

A Newsletter for the Members of the Kentucky Chapter

Fall 2018



Daniel J. O'Brien, MD, FACEP
President

[Ashlee Melendez, MSPH, BSN](#)
Executive Director
Phone: 502.852.7874 | [Website](#)

The Practice of Wellness **Martin Huecker, KACEP Education Committee Chair**

Move. Rest. Nutrition. Wisdom. Community.
Build resilience.
Be present.

<https://practiceofwellness.com/>

Leadership and Advocacy Conference **Casey Lawson, MD and Setareh Mohammadie, MD**

University of Kentucky Department of Emergency Medicine

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 meet face-to-face with our Congressional representatives. We are 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 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.



McCaskill Report on Anthem ER Policy Shows Thousands of Denied Claims, Poorly Enacted Policy

If you are seeing an increase in your denied emergency department claims please contact [Ashlee Melendez](#), KACEP Executive Director. KACEP is working with your state legislators and national ACEP to advocate for patient rights and fair payment. [View Full McCaskill Report here.](#)

Patient Balances after Insurance, Uninsured Rate Continue to Rise; Patient Billing More Complex Than Ever

Charity Singleton Craig Freelance writer and editor for CIPROMS

Originally published in CIPROMS Medical Billing [blog](#). Reprinted with permission from CIPROMS.

Patient balances after insurance grew 67 percent from 2012 to 2017, according to a [TransUnion Healthcare study](#) announced earlier this summer.

The good news is that patients with insurance tend to pay more on their balances than self-pay patients. Based on a 2017 [Crowe Horvath analysis](#), uninsured patients pay approximately 6.06 percent on the dollar, while patients with insurance pay 15.51 percent overall.

The bad news is that patients with insurance who have higher and higher deductibles have increasingly lower payment rates. For instance, for patients with balances from \$1,451 to \$5,000, the payment rate is more than 25 percent, but when the balance goes up to \$5,001 through \$7,500, the payment rate is only 10.2 percent. For balances of \$7,501 through \$10,000, the payment rate is 4.1 percent, and with patient balances of more than \$10,000, providers can expect about 0.9 percent payment rate.

Also in the bad news column, a [recent Commonwealth Fund report](#) indicated that the uninsured rate of working adults ages 19 to 64 rose 3.3 percent in 2018. That means more patients who fall into the 6.06-percent-on-the-dollar rate that Crowe Horvath uncovered.

And together, high deductibles and a growing uninsured rate translate into greater patient debt. According to a [July 2018 study published in Health Affairs](#), one in six Americans have past-due health care bills on their credit report, which totals around \$81 billion of debt. And though older Americans typically have greater healthcare expenses, the study found that 11 percent of those with medical bills in collections were 27-years-old — the largest share observed in this new study. Not only did fewer older adults have medical debt, the average size of medical debt decreased as patients grew older, dropping nearly 40 percent from patients age twenty-seven to sixty-four.

As the extent of the problem with patient billing becomes clearer, the potential solutions become more complex.

Point-of-Service Collections

Point-of-service collections are one strategy healthcare providers are using. From the doctor's office to the emergency department to the surgical suite, collecting as much of the patient balance as possible as early as possible means more overall revenue. It also necessitates having the right staff in the right positions, trained and ready for collecting.

"It's one thing to ask insurance companies for money; it's another to ask people for money," said [Louis Longo, managing director at BDO Consulting](#). "Having the right people that know how to effectively and appropriately ask for payment is important."

Collecting money from patients at any point in the revenue cycle, but especially at point-of-service, also means educating patients who may not understand basic features of their health insurance policy or the likelihood of receiving bills from multiple providers for a single visit.

"Many patients today who purchased health insurance for the first time on the Affordable Care Act marketplaces don't fully understand their benefits or health plan design," [writes Brooke Murphy](#). "The responsibility falls on the front-end revenue cycle staff [or any staff member engaging directly with patients] to educate patients."

Multiple Payment Options

Another strategy is to have multiple payment options and to keep expanding that list as technology develops. According to [Black Book's 2017 Revenue Cycle Management survey](#), 62 percent of medical bills were paid online in the first half of 2017 and 95 percent of consumers polled said they'd pay online if given the option.

