

A Newsletter for the Members of the Oklahoma College of Emergency Physicians

Winter 2019



**Jeffrey Goodloe, MD, FACEP, President**

**[Gabe Graham](#), Executive Director**

**918.809.9464 | [Website](#)**

## **President's Message**

**Jeffrey M. Goodloe, MD, NRP, FACEP, FAEMS  
OCEP President**

Someone alert Drs. Michael Smith and Jeff Dixon because this version of the OCEP's President Message will be over quickly! BUT....there's great reason for my brevity: **I'm going to ask you to invest your time in you by reading Dr. Jim Kennedy's column that follows.** You are likely aware Jim is our excellent OCEP Vice President and hopefully, you are also aware that Jim heads up our OCEP State Legislative Advocacy Program. You are about to receive a wonderful gift of Jim's insightful, dedicated work in discerning the current Oklahoma legislative bills we need to know about and we need to watch closely, being ever ready to spring into action. Don't forget about the federal level that national ACEP does so well in marshaling our voices, too. At the start of Oklahoma's 2019 legislative session though, our OCEP focus is decidedly more local in serving you.

Please, please, please read Jim's column in its entirety. The seeming banality of a bill today could have significant financial impact on all your tomorrows very soon. Your OCEP BOD in unison is committed to representing you, empowering your voice,

throughout this legislative session. I will quickly share that we have been able to partner with the Oklahoma County Medical Society to secure four spots for OCEP in the Oklahoma Legislative “Doctor of the Day” program to help elevate awareness of OCEP and its emergency physician members. I’m already anticipating opportunities I will have to share how important your work accomplished is on April 8th, my day of service at 23rd & Lincoln in OKC. Stay tuned for the next newsletter for impressions from the day.

And seriously, with that...one quote to share and then on to Jim’s fantastic work, supported in part by Craig Price and Harry Monroe on the national ACEP staff. Craig and Harry are instrumental in getting us weekly updates on Oklahoma legislative bills that are in the emergency medicine realm. We couldn’t have the advocacy we do without this national support. I directly shared this with our national ACEP Board of Directors so they will continue funding and growing this legislative lifeline.

“Change is inevitable, but growth is optional. Growth is the only guarantee that tomorrow will be better than today.” – John C. Maxwell

Stay safe, make a difference, and have some fun AND GROWTH while doing it!

---

## **State Legislation** **James R. (“Jim”) Kennedy MD, MPH, FACEP**

Dear OCEP Members,

As your OCEP State Legislative Officer, I’m back at it in 2019 with the new state legislature that convened on February 4th with new Governor Stitt’s State of the State Address.

I know what you might be thinking. As an ER doc, why on earth would I care about what the Oklahoma State Legislature has going on? I could talk your ear off on why it matters, but the cliff notes version is that what bills get passed at 23rd and Lincoln can have a huge impact on both your daily life and your work as an EM physician. Policy is difficult to change on a national level, so, accordingly, there is a lot of work being done in state legislatures across the country on every topic imaginable, not the least of which is health care. There were approximately 2800 bills introduced this year and there are many that have health care implications. As is increasingly the case, the insurance companies are

hard at work ghost writing legislation and feeding it to lawmakers for them to introduce that ultimately enhance their bottom line. The cost savings are often times at the expense of patients or the physicians caring for them. Past bills have ranged on numerous topics, including physician reimbursements and mid-provider independent practice. I have isolated few of the 2019 bills that could have an effect on your patients or your work as an EM physician and have tried to condense them here for your review.

**HB 2638** - This has to do with the concept, of which, frankly, I was unaware; Step Therapy and Step Step Therapy Exception. It is an approach to medication prescription that is intended to control the costs and risks posed by prescription drugs by essentially protocoling therapies for every medical problem you can imagine and forcing a physician to, not only be aware of, but to follow or risk running afoul of the law. There are many pitfalls of this concept and the insurance industry has been quick to put up a website called "Fail First Hurts", which, ostensibly, points out these problems as risky medically and time consuming for the physician and the consumer. It also risks profits for the insurance industry as cheaper, less profitable alternatives are pushed, but that is another issue. I don't think any of us wants state law telling physicians what they can and can't prescribe.

