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Emergency Medicine
Staten Island, NY

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PRESIDENT'S MESSAGE



Brahim Ardolic, MD FACEP
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What Is The Value Of What We Do?

It seems like a very simple question, and yet it can be quite daunting to answer. You are already probably asking me to clarify: Do you mean the societal value, the value to the patient or the economic value. I would ask you all to consider all three as we are being asked to consider these questions by our patients, and our legislators both in Albany and Washington DC.

First, what is our societal value? There is no question that we have become the most comprehensive medical safety net that there has ever been. We are always there and always available. This is true even as we go through a historically bad flu season that has tested our ability to be there for our patients. Our legislators acknowledge more and more that we are THE safety net. This recognition comes at a price though. Just in the last few years, we have been asked to offer HIV testing, become more involved in the opioid epidemic and create follow up systems for outpatient tests. These mandates continue to come to the specialty that is always there and is absurdly stretched. This however, is precisely why we get these mandates. We are the only ones who are always there, at all times, regardless of the presenting complaint. Sadly, this means that many legislators see our EDs as the easiest way to make sure HIV testing gets done, for example. Most will acknowledge this isn't the ideal way. It's just one of the few parts of the system that hasn't failed the patients.

These pressures will continue. The drug epidemic and the mental health crisis aren't going away. Far from it, we still haven't addressed the capacity issues for proper care of either of these conditions. This means that we still have to care for so many that have been failed by the system. Now the governor wishes to remove our 5-day exemption for narcotic prescriptions. This will continue to place pressure on you to do one more thing, even though all data shows a marked drop in prescriptions written in the ED.

The value to the patient is a much related answer but with a substantial twist in New York. We create value for every patient in this country because we can't keep our own trainees. We continue to lose over half of the residents we train. The reasons for this are very clear. Our salaries, compared to most of the country are not very competitive, our cost of living is higher, our malpractice environment is well worse than the average and our emergency departments are amongst the most crowded in the country. This is occurring as the patients throughout the nation are getting sicker on average.

This brings me to the economic value. I recently was advising one of my residents who owed \$500,000 in student debt. He told me that he had to leave New York, as he couldn't afford to live here. He said he needed to go somewhere that would help him pay off his loans before retirement.

These issues aren't going away anytime soon. Our revenue is experiencing dramatic downward pressure from the insurance companies who are always looking to new and creative ways to

save money. This continues to occur while many of us spend more and more time with an average patient, as their needs are clearly more.

Now a full review of our E + M codes is going to be undertaken. This will start in February with many of you getting a survey, via email about your practice and specifically about certain types of services you deliver. If you get one, please open, complete the entire survey and return it by the given deadline. Look at the questions they are asking and give an accurate assessment of the amount of effort and time you take to do these things. These surveys are critical to the proper evaluation of these codes.

In closing, I just want to emphasize that this isn't meant to be fatalistic. I believe this is a great time to be an ED doc. I can't imagine doing anything else. However, a smart person once said you are either at the table or on the menu. We need your help when we ask you to call Albany and we need you to look for these surveys!

"I believe this a great time to be an ED doc. I can't imagine doing anything else. However, a smart person once said you are either at the table or on the menu."

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SOUND ROUNDS



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Alternate Methods to Identify Early Intrauterine Pregnancy



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Case

A 35 year-old female, G2P1, presented to the Emergency Department (ED) with mild suprapubic pain for two days. The patient reported a positive home pregnancy test yesterday. She had nausea along with mild pelvic cramping. The patient's vital signs were within normal limits with blood pressure 121/77 mmHg, heart rate of 97 bpm, respirations of 15 breaths per minute and SpO2 100% on room air. She was afebrile with a temperature of 36.7F. Physical exam revealed a soft abdomen with minimal suprapubic tenderness. On speculum exam, the cervical os was closed without active bleeding or discharge. No cervical motion tenderness was noted during the bimanual examination.

Transabdominal point of care ultrasound (POCUS) was performed using a Zonare Z.One PRO 4-1MHz phased array transducer (Mountain View, CA) and a gestational sac was identified without definitive evidence of intrauterine pregnancy (IUP). No adnexal masses or free fluid in the pelvis were identified (Figure 1). The patient refused transvaginal ultrasound. POCUS using a high frequency linear transducer was then performed. A small anechoic gestational sac was visualized with a yolk sac, confirming IUP (Figure 2).

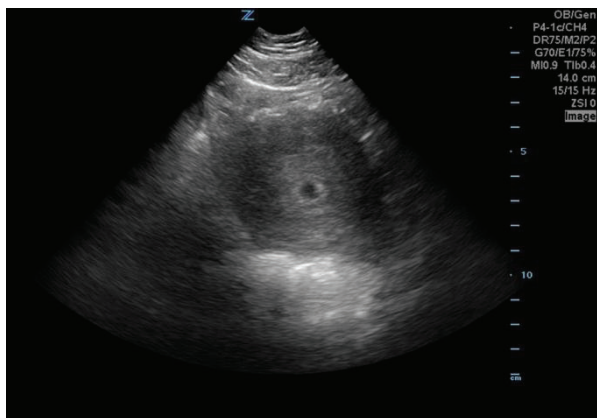


Figure 1. Transabdominal ultrasound of the uterus using the phased array transducer demonstrating a gestational sac but no definitive evidence of intrauterine pregnancy.

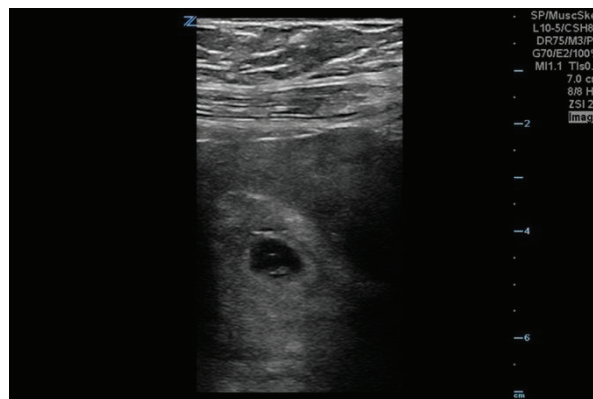


Figure 2. Transabdominal ultrasound of the same patient using the high frequency linear transducer demonstrating a gestational sac containing a circular echogenic structure with anechoic center consistent with yolk sac.

Discussion

Ectopic pregnancy is a leading cause of maternal morbidity and mortality in the first trimester of pregnancy. The incidence of ectopic pregnancy is on the rise for multiple reasons including the increasing prevalence of PID and growing number of patients receiving fertility treatments.¹ Any female patient who presents to the emergency department with vaginal bleeding, abdominal pain or pelvic pain along with a positive pregnancy test requires an ultrasound to identify the location of the pregnancy. An ectopic pregnancy is a true emergency requiring emergent obstetrics consultation and must be identified promptly to prevent morbidity and mortality in often young, healthy adults.

The primary purpose of focused pelvic ultrasonography (US) by ED physicians on symptomatic first trimester pregnant patients is to detect an intrauterine pregnancy (IUP).² Detection of an IUP by ED physicians is considered sufficient to rule out ectopic pregnancy.³

The American College of Radiology, American College of Obstetrics/Gynecology, American Institute of Ultrasound in Medicine, Society of Radiologists in Ultrasound (ACR-ACOG-AIUM-SRU) joint guidelines in the evaluation of obstetrical ultrasonography indicate that pelvic ultrasonography to detect an IUP can be performed transabdominally or transvaginally.⁴

The curvilinear or phased array transducers are used in a transabdominal approach on initial POCUS evaluation of the uterus for an IUP. An IUP is confirmed if a gestational sac containing a yolk sac or fetal pole is identified. The transabdominal evaluation for IUP requires minimal preparation and is noninvasive. Low-frequency transducers, however, may limit the resolution of small structures, such as the yolk sac, which must be identified to confirm an IUP. The transabdominal approach may fail to identify in excess of 25% of intrauterine pregnancies.⁵ Further evaluation with the endocavitary approach is usually warranted.

Prior to further evaluation with the endocavitary transducer, the high frequency linear transducer (10MHz) can be applied with a transabdominal approach to assess for IUP in a thin patient in the first trimester. The same technique that is used for the lower frequency probes can be implemented. Little to no additional training is required. The higher resolution of the linear probe allows for confirmation of IUP that may not have been possible using the lower frequency probes. Confirmation of IUP in this manner can decrease the need for transvaginal ultrasound. This will limit patient discomfort, decrease length of stay and decrease additional testing as well as overall cost.⁵

Indications

Positive pregnancy test without prior confirmed IUP and any of the following:

- Abdominal Pain
- Pelvic Pain
- Vaginal Bleeding

Technique

- The patient should be placed in the supine position.
- For best image quality the patient should have a full bladder.
- Use a phased array or curvilinear transducer.
- Scan the uterus in transverse and sagittal planes with a transabdominal approach. Be sure to assess the adnexae for any abnormalities and the pelvis for any free fluid.
- Identify the uterus and scan through its entirety to assess for evidence of IUP.
- IUP is confirmed if a gestational sac containing a yolk sac is identified.
- If a yolk sac cannot be identified with a phased or curvilinear transducer, use the linear transducer to again identify the uterus and scan through its entirety in two planes to assess for evidence of IUP.

- If an IUP cannot be identified with this approach, the patient will then require an endocavitary ultrasound examination to confirm pregnancy location.
- If a definitive IUP is not identified by the emergency provider, rate of ectopic pregnancy is estimated at 15%.⁶

Pitfalls and Limitations

- Exams using the linear transducer may be more difficult in obese patients. Mild pressure can be applied to aid in visualization of structures.
- Do not rely solely on a “discriminatory zone” to determine the need for ultrasound. Ultrasound should be performed on all symptomatic first trimester pregnancies regardless of β hCG level.
- Endocavitary US provides higher resolution of uterine contents and is most effective at identifying IUP. This modality also visualizes the adnexae with higher resolution, which can be used to further evaluate for ectopic pregnancy or other pathology.
- The endocavitary US examination requires an ultrasonographer or physician with competency in this examination and may not always be readily available.

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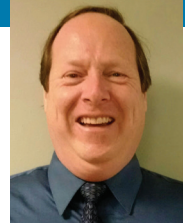
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The Leader in You – Mastering the Challenges of Leadership

We all have our own idea of what leadership is and what good leadership looks like. Whether it is a historic or global figure, or someone more personal and specific to us as an individual, we all have memories of successful leaders. When we reflect further we can answer the question of what makes them successful leaders. Some may be considered natural leaders, because of what they accomplished or how they did it. That could be true, but what is even more important is the fact that research has shown that leadership is a learnable skill¹. No matter who you are, where you come from or what you do – exemplary leadership can be learned.

Over 30 years ago, James Kouzes and Barry Posner introduced the world to their research through the release of their book, *The Leadership Challenge*. Their research comprised of thousands of interviews of people from around the world that were credited with accomplishing incredible things. The results of their research revealed that when people were asked what they considered were important leadership characteristics, the results identified many of the same items. The top four leadership traits considered the most important were: Honesty, Forward Looking, Competent, and Inspiring¹. In their analysis of over 75,000 interviews, they were able to identify the five domains of exemplary leadership each with two commitments and six behaviors. All, in all, the work of Kouzes and Posner has shown that not only can leadership skills be taught, but there is a manageable finite area of study with: Five Exemplary Leadership Practices, 10 Leadership Commitments and 30 Leadership Behaviors.

The mnemonic (**M-I-C-E-E**) can be used to remember the five exemplary leadership practices^{1,2,3}.

- M – Model the Way
- I – Inspire a Shared Vision
- C – Challenge the Process
- E – Enable Other to Act
- E – Encourage the Heart

Model the Way encourages leaders to behave the same way they encourage others to behave, with their own voice and values. It aligns with the two commitments¹:

- Find your voice by clarifying your personal values.
- Set the example by aligning actions with shared values.

Behaviors that support alignment to model the way include; setting a personal example of what you expect of others, spending time and energy making certain that people you work with adhere to the principles and standards we have agreed upon, following through on

the promises and commitments that you make, asking for feedback on how your actions affect other people’s performance, building consensus around a common set of values for running the organization and being clear about your philosophy of leadership¹.

Titles and labels do not give credibility, it is your behavior that will win you respect. Leaders need to set the standard and act as role models to their team. Leaders need to keep their commitments, do what they say they will do and follow through on their promises. They also need to be willing to get their hands dirty and jump in and help when the going gets rough. To be an effective leader, it is important to model the behavior that you expect others to also exhibit^{1,2,3}.

Inspire a Shared Vision focuses on developing and articulating a compelling future state and positively influencing others to embrace it. Leaders passionately believe they can make a difference. The two commitments associated are¹:

- Envision the future by imagining exciting and ennobling activities
- Enlist others in a common vision by appealing to shared aspirations

Behaviors that support alignment to inspire a shared vision include; talking about the future trends that will influence how the things get done, describing a compelling image of what the future could be like, appealing to others to share an exciting dream of the future, showing others how their long-term interests can be realized by enlisting in a common vision, painting a “big picture” of what the team can aspire to accomplish and speaking with a genuine conviction about the higher meaning and purpose of the work¹.

