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President's Letter

Kathryn K. Dierks, DO, FACEP

Greetings, my fellow emergency medicine colleagues!

I hope you are enjoying this beautiful fall weather. As I write this I am looking out across Iowa's breathtaking landscape at the kaleidoscope of orange, red and yellow leaves. The Mississippi River is calm and glistening today providing a reflection of the changing tress. Barges are slowly floating along the river making their last trips down the river. This is just one of the many reasons Iowa has stolen my heart and claimed me as one of its own. What I love even more about Iowa is the community of physicians that share a deep passion and dedication to ensuring that our patients receive superior care and fair coverage. This is a community of physicians that makes me proud to work in Iowa.

Our Iowa ACEP Board continues to work closely with Iowa Medicaid regarding the change in reimbursement that went into effect starting August 1, 2018. In July, the Iowa Department of Health Services (IDHS) released Informational Letter NO-1919 detailing the following:

- "starting August 1, 2018, a claim for an emergent service must contain an approved emergent diagnosis in the primary (first) position to receive the full reimbursement amount of the claim. If the primary (first) diagnosis on the claim is not emergent, the member will be responsible for any applicable copay amounts."

Included with the information letter was a list of 721 ICD-10 diagnoses codes that are now considered to be "non-emergent" diagnoses and will no longer receive full reimbursement. They will now receive only 50% reimbursement and require Medicaid patients to pay a copay. Diagnoses that are now on the "non-emergent" list including diagnoses such as chest pain, abdominal pain, epigastric pain, fever and headache. All of the codes on the list are those diagnoses that we use every day after we have performed our federally mandated EMTALA medical screening exam and have ruled out life threatening emergencies.

In addition to the major conflict with our EMTALA obligation, this new change is further problematic because it violates the federal prudent layperson standard and places the burden of self- diagnosis on the patient. All of these diagnoses carry chief complaints that could potentially carry a life-threatening diagnosis that any prudent layperson could expect that, without emergency department evaluation, they could potentially die. For example, if a patient with a history of coronary artery disease is experiencing chest pain, he will present to the

Emergency Department (ED) for assessment of his chest pain and determination of whether or not a life-threatening condition exists. In some cases, we determine that the chest pain is benign and in other cases the chest pain may be related to emergent causes such as unstable angina, myocardial infarction or heart failure. However, these diagnoses are made after work up is performed.

We drafted a letter to Governor Kim Reynolds and Medicaid director Mike Randol to address our concerns, and as a result we had the pleasure of meeting with Director Randol at the state capitol in Des Moines. Although Medicaid was not willing to redact their letter and restore the 721 diagnoses codes to the “emergent list,” we asked if they could restore the top 20 of our most common diagnoses/chief complaints that can pose imminent threat to life back onto the list. After much negotiation, Medicaid will only be placing four codes back onto the list including chest pain unspecified, chest pain other, abdominal pain and fever, with a provision that they will be placed back on the list starting January 1, 2019. In the interim, our hospitals will continue to lose money for caring for these patients.

Although we have made slight progress, we still have a long way to go to ensure that our patients are protected and ensure that we can keep the doors open to our emergency departments to care for those who need us most. We are partnering with the Iowa Medical Society (IMS), National ACEP, and Georgia ACEP to move forward with this issue and have several upcoming meetings. Georgia is facing a similar issue with Anthem Blue Cross for which National ACEP has filed a lawsuit. We appreciate the support of our colleagues!

We will continue to fight for what is right for patients and providers and to protect our specialty. We are the safety net for the community. We are here to help patients no matter who they are, regardless of their ability to pay, and no matter what time of day. We are emergency medicine!

If you would like to participate with our Iowa ACEP advocacy team, please contact me by clicking [here](#). Also, if there are any other issues you are facing in your hospitals or communities, please let us know so that we can work together!

