



NC Chapter Update



A Newsletter for the Members of North Carolina ACEP

Summer 2013

From the President Stephen Small, MD, FACEP

I want to welcome all of the new and returning NCCEP board of directors and councillors and also thank all of the retiring leaders for your service and dedication to North Carolina Emergency Medicine. In addition, I want to thank everyone for giving me the honor of being your president for the next year. I am very fortunate to have such great mentors and colleagues within the state and hope to continue the great things that my predecessors have pushed forward. I also want to thank my family and partners for supporting me in my service to NCCEP.

I want to take this opportunity to update everyone on the state of Emergency Medicine in North Carolina and also to follow up on several on-going issues. At this point, our largest issue is the fate of Medicaid both in terms of administration and reimbursement. As Greg Cannon reported in the past EPIC, the specter of managed care dominating NC Medicaid is still of great concern and without any definite resolution. We are working together with the NCMS and other concerned parties to help support the continuance of CCNC. Medicaid reimbursement is a very hot topic within the NC budget with proposed planned cuts still on the table. NCCEP has been tirelessly working on your behalf to lobby and educate legislators about our specialty and the downward effects of Medicaid reimbursement cuts on access to care. We should all give our NCCEP executive director and lobbyist, Colleen Kochanek, a huge "Thank You" as she has been instrumental in fighting our fight. By working with NCMS she was able to get the proposed 4% reimbursement cut reduced to 2%. In addition, she also found buried in the budget proposal a provision that would have limited EM reimbursement for any Medicaid patient found to have a "non-emergent" diagnosis upon discharge. She was able to work on our behalf to have this provision revised as well so that it would no longer effect emergency medicine. Unfortunately, the NC state budget has not been agreed upon and is still in limbo. So while the above Medicaid issues seem more agreeable to us, nothing is certain until the budget is passed.

In follow-up on the proposed new helmet law, NCCEP was instrumental in blocking this bill. Dr. David Kammer, surrounded by a horde of PM&R residents, testified to the legislature about motorcycles and head injuries. Evidently he gave very compelling testimony. Great job David!

I also wanted to thank the CMC residency program for allowing me to speak with the residents about organized medicine and advocacy. This rounded out the state-wide residency tour started by Drs. Mike Utecht and Greg Cannon.

Last but not least, we all just returned from our annual CME event on Kiawah Island – now called the Coastal Emergency

North Carolina College of Emergency Physicians



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Medicine Conference (CEMC). We have retired June Jam but are quite fired up about CEMC. The conference is a collaboration between the NC, SC, and GA chapters. Attendance was incredible with over 175 attendees and garnered us national exposure as five ACEP board members were present. All signs point to a very successful conference. I encourage you all to attend next year as it was great family fun!





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Psych Boarding: New Strategies and Considerations

Daniel Minior, MD, FACEP and Bret A Nicks, MD, MHA, FACEP

Over the past 30 years, the resources and care processes have changed greatly for one of our most challenging patient populations, psychiatric patients. North Carolina emergency departments are facing an ever growing number of psychiatric patients in need of acute stabilization – with a decreasing number of inpatient options. The recent economic downturn exacerbated this situation with an increase in uninsured and underinsured no longer able to afford stabilizing treatment concurrently with declining available state and federal resources as well as a trend away from onsite resolution of issues in households, group homes, and long term care facilities. This trend away from community-based prevention and intervention has created the proverbial perfect storm of psychiatric boarding in the ED – the one place that will still care for them 24/7. This article discusses some of the basic strategies to best ameliorate the burden of acute and subacute stabilization of mental health patients and improve the quality of care provided when boarding occurs.

Key Points:

Establish a mental health care team

Update routine rescue medications & restart (or initiate) psychotropic medications

Consider having centralized monitoring

Develop a coordinated suicide risk policy

Refine/optimize psychiatric admission processes

Engage hospital administration to support change

Empower Law Enforcement

WHO'S ON YOUR TEAM?

