

A Newsletter for the Members of the Kentucky Chapter

Winter 2019



Timothy G Price, MD, FACEP
KACEP President

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Meet the President **Timothy G Price, MD, FACEP**

Dr. Tim Price is an Associate Professor at the University of Louisville, Department of Emergency Medicine (DEM), where he has worked for over 22 years. Although emergency medicine has been his career, Emergency Medical Services (EMS) is his passion. Tim is the Chief of the Division of EMS and Director of the EMS Fellowship in the department as well as the Medical Director for Anchorage/Middletown Fire and EMS.



Tim has been involved with the KY Chapter of ACEP since 1996. He has been chair of the Education Committee, EMS Committee, President Elect and now President. He also serves as an alternate Councillor for national ACEP as a KACEP representative.

Tim's hobbies include flying airplanes and admiring his new grandson, Lance.

Assault From All Fronts

Melissa Platt, MD, FACEP

Chair, Reimbursement Committee

Emergency medicine is the only specialty that is obligated to see patients regardless of the ability to pay 24/7/365. We are touted as the safety net for a fractured healthcare system (and I use "system" in the loosest sense). Society has relied on us to help in the greatest time of need, to fill in where others refuse, to be cost effective and to never be wrong. It has become a presumed right and an assumption that we will always be there. These demands come at a cost that insurance companies are no longer willing to pay. Over the last several years, there has been an all-out assault on our practice of medicine with attacks on multiple fronts.

Insurance companies are at it once again, but have they really ever stopped. Hopefully by now, everyone knows that Anthem had been retrospectively denying payment for care that had been deemed as non-emergent. While they state that there is not a denial diagnosis list, they do admit that non-physicians review the charts to deem appropriateness. At the very least, we have to waste precious administrative time fighting insurance denials. Emergency medicine rallied troops to fight the denials even having ACEP file suit against Anthem but the battle took on another dimension.

Insurance companies sent letters to their clients warning them that their emergency department visit might not be covered if it wasn't a true emergency. This scare tactic had left patients to try to decide if what they were experiencing was something serious. Personally, I think that this is demeaning to patients because insurance companies first gut reaction is to assume people are inappropriately using the emergency department. The majority of ED patients come because they are experiencing what they believe is worthy of treatment. They don't just come to hang out with us. No one wants to be an ED at 4 am. The insurance companies took their battle to their clients. Their clients have yet to challenge this in an organized fashion. I can only imagine how daunting of a task this

would seem.

The newest fight, a flyer went out to Kentucky Medicaid recipients that there is now an \$8 co-pay for emergency department visits of a non-urgent matter. How is the patient again to know if something is urgent or non-urgent? What if there is no other place for these patients to go at 3 am? How is it feasible to collect a co-pay when the insurance companies' definition of non-urgent is not known until well after the visit has ended? But yet, this is exactly what Medicaid has implemented and the battle continues.

Copays

A copay is a fee that is charged for some health care services. If you receive a service that requires a copay, you pay the provider at the time of service. You can ask if there is a copay when you schedule an appointment. The list of services that will require a copay are below.

Service or Item	Copay
Generic drug	\$1
Brand-name drug that does not have a generic	\$1
Brand-name drug that has a generic version available	\$4
Specialty visits (chiropractor, dental, vision, podiatry (foot))	\$3
Therapy services (physical therapy, speech therapy, occupational therapy)	\$3
Office visit (with a physician, physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, nurse midwife or any behavioral health professional)	\$3
Laboratory, diagnostic, or X-ray service	\$3
Outpatient hospital service	\$4
Durable medical equipment	\$4
Outpatient surgery (ambulatory surgical center)	\$4
Emergency room visit for a nonemergency service	\$8
Inpatient services (hospital admission or mental health/substance abuse admission)	\$50

EDIE UPDATE

Wes Brewer, MD, FACEP

So what's not to like about a program that saves money, improves patient care and makes our professional lives easier. Several of your Board members have been working with Collective Medical Technologies to bring EDIE to Kentucky. This is an emergency department pre manage program that we hope to deploy in the near future. This program grew out of a payment crisis in Washington and has spread to several states including some of our border states. It is a computer program that helps to fill in the deficiencies that plague many of our electronic record systems.

