THE NEWSLETTER
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

VOLUME 20, ISSUE 6
NOVEMBER/DECEMBER **2013**

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INSIDE

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~ELECTION~ ISSUE

SPECIAL ELECTION ISSUE

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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)
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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 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $150 (Non-voting status)
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Transitional Member: $55 (voting in AAEM/RSA elections only)
International Resident Member: $25 (voting in AAEM/RSA elections only)
Student Member: $25 or $55 (voting in AAEM/RSA elections only)
International Student Member: $25 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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President's Message

Meaningful Reform

William T. Durkin, Jr., MD MBA FAAEM

As I write this column we are in the throes of a government shutdown and a looming debt-ceiling crisis, while Congress finds a way to pay for promised benefits with insufficient funds. Then there is the initiation of the ACA (aka Obamacare), with all the bureaucratic snafus that go along with most new government programs. There should be fewer uninsured once the computers and websites are fully operational. However, many health care systems are cutting back their work forces in anticipation of decreased reimbursements. Obscured by these stories are reports from states such as North Carolina, New Hampshire, and Massachusetts of new transparency laws — the first step to true health care reform.

Transparent hospital charges will allow patients to compare rates for different hospitals online, much the way they select airfares and hotels on Expedia. Presently, patients are blind to these charges. It is not uncommon for two hospitals in the same metropolitan area to have radically different rates for similar emergency, inpatient, and outpatient services. Having that information at hand would be very valuable to any patient with a high deductible or limited insurance coverage. The other important piece of information is quality data. That would not be difficult to compile in the age of computerized records. Having cost and quality data on hospitals would greatly aid any patient in selecting a hospital. Institutions that are overpriced will either need to become more efficient or justify their higher price by demonstrating superior outcomes, better service, etc. As ACOs come into play, reimbursements will be further squeezed and hospitals and providers will need to improve efficiency and demonstrate better outcomes.

Of course, this works only if patients have some responsibility for their health care costs. Some "skin in the game," if you will. Consumers become much more interested in the cost of services when they actually bear some of those costs. High-deductible policies and health savings accounts have become more popular in recent years. They are cheaper to buy but also place the consumer at some financial risk. We see this in practice, as when a patient inquires about the cost of a prescription versus those who want the Z-Pack for a URI because they are responsible only for a $5 co-pay, making cost no object for them. Patients tend to be more discriminating when they must bear some out of pocket costs.

The other piece of the puzzle that must be put into place is to make health insurance portable, available across state lines, and independent of employment — just as auto and other types of insurance are today. It is hardship enough to lose a job, but to lose your health insurance at the same time compounds the disaster. Sure, COBRA extensions are available, but they are very costly and have an end-date. If employers who provide health insurance instead provided an allowance, whereby employees could purchase their own policy based on their own needs and budget, things would be less complicated. The policy then belongs to the individual, who wouldn't be tied to a particular job by the need to hang on to insurance. Currently, if you have auto, life, or disability insurance you can keep those policies no matter where you work or live. Health insurance should be the same way. To me it makes more sense than hiring only part-time employees to get around ACA rules.

Of course, the final reform I would like to see is comprehensive tort reform. Numerous studies have documented the unnecessary costs associated with defensive medicine. It is in the billions of dollars. Most physicians do their very best for their patients. We pride ourselves on the excellence of the care we provide. An unexpected outcome or less than perfect result should not mean a lawsuit costing tens of thousands of dollars just to defend, not to mention the associated time lost from work and the significant emotional distress that goes with being accused of negligence.

As shown by Studdert, et al., (*N Engl J Med* 2006;354:2024-33), 40% of malpractice claims involve either no injury at all or no error — not just no negligence, but no error — yet 16% of no injury claims and 28% of no error claims still result in a payment to the plaintiff. And for the latter, the average payment is over $313,000. What's more, the average lawsuit takes over five years to resolve. I have seen several excellent emergency physicians leave the specialty, totally disillusioned after such an experience. This is a loss to their communities as well as the specialty, and this is one of the reasons AAEM favors tort reform beyond caps on noneconomic damage awards.*

In the state where I received my first medical license, in order to bring a malpractice suit a plaintiff had to have the case reviewed by a panel consisting of a physician, an attorney, and members of the community. If, after reviewing expert testimony, they thought the plaintiff had a good case, the case could proceed. If not, the plaintiff could still proceed but had to post a bond to cover defense costs in the event of defeat. Not a bad system — too bad it fell by the wayside! Some states have legislated meaningful tort reform. Texas recently passed a law that states there must be "willful and wanton" misconduct for a successful malpractice suit. That raises the bar significantly! Others have caps on pain and suffering awards. An interesting system is the one in New Zealand, where they have socialized medicine. When there is a claim of malpractice all parties are brought to the table, the case discussed, and an agreement made right there. Any monies paid are paid by the state. While I am not sure we would ever get to that point, I do think that malpractice claims should be taken out of the courts and reviewed by unbiased panels. Of

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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.

course the devil is in the details, and the trial lawyers would block that as best they could, but the current situation is unbearable.

As we work our way through the present iteration of health care reform, we should bear in mind that true reform requires transparency in cost, quality, and outcomes; consumers must bear some responsibility for the cost of their health care; health insurance should not be linked to employment but rather owned by the insured, as is the case with other types of insurance; and tort reform must occur, so that physicians can practice to the best of their abilities without the fear of being hauled into court just because of an untoward outcome.

*A gross negligence standard for malpractice in emergency care is much more preferred than the currently, more common, ordinary negligence standard. See our White Paper on Tort Reform for more information. (http://www.aaem.org/em-resources/position-statements/tort-reform). ■

AAEM/RSA Advocacy Day was a Success!

On October 9, 2013, AAEM and AAEM/RSA members traveled to Capitol Hill to meet with congressional leaders, to learn about health care issues, and to advocate for emergency medicine.

Advocacy Day participants

(L-R) AAEM/RSA President Dr. Meaghan Mercer; Rep. Joe Heck (R-NV); and AAEM President Dr. William Durkin

(L-R) AAEM/RSA President Dr. Meaghan Mercer; Rep. Diane Black (R-TN), a former ED nurse; and AAEM President Dr. William Durkin

(L-R) AAEM/RSA President Dr. Meaghan Mercer; Ganesh Nagaraj, RSA Advocacy Committee member; Rep. Eric Swalwell (D-CA); and AAEM President Dr. William Durkin

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Join In

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board of Directors

As I write this column I have just returned from Marseille, France, and the seventh Mediterranean Emergency Medicine Congress (MEMC). This meeting occurs every other year and is cosponsored by AAEM and the European Society for Emergency Medicine (EuSEM), as well as the emergency medicine society of the host country. This is always a good meeting, not just because it is held in great locations like Nice, Sorrento, Valencia, the Greek island of Kos, etc., but because it is so interesting to meet emergency physicians from all over the world. The differences in how emergency medicine is done around the globe are fascinating, but what constantly amazes me is how much emergency physicians have in common, no matter where we are from, and how our struggles and those of our specialty are similar everywhere. If you haven't yet been to one of the international emergency medical meetings that our Academy cosponsors, I urge you to go to the eighth MEMC in 2015, the second PEMC (Pan-Pacific Emergency Medicine Congress) in 2014, or the next Inter-American Emergency Medicine Congress (IAEMC) in 2014. AAEM dominates the U.S. end of international emergency medicine, and you should take advantage of that — if you don't already.

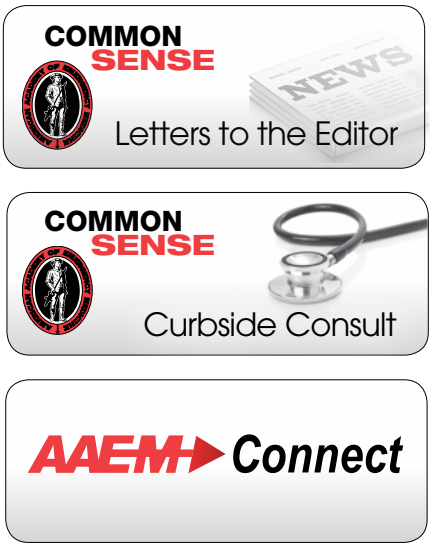
Coming up more immediately, however, is the most important meeting of the year: the Academy's 2014 Scientific Assembly at the New York Hilton Midtown, February 11-15. If you don't attend AAEM's Scientific Assembly, you are missing out on an incredible opportunity: a chance to network with the best emergency physicians in the country, see old friends, interact with emergency physicians of similar ethics, and get the best emergency medicine CME available anywhere — designed specifically for board-certified specialists in the field. In short, a chance to renew your spirit and get smarter at the same time, and all of this in New York City, home to thousands of great restaurants, Broadway, and one of my favorite museums in the whole world, the Metropolitan Museum of Art. (For those of you who don't know me, I am a hopeless museum geek. My wife and I spent a few days in Paris on our way back from Marseille, mainly so I could visit the Louvre and the Musee d'Orsay. I have now been to what I believe are the top ten museums in the world, and can die happy).

There are plenty of self-interested reasons for you to attend, but I want you to be there for another reason too, a reason that is less obviously self-interested. **AAEM needs you**. The Academy needs your active participation, which means coming to the annual business meeting. There you will hear our president's yearly update on AAEM's activities and the state of the Academy, hear from candidates for office and the board of directors, get the chance to ask them questions, and then vote people into or out of those positions. Of course you should read the written candidate statements carefully, but there is nothing like being face-to-face with the candidates and asking them questions.

Not everyone in the Academy can or should run for the board of directors or an executive office, or chair a committee, but I firmly believe that all of us should come to every Scientific Assembly and attend the annual business meeting. That's just good AAEM citizenship, like jury duty and informed voting are good U.S. citizenship. And unlike the situation in our national politics, there is no justification for adopting libertarian humorist P.J. O'Rourke's stance on voting: "Don't vote, it just encourages the bastards" (http://www.c-spanvideo.org/program/296475-1).

I am a Founding Fellow of AAEM, and in the 20 years of my membership I have never once had to vote for a candidate who I thought was the lesser of two evils. My dilemma is almost always having to choose between excellent candidates, a painful but pleasant problem to have. And unlike some medical societies, AAEM is a direct democracy. You won't be voting for representatives to an assembly, which then votes people onto some kind of council, which then chooses the leadership from a preselected and limited slate of candidates. You will be voting directly to choose the leaders of our Academy — one member, one vote, majority rules — simple and clean. Come to NYC and be part of that. And if you see me there, whether at the SA or in the Met, let me know what you think of *Common Sense*. Join in! ■

We're listening, send us your thoughts!



Letters to the Editor

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board of Directors

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

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make *Common Sense* an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the "Letters to the Editor" feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

Letter in response to the July/August "Law and Emergency Medicine" article titled, "Medical Liability and the Emergency Physician: A State by State Comparison — Part 1."

Good Afternoon,

I have been a member for a year or two and found the article on state malpractice from Greg Roslund very interesting. I am interested in the states Nevada and Louisiana. When are the following articles coming out?

Sincerely,
— Charles Todd, MD FAAEM

The next installment of Dr. Roslund's series on the medical tort climate in each state, Georgia through Maine, will appear in the Jan/Feb issue. That will take care of Louisiana for you, with Nevada in the following installment. I am glad you find the series useful. Dr. Roslund put a tremendous amount of work into it. ■

— The Editor

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Health Care Reforms Play Central Role as Government Shuts Down Over Fiscal Debate

Williams & Jensen, PLLC

The House and Senate returned in September from a month-long recess, and started negotiations on a pair of major fiscal issues: government funding and the nation's debt limit. The current funding agreement expired on September 30th, and without a deal, a partial government shutdown commenced on October 1st — the first day of fiscal year 2014. The last shutdown occurred in 1995 and carried over into 1996, spanning 21 days.

The shutdown was the result of an impasse over funding for the Affordable Care Act (ACA), better known as "Obamacare." The House passed three separate short-term continuing resolutions (CRs) to keep the government funded for the next several months, but attached a variety of ACA-related measures, all of which were subsequently "tabled," or killed, by Senate Majority Leader Harry Reid (D-NV). The amendments included: (1) one year delay in ACA implementation; (2) one year delay in the ACA's individual mandate; (3) repeal of the ACA's 2.3 percent excise tax on medical devices; and (4) requiring Members of Congress, congressional staff, and political appointees to enroll in the ACA exchanges without an employer subsidy for coverage. With House leadership in a stand-off with Senate leadership and the administration, the funding issue could continue to dominate the D.C. landscape for the remainder of the year.

Further, the U.S. Department of the Treasury has estimated that the nation's debt limit will be reached by October 17th at the latest, and lifting this cap will also require congressional action. There have been discussions about attaching a number of health care provisions as part of a proposal to raise the debt ceiling, although these decisions are not final and the introduction of this legislation had been put on hold as Congress turned its full attention to the government shutdown. Health care provisions that were considered included: (1) enact medical liability reform that is estimated to reduce the federal deficit; (2) increase Medicaid means-testing; (3) adjust payments to disproportionate share hospitals; and (4) defund the ACA's Prevention and Public Health Fund.

The congressional agenda will likely continue to be centered around fiscal issues for the remainder of 2013, although Congress must eventually pivot to other end-of-year priorities, including the Medicare Sustainable Growth Rate (SGR) and other revenue measures that expire at the end of the year. However, with the focus on larger fiscal issues the House and Senate do not appear poised to finalize any other major legislative priorities, but any "grand bargain" style negotiations that are commenced between Congressional Republicans and the administration may pull in other budget issues like SGR.

CBO Releases Score of House SGR Repeal Bill

In September, the Congressional Budget Office (CBO) released its cost estimate for House SGR repeal legislation (H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013). According to the analysis, the legislation and its permanent SGR repeal will cost $175.5 billion over the next 10 years. The total cost is consistent with CBO's most recent estimate that freezing SGR payments would cost roughly $140 billion over the next 10 years. CBO estimated that the new payment system included in the House bill will cost an additional $36 billion. The legislation updates Medicare payment rates until 2019, and is then replaced with two new payment models.

The bill was introduced by Representative Michael Burgess, MD (R-TX), and would repeal and replace the SGR with a new policy to change physician payments in two phases: (1) permanently repeal SGR and replace it with a five-year period of stable physician payments; and (2) create an Update Incentive Program that would link payments to quality of care. The legislation would also allow physicians to opt out of the fee for service (FFS) program and participate in alternative payment models (APMs). H.R. 2810 was reported unanimously from the House Energy & Commerce Committee this summer, but the legislation did not include any provisions to offset the cost of the bill.

The House Ways & Means Committee may also convene a markup on "doc fix" legislation later this year, although the timing of this effort is unclear. Given the cost of full repeal, the best opportunity for permanent SGR reform remains a congressional "grand bargain" on government funding, debt, entitlement reform, and taxes. If this kind of deal is not secured, the House and Senate will attempt to work together on another temporary SGR fix (one to two years) to prevent the 25 percent Medicare reimbursement cut set to begin on January 1st.

Congress on Track to Send Emergency Epinephrine Bill to President

On October 2nd, the Senate Health, Education, Labor, and Pensions (HELP) Committee is set to hold a markup on H.R. 2094, the School Access to Emergency Epinephrine Act. Backers of the legislation expect bipartisan support for the bill, which was already passed by the U.S. House of Representatives in July. If the legislation is reported with bipartisan support in committee, the sponsors will seek to pass the bill by Unanimous Consent (UC) in the Senate, meaning that there will be no debate or amendments to the measure. Passage in the Senate would send the bill to President Obama for his signature.

The legislation would encourage states to enact laws that require schools to plan for severe allergic reactions by allowing the Department of Health and Human Services (HHS) to give funding preference to states for asthma-treatment grants if they meet the following requirements: (1) maintain a supply of epinephrine; (2) allow trained school personnel to administer epinephrine; and (3) implement a plan to ensure that trained personnel are available during all hours of the school day. Under the legislation, states must also certify that their laws have been reviewed to ensure that liability protections are afforded to school staff who have been trained to administer epinephrine.

H.R. 2094 represents a delicate compromise on medical liability language, which has been an issue of particular contention between

Continued on next page

Congressional Republicans and Democrats. Last year several House Committees advanced a number of medical liability reform bills that were passed by the House but not acted on by the Senate.

ACA Implementation Continues; Enrollment Begins October 1st

On October 1st open enrollment began for the ACA's health insurance exchanges. As expected, there were a number of glitches associated with the roll-out, with Democrats claiming success and Republicans citing access problems and delays.

The Administration made a number of high-profile announcements regarding implementation of the ACA in advance of October 1st. The U.S. Department of Health & Human Services (HHS) announced a delay in online enrollment for small businesses seeking to participate in the Small Business Health Options Program (SHOP) exchanges. HHS officials indicated that small businesses can begin enrolling online in November. Meanwhile, reports surfaced that the website designed for Spanish-language speakers to enroll in the health insurance exchanges would also not be ready by October 1st. A number of Congressional Republicans have said these reports are further evidence that the ACA should be delayed for a year, as part of the government funding measure or legislation to increase the debt ceiling.

The Centers for Medicaid and Medicare Services (CMS) announced that it had granted a waiver for Arkansas' Medicaid expansion proposal. With this waiver, Arkansas will be allowed to use funding to purchase private health insurance plans for Medicaid enrollees under the Medicaid expansion. Iowa has submitted a proposal to CMS that would allow for similar coverage under the state's Medicaid expansion, and Pennsylvania has also had discussions with CMS about this type of plan.

At the end of August the Internal Revenue Service (IRS) released the final rule on the ACA's individual mandate, entitled "Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage." The rule provides guidance to individual taxpayers on their liability under section 5000A of the Internal Revenue Code, for a penalty for failing to maintain minimum essential coverage. The rule provides clarity on the monetary fine that non-exempt individuals must pay if they do not obtain health insurance. In year one, the penalty is $95 or one percent of household income, and gradually increases to $695 or 2.5 percent of household income in 2016. After 2016, individuals are penalized based on a cost-of-living formula applied for that calendar year.

The rule also finalizes a number of exemptions for individuals that do not have to pay the penalty. Exempt individuals include those that have their health coverage lapse on a temporary basis between jobs. Many of these exemptions were previously outlined in proposed rule published earlier this year. Notably, the rule also exempts Medicaid-eligible individuals that live in states that have not participated in the ACA's Medicaid expansion. Michigan became the 25th state to approve the Medicaid expansion, while 21 states have decided not to approve the expansion. The penalty for individuals who do not maintain minimum essential health coverage goes into effect on January 1, 2014.

Key House Committees Release Medicare Reform Paper

Republicans on the House Ways & Means Committee and House Energy & Commerce Committee released a joint white paper entitled, "Modernizing Medicare for the 21st Century." The document, which is subtitled, "Why Medicare is Outdated and Beneficiaries Deserve Better," is the first in a series of Medicare policy papers to be released by the two committees. The paper reviews: "(1) the traditional Medicare cost-sharing framework and the impact current thresholds have on beneficiaries — often leaving them unprotected against catastrophic costs; (2) the impact of supplemental coverage with low cost-sharing requirements that reduce incentives to seek cost-effective care; and (3) how modernizing the traditional cost-sharing features could better align beneficiary incentives, ensure beneficiaries greater out-of-pocket predictability and reduce overall Medicare costs."

The document recommends that structural reforms to Medicare should make the program easier to navigate, protect seniors, and reduce costs. It includes several potential changes to the traditional Medicare benefit structure, including the establishment of a single combined annual deductible for Medicare Parts A and B and a simplified coinsurance rate that is applicable to spending above the unified deductible. The paper discusses at length the need to enact reforms that protect Medicare beneficiaries from catastrophic costs.

