A Newsletter for the Members of the Utah Chapter - Winter 2026

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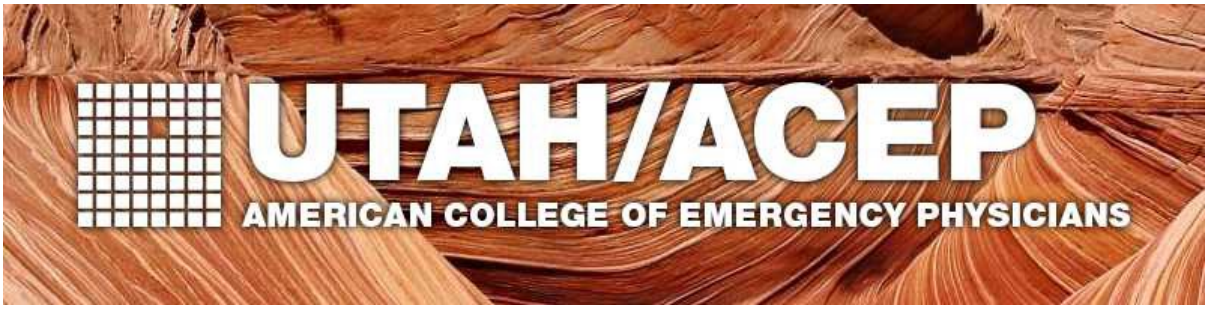

In this edition:

News from ACEP:

Hospital Quality Ratings: What Emergency Physicians Need to Know

By Tim Jahn, MD, FACEP

Hospital quality ratings—particularly **Leapfrog Hospital Safety Grades** and **CMS Star Ratings** are publicly reported online sites that can affect:

- **Reputation and patient trust**
- **Finances and payer negotiations**
- **Recruitment, retention, and staffing**
- **Administrative pressure on frontline clinicians**

The Two Rating Systems That Matter Most

1. Leapfrog Hospital Safety Grade (A–F)

Leapfrog scores focus upon patient safety and preventable harm. The "Leapfrog" rating system began in 2002 and started reporting in 2012. Developed by the Business Roundtable which included more than 60 large employers, including General Motors, General Electric, Walmart and Boeing. The companies were interested in a quality tool for the healthcare agencies they contracted with. The scores are published twice annually.

The **key domains** are: Hospital-acquired infections (CLABSI, CAUTI, SSI), Medication safety, Patient safety indicators (falls, pressure injuries, complications), Nurse staffing & safety culture.

Emergency physicians influence these scores as central lines, urinary catheters, and antibiotics often start in the ED; early documentation affects whether conditions may be coded as present on admission, ED culture strongly influences hospital-wide safety behaviors.

Bottom line: Leapfrog is highly sensitive to **early decisions, documentation, and infection prevention**, all of which frequently begin in the ED.

2. CMS Star Ratings (1–5 Stars)

CMS Star ratings utilize hospital performance using Medicare data and are published annually.

The **key domains** are**:** Mortality, Readmissions, Patient Experience (HCAHPS), Safety of Care and Timely & Effective Care.

ED physicians affect these scores as ED care sets the trajectory for mortality and complications; admission decisions affect readmissions and length of stay; communication, pain control, and discharge clarity influence patient experience scores—even for admitted patients.

Bottom line: CMS Stars reflect **patient survival and how well they understand their care**, much of which is shaped in the ED.

Why You, as an Emergency Physician, Should Care

1. Your Clinical Work Is Scored—Whether You Like It or Not

Even though emergency physicians are not individually graded, **ED-driven outcomes that are attributed to the hospital** include: sepsis outcomes, early complications, infections linked to ED-placed devices and mortality within the first 24–48 hours.

2. Better Scores Protect the ED

Hospitals with strong ratings are more likely to trust clinician judgment, invest in staffing and resources, defend physicians when metrics are challenged.

3. Ratings Affect Resources and Staffing

Leapfrog and CMS scores influence capital investments, nursing ratios, support services (pharmacy, case management), ability to recruit physicians and nurses. Stronger scores make it easier to argue for: ED staffing support, observation units, clinical pharmacists and throughput solutions.

