

PRESIDENT'S LETTER

Back to School: Set Priorities for Success



Valerie J. Phillips,
MD, FACEP

This time of year always brings mixed feelings for me. On the one hand, I'm sad that summer is ending and my kids are back in school. But on the other hand, I find myself becoming reenergized to begin or complete projects both at home and at work.

Perhaps this stems from not having the daily vision of my children "sleeping in", biking, hanging in a tree reading, and goofing off with friends as I head off to work. Who among us doesn't envy those that can slow down and enjoy summer for all it has to offer! It can be hard to stay motivated during the dog days of summer.

Of course, my children don't share my energy this time of year. Back to school shopping is a dreaded chore, and their angst about getting up early and rejoining the grind is palpable. Oh yeah, and don't forget about the return of homework: I can hear their groaning before the school year even starts. But helping my kids get organized for school, opening new school planners, and seeing their excitement about reuniting with school friends might be contagious.

Being reenergized and ready to take on new

projects is sometimes overwhelming. I find that my list quickly becomes too long. As we head into fall, I'm already trying to prioritize.

One of the things I like to do first is to schedule some time for educational topics of my choosing – yes, my choosing. All of us do CME topics required by our practice site, but I look forward to picking some offerings that I genuinely enjoy. I am eager to attend some of ICEP's upcoming programs, especially the Ultrasound for Emergency Medicine workshop on November 30. As we have brought some younger partners into our practice, we are increasing the use of bedside ultrasound, and I'm eager to catch up. If this sounds familiar, consider attending the Ultrasound course with me; see story on Page 4 for details.

Over the years, I've realized that putting these things – the things I'm interested in and looking forward to – into my schedule early is the only chance that those dates won't be filled with something else.

I'm also looking forward to ACEP16 Scientific Assembly in Las Vegas in October. This year is particularly exciting because we will watch our own ICEP member, Rebecca Parker, MD, FACEP, take the office of ACEP President – only the third ICEP member in history to hold this position! I am also eager to attend some educational sessions on new models for teaching and learning that I can incorporate into my teaching role. The bar has certainly been raised when it comes to keeping younger paramedic

and medical students engaged. What used to be a 20- to 30-minute attention span has decreased to 5 to 10 minutes with numerous embedded media platforms necessary just to maintain attentiveness, and I need help meeting this challenge! I also enjoy EMS updates, and applying new research to my clinical practice. Hopefully, when it comes to take-home points from these lectures, "what happens in Vegas, stays in Vegas" won't hold true. (I'm sure there will be some other adventures that I'll be glad will stay there ...)

The next thing I have learned is to look at is the kids' school schedule early. Just as happens with CME scheduling, no-school days are an opportunity lost if I don't mark those days early. I am trying to listen to the recommendations about work-life balance, and preserving these days off that tie into a weekend is helping. Too often my schedule becomes filled with scattered shifts, meetings, and other work commitments, and suddenly I've found that opportunities for "balance" have been scheduled away. Each year, I try harder to commit to this thinking. Finding work-life balance will always be a challenge but planning my schedule as far ahead of time as possible helps me focus a little bit more on "life" and a little less on "work" when the opportunity arises.

With my schedule worked out for the upcoming months, now I can prioritize the remaining work topics that are on my desk! Just some simple things like updating and exercising our

■ CONTINUED ON PAGE 2

InsideEPIC

2016 - Issue 4

Highlights of Legislative
End of Session Report

■ page **3**

New Topic to be
Presented at Ultrasound
for Emergency Medicine
Course on Nov. 30

■ page **4**

Member Perspective:
Naloxone Prescription
by Emergency Physicians
Strongly Encouraged

■ page **6**

Statewide Research
Showcase Abstract
Round-Up

■ page **8**

Back to School: Set Priorities for Success

from Page 1

emergency preparedness plans, including an active shooter scenario, moving forward with the mobile integrated health efforts – good thing I'm feeling energized!

Now it's your turn: What helps you stay energized? How do you find work-life balance? Share your ideas at Facebook.com/icepfan, tweet them to @icepemergency or email vphillips@icep.org. Your best tips will be collated into an upcoming EPIC article. Let's learn from each other as we navigate the challenges of our careers in emergency medicine.

As your summer schedule morphs into fall, please do something for yourself. Take a look at the opportunities for ICEP and ACEP involvement. Prioritize your professional growth before your schedule gets full.

Here's to a busy, productive and rewarding fall!



— Valerie J. Phillips, MD, FACEP
ICEP President

Physicians Encouraged to Give Back with EM Day of Service in Sept.

As emergency physicians, residents, nurses, physician assistants, and medical students, we are servant leaders in our communities. We care and advocate for our patients while working clinically. We also respond to the call to give back to the communities we serve. The EM Day of Service was created with this essential concept in mind. The EM Day of Service is a specialty-driven event where emergency care providers identify community needs and volunteer to address those needs.

