

# COMMON SENSE

VOICE  
OF THE AMERICAN ACADEMY OF  
EMERGENCY MEDICINE

VOLUME 22, ISSUE 5  
SEPTEMBER/OCTOBER 2015



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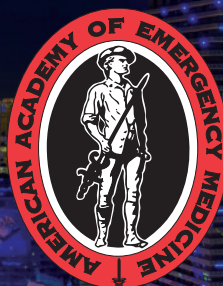
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## COMMONSENSE

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### AAEM Mission Statement

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine and to ensure a high quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

### Membership Information

Fellow and Full Voting Member: \$425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)

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## President's Message

# The AAEM Physician Group

Mark Reiter, MD MBA FFAEM  
AAEM President



AMERICAN ACADEMY  
OF EMERGENCY MEDICINE

PHYSICIAN GROUP

Supporting Independent Practices

For years, AAEM has been the strongest advocate in the house of medicine for physicians owning and controlling their own practices, and our new AAEM Physician Group initiative strives to make this a reality for more emergency physicians. Practices owned by a small subset of their physicians or entirely owned by lay corporations are much more likely to lack transparency, political equity, and financial fairness. This creates conditions ripe for exploitation — as I've heard firsthand from many, many emergency physicians throughout my AAEM presidency. AAEM has worked hard to promote equitable, democratic, physician-owned practices throughout its existence. We have educated our membership on the pros and cons of different practice models. We have created a variety of resources to help existing practices thrive and to assist physicians in founding their own, new emergency medicine practices. We have fought aggressively in the political and legal arenas against infringements on physician practice rights and unfair work environments.

Despite AAEM's efforts, physician-owned practices are under significant threat. Small practices may have difficulty developing and maintaining the infrastructure needed to be successful in the face of new realities in health care, such as accountable care organizations and value-based purchasing. The two largest for-profit emergency physician contract management groups, EmCare and Team Health, are now worth ~\$7 billion and \$5 billion respectively, and have been increasingly using their financial clout to acquire smaller practices. Likewise, they have enormous marketing and sales budgets that dwarf those of smaller competitors. It can be a lonely, dangerous world for a small emergency medicine group.

For years, AAEM's leaders have considered ways to combine the advantages of small, democratic groups of physician-owners with the economies of scale, expanded services, and clout of large groups. Likewise, we have had many discussions on what can be done to minimize the time, resources, and risk to emergency physicians who want to create their own emergency medicine group or bring control of their group back to the physicians who are actually practicing medicine in the emergency department.

Upon becoming AAEM's president last year, I felt it was time to make this concept a reality. During our strategic planning retreat in May 2014, AAEM's board of directors voted to make the formation of the AAEM Physician Group our top priority over the next two years. We then created a task force, chaired by Dr. David Lawhorn and Dr. Robert McNamara, to help the Academy achieve this objective. We envisioned a new paradigm, whereby smaller emergency physician groups could become part of a national collaboration, with access to best-in-class practice management services provided at fair market value, while fully maintaining local ownership and control. In addition, as part of the larger AAEM Physician

Group, these practices would have significantly more clout and marketing/sales muscle when competing with much larger entities to maintain their contracts or expand. Likewise, the AAEM Physician Group could actively seek out new, high quality emergency department contracts and then set up local, democratic groups at these sites. We developed a set of fairness principles that participating groups would be required to meet (a reasonable path to partnership, due process, political equity, and financial fairness), to ensure that the commitment to a fair, transparent working environment would be maintained.

One of the early decisions we faced was whether to build the AAEM Physician Group from scratch, or to partner with an existing company and refine and improve on its current services. The task force decided to put out a request for proposals, to better gauge what existing firms had to offer. After reviewing the proposals, we selected four companies to make presentations to the task force in person at the February 2015 AAEM Scientific Assembly in Austin. We were very impressed with each presentation and ultimately decided to perform further due diligence on the top three contenders. After an exhaustive process of on-site visits, research, and discussions with existing and former clients of the three, the task force recommended to the AAEM board that we partner with the practice management firm PSR.

PSR has been an outstanding partner and is committed to honoring AAEM's dedication to creating successful, equitable, emergency medicine practice environments that are free from exploitation. PSR already provides a comprehensive suite of top-notch practice management services to its many clients. The AAEM Physician Group will utilize many of these core services, while adding additional services to utilize the clinical, educational, operational, and organizational expertise of the Academy. The AAEM Physician Group will create a comprehensive network in which all practices maintain full local ownership. Existing democratic groups willing to commit to truly fair practice environments will now have a great way to improve their operations and better compete in a rapidly consolidating marketplace. In addition, as the AAEM Physician Group starts new democratic group practices, physicians interested in becoming a partner on day one of joining their new practice will have vastly increased opportunities to do so.

I write this shortly after returning from a very productive two-day strategic planning session on the AAEM Physician Group. We are very excited about the progress we are making. We plan on officially launching the AAEM Physician Group at our next Scientific Assembly, in February 2016 in Las Vegas, although we hope to be in a position to start working with local groups before then. I am very excited about this initiative — the AAEM Physician Group has the potential to transform the marketplace. ■

# My First Board of Directors Meeting

Jonathan S. Jones, MD FAAEM  
Assistant Editor, *Common Sense*  
YPS Director



Have you ever wondered what boards of directors do? I have. I always thought board meetings consisted of a lot of “yes men/women” agreeing with the chair/president/CEO/bigwig, voting themselves more money and power, and laughing at all the suckers who weren’t on the board. Until May, my only board experience was with a few small, local non-profits. These didn’t operate as

much. So even after considering my personal experience, I firmly concluded that boards were mostly useless and that board meetings were entirely useless.

I looked at AAEM’s bylaws (easily accessible via [www.aaem.org](http://www.aaem.org)) to see what its board did. The Academy’s board consists of 15 members: five officers, eight members-at-large, one YPS member, and one resident member. The board generally meets four times a year. All board meetings are open to any AAEM member and any member may submit an agenda item for discussion or a vote.

That sounded fairly decent to me, so this past year I ran for the YPS position on AAEM’s board. I decided to run because the Academy was different than every other professional organization with

ever wonder what organization presidents do? I have. I can’t speak for other organizations, but AAEM’s president does a lot. Over the past year he advised 69 members on various matters, gave 42 media interviews, and traveled to 22 events. That doesn’t even include the president’s many organizational and administrative responsibilities. And I thought I was busy!

“Your board members care, they argue, they are not scared of each other, and they are dedicated to the Academy.”



The first real controversy came with the treasurer’s report.

Maybe controversy is too strong a word, since no one was embezzling money or anything like that, but we did have an energetic discussion on the Academy’s investments. In my opinion, AAEM charges very fair dues and I feel I receive far more in value than it costs me to be a member. That said, through prudent budgeting AAEM does occasionally make a profit and so has a financial reserve. The board, and specifically the treasurer, is respon-

“I learned that I had been wrong about boards, their members, and their meetings.”

sible for investing this money wisely so as to maximize the value to AAEM and its members. While reviewing the report, some members noticed that the company that manages the Academy’s portfolio had invested a portion of AAEM’s money in tobacco and cigarette companies. This is when I learned that there are no “yes men/women” on our board.

Personally, I feel that tobacco is a huge public health problem and that by investing in tobacco companies we are effectively endorsing their product. It seemed to me that it was unethical for AAEM to invest in these companies. Other board members felt that our small investment in these companies did not assist them in any way, and since billions of other dollars are invested in the companies our small investment was not an endorsement and did not encourage tobacco use. They felt that it would be unethical for the board not to maximize return on investment for Academy members. I had to admit that was a good point. Should I support the principle to oppose tobacco or the principle to protect our members’ assets? Which principal was more important?

which I had been involved, and I hoped that the Academy’s board might be different too. Despite stiff opposition from no one, I won the election and attended my first board meeting on May 5 in Chicago, in a less-than-glamorous airport hotel. I learned that I had been wrong about boards, their members, and their meetings.

This board meeting started like most others, with a review and approval of the minutes of the last meeting. That was boring and uncontentious, and I wondered how mind-numbing it would be to sit through an entire day of this. Next were the president’s and treasurer’s reports. Did you

Continued on next page



That last question is actually the wrong question to ask. The correct question is, "Which principal is more important to the Academy?" Directors are elected to represent the members. It was a tough call, but I felt that by replacing tobacco assets with other similarly performing investments, the Academy would have a stronger voice when addressing politicians, the media, and others. Ultimately, the board voted to divest AAEM of all tobacco company holdings, but the vote was not unanimous.

This was still very near the beginning of the board meeting and we hadn't yet gotten to the truly interesting topics, but I knew I had made the right choice. Not on the tobacco vote — I'm still not sure there is an absolutely right choice on that — but on my decision to run for a board position. I knew this was a good board. This was a board with members who spoke their minds and who were passionate about the Academy and its mission.

The rest of the meeting did not disappoint. We discussed and voted on bylaws changes, membership status, joint ventures, education initiatives, advertising, future meetings, member benefits, and potential lawsuits. A few discussions were fairly simple and straight-forward and resulted in universal agreement. Most were not. Your board members care, they argue, they are not scared of each other, and they are dedicated to the Academy.

I left my first board meeting more confident than ever in the health of AAEM. This is not some organization resting on its past accomplishments or content with the status quo. The Academy is growing and evolving so as to continue to protect the best interests of EM patients and physicians. I am proud to serve the Academy and am already looking forward to the next board meeting. I've also just bought a book on how to win arguments. I'll let you know if it works. ■

Submit a "Letter to the Editor" at [www.aaem.org/publications/common-sense/letters-to-the-editor](http://www.aaem.org/publications/common-sense/letters-to-the-editor).

