VOICE
OF THE AMERICAN ACADEMY OF
**EMERGENCY MEDICINE**

# COMMONSENSE

VOLUME 23, ISSUE 2
MARCH/APRIL **2016**

WWW.AAEM.ORG

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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 quallity 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)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Please visit www.aaem.org for special eligibility criteria)
International Member: $150 (Non-voting status)
Resident Member: $60 (voting in AAEM/RSA elections only)
Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
Student Member: $30 or $60 (voting in AAEM/RSA elections only)
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*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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AAEM-0116-046

President's Message

# Advancing the Academy's Mission

Kevin Rodgers, MD FAAEM
AAEM President

I want to thank the membership for the opportunity to lead and serve the premier organization in emergency medicine, AAEM, as it continues to fight for the individual, board-certified, emergency physician. At the Scientific Assembly (AAEM16) in February — from our town hall session to the numerous committee, task force, and interest group meetings I attended — I saw the tremendous passion our membership has for advancing AAEM's unique agenda. During the town hall session I implored each AAEM member to take every opportunity to remind colleagues, residents, medical students, and hospital administrators that AAEM is not "just another organization" like ACEP, CORD, or SAEM. Our focus on protecting the rights of BC/BE emergency physicians and advocating for fair and equitable practice environments makes AAEM unique. No other EM organization has that focus.

Over the next two years as your president, my passion will be to advance the Academy's mission and insure that AAEM's future is a bright one. AAEM must steadfastly concentrate on supporting our members, identifying and counteracting threats to our practice and our future. As the influence and control of contract management groups (CMGs) continues to grow, as more illegal joint ventures invade the practice of EM, and as states and the federal government threaten appropriate and fair reimbursement for EM services with the elimination of balance billing and the bundling EM professional fees into a global hospital payment, AAEM must diligently address each and every threat.

One of the most exciting events at the Scientific Assembly, and probably the one with the most potential impact, was the launch of the AAEM Physician Group (AAEM-PG). It will maintain the stability and support the growth of existing EM groups that provide equitable and fair practice environments, as well as provide the infrastructure for new groups to develop. Based on the restoration of physician autonomy and the creation of group practices bound to the principles of the Academy, the AAEM-PG offers EM groups and hospitals a desirable and viable alternative to CMGs and the corporate practice of medicine. By providing a nationally recognized name, expertise, economies of scale, professional management, and bench strength the AAEM-PG is the answer to maintaining group longevity and physician autonomy and an antidote to physician burnout. This is a major and innovative step in the right direction, aimed at securing that bright future for our specialty.

I would also like to recognize a cadre of individuals whose tireless efforts support AAEM's mission and serve its members. First, tremendous thanks to the board of directors (BOD). Under the leadership of President Mark Reiter, the BOD has been instrumental in the Academy's recent successes. Although we must unfortunately say farewell to departing BOD members Bill Durkin (Immediate Past-President), John Christensen, Dave Lawhorn, Joe Lex, and Andy Mayer, I hope these incredibly productive individuals will continue to provide leadership to the Academy in other ways. I would also like to welcome new members of the BOD: David Farcy (President-Elect), Lisa Moreno-Walton (Secretary-Treasurer), Robert Stuntz (YPS Director), Megan Healy, Jonathan Jones, Terry Mulligan, Brian Potts, Joel Schofer, and Tom Tobin. Each of these individuals has been a tireless advocate for the Academy, and they will now make AAEM even stronger.

"Over the next two years as your president, my passion will be to advance the Academy's mission and insure that AAEM's future is a bright one. AAEM must steadfastly concentrate on supporting our members, identifying and counteracting threats to our practice and our future."

I would also like to recognize and thank co-chairs, Chris Doty and Evie Marcolini, and the 16 members of the Scientific Assembly Sub-Committee, for once again developing and implementing the best EM educational meeting in the world. The meeting broke AAEM's previous Las Vegas attendance record and provided a diverse lineup of cutting-edge presentations that will change practice and have a positive impact on our patients. And the Scientific Assembly is still free to Academy members! Of course the Scientific Assembly would not be a success without the incredible support of AAEM staff members Kathy Uy, Emily DeVillers, Laura Burns, Madeleine Montony, Tom Derenne, Ginger Czajkowski, and Darcy Welsh — led by Janet Wilson and Kay Whalen. Hats off to everyone who contributed to this incredible and innovative meeting.

Keeping our members informed will continue to be one of my top priorities. We continue to improve and update our website at www.aaem.org. We now have thousands of members communicating with AAEM via social media. Our new podcast program has been very successful, and we are always looking for new ideas and new speakers. Andy Walker, winner of the 2016 James Keaney Award, has done an exceptional job of developing *Common Sense* into a top-notch platform for the Academy.

If you are not already a member of an AAEM committee, please consider joining one of our 16 committees (www.aaem.org/about-aaem/leadership/committees).This is a great way to support AAEM, get involved, learn something, meet new colleagues, and help increase the productivity and impact of the Academy. Also, let us know if you have an idea for a project you would like to work on with AAEM. I want to make sure we involve as many interested members as possible.

I love to hear feedback from our members — feel free to email me at kgrodger@iu.edu. ■

# Fighting for You, and Too Often Alone

Andy Walker, MD FAAEM
Editor, *Common Sense*

*Remember: what appears in "From the Editor's Desk" is nothing more than my personal opinion, not an official statement from the American Academy of Emergency Medicine. Whether you think I am a genius or an idiot, I hope you will write a letter to the editor and tell me about it.*

Our Academy's board of directors was in Washington, D.C. on December 10 and 11. One day was spent in a board meeting and the other in meeting with regulators, legislators, and congressional staffers — fighting for you and your ability to take proper care of patients in the emergency department. Three issues were the focus of those meetings.

## Joint Ventures

Over recent years, several hospital chains have launched joint ventures (JVs) with corporate staffing companies — better known as contract management groups (CMGs). Probably the most notable of these is the one between HCA and EmCare, although it doesn't differ in any way I can see from other hospital/CMG joint ventures. But using the HCA/EmCare JV as an example, since HCA was already free to contract with EmCare to staff its emergency departments — and was doing so in a number of hospitals — why would it form a joint venture with EmCare? In my opinion there is only one reason: to conceal a kickback paid by EmCare in return for the contracts to staff HCA emergency departments.

Formerly, the hospital would bill the patient (or insurer) for hospital services and EmCare would bill for physician services, and each party kept what it collected. Now, under the JV, EmCare shares part of its physicians' professional fees with the hospital. Imagine if a hospital administrator went to a local, independent, physician-owned emergency medicine group and said, "I'll let you keep the ED contract if you kick back $250,000 a year to the hospital." I suspect even the demand would be illegal, much less actually paying the kickback and then billing the federal government (Medicare, Medicaid, etc.) for services rendered. Independent, democratic EM groups cannot — and should not — compete with such bribery, giving hospital/CMG joint ventures the power to drive the private practice of emergency medicine out of existence. Although I cannot go into detail, AAEM continues its effort to stop these JVs.

## Balance Billing

At both national and state levels, there is a movement to ban balance billing by emergency physicians. It has already happened in California, and in D.C., the End Surprise Billing Act of 2015 (HR 3770) would do the same thing. I believe we convinced several legislators — including some of the bill's co-sponsors — that a ban on balance billing is a horrible idea with disastrous consequences they hadn't considered, so this bill is extremely unlikely to advance. However, there is a more dangerous movement against balance billing in the executive branch. In November the Dept. of Health and Human Services, the Dept. of Labor, and the Internal Revenue Service issued a joint rule under the Affordable Care Act ("Obamacare") that implies they will ban all balance billing in the near future.

What's wrong with prohibiting balance billing by emergency physicians — doesn't that protect emergency department patients from being surprised by high out-of-pocket costs? No, prohibiting balance billing does not protect patients — it protects insurance companies. And judging by the annual compensation of their CEOs, insurance companies are doing just fine, thank you.

For those of you who have never dealt with insurance companies, I'll explain in a slightly more graphic way than we did in Washington. Let's say an imaginary insurance company called Distributed Insurance Companies of Kalamazoo, Houston, Erie, and Detroit (DICKHEAD) comes to your group and says, "Here is a contract to join our network and get paid $50 every time you see one of our covered patients; take it or leave it." Being in-network usually means accepting a set fee from the insurer and getting little or nothing else. Being out-of-network usually means you can bill whatever you think is fair, and although the insurer will pay more than if you are in-network because you haven't contractually agreed to a discount, the patient bears some of the increased cost too.

There are advantages to being in-network. Your group gets paid faster and more reliably with less paperwork and administrative overhead, and has lower billing costs. And especially in the ED, many patients aren't going to pay any out-of-pocket fees anyway, so trying to collect wastes both time and money. However, at the level of reimbursement offered you can't staff your department with PAs or nurse practitioners 24/7, much less with board-certified emergency physicians. And like all EM groups, yours carries a huge charity burden (Medicaid, Medicare, self-pay, etc.) and needs to charge patients with private insurance enough to make up for some of the free care you render. So, your group decides to "go nonpar" (nonparticipating) and stay out-of-network. Now when a DICKHEAD patient comes to your ED, he has to pay a larger percentage of his bill out-of-pocket than if you were in-network. That is balance billing — billing an insured patient for costs his insurance doesn't cover, rather than taking whatever the insurance company offers and stopping there.

When this happens in the real world, the out-of-network patient goes back to his employer and complains about DICKHEAD insurance being inadequate (or shops for new insurance if he is buying his own). The employer then complains to the insurer, and more often than not DICKHEAD eventually comes back to the bargaining table and finally agrees to a contract that meets the needs of all concerned.

As I said, there are huge advantages to being in-network for an EM group, and the pressure to participate with a particular insurer is especially severe if the group's hospital is already in-network. A legal ban on balance billing isn't necessary. However, if it is impossible for emergency physicians to balance bill, if we can't even threaten to go nonpar with an

Continued on next page

insurer, every emergency department in the country will be completely at the mercy of insurance companies. Because of EMTALA, insurers know we have to see their patients. Unlike private offices or clinics, EDs can't screen out and turn away patients from out-of-network insurance plans. If emergency physicians can't threaten to go nonpar and balance bill, insurers will decide entirely on their own what they will pay us for taking care of their clients — knowing that we will take care of those patients regardless. Insurers will choose to pay very little for emergency services, often not even enough to keep the EM group alive or the doors of the ED open. That is just what happened in California — hospitals closed and the state lost EDs after the ban on balance billing, especially in poor areas that were already medically under-served. As so often happens when government intervenes, the Law of Unintended Consequences reared its ugly head. An effort to protect patients and improve access to care actually protects insurance companies and reduces access to emergency care. Government would do well to remember that nothing is free. If it is easy for insurers to pay next to nothing for emergency medical care, next to nothing is just what patients will get.

## Due Process

If you are a partner in a democratic EM group or faculty in an academic ED, it is extremely unlikely that you will be fired "without cause" (except during some probationary period that follows being hired). If you are accused of incompetence or some kind of wrong-doing, you will be given a chance to respond to the charges against you. In a democratic EM group, your partners will then vote on whether or not to retain you in the group, according to the group's bylaws. In an academic hospital your department chair, and maybe even a dean, will review the facts and decide your fate. In any case, you are assured some kind of peer review and due process rather than arbitrary termination based on the whim of a single person who may have no medical training at all.