Mental Health Specialist

It is extremely important in high volume emergency departments to have 24/7 access to a mental health professional. This person is typically a licensed social worker who has experience with the disposition of psychiatric patients. After medical clearance, the mental health specialist evaluates the patient for the appropriate level of resources and performs the myriad of duties necessary to admit a patient to a psychiatric facility. Short of the admission, they establish a patient's placed on a waiting list. This process is extremely labor-intensive and also very time-consuming. It needs dedicated resources to work efficiently. In low volume psychiatric EDs, this professional may be a community-based resource, shared between facilities, or contracted as on-call.

Psychiatry/TelePsych Consultant

If your ED has a psychiatrist on-call 24/7, you are the exception. If not, another increasingly available resource is integrating the same approach through telemedicine. Regardless of the approach, after medical clearance, the psychiatrist can provide definitive input regarding involuntary commitment status, remove the patient from involuntary commitment, and deliver state-of-the-art medical management for the acutely decompensated patient as well as initiate medication recommendations. When psychiatric patient boarding occurs, the psychiatrist should round daily (perhaps twice daily) providing further care recommendations and medication adjustments. In circumstances where boarding is prolonged, early initiation of psychotropic medications may stabilize a patient to the point of discharge prior to placement.

Both care processes have associated costs and variability with providers. Overcoming the discomfort of not having an on-site provider, lack of familiarity with local resources, and susceptibility to technological difficulties have been cited as concerns for TelePsychiatry - but the upsides are usually found to outweigh these concerns.

Nursing and Support Staff

Having nursing, security, and ancillary staff, such as sitters, on-board is essential. Development of a care process for mental health patients, especially those boarding while awaiting placement, is essential to ensure quality and safety. All facilities have policies and procedures in place for restraints - but far fewer have established care order-sets for boarding psychiatric patients. Define your team and put such an order-set into place.

RESCUE MEDICATIONS

The use of rescue medications is extremely important with the care of psychiatric patients and something unique within the emergency medicine skill set. Knowing what is available on formulary and establishing known first-line agents (and having them built into your EHR) is invaluable. In addition, early recognition and intervention prior to substantial behavior escalation should be the goal. If a patient should require pharmacologic intervention, appropriate documentation of medication, dosing, and effect is most helpful should re-escalation occur at some point while awaiting appropriate transition of care.

RESTARTING (or initiating) PSYCHOTROPIC MEDICATIONS

Many of our mental health patients have been previously diagnosed and treated for their underlying condition. Many have worsening symptoms and behaviors because they have stopped their medications due to financial constraints, use illicit substances, or have concurrent medical illnesses that are uncontrolled. After medical stabilization, restarting therapeutic medication is an essential basic care strategy. Although identifying the most recent or effective strategy may be challenging, increasingly available EHR data can help. If unavailable, family members and or previous community partners may be able to find this information. Restarting these medications during the transition of care assists with stabilization and is worth the investment of time on the front end. Again, use of a 'Psychiatric Boarding Order Set' will help to align the care processes within your ED and streamline the care processes.

CENTRALIZED MONITORING

Because acutely decompensated psychiatric patients are very unpredictable, they need constant supervision. While this is typically performed by a sitter, when unavailable, the duty may fall on an ED Tech or CNA. As an alternative to pulling ED Techs or CNAs away from their duties, establishing central video monitoring of psychiatric patients enables one person to do the job of many. While not cost neutral to set up, it is a wise investment in the long term for EDs that routinely have numerous psychiatric patients boarding. Establishing this monitoring process must coincide with care processes and communication with nursing staff and an assigned security guard who can help during times of escalation.

RISK STRATIFICATION

Most experienced providers will agree that not all psychiatric patients need involuntary commitment or inpatient care. However, limited outpatient resources and medical-legal risk often force the inpatient card. In situations surrounding suicide risk, stratifying between high and low risk circumstances may allow for some outpatient care dispositions. High risk individuals are easy to identify, such as the widowed elderly man with known mental health and substance abuse issues with suicide threats using his arsenal at home. Low risk individuals have few if any known red flags and may have mentioned self-harm in front of someone but without a plan and is remorseful regarding the events leading up to the assessment. If sending a low risk patient home, clear documentation about the decision making is essential. In addition, coordination of prompt (1-3 day) follow-up, observation by reliable family or friend, removal of ongoing threats, and a crisis plan should be established.

