PRESIDENT’S MESSAGE

Abhi Mehrotra, MD, FACEP

Welcome to the spring edition of the Epic! As I suspect is the case for most of our membership, I am ready to move past the winter months!

As noted in prior editions, I hoped to make this year focused on collaboration and the growth of NCCEP. In this issue, I will briefly review some national concerns relevant to our practice while also highlighting state issues.

On the national front, ACEP has a number of initiatives at the forefront. A few of interest:

• Coalition on Psychiatric Emergencies – ACEP is coordinating efforts to evaluate options for the crisis in psychiatric care and the impact on EM. This includes closely monitoring the situation with the Washington state chapter. The link here (http://newsroom.acep.org/2014-08-15-Psychiatric-Boarding-in-Emergency-Departments-Ruled-Unconstitutional-in-Washington-State) provides a brief background on the issue.

• Simplifying Sepsis Initiative – Sepsis and bundles of care have taken hold at many of our hospitals.

This is an effort to reassess the recognition and care delivery.

• Clinical Emergency Data Registry (CEDR) – This is a new initiative undertaken by ACEP to function as a Qualified Clinical Data Registry (QCDR). This avenue will allow Emergency Physicians to qualify

President’s Message – continued on page 2
for reporting to CMS for Physicians Quality Reporting System (PQRS) measures. Hopefully, this becomes an easier method for us to submit to value based payment measures while also providing excellent care for our patients. More information can be found at: http://www.acep.org/CEDR/.

- **Rural EM Task Force** – ACEP is actively looking at how to better meet needs of our patients in rural areas of the country. We should have more information by the time of this year’s annual meeting (October).

While your chapter is involved in many of these initiatives, we are spending significant effort on issues impacting our state. Again the theme of collaboration is applicable here:

- **Psychiatric Boarding** – As noted above, ACEP is working to create a coalition on this issue. We are doing much of the same in NC. We worked with the North Carolina Psychiatric Association to pass a resolution at the North Carolina Medical Society. While waiting for action there, we are working to coordinate a working group of stakeholders to investigate solutions. We have also been working to support innovative programs, such as that in Wake County. Former NCCEP President Brent Myers has led an initiative to transport patients needing primarily psychiatric care to appropriate facilities. This program was recently highlighted in the *News & Observer* (http://www.newsobserver.com/news/local/counties/wake-county/article14433806.html).

- **Procedural Sedation** – I am happy to report that the North Carolina Board of Nursing has ruled that it is within the nursing scope of practice to administer procedural sedation medications while the provider is performing the procedure. This was a significant undertaking in coordination with our NC Emergency Nurses Association colleagues — this was a success due to our collaborative efforts. Further information is available in the specific article in this Epic.

- **Medicaid Reform** – This is an issue both retrospectively (the withhold that has now become a cut) as well as prospectively (what structure will the NC Medicaid program take?). We are continuing to work with NCMS and partner organizations to keep abreast of possible changes.

Finally, I want to bring up some specific NCCEP opportunities and invite your participation:

- We have many Committees that need your participation. Please take a look here (http://nccep.org/nccep-committees/) and let us know how you would like to be involved.

- **ACEP Committees** – if you are interested in serving on an ACEP Committee, service on an NCCEP Committee is a great avenue to show involvement and obtain a letter of support.

- **ACEP’s Legislative Advocacy Conference** (http://www.acep.org/lac/) will be held May 3-6 in Washington, DC. This is a great opportunity to interact with leadership of both NCCEP and ACEP as well as to lobby our legislators on issues affecting our patients and practice.

- **The Coastal Emergency Medicine Conference** – this is our joint annual conference with the South Carolina and Georgia chapters (http://www.coastalemergencymedicineconference.org/). This year, we are also coordinating with the Government Services Chapter of ACEP for this meeting. Top notch speakers and a great location — come and join us!

- **Board Meeting** – our next Board meeting is April 15th in Greensboro. You are welcome to attend.

Thank you for all the efforts you put forth to care for patients in our state. As you know, we continue to face obstacles to delivering the best care possible. Become involved in NCCEP and help us to address those issues!
ELECTIONS:

This year, NCCEP will be electing the President-Elect, Secretary-Treasurer, and 4 Board members.

The Nominating Committee has nominated Dr. Jennifer Raley as President-Elect and Dr. Jeff Klein as Secretary-Treasurer.

Members are asked to cast their votes, using the ballot on the last page of the EPIC. Directions for absentee balloting for those unable to attend the annual meeting are noted.

CANDIDATE FOR PRESIDENT-ELECT

Jennifer Raley, MD, FACEP

It would be an honor to serve as President-Elect for the NCCEP Board of Directors. In my 6 years on the NCCEP Board, I have had the pleasure of working closely on several issues that have positively impacted our specialty. Several years ago, I worked with a small group to improve ultrasound and sedation reimbursement from BCBS. In 2014, I chaired the NCMS Taskforce on Worker’s Comp rates for the State of NC which will result in a significant increase in reimbursement for all NC Emergency Physicians starting July 1, 2015. In addition, I spent nearly 3 years helping to advocate for changes to the NC Board of Nursing Policy on Procedural/Deep Sedation which recently resulted in a revised policy that makes sense for Emergency Medicine and our patients. Through this work, I have learned a tremendous amount about the business of Emergency Medicine and also the politics of our specialty in NC. My goals as president-elect are to continue to work toward reasonable reimbursement rate from governmental and private payers for our specialty, ensure unimpeded access to care and give our patients a voice through advocacy.

I am currently the Vice President and Managing Partner for Wake Emergency Physicians in Raleigh, NC and previously served as the Chair and Medical Director for the Emergency Department at WakeMed Raleigh Campus as well as Vice-Chair at WakeMed Cary Hospital. In addition, I served for 2 years on the National ACEP Reimbursement Committee and currently chair the Reimbursement Committee for NCCEP. I served as the Course Director for NCCEP’s fall conference for 5 years and previously served on the Education Committee for NCCEP. I look forward to continuing to serve our specialty and state if elected to the office of President-Elect.