According to the committees, the additional policy proposals that will be released over the next several months will identify flaws in the existing traditional Medicare framework and propose and seek public feedback on additional Medicare reform concepts.

CMS Requests Comments on Potential Release of Medicare Physician Data

In August, CMS reached out to stakeholders in the physician community to request public comment on policies with respect to the disclosure of individual physician payment data. The document cited CMS's commitment to data transparency, including the release of information on hospital charges for common inpatient services, which received considerable news coverage earlier this year. It also noted a recent legal development in which a Florida court lifted a permanent injunction issued in 1979, which prevented the agency that preceded HHS from disclosing annual Medicare reimbursement payments in a way that was identifiable at the individual physician level.

AAEM submitted a comment letter that highlighted its mission to support fair and equitable practice environments for emergency physicians, including the principal of "open books." As part of the release of this data, AAEM strongly encouraged CMS to produce a separate document that goes directly to the individual physician that discloses how much the physician received from Medicare during the reporting period. The physician can then compare this data with reports from the contract management group or billing company. AAEM cited the benefits of a transparent system that will result in better patient outcomes and more efficient Federal health care programs. AAEM also asked that CMS consider including several disclosure statements to accompany the release of this data, including a note that the monies listed may not be paid directly to the physician, and that the data does not represent the final amount of money earned by physicians in exchange for their services — but is reimbursement before malpractice insurance, billing, and numerous other costs inherent to the expensive practice of medicine. ■

Blast from the Past

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board Member

Throughout 2013, *Common Sense* has been celebrating AAEM's twentieth birthday by reprinting articles from its first few issues. In this next to last installment of "Blast from the Past," we instead reprint the Academy's recruiting pamphlet from 1994. Enjoy. ■

American Academy of Emergency Medicine

Membership Fees:

FULL VOTING MEMBER (BOARD CERTIFIED IN EMERGENCY MEDICINE OR PEDIATRIC EMERGENCY MEDICINE)	$195.00
RESIDENTS AND FELLOWS	$ 50.00
ASSOCIATE MEMBERS (NON-VOTING STATUS, PHYSICIANS, HOSPITAL ADMINISTRATORS, NURSES, HEALTH POLICY PLANNERS, ETC.)	$100.00
LIFETIME MEMBER	$2500.00

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AAEM

American Academy of Emergency Medicine
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Santa Fe, NM 87504
1-800-884-AAEM

when minutes count

Please make checks payable to the American Academy of Emergency Medicine.

QUESTIONNAIRE RESULTS

Source: 14,363 AMA list of Emergency Physicians; 1000 random sample

- *87% of Emergency Physicians believe that ACEP policy should be changed to allow candidates to run from the membership at large with a ONE PERSON/ONE VOTE system enacted.*
- *70% of physicians believe ACEP most closely represents the interests of multi-hospital contract companies and sole proprietors.*
- *91% of Emergency Physicians would prefer to work in democratic groups. Only 4% wanted to work for multi-hospital contract companies.*
- *84% support national emergency medicine reform which requires that professional income of emergency physicians be derived from those medical services rendered to the patient by the physician or under the physician's direct, personal, and continual medical direction.*
- *94% of Emergency Physicians support national emergency medicine reform which affirms that exploitation of emergency physicians by other emergency physicians is unacceptable, unethical behavior.*
- *48% feel than an alternative organization to ACEP is needed to change present national emergency medicine policy.*

when minutes count

An Exciting New Chapter in Emergency Medicine is Beginning!!

Why do we need a new organization, The American Academy of Emergency Medicine, as the voice of the Specialist Emergency Physician?

The American College of Emergency Physicians (ACEP) has embarked upon a short and long-term strategy which is destructive to the development of the specialty of Emergency Medicine.

This strategy is contrary to the interests of the vast majority of Emergency Physicians. Because of the prior leadership and the non-democratic nature of ACEP, these destructive strategies are virtually impossible to change.

A random survey of Emergency Physicians demonstrated that 91% would prefer to work in democratic groups. Only 4% wanted to work for multi-hospital contract companies. 87% of the surveyed Emergency Physicians would like to see a democratic election process in ACEP. 94% of the Emergency

Continued on next page

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Physicians who responded to the survey believe that exploitation of Emergency Physicians is unacceptable ethical behavior.

The problem is that ACEP apparently has become the servant of the exploitative multi-hospital groups and no longer listens to the membership. The multi-hospital groups are eroding respect for our profession, decreasing our "job satisfaction" and siphoning off vast sums of money from Emergency Physicians' fees.

We have not worked diligently for many years to create a cadre of migrant hourly workers to be exploited by unethical contract management groups. The once idealistic American College of Emergency Physicians has developed serious internal problems and is no longer looking out for the best interests of the field of Emergency Medicine and the membership of ACEP.

The remedy is the **American Academy of Emergency Medicine** (AAEM). The time is right for the voice of the Emergency Medicine Specialist to be heard with strength and clarity. We are in a time of crisis in Emergency Medicine. Many Specialist Emergency Physicians are deeply concerned. We must protect and nurture our specialty, ensure physicians' well-being and assure quality care for our patients.

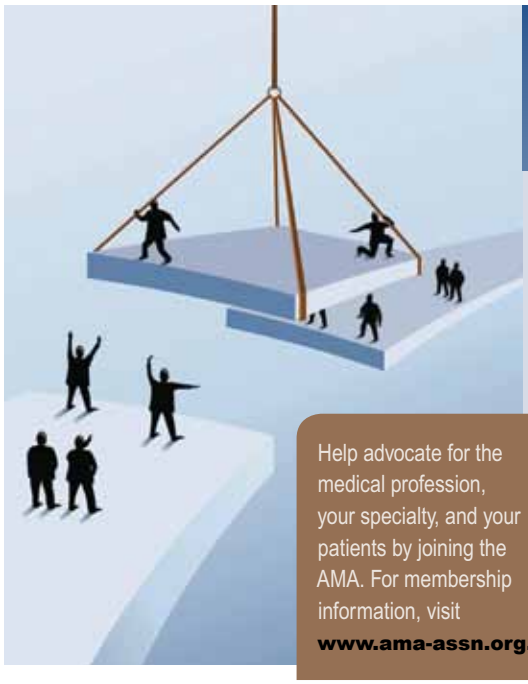
Why the Strategy of the American College of Emergency Physicians (ACEP) is Failing its Membership:

DID YOU KNOW THAT:

- ACEP refused to allow any discussion of resolutions concerning multi-hospital contract groups at the annual meeting in 1993.
- More than half of the past 21 presidents of ACEP are involved with contract groups.
- ACEP refused to allow its membership list to be used for an opinion survey of its membership regarding contract management companies.
- At the annual ACEP meeting in 1993 discussion was not allowed on a resolution concerning exploitation of Emergency Physicians.
- Members of ACEP pay large membership sums to a non-democratic organization whose short and long-term strategies are opposed to the desires of the vast majority of its members.
- The *vice-speaker* of ACEP is a large contract holder. The vice-president is associated with a large contract group as is the immediate past president and many members of the past and present board of directors.

The American Academy of Emergency Medicine Offers:

- Voting membership restricted to board-certified Emergency Physicians (through ABEM) or to those certified in Pediatric Emergency Medicine
- Democratic and open elections
- A professional stance opposed to the exploitative multi-hospital groups which are threatening the integrity of our profession
- Reasonably priced CME designed for the Specialist Emergency Physician
- A newsletter and plans for linkage with an established journal
- A broad view of health care reform and awareness of the need for Emergency Physicians to become deeply involved in important cost-saving and productivity-enhancing measures
- Support for equitable contract relationships, anti-profiteering legislation and the overall well-being of the Emergency Physician
- Governmental and legislative involvement
- Fellowship status



Help Us Bridge the Gap

Join the AMA!

Having the support of physicians from many specialties can help us resolve some of EM's most important problems. Currently, AAEM has no seats in the American Medical Association (AMA) House of Delegates (HOD). Help us reach our goal of 50% of AAEM members also holding membership in the AMA so we can add our voice to the deliberations with a seat in the HOD.

Help advocate for the medical profession, your specialty, and your patients by joining the AMA. For membership information, visit www.ama-assn.org.

Help advocate for the medical profession, your specialty, and your patients by joining the AMA. For membership information, visit **www.ama-assn.org.**

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 1-1-13 to 9-17-13.

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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Upcoming Conferences: AAEM Sponsored and Recommended

AAEM is featuring the following upcoming endorsed, sponsored, and recommended conferences and activities for your consideration.

For a complete listing of upcoming endorsed conferences and other meetings, please log onto: http://www.aaem.org/education/aaem-recommended-conferences-and-activities.

February 11-15, 2014

- 20th Annual Scientific Assembly
  New York, NY
- Preconference Courses
  February 11, 2014
  Advanced Ultrasound
  Introductory Ultrasound
  Resuscitation for Emergency Physicians
  Pediatric Emergency Department Simulation: Critical Skills from Delivery to Stepping on the School Bus
  Health Care Reform: Is Your ED Prepared? The Operations Management Perspective (Presented by the Operations Management Committee) — 2 day course

  February 12, 2014
  High Risk Electrocardiography
  Living the Tactical Life: Lessons and Skills from Tactical Military Medicine (Jointly sponsored by USAAEM)
  Medical Student Track
  http://www.aaem.org/AAEM14

March 15-16, 2014

- 3rd Annual FLAAEM Scientific Assembly
  Miami, FL
  www.flaaem.org

Do you have an upcoming education conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Emily DeVillers to learn more about the AAEM endorsement and approval process: edevillers@aaem.org.

All sponsored and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

AAEM-RECOMMENDED CONFERENCES

November 22-24, 2013

- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

December 8-13, 2013

- 34th Annual Current Concepts in Emergency Care
  Wailea, HI
  www.emergenciesinmedicine.org

March 14-16, 2014

- The Difficult Airway Course: Emergency™
  Orlando, FL
  www.theairwaysite.com

April 4-6, 2014

- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

May 2-4, 2014

- The Difficult Airway Course: Emergency™
  Boston, MA
  www.theairwaysite.com

May 30-June 1, 2014

- The Difficult Airway Course: Emergency™
  Dallas, TX
  www.theairwaysite.com

June 11-14, 2014

- International Conference on Emergency Medicine (ICEM 2014)
  Hong Kong
  www.icem2014.com

September 12-14, 2014

- The Difficult Airway Course: Emergency™
  Baltimore, MD
  www.theairwaysite.com

November 14-16, 2014

- The Difficult Airway Course: Emergency™
  San Diego, CA
  www.theairwaysite.com

The Business of Emergency Medicine

ED Claims Management: Clearinghouse vs. Direct Filing

Kelly Davies, MS
Vice President of Operations
Medical Management Professionals

How emergency medicine (EM) groups manage their revenue plays a critical role in their profitability. As Lee Iacocca once said, "You can't do today's job with yesterday's methods and be in business tomorrow." The financial health of a practice depends on timely, accurate coding and billing that leads to fast and fair reimbursement from payers (insurers), and minimizes reliance on out-of-pocket payments by patients. A key decision in revenue cycle management is choosing how to submit claims — either by using a clearinghouse or filing directly.

A clearinghouse assists with the claims management portion of the revenue cycle, and can be used by either a billing company — if the billing company doesn't provide this service in-house — or the medical practice itself to file claims quickly and accurately. Filing separate claims directly with payers slows down the reimbursement process tremendously, and it does not allow the biller to see where the claim is in the billing process. A clearinghouse is essentially a giant database and software tool that gives billing companies and practices the ability to file claims with a variety of payers with one click of a button, as opposed to sending out one claim at a time to each payer. It also allows the biller to see the status of each claim, reasons for denials, days in accounts receivable, etc. In addition, a clearinghouse provides for the instant resubmission of erroneous claims that have been corrected.

Transparency Crucial to the Billing Process

Transparency allows a view of each step in the claims process, ensuring appropriate reimbursement for all services rendered. Clearinghouses provide an easy way to view all claims in the billing cycle in one location. Practices can also access tools that help them analyze and enhance productivity, ultimately increasing revenue. For instance, a practice might look at how many claims were filed per specific payer, days in accounts receivable, number of claims denied, or the RVUs generated by each physician. With access to this kind of data, a practice can make month to month comparisons in order to benchmark for improvement. While transparency is possible with both a clearinghouse and direct filing, it is much more difficult to view the status of all claims when a practice chooses to file directly, because a clearinghouse offers the entire gamut of electronic information in one place with a few clicks of a button. Compare this to filing claims directly with each payer, and then waiting to hear back from each payer on the status of each claim.

This is a simplified step-by-step description of the billing process:

Front-end Processes

- Coding — Assures correct procedure and diagnosis entry into the billing system, and involves routing specific types of dictated reports to coding specialists.
- Charge Reconciliation — Reconciles hospital events with billing system entries for every procedure or case.
- Claims Management — Assures claims are properly entered and submitted to payers. Clearinghouses provide web-based feedback on claims within minutes and allow changes to be made online.
- Payment Posting — Allows patients to pay bills online through payment portals and allows electronic posting of third party payments.

Back-end Processes

- Denial Management — Minimizes claim denials using compiled information about payers and previously denied claims.
- Reimbursement Tracking — Provides rapid access to accurate information on whether payers are paying at the practice's contracted rate.
- Eligibility Verification — Verifies third-party coverage for patients who the hospital lists as self-pay. This step can also be considered a front-end process.
- Reporting — Runs online, comprehensive, analytical reports on a practice's operational and financial data.

The Evolution of Claims Filing

With the passage of HIPAA in 1996, claims filed on paper forms began to disappear and electronic usage began to grow fast. By mandating electronic health care transaction standards, including the ANSI X12 837 standard for health care claims, HIPAA truly revolutionized the claim filing process. These standards lessened the technology burdens associated with electronic filing, allowing physician practices and small businesses to take advantage of electronic efficiencies.

Despite this, the reimbursement process remains cumbersome and confusing. Electronic claim submission is easier, but it has enabled each payer to institute complex and highly specific coverage and reimbursement rules. As a result, health care providers need equally sophisticated technology to identify errors before claim submission, and to reconcile claims, payments, and contracts to ensure that the proper reimbursements are being received. A clearinghouse can help:

- File clean claims expediently
- Beat filing deadlines
- Ease secondary filing
- Generate reports that aid in future error reduction
- Post payments automatically
- Verify patient eligibility

Proactive Efficiency in Claims Editing

When a practice or billing company works with a clearinghouse, they accumulate one entire batch of insurance claims and then submit them in one file to the clearinghouse. The clearinghouse then breaks out the different insurers and transmits all the claims files directly to the

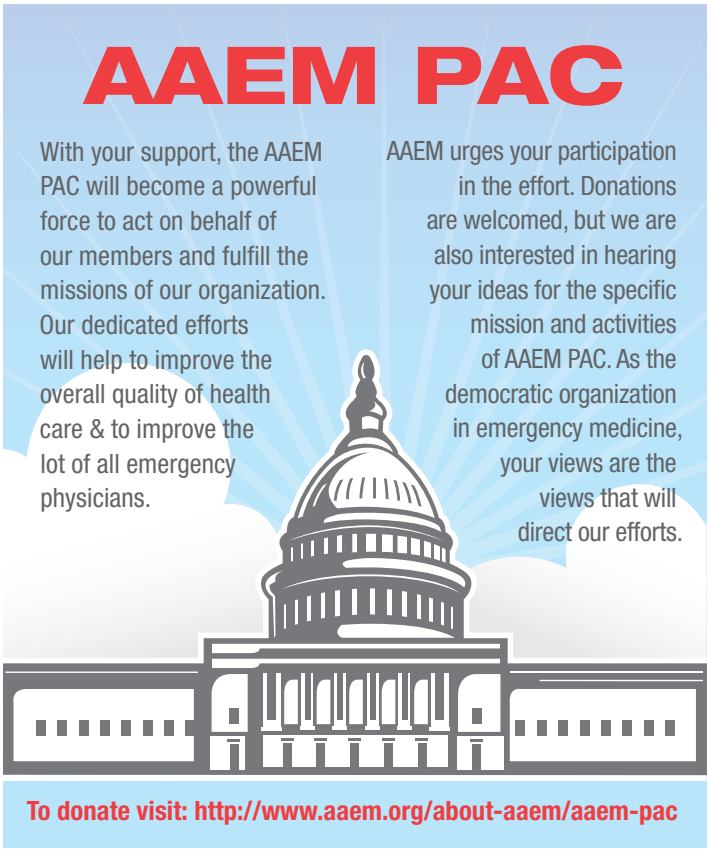
Continued on next page

appropriate payer — usually with the click of a button. It then tracks and reports on the results of those claims, allowing all rejections to be viewed on one dashboard. Rejected claims are ready for correction and re-filing immediately, and future rejections are reduced because the clearinghouse maintains a database of rejected claims and the required corrections, and going forward screens claims for errors and corrects them before submission. This shortens accounts receivable (A/R) turnaround times. With direct filing, verification reports and tracking details are received individually from each payer. Thus, a practice is forced to look at each payer in a separate dashboard to manage claims and remittances.

A clearinghouse can also help with Medicare's Physician Quality Reporting System (PQRS) and the opportunity for increased physician reimbursement that goes with it. For example, clearinghouses use an "edit wizard" on the front-end of the process, before the claim is submitted to Medicare. The wizard scrubs the claim and notes whether it is PQRS-eligible via a designated CPT code. Any required additional information is provided, including modifiers that make the claim eligible for a PQRS bonus.

A Dashboard with Business Intelligence

Clearinghouses also provide the advantage of billing intelligence, which means practices can often foresee business trends and respond strategically. A good dashboard shows all trends in denials across all payers in one place. A practice can view trends, be it a rejection from all payers or just one, which helps in coding and productivity. When filling directly a practice would need to work with each payer individually to identify a trend or the reason behind an ongoing error.



Not All Clearinghouses Are the Same

The business models and service offerings of clearinghouses in the market today vary dramatically. On one end of the spectrum are vendors who offer little more than claim submission and payment tracking services. On the other are vendors who complement basic clearinghouse services with tools to reduce denials, automate manual tasks, and ultimately improve their client's business performance from patient check-in to final payment. The best vendors offer proactive and comprehensive customer support and training to help their clients.

Getting What You Pay For

Cost is something that a practice should consider if it wants to work with a clearinghouse. Practices often use a clearinghouse in addition to having an in-house coding and billing operation or outside billing company. Clearinghouses have several different fee structures:

- Per claim
- Per practice volume
- By the number of providers
- A combination of the above

Filing directly is less expensive, but a practice will get what it pays for in limited information and claims that are manually inputted by personnel who work harder rather than smarter. Billing companies often bundle the clearinghouse function — and its cost — in with their other services such as coding, file maintenance, process management, upkeep of submission formats, and continuous knowledge of the requirements of all individual carriers. With the added revenue that would otherwise be missed, a practice usually gets a nice return on what it pays for clearinghouse services.

In closing, a good clearinghouse streamlines the claims management process and provides transparency in the billing cycle. It is important that a practice understand its options: work directly with a clearinghouse, use a billing company that works with a clearinghouse, use a comprehensive billing provider that includes clearinghouse functions in its services, or manage claims entirely on its own.