### AAEM Antitrust Compliance Plan:

As part of AAEM's antitrust compliance plan, we invite all readers of *Common Sense* to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at [info@aaem.org](mailto:info@aaem.org) or by calling 800-884-AAEM.



## Strength in Numbers AAEM 100% ED Groups

### ■ AAEM 100% ED Group Membership

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified and board eligible physicians. Each hospital/group that participates in the group program will now have the option of two ED Group Memberships.

- 100% ED Group Membership — receives a 10% discount on membership dues. All board certified and board eligible physicians at your hospital/group must be members.
- ED Group Membership — receives a 5% discount on membership dues. Two-thirds of all board certified and board eligible physicians at your hospital/group must be members.

For these group memberships, we will invoice the group directly. If you are interested in learning more about the benefits of belonging to an AAEM ED group, please visit us at [www.aaem.org](http://www.aaem.org) or contact our office at [info@aaem.org](mailto:info@aaem.org) or (800) 884-2236.

For a complete listing of 2015 100% ED Group members, go to [www.aaem.org/membership/aaem-ed-group-membership](http://www.aaem.org/membership/aaem-ed-group-membership).

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# Letters to the Editor

Andy Walker, MD FAAEM  
Editor, *Common Sense*



A "Letters to the Editor" feature is available on the *Common Sense* section of the AAEM website. Members must log-in with their AAEM username and password to read or post letters, or to comment on letters ([www.aaem.org/publications/common-sense](http://www.aaem.org/publications/common-sense)). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in *Common Sense*.

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make *Common Sense* an interesting read and a good

use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the letters to the editor feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

## Letter in response to the May/June 2015 "From the Editor's Desk" article titled "Is MOC a RPITA?":

I read your most recent article, "Is MOC a RPITA?" You wrote exactly what each of us is thinking. Much like the invasion of CMG's into our specialty, we have only ourselves to blame for the situation we find ourselves in. The "right thing" for those most affected is never done unless they are actively involved in the process. If physicians would refuse to sign contracts and work for CMG's, then CMG's would not continue to grow and would disappear from the landscape. Sorry, I digress.

As a specialty we have allowed others, including non-physicians, to dictate to us rather than work for us and in conjunction with us. As you referenced in the article, following the money usually gets to the root of the problem. The solution that you allude to finding is actually, at least partially, in your article. ABIM's membership had to show a possible alternative before ABIM would listen.

To ABEM's credit, they have developed a good infrastructure for test question development and test administration. Where they are failing is in establishing reasonable expectations and goals for recertification.

We must take back control of our own board certification process. If ABEM continues its stance of not being responsive to the membership it serves then we need to eliminate or circumvent its control. I would suggest that AAEM develop an alternative board certification process.

The process would still have individuals take tests through ABEM. Each physician could choose doing either the annual LLSA exams over ten years or take the ConCert exam at the ten-year mark. Physicians would provide documentation of successful completion of one of the two tracks and AAEM would then provide them with board certification.

ABEM would basically become a vendor for testing and would not control or be able to dictate the process.

I am confident we all agree that board certification is beneficial to patients and our specialty. We just want a fair, effective, and minimally burdensome process to maintain it.

Some may say this is a less than ideal process since it adds a step and involves an additional entity. Others may say it's a significant improvement since it eliminates power being concentrated in one entity. Either way the process would be an improvement over what we are currently being subjected to.

Best Regards,  
— Tom Tobin, MD MBA FAAEM FACEP

I find your idea of allowing board-certified emergency physicians to choose either the ConCert or the LLSA tests creative and worthy. I hope both ABMS and ABEM are open minded, flexible, and reasonable enough to consider such excellent ideas and make MOC more evidence-based and far less burdensome. That would be preferable to AAEM getting into the board certification business or having other "alternative boards" spring up, but if ABMS and ABEM refuse to listen to their diplomates alternative boards are inevitable.

Thank you for your letter. I hope it prompts other members of AAEM to write in with their own outside-the-box thinking.

— The Editor

## Letter in response to the May/June 2015 "From the Editor's Desk" article titled "Is MOC a RPITA?":

Thank you to the editor for cogent commentary on this question. The answer to the question is an emphatic YES! ABEM's mission should be ensuring that board certified physicians are keeping their knowledge up to date. They have stepped beyond their comfort zone with the silly Assessment of Practice Performance (APP). The APP is also redundant in that physicians already have plenty of parties assessing our practice performance from medical directors to nurses to administrators to patients to trial lawyers to payors to government bureaucrats (did I leave anyone out?).

AAEM should piggyback on the recent suspension of APP by the American Board of Internal Medicine and pressure ABEM to do the same.

— David Hoyer, MD FAAEM

Continued on next page



Thanks for your letter. The Academy is doing just what you suggest with ABEM, but it would help if ABEM, AOBEM and the ABMS heard directly from their diplomates on the topic of MOC and its (endlessly growing number of) various components. If individual physicians take this lying down MOC will never improve, but get steadily more burdensome and expensive.

<https://www.abem.org/public/general-information/contact-us>

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— The Editor

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Letters to the Editor



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# Congress to Attempt ACA Modifications in Coming Months

Williams & Jensen, PLLC

In the five years since passage of the Affordable Care Act (ACA), Congress has yet to make any substantive changes that many thought would be inevitable once the Administration began implementation. Several factors have held back legislative attempts to modify the law, including divided party control of Congress until 2014 and the opposition of some Republican Members to changes, on



the grounds that full repeal was preferable to “fixing” the law. Perhaps the most important factor slowing these changes was a series of legal cases, including the latest ruling by the U.S. Supreme Court in June upholding the constitutionality of the ACA’s health care subsidies.

Leaders of the House and Senate now appear intent on advancing legislative efforts to modify the ACA in the remaining months of 2015. In particular, Congress may focus on bills that have some bipartisan support, such as the *Protect Medical Innovation Act* which passed the House earlier this year and awaits consideration in the Senate. The measure would repeal the ACA’s excise tax on medical devices for all sales occurring following enactment of the law. Another bill that has passed the House and could be taken up by the Senate is the *Protecting Seniors’ Access to Medicare Act*, which would repeal the ACA’s Independent Payment Advisory Board (IPAB). IPAB has been among the most controversial provisions of the ACA since its passage, with physician groups and advocates for seniors asserting that the 15 member panel would ultimately be empowered to make decisions that will have a negative impact on Medicare coverage. Proponents of IPAB have argued that the panel is an important tool to help bend the Medicare cost curve and that an independent commission is necessary to make the tough decisions that Congress may not be willing to endorse.

A third bill that may receive consideration in the House and Senate is the *Protecting Affordable Coverage for Employees Act*, legislation that has over 200 co-sponsors in the House and nearly 30 co-sponsors in the Senate. The bill would amend the ACA’s employer mandate by changing a provision that would re-classify businesses that have between 51 to 100 employees as small businesses beginning in 2016. This legislation and similar efforts are receiving particular attention due to growing concerns about rising health insurance costs for employers and individuals. State Insurance Commissioners across the country are reviewing proposed rate hikes that in some cases exceed 25 percent for 2016. In explaining the rationale for the proposed increases, many plans cited enhanced emergency department utilization as one of the primary factors.

While all of the above legislative proposals have some level of bipartisan support, it is not clear that there would be the 60 votes needed in the Senate to advance any of these bills over a Democratic filibuster.

One effort that is not expected to succeed is an additional attempt to fully repeal the ACA. However, the latest effort has a twist, in which Congressional Republicans will seek to use a process known as budget reconciliation. Under reconciliation, legislation can advance in the Senate with 51 votes rather than 60. This is significant because Republicans hold 54 seats in the Senate, meaning that they can pass ACA repeal legislation without votes from any of the chamber’s Democrats. This process could allow a repeal bill to be sent to the President for the first time since the law was passed in 2010. However, President Obama has indicated he will veto the bill and there are not sufficient votes in the House or Senate to override the veto.

## Development and Delivery of Cures

In July, the House approved the *21<sup>st</sup> Century Cures Act*, bipartisan legislation that resulted from a major initiative undertaken by the House Energy and Commerce Committee that began in 2014. The bill authorizes \$2 billion in annual additional funding for the National Institutes of Health (NIH) over the next five years, and seeks to enhance drug and medical device development by creating several new approval pathways and streamlining elements of the clinical trials process.

“AAEM is developing comments for CMS that outline the emergency medicine perspective on composite score criteria under MIPS and the use of APMs.”

Members of the Senate Health, Education, Labor and Pensions (HELP) Committee have suggested that they plan to take a different approach to research funding, perhaps resulting in more modest increases for agencies like the NIH. However, the Senate is expected to maintain or build on provisions in the House bill to modernize the drug development process. The Committee is expected to continue work on the bill this fall, and could produce its own legislation proposal before the end of the year.

## 2016 Physician Payment Schedule and SGR Replacement Policy

On July 8, the Centers for Medicare and Medicaid Services (CMS) proposed the first update to the physician payment schedule following the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), which repealed the Medicare Sustainable Growth Rate (SGR). CMS publishes these rules on an annual basis, but this year there is an opportunity to comment on the framework for the new Medicare payment system that will be in place after 2019.