ADMINISTRATION 101

As the specialty environment for acute care interventions, the ED excels the immediate stabilization, workup, and disposition of patients in their time of crisis - and is not the ideal environment for patient boarding. Increasingly, patient admissions (now greater than 50% at most facilities) come through the ED due to enhanced diagnostic and therapeutic processes that enhance patient care and outcomes. Boarding patients, whether psychiatric or medical, comes at a cost for both the patients awaiting

emergency care, and the hospital as well. In 2012, a study found the cost of psychiatric boarding was found to be ~\$2264 in lost revenue per psychiatric boarder. Multiply that cost by the number of boarders each year and there are substantial benefits for Hospital Administrators to finding a solution. Not to mention the negative impact on patients waiting to be seen in the ED and the preferential impact of choosing another ED for their medical emergencies.

ENGAGING LAW ENFORCEMENT

Involuntarily committed patients often arrive in our emergency departments in the custody of law enforcement. Law enforcement seeks to turn that custody over to hospital security services because watching psychiatric patients in the emergency department is a tremendous investment of financial and manpower resources. To foster good relations, many hospitals comply with the request and assume responsibility. This ends up overburdening the often far stretched emergency department security resources, particularly with agitated, violent, and unpredictable patients. If transfer of custody exists, it makes sense to change policy to reenlist the aid of law enforcement. Although reversal of this trend is not easy and often has political overtones, it is appropriate because it ultimately is a great service to law enforcement to have these patients adequately treated.

Legislative Committee Report: Advocacy working for you – again! Gregory Cannon, MD, FACEP

As many of you are aware, this has been a rather tumultuous long session. We are always concerned during the long session because it is when new bills are introduced and we find ourselves having to defend/oppose the same recurring issues such as revocation of motorcycle helmet laws. This session has been particularly active because of the super majority of Republicans in both houses. As many of you that have been reading this report for years know, I am always concerned when one of the parties has an uncompromising majority. That is when things can get partisan and ideological. We have to be very observant about what is going through the legislature. One excellent example is what happened last month when the budget was submitted by the senate. Read this:

SECTION 12H.13.(f) Effective January 1, 2014, non-emergency services provided in an emergency room shall be reimbursed based on a single fee. The Department of Health and Human Services, Division of Medical Assistance, shall establish such a fee. This fee may not be cost-settled.

That is scary. It is even scarier to know that the fee they plan on establishing is based on an office based primary care physician visit. So, you save someone's life for 45 minutes and all you receive is a well patient primary care visit fee! This would affect every emergency provider in this state well into the 4 digit range in reimbursement. Our lobbyist, Colleen Kochanek, found this while reviewing the bill at 10 pm at night. She was the only one that caught it! Not even NCMS picked up on it. To make things worse we had to deal with this while we were starting the conference down at Kiawah Island (which was excellent, by the way). A special thanks to Ed Gaines and NCMS for assisting us in drafting and presenting an amendment made in committee in the House to revise this horrible provision to clarify that it does not apply to emergency physicians. The provision would have cut our rates but not effect whether or not a Medicaid patient decided to go to the emergency department or their primary doctor.

It just goes to show that you have to have advocacy and someone looking out for you or you will be abused by the system. No specific legislator took "credit" for that provision. Sometimes things like this are put in by staffers who saw language from another state and thought it would be a good idea to save money. It does not matter the party involved – it can happen any time and that is why we are looking out for you.



Reimbursement Committee Report Charles Bregier, MD, FACEP, Chair

No response from BCBSNC regarding paying Ultra Sound codes. The edits were supposed to be removed from ClaimCheck, but we would like to know what our ED groups experience is with getting paid for these. If groups are being paid, then this is a non-issue; however, please send the Reimbursement Committee feedback about your experience.