Kelly Davies, MS, is the Vice President of Operations for Medical Management Professionals, Inc. (MMP) in its East Region Office in Knoxville, Tennessee. She is a member of the Medical Group Management Association, Radiology Business Management Association, American Healthcare Radiology Administrators, and the Society for Computer Applications in Radiology. Ms. Davies graduated from the University of Tennessee with a Bachelor's degree in English Literature and obtained her Master's of Science degree in Executive Leadership and Organizational Change from Northern Kentucky University in Cincinnati, Ohio. ■

View from the Podium

Michael L. Epter, DO FAAEM
Chair, Education Committee

"Start spreading the news … I want to be a part of it New York, New York …"

Scientific Assembly 2014 is almost here! This premier educational event will take place in the Big Apple at the New York Hilton Midtown, February 11-15th, 2014. As we draw nearer, it's never too early to start getting excited about Scientific Assembly — so let's do it! The highlights presented below culminate the work of a simply outstanding educational team and committee work. Here's a sneak peak at what promises to be a fantastic event that has come to define our organization.

Preconference offerings on February 11th and 12th include:

- Resuscitation for Emergency Physicians
- Health Care Reform: Is Your ED Prepared? The Operations Management Perspective — presented by the Operations Management Committee
- Introductory Ultrasound & Advanced Ultrasound
- High Risk Electrocardiography
- Living the Tactical Life: Lessons and Skills from Tactical Military Medicine — jointly sponsored by USAAEM
- Pediatric Emergency Department Simulation: Critical Skills from Delivery to Stepping on the School Bus!

Given the success of the 2013 Scientific Assembly format and to further increase the opportunities for networking, the 2014 program will incorporate an additional half day and will begin on February 12th at 1pm.

The conference will have nine robust plenary sessions with a mixture of clinical updates as well as critically important topics about the changing landscape of health care and the impact of these changes on our practice. Topics include:

- Lessons Learned from Unforeseen Tragedies — William V. Begg, III, MD; Paul D. Biddinger, MD FAAEM; John F. Brown, MD MPH
- What Would Osler Think? How Social Media Will Change Your Practice of Emergency Medicine — Michael C. Bond, MD FAAEM

Clinical plenary sessions with preeminent speakers include:

- Best of the Best in Cardiology — Amal Mattu, MD FAAEM
- Best of the Best in Pediatrics — Ghazala Q. Sharieff, MD MBA FAAEM FACEP
- Best of the Best in Resuscitation — Corey M. Slovis, MD FAAEM
- Best of the Best in Infectious Disease — David F. Gaiseki, MD
- Best of the Best in Neurology — Stuart P. Swadron, MD FAAEM
- Best of the Best in Trauma — Bernard L. Lopez, MD MS FAAEM
- Updates in Toxicology — Cases from the Front Lines of the New York Poison Control Center — Robert S. Hoffman, MD

In keeping with the spirit of providing attendees a cutting edge conference, with up-to-date results oriented and clinically relevant didactic sessions, the following new tracks have been added for 2014:

- In a New York Minute — Critical Care in Your ED
- You Want Me To Do What? Consultant Requests — Dogma or Substance?
- Novel Approaches to Vulnerable Patient Populations
- Advances in Ultrasound — Hype or Help?
- Provider Beware! Simple Complaints that Can Take a Turn for the Worse
- We Should Do _____ More Often: New Standards or Wild West Emergency Medicine?

These new tracks complement the timeless attendee favorites:

- Point-Counterpoint — Hot Button Topics!
- Pediatric Emergencies — Not Just Younger Adults
- Nuts and Bolts of Emergency Medicine Practice
- Emergency Imaging

Specialty Tracks for 2014 include:

- Getting Techy With It! Information Technology for EPs (developed by Michael C. Bond, MD FAAEM)
- 2nd Annual International Emergency Medicine Education Track
- EMS Track

If you think it couldn't get any better than all of the content listed above, IT CAN! On the afternoon of February 13th, we will pilot a track wherein speakers will be given a topic and have six minutes and 40 seconds (20 slides with 20 seconds per slide) to present "just the facts." This high yield format has gained widespread acceptance in the Pan-Pacific and internationally and promises to be a hit at Scientific Assembly.

We are proud to offer the first "Emergency Medicine Physician Assistant Fellowship Challenge Bowl" and to bring back after a successful inaugural year the "Diagnostic Case Competition." For additional information and solicitation of cases visit www.aaem.org/AAEM14/competitions.

Other annual favorites to round out the program:

- Open Mic — to provide AAEM members the opportunity to expound on a cutting edge topic of their own by presenting a 25 minute lecture on a topic of their choosing. The top speaker(s) will be invited to give a formal presentation at the 2015 Scientific Assembly in Austin, TX.
- Emergency Medicine Photo Contest
- AAEM/*JEM* Resident and Student Research Competition
- RSA/YPS Track — including the Resident In-Training Exam Review
- Medical Student Track — February 12th, 2014
- 2013 LLSA Review Track

As customary for the conference, there is no registration fee for AAEM members (deposit is refundable). For more information, visit www.aaem.org/AAEM14 and don't forget to register for the preconference courses at the discounted member rate.

Expect nothing less from your professional organization — the best emergency medicine CME at no charge in a prime location presented

Continued on next page

by top clinician educators in emergency medicine. AAEM Scientific Assembly — perpetually advancing emergency medicine for the clinician, proudly a premier educational conference.

As always, contact me anytime (michael_epter@dmgaz.org) with your comments/suggestions as to how the committee, Scientific Assembly, and the organization itself can be at the forefront in EM education by offering you content and resources that you rely on to treat the people that matter most — our patients.

"Come on, come to … New York, New York, New York." ■

www.aaem.org/AAEM14

JOIN A Committee!

The ACCME Subcommittee, a branch of the Education Committee that maintains AAEM's CME Program, is actively recruiting members.

Subcommittee activities include:

- Ensuring that each educational activity meets the criteria set forth by the Accreditation Council for Continuing Medical Education (ACCME)
- Reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly sponsored activities to ensure all ACCME guidelines are met and the appropriate number of CME credits are determined

To learn more about the responsibilities of all of our committees and to complete an application, visit: www.aaem.org/about-aaem/leadership/committees

Through the Patient's Eyes: Waiting for Test Results

Craig Norquist, MD FAAEM
Chair, Practice Management Committee

Having a serious medical ailment, or even thinking that you do, is undoubtedly one of the greatest sources of stress and anxiety one can experience in a lifetime. As emergency physicians (EPs) we unknowingly contribute to this stress — often hidden by the patient — by not communicating updates or test results in a more proactive fashion. While being ill is frightening enough, that fear is compounded during the diagnostic testing and waiting period. I believe that, with greater awareness of how and when we communicate what's to come during a patient's time with us in the emergency department, we can reduce patient anxiety — even if just a little.

This past May, I had a lump in my arm that was biopsied and proved to be non-Hodgkin's lymphoma. Additional tests were required to properly stage the disease and determine the course of treatment, not unlike other ailments. As I recall the internal conversation in my mind, I wanted — no, I needed — the tests, results, and course of action settled right away. Interestingly, I did not communicate my sense of urgency to my physicians; I just expected they would act with urgency — and not because of my position in the hospital system. Being medical staff president, working in an efficient hospital system with connections in many departments, I undoubtedly had the best care available at that very moment, and it was great. But I still had to wait, and along with waiting the anxiety continued to build. The waiting was hours, days, and sometimes weeks. Being diagnosed with cancer of any kind is a struggle enough by itself. Having to wait to find out how extensive it is or what the treatment plan will be is another level of stress and emotional turmoil that is hard to express. Having no answers leads to dwelling on worst-case scenarios, and even to considering "What if they are not telling me everything to protect me?" The mind can run wild with fear and ridiculous thoughts of what might be going on.

The variability in waiting times can be attributed to busy physician schedules, weekends, or just general schedule conflicts, since I was still working shifts. But I do believe there is a way to curb some of the waiting-induced stress, through a better setting of expectations and communication of even preliminary results.

It seems that on every shift, and almost with every patient, we are pressured for the results of blood tests, pregnancy tests, X-rays, or scans. We are pressured by throughput time metrics from our groups, our hospitals, ourselves, and now even CMS. It's hard not to push back with some snide remark like, "Well, it's a lot faster than your doctor could get in the office," or the honest but often unappreciated, "We're really busy today." It is so much easier to wait for everything to come back and then "close the deal" with the patient, with all the results and your plan in one visit back to the bedside. That makes sense in our world and in our minds, but for the patient it is often an excruciating wait. That is how I often worked in the department, and I thought it was working well — for me at least. Then I became a patient, and things changed.

Not that every patient in the department has a life-changing diagnosis like cancer, or even a complex diagnosis or ailment, but the waiting is similar. Often the patient has made the mistake of looking his symptoms up on the internet and already has a worst-case scenario in mind. Sometimes patients are embarrassed but will tell us they have already researched their symptoms, and will tell us exactly what their fears are. Other times, in some sort of weird "guess what I'm thinking" game, they intentionally test us to see if we bring up their worst-case scenario. To us, patients with abdominal pain are a challenge: make sure that they don't have appendicitis, diverticulitis, cholecystitis, or some other –itis, and get them out the door as fast as possible. To the patient, "This horrible pain in my abdomen is surely cancer, since my friend who is a premedical student pressed on it and felt a mass." If we don't know what patients are thinking, we will never meet their expectations for the visit.

With the number of tubes of blood, urine samples, X-rays, CT scans, and ultrasounds some patients get in the ED, combined with the lack of information or feedback on results, time in the ED can become a frustrating and difficult experience for both patient and provider. Giving continual updates on both positive and negative test results, even if you have no idea what is going on yet, serves to prove to the patient that

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you are keeping their condition on your mind and that you haven't forgotten them. It also calms the idle mind with little bits of positive reinforcement like normal kidney function or normal white blood cell counts, and it gives them the opportunity to ask questions that they might have forgotten to ask earlier. For some EPs, the fear of being asked numerous questions and getting trapped is the greatest reason to not go back into the room. If done correctly, however, and if patients feel you will truly return, they often respect your time and ask a few detailed questions at a time. This will usually prove easier to handle than a multitude of questions at the end of the visit when trying to wrap-up.

Frequent visits also give you repeated opportunities to adjust expectations to a reasonable level. The patient who fears he might have colon cancer can get some tests to suggest otherwise in the ED, but we know that he will ultimately need a colonoscopy. Hearing that several times is more likely to stick with patients and family members than one closing discussion, such as "All of your tests here are normal but you should follow up with your primary care doctor or a GI doctor for more testing."

I ultimately had all the blood tests, PET scans, biopsies of lymph nodes and bone marrow, etc. I have the privilege of checking my own test results if they are done in my hospital system, and did so frequently. Tests done outside my system proved to be frustratingly unavailable, forcing me to wait and think worst-case until my next appointment or until the oncologist called with results. Fortunately, my cancer is slow-growing and does not currently require chemo. Unfortunately, I still do research on the internet and come across survival rates, drug side effects, and other horrible things that may never apply to me — which doesn't stop my mind from racing into worst-case scenarios. In one day I've gone from thinking about where I'll be buried to thinking that I might never need chemo, often several times per day — and I'm a (somewhat) educated patient.

Put yourself in the place of patients, and maybe then you can understand their anxiety over getting the test results they need to put their racing minds at ease. By treating each patient the way I want to be treated, more patients and family members are thanking me and asking if I have a practice outside of the department, as they want me to take care of them long term. To me, that is one of the greatest compliments we can get in our specialty. My length of stay times have not crept up, and I leave each shift with a better feeling about having really helped some patients. I urge you to give it a try and see how much your patients appreciate being kept up to speed on what is going on. ■

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AAEM: The Trusted Advocate of Fairness in Emergency Medicine™

John Christensen, MD FAAEM

The Academy is considering the launch of a major new initiative in support of principles 4 and 5 in its mission statement:

The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the American Academy of Emergency Medicine.

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.

Many emergency physicians (EPs) have been exploited as revenue-generating commodities, almost since emergency medicine's (EM's) inception. At the root of this exploitation is over 30 years of distortion in the process of assigning a fair market value (FMV) to EM management services. EPs have been deprived of *critical details* on the business of EM, and this has resulted in the disenfranchisement of the physicians at the very heart of our specialty — those whose expertise and medical licenses allow them to render patient care in the emergency department (ED). Perhaps most disturbing of all, EPs who have dared to question the fairness of certain business schemes have been terminated from their positions without being afforded due process or peer review. A culture of intimidation has thus pervaded the workplace for many EPs. AAEM believes that a fair and equitable practice environment is essential for EPs to provide the highest quality patient care. Any intimidation, whether subtle or overt, undermines patient care. Because a significant number of EM business entities have corrupted the fair market valuation process, and because countless EPs have suffered from lack of due process, a *trusted advocate of fairness in EM* is needed.

On December 3, 2012, AAEM's board of directors unanimously approved my proposal for AAEM to explore the feasibility of becoming *The Trusted Advocate of Fairness in Emergency Medicine*™. This would include the establishment of a *Practice Fairness Council (PFC)*™ and the continued development of an *AAEM Practice Fairness Toolkit* (the *Toolkit*)™. As the first three members of a planned nine-member *Practice Fairness Council*; Mike Pulia, Bob McNamara, and I hope to be joined by six more AAEM members with a passion for taking the concept of defining "fair and equitable practice arrangements" to its highest level.

Before addressing the "how" and the "why" behind this potential new benefit for AAEM members, we must start with several key definitions. *Trust* is defined as a "firm belief or confidence in the honesty, integrity, reliability, or justice of another person or thing."[1] A *trustee*, in a broad sense, is anyone standing in a position of trust or responsibility for the benefit of another.[2,3] The duties of a trustee, which may be fiduciary, include commitments to be impartial and loyal, not to seek profit from the relationship of trust, to avoid conflicts of interest, and to administer and advise in the best interests of those depending on the trustee.[4,5] An *advocate* is one who assists, defends or pleads for another.[6] Though *not* functioning as a trustee in a legal sense, a *trusted advocate* may choose to embrace the *qualities* of a trustee in advancing fairness in the practice of emergency medicine. The definition of *fairness* is discussed below and will appear in expanded detail in the full version of this article, posted on the AAEM website.

With the sweeping changes in the U.S. health care system driven by the Patient Protection and Affordable Care Act, I believe that fairness is the single most important concept in the entire reform process. I recently asked the head of a large EM group to define fairness in EM. His reply was both candid and alarming: "I don't like that word. I don't know what that word means — it means different things to different people." Fortunately, explicit definitions of fairness and fair market value do exist. The *Toolkit* rigorously addresses the determination of fair market value and is designed as a comprehensive, dynamic, evolving document open to input from interested AAEM members. Academy members will have access to a powerful analytical instrument, to help guide the employment decisions that determine the trajectory of their careers.

And now, the all-important "why" at the heart of this initiative. While inroads have been made to support fair practice environments — largely as a result of AAEM — the Academy believes that contract management groups (CMGs) have refined their strategies to obscure the fair market value of both management services and EM practices. CMGs now use phrases like "the feel of a local group," "quality of life," "democratic," "truly democratic," "transparent," "physician-owned," and "partnership" as smokescreens to hide steep organizational hierarchies, inflated compensation arrangements for physician executives, corporate profiteering, and pyramid growth schemes that victimize emergency physicians. A number of smaller EM groups with lopsided ownership models are equally culpable. Newly minted EPs continue to be the target of recruitment activities that prey upon their lack of access to the truth about the employment arrangements available to them. As a *Trusted Advocate of Fairness in Emergency Medicine*, the *Practice Fairness Council*, informed by the application of the comprehensive AAEM *Practice Fairness Toolkit* and rendering opinions on the fairness of business arrangements, would go a long way towards eliminating this problem.

Emergency medicine needs a *trusted advocate* charged with promoting due process and truly fair negotiations, to ensure that employment arrangements between EPs and any contracting entity, large or small, are based on fair market values. And fairness extends not only to initial employment agreements, but to internal operations as well, where EPs may be the victims of management policies that exploit and subjugate them. The *Practice Fairness Council* can support AAEM members who are seeking due process after being sanctioned for questioning the fairness of a business model.

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A *trusted advocate* can thus protect medical professionalism and ultimately promote the highest quality of emergency care. Because medical staff bylaws at every hospital charge the medical staff with continuously improving the quality of care, the trusted advocate — as a protector of medical professionalism — can enhance the EP's alignment with the medical staff. This helps shift the emphasis back where it belongs: to the emergency physician providing patient care, rather than on the management entity profiting from the EP's labors.

Fair Market Value Standards: Clear evidence that fair market value matters in emergency medicine — just as it matters everywhere else.

Multiple public policies underscore the importance of fair market value (FMV) concepts and standards, and a broad consensus of business valuation standards has at its heart a formal definition of the FMV of property, including *intangible assets* — which are clearly the central issue in any financial appraisal of EM operations and management services.[7,8] Several standards are used nationally for FMV determinations. The application of these standards to EM business entities is long overdue.[9]

IRS Revenue Rulings provide interpretive regulations that add operational substance to the tax laws passed by Congress. *Revenue Ruling 59-60*, widely cited by courts and used in the appraisal community since its publication in 1959, defines FMV:

> "The price at which property [including intangibles] would change hands between a willing buyer and a 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 the common facts."[10]

Thus no transaction is fair without "common knowledge." Any tampering with this common knowledge, shared by the two negotiating parties, is the point at which the process becomes corrupt and the "fair" disappears from fair market value. Sadly, the history of EM is rife with obfuscation of the finances at the heart of EM business arrangements. As information is withheld, often in ways both subtle and intimidating, arrangements become schemes. With limited choices in a marketplace often dominated by CMGs, emergency physicians lose the fair practice environment vital to the delivery of the highest quality emergency care, and patients suffer.

In summary, the universal themes of fair market valuation are 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. Emergency medicine has never had a trusted advocate committed to the promotion of complete transparency and the absence of compulsory win-lose terms in negotiations. The lack of transparency and coercive negotiations in EM are the stuff of legend, and one of the driving forces behind the formation of the AAEM. The Academy is therefore the natural body to give birth to a formal trusted advocate that can champion fairness in EM.

The *Practice Fairness Council*: From concept to working reality.

Responsibilities and functions of the *PFC* will include:

- The solicitation of *PFC* members from AAEM's membership at large, the selection of applicants, and the submission of chosen applicants for approval by the AAEM board of directors.
- The development of methods to measure the value of good will at multiple operational interfaces in EM practice, and to assure accurate attribution of the good will value to the individual who produced it.[11] This may be the most important aspect of the fair market valuation process in determining reasonable management charges.
- The development of web-based practice management surveys. The *PFC* will invite EM groups to describe their business models, survey AAEM members on these models, and post the results along with member comments. If survey participants with direct experience of the surveyed business models have information contradictory to that supplied by the EM groups, these discrepancies will be investigated.
- The development of a scale to rate the *fair value* offered to an EP by an EM group. The concepts behind Transparency International and WorldBlu.com can inspire and inform the development of an EM group rating methodology.[13,14] Such a rating process could trigger positive reform in EM groups with low scores.
- The creation of a hotline or website that would provide Academy members with the best available information on practice arrangements that appear to lack transparency and fairness.
- The creation of a request-for-evaluation pathway, through which the *PFC* would use the *Toolkit* to render a detailed opinion on a specific arrangement in question. Such opinions would be published for the benefit of AAEM members. The cumulative organizational learning that would occur through this process will increase the overall degree of fairness in practice arrangements open to AAEM members.[12]
- The creation of a summary of best practices identified in the survey and of a "Perfect EM Practice Model," as a theoretical ideal to inspire management innovation[16] in existing EM groups.
- The development of feedback mechanisms to drive the *PFC* and *Toolkit* to the highest level of value to Academy members. Input from AAEM members on all aspects of the PFC concept and its implementation will be accepted, reviewed, published, and integrated into the process.

