

COMMONSENSE

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AAEM Mission Statement

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine and to ensure a high quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

Membership Information

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President's Message

What Does a Democratic Emergency Physician Group Look Like?

Mark Reiter, MD MBA FAAEM
AAEM President

In a famous 1964 Supreme Court case, Justice Potter Stewart described his test for defining pornography as “I know it when I see it.” Similarly, defining whether an emergency physician group is “democratic” is often in the eye of the beholder. In addition, there is a wide continuum between a completely democratic group and one that is not at all democratic, with most groups falling somewhere in between. From my perspective, there are four key criteria to assessing how democratic a group is.

1. **Political equity** — a fair voice in the decisions of the group.
2. **Financial equity** — a fair share of the profits and assets of the group.
3. **An equitable pathway to partnership** — fair length, clearly stated expectations, transparent process, and fair outcome.
4. **Group transparency** — especially in financial affairs.

“Fair” is what subjectively seems reasonable to the individuals involved. There is, of course, a wide spectrum of what is “fair.” I consider fairness in political equity to mean either each partner has an equal vote in major decisions or each partner has an equal vote in electing representatives who make those decisions.

I consider fairness in financial equity to mean each partner earns a portion of the group’s profits based on either percentage of hours worked or percentage of billings/collections, with any adjustments for factors such as schedule, performance, administrative duties, etc., made transparently and by majority agreement of the partners. Each partner should have a claim to their share of group assets, such as their portion of accrued collections not yet paid out.

I consider a fair path to partnership to be no more than two or three years in length, and a fair income differential (for the same work) between partner and associate to be at most 20-30%. The criteria for partnership should be clear, and upon satisfaction of those criteria partnership should be virtually assured.



I consider transparency to mean that the business of the group is open to all partners, and in most circumstances partnership-track associates. Sensitive information — especially financial information such as group expenses and the billings, collections, and compensation for each member of the group — should be automatically provided to all partners since many will be uncomfortable requesting this information.

Emergency physicians are not naive — “I know it when I see it” often applies. Highly qualified emergency physicians will seek out fair, democratic groups and avoid unfair, undemocratic groups. Fair, democratic groups will have minimal turnover while unfair, undemocratic groups will often have a revolving door for physicians. I encourage all emergency physicians to periodically examine their group’s structure and processes, and to strive to ensure that the group lives up to their ideals. ■

We're listening, send us your thoughts!



Come to Las Vegas and Vote!

Andy Walker, MD FAAEM
Editor, *Common Sense*



I write this column the day after returning from Rome, site of the very successful eighth biannual Mediterranean Emergency Medicine Congress (MEMC VIII). If you weren't there, you missed a great meeting in one of the world's greatest cities. Rome is full of magnificent art, important history, and superb food — and gelato! — and the MEMC is always a fascinating and high-quality conference. And it is always in a fantastic location. If you weren't in Rome for MEMC VIII, you should first kick yourself and then plan on using some of your CME money for MEMC IX in two years.

Even if you missed MEMC VIII, the good news for you is that in just a few months you can attend what I believe is the best emergency medicine conference in the world, the AAEM Scientific Assembly. The 22nd Annual Scientific Assembly will be held February 17-21 at the Planet Hollywood Resort and Casino in Las Vegas. If you have never attended the Scientific Assembly, you will be amazed at how much better it is than any other meeting in our specialty. If you have attended before, I know I will see you there again.

While at the Scientific Assembly, I urge you to come to AAEM's annual business meeting and election forum. At the business meeting you will be briefed on the state of our Academy by its president, Mark Reiter, and hear about all the things the Academy has done over the past year to protect you and your patients — things no other specialty society in emergency medicine even attempts. One of the things you will hear about is the launch of the AAEM Physician Group, a revolutionary new way for the Academy to support existing independent, democratic, physician-owned emergency medicine groups and create new ones. We hope the AAEM Physician Group will give hospital administrators a place to turn for emergency department staffing other than the exploitative, unfair, lay-owned staffing corporations we unfortunately know so well.

You will also get to hear from those running for AAEM offices and for the board of directors, ask them questions, and judge their answers. **This is important.** AAEM is doing away with the position of vice-president and substituting the position of president-elect. Thus, at the 2016 Scientific Assembly you will be voting for both the Academy's president and its president-elect — the next four years of our top leadership position in one election. The secretary-treasurer's job is also up for grabs, as are three at-large positions on the Academy's board of directors and the YPS director slot on the board. If you see the candidates in person and ask them questions face to face before you vote, you will cast a better vote than if you rely on their written statements in *Common Sense* alone.

Submit a "Letter to the Editor" at www.aaem.org/publications/common-sense/letters-to-the-editor.



" While at the Scientific Assembly, I urge you to come to AAEM's annual business meeting and election forum ... you will get to hear from those running for AAEM offices and for the board of directors, ask them questions, and judge their answers. **This is important.** **"**

I was on the Academy's board of directors for several years, up until last February, and because I am editor of *Common Sense* I still attend board meetings as an *ex officio* member. Although I have been in the minority position on a couple of important issues recently, I remain in awe of and grateful for the intelligence and character of those on AAEM's board of directors. If you have been made cynical by the corruption and conflicts of interest that seem so rampant in American health care, seeing the Academy's board in action will restore your hope. Every single person on the board is smart, ethical, and committed to the belief that:

A physician's primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference.

If you believe in AAEM's Mission and Vision Statements and want to push emergency medicine back in the right direction, you should run for a leadership position or serve on a committee or task force — or nominate someone you know who would make a valuable contribution. But if you can't do that, at least be an active participant in the Academy's elections. Simple as it is, that is a critically important role — especially since AAEM's leadership is elected directly by its members (one of the things that I believe makes AAEM superior to ACEP). At the very least read the candidate statements carefully and vote, but I urge you to come to Las Vegas and see the candidates in person instead. You will be glad you did. And as I said, AAEM's Scientific Assembly is the best meeting in the emergency medicine world. And it's in Las Vegas! ■

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AAEM Holds Capitol Hill Advocacy Day

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On September 29, AAEM members descended upon Capitol Hill for a breakfast discussion of key issues facing emergency physicians, followed by a day of meetings with Senators, House Members, and Congressional staff. Led by the AAEM Government Affairs Committee and the AAEM Residents and Students Association (AAEM/RSA), residents, students, AAEM board

members, and Government Affairs Committee Members all participated in the 2015 Advocacy Day. In total, the group participated in over 40 meetings, and gathered over lunch to receive remarks from Congressman Joe Heck (R-NV), who is seeking to become the only emergency medicine physician to be elected to the United States Senate.

The need to protect due process rights for physicians was among the primary topics discussed during meetings on Capitol Hill. Citing their personal experiences, AAEM members discussed this issue from the viewpoint of patient safety. AAEM noted the broad support among the physician community for the protection of these rights. Other issues discussed at these meetings were the need for more funding for Graduate Medical Education (GME), the problem of rising medical student debt, and feedback on the Medicare Sustainable Growth Rate (SGR) replacement policy being developed as a result of the passage of legislation repealing the SGR earlier this year.

AAEM Comments on Physician Payment Policy

On September 28, the Centers for Medicare and Medicaid Services (CMS) issued a Request for Information (RFI) regarding implementation of several aspects of the new payment model that will eventually replace the Medicare Sustainable Growth Rate (SGR). SGR was repealed earlier this year by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The legislation mandates a period of stable 0.5 percent Medicare payment increases over the next five years before a new payment system for Medicare goes into effect. This period is intended to provide CMS time to work with physician specialty groups, medical societies, patient advocates, and other stakeholders to develop a system that incentivizes quality and efficient care while rewarding good providers with higher payments.

As part of the first step of this process, CMS sought comments on the Merit-based Incentive Payment System (MIPS), the use of Alternative Payment Models (APMs), and incentive payments for participation in APMs. AAEM provided comments offering the perspective of emergency medicine on the criteria for earning incentive payments and the use of APMs. AAEM encouraged CMS to develop an incentive structure that

allows emergency physicians to engage in a patient-centered system that is free from corporate influence. The Academy also highlighted some of the challenges of developing appropriate APMs given the unique nature of emergency care, and encouraged CMS to develop robust options to allow emergency physicians to choose from a range of payment models that will give them an opportunity to earn bonus payments.

AAEM asked CMS to avoid applying a one-size-fits-all payment model to emergency medicine, and to consult with AAEM and other stakeholders that have already established clinical guidelines and principles for emergency care that can be incorporated into the new payment model.

Congress Embarks on New Era of ACA Changes; Continues Work on Drug Development and NIH Funding

In September, Congress passed the bipartisan Protecting Affordable Coverage for Employees Act, which provides states the authority to prevent companies with 51 to 100 employees from being forced into the "small group" health insurance market starting in 2016. While targeted in scope, the bill represented the most significant legislative change to date of the Affordable Care Act (ACA) in the five years following its passage. The ease at which this legislation passed Congress with the support of both parties signaled an end to years of resistance by some Members of Congress to make improvements or changes to the law.

Members of Congress that have championed other ACA modifications are now optimistic that their proposals could be next. These include a number of efforts with some bipartisan support, such as repealing the ACA's 2.3 percent excise tax on medical devices and the so-called "Cadillac tax" on high cost health plans. However, both of these efforts would have to be paired with revenue increases or spending cuts to replace the money lost by repealing the provisions, and it will be challenging for Members of Congress to find an agreement to move forward.

Congressional committees have also started the process of making recommendations on the budget reconciliation process, which would allow a package of ACA changes to advance through the U.S. Senate with 51 votes rather than 60. To date, the Committee has reported recommendations for modifying the ACA including repeal of the law's individual and employer mandates, repeal of the medical device tax, and repeal of the Cadillac tax. The legislation may also repeal the Independent Payment Advisory Board (IPAB), which has been raised as a concern by physician groups and advocates for seniors since passage of ACA. The IPAB, which still does not have any appointees, would be composed of a 15 member panel that would ultimately be empowered to make recommendations that could adversely impact coverage under Medicare. Finally, the bill may also defund the remaining balance of the ACA's Prevention and Public Health Fund, which was established to provide dedicated funding for public health.

Continued on next page



AAEM and AAEM/RSA members gather on Capitol Hill for 2015 Advocacy Day. The group participated in over 40 meetings.



Senator John Barrasso (R-WY) (left) with AAEM past president, William Durkin, Jr., MD MBA FAAEM (right)

While the reconciliation process is likely to land a bill on the President's desk that makes significant changes to the ACA, the President is expected to veto such a bill and Congressional Republicans likely lack the votes to override his opposition in the House or Senate.

Meanwhile, a bipartisan, bicameral effort continues to advance legislation to enhance drug and medical device development by establishing new approval pathways and streamlining certain requirements. A bill approved by the House in July would also authorize a substantial increase in funding for the National Institutes of Health (NIH) over the next five years.

Leaders on the Senate Health, Education, Labor and Pensions (HELP) Committee are examining their own proposal that seeks to modernize the drug development process. The Senate has yet to release legislation, but they have held hearings exploring improvements to the drug discovery and approval process, and received testimony from the NIH, the U.S. Food and Drug Administration (FDA), and others. Given the bipartisan support for many of the improvements being considered by the House and Senate, advocates of the legislation remain hopeful that a bill could be signed into law by President Obama by the end of 2016. ■

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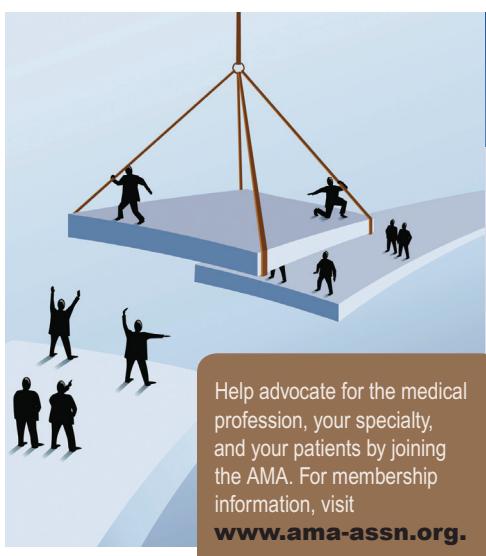
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Join the AMA!

