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Matt Kaufman, MD

Emergency Medicine
Staten Island, NY

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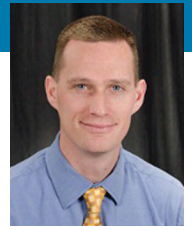
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PRESIDENT'S MESSAGE



Jeremy T. Cushman, MD MS FACEP
Associate Professor and Chief
Division of Prehospital Medicine
University of Rochester

NYour ACEP

I have just returned from our Scientific Assembly in Lake George, and for those who attended, I think you will agree the experience was second to none. From dozens of outstanding poster and oral research presentations to the cutting edge talks by Drs. Hoffman, Noble, Noonan, Regan and Viccellio, the annual assembly continues to provide outstanding educational and research offerings in one of the most beautiful locations in our state. There are far too many individuals to thank, but the many members of the Education and Research Committees put together yet another phenomenal program. For those who did not join us, mark your calendars: July 9-11, 2019 at the Sagamore!

While enjoying the education and social camaraderie the Scientific Assembly brings, we also paused to recognize the contributions of four of our peers who have given

of themselves to advance our specialty. Drs. Arlene Chung and Moshe Weizberg received the *Advancing Emergency Care Award*, while Dr. Kaushal Shah received the *Physician of the Year Award*. With decades of service to our specialty and New York ACEP, we also recognized the tremendous career of Dr. John McCabe with the *2018 Edward Gilmore Lifetime Achievement Award*. These tremendous leaders continue to give selflessly to our specialty and we are all extremely grateful.

This meeting also marked the transition of some members of the Board. We said thank you to Drs. Stuart Kessler, Matthew Foley, and Louise Prince who finished their terms on the Board. Louise, having previously served

as your President, leaves the Board after 16 years of service (Wow!). We welcomed new Board Members Drs. Arlene Chung and Robert McCormack, who join an amazing team I have the privilege of working with as we support you and your practice of emergency medicine in New York.

I am humbled to succeed Dr. Brahim Ardolic as your President. Brahim has worked passionately and tirelessly for New York ACEP, and it's been incredibly rewarding to work with, and be mentored by him. Like so many who get involved with New York ACEP, the years of service have led us to become great friends along

the way. As my term begins, we will take full advantage of the great momentum established by Brahim and the Board over the years. Our Emergency Medicine

Resident Committee is tremendously active and engaged; our committees have a new Chair and Board Liaison structure to facilitate leadership opportunities and move ideas to action, we have an aggressive advocacy agenda for this coming year and we look to identify ways that New York ACEP can truly be NYour ACEP. My goals are simple: to leverage the power and influence of NYour ACEP to help you and your practice. Whether it's setting off on your career or managing burnout, advocating for our patients or providing relevant, cutting edge education; sharing our research successes or enhancing our clinical practice; or providing a venue for us to talk, share, and be well – I welcome your ideas and your engagement in NYour ACEP.

“My goals are simple: to leverage the power and influence of NYour ACEP to help you and your practice.”

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2018 Resident Research Conference

**Wednesday
November 7**

Icahn School of Medicine

SOUND ROUNDS



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Guest Author:
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Shoulder In or Out?

A 32 year-old male with history of shoulder dislocations presents for right shoulder pain and difficulty ranging his right upper extremity after practicing mixed martial arts and is concerned he may have dislocated his shoulder again. There appears to be a deformity to the right shoulder. Do you order some analgesia and a shoulder radiograph and move on to the next chart in the rack? Or do you perform a point-of-care ultrasound, diagnose the anterior shoulder dislocation and quickly reduce it?

Introduction

Point of care ultrasound (POCUS) is gaining traction and expanding as a diagnostic modality for a variety of musculoskeletal conditions. There is growing literature supporting the utility of POCUS in diagnosing dislocated shoulders. Small prospective studies demonstrate 100% sensitivity and specificity of POCUS compared to x-ray for dislocations^{1,2} and also demonstrate high sensitivity for associated fractures.¹ There have been a few different techniques proposed to make the diagnosis of dislocation.^{2,3} We discuss a standardized single-view for the posterior approach. This technique is easily obtainable by novice sonographers and highly accurate.²

Indications

- Shoulder deformity
- Shoulder pain
- Trauma

Technique

- Position patient seated upright on stretcher.
- Use a high-frequency linear array (12-6 MHz) or a low frequency curvilinear array (5-1 MHz) transducer.
- Palpate the scapular spine and humeral head.
- Orient transducer transversely, posterior to the shoulder over the scapular spine and humeral head with probe marker to the patient's left.
- Having the indicator direction to the sonographer's left rather than the patient's right, which provides a mirror image on the screen, may make it less confusing for some sonographers (Figure 1).
- Visualize the scapular spine, glenoid rim and humeral head. Remember bone is strongly reflective of ultrasound beams.

You may only see the near field portion of the humeral head, glenoid, and scapula. (Figures 2a and 2b).

- Place horizontal lines tangent to the most posterior part of both the glenoid and humeral head.
- Measure the distance between these parallel lines with a third perpendicular line, which is the glenohumeral separation distance (GhSD, Figure 3).



Figure 1. Proper probe position. The indicator is directed to the sonographer's left (white arrow).



Figure 2a. Ultrasound image of a normal right glenohumeral joint. A nondisplaced humeral head and glenoid is identified with linear probe.

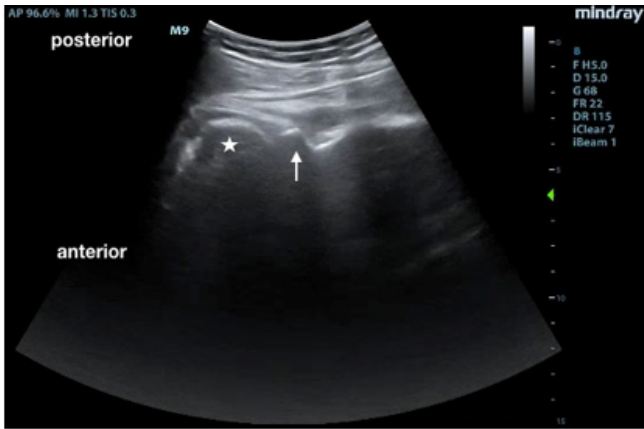


Figure 2b. Ultrasound image of a normal glenohumeral joint. A nondisplaced humeral head (star) and glenoid (arrow) is identified with a curvilinear probe.

1) Normal shoulder

- GhSD > 0 indicates normal shoulder position

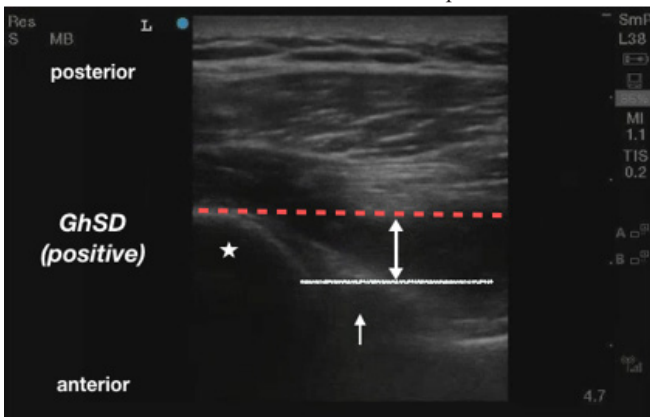


Figure 3. The glenohumeral separation distance (GhSD) is measured as the distance between two horizontal lines tangent to the most posterior part of the glenoid and humeral head. A normal shoulder GhSD > 0, as depicted in this image.

2) Anterior Dislocation

- Anterior dislocation will be further away in the far field compared to the glenoid (Figures 4a & 4b).

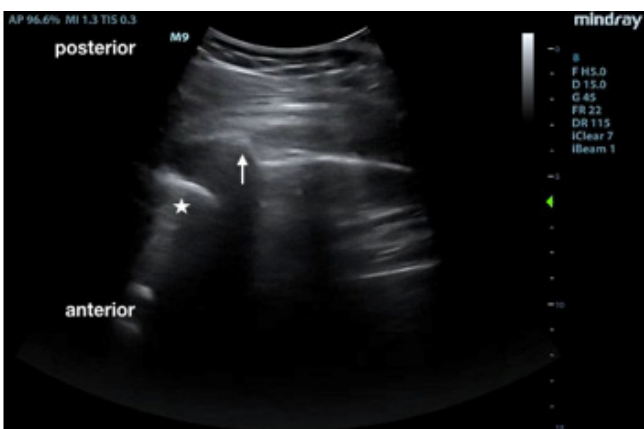


Figure 4a. Left anterior shoulder dislocation. Note the humeral head (star) relationship to the glenoid (arrow).

- GhSD < 0 (negative) indicates an anterior dislocation.

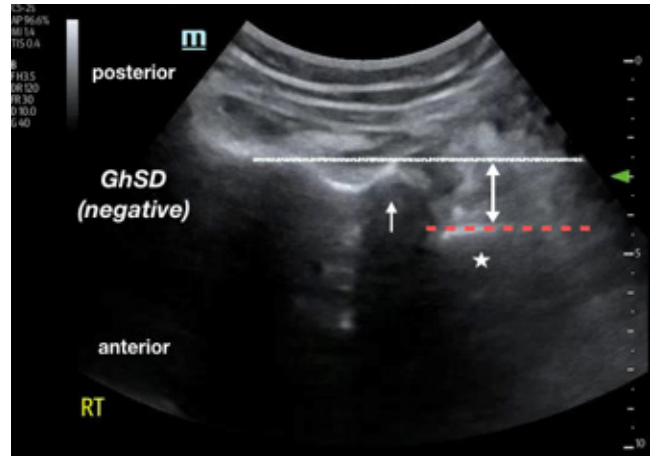


Figure 4b. Right anterior shoulder dislocation.

