***Chapter News***

**North Carolina College of Emergency Physicians**

February 2022

## In This Issue



## President's Message

### By: Jennifer Casaletto, MD, FACEP

“An incident is just the tip of the iceberg, a sign of a much larger problem below the surface.” – Don Brown

It’s no secret to anyone who has turned on a radio, a television, or scrolled through the recent news on their smartphones that workplace violence is increasing. It seems near daily that we are hearing about another passenger being removed from an airplane for displaying verbally or physically aggressive behavior. While the airlines are currently capturing media headlines, this verbally and physically aggressive behavior has been increasing in our emergency departments for over a decade. In a fall 2018 ACEP survey, 80% of emergency physicians said violence in their emergency department has harmed patient care. In addition, 47% of emergency physicians had been assaulted by a patient or family member, while only 3% were able to press charges with the support of their hospital and local law enforcement. A Mayo Clinic study cited a 200–300% increase in assaults on staff since the pandemic began. Just this past month, there were back-to-back assaults in North Carolina emergency departments that resulted in severe injuries and at least one fatality. On January 14th, a man being medically evaluated after being arrested attacked a police officer before grabbing the officer’s gun and firing multiple shots in the emergency room. He was shot and killed by a Duke police officer while in the treatment area of the Duke University emergency department. Just days later, on January 18th, two staff members at New Hanover Regional Medical Center in Wilmington were violently attacked by a patient who has since been charged with two counts each of attempted first-degree murder and assault by strangulation.

What progress is being made? On January 1, 2022, The Joint Commission (TJC) began enforcing new workplace violence prevention requirements obligating hospitals to conduct an annual workplace

assessment and take action to resolve workplace violence safety and security risks, establish a process to monitor workplace hazards, train licensed practitioners in prevention, recognition, response, and reporting of workplace violence, and develop response plans that specify policies and procedures to prevent and respond to workplace violence. On the public relations side, ACEP is working together with the Emergency Nurses Association (ENA) on the "No Silence on ED Violence" initiative which began campaigning for action to ensure a violence-free workplace for emergency physicians and nurses in 2019. As part of this initiative, Dr. James Phillips will be delivering an address as part of this May's ACEP Leadership and Advocacy Conference entitled "#No Silence on ED Violence: Is it Time to Push the Panic Button?" which will explore risk factors for ED violence, ED/hospital deficiencies with the potential to place physicians at risk, and mechanisms to reduce healthcare associated workplace violence. Legislatively, ACEP has worked with Rep. Courtney (D-CT) to develop and advance H.R. 1195 (Workplace Violence Prevention for Health Care and Social Service Workers Act) and continues to advocate for companion legislation to be introduced in the Senate. If you haven't already, please joint ACEP's 911 Network, enabling you to receive Action Alerts when it's time to contact your legislator for their support. (Link to join 911 Network) Regulatory aspects are also being addressed, as the Occupational Safety and Health Administration (OSHA) has convened a panel, including an ACEP representative, which will begin meeting this year and is tasked with guiding the development of new standards regarding workplace violence. Here in North Carolina, assaulting a healthcare worker has been a felony since 2015 and Gov. Roy Cooper signed a law in 2019 that makes assaulting a healthcare worker a Class D felony, punishable by up to 13 years in prison. Leaders from NCCEP and the NCMS will be meeting with the North Carolina Healthcare Association to push for hospital-based action to improve ED staff safety and ensure hospital support for pressing charges against those who threaten or injure ED staff.

Less than a week after my December 16th email to you regarding recent developments related to the No Surprises Act (In case you missed it, here's a link to the 12/16 email), ACEP, the American College of Radiology (ACR), and the American Society of Anesthesiologists (ASA) filed suit against the federal government charging that the interim final rule (IFR) created by HHS contradicts the balanced and fair reforms dictated by the language of the No Surprises Act and will ultimately harm patients and access to care. (For further details of that lawsuit click here.) ACEP, the ACR, and the ACA filed a motion for summary judgement on February 9, 2022. With regard to the previously discussed Texas Medical Association suit, an expedited hearing was held as scheduled February 4, 2022; arguments were presented by both sides, but no decision has yet been made. No further updates are currently available regarding the AMA/AHA suit.

