



EPIC

January/February 2020

A Publication of the North Carolina College of Emergency Physicians

President's Message

By: Sankalp Puri, MD, FACEP

The past year was very busy for NCCEP as the College was fully engaged with the multitude of issues facing Emergency Medicine both statewide and nationally. NCCEP opposed many State-sponsored bills, the most important of which was the Greater Transparency in Health Care Billing. Although on the face, the bill sounds good, it would have eliminated balanced billing making fair payment almost impossible and giving insurance companies greater leverage at the expense of clinicians. We opposed this bill by working with a variety of legislators and stakeholders and while we had success at the State level, things at the federal level have really heated up and are still in a state of flux. We also worked on legislation regarding helmets, telehealth, Medicaid Transformation, and opioids as well as many others.



The new year brings persistent challenges to our specialty, and NCCEP will be front and center in advocating for our patients and members. The elephant in the room continues to be concerns for Balanced Billing. We urge you to continue to speak not only to your North Carolina Representatives and Senators about this important issue but also to your Federal Senators and Representatives. Lobbying by the health insurance industry is strong, but with persistent education, it will become clear that fair payment is the only option for services provided to patients in the Emergency Department.

NCCEP will host the North Carolina Medical Director Summit on March 6, which provides the perfect venue to bring leaders of Emergency Departments together for education and discussion relating to issues for Emergency Departments throughout our state and we hope you can attend. NCCEP board meetings are open for any members to attend, and I encourage you to give your time to the NCCEP by getting involved in a committee, attending a conference, or participating in our calls to legislative action. Our next Board meeting will take place in Greensboro on April 22; please reach out to me or any Board member if you have a desire to be involved or would like to attend. The 2020 Coastal Emergency Medicine Conference hosted by GCEP, NCCEP, & SCCEP will take place June 12 – June 14. This is a wonderful conference at a gorgeous venue, and we would encourage all of you to consider this event. If NCCEP can be of any assistance, please do not hesitate to reach out to us. We look forward to working on your behalf this year.

EMRA's 45 Under 45

Congratulations to NCCEP's Past President and Councillor, Abhi Mehrotra, MD, MBA, FACEP, on being recognized as one of EMRA's 45 Under 45: Influencers of EM. As EMRA celebrated 45 years of supporting the future of emergency medicine, it recognized 45 Under 45 influencers in Emergency Medicine ([#EMRA45u45](#)), and recognized outstanding young physicians whose contributions embody the spirit of the specialty. You may read more about the award and see a list of recipients [here](#). Congrats, Dr. Mehrotra!

CRASH-3 Trial

Dear Colleagues:

I wanted to make you aware of the CRASH-3 Trial results that were published in *The Lancet* last Fall that have implications for the broad emergency medicine community.

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)32233-0/fulltext#seccestitle160](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32233-0/fulltext#seccestitle160)

You may recall that the earlier CRASH-2 Trial looked at trauma patients at risk for hemorrhage and is the major evidence for our use of tranexamic acid (TXA) in hemorrhagic shock. CRASH-3, which looked at isolated head injury, will also probably change our practice once our trauma and neurosurgery colleagues have a chance to discuss the results. My bottom line summary is as follows:

- 1) Based on the results of CRASH-2 and CRASH-3, TXA is safe in multi-system trauma patients in hemorrhagic shock who happen to have concomitant head bleeds. We should continue to give TXA to all trauma patients at risk for hemorrhagic shock as soon as they arrive regardless of what their head CT shows. The dose for TXA in all trauma patients is still 1000 mg infused intravenously once over 10 minutes and given within 3 hours of injury, followed by 1000 mg intravenous infusion over 8 hours.
- 2) TXA is safe and likely improves mortality in isolated head trauma with a Glasgow Coma Scale (GCS) < 13 – a little. Most, if not all, of this mortality benefit is in the mild to moderate (GCS > 8) patients and may work by preventing their early deterioration. Patients with GCS of 3 and unreactive pupils will not benefit - it's not a miracle drug. Keep in mind that this modest improvement in mortality is in keeping with other drugs that affect hemostasis with a number needed to treat for mortality prevention of roughly 66. In other words, TXA is an adjunctive therapy to definitive surgical management, and not itself a cure.
- 3) Give TXA early since severity-adjusted outcomes showed that earlier is better when it comes to mortality. TXA after 3 hours is unlikely to improve outcomes. For those working in the community, you will need to coordinate with your local trauma centers and EMS systems to make sure they are on board since they will likely receive the patients while the infusion is still running.
- 4) TXA did not appear to increase the risk of thromboembolic events such as stroke, venous thromboembolism, etc.
- 5) TXA improves survival but not disability after head injury. This was a bit surprising to me and will likely be a point of debate about the study. However, keep in mind that CRASH-2 improved mortality from hemorrhage without changing transfusion requirements, so weird things can happen in science.

