A Newsletter for the Members of the Arkansas ACEP Chapter

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From the President
Charles C. Scott, MD, FACEP, PhD

I want to welcome you to our chapter e-newsletter. My name is Charles “Corey” Scott, MD, PhD, FACEP. I am currently the Director of two emergency departments in Arkansas. CHI St. Vincent North in Sherwood and CHI St. Vincent Morrilton in, well, Morrilton. The latter of the two is a critical access hospital. I would like to discuss the recent loss of a great Arkansas Emergency Physician, introduce myself as well as discuss how we can help make our lives as emergency physicians better.

“I would like to introduce myself. I am a man of wealth and taste.”
-some English hippies

Of course, I am not either, but I can always hope to attain such characterization. My background is as varied as many in our profession. I started out as a Mechanical Engineering student with a strong interest in research. I finished a Master of Science in Mechanical Engineering and did not continue to a PhD because I thought being a Medical Doctor would help my research.

My course in life directed me into clinical practice, Arkansas, and servant leadership. You can thank my wife, Angie. We came here for her Developmental Behavioral Pediatrics fellowship, which is three years beyond a pediatrics residency to reduce your salary. She is one of six or so in the state. We have both taken to central Arkansas, as well as the rest of the state. Professionally, I have served on many committees and been active with the state trauma program, MEMS advisory, Injury and Violence prevention, which includes suicide prevention and helping re-write the state’s Sexual Assault Hospital Protocol guide. I have been Doctor of the Day at the Capitol and encourage you to do so, and also encourage you to work with the Arkansas Medical Society. I have attended the **Leadership and Advocacy Conference** in DC for the last several years, meeting with our national legislators.

I would like to thank everyone who has participated in Arkansas ACEP and reinvigorating the organization over the years. I hope to lead us to being more active politically, particularly keeping our practice in our own hands. I also hope to coordinate better with our Emergency Residencies in Arkansas, as well as the medical schools. I would also like to bring more activity and attention to Northwest Arkansas and South Arkansas.

Sadly, we recently lost another pioneer of Emergency Medicine in Arkansas. Dr. Paul Veach passed from complications of colon cancer. While he was CMO of Schumacher, then HPP, he also had numerous roles in leadership. Of great note, I think his legacy will be more, he passed on his wisdom and his compassion. He was one my mentors and stands out as teaching me about being human and an

emergency doctor. He wrote one of the best articles I have ever read about Emergency Medicine in the Spring 2018 Arkansas ACEP newsletter (May 14). Dr. Veach talked about burnout and treating patients as real, whole people. He derided the “us vs them” attitude and asking patients, “why did you come to the ED?” as symptoms of a problematic culture in the ED. I think his article was on point. I try to influence the culture of my EDs to not tell anyone to run when they first enter. To not question why a patient came to the emergency department, but to try and understand why they came. I know this sounds like I am naïve, but I guaranty you that is not the case and does not equate at all with giving out narcotics. When I am successful in implementing Dr. Veach’s philosophy, my shifts are less stressful and my patients generally happier. He was humble, compassionate, funny, brilliant, and an absolute role model. He will be missed!

Finally, please feel free to **contact** me should you need anything. I welcome any suggestions on how we can work together as members of the Arkansas chapter.

Human Trafficking
J. Shane Hardin, MD, PhD, FACEP
Councillor

Human trafficking is defined as the use of force, fraud, or coercion to obtain some type of labor or commercial sex act. It is often confused with human smuggling which is the illegal movement of persons across borders. Human trafficking is not limited to major metropolitan areas along the coasts, but it occurs in every state including Arkansas. In fact, Arkansas is located between three of the top trafficking jurisdictions in the country (Houston, New Orleans and St. Louis). It is important for emergency physicians to recognize the signs of trafficking because the emergency department is one place where victims come into contact with people that can help them.

Human trafficking victims may present to the emergency department as a result of injuries or illnesses related to their work. Sex workers are at high risk for sexually transmitted infections and physical abuse. Victims often provide a history that is vague and inconsistent. On physical exam, they may have signs of abuse such as bruises of varying ages. The victims may also have tattoos that serve as a sign of ownership by the trafficker. Substance abuse, sexually transmitted illnesses and psychiatric illnesses are common among the victims.

It can be difficult to interview victims because they tend to be distrustful and emotionally vulnerable. Questions should be asked in a nonjudgmental, nonthreatening manner. Often times their trafficker will be present to control what the victim says which is why it is important to talk to the patient alone. The trafficker may also act as an interpreter which is one reason why it is better to use a professional interpreter. The victim will often seem submissive and defer to the trafficker. They may be evasive in responding to simple questions such as where they live and work. The victims may misinterpret friendly behavior as “grooming” and normal body language as threatening.

Certain populations are at a higher risk for becoming victims. Vulnerable groups include runaways, children in foster care, and the homeless. Often times, they engage in “survival sex” to obtain food, drugs or money. Many states including Arkansas have safe harbor laws which treat trafficked minors as victims instead of criminals. These states are targeting the people buying the sex.

In Arkansas, the top venues for sex trafficking include hotels, motels and truck stops. The top labor trafficking venues include traveling sales crews, domestic workers, and health and beauty services (i.e., nail salons and massage parlors). Most of the victims are female adults that are US citizens. However, children, adult males, and non citizens are also victims.

Human trafficking is considered a form of abuse under federal law (Justice for Victims of Trafficking Act). Therefore, it is appropriate to report suspected cases of trafficking involving minors to the state child abuse hotline. However, we must obtain consent from adult victims to make a report to the police. Because of fear of deportation, harm to themselves or their families, or other factors, the victims may be unwilling to speak to police. As in all cases of abuse, it is imperative for emergency department staff to watch for suspicious signs and symptoms.

There are several resources to find out more about human trafficking. **The National Human Trafficking Hotline** or by calling 1-888-373-7888 to report suspected cases and it also provides help for victims. There is a recent edition in ACEP’s Critical Decisions in EM which has a CME article about sex trafficking (December 2018, Volume 32, Number 12). The Department of Homeland Security has their **Blue Campaign** to fight trafficking. There is also an excellent **podcast** by Noor Tagouri called Sold in America that is about sex trafficking.

Resident Corner
Rawle A. Seupal, MD

Once again, we have several important announcements since our last installment:

- **ICARE19** will be held **April 5-7** in Little Rock. The curriculum will be very high yield and we will have an intensive cadaver procedure lab the day before at a fraction of the cost anywhere else!

- I am very excited to announce several new additions to the academic faculty:
    - **Dr. Marc Phan** who is completing his critical care fellowship at UAMS this year.
    - **Dr. Jason Arthur** who is completing his Ultrasound fellowship this year

    - **Drs. Lauren Evans**, **Meryl Pampolina**, and **Brian Russ** who will graduate our EM residency this year.

- Match Day is coming up quickly. We expect to match another class of 10 outstanding interns and will include that information in our next installment.

- **Dr. Jerilyn Jones** is now the ADH Director of Disaster Preparedness. She will lead our State's efforts in both response and preparedness.

- **Dr. Sofie Morgan** has been promoted to the Associate Chief Quality Officer for the Patient Experience at UAMS. This places EM squarely in the C-Suite to add to the collection of leadership we have throughout the institution!

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 **Arkansas 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 Arkansas Chapter.

Welcome New Chapter Members

Morgan Danielle Sweere Treece - Medical Student
Kylie Hayes - Medical Student
Taylor M. Freeman - Medical Student
Brendan Lawrence Mahoney - 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.

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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