VOICE
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

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INSIDE

AAEM-PG Welcomes First Group: Greater San Antonio Emergency Physicians

AAEM-PG is a national physician group that adheres to the values of AAEM and fosters a management setting based on fairness and transparency where each is an owner.

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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 quallity 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

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Please visit www.aaem.org for special eligibility criteria)
International Member: $150 (Non-voting status)
Resident Member: $60 (voting in AAEM/RSA elections only)
Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
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International Student Member: $30 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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President's Message

Physician Burnout or Physician Resiliency?

Kevin Rodgers, MD FAAEM
AAEM President

Are you satisfied with your work-life balance? Does your job provide fulfillment and happiness? Is there more to your professional career than just your clinical job? Certainly thought provoking questions, if you stop and take the time to really ponder the answers. Or as I should say, if you actually have the time to examine your life. How about even more serious questions: are you depressed, have you considered suicide? Not exactly a happy topic for a President's Message, I know, but the recent suicide of an EM resident has placed the "burnout epidemic" squarely in the spotlight. Of all occupations and professions in the U.S., doctors are at the top in risk of suicide, two times more likely to commit suicide than the average American. Perhaps even more alarming, after accidents suicide is the most common cause of death among medical students.

> "Almost 7,000 physicians completed surveys in the Mayo study […] 54% of the physicians reported at least one symptom of burnout in 2014."

In response, the concept of physician wellness and resiliency is a growing area of focus for health care professionals at every level of training and practice. Burnout specifically in emergency physicians received considerable attention when a December 2015 *Mayo Clinic Proceedings* study found EM to be the #1 "burnout" specialty. Researchers repeatedly cite three elements that define burnout: 1) emotional exhaustion, the depletion of emotional energy associated with work-related demands; 2) depersonalization, a sense of emotional detachment from one's patients or job; and 3) low personal accomplishment, a diminished sense of self-worth or efficacy related to your professional career. Does this touch home with you?

Almost 7,000 physicians completed surveys in the Mayo study. Using the Maslach Burnout Inventory, which focuses on emotional exhaustion and depersonalization, 54% of the physicians reported at least one symptom of burnout in 2014, compared with 45% in 2011 (P<.001). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (48.5% vs 40.9%; P<.001). In contrast to physician trends, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working U.S. adults.

What is the solution? For current and future medical students and residents, a cultural change is necessary, one that raises awareness of the signs of burnout and erases the stigma of "weakness" associated with admitting to burnout. This enhanced recognition, coupled with a wellness curriculum that focuses on physical health, social connectedness, and effective use of stress management, will empower future generations of physicians with the resilience necessary to overcome the challenges and stress associated with practicing medicine. Both the AAMC (medical students) and ACGME (residents) have embarked on developing comprehensive wellness programs to provide future physicians with the skills necessary to manage a healthy work-life balance.

But what about those of us who entered practice without formal wellness training? How do we cope with the well-recognized challenges facing emergency physicians: circadian disruption, malignant malpractice litigation, infectious disease exposure, inadequate nutrition and exercise, the electronic medical record, and financial instability associated with excessive work hour-life style trade-offs? At a recent meeting of the leaders of various EM organizations at the SAEM meeting in New Orleans, the majority of our discussion focused on the wellness and resiliency of practicing emergency physicians, or the lack thereof. In order to address the wellness void that exists for the practicing EP, a "wellness/resiliency summit meeting" with representatives from all major EM organizations will occur in February 2017, with the goal of defining the problem (burnout) as well as its solution (resiliency). In conjunction with this effort, AAEM has created a new committee that focuses on the wellness of our members. If you have expertise in this area or want to improve the plight of our members, please consider joining the Wellness Committee chaired by Robert Lam.

These initiatives are certainly a major step in the right direction, but fail to address another cause of burnout that is at the very core of AAEM's mission: workplace fairness.

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In an AAEM survey of U.S. emergency physicians:

- 75% of board certified emergency physicians have felt financially exploited at some point during their career.
- 49% have considered leaving the field due to unfair business practices.
- 52% can be terminated without due process.

Certainly the angst over this inexcusable lack of workplace fairness is as much responsible for emergency physician burnout as the causes cited above. Luckily for some of you, a solution is already available — the AAEM Physician Group (AAEM-PG). Since its inception, AAEM has been the strongest advocate in EM for physician-owned and -controlled practices. AAEM-PG strives to make that a reality for more emergency physicians, coupled with AAEM's principles of workplace fairness. It is time for a new era in EM physician group management. The AAEM-PG holds true to the values that have guided AAEM for over 20 years: fairness, transparency, and unyielding dedication to the welfare of the individual emergency physician. I encourage you to:

> "In conjunction with this effort, AAEM has created a new committee that focuses on the wellness of our members. If you have expertise in this area or want to improve the plight of our members, please consider joining the Wellness Committee chaired by Robert Lam."

- Be part of a practice where you have an equal voice and physicians take care of each other.
- Be part of a practice that is run by the local physicians, for the local physicians.
- Be one of the few emergency physicians who sees what is billed and collected in your name.

Interested in eliminating a major cause of emergency physician burnout? Contact AAEM-PG Chief Medical Officer Robert McNamara, at info@aaempg.com, or visit the website at www.aaemphysiciangroup.com. ■

This is life as an AAEM member — Renew Today!

You are connected.

AAEM is over 8,000 members strong and growing. We offer multiple ways for you to get involved with the topics that matter most to you through engaging committees & projects plus multiple ways to network with fellow members in the U.S. and around the globe.

You have an advocate in your corner.

For over 20 years we have been committed to your personal and professional well being. Our primary concern is supporting you: your practice rights, your autonomy, your relationship with your patients. That's the AAEM difference.

You have access to top-tier benefits.

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You have a strong voice.

Your concerns reach the ears of our leaders in Washington. AAEM actively works to ensure the needs of EPs are being addressed on the national and state levels. We offer support & legal assistance to members whose rights are threatened. The strength of the Academy is in your corner.

Join the AAEM Critical Care Medicine Interest Section!

- **Open to any AAEM or AAEM/RSA member** with an interest in critical care, including students, residents, fellows and attendings. We are looking to gather 50 charter members to kick off this new section.
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- **Dues for AAEM members are set at $50** and dues for international and RSA members will be determined soon. Watch the fall membership mailing for more information.

Sign-up with your interest at:
www.aaem.org/forms/critical-care-application.php

AMERICAN ACADEMY OF EMERGENCY MEDICINE

CRITICAL CARE MEDICINE
Interest Section

The Medical-Industrial Complex

Andy Walker, MD FAAEM
Editor, *Common Sense*

"In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the military-industrial complex. The potential for the disastrous rise of misplaced power exists and will persist."

President Dwight Eisenhower spoke the words above in his farewell address to the nation, three days before John Kennedy took the oath of office in 1961. Strangely enough, it was reading the April issue of *Emergency Medicine News* (Volume 38, Issue 4) that made me think of Eisenhower and the phrase he invented, "the military-industrial complex." As I read *EM News*, I noticed a probably unintentional theme: an outcry against the medical-industrial complex, more commonly called the corporatization of medicine, and the accompanying loss of professional autonomy for physicians.

First there was the editorial "Working for Mr. Business" by Martha Roberts, who is a nurse practitioner and the daughter of one of the founders of our specialty, Dr. James Roberts. I urge you to read it in its entirety, but among her most important points is this:

> *"Administration is always telling us to jump, and we act like we can jump as high as their expectations require. Patients complain, administrators lecture, and sentinel events are increasing. The wait times may be improving, but is the care? Providers feel they are getting the short end of the stick while getting stuck with more complex patients daily. Their scores are dropping not because they are making poor clinical decisions, but because they did not provide the Splenda or the words a patient wanted to hear.*
>
> *Hard-working ED staff are burned out, making other employment decisions, and even quitting the profession entirely.*
>
> *[...] Why are we leaving the decisions to our administrators who have no role in patient care whatsoever? [...] The administration should be you and me. [...] It's time you stop working for Mr. Business.*

On the very next page is a letter to the editor from Dr. Eric Senn, which includes:

> "*I left emergency medicine a couple of years ago for an urgent care practice, and I am gleefully happy! The hospital system and the government succeeded in eviscerating the specialty over more than 20 years."*

Then comes another of Dr. Edwin Leap's excellent commentaries, "Doctors and Nurses Getting in Trouble." Dr. Leap bemoans the current corporate culture in hospitals, which makes it far more important to avoid trouble than to do good for patients:

> "*Me: "Patient in bed two needs an ECG!" Nurse: "You have to put in the order first, or I'll get in trouble." In fact, this theme emerges again and again when I ask for things like dressings, splints, labs, or anything else on a busy shift. I've expressed my frustration about physician order entry before, and I know it's a losing battle. When there is one of me, three or four of them, and 10 patients or more, it's difficult to enter every order contemporaneously. But I know, "you'll get in trouble.*
> *[...] Now that we have given all of medicine to the control of persons trained in management, finance, and corporatism, that's the thing they have to offer. Rules, regulations, and, ultimately, threats [...] Never mind that seeing patients in a timely manner is rendered nigh impossible by the overwhelming and growing volumes of patients coupled with the non-stop documentation of said patients for billing purposes. Keep shooting for those times! Times are easier metrics to measure. Times are easily reported to insurers and the government. Times, charts, rules followed, rules violated. The vital signs of corporate medicine in America today."*

"We physicians take an oath to put the medical needs of our patients above our financial self-interest, and nearly all emergency physicians adhere to that oath. Hospital administrators, insurers, and government bureaucrats take no such oath and feel no such ethical obligation."

Dr. Leap also points out that we can't turn to government for help. It has brought even more crushing bureaucracy and micromanagement to health care than corporate hospitals and insurers. In fact, it would be more accurate to label the problem the government-medical-industrial (GMI) complex, rather than the medical-industrial complex.

The casualties of the GMI (pronounced "Jimmy") complex are hidden, buried in background noise and blamed on other things, but I have no doubt that GMI is a killer. Between the distractions, delays, and errors generated by computerized physician order entry and the electronic medical record; GMI's obsession with metrics and customer satisfaction scores over actual medical quality; and the desire of doctors and nurses to stay out of trouble by avoiding the wrong thing, rather than being motivated mainly by a desire to do the right thing — I suspect GMI has killed hundreds, if not thousands, of Americans. In losing our professional autonomy, administrators and bureaucrats have taken control of our work space — the ED. While this is obviously bad for emergency physicians, generating burnout and driving good doctors out of the ED, it is also very bad for patients.

