New York ACEP has been working with the Department of Health for two years to advance emergency medicine's position on observation services. As a result of many phone calls, letters, and meetings with Governor Cuomo's staff, I am pleased to highlight the fact that the observation unit operating standards policy published in the New York State Registry in September which New York ACEP strongly supported was adopted January 11, 2012. Under these new regulations, observation services in hospitals must take place in a dedicated, physically separate and distinctly staffed observation unit that is under the direction and control of emergency services. Although we recognize that logistically this may not always be possible in all hospitals, New York ACEP took the strong position that such a policy strengthens emergency medicine's position as hospital based physicians and ultimately will provide the safest and most expeditious care for our patients. I am proud to report the notice of adoption prominently highlighted comments submitted by New York ACEP and emergency physicians. The standards acknowledge that observation units operate most efficiently and effectively under the direction of the emergency department. The notice of adoption stated, "emergency departments care for a diverse set of patients, routinely manage the array of diagnostic tests and short-term treatments necessary to make decisions concerning admission and discharge within short timeframes, and are best equipped for directing patient care in observation units." Congratulations to our Government Affairs

Committee, New York ACEP leaders and membership for this success.

There are a number of exciting educational offerings this spring and summer. Wednesday, May 2, 2012 New York ACEP will present the annual **ED Leadership Forum** at the New York Academy of Medicine in New York City. This dynamic one-day meeting will provide crucial information for emergency department leaders throughout the state both in academic and community practices.

The National ACEP annual **Leadership and Advocacy Conference** in Washington, DC will be held May 20-23 at the Omni Shoreham Hotel. This meeting provides a unique opportunity for New York ACEP members to advocate for issues important to emergency department physicians and our patients. I am extremely proud of the fact that last year, New York had more members at this meeting than any other state in the country. We hope to build in this success and have even more New York ACEP members in attendance at the 2012 meeting.

On July 9-11, New York ACEP sponsors its annual **Scientific Assembly** at the Sagamore Resort on Lake George. This year's educational offerings promise to be more robust than ever. This meeting is a great opportunity to obtain valuable education, learn about the latest breakthroughs at the research forum and meet other New York ACEP members. The Sagamore Resort, a world class resort, is a wonderful family destination. I invite all of you and your families to come join us at the Sagamore in July.

I hope you are all weathering the winter months well and taking advantage of the wonderful winter recreation that New York State provides. As always, I welcome you to become involved in New York ACEP activities and look forward to seeing you at our upcoming meetings. ■

DEADLINE
APRIL 2, 2012

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Delivering “The News” in the Emergency Department

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In emergency medicine, I would hazard a guess that we have all had to deliver the news; “Your loved one has died.” “We have found something on your CT scan.” “Your blood tests have shown something abnormal.” The ways in which this information is delivered frames family and patients’ future thoughts and remembrances of these moments. The emergency department can be a higher challenge with regard to these moments, as this information typically must be delivered in an unexpected situation/quite suddenly. Although I am sure we have all done this at some point, some refreshers on the established guidelines for doing this may be helpful for our practices.

Buckman described some guidelines in 1992 for delivering bad news as follows:

1. Physician preparation
2. What does the patient know?
3. How much does the patient want to know?
4. Sharing the information
5. Responding to feelings
6. Planning and follow-up

Step 1 involves fully knowing the patient and the patient’s information, the identities of those you are speaking with, gathering yourself and planning what it is you are going to say. Sitting down is often helpful. Step 2 and 3 are typified by finding out what the patient knows and wants to know, i.e. perhaps they do not wish to know the worst case scenario. Establishing what they know so far to help them think about what is going on and to know what discussions have already occurred is of great benefit. Step 4 is sharing the information or

‘News.’ An opener can prepare them as in “I am afraid I may have bad news.” Of course using non-medical language or lay speak is preferred for understanding. Allow some time for the information to sink in. Generally it is thought best to avoid “I’m sorry” although this may show empathy, it may be misinterpreted as guilt or that something was done wrong. Instead, try other phrases such as “I wish things were different.” Step 5, reacting to feelings, can have a wide range of responses. Allow the responses to occur – grief should be expressed – but be prepared for unpredictable and possibly wild behaviors. Social workers, nurses, clergy, etc. being present can help with this process. Step 6 is the overall wrap-up to the process – planning and follow-up assuming patient survival. This may include preparing the family for the worst should they decompensate in the hospital, what steps are next in the process, who to talk to next, what to expect, or even asking again for clergy/social work to talk with the patient/family about what is to come.

Delivering the news of death is of equal awkwardness for many as compared to bad news about a surviving patient. There is much crossover with the process. Use the already outlined guidelines above plus what Quest TE *et al* described as the following elements:

1. Introduce self and role
2. Sit down
3. Assume a comfortable communication distance
4. Use acceptable tone/rate of speech
5. Make eye contact
6. Maintain open posture

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ultrasound sound rounds

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

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Ultrasound Evaluation for Appendicitis

Indication

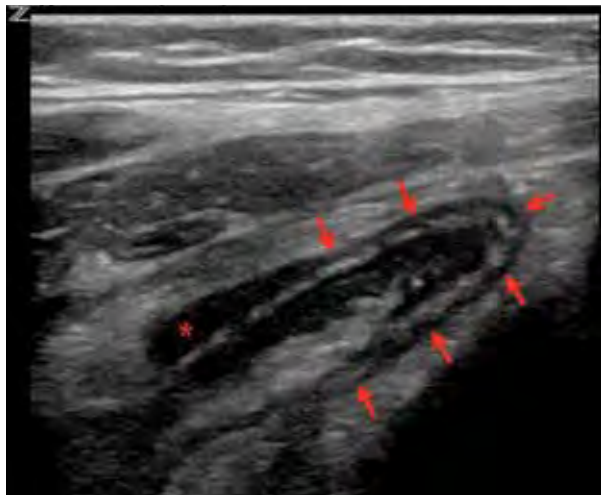
- Abdominal pain.

Technique

- Place a high frequency linear transducer at McBurney's point of the patient's abdomen or at the point of maximal tenderness. A curvilinear transducer may be used for obese patients.
- Evaluate in both sagittal and transverse planes.
- Use gentle, graded compression with the transducer to displace bowel gas.
- Landmarks: Identify the psoas muscle and iliac vessels. See *Fig 1a and 1b*.



Figures 1a (left) and 1b (right): The appendix is frequently encountered anterior to the psoas muscle (asterisk) and external iliac vessels (arrow). Nonspecific free fluid, instead of the appendix, is present in this image.



- The longitudinal view of the appendix appears as a blind-ended tubular structure. See *Figure 2*.

Figure 2 (left): Longitudinal view of a 7mm inflamed appendix (arrows) with periappendiceal fluid (asterisk).

- Scan the entire length of the appendix proximally to the cecum.
- Visualize the transverse view of the appendix (target sign). See *Figure 3*.



Figure 3 (above): Target sign. Transverse view of the appendix (arrows).

- Measure the diameter of the appendix from outer wall to outer wall. $>6\text{mm}$ is suspicious for acute appendicitis. See *Figure 4*.

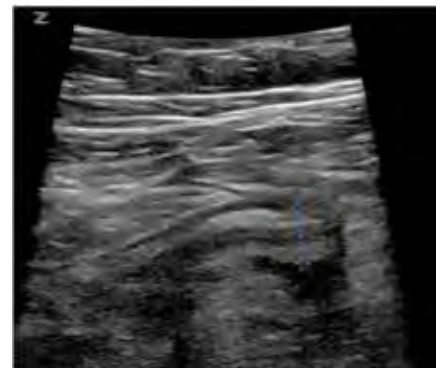


Figure 4 (above): Longitudinal view of a 7.8mm inflamed appendix with periappendiceal fluid.

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Ultrasound Evaluation

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- Nonspecific signs of acute appendicitis include visualization of free fluid and an appendicolith. See Figure 5.

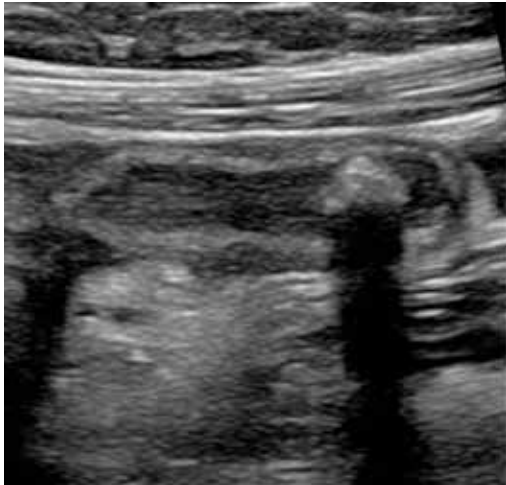


Figure 5 (above): Longitudinal view of a 7.9mm inflamed appendix with a large appendicolith.