The *EM Practice Fairness Toolkit* will give every AAEM member the opportunity to understand the theory and practice of business valuation. It is nearly complete, and begins with essays on "Quality in Health Care," "Value in Health Care," and the all-important topic of "Fairness in Health Care Systems." A chapter on "Fair Market Value Standards" is followed by overviews of the three basic approaches to business valuation. The "Corporate Practice of Medicine" is explored in detail. Sections on "EM Group Legal Structures" and "Management Services Organizations" demystify these important topics. A review of the principles of financial and investment accounting includes discussions of intellectual capital, goodwill, start-up and doomsday balance sheet concepts, and activity-based costing. The opportunity cost of capital

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(the economic value of your medical license and ABEM or AOBEM certification), the time value of money, and pyramid growth schemes are all covered.

No treatise on business valuation would be complete without a review of economic theory as it applies to valuation. The *Toolkit* covers micro-economics; behavioral and neuroeconomics; identity economics; market structures, with an emphasis on monopsonies, the bane of EM; information economics — including information asymmetry, the principal-agent dilemma, and conflicts of interest; and corruption in individuals and organizations. The *Toolkit* ultimately rests on some of the concepts explored by 11 Nobel Laureates, whose contributions I summarize. Finally, the *Toolkit* provides an overview of game theory in the business of EM.

The Toolkit is designed to be a wiki-text, open to input from AAEM members. Academy members make up an extraordinary group of thousands of individuals, each with over 23 years of undergraduate, graduate, and postgraduate education. As the *Toolkit* will demonstrate, the intellectual capital value of AAEM's membership is in the multibillion dollar range. Each of us has mastered the vast and complex world of medical biology. The *Toolkit* may look like a lot, but it doesn't come close to all we had to learn to achieve fellowship in AAEM. I believe the *Toolkit's* key topics will prove easy to grasp. The real value of the *Toolkit* is that it connects all the dots, allowing us to know what the practice of emergency medicine is really worth. Its table of contents will appear in the next issue of *Common Sense*.

What's next?

Although I have nearly completed the *Toolkit* and brought the *Trusted Advocate of Fairness in EM* project to the launching point, we must work together to make the project a reality. It will be a labor-intensive effort that requires a long-term commitment by AAEM, and the personal commitment of many of its members. With enough support from Academy members, we can address the tag-line of *Business Valuation Resources*[15] and answer the big question about the practice of emergency medicine: what's it worth?

If you want to know more, send me an email. I would also be happy to answer questions submitted as a letter to the editor of *Common Sense*, or talk to you in person at the Scientific Assembly in NYC in February. The *Practice Fairness Council* now requests applications from members of the Academy whose interest has been piqued by the *Trusted Advocate of Fairness* concept, the *Practice Fairness Council's* potential, and the outline of topics covered in the *Toolkit*. I would like to see the *Toolkit*, with input from many AAEM members, published as a textbook with the proceeds going to AAEM. I hope those on the *PFC* will bring a burning passion for fairness to our work. If you want to serve on the *PFC*, send me your CV and a one-page email expressing your interest (or email info@aaem.org). Let's make this happen and change emergency medicine forever!

John B. Christensen, MD FAAEM

AAEM Board of Directors
Founding Chairman, AA*EM Practice Fairness Council*
Founding Editor, *The EM Practice Fairness Toolkit*

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Cracking the Code: Fixing the Crowded Emergency Department, Part 2 — Creating the Analytic Model

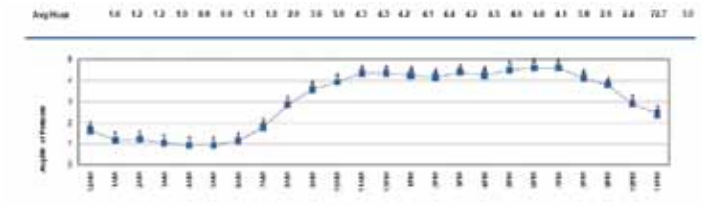
Joseph Guarisco, MD FAAEM
Chair, Operations Management Committee

Welcome back! This submission, part 2 of a three-part series, directed at understanding and solving the problem of emergency department crowding, will focus on an analytic model that can be used to create work-flow and staffing solutions to the problem. Part 1, published in the Sep/Oct issue of *Common Sense*, sought to create a burning platform for change. The burning platform is built on understanding the impact of crowding on patient satisfaction, service goals, quality of care, financial performance, and risk management. Part 1 examined why this problem must be addressed and sought to establish a sense of shared purpose between those who practice emergency medicine and those who manage and administer the resources and processes that enable solutions. It explained why failure to meet this challenge jeopardizes the success of emergency departments (EDs), hospitals, and entire health care systems.

Solutions to ED crowding obviously involve operational issues at all levels, including patient intake, departmental throughput, and outflow from the department. Those of us who practice emergency medicine know that the major obstacle to throughput is output to the inpatient units of the hospital, most importantly due to constraints such as bed availability. Despite that reality, those of us in operations believe that a major opportunity exists on the input side to mitigate, if not eliminate, the impact of hospital crowding on ED operations. Therefore, part 2 of this series continues to focus on the input side of ED operations as a major game-changer in ED crowding.

We now begin to build the operational model in which we harvest performance and operational data as inputs to predictive analytic tools. This involves gathering data, validating it, and most importantly understanding it. The importance of analytics in ED operations is driven by the realization that much of what we experience in the ED is predictable. What appears to most to be chaos is simply variation around predictable events. Mapping and understanding variation creates the opportunity to predict events within a range of probabilities, allowing us to solve ED crowding mathematically. This ultimately provides the solution to crowding which will be explained in detail in part 3. So, let's build that operational model.

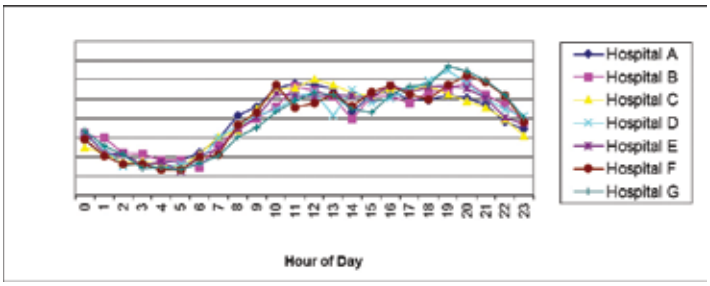
Below are patient arrival demand curves at two very different emergency departments in the Ochsner Health System[3] — one ED seeing 30,000 patients/year and one seeing 60,000 patients/year.



North Shore ED 30,000 visits/year

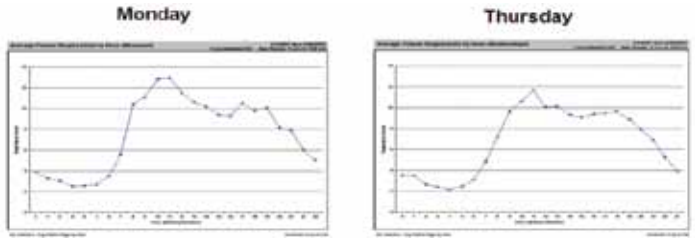
Jefferson ED 60,000 visits/year

The demand curves above are virtually identical for these two emergency departments. Is this predictability unique to a particular system or region? The answer is "no." In the normalized graph below, the relative demand curve for all seven of these emergency departments, part of the Banner Health System,[2] are virtually identical.



Arrival Distributions for Seven EDs (volumes normalized)

If I created a transparency for each of the three images above, reflecting data from all nine hospitals in two health care systems, layered them one over the other and normalized the volume differences, the patient arrival curves would mirror each other almost identically. Drilling this theory of predictability down one level and showing the patient arrival curve for two different days throughout the year, Monday and Thursday — once again from our experience at the Ochsner Health System[3] in New Orleans — we will see the same high degree of predictability.



Obtaining this type of data is easy now that most EDs are automated, and I don't think this predictability surprises anyone who works in our specialty. Next, let's take it one step further and look at acuity for multiple emergency departments. Again, these data from the Banner Health System[2] reflect the acuity distribution of patients from the same seven

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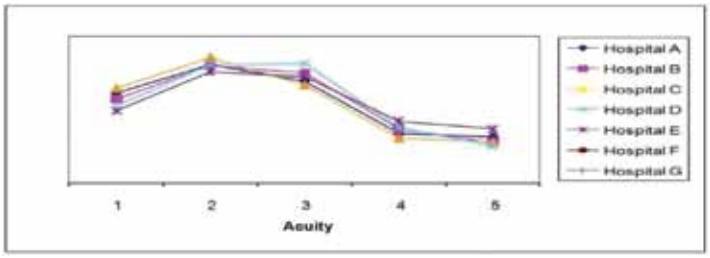
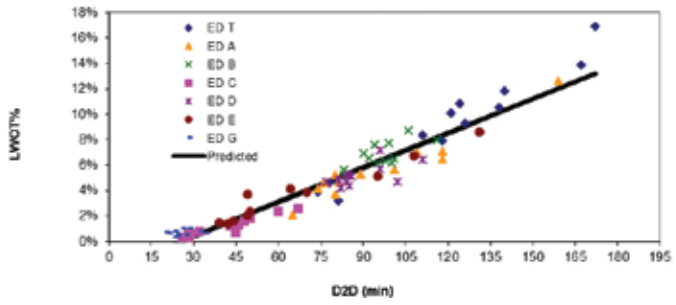
EDs, and are shown in the image below. The data are once again normalized for varying volumes at each site, so that the relationship of one facility to the other in terms of acuity distribution is clear.



Acuity Distribution at Seven Banner Health EDs (volumes normalized)

As shown in part 1 of this series, wait times are directly related to patient satisfaction. The graph below, also based on data obtained from the Banner Health System,[2] shows the predictable "left without being seen" (LWBS) rates based on patient wait times. The graph shows multiple emergency departments and multiple times at each facility, and the resulting predictable impact on the LWBS or "left without treatment" (LWOT) percentages.

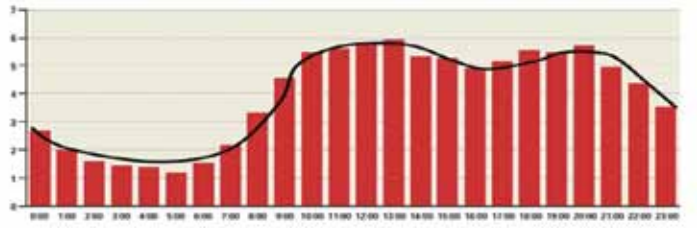


LWOT percent at Various Wait Times

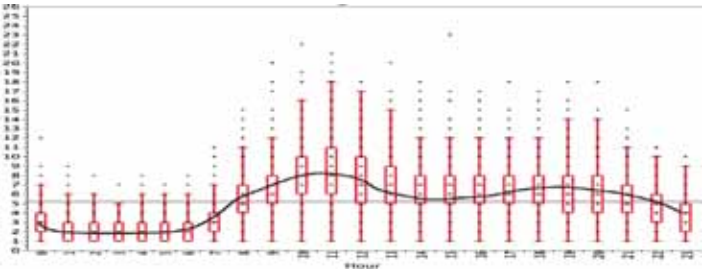
Enough, right? You get the point. We know with great predictability the average number of patients who might arrive on any given day, during any given month, in any year. We also know with great predictability the average acuity distribution. We even know how long patients will wait on average before they get frustrated and leave. Stating this in simpler terms: on average we know how many patients are coming; we know when they're coming; we know how sick they will be; and we know how long they will wait. With such powerful predictive analysis at our disposal, the question that must be asked is why is the problem of ED crowding so difficult to solve? Why can't we have just the right number of nurses, physicians and beds at the right times to meet this predictable demand? The answer is hidden in a simple but poorly understood phenomenon known as variation. Failing to measure, map, and understand "variability around the mean" is partly responsible for our failure to fully and finally solve the crowding problem.

So now let's explore variation and use that knowledge to provide the solution to crowding. Remember that crowding is simply the result of more patients seeking ED services than are available. Most health care systems and EDs attempt to solve capacity issues by allocating resources, both providers and beds, on the basis of data focused around the mean — as shown in the graphs above. This means that half the time we meet or exceed patient demand and half the time we fail. This is why the CEO calls three days a week to ask "What happened last night?" The answer is "Well, we had a bad night." The point is that unless we understand variability and probability, then three to four days a week we will have a bad night. That's probability. It's just math.

Don't get me wrong. By itself, understanding variation and how we calculate probabilities will not solve the problem. The solution requires a different staffing model and different work-flow. That will be explained in part 3 of this series, in which we look at staffing to 95% demand probabilities rather than 50%. For now let's continue to build the basis for the solution. Let's look at the data from a variation and probability viewpoint, by looking once again at average patient arrivals on a distribution curve represented by a bar chart overlaid by a curvilinear line, as below.

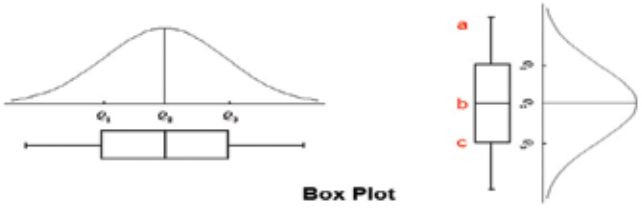


This chart does not reflect what happens in a real ED. The second chart below[1] uses that same curvilinear line based on patient arrivals, but this time displayed as box plots showing the reality that created the mean arrival patterns displayed in the graph above.



Box Plot Arrivals 24 Hours

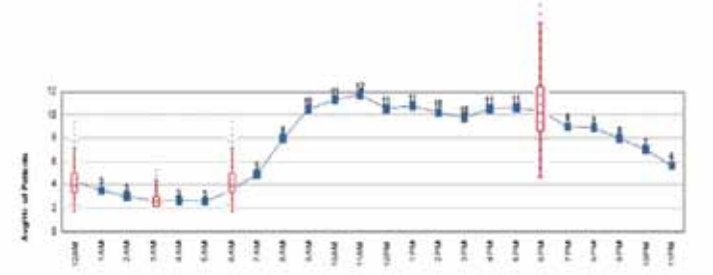
The box plot shows patient arrivals using large numbers of data points, showing how the average was created from a variety of actual arrivals. The distribution of actual arrivals is shown. As shown below and explaining box plots further, the middle (b) of each box indicates the mean or average, with the upper limit (c) of the box being the 75th percentile and the whisker at the top of the line (a) representing roughly the 90th percentile of the data set. It's the classic Gaussian curve turned on its head. It is important to state that our goal is not to predict the expected volumes and required staffing precisely, but to define required resources to match demand within a range of probabilities. This is how all service industries match customer demand. Meeting service demands with a 90% probability (vs. a 50% probability) is the goal. That's important!



Box Plot

Continued on next page

Another way to visualize this for even more clarity is to display, as below, the variation in the original patient arrival curve shown at the beginning of this article.



Arrival Curve with Box Plot

Management would typically shoot for staffing for the mean and then hoping for the best. Whether it's physician productivity (patients per hour) or nursing FTEs (full-time equivalents) per visit, calculating labor standards to the mean will result in failure half the time. So how does one succeed in meeting customer (patient) demand 90% of the time? In the current health care environment very few health systems have the financial power to solve this without fundamentally changing both ED work-flow and staffing models. There is a practical solution that allows 90% service guarantees with minimal financial risk.

Solving this problem of demand matching, with the probability that you will have adequate provider resources 90% of the time, essentially solves one of the two major causes of ED crowding. Besides labor (physicians and nurses), the other major resource constraint is space — physical ED beds. The staffing model that will be proposed in part 3, drives a work-flow solution that, in the end, also drives the space solution by creating virtual ED space.

So, in the next and final submission in this series we will explore an integrated work-flow and staffing model that allows you to "crack the code" on this problem. Successful industries have created business models with a cost structure that provides for service demand matching at the 90% probability level, but that maintain operating margins. I suggest that we can do the same. See you next time. ■

1. Ed Popovich. (2002 – 2005) at Boca Raton Community Hospital (now Boca Raton Regional Hospital).
2. Door-to-Doc (D2D) Patient Safety Toolkit. Banner Health and Arizona State University. AHRQ Grant #Hs015921-01.
3. Ochsner Health System, Jefferson, LA.

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Lake Emergency Services and the Road Less Traveled

Carol A. Cunningham, MD FAAEM

Dr. Kenneth A. Weiner incorporated Lake Emergency Services (LES) in 1984, and for the next 25 years LES staffed the emergency departments of Lake Hospital System (now Lake Health), a two-hospital system in Ohio's Lake County, east of Cleveland. As a native Clevelander, I was eager to return to the area in 1990 when I completed an emergency medicine residency at the University of Cincinnati. When I interviewed with LES, I was impressed by the genuine care LES physicians showed for their patients, their team spirit, and their pride in owning their own emergency medicine practice. I joined the group in July of 1990, and in 1992 became the first new shareholder in the corporation since the original group of eight launched LES. Our enthusiasm for owning LES and making our small business the best emergency medicine practice in the greater Cleveland area was powerful. LES played a significant role in improving the image and reputation of Lake Health, our patient census steadily increased, and our practice grew to meet the needs of the hospital and the community.

By 2010, LES was composed of 21 emergency physicians and eight PAs. We provided the emergency department staffing for Lake West and TriPoint (which replaced Lake East Hospital in 2009), Lake Health's two hospitals. For 25 years we remained dedicated to Lake Health and the community — through several ED renovations, the construction of two new EDs, and the construction of a whole new hospital. Nevertheless, when the president of LES arrived at a meeting in July of 2010 to discuss the staffing of a planned new free-standing emergency department, the hospital CEO informed him — without prior warning or any explanation — that our contract had been terminated. The decision was all the more surprising since there is a significant shortage of emergency physicians in Ohio, especially in the Cleveland area. Despite a flood of offers from recruiters, contract management groups, and other hospitals, LES members stuck together and partnered with another physician-owned emergency medicine group to add manpower, and then submitted a bid to regain the contract. Various parties tried to splinter our solidarity with offers of compensation too lucrative to be sustained over time, along with other temptations. As highly competent, experienced, and worldly emergency physicians with more than our fair share of character and fortitude, we refused to prostitute ourselves and sell our integrity to the highest bidder.

In September of 2010, we learned that Lake Health had awarded a three-year contract to EmCare, and Lake Health's administration had instructed EmCare to offer all of us employment. We attended an informational dinner sponsored by EmCare. Dr. Rebecca Parker, EmCare's regional medical director and a member of ACEP's board of directors, presented EmCare's compensation proposal and encouraged us to complete applications for employment. The quality of the compensation package was, in our opinion, woefully inferior to what we earned as physician-owners of LES. We left the EmCare folders on the table or tossed them in the garbage on our way to the parking lot. In subsequent weeks our suspicions were confirmed, when phone calls from EmCare indicated that the expected number of clinical hours per month was more than many of us worked during residency. In addition, the compensated time set aside for administrative duties was one third to one half of that LES had provided. Attempts by some to negotiate changes in the EmCare offer were stonewalled by Dr. Parker, who declined to present some of our requests to her corporate superiors. LES physicians who were members of ACEP were left stunned and scratching their heads, wondering what happened to the claim from ACEP's mission statement that it was "the leading advocate for emergency physicians."