3) Posterior Dislocation

- Posterior shoulder dislocations will be significantly displaced in the near field, more than 1cm from the glenoid (Figure 5).



Figure 5. Left posterior shoulder dislocation. Note the distance of humeral head from the glenoid.

Tips

- Consider the low frequency probe for a larger body habitus as it provides better depth of penetration, larger footprint and greater field of view.
- Image the contralateral, unaffected side for comparison.

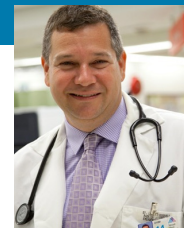
Pitfalls

- Inadequate visualization of the most posterior aspect of the glenoid and/or humeral head, may lead to inaccurate GhSD measurements.
- Inadequate amount of gel or excessive pressure with the probe can cause patient discomfort and may limit a thorough ultrasound exam.

References:

1. Gottlieb M, Edwards H. BET 1: Utility of ultrasound in the diagnosis of shoulder dislocation. *Emerg Med J* 2016;33:671–672.
2. Lahham S, et al. Pilot study to determine accuracy of posterior approach ultrasound for shoulder dislocation by novice sonographers. *West J Emerg Med.* 2016;17(3):377–382.
3. Abbasi S, Molaie H, Hafezimoghadam P, et al. Diagnostic accuracy of ultrasonographic examination in the management of shoulder dislocation in the emergency department. *Ann Emerg Med* 2013;62:170–5.

PRACTICE MANAGEMENT



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The Ongoing PALS Saga in New York State

On May 8, 2018, the New York State Department of Health (DOH) issued a “Dear CEO letter” which reaffirmed that board certification in emergency medicine is considered equivalent training and experience with regard to ATLS and ACLS, but this residency training and board certification would not be equivalent for PALS. Almost immediately after this letter was issued, New York ACEP started hearing from colleagues, and members, upset that they are now required to take PALS. This response took many of us who have been trying to address this issue for the past several years by surprise, as it is not actually a new requirement, just a reaffirmation that it is required. We in emergency medicine do not think this merit badge approach is necessary and that the time and money involved would be better spent on more appropriate CME activities. However, to truly understand this issue and where we are currently in New York requires an understanding of the background of this fight. New York ACEP has been addressing this issue for several years already and has been engaged with the Department of Health on multiple occasions regarding this requirement. It is always helpful to know where we have been to understand the true scope of the issue and help guide possible future steps.

The requirement actually is specified in the New York State Department of Health Codes, Rules and Regulations, Part 405 Hospitals-Minimum Standards, Section 405.19 Emergency Services. This section covers requirements for Emergency Departments. With regard to ATLS, ACLS, and PALS the relevant language is:

- d) Staffing. The following requirements are applicable to all organized emergency services:
 - (1) Emergency service physician services shall meet the following requirements:
 - (i) The emergency services attending physician shall meet the minimum qualifications set forth in either clauses (a) or (b) of this subparagraph.
 - (a) The emergency services attending physician shall be a licensed and currently registered physician who is board-certified in emergency medicine, surgery, internal medicine, pediatrics or family practice and who is currently certified in advanced trauma life support (ATLS) **or has current training and experience equivalent to ATLS**. Such physician shall also have successfully completed a course and be current in advanced cardiac life support (ACLS) and pediatric advanced life support (PALS) **or have had current training and experience equivalent to ACLS and PALS**. You will note the relevant phrase which I bolded is current training

and experience equivalent to. This led to finding what “equivalent to” actually meant in the eyes of the Department of Health and their surveyors. Let us first address ATLS and ACLS, as this is an area where New York ACEP has been successful on multiple occasions convincing New York State DOH that we do in fact possess equivalent training and experience, thus not requiring ACLS or ATLS currency. This dates back to 1988, when New York ACEP received the first letter from the Department of Health agreeing that emergency medicine training and board certification was in fact equivalent to ATLS and ACLS. Of course we all know that our training greatly exceeds the very minimal ATLS and ACLS standards. In fact, we have received correspondences from the Department of Health in 1988, 1996 and 2000 all affirming this position. Here is an excerpt from their August 29, 2000 letter addressed to Dr. Verdile, then New York ACEP President:

Appropriateness Review Standards for Trauma Centers section 708(5)(1)(3)(ix) requires all physicians who are members of the trauma team to have current certification in advanced cardiac life support (ACLS) and advanced trauma life support (ATLS) or have training and experience equivalent to ACLS and ATLS. The Department has reviewed this standard which clearly allows consideration of equivalent courses or experience to meet ATLS/ACLS certification standards. It is our opinion that a Board Certified Emergency Medicine physician meets and exceeds the standard for ATLS and ACLS certification by virtue of completing a training and residency program in emergency medicine. Therefore, board certification in emergency medicine meets the requirement of this section of the code.

None of these letters, however, specifically addressed the PALS requirement. At the time, it was not clearly stated in the regulation that PALS was required. We will come back to the ATLS and ACLS issue again in a little while as it became relevant during our PALS strategy with the state in recent years. The PALS and other pediatric care standard issues came to the forefront in New York in April 2012 in the case of Rory Staunton, a 12 year old boy who died from severe sepsis in New York City, which led to the Department of Health conducting an investigation and ultimately adopting a new minimum standard for Hospital Pediatric Care under Title 10, Section 405 of the New York Codes, Rules and Regulations (NYCRR), effective April 1, 2014. This regulation known as the “405 regs” by hospital administrators and quality departments is where the PALS requirement came from. As of April 1, 2014 the New York State DOH has required PALS or equiva-

lent training for emergency medicine boarded physicians. Additionally, the DOH tasked the EMSC (State Emergency Medical Services for Children Advisory Committee) with developing a guidance document to assist hospitals in meeting the new regulations. This committee issued a document called Minimum Pediatric Care Standards for New York State Hospitals, Emergency Departments and Intensive Care Units: 2015 Guidance Document. Within this document, they made the following recommendation to regulation 405.19:

405.19 Emergency services.

(b)(2) At least one clinician on every shift must have the skills to assess and manage a critically ill or injured pediatric patient and be able to resuscitate an infant or child. The emergency service shall be directed by a licensed and currently registered physician who is board-certified or board-admissible for a period not to exceed five years after the physician first attained board admissibility in emergency medicine, surgery, internal medicine, pediatrics or family practice, and who is currently certified in advanced trauma life support (ATLS), or has **current** training and experience equivalent to ATLS. Such physician shall also have successfully completed a **current** course in advanced cardiac life support (ACLS) **and pediatric advanced life support (PALS)** or have had **current** training and experience equivalent to ACLS **and PALS**. A licensed and currently registered physician who is board-certified or board-admissible in psychiatry for a period not to exceed five years after the physician first attained Board-admissibility, in psychiatry may serve as psychiatrist director of a separately operated Psychiatric emergency service. Directors of separately operated psychiatric emergency services need not be qualified to perform ATLS, **ACLS and PALS or have current training and experience equivalent to ATLS, ACLS and PALS.**

EMSC Committee Recommendations: This requirement emphasizes the need for emergency department and emergency service physicians, physician assistants, nurse practitioners, and nurses to have current (up-to-date) education and training in pediatric resuscitation. PALS must be taken every two years to maintain current certification.

Note the emphasis they added by underlining certain parts of the text. It was clear from their recommendation that they felt PALS was required of all emergency physicians and not equivalent training by virtue of emergency medicine residency training. Additionally, this training was now required of all providers caring for children including board-certified pediatric critical care physicians, fellowship trained pediatric emergency physicians, and acute care general pediatricians.

Faced with this document produced in 2015, it became readily apparent that we needed to take some action at New York ACEP to address these recommendations. Our concerns were twofold; first they implied in their recommendations that they thought ACLS and ATLS should be required of emergency physicians, and secondly, that current certification and PALS was mandatory. Having previously received letters on three different occasions from the Department of Health deeming emergency medicine residency training equivalent for ATLS and ACLS certification, we first wanted to re-verify this with the state in light of the new recommendations. Additionally, now that PALS was added as a requirement using the same argument, New York ACEP wanted to address the fact that requiring PALS of board-certified emergency physicians was excessive and unnecessary. To that end, we sent a letter dated December 18, 2015 to the Department of Health

yet again making the case that these types of merit badge courses were unnecessary and inappropriate for emergency physicians. In the letter we stated the following:

“As we discussed on the call, New York State Regulations (Title 10, 405.19) governing emergency services provide requirements for physicians to be certified in advanced trauma life support (ATLS), advanced cardiac life support (ACLS) and pediatric advanced life support (PALS) **or have current training and experience equivalent to ACLS, ATLS, and PALS.** The Department of Health has ruled, in three different letters, that residency training and active ongoing board certification for emergency physicians meets the training and experience equivalency standard set forth in the regulations.

New York ACEP believes that these same principles apply to all advanced life-support courses, including PALS, and **respectfully requests the New York State Health Department to clarify that board certified emergency physicians are not required to be certified in PALS because their training and experience meets and exceeds the standard for PALS.**”

In addition, we included with the letter a copy of the EM clinical practice model describing the extensive training that emergency medicine residents undergo specifically related to pediatric care. This letter went unanswered by the state Department of Health, despite inquiries regarding their position. Given the wording of the recommendations from EMSC, it was felt that even ATLS and ACLS were now called into question despite previously receiving confirmation from the health department that our training and experience was equivalent. This left the Board of Directors in the position of making a decision of either continuing to push the issue related to PALS, understanding that the result could be the Health Department issuing a ruling that all three courses were now required, or awaiting response for further guidance regarding the PALS specific issue. Given the fact that it was being required of other pediatric specialties providing critical care, understanding that those specialties were challenging the decision as well.