We physicians take an oath to put the medical needs of our patients above our financial self-interest, and nearly all emergency physicians adhere to that oath. Hospital administrators, insurers, and government

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bureaucrats take no such oath and feel no such ethical obligation. But because these people have taken control of our work space, and because most emergency physicians can be fired without cause and without peer review or due process for defying such people, many of us are no longer free to exercise our hard-earned professional judgment as we think best for patients.

Emergency medicine always seems to be "the canary in the coal mine" when it comes to problems facing the medical profession, and this issue is no exception. As a hospital-based specialty — except for the growing free-standing ED movement — we are dependent on largely non-physician hospital administrators for our livelihood, and our specialty has been dominated by predatory staffing corporations (contract management groups, or CMGs) from its founding.

In fact, as I finished the April issue of *EM News* and came to the classified ads at the back, I was jarred to find them dominated by CMGs like EmCare,* which routinely include a clause allowing termination without cause in their employment contracts — denying emergency physicians peer review and due process, even after some post-hiring probationary period has expired. The issue was full of warnings against the GMI complex, but then full of ads from the worst practitioners of corporate medicine.

To use Eisenhower's words, we have indeed seen the "disastrous rise of misplaced power." But what can we do about it? Although extremely wealthy and powerful forces make up the GMI complex, we can mitigate the damage done and moderate the danger to our patients by reclaiming some of our professional autonomy. AAEM is working primarily on two fronts to accomplish this. 1) The Academy and its lobbyists in Washington are working hard to obtain guaranteed peer review and due process for emergency physicians. This would give us the protection we (unfortunately) so often need in order to do the right thing for our patients, who are often looked on as difficult and undesirable by hospital administrators and even other physicians, and the protection we need to point out and correct situations in our EDs that endanger patients or staff. 2) The Academy recently launched the AAEM Physician Group, to support existing physician-owned, democratic groups that comply with Academy principles and to found new ones. Such groups guarantee due process and peer review to their physicians.

As more and more emergency physicians and other hospital-based specialists become employees, I predict the Academy will eventually open a third front in the war to protect doctors and patients: unionization. But that's a topic for another column...

* ACEP's president-elect, Rebecca Parker, is part of upper management at EmCare and its parent company, Envision Healthcare. From the EmCare website:

"Dr. Rebecca Parker [...] serves as Senior Vice President of Practice and Payment Integration for Envision Healthcare and Executive Vice President for Leadership Development and Education for EmCare. Dr. Parker serves on the Board of Directors for the American College of Emergency Physicians and was elected to the position of president elect by the ACEP Council in October 2015."

Below are two things from the Nov/Dec 2013 issue of *Common Sense* that relate to Dr. Parker and EmCare, and Dr. Bob McNamara's editorial from that issue appears in its entirety immediately following this installment of "From the Editor's Desk."

> "Emergency medicine always seems to be 'the canary in the coal mine' when it comes to problems facing the medical profession, and this issue is no exception."

1) From "Lake Emergency Services and the Road Less Traveled," by Carol Cunningham, MD FAAEM:

"In September of 2010, we learned that Lake Health had awarded a three-year contract to EmCare, and Lake Health's administration had instructed EmCare to offer all of us employment. We attended an informational dinner sponsored by EmCare. Dr. Rebecca Parker, EmCare's regional medical director and a member of ACEP's board of directors, presented EmCare's compensation proposal and encouraged us to complete applications for employment. The quality of the compensation package was, in our opinion, woefully inferior to what we earned as physician-owners of LES. We left the EmCare folders on the table or tossed them in the garbage on our way to the parking lot. In subsequent weeks our suspicions were confirmed, when phone calls from EmCare indicated that the expected number of clinical hours per month was more than many of us worked during residency. In addition, the compensated time set aside for administrative duties was one third to one half of that LES had provided. Attempts by some to negotiate changes in the EmCare offer were stonewalled by Dr. Parker, who declined to present some of our requests to her corporate superiors. LES physicians who were members of ACEP were left stunned and scratching their heads, wondering what happened to the claim from ACEP's mission statement that it was "the leading advocate for emergency physicians.

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[...] The LES contractual definition of a full-time physician was 120 hours per month, while EmCare offered us contracts mandating 160 hours per month. The double and triple physician coverage and PA that LES provided during the busiest parts of the day were reduced to single physician coverage, with sporadic double physician coverage. The 8-hour shifts that LES instituted in 1992, to promote the faster delivery of better patient care, support physician wellness, and prevent burnout were replaced by EmCare with 12-hour shifts.

[...] At the request of Lake Health's CEO, I met with her in January of 2011 to discuss Lake Health's emergency medical services, since I had served as EMS medical director since 1995. During our conversation she expressed surprise that nearly everyone in LES refused to work for EmCare. She thought that working for a corporation whose regional medical director was on ACEP's board of directors would be attractive to us.

[...] The contract between Lake Health and EmCare was abruptly terminated in March of 2013, almost a year before its expiration date. When they learned that the contract had been canceled, several members of Lake Health's medical staff contacted us and begged us to return as an independent group. However, the administrators who initiated our departure remained in place."

2) Part of an introduction I wrote to another article about the same episode:

[...] note the role a member of ACEP's board of directors played in EmCare acquiring the Lake Health contract. A similar story is unfolding now in Tennessee, where EmCare has launched a joint venture with HCA, which is taking over the ED contracts at several HCA hospitals in the state...The CEO of EmCare's South Division is Dr. Terry Meadows, a member of ACEP and one of the directors of its Florida chapter. Other EmCare leaders also play leadership roles in ACEP. Dr. Russell Harris, CEO of the North Division, is a past president of ACEP's New Jersey chapter. Dr. Angel Iscovich, West Division CEO, is "an active member of ACEP" according to EmCare's website. Dr. Thom Mayer, EmCare's executive vice president, is a member of ACEP and winner of its Speaker of the Year award. EmCare's chief medical officer, Dr. Kirk Jensen, is also a member of ACEP and another winner of its Speaker of the Year award. Dr. Dighton Packard, CMO of Envision Healthcare — EmCare's parent company — is a past-president of ACEP's Texas chapter. ■

Our Opinion

Robert McNamara, MD FAAEM
CEO, AAEM Physician Group

Reprinted from the November/December 2013 issue of *Common Sense. Dr. Bob McNamara offers editorial commentary on Dr. Cunningham's story.*

The upbeat tone of Dr. Cunningham's message inspires admiration for her and her colleagues, and their resolute action. However, if you take a step back you will see that this story encompasses much of what is wrong with emergency medicine, and why it was necessary to create AAEM. In my opinion, the facts are clear. A leader of ACEP helped destroy an independent, democratic emergency medicine group. What purpose did that serve? What these emergency physicians built and nurtured over the course of 25 years was ruined. Dr. Parker was a principal agent in disrupting the careers of the LES emergency physicians. Can any EmCare bonus justify that?

At the time this story was unfolding, Dr. Cunningham and her colleagues sought AAEM's support. We quickly responded with letters to the hospital Board of Trustees and leaders of the medical staff, questioning why they would threaten the integrity of patient care by bringing in a for-profit corporation. We went further and sent a request to the Ohio State Medical Board, asking for a review of the planned EmCare arrangement based on our concern over fee-splitting. Sadly, the group lost the contract anyway. LES probably never had a chance to retain the contract because the hospital CEO believed EmCare's pitch that the docs would roll over, stay, accept their loss of independence, and work for EmCare — a pitch made more credible by the fact that Dr. Parker was on ACEP's board of directors at the time. As Dr. Cunningham suggests, subsequent reports indicate that this decision not only affected the LES emergency physicians, but also the patients they left behind.

What we are left with is another cautionary tale for administrators who listen to the Dr. Parkers and EmCares of the world. On September 24, 2013, a story by Matt Skrajner in *The News Herald* reported that EmCare has lost its contract to staff Lake Health's three EDs, replaced by EMP (Emergency Medicine Physicians) of Canton, Ohio. As in many other cases — such as Methodist Hospital in St. Louis Park, MN* — hiring a corporate group to replace a stable and proven physician-owned group has proven risky. More importantly, the population served by Lake Health has moved further away from the essential component of AAEM's Vision Statement: 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.

What should you do? If you are part of an independent democratic group now, consider sending this article to your administrator — being fully aware that your contract is always being pursued by contract management groups. Second, applaud Dr. Cunningham, her colleagues, and yourself for supporting AAEM in its quest to protect individual emergency physicians and their patients rather than corporations — and ask yourself why you would support any professional society that doesn't share those values.

*In 2004 EmCare acquired the ED contract at Methodist Hospital in St. Louis Park, Minnesota. EPPA, a private democratic group serving the hospital since 1969, was not told the contract was up for bid until after it had been awarded to EmCare. No request for proposals was issued. EPPA asked AAEM for assistance. The Academy offered legal counsel, made an argument on EPPA's behalf to the hospital, filed a complaint with the state attorney general, and with EPPA jointly filed suit against both EmCare for violating corporate practice of medicine and fee-splitting laws and the hospital for breach of contract. Three weeks later Methodist Hospital terminated its relationship with EmCare and re-contracted with EPPA. EPPA continues to serve Methodist Hospital and several other local hospitals. This case had a chilling effect on corporate groups' plans to move into Minnesota, and they have so far been unable to establish a significant foothold there. (This footnote is taken from a review of AAEM legal actions on behalf of independent emergency medicine groups by Dr. Mark Reiter and others, which appeared in the Jan/Feb 2014 issue of *Common Sense*.) ■

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Letters to the Editor

Andy Walker, MD FAAEM
Editor, *Common Sense*

A "Letters to the Editor" feature is now available on the *Common Sense* section of the AAEM website. Members must login with their AAEM username and password to read or post letters, or to comment on letters (www.aaem.org/publications/common-sense). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in *Common Sense*.

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make *Common Sense* an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the letters to the editor feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

Bemoaning the eHarmony Mentality of Job Applicants

We've all seen the ads. You know, the dating site that strives to pair you with the perfect mate based on "29 dimensions of compatibility." It seems like there are a lot of matching services out there and not just for dating. A few clicks and setting of parameters and you can find the perfect hotel, the perfect travel itinerary and the perfect car. Does the same apply to the perfect job?

I've been very fortunate to have the opportunity to lead a group of physicians at a once small, but now much larger, community hospital in Texas. Our group has grown with the hospital and we've even added on a sister hospitalist group to help expand our services and improve patient flow on the inpatient side. Our two groups employ just under 30 full and part-time physicians. But as with most groups in our area we continue to expand and could stand to add a few more docs.