High-Impact Ways Emergency Physicians Influence Scores

Emergency physicians can help by: Avoiding unnecessary Foley catheters and central lines, documenting device necessity and timely removal plans, clear documentation of present-on-arrival conditions, thoughtful admission decisions and handoffs, clear communication with patients and families. These actions directly affect **infection rates, mortality, readmissions, and patient experience**—the heaviest-weighted components of both ratings.

Take-Home Message

Hospital quality ratings are not abstract administrative scores. They: reflect outcomes shaped early in the ED; drive hospital behavior toward (or away from) frontline clinicians; influence resources, staffing, and professional autonomy. When ED physicians engage with quality intentionally, they help protect both patients and the practice of emergency medicine.

Step by Step: Why Walking is the Most Underrated Workout

By Robert Stephen, MD

Medicine is a two-way street. Sometimes, the patients we see teach us things about ourselves or the world or can awaken in us a curiosity about some aspect of their case that strikes a chord in us. A while back, I took care of an elderly patient with an acutely painful condition. He was lean, obviously fit, spry, with

minimal medical history. When I inquired about his obvious fitness, he told me proudly, with no small justification, he hikes over 10,000 vertical feet every weekend. In fact, he has been traipsing about the mountains of Utah for nearly 5 decades and has simply never stopped. He has stayed active, always moving. Injuries and misadventures only ever slightly derailed this lifelong habit. Not only did he not look worse for the wear, he was hale and hardy, mentally sharp, content and confident. He was in fact positively thriving and fortunately the cause of his visit that day should not hinder his perambulations in the future.

And this got me thinking about hiking. And then about plain old walking. And fitness. And longevity. And maybe, just maybe, one doesn't have to do the Utah Thing, scaling peaks year-round, running ultramarathons, or biking absurd distances to reap the benefits of exercise, including healthful longevity. One can simply walk, frequently, consistently, at a decent clip.

It turns out walking has been studied hundreds of times in the last decade and it has been shown to be an effective therapy for just about everything we as physicians are supposed to care about in our patients (and ourselves): hypertension, lipid profiles, diabetes prevention and amelioration, stroke prevention, CV disease prevention, immune function, weight management, stability, flexibility, longevity, strength and balance. And of course, mental health (I will be assiduously avoiding the "W" word here).

By the numbers: for adults, aim for at least 150 minutes of moderate-intensity aerobic activity per week. So, say, roughly 30 minutes on 5 days of the week. Even better news, shorter walks are meaningful as well: one study found that just 15 minutes per day of brisk walking was associated with nearly a 20% reduction in mortality. On the steps front, research shows that even walking 4,400 steps/day in older women was tied to a 41% lower mortality rate compared with ~2,700 steps/day, and that increasing step count further up to ~7,500 offered more benefit.

Most of us have smart phones and there is a bewildering surfeit of fitness apps. If you have a smartwatch and willingly subject yourself to the tyranny and surveillance of the infernal pairing of watch and phone, you can monitor (i.e., obsess over) your activity. If that motivates you, great. However, while it is sad to have to say it, one does not have to have a phone or watch or really even monitor steps and intensity with digital precision. People have been walking for millennia without devices and the benefits still accrue.

What about the vaunted "10,000 steps a day"? Well, yes, the more the merrier but it has been shown that you can still get substantial benefit from fewer steps, so don't get too hung up on numbers, despite what your app or watch may tell you. In fact, some data suggest the magic number may be around 7,000 steps per day, which is much more attainable. Steps beyond that may add only incremental benefit.

Intensity matters. A "moderate" pace typically means you're breathing heavier than normal, may feel your heart beating faster, but you can still talk. Brisk walking (versus a leisurely stroll about the grounds) is linked with greater reductions in cardiovascular mortality. If you ramp it up a notch (intervals, faster pace, hills, mountains) you'll increase the benefit. Consider taking the stairs instead of the elevator. While higher intensity is arguably a bit better, the main point really is even moderate walking is beneficial as long as it is done regularly. Consistency is more important than perfection.

Timing of walks has not consistently shown one time of day is better than others. However, post prandial walks may help with digestion, blood sugar levels and weight loss.