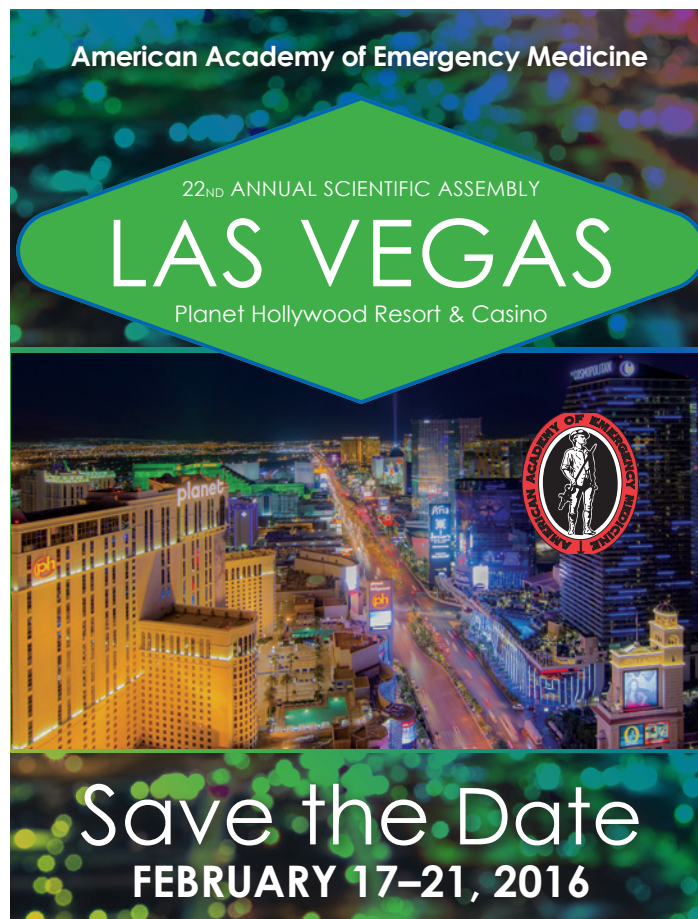
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CMS is seeking input on issues around the development of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Following the period of 0.5 percent Medicare payment increases between now and 2019, physicians will have the opportunity to earn bonus payments or incur penalties based on their composite score under the MIPS. Physicians that receive substantial reimbursement through APMs are also eligible for bonus payments. CMS also plans to send out a broader Request for Information (RFI) later in the year around the SGR replacement policy. AAEM is developing comments for CMS that outline the emergency medicine perspective on composite score criteria under MIPS and the use of APMs.

### September Advocacy Day

AAEM and RSA will hold their 2015 Advocacy Day in Washington, D.C. on September 29. Academy members will come to Capitol Hill to meet with key Members of Congress and their staff to advocate for issues important to emergency physicians. AAEM and RSA will be highlighting the growing support for due process rights for physicians, and discussing other important issues such as GME funding and medical student debt reform. With the permanent Medicare Sustainable Growth Rate (SGR) replacement signed into law in April, this is an ideal time to visit the Hill to discuss important issues facing physicians that deserve Congressional attention. Additional information about the fly-in and instructions for registration are available on the AAEM website at: [www.aaem.org/advocacy/aaem-advocacy-day](http://www.aaem.org/advocacy/aaem-advocacy-day). ■

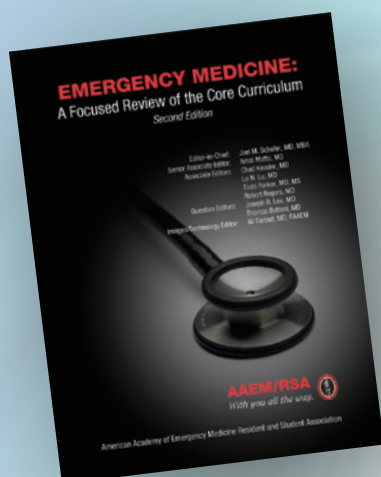


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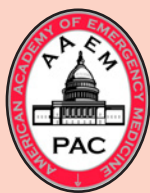


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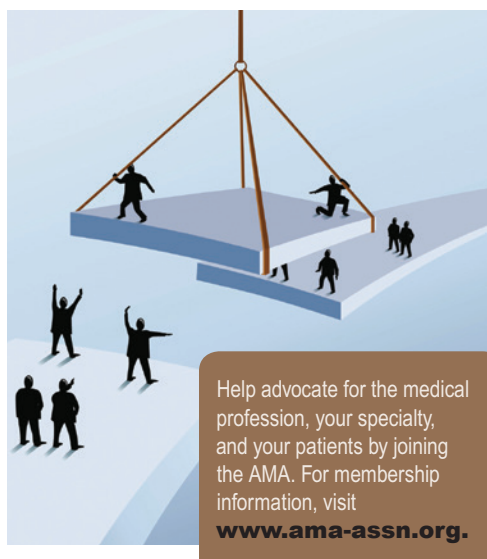
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# Planning Your Personal Finances — How to Select a Financial Adviser

Joel M. Schofer, MD MBA CPE FAAEM  
Secretary-Treasurer, AAEM  
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In the last “Dollars & Sense” I described a do-it-yourself way of creating a retirement plan with a high likelihood of success. Not everyone feels comfortable managing their own finances, though, so in this edition I’d like to discuss whether to get help planning your personal finances and how to select an adviser if you need one.

## Do You Need Financial Advice?

It isn’t hard to manage most of your financial life if you are willing to learn a little, spend a small amount of time on your finances, and get help only when you need it. The areas you’ll need to address include creating and executing an investment plan, managing your assets, maximizing tax-efficiency, tax preparation, insurance, estate planning, asset protection, and other areas depending on your situation.

This list can be daunting to many, and most physicians are busy and would prefer if someone did this for them or helped them out significantly. If you’re in this camp, you likely need financial advice. In addition, some people want access to investments that they can’t get on their own like hedge or venture capital funds. I’m not one of these people, but if you are you’ll need an adviser.

## How Do You Select an Adviser?

There are a number of important factors to consider when selecting a financial adviser. These include:

### 1. How are they paid?

You want a “fee-only” adviser who is going to be paid a flat fee, hourly fee, or percentage of assets under management. Avoid any adviser who is compensated with commissions on trades or the investments they sell you. This will ensure that their incentives are aligned with yours.

### 2. How much are they paid?

Whether you are paying a flat fee, hourly rate, or percentage of assets you should be able to get an adviser for under \$5,000/year. The industry standard for a percentage of assets fee is 1% of assets under management, but you should be able to find this service for significantly less. Vanguard’s asset management service is 0.3%, for example, as are many of the “robo-advisers” I’ll discuss at the end of this article. Also, make sure the adviser discloses any additional fees you will have to pay.

### 3. What are their credentials?

There are a lot of different credentials that financial advisers can have, and many of them are nearly meaningless, like a physician having a BLS card. The ones that represent significant training and education include Chartered Financial Analyst (CFA), Certified Financial Planner (CFP), or Chartered Financial Consultant (ChFC).

If they are an insurance agent, Chartered Life Underwriter (CLU) is a quality credential. If they have an MBA, CPA, or JD that can be a plus as well. The rest of the credentials you’ll see mean little.

### 4. What services do they offer?

As discussed in the second paragraph, there are a lot of services you may want or need. Make sure that your adviser either provides the ones you want or has someone who can. Also make sure it is clear which of these services your fee includes and which it does not.

### 5. How much experience do they have?

We’ve all been medical students and residents, so we’ve all been inexperienced professionals. Looking over our shoulders most of the time, however, was a supervisor with experience. Make sure your adviser has experience, specifically with physicians. We have unique problems like sizable student loans and professional liability issues that they should be familiar with.

### 6. What is their investment philosophy and is it compatible with yours?

Make sure that they can explain their financial philosophy to you in a manner that makes you comfortable and that you can comprehend. You don’t want to hire an adviser who talks over your head. Just like a doctor who avoids using complex medical jargon when talking to patients, an effective financial adviser should be able to make complex subjects understandable for clients. Also, make sure their investment philosophy is compatible with yours. If you are a believer in passive index investing, you don’t want to hire an adviser who believes primarily in active management.

## Are There Other Options?

“Robo-advisers” are online tools that have lower fees than a financial adviser but less of that personal touch. Betterment.com or Wealthfront.com are two of the larger companies, but there are others as well. While I have never used these services, I think they are worth considering when you are examining all your options for obtaining financial advice, especially because the price is right.

## What Do I Do?

As someone who writes a financial column I have a personal interest in this, stay reasonably up-to-date on the latest developments, and do most of my own financial management. When I need help or feel like I’m in over my head, I have access to CFPs from Vanguard, a CPA, and an estate-planning attorney I can call in a pinch.

*If you have ideas for future columns or have other resources you’d like to share, email me at [jschofer@gmail.com](mailto:jschofer@gmail.com).*

*The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense or the United States Government. ■*

# Mass General in the PIT

Brian J. Yun, MD MBA  
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## Introduction

Emergency department (ED) crowding has been associated with myriad adverse outcomes.<sup>1-4</sup> In a world of increasing capacity constraints, the efficient use of resources is vitally important to a properly functioning ED. Emergency providers are constantly challenged with balancing the care of individual patients with the needs of a whole department, including many patients who have not yet been seen and remain in the waiting room. In addition, patient satisfaction is increasingly important and is closely linked to wait times.<sup>5</sup> According to the National Hospital Ambulatory Medical Care Survey, more than 30% of patients wait an hour or more to see a provider in the ED.<sup>6</sup> As an ED leader, addressing crowding is necessary to improve both patient satisfaction and clinical outcomes.

There are many options when it comes to tackling the problem of ED crowding. Over a decade ago Asplin et al., introduced a conceptual framework for ED crowding (the input-throughput-output model).<sup>7</sup> While the most effective solutions would address all three components in the model, this is rarely feasible, especially with regard to patient input or limiting exit block (inpatient boarding). Recently there have been positive experiences with the provider in triage (PIT) model, which focuses primarily on the throughput component, and is often within the influence of an ED leader.

