NC Chapter Update

A Newsletter for the Members of North Carolina ACEP

Winter 2013

From the President
Gregory Cannon, MD, FACEP
13.0.0.0.0

North Carolina College of Emergency Physicians

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If you are reading this it means that we have safely made it past the doomsday scenario that was supposed to occur at the end of December 21, 2012. It corresponded to the Mayan calendar turnover from 12.19.19.17.19 to the date at the top. It represents about 394 years from the last baktun (12.0.0.0.0), so not the thousands of years indicated by the doomsayers. The end of the world on this day was popularized by a movie a couple of years ago as well as other people. Meanwhile, the Mayan descendants thought the concept of Armageddon ridiculous and all they were planning for were end-of-the-baktun parties. In general, it just goes to show how predicting the future can be full of peril and inaccuracy. However, one of the things we need to do in organized medicine/emergency medicine is exactly that – read the tea leaves and decide how to protect our profession and patients from potential threats. In this issue, I want to reflect on new information we have at hand based on the events of the last six months and to peer into the crystal ball a bit and see what we might face in the near future.

As you are well aware, the Supreme Court handed down its rulings on the Affordable Care Act at the end of June. This essentially ended all practical attempts to overturn the law. Unfortunately, in my opinion, as emergency physicians the one part of the law that was struck down was the one we really needed to stand. By not forcing states to expand Medicaid, we are left with a significant revenue loss since we would see significant numbers of people on the new Medicaid rolls in the emergency department (especially given the lack of primary care infrastructure). Many of these patients we see are currently uninsured. It is too early to say whether or not North Carolina will buy into expanded Medicaid. The federal government will pay for the expansion for a few years, and then pay for most of it for a few years, and then all of a sudden the states that participate will be left with a gigantic bill that they have to fund themselves (and invariably will not be able to afford).

Another major element is the concept of Accountable Care Organizations and how emergency medicine fits into that scheme. I have heard several talks regarding this topic at various venues, and the truth is no one can say anything for sure. There is a significant lack of regulatory guidance coming from DHHS with respect to the ACA. Already CMS sponsored ACO pilot programs at select institutions have run into major issues. The main concern from an emergency medicine point of view is whether or not ACO's will create a tremendous pressure for us as independent groups (large or small) to become employees of hospitals. One major element of this is the concept of bundling. If someone comes in with a hip fracture, then the institution will receive one payment for the episode of care. This will be divided up among the hospital, the orthopedist, the anesthesiologist, the radiologist, and the emergency physician among others. Just how is that pie going to be divided? Unfortunately, there is just not enough information to act on at this point.