Leaders need to be curious about what is going on around you – especially things that aren’t working well. Asking “What’s next?” about every project long before it is completed. It is always important for a leader to ask the key questions of, “Where are we going?” and more important, “Is this where we want to go?” Spending time thinking and finding out about the future while listening to what others find important is valuable. Weaving together your own hopes and dreams with those of your team to bring everyone on the same page is important^{1,2,3}.

Challenge the Process encourages looking outside your own specialty to be innovative. The two commitments associated are¹:

- Search for opportunities by seeking innovative ways to change, grow and improve.
- Experiment and take risks by constantly generating small wins and learning from mistakes.

PRACTICE MANAGEMENT

Behaviors that support alignment to challenge the process include; seeking out challenging opportunities that test your own skills and abilities, challenging people to try out new and innovative ways to do their work, searching outside formal boundaries of the organization for innovative ways to improve what you do, asking “what can we learn?” when things don’t go as expected, making certain that you set achievable goals, making a concrete plan and establishing measurable milestones for the projects and programs that you and the team work on¹.

Actions that align with the practice to challenge the process include: assigning meaningful work so the team can see how their efforts contribute significantly to outcomes, setting incremental goals and milestones, breaking big projects down into achievable steps, continuously experimenting with new ideas through model sites, pilot projects, and trials, analyzing successes and failures and sharing lessons learned^{1,2,3}.

The only constant in the world is change. Exemplary leaders are not satisfied with the status quo and are always looking to the future. Challenge the process is not about rebelling against the current process, it involves seeking opportunities to become better. There must be a willingness to sometimes make mistakes as long as these mistakes result from taking risks which could potentially greatly benefit the situation. Everyone must learn from those mistakes to not repeat the same mistakes again.

Enable Others to Act is about creating a safe and trusting environment for people to collaborate, experiment and engage. Exemplary leaders foster collaboration by building trust and facilitating relationships. The two commitments associated are¹:

- Foster collaboration by promoting cooperative goals and building trust.
- Strengthen others by sharing power and discretion.

Behaviors that support alignment with enable others to act include; developing cooperative relationships among the people you interact with, actively listening to diverse points of view, treating others with dignity and respect, supporting the decisions that others make on their own, giving people freedom and choice in deciding how to do their work, and ensuring that people grow in their jobs by learning new skills and developing themselves¹.

Actions that align with enable others to act include: sharing information about yourself – your hopes, your strengths, your fears, your mistakes – the things that make you who you are. Spending time getting to know the team and what is important to them as individuals. Showing concern for the problems and aspirations of others. Listening, listening, and listening some more. Putting the interests of the organization and of your team ahead of your own. Clearly articulating and frequently reiterating the common goals that you are all striving to achieve and the larger purpose of which everyone is a part of^{1,2,3}.

Encourage the Heart - focuses on being sincere in all that we do and with our interactions with each other. The two commitments associated are¹:

- Recognize contributions by showing appreciation for individual excellence.
- Celebrate the values and victories by creating a spirit of community.

Behaviors that support alignment with encourage the heart include; praising people for a job well done, making it a point to let people know about your confidence in their abilities, making sure that people are creatively rewarded for their contributions to the success of projects and initiatives, publicly recognizing people who exemplify commitment to the shared values, finding easy and sincere ways to celebrate accomplishments and giving members of the team appreciation and support their contributions¹.

Key Take Aways to Master the Challenges of Leadership^{1,2,3}

- As leaders we must motivate and support everyone in good times and bad.
- Lead by example and model the way by setting an example for others to follow.
- Leaders do not ever ask someone to do something that they would not be willing to do themselves.
- Inspire an inclusive vision that is shared by all.
- Inspired people are capable of accomplishing amazing things.
- Engagement of the team is crucial to obtain their full commitment.
- Practice continuous improvement by challenging the process and focus on small wins and build on them.
- Leaders need to innovate and create change.
- Create a culture of support and encourage everyone to experiment and take risks.
- Leaders promote the team concept that everyone is in it together.
- It is imperative to put the needs of the team before the personal needs of the leader.
- A culture where accomplishments are celebrated inspires everyone to work hard.
- The heart is the biggest driving force in motivating a group. We need to think with our head but lead with our heart.

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Shortcomings in Sickle Cell Management

Sickle cell disease and its associated co-morbidities are common conditions seen by emergency physicians. Although sickle cell disease itself is relatively uncommon, affecting about 100,000 Americans¹, a subset of patients are high utilizers of the emergency department. Hence emergency physicians (EPs) have become familiar with sickle cell's debilitating pain crises mandating treatment with high-dose opiate therapy. EPs are also acutely aware of red flags in sickle cell patients that may be tip-offs for occult life-threatening infection, ischemia or aplastic anemia. For unstable sickle cell patients, we perform life-saving interventions effectively and rapidly. But the sickle cell patients for whom we must strive to improve our care are those that present only with pain crisis without notable red flags.

Sickle cell disease is an inherited autosomal recessive disease caused by a point mutation in the beta-globulin gene of hemoglobin. This mutation causes the beta-globulin chain to polymerize in response to stressors, giving red blood cells a transient, yet clinically significant, "sickle" appearance. This sickling of the red blood cells can lead to aggregation and occlusion of small blood vessels, for which patients experience significant pain as a result. Because of these pain episodes, which may be variable in onset and intensity, hematologists and pain medicine specialists prescribe high-dose oral opiates to be used during acute episodes. Sometimes, though infrequently, these oral medications fail to control pain, necessitating a visit to the Emergency Department.

Once sickle cell patients reach the Emergency Department, their initial requests of high-dose opiates can be misinterpreted as drug-seeking behavior, especially as the majority of sickle cell patients appear well upon presentation. In a 1997 survey² conducted of both emergency physicians and hematologists, EPs were more likely than hematologists to characterize patients as addicted to opiates, with a staggering 53% of EPs believing more than 20% of their sickle cell patients were drug addicts. In a 2009 survey of mainly acute care nurses³, at least two-thirds of participants felt that patients exaggerated discomfort or otherwise exhibited secondary behavior in order to obtain narcotics. This thought process has a noticeable effect on quality of care as providers and staff who exhibit this type of thinking tended to be less prompt in re-dosing analgesia for sickle cell patients⁴. The actual number of true addicts among sickle cell patients is small⁵⁻⁶, with a 2003 study showing that only 2% of sickle cell patients meet the DSM-IV criteria for substance dependence⁷. But despite that low percentage, emergency physicians are hesitant to dose and re-dose sickle cell patients with the requisite analgesia they need to overcome their crises, which is a source of significant frustration for these patients⁸.

Because emergency providers often see the same sickle cell patients coming to their emergency department⁹, a negative interaction during one visit can compound and lead to further negative interactions

in subsequent emergency department, and even outpatient, visits.

This downward cycle is devastating as sickle cell patients require a comprehensive level of care that far supersedes what the emergency department is able to provide; multimodal care with a hematologist, primary care physician and chronic pain physician are necessary.

The vast majority of sickle cell patients should also be on both a breakthrough pain regiment and hydroxyurea, a medication which causes higher expression of fetal hemoglobin (fetal hemoglobin, or HbF, lacks the mutated beta-globulin chain which induces sickling of red blood cells).

Rather than thinking about secondary intent in our sickle cell patients presenting with pain crises, emergency physicians should make every effort to treat their pain, with high-dose narcotics if need be. Furthermore, EPs should encourage and reinforce positive practices by asking sickle cell patients about when they last saw their hematologists as well as whether or not they are on hydroxyurea or a pain regiment. If EPs detect a lack of thorough outpatient care, prompt referral should be initiated. These actions not only act in the best interest of our sickle cell patients, but also help to rebuild their trust in the medical field.

It is important to remember that sickle cell disease significantly impacts life expectancy; patients have a median age of death in their 50s with end-stage renal disease and its complications the most common cause¹⁰. Ensuring that our sickle cell patients receive timely care both within and outside the emergency department has drastic long term benefits for their health; comprehensive care planning for sickle cell patients has been linked to extended life expectancy as well as improved quality of life and decreased utilization of the emergency department¹⁰⁻¹². Medical care for sickle cell patients is continuing to improve. New techniques are being discovered, and existing therapies, such as bone marrow transplantation, are constantly being perfected. But for now, the data shows that emergency physicians can provide better care to acutely ill sickle cell patients. By doing so, we are supporting these patients through a difficult, debilitating disease and creating a positive environment where sickle cell patients can get the care they need.

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Congratulations to New Fellows of the American College of Emergency Physicians

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New York ACEP New Speaker Forum

Open to Attendings
Deadline: March 12, 2018

Presentation Date
Tuesday, July 10 at 4:30 pm



2017 New Speaker Forum Winner
Jessica Noonan, MD FACEP

If you are considering professional speaking and would like to gain experience, this forum was designed for you. New York ACEP will showcase members who are dynamic lecturers, but may be new to presenting at the state or regional level.

Speakers must be attending physicians, who are New York ACEP members, and have never presented at the national level.

The topic for the New Speaker Forum is "Best Practices in Emergency Medicine." The Forum will be held Tuesday, July 10 at 4:30 pm-5:30 pm at the Sagamore Resort on Lake George. Applicants will be selected to give a 15 minute presentation on this topic.

Candidates interested in presenting at New York ACEP's New Speaker Forum need to apply by 11:59 pm, March 12, 2018.


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Theodore Albright, MD

Theodore Albright, MD
Emergency Medicine Resident (PGY-2)
SUNY Upstate Medical University

I am originally from Nevada and had to purchase an umbrella when I moved to Syracuse. My interests include medical device development, government affairs/advocacy and enjoying the great Syracuse weather as much as possible!

New York ACEP is a group of excited and engaged physicians who have helped me learn about the pressing legislative issues in our state and advocate for EM physicians across the state and the country while providing me with a wonderful group of mentors.



David L. Ng, MD FACEP

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Chief of Emergency Medicine
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I am board certified in both Emergency Medicine and Clinical Informatics after completing residency at Northwell Health. My interests include optimizing patient flow and enhancing EMR usability.

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No Medical Student Left Behind: Don't Let Assessment Fatigue Jeopardize Student Evaluation

As spring approaches, we are entering a time when our interns and residents are becoming independent thinkers and are able to function more autonomously in the Emergency Department (ED). Throughout the year we have put much time and effort into molding their decisions, analytical skills and patient care capabilities. The art of evaluating and giving feedback is so crucial to their success, but also demands a great deal of effort and thought. Just as our feedback process for residents becomes a little less involved, our third year medical student rotations begin to ramp up. As faculty, we must identify students who are perfectly paired with the specialty of emergency medicine (these are the easy ones), mentor those who require slightly more guidance and identify students who could be a poor fit despite their eagerness to pursue it.

Depending on the medical school, emergency medicine may or may not be a required course and may or may not be offered to third year students. For those students committed to our specialty, the spring of third year is often their first opportunity to participate in a clerkship or elective that will actually matter as they apply for residency.

It is our responsibility as faculty members to be diligent and thoughtful in their evaluations; but this can prove difficult after months of intensely evaluating interns, residents and other students. Evaluation and assessment fatigue can set in, which is a danger for both our students and our future selves. We must remember that a student becomes someone's intern, someone's resident and ultimately a colleague from whom we receive signout and depend upon to help us run a department. Hence, giving accurate and worthwhile feedback to our students is imperative since the downstream effects of mediocre feedback may not be felt until it is too late. "Read more and expand differentials" just doesn't cut it for our students.

In emergency medicine, the Standardized Letter of Evaluation (SLOE) has allowed us to create a more level playing field for the comparison of students and may be helpful when evaluating and giving feedback to students after shifts as well. It requires us to compare each student to their peers with respect to seven important qualifications.

For each of these qualifications, we are tasked with determining if the student is above, at the level of, or below their peers. The categories focus on the things we really care about in clinical emergency medicine. Hubert and Epstein discuss the notion of competence in medicine and define it as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities being served."³ Considering this, the SLOE does a reasonable job of assessing and communicating a student's competence. Let's take a closer look at these qualifications.

Commitment to and knowledge of the specialty

This may be difficult to assess based on one shift with a student, but we can usually determine whether or not the student "gets it." Does he or she have insight into what we are trying to achieve in the ED in terms of identifying life-threatening diagnoses and initiating the appropriate management?

Work ethic, willingness to assume responsibility

The last thing anybody wants to deal with is a lazy colleague. Does the student work hard, get involved and generally take an appropriate level of responsibility for his or her patients?

Ability to develop and justify an appropriate differential and a cohesive treatment plan

How well does the student gather and synthesize information from the patient in order to create a sound plan that shows consideration for an EM specific differential?