At the heart of these innovations is the realization that not every ED patient requires a traditional ED bed. Based on work at Inova Fairfax Hospital, 30-50% of patients do not need a bed.<sup>8</sup> An ED's bed capacity is fixed. Assuming a perfectly efficient system, if every patient in the ED has a length of stay (LOS) of four hours, each bed can be changed only six times in a day. If the LOS increases to eight hours, at most three patients can be seen in each bed in 24 hours. Since an ED bed is a precious resource, it is important to match this resource appropriately to the patients who need it.

## Types of Provider in Triage Models<sup>5</sup>

A number of PIT models exist. While all include a provider seeing patients at triage, the number and types of providers used may vary. In addition, depending on the space available, a separate internal holding area for patients awaiting treatment and test results may or may not exist. Staffing models may also differ. For example, some PIT models are staffed only during certain hours while others are activated only when a collection of surge criteria are met.

## Provider in Triage

In this basic model a physician or advanced practice clinician (APC) is placed in triage. The provider's goal is to facilitate the triage process by rapidly evaluating and moving sick patients to the main ED, ordering diagnostic tests to begin the work-up for patients who will ultimately be placed in a bed, and discharging patients with low resource-utilization needs directly from triage. With this model, while door to physician time and length

of stay of discharged patients will improve, the length of stay of admitted patients may not improve. Patients who are not initially discharged must wait for a bed to open up in the main ED in order to continue the care process. As a result, while the receiving provider in the main ED may have the patient's lab results, the patient still has to wait for an open bed.

## Team Triage and Treatment

The Team Triage and Treatment program incorporates a team based approach in triage. This team includes the physician, nurse, scribe, reg-



Figure 1



Figure 2

istrar, and technician. They see the patient together and have assigned duties like a NASCAR pit crew. Inova Fairfax Hospital incorporated this type of model and found that 34% of patients could be treated and discharged, patient safety occurrences decreased by 14%, throughput time decreased by 64%, left without being seen rates decreased, and patient satisfaction improved.

Continued on next page



### Two-Step Physician in Triage and Advanced Practice Clinician Model

This model incorporates a physician in triage and an APC at a separate internal holding area. If the physician determines that a patient is too sick or complicated, the patient is sent to the main ED. However, if appropriate the physician will order tests and the patient is then transferred to a holding area where the APC will receive the patient and coordinate the patient's care with the physician in triage.

### Massachusetts General Hospital (MGH) Model

Massachusetts General Hospital created a comprehensive screening area to address a significant overcrowding problem and its subsequent effects in 2007. In 2006, some patients waited as long as eight hours in the waiting room before seeing a provider.



Figure 3



Figure 4

Prior to the start of the initiative, the MGH ED had a pediatric unit plus four separate adult units: the Acute Care area (highest acuity), two Urgent Care areas, and a Fast Track (lowest acuity). Over a year-long period, a multidisciplinary team of physicians, nurses, administrators, and support staff created a model called Supplemented Triage and Rapid Treatment (START) that was instituted in December of 2007. After triage,

all Urgent Care patients received a screening examination in dedicated screening rooms. After the screening examination, the provider ordered appropriate diagnostic studies and treatment such as analgesic or anti-emetic medications. The patient then waited in an internal waiting room staffed by nurses, who initiated treatment or drew labs as requested. Unless the patient was deemed to require more resources than could be provided, the emergency medicine screening provider continued to be the primary provider for the patient in the post-screening area. Approximately 20% of patients were discharged or admitted from the post-screening area without further evaluation in other clinical units.<sup>9</sup> In the three years following the formation of START, the median length of stay for all ED patients went down by 56 minutes. Discharged patients showed the largest decrease, with a reduction of 60 minutes. Consistent with what Inova discovered after implementing a provider in triage program, 29% of patients were discharged without the use of a monitored bed. The median door-to-room time decreased from 18.4 minutes to 9.9 minutes.<sup>10</sup>

The MGH model has grown to accommodate more than 50% of our patient volume. The Screening Area, now called Evaluation, has grown from the original four bays (Figures 1 and 2) to include nine evaluation rooms. The post-screening area, now called the Clinical Decision Unit, has expanded to accommodate more chairs and eight stretchers (Figure 3). The space includes nursing stations and an area where labs can be drawn (Figure 4).

### Staffing

Physicians are the predominant providers in our staffing model. In the Inova Fairfax model the ED uses senior clinicians, as they are more likely to be selective in terms of ordering diagnostic tests. However, a growing number of departments incorporate APCs in the staffing model, with varying degrees of supervision from physicians. A study by Nestler et al., showed that the addition of APCs during busy times was associated with decreased length of stay and a lower proportion of patients who left without being seen.<sup>11</sup>

New issues have surfaced with the development of the PIT model, primarily at academic medical centers or hospitals that have rotating emergency medicine residents. Studies by Svirsky et al., and Partovi et al., showed that residents in triage were effective at decreasing patient length of stay.<sup>12,13</sup> In terms of education, a study by Nicks et al., showed that though there were no perceived negative or positive impacts on resident education, attendings and residents felt that the development of a differential diagnosis was negatively impacted.<sup>14</sup> With the growth of PIT programs nationwide, emergency medicine residents need to be prepared to staff them, and after graduation will need to feel comfortable providing supervision to APCs or residents in triage. Since many bread-and-butter patients will be seen at triage in this model, residents should rotate through that area to get sufficient exposure to these patients. Further studies need to be done to determine the optimum way to meet both the educational and clinical missions of academic EDs with PIT programs.

Our PIT program at MGH incorporates Physician Assistants, with attending physician oversight. Senior emergency medicine residents also staff the Evaluation Area and see patients with attending supervision.

Continued on next page



## Benefits and Limitations

A number of studies focusing on provider in triage models have shown decreased door to provider times, reductions in left without being seen rates, and reductions in length of stay.<sup>8-10,12,15-22</sup> In many cases patient satisfaction has also increased. However, in emergency departments that use internal holding areas, the space must be set up properly or violations of privacy will be an issue. As a result, having dedicated consultation rooms is important. In addition, the biggest capacity gains from PIT come from the treatment and disposition of low resource-utilization patients. Due to shifting bottlenecks, there are limited benefits for a patient awaiting the results of diagnostic tests ordered at triage. While lead-time is reduced, inefficiency elsewhere in the system has a bigger impact on throughput time. As a result, it is important to continue to work on reducing bottlenecks downstream.

## Conclusion

While there are variations on the provider in triage model, all are designed to improve ED efficiency by addressing patient volume in the setting of limited space. In order to determine which model best fits a hospital, a multidisciplinary team must be formed. Importantly, each ED that seeks to develop a PIT program needs the support of its hospital administration. With successful implantation, a hospital may see not only improved patient outcomes but also increased staff satisfaction.

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# SGR Repeal Means Acronym Soup

Government Affairs Committee

After 12 years of advocacy, the Medicare Access and CHIP Reauthorization Act of 2015 did away with the Sustainable Growth Rate (SGR). Physicians claimed victory after successfully coming together and encouraging their representatives in Washington to address this critical issue. Here is a summary of how this happened, and what AAEM as an organization needs to do going forward.

H.R. 2, the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), was introduced on 24 March 2015 by Congressman Michael Burgess (R-TX). It sailed through House committees and passed the lower chamber by a wide margin (392 to 37). The Senate considered the bill and also passed it by a large margin (92 to 8). Most in Washington were surprised at how quickly Congress came together to repeal the SGR this year, after temporarily patching the formula 17 times over 12 years at a cost of \$154 billion. Physician advocacy groups and specialty societies were strongly unified in this effort, maintaining pressure on legislators in the final days before the deal to avoid yet another short-term fix that would kick the can down the road one more time. AAEM members took part in the National Physicians Call-In Day in March and AAEM also provided information and encouraged additional outreach to Members of Congress.

The bill amends title XVIII of the Social Security Act to repeal the SGR and reauthorize the Children's Health Insurance Program. However, the MACRA legislation introduces a new wave of changes to Medicare payments that all physicians should be aware of.

This article has already introduced two important acronyms: the SGR (which most of us already knew too well) and MACRA (the bill that replaces the SGR). Several others are also worth remembering, such as APM, MIPS, VBM, PQRS, MU, and CPIA.

## What happens first?

MACRA allows for stable Medicare physician payments through 2019, with 0.5% annual increases each year. After 2019, payments remain stable through 2025 but there is the opportunity to receive bonus payments by participating in either the Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs). After 2025, physicians in APMs will receive a 1% pay increase and all others will receive a 0.5% increase.



“While the SGR is gone, physician engagement in payment policy and the establishment of quality standards is still critically important.”

## What happens after 2019?

After 2019, physicians will have to choose between one of two programs in order to receive increased Medicare reimbursement.

1. The MIPS program rolls several established programs into one. It combines the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM), and the Electronic Health Record Meaningful Use Program (MU).

MIPS will require physicians to collect data across several categories. Based on these data, physicians will be assigned a composite score from zero to 100. This will be calculated using results from quality measures (an area for future engagement), resource use (based on the current Value-Based Modifier), Meaningful Use (examples include e-prescribing), and Clinical Practice Improvement Activities (these could potentially be similar to ABEM's maintenance of certification). The composite score will determine which physicians receive bonus payments and which are penalized.