Congressional Visits

Kathryn K. Dierks, DO, FACEP

I live in the Quad Cities and work at Genesis Medical Center, which is located in the state’s 2nd district. Congressman Dave Loebsack has been our representative since 2007 and has been a huge support to Iowa and National ACEP. My esteemed colleague, Dr. Kelly Douglas, and I had the distinct pleasure of meeting with Congressman Loebsack at Genesis on October 12. We discussed primarily the Iowa Medicaid reimbursements changes and the need for mental health funding. Congressman Loebsack listened very astutely to our concerns and expressed his ongoing support for these issues. He shares our same concern for how

privatization of Medicaid is impacting the delivery of care in Iowa and will do his best to ensure changes are made for the protection of our patients and our specialty. He continues to make mental health funding a top priority in this state. As funding for mental health decreases, patients are decompensated and there is no place for them to go other than the emergency department. Because inpatient beds are scarce and there are limited outpatient facilities to keep patients from reaching a crisis point, patients are sadly left to wait in the emergency department for prolonged hours and often even days until treatment is available.

Dr. Hans House, associate professor at the University of Iowa, posted a screen shot of his ED board during an average shift. Listed were 19 psychiatric emergency patients with wait times ranges from two to twenty eight hours! We shared this list with Congressman Loebsack and he was appalled at how dire this situation has become. He will continue to vote on legislation that will help provide funding for mental health. Whether taking the time to speak with us in his Washington DC office or meeting with us at our hospital, Congressman Loebsack continues to support emergency medicine.

We sincerely appreciate his leadership!

Psych - Depression	3	28:05
Psych - Other	2	08:09
Psych - Other	3	06:22
Psych - Other	3	22:50
Psych - Other	2	25:12
Psych - Other	3	32:04
Psych - Other	3	52:14
Psych - Other	3	78:44
Psych - Other	2	19:26
Psych - Other	2	13:33
Psych - Other	2	02:34
Psych - Overdose	2	13:47
Psych - Suicidal	2	07:08
Psych - Suicidal	2	22:55
Psych - Suicidal	2	04:06
Psych - Suicidal	2	06:10
Psych - Suicidal	2	02:21
Psych - Suicidal	2	14:59
Psych - Suicidal; Alcohol Problem	2	17:37



Ultrasound in Medicine

Kathryn K. Dierks, DO, FACEP

I am a firm believer in the power of ultrasound and how in just a few short minutes, we can make rapid diagnoses in real time right at the bedside. Standard training dictates that we evaluate the patient and perform a physical exam with our eyes, our hands and our stethoscopes. While this will always be an important piece of assessing our patients, the real magic is in point of care bedside ultrasound. Stethoscopes are so passé. With ultrasound, not only can you make vital diagnoses in just a few moments, you can also devise a treatment plan before the patient even has an IV in place! Such was the case last night in the emergency department and because of a diligent physician and an ultrasound machine, a patient's life was saved.

I was working in the department last night when one of my colleagues, Dr. Mohr, took care of a patient with back pain. We were sitting at the desk doing our charting when he heard a man howling in pain. He was a 57-year-old male who checked in for back pain. Upon arrival to the ED, his triage vital signs were all unremarkable. He stated that he was having left sided back pain for two days that was initially mild but became progressively worse. His symptoms seemed characteristic of renal colic. The patient was initially resting comfortably in the room, but he then started to moan in pain. Initially his cries were mild, but suddenly his cries were piercing and unrelenting. Springing into action, Dr. Mohr scurried down the hallway pushing the ultrasound machine into the room. After a few minutes, Dr. Mohr came out of the room stating, "do we have vascular surgery on call? This patient has a ruptured AAA." Dr. Mohr carefully observed on the ultrasound that his aorta was enlarged at 6.5 cm and there was intramural thrombus with a surrounding hematoma and free intraperitoneal fluid. He immediately started aggressively resuscitation including emergency release blood, administration of TXA, and placement of a central line. Immediate arrangements were made for transfer to a facility with vascular surgery on call. The patient underwent CT scan confirming the diagnosis of a 6.5 cm infrarenal ruptured AAA. The patient was resuscitated, stabilized and transferred for surgical management. The patient underwent placement of an aortic graft and is now recovering without complication.

Without a keen physician and bedside ultrasound capability, this patient could have easily died in the department while waiting for a CT scan. Because of this rapid diagnosis, the patient was diagnosed, stabilized and dispositioned in a short period of time. And most important, the patient is alive and well. Keep up the great work and happy scanning!

If you have any interest in a point of care ultrasound training session at our Iowa Chapter Annual Meeting, please contact me by clicking [here](#).

