



Nicholas A. Aunchman, MD, FACEP
President

[Adriana Alvarez](#)
Executive Director
Phone: (800) 798-1822, Extension 3312
Fax: (972) 767-0056

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From the President

Nicholas A. Aunchman, MD, FACEP

Happy spring and new year. Apologies that we've been radio silent from the office for a little bit. We are in the middle of a transition of officers here at Vermont ACEP, I wanted to let everyone

know what's coming down the pipeline and what to expect and look forward to in the coming year.

First and foremost, I will be taking a quieter role at ACEP but staying on the Board to help out with further endeavors. I have had a lot of fun as President of VT ACEP and think I can make the analogy of drinking from a garden hose to the amount of opportunities and involvement ACEP has offered me. My successor was elected at our last meeting last year, Dr. Ryan Sexton. Dr. Sexton is a good friend and colleague as well as fellow VT ACEPer. Ryan completed his medical school at the University of Vermont and his emergency residency at Cooper University Hospital in Camden, NJ. We passed in the halls at the UVM Larner College of Medicine, but in NJ Ryan was my chief resident and someone I learned a lot from. He returned back to Vermont a few years ago with his family and is currently the ED Director at Northeastern Vermont Regional Hospital. Ryan has a rich history in leadership and is excited to take on the new role.

Dr. Christopher Barsotti who works part time at Southwestern Medical Center in Bennington, Vermont has also joined the team and will be taking on the role as Secretary/Treasurer. Chris has been very involved in ACEP on a national level and currently serves as Chair of the Trauma and Injury Prevention section at ACEP, and participates in the Committee on Preparedness of the Massachusetts Medical Society. Chris brings a lot of experience and knowledge to the team and we look forward to his involvement.

Ryan, Chris and I plan to continue to try to expand VT ACEPs membership and involvement at a national level on hot topics. We are also planning to organize the first ever VT ACEP chapter conference next summer and will be reaching out to national speakers for involvement. Our aim is to design a conference that will be fun and educational, but also highlight the splendor of Vermont and what it has to offer.

I do not think I can close out the newsletter without also offering congratulations to the University of Vermont Emergency Medicine Division on its recent ACGME accreditation for Vermont's first ever emergency medicine residency. The residency was a long way coming and a huge win for the department. So many have been involved for so many years from Drs. Weimersheimer and Herrington initially getting the ball rolling to Dr. Bounds polishing off the process. Dr. Richard Bounds will take the role of the Residency Director and we will all welcome the first class in 2019. As an EM doc in Vermont, staff at UVM and a member of ACEP, I think this is fantastic and will bring a lot of great education and hopefully future doctors to our great state.

Preparing to Give Testimony before State Legislators

Harry J. Monroe, Jr.
Director, Chapter and State Relations, ACEP

Over the years, I have worked with many lobbyists preparing for upcoming meetings. In some of those instances, the lobbyist would be gathering information to represent us himself in meetings of stakeholders or legislators or staff. In other instances, the legislator was preparing the client to give testimony at a legislative hearing.

In all of these circumstances, every good lobbyist I have worked with has required an answer to this question: what is the argument of the other side? What will our opponent say?

If you do not have a fair answer to that question, then you are not yet prepared to provide your testimony.

Because we tend to live in an environment in which we share our views with people who agree with them, too often we fail to think through the alternative point of view. Thus, insurers are against us, we often state, for example, because they are only in this for the money. They don't care about their "customers," our patients. The bottom line for their shareholders is their only concern.

My point is not that there is not a point to this. However, no insurer is going to arrive at a hearing to explain that, you know, we caught him. He doesn't care about anything but making a buck.

There are no Perry Mason endings at legislative hearings. Insurers don't confess.

The truth is that insurers, wrongly I think most of the time, have their own story, their own rationale, for their policy. We have to understand that story so that we are sure to be able to counter it – and to avoid walking into traps as we tell our own story.

None of this to say that we should have a need to fully explain or defend the insurer's point of view. Quite the contrary, a more typical approach, as appropriate, would be to briefly summarize the opposition's position before pivoting to an explanation as to why it is wrong and how we have a better solution to the problem that the policy maker wants to solve.

That sort of response is a way of showing ourselves to be fair minded and solutions oriented. It is a crucial part of effective state advocacy.

Articles of Interest in *Annals of Emergency Medicine*

Sam Shahid, MBBS, MPH
Practice Management Manager, ACEP

ACEP would like to provide you with very brief synopses of the latest articles in [Annals of Emergency Medicine](#). Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Kellogg K, Fairbanks RJ.

Approaching Fatigue and Error in Emergency Medicine: Narrowing the Gap Between Work as Imagined and Work as Really Done.

Annals of Emergency Medicine – April 2018 ([Epub ahead of print](#))

This is an editorial commenting on an article by Nicolas Perisco and colleagues, "Influence of Shift Duration on Cognitive Performances of Emergency Physicians: A Prospective Cross-Sectional Study." The article reports that there was significant cognitive decline after a 24 hour emergency shift, though not one after a 14 hour shift. The editorial goes on to describe some of the consequences of their finding, for example the fact that any cognitive decline likely also occurs in all emergency workers. They suggest we repeat the study using 8 and 12 hours shifts which are more common in the US.