Who should join the movement?

While driven by EM residents and medical students, all emergency healthcare providers are invited to participate! Emergency physicians, PAs, nurses, nurse practitioners, paramedics and others involved in the emergency care of patients are encouraged to volunteer in communities across the country.

When is EM Day of Service?

Pick a day – any day or several days – in

September every year! Plan your service time anytime between September 1 and September 30. By choosing several days during the month, this will help you manage clinical hours and volunteer hours. Perhaps some work while others volunteer and vice-versa. It's up to you to determine the most efficient scheduling of your volunteer project

How to participate?

Volunteer in your own community. Decide where the needs are greatest and go into action!

It's free – all you need to do is register online at EMRA.org/emdayofservice. Once we receive your registration, you will receive a promotional packet containing the EM Day of Service logos, fill-in-the-blank fliers, and press release you can customize to send to media outlets, community organizations and your institution.

Questions? Need help? Contact us at emdayofservice@emra.org

ACEP Seeks Comments for Clinical Policy on Psychiatric Patients in ED

The draft "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department," is in the review stage of ACEP clinical policy development and is open for comments. To view the draft policy and comment form, go to: <https://www.acep.org/Clinical—Practice-Management/Clinical-Policy-Comment-Form—Adult-Psychiatric-Patient/>

The draft is open for comments until September 19, 2016.

For questions, please contact Rhonda Whitson, RHIA, ACEP Clinical Practice Manager, at rwhitson@acep.org.



Illinois College of Emergency Physicians
3000 Woodcreek Drive, Suite 200
Downers Grove, IL 60515
Phone 630.495.6400 Fax 630.495.6404
www.icep.org

Editor

Cai Glushak, MD, FACEP

ICEP President

Valerie J. Phillips, MD, FACEP

Executive Director

Virginia Kennedy Paly

Managing Editor

Kate Blackwelder

Illinois EPIC is published by the Illinois Chapter, American College of Emergency Physicians. Opinions expressed in this newsletter do not necessarily express the views of ICEP.

All advertisements appearing in the Illinois EPIC are printed as received from the advertisers. Advertisement in the EPIC does not imply endorsement of any product or service by the Illinois College of Emergency Physicians. ICEP receives and publishes

advertisements but neither reviews, recommends or endorses any individuals, groups or hospitals who respond to these advertisements.

For membership or advertising information, call 630.495.6400 or dial toll-free 888.495.ICEP. Or visit ICEP online at ICEP.org

© 2016



Highlights of Legislative End of Session Report

The spring legislative session ended in June, with 20 bills of interest to ICEP and its lobbyists signed into law. Among the notable changes signed by Governor Rauner are:

- **Amendments to the EMS System Act:**

1. **Freestanding emergency centers:** Requires a freestanding emergency center to limit its participation in the EMS System strictly to receiving a limited number of patients by ambulance (rather than a limited number of ambulance runs by emergency medical vehicles).
 2. **EMS definitions:** Defines “clinical observation” and “medical monitoring”. It provides that “Basic Life Support (BLS) Services” includes medical monitoring and clinical observation and provides that “non-emergency medical services” includes clinical observation.
 3. **Epinephrine vials:** Permits EMT, EMT-I, A-EMT, or paramedics who have successfully completed a Department of Public Health approved course in the administration of epinephrine to administer epinephrine from a glass vial, auto-injector, ampule, or pre-filled syringe (rather than administer epinephrine from a vial).
- **Opioid abuse:** Amends the Drug Court Treatment Act to provide that if the defendant needs treatment for opioid abuse or dependence, the court may not prohibit that the defendant participate in and receive medically assisted treatments under the care of a physician licensed in Illinois. It also provides that drug court participants may not be required to refrain from using medication assisted treatment as a term or condition of successful completion of the drug court program.
 - **Illinois Poison Center funding:** Designates funding for the Illinois Poison Center for State fiscal year 2017 and State fiscal year 2018 through disbursements from the Healthcare Provider Relief Fund. This is an initiative of the Illinois Health and Hospital Association.
 - **Mobile Healthcare Task Force:** Creates the Mobile Integrated Healthcare Task Force and includes an appointment of an

Illinois emergency physician appointed by the Director of Public Health. The task force will identify and recommend ways that the State of Illinois can incorporate changes in our health care delivery system in order to increase the collaboration and utilization of our current health care workers while decreasing the associated costs.