ACEP18 - Council Meeting Update

Ryan M. Dowden, MD, FACEP

The ACEP Council convened in San Diego on September 29-30. I was honored to serve along with Drs. Sokol and Buresh as one of our Councillors. Drs. House and Hoper were also present at the meeting and served as Alternate Councillors.

Since we have a young chapter composed of a number of student and resident members, I thought I would fill you in on what the Council is. I suspect some of our members already in practice may not even entirely understand this.

The Council is composed of Emergency Physicians who are elected or appointed from each of the 53 chartered chapters of the college, EMRA (Emergency Medicine Residents' Association), SAEM (Society for Academic Emergency Medicine), CORD (Council of Emergency Medicine Residency Directors), and AACEM (Association for Academic Chairs in Emergency Medicine), and each of the College's sections of membership. This year, there were 417 Councillors.

The Council elects the Board of Directors, Council officers, and the President-Elect of the College. The Council shares responsibility with the Board of Directors for initiating policy, and the Councillors shape the strategic plan of the College by providing comments on behalf of the constituencies they represent. The Council also provides a participatory environment where policies already established or under consideration by the Board of Directors can be debated.

The Council is led by a Speaker and Vice-Speaker; the Council officers. This year these positions are held by Dr. John McManus as Speaker and Dr. Gary Katz as Vice-Speaker. These are very important leadership positions within the College. The Speaker and Vice-Speaker work closely with the ACEP Board of Directors and the Council Steering committee to help shape the strategic direction of the College.

Highlights from the 2018 Council Meeting include the following:

- Ratification of the Board's election of Dr. Vidor Friedman as the President-Elect, replacing John Rogers following Dr. Rogers' voluntary resignation from this position in June.
- Election of Dr. William Jaquis as the 2019 President-Elect
- Re-Election of incumbents Drs. Mark Rosenberg and Christopher Kang to their second, and final, 3-year term on the Board of Directors
- Election of new Board of Directors members Drs. Anthony Cirillo and J.T. Finnell

Resolution one (Yes, Number 1) was adopted by consent and is a commendation for our own Dr. Hans House:

“RESOLVED, That the American College of Emergency Physicians commends Hans R. House, MD, FACEP, for his service as an emergency physician, clinical investigator, educator, and leader in a life-long quest dedicated to the advancement of the specialty of emergency medicine.”

Other actions the college will pursue over the coming year based on the directives of the Council include the following:

Addition of one seat on the Council for a representative from the American College of Osteopathic Emergency Physicians. A task force will also be assembled to study the growth of ACEP membership and thus the Council as well. Chapters will be encouraged to appoint/elect Councillors that reflect the diversity within their membership.

Promoting the safest, most-efficient practice environment for Emergency Physicians and all ED staff, the council passed resolutions to help provide resources for EPs on: the legal and ethical obligations for law enforcement requests with or without warrant, work with other organizations to develop regulatory and legislative efforts regarding surreptitious recording of Emergency Department encounters, make POLST forms more widely accessible for use and accessible in the medical record, clarifying the emergency physician's role in signing death certificates, and develop and distribute to members an evidence based toolkit for methods to encourage emergency department antimicrobial stewardship.

Physician mental health and suicide was discussed at great length. The Board was directed convene a panel to study the factors leading to Emergency Physician depression and suicide and report back to the Council in 2019 with an action plan to address this significant issue to our specialty. Furthermore, ACEP will be encouraged to work with partner organizations to support efforts to remove stigmas of mental illness which may prevent physicians from seeking mental healthcare and/or disclosing mental illness on credentialing and licensure applications.

Delivery of care for the mentally ill and opiate addicted patients we serve continued to be on the forefront of discussions. Resolutions passed and actions to be taken by the College include directives advocating for funding from both federal and state governments for initiating medication assisted treatment programs in the Emergency Department, pushing for inclusion of methadone in state PDMP's, payment for opioid sparing pain treatment alternative therapies, and continued support for naloxone availability and layperson training in its use. The Council also requested the College develop a toolkit for care of the boarded psychiatric patient in the ED and develop and make available to members educational materials for care of patients with autism spectrum disorder.

