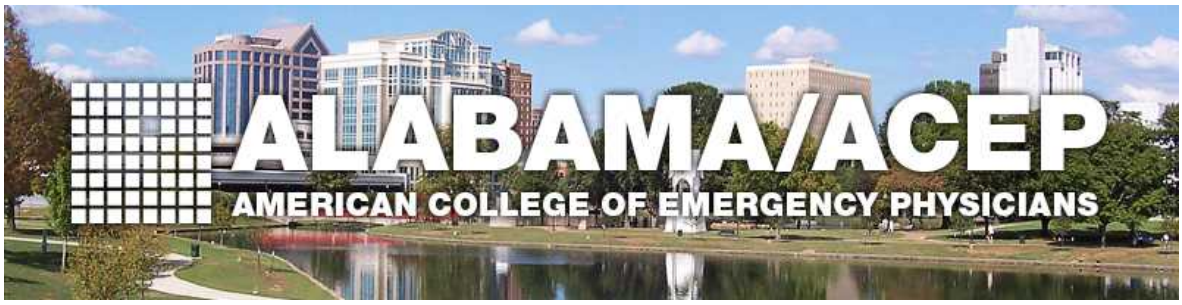
A Newsletter for the Members of the Alabama Chapter

Summer 2018



Michael Bindon, MD, FACEP
Alabama Chapter President

Denise Louthain, Executive Director
Phone: 877-225-2237 | Website

ALACEP President's Message
Michael Bindon, MD, FACEP

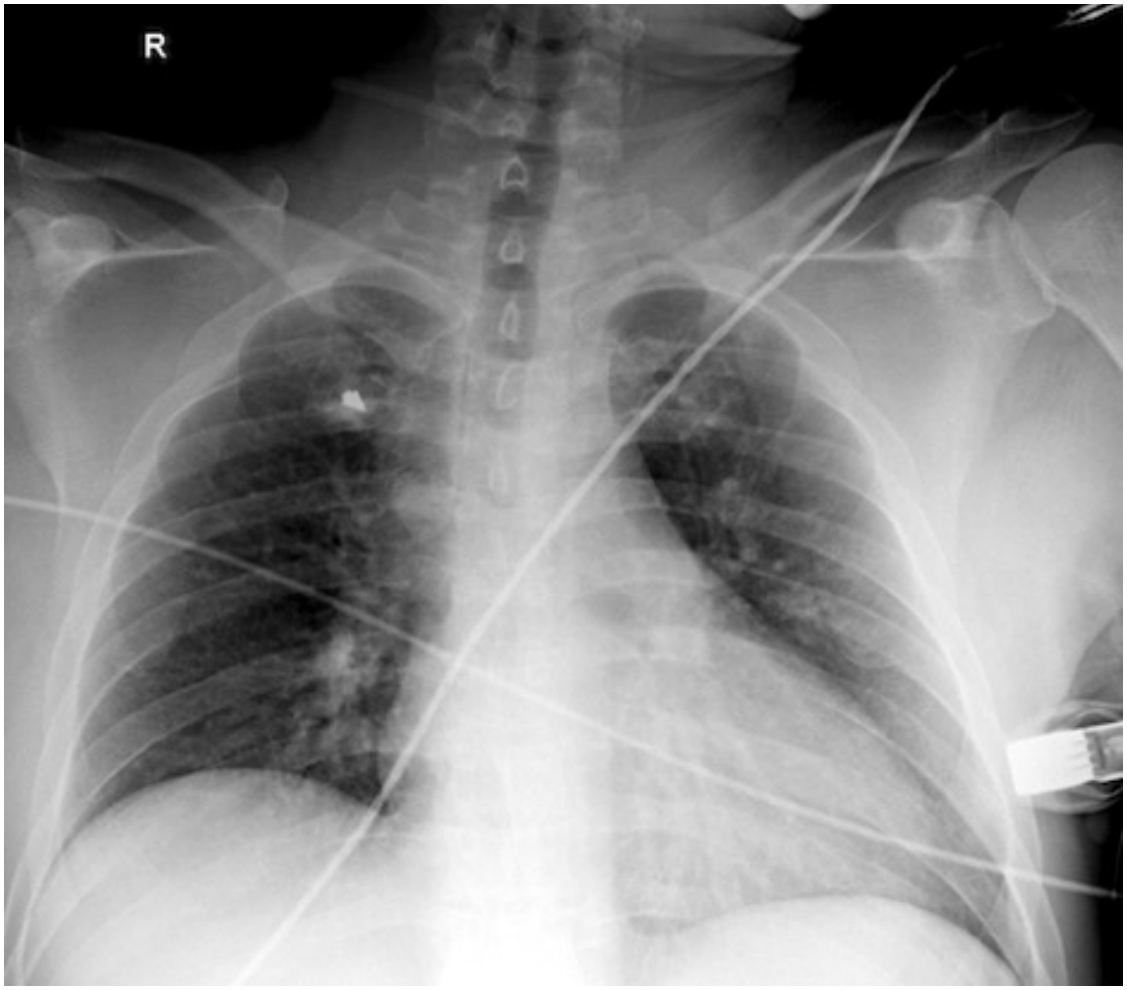
July is always an exciting time of turnover and transition in medicine. July includes first year med students in anatomy labs, new interns getting used to the long coats, and freshly minted attendings starting their post-residency careers. It is also the time when our state chapter passes the leadership reigns. As your new President, I would first like to say thank you to our immediate past President, Dr. Sarah Nafziger. Dr. Nafziger was our first president to serve the new two-year term and did a phenomenal job leading us and representing EM in our state over the past two years.