During the last week of our contract, many of us were approached by members of Lake Health's medical staff, asking in panicked tones if we were going to stay. Apparently, someone had erroneously informed them that all of us were going to sign contracts with EmCare. Forty-eight hours before the end of our contract, several other LES physicians and I were approached individually by an EmCare administrator who flew in from Texas. She confessed that they needed us, even if only temporarily, to provide coverage during the transition and offered us a ridiculous amount of money to do so. We declined.

At the stroke of midnight on November 7, the contract between LES and Lake Health officially ended. We said farewell to the patients and families we diligently treated and attentively served, and the emergency departments that we staffed for 25 years, with our heads held high and our hearts bursting with pride. Only two physicians, both of whom had been with LES less than six months, stayed behind with EmCare. As we gathered at a local tavern to commemorate LES and all its good work, we were joined by a multitude of ED nurses and hospital staff, some of whom were sobbing at the reality of our departure. We had the DJ play Bob Marley's "Exodus," as we danced in celebration of our escape from all the administrative and contractual madness.

In the months that followed, we witnessed significant and telling changes in Lake Health's EDs, both of which averaged approximately 40,000 visits per year at the time of our departure. The LES contractual definition of a full-time physician was 120 hours per month, while EmCare offered us contracts mandating 160 hours per month. The double and triple physician coverage and PA that LES provided during the busiest parts of the day were reduced to single physician coverage, with sporadic double physician coverage. The 8-hour shifts that LES instituted in 1992, to promote the faster delivery of better patient care, support physician wellness, and prevent burnout were replaced by EmCare with 12-hour shifts.

At the request of Lake Health's CEO, I met with her in January of 2011 to discuss Lake Health's emergency medical services, since I had served as EMS medical director since 1995. During our conversation she expressed surprise that nearly everyone in LES refused to work for EmCare. She thought that working for a corporation whose regional medical director was on ACEP's board of directors would be attractive to us. I realized then that the hospital's leadership did not understand that they had destroyed a local small business, nor did they appreciate the value

Continued on next page

of a proven team of experienced, board-certified emergency physicians who were deeply invested in the success of their hospital and community. Lake Health had disposed of a treasure as though it was worthless. The entire debacle ended on an amusing note in August of 2011, when Lake Health named its TriPoint ED after the county's biggest funeral home, following a significant donation to the Lake Health Foundation.

Fast forward to 2013, and you will find that the former LES emergency physicians are happy, fulfilled both personally and professionally. I now work for another equitable democratic emergency medicine group in the area, at a hospital system that is ranked as one of the best in the nation. The physicians in my new group are firmly committed to our patients and constantly seek to make our emergency department, hospital, and group even better. I am again blessed to be in a group that provides the support and flexibility I need to continue the EMS aspect of my career at the local, state, and national levels. This would have been impossible for me under the suffocating contractual parameters that EmCare proposed. Thanks, in part, to AAEM, jobs like mine are not as hard to find as they used to be.

We who were part of LES continue to receive praise from our former patients, who wish we were still practicing at Lake Health, but none of us regret escaping the corporate shackles. Since it is always best to take constructive action after going through a bad experience, I presented a resolution to the ACEP Council in September of 2011, requesting that ACEP adopt a policy that its directors shall not use their positions in ACEP for the purpose of, or during the process of, conducting corporate business — except as necessary to further the business of the College. This kind of requirement is standard for many corporations in our nation, including those outside the medical field. Sadly, the ACEP Council elected not to take action on my resolution.

The contract between Lake Health and EmCare was abruptly terminated in March of 2013, almost a year before its expiration date. When they learned that the contract had been canceled, several members of Lake Health's medical staff contacted us and begged us to return as an independent group. However, the administrators who initiated our departure remained in place.

The emergency physicians of Lake Emergency Services stood up to the corporate practice of medicine, by walking away in unison from EmCare and the professional lives that we had known for 25 years. I have never been more proud of my LES partners than on that day, and I will always have high regard and infinite respect for each and every one of them. Like most people, we had families to support and mortgages, loans, and school tuition to pay. But all of us elected to do what we thought was right for ourselves, our specialty, and our profession. We declined the convenient and comfortable security of the moment, which would not have been stable in the long-term. Instead we broke from the herd, followed Stevie Wonder's advice, and headed for higher ground. We now use the wisdom gained from this experience to educate young emergency physicians about the pitfalls and inequities that lurk in employment contracts, and warn them not to be blinded by up-front dollars or the credentials of the smiling individual selling the position. We try to inspire them with the economic value of owning and running their own practice, and with the satisfaction of knowing that their hard-earned revenue was both fairly obtained in return for excellent patient care and fairly distributed to those in the practice, rather than enriching corporate administrators or shareholders a thousand miles away — none of whom were in the ED at 3:00am trying to save the life of the combative, intoxicated patient with a stab wound to his chest.

Our message is simple. As board-certified specialists in emergency medicine, we choose not to be the victims of greedy corporations or unscrupulous contract-holders. We prefer to be the captains of our own fate. And when you stand before the mirror, we want you too to see someone with the independence, courage, and adaptability it takes to be the driver of your own career.

Two roads diverged in a wood, and I,
I took the one less traveled by,
And that has made all the difference.
— Robert Frost ■

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Our Opinion

Robert McNamara, MD FAAEM
Past Presidents Council Representative
AAEM Board of Directors

Dr. Bob McNamara offers editorial commentary on Dr. Cunningham's story.

The upbeat tone of Dr. Cunningham's message inspires admiration for her and her colleagues, and their resolute action. However, if you take a step back you will see that this story encompasses much of what is wrong with emergency medicine, and why it was necessary to create AAEM. In my opinion, the facts are clear. A leader of ACEP helped destroy an independent, democratic emergency medicine group. What purpose did that serve? What these emergency physicians built and nurtured over the course of 25 years was ruined. Dr. Parker was a principal agent in disrupting the careers of the LES emergency physicians. Can any EmCare bonus justify that?

At the time this story was unfolding, Dr. Cunningham and her colleagues sought AAEM's support. We quickly responded with letters to the hospital Board of Trustees and leaders of the medical staff, questioning why they would threaten the integrity of patient care by bringing in a for-profit corporation. We went further and sent a request to the Ohio State Medical Board, asking for a review of the planned EmCare arrangement based on our concern over fee-splitting. Sadly, the group lost the contract anyway. LES probably never had a chance to retain the contract because the hospital CEO believed EmCare's pitch that the docs would roll over, stay, accept their loss of independence, and work for EmCare — a pitch made more credible by the fact that Dr. Parker was on ACEP's board of directors at the time. As Dr. Cunningham suggests, subsequent reports indicate that this decision not only affected the LES emergency physicians, but also the patients they left behind.

What we are left with is another cautionary tale for administrators who listen to the Dr. Parkers and EmCares of the world. On September 24, 2013, a story by Matt Skrajner in *The News Herald* reported that EmCare has lost its contract to staff Lake Health's three EDs, replaced by EMP (Emergency Medicine Physicians) of Canton, Ohio. As in many other cases — such as Methodist Hospital in St. Louis Park, MN* — hiring a corporate group to replace a stable and proven physician-owned group has proven risky. More importantly, the population served by Lake Health has moved further away from the essential component of AAEM's Vision Statement: A physician's primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference.

What should you do? If you are part of an independent democratic group now, consider sending this article to your administrator — being fully aware that your contract is always being pursued by contract management groups. Second, applaud Dr. Cunningham, her colleagues, and yourself for supporting AAEM in its quest to protect individual emergency physicians and their patients rather than corporations — and ask yourself why you would support any professional society that doesn't share those values.

*In 2004 EmCare acquired the ED contract at Methodist Hospital in St. Louis Park, Minnesota. EPPA, a private democratic group serving the hospital since 1969, was not told the contract was up for bid until after it had been awarded to EmCare. No request for proposals was issued. EPPA asked AAEM for assistance. The Academy offered legal counsel, made an argument on EPPA's behalf to the hospital, filed a complaint with the state attorney general, and with EPPA jointly filed suit against both EmCare for violating corporate practice of medicine and fee-splitting laws and the hospital for breach of contract. Three weeks later Methodist Hospital terminated its relationship with EmCare and re-contracted with EPPA. EPPA continues to serve Methodist Hospital and several other local hospitals. This case had a chilling effect on corporate groups' plans to move into Minnesota, and they have so far been unable to establish a significant foothold there. (This footnote is taken from a review of AAEM legal actions on behalf of independent emergency medicine groups by Dr. Mark Reiter and others, which will appear in the Jan/Feb issue of *Common Sense*.) ■

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Crisis and Opportunity

Eric S. Csortan, MD FAAEM

Dr. Csortan, author of the story below, was once part of Lake Emergency Services — the group eventually displaced by EmCare, as described in Dr. Carol Cunningham's article in this issue of Common Sense. *There are several lessons to be learned from the experiences of these two emergency physicians. First, save your money. No matter how great a job you and your group are doing, you can lose your job with little warning, at any time. Having six months or more of income saved up and easily available will give you incredible peace of mind, and the flexibility to respond as you want when you are challenged by a job loss. Second, you and your group must be flexible and responsive to the needs of your hospital CEO. That doesn't mean you have to agree to every bad idea that comes up, but it means you must figure out what the CEO* ***really*** *wants and why, and help him or her get there. Your response to a proposal or idea should never be "No, that is a horrible idea." It should be "Yes, that is a great idea, but..." Third, no matter what, you will almost certainly lose a job or two or three during your career in emergency medicine. Many hospital CEOs are just clueless, or couldn't care less about the actual quality of their EDs as long as there are few patient complaints. Sometimes that turns out to be the best thing that ever happened in your professional life. Look for the opportunity hidden in the crisis and strive to adapt, improvise, and overcome.*

Last, note the role a member of ACEP's board of directors played in EmCare acquiring the Lake Health contract. A similar story is unfolding now in Tennessee, where EmCare has launched a joint venture with HCA, which is taking over the ED contracts at several HCA hospitals in the state. This is displacing three independent, physician-owned groups in the Nashville area — at least one of which is fully equitable and democratic. It is a group I was part of until I entered semiretirement a year and a half ago. The CEO of EmCare's South Division is Dr. Terry Meadows, a member of ACEP and one of the directors of its Florida chapter. Other EmCare leaders also play leadership roles in ACEP. Dr. Russell Harris, CEO of the North Division, is a past president of ACEP's New Jersey chapter. Dr. Angel Iscovich, West Division CEO, is "an active member of ACEP" according to EmCare's website. Dr. Thom Mayer, EmCare's executive vice president, is a member of ACEP and winner of its Speaker of the Year award. EmCare's chief medical officer, Dr. Kirk Jensen, is also a member of ACEP and another winner of its Speaker of the Year award. Dr. Dighton Packard, CMO of Envision Healthcare — EmCare's parent company — is a past-president of ACEP's Texas chapter. I doubt that AAEM's membership would tolerate Academy leaders who were working to put independent emergency medicine groups out of business. ACEP's membership shouldn't either. And don't even get me started on the overlap between ACEP's "Heroes of Emergency Medicine" and Team Health's management...

— The Editor

As a working emergency physician for more than 22 years, I have been an employee, an independent contractor, and a partner. I have also declined partnerships and directorships for a variety of reasons. Until three and a half years ago, I had never been part of a truly equitable, democratic group. My medical school training was at the Johns Hopkins School of Medicine in the late 1980s, with great teachers such as Gabe Kelen and Eric Noji, when emergency medicine was still a subsection under the Department of Surgery. My eyes were opened to a whole new world of emergency medicine during the two months I spent at Denver General, under the tutelage of Peter Rosen and John Marx. I completed my residency in EM in Grand Rapids, Michigan, under Gwen Hoffman. It was truly a privilege to know and train under these extraordinary teachers and emergency physicians.

Over six years of my life were then spent working hard and becoming a partner in a private emergency medicine group, in a high-volume tertiary care center in coastal Florida. Though not fully democratic, the group was essentially benign and run fairly under the direction of our chairman, who had held the contract for over 20 years. One day the CEO of the hospital decided that the emergency medicine group would be seized and we would all become employees of the hospital. There was no advance warning, discussion, or negotiation. We were handed the worst contract I have seen in 22 years of looking at emergency medicine contracts. I looked for employment elsewhere.

Three and half years ago I joined Brevard Emergency Services (BES), also in Florida. This turned out to be the most democratic and fair-minded group of highly qualified, board-certified emergency physicians with whom I have ever had the honor to work. From day one, even before partnership had been obtained, there was complete transparency. I was invited to every meeting and all books were open to me. However, things would not continue on this happy path.

Health First is a healthcare system that includes, among other things, four hospitals in Brevard county. BES provided emergency physicians for two — one of which is the designated trauma center/tertiary care center for the county. Space Coast Emergency Physicians, another democratic group, provided care at the other two Health First EDs. In September of 2011, Health First hired a new CEO, Steve Johnson, who immediately began to make changes. We soon learned that our services would likely be outsourced to a contract management group (CMG), Team Health. Radiology and anesthesiology groups at the four hospitals were drawing approximately $14 million/year in subsidies from Health First, whereas BES and Space Coast Emergency Physicians cost the hospital system nothing in subsidies. Jumping at the prospect, Team Health agreed to provide anesthesia and radiology services at no additional cost, if in exchange they could acquire the emergency medicine contracts at all four hospitals. Our new CEO had worked with Team Health in the past in an eight-hospital system. We feared there was little chance of retaining our contract. Luckily, this CEO turned out to be different than others with whom I have dealt. He said that all of us could retain our contracts if we could rid the hospital system of subsidies.

Continued on next page

This was a huge opportunity, and Brevard Physicians Associates (BPA) — a new multi-specialty, independent, physician-owned group — was born. Eighty radiologists, anesthesiologists, and emergency physicians from several independent practices came together over several months and formed BPA. Through painful restructuring, we were able to eliminate subsidies from the hospital system. I have always said that it is difficult to get five physicians to agree on what to have for lunch, let alone policy, but we were able to agree on the structure of this new company. Through the exhaustive efforts of several people, including Dr. Marty Brown (chairman of BES) and Dr. Michael McGoohan (chairman of Space Coast Emergency Physicians), we were able to successfully negotiate a contract between BPA and the Health First hospital system. The newly minted BPA launched its independent practice on October 1, 2013. It employs 80 physicians and 50 mid-level providers and is owned, operated, and controlled by its member physicians.

This is the first group of its kind of which I am aware. It is a very exciting development and a testament to what unity and solidarity among physicians can accomplish. In overcoming a potential hostile takeover by Team Health, we saved independent medical practices in three specialties. Our plan can serve as a model for other groups to maintain primary ownership of their practices in the midst of a CMG takeover. I believe that physician ownership improves overall patient care and safety. I look forward to being a part of this evolving organization in the years to come, and to seeing how other groups transform their crises into opportunities for the betterment of hospital-based physicians and their patients. ■

Thank You!

We would like to recognize and thank the following ED groups for participating in our 2013 100% and 2/3 Group Membership. We sincerely appreciate the enthusiastic and continuous support of these physicians and their groups.

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- Doctor Urgent Care – LA
- Drexel University College of Medicine – PA
- Eastern Carolina Emergency Physicians (ECEP) – NC
- Edward Hospital – IL
- Emergency Physicians of Community Hospital Anderson (EPCHA) – IN
- Emergency Physicians at Sumner, PLLC (EPAS) – TN
- Emergency Specialists in Oregon, (ESO) – OR
- Florida Hospital – FL
- Fort Atkinson Emergency Physicians (FAEP) – WI
- Fredericksburg Emergency Medical Alliance, Inc. – VA
- Newport Emergency Physicians, Inc. – RI
- Northeast Emergency Associates – MA
- OSF Saint Anthony Medical Center – IL
- Physician Now, LLC. – VA
- Salinas Valley Memorial Hospital – CA
- Southern Colorado Emergency Medical Assoc (SCEMA) – CO
- Space Coast Emergency Physicians – FL
- Temple University Hospital – PA
- University of Louisville – KY
- West Jefferson Emergency Physician Group – LA

AAEM 2013 ED Group Membership

- BayCare Clinic – WI
- Middle Tennessee Medical Center – TN
- University of Mississippi – MS

EmCare Goes Public — Again

Mark Reiter, MD MBA FAAEM
Vice President, AAEM

On 14 August 2013, Envision Healthcare Holdings (ticker EVHC), the parent company of EmCare, completed its initial public offering (IPO) and became a publicly traded company. EmCare was founded in 1972 by Dr. Leonard Riggs, who became ACEP's president in 1981 and has since received several prestigious awards from ACEP. Dr. Riggs is one of several leaders in our specialty who AAEM believes helped bring emergency medicine to its current state of corporate control. The desire of many emergency physicians to roll back this corporate domination played a large part in the founding of AAEM in 1993.

In 1997, EmCare was sold for $400 million to Laidlaw, a transportation company which at that point specialized in school busing and trash hauling. In 2004, EmCare and American Medical Response (AMR), an ambulance company, were sold to Onex, a consortium of private equity firms, for $828 million. In 2005, EmCare became a publicly traded company listed on the New York Stock Exchange, until it was taken private again in 2011 by several private equity firms. Now, along with AMR and restructured as Envision Healthcare Holdings, EmCare has again gone public.

When a company files with the Securities and Exchange Commission (SEC) to sell shares of stock to the public, it publishes an S-1 IPO prospectus. The S-1 outlines the company's business model, financial status, ownership, and any risks associated with the offering. A review of Envision's IPO prospectus (www.nasdaq.com/markets/ipos/filing.ashx?filingid=8939393) offers an interesting look at the largest staffing company (by number of contracts) in emergency medicine. Here are some excerpts from the S-1.

On the emergency department staffing market:

> *We believe the physician reimbursement component of the ED services market represents annual expenditures of nearly $18 billion. The market for outsourced ED staffing and related management services is highly fragmented, with more than 1,000 national, regional and local providers handling an estimated 130 million patient visits in 2010. There are nearly 5,000 hospitals in the United States that operate EDs, of which approximately 65% outsource their ED physician staffing and management. We believe we are one of only five national providers and the largest provider based on number of ED contracts.*
>
> *During 2012, EmCare had approximately 10.5 million weighted patient encounters in 44 states and the District of Columbia. As of December 31, 2012, EmCare had an 8% share of the total ED services market and a 12% share of the outsourced ED services market based on number of contracts. EmCare's share of the combined markets for anesthesiology, hospitalist, radiology and surgery services was approximately 1% as of such date. TeamHealth is our largest competitor and has the second largest share of the ED services market with an approximately 6% share based on number of contracts. Other national providers of outsourced ED services are Hospital Physician Partners, Schumacher Group and California Emergency Physicians."*

Assuming the above data are correct, it is discouraging to AAEM that so many EDs use contract management groups — although in this context "outsourcing" probably includes all emergency physicians who are not employed directly by the hospital. The Academy believes private, democratic groups run by physician-owners provide both superior working conditions for emergency physicians and superior care for patients.

