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## Spotlight On...Dr. Orlee Panitch

Orlee Panitch, MD, FACEP



1. MD ACEP Position

*I am the current President of Maryland ACEP*

2. Where do you practice?

*I have been with the MEP practice since 1998. In 2016, we merged with other national groups to form USACS.*

*I have always practiced in Maryland, and have worked at many of our sites. Currently, I'm working mostly at Frederick Memorial Hospital, Union of Cecil County, Germantown Emergency Center and Shady Grove Adventist Hospital.*

3. What drew you to Maryland?

*I came to the DC Metro area for residency, following my husband, who came here to practice tax law. After completing my residency at the joint George Washington/Georgetown program (have since separated), we settled in Montgomery County. Soon my kids were born, and we realized that this is a great place to raise a family. We've never left.*

4. What's on your ED playlist?

*Nothing. Most of the time, the ED is noisy enough. But, I love it when someone else plays music. I never do it myself. I suppose if I did, I'd play Tom Petty. Everyone seems to like him. I had the chance to see him live last summer in Baltimore before his tragic end. It's a great reminder of how fragile life can be. And how opioid addiction affects everyone. Absolutely everyone.*

5. What's your favorite thing about EM?

*This is always evolving. In the earlier part of my career, I was completely intrigued by the 'game' of keeping the ED running -the busier, the better.*

*The challenge of taking utter chaos and making it calm. As I have aged, I have really enjoyed the patient interactions, and while it sounds super morbid, I have really gotten a lot of satisfaction out of end of life care. Helping a patient and their family find peace and comfort during very difficult transitions is immensely fulfilling.*

6. Interesting fact about you.

*I LOVE dogs. I have always had dogs, and always will. I have two but would happily have more.*

7. Goal in leadership.

*We are so fortunate to live in Maryland. Maryland has the unique opportunity to be the 'laboratory' for CMMI and CMS - we are trying out new programs here. My goal is to get the Emergency Department at the center of the minds of the HSCRC and other administrators who are planning our innovations. The ED has so much to offer in terms of resources and plays such a large role in the disposition of patient. Our legislators and administrators need to recognize the value the EM plays in the healthcare arena, and work with us.*



### **Sepsis Public Awareness Campaign**

Stefanie K. Gilbert, MD

Department of Emergency Medicine

Adventist HealthCare Shady Grove Medical Center

The state of Maryland recognizes the seriousness and severity of sepsis by recently passing legislation (HB 1467 / SB 574) requiring the development of

a coordinated and comprehensive public awareness and prevention campaign centered around sepsis. As a result, the General Assembly directed the Secretary of the Maryland Department of Health to establish a workgroup to develop this campaign which contained a variety of health care professionals, including an Emergency Medicine physician, among other individuals such as sepsis survivors and family members of patients affected by sepsis.

Highlights of the campaign include defining sepsis in layman's terms, risks associated with sepsis such as lifelong organ dysfunction, amputation and death, symptoms and signs to be cognizant of, what to do if symptoms of sepsis are present including directly communicating the word "sepsis" to healthcare providers, and methods for preventing sepsis including the need for timely identification and treatment of infection.

Also included in the campaign are public-friendly educational resources as well as cost-effective methods for disseminating this important information to the general public. Resources include easy to understand fact sheets, materials specific to the pediatric population, and testimonials from sepsis survivors and family members in the form of online videos which were gathered from a variety of sources including the Centers for Disease Control and Prevention (CDC), the Sepsis Alliance, and the Rory Staunton Foundation among others. A variety of cost-effective methods for information delivery are also outlined including educational flyers in public spaces such as schools and healthcare venues, social media posts, partnerships with local elected Maryland officials, coordinated efforts with the healthcare community including hospitals and Emergency Departments as well as promoting the upcoming Sepsis Awareness Month which is during the month of September and World Sepsis Day on September 13.

Although this robust campaign is specifically tailored to increase the public's awareness of sepsis as dictated by the legislation, we as Emergency Medicine providers certainly play an essential role in educating the public as well through our daily interactions with patients and their visitors every day in Emergency Departments across the state of Maryland. Spread the word about the sepsis, and remember that early identification and rapid treatment, including early antibiotic administration, are vital for sepsis survival.

## **The Kiddie Corner - August 2018**

Erik P. Schobitz, MD, FAAP

Pediatric Drowning



This month we want to review the topic of drowning in children. The purpose of this article is to briefly review drowning in children as to risk factors, presentations, management strategies, and briefly discuss what has been penned in the media as "dry drowning". As a reminder - this is a brief review and not designed to set a standard of care, information is gleaned mostly from "Up To Date" and other readily available sources often while this author is at work clinically so please forgive any misspellings or citation errors!

