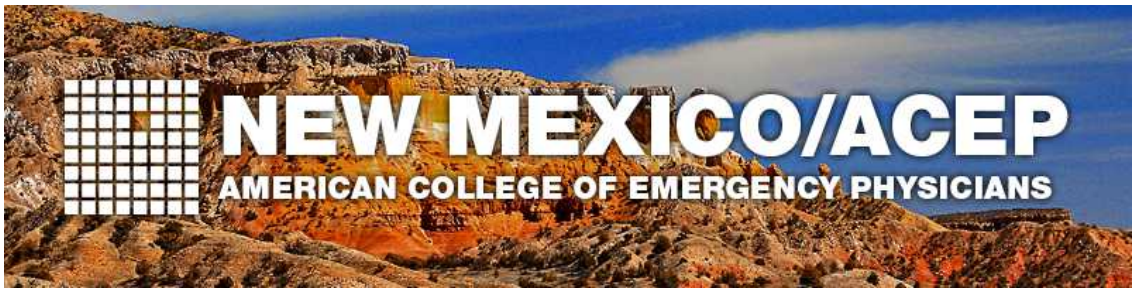
A Newsletter for the Members of the New Mexico Chapter



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From the President
A. Robb McLean, MD, FACEP

It is shaping up to be an interesting year in Emergency Medicine between the potential repeal and/or replacement of the ACA, the budgetary crisis occupying the state legislative session, and state-wide initiatives like the ED Information Exchange and the New Mexico Hospital Association Behavioral Health Taskforce. There is no better time to get involved in New Mexico ACEP and the numerous collaborative efforts we are undertaking!

To update recent newsletter items, NM ACEP surpassed the 200-member threshold at the end of 2016 which creates a third voting council seat for NM ACEP at the National Council meeting in October of this year. The “ER is for Emergencies Workgroup” and the New Mexico Clinical Consensus Committee, chaired by Heather Marshall and me, are steadily making progress on the introduction of the ED Information Exchange to New Mexico. Collective Medical Technologies has contracts in place with numerous facilities and is in negotiations with a number of others. We anticipate initial “go-live” dates of the EDIE early this spring in pockets of New Mexico, which is incredibly exciting.

The New Mexico Hospital Association(NMHA), which helped galvanize the Medicaid MCOs' adoption of the EDIE, has also involved NM ACEP in the creation of a document entitled*"Recommended Opioid Risk-Reduction Strategies and Prescribing Guidelines in New Mexico Emergency Departments."* This was recently distributed via the NM ACEP list-serve. The NMHA is also organizing the Behavioral Health Taskforce mentioned above. If you find behavioral health access and resources a challenge for patients in your department, please reach out to me, or to Beth Landon, at the NMHA to get involved!

Lastly, **the 38th Annual New Mexico ACEP Emergency Medicine Symposium is scheduled for Saturday, April 20, 2017.** Please put a hold on your calendars! We have an excellent agenda, including a National ACEP board member, Dr. Hans House, presenting on Rural Emergency Medicine as well as presenting updates on national developments impacting Emergency Medicine. Dr. House is the Vice Chair for Education at the University of Iowa Department of Emergency Medicine and he will be judging resident research presentations this year.

Please send updates for the next newsletter directly to **me**.

Upcoming NM ACEP Events - Mark Your Calendar!

Saturday, April 29, 2017

New Mexico ACEP Spring Dinner Meeting
Albuquerque, New Mexico

38th Annual New Mexico ACEP Annual Symposium
CME Event

Call Me, Maybe?
Daniel Becchi, MD
University of New Mexico
Resident, Department of Emergency Medicine

The sound of the page cuts through the soft silence of the darkened room. It upturns the quiet ease of the mind, scrambling it- abruptly and violently- forcing the senses back into reality. Not asleep, but neither awake, you have been uneasy, floating in that in-between of nervous waiting, marring any semblance of repose. You fumble to definitively silence the piercing blare.

Lights, pen, paper, and a rousing shake attempting to ripen your senses for what awaits. You squint at the number on the screen. The LCD backlight illuminates the digits and you immediately recognize it. “Oh no” you think to yourself briefly. None-the-less, you reflexively pick up the phone to return the call, knowing that it only means one thing.

Flatly you respond- “Hello, I was paged, how can I help you”. It is the most civilized semblance of a pleasantry you can muster at 3 AM.

On the other end, an upbeat voice chimes away. It takes a moment for the words to connect through the groggy impedance whirling through your head. An abstract frustration begins to percolate. The irritation is generalized. It is the caller, the nurse, the patient, the doctor on the other end, the department, the wee-hours of the morning, the nocturnal world outside slumbering without you, the responsibility of your newly assigned duty; all serving to stoke the flames.

Some patchy story is delivered with an air of certainty. It is punctuated by a request much less a demand for your service, an admission, a consult, some definitive disposition hopefully from the department. You have no say in the matter. It is a unidirectional relationship and you are on the receiving end. Wearily, you collect your notes and make your way to the department, to service the consult.

As emergency medicine providers, we are one of the few anointed specialties granted amnesty from the trying responsibility of a professional call schedule. By virtue of the role and responsibilities we have shouldered, we have become the 3AM callers, unashamed but blameworthy in our actions. We are the hounds, the insistent ones. We are those who press frazzled and frustrated consultants for a recommendation, admission or timely impression.

Residency training is likely the last time a seasoned EM provider has had the opportunity to take protracted and physically exhausting multi-day or overnight call. During these opportunities, one works on behalf of a variety of consulting services. These experiences, obviously, have many educational returns. However, in addition to the intrinsic academic benefit, taking call engenders a subtle but equally significant and substantive learning point - a renewed effort at discretion.