For those interested in TXA but not currently using it, I recommend that you start with this *Lancet* article and discuss it with your hospital's Pharmacy and Therapeutics Committee to make sure that you have institutional buy-in. Then, have your department leadership discuss it with trauma and neurosurgical colleagues at your institution or your referral centers if these patients are typically transferred. Feel free to drop me a line if you have questions or concerns about my bottom line. In the meantime, keep plugging along in your current practice until your department leadership has a chance to discuss the results with you admitting services or receiving trauma centers.

Sincerely,

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It is a Tough Call...A review of *CEASE: a guide for clinicians on how to stop resuscitation efforts.*

By: David A. Masneri, DO, FACEP, FAAEM and R. Darrell Nelson, MD, FACEP, FAEMS

Emergency medicine physicians frequently face the challenging decision of "calling the code." Stopping resuscitation is complex and involves clinical, ethical, team and family dynamics, as well as emotional factors and is further complicated by the fluid environment of the emergency department. The decision to stop is often made with incomplete information. This decision must then be properly communicated to the team and family.

Despite guidelines for initiating and continuing cardiopulmonary resuscitations, limited resources exist to guide the decision to stop. This decision is mainly a clinical decision based on judgment of the subjective and objective information available. Torke, et al, provide a framework, summarized by the mnemonic **CEASE** (Clinical features, Effectiveness, Ask, Stop, Explain), to stop resuscitation and communicate that decision to the team and family.

Read the full article [here](#).



REGISTER NOW!



**MEDICAL
DIRECTOR
SUMMIT 2020**

March 6, 2020

10:00 am – 3:00 pm

Grandover Resort & Conference Center
Greensboro, NC

Are you ready to be inspired? To spend time learning alongside and from your Emergency Medicine colleagues? To gain unique insights into challenges ahead in 2020 and beyond? The 4th Annual North Carolina Medical Director Summit (MDS) at the Grandover Resort and Conference Center is scheduled for March 6, 2020.

This unique opportunity brings together the collective expertise and experience of NC Emergency Medicine leaders – and those aspiring to lead in the future! This summit will continue to tackle many of the difficult challenges that we face each day and equip you to have a positive impact. With a focus on collaborative solutions based on team discussions, we will learn from each other as we prepare for the future of EM and advocating for our specialty. Whether new to the medical director leadership teams of North Carolina or one that participated in the previous years, we hope to engage you regarding the clinical challenges and potential solutions, current and future legislation that will impact our specialty, advocacy, and being part of the future of Emergency Medicine in North Carolina and beyond. We hope that this recurrent central location will allow for broad participation. Save the date – we look forward to learning from each of you once again.

[Register for the Medical Director Summit](#)

Palliative Pause in the ED

By: Justin Brooten, MD

Patients with palliative care needs in the emergency department (ED) can evoke a variety of responses from emergency medicine (EM) physicians. For some, this can be viewed as a potentially rewarding opportunity to significantly impact a patient's trajectory of care, but for others, this may be viewed as a daunting task to undertake while managing a busy ED. In addition to our mandate to provide evidence-based lifesaving care, as EM physicians we are being called upon more frequently to address potentially unmet palliative care needs while caring for the chronically and critically-ill. In one study of adults over age 65, over half visited the ED in the last month of life, and 75% visited the ED in the last six months of life. Of the group seen in the last month of life, 77% were admitted to the hospital from the ED and 68% died during admission.¹ Studies on ED intubation outcomes in older adults further highlight potential need to explore transitions in care when treating patients at high-risk for poor outcomes, regardless of

whether or not aggressive care is pursued. In two studies of a cohort of 41,263 patients over age 65 who were intubated in the ED, over one-third of patients who were intubated died during admission, most only survived 2 to 3 days.^{2,3} Surprising as these figures may be in and of themselves, it is more significant when combined with the fact that that most patients and their families report an inclination towards less aggressive interventions and/or comfort measures if it is perceived that a patient is nearing end of life.^{4,5} In the midst of trying to provide optimal critical care, how do we reconcile these statistics and consider when the primary role of an EM physician may not only be to attempt to save life, but to acknowledge and address when a disease process has reached the limits of medical science to provide a favorable outcome?

