

New York American College of Emergency Physicians

ADVANCING EMERGENCY CARE 

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President's Message

It Takes Strong "Associations"

Daniel G. Murphy
MD MBA FACEP
Department of
Emergency Medicine
St. Francis Hospital
The Heart Center



I am proud to announce New York ACEP has done some heavy lifting in early 2014 in response to a very significant threat.

On January 15, we were made aware that a solution to the 'out-of-network problem' was contained in the New York State budget released by Governor Cuomo. This was compelling news, as our Governor has used the budget process very effectively during his tenure. Shockingly, the 'solution' was focused on 'emergency services' and the first draft of the proposed law was a potential catastrophe for emergency medicine professional reimbursement rates.

Essentially the new law (embedded in the budget) would exclude 'emergency services' from being included in new health insurance products designed to cover 'out-of-network' care at reasonable rates. Worse yet, the insurers would be held responsible only for keeping their customers protected from additional out of pocket expense and could pay for out-of-network emergency services what they, the insurer, thought was 'reasonable.' If physicians had a problem with those rates, they could appeal each and every bill to an independent dispute resolution entity (IDRE).

Our hearts were in our mouths.

Some background is advisable for this complex issue – an issue that your New York ACEP Government Affairs Committee has been working arduously on for many years:

1. A balance bill is when a practitioner bills the patient for the difference between what the insurance company paid and the original charge for professional services when practitioners, or their delegated entity, do not have a contract with the patient's insurer.
2. Emergency physicians often have little negotiating leverage against health insurance behemoths, especially when a region has a limited number of competing insurers. The emergency physicians can be left with 'take it or leave it' rates. The viable option of

'leaving it' and remaining 'out-of-network' is often crucial to successful negotiations.

3. Emergency physicians work in departments and groups of different sizes and governance. Some emergency physicians are employed and/or academic and feel distant or insulated from this issue. That is a misconception. The value (and pay) of all emergency medicine is at stake. The market directly or indirectly drives wages for all.
4. The insurance companies resent out-of-network charges and have tried several tactics over the years to outmaneuver them. New York ACEP was crucial in pointing out that the Ingenix database was corrupt and 'rigged' and we applauded loudly when then Attorney General Andrew Cuomo gutted it. The Ingenix database was constructed by the insurance companies and purported to represent regional "Usual and Customary Rates (UCR)" for out-of-network services.
5. There are legitimate consumer complaints about 'egregious' or 'surprise' out of network bills that the state regulators and politicians take quite seriously. It is very important to know that NONE of those complaints over the years have involved emergency medicine. Our charges tend to be three digits, not four, and certainly not five.

We are well known to several key elected officials and regulators in Albany. We have used your New York Emergency Medicine Political Action Committee money wisely and we contract with a very effective Albany lobbying firm, Reid, McNally and Savage.

We made numerous conference calls to elected officials, national ACEP, experts from within our membership and experts from other states that have successfully or

unsuccessfully fought similar battles. We met with our colleagues at Medical Society of The State of New York (MSSNY).

Our Lobby Day, March 4, was well attended and extremely effective. We stated that emergency medicine could not support the bill as written. We reminded them that our specialty represents those physicians who staff New York's emergency departments, the "safety net," 24-hours a day, 7-days a week. We reminded them that we are "open" when all private offices and urgent care centers are closed and shuttered for the night and we are equipped and trained to handle all levels of acuity. We reminded them that we treat anyone who comes to our doors, regardless of their ability to pay, and that it is an honor and privilege to do so.

We also made a counter-proposal.

We asked that the E&M codes used by emergency physicians be excluded from the bill if they are less than \$1,200.

The amendment was included in the final bill negotiated between the Assembly, Senate and Governor's Office – except that they scaled back the \$1,200 threshold to \$600. That is how sausage is made in this republic.

In the end, instead of 100% of out-of-network emergency medicine professional revenue being dictated by insurance companies, perhaps 10-25% of our bills (those >\$600) will need to go to IDRE arbitration. Those bills that are less than \$600 will be secure as long as they do not surpass 120% of the newly refined and scrubbed UCR database ("Fair Health"). The \$600 watermark will be adjusted over time with inflation. The option of balance billing remains intact.

Admittedly, to our chagrin, emergency physicians may need to get familiar with the IDRE process in 2015 for our higher charges. Be assured that New York ACEP will work ceaselessly to ensure that the IDRE process is manageable and fair. ☘

Hospital Throughput – Taking a Lesson From the ED

Keith E. Grams
MD FACEP

Associate CMO, Patient Throughput
and Capacity Management
Chief, Emergency Services
Rochester General Health System



About a year ago, we described how a process change within the emergency department (ED) resulted in improved ED throughput. Implementation of a different ED triage flow model yielded significant – and sustained – improvements in several key metrics; including door-to-provider, left-without-treatment, left-without-being-seen, as well as several others.

Similar to other hospitals, we are constantly in a “bed crunch” due to boarding hospital inpatients within the ED. At times the ED houses the largest inpatient unit throughout the entire hospital. As we all know, even with well over 50% of the ED essentially shut down, the ED is still expected to provide care for the day’s incoming patient volume.

With continued hospital overcrowding we had one of two options: construct additional beds or improve patient throughput. Financial constraints served to eliminate the first choice relatively quickly. This helped focus efforts on an in-depth evaluation of the entire process surrounding patient throughput. By decreasing the patient cycle time, we would then be able to move more patients through the system and (hopefully) decrease ED boarding.

To begin the procedure, we reviewed the patient flow during the entire hospital admission. Once this process was mapped out we outlined areas of potential. All of these areas had their own challenges, some more substantial than others (i.e. surgical leveling, radiology turnaround times, testing availability on the weekends, etc.). Having already demonstrated improvements following a revamped ED triage process, we outlined how the initial “triage” of inpatient stay could be improved. This “inpatient triage” defined as the time from patient admission until the admitting physician’s evaluation and the initial orders enacted.

I have worked at sites that have made changes to this process, but each had distinct limitations. We did not want to simply station an inpatient physician team in the ED to see admitted patients and write the orders, as this would improve a small piece

of the process. We reviewed the entire process to determine how to construct a procedure that would translate maximal results directly to the patient. For example, it is of limited benefit to the patient if an admitting physician generates a series of orders that cannot be followed by an ED nurse busy with multiple patients. Having learned that the best approach to ED triage was the team approach, we set out to identify the key team components to get to the patient as early as possible with maximal benefit.

We further generated a detailed map of the admission process to identify the key elements. Utilizing this map, we were able to identify the initial players and set goals for the initial pilot. Reviewing the current process and limited data available, we could see that patients may wait hours after admission until they see their admitting physician (no real surprise with that discovery). Likewise, even after the admission orders were written, it could be several hours until the orders are “taken off” and translated to allow the bedside nurse to initiate care. This was especially true when the patient boarded in the ED, as the ED nurse was usually occupied with caring for the continual incoming patients.

We chose to follow several time intervals, including admission-until-provider-evaluation-completed and the admission-to-medical-administration-record-completed. These metrics helped to outline the standard work that could be expected from the team on a daily basis. Defining the endpoint was fairly easy; the patients seen by this Patient Centered Admission Team (PCAT) would be expected to have a lower length of stay compared to their counterparts that were not seen by this team.

Minimal adjustments were made to the initial team. The team consisted of an inpatient physician (hospitalist), a scribe to assist the physician, a pharmacist, two nurses and a patient care technician (PCT). Each member of the team had their specific duties described to ensure a standard process would be followed and to minimize non-value added steps. By mapping out

these pieces, we were able to orchestrate the approach to maximize the team’s efficiency.

Step 1

Once the hospitalist identifies the patient, the PCT locates the patient and obtains a set of vital signs. This ensures that the physician has updated information, as the most recent vital signs may be a few hours old. In addition to the vitals signs, the PCT also brings a scale to ensure that an accurate weight is obtained – often a challenge in a busy ED. After completion of these duties, the PCT then assists the nurses as needed before proceeding to the next patient.

Step 2

The second person to enter the room generally is the pharmacist. They review the patient’s medication list directly with the patient, often beginning with the current list within the electronic medical record (EMR) – which can generally be assumed to be incorrect. The pharmacist would also obtain a list of the pharmacies that the patient utilizes. After completion of this brief interview, the pharmacist begins calling the pharmacies to collaborate all the information provided. With all of these sources, the pharmacist collates the information to a clear and succinct medication list. This step can take some time, but is well worth the effort in generating an accurate list to build on for the admission.

Step 3

During Steps 1 and 2 the hospitalist generally spends their time reviewing the medical record available in the EMR, including past notes and the ED provider’s evaluation. Step 3 essentially begins with the hospitalist, scribe, and primary nurse entering the patient’s room and the physician beginning their history and physician. The presence of the nurse helps to minimize the double questioning that is all too common. After the physician completes their portion they exit the room to finalize the documentation with the scribe. Upon the physician’s departure, the primary nurse can complete the rest of the required admission documentation and to complete their assessment.

Once the physician completes their documentation they can review a verified medication list as they write the initial inpatient orders. The pharmacist can also monitor the initial orders to facilitate pharmacy verification and to make any needed changes (i.e. formulary substitutions, ensuring proper antibiotic coverage, etc.). Also occurring during Step 3 is the identification of the next patient for PCAT, allowing the PCT and pharmacist to begin the next cycle.

Step 4

With a now complete medication list, admission history and physical, and initial inpatient orders, the secondary nurse begins to administer the key medications to the patient. This extra resource allows minimal delay from order entry until care initiated, which would be significantly longer if the ED nurse was expected to incorporate this additional work into his/her duties. Once this process is complete, the secondary nurse hands off to the bedside nurse, which is commonly the ED nurse since the patient is often still boarding.

Initial Pilot Results

The initial pilot demonstrated a remarkable decrease in the time from admission until seen by admitting physician. This was not too surprising, since the process was designed to minimize this delay. The average time from admission until minimum admissions requirement (MAR) completion also dropped significantly – from 8 hours to less than one hour. Minimizing these initial hospitalization delays resulted in improved overall throughput. The PCAT patient's hospitalization Length of Stay (LOS) was shorter by nearly 0.9 days.

As a pleasant surprise, we also discovered that the PCAT patients had a lower readmission rate – 8% vs a baseline of 15%. As we investigated the factors behind this decreased readmission rate, it appeared that the primary driver was the accurate medication list. Anecdotally, the PCAT patients were also discharged earlier in the day since the accurate medication list greatly facilitated the discharge medication reconciliation.

Full implementation

For full implementation, we needed to generate a business case argument. We had to demonstrate that these additional positions would ultimately ensure a return on investment (ROI). To justify the team

composition, we were able to calculate the required LOS improvement and minimal patient volume to meet financial expenditures. With the near constant hospital overcapacity, we utilized the saved bed days as the primary financial driver. These numbers will vary based upon each hospital's finances, but can be readily calculated with some basic data. With your profit-per-case and average hospital LOS in hand, you can calculate how much each bed day is worth (e.g. if profit per case is \$2,000 and average LOS = 5 days, then each bed day is worth \$400). By decreasing the LOS you are essentially generating additional patient capacity, thereby increasing profitability.