And finally, if possible, do your rounds outside. It looks as though that is better for your sense of well-being, creativity and general all-round health than inside. No real surprise there, and this is Utah. There are hills and dales, mountains and valleys, deserts and forests close by and easily accessible. But if you can't get

outside don't forgo a walk. Get on a treadmill or indoor track. Any movement is better than none.

In his fascinating book "The Making of the Atomic Bomb", Richard Rhodes tells of the inspirations and insights that came to the scientists contemplating the nature of the atom and of the universe, like Leo Szilard and Werner Heisenberg amongst others, while, you guessed it, walking. In fact, those titans of 20th century physics did a lot of walking and thinking. While it may not guarantee one a Nobel prize, there must be something to it.

Most of my patients in the ED don't ask me about exercise, but some do. I think many Americans equate exercise with cheerless gyms, over-priced fitness clubs, or harder endeavors like running and despair. I tell them about the benefits of simply walking. That walking alone can get you about 85% or so of the benefits of exercise and that it is most effective for those who are sedentary or have co-morbid conditions. It is not a panacea. To really get the full benefit of exercise and age well, resistance training and flexibility and balance exercises are also needed. But a good first step, so to speak, is the humble, free, easily accessible, routine thing we do every day. So, walk, stroll, saunter, peregrinate, amble, perambulate, hike, mosey, promenade, trek, trudge, or ramble. It's good for what ails you and just might be the easy key to living better and longer.

Article Review: NICO Trial - Noninvasive Airway Management in Comatose Patients with Acute Poisoning

By Joshua Berko, DO, PGY-3

The management of airway interventions in comatose patients with suspected acutepoisoning is a subject of significant debate in emergency medicine. The decision to intubate is often made quickly, following standard guidelines that aim to protect the patient's airway and prevent complications such as aspiration. However, there is limited evidence to suggest that routine intubation in patients

with altered mental status due to poisoning is always necessary. The NICO Trial, published as “Effect of Noninvasive Airway Management of Comatose Patients with Acute Poisoning: A Randomized Clinical Trial,” offers valuable insights into whether a more conservative airway strategy might be safer and more beneficial.

Background and Rationale

For patients with trauma or severe brain injuries, the decision to intubate is straightforward; protecting the airway is the highest priority. In cases of acute poisoning, however, the need for intubation is less clear. Current guidelines often err on the side of caution, leading to early intubation even when the patient might not have immediate respiratory compromise. But what if withholding intubation, in the absence of clear emergency criteria, results in better outcomes? The NICO trial was designed to answer this question by comparing a conservative approach of withholding intubation to routine practice in comatose patients with poisoning.

Study Objective

The objective of the NICO trial was to evaluate the clinical outcomes of patients who had intubation withheld versus those who underwent routine airway management with intubation. Specifically, the study focused on comatose patients with a Glasgow Coma Scale (GCS) score of less than 9 due to suspected acute poisoning. The researchers aimed to determine whether a strategy of withholding intubation could reduce hospital length of stay, ICU admissions, and adverse events like pneumonia, while maintaining patient safety.

Study Design

The NICO trial was a multicenter, unblinded, randomized parallel-group trial

conducted in 20 emergency departments and 1 intensive care unit (ICU) across France. It enrolled 237 patients, with 225 included in the final analysis. The trial spanned from May 2021 to April 2023 and included adult patients with suspected acute poisoning, a GCS of less than 9, and no immediate respiratory distress or other conditions necessitating immediate intubation. Patients were randomized in a 1:1 ratio to either the intervention group, where intubation was withheld unless specific emergency criteria were met, or the control group, where intubation was performed at the discretion of the treating physician.

Population and Exclusions

The trial focused on adult patients over 18 years of age with suspected acute poisoning and a GCS score of less than 9. The mean age of participants was 33 years, and 38% were female. Alcohol was the primary toxin, accounting for 67% of poisonings. Patients with pregnancy, respiratory distress, brain injury, shock, or the need for immediate intubation based on other clinical factors were excluded. Additionally, those who were incarcerated or under legal protection, as well as patients who withdrew consent or had deviations from the protocol, were not included in the final analysis.