We would like to solicit someone to step up and become the Reimbursement Committee Chair in the next year or so. What is required is a keen interest in billing/payer/reimbursement practices, and working with their billing company and NCCEP to identify issues and work to find solutions. This also positions the new Chair to become a reimbursement and coding expert for their group. If you are interested, please contact me so that we can discuss.



Clinical News

Opioid Overdose Deaths Skyrocket in Women

American women are dying from prescription drug overdose at historically high rates, the Centers for Disease Control and Prevention announced July 2.

[Read the entire article](#)

Apixaban Beats Warfarin on Safety in Acute VTE

In patients with acute venous thromboembolism, 6 months of treatment with the oral-anticoagulant apixaban was as effective as was standard therapy with subcutaneous enoxaparin for a week followed by oral warfarin, and apixaban caused significantly fewer major bleeding complications in a randomized, multicenter trial with more than 5,000 patients.

[Read the entire article](#)

Eight principles outlined for safe opioid prescribing

Opioids aren't always appropriate for treating pain, and if they have to be prescribed, they must be used cautiously and at the lowest effective dosage, Dr. Lynn R. Webster advised.

[Read the entire article](#)



Fall Conference 2013

The NCCEP 2013 Fall Conference "Excellence in Emergency Medicine: Update in Trauma and Emergency Care" will be held **November 4 – 7, 2013**, at the beautiful Grove Park Inn Resort & Spa in Asheville, North Carolina. In addition to earning CME credit**, participants have the opportunity for plenty of down time and relaxing activities, including golf, spa treatments, listening to jazz music in the Great Hall, and dining in one of the resort's many dining areas.

Rooms are being held at the Grove Park Inn Resort & Spa, Asheville, NC with special convention rates of: \$209/night for Run

of House rooms; \$264/night for Mountain View rooms; \$239/night for Resort View rooms; and \$279/night for Premium rooms. Room rate does not include meals, and is subject to state and local taxes. Please make your reservation by October 4, 2013, to receive these special group rates. Reservations received after this date will be subject to prevailing rates and availability. Identify yourself as attending the North Carolina College of Emergency Physicians' meeting (**Group Code 1004478**). Rooms may be reserved by contacting the hotel directly at (800) 438-5800 or [online](#). One night's deposit at time of booking is required to confirm all reservations. **Interested in the Grove Park Inn Resort & Spa amenities?** Contact the Grove Park Inn directly. Amenities are at your expense. Call early for spa and golf reservations. Spa: (877) 772-0747.

[Online](#) registration coming soon!

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Access to Care Committee Report Charles Bregier MD FACEP, Chair

We continue to network with CNCC and CPI (now renamed Project Lazarus) to identify high Emergency Department utilizers to reduce imaging and other ED costs. This is paramount to maintaining Medicaid payment rates and allows NCCEP to be part of the solution for cost savings in health care. ED groups are strongly encouraged to use the Medicaid Portal and CSRS to work collaboratively to reduce costs and improve efficiencies.



2013-14 NCCEP Board of Directors and Councillors

The membership elected NCCEP's new leadership at the annual meeting on June 8, 2013, and we are pleased to announce the following as your NCCEP Board of Directors and Councillors for 2013-14:

Officers

Stephen Small, MD, FACEP
President

Abhi Mehrotra, MD, FACEP

President-Elect

Bret Nicks, MD, MHA, FACEP
Secretary/Treasurer

Gregory J. Cannon, MD, FACEP
Immediate Past President

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Matthew Bitner, MD, MEd, FACEP
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Coastal Emergency Medicine Conference



The first annual Coastal Emergency Medicine Conference was held June 7-9, 2013, in Kiawah Island, South Carolina. The conference was jointly hosted by the North Carolina, Georgia, and South Carolina ACEP Chapters, and we had over 175 people in attendance, including 5 ACEP Board members! The meeting was a great success. On Friday night, attendees mingled with their colleagues at the reception and visited with our sponsors and exhibitors while the kids were engaged in their own "movie night." On Saturday evening, attendees and their families gathered at Mingo Point for a live band, oyster bake, and pig roast, as well as a very entertaining hula hoop contest, and

much fun was had by all.