- **Hospital sepsis protocols:** Makes changes in provisions concerning requirements for sepsis protocols and the reporting of sepsis protocols. It requires hospitals to provide sepsis protocols to the Department of Public Health upon request and also requires hospitals to collect certain sepsis-related data (rather than report it to the Department).
- **Epinephrine auto-injectors:** Creates the Epinephrine Auto-Injector Act, which provides that a health care practitioner may prescribe epinephrine auto-injectors in the name of an authorized entity where allergens capable of causing anaphylaxis may be present. It provides that any employee, agent, or other individual of the authorized entity who has completed the required training program may either provide or administer an epinephrine auto-injector to a person whom they believe in good faith is experiencing anaphylaxis.
- **School Code asthma action plan:** Annually requires each school district, public school, charter school, or nonpublic school to request an asthma action plan from the parents or guardians of a pupil with asthma, and sets forth provisions concerning the asthma action plan.
- **EMS definitions in the Criminal Code:** Redefines various statutes in the Criminal Code of 2012 concerning bodily harm directed against emergency medical services personnel. It provides that “emergency medical services personnel” includes all ambulance crew members, including drivers or pilots.

Read the full End of Session Report online at ICEP.org.

Thrombosis Showcase Set for Sept. 26

ICEP will host a free product showcase, “Thrombosis: AFib & DVT/PE - An Exploration in Risk Reduction”, from 12:00 to 1:00 PM on September 26, 2016 at the ICEP Conference Center. All ICEP members are invited to attend.

The program is part of a chapter grant program sponsored by Janssen Pharmaceuticals and will be presented as part of the ICEP Board of Directors meeting. ICEP Board members, as well as the ICEP Councillors for ACEP16, will be in attendance at the product showcase.

The one-hour presentations will include lunch but does not provide CME credit. To register to attend the free seminar, visit ICEP.org/janssen.

Join ICEP at ACEP16 for Inauguration Reception, Exhibit Booth

ICEP is gearing up for another exciting year at ACEP16! ICEP member Rebecca Parker, MD, FACEP, will assume the ACEP Presidency at the Council Meeting on October 15.

Immediately following the Council Meeting, ICEP will host, in conjunction with EmCare, a Presidential Inauguration Reception in honor of Dr. Parker. The reception will be held from 6:00 to 7:30 PM at the Mandalay Bay Convention Center, Mandalay Bay Ballroom J. All ICEP members past and present who are attending ACEP16 are invited to join us for the celebration.

Once ACEP16 kicks off, visit ICEP staff and members in the Exhibit Hall at Booth 745 on October 16-19.

New Topic to be Presented at ICEP's Ultrasound for EM Workshop on Nov. 30

ICEP's Ultrasound for Emergency Medicine Workshop will now include cardiac ultrasonography with live-model practice, updated this fall by popular demand.

Pelvic ultrasonography has been eliminated as the result of feedback from the ICEP membership and past course participants, who indicated this skill is rarely performed in the emergency department.

The updated course will be presented Wednesday, November 30 at the ICEP Conference Center in Downers Grove.

The course will continue to feature two tracks: a Basic course for physicians with minimal experience seeking both didactic lectures and hands-on practice in ultrasound technique; and a Fast Track course for physicians with prior ultrasound experience seeking hands-on practice only.

Registration is open online now at ICEP.org/ultrasound. The cost for ACEP members is \$450 for the Basic Course or \$300 for

the Fast Track Course. The cost for non-member physicians is \$499 for Basic and \$350 for Fast Track. Space is limited due to the hands-on nature of the program, so please register early to reserve your spot.

The Basic course agenda include the following topics:

- Ultrasound basic and knobology, presented by Course Director Robert Rifenburg, DO, RDMS, FACEP
- Cardiac ultrasonography, also presented by Dr. Rifenburg
- Fast Exam, presented by Monika Lusiak, MD
- Gallbladder, presented by Joseph Colla, MD, RDMS
- AAA, presented by Joseph Peters, DO, RDMS, FACEP, FACOEP, FACOI

- Ultrasound-Guided Peripheral IVs and Central Lines, presented by Troy Foster, MD, RDMS, FACEP

Both the Basic and Fast Track courses feature hands-on skill stations to practice: cardiac, gallbladder and AAA, Fast Exam, and peripheral IVs and central lines. All stations will be live-model except for peripheral IVs and central lines.

The Basic course runs from 7:15 AM to 1:40 PM. The Fast Track course runs from 7:30 AM to 11:05 AM. The course is approved for a maximum of 5.5 *AMA PRA Category 1 Credits*[™].

View the complete course brochure at ICEP.org/ultrasound for a detailed agenda, program objectives, and complete faculty listing.



ICEP Board Member Dr. Napoleon Knight Elected to Board Chair Position for AAPL



**Napoleon Knight,
MD, MBA,
FACEP, FAAPL**

Napoleon Knight, MD, MBA, FACEP, FAAPL, of Urbana, was elected as the Chair of the Board of Directors of the American Association for Physician Leadership (AAPL). He will serve a one-year term.

Dr. Knight has served as a member of the

AAPL Board of Directors for four years.

Dr. Knight is Medical Director for the Regional Alliance for Healthcare Excellence at Carle Health System in Urbana and Medical Director of the Emergency Department at Crawford Memorial Hospital in Robinson.

