PENNSYLVANIA COLLEGE of EMERGENCY PHYSICIANS
ADVANCING EMERGENCY CARE

PACEP NEWS

FALL 2023

Richard J. Hamilton, MD, MBA, FACEP
PACEP President 2023–2024

EXECUTIVE PRIVILEGE

"Welcome to Philly!" ACEP23

By Richard J. Hamilton, MD, MBA, FACEP

For Pennsylvania emergency physicians, the annual meeting in Philadelphia in October was a huge success. First and foremost, it's my pleasure to congratulate our very own Chadd Kraus DO, DrPH, CPE, FACEP on his election to the ACEP Board. Chadd's career has been one distinguished by devoted service to EM organizations at all levels, thoughtful scholarship and research, and devoted teaching and clinical care at the bedside. He will be an amazing addition to the Board and, I believe, a transformative force.

In this issue, you'll also get to read about the many successes we had at the ACEP council, with eight resolutions written or co-sponsored and seven resolutions adopted or referred directly to the Board for action.

The meeting opened with a fascinating session on decision-making in emergency medicine by Helena Boschi, PhD, MSc. We work in a rapid, high-stakes environment and can use the integrated findings from neuroscience psychology and behavioral economics to improve our decision-making processes. We need to understand how our mindset and mood, including our cognitive biases, might affect diagnoses and treatment decisions, understand how stress impacts decision quality, and implement evidence-based protocols to enhance the consistency and effectiveness of care. For example, when you find your mindset is a little biased toward the possibilities of a diagnosis, rely on evidence-based scores or calculators to make emotionless risk estimations.

In a keynote session, FTC Chair Lina M. Khan and healthcare researcher Lawton R. Burns, PhD, MBA, discussed the detrimental impact of healthcare consolidation.

As FTC Chair, Khan has advocated for stronger antitrust enforcement, particularly concerning technology companies. She has expressed concerns about the market power of major tech firms and has been vocal about the need to address anticompetitive practices. Khan emphasized the FTC's renewed focus on promoting fair competition and mentioned proposed bans on non-competes. Many physicians asked about countering

> **"...political action and advocacy is job one for organized emergency medicine. We need to tell our stories, and we need to tell them to our government leaders and its agencies.**

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private equity's impact on emergency physicians and health care. Khan discussed the FTC's efforts, such as requiring companies to report their acquisition history to prevent harmful consolidation. In addition, she was clearly interested in hearing individual stories about non-competes and private equity.

Lawton R. Burns, Ph.D., MBA, is a renowned expert in healthcare management and economics. He has extensively researched and written about the impact of private equity and consolidation in the healthcare industry. His work delves into the dynamics of how private equity firms invest in healthcare organizations and the subsequent effects of these investments on the industry. Burns highlighted the trend of healthcare entities merging with the result of an increase in size and revenue rather than an improvement in care quality or reduced costs. His description of the healthcare landscape as one of chaotic non-collaboration rang true. He also stressed the importance of personal stories and political advocacy where healthcare consolidation adversely affected patient care.

After the meeting, I spent some time reading publications from Dr. Burns. His work concludes that healthcare consolidation (both vertical and horizontal), despite the best of intentions, has not resulted in higher quality at reduced cost. It is rising faster than growth in gross domestic product (GDP) despite a multitude of reform efforts. One particularly interesting observation he has made is that the single most disruptive force in US health care may be the federal government and CMS. The US government and CMS makes decisions that force corporations, physicians, hospitals, and insurers to respond. None of these changes have demonstrably resulted in improved quality of care. Burns concludes that quality only improves when physicians change how they work, not how they get paid or what organizational structure employs them. I would argue that reducing payment for physician services means that physicians have to work faster with less opportunity for meaningful interaction with patients and has reduced the quality-of-care relative to the improvement in diagnostic technology. One further observation that Burns makes is that trends in larger practice size and hospital system formation have been occurring slowly for decades. Because of this slow change, physicians have been able to make gradual adjustments and adaptations, albeit unhappily in many cases. I suppose that makes us the frog that slowly gets boiled. The truth is that, so far, consolidation is associated with higher costs, doubtful improvements in quality, and more stressed physicians - all contrary to what transformation advocates had envisioned.

What does this all mean for us as emergency physicians? First, reflect on the observation that the only true disruptor to the healthcare industry is the government and CMS. Physicians, payers, corporations, hospitals - they are all in react mode! That means that - bar none - political action and advocacy is job one for organized emergency medicine. We need to tell our stories, and we need to tell them to our government leaders and its agencies.

Those stories are powerful and are the currency of change. Get involved folks! It's the only way things will get better! ■

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- Three continuous years of ACEP membership
- Board Certification in EM the ABEM or AOBEM or Pediatric EM by ABP
- Three years of active involvement in EM (exclusive of residency training)
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If you are interested in joining a committee, **visit here.**

Future PACEP Scientific Assemblies at Kalahari Resorts & Conventions, Pocono Manor, PA

2024 May 1–4 | **2025** April 23–26

SAVE THE DATES

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Ashleigh Martinez
Ashley Mawhinney
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Lobbyist Update

By Bigley and Blikle, LLC

Jonathan Bigley
Partner, Bigley & Blikle

BEHAVIORAL HEALTH FUNDING ADVANCES

On October 4, the House passed a Fiscal Code bill containing authorization for the already appropriated $100 million in behavioral health funding. HB 1300 received a bipartisan vote of 121 – 82. The Senate will receive and refer the legislation to committee during the October 16 week. Its fate in the Senate is to be determined.

As noted, the Fiscal Code provides authorization for state agencies to spend appropriated funds. It is a necessary budget-related bill for a complete state budget. HB 1300 was loaded up with many Democratic priorities and a few initiatives favored by the Senate Republicans. Whether the bill's House passage leads to genuine budget negotiations among the majority parties and the Governor's Office is yet to be seen.

TELEMEDICINE INCHES FORWARD/E-CONSULTATION LEGISLATION TO BE INTRODUCED

SB 739, Senator Elder Vogel's (R, Beaver) Telemedicine legislation, moved from the Senate Calendar to the Appropriations Committee for a fiscal review on October 4. This is a necessary precursor to Senate Final Passage for the bill. Through PACEP's efforts, language prohibiting healthcare insurer reimbursement for physician-to-physician consultations was struck from the legislation. We anticipate SB 739 will receive Senate Final Passage before the fall session ends in December.