With the May 8, 2018 Dear CEO letter, the Health Department finally addressed this issue by reaffirming board certified emergency medicine physicians do not have to maintain currency in ATLS or ACLS, and/or training is considered equivalent. They further stated that they will not be considered to have current training and experience equivalent to PALS.

Subsequent to issuing this letter, ABEM on May 25, 2018 sent a letter to the New York State Department of Health largely making the exact same argument that New York ACEP made in 2015, including the practice model of EM describing emergency physicians training and pediatric care. This letter was cosigned by every major emergency medicine organization including ACEP. To our knowledge the state has not responded to this most recent letter.

So where does this leave us now? Having the state reaffirm that ACLS and ATLS are not required takes those issues off the table. This allows us to focus solely on the remaining issue of PALS certification, in which we absolutely feel we have equivalent training and experience. We will continue to push for the removal of this requirement by the Department of Health, and will continue to work in conjunction with national ACEP and all other emergency medicine organizations in this regard. We will plan to reach out to representatives from other specialties who were unduly burdened by this requirement, such as

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pediatric critical care. Some hospitals and health systems in New York have addressed the issue by creating their own internal training and by getting the state to approve it as equivalent training. These programs may include powerpoint based, or webinar based training with a test at the end. Similar to what New York ACEP did with the pain management education requirement, we are exploring creating or adopting a similar program for our membership to allow them to more easily complete this requirement while we continue to push for its elimination.

In conclusion, New York ACEP continues to advocate for members on this and all other issues that have an impact on our members practice within New York State. We welcome and need membership involvement in our advocacy efforts, including getting involved with our committees, advocating with your local representatives, and responding to New York ACEP alerts on potential legislative changes.

Save The Date

2018 Resident Research Conference
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Icahn School of Medicine at Mount Sinai

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Re-orienting Orientation

Rewind. It's the last few months of medical school, your last rotation is coming to an end, you are putting on your cap and gown, you are enjoying your last moments of vacation and freedom... and week by week, the waves of excitement, dread, anxiety, and in my case, nausea started to hit harder and harder. July 1 was very soon upon me, intern year had officially begun, and I had absolutely no idea what I was doing, which is very much the case for the vast majority of brand new interns.

We all know that intern year is a tough time. The new environment, the new faces, the new system, the new title and responsibility-- all of which seems to hit on the very first day of intern year. Cue, panic.

Luckily, in Emergency Medicine, a majority of programs have an orientation period to acclimate and transition the newly minted physicians to residency. The lengths and styles of orientation vary from program to program, but the goals are all the same - to transition an apprehensive medical student to a confident functional intern. This year, as a senior resident I helped to re-orient orientation. #makeorientationgreatagain



To accomplish this, we started with the basics. The very basics. Because as we all know, we did not know (a lot). Traditional didactics are a great launching point for the fundamentals. We started core topic didactics and procedures in the classroom to establish a good foundation. Topics included chief complaint-based scenarios, EKG, and CXR basics. We also got their hands dirty with a slit lamp intro and suture and splint lab.



Next, we moved to the simulation lab where we had low fidelity and high fidelity models to practice central lines, intubations, lumbar punctures and chest tubes. We deconstructed BLS, ACLS and PALS and wove them into our didactics and SIM lab as our faculty were all instructors in these certification courses. To make it even more fun, we finished off the end of these boot camps with a chest tube showdown, in a race to place the most secure chest tube.



After mastering these skills and the muscle memory that comes with doing procedure repetition, they moved onto a bioskills cadaver lab for advanced practice of not only these procedures, but also difficult airways, joint reductions, and cricothyroidotomy and thoracotomy.

But even the best of practice doesn't hold a candle to real life experience. Putting a lot of the foundations into action, they start working mini-shifts during orientation. One-on-one with a senior resident, they are being guided through the patient flow, refining H&Ps, assessments and plans, working out the kinks of the EMR, calling consultants, and, in general, learning how to be a new doctor.



While the building blocks of Emergency Medicine are being laid down and some of the fear and nausea wane, we are also trying to keep them excited about this new journey; not only by socializing with each other and their new emergency department (ED) family, but also with the global medical community via social media. With Twitter and FOAMed, new interns are introduced to new means of learning and keeping up with the latest and greatest, and also to the vast network and global presence of EM online. To help break in their newly created Twitter accounts, they are pitted against one another in a race to find all the essential equipment, locations, and some of the wonderful personnel in an ED twitter based scavenger hunt. Doing so is not only fun, but useful in locating a lot of the frequently and sometimes infrequently used items that they will need throughout their time here.



By breaking down orientation into these manageable chunks of skill sets, knowledge, FOAMed, and camaraderie and building upon them with lectures, sim, and mini shifts, hopefully you too, can re-orient orientation, and grow and nurture your own new Emergency Medicine physicians!



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**For more information, please contact:
Daniel G. Murphy, MD, MBA, Chairman
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Michael W. Dailey, MD FACEP
Professor of Emergency Medicine
Albany Medical Center

Naloxone Co-payment Assistance Program (N-CAP)

The emergency physicians in New York State are no strangers to the opioid epidemic. We have been working hard to impact the tragic ramifications of this societal trend on our communities. Through our work with EMS and law enforcement, we have extended naloxone administration to both our basic life support ambulances and the police, with literally thousands of overdoses reversed by these programs alone. Many emergency departments have become involved in supporting, advertising or issuing community access naloxone kits and allowing community responders to impact survival as well.

Currently in New York, people can present to a pharmacy and request naloxone from the pharmacist and have their request fulfilled using either a patient specific prescription, or through a standing order at over 2,000 pharmacies. This applies to either individuals who are themselves at risk for an overdose or their friends and family members. Individuals getting naloxone at these pharmacies do not need a prescription from their health care practitioner. They simply need to ask for naloxone at the pharmacy counter and present their insurance information as they do for any other medicine.

New York State has developed an exciting new program that will extend the reach of community naloxone and save money at the same time. Welcome N-CAP – the Naloxone Co-payment Assistance Program. N-CAP is specifically for individuals who have prescription coverage as part of their health insurance plan; N-CAP ensures that there are no or lower out-of-pocket expenses when getting naloxone at a participating pharmacy. This program can be used for an initial supply of naloxone or for individuals who need refills or are replacing expired kits.

For emergency physicians, this means that we can counsel a person at risk of overdose, as well as their friends and family members, and then either suggest they go to a pharmacy to obtain naloxone or give them a prescription for it. Pharmacies must be participating in the New York State AIDS Drug Assistance Program to participate in N-CAP, but this includes all large chain pharmacies, many smaller chains and quite a few independents as well.

N-CAP is not meant to replace the fantastic work being done by Opioid Overdose Prevention Programs with their community naloxone trainings and distribution, in fact, for those without any insurance who are not covered by N-CAP, the Opioid Overdose Prevention Program will remain the primary means of gaining access to naloxone kits. These programs, at many emergency departments, needle exchanges, counseling centers, primary care

offices, jails, and countless other places, will continue to serve the disenfranchised.

Pharmacies may have the newer single step Adapt intranasal product with 4mg in 0.1 ml, the Amphastar product with 2mg in 2ml and an atomizer, or the traditional 0.4mg IM formulation. You should check with the pharmacies local to you to see what they have available. All formulations seem to have relatively equal efficacy, but the skillset of the individual you are prescribing to or guiding to the pharmacy should direct the formulation – users of injection drugs are better suited to IM formulations and untrained personnel may be better served with an IN version.

Having emergency department (ED) physicians utilize this pharmacy distribution will allow individuals increased access to naloxone, as well as decrease the expense of additional distribution through community access programs. Co-payments for naloxone in an amount up to \$40 for each prescription dispensed will be billed to N-CAP, this is a decrease in expense from the nearly \$70 per kit cost for distribution at a community site. Other advantages include that pharmacies are open evening hours and weekends and have multiple locations. Refills can also be obtained from any of the 2,000 participating pharmacies, as can replacement kits for any that may have expired.

A directory of registered Opioid Overdose Prevention Programs as well as the list of pharmacies with a standing order are available on <https://www.health.ny.gov/overdose>.

On behalf of the emergency physicians working with the New York State AIDS Institute Opioid Overdose Prevention programs, we wish good luck to Dr. Sharon Stancliff, as she leaves the Harm Reduction Coalition and moves on to new projects. Thank you for your leadership, your teaching and your continued support as we develop programs to battle the disease of addiction.



EMERGENCY MEDICINE FACULTY

Weill Cornell Medicine's new academic Department of Emergency Medicine, led by Dr. Rahul Sharma, is seeking motivated full-time residency-trained academic Emergency Medicine faculty. We are seeking candidates to join a diverse enthusiastic group of academic Emergency Physicians at one of the premier academic medical centers in the nation.

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New York Presbyterian Hospital-Weill Cornell Medicine is an equal opportunity employer- Minorities/Women/Vets/Disabled encouraged to apply.

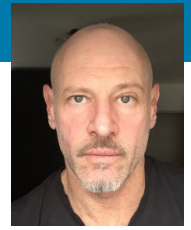
Please send curriculum vitae and cover letter to:

Rahul Sharma, MD, MBA, CPE, FACEP
Emergency Physician-in-Chief
ras2022@med.cornell.edu

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EDUCATION

Joshua Schiller, MD
Assistant Program Director
Department of Emergency Medicine
Maimonides Medical Center



Author:
Tina Dulani, MD
Assistant Professor
Department of Emergency Medicine
Northwell Health, NSUH/LIJ

Be a Better Educator with FOAMed

You are working the overnight shift on an unusually slow night in the ED when your resident excitedly presents her next patient to you. He is a 27-year-old man with a history of nephrolithiasis, complaining of classic left-sided flank pain radiating to his groin. His exam is significant for left CVA tenderness. The patient is allergic to NSAIDs and does not want opioids because of severe nausea experienced in the past. Your resident suggests intravenous lidocaine for pain control. Although you have heard about this alternative treatment, you have never tried it. You ask your resident where she learned about it and she enthusiastically states she read about it on an academic emergency medicine “blog.”

