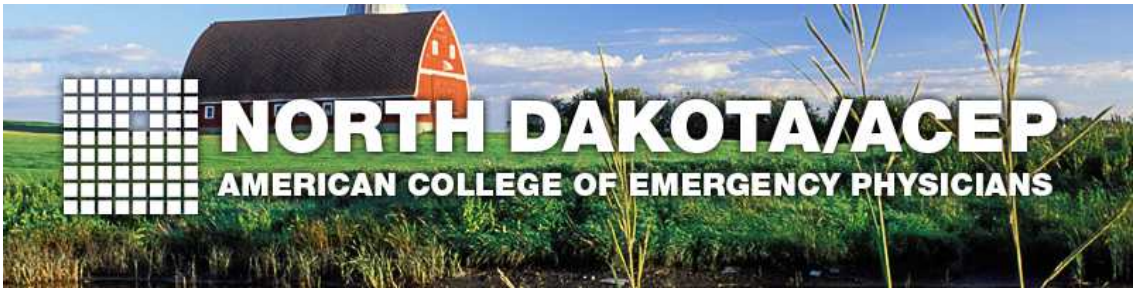
A Newsletter for the Members of the North Dakota ACEP Chapter



Kevin S. Mickelson, MD, FACEP
President

Adriana Alvarez
Executive Director
Phone: (800) 798-1822
Fax: (972) 767-0056

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From the President
Kevin S. Mickelson, MD, FACEP

Hello from the North Dakota Chapter. I would like to take the time to review some of the important issues directly affecting our practice at the national and local levels.

As you may be aware, Anthem Health Care of Georgia had been retroactively denying claims for ED visits post diagnosis. ACEP is sueing **Anthem** for its recent decision to deny ED visits retroactively. This policy violates the Prudent Layperson definition established by congress in 1997. It is important to spread the word to your patients to "retain the Prudent Layperson definition" and to resist any statewide or national attempt to redefine this important landmark piece of legislation. Succinctly stated "any medical or behavioral condition of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy." Any attempt to back pedal on this issue is unacceptable to any ED physicians.

Secondly, be aware of national trends changing staffing **ratios** to include AP's (Advance Providers; NP's and PA's). The exact ratio of AP supervision, 1:1, 1:2 is not clear.

Current Provider to Patient ratios or PP varies between 2 to 2.3 nationally. The following table portioned by volume and years demonstrates a trend towards increasing PP using AP's but does not definer the ratio of supervision. Below is a link showing productivity changes over the years using AP's published in **ACEPNow**.

ACEP suggests the following guidelines for AP's:

- PAs and APRNs do not replace the medical expertise and patient care provided by emergency physicians.
- PAs and APRNs working in EDs should have or acquire specific experience or specialty training in emergency care and should receive continuing education in providing emergency care.
- Credentialing procedures for PAs and APRNs in the ED must be specifically stated and approved by the facility governing body with input from the medical staff and must meet the requirements of the federal or state jurisdictions in which they practice.
- PAs and APRNs must be appropriately certified by their respective certifying bodies.
- Due to variations in state laws and regulations, it is imperative that emergency physicians, PAs and APRNs are aware of their scope of practice as well as physician supervision responsibilities and requirements.
- The PAs and APRNs scope of practice must be clearly delineated and must be consistent with federal and state laws and regulations.
- PAs and APRNs working in EDs should participate in a supervised orientation program, including demonstrating knowledge of specific ED policies and procedures and the requisite knowledge base to function safely and appropriately in the ED.

