On the Streets
CARING FOR HOMELESS PATIENTS IN THE EMERGENCY DEPARTMENT

By Ashley Larrimore, MD and Sam Licciardo, MD
UMass Memorial Medical Center

Homelessness is a major problem in the United States. The Department of Health and Human Services defines a homeless person as “an individual who lacks a fixed, regular, and adequate nighttime residence.” This includes those living on the streets, in shelters, hotels, or temporarily staying with friends, relatives, or neighbors. In 2011, the U.S Department of Housing and Urban Development’s Continuum of Care point-in-time count identified 636,017 people who were homeless in the United States, with 166,644 of these individuals living in Massachusetts. In Worcester County alone there were 1,315 homeless men, women, and children. Of these individuals, 919, nearly 70% were part of a homeless family. According to the Massachusetts Coalition for the homeless, the number of individuals experiencing homelessness in the state has more than doubled since 1990.
Prescription opioid overdose and drug poisonings are a growing problem in the US and a common presenting diagnosis for patients seen in the Emergency Department (ED). There is data which suggests that more people in Massachusetts are dying from drug overdose than from motor vehicle accidents. The CDC estimates a 400% increase in death from opioid overdose between 1999 and 2010 with 16,000 opioid deaths in the US in 2010. There are close to 500,000 ED visits a year for prescription pain killer drug overdoses. Harm reduction strategies for opioid overdose are necessary and the ED is uniquely positioned to provide interventions for these patients.

Since 1999, overdose education and naloxone distribution (OEND) programs have been implemented in many communities across the nation such as NY, Chicago, San Francisco, New Mexico and Massachusetts. These programs target those either at risk of opioid overdose, or likely to be bystanders in an overdose, and provide education on the prevention and recognition of an overdose, and on effective overdose interventions such as administering nasal naloxone, performing rescue breathing, and calling 911. They distribute nasal naloxone rescue kits for use in the community during a witnessed overdose while waiting for EMS services to arrive. Traditionally, these

“50,000 individuals were trained in OEND, resulting in over 10,000 opioid overdoses reversed with nasal naloxone in the community”

Steps After Residency: What do Massachusetts EM Residents have planned for the future?

By Jasmine C. Mathews, MD
Boston Medical Center

Physicians are constantly preparing for the “next step.” It is natural, then, that EM residents are already thinking about their post residency position just as July 1 of intern year rolls around. What do we need to know about finding a job? What makes us good candidates? Is my training program setting me up to be a competitive candidate and successful physician? I polled the graduating class of EM residents in the five Massachusetts programs and asked them about their job search experiences this year in an effort to answer some of these questions.

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Photo from GoLocalWorcester.com

As Emergency Physicians, we serve a disproportionately high number of homeless patients. While the disease processes that affect these patients are often no different from housed patients, and include hypertension, diabetes, peripheral vascular disease, respiratory disease, chronic liver disease, infectious diseases, and chronic renal disease, their social circumstances often complicate efforts to manage and treat these diseases. According to the National Health Care for the Homeless Council, homeless individuals are three and half times more likely to present to and ED secondary to complications from lack of simple hygiene, nutrition, and first aid.

Mental health concerns comprise a large amount of ED visits. Homeless individuals are more likely than the general population to have schizophrenia, depression, and substance abuse problems, according to D’Amore et al., Acad Emerg Med 2001. Routine screening for substance abuse and depression is important in these patients, regardless of their chief complaint. Clinicians should be aware of what resources, such as case management, are available in their community. Coordinated treatment for individuals with mental illness and substance abuse, as noted by Fitzpatrick-Lewis et al, BMC Public Health. 2011, results in better clinical outcomes then care that does not involve case management.

Other illnesses that may be more frequently seen in our homeless patient population are skin diseases like scabies, eczema, and cellulitis. Homeless men and women are also more prone to infections such as tinea pedis, as well as non-infectious foot pathologies like neuropathy, plantar fasciitis, corns, and calluses that are both painful and inhibit their ability to carry out their daily activities. In addition, exposure to cold weather and rain can cause problems like frostbite and trench foot, which if left untreated, can be limb threatening. Clinicians should remember that patients may not have access to basics like clean dry clothing and socks, properly fitting footwear, or the ability to pay for medications that may be costly and require a long course of treatment.

Respiratory illnesses such as pneumonia, influenza, or tuberculosis are some of the more serious and common presentations among homeless patients and are a major cause of morbidity in this population. Individuals suffering from alcohol, drug, and tobacco addiction; and those with HIV have a particularly elevated risk of developing these illnesses. If possible, emergency physicians should consider immunizing their homeless patients against influenza and pneumonia before discharge, especially if these patients do not have a regular source of care. Clinicians should also consider tuberculosis in the differential diagnosis in their homeless patient who present with cough and a fever for more than one week as they are at increased risk for the disease.