That is not the case if you work for a CMG. Whether you are an employee or an independent contractor, if you work for a CMG you can not only be fired "for cause," with some degree of advance notice you can be fired "without cause." And if the hospital administrator requests that you be taken off the schedule, termination can be immediate and without any notice at all. Read your contract. I can just about guarantee that somewhere in it are clauses saying what I just described, and that you have waived your right to due process — meaning you can be fired for no reason at all and that you automatically resign your medical staff privileges when that happens. Think about that for a minute. You can be fired immediately and "without cause" at the request of a non-physician hospital administrator. Now, how secure do you feel twisting the arm of that cranky cardiologist who doesn't want to take your STEMI patient to the cath lab at 0300; or refusing to transfer the indigent alcoholic patient with cirrhosis and upper GI bleeding that your gastroenterologist doesn't want to take care of, and your hospital administrator doesn't want lingering in the ICU for a few weeks before he dies, running up huge bills that will never be paid?

Let's face it: emergency physicians care for some of the most undesirable patients imaginable — undesirable to hospital administrators who only care about hitting their corporate metrics and getting their bonuses, and sometimes even to other physicians too. We take pride in taking care of patients others shun, and in standing up for those patients and fighting for them when we have to. But what if you knew you might be fired just for doing the right thing, for taking good care of your patient or for complying with EMTALA? Your right to due process and peer review doesn't just protect you, it protects your ability to be a good doctor. It protects your patients.

There is one other reason emergency physicians should be guaranteed due process. In theory, if you go to the CMG you work for and ask to see how the CMG codes your professional services, what it has billed for those services, and how much it has collected — it is legally bound to give you that information. However, this is a sure way to get yourself fired. Not because you asked to see the books — of course not — but "without cause." As long as you can be fired without cause, without peer review and due process, it is impossible to protect yourself against accusations of billing fraud or to protect the federal government, the usual victim of that fraud. As we argued in Washington, protecting the right of emergency physicians to due process protects both patients and those who pay the bills.

## Too Often Alone

Our Academy is not alone in the effort to protect the ability of emergency physicians to balance bill. This is one of the few things that AAEM, ACEP, democratic groups, academic medical centers, and even CMGs agree on. No one wants to be left completely at the mercy of insurance companies. And although I know of no organization as passionate or active on the due process issue as AAEM, we do have allies. The AAEM/RSA, ACEP, EMRA, CORD, the American Society of Anesthesiologists, the American College of Legal Medicine, and the Society of General Internal Medicine all cosigned a letter on this topic written by AAEM for various government recipients, and the American Academy of Family Physicians sent its own letter on the issue.

On joint ventures however, AAEM is alone — despite my widely shared opinion that hospital/CMG joint ventures violate both federal and state laws and, as I said, threaten the private practice of emergency medicine with extinction. So, where is ACEP? Where is ACEP? ACEP is where it always seems to be when there is a conflict between individual emergency physicians (and their democratic groups) and the corporations that exploit us, prey on us, and enrich their owners and managers with our hard-earned professional fees. ACEP is with the CMGs, in the corporations' corner. In future columns I'll take a closer look at this consistent pattern of behavior, and try to explain it.

I think I had better make the disclaimer under the title of this column a permanent part of "From the Editor's Desk." To quote Bette Davis in *All About Eve*, "Fasten your seat belts, it's going to be a bumpy night."

If you want to help AAEM fight for your ability to control your own practice, take good care of patients, and be fairly compensated for your work — do something! The link below is an easy place to start.

http://www.aaem.org/calendar/current-news&item=4400. ■

Submit a "Letter to the Editor" at www.aaem.org/publications/common-sense/letters-to-the-editor.

# Senate Nears Passage of Drug Overdose and Addiction Legislation

Williams & Jensen, PLLC

In March, the Senate began consideration of the "Comprehensive Addiction and Recovery Act," (S. 524), legislation sponsored by Senators Sheldon Whitehouse (D-RI), Rob Portman (R-OH), Amy Klobuchar (D-MN), Kelly Ayotte (R-NH), Christopher Coons (D-DE), and Mark Kirk (R-IL) that would authorize programs to combat prescription drug and opioid abuse as well as increase the availability of naloxone for overdose victims.

S. 524 directs the Secretary of the Department of Health and Human Services (HHS) to convene a Pain Management Best Practices Inter-Agency Task Force to review, modify, and update, as appropriate, best practices for pain management, including chronic and acute pain, and the prescription of pain medication. Task Force members will include representatives from various government entities, including the Department of Veterans Affairs, the Food and Drug Administration, the Drug Enforcement Agency, and the National Institutes of Health.

The task force is directed to provide a report to Congress which includes: the strategy for disseminating best practices for pain management and prescription of pain medication; the results of a feasibility study on linking the best practices to receiving and renewing registrations of manufacturers or distributors under the Controlled Substances Act; and recommendations for effectively applying the best practices to improve prescription practices at medical facilities, including the Veterans Health Administration.

The legislation also authorizes State Demonstration Grants. Such grants may be used to make opioid overdose reversal drugs, such as naloxone, available for use by first responders. Additionally, the grants may provide training and resources to first responders on how to use opioid overdose treatments. Technical Assistance Grants are to be used, among other things, to provide technical assistance and training on the use of opioid overdose reversal drugs.

Notably, an amendment from Senator Jeanne Shaheen (D-NH) to provide $600 million in emergency spending to combat opioid abuse failed on a procedural vote. Shaheen and others argued that emergency funding is needed to help communities that are battling opioid and heroin abuse. However, Senate Majority Leader Mitch McConnell (R-KY) argued that the federal government already has $400 million in unspent funding from the budget deal that passed Congress in December.

Several amendments with strong bipartisan support were adopted with this legislation, including both a provision to strengthen consumer education about the risks of opioid abuse and addiction, and a proposal to establish a drug management program for at-risk beneficiaries under the Medicare program. An amendment that was still pending to the bill from Senator Joe Donnelly (D-IN) would provide follow-up services to individuals who have received opioid overdose reversal drugs.

If the bill clears the Senate with strong bipartisan support as expected, the bill would likely be taken up by the House. The increased attention around opioid and heroin related deaths makes this legislation one of the few health care initiatives that could be enacted in an election year. Companion legislation authored by Representatives Jim Sensenbrenner (R-WI) and Tim Ryan (D-OH) has bipartisan support, but has yet to advance through any of the three Committees to which it was referred last year. Speaker Paul Ryan (R-WI) has also signaled interest in mental health and criminal justice reform legislation.

## House Fails to Override Veto of ACA Legislation; Announces Health Care Task Force

The House attempted and failed to override President Obama's veto of reconciliation legislation that would have repealed significant elements of the Affordable Care Act (ACA). The Restoring Americans' Health care Freedom Reconciliation Act of 2015 (H.R. 3762) failed by a vote of 241-186, nearly entirely along party lines. Approximately 50 House Democrats and more than a dozen Senate Democrats would have been needed to successfully override the veto. While both chambers clearly lacked the necessary votes from Democrats to support the override, Republicans touted the reconciliation effort as the first time a bill to repeal key elements of the ACA was sent to the President. Speaker Ryan said the vote demonstrated a "clear path to repealing ObamaCare without 60 votes in the Senate," and concluded that a Republican President next year would be able to pass this bill repealing key elements of the ACA with a simple majority of votes in the Senate. Democrats agreed with the idea that this vote raised the stakes of the 2016 election, noting the potential for millions of Americans to lose access to health insurance.

The bill falls short of full ACA repeal because of the strict rules under the budget reconciliation process that was used to advance the bill with a simple majority in the Senate. However, the bill eliminates the ACA's Medicaid expansion, the individual mandate to purchase health insurance, and the employer mandate to provide health insurance. The legislation also repeals the medical device tax and the ACA's "Cadillac" tax on high cost health insurance plans. Both of these taxes were suspended for

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two years as part of the end of year agreement on spending and taxes that was signed into law on December 18.

Republicans have not held a vote on a comprehensive plan to replace the ACA, but Speaker Ryan announced the creation of a "Health Care Reform" Task Force, with the stated goal to "repeal and replace Obamacare with a patient-centered system that gives patients more choice and control, increases quality, and reduces costs." Members of the Committee-led Task Force are House Budget Committee Chairman Tom Price (R-GA), House Education and Workforce Committee Chairman John Kline (R-MN), House Energy and Commerce Committee Chairman Fred Upton (R-MI), and House Ways and Means Committee Chairman Kevin Brady (R-TX).

The Task Force plans to focus on five goals: (1) provide Americans with access to health insurance coverage that is affordable and portable; (2) give Americans the freedom to pick plans and providers that best fit their health care needs; (3) protect quality of care and patients with pre-existing conditions; (4) promote enhanced competition through new technologies, better cures and treatments, and lower prices; and (5) save Medicare and Medicaid to strengthen security for seniors and vulnerable patients.

To realize these goals, the Task Force plans to hold hearings and explore innovations in employer-provided health care coverage, health tax expenditures, and increasing the flexibility of states under the Medicaid program. ■



# We're listening, send us your thoughts!

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## 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 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 or contact our office at 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**.

# Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 11-4-15 to 3-21-16.

AAEM established its Foundation for the purposes of (1) studying and providing education relating to the access and availability of emergency medical care and (2) defending the rights of patients to receive such care and emergency physicians to provide such care. The latter purpose may include providing financial support for litigation to further these objectives. The Foundation will limit financial support to cases involving physician practice rights and cases involving a broad public interest. Contributions to the Foundation are tax deductible.

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**Contributions $1,000-$2,499**

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# Dollars & Sense: Disability Insurance

Joel M. Schofer, MD MBA CPE FAAEM
Commander, Medical Corps, U.S. Navy
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If you never worked again, would you have enough money to live comfortably? If the answer is no, you need disability insurance (DI), which is probably the type of insurance most neglected by physicians. Many physicians have life insurance, but the chances you will die early are much lower than the chances you will become disabled.

## Introduction to DI

There are three types of DI. The first type, an individual policy, is usually the most comprehensive protection because it can be tailored to your individual situation. The second type, a group policy, is provided and paid for by an employer. The third type, an association policy, is available to members of an association. The terms of the policy are set and modified by the association and can be cancelled by either the association or the insurance company.[1]


The association and group policies are often cheaper, but are generic and can be ill suited for your specific situation. They usually have weaker definitions of disability than an individual policy and often cannot be taken with you when you change employers or leave the association. They might be your only option, though, if you have medical problems or other issues that prevent you from qualifying for an individual policy.

"If you never worked again, would you have enough money to live comfortably? If the answer is no, you need disability insurance (DI), which is probably the type of insurance most neglected by physicians."

## "Own Occupation" Coverage

One very important feature that group or association policies often lack is true "own occupation" coverage. "Own occupation" means the policy will cover your specific occupation as an emergency physician, and will not require that you are unable to work in alternative jobs before qualifying for benefits, such as urgent care, occupational medicine, or other specialties.

Martin breaks the "own occupation" issue down into tiers of coverage. Tier 1 is the weakest form of DI and states that if you can work in any profession, you are no longer disabled. Many group policies revert to this after two years. Tier 2 is the most common form of DI for physicians. It pays you a benefit if you cannot work in your specialty, as long as you are not working in any other capacity. Tier 3 is the desired coverage whenever possible. It says you are disabled if you cannot perform the duties of your specialty, and it does not matter if you work in any other capacity. Just because you have something an insurance agent calls "own occupation" or "specialty specific" coverage, that doesn't necessarily mean you have Tier 3 coverage, so you really need to get into the details of any DI policies you are considering.[2]

## Important Features

The most important portion of your policy is the definition of disability. There are many different definitions, but this definition is the portion of the policy that determines if benefits will be paid. In addition to the definition of disability, the benefit period is the period of time during which you will receive benefits when disabled. The most common options are two years, five years, or to age 65-67 — and the longer the better.[1]

In addition to specialty specific coverage, you want a policy that is:

- Adjustable, so that you can modify your coverage as your situation changes and your income rises.
- Non-cancelable, meaning that the company can't raise your rates, reduce your benefits, or cancel your policy.
- Guaranteed renewable, so that you can renew each year without a medical exam.

