



NC Chapter Update



A Newsletter for the Members of North Carolina ACEP

Summer 2012

From the President Gregory Cannon, MD, FACEP

WE HAVE ARRIVED

I hope all of you are enjoying summer in our beautiful state. I would like to start by thanking everyone for giving me the opportunity to serve as President of the College. I have been involved with NCCEP since 2004 and have witnessed a great deal of change in the last 8 years. In this issue, I would like to reflect on what I have observed during that time. Our current position as a chapter is very solid and this is due in large part from sound decision-making by past NCCEP board members and leaders. When I first joined NCCEP, we had just under 600 members and now we have about 940. We are now the tenth largest chapter in the country. We have worked hard to make sure that everyone who can be a member is a member. We have also worked hard to increase resident interest and participation in the College.

One of the big changes I have witnessed over the years is the increased presence that NCCEP has achieved in state politics. We are now a well-known and respected voice for emergency medicine at the state legislature. Our College has also worked hard to collaborate with other groups in organized medicine such as the NC Medical Society and the NC Hospital Association. These activities proved crucial to the success of the liability reform law that passed last summer. These relationships will continue to serve us well. I would be remiss if I did not mention that the ongoing efforts of our lobbyist, Colleen Kochanek, have been crucial in making this happen.

Speaking of Colleen, she is now formally established as our executive director after serving in a temporary capacity for over a year. She has done an outstanding job in reorganizing our finances and operations, and we are now more efficient and on a firm financial footing.

Our members continue to participate actively at the national level. I can remember 6 years ago at the Leadership and Advocacy Conference in Washington when there were just 3 of us on Capitol Hill visiting our senators and representatives. In the last couple years, we have had around 17 people making the visits. We have several members who serve on ACEP committees, sections and on the council, but more on that next time.

Our educational offerings have also improved considerably in the last few years. The first June Jam I went to was the last one that we had at Wrightsville Beach. At that point the size of the meeting outgrew any conference facilities available on the North Carolina coast. For the past 7 years we have had our annual scientific and business meeting at Kingston Plantation near

North Carolina College of Emergency Physicians



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Myrtle Beach. Beginning next year we plan to host a combined meeting with the Georgia and South Carolina chapters in early June. For the past 3 years we have had a fall conference at Grove Park Inn in Asheville which is steadily growing in popularity as well. We hope you can avail yourself of these excellent educational and networking opportunities.

Finally, we have updated our technology on several fronts. We have revamped our website, and I hope you can take advantage of what it has to offer. As you can see, we have worked hard to position ourselves as your advocate for emergency medicine at the state level. We strive to make the benefits of membership far outweigh the cost, and to complement your membership in ACEP. We also welcome your participation in NCCEP through participation on our committees or as a future leader. Please let myself or a board member know if there is anything we can be doing to improve your professional endeavors. That is why we are here.



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Emergency Medicine IQ

Practice Management: Readmissions

Abhi Mehrotra, MD, FACEP and Bret A Nicks, MD, MHA, FACEP

Readmissions – while not the typical explicative one might hear from a patient in the ED, it is increasingly spoken in the administrative realm – let alone when we call our admitting consultants. That word has led to more meetings recently than we care to recall and even national conferences on the topic. If you haven't already been engaged in these discussions, you will – it is unavoidable. (Yes, that was a pun – please laugh.)

Let's take a few steps back and discuss this concept. The Centers for Medicare & Medicaid Services (CMS) has established publicly reportable measures related to both process of care and outcome of care measures. In general, we are all familiar with the medical care core measures because it impacts our daily clinical care, such as:

- Myocardial infarction (e.g. aspirin at arrival for MI, door to PCI in 90 minutes)
- Pneumonia (e.g. blood cultures, antibiotic selection, etc...)