PACEP's advocates have drafted additional legislation that would require healthcare insurers to provide reimbursement for physician-to-physician consultations. Although many commercial and Blue Plans operating in Pennsylvania provide such coverage, the practice is not uniform across all insurers. PACEP's legislation is expected to be introduced in the House before the holiday break in December.

As originally drafted, SB 739 contained language that would have prohibited healthcare insurers from providing reimbursement for provider-to-provider consultations. Knowing that provider-to-provider consultations are vital to Emergency Medicine, past president Chadd Kraus, MD flagged this issue for advocacy action. The B & B Team drafted corrective language and successfully lobbied Senator Vogel's and the Senate Banking and Insurance Committee's staff for its inclusion. We anticipate SB 739 will receive Senate Final Passage in the fall.

VENKAT MEDICAL DEBT RELIEF FINDS A SECOND LEGISLATIVE VEHICLE

Representative and former PACEP president Arvind Venkat's Pennsylvania Medical Debt Repayment Program was inserted into a Fiscal Code bill that passed the House of Representatives on October 4. A budget-related bill, the Fiscal Code authorizes state agencies to expend funds that are appropriated in the General Appropriations or state budget bill. The Medical Debt Repayment Program insertion into the Fiscal Code vehicle, HB 1300, demonstrates

Representative Venkat's growing influence in the House Democratic Caucus, and its leadership's commitment to enact this important program.

This innovative legislation is designed to leverage government funds to relieve the medical debts of thousands of low-income residents. The original bill, HB 78, passed the state House on a bipartisan 114 – 89 vote on June 26. HB 78 remains in the Senate Health and Human Services Committee.

NONCOMPETE LEGISLATION GETTING LEGS

House Health Committee Chair Dan Frankel's legislation prohibiting noncompete agreements for physicians and other healthcare professionals is nearing legislative action. According to Chairman Frankel, "Pennsylvania is in a minority of states that have no laws on the books to limit the use of restrictive covenants, also known as non-competes, which puts us at a competitive disadvantage when it comes to attracting top talent to our medical community." Representative Arvind Venkat is the prime co-sponsor of HB 1633. The legislation is expected to be reported from the House Health Committee before the fall session ends.

VENKAT CONTINUES TO OUTRAISE NEARLY EVERYONE

Representative Arvind Venkat's prodigious fundraising efforts will likely top $300,000.00 by year's end. Rarely do rank-and-file House members garner these kinds of numbers, let allow a freshman legislator. Buoyed by the raised $40,000 plus captured during a May Harrisburg fundraiser sponsored by PEP-PAC, Representative Venkat has held events in Allegheny County and across the state to stave off any potential challenger and to assist medically-like minded colleagues. His healthcare policy acumen and his fundraising abilities combine to create this rising star in the House Democratic Caucus. Congratulations to Representative Venkat. ■

2023 PACEP Virtual Residency Fair Recap

By Dhimitri Nikolla, DO, MS, FACEP

Dhimitri Nikolla, DO, MS, FACEP
PACEP Wellness/YP Committee Chair

The 2023 PACEP Virtual Residency Fair was a great success! We had 15 emergency medicine residency programs join us, and 86 applicants registered from 72 different medical schools. It was the most diverse group of applicants since we began this event in 2020!

We received very positive feedback from both programs and applicants. However, we strive to continue to improve the event so that it continues to be valuable to both programs and applicants. For example, next year, we are considering holding a speed dating event where smaller groups of applicants rotate between programs for shorter periods. This would ensure that each program gets face time with each applicant and each applicant gets a more personal interaction with each program. ■

2021 National Assessment of Pediatric Readiness of U.S. Emergency Departments During the COVID-19 Pandemic[1]

If all EDs were pediatric ready, at least 1,400 children's lives could be saved each year.[2]

In 2021, the National Pediatric Readiness Project — led by the federal Emergency Medical Services for Children Program[3] in partnership with the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association — assessed EDs' pediatric capabilities according to the latest national guidelines. The results were published in *JAMA Network Open* in July 2023.

About Responding EDs

3,647
EDs responded of 5,150 surveyed. 3,557 were used for analysis.

81%
treat fewer than 10 children each day.

98%
are not within a pediatric-specific hospital (i.e., they see adults and children).

MEDIAN SCORE: 69.5 OUT OF 100

Improved Pediatric Readiness

Scores improved in five of six domains since the last assessment in 2013.[4]
Examples of improvements include:

97%
of recommended pediatric equipment is present in EDs on average.
up from 89%

75%
of EDs weigh and record in kilograms to prevent medication errors.
up from 49%

73%
of EDs have a pediatric mental health care policy.
up from 44%

67%
of EDs have a policy for physicians' pediatric competency evaluations.
up from 39%

50%
of EDs have pediatric quality improvement plans.
up from 45%

A Key Concern

The presence of pediatric emergency care coordinators (PECCs)—key drivers of readiness—declined, likely due to staffing shortages tied to the COVID-19 pandemic.

29% of EDs have both a physician and nurse PECC.
down from 42%

How EDs Can Improve Readiness

A score of **at least 88** is associated with significantly improved survival.[1,5]
Three components of readiness have the largest impact:

1. Designating PECCs — ideally both a physician and a nurse
2. Implementing pediatric-specific quality improvement plans
3. Ensuring staff includes physicians board-certified in emergency medicine or pediatric emergency medicine

National PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

Learn about pediatric readiness or access resources at pediatricreadiness.org.

Take the assessment at pedsready.org.

1. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807059
2. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800400
3. The program is part of the Health Resources and Services Administration's Maternal and Child Health Bureau.
4. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2214165
5. https://pubmed.ncbi.nlm.nih.gov/31444254/

This EMSC Innovation and Improvement Center and EMSC Data Center infographic is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards totaling $3M and $3.2M respectively with 0 percent financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

230621 . Updated 7/18/23

Exploring the Many Uses of Ketamine

By Chris Walsh (MS IV, Sidney Kimmel Medical College)

Chris Walsh
(MS IV, Sidney Kimmel Medical College)

Throughout my rotations, its use was almost ubiquitous, whether on Neurology, Internal Medicine, Anesthesia or in Emergency Medicine, ketamine always seemed to find its way into the discussion of treatment plans. In this brief article, I will discuss a few of the many uses for ketamine, specifically as it relates to the management of patients in the emergency department.

