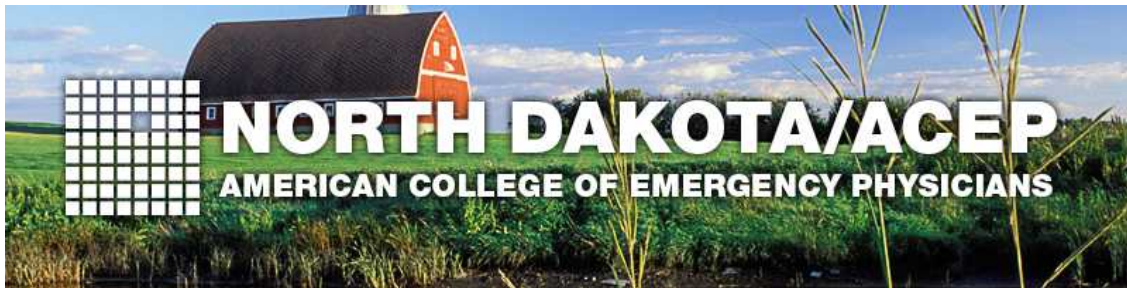


A Newsletter for the Members of the North Dakota ACEP Chapter



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

Dear Fellow Docs,

National ACEP in San Diego was a rousing success and one of the best attended ACEP conferences on record. ACEP continues to be the leading practice and political leader in the field of Emergency Medicine across the world.

National ACEP has approved the North Dakota Chapter Bylaws revision which was long overdue! This will allow us to continue functioning as an active small chapter within the umbrella of National ACEP. My thanks to Adriana and Charles Heinrichs of the National ACEP Bylaws Committee for their outstanding guidance during this process! Your national ACEP dues are working.

Physician burnout and physician suicide, was again a topic of discussion though making physician suicide a Sentinel Event was not adopted. Loss of autonomy, pressure to see patients faster, poor outcome, malpractice all major contributors. If you feel, you are not alone. Physicians are retiring at an alarming rate. All to the rescue....don't count on it. Talk to each other, don't be afraid to share. EVERYONE feels this at one time or another. Reach out to your partners and their families in support. Many voiced that seeking professional help made it difficult to find work. State Medical societies and Boards need to do a better job of policing job application questions from infringing on the right of privacy in this regard! Talk to your State Medical Board and voice your concerns.

North Dakota ACEP membership has dropped in part, due to the loss of nine ND resident CHI ED physician's. Some are moving out of state, others staying, but perhaps not practicing in the ED. In the interim, CHI St. Alexius continues to recruit while using locum doctors from Health Source, a small locums firm centered in Montana. This loss is nearly 25% of the actively practicing residency trained, board certified positions in the state.

New officers were elected to the board. Click [here](#) to read about it.

We continue the fight against [Anthem's](#) attempts to reverse the Prudent Layperson standards for defining an emergent condition.

Past ACEP President Paul Kivela responds to a [New York Times](#) editorial characterizing ED's and ED physicians as expensive and inefficient. Who else is mandated Federally to see every patient that comes through the door, bring all resources to bear to establish stability regardless of ability to pay? A big attaboy to Dr. Kivela.

Be on the lookout for AFM, acute flaccid myelitis as several cases have been reported in Minnesota. It usually starts with a respiratory or GI illness, then proceeds to muscle weakness

in the cranial or limbs, peaking in September and October. Blood, stool, CSF, nasal swab and serum are requested by the CDC for confirmation and further study. Contact the North Dakota Department of Health, the CDC at 701-328-2378 or [limbweakness@cdc.gov](mailto:limbweakness@cdc.gov) respectively.

I hope this letter finds you and your family well and thriving!

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## **Clinical Scoring to Risk Stratify and decrease CT use in Diagnosis of Pediatric Appendicitis**

### **Sarah McCullough, MD, FACEP**

#### **Secretary/Treasurer**

There are continued efforts to reduce radiation exposure, particularly for pediatric patients. PECARN Pediatric Head Injury/Trauma Algorithm is being used to risk stratify and decrease head CT utilization. There are clinical scoring systems that have been validated for pediatric abdominal pain and they should be used to decrease use of CT in diagnosing pediatric appendicitis. According to The National Surgical Quality Improvement Program data, 26.1% is the median rate of preoperative CT in patients diagnosed with pediatric appendicitis. Since 10% of pediatric patients with abdominal pain presenting to the ED and 25% of those referred to the ED with abdominal pain are diagnosed with appendicitis we need to determine ways to limit radiation exposure. Ultrasound is fast approaching the standard of care to evaluate for appendicitis.