One of my mentors during palliative care fellowship coined the phrase "palliative pause" to illustrate a thought process that can be employed amidst the ABCs, algorithms, and treatment bundles that are a necessity in a frenetic ED. As difficult as it may seem to have any type of pause in our workflow, I have found this to be a very helpful approach in integrating palliative care principles alongside provision for acute interventions. When faced with a very ill patient with a poor prognosis, there are several questions to considering how best to approach the patient and their family:

- Is this patient likely to die in the near future as a result of this disease process regardless of what we do in the ED or in the hospital?
- Am I about to undertake an intervention for this patient that has a high likelihood of being unhelpful, and simultaneously uncomfortable?
- Is the patient or family prepared for what aggressive care may look like in the near future, have they discussed this, and what guidance has been provided to help make critical decisions right now?

Some situations provide us a relatively short amount of time to assess and make recommendations based on the hopes, worries, and wishes of a patient and their family, such as whether or not to pursue mechanical ventilation in a likely terminal situation. Other encounters may be opportunities to provide resources they may never have considered, such as the COPD patient you have admitted three times this month, who is likely going to survive another day, but has never considered that they have a terminal illness and need to plan for the future and establish their goals. Ultimately, EM physicians should not underestimate the significance of their position to influence trajectory of care and outcomes for our patients and their families as we face the front lines of palliative care.

References:

1. Smith AK, McCarthy E, Weber E, et al. Half of older Americans seen in emergency department in last month of life; most admitted to hospital, and many die there. *Health Aff (Millwood)*. 2012 Jun;31(6):1277-85. doi: 10.1377/hlthaff.2011.0922. Erratum in: *Health Aff (Millwood)*. 2012 Jul;31(7):1650. PubMed PMID: 22665840; PubMed Central PMCID: PMC3736978.
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8th Annual

COASTAL EMERGENCY MEDICINE CONFERENCE

FRIDAY, JUNE 12 - SUNDAY, JUNE 14, 2020
Kiawah Island Golf Resort, Kiawah Island, SC

www.coastalemergencymedicineconference.org

Psychiatric Observation: New Guidance from CPT Committee

By: Brian Hiestand MD, MPH (@wizard_of_Obs) & Bret Nicks, MD, MHA (@DrBretNicks)

Traditionally, observation services have been established as the provision of diagnostic and therapeutic interventions over a limited period of time to determine whether an outpatient will require admission and inpatient services. Therefore, by definition, patients meeting inpatient criteria from the outset were excluded from the observation setting. With regards to patients presenting with psychiatric emergencies, EDs across the country have been inundated with patients with clear needs for psychiatric inpatient care, but no inpatient psychiatric beds available to admit or transfer them to. As a result, these patients board in EDs for hours or days (or longer), and while the ED provides a safe environment and manages their care, no "credit" is received beyond the initial E&M.

In July 2019, however, the CPT committee issued new guidance on this topic. In CPT Assistant (official newsletter) the CPT committee stated unequivocally that observation codes were appropriate in the

setting of a patient who met inpatient criteria for psychiatric illness, but who had to board in the ED for an extended duration while receiving ongoing medical and psychiatric reassessments.

As discussed in the previous sections, observation codes are time-dependent, and cannot be billed concurrently with an ED E&M code such as 99285 (at least, not by the same group / same specialty / same Tax ID number – a topic for a later column). In the setting above, first day observation service (99218-99220 depending on complexity) would substitute for the ED E&M, and subsequent day observation codes (99224-99226) would be used for each sequential day until admission or transfer. Two caveats: 1) Ongoing care must be provided to the patient by the EM physicians during their stay. For those of us who do not have a separate psychiatric ED run by our psychiatric colleagues, this is the default mode of operations; 2) At minimum, daily notes (with more frequent documentation as appropriate with any status changes) that meet the documentation requirements for subsequent day observation codes must be written.