On medical professional contracts:

> *We contract with healthcare professionals as either independent contractors or employees to provide services to our customers. The healthcare professionals generally are paid an hourly rate for each hour of coverage, a variable rate based upon productivity or other objective criteria or a combination of both a fixed hourly rate and a variable rate component. We typically arrange for professional liability and workers compensation coverage for our healthcare professionals. The contracts with healthcare professionals typically have one-year terms with automatic renewal clauses for additional one-year terms. The contracts can be terminated with cause for various reasons, and usually contain provisions allowing for termination without cause by either party upon 90 days' notice. Agreements with physicians generally contain a non-compete or non-solicitation provision and, in the case of medical directors, a non-compete provision. The enforceability of these provisions varies from state to state.*

AAEM considers non-compete clauses (restrictive covenants) to be unethical, especially since emergency physicians do not have access to any trade secrets and do not take patients with them to their new jobs. AAEM considers due process to be a fundamental right of emergency physicians and notes in our mission statement, "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." You can read the AAEM White Paper on Restrictive Covenants at www.aaem.org/em-resources/position-statements/practice-rights.

On the corporate practice of medicine and fee-splitting:

> *EmCare employs or contracts with physicians or physician-owned professional corporations to deliver services to our hospital customers and their patients. We frequently enter into management services contracts with these physicians and professional corporations pursuant to which we provide them with billing, scheduling and a wide range of other services, and they pay us for those services out of the fees they collect from patients and third party payers. These activities are subject to various state laws that prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. In*

Continued on next page

> *addition, various state laws also generally prohibit the sharing of professional services income with nonprofessional or business interests. Activities other than those directly related to the delivery of healthcare may be considered an element of the practice of medicine in many states. Under the corporate practice of medicine restrictions of certain states, decisions and activities such as scheduling, contracting, setting rates and the hiring and management of non-clinical personnel may implicate the restrictions on the corporate practice of medicine. In such states, we maintain long-term management contracts with affiliated physician groups, which employ or contract with physicians to provide physician services. We believe that we are in material compliance with applicable state laws relating to the corporate practice of medicine and fee-splitting. However, regulatory authorities or other parties, including our affiliated physicians, may assert that, despite these arrangements, we are engaged in the corporate practice of medicine or that our contractual arrangements with affiliated physician groups constitute unlawful fee-splitting. In this event, we could be subject to adverse judicial or administrative interpretations, to civil or criminal penalties, our contracts could be found legally invalid and unenforceable or we could be required to restructure our contractual arrangements with our affiliated physician groups.*

AAEM and others consider the corporate practice of medicine to be unethical, and it is restricted or banned in most states (learn more at www.aaem.org/em-resources/critical-em-and-practice-issues/corporate-practice). Envision's S-1 notes, however, "In such states, we maintain long-term management contracts with affiliated physician groups, which employ or contract with physicians to provide physician services." The Academy believes that the use of such intermediaries by contract management groups (CMGs) is nothing more than an attempt to circumvent corporate practice of medicine laws, and these intermediaries exist solely to provide a corporate veil for CMGs to hide behind as they violate those laws. The "affiliated physician groups" do not normally have the option of canceling their contracts with the CMG and retaining another company to provide management services for their EDs. The physicians, however, do work at the pleasure of the CMG. The CMG can fire its emergency physicians, but its emergency physicians cannot fire the CMG. Unfortunately, the Academy has so far had only limited success in its efforts to challenge these arrangements in state courts.

On Envision's executive compensation:

> *On October 1, 2012, the Company issued $450 million of PIK Notes due 2017. In connection with the transaction, the net proceeds from the offering were used to pay a special cash dividend to the Company stockholders, and cash payments to holders of stock options from the Rollover, including each of the named executive officers as follows: William A. Sanger — $5,566,845; Randel G. Owen — $2,319,502; Todd G. Zimmerman — $1,159,751; Mark Bruning — $492,080; and Dighton C. Packard, M.D. — $345,075.*

In addition to that special dividend, according to the S-1 from EmCare's 2005 IPO, William Sanger received a $12,691,032 bonus for assistance with the sale of the company from Laidlaw to Onex. Don Harvey was given a $2,270,002 bonus. By taking EmCare public, then private, then public again, EmCare's top executives have taken multimillion dollar special distributions on several occasions. Did EmCare physicians share in that windfall?

> *In connection with or following the Merger, there were 1,976,612 new options to purchase common stock of the Company granted as a result of options rolled over by executives and other key employees in the Merger and other options granted to the executives, a director and other key employees. As of December 31, 2012, Mr. Sanger held 825,832 options, Mr. Owen held 241,442 options, Mr. Zimmerman held 139,190 options, Mr. Bruning held 90,566 options, and Dr. Packard held 43,222 options.*

These stock options will likely be worth a fortune. Also note that during EmCare's 2005 IPO, William Sanger received stock options for 1,482,168 shares, Don Harvey received stock options for 370,542 shares, and EmCare purchased 3,509,219 shares of stock for its executive stock option program.

Total Compensation of Top Executives:

Name and Position	Year	Total Compensation
William Sanger, President/CEO	2011 2012	$10,161,860 $8,938,442
Randel Owen, EVP COO CFO	2011 2012	$3,421,732 $3,622,232
Todd Zimmerman, EVP	2011 2012	$2,136,219 $2,517,159
Dighton Packard, MD CMO	2011 2012	$1,368,001 $1,507,112

As the data above demonstrate, Envision's top executives have made a more than comfortable living in recent years, and the S-1 shows that each of Envision's top four executives will receive over $1 million if terminated — with Mr. Sanger being entitled to ~ $2.4 million in severance. The S-1 states that EmCare's physician contracts typically allow for termination without cause with 90 days notice. Do EmCare emergency physicians receive such lucrative severance packages when terminated?

Shares Owned by Top Executives:

Name and Position	Shares Owned	Recent Market Value
William Sanger, President/CEO	488,332	~ $12.2 million
Randel Owen, EVP COO CFO	183,161	~ $4.6 million
Todd Zimmerman, EVP	83,642	~ $2 million
Dighton Packard, MD CMO	28,535	~ $0.7 million

(based on recent stock price of $25/share)

From the data above it is clear that the company's top executives have accumulated significant wealth via Envision stock. Few, if any, of the emergency physicians generating the company's revenue have shared in this.

Continued on next page

Revenues, Expenses, Profits:
In 2012 EmCare's revenues (physician staffing only, excluding AMR) were $1.915 billion. Emergency medicine accounts for most, but not all, of EmCare's revenue. Compensation and benefits (excluding professional liability insurance) were $1.495 billion, or 78.1% of net revenue. Envision does not break out profitability for EmCare separately from AMR, so the S-1 does not paint a clear picture of EmCare's profitability.

Based on the available information, however, EmCare's gross margin appears to be very similar to TeamHealth's 22% gross margin, described in Dr. Robert McNamara's 2010 article in *Common Sense*, "Give a Shift a Week to the Company: An Analysis of the TeamHealth IPO" (www.medscape.com/viewarticle/720330). Dr. McNamara estimates that $76,000/year is taken from each TeamHealth physician's collected professional fees and paid to the company.

The stock market clearly seems to consider outsourced physician services to be a lucrative enterprise. Based on Envision's recent stock price of $25, the company has a market capitalization of ~ $4.2 billion, despite its overall debt exceeding $2.2 billion. TeamHealth's (ticker: TMH) recent stock price of ~$40 corresponds to a market capitalization of ~$2.8 billion.

AAEM is concerned about the control of emergency medicine practices by contract management firms with lay shareholders and private equity firms behind them. Strategies that are best for shareholder profits are often not best for doctors and patients. In our opinion, executives beholden to shareholders simply do not hold the same values as physicians dedicated to patients. Likewise, they may not consider the career longevity of their employee-physicians to be of high importance. They can simply replace those that burn out with new physicians, possibly even at lower cost using physicians without emergency medicine training. AAEM is committed to protecting the rights of emergency physicians; to fostering the establishment of new equitable, democratic groups; and to helping existing democratic groups compete successfully in the marketplace. ■

AAEM President Attends National Medical Association (NMA) Meeting

AAEM president, Dr. William Durkin, attended the NMA 2013 Annual Convention & Scientific Assembly in Toronto, Ontario, Canada, July 27th-31st. The theme of the convention was "Health Equities Across Borders." ■

(L-R) Travon Thompson, MD, Vice-Chairman, Emergency Medicine Section, National Medical Association (EMS/NMA); William T. Durkin, Jr., MD MBA FAAEM, AAEM President; Ugo Ezenkwele, MD MPH, Chairman, EMS/NMA; Andrew Sama, MD, ACEP President; and M. Tyson Pillow, MD M.Ed

(L-R) Cynthia Price, MD; Andrew Sama, MD, ACEP President; Ugo Ezenwele, MD MPH, Chairman, EMS/NMA; and William T. Durkin, Jr., MD MBA FAAEM, AAEM President

Research Abstracts from the Seventh Mediterranean Emergency Medicine Congress

Gary M. Gaddis, MD PhD FAAEM

The Seventh Mediterranean Emergency Medicine Congress (MEMC VII) was held September 8-11 at the Palais des Congrès et des Expositions de Marseille, in Marseille, France. Greek sailors first settled around Marseille's harbor more than 2,600 years ago. Marseille is the oldest city in France, and its second-largest city. The city gave the world the culinary gift of bouillabaisse. In fiction, much of *The Count of Monte Cristo* is set in Marseille, at the prison Chateau d'If on an island just beyond its harbor, where in reality, the famous Man in the Iron Mask was imprisoned before being moved to the Bastille in Paris, where he died. Marseille has been specially designated as the European Capital of Culture for 2013. Thus, Marseille provided a very interesting and enjoyable venue for the Congress. Its metro system permitted easy access between the Congress center and the historical harbor area, crowned by Notre Dame de la Garde, the landmark church that overlooks the harbor.

The Congress, biennially convened jointly by the American Academy of Emergency Medicine (AAEM) and the European Society for Emergency Medicine (EuSEM), was very successful. In addition to attracting a record number of attendees, more than 800 research projects were presented. MEMC VII maintained the tradition that each MEMC sets a new record for the number of research abstracts presented. In addition, there were seven didactic tracks and one French language track every day, with a wide variety of highly relevant content being presented, to complement the six plenary talks held at the meeting.

Two highlights of the first evening's Opening Ceremony were the authors' presentations of the three abstracts that were finalists for the "Best Abstract" award, and the presentation of awards. The competition for "Best Abstract" is sponsored by the *Journal of Emergency Medicine*, and Editor-in-Chief Stephen Hayden presented the winner and runners-up with their awards. The Falck Foundation presented its award for the best prehospital-EMS abstract.

The winner in the "Best Abstract" category was "NR2 Antibody as a Predictor for Neurologic Recovery in Post-Cardiopulmonary Resuscitation Patients," presented by Dr. Sahar Farahmand on behalf of her team from the Iran University of Medical Sciences in Teheran. Runners up included Dr. Michael S. Malloy, who is at the Department of Emergency Medicine of Limerick University Hospital in Limerick, Ireland, and who presented "The Utility of Social Media in Disseminating Information During Disasters: The Hurricane Sandy Experience;" as well as Dr. Nicholas DuBlanchet, who presented ""Prognosis of Pulmonary Embolism: Retrospective Assessment of the Correlation Between the Pulmonary Embolism Severity Index (PESI) and the Inversion of the Right to Left Ventricular Diameter Ratio on Initial Computed Tomography," on behalf of his team from CHU Gabriel Montpied in Clermont-Ferand, France. To further illustrate the international nature of the presenters, Dr. Farahmand is currently pursuing further research training in Vancouver, BC, and Dr. Malloy is a member of a team from the Harvard Affiliated Disaster Medicine/Emergency Management Fellowship. The Falck Foundation prize for EMS research was accepted by Dr. Christian Hohenstein, on behalf of his research team, and was awarded for "Accuracy of Diagnosing Sepsis and Early Antibiotic Treatment in the Prehospital Setting" by Ole Bayer et al., from the University Hospital of Jena in Jena, Germany.

We wish to recognize and thank the more than 70 abstract reviewers and oral abstract session moderators who contributed their time and talents to help make the meeting a success. The reviewers and moderators are noted below. Without their participation, the research function of the Congress could not have occurred.

Planning has already begun toward future congresses, the site and date of which have yet to be determined. We look forward to your future contributions to global emergency medicine research.

Gary M. Gaddis, MD PhD FAAEM
Research Abstracts Co-Chair
American Academy of Emergency Medicine

On behalf of myself and:
Colin A. Graham, MB ChD MPH MD
Research Abstracts Co-Chair
European Society for Emergency Medicine

Abstract Judges

John Allegra (AAEM)
Helen Askitopoulou (EUSEM)
Michel Baer (EUSEM)
Abdelouahab Bellou (EUSEM)
Richard Body (EUSEM)
Christoph Dodt (EUSEM)
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Abstract Moderators

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Kurt Anseeuw (Belgium)
Jay Banerjee (UK)
Gautam Bodiwala (UK)
Richard Body (UK)
Stephen W Borron (USA)
Phil Bossart (USA)
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Lisa Kurland (Sweden)
Mark Langdorf (USA)
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Sabine Lemoyne (Belgium)
Millie Willy (USA)
Richard Nowak (USA)
Riccardo Pink (Italy)
Patrick Plunkett (Ireland)
John Sakles (USA)
Alessandra Conforto (USA)
James Connolly (UK)
Julio De Pena (USA)
Arnold Feltoon (USA)
Yonathan Freund (France)
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Ian Higginson (UK)
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Steven Shirm (USA)
Anna Spiteri (Malta)
Jiriporn Sri-on (USA)
Kahtleen Steward (USA)
Charles Stewart (USA)
Ahmad Wazzan (Saudi Arabia)
Scott Weiner (USA)
Prasit Wuthisuthimethawee (USA)
Youri Yordanov (France) ■

American Board of Emergency Medicine (ABEM) Election News

James H. Jones, MD, Assumes Office as President of ABEM

Dr. Jones has been a member of the board of directors since July 2005, and was elected to the Executive Committee in 2010. Since 1988, he has served ABEM in a variety of capacities, including as examination editor, item writer, and oral examiner. He currently serves as the chair of the Academic Affairs Committee, the Communications Committee, and the CME Task Force. He also serves as a member of the Test Administration Committee and Test Development Committee. Dr. Jones has represented ABEM as a member of the Emergency Medicine Milestone Project Working Group and as a liaison to the Medical Toxicology Subboard. He has also been an editor and reviewer for a number of academic emergency medicine journals.

Dr. Jones received his medical degree from The Ohio State University College of Medicine, and completed his residency training in emergency medicine in 1982 at Wright State University in Dayton, Ohio. He is Professor of Clinical Emergency Medicine in the Department of Emergency Medicine at the Indiana University School of Medicine (IUSM), where he serves on the Curriculum Council Steering Committee and the Promotion and Tenure Committee and represents the IUSM on the Association of American Colleges' Council of Faculty and Academic Societies. In addition, he is the Medical Director of the Wishard Memorial Hospital Emergency Department in Indianapolis, Indiana. His area of research interest is in emergent airway management.

Francis L. Counselman, MD, Elected to Office of President-Elect of ABEM

Dr. Counselman has been a member of the board of directors since July 2008, and was elected to the Executive Committee in 2011. Since 2003, he has served ABEM in a variety of capacities, including as examination editor, item writer, oral examiner, and member of the Relevance of Examination to Physician Practice (REPP) Task Force Advisory Panel. He currently serves as the Chair of the Nominating Committee and Test Development Committee, and is a member of the Academic Affairs Committee, Finance Committee, MOC Committee, and Research Committee. Dr. Counselman has also represented ABEM on the EM Model Review Task Force and the Initial Certification Task Force. He has been active in a number of national organizations, including the Accreditation Council for Graduate Medical Education, American Board of Medical Specialties, American College of Emergency Physicians, Association of Academic Chairs of Emergency Medicine, Council of Emergency Medicine Residency Directors, and the Society for Academic Emergency Medicine.

Dr. Counselman received his medical degree from the Eastern Virginia Medical School in Norfolk, Virginia, where he also completed his residency training in emergency medicine. He is currently Distinguished Professor of Emergency Medicine and Chair of the Department of Emergency Medicine at Eastern Virginia Medical School, and member of the Emergency Physicians of Tidewater. His current areas of research interest are respiratory emergencies, marine envenomation, and graduate medical education.

At its July 2013 meeting, ABEM also elected the following directors to the 2013-14 Executive Committee: John C. Moorhead, MD, Immediate-Past-President; Barry N. Heller, MD, Secretary-Treasurer; Michael L. Carius, MD, Member-at-Large; and Rebecca Smith-Coggins, MD, Senior Member-at-Large.

The American Board of Emergency Medicine (ABEM) certifies emergency physicians who meet its educational, professional standing, and examination standards. Its mission is to ensure the highest standards in the specialty of emergency medicine. There are currently over 30,000 ABEM-certified emergency physicians. ABEM is not a membership organization, but a non-profit, independent, evaluation organization. ABEM is one of 24 medical specialty certification boards recognized by the American Board of Medical Specialties. ■

COMMITTEE UPDATE: Legal

As was noted in the last update, the Remarkable Testimony Website has been revised and renamed the Remarkable Testimony/Actions webpage, and now includes due process cases as well as remarkable testimony cases. The committee leadership is further exploring options to augment the data available on the Expert Witness Database. We hope to be able to submit proposals to the entire committee prior to the end of the calendar year.

The committee has also reviewed options for providing an arena for the exchange of ideas, including list servs, blogs, and discussions boards. Blogs are being utilized by other groups within AAEM, and the committee is evaluating such a product for the committee.

If anyone is interested in becoming a member of the Legal Committee please contact Tom Derenne at tderenne@aaem.org or (800) 884-2236.

Andrew Pickens, MD JD MBA FAAEM
Chair, Legal Committee ■

AAEM FLORIDA

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AAEMCS 2012

Decision Rules are for Wimps; I Don't Need No Stinking Decision Rule!

Jonathan Jones, MD FAAEM
YPS Board Member

Has that thought ever crossed your mind? Well, honestly, I hope it has. Why? Because we've trained most of our lives to learn to be great doctors and diagnosticians. If all we needed were a few rules or a phone with an app or seven, then why did we waste so much time in the prime of our lives studying and reading and learning how to think?

So are decision rules an affront to our chosen career? Are they an attempt by the "man," the hospital administrator, the contract management group, the Illuminati, or maybe even by the ACA to eliminate us over-qualified and over-paid doctors? Or are they tools to assist us in our practice?

Maybe we should examine a select few to find out. Let's start with our friends from the north.

Ottawa Ankle Rule

Mr. Smith is an 85 y/o male with dementia, CHF, CAD, COPD, PVD, diabetes, and renal insufficiency who twisted his ankle after slipping on some water at his house. He does not remember the exact mechanism of injury or how his foot turned. He reports pain, swelling, and bruising to the lateral aspect of his ankle and has no other complaints. He tried to "walk it off" but the swelling has worsened. On exam he has edema and ecchymosis near the lateral malleolus without tenderness. He has a slightly unsteady gait, but can bear weight.

Does Mr. Smith need an X-ray? The Ottawa Ankle Rule states that an X-ray is indicated if the patient has pain in the malleolar zone AND one of the following: tenderness at the medial malleolus; tenderness at the lateral malleolus; inability to bear weight immediately after the incident or while in the ED.

According to the rule he does not require imaging. So how comfortable do you feel with that? Depending on the review, the rules are 96-100% sensitive for a fracture.[1] That's pretty darn good, so you should feel fine discharging him home with an ACE wrap. Except of course, those studies didn't all show 100% sensitivity. So do you break the rule and order what any bean counter would certainly label as an unnecessary X-ray? I would, and it's not because I disagree with any of the data, findings, or conclusions about the Ottawa Ankle Rule. It's because the rules were developed to treat a population. While, in general, we do treat populations, we also must be cognizant of the strength and weaknesses of studies and the rules derived from them. If the population studied exactly mirrors our own patient population, then we're good to go. But no study population exactly mirrors our own patient population. So, do we ignore the rules? Nope. We use the rules as a guide for treating an individual patient from our larger population.

