Chapter News

North Carolina College of Emergency Physicians

February 2023

In This Issue

President's Message

Dear North Carolina College of Emergency Physicians,

We just wrapped up our January board meeting, during which we discussed several pressing issues facing our profession, including ED overcrowding, burnout, increasing pressure from difficult insurance reimbursement tactics, and our forward-looking advocacy agenda.

Regarding ED overcrowding, we discussed a variety of potential solutions that would help the problem; while acknowledging that there is no simple solution. After a good discussion by the Board, we feel our efforts need to work on the need for hospitals to flatten their OR schedules in order to reduce the number of patients waiting the in the ED for a bed upstairs. We also need to limit the number of beds taken in a block early in the week when our volumes are highest. Obviously, the nursing shortage doesn't make this any easier and we want to encourage our Hospitals, Colleges, Counties, Community Colleges and others to work to get more nurses in North Carolina. We also discussed the importance of addressing burnout among emergency physicians while this incredibly stressful period continues. It is tough right now but together we will get through this if we continue to look out for each other during these challenging times.

On the issue of reimbursement, we discussed the increasing pressure from insurance companies giving lower reimbursement rates, painful arbitration or just flat out not paying at all. We continue to monitor the ongoing litigation pushing back against these pressures in order to ensure that we are able to provide high-quality care to our patients while getting fair reimbursement.

Finally, we discussed our forward-looking advocacy agenda. There are so many health care issues right now, but we would like to prioritize overcrowding, violence in the emergency department, and increasing our behavioral health options. Of course, we will continue to work on reimbursement issues, Medicaid Expansion and Scope issues and the many other health care issues and public health issues which we expect to see this session. We are committed to working with state legislators to pass laws and regulations that will help our patients, protect emergency physicians and other healthcare workers and provide a working environment where we can provide the best health care

possible.

Thank you for your attention to these important issues. We look forward to continuing to work together to address the challenges facing our profession and to improve the care we provide to our patients.

Important Future dates:
- Medical Directors Summit: March 17, 2023
- April 19, 2023: Legislative Day/Board meeting Raleigh Country Club, Raleigh, NC
- June 9, 2023: Kiawah Island Board meeting/Coastal Emergency Medicine Conference
- October 23-26: Fall Meeting at the Omni Grove Park Inn, Asheville, NC

Sincerely,
Thomas Bernard, MD, FACEP
President of North Carolina Board of Emergency Physicians

Lobby Day

Please join us for our Lobby Day on April 19, 2023, in Raleigh in the morning and then head down to the legislative building in the afternoon and meet with legislators who have an impact on health care legislation. We will meet for our Board meeting and lunch at the Raleigh Country Club in Raleigh. **Please arrive by no later than 11:30 am for our legislative "training" and overview.**

RSVP HERE

All members are invited to attend; however, we request that you sign up by no later than **Monday, April 10th**, if you are planning to attend so we can create groups and plan for a successful event.

Ongoing Uncertainty Can Be Exhausting – We Live It Everyday

By: Bret Nicks, MD, MHA, FACEP

There is often one thing stated about uncertain times – they will return with certainty. Considering not just our most recent experience with COVID-19 and the subsequent nursing staffing challenges, but the new paradigm shift in our documentation, billing and coding. Moreover, just like the predictable variability of our patient arrivals (i.e. acuity, illness, trauma, etc.), one thing is certain, we can be confident that future events will trigger uncertainty for our families, our teammates, our organizations, and ourselves. However, no matter how tough things get, you get to choose how you respond.

It is one thing to lead through a crisis, to drive the *esprit de corps* with a missional mindset – but how long can you last in that stage? And what does it look like as you lead out of one crisis into what will be that new normal – and how do you (and your teams) recharge? Despite our EM training, if the rate of change has led to points of fatigue or even some level of leadership paralysis, which is not surprising. Nevertheless, do not let that stop you from acting on what you will learn in the next few minutes.

As leaders, it is incumbent on us to flip the focus from fear toward a more positive future perspective. We face an uphill battle on a daily basis. Moreover, while we hope it is not a Sisyphysean effort, keeping in mind why we embrace these challenges (i.e. our patients, our specialty) can provide some solace. Uncertainty is real, however, when it turns to fear, recognize that focusing on fear paralyzes and isolates. Hope, well articulated, motivates. And remain motivated you must. (Thanks, Yoda)

In times of crisis, the fall appears faster than expected – and as leaders, we feel an exaggerated effect. However, standing confidently in times of uncertainty is empowering – especially as we continue to stand after the smoke begins to clear. Confidence provides clarity in direction and vision. Commonly, how we view things determines the direction of our actions.