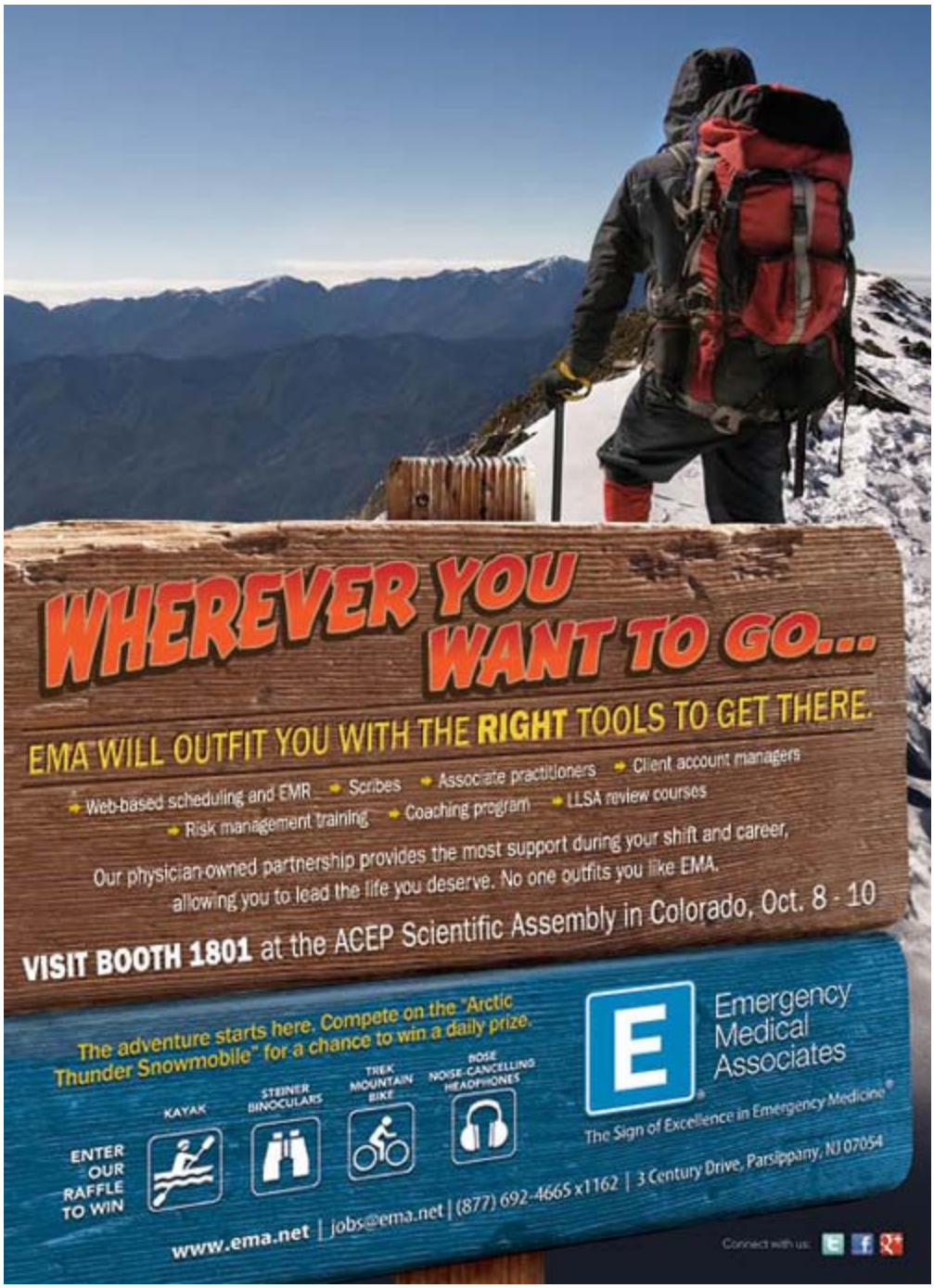
Another important element for us at NCCEP has been protecting the liability reforms we worked hard to achieve over a year ago. For me, the most important election in North Carolina after the governor's race was the contest for the Supreme Court. Associate Justice Paul Newby was narrowly reelected 51-49 over challenger Sam Ervin, Jr. This race had a huge amount of

money- over $3 million- thrown at it, with plenty of funding from national sources. This is a critical win for organized medicine and liability reform in the state. We know very well that the trial bar is picking “just the right case” to send through the courts and push for overturning non-economic damage caps and other elements of the law. The current court is considered 4-3 in favor of liability reform in general and will remain so for now. Given what has happened in other states recently I cannot stress the importance of that election result.

Regardless of your politics, from an NCCEP standpoint I see the election of Pat McCrory as a positive. He is the uncle of an emergency physician in the state and he understands our issues. Hopefully, he will govern from a pragmatic, economically focused platform. Since the legislature notched some gains for Republicans in both houses, it will be his job to keep the supermajority from overstepping its bounds. That may be a difficult job.

As I finish this article the “fiscal cliff” has been temporarily averted. However, the social network cliff of support for our state’s and nation’s emergency departments has not. We are accused of being an expensive problem in the health care arena when really we are a fairly efficient solution to many of the problems that have been left unsolved in the system. We need to continue to let people, the press, and politicians know about our value.

