

A Newsletter for the Members of the Kentucky Chapter



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From the President **Dan O'Brien, MD, FACEP**

Emergency Nurse Practitioners

Advanced practice registered nurses (APRN) are shouldering an ever increasing burden of the healthcare provided in the United States today. There are many reasons: healthcare reform, economics, a chronic physician shortage to name a few. My goal is not to discuss the reasons, but to address the issues and requirements for performing these duties safely.

The APRN are defined in KRS 314.011 (8) and regulated by the Kentucky Board of Nursing. The regulations refer to education in a specific role: nurse practitioner, nurse anesthetist, nurse midwife and nurse clinical specialist. Advanced practices are recognized through certification by a recognized national organization. With the recognition of the Emergency Nurse Practitioner

Certification and the development of a host of academic centers providing training in this specialty, a question has arisen regarding the appropriate scope of practice for APRN providers in the emergency department who practice in this environment without certification as an Emergency Nurse Practitioner.

For Emergency Nurse Practitioner eligibility criteria, visit the [American Nurses Credentialing Center \(ANCC\)](#).

The Kentucky Board of Nursing publishes [guidelines](#) for determining whether an APRN is operating within the scope of practice defined by their certification, training and regulation.

There are no prohibitions in Kentucky that would prevent an APRN from working in the emergency department however, with the recognition of the training requirements of the Emergency Nurse Provider as well as the curriculum defined by the American Association of Critical Care Nurses, and the American Association for Nurse Anesthetists, it is important that APRN providers use [the matrix provided by the Kentucky Board of Nursing](#) to review their practices in light of the current requirements.

For current APRN providers who work in an emergency department there are options for certification through demonstrating a portfolio that provides evidence of certain requirements. Consult the [ANCC Certification through Portfolio Application Requirements](#).

It would appear from a pragmatic position that APRN providers without the Emergency Nurse Practitioner would be able to continue to practice in an emergency department but would exclude caring for patients outside their scope of practice. This would require some form of double-coverage environment. Nurses with extensive clinical time in the emergency department may be able to apply for and receive the necessary certification based on their clinical experience and additional bridge training. Nurses considering practice in the emergency department would be well served by considering the appropriate specialty certification. In many ways, this echoes the debate of the mid-eighties amongst physicians staffing emergency rooms. I suspect it will evolve similarly.

References:

[KBN GUIDELINES FOR DETERMINATION OF APRN SCOPE OF PRACTICE](#)

[AAENP ENP Program Info](#)

[American Nurses Association, Scope and Standards of Practice](#)

[American Nurses Credentialing Center, Emergency Nurse Practitioner Eligibility Criteria](#)

The Cost of Not Doing Business Ryan Stanton MD, FACEP

These are amazing times in which we live. Who would have thought that there would be a time that healthcare coverage would be unaffordable for most and that the insurance industry would steer the ship of care payments.

This year has been a huge challenge to say the least. None of us know where healthcare is headed, and neither side of the political aisle seems to have an answer that is gaining viable traction. At this point, I feel like the two most important driving forces in healthcare politics are votes and corporate money. Finding the patient/provider aspect is like finding a rainbow unicorn being ridden by a monkey quoting Shakespeare. Yes...that rare.

The bigger challenge is that Kentucky is ground zero for insurance experimentation on what they can get away with NOT paying. Anthem announced a plan to stop payment on “non-emergent visits to the ED.” Unfortunately, the “non-emergent” is determined by the final diagnosis...the old retrospectoscope. We have seen lists that include such benign conditions as chest pain with shortness of breath, headache, and abdominal pain. We all know those have no business in the ER!!! Basically, if you don’t diagnose someone with a life-threatening condition, it has the potential to be flagged as “non-emergent.” I have received several notifications from friends inside and outside medicine of cases that were deemed “non-emergent” and thus refused. One is a friend that went into a local ER with debilitating abdominal pain and was diagnosed with a ruptured ovarian cyst. It wasn’t life threatening, but her insurance company felt she was ok to just sit around with the pain and concern until she could get in to to see her PCP. When this happens, the patient gets the full bill and the doc likely gets little or nothing. This is bad for everyone. The kicker in all of this is that the insurance industry is mounting a well-funded campaign to paint emergency departments and physicians as the culprits in the “surprise bills” and gaps in coverage.