Ability to work with a team

This is arguably one of the most important skills for students, residents and all providers in the emergency department, yet there is no standardized test to evaluate this skill. It is something we assess through our interactions with students and our observations of how they function within the department.

EDUCATION

Ability to communicate a caring nature to patients

This is also not a skill that can be easily scored or tested. While these students may never have had exposure to the emergency department, they must be able to relate to people. Our job requires that we quickly establish rapport with patients and their families in order to gain their trust and confidence.

Focusing on and personally assessing each of these seven qualifications as we work with medical students will help make our feedback pertinent and worthwhile. It will benefit both our students and our colleagues who will write and ultimately read the letters of evaluation. While such an evaluation is one extra step during or after a busy shift, its significance cannot be overstated. We can (and should) do our part to ensure that our emergency departments are populated by bright, diligent, capable and enjoyable students as they pave their path to residency.

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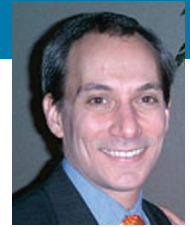
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Standard Anatomic Terminologies: Comparison for Use in a Health Information Exchange-Based Prior Computed Tomography (CT) Alerting System.

Beitia AO, Lowry T, Vreeman DJ, Loo GT, Delman BN, Thum FL, Slovis BH, Shapiro JS; Icahn School of Medicine at Mount Sinai, New York, NY; JMIR Med Inform. 2017 Dec 14; 5(4):e49.

BACKGROUND: A health information exchange (HIE)-based prior computed tomography (CT) alerting system may reduce avoidable CT imaging by notifying ordering clinicians of prior relevant studies when a study is ordered. For maximal effectiveness, a system would alert not only for prior same CTs (exams mapped to the same code from an exam name terminology) but also for similar CTs (exams mapped to different exam name terminology codes but in the same anatomic region) and anatomically proximate CTs (exams in adjacent anatomic regions).

Notification of previous same studies across an HIE requires mapping of local site CT codes to a standard terminology for exam names (such as Logical Observation Identifiers Names and Codes [LOINC]) to show that two studies with different local codes and descriptions are equivalent. Notifying of prior similar or proximate CTs requires an additional mapping of exam codes to anatomic regions, ideally coded by an anatomic terminology. Several anatomic terminologies exist, but no prior studies have evaluated how well they would support an alerting use case.

OBJECTIVE: The aim of this study was to evaluate the fitness of five existing standard anatomic terminologies to support similar or proximate alerts of an HIE-based prior CT alerting system.

METHODS: We compared five standard anatomic terminologies (Foundational Model of Anatomy, Systematized Nomenclature of Medicine Clinical Terms, RadLex, LOINC, and LOINC/Radiological Society of North America [RSNA] Radiology Playbook) to an anatomic framework created specifically for our use case (Simple Anatomic Ontology for Proximity or Similarity [SANOPS]), to determine whether the existing terminologies could support our use case without modification. On the basis of an assessment of optimal terminology features for our purpose, we developed an ordinal anatomic terminology utility classification. We

mapped samples of 100 random and the 100 most frequent LOINC CT codes to anatomic regions in each terminology, assigned utility classes for each mapping and statistically compared each terminology's utility class rankings. We also constructed seven hypothetical alerting scenarios to illustrate the terminologies' differences.

RESULTS: Both RadLex and the LOINC/RSNA Radiology Playbook anatomic terminologies ranked significantly better ($P < .001$) than the other standard terminologies for the 100 most frequent CTs, but no terminology ranked significantly better than any other for 100 random CTs. Hypothetical scenarios illustrated instances where no standard terminology would support appropriate proximate or similar alerts, without modification.

CONCLUSIONS: LOINC/RSNA Radiology Playbook and RadLex's anatomic terminologies appear well suited to support proximate or similar alerts for commonly ordered CTs, but for less commonly ordered tests, modification of the existing terminologies with concepts and relations from SANOPS would likely be required. Our findings suggest SANOPS may serve as a framework for enhancing anatomic terminologies in support of other similar use cases.

Efficacy of a Massive Transfusion Protocol for Hemorrhagic Trauma Resuscitation.

Lim G, Harper-Kirksey K, Parekh R, Manini AF; Icahn School of Medicine at Mount Sinai, New York, NY; Am J Emerg Med. 2017 Nov 29.

OBJECTIVES: New paradigm shifts in trauma resuscitation recommend that early reconstitution of whole blood ratios with massive transfusion protocols (MTP) associated with improved survival. We performed a preliminary study on the efficacy of MTP at an urban, Level 1 trauma center and its impact on resuscitation goals.

METHODS: A case-control study was performed on consecutive critically-ill trauma patients over the course of 1 year. The trauma captain designated patients as either MTP activation (cases) or routine care without MTP (controls) in matched, non-randomized fashion. Primary outcomes were: time to initial

transfusion; number of total units of packed red blood cells (pRBC) and fresh frozen plasma (FFP) transfused; and ratio of pRBC to fresh frozen plasma (pRBC:FFP). Secondary outcomes were in-hospital mortality, and length of stay.

RESULTS: Out of 226 patients screened, we analyzed 58 patients meeting study criteria (32 MTP, 26 non-MTP). Study characteristics for the MTP and non-MTP groups were similar except age (34.0 vs. 45.85 years, $p = 0.015$). MTP patients received blood products more expeditiously (41.7 minutes vs. 62.1 minutes, $p = 0.10$), with more pRBC (5.19 vs 3.08 units, $p = 0.05$), more FFP (0.19 vs 0.08 units, $p < 0.01$), and had larger pRBC:FFP ratios (1.90 vs 0.52, $p < 0.01$). Secondary outcomes did not differ significantly but the MTP group was associated with a trend for decreased hospital length of stay ($p = 0.08$).

CONCLUSIONS: MTP resulted in clinically significant improvements in transfusion times and volumes. Further larger and randomized studies are warranted to validate these findings to optimize MTP protocols.

Choice of Resuscitative Fluids and Mortality in Emergency Department Patients with Sepsis.

Sethi M, Owyang CG, Meyers C, Parekh R, Shah KH, Manini AF; Icahn School of Medicine at Mount Sinai, New York, NY; Am J Emerg Med. 2017 Oct 7.

OBJECTIVE: Balanced resuscitative fluids (BF) have been associated with decreased incidence of hyperchloremic metabolic acidosis in sepsis. We hypothesized that higher proportions of BF during resuscitation would thus be associated with improved mortality in Emergency Department (ED) patients with sepsis.

METHODS: This was a retrospective chart review of adult ED patients who presented with sepsis to a large, urban teaching hospital over one year. The choice of resuscitation fluid in the first two days of hospitalization was defined as either normal saline (NS) or balanced fluids (BF; Lactated Ringer's or Isolyte). The primary study outcome was in-hospital mortality, which was analyzed with multivariable logistic regression based on the proportion of BF received during the initial ED resuscitation.

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RESULTS: Of 149 patients screened, 33 were excluded, leaving 115 for analysis, of whom 18 died (16% overall mortality). 61 (53%) patients received BF and NS, 6 (5%) patients received BF exclusively, while 48 (42%) patients received NS only. The mean number of liters administered was 5.4, and the mean percentage of BF administered was 29%. In univariate analysis, a higher proportion of BF was associated with lower odds of mortality (OR 0.973 [95% CI 0.961-0.986], $p=0.00003$). This association held true in multivariable models controlling for comorbidities and admission lactate level.

CONCLUSIONS: We found that the proportion of BF during the initial ED resuscitation in septic patients was associated with a significant reduction in mortality. This association provides the necessary rationale for future randomized clinical trials of BF resuscitation in sepsis.

A Randomized Controlled Trial of a Single Dose Furosemide to Improve Respiratory Distress in Moderate to Severe Bronchiolitis.

Williamson K, Bredin G, Avarello J, Gangadharan S; Cohen Children's Medical Center of New York, New Hyde Park; J Emerg Med. 2017 Nov 22.

BACKGROUND: Bronchiolitis is one of the most common disorders of the lower respiratory tract in infants. While historically diuretics have been used in severe bronchiolitis, no studies have looked directly at their early use in children in the emergency department.

OBJECTIVE: The primary objective of this study was to determine whether a single early dose of a diuretic in infants with moderate to severe bronchiolitis would improve respiratory distress. Secondary objectives examined whether it reduced the use of noninvasive ventilation and hospital length of stay.

METHODS: Patients diagnosed with clinical bronchiolitis were enrolled at a tertiary care, academic children's hospital over a three year period. This was a double-blind, randomized controlled trial in which subjects were randomly assigned to either furosemide or placebo. Respiratory rate and oxygen saturation at the time of medication delivery and at 2 and 4 post-intervention was recorded, as well as other data. Exact logistic regression was used to examine associations.

RESULTS: There were 46 subjects enrolled and randomized. There was no difference in

respiratory rates, measured as a decrease of $\geq 25\%$, at both 2 and 4 after intervention between furosemide and placebo groups (odds ratios 1.13 and 1.13, respectively). There was also no difference in oxygen saturation, intensive care unit admission rate or hospital length of stay between groups.

CONCLUSIONS: While theoretically a single dose of a diuretic to reduce lung fluid would improve respiratory distress in children with bronchiolitis, our randomized controlled medication trial showed no difference in outcomes.

Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial.

Chang AK, Bijur PE, Esses D, Barnaby DP, Baer J; Albany Medical College, Albany JAMA. 2017 Nov 7; 318(17):1661-1667.

IMPORTANCE: The choice of analgesic to treat acute pain in the emergency department (ED) lacks a clear evidence base. The combination of ibuprofen and acetaminophen (paracetamol) may represent a viable nonopioid alternative.

OBJECTIVES: To compare the efficacy of four oral analgesics.

DESIGN, PARTICIPANTS AND

SETTINGS: Randomized clinical trial conducted at two urban EDs in the Bronx, New York that included 416 patients aged 21 to 64 years with moderate to severe acute extremity pain enrolled from July 2015 to August 2016.

INTERVENTIONS: Participants (104 per each combination analgesic group) received 400 mg of ibuprofen and 1,000 mg of acetaminophen; 5 mg of oxycodone and 325 mg of acetaminophen; 5 mg of hydrocodone and 300 mg of acetaminophen; or 30 mg of codeine and 300 mg of acetaminophen.

OUTCOMES and MEASURES: The primary outcome was the between-group difference in decline in pain two hours after ingestion. Pain intensity was assessed using an 11-point numerical rating scale (NRS), in which 0 indicates no pain and 10 indicates the worst possible pain. The predefined minimum clinically important difference was 1.3 on the NRS. Analysis of variance was used to test the overall between-group difference at $P=.05$ and 99.2% CIs adjusted for multiple pairwise comparisons.

RESULTS: Of 416 patients randomized, 411 were analyzed (mean [SD] age, 37 [12] years; 199 [48%] women; 247 [60%] Latino). The

baseline mean NRS pain score was 8.7 (SD, 1.3). At 2 hours, the mean NRS pain score decreased by 4.3 (95% CI, 3.6 to 4.9) in the ibuprofen and acetaminophen group; by 4.4 (95% CI, 3.7 to 5.0) in the oxycodone and acetaminophen group; by 3.5 (95% CI, 2.9 to 4.2) in the hydrocodone and acetaminophen group; and by 3.9 (95% CI, 3.2 to 4.5) in the codeine and acetaminophen group ($P=.053$). The largest difference in decline in the NRS pain score from baseline to two hours was between the oxycodone and acetaminophen group and the hydrocodone and acetaminophen group (0.9; 99.2% CI, -0.1 to 1.8), which was less than the minimum clinically important difference in NRS pain score of 1.3. Adverse events were not assessed.

CONCLUSION: For patients presenting to the ED with acute extremity pain, there were no statistically significant or clinically important differences in pain reduction at two hours among single-dose treatment with ibuprofen and acetaminophen or with three different opioid and acetaminophen combination analgesics. Further research to assess adverse events and other dosing may be warranted.

Predictors, Prevalence and Outcomes of Early Crystalloid Responsiveness Among Initially Hypotensive Patients With Sepsis and Septic Shock.

Leisman DE, Doerfler ME, Schneider SM, Masick KD, D'Amore JA, D'Angelo JK; Hofstra-Northwell School of Medicine, Hempstead; Crit Care Med. 2017 Nov 3.

OBJECTIVES: The prevalence of responsiveness to initial fluid challenge among hypotensive sepsis patients is unclear. To avoid fluid overload, and unnecessary treatment, it is important to differentiate these phenotypes. We aimed to 1) determine the proportion of hypotensive sepsis patients sustaining favorable hemodynamic response after initial fluid challenge, 2) determine demographic and clinical risk factors that predicted refractory hypotension, and 3) assess the association between timeliness of fluid resuscitation and refractoriness.

DESIGN: Secondary analysis of a prospective, multisite, observational, consecutive-sample cohort.