Image courtesy of Anita Datta, MD RDMS, New York Hospital Queens

- In acute appendicitis, the appendix is non-compressible and lacks bowel peristalsis.
- Color doppler evaluation in acute appendicitis may demonstrate wall hyperemia.

Table 1. Summary of criteria for ultrasound diagnosis of acute appendicitis

Blind-ended tubular structure
Target sign
>6mm diameter
Aperistalsis
Non-compressible

Pitfalls and limitations

- False positives: Terminal ileitis, Crohn's disease, right-sided colonic diverticulitis, appendiceal tumors, lymph nodes.
- Pain, patient's body habitus, lack of operator experience and bowel gas may limit the ultrasound evaluation.
- The retrocecal appendix and perforated appendix may be difficult to visualize with ultrasound.
- The landmarks to locate the appendix may not be applicable in the pregnant patient.
- Lack of visualization of the appendix does not rule out acute appendicitis. Computed tomography may be warranted if ultrasound is inconclusive. ■



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EMT Education in the ED

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A crucial part of a prehospital provider's education is the clinical time spent in the hospital. Students in an EMT-Basic class are required to log 10 hours of clinical time. This experience can occur with an ambulance service, in a hospital emergency department or both. Advanced EMT (Intermediate, Critical Care or Paramedic) students will spend dozens, possibly hundreds, of hours in the hospital setting during their training. The utility and importance of field time for the EMT student is without question and is beyond the scope of this discussion. Our role as physicians in the emergency department can include supervising these students or at least facilitating their experience. This article will review how the physician can provide a suitable learning environment for these types of healthcare students.

EMT-Basic

While some of these students have considerable healthcare experience, most have none. This is the first time they are interacting with a patient. While trying to memorize the steps in the initial assessment, learn how to measure blood pressure, and worrying about the practical exam, they are also learning how to take a history from an individual who is ill. Medical schools spend considerable time and energy teaching this aspect of patient care, and the hospital is an excellent place for our future EMTs to learn this as well. Perhaps the next time you are working clinically, and an EMT student is "observing," you can ask him/her to take a history from a patient with a relatively simple complaint. Go with the student for the encounter and then debrief what he/she did well and might consider changing.

Other teaching opportunities when an EMT-Basic student is in the department include vital signs, what happens after a patient reaches the emergency department, anatomy and differential diagnoses. It is certainly vital for the EMT-Basic to be able to competently and quickly assess vital signs. Many students struggle to understand the concept of blood pressure and what they should be listening for. We can ask nurses and other staff members to have students take vital signs on patients and teach them proper technique. Another aspect of the curriculum that can always receive more attention is anatomy. We can take the opportunity to point out normal and abnormal anatomy in our patients.

Skill practice can also be incorporated into the emergency department clinical rotation. EMT-Basic students can practice Bag-Valve-Mask (BVM) technique, applying oxygen and inserting Oropharyngeal Airways (OPAs) and Nasopharyngeal Airways (NPAs). Splinting technique for fractures can also be discussed and demonstrated. EMT-Basic students should also assist in resuscitations by performing CPR — this is invaluable and cannot be understated.

Unfortunately, many of our new EMT students do not get these sorts of experiences in our emergency departments. The student is often used to transport patients, shuffle paperwork, fetch equipment or simply observe but not interact. Perhaps sometimes we feel less responsibility as these students are not our own (residents or medical students), but as physicians, we know the importance of well-trained prehospital providers and assigning them these tasks robs them of the opportunity

to learn skills that will help them in their future practice.

The EMT-Basic student needs to learn the art of being a healthcare provider, specifically how to speak with patients, take a history and perform a physical exam. They also have certain procedures they are learning and should be able to practice those in a controlled setting as well. Finally, if you have a student working during your shift, take time to engage that student regarding different scenarios and expectations of good prehospital care.

The Advanced EMT

The clinical experience for the advanced provider is similar in some regards but quite different in others. These students are already prehospital providers and do not need to spend as much time learning the art of the history and physical exam. However, they do provide more advanced care and thus formulating a differential diagnosis and performing advanced procedures are very important. These providers will be leading resuscitations while working in the field, so make sure they are present whenever a resuscitation is occurring in the department. You can talk through ACLS guidelines and general pearls of running a code. Many of these providers are learning the art of intravenous access as well. Pairing them with an experienced nurse can help develop their skills and confidence in this area. We should try to avoid assigning advanced provider students to work with nurses all of the time. These healthcare providers will be making critical decisions in the field and providing care similar to the scope of a physician. All advanced level students should spend some, if not most, of their hospital time working directly with a physician.

Practical Considerations

I would be naïve to suggest that this model of engagement is always possible, every day, in every emergency department. Certainly, this is not the case. Every department is concerned with throughput. Academic hospitals have other priorities such as teaching medical students and residents. A variety of other students spend time in the emergency department as well, such as nursing students and students of other allied health professions. There are

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Job Hunt 2012

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Completion of residency is bittersweet. On one hand, the sails are up and we are completing a journey towards being an independent physician. For some of us that journey began as early as kindergarten, while for others it was a mid-career epiphany. On the other hand, finishing residency can be equated with cutting the towline. Where do we go from here? How do we navigate to open waters from the channel?

The “Job Hunt 2012” technically began this past August, with the updating of CVs, creation of cover letters and the list of places to apply. However the foundation for the hunt started months to years prior, as we watched the class ahead of us go through a similar process, then graduate and move into their chosen role. This was accompanied by a mixture of excitement around the opportunities, nerves as to what would change for our year, and jealousy that the class ahead was finished with the process.

What did we learn from the prior classes? Anything is possible.

What did we feel this time around? Sure, anything is possible, but the competition is increasing.

With the general economic instability, a need for job security, and a shift towards emergency medicine as an increasingly popular specialty choice, graduates are arguably likely starting to feel some pressure. In the early stages, that pressure is felt primarily in the academic sector.

Traditionally, one of the perceived benefits of doing a four-year versus a three-year residency was the ability to translate

that training more immediately into an academic environment, without having to pursue a fellowship. However, the sentiment is growing that further specialization, even if just for academic purposes, will be the wave of the future. Emergency medicine physicians will need to have an additional skill or expertise to teach. Residency programs are going to be held increasingly accountable for the quality of education provided.¹

Thus, more residents from four-year programs are looking into fellowships, furthering the overall trend toward specialization throughout health care.

Another possibility for the perceived increase in competition for academic jobs is that there are fewer available, as those with academic positions are staying in them for longer and retiring later. Emergency medicine residency is a popular option, leading to more graduates. While new residencies are developing, the demand may be outstripping the supply.

Many of the residents graduating from four-year programs, on the other hand, are looking for community or large group practice settings. This market still appears to be eager to entertain all applicants. For a period this fall, there would be several calls to the emergency department each day looking for myself or one of my classmates. When asking the caller what I could help them with, they announced their recruiting position and if we could talk further about job opportunities.

Besides the fact that I have a personal objection to recruiters interrupting physicians unprompted during clinical hours in

patient care areas, this aspect of the job hunt has not slowed down. Anecdotally, there seems to be plenty of community positions still available. Although if trends continue as anticipated, that plenty may become few.

After interviewing at community sites, group practices, as well as academic institutions, I personally opted for a Geriatric emergency medicine fellowship. While interviewing, I was open about the fellowship that I was considering, and to my surprise, the universal response was: “Wow, I didn’t know that existed. But since it does, it’s a great opportunity!”

Our geriatric population is growing and has a unique set of needs. While from my naïve point of view I do not anticipate geriatrics breaking off from general emergency medicine in a fashion such as pediatrics has, it deserves equal attention, research and advocacy. Everyone wants a physician knowledgeable in emergencies inflicting their parents, elderly loved ones, or even themselves as time marches on!

References

1. Accreditation Council for Graduate Medical Education. Emergency Medicine Guidelines. http://www.acgme.org/acWebsite/RRC_110/110_guidelines.asp, accessed 1/10/12. ■

The author is currently the resident representative to the New York ACEP Board of Directors.



EMT Education in the ED

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also significant limitations resulting from a lack of knowledge of the role of the EMT or advanced EMT. An EMT student paired with someone who does not understand the role of EMS is a recipe for disaster.

In addition, some students show more motivation than others. Finally, each hospital may have different policies regarding who can and cannot supervise EMS students. These rules may be even more stringent for advanced level students.

