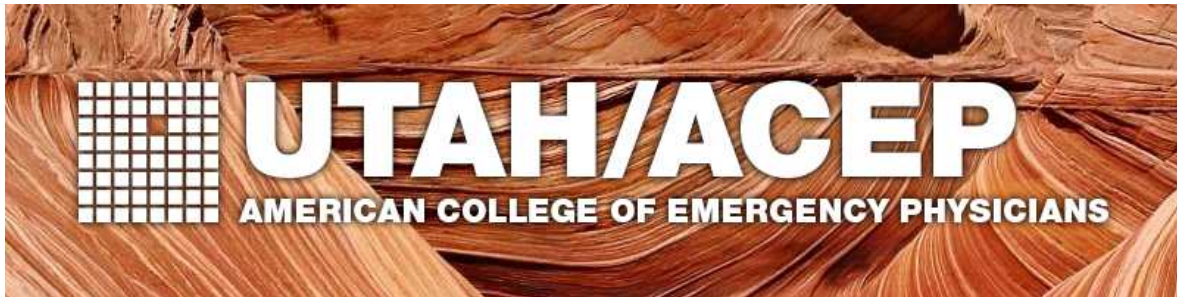


A Newsletter for the Members of the Utah Chapter

Summer 2018



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**President's Report: 2018 ACEP Leadership and Advocacy
Conference (LAC)**
David Mabey, MD
Utah Emergency Physicians
UCEP President

As physicians, we are called on to be community leaders and advocates for our fellow physicians and, most importantly, our patients. I was honored to attend the 2018 Leadership and Advocacy Conference in Washington, DC with two other Utah physicians: Dr. Alison (Aly) Smith, a member of the Utah Valley Emergency Physicians group, and Dr. Kara Sawyer, a PGY-3 and chief resident in the University of Utah's

Emergency Medicine program.

Several key topics were covered. A prominent issue was related to balanced billing. We had many discussions around this topic, as well as Anthem's tendency to deny claims for "nonemergent conditions." Last month, for example, I learned that the family of a pediatric fever patient I saw had their insurance claim denied because the insurance company reasoned that this was not an emergent situation.

This battle has come to affect our patients, and we cannot sit idly by and let it become the norm. If you become aware of a patient's claim being denied, please be proactive about it. Inform me or another UCEP board member about the situation so we can take action. Some strategies we as physicians can enact to combat insurance denials include the following:

1. Report what the patient was concerned about in your documentation. For instance, if a patient comes in for a fever, but was concerned about meningitis, then document this.
2. Be generous with your final diagnosis. Obviously we don't want to commit fraud, but if the patient's headache is severe, list the final diagnosis as "severe headache."
3. If you find out this happened to your patient and you are able to contact him or her, tell the patient to appeal twice. On the second appeal, most insurance companies will just pay the claim rather than continue to invest time into the denial. Also advise the patient to report their insurance company to our state insurance commissioner. If a company gets enough complaints, the commissioner is obligated to investigate.

On Capitol Hill, we were able to meet with the legislative assistants for the majority of our house representatives and both senators. We were advocating for three issues that could impact our practice locally.

1. The Opioid Crisis - We supported two bills. One was to give funding to EDs to find and implement opioid alternatives to treat pain. The second was to give funding to EDs to get people into drug treatment more effectively. While there are many bills before congress, these seek to treat both ends of the crisis, while not inflicting onerous burdens on us in our EDs.
2. Drug Shortages - We asked our representatives and senators to sign a petition to the FDA requiring them to form a taskforce to investigate drug shortages, then to report back with the root causes and a plan to address the shortages.

3. PAHPA - We asked that the Pandemic and All-Hazards Preparedness Act (PAHPA) be renewed and strengthened. This act provides funding for an office to coordinate disaster response and allows military members to aid community EDs in the case of a natural disaster or mass casualty incident.

At this point, progress has already been made on each of these issues. Funding has been approved to help get people into treatment for opioid addiction. The letter to the FDA has been sent. PAHPA is moving to full committee. [This 4-minute video from ACEP](#) sums this up nicely.

Thank you for your time and efforts on the part of your patients and your specialty.