Having the support of physicians from many specialties can help us resolve some of EM's most important problems. Currently, AAEM has no seats in the American Medical Association (AMA) House of Delegates (HOD). Help us reach our goal of 50% of AAEM members also holding membership in the AMA so we can add our voice to the deliberations with a seat in the HOD.

Help advocate for the medical profession, your specialty, and your patients by joining the AMA. For membership information, visit www.ama-assn.org.

Upcoming Conferences: AAEM Directly & Jointly Provided and Recommended

AAEM is featuring the following upcoming conferences and activities for your consideration. For a complete listing of upcoming conferences and other meetings, please visit: www.aaem.org/education/aaem-recommended-conferences-and-activities.

AAEM CONFERENCES

February 17-21, 2016

- 22nd Annual AAEM Scientific Assembly
Las Vegas, NV
www.aaem.org/AAEM16

AAEM JOINTLY PROVIDED CONFERENCES

November 12, 2015

- California Chapter Division (CAL/AAEM) San Francisco Speaker Series
San Francisco, CA
www.calaaem.org/news

November 19, 2015

- Delaware Valley Chapter Division (DVAAEM) Residents' Day and Meeting
Philadelphia, PA
www.aaem.org/membership/chapter-divisions/dv-residents-day

AAEM-RECOMMENDED CONFERENCES

November 20-22, 2015

- The Difficult Airway Course: Emergency™
San Diego, CA
www.theairwaysite.com

December 6-10, 2015

- Emirates Society of Emergency Medicine
Abu Dhabi, United Arab Emirates
www.esemconference.ae

December 6-11, 2015

- 36th Annual Current Concepts in Emergency Care
Maui, HI
<http://emergenciesinmedicine.com>

January 14-18, 2016

- International Conference in Emergency Medicine and Public Health (ICEP-Q) 2016
Doha, Qatar
www.hamad.qa/EN/All-events/EMC5

March 18-20, 2016

- The Difficult Airway Course: Emergency™
Phoenix, AZ
www.theairwaysite.com

April 8-10, 2016

- The Difficult Airway Course: Emergency™
Atlanta, GA
www.theairwaysite.com

April 29-May 1, 2016

- The Difficult Airway Course: Emergency™
Boston, MA
www.theairwaysite.com

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Emily DeVillers to learn more about the AAEM endorsement and approval process: edevillers@aaem.org.

All provided and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

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22ND ANNUAL SCIENTIFIC ASSEMBLY

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FEBRUARY 17–21, 2016



Congratulations – AAEM Physicians Certified for 30 Years

This year, the American Board of Emergency Medicine (ABEM) is recognizing emergency physicians who have marked 30 years or more of being board certified in emergency medicine.

AAEM joins with ABEM in recognizing the dedication these physicians show to our specialty, the recognition of the value of board certification, and their commitment to caring for acutely ill and injured patients. Thank you.

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Lily Christine Anne Conrad, MD	Gary Edward Gries, MD	Richard D. Kraft, MD	Myo Nwe, MD	Stuart Alan Simon, MD	† Deceased
Kenneth Alan Corre, MD	Mark L. Grobelny, MD	Richard S. Krause, MD	John J. O'Donnell, MD	Anna Sinclair, MD	
Adam Costarella, MD	Paul B. Grossman, MD	William Gerard Kristan, MD	David W. Olson, MD	Asok K. Sinha, MD	

Planning Your Personal Finances — How to Select a Financial Adviser

Joel M. Schofer, MD MBA CPE FAAEM
Secretary-Treasurer, AAEM
Commander, U.S. Navy Medical Corps



Whether you are managing your investments by yourself or getting help, you need to understand one critical concept: the expense ratio of your investments. Every mutual fund and exchange-traded fund (ETF) has an expense ratio, and keeping it as low as possible is key to your long-term financial success.

What is an expense ratio?

The expense ratio is the percentage of a fund's assets that are used to pay expenses. In other words, if you invest in a mutual fund with a 1% expense ratio and that fund makes 10% in 2015, you'll only get a 9% return on your investment because 1% goes to pay expenses. The less of your return used to pay expenses, the more you get to keep for yourself.

“ Small differences in expenses can make huge differences in long-term investment returns, so you need to pay attention to the expense ratios of your investments.”

What is the average expense ratio?

An average stock mutual fund has an expense ratio of 1%, but the expense ratios for mutual funds that are similar in composition can vary wildly. For example, if you look at a list of Standard & Poor 500 index funds, you will find expense ratios as low as 0.05% (Vanguard S&P 500 Index Fund Admiral Shares, VFIAX) and as high as 0.6% (Great-West S&P 500 Index, MXVIX). While 0.55% does not seem like a big difference, keep in mind that costs endure forever, and small differences compounded over years will cost you a lot of money.

Let's pretend that when you are 25 years old your grandparents give you \$10,000 to invest in an S&P 500 index fund for 50 years, during which you earn a 9.5% return. If you invest in the Great-West index fund with the 0.6% expense ratio, you will wind up with \$683K. If you invest in the

Vanguard index fund with the 0.05% expense ratio, you will have \$902K. That 0.55% difference in expense ratios costs you \$219,000! Small differences in expenses can make huge differences in long-term investment returns, so you need to pay attention to the expense ratios of your investments.

This difference is even more dramatic when you compare actively managed funds to passively managed index funds. Because actively

managed funds have higher expense ratios than index funds, it is very difficult for an active manager to beat the comparable index over the long-term. That is why I invest 100% in index funds.

When you are picking your investments, keep in mind that you can't control what happens to the market but you can control which investments you choose and the expenses you pay. Any time you are looking

to invest in a mutual fund or ETF, you should search for similar funds and compare expense ratios, which you should try to keep below 0.5% (or even 0.25%, if possible). At a minimum, make sure you take a look at the Vanguard version of the investment you are considering, since its expense ratios are the lowest in the industry and Vanguard never charges extraneous fees, like loads. There is no reason to pay higher expenses for what is essentially the same investment product. It will cost you a ton of money over the long-term.

If you have ideas for future columns or have other resources you'd like to share, email me at jschofer@gmail.com.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense or the United States Government. ■



Join Us in Las Vegas! A Special Invitation from the Scientific Assembly Subcommittee

Christopher Doty, MD FAAEM
Evie Marcolini, MD FAAEM
AAEM16 Subcommittee Co-Chairs

The 22nd Annual Scientific Assembly Subcommittee is very excited about the upcoming conference — it is shaping up to be a “don’t miss” event. By popular demand, we will be meeting in Las Vegas at the new Planet Hollywood Hotel and Casino, February 17-21, 2016. Las Vegas is a favorite destination for many, with its easy access, temperate winter weather, and multitude of options for cuisine and entertainment. But that’s not all...

Our lineup this year will entice all of you in one way or another. We have combed through your evaluations and suggestions and will feature not only your favorite speakers, but new and exciting ideas that build on the innovation started by Joe Lex and the Pecha Kucha (PK) sessions.

In addition to the PK sessions we will bring back the perennial favorite, Point-Counterpoint, so be prepared for fiery topics such as “Naxolone Prescriptions from the ED” and “Gun Control is a Public Health Problem.” We have also added new tracks such as “Palliative Care in the ED” and “When to Say No to Your Consultant.”

We look forward to focused tracks hosted by the Resident and Student Association (AAEM/RSA) & the Young Physicians Section (YPS), EMS Committee, and Women in Emergency Medicine Interest Group, as well as the ever-popular Open Mic and AAEM/JEM Resident & Student Research Competition.

Our pre-conference sessions are typically in high demand and this year should be no different, so sign-up early for popular sessions such as Resuscitation, Ultrasound, Simulation, and EKG Review. The 2015 LLSA Review Course will be back. This is a great way to fulfill the LLSA requirement, in a collaborative interactive session where learning is key.

We have worked hard to stick with successful traditions and favorite speakers at the AAEM Scientific Assembly, and have balanced that with

new ideas and innovations. Our AAEM16 Subcommittee comprises a solid group of folks, steeped in education at their home institutions and dedicated to bringing you educational content that stimulates and informs. We aim to keep you abreast of the latest in emergency medicine and leave you wanting more.

“We have worked hard to stick with successful traditions and favorite speakers at the AAEM Scientific Assembly, but have worked equally hard to balance that with new ideas and innovations.”

We ask one favor of you. For each session and at the end of the conference, please take the time to give us feedback. As we go through this process every year, it is critically important to know what you liked, what you didn’t like, and why. We value your thoughts and ideas and use them to shape next year’s program. Constructive feedback is very useful to the individual speakers. We appreciate that it does take some time, but in the spirit of AAEM we want to present a conference that is valuable and interesting to you.

Registration is now open, so visit www.aaem.org/AAEM16 today! Thanks, and see you in Vegas! ■



See you in Las Vegas!

“AAEM’s Annual Scientific Assembly — perpetually advancing emergency medicine for the clinician and proudly the premier clinical conference in emergency medicine.”

Scientific Assembly Highlights



Invite a Friend

If you’re a veteran of Scientific Assembly, or if you’re planning on attending for the first time in 2016, consider inviting a friend or colleague to join you. Encourage residents and medical students interested in emergency medicine to attend as well. CME will be available; presented by the top clinician educators in emergency medicine.

Travel to Las Vegas

In addition to attending the premier clinical conference in emergency medicine, take advantage of all the city has to offer. While planning an evening of entertainment, look to the growing roster of gourmet restaurants and unparalleled wine and food adventures in Las Vegas. A host of fine dining and lifestyle magazines have honored the city for its fantastic fare and hailed individual restaurants for their exquisite cuisine. To accompany its growing list of world-class chefs, Las Vegas has attracted more master sommeliers than any other U.S. city. After dinner, you can experience a variety of night spots — there are many reasons why Las Vegas commands the title as “The Entertainment Capital of the World.”

If you’re visiting Las Vegas, from outside the United States, you may need a visa to enter the country. Visa requirements for entering the United States can be found at: www.aaem.org/AAEM16/travel.

EXHIBITING OPPORTUNITIES

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VIEW THE EXHIBITOR PROSPECTUS AND LEARN MORE ABOUT SPONSORSHIP
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Register

For up-to-the-minute information about registration and Scientific Assembly — follow AAEM on social media. Visit AAEM Connect, our interactive dashboard, to view updates from Facebook, Twitter, LinkedIn, the AAEM blog, and podcasts at www.aaem.org/connect. Look for hashtag #AAEM16. ■



Thank You!

AAEM 2014 100% ED Group Membership

- Amarillo Emergency Physicians — TX
- American University of Beirut — Beirut, Lebanon
- Campbell County Memorial Hospital — WY
- Cascade Emergency Associates — WA
- Chesapeake Emergency Physicians — VA
- Doctor Urgent Care Clinic — LA
- Drexel University College of Medicine — PA
- Eastern Carolina Emergency Physicians (ECEP) — NC
- Edward Hospital — IL
- Emergency Physicians of Community Hospital Anderson (EPCHA) — IN
- Emergency Physicians at Sumner, PLLC (EPAS) — TN
- Emergency Specialists of Oregon (ESO) — OR
- Florida Hospital — FL
- Fort Atkinson Emergency Physicians (FAEP) — WI
- Fredericksburg Emergency Medical Alliance, Inc. — VA
- Glendale Adventist Emergency Physicians, Inc. — CA
- Long Beach Emergency Medical Group — CA
- Newport Emergency Physicians, Inc. — RI
- North ED Physicians — FL
- Northeast Emergency Associates — MA
- Physician Now, LLC — VA
- Salinas Valley Memorial Hospital — CA
- Southern Colorado Emergency Medical Association (SCEMA) — CO
- Temple University Hospital — PA

We would like to recognize and thank the following ED groups for participating in our 2014 100% and 2/3 Group Membership. We sincerely appreciate the enthusiastic and continuous support of these physicians and their groups.

