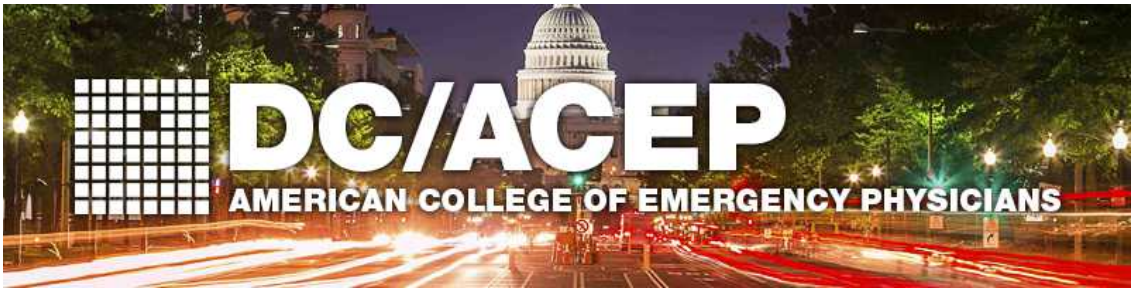
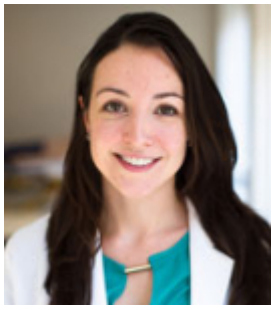
A Newsletter for the Members of the District of Columbia ACEP Chapter





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From the President
Guenevere Burke, MD

Best wishes for 2018 from DC ACEP!

In this newsletter, you will find updates from our diverse membership including residents, students, local and national leadership.

As a brief update on recent chapter events, DC ACEP was well represented at Scientific Assembly held in October. Some highlights:

Chapter President, Guenevere Burke, kicked off the Council Meeting with a welcome address to the Council.

Past-President, Dr. Liferidge was elected to the national Board of Directors. Dr. Liferidge reflects on the journey in a brief article below. Congratulations, Aisha!

DC ACEP hosted a lively reception in collaboration with Maryland and Virginia ACEP with support from Physicians for Fair Coverage. The event stirred new relationships and collaborations. Please let us know if you have additional ideas for engaging with others in the region.

Dr. Kirilichin, Dr. Powell and Dr. Liferidge representing the chapter at the Council Meeting held at ACEP17 in Washington.

Please stay tuned for additional updates on our Winter Member Benefit, which will take place in February. More information coming soon!

From a Past-President
Aisha T. Liferidge, MD, FACEP

Joining ACEP Board: A Surreal Realization

As Sonja Montgomery, ACEP Governance Operations Director, smiled and handed me a blue folder with a name tag that read “Aisha Liferidge MD, MPH, FACEP - Board of Directors,” she said, “congratulations on winning the election and we’ll see you in the morning at 7:00 am for orientation!” Smiling back, I replied, “Thank you so much! Sounds good!” Yet as I turned to walk away, I thought, “Wait! Did she just say 7:00 am tomorrow morning?!”…And so, it began; after nearly a year of intense preparation consisting of fortifying my knowledge on various emergency medicine related topics and familiarizing myself with national ACEP and state Chapter operations, all my hard work had paid off. On Saturday, October 28th I was elected to the American College of Emergency Physicians Board of Directors. There were 8 candidates for 4 positions, and I was one of two non-incumbent candidates elected by a delegation of 410 emergency physician representatives from all 53 Chapters, including the District of Columbia, Government Services, and Puerto Rico.

My decision to accept the nomination to run for the Board in the spring of 2017 was not made lightly. I thought long and hard about it to ensure that the timing was right for me, knowing that serving the College as a Board member is essentially a full-time commitment which requires

expert-level knowledge. In addition to having accrued 12+ years of national and state level experience within ACEP - ranging from serving as councillor, chair of task forces and subcommittees, and President and Board member of state Chapters - I knew that a successful run for the Board required me to additionally be well-versed on key, sometimes unprecedented, current issues facing our patients, specialty, and the health care system. Many of these topics reflect the unfortunate fact that emergency medicine is currently under attack and being questioned as an essential and fundamental health care service; for example, insurance companies and even government regulations have recently challenged the prudent layperson standard by refusing patient reimbursement for emergency services, failed to pay physicians fairly based on out of network billing practices, and tried to remove emergency services as an essential benefit from health care reform legislation. In addition to understanding and creating strategy around crucial issues such as these, I additionally spent the past year learning more about all the amazing work being done at the state Chapter level, such as effective mental health reform as related to emergency department boarding and initiatives to combat the opioid crisis. I also learned about the challenges faced by states and brainstormed with them about ways that national ACEP might assist.