Abscess Management: The Reformation of an Antibiotic Nihilist

By Rob Bryant, MD

**Adjunct Assistant Clinical Professor of Emergency Medicine
at Utah Emergency Physicians and REBEL EM Guest
Contributor and Author**



Abscess management has evolved somewhat in the 14 years since my residency graduation. The point at which antibiotics are likely to be more helpful than harmful is not always easy to assess, and evidence-based expert opinion has flip flopped impressively.

Based on current evidence, I would like to answer 3 big questions that every clinician may have when confronted with an abscess:

1. Who needs antibiotics?
2. Which abscesses need to be drained?
3. How should abscesses be drained?

A Brief History:

Community Acquired MRSA has caused an increase in ED visits for skin and soft tissue abscesses since the turn of the century. In 2003 after >1000 LA county prison inmates contracted skin and soft tissue abscesses after 'spider bites' extensive and expensive efforts were put into eradicating spiders from LA county prisons. This did not change the rates of skin and soft tissue infections. Despite the multiple patients presenting with 'spider bites' who are besmirching the good name of spiders everywhere we know that almost all 'spider bite' abscesses are due to CA-MRSA. CA-MRSA has also affected multiple professional sports teams, including the NFL.

Who Needs Antibiotics?

Emergency physicians have a front row seat to patients presenting with complications of indiscriminant use / overuse of antibiotics. We are beset upon on a daily basis by the worried well who have expectations of receiving antibiotics for a myriad of complaints where antibiotics will not help and may hurt. We are attracted to evidence that supports fewer medication interventions, thereby decreasing the incidence of medication related adverse events.

The Evolving Recommendations for Antibiotics After Abscess Drainage:

2007 Hankin, Everett, Are antibiotics necessary after incision and drainage of a cutaneous abscess? Systematic review. Annals of EM, 2007. [PMID: 17577944](#)

- 5 studies, 1 abstract, 30 year review.
- No clarification of degree of overlying cellulitis in the studies reviewed.
- Conclusion: NO NEED FOR ANTIBIOTICS AFTER SIMPLE I AND D.

2010 [EBmedicine.net](#). **Emergency Department Infections in the Era of Community-Acquired MRSA. October 2010.**

- Recommend empiric CA-MRSA coverage if:
- Systemic signs and symptoms are present
- Comorbidities (DM, immune system impairment)
- Critical anatomic location (face, genitourinary)
- Surrounding cellulitis
- Large size (No specific size is mentioned)
- **5cm abscess size cutoff?**
 - The 5cm cutoff /breakpoint for antibiotic administration is an interesting choice. There is variation in the literature of whether to measure the diameter of total infected site, versus clinically apparent area of fluctuance, versus confirmed cavity size as measured by bedside ultrasound.

Lee et al. Pediatric Infectious Disease Journal 2004. [PMID: 14872177](#)

- 69 patients. Prospective cohort study.
- I and D alone did not resolve abscesses larger than 5cm.
- All patients received antibiotics.(mostly cephalexin, or amoxicillin)
- 58 patients managed as outpatients with CA-MRSA abscesses.
- No differences in outcome in the patients whose antibiotics were changed to CA-MRSA specific coverage.
- **Terminology:** Abscess size vs infected site diameter. This study uses 'infected site diameter'.

Any time we are using our measurements to make clinically important decisions we need to take into account the accuracy of the measurements we are obtaining. As it turns out, we are not as good at obtaining measurements as we would expect:

Measurement – Size matters: how accurate is clinical estimation of traumatic wound size? Injury 2014. [PMID: 22592151](#)

- 50 providers evaluated wounds, asked about management, and estimate of wound length.
- There was significant inter-provider variability.
- Men consistently over estimated wound length. Women consistently under estimated wound length.

- If we are not good at estimating laceration size, abscess size estimation is unlikely to be any different.