Ketamine was originally introduced to clinical medicine as an anesthetic in the 1960's, with the first paper published about it in 19661. It exists as two distinct isomers and is marketed as a racemic mixture1. It is soluble in both water and lipids, lending to its ability to be administered via IV, IM, oral, nasal, rectal, subcutaneous, and epidural routes1. While ketamine's predominant mechanism of action is antagonism of NMDA receptors, it also has clinically significant effects at a wide range of glutamate-independent receptors, lending to its large treatment profile4. Now, let's talk about ketamine's use in the Emergency Department!

In my experience within the Emergency Department, many of the discussions about ketamine were related to intubation. Rapid sequence intubation, although commonly performed, is not without risk, among the greatest of which are hypoxia, acidosis, and hypotension3. Ketamine, however, provides improved hemodynamic stability when compared to other agents, in addition to offering longer duration of action, analgesia, amnesia, and sedation3. Deciding when and how to intubate a patient is something that I will confront as a resident, and having an option of using a medication like ketamine can mitigate some risks associated with such a procedure, calming my own nerves while performing it.

Acutely agitated patients are not uncommon to the emergency department, and as many of us know, they sometimes require chemical restraint. I have seen this achieved with haloperidol, droperidol, and benzodiazepines depending on the severity of the situation. I learned that ketamine could offer us another choice, given that it has properties to maintain hemodynamic stability while inducing dissociation to calm agitated patients.2. In a prospective single-institution study, patients who received ketamine to treat acute agitation achieved sedation more reliably at the 5- and 15-minute mark and had a shorter median time to sedation compared to patients treated with a combination of haloperidol/lorazepam2. This provides a useful alternative in the management of agitated patients, although I would like to find additional studies to support this finding.

Lastly, pain management in the emergency department is a complicated task, especially amid the ongoing opioid epidemic. For patients presenting to the Emergency Department who have needs related to pain management, over-the-counter options, such as ibuprofen and acetaminophen may have been exhausted prior to their arrival. In such patients, ketamine offers a promising non-opioid alternative to acute pain management. Ketamine can be used in the emergency department in sub-dissociative doses (either through IV push, short infusions, or continuous infusions) without the need for monitoring, and has been shown to decrease the need for post-ketamine analgesia5,6. This is an exciting modality that could improve patient satisfaction without contributing to the over-prescribing of opioid pain medications.

Exploring novel uses for medications that have been around for decades is quite an exciting aspect of medicine, and the possibilities for ketamine are just beginning. In my future practice, I hope to learn more and discover new uses for existing medications and lean into the art of medicine that makes this profession so rewarding. ■

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ACEP Council 2023

"Welcome to Philly … the City of Brotherly Love and Sisterly Affection." Richard Hamilton, MD, MBA, FACEP, PACEP President, dressed as Rocky, kicked off the welcome to ACEP Council 23 in Philadelphia from October 7th through October 8th.

Here is a brief review of the ACEP Council. Once a year Council meets to introduce and discuss resolutions that shape and direct the work and mission of the College. The mission not only brings us together, but it also brings us alive. To help put our mission into action, the delegates vote on resolutions to make changes to the bylaws, the College Manual, and Council Standing Rules. Importantly, Council provides all members of ACEP the ability to contribute to the work of the College. This openness and invitation help us to further advance the Council's mission through governance, membership, advocacy, public policy, and emergency medicine practice. Drafting resolutions and participating in Council is our opportunity to have our voices heard on critical topics affecting our patients and our profession.

PACEP is actively involved in the Council. This year alone, our Pennsylvania chapter sent a delegation of 31 councilors to participate in the meeting. Of those 31 councilors, PACEP is allotted 18 voting members, and the remainder serve as alternates. Our PACEP colleagues submitted six resolutions and co-sponsored an additional two resolutions out of 62 presented at the 2023 Council. One submission was a memorial resolution for Michael Kleinman, DO. The outcome of resolutions results in one of the following four actions: (a) adopted (with amendments), (b) referred to the Board, and (c) not adopted.

Below please find a list of Pennsylvania's resolutions and the actions taken by Council:

- Opposing Sale-Leaseback Transactions by Health Systems (referred to the Board)
- Addressing the Growing Epidemic of Pediatric Cannabis Exposure (adopted)
- Addressing Pediatric Mental Health Boarding in Emergency Departments (adopted as amended)
- Advocating for Increased Funding for EMS (not adopted)
- Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals (adopted as amended)
- In Memory of Michael Kleinman, DO (adopted)
- Cooperation Between National ACEP and State Chapters (Co-Sponsored) (referred to the Board)
- ACEP Financial Decision Transparency (Co-Sponsored) (adopted as amended)

In closing, ACEP Council 2023 was a tremendous success. Like past Council meetings, the deliberation of resolutions continues to enhance the quality of patient care, maintain physician wellness, protect reimbursements, and prevent the scope of practice creep.

We hope that you enjoy a few of the photos from ACEP Council, our PACEP Delegation Dinner, and our Pennsylvania hosted reception at The National Constitution Center. ■




Pennsylvania




American College of Emergency Physicians


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Pennsylvania


2023 Pennsylvania Department of Health Prehospital Protocol Updates: TXA and Blood Product Administration Protocols

By Christopher Berry, MD, FACEP

Christopher Berry, MD, FACEP
PACEP EMS Committee Co-Chair

The updated 2023 PA DOH Prehospital Protocols launched the end of the first week of October 2023. There are several updates this cycle which are important for emergency medicine physicians or agency medical directors to be aware of. This newsletter cycle, we will look at two new optional protocols to supplement the treatment of hemorrhagic shock in the prehospital environment.

Tranexamic Acid (New protocol, optional, for Advanced Life Support providers):

Tranexamic Acid (TXA), an antifibrinolytic, is now an optional treatment for patients with suspected hemorrhagic shock. The chosen dose for TXA is 1 gram in 100 ml of NSS. Administration is allowable in patients with traumatic bleeding in a non-compressible site (traumatic or post-partum hemorrhage) who either have signs/symptoms of shock OR if the systolic blood pressure is <90 mmHg. Exclusion criteria include patient age less than 15 years, known TXA allergy, isolated head injury, time elapsed from injury/bleeding initiation > 3 hours,

For agencies interested in implementing TXA in the field, it would be important that they coordinate with their local trauma/receiving centers on implementation of these protocols and communicate clearly when this medication has been provided. Some centers may wish to administer a TXA infusion of an additional gram after prehospital administration.