I've placed recruiting ads online with some success but of late have been seeing a somewhat disturbing trend with our applicants. Or maybe I should say with our applicants' spouses. Yes, I said spouses. It first started with our hospitalists when we formed that group about 4 years ago. I interviewed an internist who wanted to bring her husband along. I thought this was a little odd but we were meeting at a restaurant offsite, he was a nice guy, and I recognize that this can be a family decision so why not? And maybe this was one of those "medicine" things we ER doctors don't quite understand. My wife is triple-boarded in internal medicine, pulmonary and critical care so I recognize some quirks exist across specialties.

But then we started getting calls from spouses making initial contact and screening positions based on what they could glean from our practice manager over the phone. And then it happened. The phenomenon crossed over to the ER side. What began as husbands tagging along for lunch, then husbands calling about jobs (and yes, it's almost always the husbands), a wife called about a job for her ER spouse. And she was very aggressive. We provided some basic information and I politely declined to do a phone interview with the wife, offering instead an interview with the candidate himself. Not only did she decline on her husband's behalf, but she wrote a lengthy nastygram to my practice manager saying that unless they knew the "hourly expectations, volume, compensation, benefits and so on" upfront then "we can't know whether it's a good fit for us" and "we can't commit to spending the day on an interview" without this information.

Not once did I ever have any direct contact with the candidate.

Call me old fashioned, and I may very well be, but it seems to me that the natural sequence of events is that you identify a job opening, you make some general inquiries, then you interview for the job and gather the bulk of your information during the interview. Maybe some follow up questions or clarifications thereafter but most of what you would learn about the job would happen onsite where you get an opportunity to see and meet people, tour the facility, watch doctors and staff in action, etc. Try to get a feel for the place firsthand.

Now, I recognize some applicants live a long way away. It's a big state, much less a big country. Many applicants are residents with limited resources. We've all been there. As much as I am not a fan of the telephone interview, we've relaxed our approach a little bit and have been more accommodating. Several of our physicians have volunteered to talk with prospective candidates by phone. We've even utilized newer technologies and have had a few FaceTime chats.

But the candidate I never met and whose wife dismissed us outright, sight unseen? He lives 55 miles away from our hospital. I Googled it. Fifty-five miles! Even with traffic would it be such a burden to come out for a face-to-face?

I regret that there is such a push to extract as much information as possible without an interview and to gauge agreeableness with the "29 dimensions of compatibility" that candidates and employers alike are missing out on opportunity for a meaningful in-person interaction. ■

— Patrick Woods, MD MBA FAAEM

Congress Advances Addiction and Mental Health Legislation Prior to Summer Break; Will Contemplate MACRA Policy upon Return

Williams & Jensen, PLLC

Congress spent the first part of summer focused on addressing several health care crises: the opioid epidemic, treatment of the mentally ill, and combating the spread of Zika virus.

In July, Congress passed and sent to the President the bipartisan Comprehensive Addiction and Recovery Act (CARA). The bill authorizes state and local grant programs to treat opioid addiction. The bill also includes modest reforms to pain management and prescribing practices and encourages responsible use of opioids. Additional aspects of the bills considered in the Senate and House focus on emergency response during an overdose, including reforms to good Samaritan laws, and increased access to naloxone and other overdose reversal medications.

Despite a push from many Congressional Democrats, no separate funding is attached to the bill for new programs. Democrats sought new funding, contending that existing appropriations are insufficient to help address the nationwide opioid and heroin problem. Republicans noted that Congress approved $135 million in Fiscal Year 2016 for opioid treatment and prevention programs through the Department of Health and Human Services (HHS) and that legislators are on track to approve a significant increase this year to provide over $250 million for these programs. Addressing the growing opioid epidemic has been a top priority for Congressional leaders in 2016.

While not completed, bipartisan legislation entitled the "Helping Families in Mental Health Crisis Act of 2016," won House approval by a vote of 422-2. The bill establishes a new assistant secretary at HHS to oversee mental health and substance abuse programs. It also includes grants for suicide prevention and early intervention for children. The final bill scales back proposed changes to Medicaid reimbursement and the Health Insurance Portability and Accountability Act (HIPAA). The House-passed bill awaits action later this year in the Senate. A similar measure, the "Mental Health Reform Act of 2015," was introduced by Senators Chris Murphy (D-CT) and Bill Cassidy (R-LA).

Following the recess, Congress will turn its attention to a Fiscal Year 2017 funding measure for HHS and other federal agencies. Congress will have to approve stop-gap legislation by September 30 to continue funding agencies at current levels.

Key Congressional policymakers are also focusing on the proposed SGR replacement policy unveiled earlier this year by HHS, outlining the new Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) that will allow providers to earn bonus payments beginning in 2019.

Continued on next page

AAEM and AAEM/RSA members gathered for a successful Advocacy Day in Washington, D.C.

Members received an update from Dr. Lemeneh Tefera from the Centers for Medicare & Medicaid Services on Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA. Access these slides on the AAEM website: www.aaem.org/advocacy/aaem-advocacy-day.

Congressman Dave Brat from Virgina met with AAEM Past President Dr. William Durkin, and AAEM members Dr. Catherine Perry and Dr. Jennifer Rabjohns.

AAEM President, Kevin Rodgers, MD FAAEM, speaks with Congressman Raul Ruiz, MD.

Under the law, HHS would measure performance through MIPS beginning on January 1, 2017. However, an effort to delay the implementation of the new payment system is gaining momentum, and Centers for Medicare and Medicaid Services (CMS) Acting Administrator Andy Slavitt suggested that while the agency's interim final rule is under consideration, CMS could be open to a delay. Several industry stakeholders support the delay, expressing concerns over new administrative burdens for physicians, the majority of which will participate in MIPS because they will not be eligible for advanced APMs. To qualify for the 5 percent bonus under MIPS, physician must provide high value care across four performance categories: quality, advancing care information, cost/resource use, and clinical practice improvement activities. Of these four categories, HHS proposes to apply a 50 percent weight in year one to the quality category.

HHS said the proposal is a "first step in an iterative implementation process" to establish a new physician payment system under MACRA. Secretary Burwell said the agency would be "listening and learning" from stakeholders on advancing the goal of implementing MACRA and creating a system that works better for providers, patients, and taxpayers.

A number of physician stakeholders have written CMS urging them to simplify reporting requirements for the MIPS categories and to exempt more physicians from MIPS under the low-volume threshold. The Senate Finance Committee held a July hearing on this topic, and both the panel's Chairman, Orrin Hatch (R-UT), and Ranking Member, Ron Wyden (D-OR), agreed that CMS needs to implement the law in a way that works for physicians.

AAEM has encouraged HHS to work with stakeholders to design quality measures that make sense for emergency physicians, rather than imposing a one-size-fits-all model that works better for other specialists. AAEM also highlighted the importance of providing emergency physicians with robust options to participate in APMs, so that they are not excluded from achieving bonus payments through the use of these models.

AAEM Meets with Dozens of Policymakers during 2016 Advocacy Day

AAEM and AAEM/RSA partnered together for the 2016 Advocacy Day in Washington, D.C. on June 14. The day began with a "lobbying 101" presentation followed by a discussion of specific issues that would be raised on Capitol Hill.

Dr. Lemeneh Tefera with CMS' Center for Clinical Standards and Quality provided participants with a customized briefing about the impact of the proposed physician payment system on emergency physicians. He provided an overview of the law and gave insights on the emergency medicine perspective. Dr. Tefera is an Adjunct Associate Professor of Emergency Medicine at George Washington University and still practices clinically. The slides from this presentation are available on the Advocacy Day section of AAEM's website: www.aaem.org/advocacy/aaem-advocacy-day.

AAEM Antitrust Compliance Plan:

As part of AAEM's antitrust compliance plan, we invite all readers of *Common Sense* to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at info@aaem.org or by calling 800-884-AAEM.

Finally, the group descended upon the Hill, meetings with dozens of Members and staff of the House and Senate. Participants highlighted the denial of due process for emergency physicians, GME funding, medical student debt reform, and discussed several bills impacting emergency medicine including the Promoting Responsible Opioid Prescribing (PROP) Act, and the Protecting Patient Access to Emergency Medications Act, which pertains to the use of controlled substances in providing emergency medical services.

AAEM and AAEM/RSA Members enjoyed a great lunch and conversation with Congressman Raul Ruiz (D-CA). Congressman Ruiz is one of two emergency physicians serving in Congress. Participants capped off a successful day with a networking event in the evening. ■

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1-1-2016 to 7-13-2016.

AAEM established its Foundation for the purposes of (1) studying and providing education relating to the access and availability of emergency medical care and (2) defending the rights of patients to receive such care and emergency physicians to provide such care. The latter purpose may include providing financial support for litigation to further these objectives. The Foundation will limit financial support to cases involving physician practice rights and cases involving a broad public interest. Contributions to the Foundation are tax deductible.

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AAEM PAC is the political action committee of the American Academy of Emergency Medicine. Through AAEM PAC, the Academy is able to support legislation and effect change on behalf of its members and with consideration to their unique concerns. Our dedicated efforts will help to improve the overall quality of health care in our country and to improve the lot of all emergency physicians.

All contributions are voluntary and the suggested amount of contribution is only a suggestions. The amount given by the contributor, or the refusal to give, will not benefit or disadvantage the person being solicited.

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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

September 17-18, 2016
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Orlando
  www.aaem.org/oral-board-review

September 24-25, 2015
- AAEM Pearls of Wisdom Oral Board Review Course
  Philadelphia, Los Angeles
  www.aaem.org/oral-board-review

September 28-29, 2016
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas
  www.aaem.org/oral-board-review

March 16-20, 2016
- 23rd Annual AAEM Scientific Assembly – AAEM17
  Orlando, FL
  www.aaem.org/AAEM17

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.

AAEM JOINTLY PROVIDED CONFERNCES

September 30, 2016
- PreGameCME: Pediatric Emergency Medicine
  Ann Arbor, MI
  www.pregamecme.com/event/pediatric-emergency-medicine-2016/

October 5, 2016
- AAEMLa Emergency Medicine Resident Conference and Annual Meeting
  New Orleans, LA

AAEM RECOMMENDED CONFERENCES

September 30-October 2, 2016
- The Difficult Airway Course: Emergency™
  Boston, MA
  www.theairwaysite.com

November 4-6, 2016
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

Make a Difference with AAEM's Educational Programs

The ACCME Subcommittee, a branch of the Education Committee that maintains AAEM's CME Program, is actively recruiting members.

Subcommittee activities include reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly provided activities to ensure all guidelines are met that are set by the ACCME (Accreditation Council for Continuing Medical Education).