Let’s face it. With the advent of Free Open Access Medical Education (FOAM or FOAMed), it is not surprising that our digital-native students turn to the Internet for their education.¹ FOAMed has changed the landscape of education and encompasses podcasts, blogs, web-based applications and social media platforms such as Twitter and Instagram. Though textbooks are still the backbone of many emergency medicine residencies, the integration of FOAMed has also become ubiquitous. Many residencies have adopted a flipped classroom approach to education, in which learners asynchronously review FOAMed material and then spend in-class time participating in valuable peer-group discussion and the application of knowledge in simulation or group activity.^{2,3}

As an educator in emergency medicine, a specialty that arguably prides itself on being adaptable, it is not only necessary to embrace FOAMed but also imperative to incorporate FOAMed into our clinical and bedside teaching practices. However, there are an abundance of resources and filtering through what is reliable and what is not can be overwhelming. How can we do this?

Academic Life in Emergency Medicine (ALiEM), a prominent medical blog that provides educational resources, attempted to critically evaluate FOAM using the Approved Instructional Resources (AIR) score and to furthermore provide modules that consist of vetted FOAM educational material appropriate for resident education (<https://www.aliem.com/aliem-approved-instructional-resources-air-series/>).⁴ Although residencies can use the AIR series, the composite modules are available for anyone’s use.⁵ This is but one starting point. Numerous reviews have been done to identify high quality FOAMed material and content leaders. Nickson and Cadogan, in their 2014 article “Free Open Access Medical education (FOAM) for the emergency physi-

cian”, outlined recommended emergency medicine FOAM blogs, podcasts, websites and notable physicians who are accessible via twitter.⁶ Many FOAM resources allow for comments and questions, allowing for open discussion in real time.

As with any source of information in medicine, critical thinking is essential when assessing the quality of FOAM. Here are some checkpoints to consider in your assessment⁷:

- 1) Is the author identifiable?
- 2) What are the author’s qualifications?
- 3) Are there conflicts of interest?
- 4) Does what I know check out?
- 5) Is it logical?
- 6) Is it referenced?
- 7) Is it supported by trusted recommendations?
- 8) How does the author respond to criticism?

Now that we have developed an approach, it is essential to be able to organize and filter the massive amount of content available online. Here are five strategies to effectively use online resources⁸:

- 1) **Use an RSS Feed:** Platforms like Feedly (<https://feedly.com>) or Newsblur (<https://newsblur.com>) allow you to create your own personalized newsletter. This works best when you do not over-subscribe.
- 2) **Use a Podcast Organizer:** Apps like Pocket Cast (<https://www.shiftyjelly.com/pocketcasts>) or Downcast (<http://www.downcastapp.com>) are easy to download and essentially keep all of your podcasts in one place.
- 3) **Wish that someone could do #1 and #2 for you?** Someone has! Life in the Fast Lane Review (<https://lifeinthefastlane.com/about/rss-feeds-social-media-links>) highlights FOAMed material weekly! Others include FOAM EM RSS (<https://www.foamem.com>)
- 4) **Use Twitter!** Yes, some of us still don’t want to tweet. But that doesn’t mean you can’t follow your fellow academic colleagues and those whose work you value to keep abreast of the current topics in emergency medicine.
- 5) **Use a custom search engine:** googlefoam.com. This is a search engine that targets relevant medical journals and reputable FOAM resources.

EDUCATION

Use these strategies to familiarize yourself with what is out there and direct your learners to sources that you trust. Your learners are likely listening to podcasts and may be accepting the information they learn as gospel. Be open minded in your interaction with your learners by telling them you are open to discussion of new approaches but that they have to cite the source and explain the evidence or resource.

With these factors in mind, you consider the resident recommendation. You recognize the blog to which your resident is referring and remember that you read the same post a few weeks ago. You believe that the evidence You pull up the post on your smart phone and refresh your memory. You and your resident then discuss the risks and benefits of using IV lidocaine and the evidence behind such an approach.

Though the leaders and creators of FOAMed content have put in great effort to disseminate their knowledge accurately, it is our job as educators to make an effort to understand what our learners comprehend and how they are applying this knowledge.

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NEW YORK STATE OF MIND



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

Point-of-Care Ultrasound Assessment of Bladder Fullness for Female Patients Awaiting Radiology-Performed Transabdominal Pelvic Ultrasound in a Pediatric Emergency Department: A Randomized Controlled Trial.

Dessie A, Steele D, Liu AR, Amanullah S, Constantine E; Division of Pediatric Emergency Medicine, Columbia University Medical Center and New York-Presbyterian Morgan Stanley Children's Hospital, New York; *Ann Emerg Med.* 2018 Jul 3.

STUDY OBJECTIVE: Radiology-performed transabdominal pelvic ultrasound, used to evaluate female patients with suspected pelvic pathology in the pediatric emergency department (ED), is often delayed by the need to fill the bladder. We seek to determine whether point-of-care ultrasound assessment of bladder fullness can predict patient readiness for transabdominal pelvic ultrasound more quickly than patient sensation of bladder fullness.

METHODS: We performed a randomized controlled trial of female patients aged 8 to 18 years who required transabdominal pelvic ultrasound in a pediatric ED. Patients were randomized to usual care or point-of-care ultrasound and then assessed every 30 minutes for subjective bladder fullness (0 to 4 ordinal scale) and qualitative bladder fullness by point-of-care ultrasound. Patients were sent for pelvic ultrasound when they reported 3 or 4 on the subjective fullness scale (usual care) or a large bladder was visualized (point-of-care ultrasound). Primary outcome was time from enrollment to completion of pelvic ultrasound. Secondary outcome was success rate of pelvic ultrasound on first attempt.

RESULTS: One hundred twenty patients were randomized and 117 had complete outcomes (59 usual care, 58 point-of-care ultrasound). Kaplan-Meier curves differed between groups ($P < .001$). Median time to successful completion of pelvic ultrasound was 139 minutes (usual care) and 87.5 minutes (point-of-care ultrasound), with difference in medians 51.5 minutes (95% confidence interval [CI] 23.4 to 77.2 minutes). All point-of-care ultrasound

patients had successful transabdominal pelvic ultrasound on the first attempt compared with 84.7% in the usual care group, with difference -15.3% (95% Bayesian credible interval -5.3% to -25.0%). Weighted κ for interrater agreement was 0.83 (95% CI 0.79 to 0.87).

CONCLUSION: Point-of-care ultrasound assessment of bladder fullness decreases time to transabdominal pelvic ultrasound and improves first-attempt success rate for female patients in the pediatric ED.

Factors Associated with Patient Involvement in Emergency Care Decisions: A Secondary Analysis of the Chest Pain Choice Multicenter Randomized Trial.

Probst MA, Tschatscher CF, Lohse CM, Bellolio MF, Hess EP; *Acad Emerg Med.* 2018 Jun 15.

BACKGROUND: Shared decision-making in the Emergency Department (ED) can increase patient engagement for patients presenting with chest pain. However, little is known regarding which factors are associated with actual patient involvement in decision-making or patients' desired involvement in emergency care decisions. We examined which factors were associated with patients' actual and desired involvement in decision-making among ED chest pain patients.

METHODS: This is a secondary analysis of data from a randomized trial of a shared decision-making intervention in ED patients with low-risk chest pain. We evaluated the degree to which patients were involved in decision-making using the OPTION-12 (observing patient involvement) scale and patients' reported desire for involvement in decision-making using the Control Preference Scale (CPS). We measured the associations of patient factors with OPTION-12 and CPS scores using multivariable regression.

RESULTS: Of the 898 patients enrolled, mean age was 51.5 years and 59% were female. Multivariable analysis revealed that only two factors were significantly associated with OPTION-12 scores: study site and use of the decision aid. OPTION-12 scores were 10.3 (SE=0.6) points higher for patients randomized

to the decision aid compared to usual care ($p < 0.001$). Higher health literacy was associated with lower scores on the CPS, indicating greater desire for involvement (OR= 0.91, $p < 0.001$).

CONCLUSIONS: Patients' reported desire for involvement in decision-making was higher among those with higher health literacy. After adjusting for study site and other potential confounding factors, only use of the decision aid was associated with observed patient involvement in decision-making. As the science and practice of shared decision-making in the ED moves towards implementation, high fidelity integration of the decision aid into the flow of care will be necessary to realize desired outcomes.

Racial Disparities in the Treatment of Acute Overdose in the Emergency Department.

Wilder ME, Richardson LD, Hoffman RS, Winkel G, Manini AF; Icahn School of Medicine at Mount Sinai, New York; *Clin Toxicol.* 2018 Jun 12:1-6.

OBJECTIVES: Racial and ethnic disparities in the United States continue to exist in many disciplines of medicine, extending to care in the Emergency Department (ED). We sought to examine the relationship between patient race/ethnicity and use of either antidotal therapy or gastrointestinal decontamination for individuals presenting to the ED for acute drug overdose.

METHODS: We completed a secondary analysis of a prospective cohort of patients with suspected acute overdose presenting to two urban tertiary care hospitals between 2009 and 2014. Race was self-identified during ED registration. Antidote administration (primary outcome) and gastrointestinal decontamination (secondary outcome) were reviewed and verified via agreement between two board certified medical toxicologists. Associations between race and outcomes were analyzed using a logistic regression model.

RESULTS: We reviewed 3,252 ED patients with acute overdose. Overall, 542 people were treated with an antidote and 234 cases were treated with activated charcoal, either single

NEW YORK STATE OF MIND

or multiple dose. Compared to Whites, Blacks and Hispanics were significantly less likely to receive any antidote. The analysis was underpowered to detect racial disparities in the administration of activated charcoal.

