Chapter News

North Carolina College of Emergency Physicians

March 2024

In This Issue

President's Message
Embracing the Conversation of Diversity, Equity, and Inclusion in EM
Upcoming Events
OBS Coding and Reimbursement 2024
Medical Director Summit Recap
Annual Membership Meeting/Call for Nominations
Coastal Emergency Medicine Conference
Navigating a SANE Deficiency - Part 2
Other News & Information
PAC
News from ACEP

President's Message

The holidays always seem to be a busy time for families and, for us, busy times at work. We are needed 24/7/365 and, therefore, someone has to work. Striving to make work life balance seems harder every year. Each year, I feel more and more that I need time to spend with friends and family. I also realize that I need time my own personal time to recharge to continue to give everyone else my best. In the winter, I try to find time to go to the mountains to snowboard, eat good food, and relax. The snow hasn't really set in yet this winter in the US, but time away is so important.

I reflect on what we as a chapter have accomplished and what are the issues that we might be able to impact this coming year. Just these past shifts over Christmas, I have lived/worked my shifts with all the issues of boarding, crowding, understaffing, and violence in the ED. Influenza is here in NC and has made its presence known bringing lots of patients that need our help. I keep working knowing there are many people who are trying to improve things. I know there are still so many Emergency Medicine (EM) Physicians that care about the future of our specialty and want to fight for it. I feel that pull to help shape that future, if possible.

I am grateful to be part of an organization that can help shape my future, NCCEP. This has been a safe place for me to meet other EM physicians across the state and country. It has allowed me to also recharge my work batteries. No one understands us as well as we do each other. NCCEP gives me the opportunity to learn, grow, and be active in doing something about our issues we face. What hope it provides to have a place to be positive and effect change.

This year we (NCCEP) were able to have legislation approved to address ED violence by requiring law enforcement on site 24/7, increasing penalties for violence against health care providers, and gathering the necessary data to continue our work protecting our members. We also worked very hard to educate the legislature about the boarding issue and, because of our efforts (and many others), substantial funding was included in this year's budget to add more mental health beds and expand mental health services, expand nursing programs, and provide pay increases for those who train nurses. The budget also included a provision that will increase the amount paid for inpatient psychiatric care from $500 to $900 per day to encourage hospitals to admit more patients. And finally,

a study will be conducted this year about the transfer of involuntary commitment patients and how we can improve that process.

We are diligently working to make the environment of EVERY emergency physician better – regardless of where they work or who their employer is. We feel that this progress has not only helped all our members, but also those emergency physicians who are not members. We will continue to do all we can to find solutions to allow emergency physicians to focus on their patients and have a supportive work environment.

Sincerely,
Jill Benson, MD, FACEP
President, North Carolina Board of Emergency Physicians

Embracing the Conversation of Diversity, Equity, and Inclusion in EM

By: Richard Jean-Louis, MD, Bret Nicks, MD, MHA, and Aaryn Hammond, MD

As we all know, emergency medicine is a demanding and dynamic field where the expanse of medical presentations requires quick decisions to save lives. Every shift, every department, every system, and every patient is different. Outcomes are influenced by a myriad of factors and are only in-part determined by the emergency department (ED) clinical care. However, exceptional clinical care is difficult to reach without a greater understanding of diversity, equity, and inclusion (DEI) in Emergency Medicine. DEI not only enriches the specialty of emergency medicine but also ensures that the best care is delivered to an increasingly diverse patient population. For a moment, let us explore the profound impact of DEI in the practice of emergency medicine.

- **Cultural Humility and Sensitivity Enhances Patient Care**

Cultural humility and sensitivity goes beyond basic competence and is a critical aspect of emergency medicine. Patients from diverse backgrounds may have unique healthcare beliefs, practices, and exigencies. Healthcare providers operating with cultural humility can navigate these differences with awareness, sensitivity and respect, ultimately providing better care. For instance, respecting the presence of cultural nuances can aid in the diagnostic process and help ensure that patients receive appropriate evaluation and treatment. Attention to cultural and ethnic diversity advocates for enhanced interpreter services and consistent and reliable use of interpreters as one example for improved care across a cultural spectrum. Respect for cultural diversity not only enhances our clinical practice but augments the patient experience.