Addressing access to care and preventing government and payor instituted barriers to that care is always an important issue for the College and its members. This year, resolutions related to that include statements that ACEP opposes collection of copays for Medicaid beneficiaries seeking ED care and advocating for legislation or regulation to repeal the Medicaid Institutions

for Mental Diseases Exclusion.

Finally, advocating for injury prevention and the safety of our patients, the council supported resolutions on supporting research and legislation on efforts to prevent violence, update our policy statement on firearm safety and prevention based on new research, support only well controlled studies of cannabis or related cannabinoids for medical, and not recreational, use, promote further research into extreme violence prevention orders and gun violence restraining orders, and stated that the College opposes separation of migrating children and their caregivers in the absence of immediate physical or emotional threats to the child's well-being.

As one of your elected Councillors, I encourage all of you to reach out to me any time you have a question or concern about College operations, pending resolutions, or an issue you would like to see the College pursue. My email is dowdenrm@gmail.com.

Representative Blum Visits - BCHC

Ryan M. Dowden, MD, FACEP

Representative Rod Blum (IA-1) visited Drs. Juneja and Dowden at BCHC in September to discuss the opioid crisis, mental healthcare, and payment issues affecting Emergency Medicine. The visit was arranged with Dr. Dowden on behalf of the American College of Emergency Physicians. Representative Blum has also shadowed Dr. Stacey Marlow-Fisher on behalf of ACEP at Allen Hospital.

As a result of this visit, Dr. Dowden was asked by Rep. Blum and his staff to be a panelist for a town hall meeting about the opiate crisis held in Waterloo on October 17.

Dr. Dowden states, "Advocating on behalf of our patients is an amazing way to feel great about Emergency Medicine and combat burnout. Attending Leadership and Advocacy Conference is a great way to get your feet wet with advocacy. Please consider going. Also, donate to NEMPAC. NEMPAC keeps emergency medicine issues front-and-center with our legislators. NEMPAC is the voice of Emergency Medicine in Washington. Without NEMPAC, visits like this wouldn't occur." Dr. Dowden is an ACEP Spokesperson, member of the 911 Legislative Network, NEMPAC Give a Shift donor, and the Past-President of Iowa ACEP.



(L-R) Steve Slessor, CEO of Buchanan County Health Center, Ryan Dowden, MD FACEP, Nadia Juneja, MD, and Representative Rod Blum, IA-1

Resident Corner **Kaila Pomeranz, DO** **UIHC Resident Representative** **PGY-2**

Wellness and burnout are co-dependent. At every major meeting there are talks and small groups held in the spirit of improving our wellness. Even with this additional focus, emergency medicine ranks among specialties with the highest levels of burnout. It is a challenging multifactorial issue, rendering singular solutions unsuccessful. Most proposed solutions seek to prevent burnout through health maintenance failing to affect change on systemic drivers of physician burnout. In residency training, wellness is an additional area to focus our efforts in order to maintain long, satisfying careers. This month in our residency didactics, we discussed second victim syndrome.

What is second victim syndrome (SVS) and why is this important to us? SVS was originally described in 2000 by Albert Wu and is "The burden that healthcare providers feel after a patient is harmed, manifesting as anxiety, depression and shame." In a broader sense, it is the impact we feel when we have an emotional response to our patient care. It is the weight of our patients that carries over into the non-clinical aspects of our lives. Our nurses, paramedics, and anyone

involved with an emotional encounter or an adverse outcome are also vulnerable.

Everyone is at risk for SVS and the results can be isolating as well as physically and psychologically devastating. The literature shows that the most benefit and improvement has is seen by holding debriefings after challenging cases and through peer-to-peer support programs. Many hospitals have developed formalized peer-to-peer support programs with increased recognition of those who may be struggling. With more awareness we can protect ourselves, our colleagues, and initiate a culture change. It is never too late to reach out and ask someone if they are okay or to ask for help.

Wu AW. Medical error: The second victim. The doctor who makes the mistake needs help too. Br Med J. 2000;320(7237):726-727

NEWS FROM ACEP



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, Thombley 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?