When a patient registers in the emergency department EDIE searches for other nearby ED visits, recent advanced imaging studies, care plans and queries KASPER before you even see the patient. Knowing that a patient has already had 6 negative CT scans in the last month and been prescribed 120 Percocet yesterday at another facility seems like information that should be obtainable but up until now is generally quite elusive. There have been quite a few meetings with stakeholders with significant enthusiasm generated. While one may never be certain that anything is predictable about Kentucky politics, I believe a critical mass is coming on board and my hope is that over the near future we will have some positive news to report and this system will be rolled out statewide. We will keep you posted.

The Practice of Wellness

Martin Huecker, MD

Chair, Education Committee

Move. Rest. Nutrition. Wisdom. Community.

Build resilience.

Be present.

Hey everyone! Hope you had a fulfilling week. Here are some ideas for wellness practice.

Carnivores:

- [Cool article](#) on Mongolian steppe dwellers based on archeologic remains. They reconstruct a traditional pastoral lifestyle where people lived in small groups, relied on a protein-rich diet and used animals for transportation. They found one dental cavity out of 252 teeth. Three people (out of 25) had inflammatory conditions. The proportion of old adults in the sample, and the fact that the pathologies recorded are predominantly the result of trauma and old age, illustrate a life with very little chronic morbidity.
- Schmorl's nodes in the spine and patterns of degenerative joint disease are suggestive of interpersonal violence, close contact with animals, and horse riding.
- An excerpt from Genghis Khan and the Making of the Modern World hit twitter recently, describing how the mongol army would survive on meat and dairy, and could live days without eating, giving them an advantage over the people they conquered. Ketogenic diets are unnatural though.

Meat is the enemy?:

- People are talking about the new Lancet EAT guideline article ([summary here](#)), basically condemning meat and recommending a vegetarian lifestyle. Of course many in the Paleo community are revolting, most making sound arguments.
- Diana Rogers of Sustainable Dish posted [this criticism](#) of the guidelines, backing up her 20 points with evidence. One quote: "On this diet you can eat 8 tsp of sugar but 1/4 egg per day."

Stress to Live Longer:

- Cool [article from Bloomberg](#) on the hardiness of Holocaust survivors. They cover a [JAMA publication](#) out of Israel. The bottom line is that those who were able to survive the Holocaust lived longer than aged matched individuals who did not suffer through such a thing. They compare this to data from US Civil War POWs with similar longevity.
- The author seems to argue for the resilience of the folks who do make it through trauma, sort of a survival of fittest. They don't discuss the epigenetic hormetic effect of living through tough times and enjoying an extended life span.

Krill:

- You want to have higher omega 3 content in your diet. But you hate to eat fish, you don't want to drink a spoon of fish oil, and you don't want the rancid oil in fish oil capsules. There is an answer.
- Krill oil comes from tiny shrimp-like creatures. This oil is somewhat lower in omega 3 content, but is more stable on the shelf. Krill oil also has astaxanthin, a molecule known to have anti-inflammatory properties, protecting against UV light and skin damage, with a host of other benefits.
- [This post](#) by Tim Ferriss covers the many reasons to take krill oil. Check out Mega Red, or the good old Kirkland brand which is almost identical but cheaper. Get some Kirkland jeans while you're at Costco.

Loving the Stranger:

- If you have not heard of Jonathan Sacks, check him out asap. A Rabbi in Great Britain, Sacks is a prolific author of books, but also free content on his site rabbisacks.org. He has a weekly segment that I just found out about!
- [A recent post](#) covered the topic of xenophobia, how tribalism pushes us to hate those who are different from us. Many religious faiths, though not always all-inclusive, do teach that we should love all people, even as much as we love ourselves. Think about this with family and friends on the other side of the political divide, with patients in different socioeconomic situations, with other drivers on the road, etc.

Quote:

The Torah asks, why should you not hate the stranger? Because you once stood where he stands now. There is only one reply strong enough to answer the question: Why should I not hate the stranger? Because the stranger is me. - Rabbi Sacks

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WEBSITE: <https://practiceofwellness.com>

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Instagram (Practice_of_Wellness)

If you know anyone who might benefit from the newsletter, just forward it along. They can [SUBSCRIBE HERE](#).