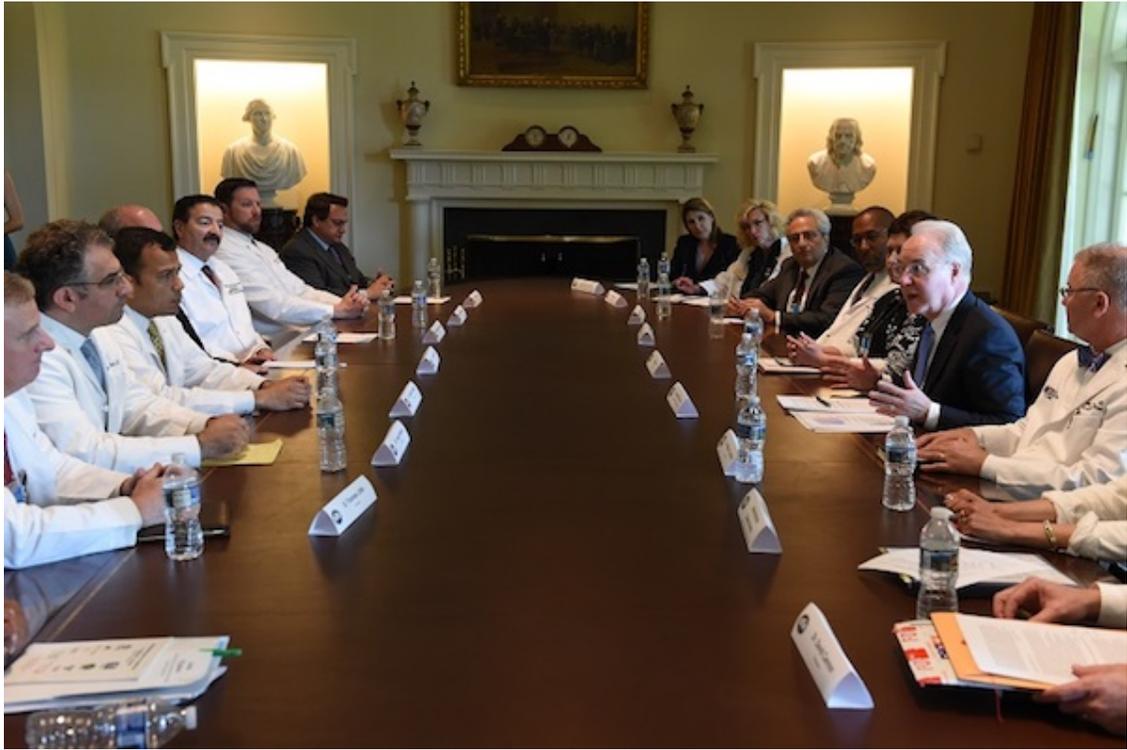
The good news is that ACEP is fighting back. I have gone to Washington DC to speak with the White House and on Capitol Hill, and I have had several meetings with legislators about the games being played by the insurance industry. ACEP has also teamed up with other stakeholders to fight back on the growing gaps and games being played by the insurance

industry. The challenge we face is that they have millions of profit dollars to spend and we are the equivalent of David standing there with a few small stones.

We do have a few tools that lean strongly in our favor...

- . Prudent layperson standard...Federal law outlines that the patient gets to determine the emergency, not the hospital, doctor, or insurance company.
- . EMTALA...We don't choose our patients, they choose us. We are also obligated by federal law to provide screening and stabilization services. This is one of our best bargaining chips with federal legislators. The insurance companies are currently using it against us, knowing we have to provide the care and that they can then skip out on the bill.
- . The numbers...Health insurers are raking in huge profits and have to report it. In the first quarter of 2017, the big 5 for-profit insurers brought in \$4.5 billion in profits, with 4 out of 5 having their highest margin in the last 5 years. It's hard for them to argue mercy from high atop a stack of cash. We must highlight the suffering of the providers and patients as our numbers fall and their's climb. Americans hate greedy big business.
- . We still wear the white hat...We must continue to enforce the message that we are there 24/7/365 to care for our patients, even if their insurance is not.
- . We want to be part of the solution...We must continue to advocate for our services, but also ways we can advance the system, promote efficiency, and curtail cost.