CONCLUSIONS: Blacks and Hispanics are significantly less likely to receive any antidote when presenting to the ED for acute drug overdose. Further studies are needed to determine national prevalence of this apparent disparity in care and to fully characterize how race plays a role in management of acute overdose.

Early Point-of-Care Testing at Triage Reduces Care Time in Stable Adult Emergency Department Patients.

Singer AJ, Taylor M, LeBlanc D, Meyers K, Perez K, Thode HC Jr, Pines JM; Stony Brook University, Stony Brook; J Emerg Med. 2018 Jun 7.

BACKGROUND: Core laboratory testing may increase length of stay and delay care.

OBJECTIVES: We compared length of emergency department (ED) care in patients receiving point-of-care testing (POCT) at triage vs. traditional core laboratory testing.

METHODS: We conducted a prospective, case-controlled trial of adult patients with prespecified conditions requiring laboratory testing and had POCT performed by a nurse after triage for: a basic metabolic panel, troponin I, lactate, INR (i-STAT System), urinalysis (Beckman Coulter Icon), or urine pregnancy test. Study patients were matched with controls based on clinical condition, gender, age, and time to be seen. Groups were compared with Wilcoxon rank-sum or Fisher's exact tests.

RESULTS: We matched 52 POCT study patients with 52 controls. Groups were similar in age, gender, clinical condition, time to be seen by a physician (3.3 h, 95% confidence interval [CI] 2.2-4.4, vs. 3.1 h, 95% CI 2.2-4.5 h, in POCT and control patients, respectively; $p = 0.84$), use of imaging, and disposition. Of 52 study patients, 3 (5.8%, 95% CI 2.0-15.9) were immediately transferred to the critical care area to be urgently seen by an emergency physician. POCT patients had a significantly shorter median (interquartile range [IQR]) ED care time than matched controls (7.6, 95% CI 5.1-9.5 vs. 8.5, 6.2-11.3 h, respectively; $p = 0.015$). Median [IQR] ED length of stay was similar in study patients and controls (9.6, 95% CI 7.9-14.5 vs. 12.5, 8.2-21.2 h, respectively; $p = 0.15$).

CONCLUSIONS: Among stable adult patients presenting to the ED with one of the prespecified conditions, early POCT at triage, compared with traditional core laboratory testing after evaluation by an ED provider, reduced ED care time by approximately 1 h.

Substance Use and Homelessness Among Emergency Department Patients.

Doran KM, Rahai N, McCormack RP, Milian J, Shelley D, Rotrosen J, Gelberg L; NYU School of Medicine, New York; Drug Alcohol Depend. 2018 Jul 1; 188:328-333.

BACKGROUND: Homelessness and substance use often coexist, resulting in high morbidity. Emergency department (ED) patients have disproportionate rates of both homelessness and substance use, yet little research has examined the overlap of these issues in the ED setting. We aimed to characterize alcohol and drug use in a sample of homeless vs. non-homeless ED patients.

METHODS: A random sample of urban hospital ED patients were invited to complete an interview regarding housing, substance use, and other health and social factors. We compared substance use characteristics among patients who did vs. did not report current literal (streets/shelter) homelessness. Additional analyses were performed using a broader definition of homelessness in the past 12-months.

RESULTS: Patients who were currently homeless ($n=316$, 13.7%) versus non-homeless ($n=993$, 86.3%) had higher rates of past year unhealthy alcohol use (44.4% vs. 30.5%, $p<0.0001$), any drug use (40.8% vs. 18.8%, $p<0.0001$), heroin use (16.7% vs. 3.8%, $P,0.0001$), prescription opioid use (12.5% vs. 4.4%, $p<0.0001$), and lifetime opioid overdose (15.8% vs. 3.7%, $p<0.0001$). In multivariable analyses, current homelessness remained significantly associated with unhealthy alcohol use, AUDIT scores among unhealthy alcohol users, any drug use, heroin use, and opioid overdose; past 12-month homelessness was additionally associated with DAST-10 scores among drug users and prescription opioid use.

CONCLUSIONS: Patients experiencing homelessness have higher rates and greater severity of alcohol and drug use than other ED patients across a range of measures. These findings have implications for planning services for patients with concurrent substance use and housing problems.

Quantification of Pain and Distress Associated With Intranasal Midazolam.

Tsze DS, Ieni M, Flores-Sanchez PL, Shen ST, Bregstein JS, O Connell NC, Dayan PS; Division of Pediatric Emergency Medicine, Columbia University College of Physicians and Surgeons, New York; Pediatr Emerg Care. 2018 May 23.

OBJECTIVES: The aims of this study were to quantify the pain and distress associated with the administration of intranasal (IN) midazolam in young children using 4 observational measures and to evaluate the degree of validity of these measures.

METHODS: We conducted a prospective observational pilot study. Children aged 1 to 7 years requiring IN midazolam were enrolled. Children were videotaped, and scores were assigned to baseline and administration phases using the Observational Scale of Behavioral Distress-Revised (OSBD-R), Children's Hospital of Eastern Ontario Pain Scale (CHEOPS), and the Faces-Legs-Activity-Cry-Consolability (FLACC) scale. The cry duration following administration was assessed. Interrater reliability and convergent validity were determined for all 4 measures. Internal consistency and responsiveness for the OSBD-R, CHEOPS, and FLACC scales were determined.

RESULTS: We enrolled 20 children. The mean OSBD-R, CHEOPS, and FLACC scores associated with administration of IN midazolam were 27.1 (SD, 13.5), 11.5 (SD, 1.2), and 8.9 (SD, 2.7), respectively. The mean cry duration was 105.5 (SD, 68.8) seconds. The intraclass correlation coefficients for all measures ranged from 0.82 to 0.99. The Cronbach α 's for the OSBD-R, CHEOPS, and FLACC were between 0.71 and 0.97. Pearson correlation coefficients for comparisons between OSBD-R, CHEOPS, and FLACC were between 0.82 and 0.96 but were between 0.32 and 0.51 for comparisons involving cry duration.

CONCLUSIONS: We have identified estimates of pain and distress associated with administration of IN midazolam in young children that can be used to determine desired effect sizes for trials that study interventions to treat this pain and distress. The OSBD-R, CHEOPS, and FLACC scales are suitable choices for outcome measures.

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Continuous Intravenous Sub-Dissociative Dose Ketamine Infusion for Managing Pain in the Emergency Department.

Motov S, Drapkin J, Likourezos A, Beals T, Monfort R, Fromm C, Marshall J.; Maimonides Medical Center, Brooklyn; West J Emerg Med. 2018 May; 19(3):559-566.

INTRODUCTION: Our objective was to describe dosing, duration, and pre- and post-infusion analgesic administration of continuous intravenous sub-dissociative dose ketamine (SDK) infusion for managing a variety of painful conditions in the emergency department (ED).

METHODS: We conducted a retrospective chart review of patients aged 18 and older presenting to the ED with acute and chronic painful conditions who received continuous SDK infusion in the ED for a period over six years (2010-2016). Primary data analyses included dosing and duration of infusion, rates of pre- and post-infusion analgesic administration, and final diagnoses. Secondary data included pre- and post-infusion pain scores and rates of side effects.

RESULTS: A total of 104 patients were enrolled in the study. Average dosing of SDK infusion was 11.26 mg/hr, and the mean duration of infusion was 135.87 minutes. There was a 38% increase in patients not requiring post-infusion analgesia. The average decrease in pain score was 5.04. There were 12 reported adverse effects, with nausea being the most prevalent.

CONCLUSION: Continuous intravenous SDK infusion has a role in controlling pain of

various etiologies in the ED with a potential to reduce the need for co-analgesics or rescue analgesic administration. There is a need for more robust, prospective, randomized trials that will further evaluate the analgesic efficacy and safety of this modality across a wide range of pain syndromes and different age groups in the ED.

Automated Pulmonary Embolism Risk Classification and Guideline Adherence for Computed Tomography Pulmonary Angiography Ordering.

Koziatek CA(1), Simon E(2)(3), Horwitz LI(2)(3)(4), Makarov DV(2)(5), Smith SW(1), Jones S(2), Gyftopoulos S(6), Swartz JL(1); Ronald O. Perelman Department of Emergency Medicine, NYU School of Medicine, New York; Acad Emerg Med. 2018 Apr 30.

BACKGROUND: The assessment of clinical guideline adherence for the evaluation of pulmonary embolism (PE) via computed tomography pulmonary angiography (CTPA) currently requires either labor-intensive, retrospective chart review or prospective collection of PE risk scores at the time of CTPA order. The recording of clinical data in a structured manner in the electronic health record (EHR) may make it possible to automate the calculation of a patient's PE risk classification and determine whether the CTPA order was guideline concordant.

OBJECTIVES: The objective of this study was to measure the performance of automated, structured data-only versions of the Wells and revised Geneva risk scores in emergency department (ED) encounters during which a

CTPA was ordered. The hypothesis was that such an automated method would classify a patient's PE risk with high accuracy compared to manual chart review.

METHODS: We developed automated, structured data-only versions of the Wells and revised Geneva risk scores to classify 212 ED encounters during which a CTPA was performed as "PE likely" or "PE unlikely." We then combined these classifications with D-dimer ordering data to assess each encounter as guideline concordant or discordant. The accuracy of these automated classifications and assessments of guideline concordance were determined by comparing them to classifications and concordance based on the complete Wells and revised Geneva scores derived via abstractor manual chart review.

RESULTS: The automatically derived Wells and revised Geneva risk classifications were 91.5 and 92% accurate compared to the manually determined classifications, respectively. There was no statistically significant difference between guideline adherence calculated by the automated scores compared to manual chart review (Wells, 70.8% vs. 75%, $p=0.33$; revised Geneva, 65.6% vs. 66%, $p=0.92$).