The New KY Drivers License: Get Ready for Changes KY Department of Transportation

Kentucky is making significant improvements to increase the security of the identity credential you rely on most through the Confident Kentucky initiative. Following a statewide rollout starting in March 2019 and ending in May, all driver's licenses, permits and personal IDs will have new security features, arrive in the mail 5-10 business days after residents apply at their local Circuit Court Clerk's office, will be moving to an eight-year lifespan and have new pricing. Once available in your county of residence, the next time you renew your current credential or if you are a first-time cardholder, you'll choose a credential in one of two new versions: standard or Voluntary Travel ID credential. Voluntary Travel ID versions have all the benefits of a standard credential plus they are federally accepted to board U.S. domestic flights and access restricted federal facilities once REAL ID enforcement begins nationwide on October 1, 2020. Documentation is required when applying for a Voluntary Travel ID, if you are a first-time cardholder or if you want a standard credential and your personal information has changed. Be confident you'll arrive prepared when applying for a new credential by following the steps at the link below or choosing from the menu of resources.

<https://drive.ky.gov/ConfidentKY/Pages/default.aspx>



The Kentucky Physicians Leadership Institute (KPLI) is the premier leadership training program for physicians in Kentucky. Each year, this exclusive program will select up to 15 physicians to participate in a series of learning events that will cultivate the growth of physician leaders across the state. The four primary events, culminating in the KMA Leadership Academy, will help address many of the challenges facing the physician community.

The success of this program is evident in the continued work of almost 30 graduates. These individuals have accepted new positions and promotions, have testified before the Kentucky General Assembly on legislative issues of importance to physicians, have appeared in television and print media and much more.

The Kentucky Physicians Leadership Institute was also awarded the AO Sullivan Excellence in Education Award from Medistar in 2018.

If you are interested in applying for the institute, please contact KMA Director of Education Miranda Mosley at 502-426-6200 or submit an application to her [via email](#).

Welcome New Member

Alexander Caleb Cooke

NEWS FROM ACEP



Bedside Tools

ACEP has a number of web-based tools for you to use at the bedside. From sepsis, to acute pain to agitation in the elderly – we've got you covered!

- [ADEPT](#) - Confusion and Agitation in the Elderly ED Patient
- [ICAR2E](#) - A tool for managing suicidal patients in the ED
- [DART](#) - A tool to guide the early recognition and treatment of sepsis and septic shock
- [MAP](#) - Managing Acute Pain in the ED
- [BEAM](#) - Bariatric Examination, Assessment, and Management in the Emergency Department. For the patient with potential complications after bariatric surgery

Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline

The new ACEP policy statement, *Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline*, was approved by the Board in September 2018 and has been endorsed by several other organizations. [Read the final version of the policy here.](#)

Social Media Policy

Make sure you're protecting yourself. ACEP has a new social media policy to help keep you and your patients safe. [Read the policy here.](#)

New Policy Statements, PREP and Information Paper

During their January 2019 meeting, the ACEP Board of Directors approved the following new or revised policy statements/PREP/information paper:

New Policy Statements:

[Autonomous Self-Driving Vehicles](#)

[Reporting of Vaccine Related Adverse Events](#)

Revised Policy Statements:

[Advertising and Publicity of Emergency Medical Care](#)

[Economic Credentialing](#)

[Emergency Physician Stewardship of Finite Resources](#)

[Medical Services Coding](#)

[Patient Information Systems](#)

[Providing Telephone Advice from the ED](#)

Revised Policy Resource and Education Paper (PREP)

[Military Emergency Medical Services](#)

New Information Paper:

[Suicide Contagion in Adolescents: The Role of the Emergency Department](#)

Articles of Interest in *Annals of Emergency Medicine* - Winter 2019

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.

Shih HM, Chen YC, Chen CY, Huang FW, Chang SS, Yu SH, Wu SY, Chen

WK. Derivation and Validation of SWAP Score for Very Early Prediction of Neurological Outcome in Patients with Out-of-Hospital Cardiac Arrest.

The aim of this study was to establish a simple and useful assessment tool for rapidly estimating the prognosis of patients with out-of-hospital cardiac arrest (OHCA) after their arrival at an emergency department (ED). A total of 852 patients admitted from January 1, 2015 to June 30, 2017 were prospectively registered and enrolled into the derivation cohort. Multivariate logistic regression on this cohort identified four independent factors associated with unfavorable outcomes: initial nonshockable rhythm, no witness of collapse, age >60 years, and pH \leq 7.00. The shockable rhythm–witness–age–pH (SWAP) score was developed and one point was assigned to each predictor. For a SWAP score of 4, the specificity was 97.14% for unfavorable outcomes in the derivation cohort. The study concluded that the SWAP score is a simple and useful predictive model that may provide information for the very early estimation of prognosis for patients with OHCA.