All the team members were incremental additions, except for the hospitalist (which was an “admitting physician” already scheduled for their team). Therefore, we needed to determine the number of patients and LOS savings that would essentially cover the salary cost of the remaining team members. With the initial two pilot findings and figures in hand we were able to present to the hospital board. Up to that point, all other projects had little impact on LOS despite all the claims. With the positive findings and financial argument in hand, we were able to gain rapid acceptance by the hospital board and the “C suite.” The first team was fully implemented and followed for a few months. With continued ROI demonstration, we implemented a second PCAT team to broaden coverage.

Non-Immediate Financial Benefits

The major reasons for PCAT implementation had to be generated primarily with respect to finances. Working through the process we also expected some less “tangible” benefits; those that are more difficult to justify with the finance folks. Patients generally seem to be more satisfied with the newer approach. We have received multiple compliments surrounding the new process, with patients citing a past poor experience with the previous process. We have also seen a decrease in number of events where a boarding patient suffered a miss or near-miss due to care delays.

The new process also resulted in greater than expected pharmacy cost avoidance. Initial estimates were about a third of the current realized gains. While not “hard dollars,” we continue to follow this estimated cost savings to further support the financial case for the PCAT process.

We still observe a decreased readmis-

sion percentage for the patient processed by the PCAT team. As we move to more penalties for readmissions, this will undoubtedly be increasingly important.

Lessons Learned (aka lessons to learn from our mishaps)

Due to some leadership changes, we observed an unfortunate decrease in the initial success of the 2 PCAT teams. Without the continued monitoring and oversight there was deviation from the standard process with significant team confusion and the loss of team dynamics. This yielded in fewer patients seen each day, as well as a slip in the LOS improvements. By “re-implementing” the standard work and holding parties accountable, we were able to again realize the process improvements. Unfortunately, the return to baseline took several months.

During this process rework, we also noticed that the daily number of patients seen was lower than ever. Resetting the daily minimum as an expectation and ensuring a constant patient flow helped to reset the process. Probably the fastest driver was open and “un-blinded” reporting of individual provider metrics. This approach fostered “natural competition” and helped to improve the metrics more rapidly. We now report the metrics regularly at a biweekly meeting as we continue to monitor the process.

Future Changes

Having returned to the original process we now see a more sustained improvement. At this point, we are reviewing the financial case for addition of a third team and/or extension of team hours. We are also exploring a modified PCAT approach. For example, there are a number of admitted patients that make it to the inpatient floors before being seen by an admitting physician. In this case the PCAT process could likely be modified, since the full team may not be necessary.

Conclusion

By reviewing the admission process we were able to identify improvement potential and to minimize non-value added steps for the patient. By implementing a Patient Centered Admission Team, we have been able to generate additional hospital capacity as well as realize “non-immediate financial” benefits with improvement patient satisfaction, patient safety and cost avoidance. This additional hospital capacity has perpetuated the financial case to continue the process as well as potentially implement additional teams. ☘

Sound Rounds

Practical Applications for the Emergency Physician

Penelope C. Lema
MD RDMS FACEP

Director, Emergency Ultrasound Fellowship
Assistant Professor, University of Buffalo
Department of Emergency Medicine



First Trimester Pregnancy Ultrasound



Guest Authors

Devjani Das, MD RDMS, Associate Director, Emergency Ultrasound
Clinical Assistant Professor, SUNY Downstate Medical Center

Josh Greenstein MD, Emergency Medicine Resident
Staten Island University Hospital, Department of Emergency Medicine

Indications

- A positive beta-HCG with an unconfirmed intrauterine pregnancy (IUP) and abdominal pain, pelvic pain and/or vaginal bleeding.

Technique

Transabdominal Approach

- Use a curvilinear or phased array transducer.
- Obtain transverse and longitudinal views of the uterus and adnexa (Figure 1 and Figure 2).
- Place transducer in the midline of the abdomen above the pubic symphysis with the probe marker aimed towards the patient's right side to obtain the transverse view.

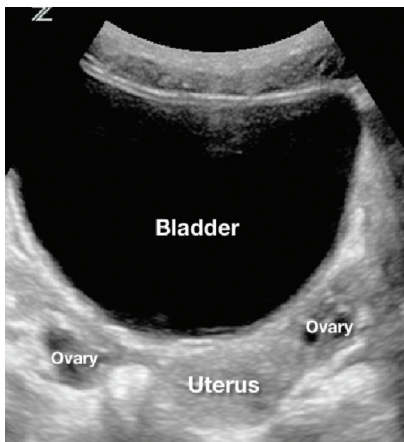


Figure 1
Transabdominal ultrasound image of the uterus and ovaries in transverse view

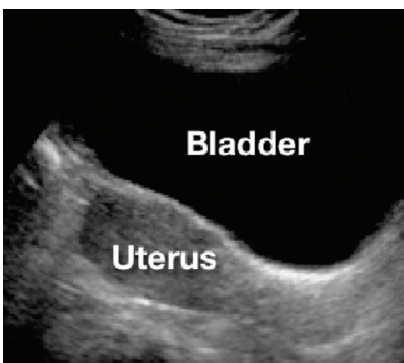


Figure 2
Transabdominal ultrasound image of the uterus in longitudinal view

- Rotate the probe marker towards the patient's head to obtain the longitudinal view.
- Scan the uterus thoroughly in the transverse (fan probe up and down) and longitudinal (fan probe side to side) views to completely view the uterus and adnexa.
- The ovaries are found lateral to the uterus but are often difficult to find in the transabdominal view.
- If no intrauterine pregnancy is identified, the transvaginal approach should be performed.

Transvaginal Approach

- Use a high frequency endocavitary probe.
- The probe should be covered with a sterile cover prior to insertion.
- Place gel within and outside the probe cover. Sterile gel should be placed on the outside of the probe cover.
- Initially insert the endocavitary probe with the probe marker towards the ceiling to obtain the longitudinal view of the uterus (Figure 3a and Figure 3b).

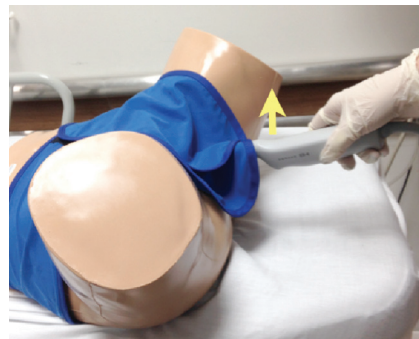


Figure 3a (left) Insertion of endocavitary probe with probe marker towards the ceiling

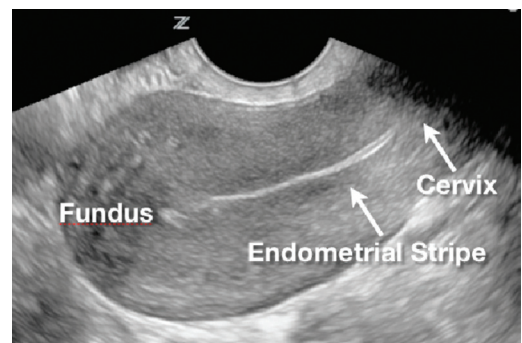


Figure 3b (right)
Transvaginal longitudinal view of uterus

- Scan through the entire body of the uterus and the surrounding structures laterally.
- Turn the probe marker 90 degree counter-clockwise so the probe marker is towards the patient's right to visualize the uterus in the coronal plane. Scan through the entire uterus anterior-posteriorly (Figure 4a and Figure 4b).

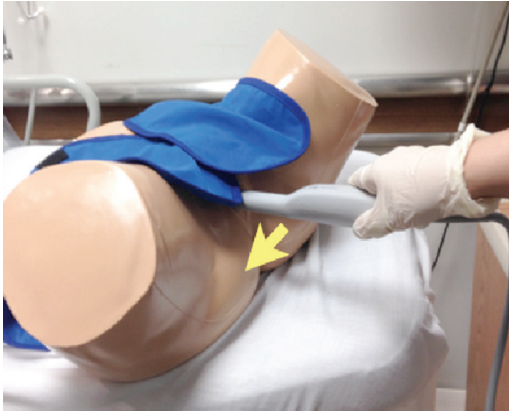


Figure 4a Insertion of endocavitary probe with probe marker towards the patient's right

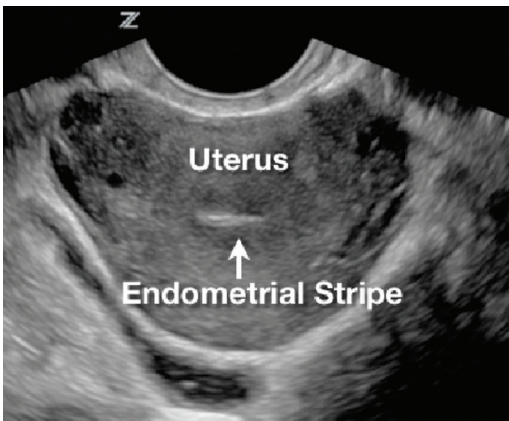


Figure 4b Transvaginal coronal view of uterus

- The ovaries can be identified by following the fallopian tubes and are located anterior and medial to the iliac vessels.

Tips

- The patient should have a full bladder with the transabdominal approach. This provides an ideal acoustic window to visualize the uterus, adnexa and ovaries.
- The bladder should be empty when using the transvaginal approach.
- Patients often experience less discomfort with self insertion of the endocavitary probe.

- The gestational sac appears as an anechoic sac within the endometrium and may be found as early as four weeks gestation (Figure 5). However, a gestational sac is not a definitive sign of an intrauterine pregnancy.



Figure 5
Transvaginal
transverse view of
gestational sac

- The first definitive sign of an intrauterine pregnancy on ultrasound is a yolk sac within the gestational sac ("sac within a sac"). The yolk sac appears as a hyperechoic ring within the gestational sac. This can typically be seen by five weeks gestation. (Figure 6)



Figure 6
Transvaginal
longitudinal view
of yolk sac

- A fetal pole and cardiac activity can be seen by the 6th to 7th week of pregnancy.

Pitfalls and Limitations

The discriminatory zone is the level of beta-hCG above which an intrauterine pregnancy should be visualized on ultrasound. Most recent literature quotes the threshold for transvaginal ultrasonography as 1,500 to 2,000 mIU/mL. The threshold for transabdominal ultrasonography is 3,000 to 5,000 mIU/mL. If the beta-hCG level is above this threshold, an intrauterine pregnancy should be visualized using either of the above modalities of ultrasound.

If no intrauterine pregnancy is identified and a complex adnexal mass and/or free fluid in the pelvic cul-de-sac is identified, the clinician should be suspicious for an ectopic pregnancy. If neither of the previous findings is identified, an ectopic pregnancy cannot be excluded. The presence of fluid in the hepatorenal recess, no identifiable intrauterine pregnancy and a hypotensive patient in the first trimester of pregnancy is essentially diagnostic for a ruptured ectopic pregnancy.

Women who have undergone assisted reproduction are at increased risk of heterotopic ectopic pregnancies.

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Toxicology

Are Benzodiazepines Better than Diphenhydramine for Drug Induced Akathisia?