Blood Products (New protocol, optional, for Advanced Life Support providers):

Packed Red Blood Cells (PRBCs), Plasma or Low Titer O+ Whole Blood (LTOWB) are now permitted for agencies meeting multiple criteria to be provided to both pediatric and adult patients with evidence of hemorrhagic shock. Prior to the rollout of this protocol, blood product administration in the field has been limited to Helicopter Emergency Medical Services (HEMS) and specialty physician response teams, generally aligned with major health networks or trauma centers. However, this limitation left large populations in the Commonwealth without access to this component of life sustaining trauma care in urban environments, where a helicopter may not be able to land or is otherwise impractical, and in rural environments on days where the weather is not conducive to delivery of HEMS team to a scene. This new protocol may help to bridge this gap in care. However, operationalizing the appropriate storage, delivery and administration of blood products in the ground environment is complex, requiring significant medical director oversight and coordination with the local EMS council, blood bank and trauma system. With the blood supply continuing to be critically low in many areas, it is imperative to involve stakeholders early in discussions. Blood product carrying services and EMS regions will need to have in place strong continuous quality improvement programs to ensure that product is being administered appropriately, safely, efficaciously, and without waste.

This new protocol may help to bridge this gap in care. However, operationalizing the appropriate storage, delivery and administration of blood products in the ground environment is complex, requiring significant medical director oversight and coordination with the local EMS council, blood bank and trauma system.

For medical directors or other emergency physicians interested in further discussions of best practices for setting up a prehospital blood

administration program, The Trauma, Hemostasis and Oxygenation Research – American Association of Blood Banks (THOR-AABB) working party produced an excellent document regarding this topic[1]. This document includes best practices on storage, transport and transfusion that would be invaluable to the multi-disciplinary team developing a prehospital blood transfusion program.

The Administration of Blood Products – Statewide ALS Protocol criteria for blood administration includes patients with evidence of hemorrhagic shock with either hypotension (aged defined), altered mental status, poor skin perfusion or tachypnea. Exclusion requirements include patients in cardiac arrest, patients with hypotension or shock unrelated to hemorrhage or patients who refuse blood product administration. It further outlines the system/agency requirements and transfusion procedure expectations, including required documentation and actions to respond to transfusion reaction. ■

1 | *Yazer MH, Spinella PC, Bank EA, Cannon JW, Dunbar NM, Holcomb JB, Jackson BP, Jenkins D, Levy M, Pepe PE, Sperry JL, Stubbs JR, Winckler CJ. THOR-AABB Working Party Recommendations for a Prehospital Blood Product Transfusion Program. Prehosp Emerg Care. 2022 Nov-Dec;26(6):863-875. doi: 10.1080/10903127.2021.1995089. Epub 2021 Nov 19. PMID: 34669564.*

CONGRATULATIONS ARE IN ORDER...

We know that our PACEP members are doing great things, but we don't always know about promotions, accomplishments, etc. If you know of someone that deserves a shout-out, please email Jan Reisinger at exec@pacep.net.

Congratulations to Chadd Krauss, DO, DrPH, FACEP for being elected to the ACEP Board of Directors! We are so proud of you!

Congratulations to the New ACEP Fellows who were approved in September & October 2023:

Alexandra M. Amaducci, DO, FACEP
Christopher L. Berry, MD, FACEP
Kevin Ross Hardy, MD, FACEP
Rebecca Mills, MD, FACEP
Paul William Sokoloski, MD, FACEP
Kyle Yebernetsky, MD, FACEP

Awards Nominations Are Now Open!

To nominate someone for one of these awards, click here.

Please visit each of the award pages linked below to learn more about each award:

- Emergency Physician of the Year
- Meritorious Service Award
- David Blunk Outstanding Contribution to Emergency Medicine
- Legislator Award
- Resident Award

Award deadline is January 3, 2024.

Applications for Resident Board Members & Leadership Fellows Are Also Now Open!

To submit a nomination for Resident Board Member, click here.

To submit an application for Leadership Fellowship, click here.

Nomination/Application Deadline is January 3, 2024.

Penn State Health Emergency Medicine

About Us:

Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. We are the only medical facility in Pennsylvania to be accredited as a Level I pediatric trauma center and Level I adult trauma center. The system includes Penn State Health Milton S. Hershey Medical Center, Penn State Health Children's Hospital, and Penn State Cancer Institute based in Hershey, Pa.; Penn State Health Hampden Medical Center in Enola, Pa.; Penn State Health Holy Spirit Medical Center in Camp Hill, Pa.; Penn State Health St. Joseph Medical Center in Reading, Pa.; Penn State Health Lancaster Pediatric Center in Lancaster, Pa.; Penn State Health Lancaster Medical Center (opening fall 2022); and more than 3,000 physicians and direct care providers at more than 126 outpatient practices in 94 locations. Additionally, the system jointly operates various health care providers, including Penn State Health Rehabilitation Hospital, Hershey Outpatient Surgery Center, Hershey Endoscopy Center, Horizon Home Healthcare and the Pennsylvania Psychiatric Institute.

JOIN OUR TEAM
EMERGENCY MEDICINE
OPPORTUNITIES AVAILABLE

We foster a collaborative environment rich with diversity, share a passion for patient care, and have a space for those who share our spark of innovative research interests. Our health system is expanding and we have opportunities in both academic hospital as well community hospital settings.

Benefit highlights include:

- Competitive salary with sign-on bonus
- Comprehensive benefits and retirement package
- Relocation assistance & CME allowance
- Attractive neighborhoods in scenic Central Pennsylvania

PennState Health

FOR MORE INFORMATION PLEASE CONTACT:
Heather Peffley, PHR CPRP - Penn State Health Lead Physician Recruiter
hpeffley@pennstatehealth.psu.edu