To learn more about the responsibilities of all of our committees and to complete an application, visit: **www.aaem.org/about-aaem/leadership/committees**

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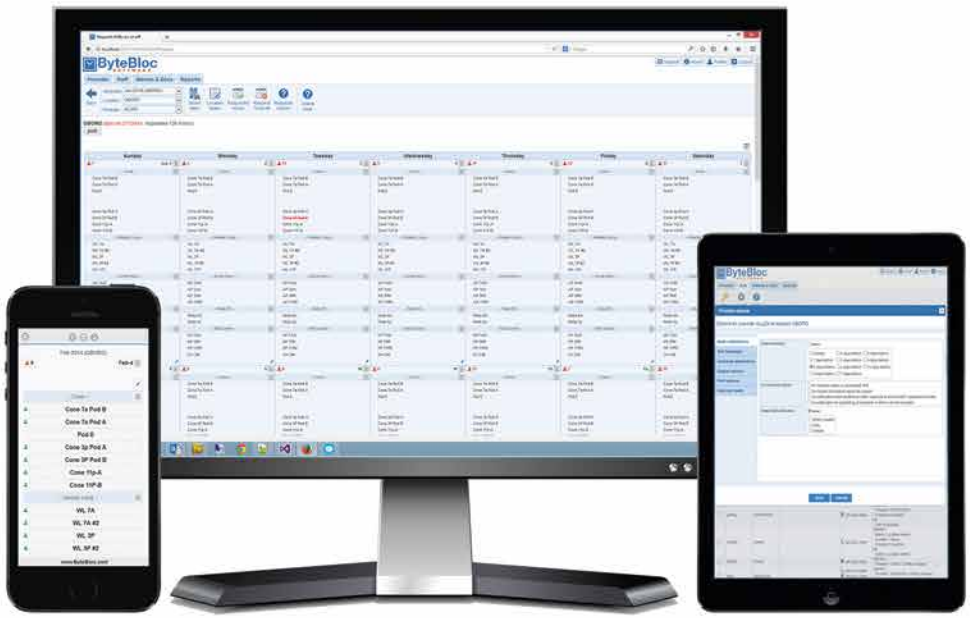

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Getting Your Annual CFE (Continuing Financial Education)

Joel M. Schofer, MD MBA CPE FAAEM
Commander, USN Medical Corps

We are all required to get continuing medical education, or CME. Just as important, however, is continuing financial education (CFE). I'm as busy as the next guy, but I am able to stay reasonably up to date on all aspects of personal finance that are relevant to my situation. Thanks to podcasts, blogs, RSS readers, Facebook, and good old fashioned books, it is easy to stay up to date. Here are some resources I recommend for your CFE.

1. **Jonathan Clements' Money Guide 2016 and his annual updates.** Mr. Clements was a personal finance columnist for *The Wall Street Journal*, has written many financial books, and has a stellar reputation. He offers solid, no-nonsense advice and covers every topic I can imagine in this guide. Since he updates the book annually, reading it is a guaranteed way to keep up to date on personal finance. In addition, he has a blog at JonathanClements.com that you can follow, and a Facebook site as well.

2. **The White Coat Investor (WhiteCoatInvestor.com).** This website is free and contains a wealth of information on personal finance topics. Founded by an emergency physician, this site is specific to high income professionals and often focuses on physicians. There are usually three posts per week, and you can follow on Facebook, e-mail, RSS reader, or by manually checking the blog. If you have questions on any aspect of personal finance, you can probably find a physician-focused answer on this site.

3. **Vanguard (VanguardBlog.com).** The Vanguard blog and Investment Commentary podcast focus on the low-cost, passive, index fund investing that have made Vanguard the king of investment companies. The blog is an excellent source of contemporary investment information and current market trends. The podcasts occur monthly and are usually less than 15 minutes in length, making them easily digestible by busy physicians.

4. **Wealthfront (Blog.Wealthfront.com).** Written by Burton Malkiel, acclaimed author of A Random Walk Down Wall Street, and other well respected financial writers, this blog is an excellent source of investing information. As you might imagine, the posts tend to focus on the benefits of utilizing Wealthfront's robo-advisor service, but even if you don't invest with Wealthfront the information discussed is universally applicable, especially if you invest passively with index funds.

5. **Mr. Money Mustache (MrMoneyMustache.com).** There is an entire early retirement culture on line, of which many physicians are unaware. If you have an interest in early retirement, you'll love this website and the story of Pete (Mr. Money Mustache), a software engineer who retired in his thirties. It is filled with investing information, as well as practical advice on how to save money in everyday life. The site has an anti-consumerism, pro-Earth bent and Mr. Money Mustache is a strong proponent of using a bicycle instead of driving a car, even in the dead of winter. He will show you that retiring early and controlling your spending doesn't have to lead to unhappiness. In fact, he'll probably convince you that the less you own the happier you'll be.

6. **Money for the Rest of Us.** This podcast is hosted by a former investment manager. He does an excellent job of reviewing personal finance and economics topics in shows that are usually about 30 minutes in length. He offers additional content to those that join his"hub,"and like most money managers he thinks he can invest on the"leading edge"of the market. In other words, he thinks he can predict the future and is a little too slanted towards active management for me. That said, however, the shows are well done and extensively researched, and very entertaining with high-quality audio. Even though I don't agree with active management, many of the topics he discusses are excellent food for thought.

If you regularly utilize these six sources of financial information, it will be easy for you to stay up to date on your CFE.

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. ■

AAEM Physician Group Welcomes First Partner: Greater San Antonio Emergency Physicians

Robert M. Mcnamara, MD FAAEM
Chief Medical Officer

AMERICAN ACADEMY OF EMERGENCY MEDICINE
PHYSICIAN GROUP
Supporting Independent Practices

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MILWAUKEE — The American Academy of Emergency Medicine Physician Group (AAEM-PG) is proud to announce Greater San Antonio Emergency Physicians (GSEP) will be joining AAEM-PG as the inaugural physician group.

AAEM-PG was founded in late 2015 with the goal of putting values that have guided AAEM for over 20 years: fairness, transparency and unyielding dedication to the welfare of the individual emergency physician, into direct action.

GSEP Joins the Team

GSEP is an independent and democratic association comprised of over 75 emergency physicians serving six hospitals and over 200,000 patients per year in San Antonio, Texas.

GSEP President, Bob Frolichstein, MD FAAEM, is excited about the new venture.

"GSEP is thrilled to be the first emergency medicine group to partner with AAEM-PG. The Academy has a long and storied history of supporting fairness and transparency, traits that mirror the ideals of our group and many other independent democratic groups throughout the country. Our practice has been searching for a solution to compete with organizations that continue to grow at the expense of the individual physician. AAEM-PG is the answer. The depth of resources and experience truly levels the playing field and ushers in a new era in emergency medicine."

A New Era in Physician Group Management

AAEM-PG seeks to improve the marketplace for emergency medicine (EM) physicians and their patients by creating a large, national group that adheres to the values of AAEM. EM physicians under the AAEM-PG umbrella practice in a setting based on equal partnerships of professional colleagues where each member is an owner. This will allow them to more fully enjoy the practice of EM and be more able to endure its inherent stresses. The patients in turn will be better served by these more professionally satisfied physicians.

As AAEM-PG CEO, Robert McNamara, MD FAAEM, notes:

"A new day is beginning in EM and it is great to have GSEP as the inaugural member of the AAEM-PG. This represents the first important step towards countering the increasing corporate control of our profession. AAEM firmly believes that its members, the patients and the hospitals we work at are much better served when physicians own their practices and remain free of influence from for-profit lay corporations. We hope to expand this model across the country and encourage other groups with a similar vision to examine what the AAEM-PG has to offer."

Top-Tier Practice Support

AAEM-PG will be supported by Intermedix, an organization with more than 35 years of experience serving the emergency medicine specialty. Intermedix will provide AAEM-PG member physicians with a comprehensive infrastructure of analytics, practice management and revenue cycle technology and services.

"We are committed to the welfare of emergency physicians by offering those who wish to remain independent a viable means to do so, without sacrificing their ability to compete in the changing health care landscape," said Joel Portice, CEO of Intermedix. "It is an honor to support AAEM-PG with a full breadth of specialized services that will allow its members to focus on practicing medicine while we ensure their financial success."

###

AAEM-PG is a national physician group that adheres to the values of AAEM and fosters a management setting based on fairness and transparency where each is an owner. AAEM-PG supports independent practices with financial and management resources. AAEM-PG believes the brightest future for EM physicians is when they own their practice. ■

Want to learn more? Start today by visiting www.aaempg.com

Electronic Health Record Implementation in Your Emergency Department

Brian J. Yun, MD MBA, Fellow in Emergency Medicine Administration, Emergency Department, Massachusetts General Hospital
Sayon Dutta, MD MPH, Partners eCare Emergency Medicine Physician Lead, Emergency Department, Massachusetts General Hospital
Kenneth Bernard, MD MBA, Assistant Director, Emergency Department, Tuba City Regional Health Care Corporation

Pre-Implementation

Creating a Culture of Change

Change is inevitable in all things, and in health care new trends evolve in disease, patient populations, technology, medical knowledge, and legislation. The sad truth is that change, especially when initiated by forces external to your department or poorly planned, is cumbersome, expensive, and often seen as a means to correct a deficiency rather than an opportunity to enrich the experience of physicians and patients. This may seem like framing, and it is. But that is exactly what emergency department (ED) leaders must do when planning the implementation of a new electronic health record (EHR). Leaders need to have a very deliberate and structured approach to a new EHR.

John P. Kotter, retired Harvard Business School professor and definitive expert on the topic, introduced the steps in the process of change in his seminal article "Leading Change" (Figure 1).[1] Kotter states that most efforts at change fail not because the ideas or projects being implemented are inherently bad, but because leaders fail to appreciate the phases of the transformative process and therefore make several missteps. As a result, most implementation projects are rejected by core stakeholders even before the process begins, assuring failure. As an ED leader, the adoption and implementation of an EHR is a ripe opportunity for you to either shine or fail miserably.

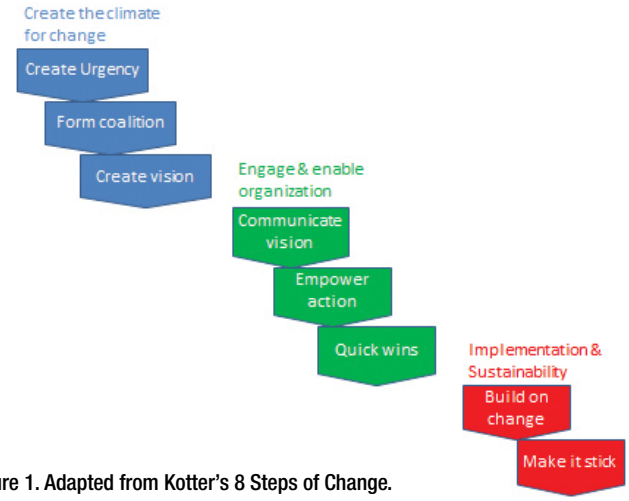

Figure 1. Adapted from Kotter's 8 Steps of Change.