<https://legiscan.com/OK/text/HB2638/2019>

**HB 2441**- This bill seeks to have hospitals notify patients of non-emergency procedure costs beforehand, or if they or the provider are out of network. I think the bill makes sense for elective, non-emergency scheduled or outpatient procedures. This would just require the hospital/provider to tell the patient whether the procedure is going to be covered in full by their insurance beforehand or is subject to balance billing if their reimbursement is below UCR, out of network or at medicaid/medicare rates in a patient not enrolled in medicare/medicaid. It would also require the hospital that contracts with the patient's insurance whether or not the actual provider is contracted with their insurance as well. I guess this is a common scenario; Hospital contracts with the insurance (covering hospital services), but the doctor working there doing the procedure does not contract (out-of-network) with the insurance and the patient is left unaware of that fact, thinking that all is OK with the insurance taking care of the service. They then get a big balance bill from the provider in an unexpected manner that could be sizeable. I feel they should be telling that to the patient anyway if it is all known before hand in an elective/non-emergency procedure. Balance billing doesn't really come into play for in-network hospital/provider issues. Most of the bill doesn't refer to Emergency Services or affect ER doc reimbursement/treatment. There is a line about emergency services however. From page 3, line 2, it states that we will notify patient about our network status when it is practical. When does "as soon as practical" start? This could be fraught with

legal peril. For instance, if the patient is being given morphine or versed on the floor and you notify them of billing issues when they are seemingly awake and coherent. They could easily claim that they were under the influence of controlled substances and do not remember and could file a grievance against the physician for not notifying them of their costs in a timely fashion.

<https://legiscan.com/OK/text/HB2441/2019>

**SB 1011** - This is a 34 page behemoth that deals with out-of-network billing, balance or surprise billing. If you scroll to Sec. 5, subsection C, it specifically states that this is not to apply to Emergency Services. Section 6 refers to Emergency Services and aims to get insurance providers to ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider. I don't immediately see where this would hurt EM physicians or their patients. Naturally the insurance industry will fight this. Any thoughts? Also, Section 10, deals with a program of Independent Dispute Resolution for out-of-network charges. This gives an independent reviewer the power to determine how much a health care provider is entitled to receive as payment for health care services in the case of a dispute over a patient's bill. This reviewer may have little to no medical experience and will, if passed, have the authority to determine what physicians get reimbursed for their services.

<https://legiscan.com/OK/text/SB1011/2019>

**SB 283** - This bill aims to require hospitals to give a good-faith estimate to each patient for procedures/treatment. I think this probably applies to outpatient, non-EM scenarios, but it does not specifically so state that, so we wouldn't want ERs being bogged down trying to compute cost estimates of what we do while doing patient care.

<https://legiscan.com/OK/text/SB283/2019>

**SB 509** - This is a Senate companion bill to HB 2638 above dealing with Step Therapy and Step Therapy Exception as seen above in HB 2638.

<https://legiscan.com/OK/text/SB509/2019>

**SB 534** - This bill aims to give children in protective custody of the state to authorize emergency medical care without a court order while, at the same time, making reasonable attempts to notify the child's parent or legal guardian. I don't see much to oppose on this one, but it will affect what we do, so I threw it in there.

<https://legiscan.com/OK/text/SB534/2019>

**SB 677** - This is another meaty bill that is attempting to deal with out-of-network billing. Section 3G deals with Emergency Services. It also aims to get insurance providers to

ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider.

<https://legiscan.com/OK/text/SB677/2019>

**SB 1033** - This is an opioid bill relating to professional conduct and disciplinary actions surrounding the prescription of opioids. The way I read this, it seems as if it would put an end to ever writing a prescription of anything to family/friends. It would also make all docs, EM included, subject to civil penalties and fines for 1) not checking the OBNDDB database for every opioid rx, 2) if one of your patients were to happen to overdose on opioids you prescribed (start an investigation of you), and 3) prevent docs from ever prescribing more than a 7 day supply for controlled substances. I agree that the opioid epidemic is at crisis levels and that we, as docs, should do our part. However, this puts us squarely in the crosshairs of the lawmakers on a hourly/daily basis, especially for those of us who work in high acuity/high volume EDs.