SETTING: Nine tertiary and community hospitals over 1.5 years.

PATIENTS: Inclusion criteria 1) suspected or confirmed infection, 2) greater than or equal to two systemic inflammatory response syndrome criteria, 3) systolic blood pressure less than 90 mm Hg, greater than 40% decrease from

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baseline, or mean arterial pressure less than 65 mm Hg.

MEASUREMENTS AND MAIN

RESULTS: Sex, age, heart failure, renal failure, immunocompromise, source of infection, initial lactate, coagulopathy, temperature, altered mentation, altered gas exchange, and acute kidney injury were used to generate a risk score. The primary outcome was sustained normotension after fluid challenge without vasopressor titration. Among 3,686 patients, 2,350 (64%) were fluid responsive. Six candidate risk factors significantly predicted refractoriness in multivariable analysis: heart failure (odds ratio, 1.43; CI, 1.20-1.72), hypothermia (odds ratio, 1.37; 1.10-1.69), altered gas exchange (odds ratio, 1.33; 1.12-1.57), initial lactate greater than or equal to 4.0 mmol/L (odds ratio, 1.28; 1.08-1.52), immunocompromise (odds ratio, 1.23; 1.03-1.47), and coagulopathy (odds ratio, 1.23; 1.03-1.48). High-risk patients (\geq three risk factors) had 70% higher (CI, 48-96%) refractory risk (19% higher absolute risk; CI, 14-25%) versus low-risk (zero risk factors) patients. Initiating fluids in greater than two hours also predicted refractoriness (odds ratio, 1.96; CI, 1.49-2.58). Mortality was 15% higher (CI, 10-18%) for refractory patients.

CONCLUSIONS: Two in three hypotensive sepsis patients were responsive to initial fluid resuscitation. Heart failure, hypothermia, immunocompromise, hyperlactemia and coagulopathy were associated with the refractory phenotype. Fluid resuscitation initiated after the initial two hours more strongly predicted refractoriness than any patient factor tested.

Transgender and Gender-Nonconforming Patients in the Emergency Department: What Physicians Know, Think and Do.

Chisolm-Straker M, Willging C, Daul AD, McNamara S, Sante SC, Shattuck DG, Crandall CS; Department of Emergency Medicine, Mount Sinai Brooklyn; Ann Emerg Med. 2017 Nov 3.

OBJECTIVE: We explore self-reported knowledge, attitudes and behaviors of emergency physicians in regard to the care of transgender and gender-nonconforming patients to identify opportunities to improve care of this population.

METHODS: From July to August 2016, we electronically surveyed the American College of Emergency Physicians' Emergency Medicine Practice-Based Research Network

of 654 active emergency physician participants. We performed frequency tabulations to analyze the closed-ended response items.

RESULTS: Of the 399 respondents (61% response rate), 88.0% reported caring for transgender and gender-nonconforming patients in the emergency department (ED), although 82.5% had no formal training about this population. The majority of physicians (86.0%) were comfortable asking about personal pronouns. Only 26.1% of respondents knew the most common gender-affirming surgery for female-to-male patients; 9.8% knew the most common nonhormone gender-affirming medication that male-to-female patients use. Almost no respondents (<3%) were aware of emergency medicine practitioners' performing inappropriate examinations on transgender and gender-nonconforming patients.

CONCLUSION: Although transgender and gender-nonconforming people represent a minority of ED patients nationwide, the majority of respondents reported personally providing care to members of this population. Most respondents lacked basic clinical knowledge about transgender and gender-nonconforming care.

Effectiveness of SBIRT for Alcohol Use Disorders in the Emergency Department: A Systematic Review.

Barata IA, Shandro JR, Montgomery M, Polansky R, Sachs CJ, Duber HC, Weaver LM, Heins A, Owen HS, Josephson EB, Macias-Konstantopoulos W; North Shore University Hospital, Manhasset; West J Emerg Med. 2017 Oct; 18(6):1143-1152.

INTRODUCTION: Alcohol use disorders (AUD) place a significant burden on individuals and society. The emergency department (ED) offers a unique opportunity to address AUD with brief screening tools and early intervention. We undertook a systematic review of the effectiveness of ED brief interventions for patients identified through screening who are at risk for AUD, and the effectiveness of these interventions at reducing alcohol intake and preventing alcohol-related injuries.

METHODS: We conducted systematic electronic database searches to include randomized controlled trials of AUD screening, brief intervention, referral and treatment (SBIRT), from January 1966 to April 2016. Two authors graded and abstracted data from each included paper.

RESULTS: We found 35 articles that had direct relevance to the ED with enrolled patients ranging from 12 to 70 years of age. Multiple alcohol screening tools were used to identify patients at risk for AUD. Brief intervention (BI) and brief motivational intervention (BMI) strategies were compared to a control intervention or usual care. Thirteen studies enrolling a total of 5,261 participants reported significant differences between control and intervention groups in their main alcohol-outcome criteria of number of drink days and number of units per drink day. Sixteen studies showed a reduction of alcohol consumption in both the control and intervention groups; of those, seven studies did not identify a significant intervention effect for the main outcome criteria, but nine observed some significant differences between BI and control conditions for specific subgroups (i.e., adolescents and adolescents with prior history of drinking and driving; women 22 years old or younger; low or moderate drinkers); or secondary outcome criteria (e.g. reduction in driving while intoxicated).

CONCLUSION: Moderate-quality evidence of targeted use of BI/BMI in the ED showed a small reduction in alcohol use in low or moderate drinkers, a reduction in the negative consequences of use (such as injury), and a decline in ED repeat visits for adults and children 12 years of age and older. BI delivered in the ED appears to have a short-term effect in reducing at-risk drinking.

Using an Alumni Survey to Target Improvements in an Emergency Medicine Training Program.

Gaeta T, Mahalingam G, Pyle M, Dam A, Visconti A; New York-Presbyterian Brooklyn Methodist Hospital; Emerg Med J. 2017 Oct 21.

INTRODUCTION: The Accreditation Council for Graduate Medical Education (ACGME) is the governing body responsible for accrediting graduate medical training programs in the United States. The Emergency Medicine Milestones (EM-Milestones) were developed by the ACGME and American Board of Emergency Medicine as a guide and monitoring tool for the knowledge, skills, abilities and experiences to be acquired during training. Alumni surveys have been reported as a valuable resource for training program to identify areas for improvement; however, there are few studies regarding program improvement in emergency medicine. We aimed to use the EM-Milestones, adapted as an alumni self-assessment survey, to

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identify areas for training program improvement.

METHODS: This study was conducted at an urban, academic affiliated, community hospital in New York city with an emergency medicine training program consisting of 30 residents over three years. Alumni of our emergency medicine training program were sent an EM-Milestones-based self-assessment survey. Participants evaluated their ability in each EM-Milestones subcompetency on a Likert scale. Data were analyzed using descriptive statistics.

RESULTS: Response rate was 74% (69/93). Alumni reported achieving the target performance in 5/6 general competencies, with Systems-Based Practice falling below the target performance. The survey further identified 6/23 subcompetencies (Pharmacotherapy, Ultrasound, Wound Management, Patient Safety, Systems-Based Management and Technology) falling below the target performance level.

DISCUSSION: Alumni self-evaluation of competence using the EM-Milestones provides valuable information concerning confidence to practice independently; these data, coupled with regular milestone evaluation of existing trainees, can identify problem areas and provide a blueprint for targeted program improvement.

Clinical and Epidemiological Characteristics of Patients with Acute Drug Intoxication Admitted to ICU.

Orsini J, Din N, Elahi E, Gomez A, Rajayer S, Malik R, Jean E; Woodhull Medical and Mental Health Center; J Community Hosp Intern Med Perspect. 2017 Sep 19; 7(4):202-207.

BACKGROUND: Drug overdose continues to be the most common cause of acute poisoning worldwide. There has been a substantial increase in drug overdose incidence and prevalence over the past decade, probably as a result of the emergence of new synthetic designer drugs. The purpose of this study is to describe the clinical and epidemiological characteristics of patients with acute drug intoxication admitted to the Intensive Care Unit (ICU).

METHODS: A single center, prospective, observational study was conducted among all adult patients with clinical signs suggestive of acute drug intoxication admitted from the Emergency Department (ED) to ICU during a 6-month period (September to March).

RESULTS: Sixty-five patients were admitted. Their median age was 49 years (mean 48.2, range 20-72), and the majority were male (48, 74%). Median Sequential Organ Failure Assessment (SOFA) score on admission to ICU was 6 (mean 6, range 0-13). Fifty-five patients (85%) had a positive urine and/or serum toxicology screen. Most commonly detected substances were: opiates (18, 33%), cocaine (13, 24%), methadone (12, 22%), benzodiazepines (10, 18%), and marijuana (9, 16%). In 16 patients (29%), >1 substance was isolated. Twenty-three patients (35%) had negative urine toxicology screen. Ethyl alcohol was detected in the serum of twenty-three patients (35%). Five patients (8%) expired in ICU.

CONCLUSION: Classic recreational drugs remain the most common substances involved in acute drug poisoning. More sensitive detection methods are warranted to identify new designer drugs of abuse such as synthetic cannabinoids.

Clinical Value of Triage Lactate in Risk Stratifying Trauma Patients Using Interval Likelihood Ratios.

Baron BJ, Nguyen A, Stefanov D, Shetty A, Zehtabchi S; Downstate Medical Center and Kings County Hospital; Am J Emerg Med. 2017 Oct 7.

Emergency physicians face the challenge of rapidly identifying high-risk trauma patients. Lactate (LAC) is widely used as a surrogate of tissue hypoperfusion. However, clinically important values for LAC as a predictor of mortality are not well defined.

OBJECTIVES: 1. To assess the value of triage LAC in predicting mortality after trauma. 2. To compute interval likelihood ratios (LR) for LAC.

METHODS: Retrospective chart review of trauma patients with a significant injury mechanism that warranted labs at an urban trauma center.

OUTCOME: In-hospital mortality. Data are presented as median and quartiles or percentages with 95% confidence intervals. Groups (lived vs. died) were compared with Man-Whitney-U or Fisher's-exact test. Multivariate analysis was used to measure the association of the independent variables and mortality. The interval likelihood ratios were calculated for all LAC observed values.

RESULTS: 10,575 patients; median age: 38 [25-57]; 69% male; 76% blunt; 1.1% [n=119] mortality. LAC was statistically different

between groups in univariate (2.3 [1.6,3.0] vs 2.8 [1.6,4.8], p=0.008) and multivariate analyses (odds ratio: 1.14 [1.08-1.21], p=0.0001). Interval ratios for LR- ranged from 0.6-1.0. Increasing LAC increased LR+. However, LR+ for LAC reached 5 with LAC>9mmol/L and passed 10 (moderate and conclusive increase in disease probability, respectively) with LAC>18mmol/L.

CONCLUSIONS: In a cohort of trauma patients with a wide spectrum of characteristics triage LAC was statistically able to identify patients at high risk of mortality. However, clinically meaningful contribution to decision-making occurred only at LAC>9. LAC was not useful at excluding those with a low risk of mortality.

Waveform Capnography: An Alternative to Physician Gestalt in Determining Optimal Intubating Conditions after Administration of Paralytic Agents.

Scoccimarro A, West JR, Kanter M, Caputo ND; Lincoln Medical Center; Emerg Med J. 2018 Jan; 35(1):62-64.

PURPOSE: We sought to evaluate the utility of waveform capnography (WC) in detecting paralysis, by using apnoea as a surrogate determinant, as compared with clinical gestalt during rapid sequence intubation. Additionally, we sought to determine if this improves the time to intubation and first pass success rates through more consistent and expedient means of detecting optimal intubating conditions (ie, paralysis).

METHODS: A prospective observational cohort study of consecutively enrolled patients was conducted from April to June 2016 at an academic, urban, level 1 trauma center in New York City. Nasal cannula WC was used to determine the presence of apnoea as a surrogate measure of paralysis versus physician gestalt (ie, blink test, mandible relaxation, and so on).

RESULTS: One hundred patients were enrolled (50 in the WC group and 50 in the gestalt group). There were higher proportions of failure to determine optimal intubating conditions (ie, paralysis) in the gestalt group (32%, n=16) versus the WC group (6%, n=3), absolute difference 26, 95% CI 10 to 40. Time to intubation was longer in the gestalt group versus the WC group (136 seconds vs 116 seconds, absolute difference 20 seconds 95% CI 14 to 26). First pass success rates were higher in the WC group versus the gestalt group (92%, 95% CI 85 to 97 vs 88%, 95% CI 88 to 95, absolute difference 4%, 95% CI 1 to 8).

NEW YORK STATE OF MIND

CONCLUSION: These preliminary results demonstrate WC may be a useful objective measure to determine the presence of paralysis and optimal intubating conditions in RSI.