Uncertainty is a leadership opportunity!

As a leader, recognize you will not always have the answers – but being able to articulate judiciously, authentically, and honestly to your team will build confidence in them. It is in times of crisis that real

leaders show up. Be that leader.

A 4-Step Process:

When a crisis hits like an unanticipated tsunami, we commonly revert to the most basic survival tendencies. We react. Often this triggers our fight or flight response – and rarely does it match the quality of response that successful leaders need in times of crisis. To overcome this natural tendency, routinely practice the R^4 approach: **Reflect, Refine, Respond, Reassess**.

In this training, I am going to show you how these simple actions can instill the confidence you need to lead your team exceedingly well when they need you most of all. To do this, let us start with our first action: **reflect.**

Reflect

To reflect, you must acknowledge the circumstances and its impact on your company and all those that make up your team. Putting it out there can be frightening – but ignoring the situation through willful denial won't help either. When discussing the current knowns and unknowns, step back and ask yourselves, as an organization, what do you stand for? This is an opportunity to reiterate your company's vision – to reflect on your WHY, embrace your just cause and solidify your organizational cultural foundation during times of uncertainty.

To lead well in crisis, leaders need to recognize not only the current situation, but their reaction to it and consider resources needed to respond as well. What do we know of the current situation and what does that mean for the organization? How are we positioned now and what must that look like into the future?

A leader must also reflect on their mindfulness. Are your thoughts and emotions in check? Constructive? Encouraging? Realistic?

- Understand the context
- Reiterate the value proposition of your company

As we take time to **reflect**, no longer will the magnitude of the moment derail your direction. But it will draw us toward our second action**: refine**.

Refine

Once you have a greater understanding of the crisis context, refining your direction - your trajectory is next. This requires looking acutely at the organization and encouraging creativity to address the uncertainties and needed contingencies going forward. Ask for creative solutions to expected (and unexpected) challenges. How do you shift your thinking from assessing the issue to winning the battle? Anticipation. During times of crisis, not all facts or details are in place to gage your decisions. It requires not just understanding the circumstances but moving from a survival to thrive mindset.

How do you do that? As you embrace your team, you must change the perspective of fear from forget everything and run to face everything and rise. It is about refining their perspective toward one of optimism, but not optimism without action.

Leaders must ask the following questions:

- What current and future threat does this current crisis pose for my business and my teams?
- What processes will need to change immediately and into the future?
- What changes are needed to mitigate risks? Align with consumer needs?
- Can you reposition a service or product to address the current reality?

This is a process that can certainly paralyze. If you spend too much time analyzing the problems, you will never get past them.

There is an old Irish proverb that says, "You will never plough a field by turning it over in your mind". What does that mean? Get after it. Adopt a cultivating mindset. **Refine** your plan. Identify what actions need to be taken and come up with an orchestrated plan that aligns your team. Most importantly, don't stop iterating.

Once you refine your plan, it is time for your next action:**respond.**

Respond

How you respond matters greatly. Once you have refined your approach, you must be intentional in outlining your **response**. Having a plan in important but implementing is essential. Successful leaders have courage to act while others hesitate. It is in times of adversity that great leaders are motivated

toward creating a new definition of reality. Are you willing to respond?

If so, consider the following as you prepare:
- Does this plan provide a clear direction based on the discussions thus far?
- Are there key strategic changes that need to be addressed?
- Has the response been clearly articulated to all leaders and team members?
- How does our planned response position us within and beyond the crisis?

By addressing such questions, we move from away from being a reactive organization to a responsive one. Recall, when we are purely reactive, we use our lowest cognitive performance. It creates a defensive, close-minded posture. Only when we reflect and refine our position can our response be intentional and on-point.

W.C. Stone said, ""Thinking will not overcome fear, but action will". And deliberate actions that draw on the insight, wisdom and perspective of your team will increase the likelihood of success – and the ability to pivot, as necessary.

Every day spent reacting to problems are days that could have been spent working on the solution.

With that mantra in mind, we move from response to our last action**reassess**.