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



Guest Author
Benjamin Kessler, MD, Toxicology Fellow
North Shore-LIJ Health Systems

Akathisia roughly translated from the Greek means “inability to sit.” It is characterized by the inability to sit still and is accompanied by the subjective sensations of anxiety and restlessness. Akathisia is a common side effect of many neuroleptics and is more associated with typical antipsychotics than atypical antipsychotics. The symptoms can easily be misdiagnosed as part of an underlying psychiatric disorder and make diagnosis more challenging.

The pathophysiology seems to involve dopamine antagonism in the mesocortical pathways but it is not completely understood. Symptoms usually occur relatively quickly and correlate with peak serum concentrations or increases in doses. Aside from adjustments of doses of antipsychotic medications, currently anticholinergics like benztropine or diphenhydramine as well as benzodiazepines are used for the treatment of drug induced akathisia. Beta blockers and alpha2 agonists have also been reportedly used. There seems to be some

controversy as to which is a more effective treatment modality.

There has been at least one blinded prospective randomized control trial for the treatment of akathisia induced by metoclopramide in an emergency department setting that compared diphenhydramine against midazolam. The study enrolled 56 patients and found that there was a quicker time to reduction of symptoms in patients that were randomized to the midazolam group. However, patients in both groups had reached an equal amount of relief from symptoms on both subjective and objective scores by approximately 15 minutes. The midazolam arm of the study was noted to have mildly higher sedation scores but there were no patients in the study who were unable to be aroused.

Additionally, there was a later study that attempted to answer if diphenhydramine was more effective than midazolam in the prevention of metoclopramide induced akathisia in the emergency depart-

ment setting. This also was a blinded, randomized, prospective trial that compared 225 patients using metoclopramide with midazolam, diphenhydramine or placebo. They found that 5% of the midazolam arm, 13% of the diphenhydramine arm and 21% of the placebo arm developed akathisia, however, the results did not reach statistical significance.

In summary, there is no clear evidence supporting use of one treatment modality over another. Midazolam may work faster than diphenhydramine but it is more sedating and may not be representative of other members of the benzodiazepine class.

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

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

Sanjey Gupta, MD FACEP
NSLIJ Franklin Hospital
516.256.6350

Stuart G. Kessler, MD FACEP
Elmhurst Hospital Center
718.334.3050

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

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

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

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

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resident representative


AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

America's Emergency Care Environment

Joshua Moskovitz
MD MPH MBA FACEP

EMS Liaison
North Shore University Hospital
Assistant Professor of Emergency Medicine
Hofstra North Shore-LIJ School of Medicine



This past February, ACEP put out its third installment in its series of emergency care reporting. The first edition in 2006 was significantly different than its 2009 counterpart, which enhanced many of the analyses from its original version. We find ourselves this year with the third installment in the series, with some improvements on the grading of its predecessor and robust changes in data.

New York State received a C grade this edition, the same as in 2009 though we escalated the ranks from 21st place to 13th place. While we had marked improvements in Access to Emergency Care (D- ⇒ C-) and Public Health & Injury Prevention (B- ⇒ B), we had significant declines in Quality & Patient Safety (A- ⇒ C+) and remained abysmal in the Medical Liability Environment (F).

The focus of this article will be specifically on Emergency Medical Services & Disaster Preparedness related issues as well as Public Health & Injury Prevention. Furthermore, it will review how New York State can improve its emergency care environment through enhancements in these activities.

In New York State we find ourselves in a unique position with EMS. Amongst the minority of states, we do not have oversight with a State EMS Medical Director; therefore protocols vary from region to region,

with 18 different regions in New York State alone. Further, there is no state funding for quality improvement within EMS systems although 28 states have established funds in place. We do excel, however, with enhanced 911 capabilities covering over 98% of our counties.

Regarding disaster preparedness, New York fared well overall, ranking 4th and receiving a B grade. Our strengths in our preparedness aspects include: emergency physician input into planning processes, accreditation by emergency management programs, state budget lines for health care surge, and the requirement that long term care facilities have written disaster plans. Areas for improvement include: addressing the needs of mental health patients, dialysis patients and chronic health needs patients in our disaster plan. Some lessons we learned downstate during Hurricane Sandy were that these patients were amongst the hardest to care for when people were struggling to get access to health care. We must prepare better during these events by anticipating where patients will receive their psychiatric medications, where end-stage renal disease patients will get dialysis, and where others with specific care needs will receive that care during crises mode.

Despite the controversies attracted by former Mayor Bloomberg's soda crusade, we as a state are fairing better than most

of our fellow Americans. Ranking 12th and receiving a B grade in Public Health & Injury Prevention, we should be proud but not complacent. We rank as a state amongst the best in health in number of traffic fatalities front occupant restraint use, child safety seat legislation and fatal occupational injuries. However, we still have areas that require further work, including increasing our child immunization rates, and our elderly influenza and pneumococcal vaccine rates that are currently below national average.

The third report on America's Emergency Care Environment is an opportunity we as a state need to take advantage of to crusade for change for the better of our patients and specialty through the improvement of our health care and also by reducing disparities. There is ample opportunity to make a difference. States such as Kansas and Oklahoma started an emergency medicine residency after the 2009 report card realizing they were one of the few states without one. Arkansas created funding for a statewide trauma system. Maine enacted motorcycle helmet laws and Arizona created liability protection for EMTALA. We as New Yorkers need to take this report card and work with our patients and representatives locally, regionally and nationally to create a healthier and safer environment to live and practice medicine. ☘



Board of Directors Election & Proposed Bylaws Amendments

This June, New York ACEP members will receive the 2014 Candidate Profile as well as proposed bylaws amendments. Through this proxy, members will elect four board candidates to serve three-year terms on the New York ACEP Board of Directors and vote on proposed bylaws amendments. As a chapter of the American College of Emergency Physicians, New York ACEP is required to assure its bylaws are in compliance with national ACEP bylaws. Proposed changes to the bylaws will both bring New York ACEP into compliance, as well as codify what is current practice. The New York ACEP Board of Directors support these amendments to the bylaws and do not believe they impart any restriction to conduct our business. Your approval of the proposed amendments to the New York ACEP bylaws is encouraged.

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

ISO 9001: Health Care's Future?



Louise A. Prince
MD FACEP

Associate Professor, Emergency Medicine
Chief Quality Officer, Upstate University Hospital



Julie A. Briggs
RN MSN CPHQ

ISO Management Representative and Patient Safety Officer
University Hospital, SUNY Upstate Medical University

DNV Healthcare Inc. was granted deeming authority for hospitals September 26, 2008 by the U.S. Centers for Medicare and Medicaid Services (CMS). They currently accredit approximately 312 hospitals in the United States. Nineteen hospitals in New York have transitioned to using DNV for accreditation including facilities in Buffalo, Syracuse and Utica along with many other upstate New York hospitals with the belief that this accreditation organization offers something different.

Det Norske Veritas (DNV) was originally a non-governmental organization from Norway that established and maintained technical standards for the construction and operation of ships and offshore structures beginning in 1864. They were organized with the objective to “safeguard life, property and the environment” by Norwegian insurance companies as a national alternative to foreign classification societies. They have spread world-wide and now provide services for quality improvement, process standardization, and managing risk in both the industrial and non-industrial settings.

ISO (International Organization for Standardization) is a worldwide federation of national standards bodies. (ISO in Greek – the same or identical). ISO 9001 details Quality Management System Requirements with the objective to set standards that meet the following objectives: Consistency (of care), Customer (patient) Satisfaction and Continual Improvement. Certification in ISO 9001 is seen throughout the world as the standard certification needed for quality driven organizations. DNV has chosen to use the National Integrated Accreditation for Healthcare Organizations standard (NIAHO) which combines the Center for Medicare and Medicaid Services Condi-

tions of Participation and ISO 9001. DNV offers annual hospital surveys with the focus of continual improvement. Survey year four not only serves as the NIAHO (CMS) certification year but also brings with it the expectation that the facility has implemented the ISO 9001 Quality Management System. The yearly visits assist the facility with identifying and improving quality on a continual basis rather than just an every third year “audit.”

The ISO Quality Management System begins with the establishment of a Quality Manual that defines how ISO 9001 fits into the organization (defines the scope of the organization; who they are and are not). It includes six required procedures that establish consistency, describe the interaction between the processes in the organization, and focus on continual improvement of the processes thus providing for consistent outcomes.

Control of Documents establishes control for all documents (internal and external) to ensure they are periodically reviewed, approved prior to use and available at the points of use. This establishes a process whereby each time a document is produced for use, it is the most current version available. Documents requiring control include policies, procedures, protocols, forms, job descriptions and competency checklists. One clinical area should be using the same document created for a specified purpose as another. There should be one policy in existence for an issue that governs the entire facility, not individual or stylized policies.

Control of Records ensures that any completed record (log, medical record, form) is stored, retained, protected or destroyed when appropriate. It establishes an easily identified list of all items stored,

their location and length of time they are retained across the institution (answers the perennial question of “what do we do with this record?”).

Audits come in three types: Internal (auditing our process), supplies and patients (satisfaction included), and external (audits by regulatory bodies for compliance). The five required audits include: Environment of Care, Clinical, Infection Control, the Quality Management System, and Utilization Review. Internal audits are performed by individuals who have no responsibility for the area/process being audited to ensure impartiality. There are scheduled areas to be audited along with recurrent time frames. Auditors return to the area to ensure prior identified issues have been corrected.

Control of Nonconforming Products addresses products or services that do not meet the intended original requirements. Examples include out-of-date products or medications, wrong side surgeries, expired food or even patient complaints. This policy establishes the procedures for how these non-conformances are managed consistently each time they occur and in every location.

The Corrective Action policy defines the organizational response to data/results that fall below the established benchmark. When the organization takes a corrective action they must always adhere to the following: Review of the identified problem, determination of cause, evaluation of the need for action to prevent recurrence, determine and implement the action, record the results of the action, and review the effectiveness of the action. An example would be a Root Cause Analysis to establish the “why” of the occurrence and the need for corrective action.

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A Time to Deny a Patient's Request

Jay M. Brenner
MD FACEP

Assistant Medical Director
Department of Emergency Medicine
Upstate University Hospital
at Community General



Assistant Professor, Emergency Medicine
Assistant Professor in the Center for Bioethics and Humanities
SUNY Upstate Medical University

PM is a 34 year-old man who presented to a tertiary care Emergency Department (ED) after an attempted hanging. The emergency physician (EP) intubated him for airway protection given a significant amount of soft tissue swelling in the neck. The Intensive Care Unit (ICU) admitted him and attempted a CPAP trial. He passed, and the ICU physician extubated him. When he awoke, he began cursing at the ICU physician and nurse. He said that he did not want to be cared for by an Indian-American physician or an African-American nurse. He only wanted to be cared for by "white doctors."

He was sedated and eventually reintubated. He did not have a health care proxy. His surrogate decision maker as determined by the Family Health Care Decisions Act (FHCDA) of 2010 was his fiancée. She approached Patient Relations (PR) to request a new attending physician, because her fiancée would have wanted to be cared for by a Caucasian physician. PR contacted the ICU physician and asked her if she would recuse herself from the care of PM. She called an ethics consult.

Should the patient's request for a "white doctor" or the patient's surrogate's request for a Caucasian physician be honored?

The greatest argument in favor of honoring this request is based on the principle of respect for autonomy. The patient has clearly stated his preference, and the surrogate has echoed it.