Every year approximately 4000 people in the US die from drowning and many, many more suffer from nonfatal drowning. Drowning was recently defined as "a process resulting in respiratory impairment from submersion / immersion in liquid" (AHA criteria, Utstein). This definition does not mean only that they died and yes - we know that it's hard for many of us to discharge someone alive with the diagnosis that they drowned! There are three basic outcomes from drowning - they died, they had a nonfatal drowning with illness/injury, or a nonfatal drowning without illness/injury. Per the AHA - terms such as near drowning, secondary or delayed drowning, and wet or dry drowning should not be used.

There is a bimodal distribution of drowning in the US - the first peak in kids less than 5 often from inadequate supervision, and the second peak is among males 15-25 years of age that often occur at beaches, lakes, and rivers. Common risk factors for drowning in the US include: inadequate adult supervision, inability to swim or to swim well enough, risk taking behavior, concomitant drug / alcohol use. Also children with seizure disorder and developmental delays are at higher risk.

How it happens: Children will often panic when submerged, while holding their breath and struggling to stay afloat they will eventually reflexively breathe. The damage is from hypoxia - either from liquid getting into the alveoli and disrupting the surfactant or due to laryngospasm. When the surfactant is disturbed they will become hypoxic - often with pulmonary edema and ARDS. This can take time to develop and warrants observation (discussed below). Neurologically the hypoxia leads to ischemia, neuronal damage, and cerebral edema. Approximately 20% of non-fatal drowning victims sustain a neurological injury. They can also have cardiac arrhythmias, electrolyte abnormalities, and rarely - renal and hematologic insults.

ED management: Upon arrival and after a quick ABCDE evaluation the symptomatic patient should have supportive care as directed by those symptoms. Reasons to intubate include: signs of neurological insult or inability to maintain the airway and signs of impending respiratory failure (tiring from a respiratory standpoint with decreased PaO<sub>2</sub> and elevated PCO<sub>2</sub> despite HFO<sub>2</sub>). For those not requiring intubation (most) provide supplemental O<sub>2</sub> to keep SaO<sub>2</sub> above 94%. A trauma evaluation should also be performed and appropriate imaging as indicated - thankfully C-spine injury is not common (but is possible) with submersion injury. For cold water drowning (very cold water such as falling through the ice, etc.) it is acceptable to continue prolonged resuscitative efforts for as we learned in med school - you're not dead until you are warm and dead. There is limited data on the neuroprotective effect of cold water but there have been some survivors with good neurological outcomes. For symptomatic patients they should be stabilized and admitted to a monitored setting, baseline labs should look for electrolyte abnormalities and (if indicated) consider looking for drug or alcohol use, consider looking for coagulopathy as well. They should have a baseline CXR and EKG. For asymptomatic patients - they should be observed for eight hours (some studies report safely discharging earlier - a review by Dr. Noonan of UTSW showed that all 75 patients studied who became symptomatic did so within 8 hours).

Outcome: Studies suggest that submersion > 5 minutes, time to BLS > 10 minutes, prolonged resuscitation, Age > 14 years, GCS < 5, ED CPR and pH < 7.1 are all associated with a poor outcome - makes sense right.

Dry Drowning and the media: Over the last several years, social media and more traditional media have suggested that delayed death, sometimes days later after no initial symptoms, can occur. They have called this Dry Drowning, a term that has had different meanings through the years and is not considered a medically appropriate term in 2018. Remember, patients should develop symptoms in the first 8 hours after submersion. These symptoms can be mild so that's why we observe the kids. A study of over 41,000 lifeguard rescues found that 0.5% of patients with minimal symptoms eventually died from drowning (Chest 1997). If the symptoms are delayed more than 8 hours - start thinking of other issues (PTX, chemical pneumonitis, pneumonia, etc.). A simple internet search shows that better information to calm this hype is readily available through both medical and lay media sources.

In conclusion: Drowning is a process resulting in primary respiratory impairment from submersion / immersion in a liquid. Hypoxia from surfactant disruption due to aspiration (may be a small amount) and/or laryngospasm causes the injury, associated C-spine injury is possible but rare, symptoms should develop within the first 8 hours after submersion. Symptomatic care and observation for 8 hours is indicated. Thanks to Up To Date and Dr. Seth Hawkins, et al. for providing much of the information for this review.