The outcome of care quality measures, which are also publicly reported, have recently also received attention from the press as well as governmental and private payers. Examples of such measures are:

- 30-day mortality for AMI, heart failure, and pneumonia patients
- 30-day readmission for AMI, heart failure, and pneumonia patients

While these measures don't directly impact the Emergency Department, as part of the system of care, we are involved in how the hospital is able to meet / perform on these measures. For the readmission measure in particular, the ED plays a vital role in facilitating hospital performance. Hospitals and health systems are devoting significant financial and personnel resources into this issue because it has become a financial issue for them. While CMS is looking only at particular diagnoses for readmission calculations, other payers are looking to cut costs by reducing all-cause readmissions. Yes, a cholecystectomy and motor vehicle collision occurring in the same 30-day period could lead to review for an avoidable readmission!

There is a body of research already on the topic of readmissions, including a paper that derives and validates a tool to predict readmission or mortality. Published in the Canadian Medical Association Journal in 2010, Walraven, et. al., describe 4 variables associated with mortality or readmission within 30 days of hospital discharge in a Canadian population. The LACE index consists of:

- L – Length of stay
- A – Acuity of the patient
- C – Comorbidity of the patient
- E – Emergency Department use

Institutions within our state, such as UNC Health System, have derived similar prediction tools to stratify patients at high, moderate, and low risk for readmission while still an inpatient on their index admission. Based on the patient's stratification, resources were put into place to address the patients at moderate and high risk. This included case management, home health, pharmacy, patient call backs, etc. While such processes are indeed a step forward at addressing the multifactorial issues related to patient care, when those efforts fail – patients return to the ED. Having a proactive system in place to identify

those at risk for possible readmission will inevitably improve the quality of care – and hopefully facilitate care courses and resources available when they do return due to outpatient care failure.

As we have seen in the past, many hospital quality efforts, while not initially focused on ED care, usually affect the Emergency Department as we are an integral part of acute care delivery – and the front door for most hospitals. Further discussion on the impact and utilization of ED Observation Units for readmissions will be forthcoming.

Most of us will agree that there will (if not already) be pressure from our respective hospital's or medical center's to help address this need when patient's present to the ED for an exacerbation or failure of outpatient management of select conditions – for reporting and financial reasons alike. Of course, this begs the greater question of the myriad underlying concerns such as current health system's coordinate care processes, local resources, patient resources, and patient compliance just to name a few. Addressing these system failures are much more challenging – and perhaps remains the reason why we are at the table from the start.

Readmissions... we would be very interested in hearing how your hospital / group is dealing with the readmission issue. Please e-mail us ([Dr. Mehrotra](#) / [Dr. Nicks](#)).

Reference:

van Walraven C, Dhalla IA, Bell C, et al. Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community. CMAJ. 2010;182:551-557.





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Legislative Committee Report Gregory Cannon, MD, FACEP

PLAYING DEFENSE

As all of you are aware, we experienced a tremendous victory in medical liability reform last year that has been in effect since October 1st. There has been considerable interest at ACEP and from other states regarding liability reform in North Carolina. I participated on a panel discussion regarding liability reform at the Leadership and Advocacy Conference in May and since then several states have contacted us regarding how we accomplished the legislation and have requested copies of the law and some of our talking points.

We obtained improvements on several fronts, but we can certainly expect that the trial bar will do everything it can do to undo what we have done. They are basically waiting for “sentinel cases” to serve as examples of why the law should be found unconstitutional. It is just a matter of time before some cases will wind their way through the courts to be a challenge of the law at the state Supreme Court level.

We certainly expect that the noneconomic damage caps will be challenged. Also, the definition of the “clear and convincing” evidence standard of negligence for EMTALA-related care is not well-defined in NC statute, and will most likely require case law to determine what that means (or to overturn it).

At this point, the makeup of the state Supreme Court becomes important. Georgia passed excellent liability reform in 2005, including noneconomic damage caps and a gross negligence standard. Since that time, the gross negligence standard has been maintained but the noneconomic damage caps have been overturned. Our Supreme Court is slanted in our favor for now, but things can change over time. North Carolina Supreme court justices are elected by the people for 8-year terms and the races are officially non-partisan.