Hall MK, Burns K, Carius M, Erickson M, Hall J, Venkatesh A.

State of the National Emergency Department Workforce: Who Provides Care Where?

This is a cross-sectional study that analyzed the Centers for Medicare and Medicaid Services' (CMS) 2014 Provider Utilization and Payment Data Physician and Other Supplier Public Use Files and found that of 58,641 unique EM clinicians, 61.1% were classified as EM physicians, 14.3% as non-EM physicians, and 24.5% as advanced practice providers. Among non-EM physicians categorized as EM clinicians, Family Practice and Internal Medicine predominated. They also found that urban counties had a higher portion of EM physicians compared to rural counties.

Stiell IG, Clement C M, Lowe M, Sheehan C, Miller J, Armstrong S, Bailey B, Posselwhite K, Langlais J, Ruddy K, Thorne S, Armstrong A, Dain C, Perry JJ, Vaillancourt C.
Multicentre Program to Implement the Canadian C-Spine Rule by Emergency Department Triage Nurses.

This multicentre two-phase study demonstrated that with training and certification, ED triage nurses can successfully implement the Canadian C-Spine Rule, as reflected by more rapid management of patients, and no missed clinically important spinal injuries.

Lumba-Brown A, Wright DW, Sarmiento K, Houry D.

Emergency Department Implementation of the Centers for Disease Control and Prevention Pediatric Mild Traumatic Brain Injury Guideline Recommendations.

These are the Centers for Disease Control and Prevention's (CDC) 2018 "Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children," published in JAMA Pediatrics. As the Emergency Department clinicians may be the first healthcare provider to evaluate an injured child they play an important role in the recognition and management of mild traumatic brain injury. The key practice-changing takeaways in these new guidelines include: using validated and age-appropriate post-concussion symptom rating scales to aid in diagnosis and prognosis; and incorporating specific recommendations for counseling at the time of ED discharge.

New Resources from ACEP

The following **policy statements** were recently revised and approved by the ACEP Board of Directors:

- Alcohol Advertising
- Trauma Care Systems

Four **information papers and one resource** were recently created by several ACEP committees:

- Disparities in Emergency Care - Public Health and Injury Prevention Committee
- Empiric and Descriptive Analysis of ACEP Charges of Ethical Violations and Other Misconduct - Ethics Committee
- Fostering Diversity in Emergency Medicine through Mentorship, Sponsorship, and Coaching - Academic Affairs Committee
- The Single Accreditation System - Academic Affairs Committee
- Resources: Opioid Counseling in the Emergency Department - Emergency Medicine Practice Committee

These resources will be available on the new ACEP website when it launches later this month. In the meantime, for a copy of any of the above, please contact [Julie Wassom](#), ACEP's Policy and Practice Coordinator.

Articles of Interest in *Annals of Emergency Medicine*

Sandy Schneider, MD, FACEP

ACEP Associate Executive Director, Practice, Policy and Academic Affairs

ACEP would like to provide you with very brief synopses of the latest articles in [Annals of Emergency Medicine](#). Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Babi FE, Oakley E, Dalziel SR, et al.

Accuracy of Physician Practice Compared to Three Head Injury Decision Rules in Children: A Prospective Cohort Study.

This study looks at the application of common decision rule regarding head injury in children and compare this to clinical judgement of experienced physicians. The authors did a prospective observational study of children presenting with mild closed head injuries (GCS 13-15). They found their group of clinicians were very accurate at identifying children who had a clinically important traumatic brain injury (sensitivity 98.8%, specificity of 92.4%). This was better than the decision rules also applied to these children which included PECARN, CATCH and CHALICE.

April MD, Oliver JJ, Davis WT, et al.

Aromatherapy versus Oral Ondansetron for Antiemetic Therapy Among Adult Emergency Department Patients: A Randomized Controlled Trial.

Inhaled isopropyl alcohol as an aroma therapy has been described as effective in treating post-operative nausea. In this study, the authors compared inhaled isopropyl alcohol to placebo, alone or with oral ondansetron. They found that the aromatherapy with or without ondansetron had greater nausea relief than placebo or ondansetron alone. They recommend a trial of aromatherapy for patients with nausea who do not require immediate IV treatment.

e Silva LOJ, Scherber K, Cabrera d, et al.

Safety and Efficacy of Intravenous Lidocaine for Pain Management in the Emergency Department: A Systematic Review.

This is a systematic review of the literature on IV lidocaine for pain. There were only 6 randomized control trials of lidocaine for renal colic. The results were variable. Lidocaine did not appear to be effective for migraine headache but there were only 2 studies of this. The authors concluded that we do not have enough data at this time to definitively comment on the use of lidocaine for pain in the ED.

White DAE, Giordano TP, Pasalar S, et al.