CANDIDATE FOR SECRETARY-TREAURER

Jeff Klein, MD, FACEP

Current Position: Associate Medical Director, Emergency Medical Association, Lumberton

Medical School: University of North Carolina at Chapel Hill

Residency: Northwestern University Hospitals, Chicago, IL

Professional Activities: Member NCCEP, Member ACEP

Candidate Statement: I am honored to have been nominated for the Secretary/Treasurer position by the Executive Committee. Over the past six years I have had the opportunity to serve as a board member of NCCEP. During this time I have enjoyed meeting with legislators such as Thom Tillis. I was honored to be part of the team effort when we passed our great tort reform bill in both the House and Senate four years ago. I have also been part of the reimbursement committee, focusing on protecting Medicaid rates as well as other issues vital to our reimbursement.

See Candidates – continued on page 4
Locally, I am a member of the physician Executive Council at Southeastern Health. We strive for physician engagement and leadership. In order to succeed in the ever changing healthcare environment, administration and physicians must work together to be successful. I am also the leader of the cost containment committee. We have implemented safe but cost effective order sets for the Emergency Department and have targeted narcotic abuse as well. I look forward to learning as much as I can and helping Emergency Medicine on the state and national level. It would be a privilege to be your Secretary/Treasurer.

**CANDIDATES FOR BOARD**

**Jennifer Casaletto, MD, FACEP**

Serving as an NCCEP Councillor for the past three years since returning to North Carolina has been an honor. The experience has allowed me to familiarize myself with emergency medicine and medical practice issues specific to our state while learning about the strategic planning and legislative priorities of our chapter board. Using that recent experience to build on past leadership experience within national and Arizona ACEP, I hope to have the opportunity to serve my colleagues as a member of the NCCEP Board of Directors.

I’m a Washington, D.C. native who learned about snow while studying biochemistry and theology at the University of Notre Dame prior to completing medical education at Vanderbilt and emergency medicine training at Carolinas Medical Center. Following residency, I practiced emergency medicine as an assistant residency director at Maricopa and residency director at Virginia Tech-Carilion. While in Arizona, I had the opportunity to serve AzCEP as councillor, secretary, and president in addition to serving our patients as chairwoman of the Arizona Governor’s Domestic Violence Council’s Health Cares About Family Violence Subcommittee and via an appointment to Arizona’s Committee on the Impact of Domestic Violence and the Courts. Nationally, service includes past-chair of ACEP’s Academic Affairs Committee and ACEP’s Young Physicians Section. Away from the hospital, you’ll find me wakeboarding with my husband, struggling through Charlotte’s Thunder Road Marathon, or being chased by our sons with light sabers!

**David Kammer, MD**

**Raleigh, NC – Wake Emergency Physicians PA**

**Residency:** Carolinas Medical Center 2012

**Medical School:** University of Washington 2009

Thank you for taking the time to vote in this year’s board election, and for your consideration of my candidacy for a continued position on the NCCEP board. I have had the privilege of previously serving on the NCCEP board as a resident board member from 2010 to 2012, and as a voting member during the last year. I am currently serving on my second term as an elected councilor for the College.

I believe NCCEP’s ability to influence dialogue rests on our earned reputation as a reliable source of information and our capacity to mobilize our base to speak up in the interest of our patients. In addition to working with my colleagues to support this critical capacity building, as a board member, I would also continue to ensure that the quality of our online presence matches the high standard of information we provide.

Prior to returning to medical school, I was a software engineer in Seattle, and think that I bring a somewhat unique technical skill set to the board. During my time with the College, I have overseen a significant upgrade in our electronic communications including a retooled and modern website, online conference registration capacity, and, for the first time, making our legislative updates available to the entire membership. We’ve also made it easier to donate to the Emergency Physician PAC. All of this was done while decreasing our total yearly spending on electronic communication.

Thank you again for your consideration. I hope to continue serving the College and its membership.

**Eric Maur, MD, FACEP**

It has been a true honor to serve on the Board of Directors for the past two years. Now that my current term is coming to an end, I humbly ask for your support as I seek re-election to the Board.
I possess several qualities and qualifications that make me a good candidate to continue serving as a Board member. The first and foremost one is experience. My experience serving on an ACEP Board first began during residency when I spent two years as the resident representative to the Pennsylvania ACEP Chapter. Being involved so early in my career gave me tremendous insight into the qualities needed to be an effective leader within ACEP along with first-hand exposure on how a Board of Directors functions.

From there, I went on to serve on the Board of Directors of the Emergency Medicine Residents’ Association (EMRA) as the ACEP Representative. In this capacity I was responsible for representing the views of EMRA to the ACEP Board of Directors and for serving as the primary liaison between the two organizations. During my two year term I attended all Board of Directors meetings and activities for both EMRA and ACEP, served as a full member on the ACEP Steering Committee, and represented EMRA on the ACEP Council.

After completing my term on the EMRA board, I went on to serve as the Councillor for ACEP’s Young Physicians Section. To date, I have now been a Councillor for seven of the past eight years. I also served on the Council Steering Committee for two of those years. As Councillor, I have had the honor of representing the Commonwealth of Pennsylvania for 3 years, EMRA for 2 years, and ACEP’s Young Physicians Section for 2 years.

In addition to serving on the NCCEP Board of Directors, I also am currently Chair-Elect for ACEP’s Young Physicians Section, and will assume the role of Chair later this year.

My experiences have provided vast insight to the challenges our specialty is facing. As these challenges continue to grow, it is important that we have well qualified leaders to help navigate through them. Health care reform is here to stay, and we need to remain strong to help mold the new models to ensure the best care (and access to it) for our patients. Along with health care reform, tort reform must somehow be included in the restructuring of our nation’s healthcare system.

There are also issues that directly impact us in our everyday practice. Does boarding inpatients in the ED ever

See Candidates – continued on page 6
Candidates – Continued from page 5

affect you? Or holding psychiatric patients for days, weeks, even a month at a time ever get in the way of your ED throughput? And are we really serving our patients by holding them trapped in the ED for weeks at a time?