Of course, the Legislature can overturn the law but for the time being, with both houses in Republican hands and most likely a Republican governor being elected in the fall, this is unlikely. Plus, as we learned over the last several years, it is much harder to pass a new law than to block one.

So, stay tuned....



JUNE JAM 2012

This year’s annual meeting was held in Myrtle Beach, South Carolina at the Kingston Plantation June 15 – 17, 2012. The meeting was a great success. On Friday night, attendees mingled with their colleagues at the reception and visited with our sponsors and vendors while the kids were engaged in their own “night out.” Then on Saturday afternoon, some of the state’s brightest emergency medicine residents competed in a “Jeopardy”-style quiz format.

Next year, instead of holding June Jam in Myrtle Beach, we will have a joint conference with the Georgia and South Carolina ACEP chapters June 7-9, 2013. We are still finalizing the details for next year’s conference, but we hope you will be able to join

us for this exciting new opportunity in 2013!

During the annual meeting the membership approved a by-laws change that will allow the elected Secretary/Treasurer to serve as the first alternate councillor at Scientific Assembly. We also presented a plaque to thank outgoing President Frank Smeeks for his service to NCCEP. Representative Daniel McComas was recognized as our Emergency Medicine Advocate of the Year in recognition of his advocacy for emergency medicine and his tireless work on Senate Bill 33; however, he could not attend and will instead accept at one of our next board meetings.

Also on Saturday, Dr. Joshua Broder from Duke University hosted the annual Lifesavers Quiz Bowl. This year, there were four residency programs represented: Carolinas Medical Center; Duke University; East Carolina University; and Wake Forest University. The residents all competed well, but it was Don Stader, MD and James Cao, MD who took home the trophy for Carolinas Medical Center for the second year in a row. Congratulations, Dr. Stader and Dr. Cao!



2012-13 NCCEP Board of Directors and Councillors

The membership also elected our new leadership and we are pleased to announce the following as your NCCEP Board of Directors and Councillors for 2012-13:

Officers

Gregory Cannon, MD, FACEP
President

Stephen Small, MD, FACEP
President-Elect

Abhi Mehrotra, MD, FACEP
Secretary/Treasurer

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Alternate Councillors

Charles A. Bregier Jr., MD, FACEP

Abhi Mehrotra, MD, FACEP



Clinical News

Analysis Supports FAST Exam in Pediatric Blunt Trauma

The bedside focused assessment with sonography for trauma exam is used infrequently in children with blunt abdominal trauma.

When the FAST exam was used in children with a low to moderate risk of intra-abdominal injury (IAI), however, there was a substantial reduction in subsequent abdominal CT use, a planned subanalysis of a large prospective, observational trial showed.

[Read the entire article online](#)

Dipstick Proteinuria Predicts Acute Kidney Injury in Septic Patients

De novo dipstick proteinuria accurately predicted acute kidney injury among 328 critically ill septic patients, a retrospective chart study has shown.

With sepsis, inflammation results in increased capillary permeability to plasma proteins, manifesting in an increased excretion of albumin into the urine. Because the production of creatinine from the muscle is reduced in septic patients, relying on changes in serum creatinine could delay the diagnosis of this acute kidney injury (AKI), according to Dr. Javier Neyra.

[Read the entire article online](#)

FDA Warns of Seizure Risk with Cefepime

The Food and Drug Administration has reported cases of a specific type of seizure called nonconvulsive status epilepticus that is associated with the use of the antibacterial drug cefepime in patients with renal impairment.

The seizures have been seen primarily in patients with renal impairment who did not receive appropriate dosage adjustments of cefepime, although in several cases patients received “dosage adjustment appropriate for their degree of renal impairment,” according to the agency. The FDA is working to revise the “Warnings and Precautions” and “Adverse Reactions” sections of the cefepime label to highlight this risk.

[Read the entire article online](#)



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Dennis Bradley Langston, MD
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Joseph Bearl Padgett, MD

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