While ACEP has served as more like a family than an organization to me over the years and I felt well prepared to take on the challenge of running for and joining the Board as an effective member. I must say that when Sonja Montgomery handed me my new name badge just minutes after the election results were announced, it felt surprisingly very surreal and that feeling continued for several days afterwards. In that moment, I realized that I had just embarked upon a new frontier of leadership which affords me extraordinary opportunity to contribute to landmark advocacy for our patients and specialty. Indeed, I am up for this next level of challenge and sincerely grateful to serve.

Balance
Rita A. Manfredi, MD, FACEP

An emergency medicine career can span decades with many years spent in the pressure cooker environment of the ED. The secret to avoiding burnout involves a strategy of balance. Jay A. Kaplan, prior president of ACEP, has written: "Balancing your personal and professional life is the key to avoiding burnout. Think of a scale of one to ten on a seesaw. Place work at one end as a one and your personal life at the other end as a ten. How is your balance? Many emergency physicians will say they're at three. In other words, they're more heavily weighted toward work."

So how do we stay balanced and grounded throughout our careers? What is the secret of maintaining equilibrium so that burnout does not have a chance to affect us?

Consider a Wheel with multiple spokes. The Wellness Wheel. Each spoke is critical for the wheel to keep turning, to maintain balance and stability.

Next, put yourself at the center of this wheel and understand that when all the spokes work together you will be balanced. This ability to balance is the secret to finding joy at work and in all the other parts of your life.

Balancing the Spokes

The Emotional Spoke Emergency Medicine is fast-paced, stressful, and unpredictable. With constant exposure to this pressure, many EPs ignore the feeling that they are overwhelmed or marginalized, setting the stage for burnout. As health care providers we have to acknowledge what we are feeling, rather than deny our emotions. We may be annoyed with cantankerous consultants or difficult patients but we have the power to choose how we will react and manage these feelings. Focusing on the consultant's positive attributes or the patient's unspoken plea for help is a way to validate the good that we do in the ED every day. Trying to be optimistic and nurturing meaningful relationships with others are key to wellbeing and balance.

The Occupational Spoke

Are you happy during your commute to the hospital as you anticipate your upcoming shift? Think about what gives you satisfaction when working in your ED. For the moment discard all the negatives and consider all the positive features present in your department. Is it the people, the system, the setting that gives you satisfaction? Do the procedures energize you? Is it the interaction with patients that is satisfying? Are you challenged by figuring out why a patient is so seriously ill? Take a few moments to recall why you chose Emergency Medicine as your specialty. There was something very captivating about becoming an emergency physician. Do you remember what that was? Think about how the challenges in the upcoming shift ARE actually what drew you to Emergency Medicine.

The “need to fix” departmental and occupational issues will always be present. The key is to balance them with the enjoyable aspects of your job. You will have to find those positives because human nature naturally gravitates to what is wrong first, rather than what is right.

The Financial Spoke

Being financially secure is a key component to your longevity as a balanced emergency physician. Part of financial wellness is to develop a PLAN by establishing goals such as providing for your family, paying your monthly bills, planning for your children’s education, and creating a nest egg that provides for a comfortable retirement and future travel. You can measure your progress and be confident of the result. Develop a financial plan and live within your means. Consider a financial advisor or CPA and protect yourself with insurance: malpractice, homeowner’s, auto, disability, and life.