But providers need to think beyond the typical online patient portal to all the ways patients pay for other kinds of products and services. For instance, 71 percent of respondents in the Black Book survey said mobile pay and billing alerts improved their satisfaction with a provider, and 89 percent of provider financial administrators expect healthcare payments will be made on phones and mobile devices by the end of 2018. However, at the time of the survey, just 20 percent of providers were ready for such electronic payments.

Offering payment plans also may help patients chip away at their balances. In that Health Affairs study referenced above, where 1 in 6 Americans had medical debt, interestingly, more than half of all the bills identified in the study were less than \$600 each. Divided up over a year, that's only \$50 a month, an amount that might be more doable to a cash-strapped patient than the \$600 bill staring him down.

Other technology options, like payment propensity analysis, automated calls and texts, statements sent by email or text, and more, can help providers create a more personalized patient experience that also can improve payment rates.

Pathways to Payment

In addition to providing more payment options once the service is rendered, when it comes to collecting patient balances, providers need to think even further back, before the patient ever comes in to be treated. According to that Blue Book survey, the other two features most in demand are insurance eligibility verification (91 percent) and cost estimation (85 percent). As well, providers can ensure patients receive all possible insurance benefits by taking extra care with prior authorizations, checking for new insurance eligibility with government payers, and by carefully documenting demographic information and other details relevant to submitting claims.

Submitting Clean Claims

Finally, providers need to understand documentation and coding guidelines in order to keep claims being paid at their fullest potential. Payer policies, like Anthem's denial of emergency department claims that they don't consider truly an emergency, mean carefully documenting medical necessity of every service performed is more important than ever.

A Glimmer of Light

There is a small glimmer of light on the horizon. As the healthcare industry continues to shift and change, the tide may be turning away from high deductible health plans.

"Skin-in-the-game isn't working," [Dr. Atul Gawande, the new CEO of a healthcare venture of Amazon, Berkshire Hathaway and JP Morgan Chase tweeted recently](#).

"Average deductibles for employer health plans tripled, and most patients can't afford to do anything except forgo care and treatment."

To that end, the [annual large-business survey by the National Business Group on Health](#), released earlier this week, showed that the share of large employers planning to offer only HDHPs declined for the first time in seven years. Also, the share of employers expecting to offer only HDHPs in 2019 was 30 percent among the 170 companies surveyed, a drop from the 39 percent in 2018.

But what comes next for patients ... and providers ... is yet to be seen.

— All rights reserved. For use or reprint in your blog, website, or publication, please contact us at cipromsmarketing@ciproms.com.

**Practice
management data
you need, from the
medical billing
company
you can trust.**



**With CIPROMS business analytics, your emergency
medicine practice has the data you need to ...**



- ◆ Monitor prudent lay person denials and other payment issues
- ◆ Track and report quality data to government and commercial payers
- ◆ Negotiate with hospitals using your payer and patient payment history
- ◆ Create physician compensation packages based on work performed
- ◆ Determine areas for provider documentation improvement
- ◆ Reconcile to hospital census logs ... and reduce lost charges and revenue

Want more information? Contact me today!



CIPROMS
Medical Billing



Casandra Curtis
VP, Business Development
3600 Woodview Trace, Ste. 400
Indianapolis, IN 46268
Phone: 317.870.0480
www.ciproms.com

Managing ED Utilization

Erin Van Zomeren
Marketing Coordinator
Collective Medical

Only 4 percent of all physicians work in Emergency Departments, but they manage 28 percent of all acute care visits. Because of high ED utilization rates, ED physicians need to make in the moment, informed decisions for better patient outcomes. Physicians in Kentucky are dealing with the same challenges occurring in EDs throughout the country – finite resources coupled with ED overutilization and avoidable readmissions leading to unsustainable costs of care.

In 2012, Washington state was realizing the excessive costs associated with ED overutilization. Washington ACEP, Washington State Medical Association, and Washington State Hospital Association collaborated on a method to effectively manage EDs and reduce overutilization without denying care to their patients.

The coalition identified three main factors behind high ED utilization: chronic medical conditions, substance abuse, and lack of access to primary care. Further investigation revealed that 85 percent of high utilizers had serious mental health issues and 48 percent of high utilizers were struggling with substance abuse. The coalition's program targeted high utilizers by addressing social, mental health, and getting to the root of the patient's substance abuse instead of fueling it or denying them care.