2. Physicians who receive a substantial amount of reimbursement through an “Alternative Payment Model” or APM are eligible for a 5% bonus payment. What are examples of APMs? There are not any currently

approved — this is something that the Secretary of Health and Human Services will determine in the future. However, examples of APMs that will likely qualify include Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMH). MACRA creates a new committee called the Physician-Focused Payment Model Technical Advisory Committee, to study APMs and make recommendations to the Secretary on which should be included. This is another opportunity for physicians to engage with CMS.

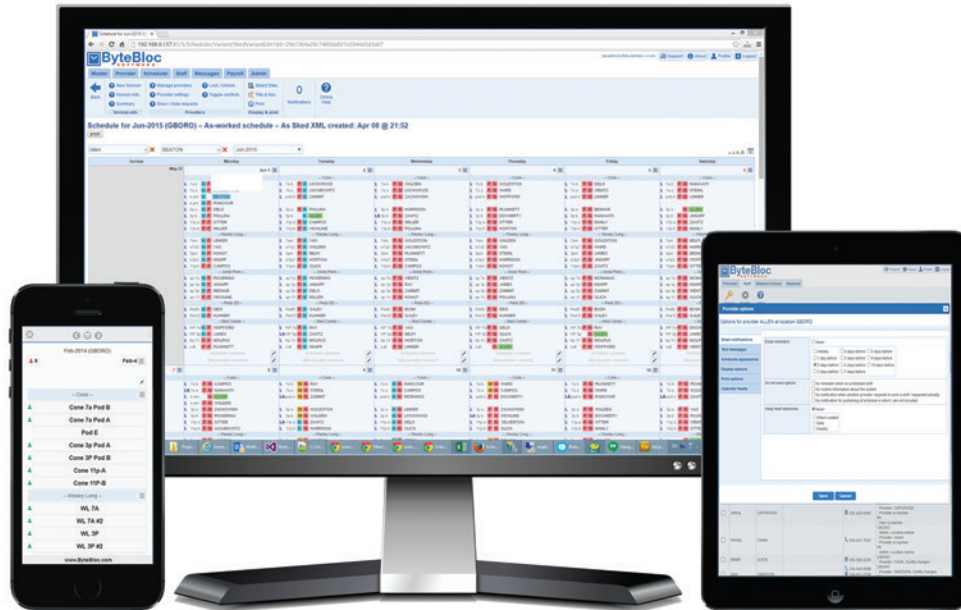
There are several other important provisions of the bill, including a two-year reauthorization of the Children's Health Insurance Program, which provides insurance for children in low-income families. Additionally, the bill explicitly states that quality standards established as a result of MACRA cannot be used as a “standard of care” for medical liability.

In summary, while the SGR is gone, physician engagement in payment policy and the establishment of quality standards is still critically important. MACRA comes with many new challenges, including the acronym soup of MIPS, APM, PQRS, VBM, MU, and CPIA. AAEM, its Government Affairs Committee, and our lobbying team in Washington will continue to seek out opportunities to engage and educate legislators and regulators on the importance of emergency care. ■



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# Call for 2016 AAEM Board of Directors Election Nominations

## Nomination Deadline: November 19, 2015 — 11:59pm CT



AAEM encourages candidates for election to the board of directors who have a previous record of service and commitment to the Academy.

Open Positions for the 2016 Election:

- Three At-Large positions
- President
- President-Elect
- Secretary-Treasurer
- YPS director

### Nominations

Any Academy member may nominate a full voting or YPS member (for the YPS director position only) for the board. Self-nominations are allowed and encouraged. You must be a YPS member to be eligible to run for the YPS director position.

In order to nominate yourself or another full voting member for a board position, please go to [www.aaem.org/about-aaem/elections](http://www.aaem.org/about-aaem/elections) to provide the following information and complete the nomination form and attestation statement.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
2. Name of nominee's medical school and year graduated.
3. Board certification status of nominee, including Board and year completed.
4. Number of ED clinical hours worked each week by the nominee.
5. A candidate statement (written by the nominee, 500 word max.) listing recent AAEM contributions, accomplishments, activities, or any other information detailing why the nominee should be elected to the board. A photo for publication may accompany the statement if the nominee wishes.

6. Any emergency medicine related business activity in which the nominee has a financial interest.
7. A current CV for the nominee.
8. AAEM Attestation Statement filled out by the nominee.
9. **Conflict of Interest Form must be completed by the nominee prior to the nomination deadline.**

The information listed above must be submitted to the AAEM office before 11:59pm CT, on November 19, 2015. Any YPS member can be nominated and elected to the YPS director position. The nomination form and required information is the same as that for a board position.

The candidate statements from all those running for the board will be available online and also featured in the January/February 2016 issue of *Common Sense*.

### President-Elect

In order to ensure clear planning and leadership succession following each presidential term, the AAEM board of directors has introduced a president-elect position on the board. This officer will serve a two year term as president-elect and then transition into a two year term as president. The 2016 election is unique in that both a president and president-elect will be elected in this transition year. In 2018, only a president-elect position will be on the ballot.

### Elections

Elections for these positions will be held at AAEM's 22<sup>nd</sup> Annual Scientific Assembly, February 17-21, 2016, in Las Vegas, NV. Although balloting arrangements will be made for those unable to attend the Assembly, all members are encouraged to hold their votes until the time of the meeting. Online voting will be available leading up to Scientific Assembly.

The Scientific Assembly will feature a Candidates Forum, in which members will be able to directly question the candidates before casting their ballots. Winners will be announced during the conference, and those elected will begin their terms at the conclusion of the Assembly.

These nomination and election procedures are what set AAEM apart from other professional medical associations. We believe the democratic principles that guide them are one of AAEM's greatest strengths and are an integral part of what makes us the organization of specialists in emergency medicine. In AAEM, any individual, full voting or YPS member can be nominated and elected to the AAEM board of directors. ■

**DEADLINE: November 19, 2015 – 11:59pm CT**


 CALL  
FOR

# AAEM Award Nominations!

**DEADLINE:**

 ★ NOVEMBER 19, 2015 ★  
11:59pm CT

**AAEM is pleased to announce** that we are currently accepting nominations for its annual awards. Award presentations will be made to the recipients at the 22<sup>nd</sup> Annual Scientific Assembly to be held February 17-21, 2016 in Las Vegas, NV.

Complete nomination criteria and the required online nomination form are found at [www.aaem.org/about-aaem/awards](http://www.aaem.org/about-aaem/awards). Self-nominations are not accepted. The AAEM Executive Committee will review the nominees and select recipients for all awards.

## Individuals can be nominated for the following awards:

**Administrator of the Year Award** — AAEM encourages members to nominate an administrator deserving special recognition for their dedication to emergency medicine and patient care.

**David K. Wagner Award** — As an organization, AAEM recognizes Dr. Wagner's contributions to the specialty by offering an award named in his honor to individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM's goals and objectives. Dr. Wagner himself was given the first such award in 1995.

**Young Educator Award** — Nominees must be out of residency less than five years and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

**Resident of the Year Award** — Nominees for this award must be AAEM resident members and must be enrolled in an EM residency training program. This award recognizes a resident member who has made an outstanding contribution to AAEM.

**James Keane Award** — Nominees for this award must have 10 or more years of experience in EM clinical practice and must be AAEM members. Named after the founder of AAEM, this award recognizes an individual who has made an outstanding contribution to our organization.

**Peter Rosen Award** — Nominees for this award must have 10 or more years of experience in an EM academic leadership position and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership.

**Joe Lex Educator of the Year Award** — This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. Nominees must be AAEM members who have been out of their residency for more than five years.

**Master of the American Academy of Emergency Medicine (MAAEM)** — Active members of AAEM may also recommend nominees to the AAEM executive committee for the Master of the American Academy of Emergency Medicine (MAAEM). Full criteria for this designation are available on the AAEM website.

## Program Director of the Year Award —

This award recognizes an EM program director who has made an outstanding contribution to the field of emergency medicine and AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association (AAEM/RSA). Nominations will be accepted for all awards until 11:59pm CT, November 19, 2015. All nominations should be submitted in writing and include:

**AAEM/RSA**  
*With you all the way.*



1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.



## AAEM/RSA President's Message

**Psychiatric Complaints in the ED — What to Keep in Mind**

Victoria Weston, MD  
AAEM/RSA President



A familiar scene in many emergency departments: you are on a busy overnight shift. You have just finished caring for a trauma patient and your part of the ED is filled with high-acuity patients. You see that a new “crisis” patient has been placed in a room, so you go assess him. You find a disheveled young male with flat affect, who appears to be responding

to internal stimuli. He is able to tell you that he had a recent inpatient psychiatric hospitalization. He is not taking his medications. He agrees to be seen by the crisis team. You leave and return to your desk to run the list and get caught up on charting.

This brief moment of calm is short-lived, as you hear a crash and shouting. You return to the room to find your patient aggressive, angry, and screaming profanities at the ED staff. You chemically sedate him and the nurse draws the requisite screening labs for medical clearance. Hours later your patient remains somnolent, with no urine drug screen, and is still awaiting evaluation by the crisis team. This is a situation experienced by most providers and is common in most EDs.

ED visits for psychiatric complaints are increasing nationally, and beds for inpatient psychiatric care continue to decrease in number. Not all institutions require screening labs to be considered “medically clear.” Indeed, many institutions have no policy on the matter. However, many state psychiatric hospitals require a number of tests prior to accepting a transfer. Nationally, psychiatric patients spend significantly longer periods of time in our EDs than nonpsychiatric patients and have high rates of recidivism. One study found that 21% of discharged patients with psychiatric complaints had return visits within 30 days.<sup>1</sup> The chaotic, busy ED is rarely a restful or quiet place for the agitated or over-stimulated patient. Patients may board for hours or even days awaiting inpatient psychiatric placement, without receiving optimal care while they wait.