These are uncertain times, and we must be more involved than ever in driving the conversation and educating on facts. You **MUST** help educate your local lawmakers, and we need to know when you start seeing these tactics from insurers. The more cases we have and stories from the patients that are negatively impacted will help us when we head to Frankfort and Washington. We have to advocate for our patients and profession. The current games being played by the insurance industry must stop or we run the risk of losing our profession and patient access.





Dr. Stanton and Dr. Alvarado speaking at the Whitehouse on healthcare reform

EDIE UPDATE
Wes Brewer, MD, FACEP

So what's not to like about a program that saves money, improves patient care and makes our professional lives easier?

Several of your board members have been working with Collective Medical Technologies to bring EDIE to Kentucky. This is an emergency department pre manage program that we hope to deploy in the near future. This program grew out of a payment crisis in Washington and that has spread to several states, including some of our border states. It is a computer program that helps to fill in the deficiencies that plague many of our electronic record systems. When a patient registers in the emergency department EDIE searches for other nearby ED visits, recent advanced imaging studies, and care plans, and it queries KASPER before you even see the patient. Knowing that a patient has already had 6 negative CT scans in the last month and been prescribed 120 Percocet yesterday at another facility seems like information that should be obtainable, but up until now it has been generally quite elusive.

There have been quite a few meetings with stakeholders, with significant enthusiasm generated. While one may never be certain that anything is predictable about Kentucky politics, I believe a critical mass is coming, and my hope is that over the near future we will have some positive news to report, and this system will be rolled out statewide. We will keep you posted.

Proposed Changes to Medicaid Expansion in Kentucky Fact Sheet from the Henry J. Kaiser Family Foundation Shared by Melissa Platt, MD, FACEP

Of specific interest is Table 1: Kentucky's Proposed Section 1115 Medical Expansion Demonstration Waiver on pages 4-7 of the Fact Sheet: [Proposed Changes to Medicaid Expansion in Kentucky](#).

For more information, visit www.kff.org.

ACEP assists DMAT teams as they prepare to respond to Hurricane Harvey

Rick Murray, EMT-P
Director, Dept of EMS and Disaster Preparedness

ACEP was pleased to furnish classroom space over the weekend of August 26 to DMAT teams from several states that were staged before they deployed. MN Chapter Executive Shari Augustine, who is a member of the MN DMAT, contacted ACEP staff to inquire of the possibility of using the ACEP Board Room for training for the various teams. Space was provided for training for over 240 members for DMAT teams and U. S. Public Health Service personnel. This provided them the opportunity to receive some last-minute training and briefings before they deployed to various areas of the Texas coast that were impacted by Hurricane Harvey.



ACEP has a lot of [resources for the public](#) about preparing for and surviving disasters and they are being promoted to general public audiences.

Also, here are some [general talking points](#) about responding to disasters. They can be helpful in talking with the news media.

National Disaster and Life Support Foundation

The National Disaster Life Support Foundation is very pleased to have partnered with the American College of Emergency Physicians (ACEP) to provide disaster medicine training and to further develop the NDLS education materials.

The NDLS program began in the late 1990's with a realization that there was a lack of standardized training for medical and nursing providers who may be responding to disasters. Individuals were medically trained within their specialty to the same National Standard, however disaster specific education was not included in the majority of medical and nursing curricula. Examples of the missing material included:

Scene safety

Standardized triage methodology

Incident Management

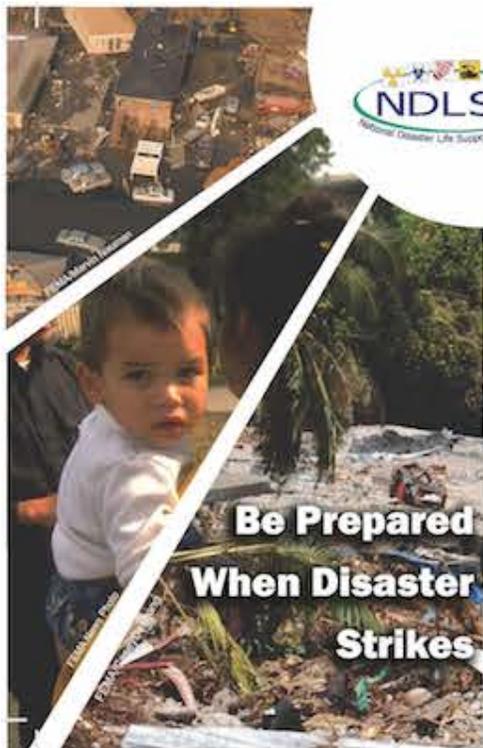
Identifying and requesting needed resources