## **A Resident's Perspective of ACEP's Leadership & Advocacy Conference**

By Ted Fagrelus, MD of Johns Hopkins University

Driving to Washington DC from Baltimore takes you past the area's largest airport, Thurgood Marshall/BWI, named for the famed advocate and Supreme Court Justice. It was Marshall who said, "where you see wrong or inequality or injustice, speak out, because this is your country. This is your democracy. Make it. Protect it. Pass it on."



With Marshall's words in mind, I entered ACEP's 2018 Leadership and Advocacy Conference. In a decade that has seen radical changes to healthcare policy and the practice of medicine, now more than ever is the time to jump in to health policy and advocacy. While there is only so much we can do for our patients during their time in the emergency department, we always have the opportunity to advocate for them (and ourselves as physicians) outside the constraints of a twelve-hour shift. In person advocacy can stir up a mix of emotions; excitement, hope, pride, and even a little anxiety, but it also allows us to put Marshall's words into action, to protect patients and physicians by advocating for stronger healthcare policies at the national level.



Advocacy is an important role of the College and ACEP's annual Leadership and Advocacy Conference is a perfect opportunity to not just "catch up" on healthcare politics, but to develop leadership skills and step forward to make a difference. This conference brings together physician leaders, health policy experts, and national politicians in an exciting integrated conference just off of Capitol Hill -or, for the Hamilton fans out there, "the room where it happens."

As a resident attendee, the core of the conference is Sunday through Tuesday. Although bookended by days for workshops and meetings, the middle threedays of this conference comprise the essential elements. The "Health Policy Primer" presented by EMRA and ACEP's Young Physician Section was a fascinating and inspiring afternoon covering core political topics in health policy. Do not mistake this for a wonky, policy-heavy afternoon of lectures; the engaging and accessible talks with young health policy leaders brought clarity to complex topics such as opioid free EDs and transparency in billing, and prepared us for the legislative visits later in the week. The afternoon continued with a star panel of healthcare journalists- Dan Diamond of Politico, Julie Rovner of Kaiser Health News, and Sarah Kliff of Vox. The three combined have nearly 250K twitter followers and their articles on various healthcare topics have likely come across your newsfeed. Monday was a deeper dive into leaderships skills for physician leaders and break-out sessions focusing on particular issues. As you've likely heard, health insurance giant Anthem has created controversy by offering policies that deny coverage for ED visits that are deemed "inappropriate" (for "non-emergent" complaints). Getting into the nuances of these policies and hearing from ACEP state chapters that have been fighting this issue helped me better understand the implications of such a policy for physicians, patients, and the health insurance market.

Tuesday was the big day -time to take everything we had discussed and learned the previous few days and head to Capitol Hill to make our voices heard. We started the morning with visits from Senator Bill Cassidy (R-LA) and Representative Krysten Senema (D-AZ). They spoke with candor and it was refreshing to their respective opinions on the future of healthcare reform. Next, off to the Hill!

This year, we focused on three major topics for our congressional visits. No surprise to anyone, the issue of opioids was front and center. We advocated for support of The Alternatives to Opioids (ALTO) in the Emergency Department Act and The Preventing Overdoses While in the Emergency Department (POWER) Act. Both are bipartisan bills that provide grants to augment emergency physicians' work on preventing opioid addiction. Second, we urged members of Congress to sign on to a congressional letter to the FDA Commissioner to convene the Drug Shortage Task Force to investigate root causes of drug shortages and develop actionable recommendations for Congress. In the ED, the difference between life and death, or pain and relief, can be a matter of minutes and seconds and patients cannot afford delays. The drug shortage problem is a complex national problem and developing a strategic approach to address the root causes is needed for emergency physicians to be able to provide appropriate and prompt medicines and fluids to patients. The third focus of this year's Congressional visits was encouraging reauthorization of the "Pandemic and All-Hazards Preparedness Act" (PAHPA). Since 2006,

PAHPA has established and enhanced critical elements of the nation's disaster preparedness and response programs. The value of this program lay in the disaster mitigation and communication coordination systems that are in place that help EMS, public health services, and medical facilities provide an integrated response in times of disaster.

Rushing from one side of the Hill to the other made this an exciting and fast paced afternoon. Along with roughly a dozen other enthusiastic Maryland state ACEP chapter members, I met with staff from the offices of Senator Chris Van Hollen, Senator Ben Cardin, Representative Elijah Cummings, and Representative John Sarbanes. It was a great afternoon and a potent reminder of the opportunity we have as emergency physicians to take our passion and expertise to our elected officials. We get to share our experience and encourage our legislators to act on behalf of our patients and their constituents. It was a great conference and a refreshing opportunity to help our patients outside of the emergency department for a change!