- **Different Perspectives Lead to Better Solutions**

In the high-pressure environment of the emergency department, having a diverse team can result in more innovative and effective solutions. Different perspectives and experiences can contribute to more comprehensive patient care plans and operational strategies. Physicians, nurses, and other healthcare professionals from various backgrounds may approach medical cases from different angles, leading to improved diagnosis and treatment. Enhanced diversity throughout all levels of leadership has been shown to improve patient care outcomes as well as operational metrics as a result of unique insights and vantage points.

- **Addressing Health Disparities**

DEI efforts also play an integral role in addressing health disparities, which are especially prevalent in emergency medicine. Addressing historical health inequities will require increased representation of underrepresented populations in the field and the acknowledgement that there are factors beyond individual patients, social determinants of health, that impact health outcomes. This not only benefits individual patients but also strengthens the healthcare system as a whole. For example, creating mechanisms to identify and account for the unmet needs of our patients will allow for the development of solutions to mitigate barriers to care including transportation, housing, access to outpatient follow up/prescriptions, etc. thereby reducing ED recidivism and missed appointment rates and improving patient engagement in treatment plans.

- **A Workforce that Reflects the Community it Serves**

One of the fundamental principles of DEI is to ensure that the healthcare workforce reflects the diversity of the community it serves. In the context of emergency medicine, this means having a team of healthcare professionals that truly reflects the gender, racial, ethnic, cultural, and socioeconomic representation of the surrounding community. It is also important to recognize that while cultural and socioeconomic differences are not always visually dependent, when patients see healthcare providers who look like them or share their cultural background, it can build trust and improve rapport, leading to

better healthcare outcomes.

- **Creating a Supportive Work Environment**

DEI extends beyond patient care and encompasses the work environment itself. A supportive work environment looks beyond diversity as a metric and fully embraces inclusion as a goal. As Simon Sinek discussed, team psychological safety is foundational for any successful organization. A workplace that values competence, hires ideal team players who value diversity and inclusion, and promotes accountability is more likely to attract and retain a talented and motivated workforce. It fosters a sense of belonging among employees, which can lead to higher job satisfaction and retention rates. In turn, this stability contributes to better patient care through a more experienced and dedicated staff.

- **Improved Quality of Care**

Ultimately, the main goal of DEI in emergency medicine is to provide the best possible care for all patients. Embracing the entire patient improves understanding, engagement, and outcomes. When diversity and inclusion are embraced, patients benefit from improved access to care, better communication, culturally sensitive treatment, and more innovative solutions. In an emergency, these factors can make all the difference between life and death.

The specialty and practice of emergency medicine are profoundly impacted by diversity, equity, and inclusion. A diverse healthcare workforce not only reflects the community it serves but also brings a range of perspectives and experiences that enhance patient care. Cultural humility, innovative problem-solving, and addressing health disparities are just a few of the benefits that DEI brings to this critical field. By fostering a supportive and inclusive work environment, we can ensure that emergency medicine continues to evolve and improve, ultimately saving more lives and providing better care to all patients, regardless of their background or identity.

Thank you for embracing the conversation for our teams, our patients, and our future.