Disability caused by mental health impairment gets special treatment in certain DI policies. A frequent feature is that policies will only cover psychiatric disability for two years. You can get policies that cover you to age 65-67, but this superior coverage will cost more. Make sure you look for other exclusions in your policies, like foreign travel, normal pregnancy, military service, acts of war, and others. If these things are important to you, you will need to see if you can get them covered. If you are active duty military looking for DI, I searched for years and was finally able to get adequate coverage through DI4MDs.com.

## How Much Coverage Do I Need?

How much coverage you need depends on a number of factors.

- How much money do you spend? Although most policies will limit your total DI coverage to 60-70% of your income, you should look to cover your expenses in the event of disability, not a certain percentage of your income.
- If you are married and your spouse works (or could work), then you may be able to rely on him/her for financial support in the event of your disability. Dual physician couples could probably live on one income if they really had to, for example. If you are single, it

Continued on next page

increases the likelihood you will need DI with substantial benefits.
- Is your DI benefit taxable or tax-free? It will be taxable if a tax deduction was taken and pre-tax dollars were used to pay for the premiums, which is usually the case in group policies. If no deduction was taken and post-tax money was used to pay for the policy, then the paid benefits will be tax-free. Obviously money that is tax-free is more valuable than money from which you must pay taxes.
- You should probably err on the side of buying more coverage rather than less. As time progresses, inflation is going to reduce the value of your benefit.

If you are trying to maximize the monthly benefit you can get, you will want to establish as much individual DI as you can before you sign up for group or association policies. The individual policy insurers will count group or association policies against the total monthly benefit you are eligible for, but the reverse is not true.

## What Options Are Available?

When you purchase a policy, there are a number of options you can accept or decline, called "riders."

- Residual disability rider. This ensures that if you cannot return to full-time work after an illness or injury but want to work part-time, you receive partial disability income until you can. This is one rider I would purchase.
- Cost of living rider or cost of living adjustment (COLA). Once you start getting disability benefits, the amount is adjusted annually for inflation. Note that this adjustment doesn't start until you are disabled and are getting benefit payments. For example, if you purchase $5,000/month of coverage now and become disabled 15 years from now, your benefit will be $5,000/month. It will not be adjusted during those 15 years — only a year after you begin receiving payments. If you are early in your career, this a rider to strongly consider. If you are late in your career, it is probably not worth it. If you are somewhere in the middle, you will have to decide for yourself.
- Future purchase option rider. This allows you to purchase additional coverage in the future without a medical examination. This is important for physicians early in their careers, who are anticipating a rise in income and a need for increased coverage. If you have already reached the peak of your earnings or are close to it, you can probably skip this rider.
- Catastrophic coverage rider. If you are disabled to the point that you cannot perform activities of daily living, you get a bump in your disability payments to cover your additional costs, like home health care. I think this is a rider to consider, depending on how expensive it is.

## How Can I Reduce the Cost of DI?

Try to reduce the expense by lengthening your "waiting" or "elimination" period. The waiting/elimination period is the time between when you become disabled and when disability benefit payments begin. If you have a substantial emergency fund saved up, you can lengthen the waiting/elimination period and lower your premiums. For example, I figured it would take the Navy at least a year to kick me out if I was disabled, so my waiting period is one year — much longer than the usual three months — which saved me some money.

Purchasing a policy in which premiums rise gradually as you age can save money early in your career, and you can then cancel the policy as your investments grow and you become financially independent — assuming you have the discipline to make that happen. When you are financially independent, you no longer need DI.

Finally, some companies offer a discount if you make your premium payment annually or as a lump sum. I was able to save 20% by paying for a five year policy all at once.

## Where Do I Get DI?

If your group/employer coverage does not meet your needs, first look for an individual policy from an insurance agent that specializes in DI for physicians. Agents should have access to discounted plans and be able to sell policies from the major DI companies, which include Berkshire, The Standard, Principal, Ameritas, MassMutual, and MetLife.[3] An agent should be able to offer you multiple policies and explain the differences in the policies and their costs. Keep in mind, though, that agents are paid to sell you a new individual policy with as many riders as possible, so they are not without bias.

The American Medical Association offers association disability policies, and AAEM has a relationship with Hays Insurance (http://www.aaem.org/benefits/aaem---hays-insurance-program), which can get you quotes for DI as well.

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If you have ideas for future columns or have other resources you'd like to share, email me at jschofer@gmail.com.

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# Improving the Patient Experience: Ten High-Yield Interventions

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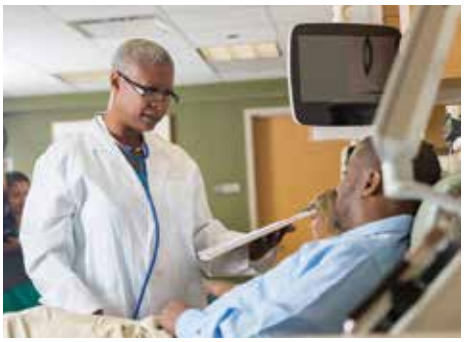
Ali S. Raja, MD MBA MPH; Benjamin A. White, MD

Patient experience and satisfaction with emergency department (ED) care is a rapidly expanding area of research, and a focus of attention for health care leaders.[1] In addition to the role patient experience plays in the perception of quality, recent literature suggests a strong correlation with goals such as improved patient adherence to physician recommendations,[2] improved staff satisfaction,[3] reduced patient complaints and malpractice risk,[4,5] and higher visit volume and revenue.[2] The Centers for Medicare and Medicaid Services (CMS) have also been developing and field testing an Emergency Department Patient Experience of Care (EDPEC) survey since 2012, and plan to create a collection of publicly reported metrics similar to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.[6]

As ED leaders consider options for improvement in the context of overcrowding and capacity restraints, some high-yield themes are emerging.[7,8] We will briefly describe those themes and the associated opportunities for intervention.



"As ED leaders consider options for improvement in the context of overcrowding and capacity restraints, some high-yield themes are emerging."

In the last decade, a number of the most significant contributors to a patient's experience in the ED have been identified. While some of these are outside the control of ED leaders (e.g., age, sex, and illness severity),[8] service factors are another matter. Several broad areas are important.[2,3,9,10]

1) Clinician attitude, empathy, and interpersonal interactions.
2) Quality of communication, information dispensation, and explanation.
3) Perceived technical skill and competence of providers.
4) Actual and perceived wait times, aspects related to quality of wait.
5) Pain Control and patient comfort factors.

## Top Ten Patient Experience Improvement Opportunities

### 1. Create a Culture of Service

Fostering a departmental culture in which each member of the staff believes he or she is able to provide excellent service improves the patient experience.[11] EDs can learn from hospitality leaders like Ritz-Carlton, where financial bonuses for customer service, real-time feedback, and employees empowered to fix problems are standard.

A culture of service starts with the hiring process, seeking out individuals with good communication skills, and can include asking all employees to sign a contract committing to service excellence.[12] Simple, discrete, and measurable patient service standards should be created and included in training for new staff members. A departmental reward program, by which all employees benefit if overall service scores reach a certain goal, may also encourage staff to "act like owners" in their interactions with patients.[12,13]

### 2. Emphasize the Importance of Empathy and Attitude

Virtually all assessments of patient experience identify staff empathy and attitude as significant factors. A caring attitude is fundamental to a high quality relationship with the patient, and some measure of empathy is present on most patient experience surveys.[3,14] Although most health care providers are inherently caring individuals, it is all too easy to forget this, especially when faced with the challenges inherent in emergency medicine. Frequent reminders from leadership, a supporting and empathetic environment, and ongoing training in empathy are effective interventions.[15] An effective acronym that emphasizes the importance of key components of caring behavior is EMPATHY: eye contact, muscles of facial expression, posture, affect, tone of voice, hearing the whole patient, and your response.[16]

### 3. Consider the Patient's Perception

It may be a cliché, but perception is reality for ED patients. When patients are more satisfied with the customer service skills of the providers and staff they encounter, their perception of medical quality improves.[17]

Much of improving the patient's perception is low hanging fruit: all providers and staff should dress professionally, scrubs should be clean, and hospital identification badges should be clearly displayed, facing outwards and above waist level.

Sitting at the bedside instead of standing leads patients to perceive increased face-to-face interaction time with their providers, and to report improved understanding of their medical conditions.[18] To make it clear how highly staff members value privacy, ask staff to remind patients why they are closing curtains or speaking softly.[19] To demonstrate teamwork, refer to other providers or staff by name when in the room together, and explain each staff member's role in the patient's care.

### 4. Improve the Quality and Frequency of Communication

The importance of regular and respectful communication in the patient experience cannot be overemphasized. Patients who feel they are well-informed during their stay in the ED have significantly higher perceptions, not only of their providers' attitudes and of the quality of their interactions with providers, but also of their medical treatment in general.[19]

Continued on next page

Even without increasing the overall time spent talking with patients and their guests, several simple interventions can improve staff-patient communication. Upon meeting patients, address them by the name they choose and use that name during each subsequent encounter. Do not assume gender pronouns. Provide opportunities for patients to state their preferences and note them accordingly. Ask who is with the patient, and engage all in the room as you discuss the care plan.

In a busy ED setting, it is easy for patients to feel lost in a shuffle of different providers and staff. Inform patients and their guests of your role in their care when first meeting them, and again at the time of discharge.

Models such as AIDET (Acknowledge, Introduce, Duration, Explanation, Thank You) may improve standardization of ideal communication behaviors and ultimately improve both clinical outcomes and patient satisfaction. This structure may also serve as a starting point for individual EDs to create their own communication standardization tools.[20] Likewise, written scripts for typical encounters (e.g., greeting patients or explaining delays) may also aid in creating clear standards of communication.[13] While every patient encounter is unique, these may serve as guides for how transporters, clinical assistants, and other staff can address and engage patients in a manner that improves the quality and frequency of communication.

### 5. Enhance the ED Environment

Just as consumers judge a retail outlet's worth by how inviting its space is, patients and their families form opinions about the quality of medical care based on the environment in which it is delivered. Several items on the HCAHPS survey relate directly to the physical environment.[6]

While all patients should expect and receive basic cleanliness, organization, and reasonable privacy while in the ED, additional improvements such as private rooms with closing doors, clean and readily available restrooms, and a lack of excessive background noise all serve to improve their experience. At Henry Ford Hospital, the Detroit Symphony Orchestra is piped live overhead and the hospital offers concierge services and a tea sommelier.[9] While this isn't possible in most EDs and will strike many as ridiculous, offering our patients a clean and quiet space should be routine.

### 6. Decrease Waste and Waiting Time Wherever Possible

Many EDs are concerned about waiting time. Wait time includes all the time spent at every step in the process, including waiting to see an emergency physician, boarding in the ED, and waiting for testing and treatment. The perception of waiting time has been linked to poor patient experience and longer waiting time has been linked to poor outcomes.[21] Patients expect to receive timely care, but wait times are multifactorial and depend on a collection of system factors that are often expensive and difficult to change. While systematic effort should be made to improve wait times, finding simple and ED-specific methods of mitigating the impact of waiting time is prudent.

A decrease in perceived waiting time, even without a decrease in actual waiting time, has been shown to improve satisfaction.[22] Therefore, one opportunity is to make patients feel like wait times are shorter. Methods of distraction, such as art work in waiting areas, have been shown to decrease patient restlessness and signs of boredom.[23] Also, being honest with patients about expected waits and explaining any delays is not only the best practice, it is simple decency. For example, telling a patient that "a critical patient needed the CT scanner, "so yours will start in about an hour" is more effective than "your CT has been delayed."