New Evidence Since 2010:

Talan D et al. Trimethoprim-sufamethoxazole versus Placebo for Uncomplicated Skin Abscess. NEJM 2016. [PMID: 26962903](#)

- 1247 Patients. I and D alone versus I and D plus Bactrim.
- Primary outcome was cure rate at 7-14 days. (No fever, decrease / no increase in size of infected area, decreased discomfort)
- Ultrasound was used in all abscesses where fluctuance wasn't obvious. Use of US allowed for accurate measurement of abscess.
- Average area of erythema: 6.5-7.0 x 5 cm
- 20% of patients had >75 sq. cm of erythema (8.7cm diameter)
- **Cure rate: 80.5% (Bactrim) vs 73.6% (placebo)**
- **Secondary outcomes:**
 - Subsequent surgical drainage: 3.4% (Bactrim) vs 8.6% (placebo)
 - Skin infections at new sites: 3.1% (Bactrim) vs 10.3% (placebo)
 - Infections in household members: 1.7% (Bactrim) vs 4.1% (placebo)
 - 1 episode of hypersensitivity reaction, fever, hepatitis, thrombocytopenia. Spontaneously resolved.
 - No episodes of C-diff.
- Conclusion: "In MRSA prevalent areas, treatment with Bactrim in addition to I and D resulted in higher cure rate".

Daum, R et al. A Placebo-Controlled Trial of Antibiotics for Smaller Skin Abscesses. NEJM 2017 [PMID: 28657870](#)

- 786 patients. I and D alone vs I and D plus either clindamycin or Bactrim.
- Primary outcome was cure rate at 7-10 days.
- Excluded patients with temp >38.5C, or those meeting SIRS criteria.
- Average area of surrounding erythema 26 sq. cm. (5x5).
- **Cure rate: 83.1% (clinda), 81.7% (Bactrim) vs 68.9% (placebo)**
- Treatment related adverse events: 21.9% (Clinda) 11.1%(Bactrim) vs 12.5% (placebo)
 - NO C-diff reported
- All participants had moderate sized areas of overlying cellulitis.

- Conclusion: “the increased clinical cure rate must be weighed against the potential risks associated with increased antibiotic use”.

Talan et al. Subgroup analysis of Antibiotic Treatment for Skin Abscesses. Annals of EM 2018. [PMID: 28987525](#)

- Subgroup analysis of patients in Talan 2016 NEJM study.
- Found consistent treatment effect for erythema / infected site size >5cm and <5cm
- Biggest treatment effect through 42-56 days seen in those with a history of MRSA (76.7% vs 56.8% (22.9%)) and fever (77.6 % vs 60.6% (16.9%))

Gottlieb et al. Systemic Antibiotics for the Treatment of Skin and Soft Tissue Abscesses: A Systemic Review and Meta-analysis. Annals of EM 2018. [PMID: 29530658](#). Reviewed on [REBEL EM](#) April 2018

- 2406 patients in 4 studies. (heavily influenced by Talan and Daum papers)
- Treatment failure rate: 7.7% (antibiotic) vs 16.1% (placebo) Calculated risk difference 7.4%
 - **NNT: 13.5**
- New lesions at different sites: 6.2% vs 15.3%,
- Absolute difference 9.1%, calculated risk difference 10%
 - NNT 11
- Diarrhea: 11.8% vs 11.2% (calculated risk difference 0.8%)
 - No cases of C-diff.

Overall, the new evidence from high quality studies since 2010 suggests a liberal antibiotic strategy would likely improve already high cure rates, may decrease MRSA recidivism, and surprisingly could do so without generating more antibiotic associated diarrhea.

Rare Antibiotic Side Effects:

We routinely caution patients against the common side effects of diarrhea, candidiasis, nausea, and also a potential increase in resistant strains of bacteria. What about the rare, and sometimes life threatening antibiotic associated skin conditions such as Stevens Johnson syndrome and toxic epidermal necrolysis? The true rates of these rare conditions are hard to calculate, 2 old studies suggest the following rates:

Roujeau J, et al. Medication use and the risk of Stevens Johnson syndrome and toxic epidermal necrolysis. NEJM 1995. [PMID: 7477195](#) _

- Population case control study to estimate incidence of SJS / TEN following exposure to several agents known to be associated with these conditions.
- Highest association: Sulphonamides, (most commonly Bactrim)
- **4.5 cases per 1 million users per week**

Chan H, et al. The incidence of erythema multiforme, Stevens-Johnson syndrome, and Toxic Epidermal Necrolysis. A population based study with particular reference to drugs uses among outpatients. [PMID: 2404462](#)

- 14 year observational study. Single health system in Seattle.
- 61 suspected cases, 16 cases attributed to drugs given before admission.
- **3/100,000 person years for Bactrim (by comparison, Nitrofurantoin was 7/100,000 person years)**

Who to use an Antibiotic On?