The most persuasive argument against honoring this request is based on the principle of justice. The hospital has an obligation to protect its employees from discrimination centered on the ethnicity and race of the physician and nurse.

Legal precedent has been established by a case in Flint, Michigan, where four nurses successfully sued Hurley Hospital for accommodating a white supremacist patient's demand that no black nurse touch his newborn child.

As an ethics consultant, my ability to fight for the non-discrimination rights of the employed physician and nurse was subverted by the PR involvement. The ICU physician felt as though she was being asked to recuse herself because of her ethnicity. The next day she requested to recuse herself because she felt as though she could no longer give good, unbiased care to the patient. Ethically, the hospital was obligated to accept her request for recusal under any circumstances. The patient was transferred to the care of another ICU physician, who happened to be Caucasian.

The experience left me unsatisfied with the response from the hospital to defend a physician's right to nondiscrimination. I approached the ethics committee with a resolution to prohibit honoring patients' requests for new physicians based on ethnicity or race. Vigorous debate ensued, but consensus could not be reached. It was tabled indefinitely.

The literature is unsettled on the question of honoring such a request from a patient. Ken Kipnis describes a case of a Korean man who refused life-saving care from Japanese physicians, because he feared that they were trying to kill him. When his care was transferred to non-Japanese physicians, he consented to treatment.

Meghan Lane-Fall writes that patient-centered care justifies tolerating bigotry. I beg to differ. Institutions have mission statements that protect their employees from discrimination. What do you think?

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- Karoub, J. "Some patients won't see nurses of different race." <http://bigstory.ap.org/article/some-patients-wont-see-nurses-different-race>. Accessed February 22, 2013.
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June

- 11 Education Committee Conference Call, 1:30 pm
- 11 Professional Development Conference Call, 3:30 pm
- 12 Practice Management Conference Call, 1:00 pm
- 18 Government Affairs Conference Call, 11:00 am
- 18 Research Committee Conference Call, 3:00 pm
- 19 EMS Committee Conference Call, 2:30 pm

July

- 7 Board of Directors Meeting, Sagamore Resort, 11:00 am-12:30 pm
- 7-9 Scientific Assembly, Sagamore Resort
- 8 Annual Meeting and Legislative Update, Sagamore Resort, 12:45-1:45 pm
- 8 Committee Meetings, Sagamore Resort, 1:45-2:15 pm
- 9 Board of Directors Meeting, Sagamore Resort, 7:00-8:00 am

September

- 10 Resident Research Conference, Icahn School of Medicine at Mount Sinai, 8:30 am-1:30 pm
- 11 Education Committee Conference Call, 2:00 pm
- 11 Professional Development Committee Conference Call, 3:00 pm
- 12 Practice Management Conference Call, 3:00 pm
- 18 Government Affairs Committee Conference Call, 11:00 am
- 18 Research Committee Conference Call, 3:00 pm
- 19 EMS Committee Conference Call, 2:30 pm
- 29 LLSA Review Course, Icahn School of Medicine at Mount Sinai, 8:00 am-1:00 pm

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Gonna Wait for the 'Two-Midnight' Hour

Salvatore Pardo
MD FACEP

Vice Chair
Emergency Department
Long Island Jewish Medical Center
Assistant Professor
Hofstra School of Medicine



Introduction

The 'Two-Midnight' Rule was born out of an effort by Centers for Medicare & Medicaid Services (CMS) to control costs by defining what qualifies as inpatient status. This is determined by whether a stay will be expected to carry across two midnights. Any stay which does not satisfy this requirement will be billed under outpatient services. The intent behind this was to decrease the amount of long observation status being used in hospitals, therefore protecting the beneficiary from paying out of pocket. However, some hospitals, providers and organizations (i.e., American Medical Association) believe the increased documentation requirements and oversight will have the opposite effect, increasing observation status and increasing out-of-pocket costs for the consumer. I agree with the latter, but only time will tell.

So, how does this affect the emergency medicine (EM) physician? Generally, I believe it affects us in at least three ways.

1. *More Free Stuff:* The Evaluation and Management code for the visit and any observation codes currently fall under and will remain classified as outpatient services. Outpatient services are reimbursed under part B. Generally, part B pays at 80% leaving 20% left to the patients' responsibility. As a result, the one day admits which formally may have been under part A (100% payment), may be downgraded to outpatient status. Thus, revenue will be subject to dispute, which generates administrative cost and likely more charity care.
2. *"Remember the Case You Saw Yesterday?"* As an emergency physician, often we have ultimate authority in the decision to admit or discharge. This has been fought for over the years and written into many hospitals bylaws. In turn, EM physicians are being asked by hospitals to not admit or hold off on admission in fear of being denied payment. Sites which are fortunate enough to have observation status as an option, frequently the option for observation is limited by the number of beds designated as Observation Status (OBS). Patients which have limited access to care or social needs are being held longer or being sent home prematurely. Result? Longer disposition times or more sleepless nights for the EM physicians.
3. *Patient and Provider Dissatisfaction:* This will be a "two for one."
 - a. Patients are already being asked to pay more in premiums and are feeling squeezed. There has been sensationalized media reporting on OBS, warning patients to avoid it. There is New York State legislation mandating disclosure of its financial impact. Ultimately, the docs will be the culprit of reaching into the patients' pockets. Expect more complaints and worse satisfaction scores since these patients will be getting "outpatient" surveys.
 - b. YOU as a physician are now being asked to think about another thing and fill out more paper with your signature. That usually goes over like a lead balloon.

Logistics

These are some of the requirements for documentation taken from the latest CMS document. Some or all of these sections may be interpreted as part of the emergency medicine physician's responsibility. It is up to the individual facility to determine how to satisfy them.

1) Physician Certification:

- a) Content: The physician certification includes the following information:
 - i) Authentication of the practitioner order:
 - (1) The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order.
 - (2) The requirement to authenticate the practitioner order may be met by the signature or counter-signature of the inpatient admission order by the certifying physician.
 - ii) Reason for inpatient services:
 - (1) The physician certifies the reasons for:
 - (a) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study;
or
 - (b) Special or unusual services for outlier cases under the applicable prospective payment system for inpatient services.

For example, documentation of an admitting diagnosis could fulfill this part of the certification requirement.
 - (2) The estimated (or actual) time the beneficiary requires or required in the hospital:
 - (1) The physician certifies the estimated time in the hospital the beneficiary requires (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed at discharge).
 - iii) The plans for post-hospital care.
- b) Timing:
 - i) Certification begins with the order for inpatient admission.
 - ii) The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13.
- c) Authorization to Sign the Certification:
 - i) The certification or recertification may be signed only by one of the following:
 - (1) A physician who is a doctor of medicine or osteopathy.
 - (2) A dentist

- (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.
- ii) Medicare considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician:
 - (1) the admitting physician of record (“attending”) or a physician on call for him or her;
 - (2) a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her;
 - (3) a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of
 - (4) a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility,
 - (5) a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above.
 - (6) The admitting physician of record may be an emergency department physician or hospitalist.
 - (7) Medicare does not require the certifying physician to have inpatient admission privileges at the hospital.
- d) Format:
 - i) No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form.

2) Inpatient Order:

- a) A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner.
- b) If the order is not properly documented in the medical record, the hospital should not submit a claim for Part A payment.
- c) Meeting the 2 midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A.

The full PDF from CMS can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf>.

Enforcement

Originally, the rule was to go into effect in October 2013 with a grace period of “probe and educate” until January 2014. This meant the penalties for noncompliance would not be levied before January, 2014. “Probe and educate” was then extended to April 2014, then again to April 2015. The delay extends the “probe and educate” period. Take note that there is **no delay in the audit potential**. Medicare Recovery Audit Contractors (RACs) can ask for monies back and the only aspect that has been delayed is the penalty for non-compliance. However, there is language which specifically states penalties could be levied if: ‘ . . . there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services . . . ’

The National Law Review (www.natlawreview.com) posted an article (**Enforcement of the Two-Midnight Rule Delayed Again, April 4, 2014**) in regard to the delay of the ‘two midnight’ rule. An excerpt below follows:

Last week President Obama signed into law a measure to extend Medicare physician pay rates for one year and to extend the enforcement delay of the ‘Two-Midnight’ rule through March 2015. Medicare Recovery Audit Contractors (RACs) are prohibited from auditing inpatient hospital claims for compliance with the rule from October 1, 2013, through March 31, 2015.

Physician documentation will be key. Certifications must clearly justify the admission and must include the reason for the inpatient treatment or diagnostic study, special or unusual services the patient will receive, the estimated time the patient will stay in the hospital, and plans for post-hospital care.

We recommend that hospitals take a proactive compliance approach that includes a focus on physician education and internal chart auditing.

The table below illustrates how the probe and educate process will go. Large hospitals will undergo a 25 sample survey and smaller hospitals a 10 sample survey. The sample taken is per provider.

	Number of Claims in Sample That Did NOT Comply with Policy		
	No or Minor Concerns	Moderate to Significant Concerns	Major Concerns
10 claim sample	0-1	2-6	7 or more
25 claim sample	0-2	3-13	14 or more
Action	For each provider with no or minor concerns, CMS will direct the MAC to: Deny non-compliant claims 1. Send summary letter to providers indicating: • What claims were denied and the reason for the denials • That no more reviews will be conducted under the Probe & Educate process. • That the provider will be subjected to the normal data analysis and review process 3. Await further instruction from CMS	For each provider with moderate to significant concerns, CMS will direct the MAC to : 1. Deny non-compliant claims 2. Send detailed review results letters explaining each denial 3. Send summary letter that: • Offers the provider a 1:1 phone call to discuss • Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims 4. Repeat Probe & Educate of 10 or 25 claims with dates of admission	For each provider with major concerns, CMS will direct the MAC to : 1, 2, 3 and 4 from previous column PLUS 5. If problem continues, Repeat Probe & Educate with increased claim volume of 100 – 250 claims

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Gonna Wait for the 'Two-Midnight' Hour

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Code 44

So what happens if you certify the encounter meets inpatient criteria and admit the patient, but then upon internal review, it does not. The answer: a CODE 44 form is used. This enables the hospital to reclassify the visit from inpatient to outpatient. Typically the status is downgraded to observation accounting for the time spent in the hospital. The critical aspect of this relies on the decision and execution happening BEFORE the patient is discharged. It certainly cannot be done in response to a denial.

There is concern regarding the "certification" being asked of the ED physicians and in regard to the liability attached to this certification. The ED leadership should have a clear understanding of how the cases will be reviewed before a claim is submitted to CMS by the hospital. There needs to be a robust internal review process. An excerpt from an American College of Emergency Physicians (ACEP) document is below:

This final rule also contained a change to the underlying regulation (not proposed in the draft) to include emergency physicians in the list of practitioners who can have hospital admitting privileges. Most EPs do not have, nor do most want admitting privileges. While this is a hospital by hospital decision, members are rightfully concerned with "certifying" medical need for the patient to stay of at least two days without having control over inpatient care.