My experiences on the local, state, and national levels have prepared me well to continue serving the NCCEP membership on the Board of Directors, and I respectfully ask for your continued support in re-electing me to the Board.

Thank you for your support.

Yogin Patel, MD, MBA, FACEP

Current Position: Divisional President, ApolloMD
Graduate School: Duke Medical School, Fuqua School of Business
EM Residency: Oregon Health and Science University

Affiliations: ACEP, NCCEP

At a time when healthcare consolidation has hit unprecedented levels and our critical role as part of the fabric of the healthcare safety net is being threatened, I’m proud of the important work done by NCCEP and ACEP. Whether it’s advocating for Medicaid expansion or critical legislation, like the Health Care Safety Net Enhancement Act of 2015 (HR 886), I believe that part of the way we can better serve our patients, is to give voice to the underserved and to our fellow providers.

I’ve always been a proud member of ACEP and I am a member of ApolloMD, one of the largest, private Emergency Physician groups in the country. I served as EMRA’s Legislative Advisor while in residency and have nurtured an interest in ACEP’s legislative advocacy work. Yet, I’m the first to acknowledge, that I have not capitalized on my ability to advocate for change in healthcare. Now, more than ever, I believe in the important work done by NCCEP, and I want to contribute to its mission. I currently serve as Divisional President with ApolloMD representing about 250 full time physicians in the state. In my role, I regularly meet with residents from across our state’s training programs to discuss life after residency, financial planning, and navigating the job search. I also regularly meet with hospital administrators, who are often caught trying to incentivize high quality care with increasingly thinner budgets and vanishing resources. Whether it’s better understanding of EMTALA obligations or shedding light on the lack of mental health resources, I’d welcome the opportunity to promote a greater awareness and stronger level of engagement around the critical issues faced by our specialty. As providers, many of us share the philosophy of high quality patient care delivered by sustainable physician groups. However, every practice is unique and the challenges faced by providers serving a critical access hospital are very different from the concerns faced by our urban trauma centers. As someone that works clinically across the state, I’d like to share perspective on these concerns. I look at NCCEP as a unique opportunity to collaborate with some of the most passionate minds in our specialty, to learn from them, and to bring fresh ideas and a humble voice to my colleagues. I would be honored to serve on the NCCEP Board. Thank you for your consideration.

Sankalp Puri, MD, FACEP

Current Position: Assistant Medical Director Emergency Department, Novant Health Presbyterian Medical Center
Staff Physician: Novant Presbyterian Medical Center, Novant Matthews Medical Center
Elected position: NCCEP Board of Director

I have been honored to serve on NCCEP Board of Directors and hope to have your consideration for re-election. I attended Wake Forest University Medical School and completed residency at Wayne State University Detroit Receiving Hospital Trauma Center where I served as a chief resident for my class. Since 2002 I have been a staff emergency physician with Mid-Atlantic Emergency Medical Associates, a multi-hospital democratic group based in Charlotte, NC. As the Assistant Medical Director of Emergency Department for an urban hospital with annual patient volume of over 125K, I have direct involvement with hospital administration. I serve on numerous committees including Vice-chairman for Emergency Medicine Peer Review and Quality Improvement for Presbyterian Medical Center, Pharmacy and Therapeutics Committee, Finance Committee in my group. I have been a member of ACEP and Mecklenburg
Medical Society since 2003. Serving on NCCEP Board of Directors has allowed me to see the enormous importance this organization has on all emergency physicians in our state and on our specialty. The medical landscape is rapidly changing and NCCEP leadership is paramount in helping to guide the specialty for our state. North Carolina emergency physicians will see critical changes affecting their professional lives. In coming years as ACO model takes hold, NCCEP will have a strong voice in fighting for issues impacting Emergency Medicine. Furthermore, decreasing reimbursement to continued emphasis to maintaining medical tort reform, to narcotic abuse in Emergency Departments, not to mention many other pertinent issues, NCCEP continues to provide leadership for all emergency physicians of North Carolina. It would be an honor and privilege to represent you for NCCEP Board of Directors.

Doug Trocinski, MD, FACEP

I very much appreciate the opportunity to be considered for a position on the NCCEP Board of Directors. I have been practicing in North Carolina since 2002. I have been active in ACEP on national committee level and education and have been active in the leadership of my group. I have had the good fortune to get to know many emergency physicians throughout our state during those years while working both in private practice and as the program director at UNC-Chapel Hill for 5 years. I believe those experiences in an independent group and an academic faculty, as well as my prior experience as a Navy Emergency Physician, have given me the ability to understand the many different perspectives and challenges that we face in our specialty during trying and unsure times. My time in the different practice types lays the foundation to talk with colleagues in any setting and, as is necessary to any elected position, to listen and communicate the priorities of those I represent in order to advance and protect our specialty as we move forward in our own state and on the national stage.

It would be an honor and privilege to serve our community on the NCCEP Board of Directors. I thank you for your consideration and look forward to the opportunity.

ED-CAHPS... ARE YOU READY?

The Emergency Department Consumer Assessment of Healthcare Providers and Systems (ED-CAHPS) is the next government-mandated survey designed to improve the nation’s quality of healthcare. In anticipation of the actual required launch, many of you may already be using one of the 3 CMS test versions. While we can all get lost in the philosophical debate related to satisfaction data, there is some data to support improved compliance and outcomes (albeit a single study from UC Davis showing higher cost of care, admission rate, and mortality associated with higher satisfaction). CMS’s goal in developing the ED version is to better understand the ED experiences from the patient’s perspective, provide objective comparisons of care received, and improve the quality of ED visits across the US.

A commonly used ED-CAHPS test survey has 61 focused questions related to the ED experience for discharged patients. Depending on the vendor providing the pilot survey, additional ED specific survey questions are commonly added. Questions focus on the timing of care, communication related to old and new medications, pain management, communication skills (courtesy, respect, listen, explain, etc). It is anticipated that this will be very similar to the ED-CAHPS that will be launched by CMS.