The Physical Spoke

“A run a day keeps depression away!” Exercising adequately (30 minutes a day 5 days a week), eating well (fruits and vegetables with little or no processed food), getting adequate sleep (set your phone alarm for nightly bedtime), and paying attention to the signs of illness and getting treatment when needed play a big role in maintaining physical balance. Avoid alcohol and sleep meds to combat the onset of burnout. Use humor to boost your immune system and make it a point to smile and say “hello” to someone in the ED you would not normally interact with. Emergency physicians who are in good shape physically will reap the psychological benefits of greater self-esteem and self-control and be less at risk for burnout.

The Spiritual Spoke

What gives you meaning and purpose in Emergency Medicine? Is it the art of helping and healing? Can you draw on your spirituality to get you through the rocky times and remain resilient? This may be a way to reverse the trend toward burnout. Recall that the Vagus Nerve is your friend. During stressful times in the ED, take a deep breath in and expire very slowly. This activates the vagus nerve and the parasympathetic system, providing a brief moment of “rest and repose” which is very similar to the effects of meditation, but can be experienced in a micro-moment in the ED. Continue this practice during your off-shift times when you can spare ten minutes in a quiet place sitting down and concentrating only on your breath moving in and out. This is such a simple practice that can help reset your equilibrium and allow you to gain a larger perspective on what is happening in your personal and professional life.

The Intellectual Spoke

As our specialty continually changes and evolves it becomes increasingly difficult to stay current with all the new treatment modalities, medications and diagnostic innovations. This can become overwhelming and contribute to a feeling of helplessness and burnout. There are many online resources to use such as FOAMed (Free Online Access Medical Education) for emergency medicine which includes podcasts, blogs, and tweets specific to our specialty which are free and easy to access. Having an open mind in emergency medicine is critical. Sharing what you know with others in the ED (for example in-service presentations to nurses and ED

staff) can be stimulating and serve as a way to challenge yourself and renew your self-esteem.

The Social Spoke
Avoiding personal interaction with others is a warning sign of burnout. How are you relating to other providers and staff in the ED and to people in your life outside the department? Developing effective relationships with colleagues, patients, friends, and our families indicates healthy social balance. Kaplan comments that in the ED "we usually approach each other with demands-I need, I want, I must have. What if instead you were to think of everyone on staff with whom you interact as an important customer? So that when you think about someone you work with, the first question you'd ask would be: If I consider this person one of my most important customers, what would I do differently in order to better serve them?" Providing support and empathy for others often is re-vitalizing to us when the pressure mounts in the ED.

Maintaining balance is a life- long learning process, every bit as important as the yearly LLSA (Lifelong Learning and Self-Assessment) required by ABEM. One might speculate that devising your own personal LLSA to evaluate balance is a strategy to combat burnout. The best way to accomplish this is to reflect how each of the above spokes contributes toward your stability as an emergency physician. Keep the wheel rolling smoothly---is not that what we try to do every day in the ED? Make this a priority of your own.

Resident Corner
Pouya M. Gharahdaghi, MD, PGY-4

From a Psychology Student to Building an Ultrasound Curriculum in India - My Path to International Emergency Medicine

PGY4 Emergency Medicine residents like myself are often advised to create a niche in emergency medicine by choosing a mentor and doing a “mini-fellowship”. After much debate, I decided to go back to the roots of what interested me in emergency medicine and incorporate that into my senior project. With this article, I intend to share my journey -- from an undergraduate psychology student to curriculum building for emergency medicine in India.

Almost 10 years ago, as I was completing my undergraduate degree in psychology, I was offered the opportunity to accompany a pathologist who was doing HIV work in Uganda. Not having any knowledge of medicine or international work, I thought it would be an interesting experience. I was assigned a project with the psychology department of Mulago hospital to find a way to promote more HIV testing for men in Kampala. While there, my Director at the time encouraged me to shadow various departments of the hospital -- my first real exposure to medicine. In Uganda, you see disease at its most severe form, and you see the effect of a few simple antibiotics on the disease course. I saw tubercular meningitis, and I will never forget the

pungent smell of a diabetic foot ulcer. That trip had a profound effect on me and changed the trajectory of my professional life forever.

When I returned to the US, I decided to pursue a career in medicine. I completed the prerequisite courses and was on my way to medical school. It took me a while to decide on a specialty, but I decided on Emergency Medicine because of the variety of illness and rapid pace of the work environment. I was also interested in the opportunity to pursue international medicine as a subspecialty.

