

A Newsletter for the Members of the Kentucky Chapter

Summer 2018



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President

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Leadership and Advocacy Conference

Casey Lawson, MD
University of Kentucky DEM Resident

Over the past 10 years of our lives, through college, medical school, and now residency, healthcare policy has been passionately debated. Throughout the majority of this time, the need to focus on learning has taken us away from being truly engaged in affecting positive change for our future practice and the patients that we serve. We are witnessing career politicians who have never worked in healthcare argue over important issues that change our day-to-day practice and directly impact the health of our patients. It is for the aforementioned reasons that the ACEP Leadership and Advocacy Conference is so important in opening the doors to advocacy and allowing us to participate in those discussions.

During the conference, attending and resident physicians from all over the country met face-to-face with our Congressional representatives. We were able to speak about the issues most pressing in our emergency departments today. Emergency rooms across the country are witnessing the opioid abuse epidemic and politicians are brainstorming policies that could positively affect this issue. Even after Congress has allocated money to battle the epidemic, the expertise and on-the-ground experience of physicians is necessary to determine how these funds are best distributed. We were also able to discuss medication shortages and speak to our representatives about the struggle that their constituents are facing when insurance companies refuse to pay for emergency care. Many of these important issues are multifactorial, and there is no easy solution. However, our representatives and their staff seemed genuinely interested in our input, and we all left the conference with a greater appreciation for the nuances of legislature.

For those just beginning their careers, we highly recommend attending the [ACEP Leadership and Advocacy Conference](#). It was a wonderful way to gain mentorship from physicians already competent in this arena, including Dr. Wes Brewer and Dr. Steven Stack, among others. For those already several years into your careers, it is never too late to get involved in affecting positive change. Being educated on the legislative process is another important tool to serving our patients and communities and advancing the practice of emergency medicine. Thank you to all of KACEP for supporting us and offering a foundation on which we can grow by giving us the necessary tools to impact the health of those we serve.

LAC Recap - A Resident's Perspective

Sarah Bennett, MD

Resident, University of Louisville

I was among a group of EM physicians from Kentucky in attendance at the ACEP Leadership and Advocacy Conference in May in Washington, D.C. We had the opportunity to meet with several members of Congress from Kentucky to discuss particular legislation regarding the opioid crisis, medication shortages, as well as disaster preparedness. Over 300 similar meetings also occurred between members of Congress and ACEP members from other states.

Of importance for Kentuckians, the Prudent Layperson Standard in the current climate of insurers denying emergency room care was among the topics discussed during the conference's educational sessions. This included a historical overview and updates on both local and national-

level actions being taken to try uphold this protection.

After the educational sessions, the meetings on Capitol Hill and catching a glimpse of the inner-workings and dynamics within a member of Congress's office, I feel better prepared to advocate for emergency physicians as well as for the protection of our patients.







Hugh W. Shoff, MD, MS **Healthcare Quality and Safety: Behind the Buzzwords**

We hear the words all the time. The government, administration, colleagues, and even our patients speak them. They have become synonymous with improvement projects, medical errors, and healthcare costs. They are the words “quality and safety”, and you can’t walk through the hospital without hearing one or both of them.

The catalyst for the push to higher quality and safer care for our patients began in 1999 when the Institute of Medicine (IOM) released its report “To Err is Human.” In that report, it was estimated that 44,000 to 98,000 deaths each year could be attributed to avoidable medical errors. At that time, medical errors placed 8th on the list of top causes of death.

In a follow-up report (“Crossing the Quality Chasm,”) in 2001, the IOM laid out six aims on which we should focus our improvement: safe, effective, patient-centered, timely, efficient, and equitable ... care. These aims were developed to guide improvement in our healthcare system. For the IOM, they are the pillars on which we could build a safer system.

Fifteen years after the IOM’s second report we may not be making significant strides. In a recent article published in the BMJ, Martin Makary and Michael Danile at Johns Hopkins School of Medicine estimate that our current rate of death due to medical errors falls between 210,000 and 400,000 deaths per year. Extrapolating data from 1999 to 2013, they estimate a mean death rate of 251,454 people per year. To put this in perspective, this would make medical errors the third leading cause of death in the United States. Such a bold statement is not without controversy. Not surprisingly, it is difficult to make a statement of causation when defining a medical error and the resulting mortality. With numbers of this magnitude being published, we need to ensure we educate ourselves. We must be able to analyze the data and accurately report the consequence of medical errors. Putting the actual number aside, what is apparent is that medical errors are still a part of healthcare. Attempting to reduce those errors, whether it decreases mortality and morbidity or not, should still be a worthy endeavor.