Continued on next page

Electronic Health Records as a Catalyst for Change: Creating Urgency

Some of the benefits of moving to an electronic record are clear. Computerized order entry and integrated clinical decision support dramatically reduce the number of medication dosing errors.[2] Standardized electronic order sets can make complex care easier — improving the use of tPA in acute stroke, for example.[3] Capturing data for research and mandated reporting is also simplified using an EHR.

Yet prior to 2008 fewer than 10% of United States hospitals had even a basic EHR.[4] Then, in 2009, the federal government catalyzed the rapid adoption of EHRs through the Health Information Technology and Economic and Clinical Health (HITECH) Act, which offered initial financial incentives for providers and hospitals to adopt an EHR and eventual penalties in Medicare reimbursements if they failed to do so.[5] To comply, hospitals must attest to "meaningful use" of their EHR — meeting set criteria that become increasingly complex over time.[6]

Beyond the other potential benefits of moving to an EHR, health care organizations and providers risk the loss of billions of Medicare and Medicaid dollars if they fail to comply with the HITECH Act. You must communicate this urgency to your department and hospital administration.

Disseminating a Vision

Your coalition includes clinicians, nurses, and other staff who can cohesively represent the needs of your department to hospital leadership. Clinical leaders in the ED should be deeply engaged in selecting the EHR, to ensure that the unique demands of the ED are met.

Once an EHR is selected, its success depends on the support and engagement of your coalition during and after implementation. Early on, identify and engage clinical champions and provide them protected time to participate in EHR implementation. After building momentum and communicating a clear vision for implementation, allow this select group to proselytize the vision of your department. Empower this group with the right level of enthusiasm and skill, to build momentum and support for implementation.

Avoid the temptation to hire only outside consultants. Consultants often lack the clinical expertise of your own staff, and are not familiar with workflows that are unique to your institution. Instead consider training a core of providers, who can then help train the rest of the providers in your practice. While an outside consultant should also be present during the training sessions to help answer EHR-specific questions, your clinician trainers (or peer educators) will be best suited to teach with your department's workflows in mind.

Implementation

Training, Staffing, and Planning

A major component of any EHR implementation is training. Work with your implementation team to ensure that training materials match your ED's workflows. Be aware that training is time-intensive, expensive, and not comprehensive. Encourage your users to practice on their own time, with exercises such as "shadow charting." Consider practicing high-stress, time-sensitive workflows — such as a major trauma resuscitation — on mock patients before you go live with the EHR.

Expect and plan for a decrease in productivity of up to 30% during EHR implementation.[7] For the first two weeks, increase staffing during the busiest times (Figure 2).[8] To reduce the risk of shifting bottlenecks, increase staffing for clinicians, nurses, and support staff.

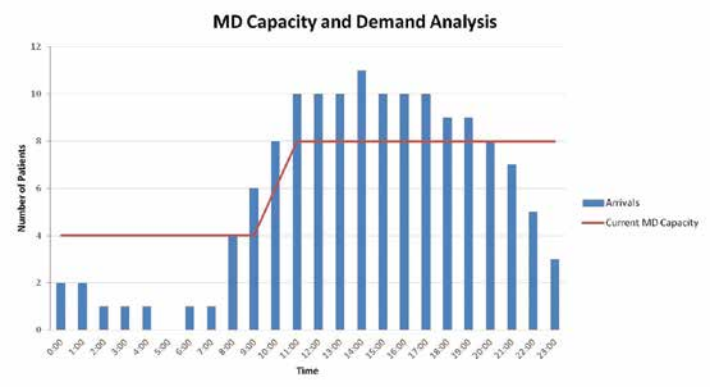

Figure 2: Analysis of patient arrivals per hour and physician capacity of seeing 2 patients an hour.

The reduction in productivity after an EHR implementation may last for three months.[9] In one study, 44% of a clinician's time was spent on data entry with only 28% spent on direct patient care.[10] As a result, consider instituting a scribe program to help recoup some of this productivity loss.

If you are the referral center in the region, consider limiting ED transfers. This should be done starting at least a week prior to EHR implementation, especially if your hospital has an inpatient boarder problem. This is important, since depending on your hospital's average inpatient length of stay, it may take a week of discharges and reduced admissions to create necessary capacity for the expected EHR implementation date. Local EMS services should be notified, and you should work with neighboring hospitals so they can anticipate increases in volume. During the first three days of implementation, consider denying all ED-to-ED transfers.

For institutions which are moving from one EHR to another, review your cutover procedures and have multiple dress rehearsals to prepare. This change is more complicated than simply turning one system off and turning another on. There may be many hours before the new system can be accessed and used. Educate staff and prepare for this downtime.

Inquire about a Help Ticket system. A robust Help Ticket system should be available 24/7. Help Tickets should be separated between Incidents and Requests. Incidents are "bugs" or "break/fixes" that affect patient care, finances, or workflow. Expect to have a lot of Incidents over the first several days, with a gradual decrease to baseline over the first three weeks of implementation. Primary issues during this time include users' ability to log in the system and see their role-appropriate tools, the mapping of orders to medications stocked in your dispensing cabinets, and the mapping of computers with the appropriate printers. Requests are enhancements that staff members believe could make the system easier to use. Try to limit new Requests during "go-live" so that your IT staff can first fix what's broken. It is also important for a point person or physician commander to keep track of Help Tickets, so trends can be noted and issues prioritized more efficiently.

Continued on next page

Trouble Shooting

Make sure that you have support staff (or super-users) in the ED 24/7, ideally for two weeks. Super-users should come from your own institution, but also consider hiring outside consultants specifically for "go-live." Make sure the super-users cover all roles in the ED, including nursing and administrative staff. Ideally, every clinician should be scheduled multiple shifts during the first two weeks to expose them to the new EHR system during a time of both increased staffing and at-the-elbow support.

It is important to have daily meetings or huddles during implementation. One meeting should ideally take place in the morning, to discuss events that occurred the evening and night before. The team should then meet with the IT people to discuss new high-priority items and any important issues that were recently resolved. Be sure to participate in hospital leadership meetings, to make ED-specific issues that jeopardize your workflows and patient care a priority.

A person or team should be designated to provide your users with regular email updates. Try to avoid multiple emails sent by multiple people, as this can lead to mixed messages or the circulation of incorrect information. Of note, while email is the easiest way to spread information to a large number of providers, staff members may quickly become inundated with emails and develop email fatigue. As a result, consider scheduling a discipline-specific staff meeting one week post go-live to provide re-education and address any questions.

Sustainable Change

Finally, take advantage of easy wins and emphasize user friendliness, mobile applications, improved practice management, easy and seamless provider or patient communication, improved research applications, standardized physician order entry, and medication management. Leaders must spread the credit and praise staff for incorporating or anchoring the new changes and embracing change as part of the organization's culture.

The process of change and EHR implementation is a long, arduous, and expensive process and morale can suffer if these early improvements are not celebrated. But take care not to mistake easy, short-term gains as the ends rather than means to successful implementation.

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Osteopathic Continuous Certification in Emergency Medicine

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The following is an overview of the American Osteopathic Board of Emergency Medicine (AOBEM) and its activities. There have been significant changes recently, and this article also explains why those changes were made.

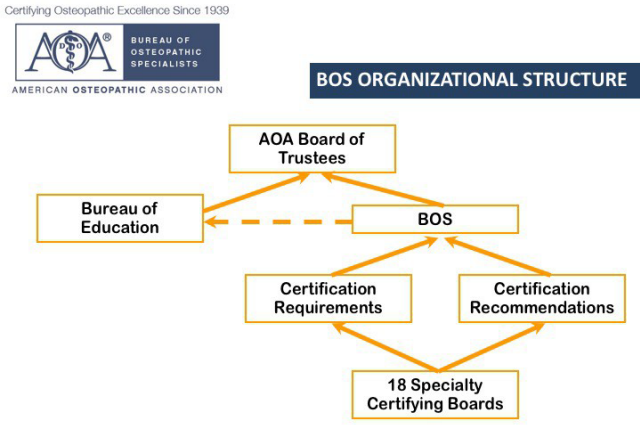
History

In 1975 a small group of osteopathic physicians met in Toledo, to discuss the need for post-graduate training in emergency medicine and organize a specialty group. Three years later the Board of Trustees (BOT) of the American Osteopathic Association (AOA) granted a charter to the American College of Osteopathic Emergency Physicians (ACOEP). One of its first missions was to establish post-graduate training standards. The first osteopathic EM residencies were launched in 1979, at the Chicago College of Osteopathic Medicine, the Detroit Osteopathic Hospital, the Grand Rapids Osteopathic Hospital, and the Philadelphia College of Osteopathic Medicine.

The BOT created AOBEM in 1980. Its first board of directors included James Budzak, DO FACOEP; Donald Cucchi, DO FACOEP; James Grate, DO FACOEP; Robert Hambrick, DO FACOEP; and Bruce Horton, DO FACOEP. By 1990 the number of directors had expanded to 12, and in 2016 the board grew to 14.

Since its first certification examination in emergency medicine was given in 1980, AOBEM's activities have increased steadily. A recertification process was established in 1994, and all certificates issued since then are valid for only ten years. In 1995 AOBEM became a member of a conjoint Board in Sports Medicine, and that same year AOBEM was given jurisdiction in Emergency Medical Services. The first examination for a Certification of Added Qualification in Emergency Medical Services was given in 1996. In 1997 AOBEM was given jurisdiction in Medical Toxicology, and the first examination for a Certification of Added Qualification in Medical Toxicology was given in 1999.

Like all AOA specialty boards, AOBEM is part of the AOA and answers to the AOA BOT. This is different from the American Board of Medical Specialties (ABMS), whose member boards are independent corporations. All AOA specialty boards function under the auspices of the AOA's Bureau of Osteopathic Specialists (BOS), which works to ensure that certification processes are consistent across specialties. The board of directors of each specialty board is composed of volunteer physicians who are in active clinical practice. Specialty boards establish certification standards through the BOS, but ultimately certification is granted by the AOA BOT rather than individual boards. See the organizational chart below if these relationships seem confusing.



Unlike specialty boards, specialty colleges are independent of the AOA — but still provide input into educational standards through the AOA's Bureau of Education (BOE). Until the Single GME Accreditation System is fully implemented, they will continue to provide accreditation standards and perform osteopathic residency site surveys.

The AOBEM Certification Process

The AOBEM seeks to accomplish its mission — to protect the public through certification in emergency medicine — by measuring performance in six core competencies.