### 7. Provide Timely Pain Management

Pain is one of the most common reasons patients come to the ED. Often referred to as "the fifth vital sign," the subjective nature of pain often makes its treatment difficult to integrate into overall patient care. However, pain management is a fundamental aspect of high-quality medical care, is important for patient comfort, and is the subject of national attention. Pain control is a major driver of patient satisfaction.[3] However, in the United States a patient with a fracture waits an average of 54 minutes before receiving pain medication.[24]

The relationship between analgesia and satisfaction is an active area of research. While it is unclear whether timely pain medication improves Press Ganey patient satisfaction scores, the preponderance of the evidence suggests that treating pain in the ED leads to higher satisfaction.[2,3,25] Both rapid identification of pain and the administration of analgesia have the potential to significantly improve patient experience.

### 8. Practice Hourly Rounding

The ED often feels as chaotic for patients as it does for staff. Patients are inundated with questions from nurses, doctors, registration clerks, and other staff. After being evaluated, patients often have unanswered questions or other unmet needs.

Hourly rounding, in which someone from the care team checks in with each patient every hour, engages patients in their care and affords patients the opportunity to feel connected to their care team. This facilitates continuous two-way communication between the patient and ED staff and provides many benefits, including improved patient satisfaction (with increased Press Ganey scores), improved patient safety, timely pain medicine administration, and decreased left without being seen rates.[26,27]

Rounding with clinical staff is resource-intensive and may not be feasible in every ED. However, hourly rounding can also include other staff who may have more flexibility, such as social workers, transporters, or volunteers.

### 9. Start a Patient Callback Program

While it is natural to consider a patient's visit over at the time of discharge, the patient's experience does not end when he leaves the ED. Patients regularly reflect on their experiences and continually re-evaluate the care they were given, as their health problems evolve over the days following discharge.

Post-discharge patient callbacks improve patient care by allowing patients to ask questions and correct misunderstandings. With moderate resource expenditure, these calls have also been shown to improve satisfaction and increase the patient's likelihood of recommending the ED by as much as 20%.[28,29,30] In addition, given recent evidence demonstrating the feasibility of text-based messaging to patients after discharge,[31] this method of communication may be a less resource-intensive alternative for post-discharge contact with patients.

Continued on next page

### 10. Solicit Regular Feedback, and Act on It

Obtaining feedback from patients and their guests improves the patient experience, both by informing future advances and empowering employees. Providing regular feedback to workers may significantly decrease turnover,[32] allowing for better retention of experienced, high-quality staff.

Feedback can obtained through traditional means such as mailed surveys and follow-up phone calls, but real-time approaches such as shadowing of patients through their ED visit may also provide useful information. Measuring simple customer service scores daily, such as"How likely are you to recommend this ED?,"allows for the trending of data over time in a way that is easily interpreted by departmental leadership and staff alike.[32]

In-person follow up, such as sending a liaison to visit inpatients admitted through the ED, may improve satisfaction — particularly for those patients who experienced an especially challenging or prolonged course in the ED.[13]

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# AAEM's Congressional Fellowship

Katrina Gipson, MD
AAEM/RSA Advocacy Committee

*This is a report from the latest member of the Academy to spend a month in the nation's capital as part of AAEM's Congressional Fellowship program.*

— The Editor


Formal medical education doesn't prepare us for the less clinical parts of our careers. There are certain things we're expected to learn on the job. For instance, if I check the box next to "observational admission" instead of "full admission," my patient's insurance may not cover the bill. Or, if my patient's insurance doesn't cover Lovenox, the alternative may be a lengthy and expensive hospital stay while he is bridged with Coumadin. Who creates these policies anyhow? Are any of them physicians? Do they even know what Lovenox is? Questions like these are a few of the reasons I pursued a Master of Public Health degree and became an active member of the Advocacy Committee as a resident.

I attended my first AAEM/RSA Advocacy Day on Capitol Hill in 2013, while still an intern. The guest speaker was Congressman Raul Ruiz [D-CA]. I was thoroughly impressed and inspired by his contributions to emergency medicine and public health. When I learned of the Congressional Fellowship offered by AAEM in conjunction with his office, I was inspired. I knew I wanted to be an advocate for our patients and our profession, and I figured this would be a good place to start.

Prior to my start date in July 2015, I was in touch with Williams & Jensen, a D.C. law firm and lobbyist that represents AAEM, as well as the Congressman's Legislative Director (LD). They gave me some insight into the office's daily operations and how past interns had contributed. I showed up in D.C. with an open mind, a willingness to learn, and a commitment to contribute to anything even remotely related to health care. Each week the LD and I set goals with respect to upcoming briefings, health care meetings and bills that might require our attention. I learned which websites and publications were reliable. I researched how citizens from the Congressman's district were affected by the issues at hand, and wrote advisory memos for the office. In short, I became more familiar with the process of making policy and the logistics of a Congressional Office. And, despite my brief time in Washington, I was also able to explore some of my own interests. I attended briefings on Value Based Insurance Design (VBID), the state of Planned Parenthood, and hate crimes. I even got to meet Beau Willimon, creator of one of my favorite TV shows, "House of Cards."

Regardless of your level of interest in health care policy, we could all stand a little real-world experience in the area. For me, the opportunity provided by Congressman Ruiz and his staff was priceless and will surely aid me as I begin my health policy fellowship at George Washington University this summer. Even those who want nothing more than a little insight into how Congress works would be well served by AAEM's Congressional Fellowship. I encourage all Academy members, regardless of their age or stage of career, to take advantage of this opportunity. ■


### AAEM/RSA Policy and Advocacy Congressional Elective

AAEM/RSA is excited to announce the addition of Congressman Joe Heck, DO (R) to the Policy and Advocacy Congressional Elective! Applicants now have the option of serving with Congressman Heck or Congressman Raul Ruiz, MD (D) for the duration of the elective.

- The AAEM/RSA Elective is a one month elective for AAEM and AAEM/RSA members interested in medical policy and advocacy.
- The elective will provide a solid understanding of legislative and policy process, which will serve to equip the elective candidate with legislative and policy work and help to empower the emergency medicine profession.
- Any interested party may apply including faculty, fellow, resident or 4th year medical student. Preference will be given to residents.

**APPLY NOW**

Applications are open for 2016. After initial screening by AAEM/RSA, final selections will be selected by the Congressman and his staff.

Applicants are responsible for their own travel and housing in Washington, D.C.

The following are potential milestones to be met. In order to maximize unforeseen opportunities, the elective would be flexible in meeting certain milestones.

- Vote recommendations
- Legislative proposals
- Congressional letters
- Collaborative meetings
- Documenting floor votes
- Other

For additional information, please call 800-884-2236 or email info@aaemrsa.org.

# AMA Interim Meeting

Joseph Wood, MD JD MAAEM FAAEM
AAEM Past President

In addition to its annual meeting each June in Chicago, the American Medical Association holds an interim meeting in various cities. In 2015 the interim meeting was the weekend of November 12, 2015, in Atlanta, Georgia. An AMA meeting is much like a political convention. Each state sends delegates who vote on various resolutions presented to the House of Delegates (HOD). Most specialty societies also have seats in the HOD. Like a political convention, proposed resolutions must work their way through various committees before presentation to the HOD.

The American Academy of Emergency Medicine (AAEM) is a member of the Specialty Service Section of the AMA. We also have a seat on the Emergency Medicine Section Council. The Section Council is currently led by John Morehead, MD, and is very well organized. It meets for three hours on two separate mornings, reviews all proposed resolutions, and assigns emergency physician delegates to every committee to monitor testimony or speak in favor of resolutions important to emergency physicians. The section council also participates in various caucuses, including the hospital-based specialists' caucus. Cooperating with specialties sharing common interests improves our ability to have our resolutions adopted by the AMA.

While hundreds of resolutions were proposed this year, the hottest topic was the Electronic Medical Record (EMR). Nobody seems to be completely satisfied with the current products. (Although I didn't speak with any of the vendors selling these programs — they might be happy). The AMA is working with the government on realistic "meaningful use" rules.

There is also a big push to require vendors to make their EMRs interoperable, meaning records from one system could be transferred to another.

I'm sure many of you are wondering, why even bother with the AMA? Doesn't AAEM lobby and represent our interests? It does. AAEM leaders have lobbied state legislatures, Congress, and federal regulators. We have met multiple times with CMS leadership on crucial topics such as due process rights for physicians. In these meetings we are inevitably asked, "Where does the AMA stand on this issue?" The AMA is still the largest and most influential organization in medicine. If the AMA isn't on our side of an issue, success is unlikely.

Fortunately, emergency medicine's influence on AMA policy has never been stronger. Many emergency physicians have gained seats in the AMA HOD through their state medical societies. The current president of the AMA, Steve Stack, MD, is a practicing emergency physician. However, our influence in the AMA is tied to membership. **If you join the AMA or renew your membership, be sure they know you are an AAEM member.** ■


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# Joe Lex, MD MAAEM FAAEM, Receives Order of the International Federation for Emergency Medicine

Andy Walker, MD FAAEM
Editor, *Common Sense*

Joe Lex has served AAEM in ways too numerous to count, most recently on its board of directors and as chair of the Education Committee's Scientific Assembly subcommittee. The Academy not only named its Educator of the Year Award after him, it has given him the James Keaney Award and made him a Master of the American Academy of Emergency Medicine — AAEM's very first, in fact. You can see part of what Joe has done in this except from his AAEM board of directors biography:

Joe Lex, MD MAAEM just retired as a Clinical Professor of Emergency Medicine at Temple University School of Medicine. He has been involved in emergency medicine for more than 48 years — as a Vietnam combat medic, emergency technician, certified emergency nurse, and then board certified emergency physician. For five years he was education chair for the American Academy of Emergency Medicine, which renamed its Educator of the Year Award the "Joe Lex Educator of the Year Award." He has spoken at hundreds of international and national emergency medicine meetings. Although he only recently acquired a cell phone, he is considered a godfather of the Free Open Access Medical Education (FOAMed) movement and has more than 4,900 followers on Twitter. His website www.FreeEmergencyTalks.net educates motivated learners around the world, and has been accessed nearly 800,000 times. His open-access Global Curriculum project at www.WikEM.org will educate emergency physicians for many years to come. He is currently working with organizations in Vietnam, Myanmar, Poland, and Argentina to improve emergency medical education.

As you can see from the letter below, Dr. Lex has now been recognized by the International Federation for Emergency Medicine (IFEM). Congratulations, Joe! ■

International Federation for Emergency Medicine

President: Dr C. James Holliman
President-elect: Prof Lee Wallis
Treasurer: Dr Andrew Singer
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ACN 145 437 216

5th November 2015

Joseph R. Lex MD
Professor of Emergency Medicine
Temple University School of Medicine
3401 N. Broad Street
1st Floor Park Ave. Pavilion
Philadelphia, PA 19140
UNITED STATES

Dear Joe,

Re: Order of the International Federation for Emergency Medicine

It is with great pleasure that I formally advise that the Assembly of the International Federation for Emergency Medicine (IFEM) has awarded you the 'Order of IFEM' (known as Fellowship of the International Federation for Emergency Medicine - FIFEM) in recognition of your contribution to the development of Emergency Medicine. It is truly well deserved.

The award entitles you to the post nominal 'FIFEM'.

The award ceremony will be held during the 16th International Conference on Emergency Medicine in Cape Town, April 18th - 21st and I will advise you of further details when the date and time of the ceremony has been set.

Please accept my personal congratulations and best wishes on this award which acknowledges you as an exceptional person who has made an outstanding contribution to international emergency medicine.