When we think of quality and safety, it conjures up visions of “metrics.” Door-to-balloon time, CLABSI, CAUTI, time to antibiotics; these are all ways we have attempted to measure the quality of care we deliver to our patients. These ideas were rooted in easily measurable, and what was thought to be easily protocolled pathologies. It is important to note that although these metrics are important to the assessment of care, it does not encompass the full breadth of quality and safety. Beyond the metrics and measures, the processes and systems around us are where real change for the better can occur.

Historically, when processes and systems are analyzed, they are done so using tools found in the work of Edward Deming. Deming’s successes in manufacturing resulted in the development of Lean Processing and Six-Sigma. Lean focuses on reducing waste and Six Sigma attempts to remove defects in the process. Further expanding on these principles are the industries of High Reliability Organizations (HROs). These organizations are known to operate in highly dangerous and volatile environments while maintaining a remarkable track record for safety. HRO’s include aviation, nuclear power, and the United States Navy. They follow five principles: preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise. The first three principles anticipate medical errors and how to prevent them, while the last two look to contain the aftermath when an error occurs. Current efforts to

improve the processes in healthcare take the principles of Lean, Six Sigma, and HROs and apply them to the very complicated, ever-changing atmosphere that is healthcare.

Now that the background has been established, how do we progress into the future? We must first educate ourselves on the principles of healthcare quality and safety and establish a base of knowledge. Next, we should examine our processes for areas of improvement. We can gain significant strides by removing unnecessary steps. We should streamline ancillary and support systems. Supply chain, lab turnaround, and radiology acquisition are some of the areas in which assessing order-to-acquisition can be optimized. Tools such as the Plan-Do-Study-Act (PDSA) cycle and Failure Modes and Effects Analysis (FMEA) can be utilized to better understand the flow as well as identify redundancies. All members of the system should be encouraged to participate. We also cannot overlook seemingly insignificant processes as improvements in individual areas can lead to large gains across the whole. Reductions in ED wait times and hospital length of stay are possible while continuing to measure those metrics deemed important to the evaluation of quality.

Metrics will continue to be an important aspect of our daily healthcare delivery, but we cannot overlook our deeper motivation. Let's revisit the six aims and focus on one in particular, patient-centered care. We cannot forget that the reason we have such an intricate and complicated system is to take care of our patients. No person comes to his or her job in healthcare with the goal of being unsafe or providing poor care. We strive to care for our patients, and every aspect of our professional involvement with them endeavors to keep them safe.

Improvement in healthcare quality and safety is a daunting, unending task. This discussion only scratches the surface. Let's open a dialogue to better understand the principles and work together to better educate and implement. The care we deliver should be of the highest quality. Unsafe care should never happen in our healthcare system, because the system should never place us in the position to provide unsafe care. Tomorrow we should look at ourselves and ask how we can improve patient care to therefore make a positive impact on our environment. If we consistently make that our mission, not only will metrics improve, but healthcare quality and safety will no longer be buzzwords. They will take on a deeper personal meaning.

Anthem Denials

On July 17, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in an effort to compel the insurance giant to rescind its controversial and dangerous emergency care policy. [Read the press release](#). On July 19, Sen. Claire McCaskill (D-MO) released a report showing thousands of denied claims in Missouri, Georgia and Kentucky that the company later deemed non-emergent. [Read the report](#).

The Practice of Wellness Martin Huecker, MD, FACEP Chair, Education Committee

Move. Rest. Nutrition. Wisdom. Community.

Build resilience.

Be present.

Hey everyone! Here are some ideas for wellness practice.

Move:

- Ok not the most optimistic data. But [The Atlantic reports](#) on a study from JAMA Internal Medicine showing counties in the US where the life expectancy is declining. Eight of the top 10 counties are in Kentucky. The article explains how some of this trend can be explained by opioid overdose deaths. But [this similar Atlantic story](#) shows another reason, Kentuckians are second worst in the nation on percentage of adults meeting the minimum exercise recommendation.
- The positive spin on this story is that we have a huge margin for improvement in Kentucky. Promote exercise in your patients or your friends today.