Washington state's answer was the ER is for Emergencies program which began in mid-2012 using the Collective platform as its technical backbone. Collective Medical provides the nation's largest and most effective network for care collaboration. Collective's risk-adjusted event notification and care collaboration platform serves across all points of care, including hospitals, payers, behavioral and physical ambulatory and post-acute settings. Backed by its network, the Collective platform identifies at-risk and complex patients and shares actionable, real-time information with diverse care teams, so they can make better care decisions and improve outcomes. It then enables each of these care team members to collaborate with one another to execute on a single, shared, and consistent plan of care for the patient.

Washington and the other states that have run a similar campaign to ER is for Emergencies, have seen incredible results in reducing medically unnecessary hospital admissions and readmissions, addressing social determinants of health, and mitigating

unnecessary emergency department use by complex patients.

To date, Collective has brought healthcare organizations in 17 states onto its network and care collaboration platform. Many of these states joined the network through state-wide initiatives, including Washington, Oregon, New Mexico, West Virginia, Massachusetts and Virginia. Collective has proven its value in reducing medically unnecessary hospital and ED admission and readmissions and has supported initiatives to mitigate the opioid epidemic.

In Washington, Collective's first state-wide initiative, a [Brookings Institution review](#) of Medicaid patients who visited emergency rooms found that together with the use of the Collective network and platform, the state saved \$34 million in ED costs and experienced a decline of 9.9 percent in overall ED visits in its first year of use, 2013. Likewise, care teams across the state have reduced opioid prescriptions coming out of the ED by 24 percent since the program's inception.

The program has impact on individual hospitals and systems as well. As examples:

CHI St. Anthony Hospital began using the Collective platform to identify patients at risk of readmission and share information with the broader care team. In September 2015, the hospital started with a baseline rate of all-cause 30-day readmissions of eight percent.

- By January 2017, the hospital had reduced all-cause readmissions rates to three percent.
- By June 2018, the hospital had reduced all-cause readmissions rates to 1.72 percent.
- This represents a 78 percent reduction in all-cause 30-day readmissions achieved in less than three years.

CHI St. Anthony also achieved:

- An overall reduction in ED Left Without Being Seen (LWBS) rates from six percent to two percent.
- A reduction in narcotic prepack prescriptions coming out of the ED by 60 percent and realized hospital cost savings of \$200,000.
- A reduction in unnecessary ED visits by identified frequent ED users from 17 percent of overall visits to 4.25 percent within 18 months.

Legacy Salmon Creek Medical Center used the Collective network as the technical backbone to its award-winning readmissions reduction program. Over a 24-month period, the hospital achieved:

- 24.9 percent reduction in all-cause 30-day readmission rates.
- 81 percent reduction in the ED visit rate by high utilizers.
- A reduction in ED visits by high ED utilizers from 3,081 per year to 573.

Media Contacts:

For Collective Medical

Erin Van Zomeren

Marketing Coordinator

801-656-9081

erin.vanzomeren@collectivemedical.com

FOR RELEASE AT 6:50am MT on THURSDAY, OCTOBER 11, 2018

Collective Medical Partners with the Kentucky Hospital Association

Partnership to uniquely foster collaboration enabling Kentucky hospitals to better combat the opioid epidemic

Salt Lake City, Utah —October 11, 2018— [Collective Medical](#), delivering the nation’s largest and most effective network for care collaboration, today announced a partnership with the Kentucky Hospital Association (KHA). The partnership supports providers across the state with real-time information at the point of care to identify and support complex patients. In addition to fostering care collaboration across KHA member hospitals and surrounding regions, the partnership will focus on helping member hospitals identify and support patients with a possible substance use disorder and will prioritize workplace safety and security for care teams.

According to the [National Institute on Drug Abuse](#), Kentucky is among the top ten states with the highest opioid-related overdose deaths—with nearly double the national rate. Related, the state has seen a 37-fold increase in Neonatal Abstinence Syndrome between 2000 and 2013.