Thank you also to Dr. Annalise Sorrentino for organizing the Southeastern ACEP Chapters Educational Conference in Sandestin last month. Those in attendance know this a great multi-state conference with outstanding lectures and great networking opportunities. Please mark your calendars for next year's conference which will be in Sandestin from June 3rd to June 6th, 2019.

Our chapter's mission is to be the voice of EM in our state as well as responding to the practice needs of our members through education, information, and advocacy. We are looking forward to a great year and plan on serving our members by fulfilling that mission. Alabama ACEP is a relatively small state chapter so the best way to accomplish this is through having lots of active member involvement. Please consider serving on committees, coming to meetings, or contacting us about issues that are important to you so that we can best represent you. Thank you for allowing us to serve you and thank you for everything you do each day as Emergency Medicine physicians!

Ultrasound Use in Diagnosis of Hemopericardium
David Pigott, Md, RDMS, FACEP
Co-Director Emergency Ultrasound, UAB

This very cool case involves a 37M who sustained a stab wound to the R chest with a screwdriver (unknown type) just prior to arrival. The patient was pale and cool on arrival with decreased responsiveness, SBP 90s. CXR was unremarkable. Note the x-ray marker in the right upper chest marking the stab wound.

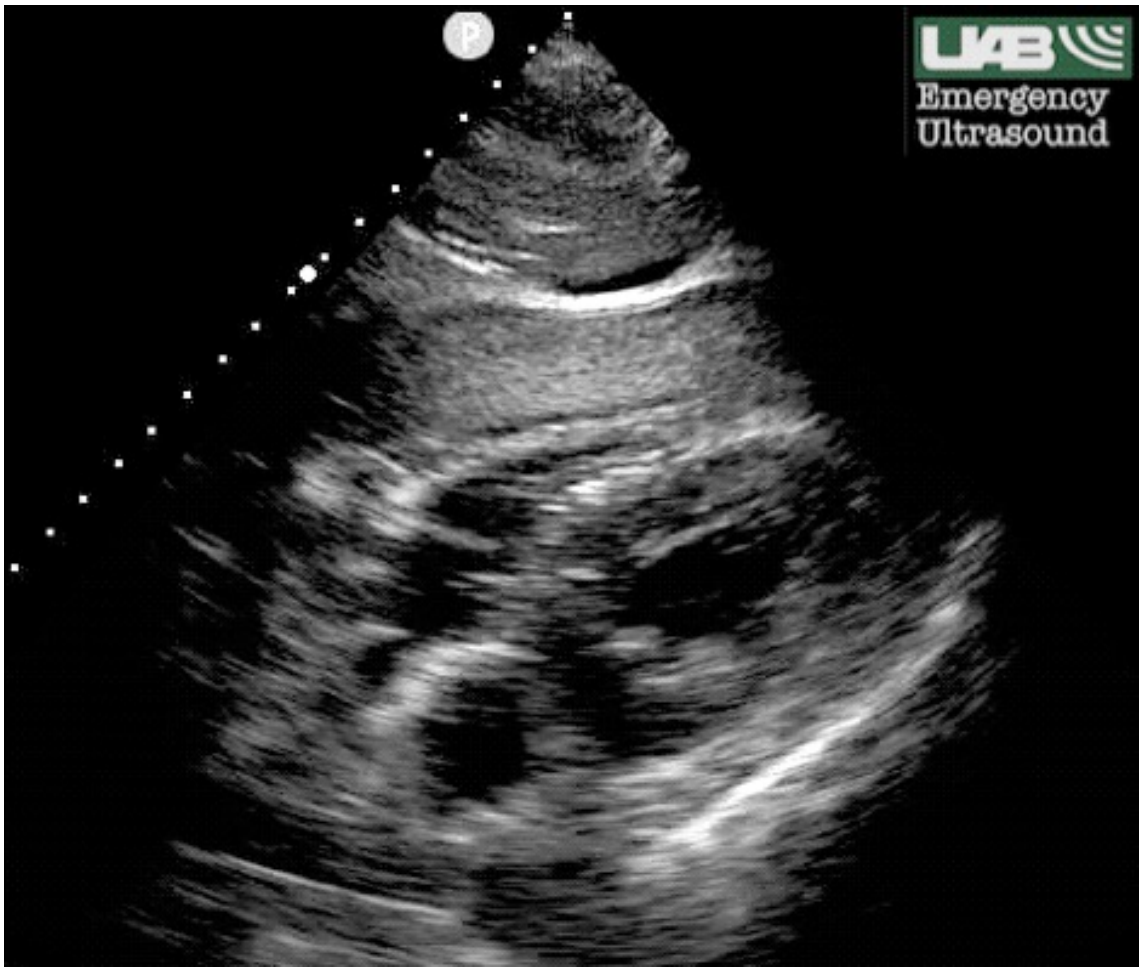


The evaluation of the patient with penetrating trauma to the chest should include rapid bedside echocardiography to rule out penetrating cardiac injury. Injuries within “the box” are much more likely to cause this type of injury. The boundaries of “the box” are defined as follows: upper border: suprasternal notch, lower border: costal margin and nipples laterally.

A 1995 study by Nagy et al demonstrated that rapid bedside echo of clinically stable patients with penetrating injury in proximity to the heart was valuable in the identification and treatment of occult cardiac injuries.