Bouncing Back Elsewhere: Multilevel Analysis of Return Visits to the Same or a Different Hospital After Initial Emergency Department Presentation.

Shy BD, Loo GT, Lowry T, Kim EY, Hwang U, Richardson LD, Shapiro JS; Icahn School of Medicine at Mount Sinai; Ann Emerg Med. 2017 Sep 27.

OBJECTIVE: Analyses of 72-hour emergency department (ED) return visits are frequently used for quality assurance purposes and have been proposed as a means of measuring provider performance. These analyses have traditionally examined only patients returning to the same hospital as the initial visit. We use a health information exchange network to de-

scribe differences between ED visits resulting in 72-hour revisits to the same hospital and those resulting in revisits to a different site.

METHODS: We examined data from a 31-hospital health information exchange of all ED visits during a 5-year period to identify 72-hour return visits and collected available encounter, patient and hospital variables. Next, we used multilevel analysis of encounter-level, patient-level and hospital-level data to describe differences between initial ED visits resulting in different-site and same-site return visits.

RESULTS: We identified 12,621,159 patient visits to the 31 study EDs, including 841,259 same-site and 107,713 different-site return visits within 72 hours of initial ED presentation. We calculated odds ratios (ORs) and 95% confidence intervals (CIs) for the initial-visit characteristics' predictive relationship that any return visit would be at a different site: daytime visit (OR 1.10; 95% CI

1.07 to 1.12), patient-hospital county concordance (OR 1.40; 95% CI 1.36 to 1.44), male sex (OR 1.27; 95% CI 1.24 to 1.30), aged 65 years or older (OR 0.55; 95% CI 0.53 to 0.57), sites with an ED residency (OR 0.41; 95% CI 0.40 to 0.43), sites at an academic hospital (OR 1.12; 95% CI 1.08 to 1.15), sites with high density of surrounding EDs (OR 1.73; 95% CI 1.68 to 1.77), and sites with a high frequency of same-site return visits (OR 0.10; 95% CI 0.10 to 0.11).

CONCLUSION: This analysis describes how ED encounters with early revisits to the same hospital differ from those with revisits to a second hospital. These findings challenge the use of single-site return-visit frequency as a quality measure, and, more constructively, describe how hospitals can use health information exchange to more accurately identify early ED return visits and to support programs related to these revisits.

2018 ED Director Forum

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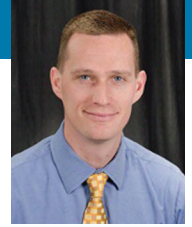
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Jeremy Cushman, MD MS EMT-P FACEP
Associate Professor and Chief
Division of Prehospital Medicine
University of Rochester

State of the (EM) State

Governor Cuomo recently outlined a number of initiatives in his State of the State report, the multi-hundred page roadmap of regulation and legislation that serve as areas of focus this coming year. In addition to the ‘usual’ threat to our practice – namely the hostile malpractice environment we New York physicians have the privilege of working in – there are a number of other policies that provide both challenge and opportunity for the coming year. At first, he is off to a good start, stating he “is committed to expanding access to quality and affordable health care for all New Yorkers.” Heaven knows EM is the only access most of our patients have to the healthcare system and this point we must leverage, but it’s the following pages that give us a glimpse of the challenges ahead.

A large portion of his address focused around the Opioid Epidemic. There will no doubt be great impact on us despite our efforts to protect the sanctity of our practice. New York ACEP has gone so far as to file a Freedom of Information Law request with the State to obtain prescribing information of other specialties as it is highly likely that we may lose our exemption to consult the Prescription Drug Monitoring Program (PDMP) for ED prescriptions. Although we have shared our data with legislators demonstrating the massive drop in prescription narcotics from the ED; and we have shared our frustrations with navigating the terrible interface of the PDMP and its impact on ED workflow; the political pressures are far too great despite our lobbying efforts. More concerning are proposals that surfaced last year that would require the ED to notify the prescriber of a patient presenting to the ED with an opiate overdose. Yeah, I’m not kidding.

There are also regulations being proposed that will require hospitals to establish policies and procedures to identify, assess and refer individuals with substance abuse disorders. If your hospital does not

have these already on the books, probably worth starting to work on them because this is also likely to pass in some form or another. They include the requirement that general hospitals will:

1. provide individuals who have or appear to have substance abuse disorders with educational materials, to be developed by OASAS in consultation with DOH, as part of discharge planning.
2. establish written policies and procedures for the identification and assessment as well as the referral of licensed and certified staff in such policies and procedures.
3. train licensed and certified staff in such policies and procedures.
4. refer individuals in need of substance abuse disorder services to appropriate programs and coordinate with such programs.
5. inform individuals who have or appear to have substance abuse disorders of treatment services that may be available, which can be accomplished verbally and/or in writing as appropriate.

I think we would all agree that establishing processes for referral are important; however New York ACEP will continue to advocate and share the challenges of achieving the goals of such legislation in an increasingly complex, overburdened,

overcrowded and underfunded emergency setting.

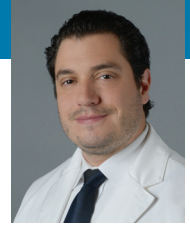
On a more promising note, there was also a focus on removing barriers and improving access to telehealth in rural areas of the state. This may help provide us with necessary specialty consultation and referral without the heavy financial and practical burdens of transferring patients to facilities with those resources. As always, however, the devil is in the details.

Certainly the State of the (EM) State provides us with challenges and opportunities as we work tirelessly to provide care to the millions of New Yorkers that come through our doors every day. This year will unfortunately be no different, but a reminder of how important your involvement in New York ACEP is – as a member, PAC contributor, committee member, senator or assemblyman visitor, or advocate for our specialty. Your participation - in any way - will help us collectively voice our simple goal: to care for our patients with the autonomy and risk protections that we need to fulfill our responsibility to care for all New Yorkers.

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Interviewed By: Joshua Moskovitz, MD MBA MPH FACEP
Associate Director of Operations
Department of Emergency Medicine
Jacobi Medical Center

DMAT Involvement



Gary Hecker, RN CCRN AEMT-CC CIC

How did you get involved in the DMAT?

I knew the Federal Government had disaster resources early in my nursing career, but I just could not figure out how to get involved (the Web was not what it is today). I learned about the New York-2 DMAT team accidentally: I was at a class on some topic and I overheard two people talking about an orientation meeting. I got the information, dragged one of my friends to join with me and have been involved ever since; that was thirteen years ago.

When did you first get involved in disaster response?

I have been an EMS provider for over 30 years and an ER/ICU nurse for twenty-five years. I was working in the ED at Bellevue for the first World Trade Center attack. I was a first responder to Ground Zero as part of my Volunteer Ambulance Corps.

Where have you gone to provide care in disaster scenarios?

Hurricane Katrina was my first real experience out the door to a national disaster. I was with my team in East Jefferson Parish for over a week. I also responded to Hurricane Ophelia and Wilma that year.

I recently deployed to Florida for Hurricane Irene. We rode out the storm in Orlando, and after the damage and needs assessment we performed a Hospital Decompression mission at Lower Keys Medical Center in Key West, FL. The hospital had evacuated for the storm and was just starting up emergency services again. Our role was to provide support to the only real health care facility available. We managed a lot of patients that would have overwhelmed a hospital trying to get back on line. Our services also provided relief to the staff there. They too are victims of the storm and are dealing with their own personal recovery as well.

We set up our Base of Operations (BOO) across the street from the hospital, mostly treating urgent-care type patients. We saw a lot of patients who were having exacerbations of chronic diseases like hypertension and diabetes due to the extreme heat and scarce resources available. Many people could not get to their primary care provider for routine care because they had evacuated. There were many “clean up” injuries and patients with mental health issues that needed to be addressed. At the end of our second week, the hospital was back to full operations and we demobilized.

For Hurricane Maria, we deployed to Manati Puerto Rico, about one hour west of San Juan. We staged in an old basketball arena and worked jointly with the Veterans Administration (VA) whom had a disaster response component for the first time with the private sector. Our team encompassed members of the Greater New York Hospital

Association, Columbia Presbyterian system, Stony Brook and Medi-Sys. This was a unique set up as we were running a Federal Medical Station (FMS) along with a BOO in the same facility. The FMS provided care to non-acute patients whom need sheltering, those who are normally cared for by their families at home. Due to the power outages and loss resources they could not stay at home. Their needs included feeding pumps, CPAP, ventilators and hospice. The FMS housed around 45-50 patients while the BOO treated an average of 200 patients a day for various acute care and critical care needs.



View of DMAT Tents and FMS beds set up in an old basketball arena in Manati, Puerto Rico.



The critical/resuscitation bay at the Red Tent inside the stadium

What was the experience like?

The experience was physically challenging. You are working in austere conditions with both operations running 24-7. We all worked twelve hour shifts with no days off. While this is something we train for, every disaster has its own unique circumstances. We have an unofficial motto of “Semper Gumby;” always flexible. We prepare for an all-hazards approaching, adapting to whatever challenges we face. Our official slogan for the National Disaster Medical System (NDMS), our parent agency, is “The Best of Care during the Worst of Times.”

I also had a few bucket list firsts. For Hurricane Irene we flew down from Washington D.C. to Orlando on Air Force C-17's. We stayed on S.U.N.Y. Maritime Training Ship ‘Empire State’ that the government uses during times of disaster. It had just come down from Texas for Harvey to Key West.

What did you find rewarding?

This was definitely one of the best deployments I have been on. Due to the large scale and multiple storms, teams backfilled with members from other DMATs. We worked with lots of wonderful people from all over the country. The people we served were warm and friendly and very appreciative of us being there to help their communities. One of the most notable memories was in the FMS in Puerto Rico. There was a man who sang to his comatose wife every day; it was very moving. No one wanted to leave when we were demobilized.

What did you find difficult?

Super storm Sandy personally affected me pretty hard. I was not certain how I would react seeing all the damage and devastation from these hurricanes, but in the end, I was all right. I was able to use my experience as a storm survivor to be a better responder and have a better understanding of the people's plight we were helping.

Would you and how would you change your participation in the future?

I am more committed than ever to be a part of DMAT. While I hope that no one ever suffers a tragedy that needs our response, I am ready to go if needed.



Sean Donovan, MB BCh BAO
Assistant Professor of Emergency Medicine
Division of Emergency Medical Services
Albany Medical Center Hospital

How did you get involved in the DMAT response?

My involvement in the recent Puerto Rico response was as a member of an ad hoc developed hospital-response team, designed to help augment federal resources including deployed DMAT teams. The request for hospital-based teams came via activation of an Emergency Management Assistance Compact (EMAC) facilitated by the Governor of New York Andrew Cuomo, in close cooperation with the Greater New York Hospital Association (GNYHA), Hospital Association of New York (HANY), and the Department of Health (DOH).

Our Albany Medical Center Team (comprised of 5 ED/ICU nurses, a respiratory therapist, physician, and led by an Emergency Manager) joined up with teams from Montefiore Medical Center, Mt. Sinai Hospital, Northwell Health, New York Presbyterian and Callen-Lorde Community Health Center to send a total of seventy-eight healthcare professionals to the island.

When did you first get involved in disaster response?

Five days prior to deployment. The planning for hospital-based teams to provide support initially began the end of September and rapidly progressed up until the initial deployment on Oct 12. Hospital teams were formally activated on Oct 6, leading to some busy interim days sorting personal gear and making family arrangements, etc.

I did not have experience in disaster response previously, though my training as an EMS fellow and emergency medicine physician was an excellent primer for the mission. Aside from core aspects of EMS care, such as familiarity with the Incident Command System (ICS), I was also fortunate to benefit from the advice and experience of several

Albany Medical Center EMS faculty, including Dr. Heidi Cordi, one of the co-founders of the American Board of Disaster Medicine.

Can you provide an overview of your team's role in the Puerto Rico response?

For the response, our team joined up with seventy other New York City based healthcare professionals and departed for San Juan on October 12. Prior to deployment, we knew to expect to be gone a minimum of 16 days. The evening of arrival into San Juan, we staged overnight at the large convention center with numerous other federal resources.

The following morning our team joined up with 27 healthcare professionals from Northwell Health and departed for Caguas, located approximately 20 miles southeast of San Juan. Our mission was to help support medical operations for a DMAT unit assigned to the HIMA San Paulo Acute Care Hospital. This particular facility was operating with an extremely high in-patient census so our role was to function as a hospital decompression unit.

On arrival to Caguas, we received handoff from the departing Florida-6 DMAT team who had been on-site for approximately five weeks and linked up with the incoming DMAT team, a mix of members from Oklahoma-1, Florida-1 & Wisconsin-1. The initial 12-24 hours were quite a busy period; having to acclimate to both hospital and DMAT tent operations, determine working shift schedules, and all while providing medical care to a large influx of new patients.