It is critically important that we perform a thorough medical evaluation for patients before we decide that they are medically clear — there are many treatable, easily missed medical causes of psychiatric symptoms. Personal case examples include a patient found to have severe hyponatremia secondary to a delayed diagnosis of lung cancer and another with anticholinergic toxicity from diphenhydramine overdose. We have a great responsibility, and committing someone to inpatient psychiatric care against their will — whether they are suicidal, homicidal, psychotic, or disorganized and unable to care for themselves — is a difficult decision to make. Patients may also intentionally overdose on prescription or over-the-counter medications, and may not disclose this information unless asked directly. One of our ED psychiatrists advises that when asking patients if they’ve thought of committing suicide, ask how close they’ve come to doing so — the answers may surprise you.

“It is critically important that we perform a thorough medical evaluation for patients before we decide that they are medically clear — there are many treatable, easily missed medical causes of psychiatric symptoms.”

Prior studies have questioned whether we are doing an adequate history and physical exam on our psychiatric patients. Tintinalli et al., found that 56% of patients had no mental status documentation at triage and that several significant medical findings were missed, including a femur fracture, HIV encephalopathy, multiple sclerosis, cardiac ischemia, and sepsis.<sup>2</sup> Another study of ED medical clearance found that only 52% of cases had a complete set of vitals, with 6% of patients having no vital signs documented.<sup>3</sup> Henneman et al., found that 63 of 100 patients with new-onset psychosis had a medical explanation for their symptoms.<sup>4</sup> By taking short cuts with our psychiatric patients — whether by inadequate history, physical examination, or vital signs — we put our patients and ourselves at risk. However, is reflexively sending more lab tests and obtaining additional imaging studies the answer? Are we using testing as a crutch for abbreviated histories and physical exams? Other studies have found limited support for universal lab testing for medical clearance, with few misses or findings that would change management.<sup>5,6</sup> We also often obtain head CTs for patients with new presentations of psychosis, yet several studies (although not based on ED patients) failed to demonstrate changes in clinical management resulting from this practice.<sup>7,8,9</sup> Prior studies have suggested protocol-driven approaches to standardize the medical clearance process, but great variation between institutions remains.<sup>10,11</sup>

Ultimately, it is incumbent upon us as ED providers to sort through these possibilities and decide how to best care for our patients. As a specialty, we shoulder the burden of a broken system with inadequate resources and spend many hours caring for these most vulnerable of patients. Many studies evaluating this issue are retrospective chart reviews. Perhaps, through additional research with prospective, ED-based studies and with initiatives to provide a more universal and evidence-based approach, we can improve our practice, standardize our medical clearance process, and better meet the needs of our patients.

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# Be a Non-Terrible Intern in Ten Easy Steps

Gregory K. Wanner, DO PA-C  
AAEM/RSA Publications Committee Chair



Welcome to residency! Now that you've had some time to learn the hospital computer system, find the coffee maker, and begin to settle into your new role as an intern, it's time for a few tips. Intern year is tough. You have a whole new set of responsibilities, and for some this is your first "real" job. There are many ways to be a terrible intern, but you *can* avoid

terribleness and become a wonderful intern.

Over my ten years in medicine, initially as a physician assistant and now as a senior resident, I've had quite a bit of exposure to interns. Plus, I was one not so long ago. As interns we all have times — often brief — when we feel brilliant, as well as times we feel completely incompetent. We have moments of enlightenment and moments when we need to be bailed out by nurses or attendings. This is to be expected. The goal is to learn from your mistakes and eventually become a great physician. To learn what you can do to further your own education, keep your attendings relatively happy, and avoid terribleness: read on.

In order to figure out what differentiates the wonderful interns from the terrible ones and develop some recommendations, I surveyed 18 attendings with a combined total of 156 years of experience working with interns. I used their responses and my own experience to develop the following ten steps to being a great intern.

**Early habits.** Develop good habits early. Don't cut corners. Get in the habit of eliciting a full history, documenting thoroughly, and giving complete sign-outs. When appropriate, do a complete physical exam and undress your patients. It's amazing what you'll find, whether it's an infected wound, a penetrating injury, or an entertainingly dirty tattoo. Learn to do things correctly now, even if it takes a little extra time.

**Be a bit nervous.** Overconfident interns hurt people. Don't hurt people. That's bad. You're not a medical student anymore and your orders actually matter. Be nervous about that. Ask questions. Look up medication doses, interactions, and basic mechanisms of action when ordering a drug. Don't rely on the nurses or the pharmacist to catch mistakes. Although they often do, you are still responsible for what you order.

**Feedback.** Request it and accept it graciously, rather than getting angry or defensive. Nearly all of the surveyed attendings rated "willingness and receptivity to learning" as the most important quality of an intern and a "know-it-all attitude" as one of the most dangerous qualities. Proclaiming "I'm the doctor!" or "In my experience..." will get you nothing but laughter and eye-rolls. Some interns have egos larger than their experience levels.

Do you? Ask for feedback about how you're doing and make changes based on what you hear.

**Assessment and plan.** You aren't in med school anymore. Now you get to make a real plan — with attending input, of course — for your patients. Adjust your differential diagnosis list as you evaluate and examine your patients. Think about which tests you want to order and why you want them. Have a plan in mind when you present to your attending or senior resident. Most attendings rated "accurate history and physical exam skills" as a very important intern quality, even above "formulating an appropriate treatment plan."

**Shut up, listen, and be humble.** That may sound harsh, but whether you're dealing with patients, nurses, or attendings this is a good recommendation. Keep quiet for a minute or two while your patient talks; interesting things will come out. Be nice and listen to your nurses; their input will save your gluteus if you let it. Learn from your attendings. Their knowledge and experience will help you develop your own practice style.



**Documentation.** This is your way of telling the story after the patient encounter is over, and both your future earnings and the outcome of the inevitable lawsuits will depend on the quality of your documentation. Be honest and document well. *Paint the picture you want others to see.* Both your colleagues and attorneys actually look at your charts. Correct spelling mistakes, review nursing notes, and tie up loose ends that are apparent in the chart.

**Learning now, speed later.** Your efficiency and speed will be important in the future, but not yet. All surveyed attendings agreed that "learning emergency medicine content" should be a main focus this year, while only 17% of attendings felt "efficiency" should be a main focus. Overall, attendings felt interns should see an average of one patient per hour. See patients, learn from them, and gradually increase your speed throughout residency.

**Off-service rotations.** Work hard and you'll gain respect from other services. They don't expect you to know everything about their specialty; that's why you're in residency. It's ok not to understand surgical concepts on your trauma surgery rotation, or how to measure a cervix on OB. You may even ask a stupid question or two. That's okay. Work hard and try hard, and they'll appreciate it. It will help when you're calling consultants later.

Continued on next page



**Lateness and call-outs.** The best way to anger your colleagues is to be late or to call-out sick for nausea or rhinorrhea. This is emergency medicine — we have IVs and anti-emetics — we can treat you. Show up to work or else you'll look like an anus, and we have a scope for that.

**Your most important teacher is you.** From reading on your own to being proactive with seeing patients and getting procedures, you are your own best teacher. From now until the end of your career, most of your learning will be self-directed. After your shifts, read about a few of your patients' conditions. This will help link clinical experience and textbook knowledge in your mind. Take advantage of clinical simulations and consider using online content such as FOAMED, but don't abandon journals and books.

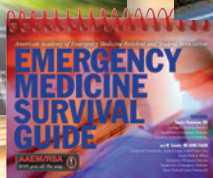
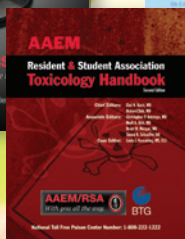
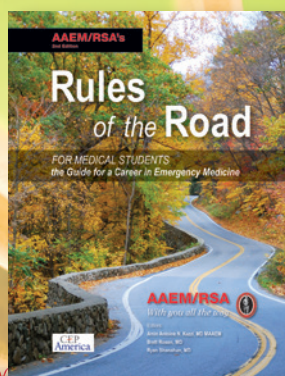
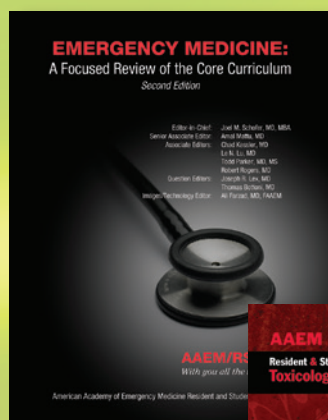
Congratulations, you are now armed with the tools for success during the rest of your intern year. Use these tools wisely. Stay humble, be nice, ask questions, welcome feedback — and you'll find yourself on the path to a successful trip through residency.

This article is featured in both *Common Sense* and the AAEM/RSA blog (<http://aaemrsa.blogspot.com>). We invite attendings, fellows, and senior residents to add their own recommendations for interns to the comments section of the blog. ■

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# Serious Bacterial Infections in the Febrile Infant

Authors: Kaycie Corburn, MD; Jacqueline Shibata, MD; Lee Grodin, MD; Raymond Beyda, MD  
 Edited by: Jay Khadpe, MD FAAEM; Michael C. Bond, MD FAAEM

Pediatric fever, especially in infants, is often a challenging and nerve-racking presentation to evaluate in the ED. The prevalence of serious bacterial infections (SBI) in young infants range from 8-20%.<sup>1</sup> There is no clear cut consensus on how to work-up these patients in the ED.<sup>2</sup> As a result, many infants are subjected to invasive, unnecessary, and costly procedures or needlessly treated with empiric antibiotics and hospitalizations. In this edition of the Resident Journal Review, we review the literature on this topic in an effort to give more clarity on how to approach the febrile infant.