CONCLUSION: The Wells and revised Geneva score risk classifications can be approximated with high accuracy using automated extraction of structured EHR data elements in patients who received a CTPA. Combining these automated scores with D-dimer ordering data allows for the automated assessment of clinical guideline adherence for CTPA ordering in the ED, without the burden of manual chart review.

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SCIENTIFIC ASSEMBLY HIGHLIGHTS

The 2018 Scientific Assembly at the Sagamore Resort featured expert faculty members, Robert S Hoffman, MD FAACT FACMT FRCP Edin FEAPCCT, Vicki E. Noble, MD FACEP; Jessica M. Noonan, MD FACEP; Linda A. Regan, MD FACEP and Peter Viccellio, MD FACEP who wowed 280 emergency physicians from around the state. Thirty-one companies participated through exhibits and support.



Awards

Each year New York ACEP honors individuals for significant contributions to the advancement of emergency care. New York ACEP members, Arlene S. Chung, MD MACM and Moshe Weizberg, MD FACEP were presented with the 2018 Advancing Emergency Care Award. Kaushal Shah, MD FACEP was presented with the Physician of the Year Award. The Edward W. Gilmore Lifetime Achievement Award was presented to John B. McCabe, MD FACEP. For more information on these awards, visit <http://nyacep.org/about-new-york-acep/awards>.

Leadership Elected

Congratulations are extended to the newly elected Board members: Arlene S. Chung, MD MACM, Maimonides Medical Center; Robert F. McCormack, MD MBA FACEP, Buffalo General Medical Center; William F. Paolo, Jr., MD FACEP, SUNY Upstate Medical University and Jeffrey S. Rabrich, DO FACEP FAEMS, Montefiore Nyack Hospital.

New Speaker Forum

Congratulations to Sally Bogoch, MD, Maimonides Medical Center, recipient of the award for best presentation for *Walking Out: Five Tips For When Your Patient Leaves AMA*.



Research Forum Winners

Tuesday's program included the Research Forum featuring oral and poster presentations. Congratulations to the following research presenters who took the annual award in their category.

Oral Presentation

- The Glass Half Full: The relationship between optimism, burn-out, and well-being.
Charles Pereyra, MD, NewYork-Presbyterian Brooklyn Methodist Hospital

Poster Presentations

- Predictors of Significant Echocardiography Findings in Older Adults With Syncope
Marc Probst, MD MS, Mount Sinai School of Medicine
- The Standardized Video Interview: Does it Help or Hurt?
Ida Li, MD, Staten Island University Hospital, Northwell Health
- The Effects of Practice Setting on Individual Doctor Press Gancy Scores
Elias Youssef, MD, Staten Island University Hospital, Northwell Health
- Emergency Department Intensive Care Unit Reduces the Cost of Diabetic Ketoacidosis Management
Victoria Zhou, BA, University of Rochester School of Medicine & Dentistry

New York Presbyterian Queens took the Crown in the 4th Annual Resident Volleyball Challenge



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

SCIENTIFIC ASSEMBLY HIGHLIGHTS

Residency Volleyball Challenge
July 11, 2018
Sagamore Resort on Lake George



2018 Volleyball Champions
New York Presbyterian Queens





EMERGENCY MEDICINE RESEARCH FACULTY

Weill Cornell Medicine's new academic Department of Emergency Medicine, led by Dr. Rahul Sharma, seeks Clinician Research faculty to join the Department at the Assistant, Associate or professor level on the Investigation Pathway. The successful candidate should have the requisite experience and training to continue a successful research career, and have a strong record of scholarship with national recognition in clinical, translational, biomedical, or health services research. Of particular interest are candidates who have experience with varied funding mechanisms. Faculty rank will be determined by the qualifications and experience of the successful candidate.

We are particularly interested in candidates who have expertise and a track record of funding in Healthcare Innovation, Technology Development, Informatics, EMS, Global EM, Wilderness Medicine, Pediatric EM, Medical Education, Resuscitation Medicine, and Simulation.

We offer a highly competitive salary, a generous support package to ensure the candidates transition and continued success, a comprehensive benefits package, and a generous retirement plan. Research infrastructure needed for success is already present within the Department, including research coordinators, a Research Associate Program, statistical support, and administrative support.

In addition to providing excellent care, and teaching house staff and medical students, the new clinician researcher will mentor junior colleagues, engage in the training mission of the department, and create collaborations throughout the medical center. He or she is expected to focus on creating new knowledge, securing extramural research funding, producing scholarly output, and engaging in the educational component of our program as it relates to research.

The Emergency Department at New York Presbyterian-Weill Cornell Medical Center serves as one of the major campuses of the fully accredited four-year New York Presbyterian Emergency Medicine Residency Program. Our Emergency Department is a high volume, high acuity regional trauma, burn and stroke center caring for more than 90,000 adult and pediatric patients. Faculty also have the opportunity to work at our New York Presbyterian-Lower Manhattan Hospital ED campus, which is a busy community hospital seeing 45,000 annual visits.

We offer programs in Medical Toxicology, Geriatric Emergency Medicine, Wilderness Medicine, Global Emergency Medicine, Simulation and Ultrasound. In addition, we offer fellowships in Geriatric Emergency Medicine, Healthcare Leadership and Management, Pediatric Emergency Medicine as well as PA and NP residencies in Emergency Medicine.

Please send curriculum vitae and cover letter to:

Sunday Clark, ScD, MPH
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**Guest Author:**

Jeffrey S. Rabrich, DO FACEP FAEMS
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Joshua Moskowitz, MD MBA MPH FACEP
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Jacobi Medical Center

EMS, The DEA and Controlled Substances

We all interact with EMS on a daily basis on our shifts in the Emergency Department, and have likely been asked to give orders for medications including controlled substances, but how much do you really know about EMS and the rules and regulations regarding their storage and administration of controlled substances? While EMS physicians are very familiar with this and comfortable with supervision, most EMS agencies in New York State have a non-EMS physician medical director and some agencies have non-emergency physician medical directors. Let's consider that your local EMS agency has come to you and asked you to be their medical director. Do you know the rules regarding their use of controlled substances? We will review the current state of EMS controlled substance use and recent changes to federal law but first let's consider the following scenario.

A local Advanced Life Support (ALS) agency responds to a call for a child having seizures. Upon arrival on the scene they find a 5-year-old male who has been seizing for 10 minutes according to the parents. The child has copious oral secretions and is unresponsive. Additionally, the call location is in a mountainous area with no cellular or radio reception. How would EMS treat this child? In addition to providing supportive care and managing the ABCs, we would all want them to give medication to stop the seizure. In most of New York State, the paramedics follow the Collaborative Protocol and would administer Midazolam 0.1mg/kg to a max of 5mg under standing orders. Standing orders are the steps in the written protocol often referred to as "offline" medical control that EMS providers can initiate on all patients meeting that particular protocol without speaking with an "online" medical control physician (or PA/NP in some regions) to get a specific order or approval to administer the desired medication. EMS across the country has been operating under standing orders in protocols for years with each protocol containing some additional "medical control" options which often contain steps or additional medications should the standing orders prove insufficient. These standing orders and written protocols exist to allow our EMS providers to initiate timely lifesaving care without having to take time to contact medical control for orders which can be time consuming or even impossible in some situations due to geography or technical limitations. Imagine in the seizing child scenario that standing orders were not allowed and the crew had to call for medical control, get a physician on the phone, present the case and get an order for midazolam which could take anywhere from 5-10 minutes all the while the child is seizing.

The US Drug Enforcement Agency is responsible for the oversight

and diversion control related to the administration of the Controlled Substances Act (CSA) of 1970. Under this act which is Title 21 of the United States Code (21 USC), there were no unique provisions for the way EMS practices and the DEA was left to enforcement actions based on interpretive guidance from the Department of Justice and the Attorney General. A few years ago, the DEA began deliberations on a provision of the 1970 CSA that was largely unenforced. This provision required a physician's written prescription to administer a controlled substance, and despite objections raised by many EMS stakeholders, including ACEP and NAEMSP, the DEA intended to criminalize the use of EMS standing orders. What this would have meant in practice is that the seizing child or the patient with the femur fracture in excruciating pain could not get treated until the crew got a physician on the phone to provide an order, or worse yet, wait until they got to the hospital. With the DEA taking such a position, it was clear that congressional action would be required to actually change the CSA to prevent this devastating change to patient care and EMS' ability to deliver rapid high-quality care.

H.R 304, introduced in the house by Representative Richard Hudson, (R-NC) known as the Protecting Patient Access to Emergency Medication Act of 2017, was passed by the House and sent to the Senate where co-sponsors Senators Bill Cassidy (R-LA), a physician himself and Michael Bennett (D-CO), shepherded the bill through the senate and was signed into law by President Trump on November 17, 2017. This was accomplished in no small part by strong lobbying efforts by numerous EMS stakeholders including ACEP, NAEMSP, the National Association of EMTs (NAEMT), Emergency Nurses Association (ENA) and others. So, what does this law now mean?

The provisions of the Protecting Patient Access to Emergency Medications Act of 2017 amends 21 USC Section 823 and instructs the DEA as follows:

- 1) This bill amends the Controlled Substances Act to direct the Drug Enforcement Administration (DEA) to register an emergency medical services (EMS) agency to administer controlled substances if the agency submits an application demonstrating that it is authorized to conduct such activity in the state in which the agency practices. The DEA may deny an application if it determines that the registration is inconsistent with the public interest.
- 2) An EMS agency may obtain a single registration in each state instead of a separate registration for each location.

EMS

3) A registered EMS agency may deliver, store, and receive controlled substances, subject to specified conditions.