“Collective has supported dramatically improved patient outcomes in states across the country, and it has become instrumental for hospitals combatting the opioid epidemic,”

says Melissa Platt MD., of the University of Louisville Health System. U of L Hospital is located in the heart of the Louisville Metro, and is the only Level 1 Trauma Center in the region. Platt continues, “We’re thrilled to join the Collective network and provide our care teams a proven technology to identify and collaborate on our high-risk and complex patients.”

Use of the Collective network and platform is proven to impact the opioid epidemic. As an example, Washington State, where Collective serves as the technical backbone to the state’s groundbreaking [“ER is for Emergencies”](#) program, has seen a 24 percent reduction in opioid prescriptions coming out of the emergency department (ED) since the program’s inception. Likewise, at [Mat-Su Regional Medical Center](#) in Palmer, Alaska, use of the Collective platform combined with statewide prescribing guidelines has resulted in a 61 percent reduction in opioid scripts written between 2015 and 2017 and a 47 percent reduction in opioids given in the ED.

“The Collective network gives our hospital a way to collaborate with other care teams to identify and develop care plans for at-risk and complex patients,” Dennis Johnson, CEO of Hardin Memorial Hospital in Elizabethtown, one of the busiest emergency departments in the state. Johnson adds that, “With Collective, hospitals in Kentucky are empowered to work with each other—and with hospitals across the country—for the benefit of our patients.”

The partnership between Collective and KHA will also target security and safety in the ED, which is a priority not only in Kentucky but in hospitals across the country. The American College of Emergency Physicians (ACEP) [announced results of a recent poll](#) of 3,500 emergency physicians finding that nearly half of those surveyed had been physically assaulted while at work. More than six in 10 of those assaulted say it has occurred within the past year. Likewise, the Occupational Safety and Health Administration [estimates](#) that of the 25,000 workplace assaults that occur annually, 75 percent occur in healthcare and social services settings – and these incidents are under-reported. The Collective network offers a unique way for facilities to record and share security and safety events for the benefit of care teams and patients. The Collective platform offers EDs the opportunity to document when a patient poses a safety threat to care providers, staff, other patients in the ED, or themselves.

“This partnership will foster collaboration between our state’s care teams, making it easier to provide patients with quality care, while achieving the larger goal of curbing the opioid epidemic and prioritizing the safety of hospital staff,” says Mike Rust, president of the Kentucky Hospital Association. “Collective has successfully helped other states

throughout the country, and we're excited to start applying the same collaborative strategies here at home."

Collective is currently partnered with more than a dozen state hospital associations across the U.S. The Collective platform is a real-time, risk-adjusted event notification and care collaboration tool is fueled by collaboration between emergent, inpatient, post-acute, mental and behavioral, and ambulatory settings, as well as stakeholders in ACOs and health plans.

"We're honored to partner with the Kentucky Hospital Association and be a part of the solution in the fight against the opioid epidemic," says Chris Klomp, CEO of Collective Medical. "We're excited to welcome hospitals across Kentucky into the nationwide movement to catch patients before they fall."

Collective is endorsed as a best practice for emergency medicine by the American College of Emergency Physicians and has been recognized by Inc. Magazine and by the MountainWest Capital Network as one of Utah's fastest growing companies.

Learn more about Collective's impact at www.collectivemedical.com.

ABOUT COLLECTIVE MEDICAL

Collective Medical empowers care teams to improve patient outcomes by closing the communication gaps that undermine patient care. With a nationwide network engaged with every national health plan in the country, hundreds of hospitals and health systems and tens of thousands of providers, Collective's system-agnostic platform is trusted by care teams to identify at-risk and complex patients and facilitate actionable collaboration to make better care decisions and improve outcomes. Based in Salt Lake City, Collective is proven to streamline transitions of care, improve coordination across diverse care teams, and reduce medically unnecessary hospital admissions. Learn more at www.collectivemedical.com and [Twitter](#), [Facebook](#), and [LinkedIn](#).

ABOUT THE KENTUCKY HOSPITAL ASSOCIATION

The Kentucky Hospital Association (KHA), established in 1929, represents hospitals, related health care organizations, and integrated health care systems dedicated to sustaining and improving the health status of the citizens of Kentucky.