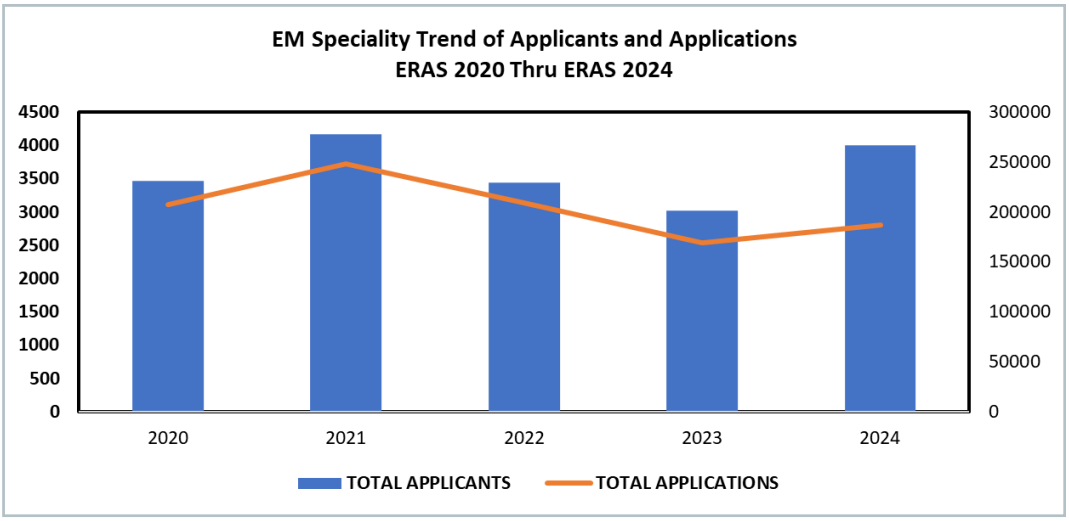
A Preview to the 2024 Application Cycle and Match for Emergency Medicine

By Elizabeth Barrall Werley, MD, FACEP

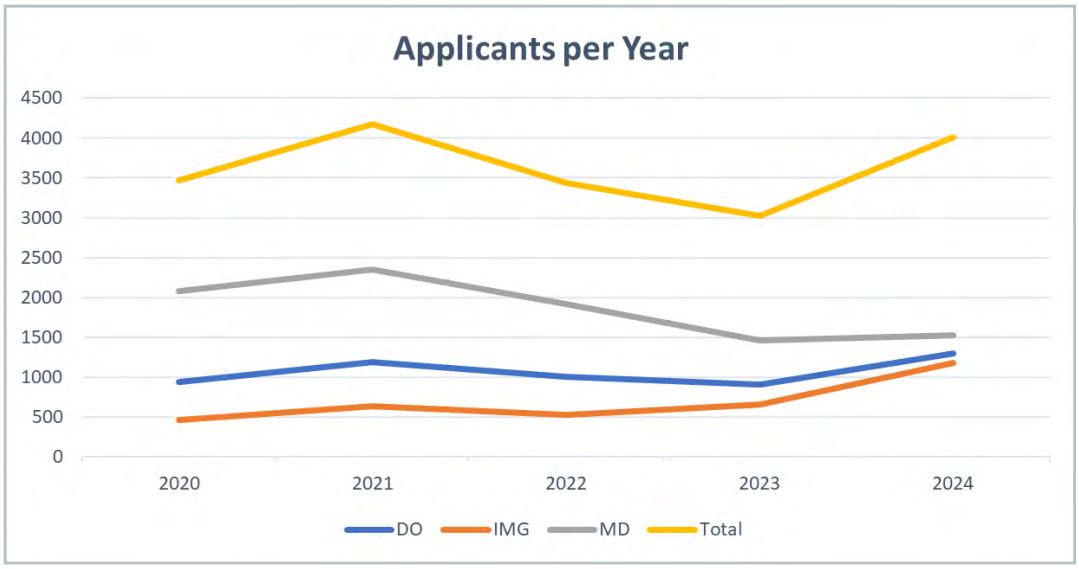
Elizabeth Barrall Werley, MD, FACEP
PACEP Vice President 2023-2024

In addition to my clinical and teaching roles, as well as my involvement with PACEP, I'm also actively involved with CORD-EM (Council of Residency Directors in Emergency Medicine). Within CORD-EM, I'm the current Chair of the Application Process Improvement Committee, and through this role, I've helped provide application and interview season guidance to applicants, advisors, and programs, developed best practices for this application and interview season, and I work with the CORD-EM Board of Directors and other groups such as the EM Match Task Force to analyze data and provide further guidance to our specialty. Additionally, another colleague and I are the two representatives for EM working as advisors with the AAMC (Association of American Medical Colleges) while ERAS (Electronic Residency Application Service) underwent a major overhaul over the past year and these changes are analyzed and refined throughout this year's application cycle for subsequent years. I say all of this to provide context and hopefully demonstrate the intended credibility with which I share any information. In preparation for the CORD Town Hall which occurred the first day of ACEP, I reached out to our colleagues at the AAMC and they were kind enough to pull preliminary application results for Emergency Medicine.

The information below is select data representing EM application data for the first 7 days after ERAS opened to programs, for the 2020 match cycle to now.



As can be seen here, there was a sizeable increase in the overall total number of applicants applying to EM, and an increase, albeit to a lesser extent, in the total number of applications. At first glance, this can be seen as reassuring, and perhaps provides some optimism for our specialty. However, there has been a rather significant shift in the applicant pool that is worth noting.



As can be seen here, the yellow line represents the blue bars from the previous graph, or the total number of applicants to EM. When you look at the breakdown of applicants, there is a convergence of applicant type, with a fairly large increase in IMG applicants, a moderate increase in osteopathic applicants, and a minimal increase in allopathic applicants, each representing not quite 1/3 of the applicant pool.

We have seen some other trends worth noting, such as an overall downtrend in the number of applications per applicant. While the over-application phenomenon may be improving, the cause of it is likely multifactorial and not all attributable to the state of EM these days as similar trends have been seen in other specialties. Additionally, overall the total number of applications and the average number of applications per program have gone down for allopathic applicants, while both osteopathic and IMG applications and average applications per program have trended up.

Questions were raised at the CORD Town Hall, and we are awaiting a response from the AAMC as it pertains to dual-applicants (applicants applying to EM and ≥ 1 other specialty) as well as US MD/DO seniors versus those ≥ 1 years out of medical school. Based on various sources, we can surmise what this information will look like, although we await formal confirmation from the data.

For further information, data is now publicly posted on the AAMC website: AAMC ERAS Statistics - Preliminary Data, although it varies slightly from what I have provided here above, as it is pulled from a different timeframe than the preliminary data provided to us; however, the overall numbers and trends are essentially similar.