In other updates, the ACEP Workforce study released last April projected a surplus of nearly 8000 emergency physicians in 2030, ACEP has continued the multi-organizational task force that conducted the study through 2022 and established additional working groups to begin advancing solutions. (Click here for further details.) Most recently, close attention has been paid to the whether this projection would impact the number of applicants choosing to enter the 2022 EM residency match. As of the end of December, applicant numbers are equivalent to those seen in December preceding the 2020 EM residency match, indicating that the EM continues to attract adequate numbers of talented medical students to compete for EM residency spots.

Lastly, two pieces of legislation at the North Carolina General Assembly that we have been working on have not made any substantial progress since our last update. Senate Bill 345, PA – Team Practice, is still in the House Health Committee and we understand that the bill was being amended to address concerns that the NC Medical Board had with some of the language. We expect to receive any amended language on the bill before it moves forward so that we can evaluate and address any concerns.

The other bill is House Bill 277, the Save Act (allows advance practice nurses to practice independently), and this bill remains in the House Health Committee, where it has not had a committee hearing. Although this bill has not made any progress in moving forward, there has been a great deal of discussion and PR from nursing groups about how this bill will increase access to care and reduce healthcare costs. We continue to share with legislators our concerns about the bill.

While our thoughts linger with our colleagues at Duke University Hospital and New Hanover Regional Medical Center, it is clear that we must continue to *focus* on these cold, cruel iceberg tips and *use* them as a reminder of the larger danger lurking beneath the surface when addressing workplace safety in our meetings with departmental and hospital leadership, in our discussions with local law enforcement and judicial members, and in our decisions regarding whom we support in local and state elections. Legendary F1 driver Jackie Stewart said, "It takes leadership to improve safety." Be that leader!

Links:

911 Network

Dec 16 President update

ACEP/ACR/ASA suit

Workforce

# Leadership & Advocacy Fellowship

The North Carolina College of Emergency Physicians' Board of Directors is excited to announce the new Leadership & Advocacy Fellowship, starting July 1, 2022. The Fellowship is designed for early-career emergency physicians passionate about improving emergency medical care in North Carolina.

Key elements of the NCCEP Leadership & Advocacy Fellowship include:
- Leadership development through mentorship and NCCEP Board of Directors meeting participation.
- Participation in advocacy on behalf of emergency physicians and our patients.
- Establishing relationships with state and national leaders in emergency medicine and health policy.

Additional information and the application may be found here.

**Application Deadline: May 15, 2022.** The Fellowship will be for one year: July 1, 2022 to June 30, 2023.

We encourage North Carolina's rising star emergency physicians to apply for this exciting opportunity! Please contact Leon Adelman with questions or to nominate a peer.

# What Are You Advocating For?

## By: Bret Nicks, MD, MHA, FACEP

Although the specialty of emergency medicine is arguably as old as the practice of medicine, our specialty history in the United States is only 60 years old. While the U.S. along with other early adopters (e.g., Canada, England, and Australia) can trace efforts back to the 1960s, the specialty of Emergency Medicine in the US began to take structure in 1968 with the formation of the American College of Emergency Physicians (ACEP) although wasn't officially recognized as a medical specialty until 1979. Since that time, emergency medicine has seen not just tremendous growth in numbers of physicians trained, but in patient's served – and perhaps one of the most influential specialties triggering change in the house of medicine.

Not only have we seen increased public awareness of pre-hospital care (e.g., *Emergency!* ) as well as emergency department care (e.g., ER ) through mainstream media. Although this may have glamorized the specialty, it certainly was a significant influencing factor that promoted the value of, demand for, and expectation of emergency medicine. Concurrently, our specialty moved forward with increased evidence-based diagnostic protocols integrated with improving bedside, laboratory, and imaging interventions. This hasn't stopped – and continues at an increasingly accelerating pace.