## Aronson P, et al. Variation in care of the febrile young infant <90 days in U.S. pediatric emergency departments. *Pediatrics*. 2014;134(4),667-677.

This study describes the variation in ED testing, treatment, hospitalization rates, and outcomes of febrile young infants <90 days old.

This is a retrospective cohort study using the Pediatric Health Information System (PHIS) database. Between July 2011 and June 2013, infants <90 days of age were eligible for inclusion if they had an admission or discharge diagnosis of fever. Infants with complex or chronic diseases as well as those transferred were excluded. Over the study period, 37,907 infants at 37 participating sites met the inclusion criteria. After exclusions, the final cohort consisted of 35,070 infants of which 22.0% were <28 days of age, 42.9% were 29-56 days of age, and 35.1% were 57-89 days of age. The proportion of infants undergoing blood, urine, and CSF testing along with hospitalization rates was inversely proportional to age. The overall SBI rate was 8.4%, with higher rates among infants <28 days old. For all groups, 5.3% had a urinary tract infection (UTI), 2.4% had bacteremia or sepsis, and 0.3% had meningitis. In total, six infants died. Testing, treatment, and hospitalization rates varied widely between institutions with hospitalization rates ranging from 3% to 65% in patients 57-89 days old. All 37 hospitals were ranked into tertiles (low, moderate, or high) based on utilization of resources. High utilization hospitals remained consistent across age groups. For example, 12 out of 37 hospitals remained in the same utilization tertile for all three age groups. Patient outcomes were similar despite the varying levels of utilization.

Since variation in care did not seem to result in worse patient outcomes, targeting some care variations may represent an opportunity to better direct resources in the management of febrile infants. For example, nearly two-thirds of the study patients received ampicillin as part of their empiric antibiotic regimen despite the facts that *Listeria* is an uncommon cause of meningitis and bacteremia beyond the first month of life and that there is significant resistance to ampicillin.<sup>3</sup> Overall, this study found that for patients <28 days of age, lower hospitalization rates lead to higher three-day revisits and later hospitalizations. However, for patients 29-56 days of age, hospitalization rates were not associated with higher three-day revisit rates or later hospitalization rates. Although more studies are needed for neonates <28 days of age, hospitalization rates for children >28 days of age may be able to be lowered without risk to the

patient. More research is needed to address these possible areas for improved resource management.

## Huppler et. al. Performance of low-risk criteria in the evaluation of young infants with fever: Review of the literature. *Pediatrics*. 2010;125:228-233.

Neonates are more vulnerable to infection due to immature immune systems. In the 1980s and 1990s investigators developed and validated criteria to identify low-risk febrile infants who may not need empiric antibiotics and hospitalization as was recommended prior to 1985. Identifying such infants could decrease nosocomial infections, adverse reactions to medications, bacterial resistance, and reduce costs to families and the health care system. In this review, the authors evaluated how well low-risk criteria for SBIs in febrile infants performed in prospective studies in which antibiotics were withheld compared to prospective and retrospective studies in which they were empirically administered. Studies of infants >90 days age, with specific infections, or with additional risk factors were excluded. The authors identified 21 studies of infants with fever, SBIs, and low-risk criteria. They found that in prospective studies in which antibiotics were initially withheld from patients who met low-risk criteria (n=870), only six patients (0.67%) became culture positive for SBI and all did well when treated with antibiotics. The relative risk (RR) of an SBI in high-risk versus low-risk patients was found to be 30.5 (95% CI: 7-68). The authors concluded that the low-risk criteria allows 30% of young febrile infants to be observed, thus avoiding complications from empiric treatment. Of note, the rate of SBIs in this low-risk cohort was significantly lower than the rate in all the other studies (2.7%, p=.01). They hypothesized that when withholding antibiotics, practitioners are more likely to collect samples carefully and do a meticulous physical exam. A weakness of this review is that there was variation in the low-risk criteria used and the age groups of the patients included (although all were <60 days old in the prospective withholding antibiotics group). Also due to design, long term outcomes were not evaluated.

## Wolff, M. et al. Serious bacterial infection in recently immunized young febrile infants. *Academic EM*. 2009; 16:1284-1289.

Because of the risk of SBIs, many infants undergo invasive procedures during the evaluation of fever. Up to 29% of infants have fever after receiving routine 2-month vaccines which results in a two- to seven-fold increase in medical utilization, procedures, and prescription of antibiotics. Realizing this, these investigators examined the prevalence of SBIs in well-appearing patients presenting with fever after recent immunization. This retrospective review examined 2,247 infants aged 6-12 weeks presenting to an urban academic pediatric ED between 2000-2007 with a temperature greater than 38°C (100.4°F) as measured at home, in a clinic, or in the ED. Exclusion criteria included gestational age less than 32 weeks, chronic illness, surgery in the last week, concurrent

Continued on next page

antibiotic use, or focal infection other than otitis media. Only infants with blood and urine cultures were included. Of the 1,978 infants with fever, 213 (10.8%) received an immunization within three days prior to the encounter. Recently immunized (RI) patients had a RR of definite SBI compared to non-recently immunized (NRI) patients of 0.41 (95% CI=0.19-0.9) with a prevalence of 3.7% (95% CI=6.8-9.2) compared to 8.5% in the NRI group. All of the infections in the RI group were UTIs. Of RI patients, 73.7% received immunizations within the last 24 hours and had a SBI prevalence of 0.6% and RR of 0.09 (CI 0.01-0.6) compared to the NRI group. Because there are risks associated with the procedures of a sepsis work-up, hospitalization, and empiric antibiotic treatment, a modified work-up may be appropriate for febrile infants presenting to the ED within 24 hours of vaccination. Limitations of this study include its retrospective design and associated biases, lack of patient outcomes, small sample size, and analysis of single-center information. However, the results suggest that for well-appearing young infants presenting within 24 hours post-immunization, a careful exam and urine testing may be appropriate management.

**Krief WL, Levine DA, Platt SL, et al. Influenza virus infection and the risk of serious bacterial infections in young febrile infants. *Pediatrics*. 2009;1:30-39.**

Influenza is a common cause of fever occurring with predictable seasonal variation which complicates the evaluation of febrile infants during flu season. Detecting influenza infection may assist in predicting risk for SBIs, and guide risk stratification and management.

In this multi-center, prospective, cross-sectional study the authors determined the risk of SBI in febrile infants younger than 60 days who tested positive for influenza compared to those who tested negative. SBI was defined as either a UTI, bacteremia, enteritis, or bacterial meningitis. They enrolled 1,091 patients from five pediatric EDs. Of the 844 who were tested for influenza, 123 tested positive and 721 negative. Patients were excluded if they received antibiotics within 48 hours of presentation or consent was not obtained. Of patients with known influenza status and for whom culture results of blood, urine, cerebrospinal fluid, and stool were available, the overall SBI rate along with the rates for UTI, bacteremia, meningitis, and enteritis were calculated. Of influenza positive patients, 2.5% (0.5-7.2% 95% CI) had SBIs, all attributable to UTIs, compared with 13.3% (10.9-16.1%) in the influenza negative group yielding a relative risk for overall SBI of 0.19 (0.06-0.59 95% CI). Of the 721 influenza negative infants there was a 2.2% rate of bacteremia (1.3-3.6% 95% CI), a 0.9% rate of meningitis (0.3-1.9% 95% CI), and a 1.7% rate of enteritis (0.3-8.9% 95% CI). The UTI rate for influenza positive patients was 2.4% (0.5-6.9% 95% CI) compared to 10.8% (8.6-13.3% 95% CI) in influenza negative patients with a relative risk of 0.23 (0.07-0.70 95% CI). However, there was insufficient power in the study to detect a statistically significant difference in risk of bacteremia, enteritis, or meningitis. This study suggests that, for febrile infants, a positive influenza test is associated with a decreased risk of UTI and overall SBI. However, SBI due to UTI is still of a high enough prevalence in influenza positive infants (2.4%) to warrant serious consideration in the febrile infant.

**Sakran W, Makary H, Colodner R, et al. Acute otitis media in infants less than three months of age: Clinical presentation, etiology and concomitant diseases. *International Journal of Pediatric Otorhinolaryngology*. 2006;70:613-617.**

Acute otitis media (AOM) is a common cause of fever in infants <3 months old. Although usually occurring in isolation, it can be associated with other SBIs including UTI, bacteremia, meningitis, or pneumonia. The authors of this study examined the incidence of these infections in a cohort of infants <3 months diagnosed with first episode of AOM. 66% percent of these patients were febrile but none were toxic in appearance. White blood cell counts along with blood, urine, and cerebrospinal fluid cultures were obtained prior to antibiotic administration. Pathogen type was examined by culture, frequency, and drug susceptibility. Of the 68 patients with AOM enrolled, 17 were less than 28 days old. Of the 68, 14 had other associated infections, including bronchiolitis in seven, UTI in six, and conjunctivitis in one. No bacteremia or meningitis cases were reported in this cohort. The study suggests that in infants <3 months with AOM, there is a low risk of bacteremia and meningitis while UTI and bronchiolitis were present in 8.8% and 10.4% of the patients, respectively. However, the small numbers in this study make it difficult to draw significant conclusions.