More information regarding the use of code 44 can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R299CP.pdf>

Summary

In summary, the cases subject to review are those which are MEDICARE ONLY but, the commercial payers will follow suit in due time. It is practically and ethically difficult to treat patients differently based on their ability to pay or by the type of insurance they hold. The hospitals and the practitioners are put into a tough position because there is an inherent conflict of interest. Is the benefit to adopt clinical practice based on the "two midnight" rule worth the risk of losing potential revenue? Does the payer mix help determine the position a hospital takes on this issue? How does a contract group or a voluntary physician respond to a hospital agenda as opposed to hospital employed physicians? How will those who play along be compensated for assuming potential risk? These are all difficult questions to answer and way beyond my pay grade.

I do believe there is opportunity to improve the type of care we provide to our patients and standardize the way we treat certain disease processes. I also believe the goals asked of us can be more readily achieved with the existence of proper after care with appropriate access for the communities we serve as physicians, hospitals, and health systems. ☘

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New York State of Mind



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



Acquiring Credentials in Bedside Ultrasound: A Cross-Sectional Survey.

Lewis RE, Saul T, Del Rios M, Emergency Ultrasound Division, Department of Emergency Medicine, St Luke's-Roosevelt Hospital Center, New York, NY; BMJ Open. 2013 Aug 30;3(8):e003502

OBJECTIVE: Although there are training guidelines to credential emergency physicians in bedside ultrasound, many faculty groups have members who completed residency without a mandatory curriculum. These physicians are therefore required to learn bedside ultrasound while out in practice. The objective of this descriptive report is to illustrate a single academic facility's experience with acquiring credentials for emergency physicians in bedside ultrasound and the faculty's impressions on the motivators of and barriers to completion of the requirements.

DESIGN: Cross-sectional survey.

SETTING: Two urban teaching hospitals with a combined volume of 170,000 visits a year.

PARTICIPANTS: 41 emergency medicine attending physicians.

INTERVENTION: Emergency medicine attending physicians underwent training and credentialing in the applications of aorta and pelvic ultrasound over a 9-month period.

OUTCOME MEASURE: After the credentialing period, we conducted a survey to evaluate the physicians' perceptions of this process.

RESULTS: There were 41 faculty members during the credentialing survey period. 11 of the faculty members were exempt from ultrasound training. We asked attending physicians (N=41 exempt and non-exempt) to complete a web-based survey after the completion of the credentialing period. Questions about the potential barriers and incentives were listed and responders were asked to rank answers on a five-point Likert scale. Of the

31 respondents, 21 (67.7%) completed the credentialing requirements by the 9-month deadline. 19 of 26 emergency medicine residency trained physicians completed the requirements compared with 2/5 of those that were not emergency medicine residency trained. Our pilot study data suggest an association between fewer years in practice and completion of the requirements.

CONCLUSION: This is a report on a single academic institution's experience with a faculty credentialing programme in bedside ultrasound for physicians with a diversity of prior experience in bedside ultrasonography. We describe the success of the credentialing process and identify survey-based faculty characteristics associated with fulfilling the requirements.

A Brief Educational Intervention is Effective in Teaching the Femoral Nerve Block Procedure to First-Year Emergency Medicine Residents.

Akhtar S, Hwang U, Dickman E, Nelson BP, Morrison RS, Todd KH, Department of Emergency Medicine, Beth Israel Medical Center, New York, NY; J Emerg Med. 2013 Nov;45(5):726-30

BACKGROUND: Hip fractures are a painful condition commonly encountered in the emergency department (ED). Older adults in pain often receive suboptimal doses of analgesics, particularly in crowded EDs. Nerve blocks have been utilized by anesthesiologists to help control pain from hip fractures postoperatively. The use of nerve stimulator with ultrasonographic guidance has increased the safety of this procedure.

OBJECTIVES: We instituted a pilot study to assess the ability of Emergency Medicine (EM) resident physicians to effectively perform this procedure after a didactic and demonstration session.

METHODS: First-year EM residents from three urban training programs underwent a 1-h didactic and hands-on training session on the femoral nerve block (FNB) procedure. A written pretest was used to assess

baseline knowledge; it was administered again (with test items randomized) at 1 and 3 months post training session. A critical actions checklist (direct observation of procedure steps via simulated patient encounter) was used to assess the residents after the training session and again at 3 months.

RESULTS: A total of 38 EM residents were initially evaluated. Thirty-three successfully completed 1-month and 3-month written test evaluations; 30 completed all written and direct observation evaluations. The mean written pretest scores were 66% (SD 9); post-test 92% (SD 5), 1-month 74% (SD 8), and 3-month 75% (SD 9). After initial training, 37 of 38 (97%) residents demonstrated competency (completing ≥ 15 of 19 critical actions) in the FNB procedure determined via direct observation. At 3 months, 25 of 30 residents (83%) continued to retain 85% of their initial critical action skills, and 3 of 30 (10%) saw an improvement in their proficiency.

CONCLUSION: A 1-h training and demonstration module yielded high competency rates in residents performing critical actions related to the FNB; these skills were well maintained at 3 months. An ongoing study will attempt to correlate this competency with procedures performed on patients.

Point-of-Care Ultrasound in the Diagnosis of Upper Extremity Fracture-Dislocation. A Pictorial Essay.

Saul T, Ng L, Lewis RE, Department of Emergency Medicine, Division of Emergency Ultrasound, St. Luke's/Roosevelt Hospital Center, New York, NY; Med Ultrason. 2013 Sep;15(3):230-6

Patients commonly present with orthopedic injuries to the emergency department (ED). Although radiographs are the standard of care for evaluating these injuries, point-of-care ultrasound is being increasingly used to make the diagnosis. This modality can

continued on next page

New York State of Mind

be useful in patients who are too clinically unstable to leave the acute care ED and in nonverbal pediatric or geriatric patients who are unable to isolate their injuries. Published case series and prospective studies highlight the emergency physician's (EP) ability to detect fractures with point-of-care ultrasound with good accuracy. The American College of Emergency Physicians ultrasound guidelines advocate fracture identification as within the EP's scope of practice. This pictorial essay reviews how to use point-of-care ultrasound to diagnose fractures and dislocations of the upper extremity.

Experimental Treatments for Cocaine Toxicity: A Difficult Transition to the Bedside.

Connors NJ, Hoffman RS, Division of Medical Toxicology, Department of Emergency Medicine, New York, University School of Medicine, Bellevue Hospital Center, New York, NY; J Pharmacol Exp Ther. 2013 Nov;347(2):251-7

Cocaine is a commonly abused illicit drug that causes significant morbidity and mortality. Although there is no true antidote to cocaine toxicity, current management strategies address the life-threatening systemic effects, namely hyperthermia, vasospasm, and severe hypertension. Clinicians rely on rapid cooling, benzodiazepines, and α -adrenergic antagonists for management, with years of proven benefit. Experimental agents have been developed to more effectively treat acute toxicity. Pharmacodynamic approaches include antipsychotics that are thought to interfere with cocaine's actions at several neurotransmitter receptors. However, these medications may worsen the consequences of cocaine toxicity as they can interfere with heat dissipation, cause arrhythmias, and lower the seizure threshold. Pharmacokinetic approaches use cocaine-metabolizing enzymes, such as butyrylcholinesterase (BChE), cocaine hydrolase (CocH), and bacterial cocaine esterase (CocE). Experimental models with these therapies improve survival, primarily when administered before cocaine, although newer evidence demonstrates beneficial effects shortly after cocaine toxicity has manifested. CocE, a foreign protein, can induce an immune response with antibody formation. When enzyme administration was combined with vaccination against the cocaine molecule, improvement in cocaine-induced locomotor activity was observed.

Finally, lipid emulsion rescue has been described in human case reports as an effective treatment in patients with hemodynamic compromise because of cocaine, which correlates well with its documented benefit in toxicity due to other local anesthetics. A pharmaceutical developed from these concepts will need to be expedient in onset and effective with minimal adverse effects while at the same time being economical.

Management of Acute Asthma in the Pediatric Patient: An Evidence-Based Review.

Jones BP, Paul A, Pediatric Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York, NY; Pediatr Emerg Med Pract. 2013 May;10(5):1-23; quiz 23-4

Asthma is the most common chronic disease of childhood, with asthma exacerbations and wheezing resulting in more than 2 million emergency department visits per year. Symptoms can vary from mild shortness of breath to fatal status asthmaticus. Given the high prevalence of asthma and its potential to progress from mild to moderate to life-threatening, it is vital for emergency clinicians to have a thorough understanding of acute asthma management. Current evidence clearly supports the use of inhaled bronchodilators and systemic steroids as first-line agents. However, in those who fail to respond to initial therapies, a variety of adjunct therapies and interventions are available with varying degrees of evidence to support their use. This review focuses specifically on evaluation and treatment of pediatric asthma in the emergency department and reviews the current evidence for various modes of treatment.

Emergency Management of Dyspnea in Dying Patients.

Shreves A, Pour T, Department of Emergency Medicine, Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, New York, NY; Emerg Med Pract. 2013 May;15(5):1-19

Many terminally ill patients seek care in the emergency department. Understanding how to elicit goals of care from dying patients and initiate basic palliative measures is well within the scope of emergency medicine. While a wide variety of factors drive patients at the end of life into the acute-care setting, dyspnea is one of the most distressing symptoms experienced by dying patients, and it is a common reason for such patients to seek care. Many underlying disease states and acute illnesses account for shortness of breath

at the end of life, and management tends to be symptomatic rather than diagnostic, particularly in those for whom comfort is the most important goal. Opioids are the most effective and widely studied agents available for palliation of dyspnea in this population, while adjuvant therapies such as oxygen, noninvasive positive pressure ventilation, and fans may also play a role. Other medications (eg, benzodiazepines and low-dose ketamine) may also be useful in select patients. The early involvement of palliative medicine specialists and/or hospice services for dying patients can facilitate optimal symptom management and transitions of care.

Prehospital High-Dose Sublingual Nitroglycerin Rarely Causes Hypotension.

Clemency BM, Thompson JJ, Tundo GN, Lindstrom HA, University at Buffalo, Department of Emergency Medicine, Buffalo, NY; Prehosp Disaster Med. 2013 Oct;28(5):477-81

INTRODUCTION: High-dose intravenous nitroglycerin is a common in-hospital treatment for respiratory distress due to congestive heart failure (CHF) with hypertension. Intravenous (IV) nitroglycerin administration is impractical in the prehospital setting. In 2011, a new regional Emergency Medical Services (EMS) protocol was introduced allowing advanced providers to treat CHF with high-dose oral nitroglycerin. The protocol calls for patients to be treated with two sublingual tabs (0.8 mg) when systolic blood pressure (SBP) was >160 mm Hg, or three sublingual tabs (1.2 mg) when SBP was >200 mm Hg, every five minutes as needed.

HYPOTHESIS/PROBLEM: To assess the protocol's safety, the incidence of hypotension following prehospital administration of multiple simultaneous nitroglycerin (MSN) tabs by EMS providers was studied.

METHODS: This study was a retrospective cohort study of patients from a single commercial EMS agency over a 6-month period. Records from patients with at least one administration of MSN were reviewed. For each administration, the first documented vital signs pre- and post-administration were compared. Administrations were excluded if pre- or post-administration vital signs were missing.