Dr. Knight completed his residency at the Denver General Affiliated Residency Program in Emergency Medicine in Denver, Colorado, after attending medical school at the University of Minneapolis in Minnesota.

The AAPL, formerly called the American College of Physician Executives, is a professional association for physician leaders that focuses on providing management and leadership skills to physicians and encourages them to assume greater roles in the delivery of health care. The AAPL administers the Certified Physician Executive (CPE) program as well as several other physician leadership educational opportunities.

Congratulations to Dr. Knight on his position.





A Physician-First Approach to Patient-Centered Care

ISMIE Mutual's Inaugural Risk Management Symposium

- | Features 10 industry thought leaders and health care innovators.
- | Concurrent breakout sessions allow you to choose the topics most relevant to your needs.
- | Insights and ideas on ways physicians can improve patient safety, quality and health IT — and reduce burnout and diagnostic error.
- | Eligible attendees may earn *AMA PRA Category 1 Credits™*.
- | All ISMIE Mutual Insurance Co. policyholders are welcome to attend free of charge (**a \$399 value**).
- | ISMIE Associates (ISMS members and employed staff of policyholders) **save \$300** at registration.
- | Other physicians, clinicians, practice administrators and risk managers also are invited to attend.

Space is Limited! Don't Miss Out


Register Today

at www.ISMIERms.com

Early Bird Pricing Available!

**Save an additional \$100 when you register
by Oct. 1; ISMIE policyholders may attend FREE.**

Questions? Contact ISMIE Mutual's Risk Management team at riskmanagement@ismie.com.

Follow us on  @ISMIEMutual, and join the conversation at
this year's symposium using the hashtag #ISMIERMS2016.



Member Response: Naloxone Prescription By Emergency Physicians Encouraged

Thank you to P. Quincy Moore, MD, Chief Resident at John H. Stroger, Jr., Hospital of Cook County for providing his perspective on use of naloxone in the emergency department as a response to ICEP President Valerie Phillips, MD, FACEP's President's Letter published in the last issue of the Illinois EPIC. (Missed the issue? Read it online at ICEP.org.)

Members are encouraged to continue the conversation and submit their own perspectives to vphillips@icep.org. Responses may be published in future issues of the EPIC.

No one ever recovered from addiction and became a productive member of society after a fatal overdose. As Dr. Phillips reasoned, "you can't get worse than dead." At John H. Stroger, Jr. Hospital of Cook County we have been prescribing naloxone to patients for five years.

While the obvious preference is for opioid overdose patients to immediately seek emergency medical attention, the sad reality is that many such overdoses go untreated. In fact, two surveys of heroin users revealed that less than half of respondents who had witnessed a heroin overdose called for an ambulance.^{1,2} Relatedly, 75% of respondents reported concern about involvement of law enforcement as a reason for delaying or not contacting EMS.¹

As emergency medicine practitioners, it is incumbent upon us to find a way to reach the far-too-many patients that never make it to the emergency department (ED). High quality data on the safety of bystander naloxone administration is lacking. However, the data we do have available point clearly to naloxone being safely administered by laypersons, and with positive impact on survival. In the context of incomplete evidence, we must remember the astounding rate at which patients are dying from opioids. Additionally, our leading professional organizations recognize the importance of bystander administration of naloxone to reverse opioid overdose. ACEP, three leading associations of toxicology, and the U.S. Substance Abuse and Mental Health Services Administration, have all offered policy statements in support of the practice.³⁻⁵

Further, there are no compelling studies supporting increased opioid use in patients who receive prescription naloxone. Two studies showed that patients decreased their usage after being prescribed naloxone, perhaps due to a feeling of empowerment.^{2,6}

In our hospital, we prescribe naloxone from the ED, and to patients being discharged from the hospital. In order to lower the risk associated with prescribing naloxone, we employ several tactics at the prescription stage. We require patients to receive training on how and when to administer naloxone, before receiving their prescription. Additionally, we instruct patients to seek medical attention for the overdose victim, discourage him from using any further opioids after receiving naloxone, and observe him for an extended period of time if they are not going to bring him to a medical facility.

After completing our training, patients receive a certificate that serves as proof to the pharmacist that that patient is now eligible to receive prescription naloxone. The certificate accompanies a prescription for two individual doses of 0.4 mg of naloxone, with two intramuscular syringes. There are also intranasal and auto-injector formulations available and used by other hospitals and non-profits.

We've all had the experience of stepping out the door to go to work and hearing a loved one tell us to "go save some lives." In San Francisco, Enteen et al showed that of patients who received prescriptions for naloxone, 11% later returned after having successfully administered naloxone for opioid reversal.⁶ This number likely underestimates the rate of successful administration, but if I can save one life by prescribing naloxone ten times, then I can really live up to my loved ones' expectations of me as a physician.