4) An EMS professional of a registered EMS agency may administer controlled substances in schedules II, III, IV, or V outside the physical presence of a medical director if such administration is authorized under state law and pursuant to a standing or verbal order, subject to specified conditions.

5) The bill specifies that a hospital-based EMS agency (i.e., an EMS agency owned or operated by a hospital) may continue to administer controlled substances under the hospital's DEA registration.

The amendments above allow for EMS to administer controlled substances under standing orders as they have been doing without fear of DEA enforcement actions. Additionally, it now allows an EMS agency who may have multiple stations within a single state to have a single registration instead of having to individually register each site.

What does this mean for those of you considering agreeing to be an agency medical director? The provisions of this Act basically codify in federal law the current practices of EMS. While the agency must

follow its controlled substances plan and comply with the Bureau of Narcotics Enforcement (BNE) rules in New York State, there should no longer be fear of undue burden by the DEA. While these changes are most welcome, it is still recommended that as the medical director signing for the ordering of the controlled substances (form DEA-222) that you maintain a separate individual DEA number for each EMS Agency you contract with. The New York ACEP EMS Committee, website and our committee members are a great resource for your EMS related questions.

References:

1. <https://www.deadiversion.usdoj.gov/21cfr/21usc/index.html>
2. <https://www.congress.gov/bill/115th-congress/house-bill/304/text>
3. <https://www.cbo.gov/publication/52762>
4. <https://www.emsworld.com/press-release/218958/senate-passes-protecting-patient-access-emergency-medications-act>
5. <http://thehill.com/blogs/congress-blog/healthcare/361410-the-little-bill-that-could-save-ems>

**Wednesday,
November 7, 2018**

9:30 am - 12:30 pm

Location
Stern Auditorium
Icahn School of Medicine at
Mount Sinai

More information
online at
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LEADERSHIP & ADVOCACY AWARD WINNER REFLECTIONS



Kathleen Li, MD PGY-4
Department of Emergency Medicine
Icahn School of Medicine at Mount Sinai

During residency, it is easy to get pulled into the minutiae of patient care – seeing one patient after another, getting through each shift as it comes. This is excellent for learning clinical skills, but can make residents lose sight of the forest for the trees. The ACEP Leadership and Advocacy Conference (LAC) is an opportunity to bring things back into perspective, and to remember that we are not just individual physicians caring for patients in a silo, but rather within a larger system. Furthermore, the conference reminds us that we can and must use our voices to advocate for change for our patients.

Each year, in addition to reviewing the basics of health policy and providing emergency physicians with updates on the state of current health care policy, the conference organizes physicians to meet with state representatives and senators about a few core, relevant issues. This year, the issues were the opioid crisis, disaster preparedness, and drug shortages. New York had a large contingent of physicians, split into two groups, who met with congressional staffers to encourage support or co-sponsorship for:

- The Alternatives To Opioids (ALTO) bill,
- The Preventing Overdoses While in Emergency Rooms (POWER) act to fund the initiation of medication-assisted treatment of opioid use disorder such as buprenorphine or methadone,
- The re-authorization of the Pandemic and All-Hazards Preparedness Act (PAHPA), and
- A letter to Food and Drug Administration Commissioner Scott Gottlieb to convene a Drug Shortage Task Force to investigate root causes of drug shortages and to develop recommendations for Congress.

The congressional meetings provided valuable insight into the lawmaking process. A few important points I will keep in mind for the future: keep it simple, make it about the patients (constituents), and the power

of anecdote. These three really go hand in hand. While some staffers may have a fairly in-depth knowledge of the complexities of the health care system, most will have little insight on how various policies affect us day-to-day – and that is what we are there to try to help them understand. Even more important we need to communicate how certain policies are affecting the patients we care for, their constituents. Furthermore, while knowing the cost and other data is important, individual stories are what gets people’s attention. Being able to tell a story about how a diltiazem shortage affected the care of a specific patient in a representative’s district is more “real” than being able to repeat the estimated cost or delays in care of drug shortages.

And showing up and making your voice heard works. One representative we met with, Rep. Yvette Clark (D-NY), became a co-sponsor on both the ALTO and POWER Acts after our meeting with her. Over 130 congressmembers signed the letter asking Commissioner Gottlieb to form a drug shortages task force, and on July 12, the FDA announced the creation of exactly that (<https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm613346.htm>).

So, while it is important to learn the essentials of treating rapid atrial fibrillation, it is equally important to remember that that tree stands within a much larger forest, and that we cannot properly tend to each individual tree without acknowledging and improving the soil and the climate of the forest as a whole.



Vincent Calleo, MD
Fellow of Pediatric
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University

This past May, I had the amazing opportunity to attend the ACEP Legislative and Advocacy

Conference (LAC) thanks to New York ACEP. I was very honored to receive the Young Physician Leadership and Advocacy Award for 2018. Although I have always had an interest in healthcare policy and reform, I will be the first to admit that I did not know how to get involved and make a difference. My experience at this conference showed me that participating in policy reform is easier than you think, and even small efforts can make a big difference.

When I first arrived in D.C. May 20, it was sunny and in the 80s, much different than the beautiful overcast weather of Upstate New York. After registering for the conference, I went to the Health Policy Primer session. This was an amazing session packed full of information about the way government runs healthcare and how health policies are influenced and formed. There was also a fantastic session on the ACA with well known journalists like Dan Diamond, Sarah Kliff, and Julie Rovner. Listening to their experiences in healthcare was riveting, and I even picked up a new podcast, PulseCheck, which I would highly recommend. Later that evening, I met some wonderful colleagues, ranging from new residents to seasoned attendings. It was really refreshing to see so many people from different levels of training come together to achieve common goals.

The second day of the conference started with the Leadership Summit. There were many wonderful speakers, each addressing problems that we all see in clinical practice. One topic that I found particularly interesting was Personal Professional Balance, given by Frank Lee and Tracy Sanson. Work/life balance and physician burnout is something that is terribly prevalent in our specialty, yet it is rarely seriously discussed in the Emergency Medicine community. The Maintenance of Certification talk was also very informative, particularly as a recent residency graduate.

The third day of LAC was the big day; it was the day we swarmed Capitol Hill to meet

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 Associate Professor Emergency Medicine,
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The Emergency Department and “Access” to Care

The redefinition of a potentially functioning medical system in which each individual is able to utilize financially non-prohibitive care into a disjointed balkanized realm of income-based insurance tribes is aided by the protean definitions of the political buzzword “access.” Access to medical care does not entail the ability to reliably obtain medical care much as medical insurance reform is not, in point of fact, healthcare reform. Regardless, the conflation of one’s potential ability to access a broken system with the delivery of a reliably accessible holistic system is never more evident than in the discussions surrounding emergency care.

Due to the fragmented nature of the U.S. medical system, emergency departments both function as a means to obtain reliable hyperacute medical care as well as a de facto medical home for those without the ability to obtain primary health-care. Its role as the latter is not however due to the much touted Emergency Medical Treatment and Labor Act (EMTALA) rather than a failing healthcare infrastructure. EMTALA was established in 1986 to ensure that any individual seeking care within an emergency department of a hospital that accepts Medicare payments would receive screening for and stabilization of any identified emergent condition regardless of ability to pay. Within its mandates is the implicit assumption that hospital emergency departments should care for all individuals based upon their acuity of illness and not their financial well-being. This however does not suffice as a substitute for an established primary health-care infrastructure or as a policy to ensure universal health-care equity. The emergency department is capable of rendering cost effective care with the goal of rapid recognition of potentially life-threatening conditions and the initial comprehensive management of said conditions once identified. Its objectives are unique and distinctive from outpatient medicine where patients can obtain preventative and longitudinal care inaccessible from within emergency departments.

This distinction has been lost on many individuals during the current and previous debates over reforming the insurance delivery systems of the United States. As the most appropriate way to provide financial security to Americans who need healthcare is adjudicated the misunderstanding of the role of emergency care within the house of medicine is yet again demonstrable. In 2007, then president George Bush, when queried about his potential veto of the expansion of the federal Children’s Health Insurance Program stated, “People have access to health care in America. After all, you just go to an emergency room.” This same sentiment was repeated by candidate

Romney and recently by Congressman Mark Meadows on CNN. The most common retort, that emergency care is more expensive than traditional care, is erroneous and misses the point entirely. Emergency departments are currently overwhelmed and overburdened with large volumes of sick patients as the population ages, accompanied by the litany of acute medical illness that living longer provides, in addition to an increase in the burden of chronic medical conditions. Simultaneously, the lack of a reasonable primary health care system and barriers to the ability to dependably obtain care systemically drives people to seek out care from emergency departments out of desperation or lack of reasonable alternatives. The issue then is not one of cost, but of collapse, as the struggles of U.S. emergency departments best reflect the functioning of the health-care system as a whole.

The results of missed primary care, barriers to preventative care, and financial restrictions to care, all show up at the emergency department, the front door of the U.S. public health-care infrastructure.

Access to health-care then results in tangible directed health-benefits much in the same way that access to private jets results in universal Cessna ownership. One always has

access to emergency departments, but this is neither a solution to the problem of a disjointed and failing system, nor is it a demonstration of compassionate governmental planning for all individuals across classes of income. True reform would entail discussions pertaining to the provision of financially non-prohibitive care for all Americans and to providing a system whereby barriers to the delivery of primary care are not systematically discouraged by erecting economic obstacles, while simultaneously referring to these very prohibitions as “accessible.” Until these issues are truly examined and realistically viable solutions proposed, the concept of the emergency department serving as the easy entry point for those without the means to obtain reliable health-care will persist. U.S. emergency departments will continue to figure out new and creative ways to care for the myriad of individuals with acute illness and those left behind by the system who, by virtue of legislative decree, have no other medical home. In the interim we will continue to define our queue within the egalitarian ideals of democracy, caring first for the sickest in our midst, regardless of their ability to pay or earning potential.