Many organizations are dedicated to the fight against homelessness. These organizations, such as the Massachusetts Coalition for the Homeless (MCH) work toward advocating for those who cannot advocate for themselves. Working with and teaching legislators about what we see every day, in the trenches are of utmost importance. It is our job to provide context for our law makers. For example, MCH notes that “between the implementation of the new regulations last fall and February 22, 2013, at least 135 families

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who received shelter only did so after first staying in a place not meant for human habitation.” Therefore legislative language should exist that allows shelter for families at “imminent risk of staying in a place not meant for human habitation”. That’s like saying you need to go into V-fib arrest from your STEMI before we’ll activate the cath lab. As Emergency Physicians, with the help of social workers and case managers we can identify those at risk and those who need appropriate housing. We can also advocate with local, state, and national organizations to impact change. Thanks to the hard work of many, an amendment was added to include language, which allows families to have access to formal shelter before staying in places ‘not meant for human habitation’.

“There is no typical homeless person, [they] come from all walks of life.”

Finding shelter can be an ominous task. For Lauren Eidt-Pearson, social worker at UMass Memorial Medical Center Emergency Department, “It is always a challenge to figure out ways to help people improve their situations. Often, resources can be provided but the person may not be able to follow up or follow through with the plan or resources that were provided to them.” It is not uncommon to have difficulty finding shelter for individuals. Some community-based organizations keep daytime hours only, and some shelters requiring prior application, eliminating ability to just walk in. Despite this, organizations are making strides to improve sheltering for ED patients. Per Ms. Eidt-Pearson, Community HealthLink in Worcester has many services available and we are currently working with CHL on a program that targets high ED utilizers. “Many patients referred to us have multiple ED visits in one year. These patients are offered the program and assigned a case manager who assists with setting up a PCP, mental health services and works on referrals to housing and other community based services.”

Hopefully by understanding more, we can provide better care. As Ms. Eidt-Pearson says, “there is no typical homeless person, [they] come from all walks of life.” We are Emergency Physicians; we are the safety net, open 24 hours a day, 7 days a week, and wanting to take care of anyone who walks in the door. In the end, we can simply take better care of our homeless patients by “listening to what they are saying, because those who really need help, may not ask for it.”

Special thanks to the editor of this article, Andrew Eyre, MD

Harvard Affiliated Emergency Medicine Residency
Across the board, Massachusetts trained graduating EM residents felt competitive in both the local and the national job markets. Approximately 30% of respondents felt that their training program made them equally competitive to other candidates, while 13% felt that their program made them more competitive than other candidates. A majority of respondents felt that promoting the strength of their residency training program was just as important as promoting their own accomplishments. Some of the most distinguishing accomplishments in the job search included being chief resident, other leadership positions, research experience, and publications. Other polled EM residents noted that unique elective experiences, whether international or local, were frequently a topic of conversation on job interviews. In addition, non-medical accomplishments such as prior jobs or other advanced degrees were also an interview focus.

Gathering information about the application process and about specific job availability was identified by our graduating colleagues as challenging. Resources such as EMRA, ACEP, MACEP and Google were helpful. In contrast, EM Job fairs were rated by residents as hit or miss in the job search process. Program directors and recent program alumni, however, were universally the most helpful resource. It was clear that establishing and cultivating contacts, networking, and contacting administrative staff directly was essential.

And so, you’ve found that job, and you’re about to sign… 20% of graduates said they had a lawyer look over their contract, but the vast majority did not. A handful enlisted the help of their program directors to review their contracts. No respondent negotiated their salary. Some, however, extended their start date, obtained their signing bonus early rather than over a prolonged period of time, and received coverage for their moving costs.

I asked these graduates to share some words of wisdom to current EM residents, and this is what they said:

- “Start early. Keep in touch with the places you are applying to and go to informational interviews (even if they don’t have a position open yet). Positions may open up in the future. Don’t feel like you have to take the first job.”
- “Choose the geographic location where you want to live first. Then find the hospitals in the area that match what you are looking for (community vs. academic, volume, coverage). Send your resume to those ED directors and you’ll find the right job.”
- “Identify places you are interested in early so that you can take second looks if you need to.”
- “Do not be passive about the search and do not sell yourself short. Timing is everything. Almost every job that initially told me they did not have a job ended up having one a couple of weeks to months later.”
- “Be persistent.”
- “Find a job where you will be happy, and where the staff is supportive of your development, stability, and happiness.”

And lastly,

- “Everyone gets caught up in the pressure of finding THE job. I kept telling myself that it was only A job... one of many out there. We all have ideas of what we want, but really have no clue. It’s no big deal if you go to a job for a year and find out it’s not for you and move on. Take everything as an opportunity to learn about things you do and do not want. Relax and remember - it’s only a job.”

Special thanks to the editor of this article, Kristin Dwyer, MD

Boston Medical Center
A Rant!
Antibiotics for Acute Pharyngitis

His name is Tucker Ford Webb, a PGY3 EM Resident at UMass Memorial Medical Center. Tucker is emphatic about many things, but as he is currently working in the pediatric emergency department this month, he has set his laser sights on the common practice of prescribing antibiotics for a sore throat. I sat down with Tucker to hear his thoughts... readers beware, he means business!