Opioid-dependent patients are some of the most marginalized patients we see. For many of them, the ED is their only point of contact with the health care system. Therefore, it is our responsibility to offer them this potentially life-saving medication, whether they are at risk for heroin, or other opioid-related overdose. I ap-

plaud ICEP for encouraging dialogue about the use of naloxone, and hope they will continue to work to remove barriers to the routine prescribing of naloxone by emergency physicians in Illinois. I strongly urge each reader to consider adopting a program to offer naloxone in your emergency department.

— Submitted by:

P. Quincy Moore, MD
Chief Resident, Emergency Medicine
John H. Stroger, Jr. Hospital of Cook County
pmoore2@cookcountyhhs.org

References

1. Baca CT, Grant KJ. What heroin users tell us about overdose. *Journal of addictive diseases*. 2007;26:63-68.
2. Bazazi AR, Zaller ND, Fu JJ, Rich JD. Preventing opiate overdose deaths: examining objections to take-home naloxone. *Journal of health care for the poor and underserved*. 2010;21:1108-1113.
3. American College of Emergency Physicians (ACEP). ACEP Policy Statement. Naloxone Prescriptions by Emergency Physicians. Available at: <https://www.acep.org/Clinical---Practice-Management/Naloxone-Prescriptions-by-Emergency-Physicians/>. Accessed July 12, 2016.
4. Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA)14-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
5. Doyon S, Aks SE, Schaeffer S. Expanding access to naloxone in the United States. *Clinical toxicology (Philadelphia, Pa.)*. 2014;52:989-992.
6. Enteen L, Bauer J, McLean R, et al. Overdose prevention and naloxone prescription for opioid users in San Francisco. *Journal of urban health : bulletin of the New York Academy of Medicine*. 2010;87:931-941.



Focus on Professional Development at Resident Career Day on September 29

There is still time to register for ICEP's Resident Career Day on Thursday, September 29 at Northwestern Memorial Hospital in Chicago. Registration is free for all ICEP members.

ICEP's half-day program is designed to provide resources and advice to residents, medical students, and young physicians as they embark on their emergency medicine careers.



The 2016 program features:

- Christopher S. Kang, MD, FACEP, of the ACEP Board of Directors, discussing the benefits of involvement in professional organizations to enhance clinical practice and satisfaction while improving patient care
- Rob Rogers, MD, of The University of Kentucky College of Medicine, demonstrating the value of lifelong learning as an essential part of maintaining clinical excellence throughout your career
- William Sullivan, DO, JD, FACEP, re-

viewing common physician employment contract terms and simple negotiating tactics to help create a favorable contract

The program also includes the "Speed Dating" Career Fair where participants network with the field's top recruiters in a round-table format to discover career opportunities and make key connections with potential employers.

Medical students and 1st year residents who don't wish to participate in the Career Fair can sit down with ACEP President-Elect Rebecca

Parker, MD, FACEP for an open forum discussion of current issues.

Resident Career Day also includes a short presentation that explores the physician's role in the organ and tissue donation process coordinated by Gift of Hope.

Life after residency brings a new set of challenges. Resident Career Day focuses on giving you the tools you need to meet these challenges head on and turn them into opportunities. Register at ICEP.org to attend.



Physician Opportunity Ottawa, Illinois



EMERGENCY MEDICINE OSF Saint Elizabeth Medical Center

- Exceptional hourly rate including full benefits and matching 401K
- 99 bed hospital with 18,000 ER annual visits
- 1.5 patients per hour with Midlevel support
- 7 exam rooms
- EPIC electronic medical record
- Member of system with well-established transfer process
- Licensed psychiatric beds
- 9 EMS agencies that service SEMC with 3 agencies that transport patients to our ED
- 80-100 EMTs that service our ED
- 130 life flights/year

Please contact or send CV to:
Stacey Morin
OSF HealthCare Physician Recruitment
Ph: 309-683-8354 or 800-232-3129 press 8
Fax: 309-683-8353
Email: stacey.e.morin@osfhealthcare.org
Web: www.osfhealthcare.org

Statewide Research Showcase Abstract

Round-Up with ICEP Research Committee

The Statewide Research Showcase is back for 2016! Each issue of EPIC will feature the Abstract Round-Up. Several abstracts that were selected for the Statewide Research Showcase at the 2016 Spring Symposium will be printed, with brief commentary provided by a member of the Research Committee. This month's commentary is provided by Wesley Eilbert, MD, FACEP.

Effect of Emergency Department Nursing Shortage on Emergency Department Throughput Metrics

Zachariah Ramsey, MD, Errick Christian, MS, John Hardwick, MD, Joseph Palter, MD; John H. Stroger Hospital of Cook County Emergency Department, Chicago, IL

Background:

Patient encounter length of stay (LOS) remains an imperative component of delivering quality care in the emergency department (ED). The role of nursing hours on ED patient LOS remains nebulous and studies have shown conflicting results. Our hospital is a tertiary care, safety-net hospital with 254 medical/surgical inpatient beds and 80 ED beds that experienced an ED nursing shortage from 4/1/15-8/4/15. We hypothesize that decreased nursing staffing hours adversely affected ED LOS metrics; namely, door-to-discharge LOS, door-to-admit LOS, and rate of patients that left without being seen (LWBS).