Once again, congratulations and best wishes,

C. James Holliman

DR C. JAMES HOLLIMAN, MD, FACEP, FIFEM
PRESIDENT

cc Associate Professor Nguyen Dat Anh, President, Vietnamese Society of Emergency Medicine
Dr Mark Reiter, President, American Academy of Emergency Medicine
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# Fairness, Greed, and Balance Billing: Insurance Companies vs. Everyone

John Christensen, MD FAAEM
CAL/AAEM President
Chair of the AAEM Practice Fairness Council
Founding Editor of the AAEM Practice Fairness Toolkit™

*Here is more on the balance billing issue from John Christensen, who just completed one term as president of AAEM's California chapter division and is now starting a second. Remember that this, like my "From the Editor's Desk column, is the author's opinion and not an official position statement from the Academy. Only AAEM's president speaks for the Academy. Whether you agree or disagree with Dr. Christensen, I encourage you to write a letter to the editor with your thoughts.*

*— The Editor*

The move to ban balance billing for emergency services — which are federally mandated by the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) — brings into focus the bewilderingly complex and profoundly unfair reimbursement regimen at the heart of the U.S. health care system. This regimen funds not only the professional services that directly benefit patients (medical care), but also the management and administration of insurance companies, hospitals, and physician groups. Unfortunately, many of the dollars spent on such overhead are consumed by insurance company profits and super-sized executive compensation packages for those at the financial apex of the American health care pyramid. In this article I outline the fundamental concepts relevant to the problem, offer an overview of balance billing, and suggest some possible solutions based on *fairness*.

"The move to ban balance billing for emergency services … brings into focus the bewilderingly complex and profoundly unfair reimbursement regimen at the heart of the U.S. health care system."

"Making health care affordable and accessible is a challenge of monstrous proportions — far beyond the most intractable of the problems I had previously tried to study,"[1] says Clayton Christensen, who spent a decade writing a highly acclaimed book on "the unfathomable, interdependent technological and economic complexity of the health-care enterprise." Making reimbursement for health care services *fair*, as defined below, is an even bigger challenge.

Steven Brill explores the unfairness in the huge difference between charges and costs in the U.S. health care system in his landmark article, "Bitter Pill: Why Medical Bills Are Killing Us"[2] and his follow-up book, *America's Bitter Pill: Money, Politics, Backroom Deals and the Fight to Fix Our Broken Health Care System*.[3] As discussed below, charges and costs are key elements in the balance billing debate, confounded by the legal compulsion of EMTALA. Remember that EMTALA requires evaluation and stabilizing treatment for all patients who present to the emergency department (ED), without any provision to pay for the services provided — much less to pay fairly. Moreover, "stabilizing" under EMTALA means something more and completely different than it means to physicians. For instance, the stabilization of a patient with appendicitis includes surgery; the stabilization of a patient with meningitis includes admission for IV antibiotics; the stabilization of a patient with a STEMI means thrombolytics or angioplasty, etc.

With the complexity and unfairness of our health care system in mind, I believe it is important to consider fairness itself, in the context of the fair market value of goods and services exchanged between two individuals, arguably the building block of any equitable economic system. In Revenue Ruling 59-60, the standard universally cited in the business valuation community, the IRS defines fair market value as:[4, 5, 6]

*The amount at which the property [including intangible assets] would change hands between a willing buyer and willing seller, when the former is not under any compulsion to buy, and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts.*

From simple two-party exchanges to the balance billing issue to the entire U.S. health care system, with its virtual googolplex of economic transactions and agents,[7] I believe that strict oversight of fair market value negotiations at every interface in the system is the missing element in health care reform in general, and in the balance billing issue in particular. Physician reimbursement must be uniquely adjusted to comply with federal anti-kickback statutes and Stark laws, which generally prohibit self-referral.[8] However, the fundamental elements of a fair transaction remain the same: 1) *common knowledge*, which is synonymous with the more popular term *transparency*; and 2) *lack of compulsion*, the option of either party to walk away until mutually favorable terms are reached.

With the preceding definition of fair market value, and by extension of a fair transaction or process, we can now turn to the balance billing issue.

**Continued on next page**

Balance billing for EMTALA-mandated ED evaluation and stabilization services refers to bills sent to ED patients by providers who do not have a preexisting contract with the insurance plan or other risk-bearing organization (RBO) responsible for covering the ED services rendered. These uncontracted providers are known as being "out of network" (OON).

The plot thickens when the hospital itself is contracted with the insurance plan in question, inadvertently fueling the patient's perception that all the providers at that hospital must be similarly contracted and thus "in network." If a physician believes that an insurance company's reimbursement rates are unacceptably low, that physician may choose not to contract with the company no matter what the hospital does. The noncontracting physician, an orthopedic surgeon or cardiologist for example, may still be part of the critically important call panel of specialists covering a given ED. The OON EMTALA-obligated provider may balance bill a patient for the difference between the provider's "usual, customary and reasonable" (UCR) fee and the amount paid by the insurer. That balance bill, often unexpected by the patient, may come as a very unpleasant surprise if the bill is substantial. Consumer (patient) backlash to balance bills has led to a variety of proposed and even enacted legislation that will be discussed below, after a look at UCR itself.

The "usual, customary and reasonable" fee concept is, in my opinion, the core issue in the U.S. health care system and the subject of literally millions of pages of opinion from a wide range of authors. The real question is, "What is fair reimbursement for every facet of health care services?" Economists, policy analysts, medical researchers, lawmakers, business valuators, stockholders, insurance and hospital industry lobbyists, consumer advocates, and medical professional organizations are among the parties who have weighed in on this highly controversial issue.

Wikipedia's first sentence on UCR reads, "Usual, customary and reasonable (UCR) was and is an American method of generating health care prices, described as 'more or less whatever doctors decided to charge.'" I believe this view should be expanded to include all health care prices, thus acknowledging that the alleged arbitrariness of UCR for a physician's professional services also applies to health care administrative and management charges, including the multimillion-dollar compensation packages of executives in the health insurance and hospital industries. This broaches the heated subject of medical loss ratios (MLRs), the proportion of health insurance dollars consumed by administrative and management services.[9, 10, 11] With genuinely fair markets,[12] those who foot the bill for health care — patients, taxpayers, and employers — could play a major role in lowering exorbitant management costs and influence provider charges too.

Returning to the movement against balance billing, some states have banned certain types of balance billing altogether, including California with the Prospect v. Northridge Emergency Medical Group decision by the state's supreme court.[13] In *Prospect*, which reversed an appellate court ruling that would have compensated a class of physicians by allowing them "to recover the reasonable value of their services,"[14] RBO plaintiff Prospect Medical Group claimed that fair payment for OON emergency service providers was equal to Medicare rates, completely denying the existing commercial market value of EMTALA-mandated services.

The *Prospect* ruling opened the door for California insurance companies to begin the systematic, progressive underpayment of many claims for EMTALA-mandated care.[15] Far more chilling, because some ED call panel providers have simply walked away from unfair rates for OON claims, patients may suffer significant and dangerous delays as emergency physicians call far and wide to find a hospital with specialists who can provide the needed services. The importance of the call panel issue cannot be overemphasized, though the general public is largely unaware of it. Without a robust call panel, care for some patients grinds to a halt until a transfer is arranged, almost always in an ambulance and sometimes even a helicopter. Insurance company strategies that underpay EMTALA providers to protect profits and executive compensation pose a significant risk to patient safety — an entirely different kind of surprise for those paying premiums and expecting a full complement of emergency services in the ED.

The National Association of Insurance Commissioners, responding to congressional pressure driven by constituent complaints about surprise balance bills, has issued model state legislation to ban balance billing. Another threat to fair reimbursement for EMTALA providers and to the preservation of the ED safety net took shape with the introduction of H.R. 3770, the End Surprise Billing Act of 2015. The Department of Health and Human Services, in conjunction with the IRS and Department of Labor, has also issued proposed Interim Final Regulations under the Affordable Care Act that would decimate payments to the providers who are struggling to maintain the EMTALA safety net.[16] At present only New York, Texas, and Connecticut have taken even a small step towards promoting a fair payment process that extends to OON EMTALA-mandated services.[17]

Myles Riner, the prolific and insightful author of the blog The Fickle Finger, and an expert on ED billing issues, recently summarized the harsh reality faced by EMTALA providers as they struggle to maintain the ED safety net:

*I think there is no longer any question that the health plans have been waging a long and multipronged campaign to undermine payments to emergency care providers, and they are succeeding*.

I believe Wendell Potter got it right when he pinpointed corporate spin as one of the most destructive forces on the American health care landscape.[12] Sadly, patients suffer and emergency physicians are cheated, while greedy insurance executives get even richer as they undermine health care value and patient safety.

## A Final Thought

For those incensed by the unfairness of how America does health care, here's a question to ponder: What would be a fair rate for a patient to pay for every aspect of comprehensive health care, not just for medical (physician) services, but for all the elements of the system — including administration and management?

Here's a clue. Look at health care systems around the world and check out T.R. Reid's *The Healing of America*, which centers on the World Health Organization's 2000 study of its 195 member countries.[18] The U.S.

**Continued on next page**

ranked 37th in health care system effectiveness and first in expenditures.

Want to work together to make some changes? Consider joining the Practice Fairness Council as a place to start.

AAEM: "The Trusted Advocate of Fairness in Emergency Medicine"™

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# AAEM16 Wrap-Up

Evadne Marcolini, MD FAAEM
Christopher Doty, MD FAAEM

Even if you missed the 22nd Annual AAEM Scientific Assembly, you probably felt the earth move wherever you were. We united the Academy's history with its future. Joe Lex, our beloved mentor, took us down memory lane with his keynote address "Forty-Nine Years in Emergency Medicine," and regaled us with stories that made us laugh and made us proud to be part of emergency medicine. Joe is retiring,

> "This conference is for you; we strive to make it meaningful, fresh, and entertaining while keeping to the mission and values of AAEM. Please send us your thoughts and suggestions and join us next year in sunny Florida!"

and starting the next chapter of his life as a mentor and promoter of jazz musicians. He pretends to be saying goodbye to AAEM, but we will keep him as close as we can since his institutional knowledge and creative passion are invaluable.

We were then whisked into the future by Zubin Damania, whose alter ego, ZDoggMD, has become an international phenomenon through medical public service and parody music videos on YouTube. Honestly, we wondered if ZDogg's irreverent style would fly with the AAEM crowd. His use of pop music parody to educate on health care, from HIV to electronic health records, is educational but "in your face," too. Zubin delivered an inspiring keynote presentation as he described his trajectory in medicine, education, and a system that has revolutionized the way that health care is delivered. Both Joe and Zubin brought the house down and inspired us all.

Giving us a sense of where we have been and where we are going, Bob McNamara gave us "The Why and What of the Academy — Where Would Emergency Medicine Be Without AAEM?" Bob's plenary reminded us of the foundational principles that started AAEM, how these principles have become even more important in today's environment of increasingly corporate medicine, and of how no other organization in our specialty attempts to protect emergency physicians and their patients from corporate domination. Other plenaries included a fantastic ECG review by Susan Torrey and updates on critical care by Peter DeBlieux, on resuscitation by Corey Slovis, and on infectious diseases by Nilesh Patel. Mimi Lu gave a phenomenal talk on new topics in pediatrics. These plenaries are an important annual update in our emergency medicine knowledge base.