Reassess

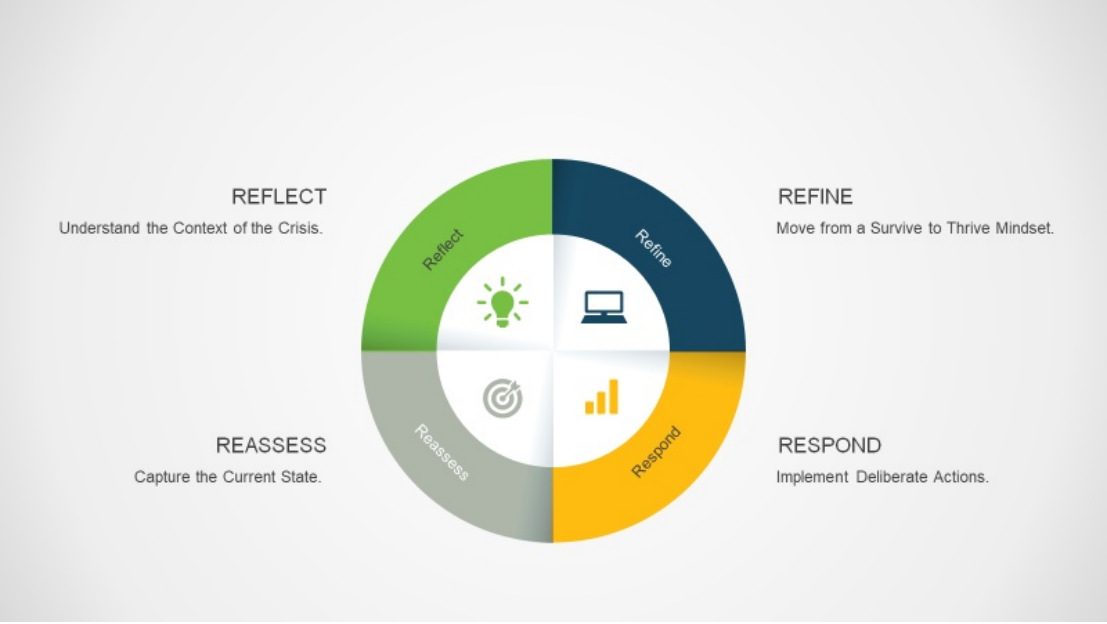
Successfully leading your business through turbulent times means not only applying the first 3 actions but keeping your finger on the pulse of any dynamic situation. Recognize, it is when we reassess that we can see the success in our previous decisions – and define when and how we must further pivot with ongoing challenges.

Consider the following:
- What has changed with the situation?
- Was the response helpful in realigning your position relative to the crisis?
- In what areas are you still vulnerable (and how can you guard against)?
- Are there new opportunities?
- What is the tank level of your team? Yourself?

The reassessment process can be likened to making half-time adjustments. How often have you seen a team come back out in the second half with a new plan, new focus, and a better sense of team? Sometimes it is simply rallying the troops. But most often, it is when the coach can reassess and make adjustments that the outcome changes.

Are you willing to adjust? To pivot? Because unlike a game that is finite, with known rules and endpoints, leading through a crisis requires an infinite mindset. It requires the willingness to continue a perpetual process of adaptations to best bring value to others.

As you **reassess**, you may find the need to**reflect** again. And after further reflection, **refine** what you think is best. That refinement often leads to a new **response** and further reassessment. By putting these 4 steps into action, you can successfully lead through turbulent times.



Upcoming Events

Medical Director Summit - 03/17/23 (Grandover, Greensboro, NC)
Board Meeting/Legislative Day - 04/19/23 (Raleigh Country Club, Raleigh)
ACEP LAC - 04/30/23 - 05/02/23 (Grand Hyatt, Washington, DC)
Board/Membership Meeting - 06/09/23 (Kiawah Island, SC)
Coastal EM Conference, 06/09/23 - 06/11/23 (Kiawah Island, SC)
Board Meeting - 09/20/23 (Grandover, Greensboro, NC)
ACEP23, 10/09/23 - 10/12/23 (Philadelphia, PA)
Fall Conference - 10/23/23 - 10/26/23 (Grove Park Inn, Asheville, NC)

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

The More Things Change… E&M Changes – Staying Alive in 2023

By: Brian Hiestand, MD, MPH, FACEP & Bret Nicks, MD, MHA, FACEP

The emergency medical evaluation and management (E&M) codes for most of our patient encounters have been completely revised - the first substantive changes to this code set in a quarter century. While the numeric codes themselves have not changed (99281 – 99285 are still in use for EM), the factors that are weighted to differentiate level of care are markedly different. Thanks to AMA CPT committee, CMS and others, the following information should be reviewed after (or concurrent with) a stiff cup of coffee.

