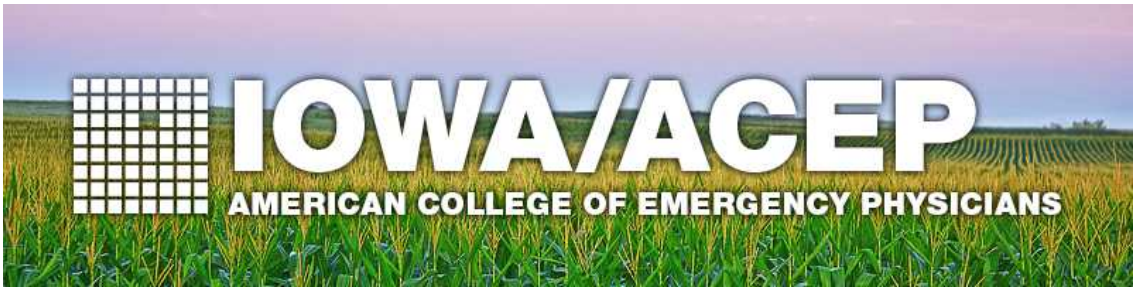
A Newsletter for the Members of the Iowa Chapter



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Kathryn K. Dierks, DO, FACEP

Introduction

Hello to all of my fellow emergency providers! This has been one of the coldest winters in many years and I hope all of you are enjoying the weather bundled up in warm homes nestled next to a fire. With the landscape covered in ice and snow, many of my favorite birds have been flocking to my feeders giving me a beautiful scene to watch. Growing up in Arizona, I never understood just how incredible it is to watch the changing seasons. Iowa is a special place to live and a wonderful place to practice emergency medicine. Although the scenery is quite beautiful, it has provided some challenges for our emergency patients and I am sure your departments have been crowded with trauma!

Advocacy Update

Our Iowa ACEP Board and advocacy team continues to work closely with Iowa Medicaid regarding the change in reimbursement that went into effect starting August 1, 2018 with informational letter No. 1919. As discussed in detail in prior newsletters, the reimbursement changes that went in to affect entail retroactive denial of emergency department visits based on “non-emergent diagnoses” for Medicaid patients. After drafting a letter to Governor Reynolds and meeting with the head of Iowa Medicaid, Mike Randol, we unfortunately did not receive our desired outcome. Aside from four diagnoses codes that have been removed from the “non-emergent” list (including chest pain unspecified, chest pain other, abdominal pain and fever) based on our recommendation, the list otherwise remains as originally published. We are working closely with the advocacy team in Dallas at ACEP headquarters and they have recruited the assistance of other ACEP chapters and the ACEP Board to further assist our chapter in efforts to protect our patients. We sincerely appreciate all of their assistance, their time and their efforts dedicated to helping us. We will be moving forward with contacting CMS and taking further action to reverse this policy. Protecting our patients and our specialty is our primary concern and we will continue to fight.

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. We take these issues very seriously.

Iowa Chapter Social Media Page

Facebook, Instagram and Twitter have become one of the best ways for family and friends to connect. They have also provided outlets for professionals to network, brainstorm and

collaborate. With that, Iowa ACEP is working on our social media network. Through our network we will be able to interact with all of our providers across the state. We can share educational experiences, professional ideas and collaborate to advance our specialty within our state. Medical students will have better access to attendings, who can serve as role models and mentors. We are looking forward to launching our social media page!

Upcoming Event

Mark your calendars for the **Leadership and Advocacy Conference** in Washington, D. C. on May 5-8, 2019! This is one of the most compelling conferences that ACEP offers. Whether or not you have any experience with political advocacy, this conference covers current healthcare policy issues and how they are affecting our specialty. Have you even been frustrated by policy changes that affect your patients and how you practice medicine? Have you ever wanted to speak directly to those policy makers and express your ideas? Then this is the conference for you! For beginners, there are seminars that review topics all the way from basic healthcare policy to how to talk to your representatives. This conference provides learners with tools to advocate for legislation in emergency medicine on both local and national levels. As a grand finale, conference participants are scheduled to meet with their assigned member of congress on Capitol Hill to discuss the legislation affecting our specialty and how their votes can influence how we care for patients. This is the most empowering experience any provider can have! If we are not the voice of our patients, then others who have no healthcare background will vote on legislation. This conference will teach you how to be the voice of your patients and your specialty! Whether you are a first-year medical student or a seasoned attending physician, we hope to see you there!

Resident Corner
Kaila Pomeranz, DO
Resident Representative - UICCM
Iowa Chapter Board

Frostbite: An Iowa Winter

While we continue to have increased amounts of snow and freezing temperatures, the cold injuries continue to fill the emergency department. How can we best care for patients affected by cold injuries?

By definition, frost bite is a freezing injury occurring when the temperature of the tissue drops below freezing. The pathway of injury is that of extracellular crystal and microvascular thrombi formation, ultimately leading to tissue destruction and cell death. This contrasts with frostnip, which is a superficial injury that resolves following rewarming.