- University of Louisville — KY
- University of Mississippi — MS
- West Jefferson Emergency Physicians Group — LA

AAEM 2014 ED Group Membership

- BayCare Clinic, LLP — WI
- Middle Tennessee Medical Center — TN



Strength in Numbers AAEM 100% ED Groups

■ AAEM 100% ED Group Membership

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified and board eligible physicians. Each hospital/group that participates in the group program will now have the option of two ED Group Memberships.

- 100% ED Group Membership — receives a 10% discount on membership dues. All board certified and board eligible physicians at your hospital/group must be members.
- ED Group Membership — receives a 5% discount on membership dues. Two-thirds of all board certified and board eligible physicians at your hospital/group must be members.

For these group memberships, we will invoice the group directly. If you are interested in learning more about the benefits of belonging to an AAEM ED group, please visit us at www.aaem.org/membership/aaem-ed-group-membership.

For a complete listing of 2015 100% ED Group members, go to www.aaem.org/membership/aaem-ed-group-membership.



The Ultimate EMR Plugin



A close-up photograph of a person's eye, showing the iris, pupil, and surrounding skin. The person appears to be wearing a blue surgical mask or cloth over their nose and mouth. The eye is looking directly at the camera.

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Prospective Case Management of Admissions in the ED at The Hospital of the University of Pennsylvania (HUP)

Thomas W. Kramer, MD
Ali S. Raja, MD MBA MPH
Angela M. Mills, MD

Introduction

Because the Centers for Medicare and Medicaid Services (CMS) is focused on the appropriate utilization of inpatient resources, it has mandated case-management and utilization review of all observation and inpatient admissions in hospitals receiving CMS payments. In response to cost pressures and demands for clinical efficiency, many emergency departments (EDs) have created observation units. At HUP — a large, academic, inner-city hospital with 650 beds and two local affiliates — we have a dedicated 17-bed Observation Unit (OBS). Initially managed by a hospitalist team, OBS was quickly turned over to the ED in order to decrease the average length of stay (LOS) of its patients — a move that was successful.

Our OBS has existed in its current form for about four years. Initially it focused on providing protocol-driven care for complaints such as chest pain, syncope, gastroenteritis/dehydration, and cellulitis. However, over this same time period insurers (particularly CMS) created more stringent rules for reimbursement of hospital admissions. In our region these rules are based on InterQual criteria. InterQual has been in existence for over 35 years and was originally designed to help with quality assurance for the Medicare and Medicaid programs. At the time, medical practice varied greatly between physicians, hospitals, and regions. InterQual and similar criteria were designed to create “norms” around treatment, LOS, and disposition. These criteria have evolved over time and now include criteria for observation, acute, and critical care admissions. InterQual is now being used as a case-management tool, to help guide the decision on whether a patient is placed in observation or admitted as an inpatient.¹

Case Management Models

Though hybrid models exist, there are two basic approaches to case-management review for level of care: retrospective and prospective. These reviews are commonly based on InterQual, Milliman, or other guidelines determined by regional trends.²

Retrospective Review

This is historically the most common approach. The patient is either admitted or placed in observation based on the judgment of the emergency and admitting physician. While the patient is in the hospital a case management team performs a review to determine final billing status.

Prospective Review

This approach has become increasingly common, and involves ED-based case review. It is now one of the approaches recommended by ACEP in a Clinical & Practice Management review.³ ED-based case managers work with physicians at the time of bed request, and use criteria such as InterQual to help determine the appropriate level of care. It should be noted that these criteria are guidelines, and that the emergency and admitting physician still control the level of care decision.



“As case management evolves and becomes more heavily ED-based, it is important to consider the new team dynamics up front.”

One of the main drivers of the increase in ED-based case management is reimbursement policy. CMS and other payers have become increasingly strict. Failure to provide adequate documentation regarding the need for admission often results in denial of payment. Typical hospital margins are <5%, so even occasional payment denials can critically affect the financial well-being of a hospital.⁴

A smattering of literature suggests that level of care decisions made by emergency physicians alone lead to an incorrect billing disposition up to 50% of the time.^{5,6,7,8} This is an ongoing problem because InterQual criteria change annually, and payer organizations continually urge the use of observation care instead of admission. For example, CMS has a strict set of rules that must be precisely followed to convert a patient from “admission” to “observation” status. Conversely, an observation patient can be admitted at any point — although not retroactively, even if admission criteria were present initially.⁵ Rules like these encourage the use of observation-level care in any questionable case, despite the fact that observation care reimbursement is only a fraction of inpatient admission reimbursement. At HUP we now have round-the-clock case managers in the ED who review all admissions.

Clinical Implications

Little research exists detailing the effect of this change in our health care system, and what does exist is indeterminate as to any benefit.⁹ With such limited evidence, we are left with only clinical experience to help us evaluate how this change is affecting quality of care. With the use of InterQual increasing at HUP over the last four years, we have noticed some trends.

Continued on next page

First, the use of InterQual has reduced our LOS. Many patients who would previously have been admitted to an inpatient service are now being placed in observation, and have a much shorter stay. Since OBS focuses on coordinating outpatient care and delivering only necessary hospital-based interventions, patients are often discharged more quickly. The financial incentives put in place by payers are successfully pushing our medical system to provide less inpatient care and more outpatient care.

At the same time, prospective case review has the potential to increase LOS for patients in the ED. Anecdotally, case managers suggest that a review takes approximately seven minutes per patient. However, our experience has shown that this estimate reflects the best-case scenario. The process is too often interrupted by a lack of data or documentation, which leads to a discussion between the case manager and clinician in order to clarify the clinical picture. Further, InterQual criteria do not apply to all patients, so complex decision-making — often involving other parties — has to be reconciled with InterQual and can further delay disposition decisions. While this process may lead to improved compliance with documentation guidelines and determination of the “appropriate” level of care, it can also cause major delays in the admission vs. observation decision.

InterQual was developed partially as a method of defining norms of care, and its increasing use in clinical decision-making has helped reduce variations in care. It is now generally accepted that reducing variations in care improves population-wide outcomes. InterQual is a highly evidenced-based set of recommendations that has been developed and validated by over 800 physicians, nurses, and allied health professionals.³ Traditionally physicians created a unique plan for each patient, but the use of InterQual has reduced patient-to-patient variations in our ED and OBS. Our case management team is wonderfully skilled at helping us determine where a patient fits into the norms, as defined by InterQual. However, it remains the physician’s duty to be vigilant and recognize those patients who are too complicated or otherwise fall outside such algorithms.

The national trend away from inpatient care has increased the number of complicated and undifferentiated patients placed in observation, thus changing the dynamic of care and influencing the observation LOS. As more complicated patients (e.g., dialysis, transplant, oncology) are placed in observation, OBS has become increasingly reliant on consulting physicians to help direct care. This has two major effects: 1) the medical care being delivered is more nuanced, and so can no longer be strictly protocol-driven; and 2) more coordination of care among services and providers is required. The net effect is a tendency to drive the average LOS in OBS up, in direct conflict with the root concept of observation medicine.

The combined effect of having more patients in OBS, with a longer average LOS, increases the risk that a dedicated observation unit will be full. If a hospital system does not have a policy for observation overflow into inpatient beds, this leads to new problems — with the boarding of observation patients in the ED. Similar to boarding inpatients in the ED, OBS boarders will contribute to ED over-crowding and sub-optimal care. The increasing use of OBS must be matched by a corresponding increase in the number of beds available in those units.

Finally, the implementation of new policies and procedures always carries the risk of confusion and conflict. Some examples include confused patients, unclear financial implications, and new clinical team dynamics. We found that even the most medically literate patients struggle to grasp the concept of an observation stay — it seems impossible that they are being placed in an inpatient bed and receiving inpatient care, all while technically remaining an outpatient. Many patients believe it is simply a way to charge them more or provide less care, despite reassurance that these are not our goals. The confusion is worsened by the fact that we are often unable to reassure them about the financial implications of an OBS stay. Observation care is usually cheaper for the patient, but each case depends on the insurance provider, the testing and treatment performed, and the final diagnosis. As with all American medical care, charges are almost never fully understood in advance due to complicated payment schemes (e.g., Medicare parts A, B, and D) and a lack of transparency.

As case management evolves and becomes more heavily ED-based, it is important to consider the new team dynamics up front. If implemented without the explicit involvement of emergency physician leadership, ED-based case management can feel like decision-making power is being wrested away from clinicians, thus creating conflict. Done well however, the integration of case management into the clinical team and decision-making algorithm adds valuable expertise in documentation and adherence to national standards of care.

Conclusions

In the mid-20th century, hospitalization typically lasted for weeks or even months. We have clearly come far in developing safe and efficient care-systems that decrease both the proportion of patients admitted and the length of stay for those admitted. However, we can still do better in providing as much outpatient care to our patients as possible. Prospective case management is one method for allocating our scarce inpatient beds and financial resources more efficiently.

References

1. Mitus AJ. The birth of InterQual: evidence-based decision support criteria that helped change healthcare. *Prof Case Manag.* 2008;13:228-233
2. http://www.mcg.com/sites/default/files/InpatientAndSurgicalCare_Providers.pdf
3. <http://www.acep.org/Clinical---Practice-Management/Utilization-Review-FAQ/> (Updated 05/22/2015)
4. Conover, C. Seriously, Steven Brill? Hospitals Make ‘Gluttonous’ Profits? *Forbes.* 28 Jan, 2015. www.forbes.com Web. 27 Aug 2015.
5. DeCoster C, Roos NP, Carriere KC, et al. Inappropriate hospital use by patients receiving care for medical conditions: targeting utilization review. *CMAJ.* 1997;157:889-896
6. McKendry MJ, Van Horn J. Today’s hospital-based case manager: how one hospital integrated/adopted evidenced-based medicine using InterQual criteria. *Lippincott’s Case Manag.* 2004;9:61-71
7. Bristow DP, Herrick CA. Emergency department case management: the dyad team of nurse case manager and social worker improve discharge planning and patient and staff satisfaction while decreasing inappropriate admissions and costs: a literature review. *Lippincott’s Case Manag.* 2002;7(6):243-51
8. Jacobs CM. Managing demand using clinical decision support tools. *Healthc Financ Manage.* 1997;51:41-42
9. Wang, Hao, The Accuracy of Interqual Criteria in Determining the Need for Observation Versus Hospitalization in Emergency Department Patients With Chronic Heart Failure. *Critical Pathways in Cardiology: A Journal of Evidence-Based Medicine.* 2013;12(4):192-196 ■

Motherhood and Emergency Medicine

Teresa M Ross, MD FAAEM

"Since you work night shifts, it's probably easy to stay up with the baby at night, right?"

Funnily enough, not so much.

We spend years preparing for our practice of emergency medicine: college, medical school, residency, perhaps a fellowship. Being an attending comes with its own set of skills to polish, but it's only a portion of the learning curve we've powered along for so many years. Each step builds on the last. We become faster, smarter, more efficient, more thoughtful — and perhaps hardened.