I would encourage you to investigate the situation at your local hospital. Do you host EMT and advanced EMT students? Who can supervise them? Do they spend any of their time working directly with a physician? Can they perform procedures within the scope of their practice under proper supervision? The state offers some guidance in this area, primarily from the Bureau of EMS. Please refer to the Pre-Hospital Care Provider Student Reference Guide (section six) along with the Administration Manual for EMS Educational Programs, both of which are available from the New York State Bureau of EMS website at <http://www.health.ny.gov/nysdoh/ems/educ.htm>.

As emergency department physicians, we work hand-in-hand with our prehospital providers. We owe it to our patients to assist in the training and education of these professionals. The next time you are working and there is a prehospital student in the department, consider how you can engage this student, so that they can gain knowledge and learn the skills they will be using on their own out in the field. ■

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the conversation!**



Delivering "The News"

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7. Give advanced warning of bad news (I'm afraid I have some bad news)
8. Deliver the news clearly (Dead/Died not "passed on" or "expired" - avoid passive phrasing)
9. Tolerate survivor reactions
10. Explain attempts to 'save' the patient
11. Do not use medical jargon – use clearly understood language
12. Offer viewing of the deceased
13. Offer to be available to the survivor
14. Conclude appropriately

Assuring that "we did everything we could" may sound cliché, but it is very appropriate. Clergy/social work is very important in these situations and it is recommended they be present for the news delivery, possibly even just prior to physician arrival. Start with identifying everyone after identifying yourself, asking a few questions on what they know – but do not overly delay getting to the point. Allow time for them to have a brief grief response and then continue on what occurred. Approach the most stable of the grievers.

Phone notification is a bit of a tricky process – you lose all direct contact. If at all possible it is highly recommended that the survivor be told to come to the emergency department as soon as possible, if feasible. Often, non-physician staff are better at this than physicians, for when pressed by a family member, it is hard to delay them when they are asking you, as a doctor, for the information. If the person on the phone is over an hour away or otherwise cannot come to the emergency department, then giving the news of death over the phone cannot be avoided. Try to have someone else in the room with the person on the other end of the line, ask them to be seated, and name the person involved. Try a few seconds of preparation and use the above steps outlined as much as one can over the phone, i.e. identify self and whom you are speaking to, find out what they know already, use non-medical jargon, say "died" not expired, etc. Do not overly delay getting to the point. Sometimes a family member will insist on knowing if their loved one has died before proceeding. Establish that they can call back

should they need time after telling them to continue the process – they may need to digest things at first.

It is more common now for families to be invited to view the resuscitation. In studies, the primary push-back for this comes from less experienced providers. Overall this has been studied more in the pediatric population. This is not feasible in complicated resuscitations and traumas. The reason to have family come in during resuscitation is to help them with the 'we did all that we could' and to aid with closure. This is ultimately up to provider comfort with this technique.

Allow the family to have their overall grief responses. It is not uncommon for anger to turn inward on themselves or outward to the staff/physician. Reassure and support as much as possible. If the situation turns violent, of course, remove yourself from the situation. The overall grief process takes six months commonly – do not expect to completely free them of this process.

The conclusion to the process should be condolences (again without "I'm sorry" instead "I understand how hard this is for you"), social work and/or clergy/chaplain involvement, and also asking the family if they desire/permit an autopsy. This can be uncomfortable, but autopsies are an important final step in the process for education and even to alleviate guilt feelings by finding the true cause of death. Allow them to view the body in a quiet setting. Sometimes the survivors become the patients when the grief response is too much for them/panic attacks/chest pain/etc. Sedatives are acceptable but in small doses. The response should not be overly blunted which would lead to not dealing with their feelings. The primary care physician of the deceased may be helpful in these situations.

Using these steps and practices will help you in "Delivering the News" in the future. Although rudimentary, it is an integral part of our practice and commonly the most awkward or uncomfortable event we may undertake in our practices. Having a plan and preparing can help alleviate the anxiety associated with giving this information, and help the families along in the process. ■

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Albany Update

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

Building on a busy fall season for New York ACEP governmental affairs efforts, the governmental relations team has already scored an early victory in 2012 with the enactment of the new “Observation Unit Standards” which were formally adopted by the New York State Health Department January 11. Below we discuss this victory and key agenda items for 2012 as the winter issue of the *Empire State EPIC* goes to print.

Observation Unit Standards

In the past two years New York ACEP leadership has met repeatedly with the New York State Department of Health (DOH) leadership to discuss Observation Unit Operating Standards. New York ACEP’s position is that the observation of patients should take place in a dedicated, physically separate and distinctly staffed observation unit that is under the direction and control of emergency services. A draft regulation published September 28, 2011 included this and other critical standards. New York ACEP provided public comments to DOH in support of the draft regulation. DOH received opposing letters from the hospital industry. The final regulation published in the State Register January 11, 2012 retains the standards sought by New York ACEP. A complete copy of the new rule can be found at http://www.health.ny.gov/regulations/recently_adopted/.

New York ACEP Calls for Liability Reforms for Emergency Physicians

Beginning an effort to bring comprehensive and meaningful liability reform for emergency physicians in 2012, New York ACEP called upon Governor Cuomo’s Medicaid Redesign Team (MRT) to recognize that “*emergency physicians are the only physician specialty that is required by law to see every patient who crosses their threshold. This mandate is contained in State law and*

the federal Emergency Medical Treatment and Active Labor Act (EMTALA). As emergency physicians, we consider it an honor and a privilege to care for all patients regardless of their insurance status or ability to pay. But the current medical malpractice crisis is straining our ability to fulfill our mission.”

In the letter to the MRT, New York ACEP stated that the current medical liability environment in the State poses an enormous threat to patient access to emergency care and shared that in the American College of Emergency Physician’s 2009 National Report Card on the State of Emergency Medicine, New York scored an F and was ranked among the worst states for its Medical Liability Environment. New York ACEP then recommended a series of reforms to the current system as outlined below.

Medical Liability Program Reforms

Based on the success of other State’s medical liability programs New York ACEP recommends the following reforms in New York State:

Enactment of Special Liability Protection for Emergency Care: To provide for the same legal protections provided to physicians in the Public Health Service to be extended to emergency physicians and on call specialists providing EMTALA-mandated emergency care. Seven other states have enacted legislation to provide such special liability protection for emergency care providers either through higher standards of liability or lower caps on damages for such care;

Medical Expert Witness Credentialing: To permit the disclosure of the identity of medical expert witnesses, require that they have appropriate qualifications including board certification

in the same specialty of the defendant and create a new element of professional misconduct for providing such testimony without a reasonable medical foundation;

Appropriate Cap on Non-Economic Awards: Thirty states have enacted some form of a cap on non-economic damages. New York should enact a \$250,000 cap on non-economic damages; and

Immunity for Apologies: Over 20 states have enacted “I’m Sorry” laws to protect health care providers who express sympathy to a patient for an unintended outcome from having the statement used in any litigation. New York should enact a similar immunity for apologies law.



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EMPIRE STATE EPIC is the newsletter of the New York American College of Emergency Physicians (New York ACEP). The opinions expressed in this newsletter are not necessarily those of New York ACEP. New York ACEP makes a good faith effort to ascertain that contributors are experts in their field. Readers are advised that the statements and opinions expressed by the author are those of the author and New York ACEP does not accept responsibility for information or statements made by contributing authors.

NEWS STAFF

JoAnne Tarantelli, *Executive Director*
Betsy Hawes, *Communication & Marketing*

The MRT's Work Group on Malpractice Reform only held one meeting over the fall and did not make any recommendation for medical liability changes in New York to the MRT or Governor. We will continue to strongly advocate with the Administration and State Legislature for the enactment of these very important reforms to New York's broken system.

Governor Cuomo's 2012-2013 Executive Budget Proposal

On Tuesday, January 17 Governor Cuomo released his \$132.5 billion Executive Budget proposal. The Budget reduces spending by 0.2 percent and closes a \$3.5 billion gap without major tax increases. The Budget includes several proposals of interest to New York ACEP members including:

- The creation of a Health Insurance Exchange as provided for in the Patient Protection and Affordable Care Act;
- The extension of the Medicaid Cap on spending for an additional year;

- The establishment of the Primary Care Service Corps Loan Repayment Program for non-physician practitioners who agree to practice full-time in an underserved area of the State;
- Funding for the Doctors Across New York program including \$1.7 million for the physician loan repayment program, \$4.3 million for the physician practice support program; \$516,000 for physician workforce studies, and \$1.7 million for the diversity in medicine/post-baccalaureate program;
- A proposal to change the Official Prescription to require all physicians to note on the prescription if a patient is "limited English proficient" (defined as an individual who identifies as being, or is evidently, unable to speak, read or write English at a level that permits such individual to understand health related and pharmaceutical information communicated in English) and to include the patient's primary language; and

- A proposal to cap Executive Compensation and administrative costs for both for-profit and nonprofit organizations that receive state funding.