Acute HIV Discovered During Routine HIV Screening with HIV Antigen/Antibody Combination Tests in 9 U.S. Emergency Departments

This study looked at HIV screening programs in 9 EDs located in 6 different cities over a 3 year period. There were 214,524 patients screened of which 839 (0.4%) were newly diagnosed. Of the newly diagnosed 14.5% were acute HIV (detectable virus but negative antibody) and 85.5% were established HIV (positive antibody test). This study reminds us that many patients with acute HIV will have a negative screening test that relies strictly on antibody. Many of these patients present with flu like illness as their initial presentation.

Axeem S. Seabury SA, Menchine M, et al.

Emergency Department Contribution to the Prescription Opioid Epidemic.

There has been much discussion of the opioid epidemic in both the professional and lay press. Emergency physicians tend to write a lot of prescriptions but for very small amounts. This study examined prescriptions for opioids from 1996-2012. During this period opioid prescription rates rose in private office settings and declined in the ED. For patients receiving high numbers of opioids, only 2.4% received opioids from the ED.

Help Fight to Protect Our Patients Against Anthem's Unlawful Practices

ACEP continues to keep the pressure on Anthem Blue Cross Blue Shield for denying coverage to emergency patients in six states with a [new video campaign](#). More will follow if this effort isn't stopped. Anthem's policy violates the prudent layperson standard, as well as 47 state laws. [Spread the word!](#) #FairCoverage #StopAnthemBCBS



Don't Miss the Premiere Event for Emergency Medicine Advocates and Leaders!

Attendees at the annual [Leadership & Advocacy Conference](#) will advocate for improvements in the practice environment for our specialty and access for our patients. First-timers will receive special training on how to meet and educate your Members of Congress while seasoned participants will build upon valuable Congressional connections. A new "[Solutions Summit](#)" has been added on May 23 where attendees will discover innovative solutions on key

topics such as opioids and end-of-life issues that demonstrate emergency medicine's value and leadership. CME credit will be given for the Summit.

Confirmed Speakers Include:

- U.S. Surgeon General Vice Admiral (VADM) Jerome M. Adams, M.D., M.P.H.
- HHS Assistant Secretary for Preparedness and Response Bill Kadlec, MD will be presenting during the Public Policy Town Hall on Emergency Preparedness.
- Amy Walter, National Editor for The Cook Political Report, will offer her predictions for the mid-term elections.
- Senator Bill Cassidy, MD (R-LA)
- Representative Kyrsten Sinema (D-AZ)

[REGISTER TODAY!](#)

Not able to attend the LAC18? Now is not the time to sit on the sidelines.

Join the [ACEP 911 Grassroots Legislative Network](#) today to help emergency medicine convey our principles and priorities to legislators in Washington DC and their home districts. With the mid-term elections coming up in November and party control of the House and Senate hanging in the balance, now is the perfect time to reach out on the local level to educate your legislators about the specialty and offer to serve as a local resource on issues relating to the delivery of health care.

Already a member of the Network? Take your advocacy to the next level. Host an emergency department visit for your legislator or invite them to meet with a group of local emergency physicians from your chapter. Visit the [ACEP Grassroots Advocacy Center](#) for detailed information on how to join the program and start engaging with legislators today!

Free Training on Medication-Assisted Treatment

Eight hours of training on medication-assisted treatment (MAT) is required to obtain a waiver from the Drug Enforcement Agency to prescribe buprenorphine, one of three medications approved by the FDA for the treatment of opioid use disorder. [Providers Clinical Support System \(PCSS\)](#) offers free waiver training for physicians to prescribe medication for the treatment of opioid use disorder.

PCSS uses three formats in training on MAT:

- Live eight-hour training
- “Half and Half” format, which involves 3.75 hours of online training and 4.25 hours of face-to-face training.
- Live training (provided in a webinar format) and an online portion that must be completed after participating in the full live training webinar (Provided twice a month by PCSS partner organization American Osteopathic Academy of Addiction Medicine)

Trainings are open to all practicing physicians. Residents may take the course and apply for their waiver when they receive their DEA license. For upcoming trainings consult the [MAT Waiver Training Calendar](#). For more information on PCSS, [click here](#).

Become an Accredited Geriatric Emergency Department Today

Recognizing that one size ED care does not fit all, [The Geriatric Emergency Department Accreditation Program](#) (GEDA), was developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter. Become accredited and show the public that your institution is focused on the highest standards of care for your community's older citizens.

Learn to Improve Patient Safety, Reduce Costs at One-Day Hospital Flow Conference

ACEP is pleased to announce this collaboration between ACEP and the American Hospital Association. Join leaders in hospital flow at the [Innovation Leadership Challenge: Collaborating to Improve Hospital Flow, Save Lives & Reduce Costs Conference](#) to learn about proven innovative processes, tools & insights prior to the AHA Leadership Summit July 25. [Register today](#).



**Vermont Chapter ACEP
c/o National ACEP
4950 West Royal Lane
Irving, Texas 75063-2524**

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