I hope to impress that with each call, we continue to challenge ourselves to ask the simple question; is this a specialty specific emergency, outside of my own capacity, and if so, must we act now, to utilize this resource in this setting. Not only do we have the responsibility to act for the good for our patient's to provide excellent medical care, but we also have the imperative to appropriately employ all the medical resources at our disposal, for our patients sake and the medical system as a whole.

Although an intense experience, the opportunity to take a protracted call has been utterly career affirming. However, it has also provided, a first hand opportunity to experience the frustration of a vague and incompletely worked-up patient and the grueling marathon of warily waiting for that call in the middle of the night. Ultimately, I hope to serve a renewed sympathy for those who lie between sleep and wake, primed and uneasy for that morale-piercing page.

Clinical News

CT Can Indicate Mortality Risk in Elderly with Trauma
NEW YORK (Reuters Health) – Opportunistic CT screening for osteopenia and sarcopenia in older adults with traumatic injury can provide insight into frailty and one-year mortality, according to Seattle-based researchers.
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HCV Infections Less Prevalent than Previously Estimated
NEW YORK (Reuters Health) – The global estimate of hepatitis C virus infection (HCV) is lower than previously thought, making World Health Organization targets for reducing infections and HCV-related deaths more attainable, researchers suggest.
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Earn CME credit while reading the number-one journal in our specialty. Each month, a new Annals of…
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Diversity and Inclusion: Our Chapters, Our Duty

Ryan P. Adame, MPA, CAE
Deputy Executive Director, California ACEP
Chair, ACEP Chapter Executives Forum
Member, ACEP Diversity & Inclusion Task Force

Diversity. Inclusion. Worthy goals or buzzwords? What do they mean to you? What is your reaction when you hear them being discussed? How much have you reflected on the diversity of your leadership, or the opportunities for inclusion in your organization? I hope you will take a moment to consider your answers to these questions, as well as to whatever feelings or emotions you experienced when you read “diversity” and “inclusion” because acknowledging our successes and shortcomings is, I believe, the first step to building organizations that better serve our physicians and, in turn, their patients.

Here are some statistics to consider about ACEP membership: women comprise 26% of total membership, 28% of committee membership, are 26% of committee chairs, and 27% of the Council. In senior leadership, women represent just 12.5% of the ACEP Board of Directors, and just 19% of Chapter presidents are female. Approximately 1% of ACEP members are African-American and another 1.5% are Hispanic. While this is just a sample of membership attributes, there are many, many other aspects of diversity to consider: other ethnic groups to be sure, but also LGBT members, religious cross-sections, as well as generational considerations.

Why does this matter? To me, this matters because we have the opportunity and the duty to help build more diverse organizations that are reflective of the memberships we serve. Beyond diversity, inclusion matters because without meaningful participation by a diverse group of people, diversity can be reduced to a demographic check-box exercise. Our task, in my view, is to assist and, when necessary, lead our physician members in meaningfully integrating voices and perspectives that are as different as the millions of patients they treat every year.

As the staff leaders within our family of organizations, we have unique access to and influence over our programs, our communications, and, most importantly, our leadership. I urge you to examine what your Chapter currently does to ensure better diversity and inclusion in leadership. Maybe right now the answer to that is “nothing.” We all have to start somewhere. Perhaps that means making inroads in your educational conference faculty’s diversity. Perhaps it means that you have to cultivate younger leaders differently, or help connect members from underrepresented groups with current leadership. Many Chapters already have resident members of their Boards of Directors but if you do not, there is another opportunity. Check that your meetings and conferences do not conflict with major religious holidays. Consider

programming aimed at unconscious bias and/or health care disparity.

There are many avenues by which our family of organizations – ACEP, Chapters, and EMRA – can build better, more diverse, more inclusive organizations for our members. But first, like our members do each and every day, we have to triage. We have to look honestly and soberly at our organizations as they are today and ask ourselves how we can make them more diverse, more inclusive for the members of today and tomorrow.

New Congress, New Administration, New Challenges

Now is not the time to sit on the sidelines. Wondering how can you influence health care policy on the national level?

Join the **ACEP 911 Grassroots Legislative Network** today to help emergency medicine convey our principles and priorities to legislators in Washington DC and their home districts.

Already a member of the Network? Take your advocacy to the next level. Host an emergency department visit for your legislator or invite them to meet with a group of local emergency physicians from your chapter.

Newly elected and veteran legislators are hiring key staff, getting up to speed on important issues, and setting priorities for the new Congress. Now is the perfect time to reach out on the local level to educate the member about the specialty and offer to serve as a local resource on issues relating to the delivery of health care.

Go to the **ACEP Grassroots Advocacy Center** for detailed information on how to join the program and start engaging with legislators today!

Emergency Department to Hospital Admission and Discharge, Developed and Provided by ACEP, SHM and Our Educational Partner

EARN FREE CME - Heart Failure Management: From the Emergency Department to Hospital Admission and Discharge

Emergency medicine clinicians and hospitalists have a unique, collaborative relationship in the continuum of care of acute heart failure (AHF) treatment- providing optimal patient care from first point of access through hospitalization to discharge.

Click **here** to take this free CME course and get up-to-date, evidence-based information on the clinical presentation of AHF, the importance of an accurate and timely diagnosis, and more! This program developed and presented by ACEP in collaboration with Haymarket and is made possible through an educational grant from Novartis.

Welcome New Members

Stewart Anderson, MD
Knox Kinlaw, MD
David Rosen, MD
Kathleen Stirling, MD

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