If Mr. Smith was actually a 25 y/o male with no medical problems, would you still break the rule? I'd suggest not. Let's look at another rule.

PERC (Pulmonary Embolism Rule-out Criteria)

Mrs. Thomas is a 45 y/o female with palpitations, chest pain, and dyspnea. The symptoms started about two hours ago while visiting her husband who is in the MICU. She has hypertension but no other PMH. Specifically, she denies estrogen use, previous DVT or PE, and recent hospitalizations or surgeries. She denies hemoptysis. Her temperature, blood pressure, and respiratory rate are all well within normal limits, her pulse is 75, and her oxygen saturation is 98% on room air. Her physical exam is completely normal.

Should Mrs. Thomas be worked up for a PE? According to the PERC criteria (Age <50, HR <100, O_2 Sat ≥95, no hemoptysis, no estrogen use, no prior DVT or PE, no unilateral leg swelling, and no surgery or trauma requiring hospitalizing in the past four weeks) she can be "ruled out" for a PE and does not need further work up. Does that sound good to you? It sounds good to me. In a large prospective study, patients who met all PERC criteria had <1% chance of having or developing a PE within 45 days.[2] That seems to me about as good a guide as we will likely get. But … I skipped over one key part of the study, the population. To which patients should we apply PERC? According to the study, only to patients with a low clinical suspicion for PE, which is likely true of Mrs. Thomas.

So, PERC is a rule which we apply after making a clinical decision. Or, in other words: once we use our extensive medical knowledge and training to determine if our patient fits the population to which the rule is meant to apply, only then may we use the rule to determine care.

Rules are useful tools that we should use when appropriate. Rules do not insult our intelligence or diminish the value of our training. Automatons with rules will not replace doctors (at least for a little while). Ignoring rules is like a carpenter building a cabinet without a hammer. But using a rule without proper training and knowledge is like that same carpenter using the hammer to pound in a screw. It might work most of the time, but the results won't be pretty.

References:

1. Bachmann LM et al. Accuracy of Ottawa ankle rules to exclude fractures of the ankle and mid-foot: systematic review. BMJ. 2003 Feb 22;326(7386):417.
2. Kline JA et al. Prospective multicenter evaluation of the pulmonary embolism rule-out criteria. J Thromb Haemost. 2008 May;6(5):772-80.

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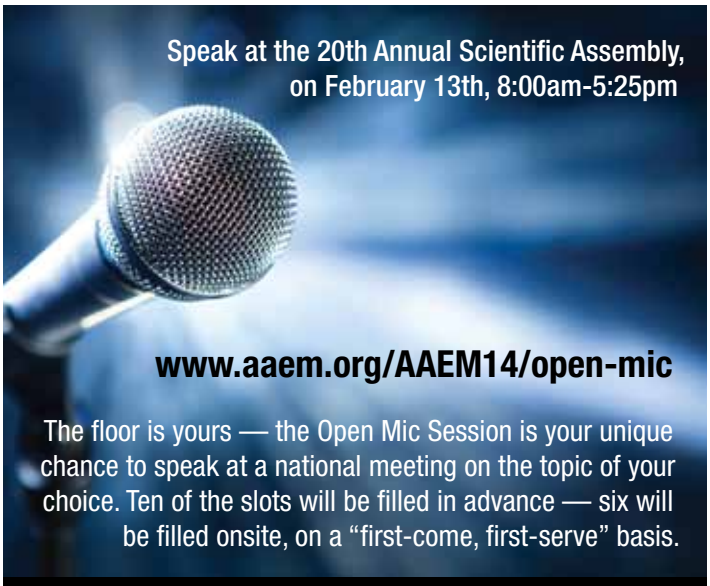

Speak at the 20th Annual Scientific Assembly, on February 13th, 8:00am-5:25pm

www.aaem.org/AAEM14/open-mic

The floor is yours — the Open Mic Session is your unique chance to speak at a national meeting on the topic of your choice. Ten of the slots will be filled in advance — six will be filled onsite, on a "first-come, first-serve" basis.

The top two speakers will be invited to give a formal presentation at the 2015 Annual Scientific Assembly in Austin, TX. To sign up, contact Marcia Blackman, mblackman@aaem.org or 800-884-2236.

Sponsored by the Young Physicians Section

Please join us for the inaugural

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Date: **Wednesday, February 12, 2013**
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How to Be an Effective Leader in the ED

Meaghan Mercer, DO
AAEM/RSA President

Leadership is creating a way for people to contribute to making something happen, developing an environment that allows cohesion and a drive toward a common goal. Leadership affects our lives on a constant basis and our role in the hierarchy changes as we shift from one environment to another: parent, boss, teacher, mentor. Leadership is a skill and learned behavior that becomes second nature over time and is important to cultivate, especially when working in the emergency department. In the ED we orchestrate the movement and flow of patients, staff, and resources, in a delicate yet chaotic balance. As we progress through residency, we gain the leadership skills to manage all the pieces until we unconsciously and fluidly become leaders in the field.

#1: Make Decisions

Being able to integrate data, understand cause and effect, calculate variables, and coming to a strategic conclusion are imperative abilities. When you first enter the medical field you want to dive into everything and get your hands on the patient, but as we progress we step further back. Over time, we develop an appreciation to take in the whole picture and direct ED flow that allows for anticipation and quick actions. We become instinctual decision makers having experienced the impact of our choices thus becoming immune to the pressure that comes with decision-making.

#2: Good Communication

Being adaptable and mastering the capacity to communicate with the melting pot of a typical ED allows for rapport with your patients, support staff, and colleagues. Effective leaders master the ability to clearly convey expectations, measure performance, and leave the door open to ideas. Physical and verbal cues can take a chaotic room to a calm working situation where each member can contribute and be utilized to the fullest. Mastery of dialogue also allows the encouragement of others to voice their opinions. There are few so wise that they cannot learn from others and allowing transmission of viewpoints gives everyone the opportunity to grow.

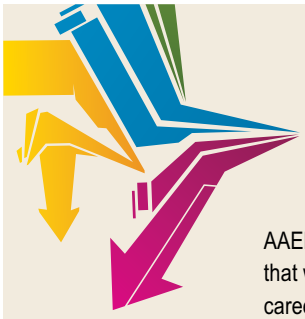
#3: Challenge Others to Think

It is easy to step into the leadership role and dictate tasks. Identify the capabilities and talent of those around you and challenge your team to reach their potential. Give people the chance for ownership and the freedom of creativity. Empower others to become leaders around you. As Lao-Tzu said, "The Master doesn't talk, he acts. When his work is done, the people say, "Amazing, we did it, all by ourselves!"

#4: Lead by Example

Leadership is an action, cultivate trust and expect more from yourself than anyone else. Be a leader that advances yourself, those around you, and take joy in your efforts. "When the Master governs, the people are hardly aware that he exists; next best is a leader who is loved, next one that is feared. The worst is one who is despised."

There are tons of ways to get national leadership experience through AAEM/RSA. As a resident you can join the VP Council and be the voice of RSA at your institution, join a committee, and run for the board of directors this February. As a student, become your medical school's EMIG contact, join a committee, or run for the Medical Student Council. The Scientific Assembly is just a few months away. Michael Gottlieb and the education committee have been hard at work finalizing the resident track. Mary Calderone, the Medical Student Council president, is creating an event that medical students shouldn't miss! The Scientific Assembly is being held in New York City on February 11th-15th and is free for all members, with refundable deposit. We hope to see you all there! ■



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Understanding the Urgent Care Clinic

Edward Siegel, MD MBA
AAEM/RSA Publications Committee Chair

Recently a family member tried to call me regarding a minor medical problem. Unfortunately I was working at the time, and our emergency department is the place where cell phone reception goes to die. I didn't know about the call until after my shift had ended and I saw the voicemail left on my cell phone. When I returned the call, I was told that the problem had already been taken care of by going to an urgent care clinic.

I must admit that I had mixed feelings about this. On one hand, I was glad that the issue was addressed and that my family member was getting the proper treatment for their minor medical ailment. On the other hand, I felt I should be the one to provide that solution, since I am the doctor in the family.

The experience led me to take a closer look at the urgent care clinic (UCC) industry, about which I knew very little, and which operates in parallel with emergency medicine.

The UCC market recorded $15 billion in revenue last year, with revenues growing 5.4% per annum over the last five years. There are over 9,000 urgent care and walk-in clinics nationwide, approximately half of which offer "full service" with lab and X-ray facilities, with over 135,000 employees. What constitutes a UCC varies wildly. While some states — such as Arizona, New Hampshire, and Delaware — have specific criteria for opening an UCC, most states do not.

Most UCC site owners are small players, owning only one or two sites. Approximately 20 organizations own more than five locations. The largest player is Concentra, with over 300 UCCs. Concentra was acquired by Humana, a publicly-held health insurer, in 2010, and has continued to pursue an aggressive strategy for acquiring other UCCs.

In addition to health insurers, other large players in the UCC markets include retailers like CVS (which itself owns Caremark, a pharmacy benefits manager) and hospitals. The rationale for hospitals to establish a foothold in the space appears to include several factors.

UCCs give hospitals the opportunity to carry their brand to multiple locations, both enabling advertising and bringing care closer to a wider range of patients. They also serve to draw in new patients (aka customers) for the hospital's specialists, bringing more reimbursement opportunities. Lastly, they offload some of the workload from the hospital's emergency department.

While Medicare-accepting emergency departments are directed by EMTALA to see all patients "regardless of an individual's ability to pay," UCCs usually ask for payment up front. A PricewaterhouseCoopers study illustrated cost advantages for patients using a UCC, finding that insured patients have average co-pays of $50 and $100 for UCCs and EDs, respectively.

Finding exact data on who works at these UCCs was more difficult for me. There is no recognized residency in urgent care medicine, though some post-residency programs designed for family medicine physicians do exist. Data on how many UCC practitioners are EM-trained versus trained in other specialties don't appear to exist, nor could I find information on the mix of doctors versus mid-level providers working at these facilities. Most references did cite emergency medicine and family medicine specialists as constituting the bulk of doctors working at these sites, alongside physician assistants and nurse practitioners.

In theory, the types of cases seen at UCCs should be of lower acuity. A 2010 Rand Corp. study estimated that 17% of cases seen in emergency departments nationwide could be treated at UCCs, resulting in an estimated savings of $4.4 billion.

That leads me to the first of many questions I had after conducting all of this research. While nearly one-fifth of ED cases could be handled in a UCC setting — if you believe the Rand Corp. — what is there to ensure that patients accurately judge their level of acuity? The risk of patients delaying appropriate care because they go to a facility ill-equipped to diagnose and treat their ailment is a real concern.

Another question centers on who is working at these facilities. After spending years establishing the value of an emergency medicine residency, how should we react to the emergency medicine-like activities of UCCs that do not require emergency medicine-trained physicians?

The "pay before treatment" business model of these UCCs also presents a problem for hospitals, as these sites will only draw those patients able to pay for their services. The result will be a worse payer mix for the ED, straining the resources of an already overburdened and underreimbursed system.

While the motive for hospitals to open UCCs seems reasonable and clear, the presence of so many insurers moving downstream into direct patient care should raise alarms. Are patients being directed to receive care based on what treatments are sold by the owner of the UCCs? Are physicians and other employees of UCCs under pressure to direct patients to treatments sold by their employers? Is there any true oversight to ensure conflicts of interest do not arise, leading to inferior patient care?

Just as I had mixed emotions about my family member seeking care from a UCC, so do I have mixed feelings toward the UCC industry. Many of our fellow residents do shifts in UCCs, both as part of their residencies and as moonlighters, and many of us will find ourselves working in UCC environments at some point after the conclusion of our residencies.

Many of our colleagues, based on blogs and editorials, see UCCs as a real threat to the emergency department. Many others appreciate the UCC as a complement to emergency departments. For me, there is no black and white answer. The UCC industry, given its size and growth rate, is here to stay. Understanding its origins, benefactors, potential,

Continued on next page

and limitations is important for us as physicians who will be interacting with this field for the foreseeable future. ■

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Resident Journal Review

Updates in Emergency Department Management of Soft Tissue Infections

Authors: David Wacker, MD PhD; Kami Hu, MD; Phillip Magidson, MD MPH; Carina Sorenson, MD; Michael Scott, MD; David Bostick, MD MPH; Michael Allison, MD; Adeolu Ogunbodede, MD
Editors: Michael C. Bond, MD FAAEM; Jay Khadpe, MD FAAEM

Skin and soft tissue infections (SSTIs) are a common entity in the emergency department (ED). This issue of the "Resident Journal Review" focuses on selected updates and review of key articles in the management of these infections. We specifically review articles on outpatient treatment regimens and antibiotic stewardship, predictors of outpatient treatment failure, clinical signs that a more serious infection may be underlying, and trends in pediatric treatment of soft tissue infections. For a detailed discussion of the individual articles please see the full review published on the AAEM/RSA website (www.aaemrsa.org/publications/aaemrsa-in-common-sense) and Medscape. Presented here is a listing of the articles reviewed and a brief synopsis of each.

Antibiotic Regimens and Stewardship

Routine treatment of skin and soft tissue infections in the ED is focused upon identification and drainage of fluid collections, followed by oral antibiotics and outpatient follow-up. The emergence of community acquired MRSA (CA-MRSA) and other resistant organisms have raised new concerns, though, about effective antibiotic regimens and responsible antibiotic stewardship. Here we review several articles on antibiotic choice and duration to guide outpatient therapy.

Khawcharoenporn T, Tice A. Empiric outpatient therapy with trimethoprim-sulfamethoxazole, cephalexin, or clindamycin for cellulitis. *Am J Med* 2010; 123(10), 942-50.

This retrospective cohort study at a single center, with a high incidence of CA-MRSA, looked at the rates of treatment success of cellulitis in outpatients treated with antibiotic monotherapy. A total of 405 patients met inclusion criteria; they were most commonly treated with cephalexin (44%), trimethoprim-sulfamethoxazole (TMP-SMX) (38%), and clindamycin (10%). Combined therapy with antibiotics and incision and drainage (I/D) was done in 28% of patients. Treatment success was significantly higher in the TMP-SMX group when compared with cephalexin (91% vs. 74%, OR 3.38; 95% CI, 1.79-6.39; p<0.001). Success rates were not significantly different in comparisons between clindamycin and cephalexin, or between clindamycin and TMP-SMX. Empiric therapy with antibiotics that cover CA-MRSA resulted in higher treatment success in this retrospective study.

Pallin DJ, et al. Clinical trial: Comparative effectiveness of cephalexin plus trimethoprim-sulfamethoxazole versus cephalexin alone for treatment of uncomplicated cellulitis: A randomized controlled trial. *Clin Infect Dis* 2013; 56(12), 1754-1762.

These investigators hypothesized that adding an antibiotic that covers MRSA would improve treatment outcomes in cellulitis when added to standard streptococcal therapy. They conducted a multicenter, prospective, randomized, double blind, placebo-controlled trial that enrolled patients with cellulitis who had less than one week of symptoms and no evidence of abscess. Patients were randomized to receive cephalexin plus TMP-SMX (intervention) or cephalexin plus placebo (control). The primary outcome was the risk difference for cure in the intention-to-treat (ITT) group, and cure was defined as resolution of symptoms other than slight residual erythema or rash at 12 days.

One hundred forty-six participants were included in the ITT analysis. Clinical cure was achieved in 85% of intervention patients and 82% of controls (risk difference 2.7%, 95% CI, -9.5% to 15%; p=0.66). These authors found no benefit to addition of TMP/SMX when treating cellulitis. The results of this are in contrast to the retrospective study by Khawcharoenporn presented earlier. The Pallin, et al., prospective randomized design adds additional weight to their conclusions; however, Pallin, et al., studied only uncomplicated cellulitis, excluding patients with abscess, whereas 44% of patients included in the Khawcharoenporn study had abscesses. Prior evidence has suggested that though streptococcal species are frequently responsible for simple cellulitis, MRSA is often the source of suppurative skin infections.[1] This may explain some of the discrepancy in benefit of CA-MRSA coverage between the two studies. Ultimately, the choice of antibiotic coverage remains dependent on local antibiotic resistance patterns, and clinical discretion.

Hepburn MJ, et al. Comparison of short-course (5 days) and standard (10 days) treatment for uncomplicated cellulitis. *Arch Intern Med* 2004; 164, 1669-1674.

The authors attempted to test the extent to which duration of antibiotic treatment affects outcome. Specifically, they compared a five-day and ten-day course of levofloxacin. The authors enrolled 121 patients from various sources including primary care clinics and urgent care facilities. All patients received five days therapy with levofloxacin, after five days patients were randomized to either receive placebo for five days (total 5 days antibiotic duration), or continue receiving levofloxacin for five further days (total 10 days duration). Exclusion criteria for randomization included worsening infection despite therapy, unimproved infection despite therapy, intolerance of levofloxacin, and missed follow up appointments. Both arms of the study had a 98% treatment success rate, suggesting the possibility that a shorter duration than the typical 7-10 day course prescribed for cellulitis could be equally successful.

While the study suggests a five-day course may be reasonable for uncomplicated cellulitis, the need for close follow up must be emphasized, particularly if a shorter course of antibiotics is used.

Continued on next page

Predictors of Treatment Failure

Most soft tissue infections can be safely managed in an outpatient setting with drainage of fluid collections, oral antibiotics and close follow-up. Occasionally, though, an abscess re-forms or infection persists despite these measures and inpatient management is necessary. Two studies set out to determine the factors associated with a higher risk of outpatient treatment failure.

Mistry RD, et al. Emergency department treatment failures for skin infections in the era of community-acquired methicillin-resistant Staphylococcus aureus. *Pediatr Emerg Care* 2011; 27(1): 21-26.

The authors of this study set out to quantify the failure rate for emergency department (ED) treatment of pediatric SSTIs, as well as to identify risk factors associated with these failures, including presence of CA-MRSA as the causative organism. Toward this goal, they performed a retrospective review of patients 18 years of age and younger with culture-positive SSTIs.

They examined several factors including demographics, initiation of antibiotics, causative organism, size of lesion, presence of surrounding cellulitis, and whether or not the initial ED treatment included drainage, but were unable to find any statistically significant associations with treatment failure (defined as any of these after initial evaluation: change in antibiotics, performance of I/D, or hospital admission). Out of 148 eligible patients, S. aureus was responsible for 87.1% of infections (66.2% MRSA, 20.9% MSSA). Eleven treatment failures (7.6%) were identified, all with S. aureus as the causative organism.

This study confirmed that most pediatric culture-positive skin infections are abscesses, and these are primarily caused by S. aureus infection. Initial ED treatment is effective 92% of the time, with most treatment failures requiring subsequent I/D and occurring regardless of whether or not initial antibiotic therapy is active against the causative agent, and whether or not that causative agent is CA-MRSA.

Olderog CK, et al. Clinical and epidemiologic characteristics as predictors of treatment failures in uncomplicated skin abscesses within seven days after incision and drainage. *J Emerg Med* 2012; 43(4), 605-611.

Using data previously collected on a cohort of 212 adult patients receiving I/D of abscess at four EDs, the authors attempted to determine if an association exists between abscess treatment failure within seven days of I/D and any of the following three variables: abscess ³5cm, surrounding cellulitis ³5cm, and MRSA positive cultures.