RESULTS: One hundred case-patients had at least one MSN administration by an advanced provider during the study period. Twenty-five case-patients were excluded due to incomplete vital signs. Seventy-

five case-patients with 95 individual MSN administrations were included for analysis. There were 65 administrations of two tabs, 29 administrations of three tabs, and one administration of four tabs. The mean change in SBP following MSN was -14.7 mm Hg (SD = 30.7; range, +59 to -132). Three administrations had documented systolic hypotension in the post-administration vital signs (97/71, 78/50 and 66/47). All three patients were over 65 years old, were administered two tabs, had documented improved respiratory status, and had repeat SBP of at least 100. The incidence of hypotension following MSN administration was 3.2%. Discussion High-dose oral nitroglycerin administration is a practical alternative to IV nitroglycerin in the prehospital setting when administered by advanced providers. The prehospital protocol for high dose oral nitroglycerin was demonstrated to be safe in the cohort of patients studied. Limitations of the study include the relatively small sample size and the inability to identify hypotension that may have occurred following the cessation of data collection in the field.

CONCLUSION: Hypotension was rare and self-limited in prehospital patients receiving MSN.

CORD-AEUS: Consensus Document for the Emergency Ultrasound Milestone Project.

Lewis RE, Pearl M, Nomura JT, Baty G, Bengiamin R, Duprey K, Stone M, Theodoro D, Akhtar S, Department of Emergency Medicine, St. Luke's Roosevelt Hospital Center, New York, NY; Acad Emerg Med. 2013 Jul;20(7):740-5

In 2012, the Accreditation Council for Graduate Medical Education (ACGME) designated ultrasound (US) as one of 23 milestone competencies for emergency

medicine (EM) residency graduates. With increasing scrutiny of medical educational programs and their effect on patient safety and health care delivery, it is imperative to ensure that US training and competency assessment is standardized. In 2011, a multi-organizational committee composed of representatives from the Council of Emergency Medicine Residency Directors (CORD), the Academy of Emergency Ultrasound of the Society for Academic Emergency Medicine (SAEM), the Ultrasound Section of the American College of Emergency Physicians (ACEP), and the Emergency Medicine Residents' Association was formed to suggest standards for resident emergency ultrasound (EUS) competency assessment and to write a document that addresses the ACGME milestones. This article contains a historical perspective on resident training in EUS and a table of core skills deemed to be a minimum standard for the graduating EM resident. A survey summary of focused EUS education in EM residencies is described, as well as a suggestion for structuring education in residency. Finally, adjuncts to a quantitative measurement of resident competency for EUS are offered.

Magnitude of D-Dimer Matters for Diagnosing Pulmonary Embolus.

Shah K, Quaa J, Rolston D, Bansal S, Bania T, Newman D, Wiener D, Lee J, Department of Emergency Medicine, Mount Sinai School of Medicine, New York, NY; Am J Emerg Med. 2013 Jun;31(6):942-5

OBJECTIVE: The objective of this study is to determine whether the magnitude of the D-dimer correlates with a higher likelihood of pulmonary embolus (PE).

METHODS: We performed an electronic chart review at our academic, tertiary care

center, annual emergency department (ED) census greater than 100,000. All patients with a chest computed tomographic (CT) scan with intravenous contrast and an elevated D-dimer level obtained in the ED between January 2001 and July 2008 were identified. Specific, predetermined, predefined data elements including sex, age, D-dimer level, and final ED diagnosis were recorded by a hypothesis-blinded extractor using a preformatted data form. D-dimer level less than 0.58 µg/mL constitutes the normal laboratory reference range for our turbidometric D-dimer assay. Data were analyzed using standard statistical methods, and a linear regression analysis was performed for correlation analysis of D-dimer and diagnosis of PE.

RESULTS: We identified 544 subjects who had both a chest CT scan performed and an elevated D-dimer level obtained in the ED. Fifty-eight subjects (10.7%; mean D-dimer, 4.9 µg/mL) were diagnosed with PE, and 486 (89.3%; mean D-dimer, 2.0) did not have a PE. The percentages of PE diagnoses for D-dimers in the ranges 0.58 to 1.0, 1.0 to 2.0, 2.0 to 5.0, 5.0 to 20.0, and greater than 20.0 (n = 11) were 3.6%, 8.0%, 16.2%, 35.3%, and 45.5%, respectively. The positive predictive value of PE for D-dimer level cutoffs of greater than 0.58, greater than 1.0, greater than 2.0, greater than 5.0, and greater than 20.0 was 10.7%, 14.6%, 22.2%, 37.8%, and 45.5%, respectively. Increasing D-dimer values were strongly correlated with the presence of PE (odds ratio, 1.1685 per stratum; P < .001).

CONCLUSION: Increasing magnitude of D-dimer correlates with increasing likelihood of PE diagnosed by CT angiography. ☼

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Dilemmas in the Pediatric Patient: What Would You Do?

Denis R. Pauzé
MD FACEP

Vice Chairman Operations
Associate Professor of
Emergency Medicine & Pediatrics
Department of Emergency Medicine
Albany Medical Center



Today we look at three different clinical scenarios in the pediatric patient, all with different treatment options. They involve chest trauma, airway management, and antibiotics for strep throat. Understanding there are many different clinical practice patterns, we ask... what would you do?

We would like to hear your anonymous responses for the below pediatric scenarios. A survey link can be found at <https://www.surveymonkey.com/s/WMHZ2GS>

For the next issue, we will look at everyone's thoughts and compare the different treatment options.

Case #1: Trauma

A 5-year-old boy arrives to your emergency department after a MVC. He was a backseat passenger in a booster seat when his car was T-boned by another vehicle traveling approximately 50 mph. He had no LOC and was hemodynamically stable per EMS. He was transported boarded and collared, and complained of chest pain. He had no other complaints.

Vitals: BP 100/60 HR 122 RR 30 100% Afebrile. On exam, he had clear lungs, anterior chest wall tenderness, normal pulses, and a benign abdominal exam. GCS of 15.

His FAST scan was negative. Chest X-ray only revealed a first rib fracture and there was no evidence of pneumothorax, pulmonary contusion or widened mediastinum.

Given the mechanism and chest x-ray finding of a first rib fracture, you are worried that the child had a significant amount of force causing the first rib fracture, and there are potential undetected thoracic injuries, such as an aortic dissection. You would then:

- Perform a chest CT scan, looking for aortic dissection.
- Perform a chest CT scan, looking for any additional thoracic injuries (pulmonary contusion, occult

pneumothorax, rib fractures etc.) not seen on chest x-ray.

- Ask for a stat echo, and would not do a chest CT scan as to avoid any radiation.
- Would not order a chest CT scan, as the mediastinum is normal and there are strong radial pulses and no hard clinical signs of dissection.

How would your management change in the above scenario, if the patient had a GCS of 12, a very small pneumothorax, and a positive FAST (but was still hemodynamically stable);

- Perform a chest CT scan, looking specifically for aortic dissection.
- Perform a chest CT scan, looking for any additional thoracic injuries (pulmonary contusion, occult pneumothorax, rib fractures etc) not seen on chest x-ray.
- Ask for a stat echo and ultrasound the lungs. Would not do a chest CT scan as to avoid any radiation.
- Would definitely not order a chest CT scan, as the mediastinum is normal and there are strong radial pulses and no obvious hard clinical signs of dissection. A chest x-ray is enough evaluation in this patient to look for significant chest trauma.

For the above patient, if he had a moderate size pneumothorax with no evidence of hemothorax, you would;

- Place a chest tube.
- Place a pigtail catheter instead of a chest tube.

Case #2: Airway

A two-month-old full term baby comes in with intermittent episodes of apnea. She has clinical symptoms consistent with bronchiolitis. She has no other past medical history. In the emergency department, she is intermittently apneic, but responds to stimulation. Because you plan to transfer her via ground to a pediatric facility 100 miles away, you decide to intubate her.

She is now awake and crying. Please select the medications you would use for intubation:

- I would not use any medications, and just use a little muscle.
- Etomidate and Rocuronium. I would pretreat with atropine.
- Etomidate and Rocuronium. I would NOT pretreat with atropine.
- Etomidate and Succinylcholine. I would pretreat with atropine.
- Etomidate and Succinylcholine. I would NOT pretreat with atropine.

If the child was 2 years old, would you use atropine for premedication?

- Yes, I always use atropine in the pediatric patient when I am intubating.
- No, I do not use atropine in the pediatric patient for intubating.

Case #3: Antibiotics and strep throat

A 7-year-old boy presents with fever and sore throat. He has a mild headache. He has no cough, vomiting or diarrhea. His physical exam reveals a temperature of 38.5 C. He is nontoxic in appearance. His tonsils are erythematous with exudates and there are no oral ulcers. He has anterior cervical adenopathy.

You are concerned about strep throat. You would:

- Give antibiotics and discharge.
- Perform a rapid strep test, treat only if positive.
- Perform a rapid strep. If negative, send a throat culture and await results.
- I usually do not treat strep throat with antibiotics. I would have a discussion with the family letting them know that antibiotics are basically useless for strep throat as they offer very little added benefit.

What would you do differently if the above child was not vaccinated, had a severe sore throat, and there were no exudates on physical exam? ☞

Unveiling the Hidden Curriculum: The Power of Positive Role Modeling

Jordana Haber
MD

Education Fellow
and Attending Physician
Department of Emergency Medicine
Maimonides Medical Center



The formal curriculum is the curriculum that is subscribed and endorsed by the medical profession. It is comprised of the course syllabus, assignments, reading and scheduled testing. In contrast, the hidden curriculum, or the informal curriculum, refers to the implicit education where values, behaviors, and principles are transmitted by means of the social environment. It is unscripted and often extremely interpersonal. It is the curriculum that occurs through informal interactions between faculty and students – what students and residents observe while on the clinical wards, as well as the cafeteria conversations. The hidden curriculum is, in essence, the lived experience of students.

While the techniques for teaching medical knowledge and skills fit nicely into a formal curriculum, elements of professionalism are more likely to be learned in the hidden curriculum. The hidden curriculum has gained much attention recently in medical education, but is not a new concept in this field. The Flexner report, published as a reform to medical education in 1910, describes that professionalism is continually evolving, ever-changing and multi-dimensional. More recent definitions of medical professionalism recognize the complex system and competing forms of professionalism.¹

The description of the Accreditation Council for Graduate Medical Education (ACGME) competency of professionalism includes that “residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.”

We expect that residents will demonstrate

1. Compassion, integrity and respect for others.
2. Responsiveness to patient needs that supersedes self-interest.

3. Respect for patient privacy and autonomy.
4. Accountability to patients, society and the profession.
5. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation.

Although there are many possible ways to teach these sub competencies, the hidden curriculum is a likely environment where medical students and residents will get exposed to professional behaviors and skills.

The hidden curriculum and its influence on modern medical professionalism is nicely articulated in Thomas Inui’s report “A Flag in the Wind: Educated for Professionalism in Medicine.” As Inui defined it,

*“Within the experience of students, but outside the courses lies the hidden curriculum, the students’ exposure to what we actually do in our day-to-day work with patients and one another – not what we say should be done when we stand behind podiums in lecture halls. It is this modeling, not only by the faculty but by the residents, that constitutes the most powerful influence on students’ understanding of professionalism in medicine.”*²

Traditional models of professionalism hold the academic community and faculty responsible to act as stewards of the professional development of physicians.³ Ensuring that all physicians accept and practice the values of professionalism has never been an easy task, and likely has only become more challenging in today’s medical climate.

