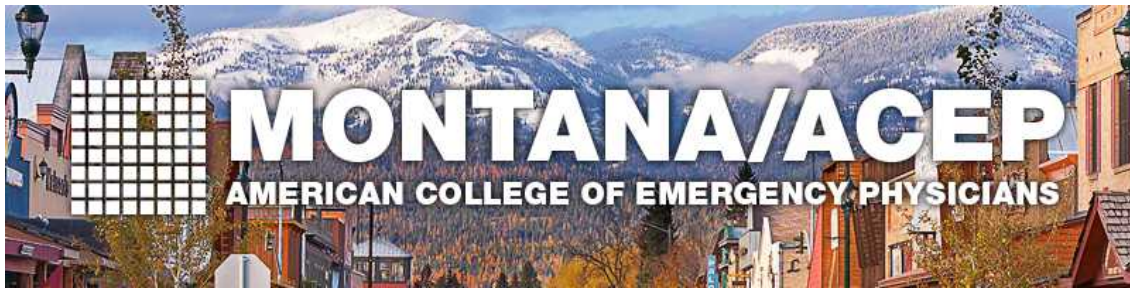


A Newsletter for the Members of the Montana ACEP Chapter



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## **From the Immediate Past President Harry E. Sibold, MD, FACEP**

### **Don't Believe It's Over Yet**

It appears that we may be in for another unusual flu season. Most of us have had a rather mild season up to now. As of the end of February, the CDC is reporting continued high levels of influenza activity though. The CDC is predicting our flu season could continue "for several more weeks, or even months". So far, it has not matched last year, where 80,000 died nationwide, but the continued high incidence levels are concerning. Just last week, they warned that a more severe H3N2 strain was accounting for nearly half of new cases.

Montana is ranked in the highest tier of Influenza Activity level by the CDC's Disease Control and Prevention Section. So, unfortunately, it's not over yet!... Keep this in your differential for those with typical symptoms.

### **Can I Have My Diet Coke, Please?**

It has been distressing for some of us that eating or even having a cup of coffee or diet coke at the work station was "outlawed" for so long. It seemed inhumane to be tied to your work station for hours at a time with barely the ability for a bathroom break, much less time to take in some fuel, caffeine or hydration during your shift.

Recently, however, the Joint Commission clarified that emergency staff can eat at an ED work station during their shift. OSHA also does not have a prohibition on eating or drinking. Common sense speaks to cleanliness and customary infection control, but your cup of java or diet beverage will no longer make you a desperado or joint commission criminal!!! Your hospital may not yet know of this, so ACEP has FAQs and information on how to advocate with your facility for policy change, if needed.

Click [here](#) for the ACEP article with resources.

### **Rural Hospitals Closing**

In February, a study was published reporting that 1 in 5 hospitals in rural areas are at risk of closing. Two thirds of those at-risk hospitals are essential to their communities. It stated: "as rural populations decline, inpatient admissions fall, more beds sit vacant, and the number of people covered by government-sponsored plans rises, these communities are left to grapple with the ramifications of losing a hospital". Though the study suggested no solutions to the problem, it is worth staying informed about this given the proportion of our state that relies on rural care.

### **2019 Montana Legislative Session**

Our 2019 Legislative session rolls on! There is proposed legislation on everything from opting out of vaccinations for students in public schools to requiring that WICHE/WWAMI positions be allocated by lottery to statutory limits on new opioid prescriptions.

Briefly, I wanted to share where to go to search out bills that may be of interest. Simply click [here](#) to search for a bill. There you can search for proposed legislation of interest or even set up an account (free) in order to track bills as they progress and send you automatic notification of changes. Your involvement can be as simple as providing written comment to law makers as they consider bills moving through the legislature. As experts on emergency care, if we aren't involved, we are missing the chance to affect Montanans' health and safety in a positive manner.

## **Adriana's Corner**

### **Member of the Year!**

Often, I hear a positive story about how one of you went above and beyond to help a patient, fellow colleague or the chapter. I feel recognition is deserved for your outstanding service to emergency medicine. Do you agree?

For this reason, we are looking for a **Chapter Member of the Year!**

When you hear about a fellow colleague, member of the chapter, who deserves recognition for demonstrating outstanding service through commitment, passion, professionalism and dedication to any aspect of emergency medicine, let me know. Send me an [email](#) with details about why recognition is deserved. I will make sure recognition is given!

A well-deserved recognition will be given via the chapter e-newsletter, the chapter website and/or announced at any upcoming chapter event. He/she will be the **Montana Chapter Member of the Year** and will have his/her name, photo and bio placed on the chapter website for the entire year.

As always, please feel free to contact [me](#) if you have any questions about the chapter and/or your membership with National ACEP or the Montana Chapter.

## **Welcome New Chapter Member**

Greg Doctor - Medical Student

## 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 ≤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.



### **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](http://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](mailto:moc@abem.org).

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