At times we have had publications that cause pause. In 1999, the IOM report, To Err Is Human, was one such article. In 2006, the IOM report, The Future of Emergency Care, was yet another. Both identified the challenges that are common with the specialty that we love, and the expectations that we have, in part, created and embraced. More importantly, both provided the proverbial shots across the bow to signal a change in direction to ensure not just the future success of our specialty, but in a broader sense healthcare in general.

In the US, according to the CDC, there are more than 130 million emergency department visits annually with ~13% requiring hospital admission. Over the past decade, there have been ~1,000 rural hospital closures and despite extending insurance coverage – access for healthcare has not improved, and perhaps worsened for those most at risk. And while our specialty has adapted incredibly well to the downstream system failures through embracing operational refinements, accepting all patient dilemmas whether emergent or not for the benefit of society and our respective systems, it has lead to the pervasive mantra, 'just let the ED figure it out'.

More than 15 years after the IOM recommendations to ensure viability of emergency care, many of the recommendations remain just that. And emergency departments are failing. Triage queues, packed waiting rooms, ambulance offloading delays or diversion, unacceptable treatment delays, waiting room disasters and frustrated patients leaving before they are seen. Our specialty is the downstream recipient

of upstream failures. And the predicted nursing shortages to the COVID pandemic and we have unprecedented boarding, wait times, and the inability to meet the needs of our patients at the most critical times.

Although likely the result of our success, emergency medicine has become the stop-gap for all of medicine. Our proud credo is that every patient's concern (24/7/365) is important and that patients cannot be turned away, regardless of their condition. Our attempts to provide unconditional service (EMTALA) have paved the way for other providers to eschew unplanned illness and injury, optimize their schedules, avoid inconvenient disruptions in always-busy days, and address countless inconvenient patient needs with a simple almost magical directive: 'Go to the ED.' But, can we fill the care gaps (or ignored patient populations) in medicine and simultaneously provide rapid, high-quality emergency care? The answer is no.

As a relatively new specialty, we have grown beyond infancy and perhaps into adolescence. However, now is the time, as we continue to mature, to stand-up for what we are, and perhaps more importantly what we are not as a medical specialty. Perhaps it is time to redefine 'emergency' - to clarify our primary mission, redefine an 'emergency patient', and re-imagine our processes. There is no better way to advocate for our patient's than to define who our patients are – and encourage appropriate care alternatives for those that are not. The system will not fix itself and for the future of our specialty and our patients, do we have the courage to step up? What are you advocating for?

# No Surprises Act Update

We wanted to provide an update on the No Surprise Act for you but afraid there is not a lot to update since the resolution is now in the hands of the Court system. As background, the "No Surprises Act" was passed by Congress December 27, 2020, as a balanced approach to removing patients from billing disputes between physicians and insurance companies for out-of-network care. As written, the law creates a fair Independent Dispute Resolution (IDR) process between physicians and insurers that would *consider a variety of factors* when determining the rate paid for the claim. During the implementation phase of the law this past Fall, the Interim Final Rule (IFR) instead established a *qualified payment amount (QPA) based on the median in-network reimbursement* as the baseline for IDR. ACEP has worked with Congress throughout the Fall to amend the IFR or slow its implementation without success.

The Texas Medical Association filed suit October 29th and the AMA and AHA filed jointly on December 9th aiming to stop implementation of the IFR's establishment of the QPA based on median in-network rate *without* slowing implementation of the remainder of the law which serves to protect patients. ACEP also filed suite along with other national physician specialty groups challenging implementation of the QPA portion of the IFR on December 22, 2021. NCCEP will support the above suits via provision of amicus (friend of the court) briefs or statements attesting our support for filed amicus briefs.

North Carolina is on the front line of this issue. Blue Cross Blue Shield and United Health Care have sent letters to physician groups seeking rate reductions for those who are currently in-network, some specifically citing the IFR. We are currently aware of five North Carolina EM groups that have received letters. Please let us know if your group has received a letter so that we can provide the information to our legislators and the NC Department of Insurance.