Chinn E, Friedman BW, Naeem F, Irizarry E, Afrifa F, Zias E, Jones MP, Pearlman S, Chertoff A, Wollowitz A, Gallagher EJ. **Randomized Trial of Intravenous Lidocaine versus Hydromorphone for Acute Abdominal Pain in the Emergency Department.**

This randomized, double blind clinical trial compared the efficacy and safety of intravenous lidocaine to that of hydromorphone for the treatment of acute abdominal pain in two emergency department (ED) in the Bronx, NY. Adults weighing 60-120 kg were randomized to receive 120 mg of IV lidocaine or 1 mg of IV hydromorphone. 30 minutes after administration of the first dose of study drug, participants were asked if they needed a second dose of the investigational medication to which they were randomized. The primary outcome was improvement in 0-10 pain scores between baseline and 90 minutes. Out of the 154 patients enrolled, 77 received lidocaine and 77 received hydromorphone and by 90 minutes, patients randomized to lidocaine improved by a mean of 3.8 points on the 0-10 scale, while those randomized to hydromorphone improved by a mean of 5.0 points. The study concluded that IV hydromorphone was superior to IV lidocaine, both for general abdominal pain and a subset with nephrolithiasis.

Ballard DW, Kuppermann N, Vinson DR, Tham E, Hoffman JM, Swietlik M, Davies SJD, Alessandrini EA, Tzimenatos L, Bajaj L, Mark DG, Offerman SR, Uli K. Chettipally UK, Paterno MD, Schaeffer MH, Richards R, Casper TC, Goldberg HS, Grundmeier RW and Dayan PS, for the Pediatric Emergency Care Applied Research Network (PECARN), Clinical Research on Emergency Services and Treatment (CREST) Network, and Partners HealthCare. **Implementation of a Clinical Decision Support System for Children with Minor Blunt Head Trauma at Non-negligible Risk for Traumatic Brain Injuries.**

This study utilized a secondary analysis of a non-randomized clinical trial with concurrent controls conducted at 5 pediatric and 8 general EDs between 11/2011 and 6/2014, enrolling patients <18 years-old with minor blunt head trauma. After a baseline period, intervention sites received electronic clinical decision support (CDS) providing patient-level ciTBI risk estimates and management recommendations. The following primary outcomes in patients with 1 intermediate PECARN risk factor were compared pre- and post-CDS: (1) ED computed tomography (CT) proportion adjusting for age, time trend, and site and (2) prevalence of ciTBI. The results showed that providing specific risks of ciTBI via electronic CDS was associated with a modest and safe decrease in ED CT use in children at non-negligible risk of ciTBI. [Full text available here.](#)

Akhlaghi N, Payandemehr P, Yaseri M, Akhlaghi AA Abdolrazaghnejad

A. Premedication with Midazolam or Haloperidol to Prevent Recovery Agitation in Adults Undergoing Procedural Sedation with Ketamine: A Randomized Double-Blind Clinical Trial

This study evaluated the effect of midazolam and haloperidol premedication for reducing ketamine-induced recovery agitation in adult patients undergoing procedural sedation. They randomized emergency department patients older than 18 years who needed procedural sedation to receive one of the following three interventions in double-blind fashion 5 minutes prior to receiving ketamine 1 mg/kg IV: distilled water IV, midazolam 0.05 mg/kg IV, or haloperidol 5 mg IV. The main study outcomes were recovery agitation as assessed by the maximum observed Pittsburgh Agitation Scale (PAS), and by the Richmond Agitation-Sedation Scale (RASS) at 5, 15, and 30 minutes after ketamine administration. For the 185 patients undergoing adult procedural sedation, premedication with either midazolam 0.05 mg/kg or haloperidol 5 mg IV was shown to significantly reduce ketamine-induced recovery agitation while simultaneously delaying recovery.