What we do know from HCAHPS (the inpatient version) is that higher ED satisfaction impacts the inpatient realm as well. But what specifically improves the ED experience? We know that shorter times from door to provider and overall length of stay improve patient satisfaction. Research also shows a clear relationship between providing good and adequate pain relief and higher patient satisfaction. Beyond that, good manners seem to go a long way.

Want to learn more?


NCCEP will keep you posted as this continues to develop.
We are EXPANDING in NORTH CAROLINA

Southeastern Regional Medical Center

Fayetteville VA Medical Center

NEW OPPORTUNITY:
• Associate Residency Director

ADDITIONAL OPPORTUNITIES:
• Staff Physicians

ASSOCIATE RESIDENCY DIRECTOR REQUIREMENTS:
• Must be DO-FACOEP trained
• Prior teaching experience and publication preferred

FAYETTEVILLE VA MEDICAL CENTER | FAYETTEVILLE

NEW LOCATION: Nestled in scenic Fayetteville, NC close to beautiful beaches, breathtaking mountain ranges and world-class golf and outdoor recreation.

SEEKING BC/BE EM PHYSICIANS
• 27,000 ED visits annually
• 10-bed, newly constructed ED
• Dedicated hospitalists handle all admissions

• 48 hours of physician coverage
• Complexity Level 2, 58-bed medical center providing general medicine, surgery and mental health services with a 69-bed long-term care unit

OUR PHYSICIANS ENJOY

✓ Superior Compensation & Comprehensive Benefits
✓ Equitable Scheduling
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✓ 95% Physician Retention Rate

Explore these positions, as well as exciting career opportunities in NJ, NY, PA, RI and NC.

Jonathan Hughes
(973) 251-1190
HughesJ@EMA.net
www.EMA.net/careers
Represent EM on the North Carolina Medical Board

The NCCEP Board of Directors encourages you to apply to serve as one of the physician seats on the NC Medical Board and represent Emergency Medicine. Applications are due to the Review Panel by July 1st.


Now is the time to apply if you have ever considered serving our State and the medical profession in this capacity as the terms of four sitting Medical Board members expire October 31.

Applicants are needed for two physician seats on the Board and for one seat that is reserved for a physician assistant or nurse practitioner. The three remaining seats (two physicians, one PA or NP) must be filled by the process set down in statute (N.C. Gen. Stat. § 90-2 and 90-3), which requires interested parties to apply via the Review Panel. By law, the Review Panel must nominate two candidates for each open seat for the Governor’s consideration. All Board Member terms are three years, beginning Nov. 1 and ending October 31, 2017.

Instructions for applying via the Review Panel:

Under North Carolina law, interested parties must apply through the Review Panel. This independent body screens applicants, conducts interviews and makes recommendations to the Governor, who then appoints physicians to the Medical Board. The Review Panel will only consider physicians (MDs or DOs) who hold active, unrestricted NC medical licenses. Applicants must be actively practicing clinical medicine at least part time and must have no history of disciplinary action within the past five years. Applications are due by July 1.

The Review Panel will interview all qualified applicants in Raleigh in August. All three of the positions for which applicants are sought currently are held by Board members who are eligible for reappointment; however, these Board Members must go through the application and interview process.

For more information, contact Jerel Noel, the Review Panel Administrator, at (919) 861-4545.
### AGENDA

**Thursday, June 4, 2015**
- 4:00 pm – 6:00 pm: Exhibitor Set Up
- 6:00 pm – 7:00 pm: GA, NC, and SC Board Meetings Board Member Reception

**Friday, June 5, 2015**
- 7:00 am – 8:00 am: Registration; Breakfast, & Visit Exhibits
- 8:00 am – 9:00 am: Getting Aims on the MMTS Exam
- 9:00 am – 10:00 am: Diagnostic Strategies for Thunderclap Headache
- 10:00 am – 10:30 am: Acute Heme/Onc in the ED: “two more” things you need to know
- 10:30 am – 11:00 am: Break & Visit Exhibits
- 11:00 am – 12:00 pm: Concurrent Session 1
- 12:00 pm – 1:00 pm: GA & NC Annual Meetings
- 1:00 pm – 2:00 pm: CEMC Golf Tournament
- 2:00 pm – 3:00 pm: Reception in Exhibit Hall & Iod’s Movie Night

**Saturday, June 6, 2015**
- 7:30 am – 8:00 am: Registration, Breakfast, & Visit Exhibits
- 8:00 am – 9:00 am: The next epidemic coming to your ED: Herd immunity, the lack thereof, and the truth about vaccines
- 9:00 am – 10:00 am: Break & Visit Exhibits
- 10:00 am – 11:15 am: Jeopardy: Tri-State Tournament
- 11:15 am – 12:15 pm: ACFP Update

**Register Four Ways:**
1. U.S. Mail
2. Fax: (305) 422-3327
Sunday, June 7, 2015
7:30 am – 8:00 am
Registration & Breakfast

8:00 am – 8:30 am
To Err is Human: Medical Decision Making and Error in Emergency Medicine
June Day, MD

8:30 am – 9:00 am
Sono in Sepsis: Catch what you are missing...
Geoff Hayden, MD

9:00 am – 9:30 am
What’s hip with the hip blocks and beyond...
Richard Gordon, MD

9:30 am – 10:00 am
Visual Diagnosis in the Poisoned Patient
William Richardson, MD

 Concurrent Session 1
8:00 am – 10:00 am
ER/IA Optimal REMS: Achieving Safe Use While Improving Patient Care in the Emergency Department
Nicholas Connors, MD

10:00 am – 10:30 am
Mystifying the Metrics: Core Measures, Optimal based care scores, finding the signals among all the noise.
Daniel A. Mandel, MD, MBA, MPH

10:30 am – 11:00 am
Appendicitis in Wes People: Updates and Controversies
Keith T. Burg, MD, PhD

11:00 am – 11:30 am
Undifferentiated Dyspepsia: Make the Diagnosis, not Mistakes
Richard Gordon, MD

11:30 am
Meeting Adjourns

ACREDITATION STATEMENTS
The Southern Alliance for Physician Specialties is accredited by the Medical Association of Georgia to provide continuing medical education for physicians.