Chris Doty and Evie Marcolini were again co-chairs of the Scientific Assembly Subcommittee and wanted to bring new faces and fresh ideas to the forefront. Nowhere was that demonstrated better than in the Pecha Kucha session, directed by Gentry Wilkerson. This rapid-fire session of great ideas and myth-busting lessons had people spilling out into the hallway, so that we had to find a bigger room to house it. Joelle Borhart directed flawless pre-conference classes that included long-popular sessions such as resuscitation and ECG workshops, but also brought us new innovations with sessions on Emergency Neurologic Life Support, ultrasound, and simulation. The main-track speakers brought us great reviews of bread-and-butter topics, as well as education on topics we probably didn't even imagine when AAEM was founded. Who would have thought that we would be listening to folks teach about ECMO, active shooters, and transgender patient care when the Scientific Assembly was started? We had it all and then some, and in Las Vegas where the lights never go down.

We had an amazing team in putting together this conference. We are grateful to our subcommittee members, who volunteered to take time away from their day jobs to work on the Scientific Assembly. We were shepherded by the sage wisdom of Kathy Uy, whose attention to detail is unsurpassed. Also supporting us were AAEM staffers Emily, Janet, and Kay — who were the "boots on the ground" in getting this conference organized.

As we consider plans for AAEM's 2017 Scientific Assembly in Orlando, we look to you for ideas, thoughts and questions. This conference is for you; we strive to make it meaningful, fresh, and entertaining while keeping to the mission and values of AAEM. Please send us your thoughts and suggestions and join us next year in sunny Florida! ■


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# 22nd Annual Scientific Assembly Competitions Winners

**AAEM/*JEM* Resident & Student Abstract Competition Winners**
This competition is designed to recognize outstanding research achievements by residents and students in emergency medicine. Out of a total 73 submissions, eight were selected for oral presentation. The top oral presentations are as follows:

1st: Patrick C. Ng, MD
2nd: Patricia De Melo, MD
3rd: Daniel Krakauer

**Photo Competition Winners**
One hundred seventy-two original photographs were presented at the AAEM 22nd Annual Scientific Assembly in Las Vegas, NV. Photographs of patients, pathology specimens, gram stains, EKGs, and radiographic studies or other visual data were submitted. The top photos are as follows:

Right Arm Pain - Utsav Nandi, MD
Shortness Of Breath - Utsav Nandi, MD

**Diagnostic Case Competition**
The diagnostic case competition highlights the salient features of an ED case and a differential diagnosis is offered, and a logical discussion is provided to argue to a final diagnosis. Emphasizing the emergency medicine approach to the diagnostic reasoning that leads to a final diagnosis. Generally, the salient features of the case are highlighted, a differential diagnosis is offered, and a logical discussion is provided to argue to a final diagnosis. The top presentation was by:

Resident Presenter: Ian D. Storch, MD
Faculty Discussant: Robert P. Lam, MD FAAEM

**Open Mic Winners**
Assembly attendees had an opportunity to present a 25-minute lecture on any topic of their choosing, allowing 16 "new voices" in emergency medicine to be heard and evaluated by education committee members and conference attendees. The top two speakers will be invited to give a formal presentation at the 2016 Scientific Assembly in Las Vegas, NV.

Ryan Riberia, MD MPH
"Launching Medical Ventures: How to Change Health Care through Business Innovation"
Matthew C. DeLaney, MD FAAEM
"Against Medical Advance: High Risks Myths and Misconceptions"

**Emergency Medicine PA Fellowship Challenge Bowl Winners**
The 3rd Annual AAEM Emergency Medicine PA Fellowship Challenge Bowl is a friendly competition among Emergency Medicine PA Fellows designed to be entertaining and educational for students, faculty, graduates, and guests.

Garrett Scray, PA-C — University of Iowa
Josiah Horneman, PA-C — University of Iowa ■


# Inaugural "Women in EM" Track was a Big Success

Megan Healy, MD FAAEM
AAEM Board of Directors

This year's AAEM Scientific Assembly marked the first time a track on Women in Emergency Medicine was offered. The track brought experts on women's issues together with both academic and community-based emergency physicians of both sexes, to talk about challenges and opportunities for change in our specialty. Other sessions at the Scientific Assembly highlighted important gender issues, from sociolinguistics and its impact on trainee evaluations to gender-specific medical care in the ED.

The Women in EM track was sponsored by AAEM's new Women in EM Committee and featured Dr. Stephanie Abbuhl, a leader in the field of physician professional development and Executive Director of FOCUS on Health & Leadership for Women at the Hospital of the University of Pennsylvania, as well as Dr. Theresa Rohr-Kirchgraber, President of the American Medical Women's Association. Dr. Abbuhl defined the challenges for women in medicine, which include unconscious bias, promotion issues, and a paucity of models for leadership styles, among others. Dr. Rohr-Kirchgraber provided a helpful overview of negotiation — an important skill to master for women in EM. Her tips include doing your homework in advance, practicing the conversation with a friend or colleague, and remembering that everything is a negotiation. She pointed out that women are less likely to start the conversation and more inclined to take the initial offer, and suffer financially as a result.

> "The Women in EM committee plans to continue to bring great educational programming to our membership as we strive to recruit, retain and champion women in our specialty."

WOMEN IN + EMERGENCY MEDICINE

The track included a lively panel discussion with Dr. Lisa Moreno-Walton, Secretary-Treasurer of AAEM; Dr. Mimi Lu, winner of AAEM's 2015 Young Educator Award; and Dr. Robin Naples, frequent lecturer on the emergency medicine circuit and Associate Program Director at Temple University. They discussed the skills which have served them well in their careers, identifying the delegation of tasks, self-reflection, and assertiveness as essential. The larger group discussed practical ideas to help men and women balance work and family — things like splitting shifts, having childcare at the hospital, finding mentors, and using outside services for things like house-cleaning and meal preparation. The group also highlighted the importance of thinking more broadly about the issues facing women, remembering that whether single or married, caring for children or parents, working in the community or academia, we will meet a variety of obstacles and must collaborate in creating solutions.

The Women in EM committee plans to continue to bring great educational programming to our membership as we strive to recruit, retain and champion women in our specialty. This year's goals include designing awards to recognize female leaders in AAEM, building a password protected resource network for members to identify collaborators in their area of expertise, and collaborating with like-minded organizations like FeminEM (www.feminem.org). To be a part of these initiatives please sign up for the Women in EM committee (www.aaem.org/about-aaem/committees) or email megan.healy@tuhs.temple.edu. We would love your input and ideas! ■

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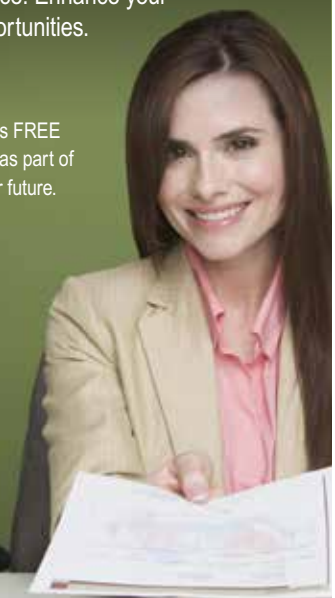

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AAEM/RSA President's Message

# Patient Satisfaction

Victoria Weston, MD
AAEM/RSA President

Patient satisfaction. It feels like sometimes the concept is overemphasized, yet another addition to the countless expectations and constraints placed on doctors. I have felt this way at times, but recently my thinking has shifted. Instead of trying to meet arbitrary Press Ganey requirements, I have focused on trying to understand patients' wants and needs in order to better connect with them.

I recently had a shift with what seemed an unusually high number of patients with difficult personalities and "supratentorial pathology." At times it was exceptionally frustrating, and although I started the shift feeling positive, by midway through the morning I could feel my spirits sinking. People had psychosomatic complaints. Some were drug-seeking and negotiating for narcotics. Some were demanding inappropriate care or tests. Some acted entitled and were rude to staff. I took this as a challenge, and tried to reframe my mind to see it as a learning experience in how to deal with difficult patients.

First, I decided to shift my perspective from my own objectives and workflow concerns to the point of view of patients. What do these people really want? Why are they in the emergency department? One of our faculty once wisely stated that people come to the emergency department because they are in pain or because they are afraid. Although it is impossible to like everyone, I tried to see parts of their experience through a different lens, as if they were a friend or family member or as if I were the patient.

For instance, one patient had a vascular malformation of the brain and had recently been discharged from inpatient neurosurgery service. She presented with mild and somewhat vague neurologic symptoms earlier in the day that had already resolved, and asked for an MRI. In addition, her husband was somewhat aggressive in asking for the MRI. Although their demeanor initially bothered me, I realized they were afraid. I put myself in the shoes of the patient and her spouse and tried to imagine how I would feel if I had a ticking time bomb inside my head. How do you know what to seek care for? When is it "the big one"? I realized that if I were in her shoes, I would not want to be in the ED and would want to return to my normal life as soon as possible. Rather than explaining that the test she was requesting was unnecessary and telling her what we were going to do, I instead asked her why she wanted the MRI and what she was hoping we could do to help her. I listened, and told her that I heard what she was saying and understood her frustrations.

When we got to the bottom line, they were in the ED for reassurance and because of poor discharge planning and unclear follow-up. They weren't sure what the signs of a recurrent bleed were, and she was afraid of a serious bleed if she stayed home. They said they would have waited, but didn't have an appointment with their specialist for another week. We did a CT, coordinated care with her specialists, and made sure she had a clear follow-up plan and a better understanding of return precautions. They left happy with their care and feeling better than when they came in to the ED.

Another patient was a morbidly obese man in his 20s with vague chest pain. After appropriate testing, including a normal EKG, we reassured him that his pain was likely musculoskeletal and were planning to send him home. Sometimes we tend to brush these patients off as anxious or as inappropriately using the health care system. However, I decided to spend some extra time talking with the patient. I told him that although we weren't concerned about anything life-threatening today, this was an opportunity to talk about his health and preventing heart disease in the future. We talked about his weight and his lifestyle – he opened up and told me he wanted to lose weight but didn't know where to start. He mentioned that he had a problem with sweets and had been to a fast-food chain earlier, where he ordered a supersized coffee drink with extra shots of chocolate and whipped cream. In the end, we made plans for him to make a few simple changes and to follow up with his primary care doctor to make additional plans to help get him on track.

People mourn the "lost" doctor-patient relationship in an era of incredible litigiousness and increasing pressures on our time and resources. We consider ourselves master diagnosticians, but we also have a chance to have an impact on the difficult or non-emergent patients we see. These encounters are opportunities for emergency physicians to help patients in ways other physicians may have overlooked. On the shift I described, I didn't do anything glamorous, didn't do any major procedures, didn't make any difficult diagnoses, and didn't make any great saves. What I did was provide reassurance, comfort, and patient education. These conversations took only a few minutes more of my time, but I believe more good was accomplished in them than in any amount of expensive lab tests and imaging I could have tossed at these problems. Sometimes the answer really is to spend more time talking with the patient. I left my shift feeling re-energized, feeling that I had taken a further step towards becoming a more compassionate and accepting physician. ■

# How Do I Know If I Go Too Slow? Improving Efficiency for Residents, Part 1

Gregory K. Wanner, DO PA-C
Thomas Jefferson University
Andrew W. Phillips, MD MEd
Stanford University, Division of Critical Care

Residency is a time for improvement. Improving procedural skills, gaining clinical acumen, and growing knowledge are chief goals during residency. Efficiency is also a necessary skill for the budding emergency physician. After learning the core knowledge of emergency medicine and becoming competent in procedures, efficiency is the next item for residents to emphasize. How can efficiency be improved? How can residents tell if they're moving too slowly or too quickly? How can a resident improve efficiency without missing important details or skimping on documentation? We will answer these questions in a two-part series. In this first article, we will review the average patient volume seen by residents, the concept of relative value units (RVUs), and touch on the idea of efficiency. In part two, in the next issue of *Common Sense*, we will discuss methods for improving efficiency based on expert recommendations and research.