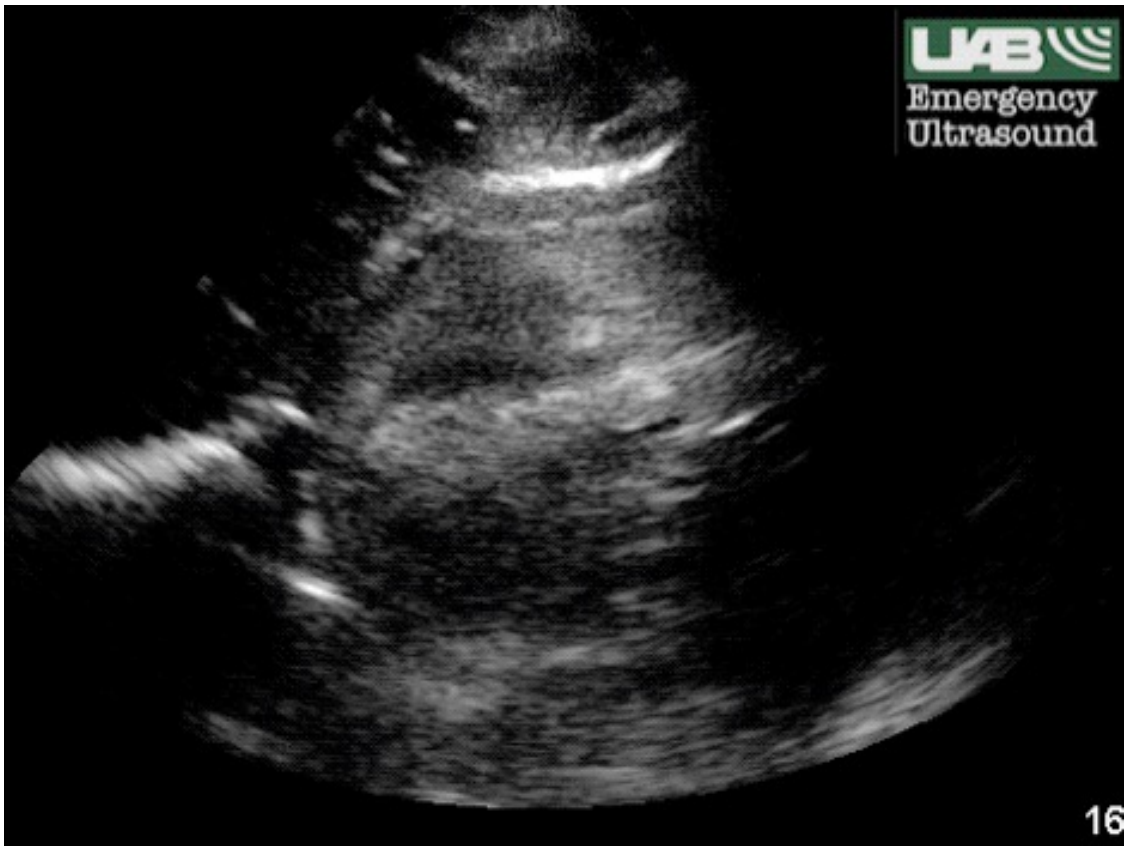
Nagy KK, Lohmann C, Kim DO, Barrett J. Role of echocardiography in the diagnosis of occult penetrating cardiac injury. *J Trauma*. 1995 Jun;38(6):859-62.

It should be noted that penetrating cardiac injury can also occur from thoracic injuries outside the box:



Claassen CW, O'connor JV, Gens D, Sikorski R, Scalea TM. Penetrating cardiac injury: think outside the box. *J Trauma*. 2010 Mar;68(3):E71-3.

Once again, a rapid bedside ultrasound provided a potentially life-saving diagnosis:



Images reproduced with permission from the UAB Emergency Ultrasound Department.

Focus on Emergency Nurse Practitioner Education and Certification

Melanie Gibbons Hallman, DNP, CRNP & David House, DNP, CRNP

Nurse practitioners (NP) of all specialties have been in emergency departments (ED) since the 1980's. Emergency nurse practitioners (ENP) are on a similar trajectory as emergency physicians were more than 30 years ago in the movement toward recognition of emergency medicine as a physician specialty in terms of scope of practice, service, and standards. In 2016 there were over 222,000 nurse practitioners working in the United States. Of this number 13,320 were practicing in emergency services and ninety-three per cent of them were academically prepared as Family Nurse Practitioners (AAENP,

2016). In 2018 the American Association of Nurse Practitioners reported the number of NPs working in emergency services to be greater than 14,000 (AANP, 2018).