- Cellulitis that you would treat if there was no abscess (including infection site size <5cm in diameter)
- Unreliable patient (poor health literacy, poor access to follow up)
- Big abscess (larger than 5cm)
- Immunocompromized (DM, steroids, elderly, significant systemic disease burden)
- MRSA recidivist. MRSA in the house, any history of previous abscess

Who to Drain?

- Some abscesses are obvious, and the use of ultrasound will be a waste of time.
- In abscesses with a lot of skin thickening, or in cellulitis without obvious fluctuance it is not always obvious which cellulitis has an abscess lurking beneath.
- **Use Ultrasound if you are not sure:**

Babic et al. In patients presenting to the emergency department with skin and soft tissue infections what is the diagnostic accuracy of point-of-care ultrasonography for the diagnosis of abscess compared to the current standard of care? A systematic review and meta-analysis. BMJ open 2017. [PMID: 28073795](#)

- Ultrasound sensitivity: 96.2%
- Ultrasound specificity: 82.9%

- If you wouldn't bet \$5 on whether a drainable abscess is present, use an ultrasound.

How to Drain?

Historically we have always packed abscesses. This has resulted in scheduled follow up visits for packing change / removal. A new (2010) technique of loop vessel drainage can potentially reduce / avoid follow up visits.

Loop Vessel Technique

Am J Emerg Med, 2018. Comparison of the loop technique with incision and drainage for soft tissue abscesses: A systematic review and meta-analysis. [PMID: 28917436](#)

- 4 Studies, 470 patients.
- Comparison of CID (conventional incision and drainage with packing) and LVT (Loop vessel technique)
- Failure rate: CID 9.8% vs LVT 4.1%

The acid test of any new intervention is whether the patients like it. Some of my happiest patients are those with recurrent shooter's abscesses who experience their first loop vessel drainage, and are extremely happy to not have to deal with a packed abscess.

Steps:

1. Incise at one edge of abscess
2. Insert mosquito forceps / yankauer suction catheter
3. Break down loculations
4. Tent the skin opposite the first incision
5. Cut down to the catheter / mosquito forceps
6. Drag Loop Vessel back through the abscess
7. (consider irrigation)
8. Make 5 throws on the first tie
9. Tie tight, but ensure no skin tension
10. Remove vessel loop in 5-7 days

For style points, try not to spill a drop of pus. As healthcare providers a big spill of pus is fun, but not so for our patients.

Take Home Points:

- There is room for a safe increase in antibiotic use

- There does not need to be reckless over-use of antibiotics
- Use ultrasound with any abscess you are unsure of
- Use a loop vessel rather than packing

Posted on [REBEL EM](#) | May 12, 2018

NEWS FROM ACEP



Updates in Reimbursement and Coding – 2018

Reimbursement and coding can be an ongoing challenge for the emergency physician. This [collection of courses on ACEP eCME](#) will give you the latest information on reimbursement, quality measures and common documentation errors to help ensure you receive appropriate reimbursement for your skilled procedural work.

New ACEP Policy Statements and Information Paper

During their June meeting, the ACEP Board of Directors approved the following new or revised policy statements:

- [Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch, and Public Emergency Aid Training](#) – New
- [Appropriate Use Criteria for Handheld/Pocket Ultrasound Devices](#) – New

- [Coverage for Patient Home Medication While Under Observation Status](#) – New
- [Delivery of Care to Undocumented Persons](#) – Revised
- [Disaster Medical Services](#) – Revised
- [Financing of Graduate Medical Education in Emergency Medicine](#) – Revised
- [Guideline for Ultrasound Transducer Cleaning and Disinfection](#) – New
- [Impact of Climate Change on Public Health and Implications for Emergency Medicine](#) – New
- [Interpretation of Diagnostic Imaging Tests](#) – Revised
- [Interpretation of EMTALA in Medical Malpractice Litigation](#) – New
- [Non-Discrimination and Harassment](#) – Revised
- [Patient Autonomy and Destination Factors in Emergency Medicine Services \(EMS\) and EMS-Affiliated Mobile Integrated Healthcare Community Paramedicine Programs](#)– New
- [Prescription Drug Pricing](#) – New
- [Relationship between Clinical Capabilities and Medical Equipment in the Practice of Emergency Medical Services Medicine](#) – New
- [Resident Training for Practice in Non-Urban/Underserved Areas](#) – Revised