Objective:

To Further define the effect of nurse staffing on ED throughput.

Design/Methods:

Electronic hospital records (EHR) of 105,887 ED visits were retrospectively queried from January 1, 2015 to December 31, 2015. This EHR was collected in conjunction with daily nurse staffing hours, which was gathered from

nurse staffing records over the same time period. The influence of ED nursing hours on important ED LOS metrics was evaluated using analysis of covariance. Total daily ED volume served as the covariate for all models. A binary variable that reflects nursing hours above-mean or below-mean was created and used as the fixed factor. ED patients' daily door-to-discharge LOS, door-to-admit LOS, and the rate of LWBS were used as the dependent variable in each model, respectively. SPSS Univariate GLM procedure was utilized for all analyses.

Results:

While controlling for total daily ED volume, nursing hours have a significant effect on the door-to-discharge LOS, $F(1, 361)=8.15, p < .001$ and the daily LWBS, $F(1, 362)=72.15, p < .001$. When comparing days with below-mean nursing hours to above-mean nursing hours, the door-to-discharge LOS increased by 19.5 minutes. LWBS increased by 6.6 patients per day. Door-to-admit LOS, however, did not appear to be significantly affected by nursing hours.

Conclusion:

Based on the analysis, nursing hours appear to have a significant impact on some ED LOS metrics, namely door-to-discharge LOS and LWBS. Further research is necessary to better understand the intricacy of the multiple factors that contribute to ED LOS.

Impact:

Ours is the first study to objectively demonstrate the significant impact of nursing hours on ED throughput and efficiency.

RESEARCH COMMITTEE COMMENTARY: I'm surprised the ED nursing shortage in this study affected only door-to-discharge times and left without being seen rates and not door-to-admission times. What I'll infer from this study is that when faced with limited manpower, ED

staff will focus their efforts on the sickest patients, i.e. those that require hospital admission.

— Wesley Eilbert, MD, FACEP

Development and Assessment of a Simulation Model of Ongoing Professional Practice Evaluations

Sara Hock, MD, Michelle Sergel, MD, Errick Christian, MS, Rene Carizey, DO, Priya Perumalsamy, MD, Rahul Patwari, MD, Galeta C. Clayton, MD, Dino Rumoro, DO MPH; Rush University Medical Center, Chicago, IL

Background:

Evaluation of procedural skills of practicing physicians has been required by the Joint Commission since 2009, a process known as the Ongoing Professional Practice Evaluation (OPPE). Several methods have been used to assess these skills, including chart review and verbal assessment of the steps to perform a procedure. However, for many medical procedures, these methods do not allow for regularly scheduled objective evaluation.

Objective:

The purpose of this study was to compare simulated procedure performance assessment to verbal procedural performance assessment.

Design/Methods:

Study participants were practicing Emergency Medicine physicians. Seventeen of 26 eligible physicians consented to take part in the study. Two simulated scenarios were developed to assess skill in placing triple lumen central catheters (CL) and in performing a lumbar puncture (LP). Each participant completed both procedures using a simulation and verbal assessment technique. Emergency Physician simulation expert raters utilized previously validated checklists for each procedure, and provided a global assessment of their confidence that the

physician was capable of performing the procedure proficiently.

CONTINUED ON
PAGE 11

	ED LOS for Discharged Pts	ED LOS for Admitted Pts	LWBS
Nursing Hours Below Median	258.9 minutes (95% CI 253.8-264.0)	443.4 minutes (95% CI 431.8-455.3)	20.7 patients (95% CI 19.7-21.7)
Nursing Hours Above Median	239.4 minutes (95% CI 234.2-244.7)	439.5 minutes (95% CI 427.3-451.7)	14.1 patients (95% CI 13.1-15.2)



Power up your future.

Ownership puts us in control.



Sign with a publicly-owned group and it could be game over. To ensure the best for your life and career, you need the power that comes from physician ownership. At US Acute Care Solutions, every full-time physician becomes an equal-equity owner in our group, no buy-in. As physician-owners, we are empowered to provide better care for our patients and the best careers and benefits, including unbeatable student loan refinancing and an industry-leading company-funded 401k. Win the future. USACS.