In contrast, becoming a mother happens just like that — BAM! Suddenly you're a parent.

Suddenly there is a whole new life competing to fit into yours, which is already at maximum capacity. Emergency physicians in particular are known to be life-loving people. We not only throw ourselves wholly into our work, but also our extracurricular activities. At the hospital, we ideally see patients at peak volume and quality. On the side we teach, mentor, and participate in administrative tasks. At home we are partners, friends, athletes, artists, gardeners, cooks, craftsmen, readers, and travelers. Up to this moment, I had mastered the art of maximizing my day so there was never a wasted minute. I ruled my clock and I could do everything myself.

And now, more! Suddenly, control was out of reach.

This new person — my child — not only has her own schedule, but it changes every day. Yes, I'm prepared in the sense that I know how to hold an infant and I don't panic if she spits up or licks the floor. But I'm still a virgin to the minute-by-minute reality of my own baby. Prepare as you like, but each child is her own.

The first month, she woke to eat every 1.5 hours around the clock. Nursing took 20-40 minutes at a time. Do the math — there wasn't time for much else. Basic tasks like eating, showering, and napping were squeezed into the cracks and happened in shifts. Additionally, despite what the lactation consultant with the rose colored glasses told me at the hospital, breastfeeding was exquisitely painful. My despair lasted almost two weeks, until finally my daughter and my body found a workable pattern. I remember how shocked I was that something so notoriously wonderful and healthy could begin so viciously. Between the pain and round-the-clock eating cycles of the baby, I was exhausted. In the end we pulled through, and I am grateful for it. Maternity leave was a blur, but I was there for every moment of it and I loved it.

Returning to work on my daughter's two-month birthday was a shock. The parental exhaustion was one thing when I was at home on baby duty, but a whole other thing when I had to return to the pace of the ED. Sure, I had worked 12-hour shifts and night shifts for years — and I even remember the rough 36-hour ICU calls as a resident — but nothing prepared me for shift work atop constantly inadequate sleep. I had created great methods over the years to adjust to circadian rhythm changes, but they

“Returning to work on my daughter's two-month birthday was a shock. The parental exhaustion was one thing when I was at home on baby duty, but a whole other thing when I had to return to the pace of the ED.**”**



Teresa Ross, MD FAAEM, and her family

couldn't overcome the complete loss of control over sleep and the constant cognitive overdrive. As draining as our work can be, both physically and emotionally, there is always an end to the shift and a time to go home and regenerate. Babies, on the other hand, keep going.

What's more, I am still breastfeeding my daughter. This means I'm out to pump for about 20 minutes every four hours. I stress constantly about the timing, trying to make my breaks minimally disruptive to patient care. The fact that breastfeeding impacts my daughter's health makes pump breaks hugely more stressful than delaying my own bathroom or snack breaks. Any overtime at the end of a shift feels like eternity, as I wait to run home to my daughter.

After a disheartening start to my first week back, I asked a fellow doc how she did it. "Well, it lasted about two months and then I had to stop," she said. I was overwhelmed. Was that the secret truth? That work would eventually dictate what motherhood could be? I felt completely out of control. Fortunately I'm still going, at least for now. I've accepted a reduction in my pace, knowing it's only temporary. Staying hydrated at work remains a challenge.

I struggle to recreate the identity of the woman I once was: the efficiency expert, the to-do list queen, the multi-tasking master. At home, we eat a

Continued on next page

lot more take-out and the plants may wilt between waterings. My journals pile up in their wrappers and my emails get pushed to the side for days, as I delay chart reviews and mandatory training modules for some ideal moment when I can give them my undivided attention. At work, I feel frustrated by the fact that I'm trying to maintain a pumping schedule that will never be as good or as frequent as breastfeeding my daughter. Thoughts fly and I feel constantly on over-drive.

Sleep is less interrupted now that my daughter is four months old, but it's still not what it used to be. Other tasks continue to happen when they can. If they happen at all, phone calls are shorter. Emails are either timely or detailed, not both. If I take the time to cook, I don't have time to eat.

I have no doubt that this change befalls my male counterparts too. Men take paternity leave and many are not only joint caretakers but primary caretakers of their children. The physical symbiosis of mother-baby does add an additional layer though. It is beautiful, but also incredibly stressful in the context of a coexisting professional identity. I want to be there for

my daughter and still work the job I love. I just never realized how quickly I'd reach the limit of how much could fit into one day.

I am lucky to have an incredibly supportive chairman, colleagues, husband, family, and baby sitter. Without them I couldn't be where I am now as the full-time working mother of an infant. I love my job, but I want to be a good parent too. I realize other parents face even more complications: single parenthood, multiple kids, lack of nearby family or support. Yet somehow, they do it.

There's no secret to pulling off the multiple commitments of motherhood and emergency medicine. Yes, I can do it. I am doing it and I love it. I just can't do it all at once. It has been incredibly stressful to realize that I have to let some things go, in order to make room for other things. They say every step of a child's growth is a fast-passing phase. I can only imagine how I will adapt my work to each one, but where there's a will, there's a way. ■

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Content Overload? Let RSS Feeds Work for You

Robert Cooney, MD MS MedEd FAAEM

These days, it's easy to become overwhelmed by the vast amount of information that circulates through our lives. When trying to keep up to date with medical topics, it's even worse. If you practiced in 1950 you could go your entire career without the amount of medical knowledge doubling. By 2010 the rate of doubling had increased to every 3.5 years, and by 2020 medical knowledge will double every 73 days!¹

If you feel overwhelmed, you're in good company. In a keynote address at the Web 2.0 Expo in 2008, new-media expert Professor Clay Shirky provided an insightful look at the economics of information. As it turns out, we don't have information overload, we have filter failure.² Since the invention of the printing press there has been an over-abundant supply of information. What matters is how we filter it.

Really Simple Syndication (RSS) is a useful tool to build filters and limit information overload. RSS is a type of software built into a majority of websites, including blogs, news sites, and medical journals. You can subscribe to "feeds" using an application called an "aggregator" or "reader." This allows you to customize and filter the information you receive. These feeds also allow you to stay up to date efficiently.

Currently, there are many readers on the market. Popular apps include:

- Feedly (www.feedly.com), for iOS and Android.
- Reeder 2 (www.reederapp.com), for iOS.
- Flipboard (www.flipboard.com), for iOS and Android.
- Press (<http://twentyfivesquares.com/press/>), for Android.

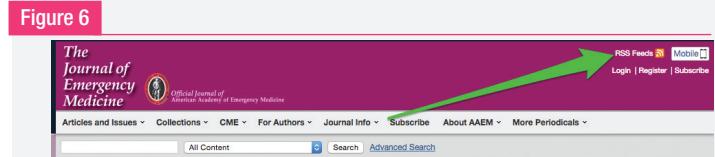
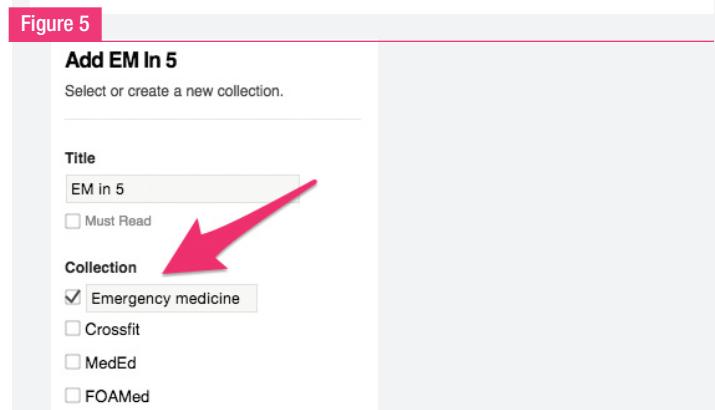
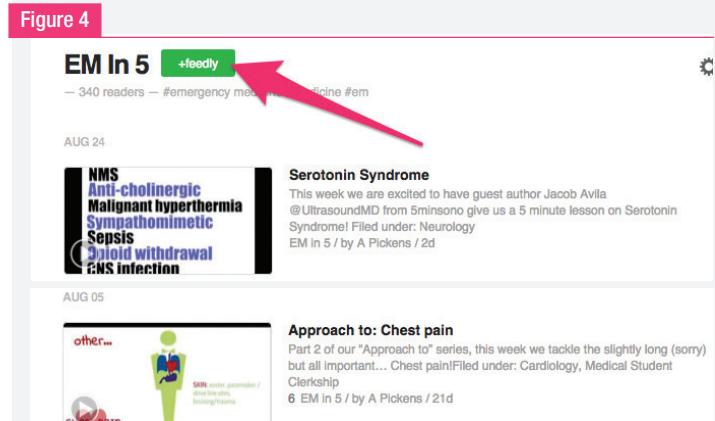
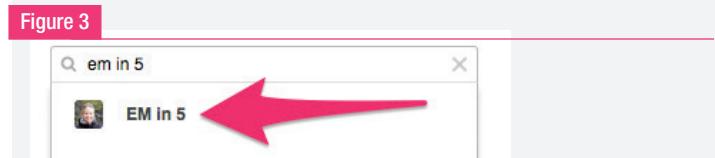
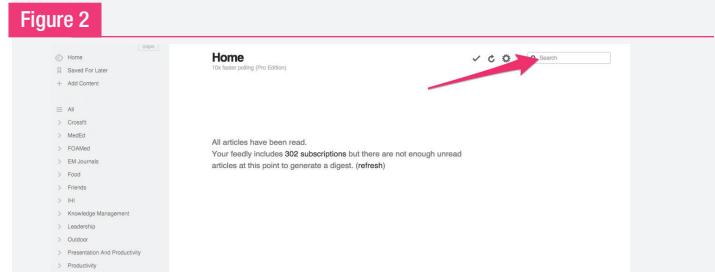
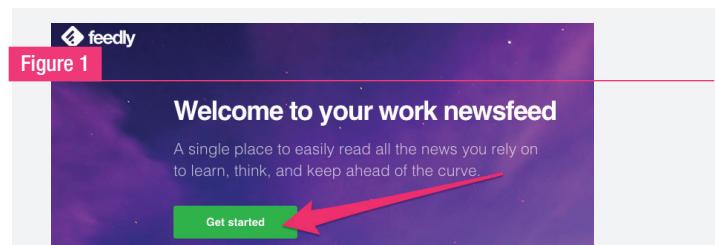
So, how do you use this tool to keep up-to-date? For the sake of demonstration, we will use Feedly to see how this works. The other applications are similar.

Step 1: Establish an account.

Like many services, you can log in with a pre-existing account or create a dedicated account. The choice is yours (Fig. 1).

Step 2: Add content.

There are many ways to add content to your RSS reader. The first thing to try is a simple search (Fig 2). Typing in the topic or the specific web address will often direct you to the desired feed. Clicking on the link (Fig. 3) will then open the feed. If you see what you are looking for, the next step is to click "subscribe" (Fig. 4). This opens a sidebar (Fig. 5) that allows you to categorize your content. Occasionally, you will not be able to locate the desired feed through the reader's search features. In this case, you must go to the website containing the feed and simply copy and paste the link from the desired feed (Fig. 6) into the search bar.



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Step 3: Process your inbox

Like any inbox, if you don't check it, it builds up. I like to process my RSS feeds during those random five-minute breaks throughout the day. One of the nice things about readers is the ability to save content to "read it later" services, such as Pocket or Instapaper. This allows you to quickly process a significant amount of information and save topics that you would like to address at a later time.

RSS is an easy-to-use tool that allows you to quickly filter information in this age of information overload. It will allow you some piece of mind that you are not missing out on important topics, ultimately saving you time while keeping you up-to-date.