To accomplish this process, we utilize clinical decision support within our electronic medical record, with an order set built for psychiatric observation as well as a structured daily note to guide the EM physicians in what they should be assessing and documenting while providing ongoing care for these patients.

It is yet unclear as to what the private and governmental payer response to a shift in billing code usage will be, but the AMA CPT committee was quite clear defining the standard. If you are doing the work, you should be compensated for it – especially as it taxes your operational resources. One thing is for certain, in the words of Wayne Gretzky, “You miss 100% of the shots you don’t take.” In other words, we know that the payers are not going to volunteer to reimburse us for the time spent keeping our patients safe while dealing with the crisis of inpatient psychiatric beds. Therefore, instituting a compliant, patient-oriented process of psychiatric observation (while getting all stakeholders at your institution) may be a substantial addition of value to your Emergency Department.

Political Action Committee

Thank you to all members who have contributed to the College’s Political Action Committee (EP-PAC) over the past year and to those who continue to contribute in 2020. Your donations allow the College to work on your behalf to give a voice to Emergency Medicine issues in our State Legislature.

You may contribute to the EP-PAC online, by mail to EP-PAC, PO Box 1038, Wake Forest, NC 27588, or on your ACEP dues renewal form.

Donate to Your PAC Online

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New Member Benefit for Physician Wellness & Assistance

The ACEP Wellness & Assistance Program was rolled out during ACEP19. It offers ACEP members exclusive access to 3 FREE confidential counseling or wellness sessions. Support is available 24/7, and sessions can be face-to-face, over the phone, or via text and online messaging. Includes 30-minute consultations for individual legal/financial matters. [Learn more.](#)

ACEP Introduces Citizen First Responder Program

ACEP's new first responder training program, *Until Help Arrives*, was officially unveiled during ACEP19 in Denver with a series of events to highlight how emergency physicians can positively impact their communities by conducting training sessions to teach the public basic life-saving skills. [Read more.](#)

New Resources to Help Small Groups

ACEP has developed new resources specifically to benefit small groups. A new Small Group Advisory Group is a team of seasoned small group members who have volunteered to support the small group practice model by sharing their expertise with other small group members who are looking for guidance or wanting to tap into the experience of others as they face various challenges unique to small groups. If your small group is dealing with an issue that you'd like to ask the advisory group about, just send us an email at smallgroups@acep.org. ACEP has also developed an online community for small group members to share ideas and discuss issues. To join that group and see the other small group resources available, go to www.acep.org/smallgroups

ACEP and ENA Team Up to Tackle Violence in the ED

ACEP and ENA have joined forces to combat violence in the emergency department through a new campaign entitled "No Silence on ED Violence." The campaign is aimed at raising public awareness of the frequency and severity of assaults against emergency physicians and nurses, and to advocate for action by stakeholders and policymakers to meaningfully address this crisis. Learn more about the campaign and help us demonstrate how widespread this problem is by sharing your story at www.stopEDviolence.org.

New online course on opioid use disorder is approved by ABEM for "Part IV"—and it's free

You already know that opioid-related deaths have risen to epidemic proportions. And that your emergency department is the only point of access many at-risk patients have to lifesaving interventions. A new ACEP course—*free thanks to a SAMHSA grant*—can teach you how to provide better care, make an immediate impact, save lives, and satisfy your ABEM PI requirement. Learn more about the [ABEM-approved pathway](#) and the [optional education module](#) now. Approved for *AMA PRA Category 1 Credits*TM

EMF Announces 2020/2021 Grant Opportunities

The Emergency Medicine Foundation (EMF) has announced its 2020/2021 research grant opportunities. Review the request for proposals and [apply for funding](#) by the February 7, 2020 deadline. Four new directed research grants are available on Nasal High Flow Therapy for Respiratory Compromised Patients in the ED, Reducing Burnout through ED Design, Better Prescribing Better Treatment Program, and Diagnostics Research, in addition to EMF partnered grants.

Geriatric Emergency Department Accreditation: Delivering Geriatric Care Standardization

Older adults account for 46 percent of all emergency department visits resulting in hospitalization. Approximately one out of every 10 hospital admissions are potentially avoidable, and the majority (60 percent) of those admissions are for patients 65 and older. Read More about GEDA in the latest [SAEM Pulse issue](#).

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website