On December 27, 2021, CMS sent a letter to Governor Cooper and Commissioner Mike Causey of the Department of Insurance to inform them that CMS has agreed to enter into a collaborative enforcement agreement with North Carolina to enforce certain provisions of the Public Health Service Act (PHS Act) also known as the No Surprises Act. Under this collaborative agreement, the state will perform the compliance functions of policy form review, investigations, market conduct examinations, and consumer assistance, as applicable under the law. Only in the event that North Carolina is unable to obtain voluntary compliance will CMS consider undertaking formal enforcement action against a health insurance issuer, health care provider, facility, or provider of air ambulance services.

ACEP has created a new webpage that has a good summary of the issue and will have updates as things progress.

# Upcoming Events

Medical Director Summit, March 4, 2022, Grandover, Greensboro, NC
Board of Directors Meeting, April 6, 2022, 10:00 am, Grandover, Greensboro, NC
ACEP Leadership & Advocacy Conference, May 1-3, 2022, Washington, DC
Board of Directors Meeting, June 10, 2022, Kiawah Island, SC
Coastal Emergency Medicine Conference, June 10-12, 2022, Kiawah Island, SC

ACEP22, October 1-4, 2022, San Francisco, CA
Fall Conference, November 7-10, 2022, Grove Park Inn, Asheville, NC (Reserve your room online here or call the hotel directly at (800) 438-5800. Identify yourself as attending the North Carolina College of Emergency Physicians' meeting (Reference: NCCEP Fall 2022 Conference).

*If you would like to participate in the Zoom Board meeting(s), please e-mail us for login information.


## Emergency Physician Leaders - Spotlight

**Michael J. Utecht, MD, FACEP**
**NCMS President *(Term: 2021-2022)***

Dr. Michael Utecht, an emergency medicine physician living in the Triangle-area, has served on the NCMS Board of Directors since 2014 and as an NCMS Foundation Trustee since last year. He has been heavily involved with various NCMS committees over the years and is a 2019 graduate of the NCMS Foundation's Kanof Institute for Physician Leadership Health Care Leadership and Management program. Dr. Utecht also is a past president of the North Carolina College of Emergency Physicians (2009-2010).

Dr. Utecht received his undergraduate degree in physiology from Michigan State University and went on to receive his MD from Wayne State University School of Medicine. He did his emergency medicine residency at Los Angeles County/University of Southern California Keck School of Medicine.

**Amy De Stefano, MD**
**NCMB Associate Medical Director**

NCCEP member Dr. Amy De Stefano, an Emergency Medicine physician with more than 25 years of experience in state-of-the-art trauma centers and rural community departments, joined the staff of the North Carolina Medical Board in January as its Associate Medical Director. Immediately prior, Dr. De Stefano practiced with Raleigh Emergency Medicine Associates and was an attending physician in the emergency department at Rex Hospital in Raleigh. She completed a Bachelor of Arts in Biology at the University of North Carolina at Chapel Hill and earned her

medical degree from the UNC School of Medicine. Dr. De Stefano completed a surgical internship at George Washington University Hospital, a research fellowship at the Carolinas Medical Center in the Department of Emergency Medicine, and residency training in emergency medicine at East Carolina University.

# No Sight? No Problem!

## By: Dillon Casey, MD

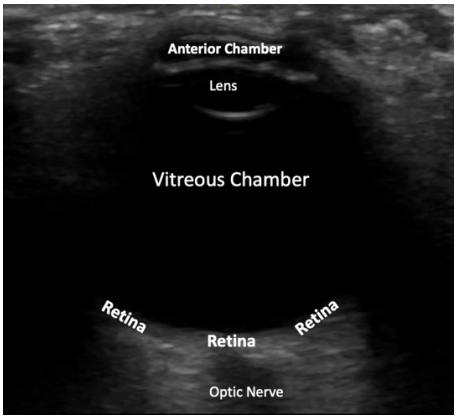
Ocular complaints are a routine emergency department (ED) chief complaint, accounting for about 3% of ED visits per year. However, the majority of EDs in North Carolina do not have ophthalmology coverage. During business hours, patients can be emergently referred to ophthalmology clinic. However, outside of business hours, patients frequently require transfer to a tertiary care center for ophthalmology consultation.