References

1. Densen, Peter. "Challenges and opportunities facing medical education." *Transactions of the American Clinical and Climatological Association* 122 (2011): 48.
2. Shiky, Clay. "It's Not Information Overload. It's Filter Failure." Accessed on 8/26/15: <https://www.youtube.com/watch?v=LabqeJEOQyl>. ■



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Sixth Inter-American Emergency Medicine Congress

Gary Gaddis, MD PhD FAAEM

AAEM members who missed the opportunity to visit Rome for the recent Mediterranean Emergency Medicine Congress, or who love to travel and want to experience another excellent international emergency medicine meeting, should consider attending the upcoming Sixth Inter-American Emergency Medicine Congress in Mendoza, Argentina, from June 8-10, 2016.

The five previous IAEMCs were held in Buenos Aires. Although Buenos Aires is an exciting destination, those who attend the 2016 Inter-American Emergency Medicine Congress will be able to experience the wine-growing region of Mendoza, not far from Santiago, the capital of Chile.

Planning is just getting underway for this Congress, which will feature Spanish and English language tracks. The Argentines have expressed a desire to emphasize cardiac topics such as what's new in resuscitation, as well as trauma and shock topics. As usual for the IAEMC, many American speakers will be on the agenda.

Look for more about IAEMC VI in upcoming issues of *Common Sense*. ■

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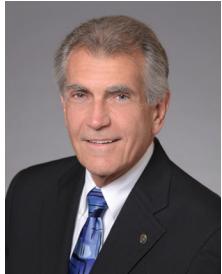
ABEM Election News



Barry N. Heller, MD FAAEM,
elected to president of ABEM

Chair of the Executive, Nominating, and Test Administration committees, and is a member of the Finance, Research, and Test Development committees.

Dr. Heller received his medical degree from Indiana University in Indianapolis, Indiana, and completed residency training in emergency medicine at Harbor-UCLA Medical Center in Torrance, California. He currently practices emergency medicine at St. Mary Medical Center in Long Beach, California, and Little Company of Mary San Pedro Hospital in San Pedro, California. At St. Mary he has served as Chair of the Department of Emergency Medicine, Chief of Staff, and Vice President of Medical Affairs. He also is an Assistant Clinical Professor of Medicine at UCLA School of Medicine.



Michael L. Carius, MD, elected
president-elect of ABEM

and Nominating Committee, and is a member of the Credentials, Executive, Finance, Research, Test Administration, and Test Development committees, as well as the CME Task Force.

Dr. Carius received his medical degree from the University of Colorado School of Medicine in Denver, Colorado, and completed a rotating internship and graduated from the Naval Regional Medical Center in San Diego. After transferring to the U.S. Air Force, Dr. Carius served as a major and became a flight surgeon. He completed residency training in emergency medicine at Los Angeles County/University of Southern California Medical Center in Los Angeles, California.

Barry N. Heller, MD FAAEM, has been elected as president of the American Board of Emergency Medicine (ABEM). Dr. Heller has been a member of the board of directors since July 2008, and was elected to the Executive Committee in 2012. He has served ABEM in a variety of capacities, including as editor, examiner, and chief examiner for the Oral Certification Examination, and as member of the Case Development and Case Selection panels. He currently serves as the

Currently, Dr. Carius is Assistant Clinical Professor in the Department of Traumatology and Emergency Medicine at the University of Connecticut School of Medicine in Farmington, Connecticut; Emeritus Chair, Department of Emergency Medicine at Norwalk Hospital in Norwalk, Connecticut; and practices emergency medicine at Bridgeport Hospital in Bridgeport, Connecticut, and Milford Hospital in Milford, Connecticut. He represents ABEM on the board of directors of the American Board of Medical Specialties (ABMS), and is a member of its Governance Committee and Special Committee on Military Physicians and Continuing Education. Dr. Carius has also been active with the American College of Emergency Physicians (ACEP): he was a member of its Board of Directors, served as its President, and in 2012, was presented ACEP's prestigious John G. Wiegenstein Leadership Award.



Melissa Barton, MD FAAEM,
added as ABEM Director of
Medical Affairs

ABEM is pleased to announce the addition of Melissa A. Barton, MD FAAEM, as Director of Medical Affairs (DMA). As DMA, Dr. Barton will focus on clinically oriented special projects and represent ABEM's interests to external organizations.

Dr. Barton received her medical degree from Creighton University in Omaha, Nebraska, and completed her emergency medicine residency training at the Sinai-Grace program at Wayne State University in Detroit, Michigan.

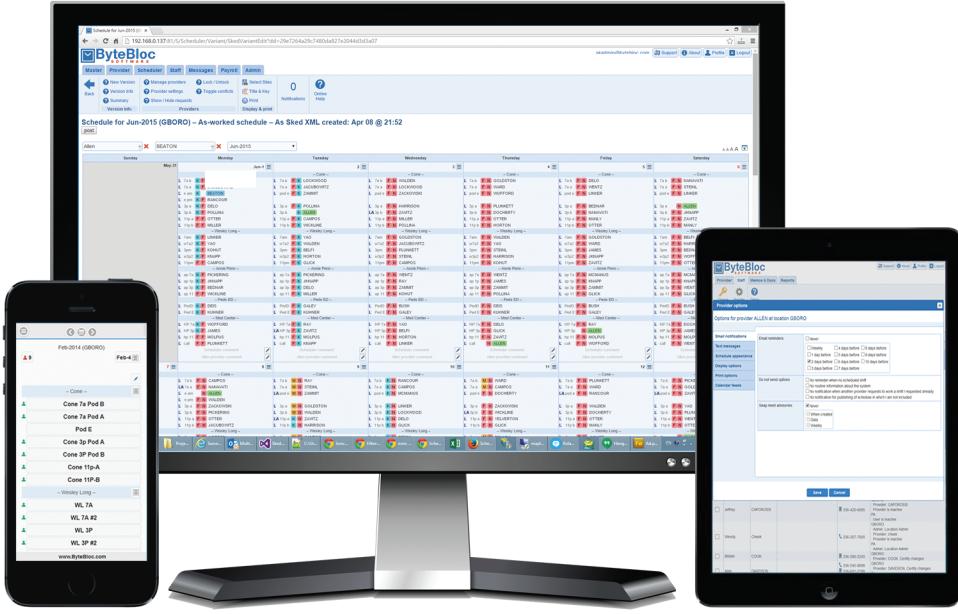
Prior to joining ABEM, she served as Residency Director and Assistant Professor at the Sinai-Grace Hospital/Wayne State University Emergency Medicine Residency Program. She has been an ABEM oral examiner for over ten years. Dr. Barton is the recipient of a number of teaching and leadership awards, and has been active in service to her community.

Dr. Barton has been ABEM certified in emergency medicine since 2002, and plans to remain clinically active.

At its July 2015 meeting, ABEM also elected the following directors to the 2015-2016 Executive Committee: Barry N. Heller, MD FAAEM, President; Francis L. Counselman, MD, Immediate-Past-President; Terry Kowalenko, MD, Secretary-Treasurer; and Robert L. Muelleman, MD, Member-at-Large. ■

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Tap into Your Network & Start a Dialogue: Twitter for EPs

Matthew Zuckerman, MD FAAEM
YPS Board of Directors



Ever wish you could go through a secret door and talk to all the smartest people in your field — find out what they're reading, what they think about what you're reading, ask them questions about the patient you're currently seeing, or just tell them you agree (or more often disagree) with them? This isn't fantasy, it's Twitter. Before you dismiss Twitter as merely a way to find out what Justin Bieber is up to, or for your annoying cousin to post pictures of his breakfast, read a little further and find out what you're missing.

Many of us scan the table of contents of a few EM journals, and maybe peruse newsletters like this one, with a vague hope that we'll find something relevant. We focus on a small amount of content because there isn't time to read the 73 EM journals indexed in PubMed and the countless blogs, newsletters, abstract presentations, conferences, and books. When I am presented with such an avalanche of information, I feel like I'm ordering off a menu that's 20 pages long, so I arbitrarily narrow my scope and hope the good stuff makes its way to me. In other words, I pick something on the front page. When that strategy fails me at a restaurant, I have found the next best option is to ask someone who has been there for advice. We use social media like Yelp to determine where we eat, and it makes sense to take the same approach with continuing medical education. So, I get by with a little help from my friends — and some smart strangers. I let them read those 73 journals and then post about the things they want to share. This expands the amount of content I am able to digest.

Traditional journals have heard the sirens' call of social media, and are making it easier to share articles on Twitter and Facebook — thus the little bird icon you see next to this article online. In no time, you can share an article with friends and colleagues and say what you think about it, or ask a question. It no longer matters how many people are physically in your department, because you're virtually connected to people across the country and around the world. It's a mini journal club of sorts.

Many newcomers are skeptical of thinking in 140-character phrases and hashtags. How much can you get out in 140 characters? Some internists might similarly ask us, how much can you fit into a five-minute patient interview? The answer: enough. Twitter doesn't replace scholarship, it augments it. Imagine if the smartest people you know could leave you copies of what they are reading, annotated with little post-it notes. That's Twitter. When Joe Lex tells me about something in medical education or Scott Weingart tells me about critical care or Leon Gussow says something about toxicology, you can be damn sure I'm going to listen to them.

Beyond those EM resources, there are thousands of indexed journals from other fields that can be relevant to patients you're seeing in the ED (or very boring if you're not a subspecialist). By connecting providers

from different backgrounds, you can learn about relevant articles long before they make it to your mailbox. For example, you probably weren't reading *Annals of Pharmacotherapy* in 2003, and didn't see an article on ondansetron and QT prolongation. Your friendly ED pharmacist might have mentioned it to you, but if not, you probably had to wait until the article in *Annals of Emergency Medicine* in 2014 before learning of the issue. Your odds of finding things out sooner go up on Twitter, because of all of those wonderful people you just don't know yet.



“It no longer matters how many people are physically in your department, because you’re virtually connected to people across the country and around the world. It’s a mini journal club of sorts.”

And how will you find out about all the great resources that aren't indexed in MEDLINE, such as blogs, podcasts, online journals, and the like? Yes, most of the internet is filled with cat pictures and stories about how vaccines cause autism, but there are also some great sites that are changing how we practice medicine on a daily basis. You can quit bathing or sleeping and use that time to read them all, or you can tap into the growing online community of EM docs and collectively share the effort of sifting through all the online content. Then, when it's convenient for you (some sign in after an ED shift, others have been known to bring their phone into the bathroom), log in and checkout what everyone has been talking about.

But wait, there's more. Twitter is about dialogue. It's a two-way street. Many of us in emergency medicine are opinionated. Anyone who's ever yelled at a television understands the need to express yourself even if no one is listening. Similarly, have you ever read a journal article or listened

Continued on next page

to a rant on EM:RAP and wanted to respond? You could sit down and write a lengthy letter to the editor, hoping it would be read and published, and several months later there *might* be a dialogue. With Twitter you can instantly find authors and ask them about their work. They might ignore you, but you're much more likely to get a response. And even if the author doesn't respond, another EM doc online probably will respond. This kind of dialogue connects the people who practice in academic meccas to single coverage community docs and advanced practice providers, and makes the world much smaller.

Recently I posted an article on chronic cystitis in ketamine users. Some EM docs responded that they had never heard of it. A urologist commented that he was seeing a fair amount of it, and even some ketamine-using patients (amazing what people will say when their real name isn't used) responded that they were pretty sure they had it. I can't imagine any room in the world where a similar conversation could take place. Twitter allows

us to network with people we didn't even know we wanted to know. Yes, there are plenty of crazy people online, but we're prepared for that working in an emergency department. If I see a new drug of abuse, I often throw it out to my social network — which includes providers and the lay public — to see if anyone has an insight. A colleague recently posted a photo of an unknown plant to speed identification. The applications are growing every day.