Our day-to-day medical care was provided in a modular tent system, referred to as the base of operations or the "BOO". We provided 24-hour care for medically unwell patients. Given our role as a decompression unit, we most often took inpatients admitted to the hospital via the Emergency Department but were waiting for inpatient beds. In addition to this, we also managed patients waiting for ICU beds to become available or conversely patients transitioning out of the ICU.



DMAT Relief Tents

What was the experience like and what did you find most rewarding?

It was such a privilege to be able to provide care to those U.S. citizens in their greatest time of need. One of the most endearing qualities of the Puerto Rican community was their absolutely amazing resilience in the face of extremely difficult conditions for the average citizen. I was humbled by how concerned the local community was with responder wellbeing, when our living conditions were far less austere than those in the region, many whom did not have access to potable water and very limited generator provided electricity.

In addition to providing care to those in need, it was also extremely gratifying to work closely with the other healthcare professionals from DMAT, Northwell Health, the U.S. Public Health Service (whom provided pharmacy services), and local hospital liaison staff. Inevitably there were many day-to-day, moment-to-moment challenges, and to be

able to overcome them with such hard working, positive individuals were truly inspiring. We arrived as colleagues and returned as family.

What did you find difficult?

Early challenges included getting prepared for deployment in a relatively rapid time period. When deploying, responders bring all necessary personal supplies and foodstuffs for an initial 72-hour period. Without prior deployment experience, we were thankful that there are quite a number of DMAT team recommended packing lists available on the Internet to serve as a guide. One of the biggest challenges to healthcare delivery was the inaccessibility of patient information. We did not have access to old medical records, and it was a laborious process to track down key information, such as accurate home medications or pertinent past medical and surgical history. Another healthcare challenge was ensuring safe disposition for discharged patients. Given complex medical comorbidities, many of our patients required some form of respiratory support at home or to link back in with dialysis services. As many of us know this can be a challenge in normal day-to-day healthcare operations, let alone in a disaster setting.

Colleagues who had gone on previous deployments had highlighted the importance of team morale and how to best utilize downtime. When not providing direct clinical care, we often played Frisbee or improvised whiffle ball, being mindful to watch out for the bull and cows that escaped a nearby farm and would often roam the hospital grounds. Our particular site, living conditions were much less austere than for many other deployed teams. Our team slept in cots dorm style, in a single room shared between 8-17 responders and obtaining adequate sleep was a challenge for many of us.

How did it differ from your expectations?

Given my lack of disaster response experience, I largely entered into the deployment without specific expectations. One somewhat surprising aspect was an overall paucity of disaster related infectious disease illnesses at our location. While there were reported cases of leptospirosis infections, overall there was much less opportunistic GI or ID related pathologies. The vast majority of care provided was for complications of typical chronic medical conditions such as diabetes, hypertension, and kidney disease etc. Our most common admissions included treatment for pneumonia +/- ventilator support, cellulitis/osteomyelitis, renal failure, stroke, or acute coronary syndrome evaluations.

Would you and how would you change your participation in the future?

I am definitely interested in future participation with disaster medical response. Since returning from Puerto Rico, several team members are exploring procedures to formally join a regional DMAT team. Albany Medical Center is also developing a more formalized response team for future potential events.

Final thoughts

I would like to express sincere gratitude to Governor Cuomo and the numerous, behind the scenes personnel who worked tirelessly to facilitate the New York hospital-based response teams, including GHNYA, HANY, DOH and New York State Governor's Office. On a more personal note, thank you to our hospital CEO, Mr. James Barba & Emergency Medicine Chairman, Dr. Christopher King for their strong support of Albany Medical Center Hospital's involvement

in the response.

I would like to urge individuals to continue contributing to disaster response efforts in Puerto Rico. Conditions on the island are quite devastating, with expectations for an extremely long recovery period. Typically funding and resources can wane as time from the sentinel event passes, please know that this extremely resilient community of U.S citizens will still require our help. AmeriCares, the American Red Cross and Project Hope are just a few of the organizations providing extensive aid to the island.

For any individuals interested in personally joining a disaster response agency, such as a DMAT team, I would recommend talking with regional team members regarding how to become involved and also to search for any open positions on the usajobs.gov federal employment website.



Christopher Tanski, MD MSEd EMT
Medical Officer, DMAT NY-4
Assistant Professor of Emergency Medicine
SUNY Upstate Medical University

How did you get involved in the DMAT?

I've been involved in NY-4 since 2009. I joined while I was in medical school because I was interested in disaster medicine. I joined as an EMT and later converted to a medical officer (physician) once I had my license.

When did you first get involved in disaster response?

I have been involved in disaster response as an EMT and had taken a number of WMD and CBRNE classes, but DMAT was my first official exposure.

Where have you gone to provide care in disaster scenarios?

I've been on several missions including disaster response and pre-staging for an event of national significance. I've been deployed for up to two weeks. One of the things I most enjoy about the experience is the ability to practice medicine, emergency medicine in particular, in its purest form. I don't have to worry as much about policies, liability, paperwork; I can just do what I think is right for the patient given a disaster scenario. The difficulty is the limited resources. We don't always have access to the same capabilities we have in a modern emergency department and so that can be challenging. Having been on the team for about eight years now, I find the camaraderie and teamwork rewarding. I always run into people on different teams that I have worked with before and am glad to work with again.

What was the experience like?

I think the element of this that I didn't fully understand when I joined is that it's not just a volunteer experience for your resume. This is a job, and you are paid, and there are requirements for ongoing training, mission readiness, committing to an on-call schedule and going at a minute's notice. You can't just join and not do anything.

The other aspect I would comment on is the necessity, for emergency physicians, of having the blessing of your group to participate. I'm fortunate to have an extremely wonderful group of partners in my department who support me when I am deployed. If your group can't cover two weeks of your absence with relatively short notice that can be a problem.

New York ACEP 2018 Research Forum Call for Abstracts



The New York American College of Emergency Physicians is now accepting abstracts for review for oral and poster presentation at the 2018 Scientific Assembly, July 10-12, at the Sagamore Resort on Lake George in Bolton Landing, New York.

The **Research Forum**, taking place Tuesday, July 10, 2018, includes oral presentations at 1:30 pm and poster presentations at 3:30 pm. This forum is designed to feature and foster resident and faculty research. Topics may address the broad range of emergency medicine practice and educational development. **Authors and institutions should not be identified in any way on the page containing the abstract.**

Abstract submissions must be in electronic format (Microsoft Word) and must include the following subsections, Title, Objectives, Methods (include design, setting, type of participants), Results and Conclusion. The abstract should be written in complete sentences using grammatically correct English. Spell out all abbreviations on first usage. Abstracts are limited to 3,000 characters (excluding spaces). Accepted abstracts will be published as received; no copy editing will be done.

Illustrations are discouraged; however, if critical, one (1) small table may be included. Figures, tables and photos must be black and white with a resolution of at least 300 dpi. *Note: tables, figures and illustrations will be considerably reduced when published causing loss of detail.*

Including the following information on the submission form for each abstract:

1. title of the abstract;
2. author(s) and affiliations;
3. IRB approval or exemption;
4. contact person's mailing address, phone/fax numbers and e-mail address;
5. information regarding previous presentations or publication;
6. potential conflicts by author;
7. if accepted, indicate who will present the abstract July 10, 2018 and their role in the project; and
8. state preference for oral or poster presentation (or no preference).
9. identification of resident if s/he will likely be first or second author on manuscript.

Although we are interested in original work, consideration will be given to abstracts presented at other conferences (SAEM, ACEP).

Oral presentations will be allocated 10 minutes followed by 5 minutes of Q&A. Twenty-four poster presentations will be allocated 5 minutes followed by 3 minutes of Q&A. Other poster submissions will be selected for display. All presenters (oral or poster) are expected to have had a significant role in the execution and report preparation of the project being presented.

Absolute deadline for abstract submission: **Monday, April 2, 2018** (11:59 pm Eastern)

deadline
April 2, 2018
11:59 pm
Eastern

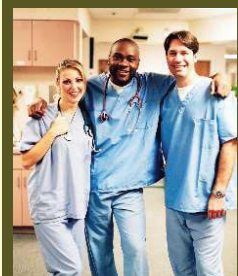
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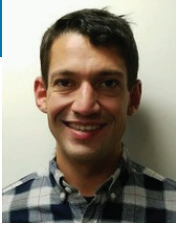
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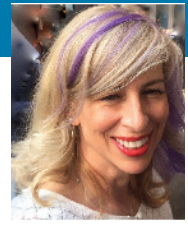
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July 10-12



Geoff Jara-Almonte, MD
Assistant Residency Director
New York Presbyterian-Brooklyn Methodist Hospital



Laura Melville, MD
Resident Research Director
New York Presbyterian-Brooklyn Methodist Hospital

Once Again, The Flu

Right about now, we are all in the thick of it. Flu Season. Your waiting room is full. Your ED beds are full. Your throughput numbers are not ideal. About halfway through your shift, many of your patients have been a variation on the one you just picked up: a 35 year-old otherwise healthy man who complains of “feeling sick” for the past 24 hours. Vital signs are T 102.8, HR 112, BP 110/72, RR 18 SpO2 98% on room air. He complains of feeling tired and fatigued along with cough, rhinorrhea, nausea, headache and diffuse myalgias, and reports he’s never felt this bad in his life. Multiple family members have had similar symptoms.

Of course, you are not alone. As of January 13, influenza activity in New York had been widespread for six weeks. A network of New York primary care providers reported 7.16% of visits were due to influenza-like-illness, more than double baseline. Over 1,600 patients were hospitalized with flu between January 7 and 13; one pediatric flu-related mortality has been reported in New York this season.¹ The CDC tracks influenza nationwide; this information can be found at <https://www.cdc.gov/flu/weekly/index.htm>. This “Flu-View” is full of information gathered from surveillance data. So right now the entire country is in the same boat.

As bad as it is, this flu season is only beginning to push the boundaries of previous years, at least in terms of number of medical visits for flu like illness (see Figure 1). Prior to this, the numbers of visits, hospitalizations and deaths had not exceeded the previous years.

“But Doc, The Flu Shot Doesn’t Work This Year!”

Patients may be particularly frustrated by the much reported lack of efficacy of the seasonal influenza vaccine. Reports from the Australian flu season reported lower-than-usual vaccine efficacy, particularly against the A(H3) strain. This has been seized on by the lay press with multiple articles suggesting that the vaccine is only 10% effective.² In fact, in Australia the overall effectiveness was 33%³ (contrasted to 39% in the United States during the 2016-2017 season).⁴ The data for this season is not yet in, but it is anticipated to be low but

still approaching 30% despite missing the H3N2 strain.

So, if your patient got the shot, you can reassure him that getting the influenza vaccine reduces the risk of severe illness, hospitalization and death. And if members of his family have not yet gotten the vaccine, it’s not too late! They may still benefit from symptom reduction even if they get sick. Only a few groups are not eligible, so your patient needs to rally his clan.

“Doc, Isn’t There Anything You Can Give Me?”

Five licensed antivirals with activity against influenza are available in the United States. The adamantanes (amantadine and rimantadine) have no activity against influenza B and circulating influenza A strains exhibit high (>99%) resistance, and are not recommended for treatment or prophylaxis of patients with influenza. Neuraminidase inhibitors (oseltamivir, zanamivir and peramivir) appear to have activity against influenza A and B and are recommended for treatment and prophylaxis of patients with suspected influenza illness or exposure by the CDC and the United Kingdom’s National Institute for Health Care and Excellence. Not surprisingly, the Canadian guidelines are similar but with more qualified recommendations.⁵

The CDC recommends treating those patients with confirmed or suspected influenza who are hospitalized and have a severe, complicated or progressive illness.⁶

This part of the CDC’s recommendation is generally agreed to be the best utilization of the tools we have. However, their last category, the “high risk for complications”-- is quite broadly defined, and includes those patients with:

- Ages < 2 or ≥ 65
- Pulmonary disease (asthma, copd)
- Cardiovascular disease other than isolated hypertension (CAD, CHF)
- Metabolic disorders (diabetes)
- Neurologic disorders (epilepsy, stroke, cerebral palsy, intellectual or developmental delay/disability)
- Immunosuppression (HIV/AIDS, or medication induced)

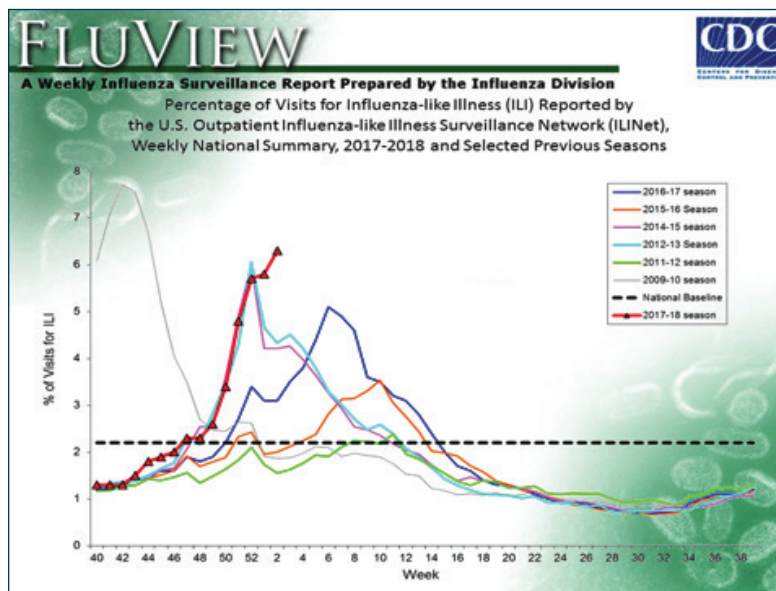


Figure 1: CDC Weekly Surveillance Report for January 13th 2018

- Pregnancy or those postpartum ≤ 2 weeks
- BMI > 40
- Native American ethnicity
- Residence in a nursing home or chronic care facility

These high risk determinations are based on the characteristics of patients who developed the most severe flu related complications, including death, in previous years. There are no randomized controlled trials looking at these patient groups. The only data supporting the use of oseltamivir in these patients is observational. CDC recommendations also allow for treatment of any patient with symptoms less than 48 hours not meeting those criteria in whom a reduction in disease duration is desired. This is an especially grey zone.