“The results of missed primary care, barriers to preventative care, and financial restrictions to care, all show up at the emergency department, the front door to the U.S. public health-care infrastructure.”

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with our Congressmen and Senators. We had an advocacy briefing session with Senator Cassidy and Representative Senema before hitting the hill. They discussed a few of the current problems with healthcare, and we were given the main ACEP talking points for this year, namely drug shortages, the opioid crisis, and disaster preparedness. Armed with the discussion topics, I met with other representatives from New York and we were shuttled to Capitol Hill. I got to meet with representatives from the offices of Senators Schumer and Gillibrand as

well as those from Representatives Tenney and Reed. Though I was initially nervous about this meeting, I was well prepared by LAC, and all the meetings went off without a hitch.

The final day of LAC wrapped the conference up well. It was a Solutions Forum aimed at addressing the Opioid Crisis. Several of the sessions were very informative, but my favorite was listening to Surgeon General Vice Admiral Adams give his Keynote Address regarding the topic. I learned a lot from the conference, and was able to put my newfound skills to use sooner than I thought.

Shortly after returning from LAC, Senator Katko visited SUNY Upstate Medical University, and I was one of the staff members selected to meet with him. I was able to educate all my colleagues on the major ACEP agenda items, and together, we had a great meeting with the Senator. LAC helped make me feel more comfortable speaking with politicians and showed me that it is much easier to make a difference than most people think. Thank you to New York ACEP for giving me the opportunity to learn more about advocacy, and I look forward to continuing this in the future!Grd

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ALBANY UPDATE



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

2018 State Legislative Session

The New York State Legislature finished the 2018 Legislative Session in the early hours of June 21, 2018. New York ACEP and Reid, McNally and Savage worked throughout the 6-month Session to protect and enhance the practice of emergency medicine. Two lobby days were held in Albany. The one March 13 focused primarily on State Budget issues, and the other on June 4 concentrated on a variety of proposals aimed at stemming the opioid crisis, legislation to ban balance billing for hospital emergency services, and support for a Community Medicine Collaborative. Although it was a very challenging year, New York ACEP was successful in meeting most of their government affairs goals.

State Budget Issues

Hospital Penalties for “Preventable” Emergency Department Visits

In a victory for New York ACEP, the Governor’s proposal to penalize hospitals for preventable emergency department visits was eliminated from the final State Budget. The proposal established a Statewide General Hospital Quality Pool and authorized the Department of Health (DOH) to create a penalty pool by establishing performance targets for hospitals to reduce potentially preventable emergency department visits and to reduce or eliminate reimbursement to hospitals based on their quality and safety scores as determined by DOH.

Extension of Excess Malpractice Program

The final State Budget includes the Governor’s proposal to extend the Excess Medical Malpractice Program until June 30, 2019 at level funding of \$127.4 million.

Cuts to Poison Control Centers Averted

New York ACEP was successful in defeating a State Budget proposal to cut funds for Poison Control Centers. The Governor’s budget proposal eliminated funding lines for 30 public health programs, consolidated the funding lines into four competitive block grants, and reduced overall funds by 20%; a total reduction of \$9,183,000. The Poison Control program was moved to a new “Health Outcomes and Advocacy” block grant and would have been forced to compete with five other programs putting their entire appropriation of \$1,520,000 at risk.

After successful advocacy efforts by New York ACEP and others, both the Senate and Assembly fought to restore these funds in the final State Budget.

Community Paramedicine Collaborative

Governor Cuomo put forward a State Budget proposal strongly supported by New York ACEP, to establish a Community Paramedicine Collaborative. Unfortunately, this proposal was rejected by the Legis-

lature in the final Budget deal.

Separate legislation was introduced in the Legislature to authorize a Community Paramedicine program (S5588 Hannon/A2733A Gottfried). The proposal authorizes emergency medical personnel to provide care in collaboration with hospitals, nursing homes, clinics, and physicians, to patients in the community. Under the direction of a physician, the program could provide: post-discharge care following hospital admissions; evaluation, stabilization and treatment of nursing home residents to avoid preventable emergency transport to a hospital emergency department; and assistance to individuals in self-managing their health or behavioral health conditions.

This legislation passed the Senate and died in the Assembly.

Key Legislation

Prohibition on Balancing Billing of Emergency Services (S6363 Hannon; S9077 Hannon; & S4241 Seward/A7611-C Cahill)

Three separate proposals were put forward and defeated to prohibit balance billing of emergency services when a patient elects to assign benefits to an out-of-network (OON) health care provider. Two stand-alone bills were introduced by Senator Hannon to prohibit balance billing. A third bill introduced by Insurance Committee Chairmen Senator James Seward and Assemblyman Kevin Cahill which pertained to adding hospitals to the Independent Dispute Resolution (IDR) process also included a provision to prohibit balance billing of emergency services.

Reid, McNally & Savage met with Senator Hannon, Senator Seward, Assemblyman Cahill and their staff. We pointed out that the current law already holds patients harmless from excessive fees and works well to protect them. Chapter 60 of the Laws of 2014 places responsibility on the health plan to ensure that the patient receives no greater out-of-pocket costs than they would have incurred with a participating health care provider. We are not aware of any examples of patient involvement in payment disputes between OON emergency providers and health care plans.

Data from the New York State Department of Financial Services (DFS) confirms that the number of complaints filed through the Independent Dispute Resolution (IDR) process for emergency services is extremely low given that the annual volume of patient visits for emergency services in the State is estimated to be 7.9 million. Data reported for the period April 1, 2015 through March 31, 2016 shows that only 262 eligible disputes were filed for emergency services.

New York ACEP’s concern is that under these bills, insurers would be free to dictate fees to emergency providers knowing that these physicians are legally bound to provide emergency care to patients under EMTALA. This would impair the ability to attract and retain qualified

emergency physicians in the State and threaten patient access to timely, life-saving emergency services.

Senator Hannon did not advance either of his bills out of the Health Committee. At New York ACEP’s request, Senator Seward and Assemblyman Cahill amended their bills to remove the prohibition on balanced billing.

Requirement for All Medical Practitioners Who Administer Overdose Reversal Agents to Report Patient Information and the Time and Place of Administration (S4374-B Amedore/A2810-B McDonald)

New legislation was introduced this year to require all medical practitioners who administer naloxone or other overdose reversal agents to a patient to report to the PMP within 72 hours of administration of the agent the following information: 1) name of patient; 2) address of patient; 3) date of birth of patient; and 4) time and place of administration.

New York ACEP opposed the bill on the grounds that it would impede timely access to patient care in hospital emergency departments. In addition, Emergency Medical Services (EMS) providers do not have access to the PMP. Since the bill requires “all practitioners” to provide the information, it will fall on physicians in the emergency department to log-in to the system and report information on patients arriving by ambulance. Mislabeled patients is also a concern because many patients receive naloxone for conditions other than an overdose.

This legislation died in the Assembly Codes Committee. It was not advanced out of the Health Committee in the Senate.

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

Legislation was defeated in the Assembly that required “every emergency room or hospital practitioner to consult the PMP registry when treating a patient for a controlled substance overdose and to notify the patient’s prescriber of such overdose.” New York ACEP communicated to the sponsors that while they support the intent of this legislation to work to alleviate the prescription drug misuse and overdose epidemic in the State, the bill as written would be extremely difficult to implement.

This bill passed the Senate and died in the Assembly Health Committee.

Mandated Physician Reports to DMV on Patient Medical Conditions (S3569 Young/A10094 Carroll)

New legislation was introduced to require reporting to the Department of Motor Vehicles (DMV) of any patient with a chronic condition which may cause unconsciousness or unawareness by all licensed physicians, physician assistants and nurse practitioners. As written, conditions that would warrant reporting include, but are not limited to, a convulsive disorder, epilepsy, fainting, dizzy spells or coronary ailments. This legislation was prompted by a number of fatalities involving drivers who reportedly suffered seizures prior to an accident. New York ACEP is opposed to this bill.

New York ACEP and Reid McNally & Savage discussed this proposal with legislators and staff the June 4 Lobby Day.

We stressed that the vague language of the bill would lead to over reporting and infringement of patient’s rights. Emergency physicians see many patients a day with some of the described symptoms who pose no risk as a driver. An unintended consequence of this legislation is that patients who fear being reported will not seek the medical care they need.

This legislation was not acted in either house. A separate bill to require a study of the issue was passed by both houses.

There is speculation the Legislature could return to Albany before January 2019 to conduct unfinished business such as extending New York City’s speed camera program, passing procurement reform and other issues. However, there is no announced date at this time

Calendar

September 2018

- 5 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 12-13 Strategic Planning Meeting, Mohonk Mountain House, 1:30-6:30 pm; 8:00 am-12:00 pm
- 13 Board of Directors Meeting, Mohonk Mountain House, 1:30-5:30 pm
- 18 Professional Development Conference Call, 2 pm
- 19 Government Affairs Conference Call, 11:00 am
- 19 Education Committee Conference Call, 4:15 pm
- 19 Research Committee Conference Call, 3:00 pm
- 20 Practice Management Conference Call, 12:00 pm
- 20 EMS Committee Conference Call, 2:30 pm

October 2018

- 1 New York ACEP Reception, Hilton San Diego Bayfront Hotel, 6-7 pm
- 10 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 11 Education Committee Conference Call, 2:45 pm
- 10 Professional Development Conference Call, 3:30 pm
- 11 Practice Management Conference Call, 1:00 pm
- 17 Government Affairs Conference Call, 11:00 am
- 17 Research Committee Conference Call, 3:00 pm
- 18 EMS Committee Conference Call, 2:30 pm

November 2018

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

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