Many emergency department physician groups include nurse practitioners but may not be fully aware of the content of academic preparation for various nurse practitioner specialties. NPs train exclusively within a declared specialty versus physicians who begin as a generalist, then specialize in residency and fellowships. The content of nurse practitioner academic and clinical preparation, state regulations, and initiatives to strengthen and formalize academic training for the ENP specialty continue to evolve to meet current demands. The academic preparation of advanced practice nurses working in emergency services varies, mostly consisting of Family Nurse Practitioner (FNP) and Acute Care Nurse Practitioner (ACNP) specializations. To align with the Advanced Practice Registered Nurse consensus model for specialty nursing practice, and to meet requirements of other national accreditation standards for professional nursing practice, an emergency nurse practitioner certification examination (ENP-C) was launched in January 2017 (AAENP, 2017). The certification exam for ENPs is only available to FNPs. This is because FNPs are trained across the age continuum, and a large majority of ED patients present with nonemergent complaints for which the FNP is academically trained to manage. FNPs may sit for the ENP-C exam via three options: (1) within an immediate 5-year period, verification of 100 hours of continuing education including 30 hours of emergency-specific procedural skills and proof of 2,000 emergency practice hours as an FNP, (2) completion of an academic master's or post-graduate ENP program, or (3) completion of an approved emergency fellowship program.

Entry-level competencies for nurse practitioners in emergency care were initially published in 2008 by the Emergency Nurses Association (ENA). Members of the American College of Emergency Physicians (ACEP) were involved with the work group that developed these competencies. The American Academy of Emergency Nurse Practitioners (AAENP) published revised Practice Standards for the Emergency Nurse Practitioner specialty in June 2018. These practice standards are based on team-centered care with the ENP practicing as part of an interprofessional ED team or when collaborating remotely with physician colleagues (AAENP, 2018). Practice standards provide a way to evaluate performance by measuring outcomes based on the five domains of ENP practice. ENP-C certification examination domains include medical screening, medical decision making/differential diagnosis, patient management, patient disposition, and professional, legal and ethical practices. This year the ENA is convening the ENP Competency Revision Work Group to work with stakeholders to review and revise the 2008 ENA competencies for the ENP. This work is projected to be completed in early 2019.

Academic preparation specific to the emergency nurse practitioner was first instituted at UT Houston School of Nursing in 1994. There are 10 graduate level academic programs and 16 clinical fellowship programs across the United States recognized by AAENP. In Alabama there are two recognized academic programs for ENP education located at The University of Alabama at Birmingham and Samford Schools of Nursing. Academically trained ENPs are prepared to provide primary care, acute resuscitation, and management of complex, unstable conditions in patients of all ages. The increased demand for specialized preparation of NPs to practice in the emergency setting is growing. Strategically addressing consistency of NP preparation in the emergency specialty along with emergency specific credentialing and training are primary focuses of AAENP, who professionally collaborates with ACEP, the ENA and the AANP in this objective.

Professional collaboration with emergency physicians and other key members of the emergency team is crucial to enhance the ENP role. As a complete team, we can meet the growing needs and numbers of patients seeking care in the ED setting. Ongoing interdisciplinary collaboration among members of our professional emergency organizations (ACEP, AAENP, ENA) is essential to developing solutions for the challenges affecting ED patient care in today's everchanging healthcare environment.

Links:
AANP Certification Board Emergency Nurse Practitioner Specialty Certification
AAENP Practice Standards for the Emergency Nurse Practitioner Specialty
ENA Competencies for Nurse Practitioners in Emergency Care

Precipitous Delivery in the Rural Emergency Department
Sean Vanlandingham, MD, MBA

The phone rang, waking me abruptly from my brief, but well-deserved nap. I was at the tail end of my favorite type of night shift. Busy, critical, and exciting at the beginning with an empty ED by 3am. I had tucked myself into our physician call room, optimistic that I could finish the shift in recumbence. The phone rang again, jarring me back into reality. As I picked up the receiver I heard my nurse's voice, "Hey doc, we've got a pregnant woman who might be ready to deliver." Now awake, I quickly made my way to the patient while simultaneously dusting off my long neglected mental archives for ED delivery.