I hope by sharing this information I've been able to provide you with factual information, helping to dispel any misinformation. We continue to watch trends with cautious optimism for our specialty. Should you have any further questions, please don't hesitate to reach out to me directly. ■

UPCOMING EVENTS

11/29/2023
Board of Directors – Harrisburg

1/31/2024
Board of Directors – (Virtual)

4/3/2024
Board of Directors – Harrisburg

4/14/24 – 4/16/2024
ACEP Leadership & Advocacy Conference (LAC) –
Washington, DC

5/1/2024
Board of Directors –
Kalahari Resorts
Pocono Manor

SUMMER 2023

PACEP ACCOMPLISHMENTS

ADVOCACY

- Submission of ACEP public policy grant for pediatric boarding

ENGAGEMENT

- Completed and distributed electronic Summer edition of PACEP News
- Continued development of lecture series by Medical Student Council
- Significant progress on "Welcome to Pennsylvania" video for showing at Council

EDUCATION

- Received an increase in the number of speaker proposals for PACEP24 SA
- PACEP24 SA Planning Committee has begun preparation for PACEP24
- Great recognition of several PACEP 2023 Medical Student Scholars for ACEP23 Research Forum

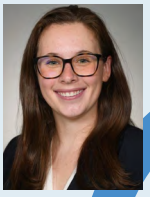
GOVERNANCE

- Maintained balanced budget
- Received approval from ACEP on PACEP Bylaws revisions as approved at recent annual membership meeting held at Kalahari in May
- Submission of (6) Council resolutions and Co-Sponsorship of (2) resolutions

SCIENTIFIC ASSEMBLY PACEP 2023 CPC HIGHLIGHT

What is the Diagnosis?

A special thank you to Alexandra Amaducci, DO, FACEP for organizing the CPC competition during Scientific Assembly and to Shelby Crowley, DO from TowerHealth for submitting the case and being the resident presenter, and Steve Schirk, MD, FACEP from Wellspan York for being the attending discussant.


CPC CASE STUDY

THE CASE

The Case – 58-year-old male patient presented with 6 days of fever and abdominal pain and states "I have typhoid fever"

- Tmax 102 F
- The fever was preceded by abdominal pain and one day of vomiting
- Abdominal pain is right sided and radiates to left flank
- Patient reports he was recently diagnosed with typhoid fever after traveling to Africa for missionary work
- Patient has been taking 2,000mg of acetaminophen q4 hours

PMH: DVT, PE
PSH: hernia repair
SocHx: never smoker, denies alcohol or drug use
Allergies: none
Current medications: ciprofloxacin, cefixime, Xarelto, mefloquine
ROS: Pertinent positive – night sweats, decreased appetite, fatigue, SOB, decreased urinary output
PE: VS: RR 30, 97% on RA, BP 128/75, HR 101, Temp 99.7F

- Constitutional: ill-appearing, no diaphoresis
- HEENT: moist mucus membranes. Mild pharyngeal erythema
- Cardiovascular: tachycardia. No murmur
- Pulmonary: no respiratory distress. Slight expiratory wheeze with no rales or rhonchi
- Abdominal: soft, mildly distended. Right sided, non-focal abdominal tenderness to palpation, with no rebound or guarding. No CVA tenderness to b/l.
- Extremities: symmetric non-pitting edema b/l. no calf tenderness.
- Musculoskeletal: Normal range of motion and neck supple.
- Neurological: A & O x3. No focal neurologic deficits.
- Skin: warm and dry
- Psych: Calm and cooperative

LABS:
CBC w/ diff –
Hgb 15.4
Hematocrit 46.1
WBC 7.3
Platelet 217

CMP –
Glucose 83
BUN 13
Cr 1.01
Sodium 139
Potassium 4.3
Chloride 103
Bicarb 24.9
AG 11
Albumin 4.1
Calcium 9.2
Protein total 7.2
Bilirubin 0.6
AST 58
ALT 82
Alk Phos 81

THE WORKING DDX:

- Anatomic/Structural—bowel obstruction, gall bladder/biliary tract, pancreatitis, appendicitis, diverticulitis, ureteral obstruction (with or without pyelonephritis, trauma, some type of thromboembolic process
- Oncologic—lymphoma or some other type of malignancy
- Endocrine—thyroid disease
- Toxin—acetaminophen, interaction of meds, poisoning
- Infectious—broad
  - Leptospirosis
  - Schistosomiasis
  - African Sleeping Sickness
  - African Tick Bite Fever
  - Chickungunya
  - Dengue
  - (Malaria)
  - Ebola
  - Marburg
  - Monkey pox
  - Hantavirus
  - Tuberculosis (TB)

What test will make the diagnosis?
What is the final diagnosis?

see conclusion on page 23

PACEP EDUCATION COMMITTEE UPDATE:

Successful Central Residents Day

By Monisha Bindra, DO, MPH, FACEP

Monisha Bindra, DO, MPH, FACEP
PACEP Education Committee Chair

On Thursday, September 7th residents and visiting medical students from WellSpan Health, Penn State Health, UPMC and Reading Hospital-Tower Health came together at Richard Nixon Park in York to celebrate Central PA Resident's Day.

The Olympic style event was hosted by WellSpan Health's Emergency Medicine Residency and was led by their program director, Amber Billet MD, FACEP.

PACEP President Richard Hamilton MD, FACEP welcomed all the programs before the start of the activities. As part of his commentary, he discussed the importance of being connected to each other and the specialty of Emergency Medicine through PACEP/ACEP. He reminded the residents that the goal of the College is to support physicians throughout the various stages of their career and enable our purpose of caring for all patients through education and advocacy.

There were 120 learners in total, who were divided into twelve groups with wild animal names to symbolize the outdoor setting. Each team rotated through a variety of hands-on skill stations that tested their toxicology, ultrasound, Sexual Transmitted Infections (STI), wilderness medicine, radiology, needle cricothyroidotomy, pericardiocentesis and splinting knowledge. The day certainly wouldn't have been a success without the creative styles of the attendings at each program. They successfully put together diverse interactive stations that challenged our residents physically and mentally.

After four hours of competition and fun inside and outside of the Nixon Nature Center, we were able to gather everyone for a group picture followed by a boxed lunch. We thank Dr. Billet and her program for hosting a fun filled day of group educational activities and friendly competition and can't wait to see what UPMC Harrisburg organizes next year!