The Southern Alliance for Physician Specialties designates this live activity for a maximum of 10.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint membership of the American College of Emergency Physicians and the Coastal Emergency Medicine Conference. The American College of Emergency Physicians is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American College of Emergency Physicians designates this live activity for a maximum of 2.00 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for a maximum of 2.00 hour(s) of ACEP Category 1 credit.

3. Phone: (770) 613-0932 | 4. Online: www.coastalemergencymedicine.org
PHYSICAL ABUSE
GUIDELINES FOR THE EVALUATION OF CHILDREN IN THE
EMERGENCY DEPARTMENT SETTING

These guidelines provide a brief summary of 1) the recommended evaluation of children in the emergency
department setting with concerns for physical abuse, 2) reporting requirements to the Department of Social Services
and law enforcement, and 3) referral to a physician/licensed medical provider with expertise in the evaluation of child
abuse/neglect.

When it is suspected that any child/adolescent may have been physically abused, it is critical that these children
receive a complete physical examination and any diagnostics needed to assist the evaluation. Thorough
documentation to include body diagrams/photodocumentation of pertinent physical findings should be included.

We recommend the following approach:

1) OBTAINING THE HISTORY:

   a. Interview caregivers independently of each other and the child. Document who was present for the
      interviews and the demeanor of the caregivers. Use quotation marks to indicate specific responses being
      provided by the caregivers.
   
   b. While detailed interviewing of children should be deferred to professionals with expertise in interviewing
      children for concerns of abuse, children may be asked open-ended questions to obtain a history and focus
      for the physical examination. The child, if at all possible, should be interviewed away from accompanying
caregivers. Document who was present with the child for the interview, the child's demeanor, and use
      quotation marks to indicate remarks/responses being provided by the child.

2) PHYSICAL EXAM:

   a. Completely examine the child (include ano-genital area, inside the mouth, between digits, palms & soles).
      Document any findings or lesions/injuries with photographs (permission not required when part of medical
      evaluation), if possible, and diagrams, being sure the site of the abnormalities/injuries are clear. Include
      measurement device with gray scale if possible. An identifying face photo of the child is helpful. Include
      with patient name, MR#, date taken and by whom.

3) DIAGNOSTICS:

   a. Use skeletal surveys, if a child under 2 years of age has suspicious fractures, bruises, or other injuries.
      *Do not use “babygrams” (i.e. whole-body x-rays) because of the high rate of false negatives. Skeletal
      surveys are rarely useful in children >5 years of age and are generally not recommended.
   
   b. Consider:
      i. Baseline labs. Laboratory screening for coagulopathies with concerning bruising/bleeding.
         Urine/blood to detect exposure to toxic substances (alcohol, illegal substances, etc.)
      ii. Head imaging (Head CT/MRI) to rule out intracranial injury, particularly if there are neck, facial, ear,
         scalp injuries, vomiting or altered consciousness present.
      iii. Abdominal trauma with screening labs (Liver Function Tests, amylase, lipase) and/or abdominal CT.
          Note: Screening labs may be normal in setting of trauma, so if clinical suspicion is high for injury,
          proceed to abd/pelvis CT.

Revised 1/2015
4) OTHER INFORMATION:
   a. Obtain the medical record, if possible, and look for repeated visits for injuries and other signs of possible maltreatment, regardless of whether history is consistent with physical findings.
   b. If possible, consult with the child’s primary care provider to discuss presentation and any concerns.

5) SAFETY/ REPORTING:
   a. Hold the child or admit him/her to the hospital if there are safety concerns, until a child protective services worker responds and takes over this aspect of management. **N.C. General Statute 7B-308 (Twelve Hour Custody)** states that any “physician or administrator of a hospital, clinic or other medical facility to which a suspected abused juvenile is brought for medical diagnosis or treatment, shall have the right, when authorized by the chief district court judge or his designee, to retain physical custody of the juvenile ...” (Please refer to your medical facility’s protocol regarding how to obtain twelve-hour custody)
   b. **Make a report to the local county Department of Social Services per the state’s mandatory reporting law for suspected child abuse and neglect.** The report should be made to the county DSS in the county where the child resides. If difficulty in connecting with the county DSS of residence, you may contact your local DSS agency to assist in making the report. To locate your DSS, click here: [http://www.ncdhhs.gov/dss/local/](http://www.ncdhhs.gov/dss/local/). All citizens of North Carolina who have suspicion(s) of child abuse/neglect are mandated reporters.
   c. A report must be made to law enforcement when the child has sustained serious injury or meets **G.S.90-21.2.** The report is made to the law enforcement agency that has jurisdiction in which the medical facility is located.

6) REFERRAL
   Refer the child to the appropriate physician/licensed medical practitioner with experience in the evaluation of child maltreatment in your particular region of the state to ensure that the child’s medical and mental health needs will be met. The referral physician/licensed medical provider should be immediately contacted and informed of the history and results of the initial examination. **Call the NC Child Medical Evaluation Program at 919-843-9365 if you need information concerning who provides child abuse/neglect evaluations in your area.**

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* ACR-SPR PRACTICE GUIDELINE FOR SKELETAL SURVEYS IN CHILDREN (2011)

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<td>Thorax (AP, lateral right and left obliques), to include ribs, thoracic and upper lumbar spine</td>
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<td>Forearms (AP)</td>
<td>Pelvis (AP), to include the mid lumbar spine</td>
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<td>Cervical spine (lateral)</td>
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<td>Lower legs (AP)</td>
<td>Skull (frontal and lateral)</td>
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SEXUAL ABUSE/ASSAULT
GUIDELINES FOR THE EVALUATION OF CHILDREN IN THE EMERGENCY DEPARTMENT SETTING

These guidelines provide a brief summary of 1) the recommended evaluation of children in the emergency department setting with concerns for sexual abuse, 2) reporting requirements to the Department of Social Services and law enforcement, and 3) referral to a physician/licensed medical provider with expertise in the evaluation of child abuse/neglect.