## Patients Per Hour

Residents often ask, "How many patients should I see per hour?" The answer is complicated. A resident's patients per hour (pts/hr) rate depends upon many factors. Table 1 provides a general idea about the average number of pts/hr seen by residents. Several studies indicate that the pts/hr increases from intern year to senior year. However there is some overlap between each year of training. Across all included studies, interns (PGY1) averaged from 0.73 to 1.06 pts/hr; PGY2 residents ranged from 0.85 to 1.33; and senior (PGY3) residents ranged from 1.05 to 1.41.[1-8] Administrative and supervisory responsibilities also increased for senior residents, perhaps reducing the number of pts/hr for PGY3 residents to some degree.[3-4] As a comparison, two studies evaluated patients seen per hour by attendings. A retrospective study of 912 attending physicians at 61 EDs showed an overall average of 1.72 (SD=+/- 0.44) pts/hr, with physicians at higher volume (over 45,000 visits/year) EDs seeing 2.07 (SD=+/- 0.32) pts/hr.[9] Another study of attending physicians indicated an average of 1.87 pts/hr while working alone and 1.99 pts/hr while working with residents.[10] Bear in mind that this is at academic centers – by definition, since we're discussing residents. Moreover, the numbers reflect not only physician speed but also patient demographics, such as whether or not pediatric patients are included or if there is a Fast Track that siphons away less complex patients – factors which are generalized in our summary.

## Factors Affecting Efficiency

Several factors affect how many patients a resident sees per hour, including shift length, patient acuity, procedures, distractions, number of consecutive shifts, and the resident's level of training.[3-5,11,12] Many of these factors change on a regular basis. Other dynamics, such as patient boarding and the number of sign-outs, also likely influence the number of patients seen per hour. Interestingly, neither ED volume changes nor working with medical students appears to have a significant effect on patients seen per hour by residents.[1,3] Length of shifts and number of consecutive shifts can influence the volume of patients seen per hour. Longer shifts appear to reduce productivity, as reported in a study of PGY-2 residents who saw 1.15 pts/hr during 9-hour shifts and 1.06 pts/hr during 12-hour shifts.[5] Conversely, productivity appears to increase with each consecutive shift. One study showed all levels of residents increased their average number of pts/hr over three consecutive shifts. For example, PGY3 resident pts/hr increased from 1.19 to 1.24 to 1.33 over three shifts.[11] Distractions, however, can reduce productivity. Emergency physicians are interrupted an average of every 5.8 minutes and are required to unexpectedly switch tasks every 8.7 minutes. The number of distractions increases with each additional patient being managed simultaneously.[12] These factors should be considered when trying to increase clinical efficiency.

## The Value of Efficiency

Becoming more efficient in the ED will benefit your patients and will eventually be financially beneficial to you. Resident compensation is not based on productivity, but that changes for many attendings. Increased efficiency will typically lead to higher pay as an attending. Many attending jobs base compensation – either a portion or sometimes all – on productivity, often quantified by the relative value unit (RVU). The RVU is a calculation based on physician work, practice expenses, and malpractice insurance costs.[9,13] Using RVUs to estimate productivity is likely more accurate than simply looking at the number of patients seen per hour. Table 1 reviews two resident studies and one attending study reporting RVU values.[1,4,9] Both resident studies show an increase in RVUs for each year of training. One study reveals an increase in RVUs for PGY-3 residents despite a decrease in the number of patients seen per hour, compared to PGY-2 residents.[4]

## Increasing Efficiency

With so many uncontrollable factors, the natural question to ask is how to improve the factors that are within your control. Fair warning: there is little research and a lot of expert opinion, but the advice is theoretically quite sound. In the next issue we will share advice from experts and research findings on how to improve your efficiency – safely.

Continued on next page

| Table 1: | | Patients Per Hour & (RVU/hr) | | |
|---|---|---|---|---|
| Article | ED type | PGY 1 | PGY 2 | PGY 3 |
| Cobb, 2013[1] | Volume 70k/yr, tertiary care, academic ED (n=24 residents) | NR | 1.28 pt/hr (3.74 RVU/hr) | 1.39 pt/hr (4.03 RVU/hr) |
| Frederick, 2011[2] | 60k/yr academic ED (n=56) | NR | NR | 1.35 pt/hr |
| Jeanmonod, 2009[3] | 65k/yr tertiary care ED (618 resident shifts) | 0.85 pt/hr | 1.13 pt/hr | 1.25 pt/hr |
| Brennan, 2007[4] | 70k/yr tertiary care, 56 bed ED. (n=70) | 0.83 pt/hr (2.51 RVU/hr) | 1.11 pt/hr (3.51 RVU/hr) | 1.05 pt/hr (3.61 RVU/hr) |
| Deveau, 2003[6] | Two academic community EDs (n=19) | 1.06/hr | 1.33/hr | 1.41/hr |
| Debehnke, 2000[7] | 469 bed tertiary care ED (40,394 visits evaluated) | 0.79/hr | 1.2/hr | 1.22/hr |
| Langdorf, 1990[8] | 2 trauma centers & 1 suburban ED (n=33) | 0.73/hr | 0.85/hr | 1.19/hr |
| Vukmir, 2009[9] | 912 physicians at 61 EDs retrospectively reviewed | Attending physicians: 1.72/hr, (4.43 RVU/hr) | | |
| NR= not reported, RVU= relative value unit | | | | |


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# An Update on Oral Hypoglycemic Medications

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Editors: George Willis MD FAAEM; Michael Bond MD FAAEM

The WHO estimates diabetes mellitus (DM) afflicts roughly 9% of all adults in the world with type 2 DM representing 90% of all cases.[1] Within the United States, diabetes prevalence has more than tripled since 1980[2] and diabetic patients account for 12 million emergency department (ED) visits annually.[3] The development and approval of new pharmacotherapies has recently accelerated. This article reviews the Oral anti-Diabetic Agents (ODAs), their common adverse effects, interactions with other medications, patient traits which predict increased risk for adverse effects, and new strategies in the incorporation of insulin therapy with ODAs. Below is a basic summary of the agents adapted from two recent review articles[4,5]

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| **Biguanides**<br><br>*Examples*:<br>• Metformin | **Mechanism**<br>• Unknown but act via the signal transduction pathway of AMPK[6]<br>**Intended Effects**<br>• Decreases hepatic glucose output (partly by decreasing circulating free fatty acids available for gluconeogenesis)<br>• Improves uptake and use of glucose by the liver and muscles<br>**Adverse Effects**<br>• Lactic acidosis, especially in the setting of renal insufficiency<br>• GI symptoms such as diarrhea and metallic taste are common |
| **Sulfonylureas**<br><br>*Examples*:<br>• Glipizide<br>• Glyburide<br>• Glimepiride | **Mechanism**<br>• Bind the ATP-dependent potassium channels of the β-islet cells, changing the resting potential and decreasing the threshold stimulus needed for secretion<br>**Intended Effects**<br>• Increased insulin secretion at all blood glucose levels<br>**Adverse Effects**<br>• Higher mortality following acute myocardial infarction[7,8]<br>• Hypoglycemia, especially with glyburide and glimepiride, which have long half-lives<br>• Weight gain |
| **Meglitinides**<br><br>*Examples*:<br>• Repaglinide<br>• Nateglinide | **Mechanism**<br>• Regulate ATP-dependent potassium channels of the β-islet cells but at a different binding site than sulfonylureas<br>**Intended Effects**<br>• Increase insulin secretion with faster onset of action (15-30 min) and shorter duration than sulfonylureas<br>• Lowers post-prandial glucose levels more than sulfonylureas with less risk of hypoglycemia<br>• Wide range of doses before meals and flexible scheduling are advantageous for patients with varied eating schedules<br>• Repaglinide is hepatically metabolized and useful in patients with renal disease<br>**Adverse Effects**<br>• Hypoglycemia is a risk if taken without a meal<br>• No studies have examined if there are adverse cardiovascular events similar to those seen with sulfonylureas |
| **α-Glucosidase Inhibitors**<br><br>*Examples*<br>• Acarbose<br>• Miglitol | **Mechanism**<br>• inhibits α-glucosidase on the brush border of the intestines, which cleaves starch and disaccharides into glucose<br>**Intended Effects**<br>• Decrease post-prandial hyperglycemia<br>**Adverse Effects**<br>• Flatulence, bloating, diarrhea |
| **Glitazones (thiazolidinediones)**<br><br>*Examples*<br>• Pioglitazone<br>• Rosiglitazone<br>• Troglitazone | **Mechanism**<br>• Activate the Peroxisome Proliferator-Activated Receptors (PPAR) transcription factors, but different drugs have different targets (PPARα and PPARγ1 and 2)<br>**Intended Effects**<br>• Increase the use of glucose by peripheral muscle and fat<br>• Decrease glucose output by the liver<br>• Induce fat storage<br>**Adverse Effects**<br>• Peripheral edema (PPARγ stimulates $Na^+$ resorption)<br>• Macular edema<br>• Weight gain<br>• Increased incidence of heart failure<br>• Rosiglitazone increases Major Adverse Cardiovascular Events (MACE)<br>• Possible increase in the risk of bone fractures |

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| **Incretins**<br>*Examples:*<br>Endogenous Incretins<br>• Glucagon-Like-Peptide 1 (GLP1)<br>• Glucose-dependent Insulinotropic Polypeptide (GIP)<br>Mimics<br>• Exenatide<br>• Liraglutide<br>DPP-4 Inhibitors<br>• Sitagliptin<br>• Saxagliptin<br>• Vildagliptin | **Mechanisms**<br>• Direct agonists of the GLP-1 receptor<br>• Inhibit the enzyme which eliminates the incretins<br>**Intended Effects**<br>• Stimulate development of β-cells and inhibit their apoptosis<br>• Increase glucose-stimulated insulin secretion by the pancreas<br>• Decrease glucagon secretion by inhibiting α-cells<br>• Decrease gastric emptying<br>• Decrease appetite via hypothalamic stimulation<br>**Adverse Effects**<br>• Vasodilation, but this may be beneficial effect for hypertensive patients<br>• Pancreatitis and pancreatic metaplasia seen with DPP-4 inhibitors<br>• Nausea seen with supraphysiologic GLP-1 stimulation of mimics<br>• Renal elimination – not for use with GFR<30mL/min |
| **Sodium Glucose co-Transporter 2 Inhibitors (SGLT-2 inh)**<br>*Examples*:<br>• Canagliflozin<br>• Dapagliflozin<br>• Empagliflozin | **Mechanism**<br>• SGLT-2, found exclusively in the proximal tubules of the nephrons, has increased expression in type 2 DM and blocking its activity decreases the resorption of glucose from urine<br>**Intended Effects**<br>• Promote excretion of glucose into the urine during periods of hyperglycemia<br>**Adverse Effects**<br>• Dehydration<br>• Increased incidence of urinary tract infections |

**Bottom Line**: ODAs may cause prolonged hypoglycemia which warrants observation. When advising Emergency Medical Services (EMS), ODAs must be considered when determining the need for transportation to the ED and to determine appropriate therapy in the field. For example, drinking a glass of orange juice will not reverse hypoglycemia in a patient taking acarbose or miglitol, since they prevent fructose from being broken down and absorbed in the small intestine. Instead, pure glucose must be used. Additionally, ODAs should be considered as potential causes for nausea, vomiting, symptoms of heart failure, and lactic acidosis, especially in the setting of acute changes in renal function.

### Asche CV, McAdam-Marx C, Shane-McWhorter L, et al. Association between oral anti diabetic use, adverse events and outcomes in patients with type 2 diabetes. *Diabetes Obes Metab.* 2008 Aug;10(8):638-45.