So, now that I've convinced you to open that door and check out what lies behind it, what's next? The first step is to set up an account. Checkout <https://youtu.be/44zuPVnKa2Q> for help. Then you have to find those smart people. I'm @matthew608b. Feel free to tell me how much you hated this column and how you'll never try Twitter. After that, you can see what people were saying at the Scientific Assembly in Austin at #AAEM15, and if you like any of those smart people, follow them to see what they post in the future at #AAEM16. Don't take my word for it — see for yourself. ■

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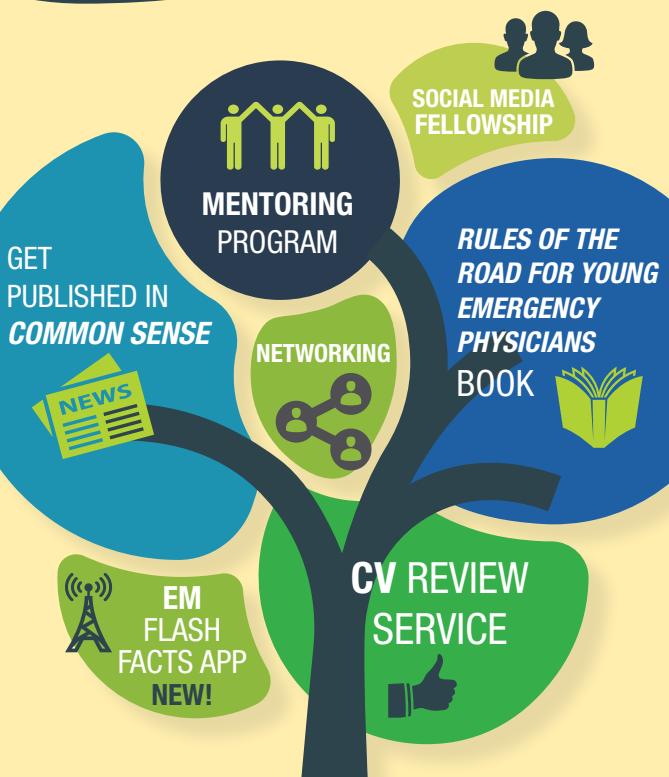


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AAEM/RSA President's Message

The Waiting Game

Victoria Weston, MD
AAEM/RSA President



I could feel her eyes on me, burning with anger. It was a hot July day and she had been waiting for hours in our crowded waiting room, and then waited even longer in our ENT room in an upright, unforgiving chair as our team cared for multiple unstable patients who had been roomed shortly after sign-out. The ED was packed with patients, new interns, and other new learners — and everything seemed to be moving so much more slowly than just a few weeks before.

When I walked into her room, I entered with a smile, made eye contact, introduced myself, and made my apologies: I am so sorry for the wait. I am glad that you came in today and appreciate your patience. I know that it has been a long wait, but I am here now and am totally focused on you. How can I help you today?

As I waited for her response and anticipated a barrage of complaints, I wondered internally for a moment if I was being cliché. I was repeating a script I'd memorized, internalized. I did genuinely want to have a good interaction with her and for her to not be upset. To my pleasant surprise,

"I try to focus on the person in front of me without my mind wandering to my other patients, the waiting room, and the lengthy to-do list of tasks waiting outside the door."

my opening set the tone for our whole interaction. Ten minutes later she was laughing and smiling, telling me about her son, a resident training in a primary care field, and how much she enjoyed teaching public school. She seemed genuinely happy and satisfied with her care. It was one of the best patient interactions I'd had the entire day, and it felt good to connect. It was about more than just patient satisfaction and Press-Ganey surveys. It was about professional satisfaction, too.

People often talk about mindfulness, being present, and being in the moment. It sounds obvious and simplistic in theory, but is not always easily done. Being mindful is challenging in most circumstances, particularly those we face in a busy emergency department, with its frequent distractions and many demands for our time and attention. It is an issue which I still find challenging, but I continue to try my best to pause and reset. I try to focus on the person in front of me without my mind wandering to my other patients, the waiting room, and the lengthy to-do list of tasks waiting outside the door.

Sometimes on a hectic day it can be hard to be positive and keep perspective. Maybe you just had a frustrating conversation with a consultant. Maybe you just ran a code and pronounced someone. Maybe you haven't had time to eat, or to sit down and really think. Sometimes people are difficult, sometimes the physical and emotional fatigue begins to set in after a long shift.

However, I have found that I provide better medical care and have improved day-to-day satisfaction when I try to give each person a fresh start. Setting a good tone from the start of the patient encounter sets the tone for the entire interaction. It is not just eye contact or shaking hands. It is acknowledging the patient's significant other who is also in the room. It is meeting people where they are. It is dropping your mental baggage at the door and really listening. To me, mindfulness is not necessarily a way of life, but a reminder to pay attention and be focused. I certainly don't claim to be an expert, and I am continuing to develop my practice style and striving to be a better physician. Nevertheless, I will keep trying to maintain my focus, be a better listener, and be a more present and attentive physician. ■



AAEM Resident & Student Association Celebrates 10-Year Anniversary Milestone



The American Academy of Emergency Medicine Resident and Student Association (AAEM/RSA), who represents over 3,000 emergency medicine residents and medical students, is proud to announce its 10-year anniversary.

Initially formed as a section under the larger AAEM association, AAEM/RSA

launched as an independent organization in 2005 outlining their vision to, "aspire to a future in which all patients have access to excellent emergency care by an emergency physician" and where "developing emergency physicians receive the highest quality training in supportive practice environments with an emphasis on personal wellness and career mentorship."

Strong Voice for Emergency Medicine Residents & Students

Over the last 10 years, the organization has expanded its membership, offered career-planning & educational member benefits, and brought members together through engaging networking and educational events. AAEM/RSA offers opportunities for involvement for its members through serving on the board of directors, vice president's council, committees, and special projects. There are now over 50 residency programs across the U.S. that have 100% membership with AAEM/RSA. The organization has published several books on topics ranging from finding your way through medical school, to how to prepare for your board exams. AAEM/RSA is committed to providing resources and being with their members all the way from the first year of medical school to residency graduation.

Joel Schofer, MD MBA CPE FAAEM, was president of AAEM/RSA at the time of its incorporation and currently serves on the AAEM board. He notes that "AAEM/RSA has become what we intended, an independent and strong voice for emergency medicine residents that defends the value of board certification and strives to ensure all residents and students have a fair and rewarding career in EM."

Defending Practice Rights and Board Certification

Mark Reiter, MD MBA FAAEM, current AAEM president and past president of AAEM/RSA, agrees on the organization's legacy of promoting board certification stating that, "establishing AAEM/RSA was an important step in recognizing that issues such as protecting the value of board certification and defending physician practice rights are of paramount importance to residents and students."

Ten Years and Beyond — The Next Steps for the Future

Looking back over the last 10 years and moving into the future, AAEM/RSA continually strives to empower residents & students and improve the specialty of EM. As current AAEM/RSA president, Victoria Weston, MD, notes "AAEM/RSA is proud to be the voice for residents and students. Over the past 10 years, we have supported residency education, fair business practices, and advocacy for our specialty. AAEM/RSA advocates that every patient should have access to a physician trained and board-certified in emergency medicine. We look forward to many more decades of providing a voice and opportunities for residents and students." ■



Introducing the AAEM/RSA Blog!

AAEM/RSA is excited to announce the launch of our blog! The blog is a great resource for both residents and students, featuring:

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A FOAM Favela

Sean Weaver, DO MPH and Nathan Cleveland, MD MS
University of Nevada School of Medicine

Favela is a term from Brazilian Portuguese that refers to a heavily populated, urban, informal settlement. In other words, a shanty town. Born out of necessity, favelas look disorganized, haphazard, temporary, and chaotic. To its inhabitants, however, the favela represents a vibrant and constantly evolving community built on cooperative living. This vibrancy has led to some of Brazil's most famous cultural contributions. Samba, capoeira, and funk all came from favelas.¹

Free Open-Access Meducation (FOAM) is the favela of medical education. Early adopters of social media in emergency medicine and critical care began sharing information through Facebook, Twitter, podcasts, and blogs. As connections were made, experts began spontaneously discussing ideas and practice habits. These conversations were open to the public and anyone could participate. Over time, a structure began to develop and the number of participants increased.² In 2012, over a pint of Guinness, emergency physicians Sean Rothwell and Mike Cadogan named this informal online community "FOAM."³

Early participants in FOAM recognized several key elements. They believed that knowledge was not proprietary. When your primary focus is medical education and good patient outcomes, the world becomes very flat. Social media created an environment where providers could figure it out together. Regardless of level of training, geographic location, health care system, or patient population emergency physicians can now share experiences, information and opinions in ways never before realized.

This energetic conversation reflects our dynamic profession, and the benefits are clear. As Joe Lex, the godfather of #FOAMed, once said:

If you want to know how we practiced medicine 5 years ago, read a textbook.

If you want to know how we practiced medicine 2 years ago, read a journal.

If you want to know how we practice medicine now, go to a (good) conference.

If you want to know how we will practice medicine in the future, listen in the hallways and use FOAM.

— Joe Lex, MD MAAEM FAAEM⁴

Successful emergency physicians are committed learners. It is commonly felt that a significant portion of our medical knowledge is obsolete in two to five years. Regardless of the rate of decay, the practice of emergency medicine demands lifelong learning. FOAM facilitates that learning. Using



Flickr Dany13

FOAM, you engage the global community of emergency medicine in real time. Instead of waiting for your favorite annual conference to confer with your peers, you have the opportunity to connect in the moment. When these interactions lead to deeper knowledge and better patient outcomes, everyone benefits.

Finally, FOAM potentially decreases the time between knowledge acquisition and clinical application. Traditional medical knowledge dissemination through print journals and textbooks can take one to two decades to get to the practicing medical community.⁵ Blogs and podcasts like *The Skeptics Guide to Emergency Medicine* audaciously strive to cut that time to less than one year.⁶ The creation of online journal clubs like *ALiEM-Annals Global EM Journal Club Series* or *The Skeptic's Guide to Emergency Medicine Hot Off the Press* have contributed to achieving this goal. Participants have the unique opportunity to interact with the lead authors of practice-changing papers. Slowly but surely, the gaps between author, learner, and clinical application are narrowing.

Improving knowledge translation has real-world implications. One example is the article "Preoxygenation and Prevention of Desaturation During Emergency Airway Management," published by Scott Weingart, MD and Rich Levitan, MD in *Annals of Emergency Medicine*.⁷ They capitalized on FOAM resources to push the information to the emergency medicine community. According to Altmetric, a company that tracks social media metrics for Elsevier, this article is in the top 5% of all articles ever tracked by their

company.⁸ FOAM enhanced the impact of the article and influenced the standard of care.

Some may be quick to dismiss examples like that. They believe the FOAM movement lacks permanence. But, much like the favelas that cling to the hillsides surrounding Rio de Janeiro, looks can be deceiving. The most famous favelas are brick and mortar and built to last. They thrive, and the cultural contributions of such communities have been significant.⁹

The FOAM movement is following a similar trajectory. It holds great potential for students, residents, and practicing physicians alike. It cannot supplant a strong foundation of basic emergency medicine knowledge, but it does enrich that knowledge base and enhance the learning process. It promotes conversation, the sharing of experience, and the dissemination of knowledge. Participate in the FOAM community and you'll be a stronger clinician.

Continued on next page

FOAM Resources	Resident Driven Content	Twitter
lifeinthefastlane.com	FOAMcast.org	@airwaycam
ALiEM.com	sobroem.com	@srrezaie
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EMLitofNote.com	Shortcoatsinem.blogspot.com	#FOAMed

Sean Weaver tweets at @_seanweaver and blogs at www.lasvegasemr.com/FOAM-Blog

Nathan Cleveland tweets at @nathancleveland.