Media Contacts

For Collective Medical
Kat McDavitt

Chief Marketing Officer

610-392-426

kat.mcdavitt@collectivemedical.com

Costs of Kentucky Legal Liability Climate October 25, 2018

The Lane Report: [Access the report here.](#)

MILLS LECTURE ACEP's Past, Present, and Future Explored By Richard Quinn

The panelists on this year's James D. Mills Jr. Memorial Lecture took a walk through the history of emergency medicine. [Read More](#)



Congratulations to the new KACEP Fellows!

Bradley Buckingham, MD, FACEP


David J Heath, DO, MS, FACEP

Andrew Peter Pacitti, DO, MSc, FACEP

Mark T Rukavina, MD, FACEP

Hugh W Shoff, MD, FACEP

Jonathan F Thomas, MD, FACEP



EDPMA
Emergency Department
Resident Management Association

**Arm Yourself: New
CMS Fee Schedule-
New Opportunities**
An **EDPMA** Workshop

Nov 28-29, 2018
Holiday Inn Express
Nashville Downtown
Conference Center
920 Broadway
Nashville, Tennessee

EDPMA Workshops: Providing RCM Tools for Over 20 Years



Did you know that Kentucky has one of the highest rates of antibiotic prescribing in the country?

[Kentucky Antibiotic Awareness](#) (KAA) is a campaign to reduce inappropriate antibiotic use across the state of Kentucky. KAA is led by health professional researchers from the University of Louisville, Department of Pediatrics, Child and Adolescent Health Research Design and Support Unit (CAHRDS).

New ACEP Information Papers and Resources

The following information papers and resources were recently reviewed by the Board of Directors:

Information Papers:

- [Advocating for a Minimum Benefit Standard Linked to the 80th Percentile of a FAIR Health-Type Usual & Customary Charge Database](#)
- [Emergency Ultrasound Standard Reporting Guidelines](#)
- [Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Medicine](#)

Other Resources:

- [Resources for Emergency Physicians – Reducing Firearm Violence and Improving Firearm Injury Prevention](#)
 - Smart Phrases for Discharge Summaries
 - [CT Scans for Minor Head Injuries](#)
 - [MRI for Low Back Pain](#)
 - [Sexually Transmitted Infection](#)
 - [Why Narcotics Were Not Prescribed](#)
-

Articles of Interest in *Annals of Emergency Medicine* - Fall 2018

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.

Anderson TS, Thombly R, Dudley RA, Lin GA. **Trends in Hospitalization, Readmission and Diagnostic Testing of Patients Presenting to the Emergency Department with Syncope**

The objective of this retrospective population epidemiology study was to determine whether recent guidelines emphasizing limiting hospitalization and advanced diagnostic testing to high-risk patients have changed patterns of syncope care. They used the National Emergency Department Sample from 2006-2014 and the State Inpatient Databases and Emergency Department Databases from 2009 and 2013. The primary outcomes studied were annual incidence rates of syncope ED visits and subsequent hospitalizations, and rates of hospitalization, observation, 30-day revisits, and diagnostic testing comparing 2009 to 2013. Their results showed that although the incidence of ED visits for syncope has increased, hospitalization rates have declined without an adverse effect on ED revisits and that the use of advanced cardiac testing and neuroimaging has increased, driven by growth in testing of patients receiving observation and inpatient care.

Trivedi TK, Glenn M, Hern G, Schriger DL, Sporer KA. **EMS Utilization among Patients on Involuntary Psychiatric Holds and the Safety of a Pre-Hospital Screening Protocol to “Medically Clear” Psychiatric Emergencies in the field, 2011-2016**

The purpose of this retrospective review was to describe overall EMS utilization for patients on involuntary holds, compare patients placed on involuntary holds to all EMS patients, and evaluate the safety of field medical clearance of an established field-screening protocol in Alameda County, California, using the data for all EMS encounters between November 1st, 2011-2016 using County’s standardized dataset. Results showed that 10% of all EMS encounters were for patients on involuntary psychiatric holds and overall, only 0.3% of these encounters required re-transport to a medical ED within 12 hours of arrival to Psychiatric Emergency Services, reinforcing the importance of the effects of mental illness on EMS utilization. [Full text available here.](#)