The Executive Budget proposal included a number of MRT proposals recommended to the Governor, however it did not address MRT proposals on scope of practice changes including one related to Nurse Practitioners (NPs). In January, New York ACEP President Joel M. Bartfield, MD FACEP expressed the College's concerns in a letter to Governor Cuomo with the proposed change to remove the collaborative agreement requirement between NPs and physicians. While not included in the Budget, we are hearing that Governor Cuomo may propose this and other changes in a separate bill later this year. We will keep New York ACEP members apprised of any new developments in this area. ■

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New York State of Mind



Pediatric stroke: A review.

Tsze DS, Valente JH., Department of Pediatrics, Division of Pediatric Emergency Medicine, College of Physicians and Surgeons, Columbia University; Emerg Med Int. 2011;2011:734506. Epub 2011 Dec 27.

Stroke is relatively rare in children, but can lead to significant morbidity and mortality. Understanding that children with strokes present differently than adults and often present with unique risk factors will optimize outcomes in children. Despite an increased incidence of pediatric stroke, there is often a delay in diagnosis, and cases may still remain under- or misdiagnosed. Clinical presentation will vary based on the child's age, and children will have risk factors for stroke that are less common than in adults. Management strategies in children are extrapolated primarily from adult studies, but with different considerations regarding short-term anticoagulation and guarded recommendations regarding thrombolytics. Although most recommendations for management are extrapolated from adult populations, they still remain useful, in conjunction with pediatric-specific considerations.

Inter-rater reliability of sonographic measurements of the inferior vena cava.

Saul T, Lewiss RE, Langsfeld A, Radeos MS, Del Rios M., Department of Emergency Medicine, Emergency Ultrasound Division, St. Luke's/Roosevelt Hospital Center, New York; J Emerg Med. 2012 Jan 11. [Epub ahead of print].

BACKGROUND: Bedside ultrasound is emerging as a useful tool in the assessment of intravascular volume status by examining measurements of the inferior vena cava (IVC). Many previous studies do not fully describe their scanning protocol.

OBJECTIVES: The objective of this study was to evaluate which of three commonly reported IVC scanning methods demonstrates the best inter-rater reliability.

METHODS: Three physicians visualized the IVC in three common views and utilized M-mode to measure the maximal and minimal diameter during quiet respiration. Pairwise correlation coefficients were determined using Pearson product-moment correlation.

RESULTS: The most reliable pair of measurements (inspiratory and expiratory) was found to be using the anterior midaxillary line longitudinal view with a Kappa value for both at 0.692.

CONCLUSION: Imaging with the anterior midaxillary longitudinal approach using the liver as an acoustic window provides the best inter-rater reliability when measuring the IVC. Our findings demonstrate that IVC measurements differ based on anatomic location.

Lipemic serum in a toddler with new-onset diabetes mellitus presenting with diabetic ketoacidosis.

Waseem M, Dave-Sharma S, Kin LL, Jara F., Department of Emergency Medicine Lincoln Medical and Mental Health Center; JOP. 2011 Dec 3;13(1):73-5.

CONTEXT: Significant hyperlipidemia causing lipemic serum in patients with poorly controlled diabetes is under-reported in children. The recognition of the severe hyperlipidemia is important for proper management and to prevent associated morbidities. Severe hyperlipidemia in patients with diabetic ketoacidosis should be considered. Case report In this case we report a 2-year-old girl with new onset type 1 diabetes mellitus, who presented with severe diabetic ketoacidosis and hyperlipidemia. Hyperlipidemia was resolved with hydration and insulin therapy.

CONCLUSION: It is important to diagnose hyperlipidemia by checking serum lipid profile for all pediatric patients presenting with hyperglycemic crisis to prevent morbidities.

Oral and tympanic membrane temperatures are inaccurate to identify fever in emergency department adults.

Barnett BJ, Nunberg S, Tai J, Lesser ML, Fridman V, Nichols P, Powell R, Silverman R., NSLIJ Healthcare System, Emergency Medicine Department, New Hyde Park; West J Emerg Med. 2011 Nov;12(4):505-11.

INTRODUCTION: Identifying fever can influence management of the emergency department (ED) patient, including diagnostic testing, treatment, and disposition. We set out to determine how well oral and tympanic membrane (TM) temperatures compared with rectal measurements.

METHODS: A convenience sample of consecutively adult ED patients had oral, TM, and rectal temperatures performed within several minutes of each other. Descriptive statistics, Bland-Altman agreement matrices with 95% confidence interval (CI), and measures of test performance, including sensitivity, specificity, predictive values, and interval likelihood ratios were performed.

RESULTS: A total of 457 patients were enrolled with an average age of 64 years (standard deviation: 19 years). Mean temperatures were: oral (98.3°F), TM (99.6°F), and rectal (99.4°F). The mean difference in rectal and oral temperatures was 1.1°F, although there was considerable lack of agreement between oral and rectal temperatures, with the oral temperature as much

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as 2.91°F lower or 0.74°F higher than the rectal measurement (95% CI). Although the difference in mean temperature between right TM and rectal temperature was only 0.22°F, the right TM was lower than rectal by up to 1.61°F or greater by up to 2.05°F (95% CI). Test performance varied as the positive predictive value of the oral temperature was 97% and for tympanic temperature was 55% (relative to a rectal temperature of 100.4°F or higher). Comparative findings differed even at temperatures considered in the normal range; among patients with an oral temperature of 98.0 to 98.9, 38% (25/65) were found to have a rectal temperature of 100.4 or higher, while among patients with a TM of 98.0 to 98.9, only 7% (10/134) were found to have a rectal temperature of 100.4 or higher.

CONCLUSION: The oral and tympanic temperature readings are not equivalent to rectal thermometry readings. Oral thermometry frequently underestimates the temperature relative to rectal readings, and TM values can either under- or overestimate the rectal temperature. The clinician needs to be aware of the varying relationship between oral, TM, and rectal temperatures when interpreting readings.

Can emergency medicine residents reliably use the internet to answer clinical questions?

Krause R, Moscati R, Halpern S, Schwartz DG, Abbas J., State University of New York at Buffalo, Department of Emergency Medicine, Buffalo; West J Emerg Med. 2011 Nov;12(4):442-7.

INTRODUCTION: The study objective was to determine the accuracy of answers to clinical questions by emergency medicine (EM) residents conducting Internet searches by using Google. Emergency physicians commonly turn to outside resources to answer clinical questions that arise in the emergency department (ED). Internet access in the ED has supplanted textbooks for references because it is perceived as being more up to date. Although Google is the

most widely used general Internet search engine, it is not medically oriented and merely provides links to other sources. Users must judge the reliability of the information obtained on the links. We frequently observed EM faculty and residents using Google rather than medicine-specific databases to seek answers to clinical questions.

METHODS: Two EM faculties developed a clinically oriented test for residents to take without the use of any outside aid. They were instructed to answer each question only if they were confident enough of their answer to implement it in a patient-care situation. Questions marked as unsure or answered incorrectly were used to construct a second test for each subject. On the second test, they were instructed to use Google as a resource to find links that contained answers.

RESULTS: Thirty-three residents participated. The means for the initial test were 32% correct, 28% incorrect, and 40% unsure. On the Google test, the mean for correct answers was 59%; 33% of answers were incorrect and 8% were unsure.

CONCLUSION: EM residents' ability to answer clinical questions correctly by using Web sites from Google searches was poor. More concerning was that unsure answers decreased, whereas incorrect answers increased. The Internet appears to have given the residents a false sense of security in their answers. Innovations, such as Internet access in the ED, should be studied carefully before being accepted as reliable tools for teaching clinical decision making.

Hepatic artery pseudoaneurysm rupture: a case report and review of the literature.

Reiter DA, Fischman AM, Shy BD., Department of Emergency Medicine, Mount Sinai School of Medicine, New York; J Emerg Med. 2012 Jan 3. [Epub ahead of print].

BACKGROUND: Ruptured hepatic artery pseudoaneurysm, a type of visceral artery aneurysm, is a rare condition that is life threatening if not diagnosed and treated

rapidly in the emergency department (ED). Patients presenting with this condition require aggressive resuscitation. Endovascular embolization is the first-line treatment option.

OBJECTIVES: We present a case of spontaneously ruptured hepatic artery pseudoaneurysm and provide a review of the current literature on this topic, focusing on appropriate ED management.

CASE REPORT: A 41-year-old woman with a history of systemic lupus erythematosus and multiple hepatic bilomas presented to the ED in critical condition with sudden onset of severe abdominal pain and hemodynamic instability. She was found to have a ruptured hepatic artery pseudoaneurysm with marked hemoperitoneum on computed tomography angiography. She was aggressively resuscitated and successfully managed via endovascular embolization.