However, it is still quite operator dependent. If the ultrasonographer is unable to visualize the appendix what next? There are 2 validated scoring systems for pediatric appendicitis that may be helpful to determine if the ultrasound needs to be ordered and to risk stratify into low, medium, or high-risk patients.

The Kharbanda Low Risk Appendicitis Score is quite simple. If there is no elevated ANC and if they have no tenderness in the right lower quadrant or they can jump and walk without pain they are low risk and no ultrasound is needed. The PAS (Pediatric Appendicitis Score) is a 10-point scoring system, easily accessible on MD Calc. It assesses right lower quadrant tenderness to cough, jump, hop, or percussion, anorexia, fever, nausea or vomiting, tenderness over the right iliac fossa, leukocytosis ( $>10,000$ ), left shift ( $ANC > 7500$ ) and migration of pain to the right lower quadrant. No imaging is recommended if the score is low risk at  $<4$ . The risk for appendicitis in these patients is not zero, but other causes for the pain should be considered. Imaging is recommended for those with medium or equivocal scores of 4-6.

Ultrasound should initially be ordered. MRI can be considered but it may take a prolonged time to obtain and may require sedation for some patients so may not be practical. Imaging along with surgical consultation is recommended for those who are high risk, 7-10. Ultrasound is recommended and if appendix is not visualized surgical consultation will help determine the

next best plan for evaluation.

These are just scoring systems to risk stratify and obviously clinical gestalt is an important factor in all patient evaluations. The time from onset of symptoms may have an effect on the score. The scoring system can be used in "shared decision making" with parents and to help determine a good follow up plan. They may be particularly helpful to decrease radiation exposure in the low risk and possibly medium risk patients. A return visit for a recheck or admission for observation may be considered instead of CT scan. In addition to using the scoring systems, discussion with our surgical colleagues to set up a well-defined plan for pediatric abdominal pain evaluation may decrease utilization of CT in this population.

## NEWS FROM ACEP



### New ACEP Information Papers and Resources

The following information papers and resources were recently reviewed by the Board of Directors:

#### Information Papers:

- [Advocating for a Minimum Benefit Standard Linked to the 80th Percentile of a FAIR Health-Type Usual & Customary Charge Database](#)
- [Emergency Ultrasound Standard Reporting Guidelines](#)
- [Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Medicine](#)

#### Other Resources:

- [Resources for Emergency Physicians – Reducing Firearm Violence and Improving Firearm Injury Prevention](#)

#### Smart Phrases for Discharge Summaries:

- [CT Scans for Minor Head Injuries](#)
- [MRI for Low Back Pain](#)
- [Sexually Transmitted Infection](#)

- [Why Narcotics Were Not Prescribed](#)

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## Articles of Interest in *Annals of Emergency Medicine* - Fall 2018

### 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.

#### Anderson TS, Thombly R, Dudley RA, Lin GA. **Trends in Hospitalization, Readmission and Diagnostic Testing of Patients Presenting to the Emergency Department with Syncope**

The objective of this retrospective population epidemiology study was to determine whether recent guidelines emphasizing limiting hospitalization and advanced diagnostic testing to high-risk patients have changed patterns of syncope care. They used the National Emergency Department Sample from 2006-2014 and the State Inpatient Databases and Emergency Department Databases from 2009 and 2013. The primary outcomes studied were annual incidence rates of syncope ED visits and subsequent hospitalizations, and rates of hospitalization, observation, 30-day revisits, and diagnostic testing comparing 2009 to 2013. Their results showed that although the incidence of ED visits for syncope has increased, hospitalization rates have declined without an adverse effect on ED revisits and that the use of advanced cardiac testing and neuroimaging has increased, driven by growth in testing of patients receiving observation and inpatient care.