When a patient presents with new onset floaters, flashes, visual acuity loss, or visual field loss, retinal detachment, vitreous detachment, and vitreous hemorrhage must be considered. Ultrasound can help rapidly narrow the differential diagnosis. Ocular point of care ultrasound (POCUS) can accurately rule-out retinal detachment [sensitivity 96.9% (95%CI 80.6-99.6%), NPV 99.0% (95%CI 94.0-99.8%)], vitreous hemorrhage [sensitivity 81.9% (95%CI 63.0-92.4%), NPV 94.3% (95%CI 86.6-97.7%)], and vitreous detachment [sensitivity 42.5% (95%CI 24.7-62.4%), NPV 91.8% (95%CI 84.8-95.7%)]. The exam can be rapidly performed with minimal training using a linear probe.

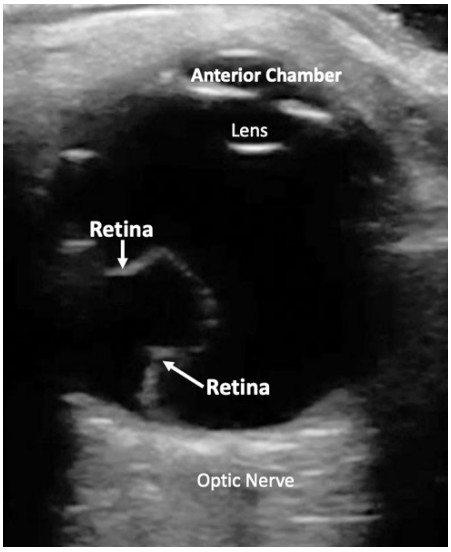
To perform **Ocular POCUS**:
1. Apply a large transparent film (such as a Tegaderm) over the closed eye, taking care to maximize surface contact between film and skin.
2. Deposit ultrasound gel liberally over the film.
3. Apply the linear probe to the orbit. Minimize direct pressure on the globe. On your machine, select the ocular or small parts preset, you may need to increase the gain for better visualization.

When interpreting the scan, the globe is the central round figure. For retinal and vitreous pathologies, look for *a thin, echogenic (bright white), moving membrane in the posterior globe* that protrudes from surrounding structures. Have the patient move their eyes horizontally and vertically several times. This distinction is critical: *retinal detachments generally do not cross over the optic nerve while vitreous detachments can cross over*.

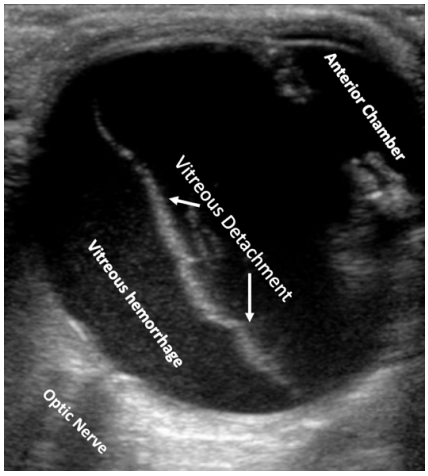
Using ocular POCUS in your clinical practice can provide reliable, objective data for determining assessment and disposition of patients who present with ocular complaints. It can improve throughput as well as potentially save your patient an unnecessary transfer to a tertiary care facility.
A. Normal Ocular Ultrasound




B. Retinal Detachment, take note of how retina is tethered to optic nerve




C. Vitreous Detachment, take note of how the vitreous causes a separation between the posterior vitreous layer and the retina while crossing over optic nerve




Link to instructional video (4 minutes): https://www.coreultrasound.com/vd-rd/

**Sources:**

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Skidmore, C., Saurey, T., Ferre, R. M., Rodriguez-Brizuela, R., Spaulding, J., & Mason, N. L. (2021). *The Journal of Emergency Medicine*, *60*(1), 80-89.
Hooker, E. A., Mallow, P. J., & Oglesby, M. M. (2019).*The Journal of emergency medicine*, *56*(3), 344-351.
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# COVID-19

We know there is a lot of information already coming your way, but we wanted to share some resources with you. Keep up the great work, and know that you are appreciated!