Upcoming Events

Board Meeting - 04/24/24 (Grandover, Greensboro, NC)
ACEP LAC - 04/14/24 - 04/16/24 (Grand Hyatt, Washington, DC)
Board/Membership Meeting - 06/06/24 (Kiawah Island, SC)
Coastal EM Conference, 06/06/24 - 06/08/24 (Kiawah Island, SC)
ACEP24, 09/29/24 - 10/02/24 (Las Vegas, NV)
Fall Conference - 10/28/24 - 10/31/24 (Grove Park Inn, Asheville, NC)

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

OBS Coding and Reimbursement 2024

By: Brian Hiestand MD, MPH, FACEP, Michael Granovsky MD, CPC, FACEP

Happy 2024. Hopefully most of you survived, perhaps thrived in 2023 with the significant changes to E&M documentation requirements and the CPT revisions for ED and Observation codes. Of course, just as we settle into a new awareness of requirements, subtle changes occur. This summary will address changes to observation-relevant reimbursement including the 2024 CMS Final Rule as well as the 2024 CPT definitions regarding timing requirements for Observation services.

Federal RVU Conversion Factor for 2024

The Relative Value Unit (RVU) is the fundamental measure of physician work (both cognitive and procedural) assigned to any given CPT code. Every year, CMS determines the dollar amount per RVU – this is the Medicare Conversion Factor (CF), and it is applied to professional billing across all specialties and settings. While complex and convoluted, the mechanisms and rationales that CMS uses to come to this valuation requires a “budget neutrality “mandate. Budget neutrality has resulted in a year over year decrease in the Conversion Factor. In 2022, the CF was $34.60, but then dropped to $33.89 in 2023. Absent congressional action, we are currently slated to see a 2024 CF of $32.74 representing a 3.4% decrease. Not only is the CF not indexed to inflation, it has been falling since 2008, when an RVU was reimbursed at $38.09. ACEP/NCCEP continues to advocate with executive and legislative leadership to reverse this trend and major advocacy efforts are currently underway to protect our revenue for 2024.

2024 Observation CPT RVU valuation

Minimal, although generally positive, changes to the total RVU valuation of observation services in 2024:

CPT Code	Description	Total RVU 2023	Total RVU 2024
99221	First day or <8 hours, low MDM	2.46	2.46
99222	First day or <8 hours, moderate MDM	3.85	3.88
99223	First day or <8 hours, high MDM	5.13	5.14

CPT Code	Description	Total RVU 2023	Total RVU 2024
99231	Subsequent day obs, low MDM	1.47	1.47
99232	Subsequent day obs, moderate MDM	2.34	2.34
99233	Subsequent day obs, high MDM	3.52	3.52

CPT Code	Description	Total RVU 2023	Total RVU 2024
99234	Single day obs>8 hours, low MDM	2.92	2.90
99235	Single day obs>8 hours, moderate MDM	4.71	4.73
99236	Single day obs>8 hours, high MDM	6.18	6.18

CPT Code	Description	Total RVU 2023	Total RVU 2024
99238	Observation DC, ≤ 30 minutes	2.39	2.41
99239	Observation DC, > 30 minutes	3.39	3.40

Split / Shared Services
Many observation units (OUs) utilize APPs to assist with patient management. Many payers, including Medicare, reduce reimbursement for services primarily reported under the NPI of the APP by 15%, unless the physician satisfies the shared service requirements. Currently, to be paid at 100%, CMS requires that the physician provide a “substantive portion” of the patient’s MDM or provides over half the clinical care time. Although CMS was considering moving to the time-based standard, the 2024 Final Rule affirmed that the shared service requirement is met when the physician made or approved the management plan accounting for the complexity of problems addressed (including independent interpretation of diagnostic studies), as well as taking responsibility for the risk of the plan to the patient, in collaboration with the APP.

There has been a point of emphasis regarding attending responsibility for shared services and Data Interpretation. This is unlikely to affect coding for patients in observation, as these patients have a high complexity of problems addressed and are in a situation where, by definition, escalation to inpatient hospitalization is being considered. However, when the independent interpretation of a test result, such as an ECG, radiology study, POCUS, or monitor strip, or discussion of care with an additional medical professional, is the key element that takes the encounter from moderate to high (relying on the Complexity of Data section), that interpretation should be performed and documented by the attending.