CONCLUSION: Ruptured hepatic artery pseudoaneurysm is a life-threatening condition that must be rapidly diagnosed and managed in the ED. Visceral artery aneurysm rupture is a diagnosis that should be considered in any patient presenting to the ED with hemodynamic instability and abdominal pain. Definitive management is with endovascular embolization.

Emergency ultrasound diagnosis of deep venous thrombosis in the pediatric emergency department: a case series.

Tein Tay E, Stone MB, Tsung JW., Departments of Emergency Medicine and Pediatrics, Mount Sinai School of Medicine, New York; Pediatr Emerg Care. 2012 Jan;28(1):90-5.

The diagnosis of deep venous thrombosis (DVT) in patients presenting to the emergency department (ED) has traditionally been limited to examinations by radiologists and ultrasound technicians. Although contrast venography is considered the criterion standard for diagnosis of DVT, time, personnel, cost, exposure to radiation, and the invasive nature of the study (need for

venous access) potentially limit the ability to perform the study in an emergent setting. Ultrasonography is an alternative method for thrombus detection and is widely preferred. However, in many health care settings, consultative ultrasound services may not be available immediately, especially after hours and on weekends. Based on recent studies demonstrating accuracy in adult patients, emergency sonographic evaluation of DVT by emergency physicians is considered a core emergency ultrasound application and is recently recommended as standard training to all emergency medicine residents. The diagnosis of DVT in children by emergency ultrasound in the pediatric ED has not been previously described. We present 3 cases of DVT in adolescents identified by emergency ultrasound evaluation in the pediatric ED.

Comparing the clinical severity of the first versus second wave of 2009 influenza A (H1N1) in a New York City pediatric healthcare facility.

Baird JS, Buet A, Hymes SR, Ravindranath TM, Zackai S, Cannon JM, Messina M, Sury, J, Green R, Della-Latta P, Jenkins SG, Greenwald BM, Furuya EY, Graham PL 3rd, Sonnett FM, Platt S, Delamora P, Saiman L., Departments of Pediatrics (JSB, AB, SRH, TMR, PLG, FMS, LS), Pathology (PDL), and Medicine (EYF), Division of Emergency Medicine (RG), Columbia University College of Physicians and Surgeons; Departments of Pediatrics (SZ, BG, SP, PD) and Pathology (SGJ), Weill Cornell Medical College; Department of Infection Control and Prevention (JMC, MM, EYF, PLG, LS), Division of Quality and Patient Safety (RG, PLG), New York-Presbyterian Hospital, National Center for Disaster Preparedness, Mailman School of Public Health (JS), Columbia University, New York; *Pediatr Crit Care Med.* 2012 Jan 5. [Epub ahead of print].

OBJECTIVE: We previously reported the epidemiology of 2009 Influenza A (H1N1) in our pediatric healthcare facility in New York City during the first wave of illness (May-July 2009). We hypothesized that compared with the first wave, the second wave would be characterized by increased severity of illness and mortality.

DESIGN: Case series conducted from May 2009 to April 2010.

SETTING: Pediatric emergency departments and inpatient facilities of New York-Presbyterian Hospital.

PATIENTS: All hospitalized patients ≤ 18 yrs of age with positive laboratory tests for influenza A.

MEASUREMENTS AND MAIN

RESULTS: We compared severity of illness during the first and second wave assessed by the number of hospitalized children, including those in the pediatric intensive care unit, bacterial superinfections, and mortality rate. Compared to the first wave, fewer children were hospitalized during the second wave ($n = 115$ vs. 76), but a comparable portion were admitted to the pediatric intensive care unit (30.4% vs. 19.7%; $p = .10$). Pediatric Risk of Mortality III scores, length of hospitalization in the pediatric intensive care unit, incidence of respiratory failure and pneumonia, and peak oxygenation indices were similar during both waves. Bacterial superinfections were comparable in the first vs. second wave (3.5% vs. 1.3%). During the first wave, no child received extracorporeal membrane oxygenation and one died, while during the second wave, one child received extracorporeal membrane oxygenation and there were no deaths.

CONCLUSIONS: At our pediatric healthcare facility in New York City, fewer children were hospitalized with 2009 Influenza A (H1N1) during the second wave, but both waves had a similar spectrum of illness severity and low mortality rate.

Medical reconciliation in patients discharged from the emergency department.

Sharma AN, Dvorkin R, Tucker V, Margulies J, Yens D, Rosalia A Jr., Department of Emergency Medicine, Good Samaritan Hospital Medical Center, West Islip; *J Emerg Med.* 2011 Dec 22. [Epub ahead of print].

BACKGROUND: Medication errors are considered to be a significant cause of morbidity and mortality. For each patient, emergency departments (EDs) are expected to compile a list of medications, reconcile them, and pass them along to the next provider. The electronic medical record provides a method to automatically capture and propagate what may be incorrect information.

OBJECTIVES: The aim of this study was to compare the medication information that patients ultimately discharged from the ED provide to the ED staff vs. the medication information the patients provide at follow-up, and to classify and quantify the types of discrepancies between the two.

METHODS: We conducted a retrospective descriptive study of a convenience sample of 36 patients who were discharged from the ED and who reported taking five or more medications. Discrepancies were identified by comparing information collected at the time of the index ED visit with that gleaned from follow-up contact within 7 days of discharge.

RESULTS: Of the 36 charts analyzed, 286 medications were provided by patients at the time of their ED visit. Subsequent determination of actual medication use on follow-up found 120 discrepancies, for a discrepancy rate of 42.0% (95% confidence interval [CI] 36.4-47.8%). One or more discrepancies were found on 86.1% of charts (95% CI 74.8-97.4%).

CONCLUSIONS: Frequent discrepancies are found in the medication information that patients provide in the ED. Requiring the ED to reconcile medication information and to pass it on to the next provider can be a source of treatment errors in the outpatient setting.

Interventions to improve the timeliness of emergency care.

Handel D, Epstein S, Khare R, Abernethy D, Klauer K, Pilgrim R, Soremekun O, Sayan O., Oregon Health & Science University (DH), Portland, OR; Beth Israel Deaconess Hospital, Harvard University (SE), Boston, MA; Northwestern University (RK), Chicago, IL; Emergency Nurses Association (DA), Des Plaines, IL; Emergency Medicine Physicians (KK), Canton, OH; The Schumacher Group (RP), Lafayette, LA; University of Pennsylvania (OSo), Philadelphia, PA; and Columbia University (OSa), New York, NY.; *Acad Emerg Med.* 2011 Dec;18(12):1295-302.

With a persistent trend of increasing emergency department (ED) volumes every year, services are intensifying. Thus,

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improving the timeliness of delivering emergency care should be a primary focus, both from an operational and from a research perspective. Much has been published on factors associated with delays in emergency care, and the next phase in this area of research will focus on exploring interventions to improve the timeliness of care. On June 1, 2011, Academic Emergency Medicine held a consensus conference titled “Interventions to Assure Quality in the Emergency Department.” This article summarizes the findings of the breakout session that investigated interventions to improve the timeliness of emergency care. This article will explore the background on the concept of timeliness of emergency care, the current state of interventions that have been implemented to improve timeliness, and specific questions as a framework for a future research agenda.

Interventions to improve patient-centered care during times of emergency department crowding.

Pham JC, Seth Trueger N, Hilton J, Khare RK, Smith JP, Bernstein SL., Department of Emergency Medicine and Department of Anesthesia Critical Care Medicine, Johns Hopkins University School of Medicine (JCP), Baltimore, MD; Department of Emergency Medicine, Mount Sinai School of Medicine (NST), New York, NY; Department of Emergency Medicine, University of Pennsylvania (JH), Philadelphia, PA; Department of Emergency Medicine, Northwestern University, Feinberg School of Medicine (RKK), Chicago, IL; Department of Emergency Medicine, George Washington University (JPS), Washington, DC; and Department of Emergency Medicine, Yale School of Medicine (SLB) New Haven, CT; Acad Emerg Med. 2011 Dec;18(12):1289-1294.