Intervention and Randomization

In the intervention group, intubation was withheld unless the patient met emergency criteria, which included respiratory distress, seizure, shock, or vomiting. If none of these criteria were met and the patient's GCS improved to greater than 8 within four hours, intubation was no longer considered necessary. Conversely, in the control group, intubation decisions were left to the discretion of the treating physician. This allowed the researchers to compare a more conservative strategy to standard practice.

Both groups followed standard rapid sequence intubation (RSI) protocols when

intubation was performed, including the use of hypnotic and paralytic agents, pre-oxygenation, and confirmation of tube placement with waveform capnography.

Outcomes and Statistical Analysis

The primary outcome was a composite of in-hospital death, ICU length of stay, and total hospital length of stay, truncated at 28 days. The trial also tracked secondary outcomes, including adverse events related to intubation, such as pneumonia, first-pass failure, and esophageal intubation.

Statistical analysis was performed using the Finkelstein-Schoenfeld method, which allowed for a hierarchical comparison of outcomes, where death was considered the most critical outcome, followed by ICU length of stay and total hospital length of stay. This enabled the researchers to rank patients as either having a “win” or “loss” based on their outcomes relative to the other group.

Results

The results were notable. Only 16.4% of patients in the intervention group were intubated, compared to 57.8% in the control group, which reflects a significant difference in airway management strategies. Moreover, 16 out of 19 intubations in the intervention group were due to clear emergency criteria. Importantly, no patients in either group died during the study period.

The ICU length of stay was also different: patients in the intervention group had a median stay of 0 days in the ICU, compared to 1 day for those in the control group. Similarly, the total hospital length of stay was shorter in the intervention group, with patients spending a median of 21.5 hours in the hospital compared to 37 hours in the control group.

Adverse events were lower in the intervention group as well. Only 8 cases of pneumonia were reported in the intervention group, compared to 16 cases in the control group. Additionally, first-pass intubation success rates were better in the intervention group, with fewer cases of first-pass failure and esophageal intubation in patients who were eventually intubated.

The study found that withholding intubation led to a win ratio of 1.85 for the intervention group compared to the control group ($P < 0.001$), indicating a significant clinical benefit for the composite primary outcome.

Discussion and Implications

The findings of the NICO trial challenge the routine use of intubation in patients with decreased consciousness due to poisoning. By withholding intubation unless clear emergency criteria were met, the intervention group experienced fewer ICU admissions, shorter hospital stays, and a lower incidence of adverse events like pneumonia. The study provides compelling evidence that a conservative approach to airway management in these patients is not only safe but also beneficial.

There are, however, some limitations to consider. The trial was unblinded, which may have influenced physician behavior—especially in the control group where the decision to intubate was left to the clinician's discretion. This raises the possibility of a Hawthorne effect, where knowing the patient's assignment could have altered the treatment approach. Additionally, the overwhelming prevalence of alcohol poisoning (67%) limits the generalizability of the findings to patients poisoned by other substances.

Despite these limitations, the trial offers important insights into airway management for poisoned patients. The clinical takeaway is clear: withholding intubation in comatose patients with suspected poisoning, when appropriate,

leads to better outcomes, including reduced ICU and hospital stays and fewer adverse events.

Conclusion

The NICO trial provides valuable evidence that a conservative airway management strategy—withholding intubation unless absolutely necessary—can lead to better patient outcomes in comatose patients with acute poisoning. This challenges the long-standing practice of routine intubation in such cases, suggesting that less invasive approaches should be considered more frequently. This study has the potential to change practice, encouraging a more individualized and cautious approach to airway management in these complex patients.

Fit.ER.Doc

By Ben Buchanan, MD, MBA, FACEP

We all know the many benefits of exercise and how challenging it can be to fit it into our busy lives. Fit.ER.Doc features an ER Doc who has successfully "Fit-In" exercise.

This issue will feature an interview with Dr. Sean Slack.

1. Tell us about yourself and your background (your training, your practice situation, etc.).

I grew up in the midwest and migrated west for college in search of sunshine and mountains. After graduating I ended up working for a urologist in Colorado and when he took a job in SLC he offered me an opportunity to follow him. I ended up working as a critical care tech in the emergency department at the University of Utah and after medical school back in Colorado, I was fortunate to return to the U for my residency. Since graduating in 2018 I have worked for Utah Emergency Physicians in Salt Lake City. In addition to my ED work I also work at the Alta Medical Clinic and Snowbird Medical Clinic in the winters.