By Tucker Ford Webb, MD and Sam Licciardo, MD
UMass Memorial Medical Center

Dr. Webb starts out, “The treatment of streptococcal pharyngitis is based on a 1974 study.” Almost immediately an emphatic first year EM resident, who will remain nameless, shouts out, “Oh yeah! That’s bullS#! right!”. Obviously this topic is near to many an EM resident heart. Dr. Webb continues, “we learn about this in medical school, specifically, the need to prevent the suppurative and non-suppurative complications.” The suppurative complications include sinusitis, although research has never proven that sinusitis is prevented by giving antibiotics; otitis media, which is easily treated if it develops and probably deserves a higher dose of amoxicillin anyway; and peritonsillar abscess, which may be slightly reduced by giving antibiotics, but if it happens, it was going to happen anyway.

The non-suppurative complications are of interest to a lot of people, especially rheumatic heart disease, which actually has an associated mortality. But as Dr. Webb points out, “No one has had rheumatic heart disease directly attributable to streptococcal pharyngitis in the past 40 years in the US, and there hasn’t even been a causative or even temporal connection between strep throat and rheumatic heart disease.

There was a study in the 1970’s, finding that patients treated with antibiotics were slightly less likely to develop rheumatic heart disease, and by slightly, we are talking a reduction from 2% to 1% in the study population. But these numbers don’t make sense. These numbers are way high.” Regarding post-streptococcal glomerulonephritis, “There is a connection to strep pharyngitis, but antibiotics don’t prevent it from developing.” How about scarlet fever? “This non-suppurative complication is easily dealt with as it comes up, and besides, it’s
Antibiotics for pharyngitis continued

generally self-limiting."

So what about the argument that antibiotics make you feel better faster? The average duration of symptoms of strep throat is about 6 days, and if you get antibiotics, it’s about 5½ days. Dr. Webb queries, “Is twelve hours worth the risk of diarrhea, C. diff, and anaphylaxis, which are all more common than complications from pharyngitis itself and far more serious?” Now if kids have DM or other comorbidities, your approach may vary. Treating conservatively is probably reasonable when the picture is complicated, but for an otherwise healthy patient with strep throat, Dr. Webb opines: “There’s no reason to treat with antibiotics”. And although the Centor criteria constitute a useful diagnostic algorithm, and rapid and DNA strep tests are widely available, “If you are not going to treat anyway, what is the point of testing in the first place? So forget about the Centor criteria, and forget about swabbing these kids’ throats.”

And with those final words of wisdom, he’s off to see the next patient…

Special thanks to the editor of this article, Michele Schroeder, MD
Baystate

Are ED Clinical Directors Born or Made?

In our rapidly changing healthcare environment, healthcare administration is becoming an everimportant component of healthcare delivery. Emergency Physicians are uniquely situated to take on these roles. We speak the language of most specialties and are faced with logistical problems outside the realm of strict medical care every day. Dr. Rafael de la Puente, a PGY2 EM resident discusses training in this exciting field!

by Rafael de la Puente, MD
UMass Memorial Medical Center

Since starting residency I have always been intrigued by the Emergency Medicine (EM) Administrative Fellowship. I had the pleasure of meeting with Dr. Martin Reznek, Vice-Chair of Clinical Operations and Director of the Administrative Fellowship at the University of Massachusetts Medical School to give me more insight on the topic.

So what exactly is the main goal of the Fellowship? The main purpose of the Administrative Fellowship is to provide the opportunity for emergency physicians to develop their administrative skills so that they can become leaders in the delivery of emergency care and health care in general. Fellows focus on learning to optimize ED quality and operations while also gaining an in-depth understanding of how the ED interacts within the greater healthcare system. Specifically, fellows learn to maximize organizational efficiency and to improve both individual and departmental patient care. Fellows are involved in multiple ED and hospital committees, and special focus is given to personal accountability in various improvement projects as well as local/national EM organization involvement.

Fellowship length ranges from one to two years. Specifically, UMass encourages a two year training program in order to pursue a concomitant Master’s Degree. It is unclear exactly how many programs there are nationwide, but when looking for a fellowship in Emergency Medicine Administration, look for one with clear educational goals and a curriculum that is well established. It is also essential to seek a program that employs physician and non-physician leaders who have broad knowledge and experience in hospital and health care system administration in urban, academic and community settings. Emergency Department administration is a very important component of the specialty of Emergency Medicine, and subspecialty training places Emergency Physicians in the unique position to be leaders in healthcare.
Do you want to write for the EM Advocate?

The EM Advocate is looking for intelligent, creative, and interesting articles to highlight resident thoughts and opinions throughout the Commonwealth of MA. Subject matter can include topics of social responsibility, interesting cases, scientific advances, emergency medicine subspecialty issues, grass roots activism, and opinions regarding public or hospital policies, etc. Please contact your residency’s MACEP representative or the Editor for opinions, ideas, and article submission. We look forward to hearing from you!

Sam Licciardo, MD
Editor in Chief, EM Advocate
Samuel.Licciardo@umassmemorial.org

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Please send correspondence to:

Sam Licciardo, MD
Samuel.Licciardo@umassmemorial.org
UMass Memorial Medical Center
Emergency Medicine
55 Lake Avenue North
Worcester, MA 01655