- The medical director of the ED or a designee has the responsibility of providing the overall direction of activities of the PA or APRN in the ED. In EMS, this is the role of the physician EMS medical director.
- PAs may function in various capacities and with varying degrees of supervision. However, as dependent practitioners, they must always function with a supervisory agreement with a physician.
- APRNs supervisory requirements (collaborative agreements) vary and independent practice is authorized in some states.
- ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care.
- Each supervising physician should retain the right to determine his/her degree of involvement in the care of patients provided by PAs and APRNs in accordance with the defined PA or APRN scope of practice, state laws and regulations, and supervisory or collaborative agreement. When such is required, the supervising physician for each PA or APRN encounter should be specifically identified.
- The ED medical director should define the number of PAs and/or APRNs whose clinical work can be simultaneously supervised by one emergency physician, guided by ED clinical needs and state laws.
- ED medical directors are encouraged to develop guidelines for PAs and APRNs outlining the types of conditions PAs and APRNs may or may not routinely evaluate and treat:
- With indirect supervision: Verbal supervising physician consultation and/or chart review/signature.
- With direct supervision: In conjunction with a supervising physician physically attending to the patient, providing face-to-face time.
- PAs and APRNs must be aware of and participate in performance improvement activities of the ED or EMS agency.
- The ED medical director should be responsible for ongoing professional practice evaluation of each PA and APRN utilizing focused professional practice evaluation, as appropriate.
- PAs and APRNs may fulfill clinical and administrative roles in which they will supplement and assist emergency physicians.
- Multiple staffing models utilizing PAs and APRNs exist. It is the responsibility of the ED medical director to identify the most appropriate staffing model to achieve operational efficiency, while maintaining clinical quality.

A well written series of articles by Joseph Guarisco, MD FAAEM, Chair, Operations Management Committee AAEM suggests 4 AP’s can replace 1 MD operationally at the ESI cutoff of 4 and 5.

Dr. Guarisco suggests an ESI (Emergency Severity Index) of 4 or 5. In my experience working with AP's, during peak times, this has morphed into 3 and sometimes 2, rarely level 1 ESI triaged patients. The degree of supervision becomes less, as sicker patients in increase in

number. ED physicians have time as their inventory.

EMR's were initially thought to save time, but in fact, may increase time charting as opposed to directing patient care. Incorporating scribes may save time and improve efficiency.

This series of articles is well worth reading for those interested in ED flow and surge coverage.

Next, I would like to discuss CMG's or contract management groups. As many of you may know, our group was replaced by a contract management group after negotiations were unsuccessful. Our Employer used a FMV (Fair Market Value)from Gallagher management group that included ED's in a surrounding state area, but not specific for Board Certified, Residency Trained ED physicians. We could not agree on the accuracy of the FMV being used. In addition, staffing changes were made without physician input and a cutback in double coverage, due to a perceived fall in patient volumes since CHI had acquired St. Alexius. The groups concerns could not be assuaged by our employer. They felt obliged to seek coverage from a CMG, when an agreement could not be reached.

Lastly, there is an ongoing ACEP campaign to increase awareness amongst ED physicians regards narcotic prescribing due to the ongoing problem with addiction and **narcotic** overdose.

There were no Level A recommendations, and only 1 level B recommendation as follows:

"In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids?

Level A Recommendations
None specified.

Level B Recommendations

For the short-term relief of acute musculoskeletal pain, emergency physicians may prescribe short-acting opioids such as oxycodone or hydrocodone products while considering the benefits and risks for the individual patient.

There were several Level C recommendations. Suffice to say, judicious use of the **NDSBP** site and short-term prescriptions for acute pain appear prudent.

A shout out to Dr. McCullough for her outstanding work in this regard! It has spread to many states and is now the method of choice for multi state review of prescribed controlled drugs.

NEWS FROM ACEP

Updates in Reimbursement and Coding - 2018

Reimbursement and coding can be an ongoing challenge for the emergency physician. This **collection of courses on ACEP eCME** will give you the latest information on reimbursement, quality measures and common documentation errors to help ensure you receive appropriate reimbursement for your skilled procedural work.

New ACEP Policy Statements and Information Paper

During their June meeting, the ACEP Board of Directors approved the following new or revised policy statements:

- **Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch, and Public Emergency Aid Training** - New
- **Appropriate Use Criteria for Handheld/Pocket Ultrasound Devices** - New
- **Coverage for Patient Home Medication While Under Observation Status** - New
- **Delivery of Care to Undocumented Persons** - Revised
- **Disaster Medical Services** - Revised
- **Financing of Graduate Medical Education in Emergency Medicine** - Revised
- **Guideline for Ultrasound Transducer Cleaning and Disinfection** - New
- **Impact of Climate Change on Public Health and Implications for Emergency Medicine** - New
- **Interpretation of Diagnostic Imaging Tests** - Revised
- **Interpretation of EMTALA in Medical Malpractice Litigation** - New
- **Non-Discrimination and Harassment** - Revised
- **Patient Autonomy and Destination Factors in Emergency Medicine Services (EMS) and EMS-Affiliated Mobile Integrated Healthcare Community Paramedicine Programs** - New
- **Prescription Drug Pricing** - New
- **Relationship between Clinical Capabilities and Medical Equipment in the Practice of Emergency Medical Services Medicine** - New