When it is suspected that any child/adolescent may have been sexually abused, the child should receive a screening exam in the ED that focuses on acute problems (e.g. trauma, vaginal discharge) and, if needed, evidence collection. The child should then be referred to a physician/licensed medical provider with experience in the evaluation of child maltreatment for full evaluation as soon as possible.

We recommend the following approach for this screening evaluation:

1) OBTAINING THE HISTORY:
   a. Interview caregivers independently of each other and the child. Document who was present for the interviews and the demeanor of the caregivers. Use quotation marks to indicate specific responses being provided by the caregivers.
   b. While detailed interviewing of children should be deferred to professionals with expertise in interviewing children for concerns of abuse, children may be asked open-ended questions to obtain a history and focus for the physical examination. The child, if at all possible, should be interviewed away from accompanying caregivers. Document who was present with the child for the interview, the child’s demeanor, and use quotation marks to indicate remarks/responses being provided by the child.

2) PHYSICAL EXAM:
   The child should have a complete physical exam with documentation of any ano-genital/extragenital lesions/injuries. If possible, photographs (permission not required) and diagrams should be utilized to document findings. An identifying face photo is helpful. Include card with patient name, MR#, date taken and by whom.

3) REMINDERS:
   a. A SPECULUM SHOULD NEVER BE USED ON A PRE-PUBERTAL FEMALE and RARELY NEEDED IN ADOLESCENTS. If a speculum exam is warranted for any medical reason (unknown source of bleeding, evaluate extent of trauma, remove a foreign body resistant to being flushed from the vaginal vault), the prepubertal child should be examined under general anesthesia/conscious sedation. A CHILD (beyond infancy) SHOULD NOT BE PHYSICALLY RESTRAINED FOR THE PHYSICAL EXAMINATION. Consideration should be given to deferring the exam to the child abuse specialist in cases where it is not immediately medically necessary to examine the child/adolescent and the child/adolescent is unable to cooperate in the ED with the exam.
   b. A NORMAL EXAM DOES NOT RULE OUT SEXUAL ABUSE/ASSAULT.
   c. Current American Academy of Pediatrics’ Guidelines for the Evaluation of Sexual Abuse of Children state that Sexual Assault Evidence Collection Kits (SAECK) are most productive if performed within 72 hours of the alleged incident, however, some programs may extend to longer time periods. (Note: Bedding and clothing can yield evidence for an extended period of time).

4) DIAGNOSTICS:
   a. Testing for STIs in prepubertal children can be complex. While cultures for gonorrhea and chlamydia remain the “gold standard”, screening for Gonorrhea and Chlamydia may be done via nucleic acid amplification tests (NAAT’s), which can be performed on a urine specimen. Follow-up repeat testing may be better accomplished by a child abuse medical provider at a subsequent appointment. (Please refer to the AAP’s Redbook or the CDC’s MMWR for additional information.) The child abuse medical provider who will be receiving the referral should be contacted prior to treatment to ensure that a second NAAT can be obtained to confirm a true positive result, and a culture can be sent. All samples testing positive should be saved by the lab for subsequent analysis if needed.

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b. Consider serologic testing for Syphilis, HIV, and HBV. Viral cultures for lesions suspicious of HSV.

c. Pregnancy testing should be performed for pubertal children.

d. Consider blood/urine testing if any suspicion of drugs or alcohol was used during the alleged sexual abuse/assault in any age child.

5) TREATMENT FOR SEXUALLY TRANSMITTED INFECTIONS:

a. Prepubertal
   i. **STI post-exposure prophylaxis is not generally indicated or advised in prepubertal children.**
      Consider consultation with a pediatric infectious disease specialist to determine if HIV nPEP (non-occupational Post Exposure Prophylaxis) is warranted.

b. Pubertal
   i. STI prophylaxis should be considered for pubertal patients with particular attention to Chlamydia, Gonorrhea, Trichomonas and HIV. Testing before prophylaxis is always recommended. Consider consultation with a pediatric infectious disease specialist to determine if HIV post-exposure is warranted.
   ii. Emergency Contraception (Plan B or equivalent) should be offered.
   iii. Refer to CDC website on Sexually Transmitted Diseases Treatment Guidelines, 2010: Sexual Assault and STDs for further information on testing and treatment [http://www.cdc.gov/std/treatment/2010/sexual-assault.htm](http://www.cdc.gov/std/treatment/2010/sexual-assault.htm)

6) “FINAL DIAGNOSIS”: In most cases, the “Final Diagnosis” will not be made in the Emergency Department setting but rather by a follow-up evaluation by the child abuse specialist. Therefore, use caution in the wording of the preliminary assessment (i.e. “no sexual abuse found”)

7) SAFETY/ REPORTING:

a. Hold the child or admit him/her to the hospital if there are safety concerns, until a child protective services worker responds and takes over this aspect of management. [N.C. General Statute 7B-308 (Twelve Hour Custody)](http://www.ncdhs.gov/dss/local/) states that any “physician or administrator of a hospital, clinic or other medical facility to which a suspected abused juvenile is brought for medical diagnosis or treatment, shall have the right, when authorized by the chief district court judge or his designee, to retain physical custody of the juvenile ...” (Please refer to your medical facility’s protocol regarding how to obtain twelve-hour custody)

b. **Make a report to the local county Department of Social Services per the state's mandatory reporting law for suspected child abuse and neglect.** The report should be made to the county DSS in the county where the child resides. If difficulty in connecting with the county DSS of residence, you may contact your local DSS agency to assist in making the report. To locate your locate DSS, click here: [http://www.ncdhs.gov/dss/local/](http://www.ncdhs.gov/dss/local/). All citizens of North Carolina who have suspicion(s) of child abuse/neglect are mandated reporters.

c. A report must be made to law enforcement when the child has sustained serious injury or meets G.S.90-21.20. The report is made to the law enforcement agency that has jurisdiction in which the medical facility is located.