It seems like almost every patient you see either should or could get oseltamivir. What do you do?

“Doc, This Stuff Is Gonna Get Me Back To Work, Right?”

For those patients in whom treatment is not definitely recommended, will elective therapy with a neuraminidase inhibitor be beneficial? At what risk?

The best data comes from a 2014 Cochrane review, which for the first time in the over 10 years of common use of these medication, utilized both published and unpublished data from Roche and found that treatment with neuraminidase inhibitors shortens the disease course by about a half-day in adults, and just over a day in children.⁷ Prophylactic treatment reduces the risk of symptomatic influenza (number needed to treat [NNT]=33) and may be useful in some circumstances. Importantly, treatment did not reduce need for hospitalization, risk of serious complications, bronchitis, sinusitis or otitis media, and it probably did not reduce the risk of pneumonia. However, side effects were quite common with oseltamivir. Mostly these were gastrointestinal: nausea (number needed to harm [NNH] = 28) and vomiting (NNH=22). In prophylactic trials headaches (NNH=32), psychiatric events, primarily in Japanese patients, (NNH=94) and renal events (NNH=150) were encountered.⁸

Hurt and Kelly’s 2016 article “Debate Regarding Oseltamivir Use for Seasonal and Pandemic Influenza” in the CDC’s journal *Emerging Infectious Diseases*⁹ is a thoughtful review of the debate between neuraminidase supporters and those who believe the data does not support the current recommendation. Their summarized findings are in Figure 2. They suggest some very practical ways research can further clarify the issues.

“So Doc, What Are You Going To Do?”

“Well, sir”, you say, “we are recommending you stay home from work, get lots of rest, drink lots of fluids and take regular ibuprofen and or tylenol for your fever and body aches. You might get better around 18 hours sooner if you take oseltamivir, but it’s pretty expensive and you do run the risk of some unpleasant side effects. Stay away from anyone you know who is high risk, get your family their flu shots and you should be getting better in about 4-5 days.”

If our patient were very sick and needed hospitalization, initiating treatment with oseltamivir is recommended, and fragile patients may benefit as well. It is unclear if all the patients in all the high risk categories will benefit from neuraminidase treatment and there is likely quite a bit of real world practice variation.

Ultimately, management of uncomplicated influenza in the ED rests on good supportive care, expectant guidance and careful consideration of your patient’s risk of developing complications or severe disease. When it comes to deciding to treat with a neuraminidase inhibitor, the decision can be made in conjunction with the patient after careful discussion of expected benefit and risk, taking into account patient preferences and priorities.

Figure 2
Summary Conclusions from Hunt & Kelly
Although debate continues, there is general agreement from meta-analyses of RCTs that oseltamivir reduces symptoms in healthy adults and adolescents with influenza by up to one day. There is disagreement on the mechanism. On one side of the debate, the Cochrane group maintains that there is a nonspecific effect of oseltamivir, whereas, on the other side, investigators sponsored by Roche maintain that oseltamivir has a specific anti-influenza virus effect.
There have been no RCTs that can be meta-analyzed to summarize the effect of oseltamivir on severe outcomes of influenza virus infection. Evidence derived from observational studies of serious outcomes consistently suggests that oseltamivir reduces the risk for death in severely ill patients with documented influenza infection.
The apparent discrepancy between a modest drug effect for healthy persons and a substantial effect on number of deaths remains unexplained. Currently, oseltamivir is the only licensed drug available for all ages.
Based on available evidence, oseltamivir should be used for treatment of hospitalized patients with laboratory-confirmed seasonal influenza and stockpiled for the treatment of patients with severe laboratory-confirmed pandemic influenza, whether hospitalized or not. These stockpiles should be widely distributed to facilitate rapid use when needed.
Without a mechanism for rapid distribution of the drug in an emergency, any potential benefit of such large-scale stockpiling will not be realized. Rapid distribution in an emergency is only likely if a mechanism exists for routine rapid distribution. In countries where such a mechanism does not exist, we see no place for stockpiling oseltamivir for widespread community use during a pandemic.
It is unlikely that conventional RCT-level evidence to support antiviral treatment of severe laboratory-confirmed influenza in hospitalized patients will appear within the next decade due to the ethical constraints of evaluating oseltamivir vs placebo, when oseltamivir is the current standard of care for the treatment of severe influenza infection. New studies should be pragmatic trials or high-quality prospective multisite observational studies and employ methods to minimize bias to the greatest extent possible.
Studies designed for assessing interventions for seasonal influenza should be readily adaptable to studies of pandemic influenza on very short notice. Because of the ethical and design constraints of RCTs, prospective observational studies are more feasible than RCTs in an emergency response situation. In addition to data on outcome, such as risk of ICU admission and death among adults, or length of stay among children, these observational studies should also record time from disease onset to treatment and time from treatment to outcome to minimize bias. Sequential data on markers of immune function in at least a subset of recruited patients would also be valuable.

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**EMERGENCY MEDICINE PHYSICIAN
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**Gary Johnson, MD, Chair,
Department of Emergency Medicine
Upstate Medical University,
750 E. Adams Street, Syracuse, NY 13210
Office: 315-464-9500 or Fax: 315-464-9501**

johnsong@upstate.edu <http://upstate.edu/emergency>

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Call For Board and Councillor Nominations

Board Nominations

Active members of New York ACEP who meet the criteria and are interested in serving on the Board of Directors are encouraged to submit their nominations to the 2018 Nominating Committee for consideration as the Committee develops the slate of candidates.

Four directors will be elected by the membership through a proxy ballot distributed at least 30 days prior to the annual membership meeting. The annual membership meeting will be held Wednesday, July 11, 2018 at the Sagamore Resort on Lake George.

Board Members with Terms Ending in 2018

Mathew Foley, MD FACEP*
Stuart G. Kessler, MD FACEP
Jeffrey Rabrich, DO FACEP*
William A. Paolo, Jr., MD FACEP*

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

Interested candidates should review the Criteria for New York ACEP Board Nomination, Board Member Duties and Responsibilities and send a completed nomination form along with a copy of their CV to New York ACEP by March, 31, 2018.

Self nomination and nominations of colleagues are accepted. To request the policies and nomination form, contact New York ACEP at (585) 872-2417 or by email at nyacep@nyacep.org.

Successful nominees will be notified after May 10, 2018. Board candidates are required to submit background information on their professional career, a photograph and answer questions posed to all board candidates. Candidates will have approximately two weeks to submit material.

Councillor Nominations

Active members of New York ACEP interested in serving as a New York ACEP Councillor are encouraged to submit their nominations to the 2018 Nominating Committee for consideration as the committee develops the slate of candidates.

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Brahim Ardolic, MD FACEP
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Livia M. Santiago-Rosado, MD FACEP

Councillors With Terms Ending in 2018

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James G. Ryan, MD FACEP
Virgil W. Smaltz, MD MPA FACEP
Peter Viccellio, MD FACEP

The Board of Directors will elect Councillors at the Thursday, July 12, 2018 Board meeting at the Sagamore Resort. Members interested in representing New York ACEP at the ACEP Annual Council Meeting (September 29-30, 2018 in San Diego, CA) should submit a nomination form and their CV to New York ACEP. New York ACEP will be represented by 28 Councillors at the 2018 ACEP Council meeting.

Nomination Deadline: March 31, 2018

ASK THE EXPERTS



Theresa Murray Amato, MD
Chair, Department of Emergency Medicine
Northwell Health
Long Island Jewish Forest Hills



Interviewed By: Robert M. Bramante, MD FACEP
Associate Chair, Emergency Medicine
Good Samaritan Hospital Medical Center
Progressive Emergency Physicians

Transitioning from Academics to Administration

This quarter we had the opportunity to interview Dr. Amato, Chair of Emergency Medicine at LIJ Forest Hills. I had the opportunity of working with Dr. Amato while she was a leader in academics as an Associate Program Director of the Emergency Medicine Residency at Northwell Manhasset and later Long Island Jewish Medical Center. She has graciously shared her insight on the transition between roles in emergency medicine and discusses some of the different and similar challenges.

How did you initially become involved in resident education?

I was involved in residency education during residency. In my role as a chief resident I assisted in evaluations and curriculum development. In addition, I assisted in interviews of resident applicants.

What did you find most interesting about your role in education?

Being in a residency leadership position has less to do with teaching than it does with actually running the program. There are many details that need to be attended to on a daily basis. It was really important to identify the struggling resident as quickly as possible. I learned early on that remediation needed to be implemented very quickly; otherwise you lose valuable time in a short training program. So I would say giving feedback was the most interesting and rewarding aspect of my role. Giving timely feedback that is constructive and supportive can make a good doctor great, and great doctor outstanding.

What was most frustrating?

Some of the “paperwork” that was required to keep the program up to date and in accordance with all the rules was, at times, daunting. It has significantly improved since I left my education role and with the newer on-line processes, it has gotten much less stressful.

On the other hand, it did teach me to be very vigilant about deadlines and requirements. The seemingly unimportant details were often the very things that would come back to bite you if you weren’t attentive.

What led to you choosing to transition from the education role to an administrative Chairperson role?

After being in residency leadership for many years, I felt I might have more to offer the department as a whole. My vice-chair at the time was

very open to allowing me to explore newer roles and responsibilities while I was still in my residency education position. I became the director of the observation unit and that gave me an opportunity to learn about budgets, scheduling and interacting with the heads of all departments in the hospital. I found the new role very rewarding. It made me appreciate how the emergency department directly impacts and is impacted by the hospital.

The skill set that you need to be successful in residency education very much translates into a skill set for administrative leadership. Honesty, integrity, hard work, attention to detail, comfortability with feedback, professionalism and interpersonal skills are important to both roles.

I transitioned to a purely administrative position when I became the associate chair. I became more involved with the operational aspect of the department and was very fortunate to be part of many new initiatives that were going on in the department. In addition, I worked closely with the performance improvement/quality associate chair and we learned to cross cover both of our responsibilities.

Shortly after that, a chair position opened up at one of our community hospitals. Although I had spent my entire career in an academic setting, I thought it would be a good challenge for me professionally and personally to take on the role.

What information/tips can you give to colleagues considering, or in the process of, changing roles in their field?

Don’t be afraid to do something out of your comfort zone. It is truly the only way to grow. Ask to take on some administrative projects and see if it’s something you enjoy. Start to get to know the leadership in your department, your hospital and your health system. The relationships you forge will inevitably come back to help you when you are looking to move up.

Always treat everyone with respect. Your reputation as a team player and someone easy to work with is important. Finally, be someone who is always looking for answers. Don’t complain. Rather find a need, come up with a few possible solutions and work with your leadership team to explore and implement them.

Did you have any resources, and what can you recommend, as resources for someone transitioning between roles?

People talk about finding a mentor, but for me a sponsor (or rather several) is what really served as a resource. You need someone who

ASK THE EXPERTS

understands your strengths and weaknesses, and who will give you honest feedback. That same person needs to be someone who can advocate for you as well.

What are the items people should consider before transitioning between roles?

My transition was not planned. It was a natural progression to increasing responsibility. Some people say you have to have a five year plan, a ten year plan, etc. But that has never rang true for me. I think it is difficult to know what your interests will be a few years from now. That being said, if you think you may be interested in a new role, reach out to your leadership and let him/her know. You may be surprised at the different opportunities there are.

You currently run an emergency department and your family. How can physicians deal with the stress of leadership roles while avoiding burnout and maintaining a work life balance?