The question then became, how do I practice emergency medicine in the international setting? Would seeing one patient at a time at a clinic in Uganda be sufficient? After taking USMLE Step 1, I participated in another medical mission trip to Nepal, where all I could do was bedside suturing. I could not get a history or communicate with the patients. To practice effectively in any environment, one should be aware of the diseases unique to that environment, understand the language and culture, and become familiar with the resources available. I wondered, how would my training of ordering stat blood work and obtaining CT Angios in a resource-rich setting translate into a sustainable way of improving health care on a global level?

My residency rank list was made according to the strength of the international program given my desire to integrate emergency medicine with my passion for international work. As a second-year Resident, I started sharing my interest with the international medicine core faculty at my residency program. Their recommendation: you might not be able to effectively treat an individual in such setting, but think bigger - by training the local clinicians that speak your language (medicine) and have familiarity with the local culture and resources, you can establish something more sustainable. There it was, something I had never thought about: working with the local practitioners in training residents the art of acute care medicine. I was excited about the opportunity to keep cutting-edge western medicine while molding it to something that can be translated into local communities. The Ronald Reagan Institute of Emergency Medicine at George Washington University had introduced the much-needed training of emergency medicine to several hospitals in India by this point. They had been working with the local practitioners, who are mostly trained in internal medicine, to develop a curriculum and establish emergency medicine training sites.

My first assignment in India was an away elective which involved visiting four different sites and giving pediatric resuscitation lectures. After a few lectures and discussions with the residents, I started to get a feel for the practice and became better at it. At this point, the thrill of working abroad, solidifying my teaching skills, as well as relaying my knowledge to the new Residents became more real.

Upon my return, the deadline to my senior project was quickly approaching and it was time to start thinking about my niche in emergency medicine. As one might suspect, I wanted a project related to international medicine - with the goal of having lasting effects on local communities. The plan became to work with our ultrasound faculty and global health department to build a curriculum which incorporates resuscitative point-of-care ultrasound in the monthly modules

created for our international programs.

Months have gone by and a pilot curriculum has been proposed and implemented. The reception of our plan has so far been positive, and I am finally starting to find ways of making the dream of global medicine that started 10 years ago become a reality. At this point in my career I am not sure where this interest will take me and what the end-point of my interest in international emergency medicine will be, but I intend to continue to translate my acquired knowledge into something practical to assist underserved communities internationally.

Dr. Pouya Gharahdaghi is George Washington University's Resident Representative for the DC Chapter of ACEP. He is an emergency medicine Resident finishing his final year with a focus on international medicine and ultrasound.

Medical Student Corner
Tiffany W. Sin, MPH

It was a crisp November morning when I walked into the unimposing steel building on K Street that houses the American College of Emergency Physicians, just a few blocks away from the White House. I was starting my first day as an intern for a 4-week elective in Health Policy as a scholarship through EMRA/ACEP. The big, serene windows and spacious desks initially struck me as a stark contrast to the constant buzz, bustle, and gore of the emergency room. I later came to realize that ACEP's DC Office accomplishes as much for the field of emergency medicine its clinician members do for their patients.

On that first day, office staff were winding down from another successful ACEP Scientific Assembly. This year, it was held in our home base of DC, with participation from more than 6700 members, speakers, and leaders from the Emergency Medicine (EM) community. Over 250 physicians participated in its White Coat Day on Capitol Hill; they met with members of Congress and staffers to advocate for Medical Liability Reform for EMTALA Services and protection for The Prudent Lay Person Standard.

In the weeks that followed, I learned that ACEP does everything from fundraising to influencing legislation and regulation. I had the opportunity to follow lobbyists during meet and greets with key health policy advisors from the both chambers; converse with Senators and Reps about key issues impacting emergency physicians; and mingle with specialty interest groups representing other specialties, medical devices, and pharmaceuticals alike. Moreover, fundraising events taught me the vital role of NEMPAC in providing financial support for key members of Congress with voting records which support ACEP's priorities.

I also attended a Congressional hearing of the Health, Education, Labor, and Pensions Committee regarding the opioid crisis. I was heart-broken to hear personal stories from witnesses about how family members overdosed. I was reassured to hear proposals from

various organizations interested in research on addiction medicine, sustained drug rehabilitation and recovery programs, and Prescription Drug Monitoring Programs. Individualized stakeholder agendas were cast aside in a collaborative effort to persuade Congress on the importance of this health crisis.