VEGAS 2016
Visit us at booth 2621



Own your future now. Visit usacs.com
or call Darrin Grella at 800-828-0898. dgrella@usacs.com



Founded by ERGENTUS, APEX, TBEP, MEP, EPPH and EMP



**CHALLENGE
YOURSELF AS
A U.S. ARMY
EMERGENCY
MEDICINE
PHYSICIAN.**

As part of the U.S. Army health care team, you can make a real difference treating the immediate medical needs of Soldiers and their families while also growing in your career:

- You'll work with the most advanced emergency technology and have the opportunity to experience a variety of settings.
- You'll develop as a leader, learn from the best and have the ability to make quality patient care your main focus.
- You'll receive excellent benefits such as special pay, as well as the potential for continuing education and career specialty options.

To learn more about joining the U.S. Army health care team, visit healthcare.goarmy.com/icep or call 847-541-3685.



Research Showcase Abstract Round-Up

from Page 5

Results:

Participants correctly completed more checklist items on the simulation-based technique (CL simulation 83% vs verbal 69%, $p < 0.001$; LP simulation 86% vs verbal 76%, $p < 0.001$). In addition, the simulation based assessment had fewer “unable to observe” items (CL simulation 0% vs verbal 14%; LP simulation 0% vs verbal 5%). Participants above the average score in this study were more likely than those below average (BA) to be rated a “5” or “very confident” on their ability to safely and correctly perform the procedure (CL simulation 88% vs 67% of BA; CL verbal 62% vs 44% of BA; LP simulation 100% vs 67% of BA; verbal 100% vs 80% of BA).

Conclusion:

Our data suggests that a simulation based assessment technique may provide a more accurate assessment of ongoing physician competence in medical procedures than verbal assessment. Additionally, above average checklist performance appears to correlate with higher expert rater confidence regarding physician proficiency.

Impact:

Using a simulated setting for assessment may provide a better assessment of physician proficiency in the same environment where remedial training may be immediately provided.

RESEARCH COMMITTEE COMMENTARY: I'd venture to say that most practicing ED physicians are unaware of this relatively new Joint Commission requirement of ongoing professional practice evaluation, but like all “JC requirements” it's something we're going to have to figure out a way to comply with. This study helps to identify more efficient and practical assessment tools to meet this goal.

— Wesley Eilbert, MD, FACEP

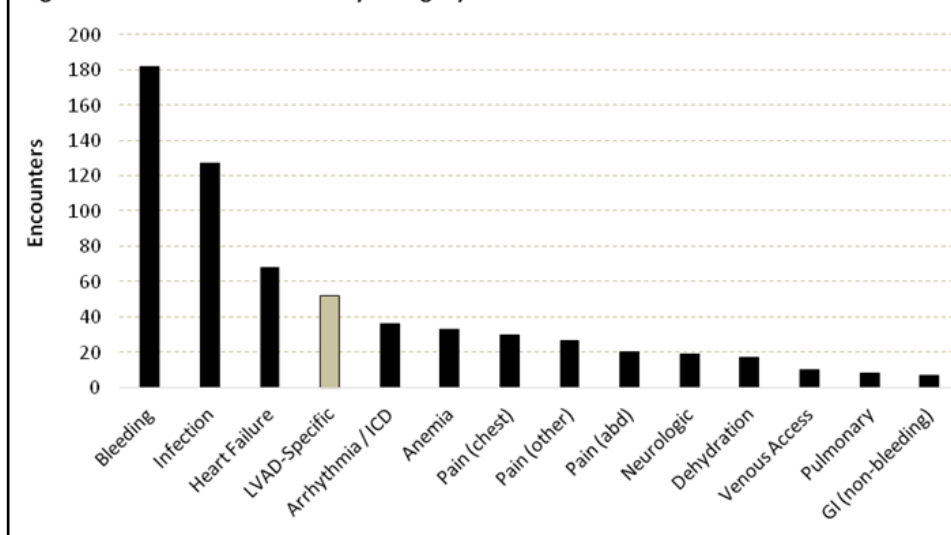
A Descriptive Analysis of Ventricular Assist Device Patients Presenting to an Urban Academic Emergency Department

Anand Gopalsami, MD, Gene Kim, MD, Eric Shappell, MD, James Walter, MD; The University of Chicago, Chicago, IL

Background:

The number of advanced heart failure patients treated with a left ventricular assist device (LVAD) is increasing with over 10,000 device

Figure 1: LVAD ED Encounters by Category



implantations to date. Despite this growing population, little is known about how these patients present to the emergency department.

Objective:

To characterize the ED presentation of LVAD patients in search of themes in epidemiology, evaluation and management that may highlight successful practices as well as areas for improvement in caring for this patient population.

Design/Methods:

A retrospective chart review was completed for all (143) institutional LVAD patients presenting to the ED over a 5-year period between July 1, 2009 and June 30, 2014. Two abstractors reviewed all ED encounters for chief complaint, ED and hospital course, diagnosis and disposition.