Visit NCCEP's COVID-19 resource page for North Carolina and NCDHHS-specific information and ACEP's site for National/CDC information.


# Other News & Information

## Membership Renewal

Please be sure to renew your NCCEP membership! We rely on membership dues to keep our Chapter running and continue to provide the valuable services we do for our members, including legislative work to protect and further the interests of Emergency Medicine at the North Carolina Legislature. If you have not yet renewed for this year, you may do so here.


# 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

# NEWS FROM ACEP

American College of Emergency Physicians®


Stay current with the COVID-19 Center. It's your one-stop-shop for clinical and legislative updates. Quick Links: Physician Wellness Hub | COVID-19 Field Guide

**1.** #BikERDocs is back on the bike! **Join the group's 30 minute '90s ride on Jan. 31 or 45 minute football pregame ride on Feb. 6.** Members interested to know about upcoming rides can sign up to be notified when rides are scheduled at www.acep.org/peloton.

**2. Grassroots Action Alert: Take Action to Increase Access to Buprenorphine.** We need your help to urge Congress to swiftly take up and pass critical legislation that will help increase access for emergency physicians to buprenorphine, lifesaving medication to help OUD patients and decrease the stigma associated with treatment. **Read our full statement.**

**3. Latest podcasts:** The honeymoon from the flu during COVID is over & Opioid Use Disorder in the ED and Beyond: Epidemic in a Pandemic.

**4. Latest Regulatory Blogs (Regs & Eggs):**

- Recent Federal Efforts to Address Provider Consolidation (Jan 27)
- ACEP Launches Website Highlighting Major No Surprises Act Requirements for Emergency Physicians (Jan 20)
- CMS Proposes Changes to Network Adequacy Requirements for Private Health Plans (Jan 13)

**5. Advocacy Win: Deductibles Added to Insurance Cards.** Our advocacy worked! Congress incorporated our idea into the No Surprises Act that went into effect on Jan. 1, 2022. Patients will now be reminded of their deductible when they pull out their insurance cards, reinforcing that the costs are due to the insurer and not the emergency physician.

**6. Workforce Minute:** ACEP President-Elect, Dr. Christopher Kang, gives us updates for each of the five pillars. Watch the 4-minute video.

**7.** Have you checked out the **new point-of-care tool for managing low-risk deep vein thrombosis**? It's free for ACEP members on the website or through the emPOC app, which now features 14 bedside tools.

**8. Preparing for ABEM's Advanced EM Ultrasonography Focused Practice Designation exam?** ACEP's next virtual Advanced EM Ultrasound prep course is coming up Feb. 8-9. Want more ultrasound content? Utilize this **new PEERCert+ module** with more than 100 content questions that match EM ultrasonography core curriculum, plus a 50-question simulated practice test. But wait, there's more! **Virtual Grand Rounds: Ultrasound-guided Nerve Blocks** is Feb. 23. Register today.

**9.** In this *ACEP Now* article, members of the Government Services ACEP Chapter **reflect on their time served in Afghanistan.**

**10. *ACEP Now* is looking for its next Resident Fellow.** It's a one-year position starting July 1, 2022. Apply by Feb. 18.

## ACEP Member Benefits

**Career Resources:** The job market is tumultuous right now. Whether you're actively looking for a position or just want to be a better advocate for yourself with your current employer, ACEP's resources can help. Check out the ACEP Career Center for information on vetted EM job opportunities, contracts, compensation reports, policy statements and more!

**ACEP Member Advantage:** Whether on shift or at home, your ACEP Membership provides perks and discounts from a variety of businesses wanting to support you.

**Wellness & Assistance Program:** Did you know your ACEP membership comes with three **free** counseling or coaching sessions available through phone, text or online chat? And for a small

extra fee, you can add on **financial and/or legal assistance**. Learn more about this free member benefit.

**Clinical Tools:** ACEP's Point-of-Care tools are transforming care at the bedside.

**View as Webpage**

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