Despite the increasing variety in ODAs, those most often prescribed are metformin, sulfonylureas, and thiazolidinediones. This retrospective cohort analysis of 14,512 patients 18 and older with type 2 DM on monotherapy with metformin, sulfonylureas or thiazolidinediones analyzed the first 395 days of therapy for the following adverse events specific to each agent: diarrhea, nausea or vomiting, abdominal pain, dyspepsia, lactic acidosis, hypoglycemia, weight gain ≥ 4.5 kg, dizziness, headache, heart failure, edema, or elevated liver enzymes.

Total adverse events occurred in 8.6% of patients taking metformin, 15.9% taking a sulfonylurea, and 19.8% taking a thiazolidinedione. Abdominal pain and dyspepsia (5% each) were the most common adverse effects associated with metformin. Weight gain was the most common side effect of both sulfonylureas and thiazolidinediones but the second most common effects for these agents were hypoglycemia (3.0%) and edema (5.3%), respectively. Patients taking sulfonylureas and thiazolidinediones were 2 and 2.5 times more likely to have adverse events than those taking metformin.

**Bottom Line**: When encountering diabetic patients with lactic acidosis, hypoglycemia, symptoms of heart failure, or elevated liver enzymes, medication adverse events should be considered.

### Quilliam BJ, Simeone JC and Ozbay AB. Risk Factors for Hypoglycemia-Related Hospitalizations in Patients with Type 2 Diabetes: A Nested Case-Control Study. *Clinical Therapeutics* 2011;33(11):1781-1791.

This large, nested, case-control study of hypoglycemic events used health care data claims between 2004 and 2008 to identify patients with type 2 DM who were taking at least one ODA for at least 12 months. From this cohort, 1339 cases of patients with identified hypoglycemic events requiring inpatient medical intervention were identified. Index density sampling was used to identify controls with 10:1 matching for a total of 13,390 control patients.

For all of these patients, the following data points were extracted: pattern of ODA use (continuous or intermittent), previous visits for hypoglycemia, complications associated with diabetes, other medications associated with hypoglycemia, and other medical comorbidities. The authors used logistic regression models to identify predictors of hypoglycemic hospitalization. The prevalence of comorbidities was higher in cases than controls (Charlson comorbidity index of 1.7 compared to 0.4 for controls), including complications of diabetes (13.4% and 5.3% respectively). The greatest predictors of admission for hypoglycemia were: previous ED visits (OR=9.48; 95% CI, 4.95-18.15) and previous outpatient hypoglycemia visits (OR=7.88; 95% CI, 5.68-10.93).

The use of metformin had a lower rate of hypoglycemia admissions when compared to sulfonylureas (OR 2.25) and thiazolidinediones (OR 1.22). Intermittent use of ODAs increased the risk of hypoglycemia.

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**Bottom Line**: In addition to the specific medication, the manner in which ODAs are taken is a predictor of adverse events. Intermittent thiazolidinedione use increases the risk for inpatient admission. Metformin may be a safer medication for patients with normal renal function as it has a decreased risk for inpatient admission, even if taken intermittently.

**Seufert J, Brath H, Pscherer S, Borck A, Bramlage P, Siegmund T. Composite efficacy parameters and predictors of hypoglycaemia in basal-plus insulin therapy--a combined analysis of 713 type 2 diabetic patients. *Diabetes, obesity & metabolism.* 16(3):248-54. 2014.**

Stepwise progression of therapy for type 2 DM traditionally begins with an oral regimen and sequentially adds insulin to achieve glycemic control as the disease progresses. Traditionally, insulin is added as a once-daily basal injection without change to ODAs, called Basal insulin supported Oral Therapy (BOT). Later, prandial injections are added, called basal-bolus therapy. This article explores an intermediate step between BOT and basal-bolus therapy, meant to avoid the frequent injections, weight gain, and other side effects of basal-bolus therapy. Called basal-plus, this therapy consists of a daily basal insulin injection and a short-acting insulin injection with the main meal of the day, as opposed to with each meal. The authors present a meta-analysis of 4 trials aimed at determining the efficacy and safety of transitioning patients from BOT to basal-plus therapy using glulisine. Endpoints included glycemic control and hypoglycemic events. The authors also focused on risk factors which may predict hypoglycemic events in patients undergoing basal-plus therapy.

They found a reduction in the average HbA1C from 7.6% to 7.1% for patients receiving basal-plus therapy and 45% of patients on this regimen achieved their A1C target. However, only 14.6% were able to do so without weight gain or any hypoglycemic event. Predictors of symptomatic hypoglycemic events were: female gender (OR 1.89), more than 10 years of DM duration (OR 2.01), and higher baseline glargine dose (OR 1.01 per unit). There were no predictors of severe hypoglycemia (BS < 36), but the low incidence of events (n=12) limits interpretation. A BMI > 30 was found to be protective against hypoglycemia (OR 0.61).

There are significant limitations to this study including its retrospective nature and the low number of severe hypoglycemic events.

**Bottom Line**: This is an attractive alternative for patients who do not want an insulin injection with each meal. EM providers need to know that patients who are female, long-term diabetics, on high doses of basal insulin, or non-obese have an increased risk of hypoglycemia with this regimen.

## Conclusion:

Type 2 DM is an increasingly common disease, treated with an expanding list of ODAs with increased risks of adverse events ranging from hypoglycemia to heart failure. As providers we need to ask about recent additions of ODAs and intensification of existing therapy. We should refresh our knowledge of the duration of action of these medications and be familiar with how they may affect our typical methods of rescue from hypoglycemia. We should also suspect adverse drug events when encountering nausea, anorexia, dehydration, and peripheral edema. The gender, body habitus, duration of DM, medication types, doses, and adherence should all warn of potential adverse events and influence disposition.

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# Mentorship: The Key to Success

Mike Wilk, MS4
AAEM/RSA Medical Student Council President

Sitting down at one of my residency interviews this past year, the program director caught me slightly off guard when he asked, "What do you think it takes to be successful?" After a skipped heartbeat and scrambling to think of an answer, I said, "strong mentorship." Even if I had more time to think of a different response, I do not think any other answer could be closer to the truth. No matter how big or how small, a major key to success has always been having strong and honest mentorship along the way.

The whole reason I chose to pursue emergency medicine was that, as a premed and medical student, I had great mentors in the field. They were always people I greatly admired who encouraged me to pursue EM as a career. They were the type of people I aspired to be, ten or twenty years down the line. While I considered other fields besides emergency medicine and enjoyed nearly all of them, it was always the people in EM that brought me back.

Not a lot makes sense as you make your way through medical school and the Match process, but having those people there to support you really does make the difference. No one makes it through medical school alone, whether it's your friends, family, classmates, residents, or faculty mentors.

Besides the many emergency physicians who have given me good advice, I have also found that great advice comes from those just a year or two ahead of me. Many have just gone through the hoops and stressors that we as medical students are currently experiencing, and there is no one better to guide you through the process. When you are struggling or unsure of the next step to take as you advance through training, these are usually the people to turn to.

Finally, don't forget to lend a hand to those behind you. Keeping in mind how much it meant to have so many people mentor me over the past several years, it is now my turn to help, advise, and mentor those following a similar path – and it's your turn too. As medical students, we often don't realize just how much knowledge and skill we gain month by month throughout our medical training. From premeds to our more junior classmates, there is nothing more valuable we can offer them than mentorship. ■

# ABMS Seeking Visiting Scholars

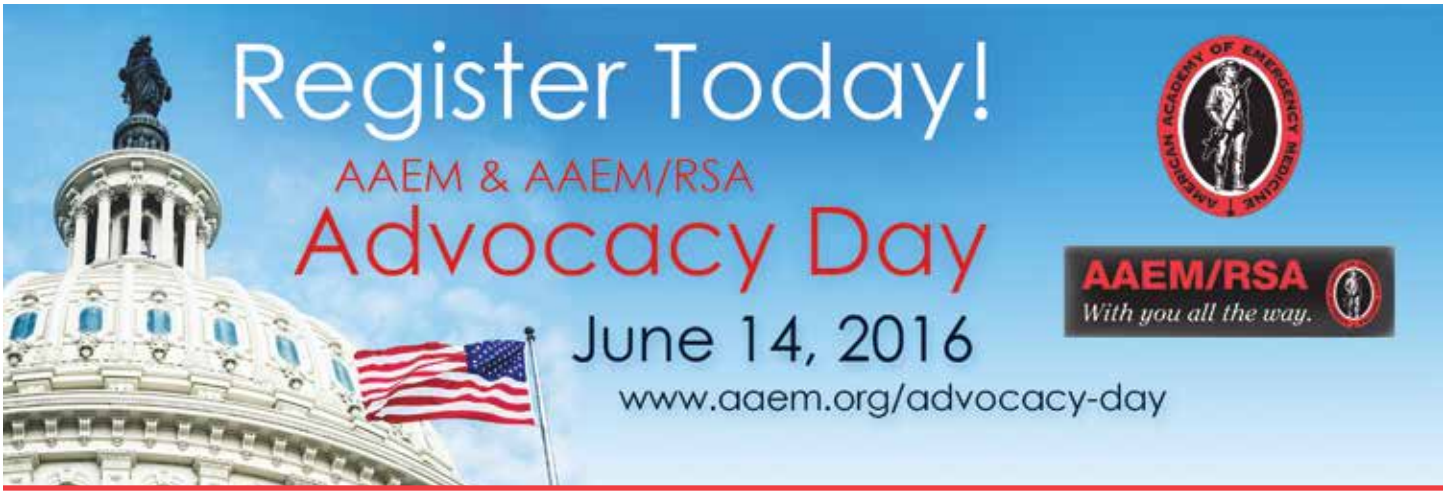
The American Board of Medical Specialties (ABMS) Visiting Scholars Program is accepting applications for the 2016-2017 class. Junior faculty, Ph.D.s, residents, fellows, medical students, public health students, and graduate students in health services research and other relevant disciplines are invited to apply to participate in this exciting and dynamic, one-year, part-time program facilitating research projects designed to improve patient care. In addition to the research project, scholars are exposed to the fields of professional assessment and education, health policy, and quality improvement, and are offered the opportunity to develop leadership skills critical to their own professional growth and success. Scholars' research should build on existing projects at their institution and generate data, tools, and activities that could be useful to specialty boards in the board certification and MOC processes.

An ABEM diplomate was selected for each of the first two classes of scholars:

Michelle Lin, MD MPH, a Health Policy Research Fellow at Brigham and Women's Hospital, and Nadia Huancahuari, MD MA, an Instructor of Emergency Medicine at Brigham and Women's Hospital. Dr. Lin examined whether community health workers and enhanced provider engagement improve the quality and cost of care for patients who frequently visit the emergency department (ED). Dr. Huancahuari is examining whether language differences contribute to disparities in ED sepsis care, and her work will include the development of a sepsis MOC module and chart review activity that will instruct ED providers on early recognition of sepsis and the effects of Sepsis Bundle completion on survival.

**The deadline to submit applications is May 31, 2016.** For more information about the program and the application process, contact ABMS at ABMSVisitingScholars@abms.org. ■

# Travel to Capitol Hill: Meet Representatives & Discuss Policy Issues

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- You will be placed in a small group with several other fly-in participants and accompanied by a guide from Williams & Jensen, that will know their way around the Hill and take you from meeting to meeting, and will carry handouts from AAEM to leave behind at offices
- You will have lunch with a Member of Congress relevant to emergency medicine and health care policy
- You will have an opportunity to network and spend time with fellow AAEM and AAEM/RSA Members throughout the day and during the debrief on Capitol Hill immediately following the day's meetings

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