Rest:

- A recent email from [The Daily Stoic](#) (a daily email newsletter that I highly recommend) pulls a quote from Mindfulness in Plain English.
 - *"The longer you keep a cup of muddy water still, the more the mud settles down and the water will be seen clearly. Similarly, if you keep*

quiet without moving your body, focusing your entire undivided attention on the subject of your meditation, your mind settles down and begins to experience the bliss of meditation."

- Try this the next time you have a free couple of minutes. Don't pressure yourself to "meditate." Just sit in a quiet place and "watch" the dust settle in your mind. It gets easier with practice.

Nutrition:

- [Healthy popsicles](#): Recipe from MDA using instant coffee, collagen protein, coconut milk, and optional sweetener. I made a batch with the Whole Earth sweetener. Very rich and delicious. Eat early in the day due to the caffeine.

Wisdom:

[Jon Kabat-Zinn sat down with Robert Wright in Louisville](#) to discuss mindfulness and Wright's newest book. Wright has written extensively on evolution and morality. He has a refreshing belief that humans over time are becoming more moral, better at cooperating (central thesis of his book Nonzero). In this interview, Wright talks about his own lack of talent with meditating, and overall skepticism toward many tenets of Buddhism. But you cannot argue with the validity, the efficacy of meditation. Whether this comes in the form of religious prayer, Vipissana meditation, dancing, singing, or any other variation. The brain seems to crave this mono-tasking, the escape from constant sensory stimuli and hedonic adaptation. Check out any of Wright's books but definitely [this interview](#).

Community:

- Please take 4 minutes to watch [this video by Cleavon Gilman, MD](#), an EM resident in NYC. He raps about the stress and burnout of medical training, but also the resilience that is possible with the right outlook. Solid song. Thanks to our chief hip hop analyst, Dr. Royce Coleman (aka "The Notorious RDC") for this tip.

Quote:

"Imagine if our negative feelings, or at least lots of them, turned out to be illusions, and we could dispel them by just contemplating them from a particular vantage point."

- Robert Wright

**Practice
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you need, from the
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medicine practice has the data you need to ...**



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Updates in Reimbursement and Coding – 2018

Reimbursement and coding can be an ongoing challenge for the emergency physician. This [collection of courses on ACEP eCME](#) will give you the latest information on reimbursement, quality measures and common documentation errors to help ensure you receive appropriate reimbursement for your skilled procedural work.

New ACEP Policy Statements and Information Paper

During their June meeting, the ACEP Board of Directors approved the following new or revised policy statements:

- [Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch, and Public Emergency Aid Training](#) – New
- [Appropriate Use Criteria for Handheld/Pocket Ultrasound Devices](#) – New
- [Coverage for Patient Home Medication While Under Observation Status](#) – New
- [Delivery of Care to Undocumented Persons](#) – Revised
- [Disaster Medical Services](#) – Revised
- [Financing of Graduate Medical Education in Emergency Medicine](#) – Revised
- [Guideline for Ultrasound Transducer Cleaning and Disinfection](#) – New

- [Impact of Climate Change on Public Health and Implications for Emergency Medicine](#) – New
- [Interpretation of Diagnostic Imaging Tests](#) – Revised
- [Interpretation of EMTALA in Medical Malpractice Litigation](#) – New
- [Non-Discrimination and Harassment](#) – Revised
- [Patient Autonomy and Destination Factors in Emergency Medicine Services \(EMS\) and EMS-Affiliated Mobile Integrated Healthcare Community Paramedicine Programs](#)– New
- [Prescription Drug Pricing](#) – New
- [Relationship between Clinical Capabilities and Medical Equipment in the Practice of Emergency Medical Services Medicine](#) – New
- [Resident Training for Practice in Non-Urban/Underserved Areas](#) – Revised

The Board also approved the following information papers and PREP:

- [Electronic Health Record \(EHR\) Best Practices for Efficiency and Throughput \(PDF\)](#) - New
- [Initiating Opioid Treatment in the Emergency Department \(ED\) - Frequently Asked Questions \(FAQs\) \(PDF\)](#) - New
- [Emergency Department Physician Group Staffing Contract Transition \(PDF\)](#)
- [Emergency Physician Contractual Relationships - PREP \(PDF\)](#) - Revised

Articles of Interest in *Annals of Emergency Medicine*

Sam Shahid, MBBS, MPH
Practice Management Manager, ACEP

ACEP would like to provide you with very brief synopses of the latest articles in [Annals of Emergency Medicine](#). Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Duber HC, Barata IA, Cioe-Pena E, Liang SY, Ketcham E, Macias-Konstantopoulos W,