Much like burns, frost bite has been historically divided into degrees of injury based off the

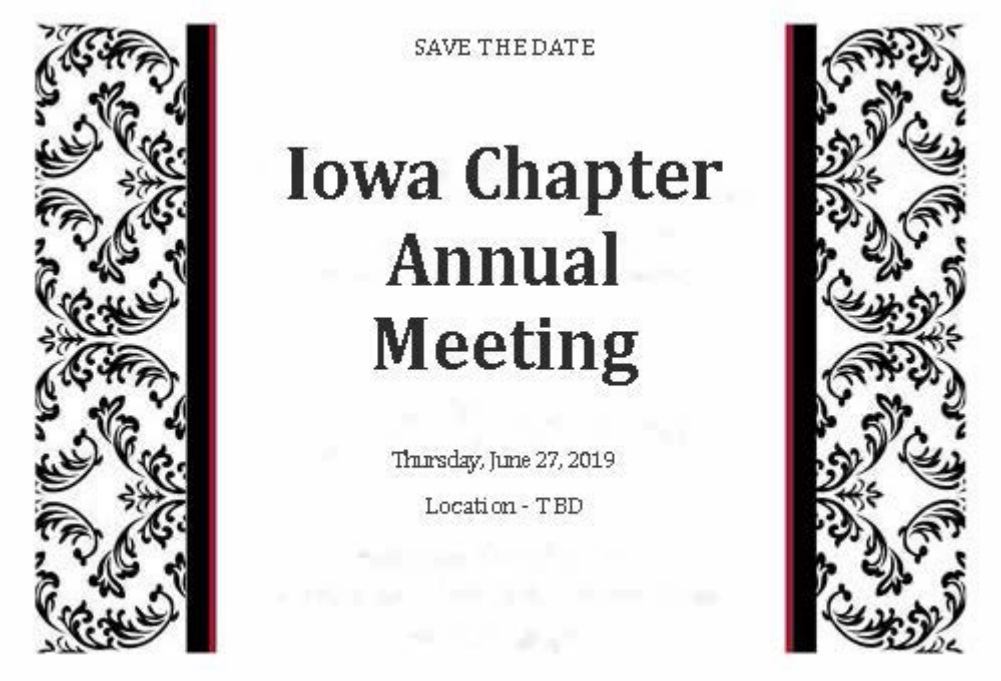
depth of impact. However, it takes several months for the tissue to fully demarcate for evaluation of injury extent. These patients must be carefully rewarmed with circulating warm water around 37-39 degrees Celsius. It is important to note that rewarming is a painful process for patients. Following rewarming, the best evidence is for good, localized wound care. Blister treatment remains controversial. Most common practice is to aspirate clear blisters and leave hemorrhagic blisters intact. There is limited data to suggest that IV tissue plasminogen activator (tPA) and heparin reduces digit amputations in frostbite when administered within 24 hours of injury. Administration of tPA should be considered for patients who are at risk for severe injuries. Prior to administration, angiography or technetium-99m triple phase bone scanning should be performed to evaluate for lack blood flow and likelihood of tissue salvage. Physical exam findings of decreased capillary refill, absent Doppler pulses, discoloration, and hemorrhagic blisters should also be used for risk assessment.

An additional point for consideration is the social context of the patient. Refreezing injuries can be devastating, and we must consider if the patient has a warm place for discharge. Patients with frost bite injuries should be carefully evaluated and discussed with a burn treatment center for management options.

References:

1. Millet, John D., et al. “Frostbite: Spectrum of Imaging Findings and Guidelines for Management.” RadioGraphics, vol. 36, no. 7, 2016, pp. 2154–2169.
2. Gonzaga, Teresa, et al. “Use of Intra-Arterial Thrombolytic Therapy for Acute Treatment of Frostbite in 62 Patients with Review of Thrombolytic Therapy in Frostbite.” Journal of Burn Care & Research, vol. 37, no. 4, 2016, pp. 323–334.
3. Bruen, Kevin J., et al. “Reduction of the Incidence of Amputation in Frostbite Injury With Thrombolytic Therapy.” Archives of Surgery, vol. 142, no. 6, 2007, pp. 546–553.

Upcoming Chapter Event



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 or know of 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 **Iowa 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 Iowa Chapter.

Welcome New Chapter Members

Nicole Sipfle - Medical Student
Daniel Allan Weidner - Medical Student
David James Marshall - 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.

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.

ACEP Awards

The nomination process for the ACEP awards is open. The deadline for all nominations and material submission is March 1, 2019.

Information for the **2019 ACEP Leadership & Excellence Awards** is available on the ACEP website. The nomination form may be submitted electronically.

The Council Awards Committee is also accepting nominations for the following awards:

Council Meritorious Service Award
Council Teamwork Award
Council Horizon Award
Council Curmudgeon Award
Council Champion Award in Diversity & Inclusion

The Council Meritorious Service Award, the Council's highest award, has been publicized through the College's formal awards program with a deadline of March 1, as well. All nominations must be submitted with the individual's CV and up to three-(3) letters of support. Please review the criteria for each award carefully before submitting your nomination(s).

If you have submitted a nomination, please ensure you receive a confirmation from Mary Ellen Fletcher that it is in the system.

If you have any questions about any of the above, please contact Mary Ellen Fletcher, Governace Operations Manager at 800-798-1822 Ext. 3145 or via **email**.

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 hemoccult 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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