## New ACEP Policy Statements and Information Paper

During their June meeting, the ACEP Board of Directors approved the following new or revised policy statements:

- [Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch, and Public Emergency Aid Training](#) - New
- [Appropriate Use Criteria for Handheld/Pocket Ultrasound Devices](#) - New
- [Coverage for Patient Home Medication While Under Observation Status](#) - New
- [Delivery of Care to Undocumented Persons](#) - Revised
- [Disaster Medical Services](#) - Revised
- [Financing of Graduate Medical Education in Emergency Medicine](#) - Revised
- [Guideline for Ultrasound Transducer Cleaning and Disinfection](#) - New
- [Impact of Climate Change on Public Health and Implications for Emergency Medicine](#) - New
- [Interpretation of Diagnostic Imaging Tests](#) - Revised
- [Interpretation of EMTALA in Medical Malpractice Litigation](#) - New
- [Non-Discrimination and Harassment](#) - Revised
- [Patient Autonomy and Destination Factors in Emergency Medicine Services \(EMS\) and EMS-Affiliated Mobile Integrated Healthcare Community Paramedicine Programs](#) - New
- [Prescription Drug Pricing](#) - New
- [Relationship between Clinical Capabilities and Medical Equipment in the Practice of Emergency Medical Services Medicine](#) - New
- [Resident Training for Practice in Non-Urban/Underserved Areas](#) - Revised

The Board also reviewed the information paper [Emergency Department Physician Group Staffing Contract Transition](#) (PDF)

## Articles of Interest in Annals of Emergency Medicine

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.

Duber HC, Barata IA, Cioe-Pena E, Liang SY, Ketcham E, Macias-Konstantopoulos W, Ryan SA, Stavros M, Whiteside LK. **Identification, Management and Transition of Care for Patients with Opioid Use Disorder in the Emergency Department**

In this clinical review article, they examine the current body of evidence underpinning the identification of patients at risk for OUD, ED-based symptomatic treatment of acute opioid withdrawal, medication-assisted treatment (MAT) of OUD upon discharge from the ED, and transition to outpatient services. In this article they also present options for targeted opioid withdrawal and management, as well as a variety of other medications to consider for symptomatic opioid withdrawal treatment for patients that do not require opioids for acute pain. Full text available [here](#).

Klein LR, Driver BE, Miner JR, Martel ML, Hessel M, Collins JD, Horton GB, Fagerstrom E, Satpathy R, Cole JB. Intramuscular Midazolam, Olanzapine, Ziprasidone, or Haloperidol for Treating Acute Agitation in the Emergency Department

In this prospective observational study of 737 patients, medications were administered based on an a priori protocol where the initial medication given was predetermined in the following 3-week blocks: haloperidol 5mg, ziprasidone 20mg, olanzapine 10mg, midazolam 5mg, haloperidol 10mg. The primary outcome was the proportion of patients adequately sedated at 15 minutes, assessed using the Altered Mental Status Scale (AMSS). Results showed that Intramuscular midazolam achieved more effective sedation in agitated ED patients at 15 minutes than haloperidol, ziprasidone, and perhaps olanzapine. Olanzapine provided more effective sedation than haloperidol. No differences in adverse events were identified. [Full text available here.](#)

Brenner JM, Baker EF, Iserson KV, Kluesner NH, Marshall KD, Vearrier L. **Use of Interpreter Services in the Emergency Department**

This paper highlights the importance of effective communication in the provider-patient therapeutic relationship and how language barriers have the potential to compromise all aspects of medical care. The authors identify that in the US, as of 2013, more than 25 million persons had limited



English proficiency, making quality medical interpreter services an important public health issue that affects a large proportion of our diverse population. They recommend that a professional interpreter should be offered if practical and available when a patient has either limited English proficiency or hearing impairment and that a modality of interpretation should be chosen between in-person, video, or telephone based on what best suits the clinical situation. [Full text available here.](#)

Nowak RM, Gandolfo CM, Jacobsen G, Christenson RH, Moyer M, Hudson M, McCord J. **Ultra-Rapid Rule-Out for Acute Myocardial Infarction Using the Generation 5 Cardiac Troponin T Assay: Results from the REACTIONUS Study**