Ryan SA, Stavros M, Whiteside LK. **Identification, Management and Transition of Care for Patients with Opioid Use Disorder in the Emergency Department**

In this clinical review article, they examine the current body of evidence underpinning the identification of patients at risk for OUD, ED-based symptomatic treatment of acute opioid withdrawal, medication-assisted treatment (MAT) of OUD upon discharge from the ED, and transition to outpatient services. In this article they also present options for targeted opioid withdrawal and management, as well as a variety of other medications to consider for symptomatic opioid withdrawal treatment for patients that do not require opioids for acute pain. [Full text available here.](#)

Klein LR, Driver BE, Miner JR, Martel ML, Hessel M, Collins JD, Horton GB, Fagerstrom E, Satpathy R, Cole JB. **Intramuscular Midazolam, Olanzapine, Ziprasidone, or Haloperidol for Treating Acute Agitation in the Emergency Department**

In this prospective observational study of 737 patients, medications were administered based on an a priori protocol where the initial medication given was predetermined in the following 3-week blocks: haloperidol 5mg, ziprasidone 20mg, olanzapine 10mg, midazolam 5mg, haloperidol 10mg. The primary outcome was the proportion of patients adequately sedated at 15 minutes, assessed using the Altered Mental Status Scale (AMSS). Results showed that Intramuscular midazolam achieved more effective sedation in agitated ED patients at 15 minutes than haloperidol, ziprasidone, and perhaps olanzapine. Olanzapine provided more effective sedation than haloperidol. No differences in adverse events were identified. [Full text available here.](#)

Brenner JM, Baker EF, Iserson KV, Kluesner NH, Marhsall KD, Vearrier L. **Use of Interpreter Services in the Emergency Department**

This paper highlights the importance of effective communication in the provider-patient therapeutic relationship and how language barriers have the potential to compromise all aspects of medical care. The authors identify that in the US, as of 2013, more than 25 million persons had limited English proficiency, making quality medical interpreter services an important public health issue that affects a large proportion of our diverse population. They recommend that a professional interpreter should be offered if practical and available when a patient has either limited English proficiency or hearing impairment and that a modality of interpretation should be chosen between in-person, video, or telephone based on what best suits the clinical situation. [Full text available here.](#)

Nowak RM, Gandolfo CM, Jacobsen G, Christenson RH, Moyer M, Hudson M, McCord

J. Ultra-Rapid Rule-Out for Acute Myocardial Infarction Using the Generation 5 Cardiac Troponin T Assay: Results from the REACTIONUS Study

The objective of this study was to determine how well a new FDA approved single cardiac troponin T Generation 5 (cTnT Gen 5) below the level of quantification (6 ng/L) baseline measurement and a novel study derived baseline/30 minute cTnT Gen 5 algorithm might adequately exclude acute myocardial infarction (AMI) in patients with suspected acute coronary syndrome (ACS) in a United States (US) Emergency Department (ED). They enrolled patients presenting with any symptoms suspicious of ACS. Baseline and 30 minute blood samples were obtained, the cTnT Gen 5 levels later batch analyzed in an independent core lab and the AMI diagnosis was adjudicated by a cardiologist and an emergency physician. They found that a single baseline cTnT Gen 5 measurement <6 mg/L and values at baseline <8 ng/L and a delta 30 minute < 3 ng/L ruled-out AMI in 28.8% and 41.0% of patients respectively. The authors did identify limitations such as single center ED, selection bias and the exclusion of patients with life-threatening illness, cardioversion or defibrillation within 24 hours of presentation, STEMI patients requiring immediate reperfusion or those who were pregnant or breast feeding, and highlighted that additional multi-center US studies evaluating these ultra-rapid AMI ruleout guidelines are needed.

Friederich A, Martin N, Swanson MB, Faine BA, Mohr NM. Normal Saline and Lactated Ringer's have a Similar Effect on Quality of Recovery: A Randomized Controlled Trial

The purpose of this single-site participant- and evaluator-blinded, 2-arm parallel allocation (1:1), comparative effectiveness randomized controlled trial study was to test the hypothesis that balanced crystalloids improve quality of recovery more than normal saline (0.9% sodium chloride, NS) in stable Emergency Department patients. 157 Patients allocated to receiving IV fluids in the ED before discharge to were randomized to receive 2 L of Lactated Ringer's (LR) or NS. The primary outcome was symptom scores measured by the validated Quality of Recovery-40 (QoR-40) instrument (scores 40-200) 24 hours after enrollment. Results showed that there was no difference in post-enrollment QoR scores between NS and LR groups. Although pre-enrollment scores were higher in the LR group, adjusting for pre-survey imbalances did not change the primary outcome. The authors concluded that NS and LR were associated with similar 24-h recovery scores and 7-day health care utilization in stable ED patients.