1. **Patient Care:** Provide care that is compassionate, appropriate, and effective.
2. **Medical Knowledge:** Demonstrate knowledge of established and evolving diagnostic and treatment methods.
3. **Interpersonal and Communication Skills:** Demonstrate skills that result in effective information gathering and communication with patients and their families, and with professional associates.
4. **Professionalism:** Demonstrate professional responsibility, adherence to the AOA Code of Ethics, and sensitivity to diverse patient populations.
5. **Systems-Based Practice:** Demonstrate awareness of and responsibility to the larger healthcare context, and the ability to use system resources to provide optimal care (e.g., coordinating care across multiple specialties, professions, or sites).
6. **Practice-Based Learning and Improvement:** Demonstrate the ability to investigate and evaluate one's care of patients, collect scientific evidence on that care, and improve it.

Initially, AOBEM certification was accomplished through a three-step process. This consisted of a written examination (Part I), an oral examination (Part II), and a site visit by a board member (Part III) who observed

Continued on next page

the candidate's practice and graded his or her care and charting (an evaluation of all six core competencies). As the number of candidates increased, however, it became logistically impossible to perform site visits for each candidate. A review of twenty charts selected by the candidate was instituted instead. Applicants who began the certification process after September 2013 are not required to complete Part III. Candidates who began the process prior to this date must still complete all three parts.

Osteopathic Continuous Certification (OCC)

In 2003 the BOS approved an AOBEM plan to begin Continuous Osteopathic Learning Assessments (COLA). Each year the board appoints a committee to take part of the core curriculum, made up of the eight-part Table of Specificity (TOS), and find the most relevant new literature in the chosen areas – along with any truly landmark articles, regardless of which section of the TOS those fall into. A 40-question exam is then developed from the ten most significant articles. The committee is charged with identifying articles from easily accessed sources such as Medscape, journals which diplomates likely already receive, and other journals which should be easy to access from local medical libraries or on line. Diplomates must currently take eight COLAs and pass six to be eligible to sit for the recertification examination every ten years, but starting with those who take the recertification exam in 2020, diplomates will be required to take and pass eight of eight.

The AOA Board of Trustees approved the BOS's recommendation to implement an Osteopathic Continuous Certification (OCC) process in 2008. The certification process for Emergency Medicine has thus evolved dramatically since its creation in 1980. What began as a onetime assessment to obtain a lifetime certificate has evolved into a lifelong learning assessment and continuous certification. Every certificate issued by AOBEM since 1994 is valid for ten years and expires on December 31 of the tenth year. In order to maintain the validity of the certificate for another ten years, the diplomate must participate in the OCC process.

The Five Part Process of AOBEM OCC (see http://aobem.org/OCC_main.shtml)

1. Professional Status: Emergency physicians must hold a valid and unrestricted medical license in the states where they practice, or in any one state if in active military practice (core competency 4).
2. Continuous Osteopathic Learning Assessment (COLA): A COLA module involves reading assigned articles from the literature and then completing an examination on line. The list of assigned articles and applications for the examination are posted on the AOBEM website. The articles cover the entire AOBEM Table of Specificity over a recertification cycle (core competency 2); as well as communication skills, cultural competency, and interpersonal skills (core competency 3); plus systems-based practice (core competency 5).
3. Cognitive Assessment (CA): The entire Table of Specificity will be covered in the CA. Diplomates are required to take this examination every ten years to maintain Osteopathic Continuous Certification. The examination consists of a computer-based multiple choice examination (core competencies 1 and 2).
4. Practice Performance: Diplomates must perform a practice assessment twice in the ten-year recertification cycle. This consists of a process whereby the clinician assesses the quality of his or her care, by comparing it to that of peers and national benchmarks. This process promotes improved care through the application of best evidence and consensus recommendations. The process consists of four steps:
   - Identify a target area for clinical improvement. The target area may be a disease entity, a clinical care issue, or an access to care issue (e.g., through-put or left-before-treatment). The target area requires a population or clinical issue that is measurable and has comparison data available. The clinician must choose appropriate data points as measures of quality. Diplomates are advised to review pre-approved projects that are listed on the attestation form at http://aobem.org/practiceperformance.shtml.
   - Collect and review data from ten patient charts in the targeted area of study. The clinician may choose charts from the entire practice group, but a minimum of three charts must be his or her own patients. This recognizes that physicians who work in low volume EDs may have difficulty collecting enough data if forced to evaluate only their own charts, and that emergency medicine is a system-based practice, so in most cases improving performance affects the entire group,

Continued on next page

- Data from the ten charts are then compared to evidence-based guidelines, expert consensus statements, or comparable peer data. Analysis of the data is then used to identify areas for improvement.
- Next, develop and implement a practice performance improvement program. This plan may include an educational piece, personal reminders, or a change in process (e.g., adding the NEXUS criteria for cervical spine imaging to the electronic medical record, in order to avoid unnecessary radiation in trauma patients).
- After implementation of the process improvement plan, review at least ten new charts in the targeted area of improvement. Analyze the data and evaluate for improvement.

Those physicians not involved in clinical practice must complete the "AOBEM Recertification Non-Clinical Form." These physicians are still required to complete the Practice Performance Module, and their status will be reported to the AOA as "AOBEM Certified: Non-Clinical."

There is also a patient communication and satisfaction component, which must be completed once during each ten-year recertification cycle. Emergency physicians are increasingly judged by their ability to communicate with patients, and assessment of communication skill has become a major measure of overall excellence. Diplomates may use any satisfaction survey or other method their departments or hospitals currently employ to satisfy this component, so long as the required AOBEM parameters are included and measured (core competency 6). AOBEM can supply a version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey Reporting Kit (version 2008) to those diplomates not currently participating in an eligible satisfaction survey program. There is an online attestation form at http://aobem.org/patient_overview.shtml.

5. Continuous AOA Membership: Diplomates must maintain continuous membership in the American Osteopathic Association. AOA membership insures that a physician meets the AOA's Continuing Medical Education (CME) requirements for certification and adheres to the AOA Code of Ethics (core competency 4). AOBEM diplomates are required to obtain 150 hrs of CME every three years, including at least 50 in emergency medicine (core competencies 2 and 6).

Diplomates are no longer required to complete an oral examination for recertification, since the core competencies the oral exam measured are now being measured by other components of OCC.

Conclusion

Specialized residency training and board certification establish initial standards for performance, but do not assure maintenance of proficiency over a lifetime of practice. Regulatory agencies, health maintenance organizations, and the public require documentation of continued professional development and education by physicians. OCC is a professional response to the need for public accountability and transparency. AOBEM believes high standards for certified emergency physicians lead to better healthcare for emergency patients. The Joint Commission strongly encourages hospitals to measure the six core competencies of their medical staff every two years, as part of the credentialing process. In the future the OCC program may help fulfill these Joint Commission requirements. Some pay-for-performance models also reward physicians for ongoing performance evaluation and evidence of involvement in performance improvement.

The American Osteopathic Board of Emergency Medicine, the AOA Bureau of Osteopathic Specialists, and the AOA Board of Trustees have attempted to construct well thought-out processes for diplomates that satisfy demands from the public, third party payers, oversight agencies, and patients. Every effort has been made to make the requirements reasonable, valuable to individual physicians, and cost-effective. The BOT and the BOS have repeatedly emphasized that these requirements should be adaptable, to meet changes in practice over time. The AOBEM is open to suggestions for improvement. Please feel free to contact us with any questions.

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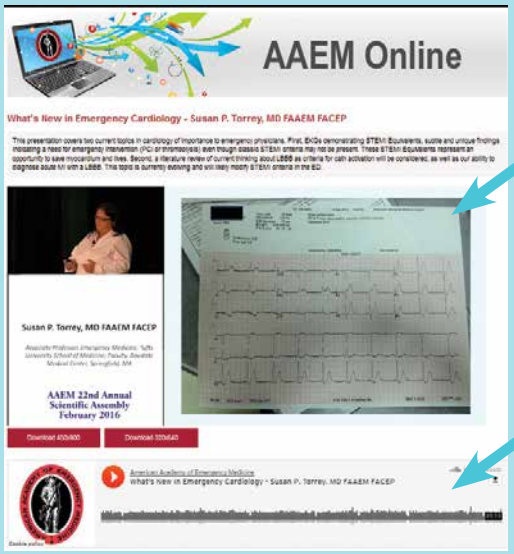

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Introducing the YPS's Newest Member Benefit: A Guide to Life after Residency — A Multimedia Production

Jennifer Kanapicki Comer, MD FAAEM
President, Young Physicians Section

That nervous anticipation you feel as the end of residency nears is natural. You may find that you practice more conservatively, question your decisions, and ask yourself, "What would I do if I was on my own?" This is normal. You are only preparing yourself for the biggest milestone in your career. Good news: the YPS is here to help.

Rules of the Road was first written over a decade ago as a guide to help residents transition to practice after graduation. It provided material on topics that were essential to early career success. While this book is provided as a member benefit to all YPS members, YPS has continually sought ways to improve it and other member benefits.

To facilitate that, YPS recently paired with very successful team at Academic Life in Emergency Medicine (ALiEM) to create the ALiEM/AAEM Fellowship. Through the efforts of the first fellow, Matthew Zuckerman, this partnership produced a multimedia product to provide helpful information for physicians navigating through their early career in emergency medicine. This new resource is *A Guide to Life after Residency*.

This multimedia guide is available to all YPS members and includes white board videos, interviews, links, and take-home points relating to important issues facing early career physicians. The convenient e-book format provides access to this valuable resource wherever life takes you.

As an introduction to this valuable resource I wanted to discuss a few of my favorite chapters:

1. The First Year Out

The first year after residency may be on your mind now as you near residency completion. While it can be a challenging year, it can also be very rewarding and formative. Since everyone's experience is a bit different, the guide's authors queried 15 recent graduates (including a mix of community and academic physicians all within five years of graduation) to compile a "Top 10 things I wish I would have known about the first year out of residency." Check out the white board presentation at: https://www.youtube.com/watch?v=259yh4OzoVc

2. Patient Satisfaction

Many residents receive little training on patient satisfaction, yet many groups and hospitals, both academic and community based, place great emphasis on it. Your reimbursement may even depend on high satisfaction scores. The e-book provides a copy of the Press Ganey survey, one of the more widely used patient satisfaction surveys. Knowing what is on the survey can greatly assist with improving your own patient satisfaction scores. Beyond providing the basic survey, this chapter also provides tips to maximize patient satisfaction while providing quality medical care as well as identifies factors associated with negative patient satisfaction ratings (aka what to avoid).