So, if you have made it this far then you will have the answer to the question that is burning in your mind: When does the Mayan Calendar really end? Well, there are 20 baktuns so the calendar goes to 0.0.0.0.0 in October 13, 4772. If the world has not ended by then, then maybe that will do it!



E-Discovery Basics for Emergency Room Physicians

David Dreifus, JD

In today's world the overwhelming majority of written information is created in electronic form, and most of that information is never printed. As a result, when a lawsuit occurs, the vast majority of the information the lawyers want to see is electronic. This includes not only electronic medical records and official e-mail, but can also include any relevant document or e-mail on a home computer, a phone, social media posts, information contained in medical equipment or devices, text messages (remember the fate of former Detroit mayor Kwame Kilpatrick who was forced out of office after the Detroit Free Press revealed the existence of 14,000 text messages between the mayor and his chief of staff, many of which described an extramarital sexual

relationship between the two, often in graphic detail), or any other media that contains information in electronic form. A friend's post of a picture of you at a party the night before a procedure that did not have a good outcome could end up before a jury. Welcome to the world of e-discovery.

What do you as emergency department physicians, and what do the mangers of your practice groups, need to know about e-discovery in order to be prepared in the event of a lawsuit and a request for electronic information? While there have been volumes written on this subject, here are a few key items.

First, you need a good records retention policy and a well thought out records retention schedule. A good records retention policy and schedule will help you retain those records you need to keep, locate those records you need to find, and dispose of those records you no longer need. An automated records management system (ARMS) will greatly assist with location of records if they ever need to be produced. Although developing and following a good record retention policy may not be easy or inexpensive, failure to have and follow a good policy is infinitely more expensive and potentially disastrous. Even worse is having a policy but not following it. There is an excellent discussion of generally accepted record keeping principles at ARMA International's website. Every practice group should have and follow a good records retention policy.

Second, you need to understand your obligation to preserve information. While your formal medical records are already subject to regulatory retention requirements, other less formal information may not be. The duty to preserve evidence attaches as soon as litigation about a particular matter can be "reasonably anticipated." Unfortunately, there is no bright line test that can be applied to determine when litigation is "reasonably anticipated." This means, however, that the duty to preserve attaches, at the latest, when litigation commences, and the duty may attach much earlier. The consequences of failing to preserve evidence early enough can result in significant sanctions from a court, as was recently demonstrated in the high stakes patent dispute between Apple and Samsung. Therefore, the rule should be, if in doubt, preserve. Whenever you begin to think there is a possibility you might be sued, then a neutral third party will likely say that litigation was reasonably anticipated at that point.

Third, you need to be able to implement an effective "litigation hold" once the duty to preserve attaches. Understanding the need to preserve evidence and being able to effectively preserve it are two different things. A litigation hold must be communicated to all "custodians" of potentially discoverable information, including your IT professionals. You must be able to identify the appropriate custodians and the locations in which electronically stored information ("ESI") might exist, including data storage locations, servers, legacy systems, medical equipment, etc. You may need to disable any automatic deletion function of your systems during the litigation to avoid the inadvertent destruction of relevant ESI. Outside counsel can assist you or your group in preparing and implementing an effective litigation hold. Working with IT professionals in this effort is critical to success, as is follow-up and compliance.

Finally, clear lines of communication need to exist between outside counsel, you, your practice group manager (or in-house counsel if you have one) and your practice group's IT staff. Managing the demands of e-discovery can be challenging, time consuming and frustrating. There is no way to sugar coat that message. The way to minimize the potential for disruption is for there to be open and clear communication between all the necessary participants in the process. The better the effort is on the front end, the less likely there is for a disaster on the back end. If you are interested in reading about a real front end train wreck and the aftermath, here is a link to a recent decision from the North Carolina Business Court on the perils of bad planning and implementation.

Save the Date!