**Bonsu BK, Harper MB. Identifying febrile young infants with bacteremia: Is the peripheral white blood cell count an accurate screen? *Annals of Emergency Medicine*. 2003;42(2):216-225.**

Realizing that over 95% of physicians obtain a peripheral white blood cell count (WBC) to screen for sepsis in febrile infants, the authors of this study investigated whether leukocytosis is a reliable sign of sepsis in infants. This was a retrospective study of infants aged 0 to 89 days without history leukemia and a ED triage temperature  $\geq 38$  C from 1992-1999. The authors calculated the predictive value of a WBC. In the 3961 eligible cases, both CBC and blood cultures were obtained in 3810 patients. The rate of bacteremia for these patients was 1%. Despite attempting to find several different values that may be appropriate levels of WBC to predict bacteremia, the authors could not determine any WBC value to be a reliable predictor for sepsis. The mean peripheral WBC for patients with bacteremia (13.9K) was not statistically different from those without bacteremia (10.9K).

This publication agrees with several other studies that have suggested the WBC is not helpful to predict SBIs in infants.<sup>5,6</sup> The authors consequently encourage physicians to add blood cultures as a routine component of the evaluation of febrile infants.

**Vaillantcourt S, et al. Repeated emergency department visits among children admitted with meningitis or septicemia: A population-based study. *Annals of Emergency Medicine*. 2014;65:625-632.**

This study investigated cases of children diagnosed with meningitis or septicemia after a previous ED evaluation and discharge in Ontario, Canada.

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Of 521 children aged 30 days to five years with eligibility for the study, 114 (21.9%) were discharged from an ED within five days prior to their diagnosis. Eleven children were discharged with an unrelated diagnosis and were excluded. Also excluded were children hospitalized for fewer than four days who were being observed for suspected meningitis or septicemia. This left 99 children who had been discharged with diagnoses of fever (most common), otitis media, upper respiratory infection, viral infection, gastroenteritis, UTI, or seizure five days prior to admission for meningitis or septicemia.

Between those children admitted after their first visit to the ED and those admitted later, there was no statistically significant difference in length of stay, intensive care unit admission, or 30-day mortality. Two main explanations were suggested. The first was that the patients were not toxic enough during their initial presentation to warrant admission and had less virulent infections or better immune system competency. The second possibility was that those who had been initially discharged had not yet developed meningitis or septicemia.

As mentioned in the subsequent article by Green et al., "Sick Kids Look Sick," it seems that the physicians in Ontario are practicing safe, effective medicine.<sup>6</sup> Various prediction algorithms and decision aid tools have come up short over the years. However it seems that a physician's medical evaluation and judgment may provide the best care for the child with infection.


## Conclusion

Despite fears that young infants presenting with fevers will have an SBI, invasive, expensive, and often traumatic evaluations may not be necessary for all of these patients. If a work-up is pursued, data from the cohort of over 35,000 infants suggests that standardized sepsis algorithms dictating management of these patients are unnecessary while taking an individualized approach to each febrile infant is appropriate. In fact, it may be prudent to do less for infants who are deemed low risk for an SBI.

Small prospective studies have shown that it is reasonable to use validated low risk criteria to support withholding empiric antibiotics until cultures prove an SBI is present. Other retrospective studies imply that recent immunization, confirmed influenza or RSV, or well-appearing infants with AOM may have a lower relative risk of concomitant meningitis or bacteremia. Given the small sample sizes and the retrospective designs of most studies, caution must still be taken with these conclusions. Using clinical judgment rather than the shotgun sepsis approach may be acceptable for treatment of these febrile infants as many of the tests used, such as WBC, and antibiotics given, such as ampicillin, may not be helpful. A thorough physical exam, urine studies, monitoring, and even close follow-up may be all that is warranted and may help physicians live up to the doctrine, "Primum non nocere" — first do no harm.


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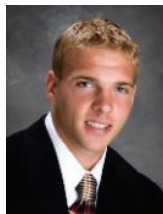
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# EMS Physicians: An Interview with Jane Brice, MD MPH

Mike Wilk, MS4

AAEM/RSA Medical Student Council President



For many medical students, myself included, EMS was the gateway to choosing medicine and emergency medicine as a career. Much of my time in college was spent working as an EMT on an ambulance and volunteering for my university's student-run EMS program, which confirmed that medicine was the right field for me. With EMS fellowships now accredited by the ACGME, this field will only continue to

expand in the coming years. Even though it is a sub-specialty within EM, diverse careers are available with this training. I recently had the pleasure of interviewing one of the leading experts in the field of EMS, Jane Brice, MD MPH, Professor of Emergency Medicine at the University of North Carolina and President of the National Association of EMS Physicians.

**Mike Wilk:** What is your background and how did you get involved in EMS?

**Dr. Brice:** The better question is how I became involved with medicine, as EMS was my first and still is my most passionate love. I came to medicine late, after a career in EMS. I graduated from the University of North Carolina with a degree in education but without a clear focus or direction. I had volunteered for a local rescue squad as an EMT while in college and found the work rewarding, challenging, interesting, and demanding of my full focus and attention. I achieved my paramedic certification shortly after college and began a 16-year professional career in EMS. I volunteered with a local fire department as a first responder, volunteered with my rescue squad, worked professionally for Durham County EMS, and flew with Carolina Air Care as a flight paramedic. I found that it was never enough. I always wanted to know more and do more for my patients. Medical school offered me that path. I always said that if medicine was just half as fun as being a paramedic, then I could live with it. It is right at half as fun.

**Mike Wilk:** What does the EMS Fellowship at UNC entail and what can residents expect to learn from it?

**Dr. Brice:** As you may know, EMS Fellowships recently became an ACGME recognized subspecialty. This is a huge achievement and the result of much hard work and effort over a long period of time. Becoming an ACGME subspecialty provides structure and standardization across the specialty of EMS for the body of knowledge residents will learn, for the experiences a resident can expect, and for the professional development a resident will be provided. Residents entering an EMS Fellowship can expect to find all the knowledge, skill, and professionalism required to begin the lifelong learning associated with becoming an EMS medical director and a leader in the field.

**Mike Wilk:** What kinds of various careers exist for physicians specializing in EMS?

**Dr. Brice:** EMS physicians are in demand in many venues. The more traditional path is for an EMS physician to join an emergency medicine practice, and as a portion of her professional obligations provide medical direction for area EMS agencies, while spending the greater portion of her time working inside an emergency department. Many EMS physicians have found fulfilling careers as full-time EMS medical directors for large, urban EMS agencies. Full-time medical directors may not practice emergency medicine inside an emergency department and may devote themselves full-time to the practice of EMS medicine. EMS physicians are also in demand in industry, public health, and emergency preparedness as well as in governmental leadership roles both at the state and national levels.



**Mike Wilk:** Can you speak on some of the recent major advancements within the EMS field?

**Dr. Brice:** EMS is busting at the seams with new, creative, and exciting research. Our leading journal is *Prehospital Emergency Care*. As an example, in the latest issue there are great articles about dealing with active shooters, data-driven mass casualty management, and the best medications to use for prehospital seizures. If you are interested in EMS this journal should be on your reading list. In addition, *Prehospital Emergency Care* has a podcast spearheaded by Dr. Phil Moy, which is fascinating. Take a listen. You can access it at the National Association of EMS Physicians website.

Continued on next page

**Mike Wilk:** What role does the National Association of EMS Physicians play?

**Dr. Brice:** The National Association of EMS Physicians (NAEMSP) is an organization of physicians and other professionals partnering to provide leadership and foster excellence in the subspecialty of EMS medicine. This organization is the leading authority in EMS medicine.

**Mike Wilk:** Where do you see EMS progressing in the future?

**Dr. Brice:** I honestly don't know. EMS medicine is a specialty on the move. Being recently acknowledged by the American Board of Emergency Medicine and the American Board of Medical Specialties as a subspecialty has put wings on our feet. Efforts are underway to discuss reimbursement issues, to integrate with leaders in government and industry, to advance our research and education initiatives, and to expand our scope to developing countries. It is an exciting time.

**Mike Wilk:** Given that other countries utilize EMS physicians and resources in very different ways, do you collaborate with other countries?

**Dr. Brice:** Yes, the National Association of EMS Physicians has very close working relationships with EMS physicians in Canada, Singapore, Korea, Taiwan, and much of Asia. We are developing relationships with EMS physicians in Latin America and hope to begin work in Africa soon. Within the next six months, NAEMSP will be hosting medical direction courses in Taiwan, Rome, Cuba, and Mexico City. There is an old saying

in EMS that if you have seen one EMS system, you have seen one EMS system. There are endless ways to deliver prehospital care and we are always learning from our counterparts in other countries.

**Mike Wilk:** How can interested medical students best get involved in EMS?

**Dr. Brice:** There are probably a million ways to be involved but three come to mind. First, seek out your local EMS medical director and offer to help. There are a million ways to help. EMS is not about fame or glory, not about being the hero. EMS is a team of people who work together to get the job done. Mostly it is long hours, doing the job no one else wants to do, and being willing to help the team move forward when everyone is maxed out and exhausted. So the jobs an EMS medical director might ask a medical student to do will be small and may look menial, but they will be important tasks that help the team accomplish the mission, whether that be an educational mission, a research mission, or a clinical mission. Say "yes," be willing to help, and more responsibility will come your way. That is equally true of life in general. The second way to get involved is to take an EMT class and be willing to be a caregiver on an ambulance. This requires time that some medical students do not have. The final way is to seek out an EMS educational institution and offer to help. Again, the tasks will be small at first, but once you prove yourself more will come your way. ■

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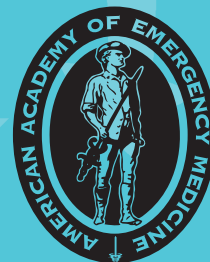
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