The advertisement features three black and white photographs on the left: a man holding a baby, a nurse attending to a patient in a hospital bed, and a young boy talking to a female doctor. To the right is a large graphic with the text "ACEP 50 YEARS" in a stylized font, with "50" being the largest and most prominent. The background of the graphic is dark with colorful, abstract brushstrokes in shades of blue, purple, and yellow.

Celebrate the depth and diversity of emergency medicine
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Explore the side of emergency medicine few see – the emotional, the heartbreaking, the thrilling, the heroic – the human side of EM. ACEP's 50th Anniversary Book, *Bring 'Em All*, reveals how far the specialty has come in its short, vibrant life. Famed photographer Eugene Richards captures the breathtaking moments that make the lives & careers of American emergency physicians. [Reserve your copy today.](#)

The advertisement features a photograph of an elderly woman with short grey hair and glasses, wearing a yellow hoodie, looking towards a young female doctor in a white lab coat with a stethoscope. The background is a bright, indoor setting with a vase of yellow flowers. On the left side of the image is the ACEP Geriatric Emergency Department Accreditation logo, which includes a stylized sunburst icon above the text "ACEP Geriatric Emergency Department Accreditation". A red banner at the bottom of the image contains the text "Geriatric Emergency Department Accreditation Program" in white.

ACEP Geriatric
Emergency Department Accreditation

Geriatric Emergency Department Accreditation Program

Interested in GED Accreditation?

Learn how to develop a Geriatric Emergency Department (GED) with this three-hour [geriatric pre-conference](#) during ACEP18. Hear from the geriatric experts who will walk you through the

increasing need for geriatric medicine focusing on GED clinical workflows, training and staff development, geriatric-focused policies and protocols, and achieving [GED accreditation](#). Panel discussions include institutions who have been awarded accreditation.

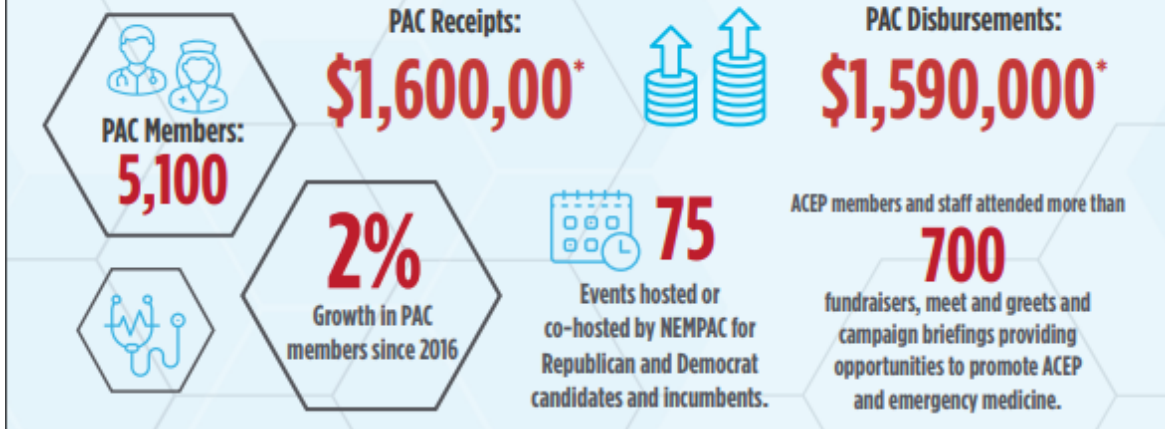


Emergency Ultrasound Tracker

Emergency physicians regularly apply for hospital credentials to perform emergency procedures including emergency ultrasound. Theoretically, ultrasound training, credentialing and billing should be no different than other emergency procedures where training occurs in residency and an attestation letter from the residency is sufficient for local credentialing. When such training occurs outside of residency, “proctored pathways” often serve to assure competency. There is still a lack of understanding and awareness in the general medical community that emergency physicians routinely train in and perform point-of-care ultrasound.