Patient-centered care is defined by the Institute of Medicine (IOM) as care that

is responsive to individual patient needs and values and that guides treatment decisions. This article is the result of a breakout session of the 2011 Academic Emergency Medicine consensus conference “Interventions to Assure Quality in the Crowded Emergency Department” and focuses on three broad domains of patient-centered care: patient satisfaction, patient involvement, and care related to patient needs. The working group provided background information and an overview of interventions that have been conducted in the domains of patient satisfaction, patient involvement (patients’ preferences and values in decision-making), and patient needs (e.g., comfort, information, education). Participants in the breakout session discussed interventions reported in the medical literature as well as initiated at their institutions, discussed the effect of crowding on patient-centered care, and prioritized, in a two-step voting process, five areas of focus for establishing a research agenda for studying patient-centered care during times of crowding. The research priorities for enhancing patient-centered care in all three domains during periods of crowding are discussed. These include assessing the effect of other quality domains on patient satisfaction and determining the effects of changes in ED operations on patient satisfaction; enhancing patient involvement by determining the effect of digital records and health information technology (HIT); rapid assessment areas with focused patient-provider communication; and meeting patients’ needs through flexible staffing, use of HIT to enhance patient communication, discharge instructions, and post discharge telephone calls.

L-carnitine increases survival in a murine model of severe verapamil toxicity.

Perez E, Chu J, Bania T, Medlej K., Department of Emergency Medicine, St Luke’s/Roosevelt Hospital, New York; Acad Emerg Med. 2011 Nov;18(11):1135-40.

OBJECTIVES: L-carnitine is an essential compound involved in cellular energy production through free fatty acid metabolism. It has been theorized that severe verapamil toxicity “shifts” heart energy production away from free fatty acids and toward other sources, contributing to profound cardiogenic shock. The primary study objective was to determine whether intravenous (IV) L-carnitine affects survival in severe verapamil toxicity. Secondary objectives were to determine the effects on hemodynamic parameters. The authors hypothesized that IV L-carnitine would increase both survival and hemodynamic parameters in severe verapamil toxicity.

METHODS: This was a controlled, blinded animal investigation. Sixteen male rats were anesthetized, ventilated, and instrumented to record mean arterial pressure (MAP) and heart rate. Verapamil toxicity was achieved by a constant infusion of 5 mg/kg/hr. After 5 minutes a bolus of 50 mg/kg of either L-carnitine or normal saline was given. The experiment concluded when either 10% of baseline MAP was achieved or 150 minutes had elapsed. The data were analyzed using Kaplan-Meier analysis, log rank test, and analysis of variance.

RESULTS: The median survival for the animals in the L-carnitine group was 140.75 minutes (interquartile range [IQR] = 98.6 to 150 minutes), and for those in the normal saline group it was 49.19 minutes (IQR = 39.02 to 70.97 minutes; $p = 0.0001$). At 15 minutes the MAP was 20.45 mm Hg greater in the animals in the L-carnitine group than in the animals in the normal saline group (95% confidence interval [CI] = 0.25 to 40.65; $p = 0.047$).

CONCLUSIONS: When compared with saline, IV L-carnitine increases survival and MAP in a murine model of severe verapamil toxicity.

The low rate of bacterial meningitis in children, ages 6 to 18 months, with simple febrile seizures.

Hom J, Medwid K., Department of Emergency Medicine, New York University School of Medicine, NY; Acad Emerg Med. 2011 Nov;18(11):1114-20.

OBJECTIVES: This evidence-based review examines the risk of bacterial meningitis as diagnosed by lumbar puncture (LP) in children presenting to the emergency department (ED) with a simple febrile seizure. The study population consists of fully immunized children between ages 6 and 18 months of age with an unremarkable history and normal physical examination.

METHODS: MEDLINE, EMBASE, and Cochrane Library databases were searched for studies that enrolled children who presented with simple febrile seizure to the ED and had LP performed to rule out meningitis. The primary outcome measure was the risk of bacterial meningitis based on findings of the LP. The secondary outcome was the rate of cerebrospinal fluid (CSF) pleocytosis in children who were pretreated with antibiotics.

RESULTS: Two studies enrolling a total of 150 children met the inclusion and exclusion criteria. The overall rate of meningitis was 0% (95% confidence interval [CI] = 0.0% to 3.0%). The rate of CSF pleocytosis in children who were pretreated with antibiotics was 2.5% (95% CI = 0.0% to 14.0%).

CONCLUSIONS: The sample size of the studies included in this review is too small to draw any definitive conclusion. However, their findings suggest that the risk of bacterial meningitis in children presenting with simple febrile seizure is very low.

Factors associated with failure to follow-up at a medical clinic after an ED visit.

Naderi S, Barnett B, Hoffman RS, Dalipi R, Houdek L, Alagappan K, Silverman R., Department of Emergency Medicine, NYU Bellevue; Am J Emerg Med. 2011 Nov 11. [Epub ahead of print].

BACKGROUND: Although emergency department (ED) discharge is often based on the presumption of continued care, the reported compliance rate with follow-up appointments is low.

STUDY OBJECTIVES: The objectives of this study are to identify factors associated with missed follow-up appointments from the ED and to assess the ability of clinicians to predict which patients will follow-up.

METHODS: Patients without insurance or an outpatient primary care provider (PCP) were given a follow-up clinic appointment before discharge. Information identifying potential follow-up barriers was collected, and the physician's perception of the likelihood of follow-up was recorded. Patients who missed their appointment were contacted via telephone and were offered a questionnaire and a rescheduled clinic appointment.

RESULTS: A total of 125 patients with no PCP were enrolled. Sixty (48%; 95% confidence interval, 39-57) kept their scheduled appointment. Sex, distance from clinic, availability of transportation, or time since last nonemergent physician visit was associated with attendance to the follow-up visit. Clinicians were unable to predict which patients would follow-up. Contact by telephone was made in 48 (74%) of patients who failed to follow-up. Of the 14 patients willing to reschedule, none returned for follow-up.

CONCLUSION: Among ED patients who lack a PCP and are given a clinic appointment from the ED, less than half keep the appointment. Moreover, clinicians are unable to predict which patients will follow up. This study highlights the difficulty in maintaining continuity of care in populations who are self-pay or have Medicaid and lack regular providers. This may have implications on discharge planning from the ED.

Preoxygenation and prevention of desaturation during emergency airway management.

Weingart SD, Levitan RM., Division of Emergency Critical Care, Department of Emergency Medicine, Mount Sinai School of Medicine, New York; Ann Emerg Med. 2011 Nov 1. [Epub ahead of print].

Patients requiring emergency airway management are at great risk of hypoxic hypoxia because of primary lung pathology, high metabolic demands, anemia, insufficient respiratory drive, and inability to protect their airway against aspiration. Tracheal intubation is often required before the complete

information needed to assess the risk of peri-procedural hypoxia is acquired, such as an arterial blood gas level, hemoglobin value, or even a chest radiograph. This article reviews preoxygenation and peri-intubation oxygenation techniques to minimize the risk of critical hypoxia and introduces a risk-stratification approach to emergency tracheal intubation. Techniques reviewed include positioning, preoxygenation and denitrogenation, positive end expiratory pressure devices, and passive apneic oxygenation.



This column is compiled by Theodore J. Gaeta, DO MPH FACEP, Residency Program Director at New York Methodist Hospital; and Chair, New York ACEP Research Committee. ■

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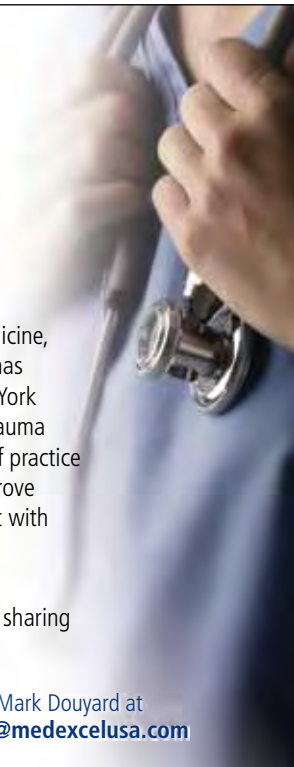
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Board Nominations

Active members of New York ACEP interested in serving on the Board of Directors are encouraged to submit their nominations to the 2012 Nominating Committee for consideration as the Committee develops the slate of candidates.

Four directors will be elected by the membership through a proxy ballot distributed at least 30 days prior to the annual membership meeting. The annual membership meeting will be held Tuesday, July 10, 2012 at the Sagamore Hotel on Lake George.

Board Members whose term ends in 2012:

Jay Brenner, MD FACEP*
Christopher I. Doty, MD FACEP*
Raymond Iannaccone, MD FACEP*
Kevin P. O'Connor, MD FACEP*

**These board members are eligible for reelection to a second, three-year term.*

Interested candidates should review the Board Criteria Policy, Board Member Duties & Responsibilities Policy and send a completed nomination form along with a copy of their CV to New York ACEP by **April 2, 2012**. Self nomination and nominations of colleagues are accepted.



For policies and nomination form go online to <http://www.nyacep.org/content/107-board-nominations>, email nyacep@nyacep.org or call New York ACEP at (585) 872-2417.

Successful nominees will be notified after May 1. Board candidates are required to submit background information on their professional career, a photograph and answer questions posed to all board candidates. Candidates will have approximately two weeks to submit material.