A significant threat to professional development is the widening gap between what is formally taught in the classroom and that which is transmitted through the culture students are exposed to in the clinical

setting, the hidden curriculum.⁴ Many of us as professionals can recall learning of derogatory stereotypes for patients during our early experiences on the hospital wards. For most, this greatly contradicted our core values and reasons for committing to a career in the medical profession. Yet, we were likely to engender these values as a right of passage, or perhaps as a coping strategy for the stress we were enduring as trainees. While most medical curriculum focuses on teaching the rules of professionalism within the formal curriculum, it does not confront this hidden curriculum.

The hidden curriculum can be an effective method to role model positive behaviors; however it has also been recognized to perpetuate the negative attitudes and behaviors found in today’s medical residents and students.⁵ Consider the influences on your own professional development. What attributes and behaviors do you associate with positive role models?

I can vividly remember the physicians I trained with as a student and resident who I felt held themselves to the highest standards and virtues of professionalism and who were also the most honest with the challenges of this task. The physicians I most respected during my training were those who were not only knowledgeable and skillful, but who also demonstrated compassion for patients others were likely to disregard, or be frustrated by. I most admired their ability to be professional even when challenged and stressed.

Elements of professionalism in medicine and attributes of a professional physician are well described for us in the literature and by accredited bodies, however, as noted by Inui, we fail to talk about the a gap that exists between these expected virtues and intentions, and what we actually do in the clinical setting. While most medical training programs include

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Unveiling the Hidden Curriculum

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curriculum in communication and professionalism, all that is learned in the classroom will be far less powerful than the culture, behavior, and language learners observe in the clinical wards. Inui comments that students, “noting the difference between what we say and what we do, [they] learn that medicine is a profession in which you say one thing and do another, a profession of cynics.”

Inui and others who have reported on professionalism in clinical medicine, recognize the need to improve the way we ensure that these attributes are acquired in our training physicians. Yet, they also bring attention to the complex and challenging environment that we work in which often conflicts with our ability to do what we say.

How can we better teach professionalism? As educators of medical students and residents, we strive to support the professional formation of our learners, and help them navigate through the conflicts and challenges they face in this domain. It is proposed that an effective strategy is to first acknowledge the influence of the hidden curriculum, be explicit about the challenges of professionalism in medicine and the discordance between the formal and informal curriculum, and work to incorporate these elements into our every day actions and systems.

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Parts of this article were in collaboration with colleagues Kathleen Crapanzo, MD and Jennifer Encinas, BA (“Unveiling the Hidden Curriculum” workshop at the KECK Innovations in Medical Education Conference 2014) Their permission was obtained to write this column. ☞



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Ask the Experts

What Should I Look for in a Contract When Approaching a New Job?



**Katherine M. Nacca
MD**
Pediatric Emergency
Medicine Fellow
SUNY Upstate
Medical University

One daunting task of finding a new job is understanding the details of your employment contract. There are legal aspects that may be confusing. Physicians must balance their desires and expectations with those of the employer. Knowing who to ask for help and where to go for more information will get this process started in the right direction. Dr. Andrew Sama offered his advice and knowledge to answer questions regarding the basics of physician contracts.



*Andrew E. Sama, MD FACEP
Chairman, Department of Emergency Medicine
Good Samaritan Hospital Medical Center
Chief, Emergency Medicine Service Line
Catholic Health Services of Long Island*

What should I look for in a contract when approaching a new job?

There are three important points to focus on when working with or for someone. If you keep these in mind when interviewing and reviewing the contract the process of finding the right job will be easier.

1. Do I trust the people or institution with whom I will be working?

It is important to have a sense of the company or group of physicians you will be working with. Consider whether you feel comfortable with the individuals and if the group will keep your best interests in mind when possible. Try to get a sense of the leadership and the kind of support that comes from the group. If possible, try to gain insight into the dynamics of the emergency department. For example, information on physician turn over can give you a clue. The group may have been looking to improve and thus did a lot of new hiring to accomplish this. Alternatively employees may feel the environment is difficult to work in, resulting in a high rate of attrition.

Another important aspect of that trust is understanding the terms of termination from a contract. Consider: Does the company have the power to end the contract abruptly without reasonable notice or without a reason? If so, what are the ramifications of this? Do you trust an employer that can let you go without cause or notice?

When interviewing and reading your contract, keep in mind this is a business agreement. However you should note the

important details of these interactions that provide insight into the company.

2. What am I being asked to do (clinical hours, non-clinical responsibilities to the department, etc.) and what is the compensation?

This area is very important and must be approached professionally. It is valuable to determine your ideal work schedule and consider what you believe to be fair compensation ahead of time. Approaching the subject of pay needs to be done tactfully.

Benefits and personal liability insurance (aka malpractice insurance) should also be taken into account. When it comes to the benefits package, physicians have different needs and wants based on family and personal obligations. It helps if you know what you are looking for. For example, do you need medical coverage for a family of four or are you covered under your spouse's plan? In addition, are you offered life and/or disability insurance? You may have to consider additional insurances independently as the benefits may not be as inclusive as you want. It

is not uncommon, though not obligatory, to secure outside coverage. You should review the details of the contract including retirement benefits, 401(k) and pension. Be aware of and understand the specifics of what is offered.

Understand the malpractice insurance that is offered, and whether it is claims made or occurrence-based. Understand how it may impact you. Occurrence-based coverage deals with any claims due to incidents that occurred during coverage even if filed after coverage has ended. Claims made insurance covers only if both incident and claim are made during policy coverage period (incident report date). Understand the finer details of both of these policies and what your contract provides.

A consent policy in your professional liability coverage may be another piece to consider in your contract. This policy allows you to give consent to settle or not in the case of a lawsuit rather than allowing the group to settle without your input. Again, review your contract closely and understand your coverage and benefits.

3. What is the exit strategy?

As noted above, be aware of concerning concepts in your contract such as "termination without cause," that allow your employers to let you go without notice or reason. Additionally, there can be restrictions for work after termination. Be aware of any restrictions and what it means for you. For example, a "non compete" clause or restrictive covenant may state you cannot work within 10-100 miles of your original job for up to one year after you leave. Will this require you to move in order to find work?

A contract should not be so steadfast that it is impossible to leave. It is important to understand that both uninformed termination and overly restrictive termination policies are problematic.

continued on next page

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Wherever you may be looking for work, these three questions should be answered confidently in order for you to get the best out of your group and contract.

Keep in mind, however, that there may be situations that limit your options. For example, if your dream job is in Honolulu, there may be only a few groups there to work for, thus making it more difficult to negotiate because of the location. Your exit strategy may be more limited. Special interests may also impact your negotiations. For example, if research is important to you and you are looking for 50% protected time with lab access, there may only be a few options. In this situation you may have to compromise on salary.

A new practitioner has to be reasonable and practical when reviewing their contract.

Knowing where to go for help is important. Most contracts are fairly standard, particularly with respect to malpractice coverage and competitive restrictions after termination. So one other important point is not to over read the contract. A third party reviewer, either a lawyer or someone who has experience in contracts, such as a trusted chairman, can help you to initially navigate the standard expectations and those things that are unusual or unreasonable. Utilizing people you know can put you in the position to negotiate the contract yourself. However, using a lawyer may ultimately save time and money as they can do the contract negotiation and assessment of the details thus relieving possible confusion and tension.

Remember, contracts are a business negotiation with the goal being to both employ you as well as protect the company. This negotiation may provide insight into the company you are working for and give you a sense of how prepared and fair the group or your employer is. Do not take it personally. Feel confident in your contract so you can truly enjoy your new job. ☘



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Work-Life ImBalance



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

For years I have reflected on the concept of "work-life balance." Under the recommendation of the RRC my residency prioritized physician wellness and taught us to recognize signs of burnout. I took those lessons to heart but it all seemed like overkill . . . until my recent crash course in multitasking and lifestyle prioritization. A couple of months ago I gave birth to five pounds of wonder, joy and amazement. She is also a source of constant need, care and attention. Now I really need to figure out how to "have it all."

I am not the first physician to put off reproductive life while working toward professional goals. I have become accustomed to flexibility in scheduling non-job related responsibilities around my demanding academic and administrative calendar. On any given Tuesday I could work 10 hours, go to the gym, run a few errands and prepare a healthy dinner. Of course I could shuffle a few things around and add a little baby into the mix. But it certainly doesn't feel like a little shuffling. I have realized I must reconsider the 24 hours of every day with a new sense of scarcity and value, since somehow I must get so much more done with what feels like much less time.

My first step is to be realistic. I must accept that what I am after is not a true balance, but the best *imbalance* I can achieve. Realizing that I must reframe expectations of what I am capable of accomplishing is hard for me but it is better to alter my expectations and be successful than be unrealistic and feel like a failure. I am also embracing several fundamental qualities that have contributed to my success as an emergency medicine physician, which will no doubt help me along the way.

Every shift on the floor I am a member of a team. I work together with nurses, residents and physician extenders. This is the only way to get the job done. The same is true of parenthood. Despite my instincts, I will not be too shy to ask for help. I will accept help when it is offered. My friends, families and neighbors are the members of my "at home" team.

As an emergency medicine provider I am a master of multi-tasking. I am unaware of any other groups who are trained to juggle several intellectual and physical activities at the same time as well as us. I will use this to my advantage. Even better than multi-tasking, I will try to "double dip" when possible. Turns out that if I read the latest articles in *Annals* out loud my baby goes right to sleep. Who knew a two month old would not find hallway boarding and ED overcrowding stimulating? I keep up with the literature and she takes a nap – WIN/WIN!

There are other strategies that have been proposed to achieve simultaneous personal and professional satisfaction. Not all of the strategies below will apply or appeal to everyone but hopefully some will come in handy.

Set Realistic Goals

Make a short list of personal and professional goals. Make the goals attainable. Keep them specific and frequently reassess your priorities. As you meet your goals, make sure to cross them off. Your sense of accomplishment and satisfaction will undoubtedly correlate with how many items you can "check off your list."

Optimize Your Work Environment

You should always seek a supportive work environment but this becomes more important if your job is no longer your number one priority. Look critically at your commute, salary or benefits package. Do you have a schedule that allows for realistic child care or face-time with your partner. Are you getting paid enough to leave home and juggle all the other things that need to get done? There are many paths to success as an emergency medicine physician while maintaining a full life outside of work. Our departments survive because some of us want to work nights, weekends or other "non-traditional" schedules.

Make Sure to Schedule Downtime

Make a point to schedule time to be with friends and family. Be creative with your time. If you are scheduled for an afternoon shift, have breakfast or lunch with

a friend. It's easy to laze around anticipating a busy shift during peak hours in the emergency department. Don't let this get in the way of contributing to your overall quality of life.

Use your weekends off to have meaningful experiences with your loved ones.

- On the weekends use the time to do an activity with your kids.
- Schedule date night with your spouse/partner well in advance. Not only will this ensure that quality time is spent, but will give you something to look forward to.

Take Your Vacation!

Many find spreading time away from work over the calendar year reenergizes them in the weeks and months that follow.