#### Trivedi TK, Glenn M, Hern G, Schriger DL, Sporer KA. **EMS Utilization among Patients on Involuntary Psychiatric Holds and the Safety of a Pre-Hospital Screening Protocol to “Medically Clear” Psychiatric Emergencies in the field, 2011-2016**

The purpose of this retrospective review was to describe overall EMS utilization for patients on involuntary holds, compare patients placed on involuntary holds to all EMS patients, and evaluate the safety of field medical clearance of an established field-screening protocol in Alameda County, California, using the data for all EMS encounters between November 1st, 2011-2016 using County’s standardized dataset. Results showed that 10% of all EMS encounters were for patients on involuntary psychiatric holds and overall, only 0.3% of these encounters required re-transport to a medical ED within 12 hours of arrival to Psychiatric Emergency Services, reinforcing the importance of the effects of mental illness on EMS utilization. [Full text available here.](#)

Yoshida H, Rutman LE, Chen J, Shaffer ML, Migita RT, Enriquez BK, Woodward GA, Mazor

### **SS. Waterfalls and Handoffs – A Novel Physician Staffing Model to Decrease Handoffs in a Pediatric Emergency Department**

The objective of this retrospective quality improvement study was to evaluate a novel attending staffing model in an academic pediatric ED that was designed to decrease patient handoffs. The study evaluated the percentage of intradepartmental handoffs before and after implementation of a new novel attending staffing model and included conducting surveys about the perceived impacts of the change. The study analyzed 43,835 patients encounters and found that immediately following implementation of the new model, there was a 25% reduction in the proportion of encounters with patient handoffs. The authors concluded that this new ED physician staffing model with overlapping shifts decreased the proportion of patient handoffs and resulted in improved perceptions of patient safety, ED flow, and job satisfaction in the doctors and charge nurses. [Full text available here.](#)

Jones AR, Patel RP, Marques MB, Donnelly JP, Griffin RL, Pittet JF, Kerby JD, Stephens SW, DeSantis SM, Hess JR, Wang HE, On behalf of the PROPPR study group. **Older blood is associated with increased mortality and adverse events in massively transfused trauma patients: secondary analysis of the PROPPR trial.**

This study sought to determine the association between PRBC age and mortality among trauma patients requiring massive PRBC transfusion using the data from the Pragmatic, Randomized Optimal Platelet and Plasma Ratios (PROPPR) trial. The authors analyzed data from 678 patients and the primary outcome was 24-hour mortality. The results showed that increasing quantities of older PRBCs are associated with increased likelihood of 24-hour mortality in trauma patients receiving massive PRBC transfusion ( $\geq 10$  units), but not in those who receive  $< 10$  units.

Roberts RM, Hersh AL, Shapiro DJ, Fleming-Dutra K, Hicks LA. **Antibiotic Prescriptions Associated with Dental-Related Emergency Department Visits.**

The objective of this study was to quantify how often, and which dental diagnoses seen in the ED resulted in an antibiotic prescription using the National Hospital Ambulatory Medical Care Survey (NHAMCS) data of visits to the ED for dental conditions during 2011-2015. Based on an unweighted 2,125 observations from the NHAMCS in which a dental-related diagnosis was made, there were an estimated 2.2 million ED visits per year for dental-related conditions, which accounted for 1.6% of ED visits. An antibiotic, most often a narrow spectrum penicillin or clindamycin, was prescribed in 65% of ED visits with any dental diagnosis, and the most common dental diagnoses for all ages were unspecified disorder of the teeth and supporting structures (44%), periapical abscess without sinus (21%), and dental caries (18%). Given that the recommended treatments for these conditions are usually dental procedures rather than antibiotics, the results may indicate the need for greater access to both preventative and urgent care from dentists and other related specialists as well as the need for clearer clinical guidance and provider education related to oral infections.

## Interested in Reimbursement for EM?

Apply for the Reimbursement Leadership Development program! Program members will gain a thorough understanding of the EM reimbursement process, be poised to assume reimbursement leadership positions, and obtain a highly valuable skill set that will help them in their professional growth, practice, and path to ACEP leadership. Deadline is Nov. 9. [Apply now](#).



## Upcoming CEDR Webinar on November 15

**Year 3 Proposed Rule: 2019 Participation in APMs**

**Speaker:** Corey Henderson, Health Insurance Specialist within the Center for Medicare and Medicaid Innovation Center CMS-CMMI | November 15, 2018 1:00 PM CST - [Register Today!](#)



ACEP • ojai, CA • Feb 19-22, 2019

ReCharge • ReEnergize • ReFocus

## Introducing BalancedED

A new, [physicians-only wellness conference](#) where you can focus on your well-being in your practice and your daily life. Join us February 19-22, 2019 at the beautiful Ojai Valley Inn in Ojai, CA to learn ways to help reduce stresses in your practice. Then, in the afternoon it's time to get

out of the course room and spend time participating in the numerous wellness activities available at the resort.