Councillor Nominations

Active members of New York ACEP interested in serving as a New York ACEP Councillor are encouraged to submit their nomination(s) to the 2012 Nominating Committee for consideration as the Committee develops the slate of candidates.

Councillors whose term ends July 2012:

Samuel F. Bosco, MD FACEP
Michael Cassara, DO FACEP
Christopher I. Doty, MD FACEP
Michael G. Guttenberg, DO FACEP
Raymond Iannaccone, MD FACEP
Stuart G. Kessler, MD FACEP
Sassan Naderi, MD FACEP
Louise A. Prince, MD FACEP
Anthony R. Ruvo, MD FACEP
Frederick M. Schiavone, MD FACEP
Peter Viccellio, MD FACEP

Continuing as Councillors through July 2013:

Brahim Ardolic, MD FACEP
Joel M. Bartfield, MD FACEP
Jay M. Brenner, MD FACEP
Gerard X. Brogan, Jr., MD FACEP
Jeremy T. Cushman, MD FACEP
Theodore J. Gaeta, DO MPH FACEP
David C. Lee, MD FACEP
Daniel G. Murphy, MD MBA FACEP
Gary S. Rudolph, MD FACEP
Resident representative (to be appointed)

The Board of Directors will elect 12 councillors at the Wednesday, July 11, 2012 Board meeting at the Sagamore Hotel. Members interested in representing New York ACEP at the ACEP Annual Council Meeting, (October 6-7, 2012 in Denver, CO), should submit a nomination form and their CV to New York ACEP. New York ACEP will be represented by 22 councillors at the 2012 ACEP Council meeting. ■

Nominations due no later than April 2, 2012

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Internet System for Tracking Over-Prescribing (I-STOP) Act. S.5720/A.8320

Daniel G. Murphy, MD MBA, Chair, Government Affairs Committee, New York American College of Emergency Physicians; Director of Emergency Services and Senior Director of Patient Care Operations, Mercy Medical Center

Last June on Long Island, where I practice, there was a heinous murder of four people in a pharmacy that was robbed by a couple stealing high volumes of OxyContin. On New Year's Eve, a federal agent who was picking up his father's cancer medication was killed trying to break up another cash and pill robbery. As the New York Times stated, "nowhere has the face of this (national) epidemic been more frightful than on Long Island, where a pair of pharmacy robberies 30 miles apart resulted in six deaths."

As emergency physicians who work every day on the front line of our health care system, we are well aware of the growing problem created by the addiction to and abuse of prescribed opiate analgesics. It is quite plausible to me that violence of the sort that has happened in pharmacies is possible in our emergency departments.

But this is a complex issue and it was in this context that your Government Affairs Committee carefully reviewed newly proposed legislation that intended to amend the public health law, in relation to creating an on-line real time controlled substance reporting system to monitor the prescribing and dispensing of certain controlled substances. After doing so, we composed the following talking points to share with the sponsor, Attorney General Eric T. Schneiderman.

The New York American College of Emergency Physicians supports the spirit and intent of S.5720/A.8320 but has reservations about how this proposed law will impact emergency department operations and emergency physicians in New York State. Our concerns fall into three categories: operational, behavioral and statistical.

1. The **operational** availability, reliability and efficiency of the proposed internet portal must function at a very high level in order to maintain patient flow and patient safety in the unfailingly hectic and interruption-driven emergency department environment of care.

- The number of emergency department patients who require pain control above and beyond what can be treated with non-controlled prescriptions is significant. The vast majority of these prescriptions are written for patients with acute illnesses and injuries, such as cancer pain and fractures. A "mandatory review of the database before prescribing or dispensing" for such routine patients in obvious need is unnecessary and time consuming, detracting from the care of other patients.

Emergency physicians in New York State are already accessing Regional Health Information Organization (RHIO) data in real time when the clinical need exists or there is a suspicious circumstance.

continued on page 24

Pediatric Emergency Medicine Physician

NYU Langone Medical Center/Bellevue Hospital Center

New York, NY

The Pediatric Emergency Medicine division at NYU School of Medicine is actively seeking BC/BE pediatric emergency medicine trained physicians to join our well-established academic group. We provide clinical services to the emergency departments at NYU Langone Medical Center and Bellevue Hospital. At NYU, pediatric patients are seen in a general emergency department with emergency medicine residents and physician's assistants. The pediatric emergency department at Bellevue Hospital is a physically separate service with pediatric nursing staff and waiting room. Bellevue is also the training site for our pediatric emergency medicine fellows, as well as pediatric and emergency medicine residents. Our academic interests include simulation (with access to a new state-of-the-art simulation center), ultrasound, trauma, and process improvement. Applications for full, part-time, or per diem work will be considered.

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Implementing a Scribe Program

continued from page 1

The benefits to the scribe are clear. Working daily in a busy emergency department environment provides exposure that cannot be gained in any other venue. They are able to gain an abundance of knowledge and experience while opening network opportunities to help launch their medical careers, all this while earning some extra money. Scribes are typically paid hourly with per diem rates ranging from ten to eighteen dollars an hour depending on regional locale.

The benefits to the physician, physician group, and department are equally attractive. Workplace and patient satisfaction levels should rise, compliance is boosted and the medical record is more accurately documented. In the age of the EMR, documentation times are increased and the scribe can get the physician to where they belong-at the bedside, developing a relationship with his or her patients. Scribe programs may also ultimately improve physician retention. Many experts argue that the revenue stream will also be improved. Arya, et al. reported with scribe support physicians evaluated 0.8 additional patients per hour with 24 additional RVU's per 10-hour shift. Improved productivity with a scribe program in place should fund itself.

There are several issues that may arise when working in a scribe-staffed emergency department. Some sites have reported the scribes have negatively impacted physician-nursing relationships creating a barrier to direct communication and camaraderie. Patients may be shy and not forthcoming answering all questions with another person in the exam room. Physicians may not engage with an EMR to the same extent if scribes are aiding them, this can potentially create alert "misses" if the scribe does not expeditiously make the physician aware. Various doctors will also adjust to working with a scribe differently. Some may love the experience and their production will elevate, others may prefer to work solo. And finally, the biggest issues facing EDs with scribe programs are related to training, implementation and attrition of the scribes themselves. Time and energy must be dedicated to developing these positions in

order to have them function appropriately. There are several approaches to equipping your ED with well-trained scribes that will be discussed in the specific sites below.

The North Shore University Hospital-Long Island Jewish Medical Center Experience

The scribe program is currently early in the implementation process, choosing the homegrown pathway to "scribe heaven." The ED team has developed a plan to recruit, train, and maintain scribes. The cost to the department will be significant as the recruiting, training, and management of this staff is no small task, however, complete control over the program is then the group's gain. Similar to other centers, there has been a partnership with a local university (Hofstra University) to offer a pre-medical introduction to a clinical medicine course designed to train students to become scribes while also giving them an exciting clinical experience. Students are given didactic sessions covering medical terminology, HIPAA, documentation of history and physical examinations, EMRs, EKG and imaging interpretation and many other details involving the day-to-day operations of an emergency department. The students then shadow emergency physicians documenting on a mock medical record performing most scribe duties other than documenting on the official chart. The students gain course credit and experience, the emergency department gains a pool of well-trained scribe candidates to choose from in the future. The interaction of the students with the physicians in completing the coursework will also aid the physicians in adapting to the workflow of a scribe environment. There are training/undergraduate courses currently being offered, though scribe hiring still lies in the human resources domain. Anticipated go-live is the first quarter of 2012.

The Albany Memorial Hospital Experience

Beginning in July 2009, the scribe program was implemented in response to rising emergency department volume and



Raio

emergency department physicians staying up to 2 hours late to dictate charts. The program was initiated as part of a solution to improve physician productivity, efficiency, and satisfaction by reducing the burden of documentation and by returning the physician to the bedside. The scribes were recruited, selected, and trained by an outside staffing company (ESquare). They were interviewed and tested on typing ability as well as medical terminology. After being selected, the scribes attended a week of didactic training followed by three weeks of clinical orientation. During the scribe training, the emergency department physicians also received orientation on how to most effectively interact with the scribes in order for the charting to be as accurate as possible.

The scribes initially were only able to complete the patient encounter documentation for the chart. As the program has matured they now effectively function as personal assistants and clinical information managers. They are able to prompt when re-evaluations and dispositions are needed, facilitate phone calls to consultants (and repeat phone calls when too much time has elapsed without a return call), and notify when labs and imaging are back (and when they haven't been done). They also remind the physicians to take breaks and take care of themselves during their shifts. Currently there is 24-hour scribe coverage, with all main-side shifts staffed from start to finish. They do not cover fast track or physician-in-triage shifts.