· Elements of the H&P: History of Present Illness, Past Medical / Social / Family History, Physical Exam, and Review of Systems – are *no longer used to establish a difference between levels* This does not mean that you can skip the H&P.

o The CPT code definitions standard refers to a medically appropriate history and/or examination for every level of care. This portion of the medical chart, rather than being omitted, has now been returned to its original purpose of a record of the patient encounter, rather than for billing.
o The CPT guidelines are also quite clear that the clinician providing the patient care is the one that determines what constitutes a "medically appropriate" H&P. Therefore, such concepts as "all other systems reviewed and negative" or documenting an atraumatic / normocephalic head exam on a patient with abdominal pain are now discardable.

The E&M levels are now differentiated purely by the documented medical decision making (MDM) and its 3 domains: 1) complexity of problems addressed (COPA), 2) data analyzed, and 3) risk of management options. These are scored to determine the appropriate E&M level based on documentation. While this is simply an introductory primer, we will go into these sections in the coming EPIC publications for those keenly interested or suffering from insomnia.

A brief note, however. The lowest complexity E&M codes – 99281 and 99282 – will almost never be utilized in ED care. They were retained to maintain parallel structure with the office-based E&M codes, and have little relevance to the actual practice of Emergency Medicine. Therefore, we will be focusing on how 99283, 99284, and 99285 (low, moderate, and high complexity) codes are differentiated.

Complexity of Problems Addressed:

COPA refers to the severity of the patient's presenting issue. An acute illness or injury that requires no diagnostic work up and poses little chance of untoward outcome is categorized as low complexity – contact dermatitis, dental pain, extremity contusion that requires no imaging. Acute illness or injury requiring diagnostic testing (cough and fever, but well appearing, requiring a COVID panel and a chest x-ray), or chronic illness with mild exacerbation (asymptomatic hypertension requiring an up-titration in medication) represents a moderate COPA. Finally, severe exacerbation of chronic disease or an acute presentation with potential threat to life or bodily function would be quantified as high COPA.

· CPT guidelines are explicit that the COPA should be assessed based on the nature of the presenting concerns, ***NOT*** on the final diagnostic testing results. The classic example is the 45-year-old with substernal burning chest pain that is worse with exertion, but also with tacos, who merits a set of troponins and an ACS work up. Even if he goes home with a H2 or PPI instead of dual antiplatelet therapy, a reasonable differential includes high risk conditions and qualifies for a high COPA.

· A patient with a head injury serious enough to warrant CT imaging, even if the CT turns out to be negative, is generally going to warrant a high COPA. This is where a reasonable and focused differential diagnosis will support the coding of the COPA.

Data Acquisition:

The data section of the MDM is simultaneously the most detailed section and the one that lends itself most to "counting boxes." Until set to memory, we recommend referring to ACEP's MDM grid early and often. A subsequent column will provide a detailed look at each of the components of the data score, but let's tour through a brief overview. There are three broad subcategories within Data:

· Category I - Tests and Documents
· Category 2 - Independent Interpretation
· Category 3 - Discussion of Results or Patient Management.

Conceptualize these as 1) Acquisition, 2) DIY, and 3) Phone a Friend...

Category 1 (data acquisition):
This includes test ordering, reviewing previous test results or external records, and the use of an independent historian such as a spouse, a parent / guardian, or EMS. Note that the use of a parent as historian, just by itself, is sufficient to qualify for at least low data complexity. For those seeing a high proportion of pediatric emergencies, you are already ahead of the game. Each separate test or test panel counts as a point – so, ordering a CBC, a chemistry panel, and an ECG will completely fulfill the data acquisition requirement. So will ordering a COVID panel, reviewing the last discharge summary, and talking to the patient's spouse for additional details. Any three elements of any type will complete Category I at a level sufficient to support a moderate or high complexity, and only two (or an independent historian) is needed to support a low complexity.