The [Emergency Ultrasound Tracker](#) was created to assist members in achieving official recognition of ultrasound skills. This tool allows you to easily keep track of ultrasound scans you have performed over the course of your career in emergency medicine. It also allows you to upload relevant documents that attest to your training. After inputting and self-attesting to your ultrasound information you may download a letter of recognition from ACEP so long as you have attested to meeting the recommendations for emergency ultrasound training put forth in the [ACEP Ultrasound Guidelines](#). We hope you find this tracker tool helpful and useful in your practice.

NEMPAC 2018 Election Cycle Facts:



NEMPAC Mid-Term Election Update

With the mid-term elections just months away, ACEP and the National Emergency Medicine Political Action Committee (NEMPAC) are focused on electing candidates who will work on bi-partisan solutions to address emergency medicine's most pressing issues. The NEMPAC Board and staff rely on input from ACEP state chapters and local ACEP members when evaluating support for incumbent legislators and new candidates – **we want to hear from you!** NEMPAC is the 4th largest medical PAC and will continue to grow with your support. Learn more about NEMPAC today by visiting [our website](#) or contact [Jeanne Slade](#). Keep an eye on your inbox for additional details about NEMPAC's activities as we get closer to the elections.

ED ICU Development and Operations Workshop Pre-Conference

San Diego Convention Center, Upper Level, 7B
Sunday, September 30, 2018 | 12:30 pm to 5:00 pm

If you have ever considered developing an ED ICU this workshop is for you. Participants will learn about staffing, reimbursement, collaborations, and business plan development, with the goal of developing and running their own ED-ICU. This program is directed at those along the entire continuum of ED-ICU development from conceptual to operational

phases. [Register here](#). For more information, contact [Margaret Montgomery, RN MSN](#).

**NEWS FROM THE
AMERICAN BOARD OF
EMERGENCY MEDICINE –
JULY 2018**



**American Board of
Emergency Medicine**

Subspecialty Certification in Neurocritical Care

The American Board of Medical Specialties (ABMS) has approved subspecialty certification in Neurocritical Care (NCC). NCC is co-sponsored by the American Board of Anesthesiology (ABA), the American Board of Emergency Medicine (ABEM), the American Board of Neurological Surgery, and the American Board of Psychiatry and Neurology (ABPN). Physicians certified by these four boards who meet the eligibility criteria for NCC will have the opportunity to become certified in NCC.

There will be two pathways to certification in NCC: a training pathway and a time-limited practice pathway. The practice pathway will start at the time the first exam is offered. Eligible pathway criteria will be posted on the ABEM website by the end of 2018. ABPN will develop and administer the examination; physicians will submit applications to their primary certifying board. The first examination is expected to take place in either 2020 or 2021.

Letter Available Refuting Merit Badge Requirements

ABEM provides a letter of support that may be submitted to hospital administrators to forego the mandatory completion of short courses or additional certifications ("merit badges") often needed for hospital privileges. Physicians must be participating in the ABEM MOC Program to obtain the letter.

The letter, signed by each representative of the Coalition to Oppose Medical Merit Badges (COMMB), details specific activities that board-certified physicians perform to

maintain certification. ABEM-certified physicians can now download the letter from their Personal Page on the ABEM portal by doing the following:

- Sign in to the ABEM portal at www.abem.org
- On the left navigation, click “Print Verification of ABEM Status”
- Under letter type, click “General Coalition ABEM”
- Click “Continue to Next Step”

Take the ConCert™ Early - Retain Your Current Certificate Date

You can take the ConCert™ Examination during the last five years of your certification (during the annual testing window). If you pass the exam early, you will still retain your certification until the expiration date on your current certificate. This is also true even after you complete all of your MOC requirements. When your current certification expires, you will be issued a new, ten-year certificate. If you take the ConCert™ Examination early and do not pass, you still retain your certification and have another chance(s) to pass it. ABEM only reports whether a physician is board certified and participating in MOC.

In 2017, 44 percent of ConCert™ test takers registered to take the exam early; that is, in a year prior to their final year of certification.

Welcome New Members

Ian James Dryden, MD
Daniel J Grace, MD
Mary Elizabeth Hatch, MD
Kayla King
Emily E Thomas, MD
Duncan E Thomas, MD
James Stewart Wagenaar, DO

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