2. What is your current exercise regimen?

My daily goal is to get a minimum of 20-30 minute kettlebell and mobility routine.

Winters are filled with alpine and ski touring days and the rest of the year on my bike. I also play hockey once or twice a week. And anytime I can get away for longer periods of time you'll probably find me on my raft rowing whitewater.

3. How has your exercise regimen changed over the years?

When my team sports days came to an end after college I got into cycling and this really was my focus for my late 20's & 30's. Combined with ski touring, my focus shifted away from pure strength training to more of an endurance focus with long days outside. Now that I have less time, an equal part of my exercise training is focusing on my dietary intake. I have done intermittent fasting for a good part of the past 5 years and found that it has been very beneficial. With a variable schedule, I've found this particularly helpful to avoid eating excess calories after 8pm even if I am on shift or coming home late or working overnight.

4. What are some of your fitness high points and low points?

A recent high point was riding the Wild Horse gravel race this summer with my wife on our tandem. I hadn't really had much time for dedicated cycling training coming out of ski season so it was really rewarding to jump on the bike and be able to enjoy the ride with a baseline level of fitness. My biggest low point is that I cannot really enjoy running anymore due to a knee injury. I miss throwing on a pair of sneakers and heading out the front door to clear my head and my lungs. Not ready for a knee replacement yet but it's coming somewhere down the road!

5. What are your current short-term and long-term fitness goals?

With snow around the corner, I'm focussing on core strength and flexibility. The further I get past 40 the more I've focussed on injury prevention, particularly overuse injuries of certain sports. I'm fortunate to get to ski with the patrollers

from time to time so that's always good motivation to stay fit and be able to keep up with the young bucks and the old timers who can still get around the mountain like they're 30, it's incredible. For the longer term, I have my eyes set on our first family bike tour. Our kids are getting close to fitting on our two tandems (thanks Dr. Stroud for the hand me down!) so I have my eye on a few routes on which we can all push ourselves individually and as a family.

6. Any fitness tips or mottos you would like to share?

Eat Less, Walk More - credit to Dr. Larry Gaul, friend, mentor and cardiologist.

7. Who is your favorite or most inspiring athlete?

My sister-in-law Courtney. She has cystic fibrosis but has been fortunate to stay healthy through an active lifestyle. Over the 20 years I've known her I've seen her accomplish so much in the endurance sports world that previous CF patients would have never dreamed of. This summer she summited Mt. Rainier without supplemental oxygen. Her dedication to her own health and fitness is really impressive and continues to motivate me when I'm feeling tired or lazy. It was great to support her in the local CF charity ride this summer and with her new medication regimen (thanks science!) I look forward to continuing to adventure with her for many more years.

8. How do you fit in fitness?

I've had to learn to get more bang for my buck with less free time. Raising young kids and combined with a variable (and often over-booked) schedule has made me shift my focus from daily multi-hour adventures to a more consistent program that I can achieve.

9. How has exercise benefited you?

Innumerable ways. Certainly having a baseline level of fitness has taken me to places in the world that many will only see in pictures. This has often been with friends and family and now being able to get my kids to these places is all the more special. Reconnecting with hockey has also reinforced what an important role team sports had on me. Working as a team in the ED and across the hospital is crucial so drawing on those prior experiences has had a big impact on my medical practice.

10. How do you prescribe exercise to your patients?

See #6 (and Dr. Stephen's article). The benefits of walking are so powerful but our society has shifted so far away from this. I try to encourage people to walk after meals as well as for short errands or easy trips around their neighborhood.

FROM NATIONAL ACEP

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

ACEP Resources & Latest News

ACEP Advocacy Win: DEA Issues Long-Awaited EMS "Standing Orders" Final Rule

In a long-awaited victory, the Drug Enforcement Agency (DEA) issued the **Registering Emergency Medical Services Agencies under the Protecting Patient Access to Emergency Medications Act of 2017 Final Rule** to ensure continued access to pain and anti-seizure medications for patients experiencing medical emergencies. **Read more**.