Outsource Your Errands and Household Chores

Utilize the resources available to you and make it convenient. Remember your time is a valuable commodity. Pharmacy and grocery items can be ordered online and delivered to your home. Set up bill payment online – no need to find your checkbook, a pen or a stamp. With a few clicks it will be done. Consider setting your bills to all be paid on the same date. You can sit down at the computer for just a few minutes and your monthly expenses will be accounted for.

Clearly, the introduction of a newborn into my life was a dramatic and easily identifiable catalyst to reframe the balance I try to achieve. Other factors may not be as cut and dry. Regardless of the cause, as emergency medicine physicians we must strive for the imbalance that best suits our own needs. I am working towards accepting that I cannot get everything done the way I did it before. What works for me will certainly not work for others and I know that even my personal needs will change as my daughter grows and my career evolves. As long as I get to enjoy the moments with her, a relationship I value and a fulfilling career, I will consider this whole journey the ultimate work life balance and a true success. ☘



Albany Update

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

New York ACEP Scores Major Victory on Out-of-Network

New York ACEP scored a major victory in the 2014-15 State Budget by getting an amendment to the out-of-network health insurance bill to exempt emergency services from the burdensome Independent Dispute Resolution (IDRE) process. The final budget bill will ensure that patients have access to emergency services and protect the emergency health care safety net.

The proposal was introduced January 15 as part of Governor Cuomo's proposed State Budget and became a prime focus of New York ACEP's well attended Lobby Day held in Albany March 4. President Daniel G. Murphy, MD MBA FACEP, Executive Director JoAnne Tarantelli, the New York ACEP membership and contract lobbyists Reid, McNally & Savage worked around the clock to stop insurance companies from dictating fees for all emergency services.

The final State Budget that passed April 1, 2014 exempts emergency services that are under \$600 (annually adjusted for inflation) when the amount does not exceed 120% of UCR (the 80th percentile of Fair Health) from a requirement that emergency physicians must accept a rate for out-of-network emergency services that is "determined reasonable" by an insurer. Under the previous version of the bill, the only recourse that a physician would have if they disagreed with the insurer's rate was to file a dispute with an IDRE **for each and every claim.**

Based on New York ACEP's analysis, this exemption will include claims for evaluation, management and most observation care provided by emergency physicians. Using the Fair Health Consumer database as a resource, New York ACEP members can reference 12 broad geographic areas for the 18 CPT codes listed in the bill at the New York ACEP web site.

The legislation does not prohibit balancing billing for out-of-network emergency services. Responsibility is

placed on the insurance company to negotiate with physicians to "ensure that the patient receives no greater out-of-pocket costs" than they would have incurred with a participating health care provider.

The legislation also establishes a new right for a patient to file an appeal through the Independent External Appeals process when an insurance company denies a patient request to receive services from an out-of-network provider. Insurance companies, health care professionals, hospitals and other health care facilities are required to disclose significant information to patients so that they can determine how insurance companies calculate rates, whether a health care provider is in their insurance company's network and, if not, what the patient will be billed for the services.

State Budget Update

A number of other proposals of interest to emergency physicians were considered in the State Budget as outlined below.

Urgent Care

The Governor's proposed State Budget included new regulation of urgent care centers. The Legislation **rejected the Governor's proposal in its entirety including provisions:**

- defining "urgent care" as treatment on an unscheduled basis to patients for acute episodic illness or minor traumas that are not life threatening or potentially disabling;
- prohibiting care for conditions that require monitoring and treatment over a prolonged period of time;
- requiring full accreditation as a condition of using the term "urgent care" or a symbol that implies "urgent care;"
- prohibiting signage, advertisements, or symbols that imply that the center is a provider of emergency medical care;
- allowing a hospital to provide urgent care or medical care and display signage and advertising pursuant to regulations of the Commissioner of

New York State Department of Health; and

- authorizing the Commissioner to promulgate regulations defining the scope of services to be provided, staffing, transmission of medical records, and other matters.

Hospital-Sponsored Off-Campus Emergency Departments

The Legislature **rejected in its entirety** a proposal to regulate Hospital-Sponsored Off Campus Emergency Departments. The proposal provided that a hospital Off Campus Emergency Department "shall generally operate twenty-four hours per day, seven days per week." However, a hospital may apply to the Public Health and Health Planning Council to operate part-time at a minimum of 12 hours per day. Approval could be made only upon a finding by the Council that local special circumstances necessitate part-time operation and with consideration for the quality and accessibility of emergency care and the public interest.

Limited Services Clinics

The Legislature rejected **in its entirety** the Governor's proposal to regulate "retail clinics" located within pharmacies, stores, shopping malls and other establishments including:

- requiring the clinics to be called "limited services clinics;"
- requiring accreditation;
- prohibiting services to patients under age 18; and
- prohibiting certain immunizations to persons under age 18.

Excess Medical Malpractice Program

The final State Budget provides \$127,400,000 for the physician excess medical malpractice program and extends one year until June 30, 2015 provisions enacted in 2013 to limit eligibility for enrollment in the program to physicians and dentists who were provided coverage through June 30, 2014, subject to openings due to attrition.

continued on next page

Elimination of Written Consent for HIV Testing

The final State Budget includes the Governor's proposal to change existing requirements for written or oral (for rapid tests) consent for HIV testing to "informed" consent by a patient or a person authorized to consent if the patient lacks capacity to do so. In order for there to be informed consent, the person ordering the test must, at a minimum, advise the individual that an HIV-related test is being performed and shall note the notification in the patient's record. Informed consent is valid until such time as it is revoked.

Elimination of Written Collaborative Agreements for Nurse Practitioners (NPs)

The final State Budget includes provisions to change the law related to the collaboration requirements between physicians and NPs.

The bill allows for NPs with more than 3,600 hours to have a collaborative "relationship" instead of a "written agreement" with one or more physicians qualified to collaborate in the specialty involved or with a hospital that provides services through licensed physicians in the specialty

involved and having privileges at such institution.

Nurse Practitioners are required to complete and maintain an attestation form created by the State Education Department describing any collaborative relationship with physicians. The NP is required to communicate with the physician to exchange information to provide comprehensive patient care and make referrals as necessary. **The form must reflect the NP's acknowledgment that if reasonable efforts are made to resolve any dispute that arises with the collaborating physician about a patient's care and they are unsuccessful, the recommendation of the physician shall prevail.** Failure to comply with all such requirements by the NP would be subject to professional misconduct.

The State Education Department (SED) is required to collect information from NPs to evaluate access to needed services, determine which NPs are practicing with a written agreement, which are practicing with collaborative relationships and other information deemed relevant. The Commissioner of SED, in consultation with the Commissioner of Health, is required to is-

sue a report based on these findings and any recommendations by September 1, 2018.

The bill is effective January 1, 2015 and expires on June 30, 2021.

2014 "End of Session" Outlook

The main focus for New York ACEP for the remainder of the 2014 Legislative Session is expected to be legislation (A1056 Weinstein) to change the current statute of limitations from two and a half years to the date of discovery. The Assembly moved this bill from the Codes Committee to the Assembly floor immediately after passage of the State Budget April 1, 2014. While there is currently no Senate sponsor of the bill, we are closely monitoring it. New York ACEP is engaging members by sending out action alerts calling for phone calls to State legislators.

According to a recent report by Milliman (*Milliman Actuarial Study, 4-9-14*) if this legislation is enacted, medical liability premiums will increase by nearly 15%, in excess of \$150 million per year.

The Legislature is scheduled to recess June 19, 2014. ☒

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ISO 9001

continued from page 10

The Preventive Action policy addresses data that reveals a negative trend requiring the organization to take action to “prevent” the situation from reoccurring or getting worse. Failure Mode Effects Analysis (determining the “what ifs” prior to a process change) or monitoring of near misses in order to change a process to prevent harm are examples of preventive actions.

ISO also requires that Senior or Top Management is responsible to ensure that the quality management system processes are established, implemented and maintained. All quality processes must report to a multidisciplinary body that has the authority to implement change and provide resources to do so. This mandates “institutional” awareness of all processes.

Hospitals are not manufacturing industries, or are they? A manufacturer knows that the business is best run by a consistent production process producing error free products that are being distributed to satisfied customers who return for more products or services. Hospitals and the practice of medicine have long been practicing based on individual provider preferences leading to variable outcomes, errors and a mixture of satisfaction of employees and patients. Hospitals are now faced with the immediate need to improve processes to save costs and to eliminate error to prevent monetary penalty. Establishing ISO 9001 standards is a step in that direction. It forces a top-to-bottom look at the facility and provides for accountability.

From a practical clinical aspect, ISO will ensure that as a provider moves from one clinical location to another, they will use the same process, form or policy. An example would be the hospital policy governing moderate sedation along with the process of care and the applicable documents and forms. This serves to limit variation and confusion plus ensures patient safety by providing consistent care. If there is an adverse outcome or even inadequate equipment, the provider will be able to consistently report that outcome or equipment and know the path that report will take and how it will be addressed each and every time.

Without consistent monitored quality, a ship will sink. Healthcare appears to have many holes in her hull. Allowing an agency originally established to ensure maritime safety into healthcare may have been an uncanny but wise choice by CMS. If permitted ISO could change the landscape. Undoubtedly, it will take time and persistence. The growing number of hospitals choosing DNV as their accreditation agency may be a sign that the foothold has been established. ☞

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SCIENTIFIC ASSEMBLY

July 7-9, 2014

MONDAY JULY 7

11:00 am-12:30 pm	Board of Directors Meeting
12:30-5:00 pm	Registration
12:30-1:30 pm	Research Forum: Poster Presentations
1:40-3:10 pm	Research Forum: Oral Research
2:30-6:30 pm	Exhibits Open
3:10-3:30 pm	Break and Exhibits
3:30-4:30 pm	New Speakers Forum, Best Practices in Emergency Medicine
4:30-5:30 pm	An Evidence Based Approach to Bleeding from Novel Oral Anticoagulants (NOACs) and Antiplatelet Agents
5:30-5:45 pm	Residents Mixer
5:30-6:30 pm	Exhibits and Networking Reception

TUESDAY JULY 8

7:30-8:00 am	Exhibits and Continental Breakfast
7:30-11:00 am	Exhibits
8:00-9:00 am	Massive Transfusion: How to Resuscitate the Critically Ill Trauma Patient
9:00-10:00 am	Dysrhythmias in the ED: Myths and Pitfalls
10:00-10:30 am	Break and Exhibits
10:30-11:30 am	Environmental Emergencies: Approach to Life-Threatening Hypo and Hyperthermia
11:30 am-12:30 pm	Emergency Cardiology Update: The Articles You've Got to Know!
12:45-1:45 pm	New York ACEP Annual Meeting and Legislative Update
1:45-2:15 pm	New York ACEP Committee Meetings

WEDNESDAY JULY 9

7:00-8:00 am	Board of Directors Meeting
8:00-9:00 am	Cases in Trauma Coagulopathy
9:00-10:00 am	Everyday Leadership: Secrets of Great Minds Through the Ages
10:00-10:15 am	Break
10:15-11:15 am	The Toxic ECG: Why Do We Get it and What Does it Mean?
11:15 am-12:15 pm	Chest Trauma Clinical Pearls

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