A positive development in the CPT guidelines is the provision of credit for the deliberate decision not to engage in testing, either through the use of decision rules (i.e. PECARN for head CT, Wells/PERC for pulmonary embolism testing, Ottawa Ankle Rules for x-ray, etc.) or shared decision-making with the patient. Obviously, the decision and rationale should be clearly stated in the chart, both to make it easy for the coder to discern this as well as for relaying your decision making within the medical record.

Category 2 (DIY): Independent interpretation of a billable test
This refers to the fact that we, as emergency physicians, often have to interpret and act on ECGs and imaging studies that will ultimately be interpreted and billed out by another professional. Think DIY interpretation: ECGs, x-ray, CT, point of care ultrasound – **AND** cardiac monitor interpretation – the simple bedside strip – will also suffice to satisfy this category. ***A crucial point***: one cannot both bill for interpreting the test as a separate billable procedure AND get credit in Category 2 for the MDM. Billing for the ECG interpretation, but then only capturing a 99284 instead of a 99285 is not ideal.

Category 3 (phone a friend): Discussion of Patient Management or Test Interpretation
Often the care of the patient requires involving another medical professional, this supports an increased complexity of data management. Involving a consultant physician, an admitting physician, pharmacist, social worker, case manager, PCP or physical therapist in the care of the patient is sufficient to meet this category. Discussion of the imaging results with a radiologist would also suffice. ***Note:*** it cannot be your partner ED doc at shift change or running a patient by your on-shift ED colleague.

A review of the MDM grid should make it clear that all the test ordering in the world alone will not support a high complexity 99285 encounter – independent interpretation or discussion of patient care with another medical professional is required to meet high complexity.

Risk of Complications and/or Morbidity or Mortality of Patient Management:

This unwieldy title from the CPT guidelines frequently leads to confusion regarding what risk is being referred to. For clarity, this section does not refer to the risk posed by the patient presentation, but the risk inherent in the treatment options we use.

Low risk is characterized by the use or recommendation of over-the-counter medications, ACE wraps, and other low risk / low complexity interventions. **Moderate risk** interventions include the use of prescription medications (whether during the ED encounter or prescribed at discharge) or the performance of minor but emergent procedures. In addition, if the patient's course of treatment is significantly complicated by social determinants of health, this would elevate the risk of patient management to a moderate level. The chart would need to *reflect both what the SDOH complexity is as well as how it affects the patient management* – a simple statement of "Patient has no insurance" would not suffice, whereas "Patient cannot establish specialty follow up as they have no insurance" would clearly state the issue.

Numerous patient management options rise to the level of**high risk**. One of the most common is the

decision around admission (which includes transfer to a higher level of care, or placement in observation status). The decision that an admission is not necessary could certainly satisfy the requirement for this level as well. However, admission should be a reasonable consideration for the patient's condition. It is reasonable to consider observation for a patient with low risk but potentially cardiac chest pain, but not a patient presenting with an uncomplicated ankle sprain.

Emergency major procedures (central lines, intubation, chest tubes) also qualify as high risk, although most of these should prompt a consideration as to whether critical care time was warranted. Likewise, the decision not to escalate care, or to honor DNR / MOLST orders qualifies as high risk, and potentially critical care depending on the patient presentation. The use of drug therapy that requires ongoing monitoring qualifies for high risk – the ACEP FAQs provide several examples of medications that would qualify for high risk, and potentially indicate the provision of critical care. Finally, parenteral administration of controlled substances takes the risk category to high.

Final Thoughts:

The final code assignment for the encounter is determined by the *highest two of the three* categories. For example, if a patient presented with cough, shortness of breath, and a mild fever (acute illness with systemic symptoms, moderate COPA), received a chest x-ray and a COVID swab (two data elements, low data complexity), and was prescribed azithromycin for the infiltrate found on the chest film (prescription drug management, moderate risk), the chart would appropriate be coded as a 99284, due to the moderate COPA and risk.

Deeper dive? We will go in depth into each of the three sections in upcoming columns. In the meantime, we would recommend the excellent FAQs provided by ACEP's Coding and Nomenclature Advisory Committee for review and education. Interested readers can also find the original documentation of the CPT guidelines from the AMA. Until then, remember to chart what you did, what you thought about, your interpretation of labs/imaging/ECGs/monitoring strips, and discussions that impact patient care.