Implementing a scribe program was not without challenges. The first, and perhaps most significant, hurdle was to get the support of the physician group. Some doctors were concerned about having another person following them around the emergency department and being at the bedside during patient encounters. Others were concerned about the cost and wanted assurance of the productivity benefit. These issues were addressed at staff meetings until partners were comfortable with the idea of starting a scribe program and could envision the proposed benefits. Recruiting was another challenge, and it cannot be emphasized enough the importance of hiring the correct person for the scribe position. While some programs recruit heavily from college and medical students, targeting EMS providers and hospital employees has led to excel-



DeMartino

lent job retention. Finally, selecting the right tools for documentation is important. Albany Memorial utilizes an EMR for scribe charts and there is a learning curve for both scribes and physicians to acclimate themselves with the software.

Many improvements have been made due to the scribe program. Emergency department physicians consistently get out on time with all of their documentation completed. There has been a virtual disappearance of doctors dictating charts from home or staying hours after the end of the shift to complete them. This has resulted in a significant increase in physician job satisfaction as measured on a pre and post scribe implementation survey. Physician productivity has increased and allowed the number of hours of coverage to remain stable in spite of increasing patient volumes. Charting is more accurate because data is captured in real time, and this increased accuracy translates into improved reimbursement because the patient records are much more detailed.

The Rochester General Health System Experience



Grams

Implementation of the program began in fall of 2010, at the larger of two sites – a 100,000-visit community emergency department in Rochester. As with Albany Memorial, the program was specifically geared to improve departmental efficiency and help minimize the time spent by a physician in front of a computer. Another primary driver was physician satisfaction as some physicians were spending 3-4 hours after their shift's end in efforts to complete documentation. The ultimate goal was to free the physician of clerical duties and to get them back to the bedside.

Rochester General also chose a contracted group (Scribe America) for implementation. This allowed for more rapid adoption since the contractor had already developed training programs and material, as well as recruitment and hiring strategies. One of the primary choices for use of a contracted group was the timesavings experienced by the physicians and medical director. Since scribes are commonly college-aged students, there may be the experience of a “variable work ethic” – use of an outside group mitigated this potential hassle.

Adoption by the physician staff was relatively rapid with only a few physicians that were resistant initially. These physicians were soon clamoring for their own scribe as they recognized the potential benefits. Currently scribe coverage is limited to physicians practicing in the adult emergency department, with an additional 20 hours of midlevel practitioner coverage daily (reserved for midlevels practicing in an ambulatory triage area). Scribe coverage was also considered for the pediatric emergency physicians, however the cost of the additional coverage was not yet justified. Once the primary site was appropriately staffed, the scribe program spread to a secondary site – a single physician staffed 21,000-visit community emergency department.

Several benefits of the scribe program were recognized. There was an increase in physician satisfaction due to the liberation from clerical duties and a decrease in the time required after shift completion. The group also realized improvement in other efficiency metrics. The number of patients seen per hour increased by 0.3-0.4, while the RVUs per hour increased up to 1.5 additional (although the scribe implementation coincided with a significant focus on coding accuracy with the hospital based coders). The department also saw a general increase in patient satisfaction over this period, but this was in conjunction with multiple other interventions underway.

Conclusion

As demonstrated above, each site benefited from differing approaches – there is no

cookie cutter formula for scribe program implementation. Each hospital has a different documentation system and emergency department physician team. A program must be tailored to meet the needs of the doctors within the constraints of available resources. Once in place, though, it has the potential to markedly improve the workday and effectiveness of the emergency department physician.

References/additional reading

1. Arya et al. Impact of Scribes on Performance Indicators in the Emergency Department. *Acad Emerg Med.* 2010;17:490-494
2. Hollingsworth et al. How do Physicians and Nurses Spend Their Time in the Emergency Department? *Ann Emerg Med.* 1998;31:87-91
3. Wiler et al. Optimizing Emergency Department Front-End Operations. *Ann Emerg Med.* 2010;55:142-160 ■

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I-STOP *continued from page 21*

- This law will require many hospitals to reorganize their internet policies and equipment, as many now block access to internet portals for security and employee productivity reasons.
- The number of data elements to be entered (15) will be time consuming and prone to error if done manually by a multi-tasked emergency physician.

Accordingly, an interface between the proposed portal, the applicable RHIO, the emergency department electronic medical record and the hospital's registration system should be a prerequisite. Institutions without such a system should be given a grace period until such a system is in place.

2. New York ACEP has concerns that the practice and **behavior** of well intentioned emergency practitioners who treat pain well will be inhibited by this law. The concern is that pain will be less adequately treated and patients will suffer due to fear of profiling or punishment or simple avoidance of a cumbersome process. We believe the purpose of this legislation is to provide a resource for practitioners and pharmacists to recognize drug-seeking behavior and manage it appropriately. To include fines and other punishments in this manner is unnecessary and counter-productive. There are other applicable laws already in place that are very clear and understood by patients, pharmacists and practitioners.

From a **statistical** and epidemiological perspective, New York ACEP has two issues:

- Section 1, line 9, states that the requirement would apply to controlled substances "or any other substances specified by the commissioner." This phrase should be deleted. Such mandatory reporting should be done for specific and well understood substances that have been identified as specific threats to the public health.
- If a system mandates data entry and tracking of a vast number of patients looking for a problem with a relatively low incidence, there is a high likelihood that data entry error and interpretation bias will erroneously attribute trends and blame to patients, pharmacists and practitioners.

This month, your president Dr. Joel Bartfield and other leaders of New York ACEP held a conference call with Justin Berhaupt, Senior Legislative Advisor to Attorney General, Eric T. Schneiderman and we are very pleased with how the call went.

The authors now seem to have a full appreciation of the importance of the state's emergency departments in dealing with this challenge. They also understand the operational constraints that we work under. Their position was very much aligned with our own. Emergency physicians would be exempted from the operational requirements of the proposed law with one caveat: our prescriptions for certain opiate analgesics would be limited to a 5-day supply.

Your Government Affairs Committee will continue to monitor this evolving legislation carefully. Let us know how you feel about the issue. Please also find the time to donate to the New York State Emergency Medicine Political Action Committee (NYEMPAC). Every \$20 or \$50 (or more) helps to wield influence and advocacy in Albany! You can go to our website home page (<http://www.nyacep.org>), click on the icon, and make a quick contribution anytime! ■



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march 2012

- 8 Practice Management Committee Conference Call, 1:00 pm
- 8 **Medical Student Symposium**, 6:00-10:00 pm, SUNY Downstate Medical University
- 9 **LLSA Review Course**, 8:00 am-1:00 pm, SUNY Upstate Medical University
- 14 Education Committee Conference Call, 2:00 pm
- 14 Professional Development Conference Call, 3:00 pm
- 15 EMS Committee Conference Call, 2:30 pm
- 21 Government Affairs Conference Call, 11:00 am
- 21 Research Committee Conference Call, 3:00 pm

april

- 2 Research Forum Abstract Submissions Due
Board of Director and Councillor Nominations Due
- 4 ED Leadership Forum Early Registration Deadline
- 11 Education Committee Conference Call, 2:00 pm
- 11 Professional Development Conference Call, 3:00 pm
- 12 Practice Management Committee Conference Call, 1:00 pm
- 15 Empire State EPIC Articles Due (May issue)
- 18 Government Affairs Conference Call, 11:00 am
- 18 Research Committee Conference Call, 3:00 pm
- 19 EMS Committee Conference Call, 2:30 pm

may

- 1 Board of Directors Meeting, 12:30-5:30 pm, New York Academy of Medicine, New York City
- 2 **ED Leadership Forum**, 8:00 am - 4:00 pm, New York Academy of Medicine, New York City
- 9 Education Committee Conference Call, 2:00 pm
- 9 Professional Development Conference Call, 3:00 pm
- 10 Practice Management Committee Conference Call, 1:00 pm
- 16 Government Affairs Conference Call, 11:00 am
- 16 Research Committee Conference Call, 3:00 pm
- 17 EMS Committee Conference Call, 2:30 pm
- 20-23 ACEP Leadership and Advocacy Conference, Omni Shoreham Hotel, Washington, DC
- 23 Sagamore Hotel Reservation Deadline
Scientific Assembly Early Registration Deadline

june

- 1 Online Board of Directors election opens
- 13 Education Committee Conference Call, 2:00 pm
- 13 Professional Development Conference Call, 3:00 pm
- 14 Practice Management Committee Conference Call, 1:00 pm
- 20 Government Affairs Conference Call, 11:00 am
- 20 Research Committee Conference Call, 3:00 pm
- 21 EMS Committee Conference Call, 2:30 pm

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