The PACEP board meeting took place onsite at the conclusion where we discussed our progress in developing a strong curriculum for our upcoming 'Bouncebacks and Bouncing Back' Scientific Assembly planned for May 2-4, 2024, at Kalahari Resort in the Poconos. We look forward to seeing many of you there and hope that you also got a chance to say hi to one another at ACEP Scientific Assembly in Philadelphia this October.

We are always looking for people to share in the collaborative efforts of the Medical Education Committee! If you are interested in joining our committee, send an email to Jan Reisinger at exec@pacep.net. We look forward to meeting you or seeing you again! ■

Did You Know PACEP Has a Job Bank?

To learn more about open positions or to learn more about advertising a position, visit the PACEP Website.

CURRENT POSTINGS INCLUDE:

- Emergency Physician - ChristianaCare
- Emergency Medicine Residency Program Director


EXIT


STIES AND MITHICS

PACEP Research Committee Update

By Eric Melnychuk, DO, FACEP

Eric Melnychuk, DO, FACEP
PACEP Research Committee Co-Chair

Do you have an interest in joining the PACEP Research Committee, have a research idea, or have a suggestion for PACEP's annual Research Forum? Please reach out to exec@pacep.net! We would be happy to work with you!

The Research Committee met on August 23rd, 2023 and began to discuss planning of next year's PACEP Scientific Assembly Research Forum, as well as ideas for upcoming newsletters. The PACEP website will also have a section for the research committee, coming soon!

The Research Committee plans to put out the initial call for abstracts for the 2024 Scientific Assembly, on November 17th, 2023. The deadline for abstract submission is anticipated to be January 10, 2024. We look forward to seeing the great research the Commonwealth is producing!

PENNSYLVANIA RESEARCH WELL REPRESENTED AT ACEP SCIENTIFIC ASSEMBLY!

The ACEP 2023 Scientific Assembly selected 448 abstracts from 15 countries to present at the research forum, and 32 abstracts were from Pennsylvania! This is a testament to the hard work Pennsylvania Emergency Medicine researchers are doing! From administration and quality improvement to toxicology and infectious disease, there is a broad representation of interests that are going to be displayed at ACEP's Scientific Assembly.

University/Health System	Abstracts Accepted
University of Pennsylvania	10
Penn State Hershey College of Medicine	9
Lehigh Valley Health/USF Morsani College of Medicine	5
Thomas Jefferson University	5
Lake Erie College of Osteopathic Medicine	2
Children's Hospital of Philadelphia	1
Total	**32**

If you attended ACEP's Scientific Assembly this year, please click here to see a complete list of abstracts. I'm sure the presenters were thrilled to have their Pennsylvania colleagues be present during their poster and podium presentations! For more information regarding ACEP 2023 Scientific Assembly, please click here.

THREE PENNSYLVANIA MEDICAL STUDENTS SELECTED AS ACEP RESEARCH FORUM SCHOLARS – CONGRATULATIONS!

The 2023 ACEP Research Forum leadership also announced 10 medical student scholars for this year's scientific assembly. Of the 10 medical students selected, 3 are from Pennsylvania! This is another impressive achievement PACEP is proud of. Nevin Adamski, Madison Heck, and Parker Maddox were selected and will be assisting with social media promotion and providing assistance to speakers and moderators. Congratulations on being selected! ■

SCIENTIFIC ASSEMBLY PACEP 2023 CPC HIGHLIGHT

The Resolution:

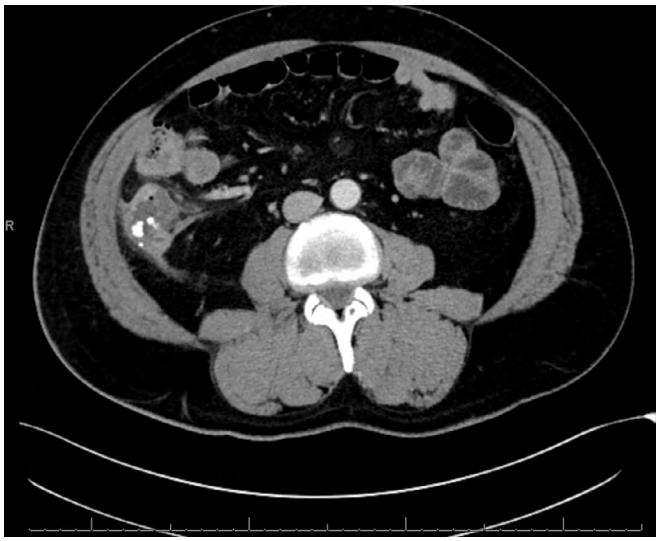
CPC CASE STUDY

RESULTS

The Case – 58-year-old male patient presented with 6 days of fever and abdominal pain and states "I have typhoid fever"

THE TEST TO ORDER:
CT of Abdomen/Pelvis with contrast

DIAGNOSIS:
Perforated appendicitis with abscess



Positive for perforated appendicitis. There is a 3.9 x 3.7 cm abscess at the point of appendiceal perforation with several small appendicoliths. There are a few small regional bubbles of pneumoperitoneum. No bowel obstruction. There is edema in the adjacent paracolic gutter.

SECONDARY DIAGNOSIS:
chronic acetaminophen toxicity

PATIENT'S COURSE:
- Acetaminophen level <10
- Received 1L fluids and antibiotics
- N-acetylcysteine initiated
- Consult to surgery and infectious disease
- Admitted to surgery with plan for IR percutaneous drainage

ACUTE APPENDICITIS FUN-FACTS:
- Most common abdominal surgical emergencies worldwide
- Incidence 100 per 100,000 person years
- Most common age group 10-19
- Male to female ratio 1:4
- More cases of perforated appendicitis in men than women

PATIENT OUTCOME
- Completed course of N-acetylcysteine, transaminitis improved
- IR drain placed with drainage of feculent material
- Abdominal fluid cultures positive for pseudomonas, candida and bacteroids
- Discharged with drain in place
- Elective interval laparoscopic appendectomy

RELEVANCE TO EM:
- Common presentations are common despite unusual travel history
- Initial features are often nonspecific or atypical

Residency Spotlight: Reading Hospital – Tower Health

By Megan Ulsh, DO

Megan Ulsh, DO
Chief Resident, Emergency Medicine Residency Program

Reading Hospital Emergency Medicine Residency

Location: West Reading, Pennsylvania

Social Media Handles: Instagram @Reading_EM_Residency

Year Founded: 2018

Number of Residents: 29

Program Length: 3 years

Website: Reading Hospital Emergency Residency Program (rhemresidency.com)

WHAT DOES YOUR PROGRAM OFFER THAT RESIDENTS CAN'T GET ANYWHERE ELSE?