[Full text available here.](#)

Remick K, Gausche-Hill M, Joseph MM, Brown K, Snow SK, Wright JL, AAP Committee on Pediatric Emergency Medicine and Section on Surgery, ACEP Pediatric Emergency Medicine Committee, ENA Pediatric Committee. **Pediatric Readiness in the Emergency Department**

The American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) published updated joint guidelines, "Pediatric Readiness in the Emergency Department," that recommend ways health care providers can make sure every injured or critically ill child receives the best care possible. The joint policy statement, published in the November 2018, represents a revision of the 2009 policy statement and highlights recent advances in pediatric emergency care that may be incorporated into all emergency departments that

care for children. The statement emphasizes the importance of evidence-based guidelines and includes additional recommendations for quality improvement plans focusing on children and disaster preparedness. [Link to *Annals* publication.](#)



See Your Impact

You serve your community. ACEP is honored to serve you. Since 1968, ACEP has united and amplified the collective voice of emergency physicians across the world. We know you face challenges, and it's our mission to protect your interests and make it easier for you to provide the highest quality care for your patients. As an ACEP member, you are a direct contributor to important initiatives that propel the profession forward. Our [2018 Annual Report](#) illustrates how your support makes an incredible impact on emergency medicine.



embrs

Emergency Medicine Basic Research Skills

Are you interested in increasing and improving research in emergency medicine?

[Emergency Medicine Basic Research Skills \(EMBRs\)](#) is a 9-day, 2-session program where participants learn how to identify clinical research opportunities and become familiar with clinical research and outcomes. Participants are also eligible to receive an EMF/EMBRs grant based on their research grant application. This course targets: Junior faculty with limited research experience; Physicians in academic and community centers who are interested in research basics; Physicians who have as part of their duties involvement in research, including mentoring young researchers; Fellows in non-research fellowships.

[Click here to learn more](#) and to put your name on the interest list. The next course will take place Dec. 2-7th, 2019 (session 1) and April 14-16, 2020 (session 2).

MOC Made Easy

The [New ACEP MOC Center](#) is the "easy button" for MOC! It's a One-Stop-Shop to keep it all together and on track for all things MOC. See what you have to do to stay certified AND what resources ACEP has to help you do it.

ABEM has made (at least) three big changes in the way they present MOC information to diplomates – 1) they launched a new website, 2) they changed the names and order of the MOC components, and 3) they changed the language they use to describe them (no more "Part" anything). ABEM also announced an alternative to the ConCert Exam, which they'll pilot in 2020 and launch in 2021.

**NEWS FROM THE
AMERICAN BOARD OF
EMERGENCY MEDICINE
FEBRUARY 2019**



**American Board of
Emergency Medicine**

Letter Available to Request Becoming ED Designated Trainer for Lab Procedures

ABEM can provide a letter of support to ABEM-certified physicians to request that their hospital laboratory director apply for a waiver for ED point-of-care (POC) testing. If the waiver is granted, a designated trainer, who may be an emergency physician, can provide annual competency testing to other ED personnel for POC testing procedures, such as hemocult or urine pregnancy testing, etc. Waivers to allow POC testing by ED personnel help reduce the burden that emergency physicians face by having to undergo annual training by a laboratory representative as well as expedite patient throughput.

The letter and additional information about the waiver are available from physicians' Personal Page on the ABEM portal. To download the letter:

- Sign in to the [ABEM portal](#)
- On the left navigation, click "Print Verification of ABEM Status"
- Under letter type, click "POCT"
- Click "Continue to Next Step"

The letter is available to physicians participating in the ABEM MOC Program.

This is the most recent letter resulting from the continuing efforts of the Coalition to Oppose Medical Merit Badges (COMMB) and is signed by each representative of the Coalition. The rationale for the letter is that physicians participating in MOC have the knowledge, skills, and abilities to provide such training. Also available is a general letter stating that ABEM certification supersedes the need to complete "merit badge" requirements. That letter explains that ABEM's MOC Program is a rigorous form of continuous professional development that contains content critical to the practice of Emergency Medicine, including procedural sedation, cardiovascular care, airway management, trauma care, stroke management, and pediatric acute care.

Certification, therefore, supersedes the need for certifications sometimes required for medical staff privileges or disease-specific care center designations.

ConCert Fast Facts

- The ConCert Exam is available twice per year—in the spring and the fall
- You can register and take the ConCert Exam during any examination administration in the last five years of your certification
- You do not have to complete all other MOC requirements to register early for the ConCert Exam
- Completing your MOC requirements early does **NOT** reset your certification expiration date (it will be good for the entire ten-year period)
- If you complete your requirements early, your new certificate will be sent toward the end of the final year of your current certification
- 60 *AMA PRA Category 1™ Credits* are available at no charge for passing the ConCert Exam and completing all other MOC requirements (go to www.abem.org, and click on “Stay Certified,” and “CME Credit Available for ABEM Activities” for more information)

If you have any questions about the ConCert Exam or other MOC requirements, please contact ABEM at 517.332.4800, ext. 383, or moc@abem.org.

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