ACEP also serves as a source of information for the public. It has, for example, spearheaded a campaign for public education surrounding indications to visit the ED. The public affairs team also develops social media campaigns, broadcasts, and interviews with EM experts from across the United States. I had the opportunity to work on one such campaign; I collected physician and resident stories to advocate for The Prudent Layperson Standard and learned about the ramifications of denied claims based on discharge diagnoses alone.

Throughout this health policy internship, I gained a deeper appreciation for what ACEP does as an organization and for the field of emergency medicine. The experience also sparked a life-long interest for me to be more involved politically with my residency program and local community. After all, a few powerful individuals on Capitol Hill make decisions that affect the lives of millions every day. With the help of ACEP, it is my hope that our collective voices may better inform and influence those few.

Tiffany Sin is a 4th-year medical student from A.T. Still University, School of Osteopathic Medicine in Arizona (SOMA). She is an aspiring emergency physician and is currently based in Washington, DC. She is grateful for the opportunity to complete a health policy internship at ACEP and is motivated to continue advocacy work in emergency medicine.

Upcoming Chapter Event

The chapter will hold a member benefit event on **Wednesday, March 21st** at **6:30pm**. This year this event will focus on **DC ACEP's Health Policy Project** in collaboration with a CRISP initiative.

Please save the date. We hope you join us. To RSVP, for this event, please click **here**.

11th Annual DC ACEP LLSA Review Conference

This conference is one of the many unique benefits available free of charge with your DC ACEP membership.

The conference will be held on **Tuesday, June 5th** in the **Pre-Clinical Science Building** in **Room LA2** at **Georgetown University**.

Breakfast will be served at 7:30am and the course will begin at 8:00am.

To register for the event, please click **here**.

We look forward to seeing you there!

Adriana's Corner

2017 is over, and the days, weeks and months in 2018 are just flying by. But, chapter business must continue. I am certain 2018 will be a great year for you as emergency physicians and for the District of Columbia chapter. I look forward to continuing to work with all of you the upcoming year. In the meantime, please contact **me** if I can help you in any way.

ACEP's Viral Video Campaign to Expose Anthem Policy

ACEP recently launched a video campaign to expose Anthem Blue Cross Blue Shield for denying coverage to emergency patients, based on an undisclosed list of diagnoses, for conditions the insurance giant considers non-urgent. For a copy of the full press release, please contact **Michael Baldyga**, ACEP Senior Public Relations Manager. This policy is active in six states - Georgia, Indiana, Kentucky, Missouri, New Hampshire and Ohio - but more Anthem states will follow, and more health insurance companies, if this effort isn't stopped. Anthem's policy is unlawful, because it violates the prudent layperson standard that is in federal law and 47 state laws.

Special thanks to ACEP video cast members Dr. Jay Kaplan, Dr. Alison Haddock, Dr. Ryan

Stanton and Dr. Supid Bose - and ACEP staffers Mike Baldyga, Elaine Salter, Darrin Scheid and Rekia Speight!

Help us make **the video** go viral and top last year's that generated nearly 300,000 views on YouTube and Facebook! Please post it to Facebook pages, e-mail it to colleagues and Tweet about it using **#FairCoverage** and **#StopAnthemBCBS**.

Help Us Celebrate ACEP's 50th Anniversary

You can help us ensure we have the most diverse, and most complete, historical collection of everything!

- Follow us on **Twitter** and **Facebook** to see our weekly Tues/Thurs 50th Anniversary posts
- Talking 50th Anniversary on social media? Use **EMeverymoment#**
- Show your EM pride with ACEP's **new "Anyone. Anything. Anytime." Facebook profile frame**
- Visit our 50th Anniversary site **here** for year-round updates
- Got something cool to share about the college's history, or your own with EM? **Click here!**

Upcoming CEDR Webinar

In depth review of the steps and process involved using CEDR for Group or Individual 2018 MIPS Reporting. Topics for this webinar will include selection of reportable measures, Advancing Care Information data entry, and Improvement Activity reporting through CEDR.