3. To Err is Human: Medical Errors

One study found that physicians with more than 18 months of post-residency experience made 50% fewer errors than those with less than 18 months experience. Therefor it is crucial for young EPs to be aware of methods to minimize medical errors as well as to understand how to deal with errors when they happen (because they happen to all of us). The e-book covers common sources of error, how to mitigate them, and includes an educational video on some high profile medicolegal cases. There video can be found here: www.youtube.com/watch?v=hSG78X_8mv0.

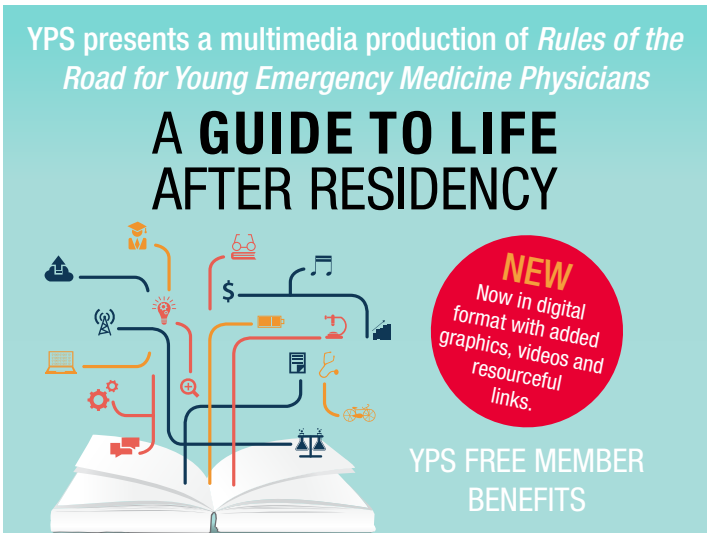
4. Career Paths

There are many roads for the young EP to take after graduation. The decision on which to take can be confusing. This chapter focuses on different career paths available to the new graduate. Useful information is provided for anyone beginning or advancing a career in academic practice, community practice, research, or ED operations and administration. It also contains information and links to additional resources concerning fellowship options and availability, grant information, and military opportunities. Finally, it contains interviews with Drs. Andy Walker, Gus Garmel, and Teresa Chan, who each took different career paths. Regardless of if you already know what career path you want to take or are just beginning to soul search, this chapter has something for you.

5. Financial Planning and Retirement Savings

Most young physicians enter practice with a large debt burden and no financial plan. This chapter covers strategies to increase immediate savings, pay off debt, establish a long-term savings plan, and plan for retirement. Ultimately it provides many tools to set you on a path to financial security.

Hopefully this teaser of *A Guide to Life after Residency* introduced you to some of what this new multimedia guide has to offer. It is an invaluable tool for those early in their career, providing useful links, videos, interviews, and resources. YPS continues to strive to make this challenging part of your career rewarding and successful. YPS members, please contact us to get the link! ■



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AAEM RSA

Innovate. Educate. Advocate.

RSA is proud to unveil their new logo to represent the Resident and Student Association.

Keep your eyes out for a newly redesigned RSA website and online materials. Your RSA leaders are working hard to provide you with the best resources to meet your needs through innovation, education and advocacy.

Join an AAEM/RSA Committee!

Advocacy Committee

Committee members staff three sub-committees, focusing on patient advocacy, resident advocacy and political advocacy both at the state and national levels. Your activities include developing policy statements, outreaching to AAEM/RSA members about critical issues in emergency medicine, and collaborating with the AAEM Government Affairs Committee.

Education Committee

Committee members plan and organize the resident educational track at the AAEM Scientific Assembly, which will be held March 16-20, 2017, in Orlando, FL. You will also assist with the medical student symposia that occur around the country.

International Committee

The International Committee will have the opportunity to contribute to international medicine projects and resource development that are helpful and beneficial to students and residents.

Membership Committee

The Membership Committee promotes our mission by building AAEM/RSA membership through recruiting, developing valuable member benefits, and communicating with residency program directors and chief residents. You will be involved with one of the most critical and exciting committees within AAEM/RSA.

Social Media Committee

The newly formed Social Media Committee will concentrate efforts from the previous Communications and Publications committees. Members will contribute to the development and content of RSA's four primary media outlets: the RSA Blog Modern Resident, the AAEM/RSA website, Facebook and Twitter. The committee also oversees development and revisions of AAEM/RSA's multiple publications including clinical handbooks and board review materials. You will have numerous opportunities to edit, publish, and act as peer-reviewers, as well as work from the ground-up in developing AAEM/RSA's expansion to electronic publications.

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AAEM/RSA President's Message

Personal Learning Networks

Mary Haas, MD (PGY-3)
University of Michigan

Over the past year I have come to appreciate the importance of concepts from sociology, psychology, and education theory on my development as a physician and educator. I recently had the pleasure of working with Drs. Felix Ankel, Anand Swaminathan, and Sally Santen on a lecture for the CORD Academic Assembly in Nashville, called Personal Learning Networks. This launched me on a study of personal learning networks and their impact on my own development so far.

A personal learning network refers to a dynamic group of connections that allow individuals to both teach and learn, share ideas and collaborate. Each individual or organization within a network is referred to as a "node." These networks reflect our values, goals and interests. They include a mixed level of expertise: peers, novices, and experts can all serve as nodes. The most effective personal learning networks include connections outside one's immediate institution and area of expertise, called "weak ties."

"A personal learning network refers to a dynamic group of connections that allow individuals to both teach and learn, share ideas and collaborate."

Although my discovery of the term "personal learning networks" occurred only recently, the concept has served an important role in my life and career for years. As early as college, I knew I wanted to pursue a career in emergency medicine. My undergraduate involvement in EM research led me to attend national meetings, which provided the opportunity to connect with both like-minded peers and inspiring leaders in emergency medicine. Networking and building relationships with those I admired motivated me to pursue emergency medicine as a career. The social nature of emergency physicians and their strong sense of community and solidarity was palpable. This remains one of most appealing aspects of our specialty.

Anand Swaminathan summed up the goal of personal learning networks in this eloquent sentence: "Surround yourself with smart people who think differently." Becoming involved in AAEM/RSA and other emergency medicine organizations has given me the opportunity to do just that, and has enriched my career as an emergency physician. I remember my first AAEM Scientific Assembly in San Diego, as a second year medical student. My research mentor Dr. Michael Pulia introduced me to the organization and encouraged me to submit our research, which was ultimately accepted as a poster presentation. In San Diego I met Meaghan Mercer, who would become a great mentor and friend. Meaghan encouraged me to follow in her footsteps and run for the Medical Student Council, and ultimately for the AAEM/RSA Board of Directors. Through these positions, I have met other residents who served as peer mentors and taught me by example, such as Vicki Weston, the outgoing AAEM/RSA President. I am honored and excited to now begin my term as AAEM/RSA President, which would not have been possible without the support and encouragement of the mentors and individuals who served a critical role in my personal learning network. Having a personal learning network has also given me the opportunity to mentor others. I have cherished the ability to mentor Mike Wilk, the outgoing Medical Student Council President and incoming chair of the AAEM/RSA Board of Directors Publications Committee. To have even a small part in the success of others is truly rewarding.

The recent expansion of FOAM (Free Open Access Medical Education) has also created the opportunity for students, residents, and other emergency physicians to expand their personal learning networks to include people from around the globe. This has led to innovative collaborations that would not previously have been possible, particularly in medical education. With remarkable ease, a quick email or Tweet to someone you admire can launch a collaborative project that has a positive impact on our specialty.

Practically speaking, there are several key points of advice for creating and expanding one's personal learning network. These are nicely summarized in a recent post by Drs. Ankel and Swaminathan on the International Clinical Educators (ICE) blog. First and foremost, don't be shy. Reach out to those you admire ("smart people who think differently"). Take advantage of social media. Follow and engage those who inspire you on Twitter. Whether you have ideas for projects or just want to make a connection, tweet or email. If you see someone at a conference you always wanted to meet in person — introduce yourself! What do you have to lose? Build your personal learning networks around topics that reflect your passions. This will transform any resulting projects into exciting endeavors rather than chores. Seek "weak ties," as those outside your immediate network provide unique perspectives that allow you to be innovative. Collaborate and use your network for academic productivity. Lastly, give back by serving as a mentor and building up others.

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AAEM/RSA Editor's Message

The Next Generation of RSA!

Mike Wilk, MD
Co-Chair, AAEM/RSA Social Media Committee

How will the next generation of medical students and residents learn? If it wasn't already obvious, textbooks are several years past their prime. Podcasts, phone apps, blog posts, and even twitter accounts are the way of the future. Textbooks are out and Free Open Access Medical Education (commonly known as *FOAMed*) is in. Almost daily, new standards of care are developed and evidence-based medical practices are updated. While the knowledge required to practice emergency medicine has never been so accessible, it has also never been so vast and difficult to navigate.

This rapid expansion of knowledge and content has not come without risk. For example, many popular podcasts discuss controversial practices that may deviate from current accepted practice such as administering Ketofol (combined Ketamine and Propofol) versus simply giving one agent for procedural sedation. While it may be exciting to try a new medical combination or procedural technique, it may not actually improve patient care and may actually worsen it.

As technology has rapidly changed the way medical students and residents learn, so RSA has changed to better serve EM students and residents. After months of discussion and debate, the RSA publications and communications committees have merged and developed into the new social media committee. I encourage you to follow us on Facebook, Twitter, and our improved peer-reviewed RSA Modern Resident Blog (http://aaemrsa.blogspot.com/).

All RSA members are encouraged to submit blog articles on any topic relevant to emergency medicine. Instructions and submission links can be found on the blog's main page. Through our new social media platforms, we look forward to bringing you the latest and greatest resources to help you through medical school, residency, and beyond! ■

Applications of Thromboelastography in Emergency Settings

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Editor: Kelly Maurelus, MD and Michael Bond, MD FAEEM

First described in the 1940s, thromboelastography (TEG) has recently re-emerged as a useful method of assessing hemostatic function in patients at risk for coagulopathy or clinically significant bleeding. TEG may be particularly useful for assessing trauma patients and other special patient populations. However, how this technology should be applied, the degree to which it can direct specific resuscitative measures, and the benefits of this approach to more traditional coagulation studies are not currently well understood.

Gonzalez E, et al. Coagulation abnormalities in the trauma patient: the role of point-of-care thromboelastography. *Semin Thromb Hemost*. 2010;36(7):723-37.

Gonzalez et al., discussed the shifting view of hemostasis from the classic enzymatic chain based approach to a cell-based model, including influences of both cellular and plasma components of clot formation. The authors then review the role of TEG and its interpretation in the trauma patient.