Updated ACEP Policy Raises Standard for Emergency Physician-Led Care

On January 27th, the ACEP Board of Directors voted to amend the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." **Read more**.

2026 HHS Funding Update

A bipartisan bill passed by Congress today funds the government through September 30, 2026. New HHS funding means bipartisan support for ACEP-led efforts. **Read more**.

ACEP Will Not Endorse New Sepsis Guidelines from the Surviving Sepsis Campaign

After a thorough and comprehensive review by a panel of experts convened from the membership of the College, the American College of Emergency Physicians (ACEP) today informed the Surviving Sepsis Campaign (SSC) that ACEP will not endorse the organization's latest update to guidelines for treatment of sepsis in emergency departments. **Read more**.

NYACEP-Supported Law Strengthens ED Security and Violence Prevention

A new law championed by the New York chapter of ACEP (NYACEP) requires hospitals in the state to establish violence prevention programs. **Read more**.

Emergency Departments Should be Safe Zones for Patients

The American College of Emergency Physicians (ACEP) is committed to ensuring that emergency departments remain places where all individuals can safely seek emergency medical care without fear. **Read more.**

ACEP Advocacy: Advancing Rural Care, Opposing Non-Competes, Fighting Bad Insurer Behavior

ACEP advocacy keeps delivering key wins for emergency medicine at the federal and state levels. The newest installment of our **members-only Capitol Rounds webinar series** keeps you current on advocacy wins, policy changes and important developments in DC and across the country. **Read more**.

ACEP to Congress: Stronger Policies, Accountability Can Stop Bad Insurer Behavior

The American College of Emergency Physicians (ACEP) welcomes today's Congressional hearings examining the bad insurer behavior that drives up premiums and increases health care costs for millions of people, limiting access to affordable insurance. **Read more**.

ACEP and National Health Care Groups Issue Joint Statement on Pediatric Readiness in Emergency Departments

The lives of more than two thousand children could be saved with new recommendations included in a **joint statement** issued by organizations focused on caring for young people in emergencies. **Read more**.

ACEP Leads Call for CMS Guidance on Signage to Prevent Violence Against Health Care Workers

The American College of Emergency Physicians (ACEP) and a coalition of health care organizations **sent a letter** urging the Centers for Medicare & Medicaid Services (CMS) to issue guidance that facilitates the posting of signage in emergency departments (EDs) discouraging violence. **Read more**.

Update on ABEM Physician Portal

ABEM recently transitioned to a new physician portal, MyABEM, and some physicians experienced account access challenges during the transition. **Read more**.

Upcoming ACEP Events and Deadlines

- **Talk with Tony**
  February 12, 2026
  6:00 PM – 7:00 PM Central Time
  Join ACEP President Dr. Tony Cirillo for his monthly chat with ACEP members. Get the inside scoop on the latest at ACEP and in emergency medicine.

- **Capitol Rounds: The Plot Thickens in DC and Statehouses**
  February 25, 2026
  2:00 PM – 3:00 PM Central Time
  Capitol Rounds is back—and the plot is definitely thickening. Join us for a fast, practical rundown of the latest developments important to emergency medicine in Washington, DC, and across statehouses nationwide, including key legislative and regulatory moves, what's gaining traction, and what to watch next.

- **The Role of HHS in Disaster Response and MASCAL Response and Medicine**
  March 17, 2026
  12:00 PM – 2:00 PM Central Time
  Explore key concepts, practical considerations, and real-world applications relevant to emergency medicine, disaster medicine, and prehospital care professionals. Gain insight into current challenges, emerging best practices, and strategies that can be applied across a variety of clinical, operational, and disaster response settings.

- **2026 ACEP Leadership & Advocacy Conference**
  April 26 – 28, 2026

Washington, District of Columbia
Join your colleagues in Washington, DC, and make your collective voices heard to inspire change for your patients and your specialty.

- **2026 ACEP Scientific Assembly**
  October 5 – 8, 2026
  Chicago, Illinois
  The world's largest emergency medicine educational conference bringing together the global EM community. Registration is coming soon!

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