Yoshida H, Rutman LE, Chen J, Shaffer ML, Migita RT, Enriquez BK, Woodward GA,

Mazor SS. **Waterfalls and Handoffs – A Novel Physician Staffing Model to Decrease Handoffs in a Pediatric Emergency Department**

The objective of this retrospective quality improvement study was to evaluate a novel attending staffing model in an academic pediatric ED that was designed to decrease patient handoffs. The study evaluated the percentage of intradepartmental handoffs before and after implementation of a new novel attending staffing model and included conducting surveys about the perceived impacts of the change. The study analyzed 43,835 patients encounters and found that immediately following implementation of the new model, there was a 25% reduction in the proportion of encounters with patient handoffs. The authors concluded that this new ED physician staffing model with overlapping shifts decreased the proportion of patient handoffs and resulted in improved perceptions of patient safety, ED flow, and job satisfaction in the doctors and charge nurses. [Full text available here.](#)

Jones AR, Patel RP, Marques MB, Donnelly JP, Griffin RL, Pittet JF, Kerby JD, Stephens SW, DeSantis SM, Hess JR, Wang HE, On behalf of the PROPPR study group. **Older blood is associated with increased mortality and adverse events in massively transfused trauma patients: secondary analysis of the PROPPR trial.**

This study sought to determine the association between PRBC age and mortality among trauma patients requiring massive PRBC transfusion using the data from the Pragmatic, Randomized Optimal Platelet and Plasma Ratios (PROPPR) trial. The authors analyzed data from 678 patients and the primary outcome was 24-hour mortality. The results showed that increasing quantities of older PRBCs are associated with increased likelihood of 24-hour mortality in trauma patients receiving massive PRBC transfusion (≥ 10 units), but not in those who receive < 10 units.

Roberts RM, Hersh AL, Shapiro DJ, Fleming-Dutra K, Hicks LA. **Antibiotic Prescriptions Associated with Dental-Related Emergency Department Visits.**

The objective of this study was to quantify how often, and which dental diagnoses seen in the ED resulted in an antibiotic prescription using the National Hospital Ambulatory Medical Care Survey (NHAMCS) data of visits to the ED for dental conditions during 2011-2015. Based on an unweighted 2,125 observations from the NHAMCS in which a dental-related diagnosis was made, there were an estimated 2.2 million ED visits per year for dental-related conditions, which accounted for 1.6% of ED visits. An antibiotic, most often a narrow spectrum penicillin or clindamycin, was prescribed in 65% of ED visits with any dental diagnosis, and the most common dental diagnoses for all ages were unspecified disorder of the teeth and supporting structures (44%), periapical abscess without sinus (21%), and dental caries (18%). Given that the recommended treatments for these conditions are usually dental procedures rather than antibiotics, the results may

indicate the need for greater access to both preventative and urgent care from dentists and other related specialists as well as the need for clearer clinical guidance and provider education related to oral infections.

Interested in Reimbursement for EM?

Apply for the Reimbursement Leadership Development program! Program members will gain a thorough understanding of the EM reimbursement process, be poised to assume reimbursement leadership positions, and obtain a highly valuable skill set that will help them in their professional growth, practice, and path to ACEP leadership. Deadline is Nov. 9. [Apply now](#).



Upcoming CEDR Webinar on November 15

Year 3 Proposed Rule: 2019 Participation in APMs

Speaker: Corey Henderson, Health Insurance Specialist within the Center for Medicare and Medicaid Innovation Center CMS-CMMI | November 15, 2018 1:00 PM CST - [Register Today!](#)



Balanced

ReCharge · ReEnergize · ReFocus

ACEP · Ojai, CA · Feb 19-22, 2019

Introducing Balanced

A new, [physicians-only wellness conference](#) where you can focus on your well-being in your practice and your daily life. Join us February 19-22, 2019 at the beautiful Ojai Valley Inn in Ojai, CA to learn ways to help reduce stresses in your practice. Then, in the afternoon it's time to get out of the course room and spend time participating in the numerous wellness activities available at the resort.

ACEP Doc Blog!