Hemorrhage accounts for 40% of all trauma-related deaths. Thus, restoration and maintenance of normal coagulation is critical for survival in the acutely bleeding patient. Many patients may initially arrive in a hypocoaguable state. Patients who survive the acute phase of trauma may then transition from a hypocoaguable to a hypercoaguable state and paradoxically face life threatening venous thromboembolic events.

The balance is delicate and life threatening, especially considering our limited understanding of coagulation. Classic laboratory tests of coagulation function were designed for assessment of anticoagulation therapy. These tests were not developed, nor have they been validated, to guide treatment of traumatic coagulopathy.

Thromboelastography (TEG) was developed in 1948 and is now being used to improve our understanding and management of traumatic coagulopathy. The process involves the spinning of whole blood in a cup. Similar to an EKG, a pin located within the cup detects viscoelastic properties of clot formation and translates them into graphic form.

The seven key parameters identified by TEG are split time (SP), reaction time (R), coagulation time (K), alpha-angle, maximum amplitude (MA), clot strength (G), and estimated percent lysis (EPL). These correlate with four viscoelastic functions of the clot: initiation, potentiation, overall strength, and fibrinolysis.

1. SP and R times represent initiation of clot formation via coagulation factor activity, similar to traditional PT/PTT/INR. SP is the time it takes for clot formation to start, at which point the tracing starts to split. R time represents further enzymatic factor activity that forms the initial clot.
2. K and alpha-angle characterize the potentiation and kinetics of clot strengthening as a function of fibrinogen activity.
3. MA and G depict clot strength. MA indicates clot strength due to platelet function. G is a calculated value that represents overall clot strength from all interactions including coagulation factors, fibrinogen, and platelet activity.
4. EPL portrays breakdown of the clot as a percentage decrease in clot strength.

The graphic patterns that result reflect multiple complex interactions involving coagulation proteins, platelets, endothelial cells, and inflammatory mediators. Individualized treatment decisions can then be determined using this this information. For example, a prolonged R suggests depletion of clotting factors and may indicate the need for FFP. A prolonged K or alpha advocates for increased use of fibrinogen concentrate or cryoprecipitate. Aminocaproic acid is recommended when significant fibrinolysis is detected by EPL >15%. TEG results may be calculated at 15-minute intervals in order to better treat the patient during the tenuous transition from hypocoaguable to hypercoaguable states.

In the future, TEG may be used to identify and manage treatment of subsequent thromboembolic events following trauma. Studies show that classic coagulation tests are unable to identify or predict thromboembolic events. Additionally, the frequency of thromboembolic events has not changed despite the adoption of prophylactic guidelines. Goal directed post-injury coagulopathy treatment using TEG may offer the ability to better titrate heparin and other medications as needed to care for the trauma patient.

Take Home Point

Proper utilization of TEG offers the potential to reduce transfusions, rapidly correct coagulation abnormalities, and ultimately improve survival. The ability to use whole blood and the availability of results within minutes are particular strengths of TEG. Limitations involve the high cost of a TEG analyzer and the training required for accurate interpretation. Treatment protocols are currently being investigated.

Da luz LT, et al. Thrombelastography (TEG): practical considerations on its clinical use in trauma resuscitation. *Scand J Trauma Resusc Emerg Med*. 2013;21:29.

Da Luz et al., performed a literature review on the role of TEG in the resuscitation of hemorrhagic trauma patients, with an emphasis on practical uses and limitations of the test. TEG clot strength is represented by the maximal amplitude (MA). Low MA corresponds with hypofibrinogenemia or platelet dysfunction. One small study of 44 patients showed that while abnormal aPTT and INR were not associated with transfusion, an abnormal TEG was significantly associated with both transfusion and thrombocytopenia (1). In another study, low clot strength was associated with increased 30-day mortality (47% vs 10%, p<0.001) (2). TEG can also detect fibrinolysis as measured by estimated percent lysis (EPL). A recent study by Ives et al., showed that hyperfibrinolsysis predicts mortality in the first 24 hours (OR 25.0, 95% CI 2.8-221. P=0.004) (3). Finally, certain TEG properties indicate hypercoagulability, although the clinical significance of this measure is unclear at this time (4).

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TEG-based transfusion algorithms in cardiac surgery and liver transplantation have been shown to result in less transfusions (5), raising the question of whether such an algorithm could be developed for trauma patients. Although a complete TEG study takes 30-60 minutes, a 583 patient study by Cotton et al., demonstrated that graphical r-TEG results could be available within minutes and are predictive of early pRBC, plasma, and platelet transfusion (6). In order to offer TEG as a point of care test in the trauma setting, the manufacturer recommends 2-3 equipment calibrations a day, and specialized training for personnel responsible for the test.

This review also highlights several limitations of TEG use in the trauma setting. A major limitation is the lack of standardization and validation. Specifically, thresholds for transfusion based on TEG values have not been established or validated, making it difficult to justify a true resuscitation algorithm based on these results alone. Furthermore, as both fibrinogen and platelet function determine clot strength, several different interventions have been proposed even for the same TEG result.

Take Home Point

Although the current data on TEG as a tool to guide product resuscitation is encouraging, more research is needed on practical applications in trauma resuscitation.

Yin J, et al. Goal-directed transfusion protocol via thrombelastography in patients with abdominal trauma: a retrospective study. *World J Emerg Surg*. 2014;9:28.

This retrospective cohort study from a single tertiary teaching hospital in Nanjing, China examined adults with abdominal trauma who received at least two units of RBCs within 24 hours of admission. Exclusion criteria included admission more than 24 hours after the time of injury, major traumatic brain injury, end stage liver disease, pregnancy, or a history of anticoagulation therapy in the previous three months. The department of surgery adopted a TEG-based transfusion protocol in 2010, which called for transfusing fresh frozen plasma (FFP) at a rate of 1-6 units based on the R value of the TEG. It prompted physicians to consider cryoprecipitate, platelets, or recombinant activated factor VIIa for patients with an α angle <60° or MA <55mm. The study compared outcomes of 31 patients treated prior to initiaition of the protocol with 29 patients treated afterward. The control group was transfused based on individual experience and interpretation of conventional coagulation testing.

The endpoints of 28-day mortality, length of stay, blood products transfused, and labs at admission as well as at 24 hours were compared using chi-square, Student's t test, and Mann-Whitney u tests. The authors found no significant difference in the amount of blood products transfused or mortality. A subgroup analysis of the most severely injured patients (16 in the protocol group and 13 in the control group) revealed that the treatment group required fewer blood products. Specifically, fewer RBC (4 units, range 3-11.5 vs 14 units, range 7.5-32, p<0.01), less FFP (4 units, range 2.9-9.8 vs 10.5 units, range 5.6-15.7, p=0.036) and fewer total blood products were needed (7 units, range 6.1-47 vs 37.6 units, range 14.5-89.9, p=0.015).

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The authors interpret their findings as support for adopting a TEG-based, goal-oriented transfusion protocol. While mortality was unchanged, use of the protocol was feasible and resulted in a reduction of blood products used. Limitations of the study are a small number of patients as many were excluded. Additionally, many of the included patients had low injury severity and low mortality (3 deaths in the protocol group and 2 in the control). More importantly, the authors state that they did not abandon conventional coagulation tests after implementing their protocol and the influence of conventional coagulation testing results on goal-directed transfusion management could not be eliminated. It is also noteworthy that many patients received 2 units of RBCs and 2-4 units of FFP in the ED prior to evaluation for enrolment in the study.

Take Home Point

Further studies are needed to determine whether a TEG-based resuscitation protocol can be implemented with beneficial clinical effects, specifically in regards to decreasing need for transfusion.

Conclusion

Thromboelastography (TEG) promises great utility in the management of coagulopathic and bleeding patients. However, further research must be done prior to large scale implementation of the test. Specifically, it is still unclear which patients would benefit from a TEG testing. Additionally, the ideal approach to logistics, cost, availability, and training of providers has not been determined. In the meantime, a TEG may be considered when platelet dysfunction or primary fibrinolysis is suspected as these conditions are poorly measured by traditional coagulation tests. At this point, TEG should only serve as an adjunct to the more traditional PT, PTT, and INR tests. Moving forward it is important that emergency providers familiarize themselves with the concepts behind TEG, work with their institutional committees to discuss how to implement TEG into their practice, and stay up to date with the evolving literature. It is very likely that as we learn more about this technology it will play a larger role in the diagnosis and management of bleeding and coagulopathic patients.

A more detailed discussion as well as list of references can be found online at www.aaem.org/publications/common-sense. ■

AAEM/RSA: Innovate. Educate. Advocate

Stephanie Cihlar, MS4

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Get involved! AAEM/RSA offers many varied and worthwhile opportunities that will enrich your medical school experience. Apply to join one of AAEM/RSA's committees (Advocacy, Communications, Education, International, Membership, Publications), become a Site Coordinator for your medical school and keep your school in close communication with AAEM/RSA's Medical Student Council, or become a Medical Student Ambassador and volunteer at the AAEM Scientific Assembly from March 16-20, 2017 in Orlando, Florida. Residents and fourth year medical students with a passion for policy and advocacy can apply for month-long Congressional Elective where they will work with Congressman Joe Heck, DO, or Congressman Raul Ruiz, MD, learning about legislative and policy work to empower the field of emergency medicine. For more information and additional benefits of becoming a member, visit aaemrsa.org.

It is my pleasure to announce the other members of the AAEM/RSA Medical Student Council for the 2016-2017 year: Vice President, Moiz Qureshi (University of Missouri Kansas City School of Medicine); Midwest Representative, Nicholas Bertucci (Midwestern University Chicago College of Osteopathic Medicine); Northwest Representative, Michelle Davis (George Washington School of Medicine); South Representative, Scott Bland (Campbell University School of Medicine); West Representative, Sasha Hallett (Midwestern University Arizona College of Osteopathic Medicine); and Ex Officio International Representative, Harshesh Amin (Ross University School of Medicine). On behalf of the AAEM/RSA Medical Student Council, we are honored to be serving you, and look forward to the year ahead! ■

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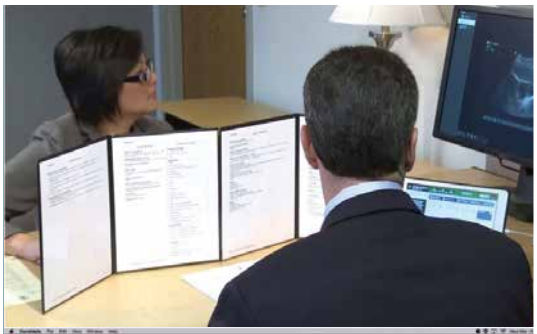

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