<https://legiscan.com/OK/text/SB1033/2019>

The OCEP Board, along with the ACEP State Legislative and Regulatory staff, will be monitoring these and any other bills that come to the fore that may affect the quality of care to our patients, reimbursements for our services or that simply increase the hassle factor of doing our job and lobby as necessary. As usual, we always welcome feedback on any and all pending legislation on medical issues. Feel free to [contact me](#) or any of the OCEP BOD members should you have any questions or concerns.

---

## Welcome New Members

Andrew Burnette, DO  
Bryan Robert Gibson  
Melissa Ann Haught, DO  
Derek Hill  
Micah Larsen, MD  
Landon Riesenber

---

## NEWS FROM ACEP



### Bedside Tools

ACEP has a number of web-based tools for you to use at the bedside. From sepsis, to acute pain to agitation in the elderly – we’ve got you covered!

- [ADEPT](#) - Confusion and Agitation in the Elderly ED Patient
- [ICAR2E](#) - A tool for managing suicidal patients in the ED
- [DART](#) - A tool to guide the early recognition and treatment of sepsis and septic shock
- [MAP](#) - Managing Acute Pain in the ED
- [BEAM](#) - Bariatric Examination, Assessment, and Management in the Emergency Department. For the patient with potential complications after bariatric surgery

---

### Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline

The new ACEP policy statement, *Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline*, was approved by the Board in September 2018 and has been endorsed by several other organizations. [Read the final version of the policy here.](#)

---

### Social Media Policy

Make sure you're protecting yourself. ACEP has a new social media policy to help keep you and your patients safe. [Read the policy here.](#)

---

## **New Policy Statements, PREP and Information Paper**

During their January 2019 meeting, the ACEP Board of Directors approved the following new or revised policy statements/PREP/information paper:

### **New Policy Statements:**

[Autonomous Self-Driving Vehicles](#)

[Reporting of Vaccine Related Adverse Events](#)

### **Revised Policy Statements:**

[Advertising and Publicity of Emergency Medical Care](#)

[Economic Credentialing](#)

[Emergency Physician Stewardship of Finite Resources](#)

[Medical Services Coding](#)

[Patient Information Systems](#)

[Providing Telephone Advice from the ED](#)

### **Revised Policy Resource and Education Paper (PREP)**

[Military Emergency Medical Services](#)

### **New Information Paper:**

[Suicide Contagion in Adolescents: The Role of the Emergency Department](#)

---

## **Articles of Interest in *Annals of Emergency Medicine* - Winter 2019**

**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.

Shih HM, Chen YC, Chen CY, Huang FW, Chang SS, Yu SH, Wu SY, Chen

**WK. Derivation and Validation of SWAP Score for Very Early Prediction of Neurological Outcome in Patients with Out-of-Hospital Cardiac Arrest.**

The aim of this study was to establish a simple and useful assessment tool for rapidly estimating the prognosis of patients with out-of-hospital cardiac arrest (OHCA) after their arrival at an emergency department (ED). A total of 852 patients admitted from January 1, 2015 to June 30, 2017 were prospectively registered and enrolled into the derivation cohort. Multivariate logistic regression on this cohort identified four independent factors associated with unfavorable outcomes: initial nonshockable rhythm, no witness of collapse, age >60 years, and pH  $\leq$ 7.00. The shockable rhythm–witness–age–pH (SWAP) score was developed and one point was assigned to each predictor. For a SWAP score of 4, the specificity was 97.14% for unfavorable outcomes in the derivation cohort. The study concluded that the SWAP score is a simple and useful predictive model that may provide information for the very early estimation of prognosis for patients with OHCA.

Chinn E, Friedman BW, Naeem F, Irizarry E, Afrifa F, Zias E, Jones MP, Pearlman S, Chertoff A, Wollowitz A, Gallagher EJ. **Randomized Trial of Intravenous Lidocaine versus Hydromorphone for Acute Abdominal Pain in the Emergency Department.**

This randomized, double blind clinical trial compared the efficacy and safety of intravenous lidocaine to that of hydromorphone for the treatment of acute abdominal pain in two emergency department (ED) in the Bronx, NY. Adults weighing 60-120 kg were randomized to receive 120 mg of IV lidocaine or 1 mg of IV hydromorphone. 30 minutes after administration of the first dose of study drug, participants were asked if they needed a second dose of the investigational medication to which they were randomized. The primary outcome was improvement in 0-10 pain scores between baseline and 90 minutes. Out of the 154 patients enrolled, 77 received lidocaine and 77 received hydromorphone and by 90 minutes, patients randomized to lidocaine improved by a mean of 3.8 points on the 0-10 scale, while those randomized to hydromorphone improved by a mean of 5.0 points. The study concluded that IV hydromorphone was superior to IV lidocaine, both for general abdominal pain and a subset with nephrolithiasis.