- **Resident Training for Practice in Non-Urban/Underserved Areas** - Revised

The Board also approved the following information papers and PREP:

- **Electronic Health Record (EHR) Best Practices for Efficiency and Throughput (PDF)** - New
- **Initiating Opioid Treatment in the Emergency Department (ED) - Frequently Asked Questions (FAQs)** (PDF) - New
- **Emergency Department Physician Group Staffing Contract Transition** (PDF)
- **Emergency Physician Contractual Relationships - PREP** (PDF) - Revised

Articles of Interest in *Annals of Emergency Medicine*
Sam Shahid, MBBS, MPH
Practice Management Manager, ACEP

ACEP would like to provide you with very brief synopses of the latest articles in ***Annals of Emergency Medicine***. Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Duber HC, Barata IA, Cioe-Pena E, Liang SY, Ketcham E, Macias-Konstantopoulos W, Ryan SA, Stavros M, Whiteside LK. **Identification, Management and Transition of Care for Patients with Opioid Use Disorder in the Emergency Department**

In this clinical review article, they examine the current body of evidence underpinning the identification of patients at risk for OUD, ED-based symptomatic treatment of acute opioid withdrawal, medication-assisted treatment (MAT) of OUD upon discharge from the ED, and transition to outpatient services. In this article they also present options for targeted opioid withdrawal and management, as well as a variety of other medications to consider for symptomatic opioid withdrawal treatment for patients that do not require opioids for acute pain. **Full text available here**.

Klein LR, Driver BE, Miner JR, Martel ML, Hessel M, Collins JD, Horton GB, Fagerstrom E, Satpathy R, Cole JB. **Intramuscular Midazolam, Olanzapine, Ziprasidone, or Haloperidol for Treating Acute Agitation in the Emergency Department**

In this prospective observational study of 737 patients, medications were administered based

on an a priori protocol where the initial medication given was predetermined in the following 3-week blocks: haloperidol 5mg, ziprasidone 20mg, olanzapine 10mg, midazolam 5mg, haloperidol 10mg. The primary outcome was the proportion of patients adequately sedated at 15 minutes, assessed using the Altered Mental Status Scale (AMSS). Results showed that Intramuscular midazolam achieved more effective sedation in agitated ED patients at 15 minutes than haloperidol, ziprasidone, and perhaps olanzapine. Olanzapine provided more effective sedation than haloperidol. No differences in adverse events were identified. **Full text available here.**

Brenner JM, Baker EF, Iserson KV, Kluesner NH, Marhsall KD, Vearrier L. **Use of Interpreter Services in the Emergency Department**

This paper highlights the importance of effective communication in the provider-patient therapeutic relationship and how language barriers have the potential to compromise all aspects of medical care. The authors identify that in the US, as of 2013, more than 25 million persons had limited English proficiency, making quality medical interpreter services an important public health issue that affects a large proportion of our diverse population. They recommend that a professional interpreter should be offered if practical and available when a patient has either limited English proficiency or hearing impairment and that a modality of interpretation should be chosen between in-person, video, or telephone based on what best suits the clinical situation. **Full text available here**.

Nowak RM, Gandolfo CM, Jacobsen G, Christenson RH, Moyer M, Hudson M, McCord J. **Ultra-Rapid Rule-Out for Acute Myocardial Infarction Using the Generation 5 Cardiac Troponin T Assay: Results from the REACTIONUS Study**

The objective of this study was to determine how well a new FDA approved single cardiac troponin T Generation 5 (cTnT Gen 5) below the level of quantification (6 ng/L) baseline measurement and a novel study derived baseline/30 minute cTnT Gen 5 algorithm might adequately exclude acute myocardial infarction (AMI) in patients with suspected acute coronary syndrome (ACS) in a United States (US) Emergency Department (ED). They enrolled patients presenting with any symptoms suspicious of ACS. Baseline and 30 minute blood samples were obtained, the cTnT Gen 5 levels later batch analyzed in an independent core laband the AMI diagnosis was adjudicated by a cardiologist and an emergency physician. They found that a single baseline cTnT Gen 5 measurement <6 mg/L and values at baseline <8 ng/L and a delta 30 minute < 3 ng/L ruled-out AMI in 28.8% and 41.0% of patients respectively. The authors did identify limitations such as single center ED, selection bias and the exclusion of patients with life-threatening illness, cardioversion or defibrillation within 24 hours of presentation, STEMI patients requiring immediate reperfusion or those who were pregnant or breast feeding, and highlighted that additional multi-center US studies evaluating these ultra-rapid AMI ruleout guidelines are needed.