The Coastal Emergency Medicine Conference will be held June 7-9, 2013, in Kiawah Island, South Carolina. This first annual regional conference will be jointly hosted by the North Carolina, Georgia, and South Carolina ACEP Chapters, and we hope to have a large turnout of our members. Please mark your calendars for this exciting new event. More information to come in 2013!
www.coastalemergencymedicine.org

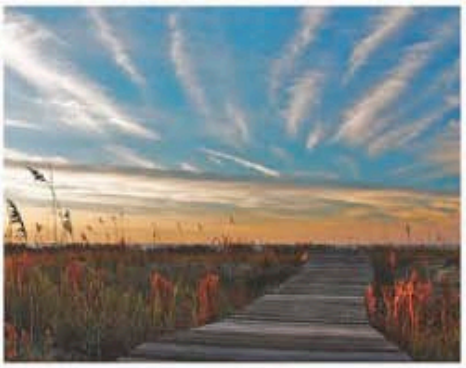
This activity has been planned and implemented in accordance with the Essential and Standards of the Accreditation Council for Continuing Medical Education. The Southern Alliance for Physician Specialties CME (SAPS CME) is accredited by the Medical Association of Georgia to offer continuing medical education to physicians. The Southern Alliance for Physician Specialties CME designates this live activity for a maximum of 15 AMA PRA Category 1 Credit(s)TM. Physicians should only claim credit commensurate with the extent of their participation in the activity.

SAVE THE DATE

Coastal Emergency Medicine Conference

Jointly hosted by

GCEP, NCCEP, and SCCEP



June 7 - 9, 2013
Kiawah Island Golf Resort
Kiawah Island, SC

For more Information and Meeting Registration, please visit the website at www.CoastalEmergencyMedicine.org

ACEP's *Leadership and Advocacy Conference* Registration Opens January 28th

Our commitment to our patients is no longer limited to the clinical skills we demonstrate in the emergency department. Due to the changing dynamics of health care, our profession requires stellar leadership as well as political effectiveness.

ACEP's *Leadership and Advocacy Conference* will provide you with a unique opportunity to meet with members of Congress and other key policy makers, hear inspiring sessions presented by nationally recognized speakers, and help you gain skills in media relations and networking for influence.

Join us in Washington, DC, May 19-22 and identify your role in advancing key issues facing emergency medicine. Together we can shape the future of emergency medicine!

Trauma Center Regulations
Michael Ghim, MD, FACEP

As of February 2012, we have 13 designated trauma centers across our state according to the North Carolina Office of Emergency Medical Services (NCOEMS), which is similar to other states of overall size and population. Holding a trauma designation for any hospital is meaningful in many ways. Trauma is a leading cause of death especially for pediatric patients and young adults, and being designated shows that a hospital is committed to providing the highest quality of care for trauma victims. Here in North Carolina, the NCOEMS is our governing body that establishes a trauma designation. The rules and policies to accomplish a designation can be found on the NCOEMS website. Many trauma centers are also accredited by the American College of Surgeons, although not necessitated by NCOEMS. Trauma centers are designated level I, II or III with level I having the highest capabilities of treating the most critical of trauma patients. We as emergency physicians (EP's) play a vital role in the evaluation and management of trauma patients and practice trauma care on a day-to-day basis. With so many trauma centers in North Carolina, chances are good that you already work for one, or may be planning on doing so. So what are your responsibilities and requirements to be part of your hospital's trauma team? (The following are excerpted from NCOEMS 10A NCAC 13P .0604, section .0900 – Trauma Center Standards and Approval)

For Level I trauma centers, an EP must be present 24 hours per day who is either board-certified or prepared in emergency medicine (EM) either by ABEM or AOBEM, and must have completed ATLS. EP's caring only for pediatric patients may, as an alternative, be boarded or prepared in pediatric EM. EP's must be board-certified within five years after successful completion of a residency in EM and serve as a designated member of the trauma team. Furthermore, the emergency department must have "a designated physician director who is board-certified or prepared in EM. All remaining EP's, if not board-certified or prepared in EM must be board-certified, or eligible by the American Boards of Surgery, Family Practice, or Internal Medicine, with each being board-certified within five years after successful completion of a residency. If not boarded in EM, EP's must be current in ATLS. All EP's must practice EM as their primary specialty. Finally, all EP's must have 20 hours of Category I or II trauma-related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years with at least 50 percent of this being external education including conferences and meetings or visiting speakers from outside of the trauma center.

