

A Newsletter for the Members of the Arkansas ACEP Chapter



Russell P. Tarr, MD, FACEP, PhD
President

[Adriana Alvarez](#)
Executive Director
Phone: (855) 475-8176
Fax: (972) 767-0056

Table of Contents

[Opioid Crisis](#)

[Expedition National Conference](#)

[ICARE18](#)

[ACEP's Viral Video Campaign to Expose Anthem Policy](#)

[Help Us Celebrate ACEP's 50th Anniversary](#)

[Upcoming CEDR Webinar](#)

[New ACEP Tool Helps you Keep Track of Ultrasound Scans](#)

[New ACEP Award](#)

[Articles of Interest in *Annals of Emergency Medicine*](#)

[Welcome New Member](#)

From a Board Member
J. Shane Hardin, MD, PhD

Why is the opioid crisis unique to the United States?

The opioid epidemic is a uniquely American problem . For example, the US makes up less than 5% of the world population, but it consumes 50% of the world's morphine . There are numerous reasons thought to account for why Americans use and abuse more opioids per capita than any other country.

Pills are cheap and easy. Patients without insurance can pay for prescription opioids. The uninsured are unlikely to pay for more expensive treatments even though they may be more appropriate (i.e., physical therapy for back pain or dental extraction for rotten teeth). A month's worth of opioids is far cheaper than a trip to the dentist or a physical therapist. Even patients with insurance will often have to have prior authorization for physical therapy and other advanced treatments. Prior authorizations take time and effort. When clinic physicians are expected by administration to see 4-6 patients an hour it is much easier to write a script than place orders for something that will require paperwork. However, in countries with universal coverage, patients are more likely to have access to non-pharmacologic treatment modalities.

Americans want a quick fix. We are a drive through/fast food culture. North America has over three times as many ATM's per capita as the European Union . We have more fast food restaurants than any other country in the world. Kentucky is number one in the country with the most fast food restaurants and it also happens to be one the states with the highest opioid related death rates . Opioids are a quick fix compared to other treatments. Americans are impatient and do not want to wait to see if they get better with the tincture of time. We not only want it now, but we also want it our way (only hydro 10's work for me).

Americans expect everything to be painless. Although it seems like common sense, surgeons are being asked to tell their patients that they will have post-operative pain . Think of all of the ads for "painless dentistry" and ads that ask "do you suffer from...". The rest of the world does not have the same expectation of a pain free existence. The aches and pains which are considered a normal part of life elsewhere are considered by Americans to be suffering that needs to be treated.

Prescription narcotics is big business. Pharmaceutical companies make about 10 billion dollars a year from opioids . The US and New Zealand are the only two countries that allow drug companies to advertise directly to consumers by advertising on television. Although most of their ads are for non-opioid medications, it encourages people to think that there is a pill out there that will cure whatever ails them. The drug companies also spend a fortune on advertising and gifts to doctors. Although it is hard to see how free pens and meals could change your prescribing practice, they would not be spending billions on advertising if it did not help their bottom line.

Physician training is also one of the factors contributing to the opioid crisis. The dramatic increase in the use of opioids began in the 1990's. At that time we were taught that patients were needlessly suffering because physicians were under treating pain. We were told that we

needed to aggressively treat pain and that patients were unlikely to become addicted to opioids that were properly prescribed . Opioids were safe meds that did not cause peptic ulcers and renal failure like NSAIDs. We were also taught that physicians should no longer be paternalistic. We were not supposed to do what was best for the patient, but we were instead to do what the patient thought was best for them (I need a Dilaudid PCA). David Brown has advocated a New Paternalism where we actually return to doing what we think is best for the patient .

At the same time we were being told that we were bad doctors for letting people suffer, the Veteran's Administration (VA) made pain the 5th vital sign and JCAHO started enforcing standards of pain assessment. Everyone was being asked not only if they were having pain, but to place their pain on a scale of 0-10. We previously assessed pain by examining the patient and taking a history. Now, the nurse records a 10 out of 10 on the pain scale while the patient eats Cheetos and plays on their phone. This practice has placed more emphasis on pain, and it encourages the expectation that we are going to reduce their pain to zero.

The VA and insurance companies also contributed to the abundance of opioids by encouraging/requiring meds to be prescribed in 90 day amounts. When 360 Percocets show up every three months it makes it easy for some of them to be diverted from grandpa's medicine cabinet.

Another change that has occurred over the last twenty years is the practice of physicians being rated by patients. Press Ganey and similar companies compile patient satisfaction scores and hospitals pressure physicians to keep the scores high . The income of physicians, especially emergency physicians, is often partially determined by these scores despite the system being extremely flawed. It is harder to not prescribe opioids when you are concerned that it will affect your pay. Also, patients are more likely now to complain to administration that you are not giving them what they want. Physicians are under more pressure to make the patient happy when they are worried about satisfaction scores affecting their pay or negative reviews on social media.

When patients do develop an opioid addiction, it is harder for them to get help in the US than it is in other industrialized countries. In Europe, addicts have treatment available to them because of the national health services. In the US, they are most often expected to pay cash for the services. An exception to this is when the services are court ordered, but that implies that their addiction has already contributed to them having legal troubles. This ends up costing society much more than if they would have had treatment before they ended up in the legal system. It is another example of American healthcare being reactive instead of proactive.

¹ Owen Amos. "Why Opioids are such an American Problem." BBC News. October 25, 2017.

² International Narcotics Control Board

³ World Bank

⁴ Tribune Wire Service

⁵ Federal Reserve Bank of Cleveland

⁶ Ryan Howard, MD; et al. "Reduction in Opioid Prescribing Through Evidence-Based Prescribing Guidelines." JAMA SURGERY. December 6, 2017.

⁷ Abby Goodnough and Sabrina Tavernise. "Opioid Prescriptions Drop For the First Time in Two Decades." New York Times. May 20, 2016.

⁸ Jane Porter and Hershel Jick, MD. "Addiction Rare in Patients Treated with Narcotics." N ENGL J MED. January 10, 1980.

⁹ David Brown, MD. "Opioids and Paternalism." The American Scholar. September 5, 2017.

¹⁰ Kai Falkenberg. "Why Rating Your Doctor Is Bad For Your Health." Forbes. Jan 2, 2013.

Expedition National Conference

The [Expedition National Conference](#) is just around the corner.

The conference will be held at the headquarters of Heifer International in Little Rock on **March 9-10, 2018**.

Four experts will attend and present at this meeting. Please click [here](#) to see the conference details and information about the presenters.

ICARE18

This year the conference will be held in Little Rock on **June 1 and 2** in the I. Dodd Wilson Building on the UAMS campus.

This conference will deliver high quality EM and Critical Care content, will maintain an interactive format including time sensitive diagnoses, trauma, pre-hospital medicine, and add an EM-Pediatrics track, bedside US education, Psychiatric, hand, ocular emergencies, and more.

You can find out more by clicking [here](#).



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

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

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

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

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

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

This study looked at HIV screening programs in 9 EDs located in 6 different cities over a 3 year period. There were 214,524 patients screened of which 839 (0.4%) were newly diagnosed. Of the newly diagnosed 14.5% were acute HIV (detectable virus but negative antibody) and 85.5%

were established HIV (positive antibody test). This study reminds us that many patients with acute HIV will have a negative screening test that relies strictly on antibody. Many of these patients present with flu like illness as their initial presentation.

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

Emergency Department Contribution to the Prescription Opioid Epidemic.

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

Welcome New Member!

Ethan P. McMoran (Medical Student)

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

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