Friederich A, Martin N, Swanson MB, Faine BA, Mohr NM. **Normal Saline and Lactated Ringer's have a Similar Effect on Quality of Recovery: A Randomized Controlled Trial**

The purpose of this single-site participant- and evaluator-blinded, 2-arm parallel allocation (1:1), comparative effectiveness randomized controlled trial study was to test the hypothesis that balanced crystalloids improve quality of recovery more than normal saline (0.9% sodium chloride, NS) in stable Emergency Department patients. 157 Patients allocated to receiving IV fluids in the ED before discharge to were randomized to receive 2 L of Lactated Ringer's (LR) or NS. The primary outcome was symptom scores measured by the validated Quality of Recovery-40 (QoR-40) instrument (scores 40-200) 24 hours after enrollment. Results showed that there was no difference in post-enrollment QoR scores between NS and LR groups. Although pre-enrollment scores were higher in the LR group, adjusting for pre-survey imbalances did not change the primary outcome. The authors concluded that NS and LR were associated with similar 24-h recovery scores and 7-day health care utilization in stable ED patients.

Interested in GED Accreditation?

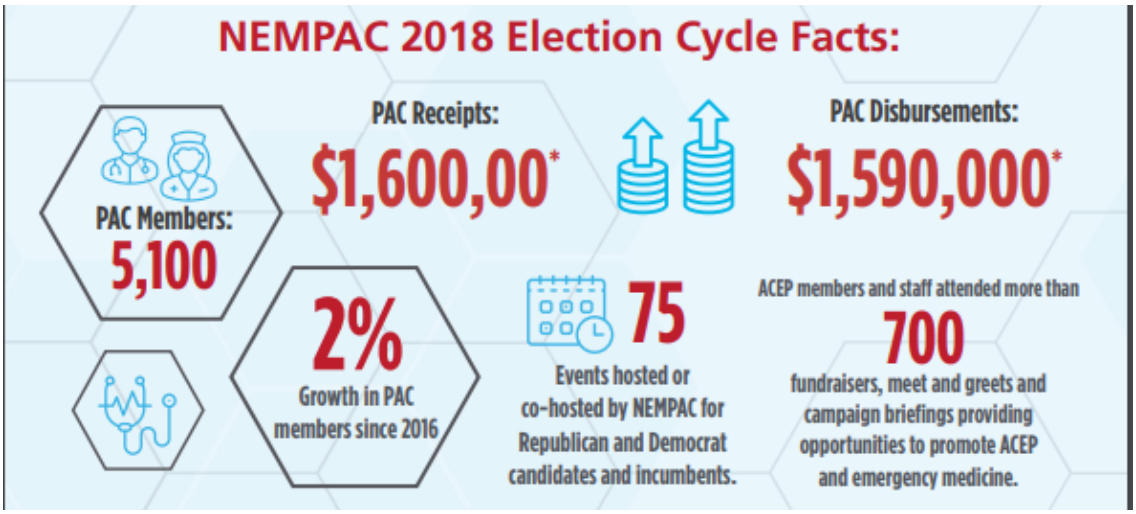
Learn how to develop a Geriatric Emergency Department (GED) with this three-hour **geriatric pre-conference** during ACEP18. Hear from the geriatric experts who will walk you through the increasing need for geriatric medicine focusing on GED clinical workflows, training and staff development, geriatric-focused policies and protocols, and achieving **GED accreditation**. Panel discussions include institutions who have been awarded accreditation.

Emergency Ultrasound Tracker

Emergency physicians regularly apply for hospital credentials to perform emergency procedures including emergency ultrasound. Theoretically, ultrasound training, credentialing and billing should be no different than other emergency procedures where training occurs in residency and an attestation letter from the residency is sufficient for local credentialing. When such training occurs outside of residency, “proctored pathways” often serve to assure competency. There is still a lack of understanding and awareness in the general medical community that emergency physicians routinely train in and perform point-of-care ultrasound.