The Board also approved the following information papers and PREP:

- [Electronic Health Record \(EHR\) Best Practices for Efficiency and Throughput \(PDF\)](#) - New
- [Initiating Opioid Treatment in the Emergency Department \(ED\) - Frequently Asked Questions \(FAQs\) \(PDF\)](#) - New
- [Emergency Department Physician Group Staffing Contract Transition \(PDF\)](#)
- [Emergency Physician Contractual Relationships - PREP \(PDF\)](#) - Revised

Articles of Interest in *Annals of Emergency Medicine*

Sam Shahid, MBBS, MPH
Practice Management Manager, ACEP

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.

Duber HC, Barata IA, Cioe-Pena E, Liang SY, Ketcham E, Macias-Konstantopoulos W, Ryan SA, Stavros M, Whiteside LK. **Identification, Management and Transition of Care for Patients with Opioid Use Disorder in the Emergency Department**

In this clinical review article, they examine the current body of evidence underpinning the identification of patients at risk for OUD, ED-based symptomatic treatment of acute opioid withdrawal, medication-assisted treatment (MAT) of OUD upon discharge from the ED, and transition to outpatient services. In this article they also present options for targeted opioid withdrawal and management, as well as a variety of other medications to consider for symptomatic opioid withdrawal treatment for patients that do not require opioids for acute pain. [Full text available here.](#)

Klein LR, Driver BE, Miner JR, Martel ML, Hessel M, Collins JD, Horton GB, Fagerstrom E, Satpathy R, Cole JB. **Intramuscular Midazolam, Olanzapine, Ziprasidone, or Haloperidol for Treating Acute Agitation in the Emergency Department**

In this prospective observational study of 737 patients, medications were administered based on an a priori protocol where the initial medication given was predetermined in the following 3-week blocks: haloperidol 5mg, ziprasidone 20mg, olanzapine 10mg, midazolam 5mg, haloperidol 10mg. The primary outcome was the proportion of patients adequately sedated at 15 minutes, assessed using the Altered Mental Status Scale (AMSS). Results showed that Intramuscular midazolam achieved more effective sedation in agitated ED patients at 15 minutes than haloperidol, ziprasidone, and perhaps olanzapine. Olanzapine provided more effective sedation than haloperidol. No differences in adverse events were identified. [Full text available here.](#)

Brenner JM, Baker EF, Iserson KV, Kluesner NH, Marhsall KD, Vearrier L. **Use of Interpreter Services in the Emergency Department**

This paper highlights the importance of effective communication in the provider-patient therapeutic relationship and how language barriers have the potential to compromise all aspects of medical care. The authors identify that in the US, as of 2013, more than 25 million persons had limited English proficiency, making quality medical interpreter

services an important public health issue that affects a large proportion of our diverse population. They recommend that a professional interpreter should be offered if practical and available when a patient has either limited English proficiency or hearing impairment and that a modality of interpretation should be chosen between in-person, video, or telephone based on what best suits the clinical situation. [Full text available here.](#)

Nowak RM, Gandolfo CM, Jacobsen G, Christenson RH, Moyer M, Hudson M, McCord J. **Ultra-Rapid Rule-Out for Acute Myocardial Infarction Using the Generation 5 Cardiac Troponin T Assay: Results from the REACTIONUS Study**

The objective of this study was to determine how well a new FDA approved single cardiac troponin T Generation 5 (cTnT Gen 5) below the level of quantification (6 ng/L) baseline measurement and a novel study derived baseline/30 minute cTnT Gen 5 algorithm might adequately exclude acute myocardial infarction (AMI) in patients with suspected acute coronary syndrome (ACS) in a United States (US) Emergency Department (ED). They enrolled patients presenting with any symptoms suspicious of ACS. Baseline and 30 minute blood samples were obtained, the cTnT Gen 5 levels later batch analyzed in an independent core lab and the AMI diagnosis was adjudicated by a cardiologist and an emergency physician. They found that a single baseline cTnT Gen 5 measurement <6 ng/L and values at baseline <8 ng/L and a delta 30 minute < 3 ng/L ruled-out AMI in 28.8% and 41.0% of patients respectively. The authors did identify limitations such as single center ED, selection bias and the exclusion of patients with life-threatening illness, cardioversion or defibrillation within 24 hours of presentation, STEMI patients requiring immediate reperfusion or those who were pregnant or breast feeding, and highlighted that additional multi-center US studies evaluating these ultra-rapid AMI ruleout guidelines are needed.