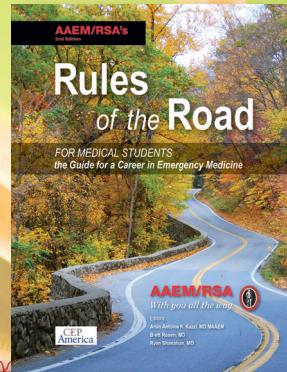
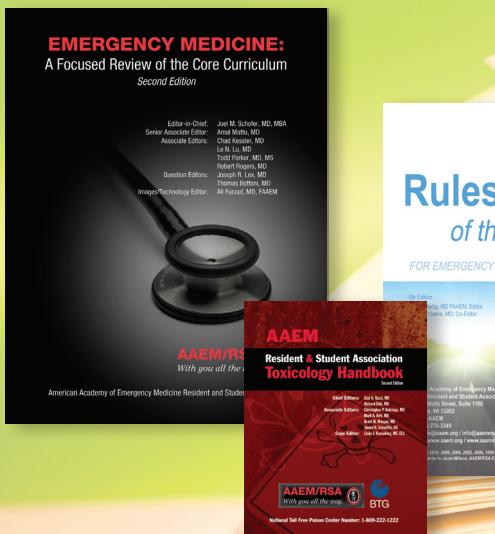
References

- Barbosa J. Favela culture makes the city. 2012. <http://www.rioonwatch.org/?p=4521>. Accessed August 31, 2015.
- Cadogan M, Thoma B, Chan TM, Lin M. Free open access meducation (FOAM): The rise of emergency medicine and critical care blogs and podcasts (2002-2013). *Emergency Medicine Journal*. 2014;31(e1):e76-e77. doi:10.1136/emermed-2013-203502.
- Nickson CP, Cadogan MD. Free open access medical education (FOAM) for the emergency physician. *Emergency Medicine Australasia*. 2014;26(1):76-83. doi:10.1111/1742-6723.12191.
- Lex J. International EM education efforts & e-learning, 2012. *Free Emergency Talks*. 2015. <http://freeemergencytalks.net/wp-content/uploads/2012/08/2012-08-21-08h00-International-EM-Education-Efforts-E-Learning.mp3>. Accessed August 31, 2015.
- Sussman S. Translation in the health professions: Converting science into action. *Evaluation & the Health Professions*. 2006;29(1):7-32. doi:10.1177/0163278705284441.
- Milne K. What is the SGEM? *The Skeptics Guide to Emergency Medicine*. <http://thesgem.com/what-is-the-sgem>. Accessed August 31, 2015.
- Weingart SD, Levitan RM. Preoxygenation and prevention of desaturation during emergency airway management. *Annals of Emergency Medicine*. 2012;59(3):165-175.e1. doi:10.1016/j.annemergmed.2011.10.002.
- BBC. Favela life: Rio's city within a city. *BBC Latin America & Caribbean*. <http://www.bbc.com/news/world-latin-america-27635554>. Published June 9, 2014. Accessed August 31, 2015. ■

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Important Considerations with Spontaneous Bacterial Peritonitis

Authors: Nicholas Santavicca, MD; David Wacker, MD; Carina Sorenson, MD; David Bostick, MD; Erica Bates, MD; Adeolu Ogunbodede, MD; Robert Brown, MD; Mark Sutherland, MD
Editors: Michael Bond, MD FFAEM and Jay Khadpe, MD FFAEM

Spontaneous bacterial peritonitis (SBP) is a most common infection affecting cirrhotic patients. Despite accounting for up to 30% of bacterial infections in this population, it often presents nonspecifically and is misdiagnosed. As its 12-month mortality is up to 66%, it is imperative to consider this disease entity and initiate the proper workup early.¹ There is often some angst among physicians about performing paracentesis and beginning treatment. As a result, we will review the literature to provide some clarity about the safety of diagnostic interventions. Furthermore, with the increase in microbial resistance due to antibiotic prophylaxis and exposure to medical fields, it is important to rapidly identify high-risk populations and initiate proper antimicrobial coverage.

Grabau C, et al. Performance standards for therapeutic abdominal paracentesis. *Hepatology*. 2004 Aug; 40(2):484-8.

The authors describe a large prospective case-series in which endoscopy assistants were trained to perform large volume paracentesis (LVP) in the outpatient setting. They addressed training requirements, time and resource utilization, as well as bleeding and other complications of the procedure.

Endoscopy assistants who completed a graduated 10-procedure training program then performed 1,100 LVPs. Paracentesis sites were identified only by physical exam without the use of ultrasound. Their competence was evaluated subjectively as well as by checklist. The mean number of procedures to reach competence was 4.4, with a range of 3-7. Volume replacement with albumin, 6-8g per liter of ascitic fluid, was carried out if greater than 5 liters of ascitic fluid was removed.

No significant bleeding complications were noted despite abnormal INR and platelet counts (PC). The lowest PC was $19 \times 10^3/\mu\text{L}$ (mean $50.4 \times 10^3/\mu\text{L}$) and the highest INR was 8.7 (mean 1.7). There were no hospitalizations, deaths, or other substantial complications noted at 24-hour follow up. The authors did not assess for complications beyond 24 hours, such as SBP. In addition, the endoscopy assistants had access to the physician in consultation if concerns arose. Of the 1,100 procedures, 23 were not performed due to the following reasons: gaseous abdominal distention ($n=2$), insufficient ascitic fluid on exam ($n=9$) or abdominal surgical scars ($n=12$). These patients were referred to radiology for ultrasound-guided paracentesis.

Take home point:

These results concur with the American Association for the Study of Liver Diseases (AASLD) guidelines that allow elective LVP to be performed in the setting of unreversed thrombocytopenia or INR elevation without significant bleeding complications or need for blood products.

Kim JJ, et al. Delayed paracentesis is associated with increased in-hospital mortality in patients with spontaneous bacterial peritonitis. *Am J Gastroenterol*. 2014 Sep; 109(9):1436-42.

AASLD guidelines call for the use of a diagnostic paracentesis in patients with ascites and cirrhosis but the importance of performing this procedure quickly to reduce mortality was not quantified until recently. In this retrospective cohort study of 231 consecutive patients with SBP and cirrhosis at two academic health centers in southern California, the authors investigated in-hospital mortality of patients with early paracentesis (EP) vs. delayed paracentesis (DP). Participants in the EP group had a paracentesis performed within 12 hours from first physician encounter and while those in the DP group had a paracentesis performed between 12-72 hours from the first physician encounter. The EP cohort represented 59% of subjects and had a mean time to paracentesis of 4.2 hours compared to 32.6 hours for the DP cohort.

The study excluded patients under 18, those with peritonitis not related to SBP, and those diagnosed with SBP more than 72 hours after the first encounter. The patients were predominantly male and Latino with mean age of 53 and a mean MELD score of 22. The procedure was performed bedside in 99% of cases and all patients received antibiotics (predominantly ceftriaxone or cefotaxime) except one who died of MI shortly after presentation. The in-hospital mortality was 13% for the EP cohort and 27% for the DP cohort ($p=0.007$).

Using univariate analyses, the authors determined other factors likely to influence mortality. They found significant associations for a MELD score >21 and creatinine $>1.5\text{mg/dL}$. In this population, MELD >21 had an adjusted odds ratio (AOR) of 5.7 and creatinine $>1.5\text{mg/dL}$ had an AOR of 3.2. These factors were well balanced between the two cohorts, and adjusting for them, delayed paracentesis had an AOR of 2.7 (95% CI 1.3-4.8). The authors further plotted in-hospital mortality against the hours delayed to paracentesis and determined an estimated increase in mortality of 3.3% per hour.

This is a strong study due to the robust number of patients and the even distribution of confounders (the etiology of cirrhosis, concomitant GI bleeding, and direct ICU admission) between the study arms. The greatest weakness of this study is the possible confounding effect of prophylactic antibiotics. In the early paracentesis group, 19% had antibiotics on-board before presenting for treatment, compared to just 7% in the delayed paracentesis cohort. Of critical importance, the exact timing of the start of antibiotics was not available for all patients, and it is this intervention which may be the most important for survival and the most critical to study.

Continued on next page

Take home point:

Early paracentesis is associated with improved survival for patients with cirrhosis and ascites.

Orman ES, et al. Paracentesis is associated with reduced mortality in patients hospitalized with cirrhosis and ascites.

Clin Gastroenterol Hepatol. 2014; 12(3), 496-503.

AASLD guidelines recommend diagnostic paracentesis as part of a standard workup for any cirrhotic patient admitted to the hospital with symptoms of ascites or encephalopathy. However, this recommendation is largely based on expert opinion, and prior to this paper there have been only scarce data to validate the benefits of this practice. Orman et al., performed a population study using 17,711 hospitalized adults, whose discharge diagnoses included cirrhosis and either ascites or SBP, as selected from the 2009 Nationwide Inpatient Sample (NIS) all-payer database of hospital discharges. The primary outcome was whether a paracentesis was performed during hospitalization. The population was then subdivided into those receiving and those not receiving a paracentesis, and a comparison was made between these groups of in-hospital mortality, length of stay, and total hospital charges. Overall, 60.7% (58.6 - 62.7% for 95% CI) of patients included underwent paracentesis.

Importantly, patients receiving a paracentesis had a 6.5% in-hospital mortality rate compared to an 8.5% rate for those not receiving a paracentesis ($p=0.03$; OR 0.55, 0.41 - 0.74 for 95% CI). Hospital length of stay and total charges were both higher for those receiving a paracentesis than those that did not (6.6 days vs 5.3 days, $p<0.001$; and \$44,586 vs \$31,746, $p<0.001$).

The main limitation of this study is its design as a population study, which leaves it vulnerable to confounding factors and makes establishment of causality difficult. In light of this, the authors make a reasonable effort to control for confounding factors in the mortality analysis. Despite these limitations, this study provides useful preliminary data suggesting that all hospitalized patients with cirrhosis and ascites might benefit from diagnostic paracentesis.

Take home point:

Although only about 60% of patients hospitalized with ascites, hepatic encephalopathy, or spontaneous bacterial peritonitis underwent paracentesis as part of their workup, the overall in-hospital mortality rate for those receiving this test was lower than for those who did not.

Terg R, et al. Serum creatinine and bilirubin predict renal failure and mortality in patients with spontaneous bacterial peritonitis: A retrospective study. *Liver Int.* 2009 Mar; 29(3):415-9.

The goal of this study was to analyze the usefulness of serum creatinine (Cr) and bilirubin levels at predicting renal failure and mortality in patients hospitalized for SBP. The authors postulated that the benefit of such a risk stratification strategy would help identify those patients who would benefit from the administration of albumin versus those patients who would not.

A retrospective chart review was conducted on 144 cirrhotic patients admitted for SBP at two hospitals in Buenos Aires, Argentina between 1995 and 1998. After the exclusion of patients with HIV, shock, acute gastrointestinal bleeding, organic nephropathy, or incomplete medical records, 127 patients were left for analysis. Eighty-one patients (64%) were classified as high risk based on the presence of initial bilirubin $>4\text{mg/dl}$ or creatinine $>1\text{mg/dl}$. The other 46 patients (36%) were classified as low risk based on their lower initial bilirubin and creatinine values. All patients were treated with antibiotics for seven days, none received albumin or any other form of plasma expansion. The primary end points were death during the hospitalization and renal failure defined as serum creatinine $>1.5\text{mg/dl}$ or blood urea nitrogen (BUN) $>30\text{mg/dl}$.