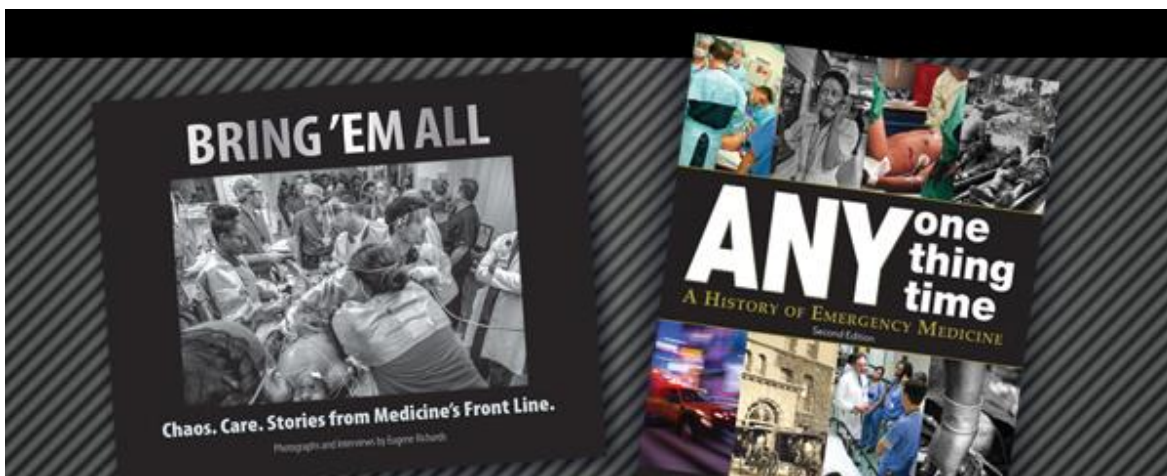
Looking for a way to increase your visibility and reach patients? Consider contributing to the ACEP Doc Blog! The blog lives on the ACEP patient-facing website www.emergencycareforyou.org. The Doc Blog offers plainly worded insight and expertise to patients from emergency physicians. Topics include health and safety tips, “day-in-the-life” experiences, passion projects and more. Our goal is to create short (500 word) posts that help put a human face on emergency medicine. Recent posts:

- [Cats, Dogs and Dander... Oh, My!](#)
- [Dear Patient: A Letter from Your Emergency Physician](#)
- [Your Summer Guide to Bug Bites & Skin Rashes](#)
- [Heat Stroke and Hot Cars](#)
- [Not the Right Time for a Selfie: A Conversation about Hawaii and Volcano Safety](#)

Contact [Steve Arnoff](#) to learn more about contributing to the ACEP Doc Blog.

Want to improve your skills managing behavioral or medical emergencies?

Come join the Coalition on Psychiatric Emergencies (CPE) for a pre-conference workshop on Dec. 12th in Las Vegas Nevada. The Coalition is presenting two pre-conferences: **Critical Topics in Behavioral Emergencies for Emergency Physicians** and **Critical Topics in Emergency Medicine for Psychiatrists**. Come improve your skills and earn CME! The early-bird rate for members is \$149. To view the full schedule and to register, visit the [pre-conference website](#).



ACEP's 50th Anniversary Books

Buy one for yourself or give as a gift! [Bring 'em All](#) and [Anyone, Anything, Anytime](#) available at bookstore.acep.org.

Improve the Care Provided to Older Patients

Become an Accredited Geriatric Emergency Department

Developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter.

ACEP.org/GEDA



Seniors make up 43% of all hospitalizations originating in the ED

In recognition of challenges with older adult presentations, [guidelines to improve ED care for older adults](#) have been established by leaders in emergency medicine. To further improve the care and provide resources needed for these complex older adult presentations, ACEP launched the [Geriatric ED Accreditation Program \(GEDA\)](#) to recognize those emergency departments that provide excellent care to older adults. The program outlines the approach to the care of the elderly ED patient according to expertise and available evidence, with implications for physician practice and ED processes of care. GEDA provides specific criteria and goals for emergency clinicians and administrators to target, designed to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter.

Become accredited and show the public that your institution is focused on the highest standards of care for your community's older citizens.



Providers
Clinical Support
System

With PCSS training, you
can help save lives from
opioid use disorder

By getting MAT trained, you can help
people take their lives back from OUD.