Friederich A, Martin N, Swanson MB, Faine BA, Mohr NM. **Normal Saline and Lactated Ringer's have a Similar Effect on Quality of Recovery: A Randomized Controlled Trial**

The purpose of this single-site participant- and evaluator-blinded, 2-arm parallel allocation (1:1), comparative effectiveness randomized controlled trial study was to test the hypothesis that balanced crystalloids improve quality of recovery more than normal saline (0.9% sodium chloride, NS) in stable Emergency Department patients. 157 Patients allocated to receiving IV fluids in the ED before discharge to were randomized to receive 2 L of Lactated Ringer's (LR) or NS. The primary outcome was symptom scores measured by the validated Quality of Recovery-40 (QoR-40) instrument (scores 40-200) 24 hours after enrollment. Results showed that there was no difference in post-enrollment

QoR scores between NS and LR groups. Although pre-enrollment scores were higher in the LR group, adjusting for pre-survey imbalances did not change the primary outcome. The authors concluded that NS and LR were associated with similar 24-h recovery scores and 7-day health care utilization in stable ED patients.



Preorder the Title that Celebrates the Depth and Diversity of EM

Explore the side of emergency medicine few see – the emotional, the heartbreaking, the thrilling, the heroic – the human side of EM. ACEP's 50th Anniversary Book, *Bring 'Em All*, reveals how far the specialty has come in its short, vibrant life. Famed photographer Eugene Richards captures the breathtaking moments that make the lives & careers of American emergency physicians. [Reserve your copy today.](#)



Interested in GED Accreditation?

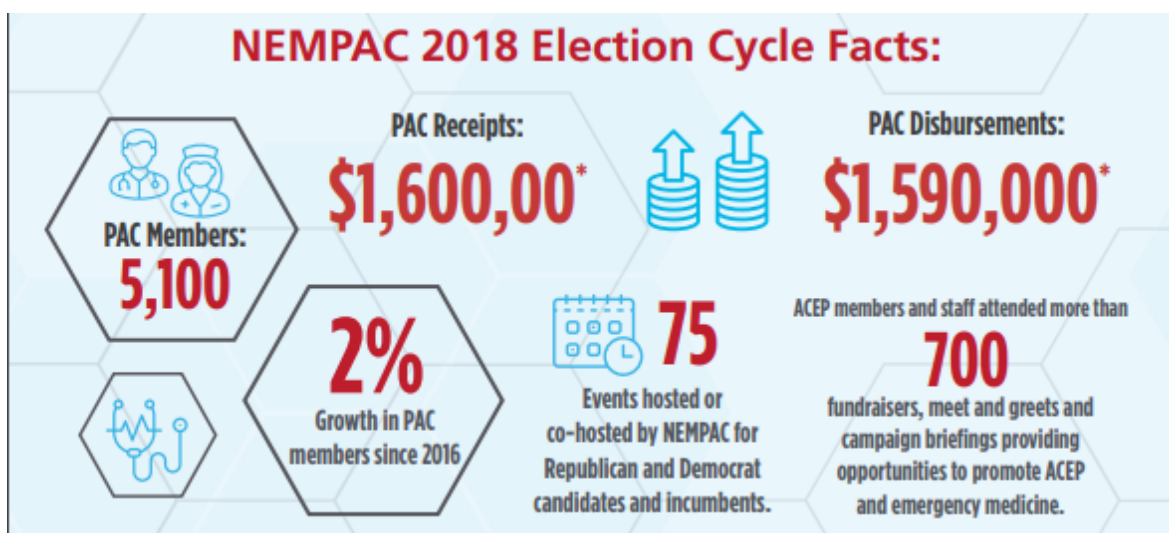
Learn how to develop a Geriatric Emergency Department (GED) with this three-hour [geriatric pre-conference](#) during ACEP18. Hear from the geriatric experts who will walk you through the increasing need for geriatric medicine focusing on GED clinical workflows, training and staff development, geriatric-focused policies and protocols, and achieving [GED accreditation](#). Panel discussions include institutions who have been awarded accreditation.