8) REFERRAL:

Refer the child to the appropriate physician/licensed medical practitioner with experience in the evaluation of child maltreatment in your particular region of the state to ensure that the child’s medical and mental health needs will be met, The referral physician/licensed medical practitioner should be immediately contacted and informed of the history and results of the initial examination. **Call The NC Child Medical Evaluation Program at 919-843-9365 or go to** [http://www.med.unc.edu/cmep/](http://www.med.unc.edu/cmep/) **if you need information concerning who provides child abuse/neglect evaluations in your area.**

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Space to document who the facility uses as their child abuse specialist

Revised 1/2015
THE EM CLUSTER AND PQRS MEASURE #317-SCREENING FOR HIGH BLOOD PRESSURE – WHAT ED PROVIDERS NEED TO KNOW

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March 4, 2015

2015 has brought the most dramatic changes to the PQRS program (Physician Quality Reporting System) for the ED provider that we have seen since the program’s inception in 2007. First, CMS has introduced “payment adjustments” for calendar year 2015 reporting, as opposed to the bonuses that have been achievable in past PQRS reporting years. For providers that do not meet CMS’s definition of “successful reporting” for the traditional PQRS program for the 2015 performance year, Medicare payments will be reduced by -2% in 2017. Public reporting of PQRS results by CMS is yet another reason for physician groups to place PQRS reporting as a high priority.

For performance year 2015, CMS defines successful reporting as reporting 9 or more measures across 3 or more NQS (National Quality Strategy) domains (1 of which must be a cross-cutting measure, see discussion below) for at least 50% of the Eligible Professionals (EPs or ED Providers) Medicare Part B patients seen during the reporting period to which the measure applies. In addition, the determination whether providers successfully report for the PQRS program is now connected to the Value Based Modifier program, which puts another potential -4% of Medicare payments at stake. Significantly, for the 2015 performance year, CMS also retired 4 of the 7 Emergency Medicine (EM) PQRS measures that have been reported by ED groups since the beginning of the program: #28 Aspirin for Acute MI, #55 12-Lead EKG for Syncope, #56 Vital Signs for Community Acquired Pneumonia (“CAP”) and #59 Empiric Antibiotic for CAP. These measures were deemed by CMS to be “tapped-out” for EM. CMS’ decision has resulted in only 8 claims-based measures available for ED providers to report, several of which do not have large patient populations associated with them, e.g. U/S for pregnant patients with Medicare, with abdominal pain.

If EPs do not or cannot (as in the case or ED providers with so many of their claims-based measures retired) report the minimum 9 measures, then EPs will be subject to the Measure Applicability Validation (“MAV”) process. The MAV is a validation process that CMS uses to determine if there were additional measures that were applicable to the EP that he or she should have reported. Within the MAV documents, CMS recently released “clusters” of measures for certain specialties. The Emergency Medicine cluster (EM Cluster) contains 3 measures: 1) Measure #54-EKG for Chest Pain, 2) Measure #254-Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain and 3) RH Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure.

CMS introduced the “cross-cutting measure” requirement for 2015 (this cross-cutting measure requirement is in addition to the above 3 EM Cluster measures). This is a requirement that EPs include at least 1 cross-cutting measure (broad-based measures that CMS released in a specific list) as one of their PQRS measures that they report. For ED providers, the only cross-cutting measure that applies is Measure #317-Screening for High Blood Pressure and Follow-up Documented. ED Providers must understand what this measure entails so that they can modify their EMR as needed in order to report this measure successfully (again, as CMS defines it). Measure #317’s denominator (the patient population that the measure is to be reported on) is Medicare patients age 18 and older who have one of the Evaluation and Management codes listed in the measure reported. The ED E/M codes 99281-99285 are listed in the measure’s denominator. This means that every Medicare patient age 18 and older is eligible to be included in this measure and should be reported. It is clear why Medicare refers to these cross-cutting measures as “broad based”.

Measure #317 requires that the physician or non-physician practitioner provide appropriate follow-up (clearly defined in the accompanying table) for different groupings of hypertensive BP readings: Pre-Hypertensive BP Reading, First Hypertensive BP Reading and Second Hypertensive BP Reading. Measure #317 defines the parameters for appropriate blood-pressure follow-up in the table on page 17.
In order to accurately report this measure, ED providers should use the categories in their documentation that CMS delineates in the above table, e.g. Pre-Hypertensive BP Reading or First Hypertensive BP Reading, and then document the indicated follow-up on the table for the category.

CMS included several “exclusions” in the measure and these should be documented by the EP if they apply, however, note that even if these exclusions apply, the patient must still be reported on with the appropriate CPT G-code:

- The patient refused to participate with either the BP measurement or the follow-up;
- The patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated;
- The patient has an active diagnosis of hypertension.

**Important note regarding patients who are admitted from the ED: Zotec received high level official clarification from CMS that in the ED, an admitted patient is considered to fall under the “Referral to Alternative/Primary Care Provider” category and, therefore, meets the criteria of follow-up documented for that patient. For non-admitted patients, however, the EP should document a referral to an “Alternative/Primary Care Provider”. The documented follow-up plan must be related to the current BP reading, for example, “Patient referred to primary care provider for BP management”. The “best practice” in performance of this measure is to also include the specific follow-up time for the category that the patient falls into, for example if this is the 1st Hypertensive BP Reading for the patient, then the ED provider should specifically note in their follow-up instructions to follow-up with the primary care physician (or other alternative provider) within 4 weeks (as per the time guidelines given in the table).