Register for the **Reporting MIPS through CEDR** webinar to be held on **March 13, 2018 at 1:00 PM CDT**. After registering, you will receive a confirmation email containing information about joining the webinar.

New ACEP Tool Helps you Keep Track of Ultrasound Scans

Emergency physicians regularly apply for hospital credentials to perform emergency procedures including emergency ultrasound. Theoretically, ultrasound training, credentialing and billing should be no different than other emergency procedures where training occurs in residency and an attestation letter from the residency is sufficient for local credentialing. When such training occurs outside of residency, "proctored pathways" often serve to assure competency. There is still a lack of understanding and awareness in the general medical community that emergency physicians routinely train in and perform point-of-care ultrasound.

The **ACEP Emergency Ultrasound Tracker** was created to assist members in achieving official recognition of ultrasound skills. This tool allows you to easily keep track of ultrasound scans you have performed over the course of your career in emergency medicine. It also allows you to upload relevant documents that attest to your training. After inputting and self-attesting to your ultrasound information you may download a letter of recognition from ACEP so long as you have attested to meeting the recommendations for emergency ultrasound training put forth in the **ACEP Ultrasound Guidelines (PDF)**. We hope you find this tracker tool helpful and useful in your practice.

New ACEP Award

Community Emergency Medicine Excellence Award
We are pleased to announce that the ACEP Board of Directors approved a new award to

recognize individuals who have made a significant contribution in advancing emergency care and/or health care within the community in which they practice. While the College currently has a number of awards to recognize excellence in emergency medicine this award is focused on the emergency physician who has made a significant contribution to the practice of emergency medicine in their community. Examples of significant contributions to the specialty and community may include, but are not limited to, community outreach, public health initiatives, or exemplary bedside clinical care.

Nominees must be an ACEP member for a minimum of five years and not received a national ACEP award previously. **Entries are due no later than May 14, 2018**.

The nomination form and additional information can be found **here**.

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 is 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 cites 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 (detectible 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.

Show Your Commitment to High Standards for Clinical Ultrasound

You have the highest standards when it comes to your clinical ultrasound program. Show that commitment to your patients, your hospital, and your payers with ACEP's Clinical Ultrasound Accreditation Program (CUAP). ACEP's **CUAP** is the only accreditation program specifically for the bedside, clinician-performed and interpreted ultrasound. Now also available - accreditation for non-ED clinical settings, including freestanding EDs, urgent care centers and clinics. **Apply Today**!

- Ensure safety and efficacy of patient care

- Meet ACEP's high standards for point-of-care delivery
- Use your own policies or draw from expert-reviewed sample documents

Geriatric Emergency Department Accreditation Program

ACEP is gearing up to accredit geriatric emergency departments. The **Geriatric Emergency Department Accreditation Program** will be accepting applications after the first of the year. There will be 3 levels of accreditation ranging from a minimal commitment to better elder care to a comprehensive well-rounded robust program. Accreditation shows your patients, your institution and your payers that your ED is ready to provide care to seniors and is a quality program that meets the high standards of the American College of Emergency Physicians. **Find out more**.

Policy Statements and PREPs Approved by the ACEP Board

The following policy statements and PREPs were approved by the ACEP Board of Directors at their October 2017 meeting.

Policy Statements
Medical Transport Advertising, Marketing, and Brokering - revised
Clinical Emergency Data Registry Quality Measures - new
Mechanical Ventilation - new
Hospital Disaster Physician Privileging - revised
Unsolicited Medical Personnel Volunteering at Disaster Scenes - revised
Sub-dissociative Dose Ketamine for Analgesia - new
Writing Admission and Transition Orders - revised
The Clinical Practice of Emergency Medical Services Medicine - new
The Role of the Physician Medical Director in EMS Leadership - new
State Medical Board Peer Review - new
Pediatric Medication Safety in the Emergency Department - new
Distracted and Impaired Driving - revised

PREPs
Sub-dissociative Dose Ketamine - new
Writing Admission and Transition Orders - new

Welcome New Members!

Asha Payne, MD, MPH
Michael K. Simmons, Jr. (Medical Student)
Mindy S. Park (Medical Student)

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