Visit pcssNOW.org

Funding for this initiative was made possible (in part) by grant nos. 5H79TI025595-03, 5U79TI026556-02 and 3U79TI026556-02S1 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Free Medication-Assisted Treatment Training

Eight hours of training on medication-assisted treatment (MAT) is required to obtain a waiver from the Drug Enforcement Agency to prescribe buprenorphine, one of three medications approved by the FDA for the treatment of opioid use disorder. Providers Clinical Support System (PCSS) offers free waiver training for physicians to prescribe medication for the treatment of opioid use disorder. PCSS uses three formats in training on MAT:

- Live eight-hour training
- “Half and Half” format, which involves 3.75 hours of online training and 4.25 hours of face-to-face training.
- Live training (provided in a webinar format) and an online portion that must be completed after participating in the full live training webinar

Trainings are open to all practicing physicians. Residents may take the course and apply for their waiver when they receive their DEA license. For upcoming trainings consult the [MAT Waiver Training Calendar](#). For more information on PCSS, [click here](#). For more information on MAT training, email [Sam Shahid](mailto:Sam.Shahid@pcssnow.org).



Funding for this initiative was made possible (in part) by grant no. 1H79T1080816-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Call for Consultants - SAMHSA State Targeted Response Technical Assistance (STR-TA) Initiative

Join over the 500 Treatment Technical Assistance (TA) Consultants already participating in the initiative to target the opioid epidemic. TA Consultant responsibilities would include:

- Supporting local multidisciplinary TA teams to provide expert consultation to providers in the delivery of OUD services (up to 10 hours a week). When asked to provide TA expertise consultants will be compensated \$100/hour for up to 10 hours a week.
- Participate in web-based training
- Participate in train-the-trainer activities (as needed)

ACEP is one of the partners in the SAMHSA STR-TA Initiative. Please email [Sam Shahid](#) for more information.



NEMPAC On Track to Reach Record Fundraising Goal

While celebrating ACEP's 50th Anniversary's in San Diego, hundreds of ACEP members also confirmed and celebrated their commitment to advocacy on behalf of emergency medicine and patients. As in years past, ACEP Council members stepped up to the plate during the NEMPAC Council Challenge to ensure that emergency medicine stays at the top of the leaderboard among medical PACs.

NEMPAC collected a record total of more than \$350,000 from Council members. Of note is the strong support by all Council members representing the Emergency Medicine Resident Association (EMRA), who strive each year to be the first group within the Council to reach 100-percent participation at the premier "Give-a-Shift" donor level. Thirty-nine state chapters and the Government Services chapter reached 100-percent participation this year. In addition, 38 Past-Presidents and Past-Council Speakers met the challenge of NEMPAC Chairman Peter Jacoby, MD, FACEP and added their support. Combined with thousands of donations from ACEP members across the country, NEMPAC is well on its way to setting an all-time fundraising record to reach a goal of \$2.3 million for the 2018 cycle.

This outpouring of support in a pivotal election year will ensure that NEMPAC can continue to educate new and veteran lawmakers and help emergency medicine identify friends and champions in Congress so that ACEP's ambitious legislative agenda stays on course. NEMPAC is tracking to contribute more than \$2 million to 27 Senate candidates and 160 House races. Candidates worthy of NEMPAC support are vetted and approved by the NEMPAC Board of Trustees who value those who will support emergency medicine issues and are committed to bipartisan advocacy.

Read the [full-length article](#) published in ACEP Now on October 3.

For more information about NEMPAC, visit [our website](#) or contact [Jeanne Slade](#).

Welcome New Members

Michael Baker
Olivia Makenzie Boyette
Camila Calderon
Bradley Casey, III
Baroosh Durrani
Nick Fahey
Ronald D Fleming, DO
Scott Michael Goodwin
Brandon Kyle Hamm
Imtiaz Hussain, MD
Jessica Leigh Javed
Kathryn Terri Knutson
Madison Bentley Kommor
Elizabeth Lehto, MD
Robin Lund, MD
Andrew Stricklin
Paige Allison Swan
Katie Ellen Thacker
Slade Thompson, MD
Edgar M VanHorne, MD
Matthew James Wilson

**Kentucky Chapter ACEP, P.O. Box 2831,
Louisville, KY 40201**

Copyright © 2018 Kentucky Chapter ACEP. All rights reserved.