There are several solutions available for Emergency Department Physician groups in order to successfully capture the documentation required for Measure #317. The solution will depend in part on the EMR or other documentation tool used at your facility. One possibility is to build the Table from Measure #317 into the discharge instructions of every patient whose insurance information indicates they are Medicare beneficiaries over age 18. The EP should indicate which of the four categories the patient falls into based on the BP reading, and make the appropriate follow-up recommendation. Another alternative would be to build the macro for this documentation directly into your clinical notes.

**CONCLUSION:**

Successful reporting for the 2015 performance year under the Claims method and EM Cluster/MAV pathway requires that the EP report on 50% of eligible cases. While time remains in the 2015 performance year to make accommodations in the medical record and still achieve the successful reporting benchmark, providers should consider this high priority in terms of getting this done in order to maximize their PQRS successful reporting.
NORTH CAROLINA BOARD OF NURSING (NCBON) VOTES TO CHANGE BOARD’S POLICY STATEMENT REGARDING ADMINISTRATION OF SOME MEDICATIONS

One of the greatest challenges in Emergency Medicine is the varied practice environments in which our providers work — and the impact of well intentioned policies that often fail to recognize this. ACEP and NCCEP recognize these challenges and work diligently to facilitate change that improves patient care and promotes our specialty. As a recent example of this, on January 30th the North Carolina Board of Nursing (NCBON) voted to change the Board’s policy statement regarding administration of medications such as Propofol, Etomidate, and Ketamine for the purpose of deep sedation by Registered Nurses (RNs) in the Emergency Department. This policy change came at the urging of the North Carolina College of Emergency Physicians (NCCEP) and is the culmination of nearly 3 years of effort by NCCEP and other stakeholders including the NC Chapter of the Emergency Nurses Association (ENA). NCCEP was highly impressed with the Nursing Board’s rigorous investigation of the evidence supporting this practice. The Education and Practice Committee scrutinized the literature and held public hearings to hear testimony from state organizations such as NCCEP, ENA, the Pediatric Society, the Society of Anesthesiologists, and various Nursing and Hospice organizations.

The NCBON position statement now expressly allows the administration of these sedation medications in the Emergency Department by RNs with some caveats. These caveats should be viewed as safeguards and shifts the responsibility for privileging for this RN competency to individual institutions rather than limit RN practice at the state level. The position statement emphasizes that RNs must possess valid competencies regarding procedural sedation and the pharmacology of drugs used. In addition, it states that privileged physicians should be physically present at the bedside during the entire time deep sedation is administered. Emergency Nurses should also have “in-depth knowledge” and validated competency of anatomy and physiology, pharmacology, and airway management skills as it relates to sedation.

Almost every emergency physician in the US would agree that the evidence supports emergency nurses administering agents such as Propofol, Ketamine, and Etomidate in the Emergency Department while the privileged physician is at the bedside, so why all the fuss? Much of the controversy is a result of the 2010 American Society of Anesthesiologists’ Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners.” While it had good intentions, this advisory recommended that, “the non-anesthesiologist sedation practitioner who administers and monitors deep sedation must be different from the individual performing the diagnostic or therapeutic procedure.” While finding two physicians in a large academic center may be an easy task, many EDs across the country are predominantly single coverage or simply too busy to have one physician dedicated to the procedure and one dedicated to the sedation. In these scenarios, it is necessary to adopt a team approach in which a nurse can push the plunger and when the patient is adequately sedated, the emergency physician can perform the procedure. In their 2011 PSA position statement, ACEP strongly supports the administration of such agents for the purpose of deep sedation by qualified Emergency Department RNs under direct supervision of a privileged emergency physician. Studies support this team approach to sedation as being safe and effective.

CMS also advocates for hospitals to let emergency departments defer to ACEP for their sedation policies. The 2011 CMS interpretive guidelines state, “CMS expects surveyors to verify that the hospital can identify guidelines that support its policies. A hospital could use multiple guidelines, for example, ACEP for sedation in the emergency department.” The CMS guidelines also reference the ENA and ACEP statement on procedural sedation and analgesia that says, “The ENA and ACEP support the delivery of medications used for procedural sedation and analgesia by credentialed emergency nurses working under the direct supervision of an emergency physician. These agents include but are not limited to etomidate, propofol, ketamine, fentanyl, and midazolam.”

The newly adopted NCBON position statement on Procedural Sedation and Analgesia will hopefully set a precedent for other nursing boards across the country. There is compelling evidence that emergency departments are unique environments where airway management and sedations are routinely performed by a team of emergency physicians, nurses, and respiratory therapists in a safe and well thought out manner.

NOTE: NCCEP would like to recognize Drs. Jen Raley, Amy Griffin and Bret Nicks for their time and efforts in researching and presenting the issue to the BON as well as following up with answers to a variety of questions. Their efforts have moved emergency medicine forward in North Carolina and assisted all Emergency Medicine providers.
North Carolina College of Emergency Physicians
2015 Elections

Election Rules:
• Regardless of the method of voting, you must vote for the specified number of candidates for each position. 
  *Ballots submitted without the correct number of votes for each position will be voided.*
• Your NCCEP membership must be current (dues paid through ACEP).

For Absentee Ballots:
• You may fax your absentee ballot to: (919) 882-1563.
• You may mail your absentee ballot to: Post Office Box 12946, Raleigh, NC 27605.
• Absentee ballots must include your name and address.
• Absentee ballots must be received *no later than 5 pm on May 29, 2015*, to be considered.
• If you are unsure if you will be able to cast your ballot at the annual meeting, complete the absentee ballot. 
  Your absentee ballot will be pulled if you are present and vote at the annual meeting.

Note:
• All new NCCEP Board members must sign the ACEP Member Expert Witness Reaffirmation Statement.

President-Elect (vote for 1 candidate)
☐ Jennifer Raley, MD
☐ __________________________

Secretary-Treasurer (vote for 1 candidate)
☐ Jeffrey Klein, MD
☐ __________________________

Board of Directors (vote for 4 candidates)
☐ Jennifer Casaletto, MD
☐ David Kammer, MD
☐ Eric Maur, MD
☐ Yogin Patel, MD
☐ Sankalp Puri, MD
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