## ACEP Doc Blog!

Looking for a way to increase your visibility and reach patients? Consider contributing to the ACEP Doc Blog! The blog lives on the ACEP patient-facing website [www.emergencycareforyou.org](http://www.emergencycareforyou.org). The Doc Blog offers plainly worded insight and expertise to patients from emergency physicians. Topics include health and safety tips, “day-in-the-life” experiences, passion projects and more. Our goal is to create short (500 word) posts that help put a human face on emergency medicine. Recent posts:

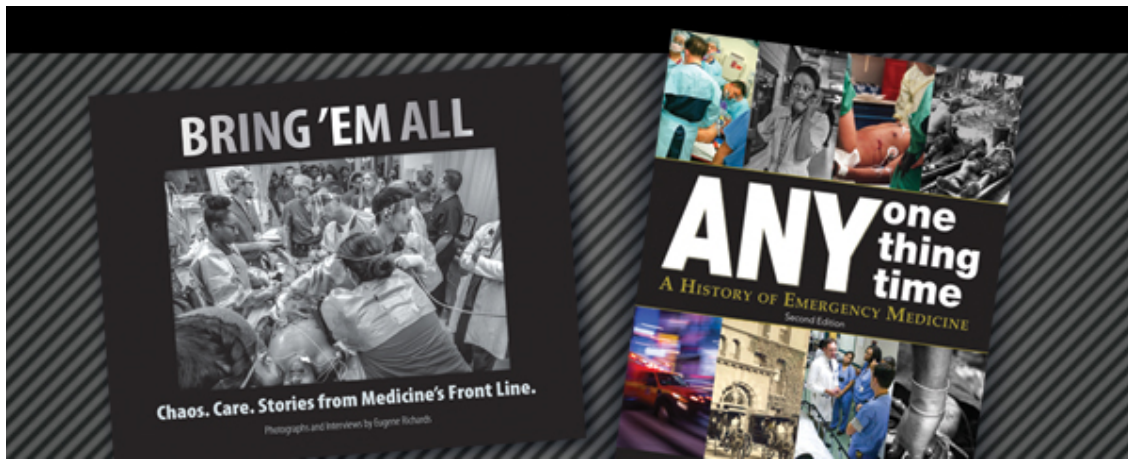
- [Cats, Dogs and Dander... Oh, My!](#)
- [Dear Patient: A Letter from Your Emergency Physician](#)
- [Your Summer Guide to Bug Bites & Skin Rashes](#)
- [Heat Stroke and Hot Cars](#)
- [Not the Right Time for a Selfie: A Conversation about Hawaii and Volcano Safety](#)

Contact [Steve Arnoff](#) to learn more about contributing to the ACEP Doc Blog.

## Want to improve your skills managing behavioral or medical emergencies?

Come join the Coalition on Psychiatric Emergencies (CPE) for a pre-conference workshop on Dec. 12th in Las Vegas Nevada. The Coalition is presenting two pre-conferences: **Critical Topics in Behavioral Emergencies for Emergency Physicians and Critical Topics in Emergency Medicine for Psychiatrists**. Come improve your skills and earn CME! The early-bird rate for members is \$149. To view the full schedule and to register, visit the [pre-conference website](#).





## ACEP's 50th Anniversary Books

Buy one for yourself or give as a gift! [Bring 'em All](#) and [Anyone, Anything, Anytime](#) available at [bookstore.acep.org](http://bookstore.acep.org).

**Improve the Care  
Provided to Older Patients**

**Become an Accredited Geriatric Emergency Department**

Developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter.

**ACEP.org/GEDA**

**ACEP Geriatric**  
Emergency Department Accreditation

## Seniors make up 43% of all hospitalizations originating in the ED

In recognition of challenges with older adult presentations, [guidelines to improve ED care for older adults](#) have been established by leaders in emergency medicine. To further improve the care and provide resources needed for these complex older adult presentations, ACEP launched the [Geriatric ED Accreditation Program \(GEDA\)](#) to recognize those emergency departments that provide excellent care to older adults. The program outlines the approach to the care of the elderly ED patient according to expertise and available evidence, with implications for physician practice and ED processes of care. GEDA provides specific criteria and goals for emergency clinicians and administrators to target, designed to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED

encounter.