Links:
https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs/
https://www.acep.org/globalassets/sites/acep/media/reimbursement/acep---2023-ed-mdm-grid.pdf
https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

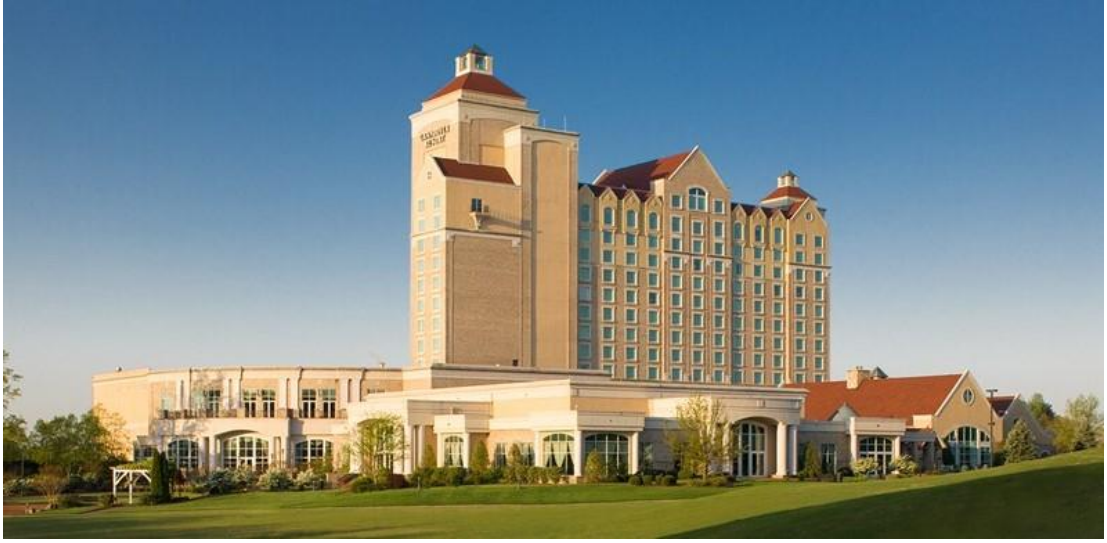
Medical Director Summit

The 2023 NCCEP Medical Director Summit will be held **Friday, March 17, 2023**, at the Grandover Resort & Conference Center in Greensboro.

This 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 operational challenges and 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 central location will allow for broad participation. We look forward to learning from each of you once again.

REGISTER HERE

View additional information, **agenda**, and registration **here**.



Emergency Physician Leaders - Spotlight

Jill Benson, MD, FACEP, NCCEP President-Elect

Dr. Jill Benson, an Emergency Medicine physician living in the Triangle-area, has served on the NCCEP Board of Directors since 2010. Dr. Benson chairs the Education Committee and now is part of the Executive Board. She has more than 20 years of experience working with Wake Emergency Physicians which staffs many Emergency Departments in central North Carolina, including a Level 1 Trauma Center. She has held several administrative positions over the past years including at WakeMed Cary, Vice-Chair of the Emergency Department and Chair of the Hospital Pharmacy and Therapeutics Committee.

Dr. Benson received her undergraduate degree in Biology from the University of Illinois and went on to receive her MD from the University of Illinois College of Medicine. She completed her Emergency Medicine residency at Hennepin County Medical Center in Minneapolis, Minnesota. She also completed a fellowship in Undersea and Hyperbaric Medicine at Hennepin County Medical Center.

Coastal EM Conference - June 9-11, 2023

Registration for this year's Coastal Emergency Medicine Conference is underway! Please join us June 9-11, 2023, in Kiawah Island, SC. We are expecting a full agenda, and the Junior Physician Workshop is back this year! If you are planning to attend, please register soon as space and villas fill up quickly!

Navigating a SANE Deficiency

By: Drs. Stacie Zelman and Beth Kolongowski

It is a chaotic evening in your critical access ED, which is not unusual these days. As you are finishing a lac repair and getting ready to see a patient with mild respiratory symptoms, the triage nurse lets you know that you really need to see the patient in room 8 as soon as possible. The patient is a 24 yo female who is presenting with a chief complaint of “Sexual Assault” that occurred approximately 4 hours prior to arrival. The one SANE trained nurse at your hospital is on vacation, and you do not recall all the exact steps in the evidence collection and documentation from your training.

All you know is that how you proceed with her care and subsequent documentation could have resounding effects on her not just physically and mentally, but perhaps as her case progresses legally.