The conclusion to this story is a happy one. 35 minutes later I found myself being thanked effusively by the family of a young, new mother who was holding her infant happily in her arms. Mother and baby transferred safely to the nearest hospital with labor and delivery, about 40 minutes away.

As ED physicians in the rural community, we worry most about the potentially unhappy birthing stories. The thought of shoulder dystocia, cord prolapse, nuchal cord, breech presentation gives all of us immediate heartburn. This is before we even consider the possibility of neonatal resuscitation. After my success story, I went home and proceeded to devour the literature on emergency obstetrics, worried that the next one might not be so easy. I am extremely grateful to Dr. Tanya Hoke and Dr. John Woods, OB/GYN physicians at UAB who volunteered their time to discuss with me the various scenarios and complications associated with delivery in the emergency department.

Below is my attempt to distill the collective wisdom I've gleaned regarding rural EDs without OB coverage facing an imminent delivery:

1. **If you can safely transfer the patient, you should.** Don't try to be a hero. If the mother is progressing slowly and it appears you have time, arrange for a transfer to the nearest facility with L&D. If there are significant complications such as cord prolapse or footling breech, do everything you can to send the patient to a hospital with L&D for emergent C-section.
2. **Use your bedside ultrasound.** It takes minimal ultrasound training to find a heartbeat and determine whether the head is down or up. Practice on your patients who are not in labor so that when the time comes you know what to look for.
3. **When deciding if transfer is safe, consider 1) the cervical exam and 2) the mother's parity.** A primigravid patient at 6cm dilation will reach 10cm in 2 hours on average. A multigravida patient at 6cm dilation will reach 10cm in less than 30 minutes on average. For this reason, the cervical exam alone is not enough to determine whether a patient is safe for transport. Discuss with the receiving OB and make a joint decision based on the specific patient you are caring for. As a precaution, just prior to putting a patient on the ambulance, do one more cervical check to ensure that they haven't progressed to a point where transfer is unsafe.
4. **If you have to deliver…be ready.** There are select scenarios in emergency medicine that we encounter only a few times in a career, but we must be ready to do them on any given day. Make it a practice to review your OB algorithms

regularly, so that they are fresh in your mind. When you are in the moment, there won't be time to "look it up". See below for helpful FOAM resources to help you.

- **Labor and Delivery in the Emergency Department**
- **Precipitous delivery in the ED**
- **The Difficult Delivery: Breech Presentation**

Wilderness Medicine Update
Walter Schrading, MD, FACEP, FAWM | Associate Professor Director, Office of Wilderness Medicine

Wilderness Medicine encompasses the skills and knowledge to care for persons ill or injured in an austere environment. Alabama is well represented with medical providers with these skills. ACEP has a **Wilderness Medicine Section** for ACEP members who are interested in learning more about the field. The Section will meet in San Diego at ACEP Scientific Assembly. Look for it on the**schedule** and come find out what all this fun and interesting field is all about.

The largest national organization is the Wilderness Medical Society which presents numerous expedition type CME programs. Here in Alabama we have the Alabama Wilderness Medical Association. This local organization partners with local environmental groups and presents a great weekend course for medical providers. The Advanced Wilderness Life Support is a CME program for physicians and allied health professionals. The next course will be held at Ruffner Mountain in Birmingham on October 12-14. Check out **https://alabamawma.org/** for details.

John E. Campbell, MD Alabama Champion of Emergency Medicine Award
The new annual Alabama Chapter ACEP award
Denise Louthain, Executive Director Alabama ACEP

A new annual award was started this year by Alabama Chapter ACEP. The purpose is to honor physicians that have provided leadership and distinguished service in the field of

emergency medicine. It will be called the John E. Campbell, MD Alabama Champion of Emergency Medicine Award and the first-year recipient is Dr. John Campbell. In the early 1980's, in addition to his practice in emergency medicine, Dr. Campbell developed a basic trauma life support course and authored a training manual for prehospital EMS providers with the first courses being taught in Alabama.