Mortality during hospitalization was 23% (19 patients) in the high-risk group compared to 6.5% (three patients) in the low-risk group ($p<0.01$). Renal failure occurred in 23% (19) of the high-risk patients and 2.6% (1) of the low-risk patients ($p=0.006$).

A major limitation of this study is that the groups were stratified based on initial creatinine, but renal failure was one of the primary endpoints. It is difficult to draw valid conclusions about an end-point ($\text{Cr}>1.5$, $\text{BUN}>30$) that is so tightly linked to the stratification criteria ($\text{Cr}>1$). This study also found a number of other variables that were significantly different between the groups, i.e., prothrombin time, BUN, AST, ALT, and MELD score. Hyponatremia was also more prevalent in the high-risk group but not significantly so. These other variables could have been confounders in this study. The authors conclude that initial creatinine and bilirubin can be used to risk stratify patients with SBP. However, it is not clear from their study that these are the only or best variables to use for risk stratification.

Take home point:

Initial variables such as creatinine and bilirubin can be used to identify SBP patients at high risk for in-hospital mortality. When admitting these patients from the emergency department such risk stratification tools may be useful in determining the most appropriate level of care. Risk stratification also can help guide initial management decisions by selecting patients who would most benefit from therapies such as the administration of albumin.

Salerno F, et al. Albumin infusion improves outcomes of patients with spontaneous bacterial peritonitis: A meta-analysis of randomized trials. *Clin Gastroenterol Hepatol.* 2013 Feb;11(2):123-30.

SBP is the most common precipitant of type 1 hepatorenal syndrome and acute kidney injury in the setting of SBP carries a high mortality. Salerno et al., performed a meta-analysis of four randomized controlled trials (288 total patients), which examined the effect of albumin infusion on renal function and mortality in SBP. Three of the trials compared albumin to no albumin, and one trial compared albumin to synthetic colloid. Albumin (20%) solution was administered in a dose of 0.5-1.5g/kg in three trials, while the fourth trial used three daily doses of 10g. Three trials used a three-day treatment period, and one trial treated for three weeks. Every trial also included antibiotic treatment. Exclusion criteria for the study included antibiotic treatment in the preceding week, HIV, cardiac or renal disease, gastrointestinal (GI) bleeding, grade 3-4 hepatic encephalopathy, and advanced age.

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Renal insufficiency developed in 8.3% of the patients treated with albumin, as opposed to 30.6% of control patients. The pooled odds ratio was 0.21, with a range of 0.19-0.3 across all trials. Total mortality for all patients was 16% in the albumin treatment group and 35.4% in the control group. Odds ratios for mortality ranged from 0.16-0.55 across studies with a pooled odds ratio of 0.34. Overall, the benefit for renal impairment and mortality was consistent across all included trials.

Strengths of this meta-analysis include only using randomized controlled trials, consistent benefits of the treatment across trials, and similar definitions for SBP and renal impairment across the trials. Unfortunately, only one of the included trials was blinded and there was some heterogeneity in the duration of albumin treatment (three days versus three weeks).

Take home point:

Albumin infusion, in addition to antibiotic treatment, may reduce both acute renal impairment and mortality for patients with SBP.

Ariza XJ, et al. Risk factors for resistance to ceftriaxone and its impact on mortality in community, healthcare and nosocomial spontaneous bacterial peritonitis. *Hepatology*. 2012 Apr;56(4):825-32.

Ariza et al., conducted a retrospective observational study on a cohort of cirrhotic patients with culture positive SPB. The trial was conducted with aims to recognize risk factors for SBP caused by micro-organisms resistant to Ceftriaxone (MR-Cef), and the clinical implications of this resistance to empiric treatment. Strengths of this study were the inclusion of diverse patients and the detailed analysis of odds of resistance based on these characteristics.

Inclusion criteria in this study were all classes of cirrhosis, and individuals with other comorbidities including HIV and immunosuppressive therapy. Exclusion criteria included culture negative SBP, secondary SBP, and polymicrobial infection. Ceftriaxone was used as initial empiric therapy after cultures were obtained and deemed appropriate in in-vitro susceptibility testing of the samples. Of the 246 culture-positive patients, basal characteristics included whether the infection was likely community acquired (N=86), health-care related (N=95) or nosocomial (N=66). Of the three subgroups nosocomial infections had the highest rates of MR-Cef.

Characteristics of ascitic fluid associated with cephalosporin susceptibility was high ascites polymorphonuclear neutrophils and leukocyte count (OR 0.89). Patients who had history of previous quinolone exposure had higher rates of MR-Cef organisms.

A greater the number of days of contact with the healthcare system was related to higher probability of MR-Cef. The authors point to wide-spread quinolone prophylaxis as being a driving factor of microbial resistance patterns.

Take home point:

It is important to identify patients with high risk of MR-Cef. Patients with prior quinolone prophylaxis, recent contact with the healthcare system, and those with in-hospital infections are more likely to have these resistant bacteria.

Mattox AA, et al. Multi-resistant bacteria in spontaneous bacterial peritonitis: a new step in management? *World J Gastroenterol*. 2014 Oct 21;20(39):14079-86.

SBP is a common source of infection in cirrhotic patients. Risk factors for SBP include a high Child-Pugh Score, low protein levels in the ascitic fluid and the occurrence of upper GI bleeding.¹ When compared to community acquired infections, nosocomial associated SBP carries a 30-day mortality >50%.^{2,3} Antibiotic prophylaxis helps decrease recurrence of SBP, but leads to multi-drug resistance. Additionally, recent hospitalization, invasive procedures, or close exposure to multi-drug resistant bacteria are all risk factors that increase the risk of acquiring nosocomial SBP.^{4,5} Epidemiologically, nosocomial SBP demonstrates a higher prevalence of gram positive organisms than community acquired SBP⁵.

Treatment options for nosocomial infections vary but the consensus is that broad spectrum gram negative coverage is needed in patients at risk for multi-resistant organisms. Choice of antibiotic should be based on local resistance patterns. Generally, piperacillin-tazobactam is the first choice in high risk patients. Carbapenems are an alternative if the patient is allergic to penicillin or the resistance patterns preclude use of piperacillin-tazobactam. If no risk factors for multi-resistant bacteria are present, then third generation cephalosporins are indicated unless cultures prove otherwise.

Take home point:

Consider multi-resistant bacteria in patients with SBP who are on outpatient prophylaxis, have been recently hospitalized, have a history of such infections, or have a history of repeated invasive procedures.

Conclusion:

Based on the literature, we recommend that all patients suspected of having SBP should receive a diagnostic paracentesis as soon as possible even if coagulopathy is present. Delaying paracentesis or antibiotic administration increases mortality. It is also important to recognize that patients with renal failure or elevated bilirubin have increased mortality which should be considered when deciding upon the patient's level of care. It is imperative to identify patients who are at risk of multi-drug resistant bacterial infection. Fluoroquinolone prophylaxis, recent hospitalization or history of multi-drug resistant bacteria should be investigated and proper antibiotic treatment should be initiated early until culture results are known. Additionally, albumin should be considered for patients with confirmed SBP to reduce renal failure and mortality.

References:

1. Garcia-Tsao G. Bacterial infections in cirrhosis: Treatment and prophylaxis. *J Hepatol* 2005; 42 Suppl: S85-S92
2. Merli M, et al. Cirrhotic patients are at risk for health care-associated bacterial infections. *Clin Gastroenterol Hepatol* 2010; 8: 979-985
3. Cheong HS, et al. Clinical significance and outcome of nosocomial acquisition of spontaneous bacterial peritonitis in patients with liver cirrhosis. *Clin Infect Dis* 2009; 48: 1230-1236
4. Wiest R, Krag A, Gerbes A. Spontaneous bacterial peritonitis: Recent guidelines and beyond. *Gut* 2012; 61: 297-310.
5. Fernández J, et al. Prevalence and risk factors of infections by multiresistant bacteria in cirrhosis: A prospective study. *Hepatology* 2012; 55: 1551-1561

Continued on next page

6. Grabau C, et al. Performance standards for therapeutic abdominal paracentesis. *Hepatology*. 2004 Aug; 40(2):484-8.
7. Kim JJ, et al. Delayed paracentesis is associated with increased in-hospital mortality in patients with spontaneous bacterial peritonitis. *Am J Gastroenterol*. 2014 Sep;109(9):1436-42.
8. Orman ES, et al. Paracentesis is associated with reduced mortality in patients hospitalized with cirrhosis and ascites. *Clin Gastroenterol Hepatol* 2014; 12(3), 496-503.
9. Terg R, et al. Serum creatinine and bilirubin predict renal failure and mortality in patients with spontaneous bacterial peritonitis: a retrospective study. *Liver Int*. 2009 Mar;29(3):415-9.
10. Salerno F, et al. Albumin infusion improves outcomes of patients with spontaneous bacterial peritonitis: a meta-analysis of randomized trials. *Clin Gastroenterol Hepatol*. 2013 Feb;11(2):123-30.
11. Ariza XJ, et al. Risk factors for resistance to ceftriaxone and its impact on mortality in community, healthcare and nosocomial spontaneous bacterial peritonitis. *Hepatology* 2012 Apr;56(4):825-32.
12. Mattos AA, et al. Multi-resistant bacteria in spontaneous bacterial peritonitis: a new step in management? *World J Gastroenterol*. 2014 Oct 21;20(39):14079-86. ■

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Why Today?

Mike Wilk, MS4
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Sitting across from a patient in her early twenties who reported pain in her left lower extremity for the past few weeks, I struggled to figure out why she was in the emergency department today. No trauma. Nothing made it better or worse. No erythema or swelling. No history of deep vein thrombosis (DVT). She was able to ambulate without issues. Physical examination did not reveal any abnormalities. The X-ray ordered in triage was normal. With a seemingly unremarkable history and physical exam, I reassured her and let her know that the attending physician would be in to see her soon.

Once the attending walked in and asked about her family history, she revealed that her mom and sister have had multiple incidents of DVT, and all of a sudden it clicked. She was concerned she might have one herself, and after a little reassurance and education on the signs and symptoms of DVT, she was out the door. In a rush to get back and present the patient in a timely fashion, I had skipped this portion of her history and was now kicking myself for it. Had my attending dismissed the patient's visit, she would have left still worried about a DVT.

Despite all the advanced diagnostic tests we now have access to, all medical students have been told by their teachers (in particular, the more senior ones) that "the answer lies in the history and physical." This experience certainly taught me that today, especially since the patient did not require any further diagnostic testing or treatment after revealing her concern.

"Finding out the actual reason for their visit can save time and effort and ultimately lead to improved patient care.**"**

One of the most important things I've learned when evaluating emergency department patients who do not seem to have a clear-cut reason for their visit, is to answer to the question "Why today?" Finding out the actual reason for their visit can save time and effort and ultimately lead to improved patient care. If you remain unsure after walking out of the room, consider going back to ask more questions. When it still remains unclear, directly asking the patient why they thought they needed to come on this particular day — while being careful to not come off as judgmental — can lead you down the right path.

Being thorough enough to gather all of the essential information, yet efficient enough not to fall behind, remains a challenge that seems only experience can master. Until I get that experience, I'll always remember to ask "Why today?" ■

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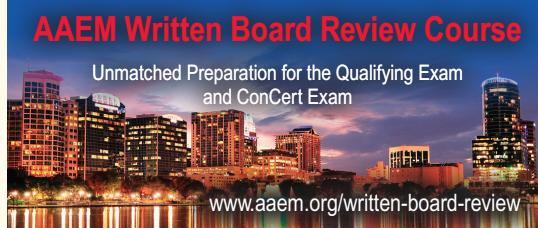
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