The **Emergency Ultrasound Tracker** was created to assist members in achieving official recognition of ultrasound skills. This tool allows you to easily keep track of ultrasound scans you have performed over the course of your career in emergency medicine. It also allows you to upload relevant documents that attest to your training. After inputting and self-attesting to

your ultrasound information you may download a letter of recognition from ACEP so long as you have attested to meeting the recommendations for emergency ultrasound training put forth in the **ACEP Ultrasound Guidelines**. We hope you find this tracker tool helpful and useful in your practice.



NEMPAC Mid-Term Election Update

With the mid-term elections just months away, ACEP and the National Emergency Medicine Political Action Committee (NEMPAC) are focused on electing candidates who will work on bi-partisan solutions to address emergency medicine's most pressing issues. The NEMPAC Board and staff rely on input from ACEP state chapters and local ACEP members when evaluating support for incumbent legislators and new candidates - **we want to hear from you!** NEMPAC is the 4th largest medical PAC and will continue to grow with your support. Learn more about NEMPAC today by visiting **our website** or contact **Jeanne Slade**. Keep an eye on your inbox for additional details about NEMPAC's activities as we get closer to the elections.

ED ICU Development and Operations Workshop Pre-Conference

San Diego Convention Center, Upper Level, 7B
Sunday, September 30, 2018 | 12:30 pm to 5:00 pm

If you have ever considered developing an ED ICU this workshop is for you. Participants will learn about staffing, reimbursement, collaborations, and business plan development, with the goal of developing and running their own ED-ICU. This program is directed at those along the

entire continuum of ED-ICU development from conceptual to operational phases. **Register here**. For more information, contact **Margaret Montgomery, RN MSN**.

NEWS FROM THE AMERICAN BOARD OF EMERGENCY MEDICINE - JULY 2018

American Board of Emergency Medicine

Subspecialty Certification in Neurocritical Care

The American Board of Medical Specialties (ABMS) has approved subspecialty certification in Neurocritical Care (NCC). NCC is co-sponsored by the American Board of Anesthesiology (ABA), the American Board of Emergency Medicine (ABEM), the American Board of Neurological Surgery, and the American Board of Psychiatry and Neurology (ABPN). Physicians certified by these four boards who meet the eligibility criteria for NCC will have the opportunity to become certified in NCC.

There will be two pathways to certification in NCC: a training pathway and a time-limited practice pathway. The practice pathway will start at the time the first exam is offered. Eligible pathway criteria will be posted on the ABEM website by the end of 2018. ABPN will develop and administer the examination; physicians will submit applications to their primary certifying board. The first examination is expected to take place in either 2020 or 2021.

Letter Available Refuting Merit Badge Requirements

ABEM provides a letter of support that may be submitted to hospital administrators to forego the mandatory completion of short courses or additional certifications (“merit badges”) often needed for hospital privileges. Physicians must be participating in the ABEM MOC Program to obtain the letter.

The letter, signed by each representative of the Coalition to Oppose Medical Merit Badges (COMMB), details specific activities that board-certified physicians perform to maintain certification. ABEM-certified physicians can now download the letter from their Personal Page on the ABEM portal by doing the following:

- Sign in to the ABEM portal at **www.abem.org**
- On the left navigation, click “Print Verification of ABEM Status”
- Under letter type, click “General Coalition ABEM”
- Click “Continue to Next Step”

Take the ConCert™ Early - Retain Your Current Certificate Date

You can take the ConCert™ Examination during the last five years of your certification (during the annual testing window). If you pass the exam early, you will still retain your certification until the expiration date on your current certificate. This is also true even after you complete all of your MOC requirements. When your current certification expires, you will be issued a new, ten-year certificate. If you take the ConCert™ Examination early and do not pass, you still retain your certification and have another chance(s) to pass it. ABEM only reports whether a physician is board certified and participating in MOC.

In 2017, 44 percent of ConCert™ test takers registered to take the exam early; that is, in a year prior to their final year of certification.

Welcome New Members

Jacy O'Keefe (Medical Student)
Zachary Michael Elliott (Medical Student)

North Dakota Chapter
c/o National ACEP
4950 W. Royal Lane
Irving, Texas 75063-2524