During the annual meeting, the membership approved a bylaws change that will allow electronic voting. We also presented a plaque to thank outgoing President Greg Cannon for his service to NCCEP. Dr. Marsha Ford was awarded the George Podgorny, MD Distinguished Service Award, which recognizes lifetime achievement in Emergency Medicine and/or distinguished service to NCCEP.

Also on Saturday, Dr. Carl Menckhoff hosted the Lifesavers Quiz Bowl. This year, teams from North Carolina, Georgia, and South Carolina competed for a chance at the trophy and bragging rights. The residents all competed well, but it was Dr. Bradley Efune (CMC) and Dr. Adam Saucerman (ECU) who took home the trophy for team North Carolina. Congratulations, Dr. Efune and Dr. Saucerman!



SAVE THE DATE!

Please mark your calendars for the next Coastal Emergency Medicine Conferences.

- June 6-8, 2014
- June 5-7, 2015
- June 10-12, 2016



Thanks to You, EMF Reached the Goal



Emergency Medicine Foundation (EMF) reached our \$1 million matching grant goal, and we could not have done it without you! Because of you, EMF is one step closer to reaching our first ever endowment. Eighteen ACEP chapters raised \$30,678 to further

emergency medicine research. EMF appreciates the generosity and leadership of these state chapters.

Auctioning Items to Further with EM Research

EMF will host a silent auction during ACEP13 to continue raising money for research. The silent auction will include signed items from entertainers and athletes, weekend getaways and many more great items. We are also taking donations to be auctioned off. You can donate items such as a weekend getaway, wine, jewelry, or an excursion package can be donated for the auction. To donate your items, go to the foundation [website](#). For more information contact Cathey Wise at cwise@acep.org or 469-499-0296.

Be a VIP at The Taste of the Northwest

The silent auction is not the only event planned for EMF during ACEP13. The Taste of the Northwest Classic at Chihuly Garden and Glass is our first-class VIP event recognizing our major donors. Donors who contribute \$1,000 or more since January 1 2013, receive complimentary tickets based on their giving level. Wiegentstein Legacy Society members receive two tickets. Individual tickets will also be available at the ACEP Bookstore for \$125. Sponsorship packages are still available. Please visit acep.org/emfevent for more information.

Because of donors and state chapters like you, EMF awarded more than \$500,000 in emergency medicine research. Research includes how physicians communicate with patients after they leave the emergency department, patient return to the ED, prescription drug monitoring, and implementing an emergency department to home transition intervention.

Thank you of your support and donations to EMF and emergency medicine research. Because of you, we can continue funding vital research to improve emergency medicine practice and patient care.



ACEP13

To register for ACEP13, click on the link below:



Welcome New Members

Mathias W Allen, MD
Bryant Allen, MD
Jon S Andrews
Jaime S Argila, MD
Tyler J Armstrong, MD
Julio M Arrieta, MD
Jacob Baalman, MD
Nathan Bach

Jessica Baxley, MD
Sandra K Beverly, MD
Josh Boyd, MD
Jonathan B Bringolf, MD
Michael WJ Brown, MD
Douglas Brtalik, DO
Devin Bustin, MD
Samuel Jan Chang, MD
Matthew James Chovaz, MD
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Simon Chung, MD
Marc Cillo, MD
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Stephen C Cooke, MD
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Kory R Dawson, MD
Rebecca J Donohoe, MD
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Paul C Flanders, MD
Christopher Scott Forsythe, MD
Eric Fountain, MD
Samuel J Francis, MD
Marama Khaled Gattan, MD
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Matthew Nicholas Gentry, MD
Amy Renee Gilleland, MD
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