8-hour Minimum: Same Day and Overnight
One element that has been clarified in the 2024 CPT definitions of the observation codes centers on observation stays that are less than 8 hours in total duration. Previously, an observation service initiated before midnight, but lasting less than 8 hours in total duration, would be covered by codes 99221-99223 for the first calendar day, followed by a discharge code of either 99238 or 99239, depending on the total time spent by the physician or APP in day of discharge care. The 2024 CPT update has now stated that an observation stay of less than 8 hours, regardless of whether the stay crossed midnight, should only be reported with the first day observation codes (99221-99223), and the day of discharge codes should not be reported. Therefore, day of discharge management codes should only be reported if the patient is discharged after an observation stay that both crosses sequential calendar days and extends greater than 8 hours. Additionally, CPT has clarified that same day Observation, if reported with 99234-99236 requires 8 hours.

Observation LOS	Number of days	Codes reported
< 8 hours	One or two calendar days	99221-99223
≥ 8 hours	Single calendar day	99234-99236
≥ 8 hours	At least two calendar days	99221-99223 for first day, 99238-99239 for final day DC

Links and references:
https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs/
Medicare and Medicaid Programs: Calendar Year 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; etc. Available at: https://www.federalregister.gov/public-inspection/2023-24184/medicare-and-medicaid-programs-calendar-year-2024-payment-policies-under-the-physician-fee-schedule

Medical Director Summit

The 2024 NCCEP Medical Director Summit was held **Friday, March 15, 2024**, 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 continues 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.

Annual Membership Meeting/Call for Nominations

This year's Annual Membership meeting will be held Thursday, June 6, 2024, at 12:30 pm, at the Kiawah Island Golf Resort in Kiawah Island, SC. Be on the lookout for a Call for Nominations and the electronic voting ballot coming soon!

Coastal EM Conference - June 6-8, 2024

Registration for this year's Coastal Emergency Medicine Conference is underway! Please join us June 6-8, 2024, 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 - Part 2

By: Beth Kolongowski, MD, Dawn Proctor, RN, Stacie Zelman, MD

Not all EDs (Emergency Department) are fortunate enough to have a sexual assault nurse examiner (SANE) present 24:7, let alone daily. In the Feb 2023 EPIC newsletter, my colleagues and I wrote a piece detailing the planning process of developing a seminar to prepare emergency medicine residents (and applicable for any practicing emergency physician) for practicing in an environment without the availability of a SANE nurse. This article shares some of the lessons learned throughout the implementation of this seminar and future actions planned as a result. If you are in a training program or a single physician coverage scenario, these insights may be helpful as you move forward to face this challenge.

Seminar Structure

The seminar was split into two one-hour sessions that took place after the resident conference. Attending both sessions was not mandatory, and residents could choose to attend only one depending on their availability. The seminar was designed this way to allow for the maximum number of residents to attend. The first session covered the SANE interview, while the second session focused on evidence kit collection. An outline of the seminar approach is below:

Based at Atrium Health Wake Forest Baptist Department of Emergency Medicine

- Taught by SANE coordinator, EM (Emergency Medicine) faculty, and EM residents
- Two, one-hour sessions:
    - 1st Session – Interview Skills
        - Detailed instruction regarding comprehensive H&P with appropriate documentation
        - Mock patient encounters
        - Debrief

      (Open Q&A was permitted throughout)
    - 2nd Session – Forensic Evidence Collection
        - Detailed instruction on evidence-collection techniques
        - Simulated evidence collection (“kit collection”), on anatomical models.

      (Open Q&A was permitted throughout)

Seminar Evaluation

An anonymous questionnaire was distributed at the beginning and end of each session to collect information on the level of residency training, prior experience with SANE patients, and confidence levels before and after the session. The questionnaire used a numerical score from 1-5 (Likert scale) to gauge confidence levels.

Fifteen pre/post questionnaires were completed for both sessions, with some residents attending both. Many more residents expressed interest but were unable to attend due to scheduling constraints. Among the attendees, eight were PGY 1, five were PGY 2, and two were PGY 3.