Navigating SANE cases in the ED can be emotionally challenging for most of us – not to mention present a significant time crunch on a busy shift. The number of hospital-based SANE programs in North Carolina has decreased significantly over the last three years. The reasons are multifactorial, but some of the common sources are burnout, decreased or loss of funding for SANE training, and the COVID pandemic stretching all health care provider resources.

Given the shortage of SANE trained nurses in many community EDs, this process often falls on the ED physicians to perform the patient interview, kit collection, specific documentation, and associated care management. In a cross-sectional survey of Emergency Medicine residency program directors, 31% noted that their programs do not require procedural competency for the sexual assault exam, and 41% reported that observation only was required to demonstrate competency in this important skill. While few physicians receive any specialized training in this regard, this skill set is in their scope of practice and when a SANE nurse is not available, they are expected to perform the interview and exam to the best of their ability.

In response to the realistic possibility of practicing in an ED or community without a dedicated SANE program, we are in the process of developing a training seminar, initially for our current EM residents at Wake Forest/Atrium Health. It is our hope that this can be scaled and/or adopted across our region (and beyond) with the intent to decrease the anxiety and increase their comfort level and competency to provide the best possible care to patients who have experienced sexual assault.

The course will be taught by the SANE coordinator, dedicated SANE nurse, EM faculty, and EM residents. The current outline is below:

Two Sessions (1 hour each):
- 1st Session – Interview skills
  - Detailed instruction on how to obtain a comprehensive H&P with appropriate documentation
  - Mock patient encounters

- 2nd Session – Forensic evidence collection
  - Simulated evidence collection (“kit collection”) on anatomical models

Our hope is that as the format evolves, even more providers, including APPs and community physicians, will be able to attend. We will construct a feedback form to help further delineate skills that can be further practiced and/or refined. If successful, we hope to make this a standing session for our residency-training program, open it up to other community providers, and provide the content model for other programs or departments to use. However, this training's ultimate goal is to make the care of these patients who have already experienced such significant trauma less daunting for all involved.

If this is a particular area of interest (or need) for you, please reach out to us. We are looking forward to providing an update later in 2023 on what we learned and how we can grow this learning opportunity.

Below are some essential resources that are helpful when evaluating patients who have experienced sexual assault even if you have the benefit of a SANE program in your department.

1. https://www.safeta.org/
2. https://www.ojp.gov/pdffiles1/ovw/241903.pdf
3. https://www.rainn.org/resources
4. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/04/sexual-assault
5. https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf

Reference for above: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3789909/

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®

Here are ACEP's latest news. For all the latest news & resources, visit: https://www.acep.org/ and follow us on social: Facebook |Twitter | Instagram.

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1. ACEP and EDPMA Submit Letter to Federal Agencies with Key Recommendations on How to Improve the Implementation of the No Surprises Act. Read more in this week's Regs & Eggs blog and check out our press release.

2. **Tell ACEP About the Impact of Non-compete Clauses.** Do you think non-compete clauses should be banned from all employment contracts? ACEP is putting together its official response to the FTC's proposed ban of non-compete clauses in employment contracts As part of that response, ACEP wants to incorporate firsthand stories from emergency physicians who have been impacted by non-compete clauses in their contracts. By filling out this questionnaire, you will be **anonymously** sharing your story. ***Note:*** *Filling out the questionnaire gives ACEP permission to use this information as part of the College's response to the proposed rule from the FTC.*

3. Your organization is invited to sign on to ACEP's letter to CMS about **extending certain codes on the Medicare telehealth list through 2024. Get the scoop**.

4. **Registration is Open for ACEP's 2023 Leadership & Advocacy Conference!** If you know, you know: LAC is the place to be if you want face time with key policymakers and a smaller conference size that allows you to network with some of the most influential physicians in our specialty. Check out some of topics the programming will dive into and **save $100** on LAC23 registration with **promo code LEADERSHIP23**.

5. New Podcast Episodes:
- The newest episode of *Frontline* tackles staffing issues in the ED with Dr. Thom Mayer.
- *ACEP Nowcast* features Richard Kamin, MD, FACEP, FAEMS, and Deborah Korn, PsyD, discussing Eye Movement Desensitization and Reprocessing (EMDR) therapy both in and out of the emergency department.

6. **Get New Resources to Educate Patients About the COVID-19 Vaccine.**

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

Visit our website