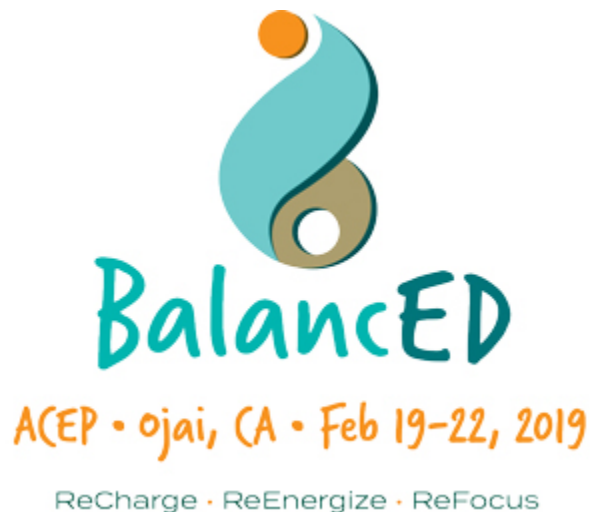
Apply for the Reimbursement Leadership Development program! Program members will gain a thorough understanding of the EM reimbursement process, be poised to assume reimbursement leadership positions, and obtain a highly valuable skill set that will help them in their professional growth, practice, and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



Introducing BalancedED

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!

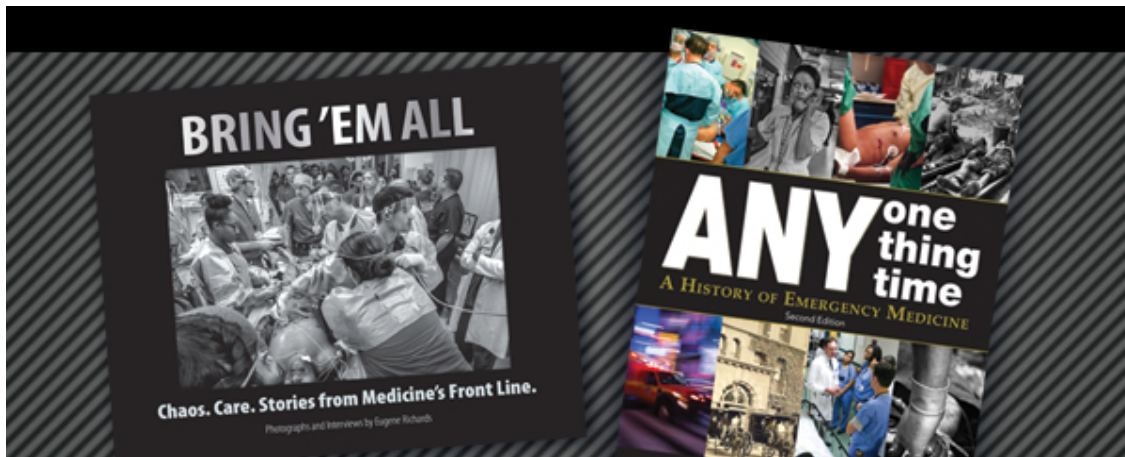
Looking for a way to increase your visibility and reach patients? Consider contributing to the ACEP Doc Blog! The blog lives on the ACEP patient-facing website www.emergencycareforyou.org. The Doc Blog offers plainly worded insight and expertise to patients from emergency physicians. Topics include health 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



ACEP Geriatric
Emergency Department Accreditation

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.



The banner features the PCSS logo (four colored squares: purple with 'P', blue with 'C', blue with 'S', and blue with 'S') on the left. To its right, the text 'Providers Clinical Support System' is displayed. The main headline reads 'With PCSS training, you can help save lives from opioid use disorder'. Below this, a larger headline states 'By getting MAT trained, you can help people take their lives back from OUD.' followed by the website 'Visit pcssNOW.org'. At the bottom, a small disclaimer mentions funding from SAMHSA and states that views expressed do not necessarily reflect official policies.

P C S S 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).



STR-TA
Consortium
State Targeted Response
Technical Assistance

Call to Action!
Navigating together for change



Funding for this initiative was made possible (in part) by grant no. 1H79TI080816-01 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

Jessica Waters - Medical Student
Tate Vernon - Medical Student
Daniel Masin - Medical Student
Alec Joseph Bunting - Medical Student
Samantha Marie Hurrie - Medical Student
Kirby Paul Lundy - Medical Student
Dakota Ann Nerland - Medical Student
Abigail Jo Bardwell - Medical Student
Kristina Judith Sousou - Medical Student
Conor Dass - Medical Student

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