Results:

A total of 620 ED encounters were identified. Of these, 431 (70%) resulted in admission, 187 (30%) resulted in discharge, 1 left against medical advice, and 1 left without being seen. Among all encounters 182 (29%) presented with bleeding problems (e.g. gastrointestinal bleeding, epistaxis), 127 (20%) had infections (e.g. bacteremia, driveline infection), 68 (11%) had heart failure exacerbations, and 36 (6%) had an arrhythmia or implantable cardioverter-defibrillator (ICD) fire (see Figure 1). Only 52 encounters (8%) ultimately had LVAD-specific issues. Of these, presenting symptoms were abnormal LVAD readings/alarms in 36 patients, grossly damaged LVAD equipment in 2 patients, and nonspecific complaints in 13 patients. All 13 patients with nonspecific complaints and 10 patients with abnormal device readings were

diagnosed with pump thrombosis. LVAD-specific treatments included hardware exchange in 10 patients and adjustment of device settings in 3 patients. No patients required CPR and no patients died in the ED.

Conclusion:

Greater than 90% of LVAD patient presentations to the ED were unrelated to device function and were managed using traditional techniques. Care for LVAD-specific complications requires familiarity with interpreting LVAD readings and recognition of LVAD thrombosis.

Impact:

LVAD patients often present to their closest ED & community physicians need to be comfortable triaging this complex population. Our study shows the care for a majority of LVAD encounters fall within the scope of EM-trained physicians, but a small subset will still require definitive care at a specialized VAD transplant site.

RESEARCH COMMITTEE COMMENTARY: From g-tubes to external fixators, we in the ED have to know other specialties' devices and their related complications. This well done study does a good job of identifying what issues LVAD patients present with to the ED. It's reassuring to others like me, who don't see these patients on a regular basis, to know that the majority of their ED presentations are unrelated to the LVAD function and require no special treatment. This fact will become increasingly important as we undoubtedly will see more of these patients in the ED in the future.

— Wesley Eilbert, MD, FACEP

ICEP Calendar *of* Events 2016

September 5, 2016

ICEP Office Closed
Labor Day Holiday

September 7, 2016

EMS Committee Meeting
11:00 AM - 1:00 PM
ICEP Board Room
Downers Grove

September 7, 2016

EMS Forum
1:00 PM - 3:00 PM
ICEP Conference Center
Downers Grove

September 9-10, 2016

Oral Board Review Courses
Chicago O'Hare Marriott
Chicago

September 12, 2016

ITLS Illinois Advisory Committee Meeting
10:00 AM - 12:00 PM
ICEP Conference Center
Downers Grove

September 26, 2016

Finance Committee Meeting
9:30 AM - 10:30 AM
ICEP Board Room
Downers Grove

September 26, 2016

Board of Directors Meeting
10:30 AM - 2:30 PM
ICEP Board Room
Downers Grove

September 29, 2016

Resident Career Day
Northwestern Memorial
Hospital, Chicago

September 30, 2016

Emergent Procedures Simulation Skills Lab
Grainger Center for Simulation and Education, Evanston
Hospital, Evanston

October 6, 2016

EM Board Review Intensive Course Committee Conference Call
2:00 PM - 3:30 PM

October 15, 2016

Presidential Inauguration Reception in honor of Dr. Rebecca Parker
6:00 PM - 7:30 PM
Mandalay Bay Ballroom J

November 15, 2016

EM4LIFE 2016 LLSA Article Review Course
ICEP Conference Center
Downers Grove

November 24-25, 2016

ICEP Office Closed
Thanksgiving Holiday

November 28, 2016

Education Committee Meeting
11:00 AM - 1:00 PM
ICEP Board Room
Downers Grove

November 30, 2016

Ultrasound for Emergency Medicine Workshop
ICEP Conference Center
Downers Grove

December 7, 2016

EMS Committee Meeting
11:00 AM - 1:00 PM
ICEP Board Room
Downers Grove

December 7, 2016

EMS Forum
1:00 PM - 3:00 PM
ICEP Conference Center
Downers Grove

December 9, 2016

ITLS Illinois Advisory Committee Meeting
10:00 AM - 12:00 PM
ICEP Conference Center
Downers Grove

December 12, 2016

Finance Committee Meeting
9:30 AM - 10:30 AM
ICEP Board Room
Downers Grove

December 12, 2016

Board of Directors Meeting
10:30 AM - 2:30 PM
ICEP Board Room
Downers Grove



Where Partnership is...

Autonomy Freedom Family Fulfillment

Chicago Suburbs

- Seeking EM trained Rock Star Physician
- 70K Rush Copley near Naperville, IL
- 40 minute drive to downtown Chicago
- 10 docs/day for 1.6-2.0 pts/hr
- Scribes and friendly EMR w/ Dragon
- Nearby freestanding ED shifts available
- *Outstanding Reimbursement Package*
- Fully owned and led by ED Physicians
- Partnership Opportunity after 2 years

Mary Deans-O'Claire
847-697-8868
Mary@EMPactPhysicians.com



www.EMPactPhysicians.com