Ballard DW, Kuppermann N, Vinson DR, Tham E, Hoffman JM, Swietlik M, Davies SJD, Alessandrini EA, Tzimenatos L, Bajaj L, Mark DG, Offerman SR, Uli K. Chettipally UK, Paterno MD, Schaeffer MH, Richards R, Casper TC, Goldberg HS, Grundmeier RW and Dayan PS, for the Pediatric Emergency Care Applied Research Network (PECARN), Clinical Research on Emergency Services and Treatment (CREST) Network, and Partners HealthCare. **Implementation of a Clinical Decision Support System for Children with Minor Blunt Head Trauma at Non-negligible Risk for Traumatic Brain Injuries.**

This study utilized a secondary analysis of a non-randomized clinical trial with concurrent controls conducted at 5 pediatric and 8 general EDs between 11/2011 and 6/2014, enrolling patients <18 years-old with minor blunt head trauma. After a baseline period, intervention sites received electronic clinical decision support (CDS) providing patient-level ciTBI risk estimates and management recommendations. The following primary outcomes in patients with 1 intermediate PECARN risk factor were compared pre- and post-CDS: (1) ED computed tomography (CT) proportion adjusting for age, time trend, and site and (2) prevalence of ciTBI. The results showed that providing specific risks of ciTBI via electronic CDS was associated with a modest and safe decrease in ED CT use in children at non-negligible risk of ciTBI. [Full text available here.](#)

Akhlaghi N, Payandemehr P, Yaseri M, Akhlaghi AA Abdolrazaghnejad

**A. Premedication with Midazolam or Haloperidol to Prevent Recovery Agitation in Adults Undergoing Procedural Sedation with Ketamine: A Randomized Double-Blind Clinical Trial**

This study evaluated the effect of midazolam and haloperidol premedication for reducing ketamine-induced recovery agitation in adult patients undergoing procedural sedation. They randomized emergency department patients older than 18 years who needed procedural sedation to receive one of the following three interventions in double-blind fashion 5 minutes prior to receiving ketamine 1 mg/kg IV: distilled water IV, midazolam 0.05 mg/kg IV, or haloperidol 5 mg IV. The main study outcomes were recovery agitation as assessed by the maximum observed Pittsburgh Agitation Scale (PAS), and by the Richmond Agitation-Sedation Scale (RASS) at 5, 15, and 30 minutes after ketamine administration. For the 185 patients undergoing adult procedural sedation, premedication with either midazolam 0.05 mg/kg or haloperidol 5 mg IV was shown to significantly reduce ketamine-induced recovery agitation while simultaneously delaying recovery.

[Full text available here.](#)

Remick K, Gausche-Hill M, Joseph MM, Brown K, Snow SK, Wright JL, AAP Committee on Pediatric Emergency Medicine and Section on Surgery, ACEP Pediatric Emergency Medicine Committee, ENA Pediatric Committee. **Pediatric Readiness in the Emergency Department**

The American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) published updated joint guidelines, "Pediatric Readiness in the Emergency Department," that recommend ways health care providers can make sure every injured or critically ill child receives the best care possible. The joint policy statement, published in the November 2018, represents a revision of the 2009 policy statement and highlights recent advances in pediatric emergency care that may be incorporated into all emergency departments that

care for children. The statement emphasizes the importance of evidence-based guidelines and includes additional recommendations for quality improvement plans focusing on children and disaster preparedness. [Link to \*Annals\* publication.](#)

---



## See Your Impact

You serve your community. ACEP is honored to serve you. Since 1968, ACEP has united and amplified the collective voice of emergency physicians across the world. We know you face challenges, and it's our mission to protect your interests and make it easier for you to provide the highest quality care for your patients. As an ACEP member, you are a direct contributor to important initiatives that propel the profession forward. Our [2018 Annual Report](#) illustrates how your support makes an incredible impact on emergency medicine.