Become accredited and show the public that your institution is focused on the highest standards of care for your community's older citizens.



Providers  
Clinical Support  
System

With PCSS training, you  
can help save lives from  
opioid use disorder

**By getting MAT trained, you can help  
people take their lives back from OUD.**

Visit [pcssNOW.org](http://pcssNOW.org)

Funding for this initiative was made possible (in part) by grant nos. 5H79TI025595-03, 5U79TI026556-02 and 3U79TI026556-02S1 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

## Free Medication-Assisted Treatment Training

Eight hours of training on medication-assisted treatment (MAT) is required to obtain a waiver from the Drug Enforcement Agency to prescribe buprenorphine, one of three medications approved by the FDA for the treatment of opioid use disorder. Providers Clinical Support System (PCSS) offers free waiver training for physicians to prescribe medication for the treatment of opioid use disorder. PCSS uses three formats in training on MAT:

- Live eight-hour training
- “Half and Half” format, which involves 3.75 hours of online training and 4.25 hours of face-to-face training.
- Live training (provided in a webinar format) and an online portion that must be completed after participating in the full live training webinar

Trainings are open to all practicing physicians. Residents may take the course and apply for their waiver when they receive their DEA license. For upcoming trainings consult the [MAT Waiver Training Calendar](#). For more information on PCSS, [click here](#). For more information on MAT training, email [Sam Shahid](mailto:Sam.Shahid@pcss.org).



**Call to Action!**  
Navigating together for change



*Funding for this initiative was made possible (in part) by grant no. 1H79TI080816-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.*

## **Call for Consultants - SAMHSA State Targeted Response Technical Assistance (STR-TA) Initiative**

Join over the 500 Treatment Technical Assistance (TA) Consultants already participating in the initiative to target the opioid epidemic. TA Consultant responsibilities would include:

- Supporting local multidisciplinary TA teams to provide expert consultation to providers in the delivery of OUD services (up to 10 hours a week). When asked to provide TA expertise consultants will be compensated \$100/hour for up to 10 hours a week.
- Participate in web-based training
- Participate in train-the-trainer activities (as needed)

ACEP is one of the partners in the SAMHSA STR-TA Initiative. Please email [Sam Shahid](#) for more information.



## **NEMPAC On Track to Reach Record Fundraising Goal**

While celebrating ACEP's 50th Anniversary's in San Diego, hundreds of ACEP members also confirmed and celebrated their commitment to advocacy on behalf of emergency medicine and

patients. As in years past, ACEP Council members stepped up to the plate during the NEMPAC Council Challenge to ensure that emergency medicine stays at the top of the leaderboard among medical PACs.

NEMPAC collected a record total of more than \$350,000 from Council members. Of note is the strong support by all Council members representing the Emergency Medicine Resident Association (EMRA), who strive each year to be the first group within the Council to reach 100-percent participation at the premier "Give-a-Shift" donor level. Thirty-nine state chapters and the Government Services chapter reached 100-percent participation this year. In addition, 38 Past-Presidents and Past-Council Speakers met the challenge of NEMPAC Chairman Peter Jacoby, MD, FACEP and added their support. Combined with thousands of donations from ACEP members across the country, NEMPAC is well on its way to setting an all-time fundraising record to reach a goal of \$2.3 million for the 2018 cycle.

This outpouring of support in a pivotal election year will ensure that NEMPAC can continue to educate new and veteran lawmakers and help emergency medicine identify friends and champions in Congress so that ACEP's ambitious legislative agenda stays on course. NEMPAC is tracking to contribute more than \$2 million to 27 Senate candidates and 160 House races. Candidates worthy of NEMPAC support are vetted and approved by the NEMPAC Board of Trustees who value those who will support emergency medicine issues and are committed to bipartisan advocacy.

Read the [full-length article](#) published in ACEP Now on October 3.  
For more information about NEMPAC, visit [our website](#) or contact [Jeanne Slade](#).

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## Welcome New Member

Sean Johnson - Medical Student

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