EP's practicing in level II or level III centers can be board certified or board eligible by ABEM or AOBEM or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practice emergency medicine as their primary specialty. They must have certified within five years of successful completion of residency. The same rule as for level I centers applies to the emergency medicine director. And finally, CME requirements are

the same for EP's working in level II and III centers as level I.

If you already work for a designated trauma center, please be sure to comply with the standards as set forth by NCOEMS. For those of you graduating from residency programs with the mindset and desire to work at fast paced, high acuity emergency departments, you are likely looking at trauma center hospitals. Be sure to keep these requirements for eligibility and continuing education in mind.

New Congress Brings New Opportunities for Emergency Medicine

Eighty-four new House members and 13 new Senators were sworn in this month as part of the new 113th Congress. The freshman class includes ACEP member Dr. Raul Ruiz, a democrat, who defeated long-time Rep. Mary Bono Mack (R) in California's 36th district. Dr. Ruiz joins ACEP member Rep. Joe Heck (R-NV), who was re-elected to a second term.

ACEP has already begun establishing our priorities in the 113th Congress. Just days after being sworn in, Representatives Charlie Dent (R-PA) and Pete Sessions (R-TX) have re-introduced an ACEP-supported EMTALA liability bill – H.R. 36. ACEP will be working hand in hand with these representatives to promote the bill and secure co-sponsors.

Please consider joining the 911 Network along with thousands of your ACEP colleagues who are taking an active role in advocating for emergency medicine and patients to the new Congress. 911 Network Members receive weekly public policy and advocacy updates via email and are asked to respond to ACEP Action Alerts when needed.

Or become a Team Captain. If you want to take your advocacy to the next level, please consider volunteering as a Team Captain for your congressional district. Team Captains play a more substantive role in national policy and advocacy efforts and receive specialized training and legislative briefings throughout the year.

- Click here to sign up for the ACEP 911 Legislative Network.
- Contact Jeanne Slade if you are interested in ACEP's Team Captain program.

Dr. Tony Cirillo (left), 911 Team Captain, was a guest of Rep. Jim Langevin (front right) at his swearing in ceremony for the 113th Congress

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EMF Research – Benefiting Your Practice

Thanks to faithful donors like you, the Emergency Medicine Foundation (EMF) continues to invest in health advocacy and basic science research to save lives, advance patient care and improve your practice.

During the 2012 *Scientific Assembly*, ACEP Councillors generously gave to EMF, raising a record $160,000 in the Council Challenge. “These passionate and competitive professionals met the challenge to personally invest in our specialty. I am proud of their commitment and generosity,” says David Wilcox, MD, FACEP, founder of the Council Challenge. “Because of the ACEP match, now is a perfect opportunity for the entire ACEP membership to generously invest in EMF and the future of our emergency medicine.”

This fiscal year, ACEP will match every dollar you contribute to EMF (up to $1 million) dollar-for-dollar to create an EMF Endowment. With your help and this extraordinary opportunity, EMF will continue to fund ground-breaking research, nurture young researchers, and support the science that benefits your practice.

Give your tax deductible gift TODAY to double your impact!

Clinical News

Flu Activity Continues to Increase
This year’s flu season, which started a month earlier than usual, continues to show increased activity across the nation.

In week 50 (Dec. 9-15), 30% of the 9,500 respiratory specimens tested in national laboratories were positive for influenza. Among outpatient visits reported to the U.S. Outpatient Influenza-Like Illness Surveillance Network, 3.2% were positive for influenza-like illness, compared to the expected national baseline of 2.2%.
Read the full article

How Long Should a Cough Last?
NEW ORLEANS – Patients tend to underestimate how long a cough should last, leading to unnecessary and inappropriate use of antibiotics, according to a review of the evidence and a survey of patient beliefs.
Read the full article

Marijuana Most Popular Drug of Abuse Among Teens
WASHINGTON – Marijuana remains popular with U.S. teenagers, with steady and even rising rates of use, according to a key federal survey.