What constitutes a disaster

Public Health impact of disasters

The NDLSF established an affiliated membership-based organization for the purpose of overseeing the development and revision of the curriculum. This organization is the National Disaster Life Support Education Consortium (NDLSEC).

The NDLSEC Annual Meeting will be held in conjunction with ACEP's 2017 Annual Scientific Assembly in Washington, D.C., October 29 – November 1, 2017.



**National Disaster Life Support™
Foundation**



**The American College of
Emergency Physicians**

*Collaborating to offer programs that
provide essential training for strengthening
healthcare preparedness and response.*

• Core Disaster Life Support®
(CDLS®)



• Basic Disaster Life Support™
(BDLS®)



• Advanced Disaster Life Support™
(ADLS®)



For more information - www.ndlsf.org
email us: info@ndlsf.org

White Coat Day on Capitol Hill at ACEP17

Decisions made by Congress influence the practice and the future of emergency medicine on a daily basis. Join your emergency physician colleagues in Washington, DC on November 1 and spread the word to legislators and their staff about the critical role of emergency physicians in our nation's health care delivery system. White Coat Day participants will be asked to attend a special advocacy training session prior to heading to Capitol Hill. Transportation will be provided and all participants will receive a customized schedule and materials to share in the meetings.

There is no fee to participate but advanced registration is required. Participants can sign-up as with their ACEP17 registration or may sign-up separately if not registered for ACEP17. Go to [White Coat Day](#) for more information or contact [Jeanne Slade](#) in the ACEP DC Office.

Register for White Coat Day at ACEP17!

DON'T MISS THE OPPORTUNITY TO VISIT CAPITOL HILL
WITH YOUR EM COLLEAGUES WHILE IN WASHINGTON, DC



**Spread the word about the critical role of emergency physicians
in the health care delivery system**

ACEP staff will schedule your visits in advance. Participants will receive advocacy training prior to the visits. Transport to and from Capitol Hill is provided. Please bring your white coat!

Advanced registration is required. Participants can sign-up with ACEP17 registration or may register separately if not attending ACEP17.

WWW.ACEP.ORG/ACEP17/HILLDAY

ACEP17 Wellness Activities and Resource Center Giveaways

Wellness & ACEP Resource Center

Sunday, October 29 - Tuesday, October 31

Location: Exhibit Hall

Stop by the wellness center in the ACEP Resource Center of the exhibit hall and discover tips from the experts to improve your well being daily. [View full list of activities and schedule.](#)

Product Giveaways

Held daily in the Resource Center

Sunday –PEER

PEER one-year membership

PEER Print Companion

Monday – CDEM

Trauma special edition

2- year print

One-year Residency Education Portal

Tuesday – ACEP eCME

My Residency Learning Portal

Trauma, Stroke, Cardiovascular bundle

Procedures and skills course

Featured guest on ACEP Frontline

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. [Read More](#)

No Emergency Department is Immune from Violence

But you can be better prepared and reduce the risk of harm to your patients, your staff, and yourself. You can implement security measures, changes in your processes and policies, education and training, and attention to design details. Learn how with these new free resources from ACEP, all in one place, easy to find -- [Violence in the Emergency Department: Resources for a Safer Workplace](#)

Welcome New Members

Jake E Berg
Kyle Bloemer, MD
Patricia Breeden, MD
Drew B Brooks
Tabitha Burton, MD
Christopher T Creech
Michael Donovan
Patrick N Grace, MD
Jared Hopkins
Rosina Hussain, MD
Charles Lewis Kieffer, MD
Connor D Ludovissy
Kevin Prince
Timothy Roach, DO
Cicero J Running Crane, MD
Johanna Said, MD
Paul VandeKoppel
Santhosh Velaga
Hutton White

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