Our unique and varied patient population is one of the major highlights of our residency program. Being a STEMI and stroke receiving center and Level I Trauma Center with a Pediatric Emergency Department, we treat a wide variety of chief complaints, patient presentations, and acuity of conditions, both medical and trauma. Additionally, our geographic location allows for significant variety in patient population. Our hospital is located in the borough of West Reading, PA, a Berks County suburb listed among some of the best places to live in Pennsylvania. Located just one mile from downtown Reading - the fourth largest city in Pennsylvania, and nine miles from Lancaster County - the largest Amish community in the United States, we are able to enjoy the diversity of caring for patients of all ages from a variety of cultural and socioeconomic backgrounds that includes a large Spanish speaking population.

Our geographic location contributes not only to our patient variety, but to local extracurricular opportunities. Many of our residents enjoy running and hiking in local parks and trails, kayaking and paddleboarding in nearby Blue Marsh Lake, skiing and snowboarding at multiple ski resorts in and around the Pocono Mountains, and attending fitness classes at various gyms including CrossFit and Orange Theory Fitness. In addition to physical fitness and outdoor activities, residents have hosted cookie-swap parties, paint classes, and game nights. On long weekends, our residents are known to travel to Delaware and New Jersey beaches and spend time in the cities of Lancaster, Philadelphia, and New York. Berks County and the surrounding areas are full of opportunities for everyone.

To ensure residents have time for extracurricular activities, family events, and personal wellness, our ED rotation schedule has a strong focus on resident wellness. Each resident works 20 nine-hour ED shifts PGY-1 year with a one shift reduction each following PGY year, and every resident is guaranteed a "golden weekend" during each of their ED blocks. Residents are able, and encouraged, to submit schedule requests to the scheduling chief resident to more easily align their personal schedules with their clinical schedules. Additionally, each resident's night-shift schedule is aggregated to limit the frequency of sleep schedule changes. Many residents attribute their ability to attend special occasions, coach their children's sports teams, and re-engage in prior hobbies to our mindful scheduling process.

Finally, our curriculum is robust in core EM areas including critical care, ultrasound, and pediatrics, as well as more nuanced subfields. Reading EM offers unique experiential learning opportunities in First Responder experiences (see above, learning from and working alongside Reading Fire Department), Wilderness Medicine, and Global Health. We host multiple wilderness medicine

events throughout the academic year, learning about environmental exposures, toxicologic emergencies, and austere resuscitation and rescues. As a program, we send a group of attendings and residents to a medical facility in the Dominican Republic for one week each year to participate in a collaborative global health and quality improvement initiative.

HOW ARE YOUR RESIDENTS SUPPORTED BY SENIORS AND FACULTY?

From the beginning of intern year, each resident receives individualized clinical, academic, and emotional support. Residents are paired with senior resident mentors and guided by experience through the challenges of intern year. Additionally, residents are paired with faculty mentors and advisors in an effort to support both academic and personal goals as residents progress through the program. While working clinically in the Emergency Department, residents are supervised by and receive one-to-one on-shift education from both core and clinical faculty. As residents progress in the program to become senior residents, they are invited to join an alumni network where past residents offer career advice, post job listings, and share post-graduate stories.

WHERE DO YOUR ALUMNI WORK?

Our graduates have gone on to work in a variety of practice settings in a multitude of geographic locations including Florida, California, and Massachusetts. Many of our graduates start jobs in community Emergency Departments, while some have gone on to work in larger academic institutions. Quite a few of our graduates have attended fellowships - in EMS, Pain Management, Advanced Airway, and Medical Informatics - with a 100% match rate among residents who have applied for fellowship. ■

CELEBRATE WELLNESS!

If you have a healthy recipe that you would like to share, please email it to Jan Reisinger at exec@pacep.net. The PACEP Wellness/Young Physicians Committee will select recipes for the PACEP website, as well as a favorite for publication in the PACEP News each quarter.

Quick Chicken and Barley Stew

(Southern Living)

INGREDIENTS:

- ☐ 3 bacon slices
- ☐ 1 tablespoon olive oil
- ☐ 1 cup chopped yellow onion (about 1 medium onion)
- ☐ 1 cup 1/4-inch-thick diagonally cut carrots (about 2 medium carrots)
- ☐ 1 cup 1/4-inch-thick diagonally cut celery (about 3 stalks)
- ☐ 1 tablespoon garlic cloves, minced (about 3 garlic cloves)
- ☐ 1 teaspoon kosher salt
- ☐ 1/2 teaspoon black pepper
- ☐ 4 (6-oz.) boneless, skinless chicken breasts
- ☐ 4 cups low-sodium chicken broth
- ☐ 1 cup uncooked quick-cooking barley
- ☐ 1 (8-oz.) package baby spinach
- ☐ 2 tablespoons chopped fresh flat-leaf parsley

DIRECTIONS:

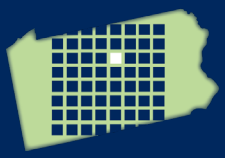
1. Cook bacon in a large Dutch oven over medium until crisp, about 6 minutes, turning once. Transfer bacon to a plate lined with paper towels, reserving drippings in Dutch oven. Crumble bacon, and set aside.

2. Add olive oil to drippings in Dutch oven; increase heat to medium-high. Add yellow onion, carrots, and celery; cook, stirring occasionally, until tender, about 3 to 4 minutes. Stir in garlic, kosher salt, and pepper, and cook until fragrant, about 1 minute.

3. Add chicken and broth to Dutch oven. Cook on medium-high until broth begins to boil, about 2 to 3 minutes. Reduce heat to medium-low. Stir in barley, and cook until chicken is cooked through and a thermometer inserted in the thickest portion reads 165°F, about 8 to 10 minutes more. Remove chicken, shred into large pieces, and return to Dutch oven. Add spinach, and stir until wilted, about 1 minute. Stir in parsley; top each serving with crumbled bacon.

NUTRITION FACTS (PER SERVING):

469	Calories
12g	Fat
41g	Carbs
51g	Protein



PENNSYLVANIA COLLEGE
of **EMERGENCY PHYSICIANS**
ADVANCING EMERGENCY CARE

The Voice of Pennsylvania's Emergency Physicians

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