There is no such thing as work life balance! I have a big family and in some ways that has helped me in running a department. You learn there is ALWAYS two sides (at least) to every story. You don't sweat the small stuff. You realize that you can have the exact conversation with more than one person and it is perceived completely differently based on their belief system, personality and perspective. You learn to delegate because it is virtually impossible to do it all. Finally, you need to listen to all views of course, but in the end running a household, like running a department, isn't a democracy. Sometimes you have to make a tough decision; some will love it, some will hate it, but in the end, if it's the right call, you just have to own it. It is the only way, and right way, to lead.



The Department of Emergency Medicine at St. Barnabas Hospital is dedicated to our Bronx community and has a strong, established teaching tradition.

The Division of Toxicology, Department of Emergency Medicine at SBH Health System, is currently recruiting an Emergency Medicine - Medical Toxicology faculty physician.

Medical Toxicologist-Emergency Physician

We are looking to expand our toxicology outreach with motivated and team-oriented individuals. We currently have two board certified Medical Toxicologists that run a bedside toxicology consultation service that sees almost 500 consults annually. Additionally, the faculty is heavily integrated into the Emergency Medicine Residency educational program. We have a fantastic and supportive chair and are well received by critical care, hospitalists, and residents throughout the hospital. The position will involve all facets of the divisional/departmental activities with the opportunity for competitive salary, professional development, and academic rank advancement.

The position available will be filled by a board certified/eligible physician Medical Toxicologist who is also board certified/eligible in Emergency Medicine and is looking for a dual role utilizing both aspects of their specialty training. EM clinical time will be based at SBH Health Systems, St Barnabas Hospital, the oldest continuing healthcare facility in New York City, which celebrated its 150th anniversary in 2016. SBH is a 422-bed, not-for-profit, non-sectarian, acute care community hospital and Level 2 Trauma Center authorized to treat the most critically ill and severely injured patients. As a New York State-designated Stroke Center and State-designated AIDS Center, we provide access to much-needed services in our community. We see an annual census of over 90,000 patients. Most recently, to help develop primary care physicians who will serve the city's underserved communities, SBH Health System became the primary clinical affiliate of the first-ever CUNY School of Medicine.

Our location is ideal. SBH is located in an area that allows exposure to a dynamic population in need of good medical care, while also providing access to a robust and diverse array of toxicologic disease. Geographically, we are located in the Belmont section of the Bronx, at the end of Arthur Avenue, near both the Bronx Zoo and the Bronx Botanical Gardens, and a quick train ride from downtown Manhattan. Additionally, the cultural and social benefits of the Bronx and the rest of NYC are all a short distance away. Manhattan, Queens, Brooklyn, and the suburbs of NYC are all readily accessible through public transportation and have an inexhaustible array of activities to satisfy whatever you enjoy.

For more information or to send a CV for consideration, please contact:
Howard Greller, MD FACEP FACMT
hgreller@sbhny.org

St. Barnabas Hospital has changed its name to SBH Health System. As a leader in the transformation of healthcare, SBH Health System brings you a new model of care that focuses on health and wellness, prevention of illness and caring for the whole you.



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TOXICOLOGY

**Joshua Nogar, MD**

Assistant Professor, Department of Emergency Medicine
 Fellowship Director, Medical Toxicology
 Northwell Health, NSUH/LIJ
 Hofstra NSUH/LIJ School of Medicine

Hepatitis Of Unclear Etiology

Case

65 year old male presented to the Emergency Department (ED) with elevated AST/ALT. His medical history was significant for coronary artery disease, obesity, hyperlipidemia and hypertension. He was referred to the ED for evaluation of possible pancreatic malignancy by his primary physician, who had been evaluating him for two weeks of diffuse pruritis. Outpatient laboratory studies had demonstrated AST/ALT in the 600s U/L and total bilirubin 2.7 mg/dL. Upon ED arrival his vital signs were: HR 76, BP 145/85, RR 18, Temp 99.0, 99% on RA. On physical exam he was well-appearing, with exception of excoriated patches of skin on his forearms. The remainder of his exam was remarkable for the absence of any abdominal tenderness. Further laboratory workup revealed: INR 0.9, lipase 85 U/L, direct bilirubin 0.7 U/L and alkaline phosphatase 350 U/L; CBC, electrolytes and renal function were normal. CT abdomen was unremarkable, and RUQ ultrasound revealed mild steatosis, normal CBD diameter and the absence of gallstones. The patient denied foraging for mushrooms, INH use or alcohol intake, but indicated that he had been using the energy supplement, kratom, to increase his stamina at the gym. It had been purchased as a powder from an internet vendor, and he had ingested approximately 1gm/day, prepared as an herbal tea for approximately one month before the onset of pruritis. He presented to his primary physician three weeks after discontinuing the supplement.

Kratom

Kratom (*mitragyna speciosa*) is a common herbal supplement in Southeast Asia that is consumed mainly for its “energy boosting” properties. Its use has recently gained popularity in Europe and the United States with toxicity that is predominantly attributed to its stimulant effects, such as hypertension, nephrotoxicity and seizures. However, it has also been associated with hepatic cholestasis. It is unclear whether or not the psychoactive compound, mytraginine, its metabolites or another constituent is responsible for the hepatotoxic effects. What is clear is that these effects appear to be dose-dependent, and typically occur after 2-8 weeks of use.

Most cases present to medical attention with a chief complaint of painless jaundice and/or pruritis, with AST/ALT levels between 500-1000 and total bilirubin 2-10 mg/dL. The final diagnosis of this condition is ultimately one of exclusion, after viral, autoimmune and anatomic causes for hepatitis have been ruled out. Virtually all reported cases of kratom-induced cholestasis exhibit complete reversibility after cessation of herbal supplement intake. Most patients have stopped using the supplement by the time they reach medical attention.

Serum mytraginine and metabolite levels are not clinically relevant and are frequently undetectable. Although this condition has been recognized since the early 2000s, the FDA has been unable to ban its distribution, and it is widely available both online and in brick-and-mortar health food and supplement shops. Kratom-induced cholestasis reinforces the importance of a thorough medication, supplement and recreational drug abuse history, as well as the inherent dangers of “safe” supplement consumption.

Case Resolution

The patient was admitted to internal medicine for 2 days, during which time he received IV NAC (for hepatitis of unclear etiology), and was evaluated by gastroenterology. His HIDA scan and viral and autoimmune serologies were unremarkable. Serum mytraginine levels were undetectable. His AST/ALT, alkaline phosphatase and total bilirubin were down trending at the time of discharge, and he exhibited complete normalization of his liver function at long-term follow up two months later.



Kratom Leaf



Kratom Powder

ALBANY UPDATE



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

Governor Cuomo's State of the State Address

Members of the New York State Legislature returned to Albany January 3 to begin the 2018 Legislative Session. Governor Cuomo delivered his annual State of the State address. In his address, the Governor stated that he would seek legislation to stem the opioid crisis, including eliminating the exemption to consult the Prescription Monitoring Program (PMP) for controlled substances prescriptions written in a hospital emergency department when the supply does not exceed 5 days. This is the second year in a row that the Governor announced his intention to eliminate this exemption. At this time, no proposal has been sent to the Legislature by the Executive Branch.

New York ACEP is strongly opposed to repealing this exemption. It was enacted in 2012 as part of the original I-STOP law in recognition of the very busy environment in hospital emergency departments and the life or death circumstances that can arise for patients. If enacted, wait time for patients will increase and access to care will be impacted. Numerous studies, including a 2015 and 2018 study in the *Annals of Emergency Medicine*, demonstrate that hospital emergency departments are not a major source of opioid prescriptions. In addition, New York ACEP has gathered data from a geographical cross section of large, medium-size, and smaller hospitals in the State which show a significant downward trend in patients leaving emergency departments with opioid prescriptions since the enactment of the I-STOP law.

New York ACEP is working with senior legislators and staff as well as the Governor's Office to make the case to retain the PMP exemption. We will continue to vigorously oppose this proposal.

2018-19 Proposed Executive Budget

Governor Cuomo released his 2018-19 proposed State Budget January 16. The spending plan totals \$168.2 billion. The Governor seeks to close a \$4.4 billion budget deficit by trimming aid to public schools, requiring online sites like Amazon to collect sales tax through purchasers, and using one-time financial settlements from the banking industry.

Of interest to New York ACEP members, the Governor put forth proposals relating to reductions in "potentially preventable emergency department visits," reducing opioid use, a community paramedicine program and other items impacting emergency medicine as outlined below.

Reduce Opioid Dispensing in the Medicaid Program by 20% by 2020 by:

- modifying formularies and clinical editing to encourage access to non-opioid alternatives;

- requiring treatment plans as a condition for opioid prescribing; and
- eliminating provider prevails for opioids.

Hospital Quality Pool/Reduce Preventable Emergency Department Visits

The Governor proposes to authorize New York State DOH to create a performance target to reduce "potentially preventable emergency department visits" and reduce or eliminate rates of payment to hospitals based on quality and safety scores. The hospital quality pool must allocate \$10 million annually to expand preventive services, including but not limited to, mental health counseling provided by a licensed clinical social worker or a licensed master social worker, physical therapy, diabetes prevention or treatment by an applied behavior analyst.

Retail Clinics

Retail practices are proposed and authorized to provide treatment for minor acute episodic illnesses or conditions, periodic wellness treatment including immunizations, treatment of minor traumas, administration of opioid antagonists in case of emergency and limited behavioral health screening and referral. Retail health services could not include procedures utilizing sedation or anesthesia, care for patients under 24 months of age or vaccinations for individuals between 24 months and 18 years of age other than flu shots. They are subject to a number of operational requirements including reporting of data to New York State DOH, maintaining a collaborative relationship with primary care providers, caring for underserved and uninsured individuals, working with the SHIN-NY and maintaining adequate accreditation and hours of operation.

Community Paramedicine Collaborative Program

A community paramedicine collaborative program is proposed to allow emergency medical personnel to provide care in residential settings. A community paramedicine collaborative must include, at a minimum:

- a general hospital, nursing home or diagnostic and treatment center;
- a physician;
- an emergency medicine provider; and
- where the services are provided in a private residence, a home care services program.

Under the direction of a physician, community paramedicine programs would support objectives identified by the collaboratives, and could include the following models:

- post-discharge care following hospital admissions;
- evaluating, stabilizing or treating nursing home residents to avoid preventable emergency transport to a hospital emergency department; and
- assisting individuals in self-managing their health or behavioral health conditions and minimizing environmental hazards in the home.

The bill would permit Medicaid reimbursement for the program subject to federal financial participation.

Transportation

The Governor proposes to eliminate supplemental payments to emergency medical transportation providers and provides for reinvesting the funding into ambulance reimbursement rates based on recommendations from the Medicaid Transportation Rate Adequacy Report.

Excess Medical Malpractice Program

The Governor proposes to extend the Physician Excess Medical Practice Program for one year at the same level as last year, \$1,274,000. No changes were made to the program.

New York ACEP Annual Lobby Day, March 13, 2017

On Tuesday, March 13 members of the New York ACEP Board and their colleagues will travel to Albany for the annual lobby day to meet with key legislators and staff on the College's 2018 legislative priorities including opposition to the elimination of the emergency department exemption for consulting the PMP before prescribing opioids, and support for initiatives that preserve the emergency health care safety net.

Following the lobby day, we will work with Executive Director JoAnne Tarantelli to continue to keep members apprised of activities in Albany as they relate to New York ACEP's government affairs goals. As we have done in the past, we will be sending out Action Alerts and other calls for grassroots activities to advance your priorities. We greatly appreciate all of your local efforts which are critical to New York ACEP's success.

Calendar

March 2018

- 7 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 8 Practice Management Conference Call, 1:00 pm
- 12 New Speaker Forum Submission Deadline
- 13 Lobby Day, 9:00 am-1:30 pm
- 13 Board of Directors Meeting, 1:30 pm-4:30 pm
- 14 Education Committee Conference Call, 2:45 pm
- 14 Professional Development Conference Call, 3:30 pm
- 15 EMS Committee Conference Call, 2:30 pm
- 21 Government Affairs Conference Call, 11:00 am
- 21 Research Committee Conference Call, 3:00 pm

April 2018

- 2 Research Forum Abstract Submission Deadline
- 4 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 11 Education Committee Conference Call, 2:45 pm
- 11 Professional Development Conference Call, 3:30 pm
- 11 Medical Student Symposium and Residency Fair, 5:30 - 9:15 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

May 2018

- 2 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 9 Education Committee Conference Call, 2:45 pm
- 9 Professional Development Conference Call, 3:30 pm
- 10 Practice Management Conference Call, 1:00 pm
- 10 Board of Directors Meeting, 1:30 pm
- 11 ED Director Forum, 8:00 am - 4:00 pm
- 16 Government Affairs Conference Call, 11:00 am
- 16 Research Committee Conference Call, 3:00 pm
- 17 EMS Committee Conference Call, 2:30 pm
- 20-23 ACEP Leadership and Advocacy Conference

June 2018

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

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