Emergency Ultrasound Tracker

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 [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](#). We hope you find this tracker tool helpful and useful in your practice.



NEMPAC Mid-Term Election Update

With the mid-term elections just months away, ACEP and the National Emergency Medicine Political Action Committee (NEMPAC) are focused on electing candidates who will work on bi-partisan solutions to address emergency medicine's most pressing issues. The NEMPAC Board and staff rely on input from ACEP state chapters and local ACEP members when evaluating support for incumbent legislators and new candidates – **we want to hear from you!** NEMPAC is the 4th largest medical PAC and will continue to grow with your support. Learn more about NEMPAC today by visiting [our website](#) or contact [Jeanne Slade](#). Keep an eye on your inbox for additional details about NEMPAC's activities as we get closer to the elections.

ED ICU Development and Operations Workshop Pre-Conference

San Diego Convention Center, Upper Level, 7B
Sunday, September 30, 2018 | 12:30 pm to 5:00 pm

If you have ever considered developing an ED ICU this workshop is for you. Participants will learn about staffing, reimbursement, collaborations, and business plan development, with the goal of developing and running their own ED-ICU. This program is directed at those along the entire continuum of ED-ICU development from conceptual to operational phases. [Register here](#). For more information, contact [Margaret Montgomery, RN MSN](#).

**NEWS FROM THE
AMERICAN BOARD OF
EMERGENCY MEDICINE –
JULY 2018**



**American Board of
Emergency Medicine**

Subspecialty Certification in Neurocritical Care

The American Board of Medical Specialties (ABMS) has approved subspecialty certification in Neurocritical Care (NCC). NCC is co-sponsored by the American Board of Anesthesiology (ABA), the American Board of Emergency Medicine (ABEM), the American Board of Neurological Surgery, and the American Board of Psychiatry and Neurology (ABPN). Physicians certified by these four boards who meet the eligibility criteria for NCC will have the opportunity to become certified in NCC.

There will be two pathways to certification in NCC: a training pathway and a time-limited practice pathway. The practice pathway will start at the time the first exam is offered. Eligible pathway criteria will be posted on the ABEM website by the end of 2018. ABPN will develop and administer the examination; physicians will submit applications to their primary certifying board. The first examination is expected to take place in either 2020 or 2021.

Letter Available Refuting Merit Badge Requirements

ABEM provides a letter of support that may be submitted to hospital administrators to forego the mandatory completion of short courses or additional certifications (“merit badges”) often needed for hospital privileges. Physicians must be participating in the ABEM MOC Program to obtain the letter.

The letter, signed by each representative of the Coalition to Oppose Medical Merit Badges (COMMB), details specific activities that board-certified physicians perform to maintain certification. ABEM-certified physicians can now download the letter from their Personal Page on the ABEM portal by doing the following:

- Sign in to the ABEM portal at www.abem.org
- On the left navigation, click “Print Verification of ABEM Status”
- Under letter type, click “General Coalition ABEM”
- Click “Continue to Next Step”

Take the ConCert™ Early - Retain Your Current Certificate Date

You can take the ConCert™ Examination during the last five years of your certification (during the annual testing window). If you pass the exam early, you will still retain your certification until the expiration date on your current certificate. This is also true even after you complete all of your MOC requirements. When your current certification expires, you will be issued a new, ten-year certificate. If you take the ConCert™ Examination early and do not pass, you still retain your certification and have another chance(s) to pass it. ABEM only reports whether a physician is board certified and participating in MOC.

In 2017, 44 percent of ConCert™ test takers registered to take the exam early; that is, in a year prior to their final year of certification.

Welcome New Members

Matthew J Chapman, MD

Justin I Hanson

Nicholas Levin, MD

Brent J Wright

Frank J Zadavec, MD

**Utah Chapter ACEP, 310 E 4500 South #500,
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