The objective of this study was to determine how well a new FDA approved single cardiac troponin T Generation 5 (cTnT Gen 5) below the level of quantification (6 ng/L) baseline measurement and a novel study derived baseline/30 minute cTnT Gen 5 algorithm might adequately exclude acute myocardial infarction (AMI) in patients with suspected acute coronary syndrome (ACS) in a United States (US) Emergency Department (ED). They enrolled patients presenting with any symptoms suspicious of ACS. Baseline and 30 minute blood samples were obtained, the cTnT Gen 5 levels later batch analyzed in an independent core lab and the AMI diagnosis was adjudicated by a cardiologist and an emergency physician. They found that a single baseline cTnT Gen 5 measurement <6 mg/L and values at baseline <8 ng/L and a delta 30 discharge to were randomized to receive 2 L of Lactated Ringer's (LR) or NS. The primary outcome was symptom scores measured by the validated Quality of Recovery-40 (QoR-40) instrument (scores 40-200) 24 hours after enrollment. Results showed that there was no difference in post-enrollment QoR scores between NS and LR groups. Although pre-enrollment scores were higher in the LR group, adjusting for pre-survey imbalances did not change the primary outcome. The authors concluded that NS and LR were associated with similar 24-h recovery scores and 7-day health care utilization in stable ED patients.



### Emergency Ultrasound Tracker

Emergency physicians regularly apply for hospital credentials to perform emergency procedures including emergency ultrasound. Theoretically, ultrasound training, credentialing and billing should be no different than other emergency procedures where training occurs in residency and an attestation letter from the residency is sufficient for local credentialing. When such training occurs outside of residency, "proctored pathways" often serve to assure competency. There is still a lack of understanding and awareness in the general medical community that emergency physicians

routinely train in and perform point-of-care ultrasound.

The [Emergency Ultrasound Tracker](#) was created to assist members in achieving official recognition of ultrasound skills. This tool allows you to easily keep track of ultrasound scans you have performed over the course of your career in emergency medicine. It also allows you to upload relevant documents that attest to your training. After inputting and self-attesting to your ultrasound information you may download a letter of recognition from ACEP so long as you have attested to meeting the recommendations for emergency ultrasound training put forth in the [ACEP Ultrasound Guidelines](#). We hope you find this tracker tool helpful and useful in your practice.

## ED ICU Development and Operations Workshop Pre-Conference

San Diego Convention Center, Upper Level, 7B  
Sunday, September 30, 2018 | 12:30 pm to 5:00 pm

If you have ever considered developing an ED ICU this workshop is for you. Participants will learn about staffing, reimbursement, collaborations, and business plan development, with the goal of developing and running their own ED-ICU. This program is directed at those along the entire continuum of ED-ICU development from conceptual to operational phases. [Register here](#). For more information, contact [Margaret Montgomery, RN MSN](#).



## American Board of Emergency Medicine

### Subspecialty Certification in Neurocritical Care

The American Board of Medical Specialties (ABMS) has approved subspecialty certification in Neurocritical Care (NCC). NCC is co-sponsored by the American Board of Anesthesiology (ABA), the American Board of Emergency Medicine (ABEM), the American Board of Neurological Surgery, and the American Board of Psychiatry and Neurology (ABPN). Physicians certified by these four boards who meet the eligibility criteria for NCC will have the opportunity to become certified in NCC.

There will be two pathways to certification in NCC: a training pathway and a time-limited practice pathway. The practice pathway will start at the time the first exam is offered. Eligible pathway criteria will be posted on the ABEM website by the end of 2018. ABPN will develop and administer the examination; physicians will submit applications to their primary certifying board. The first examination is expected to take place in either 2020 or 2021.

## Letter Available Refuting Merit Badge Requirements

ABEM provides a letter of support that may be submitted to hospital administrators to forego the mandatory completion of short courses or additional certifications ("merit badges") often needed for hospital privileges. Physicians must be participating in the ABEM MOC Program to obtain the letter.

The letter, signed by each representative of the Coalition to Oppose Medical Merit Badges (COMMB), details specific activities that board-certified physicians perform to maintain certification. ABEM-certified physicians can now download the letter from their Personal Page on the ABEM portal by doing the following:

- Sign in to the ABEM portal at [www.abem.org](http://www.abem.org)
- On the left navigation, click "Print Verification of ABEM Status"
- Under letter type, click "General Coalition ABEM"
- Click "Continue to Next Step"

## Take the ConCert™ Early - Retain Your Current Certificate Date

You can take the ConCert™ Examination during the last five years of your certification (during the annual testing window). If you pass the exam early, you will still retain your certification until the expiration date on your current certificate. This is also true even after you complete all of your MOC requirements. When your current certification expires, you will be issued a new, ten-year certificate. If you take the ConCert™ Examination early and do not pass, you still retain your certification and have another chance(s) to pass it. ABEM only reports whether a physician is board certified and participating in MOC.

In 2017, 44 percent of ConCert™ test takers registered to take the exam early; that is, in a year prior to their final year of certification.

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