As expected, the PGY1 attendees were the least experienced with this patient population, with the majority having seen less than 5 sexual assault patients, followed by the PGY 2 attendees having seen on average 5-10 sexual assault patients. The two PGY 3 attendees were the most experienced group, having seen between 5-10 and 11-30 patients respectively.

We received positive feedback from all the participants in both seminars. Two attendees shared their appreciation and hoped for the program's continuation. It was also suggested that it should be made mandatory eventually. However, some participants suggested having more time for running through cases and including more topics on pediatrics.

Overall, we are pleased with the success of our first attempt at this type of program. This feedback from the participants and our internal debriefing allowed us to better understand the spaces where we need to expand on and improve the program.

Lessons Learned

We found that scheduling was the main challenge in conducting the seminar. Our residency program has 45 residents, with 15 in each class. Most of them are on off-service rotations or in the emergency department without protected time outside of resident conferences. This makes it difficult for many residents to attend the seminar at any given time. We thought that scheduling the seminar after protected conference time would allow for the greatest number of participants. This may be the case, but we are still exploring other scheduling options to increase participation.

We also learned that we should allocate more time for the forensic kit collection portion of the seminar. We discovered that with the introductory didactic section, we didn't have enough time to practice hands-on forensic kit collection on the practice models and give this piece the attention it deserved.

Lastly, we learned that everyone can gain something from this type of seminar, no matter your training level. While most participants were early in their residency (PGY1), all participants indicated that this training was valuable. Hopefully, we can get more participants of all levels and even incorporate medical students, APPs (Advanced Practice Providers), and attendings in the future.

Next Steps

We are designing our approach for the next seminar. Building on what we learned from the last one, we hope to implement the following changes:

- Identify optimal time for 4-hour training (i.e., tied to resident conference)
- Dedicate more time to the SANE exam/kit collection simulation
- Include sections on interpersonal violence and human trafficking
- Involve medical students and attendings

Recognizing the awareness and educational needs in this area go beyond the SANE exam but need to include the often-forgotten population of human trafficking. However, the physical process of the SANE exam is what causes the most anxiety and concern of the physicians. Addressing the insights noted above, we believe this program will improve the comfort and competency of all providers taking care of sexual assault patients. And we believe that it is something that can be created elsewhere and

hope that this will provide the resources for you to consider integrating a similar intervention into your educational curriculum or your community ED (Emergency Department). Please contact us directly if you have questions or are interested in doing something similar: szelman@wakehealth.edu.

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.

ACEP Executive Director Susan E. Sedory, MA, CAE, announced this week that she will step down from her role as chief executive officer effective June 2025. Ms. Sedory took the helm at ACEP as the COVID pandemic accelerated in July 2020 and deftly adapted ACEP staff and strategy to meet member needs in unpredictable times. Read more about her tenure and the plan to find her successor.

FTC Holds Workshop on Private Equity in Health Care, Issues RFI: The Federal Trade Commission (FTC), Department of Justice (DOJ), and Department of Health and Human Services (HHS) held a virtual workshop, "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care," on Tuesday afternoon. The Departments then issued a request for information (RFI) seeking public comment on deals that involve health care providers, facilities or ancillary products or services. READ MORE

Related: ACEP is voicing emergency physicians' deep concerns about private equity, corporatization and consolidation at the highest levels of government. A summary of ACEP activity and resources is available here.

ACEP, along with EDPMA, again called out bad insurer behavior and request immediate enforcement in a letter to federal agencies last week. In direct violation of the No Surprises Act, a pattern of health plans altering patient cost-sharing amounts after an independent dispute resolution (IDR) payment determination.

ACEP Provides Feedback on CMS Boarding Measure: Read ACEP's feedback, based on member input, on a new CMS measure to track boarding in the ED.

View as Webpage

Visit our website