This year’s data from the annual Monitoring the Future survey found that marijuana was the No. 1 drug used by students in the 8th, 10th, and 12th grades. About 35% of high school seniors said they smoked pot in the past year, consistent with 2011 usage. Daily use among seniors also stayed flat, at around 7%.
Read the full article

Practice Management: The More Things Change…
Bret A Nicks, MD, MHA, FACEP

The Physician Quality Reporting System (PQRS), the seven-year-old Medicare project designed to encourage doctors to report quality measures, became a permanent fixture on the Medicare landscape in 2011. January 2012 marked the start of a new year of PQRS reporting – many of you have been participating since that time. Keep in mind, for 2013, results will drive “payment adjustments” (penalties) in 2015 at least in the current process proposal noting the Centers for Medicare & Medicaid

Services (CMS) will impose a 1.5% penalty in 2015 and a 2% penalty for 2016 and after.

Previously known as the Physician Quality Reporting Initiative (PQRI), the program continues to adjust the number of existing quality measures that emergency physicians may capture, with being 17 the total number of measures that emergency physicians are eligible to report.
For all physicians, 2012 saw incentive bonuses paid by CMS for successfully reporting the appropriate number and type of quality measures cut in half, from 1% of total allowed Medicare Part B claims to .5% of Medicare claims. The reduction from early-program incentive levels reflects the coming shift from a voluntary program to one that incorporates financial penalties for non-participation. Starting in 2015, physicians that elect not to participate in PQRS will lose 1.5% of allowable Medicare claims. In 2016, and for subsequent years, the penalty for non-participation will increase to 2% of Medicare claims. So early participation and making this a routine habit is essential for your practice.

Reporting Requirements

Although providers previously could choose to report PQRS results for either the full 12 calendar months or for a six-month period, the 2012 program eliminated the half-year option. For 2013, several reporting options exist in which an eligible professional may meet the criteria for satisfactory reporting on individual quality measures. Each reporting option consists of the criteria for reporting the data and results on individual quality measures applicable to a given reporting mechanism and reporting period.

While the eligible measures for emergency physicians increased this year (see chart), several are unlikely to be encountered in an emergency department setting. Therefore, most observers anticipate that emergency physicians will continue to primarily report at least three of the measures that are applicable to emergency medicine as has been done in the previous years.

Codes Applicable for Emergency Medicine

MEASURE	DESCRIPTION
28	Aspirin (ASA) for Acute Myocardial Infarction (AMI)
31	Stroke and Stroke Rehabilitation: DVT Prophylaxis
35	Stroke and stroke rehabilitation screening for dysphagia
54	12 Lead EKG for Non-Traumatic Chest Pain
55	12 Lead EKG for Syncope (New Cat II codes – new G codes)
56	Vitals Signs for Pneumonia
57	Assessment of Oxygen Saturation for (CAP) Pneumonia
58	Assessment of Mental Status for (CAP) Pneumonia
59	Empiric Antibiotic given/prescribed for (CAP) Pneumonia
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol
91	Acute Otitis Externa (AOE): Topical Therapy
92	Acute Otitis Externa (AOE): Pain Assessment
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
252	Anticoagulation for Acute Pulmonary Embolus Patients
253	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
254	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
255	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure

Also, don't forget to check out the ABEM PQRS Maintenance of Certification Incentive Program to see if you qualify.

Welcome New Members

Bryant Allen, MD
Jessica Baxley, MD
Nkemka Ezeamama, MD
Diana Godfrey, MD
David Kiefer, MD
Lacey King, MD
Ryan McFague
Scott Owens
Sarah Rackers, MD
Karina Reyner, MD
Alexander Winters, MD

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