---



# embrs

## Emergency Medicine Basic Research Skills

### Are you interested in increasing and improving research in emergency medicine?

[Emergency Medicine Basic Research Skills \(EMBRs\)](#) is a 9-day, 2-session program where participants learn how to identify clinical research opportunities and become familiar with clinical research and outcomes. Participants are also eligible to receive an EMF/EMBRs grant based on their research grant application. This course targets: Junior faculty with limited research experience; Physicians in academic and community centers who are interested in research basics; Physicians who have as part of their duties involvement in research, including mentoring young researchers; Fellows in non-research fellowships.

[Click here to learn more](#) and to put your name on the interest list. The next course will take place Dec. 2-7th, 2019 (session 1) and April 14-16, 2020 (session 2).

---

### MOC Made Easy

The [New ACEP MOC Center](#) is the "easy button" for MOC! It's a One-Stop-Shop to keep it all together and on track for all things MOC. See what you have to do to stay certified AND what resources ACEP has to help you do it.

ABEM has made (at least) three big changes in the way they present MOC information to diplomates – 1) they launched a new website, 2) they changed the names and order of the MOC components, and 3) they changed the language they use to describe them (no more "Part" anything). ABEM also announced an alternative to the ConCert Exam, which they'll pilot in 2020 and launch in 2021.

---

**NEWS FROM THE  
AMERICAN BOARD OF  
EMERGENCY MEDICINE  
FEBRUARY 2019**



**American Board of  
Emergency Medicine**

## **Letter Available to Request Becoming ED Designated Trainer for Lab Procedures**

ABEM can provide a letter of support to ABEM-certified physicians to request that their hospital laboratory director apply for a waiver for ED point-of-care (POC) testing. If the waiver is granted, a designated trainer, who may be an emergency physician, can provide annual competency testing to other ED personnel for POC testing procedures, such as hemocult or urine pregnancy testing, etc. Waivers to allow POC testing by ED personnel help reduce the burden that emergency physicians face by having to undergo annual training by a laboratory representative as well as expedite patient throughput.

The letter and additional information about the waiver are available from physicians' Personal Page on the ABEM portal. To download the letter:

- Sign in to the [ABEM portal](#)
- On the left navigation, click "Print Verification of ABEM Status"
- Under letter type, click "POCT"
- Click "Continue to Next Step"

The letter is available to physicians participating in the ABEM MOC Program.

This is the most recent letter resulting from the continuing efforts of the Coalition to Oppose Medical Merit Badges (COMMB) and is signed by each representative of the Coalition. The rationale for the letter is that physicians participating in MOC have the knowledge, skills, and abilities to provide such training. Also available is a general letter stating that ABEM certification supersedes the need to complete "merit badge" requirements. That letter explains that ABEM's MOC Program is a rigorous form of continuous professional development that contains content critical to the practice of Emergency Medicine, including procedural sedation, cardiovascular care, airway management, trauma care, stroke management, and pediatric acute care.

Certification, therefore, supersedes the need for certifications sometimes required for medical staff privileges or disease-specific care center designations.

## ConCert Fast Facts

- The ConCert Exam is available twice per year—in the spring and the fall
- You can register and take the ConCert Exam during any examination administration in the last five years of your certification
- You do not have to complete all other MOC requirements to register early for the ConCert Exam
- Completing your MOC requirements early does **NOT** reset your certification expiration date (it will be good for the entire ten-year period)
- If you complete your requirements early, your new certificate will be sent toward the end of the final year of your current certification
- 60 *AMA PRA Category 1™ Credits* are available at no charge for passing the ConCert Exam and completing all other MOC requirements (go to [www.abem.org](http://www.abem.org), and click on “Stay Certified,” and “CME Credit Available for ABEM Activities” for more information)

If you have any questions about the ConCert Exam or other MOC requirements, please contact ABEM at 517.332.4800, ext. 383, or [moc@abem.org](mailto:moc@abem.org).

---

Oklahoma College of Emergency Physicians, 44065 E. 221st Street S,  
Porter, OK 74454

Copyright © 2019 Oklahoma College of Emergency Physicians All rights reserved.