His leadership in emergency medicine extends far beyond Alabama. The International Trauma Life Support course and manual is now translated in several languages and is taught in the United States, Africa, Asia, Australia, Canada, Caribbean, Europe, Latin America, Middle East and South America.

2018 ACEP Southeastern Chapters Educational Conference: Emergency Medicine Then & Now
June 4-7, 2018
Destin, Florida

This past June the annual ACEP Southeastern Conference was held in Destin, FL. This conference now involves 9 states and was the biggest conference yet. There were over 200 participants. New this year was the Bootcamp for the Nurse Practitioners and Physicians Assistants which was very well received. **The dates for next year are June 3-6, 2019 at the same location, Sandestin Golf and Beach Resort, Destin, Florida**. Save the Date! We want to see you there.

NEWS FROM ACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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

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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 laband the AMI diagnosis was adjudicated by a cardiologist and an emergency physician. They found that a single baseline cTnT Gen 5 measurement <6 mg/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?

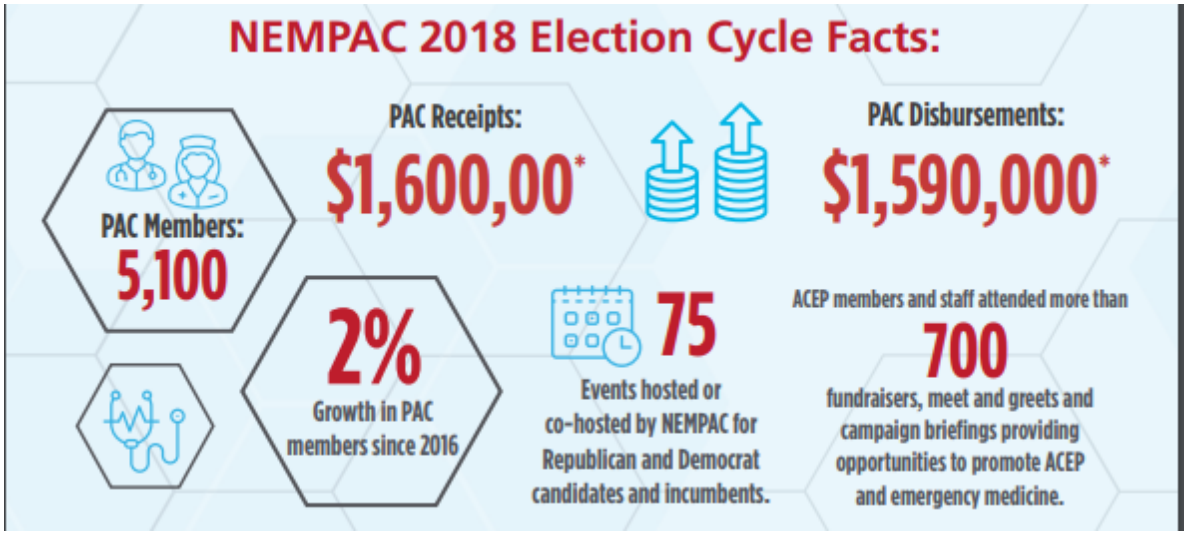
Learn how to develop a Geriatric Emergency Department (GED) with this three-hour **geriatric pre-conference** during ACEP18. Hear from the geriatric experts who will walk you through the

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

Darcy B Autry
Daniel Becak
James M Broome
Julie Brown, MD
Brandon C Buchel
Brock Stephen Clark
Nkele A Davis
Shelly Haferkamp
Caleb Holder
Zachary C Holley
Maxwell J Jabaay
Charles Johnson
Nicole Wai-Ga Lau

John Gunnar Magnuson
Bilal Hussain Piracha, MD
Amanda B Smith, MD

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