The authors found no significant difference in seven-day failure rates between abscesses ³5cm and those <5cm (26% vs. 22%, respectively, p=0.66). Similarly, the amount of surrounding cellulitis (<5cm vs. ³5cm) was not significantly associated with treatment failure (27% vs. 16%, respectively, p=0.1). Thirty-one percent of patients with MRSA-positive cultures failed treatment compared to 10% of patients without MRSA. Therefore, MRSA-positive cultures were a significant predictor of treatment failure (OR 4.7, 95% CI 1.9-11.7, p=0.001). However, the authors also found that neither abscess size nor size of surrounding cellulitis was significantly associated with MRSA-positive cultures.

In conclusion, SSTIs caused by MRSA have a higher rate of treatment failure; however neither the size of the abscess nor surrounding cellulitis was associated with outcomes.

Predictors of Deeper Infection

Although most presentations of cellulitis are limited anatomically to a single area and do not penetrate beyond the subcutaneous tissues, vigilance must be maintained for infections that have expanded to include deeper tissues (necrotizing fasciitis, tenosynovitis, osteomyelitis, septic arthritis), or spread systemically into the bloodstream. Two recent articles explore signs and symptoms suggestive of a more serious infection.

Peralta G, et al. Risk factors for bacteremia in patients with limb cellulitis. *Eur J Clin Microbiol Infect Dis* 2006; 25, 619-26.

This retrospective study reviews risk factors associated with bacteremia in patients presenting to the ED with limb cellulitis. The authors reviewed 2,678 patients presenting to a single ED with limb cellulitis, of whom 308 (about 11%) had blood cultures drawn, and 57 (18.5%) of these were found to be bacteremic. Factors most strongly associated with bacteremia were absence of previous antibiotic treatment (odds ratio 4.3, 95% CI 1.6-11.7), a length of illness less than two days (odds ratio 2.44, 95% CI 1.07-5.56), presence of two or more comorbid factors such as COPD, diabetes, renal failure or obesity (odds ratio 4.3, 95% CI 1.6-11.7), and proximal limb involvement (odds ratio 6.0, 95% CI 3.03-12.04). Although these results appear to highlight sub-segments of the population that may benefit from further diagnostic studies, this paper is limited in that no guidelines dictated which cellulitis patients received blood cultures, thereby making them eligible for inclusion. One could assume that patients with more severe cellulitis, abnormal vital signs, or who were toxic appearing were more likely to have had cultures drawn, thus biasing the study population toward sicker patients.

Based in part on this data, the Infectious Disease Society of America recommends against routine blood cultures for most patients presenting to the ED with isolated cellulitis as there is significant cost and limited benefit.[2] Specific patient populations, those who are immunocompromised, have multiple comorbid medical conditions, have a head or neck cellulitis, or possess the risk factors outlined in this paper may be more likely to be bacteremic. ED physicians should evaluate these patients on a case-by-case basis when deciding on the value of blood cultures.

Margaretten ME, et al. Does this adult patient have septic arthritis? *JAMA* 2007; 297(13), 1478-88.

Bacterial infection can cause significant, irreversible joint damage, but discerning a septic joint from a sterile inflamed joint or simply a superficial skin infection overlying a sterile joint poses a challenge. To address this, the authors of this paper performed a meta-analysis of studies that evaluated sensitivity and specificity of various presenting factors for

Continued on next page

infectious arthritis, including risk factors, laboratory studies and physical exam findings.

Their results were most notable for identified risk factors. Importantly, of the risk factors studied, a skin infection overlying a prosthetic knee or hip carried the strongest positive likelihood ratio for septic arthritis (15.0, 95% CI 8.1-28.0). Similarly, a skin infection overlying a native joint carried a positive LR of 2.8 (95% CI 1.7-4.5). Other predictive risk factors included age >80 (3.5, 95% CI 1.8-7.0), history of diabetes mellitus (2.7, 95% CI 1.0-6.9), rheumatoid arthritis (2.5, 95% CI 2.0-3.1), recent joint surgery (6.9, 95% CI 3.8-12.0), hip or knee prosthesis (3.1, 95% CI 2.0-4.9), and infection with HIV-1 (1.7, 95% CI 1.0-2.8). For all of the risk factors listed, the negative likelihood ratio was less than one, suggesting that the absence of any of these does not make the diagnosis less likely.

In light of the elevated likelihood ratio for septic arthritis in the setting of overlying soft tissue infection, emergency physicians must maintain a strong clinical suspicion when evaluating cellulitis. No single element of the history, finding on physical exam or laboratory study reviewed in this paper definitively diagnoses or rules out joint sepsis.

Updates in Management of Pediatric SSTIs

Skin and soft tissue infections continue to be a common pediatric ailment just as in adults. Also similar to adults, the spread of CA-MRSA has muddied the waters of antibiotic choices in pediatric emergency departments (PEDs). We review two recent papers investigating treatment strategies for SSTIs in pediatrics.

Kharazmi SA, et al. Management of afebrile neonates with skin and soft tissue infections in the pediatric emergency department. *Pediatr Emerg Care* 2012; 28(10), 1013-16.

To better characterize patterns in the management of pediatric skin and soft tissue infection, the authors performed a retrospective cohort study examining neonates ages 0-28 days old seen for SSTI in two large PEDs over a six year period. Included subjects were reviewed as to the type of SSTI present, the types of cultures taken and their outcome, whether antibiotics were given, and whether the patient was admitted. Patients were followed up within one month of the initial visit to identify any potential treatment failures.

One hundred and four neonates were included in the study. Blood cultures were obtained in 13% of pustulosis cases, 96% of cellulitis cases, and 69% of abscesses. Urine cultures were obtained in 0% of pustulosis cases, 62% of cellulitis cases, and 35% of abscesses. CSF cultures were obtained in 0% of pustulosis cases, 53% of cellulitis cases, and 25% of abscesses. Methicillin-resistant S. aureus was found in 25 of 49 cultures obtained by drainage or skin swabs. Of note, none of the study subjects had a positive blood, urine, or CSF culture.

Patients with cellulitis were more likely to have blood cultures drawn (OR 13.7; CI 3.03-62.3), to receive IV antibiotics (OR 5.87, CI 2.16-15.0), and to be admitted to the hospital (OR 5.62, CI 2.16-14.6) as compared to other SSTIs studied. Pustulosis cases were the least likely to receive blood cultures, IV antibiotics or to be admitted. Only four of the 36 discharged neonates returned to the ED within 72 hours after discharge. No neonate returned with a fever. Reviews of all return visits showed no neonate returned for fever or skin and soft tissue infection related complaints within 28 days.

Of the neonates included in this study, none were found to have bacteremia, a urinary tract infection, or meningitis. This suggests that for afebrile neonates with SSTI obtaining cultures may be unnecessary. As always, though, clinical discretion should dictate management.

Duong M, et al. Randomized, controlled trial of antibiotics in the management of community-acquired skin abscesses in the pediatric patient. *Ann Emerg Med* 2010; 55(5), 401-407.

The authors investigated whether a course of antibiotics post-drainage of skin abscess improved cure rates relative to drainage alone. They conducted a randomized controlled trial, in which afebrile pediatric patients presenting to a single, large urban emergency department with skin abscess were randomized to receive either TMP-SMX or placebo for 10 days following drainage of their abscess. Patients were followed at 10 and 90 days. The primary endpoint was treatment failure at 10 days; the secondary endpoint was formation of a new lesion at either the 10 or 90-day follow up points.

Of 1,305 patients presenting with abscess during the study period, 161 were enrolled in the trial and randomized, 76 (52%) to the placebo group and 73 (48%) to the antibiotic group. Both groups had similar rates of treatment failure: 5.3% in the placebo group and 4.1% in the antibiotic group. The difference of 1.2% established non-inferiority with a one-sided 95% confidence interval of -∞ to 6.8%, suggesting that antibiotics following drainage of skin abscess do not definitively improve outcomes.

Conclusions

The management of skin and soft tissue infections in the ED continues to be challenging, especially in the face of increasing incidence of drug-resistant bacteria. Good antibiotic stewardship through knowledge of local antibiograms and appropriate duration of treatment will help improve outcomes now and for years to come. Similarly, recognition of signs that outpatient treatment of an SSTI may fail, or that there may be a deeper infection will help avoid return trips to the ED, and reduce morbidity associated with missed infections. ■

Additional Resources

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Medical Student Council President's Message

"That's So Meta": Cognitive Bias

Mary Calderone, MS4
AAEM/RSA Medical Student Council President

I was nearing my second month of emergency medicine as a fourth year student, buzzing around the department with the excitement of finally having "learned the ropes." I had improved immensely in both my patient evaluations and my presentations, and I started to experience genuine confidence in my assessments and plans. Basically, it was the perfect storm for being appropriately humbled.

Sure enough, that very shift I evaluated a patient with abdominal pain and nearly missed an acute appendicitis. In subsequently analyzing my pitfall, I realized I had focused so much on the subjective description of the pain's location (bilateral upper quadrants), that I ignored a discordant objective exam finding: voluntary guarding in the right lower quadrant. "No, he doesn't have appendicitis," I thought, "He reports no pain in the RLQ, and although he is tensing up when I palpate there, he says his pain is higher up." During my presentation, I confidently stated that this patient was likely suffering from "gastritis, peptic ulcer disease, biliary colic or pancreatitis," that his abdomen was "overall benign," and that he would not require a CT scan — labs would be sufficient for now. Sure enough, his CBC returned with an elevated white blood cell count and the CT abdomen (ordered by an astute resident who evaluated the patient after me) showed a dilated appendix consistent with early acute appendicitis. I left that night with mixed emotions, experiencing a combination of fear and guilt for having overlooked a critical diagnosis and a sense of relief that my superior had caught my error.

Since that night, which I considered an important wake up call, I've spent a great deal of time reflecting on the topic of diagnostic error. Studies have shown that the specialties most prone to diagnostic uncertainty are predictably also the specialties most prone to diagnostic error. Emergency medicine, in particular, has been described as a "natural laboratory of error" due to a unique milieu of rapid decision-making based on limited information in high-stakes, emotionally-charged situations. This environment, although appealing to those of us who thrive on the challenge, has its consequences: approximately half of all litigation brought against emergency physicians arises from delayed or missed diagnoses.

We can't change the fact that we're human, and in case you haven't heard, humans make mistakes. Thus the question is, how do we overcome our limitations? Medical school might teach us how to think like doctors, but great clinicians take it a step further and learn how to think about how they think. Yes, that sounded weird, but you read it correctly. This concept of "metacognition" refers to an approach to problem solving that requires one to step back from the immediate problem and reflect on the thinking process itself. The metacognitive approach requires awareness of the various types of cognitive bias as well as strategies to overcome them. Given that over 30 different types of cognitive bias exist, this poses a challenge. Dr. Pat Croskerry wrote an excellent paper in the August 2003 issue of *Academic Medicine*, detailing various examples of cognitive bias — a few of which I will highlight here.

My anecdote of the missed appendicitis serves as an example of "the overconfidence bias," or the tendency to believe that we know more than we do. This bias leads us to act on incomplete information and overemphasize opinion over evidence, which can subsequently result in overly aggressive definitive action or equally deleterious delays in critical interventions. At the novice level, beware having overconfidence that your patient is not sick and in need of urgent intervention. Certain conditions should remain diagnoses of exclusion until you've gained the experience to competently conclude otherwise.

By the end of your first emergency medicine rotation, you are bound to have encountered a sick patient who snuck through the triage process and is now sitting in a fast track room, unconnected to the monitor and potentially on the brink of decompensating. This sets up the classic scenario of "triage cueing," the tendency to assume a patient's level of acuity based on their initial triage classification. As the physician evaluating that patient, it becomes your responsibility to verify that they have been triaged appropriately and ensure they are placed in the part of the ED that will provide you with the best access to resources in case that patient's condition rapidly deteriorates.

Every emergency department has its "frequent flyers," which can present another scenario ripe with the potential for cognitive bias. The "posterior probability error" occurs when a physician bases the estimate of disease likelihood on a patient's prior presentations. Even if a patient frequently presents to the ED with panic attacks, chalking up that patient's chest pain to anxiety may divert you from making a critical diagnosis such as acute coronary syndrome. ED presentations of the same patient for the same complaint can differ, and you must take the appropriate steps to identify important changes in their health status and the etiology of their complaint.

These few examples only scratch the surface of a large body of literature exploring the root of medical error. In most cases bias is multifactorial, with multiple forms simultaneously at play. Sometimes, the same intuition or inclination toward decision-making and action that will save one patient's life will harm another, and even the utmost awareness of potential pitfalls and their solutions will not prevent all errors. For that reason, you should ask the following questions when deciding if emergency medicine is the right fit for you: are you comfortable making decisions despite uncertainty? Can you cope with the fact that you will make mistakes, and will you dedicate yourself to learning from them? And perhaps most importantly, when you do make errors, can you recover quickly enough to walk into the next patient's room with a fresh mind, ready to give that patient your full attention? ■

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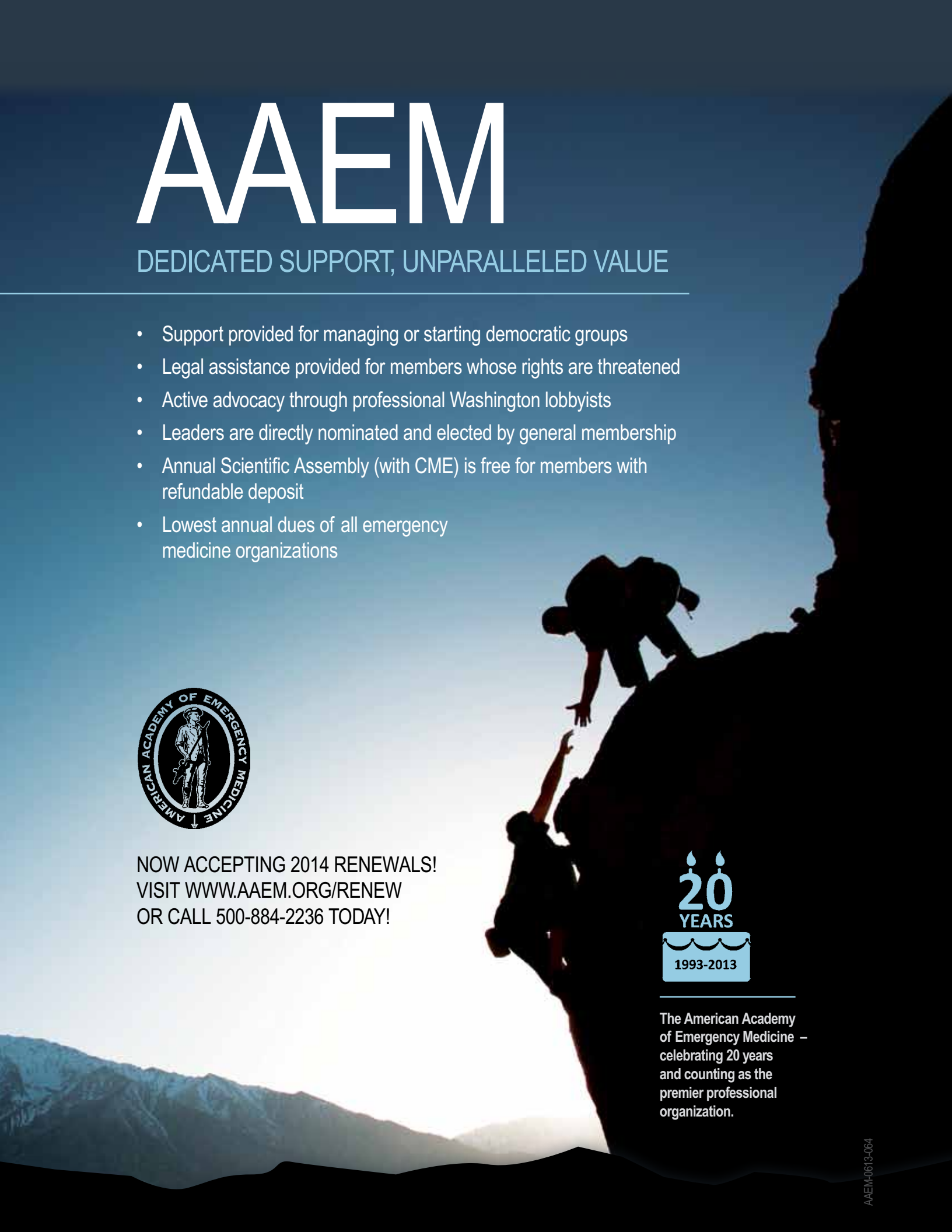

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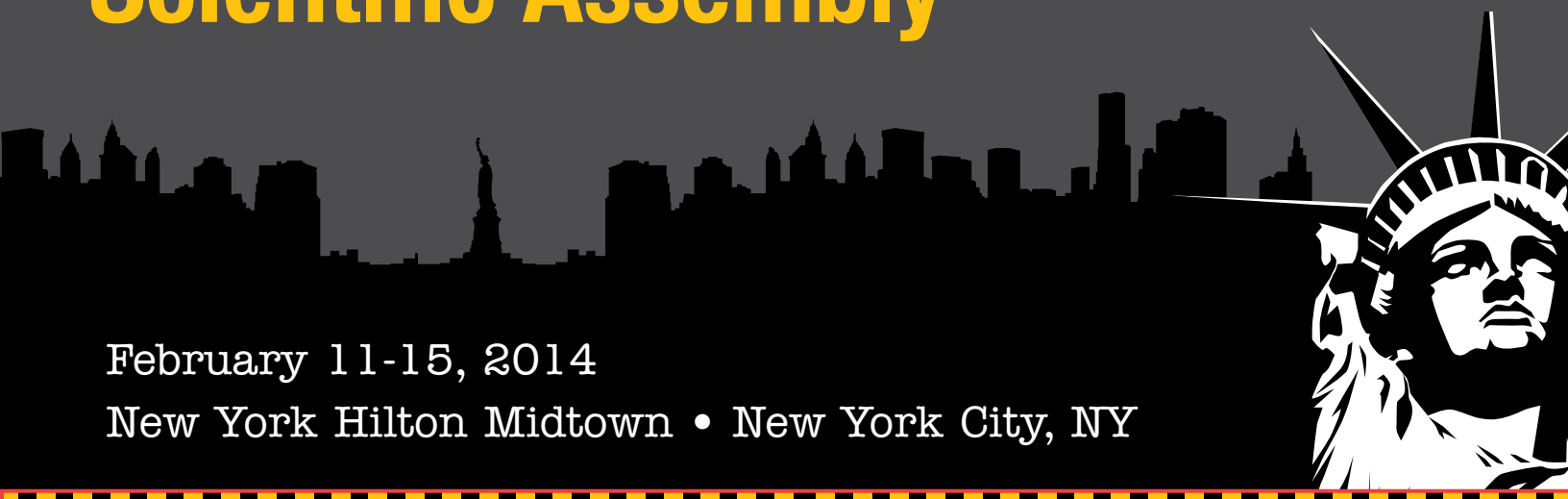
20th Annual Scientific Assembly



February 11-15, 2014

New York Hilton Midtown • New York City, NY

Registration Now Open!

Free* Registration for Members

**With refundable deposit*

Preconference Courses

February 11, 2014

- Advanced Ultrasound
- Introductory Ultrasound
- Resuscitation for Emergency Physicians
- Pediatric Emergency Department Simulation: Critical Skills from Delivery to Stepping on the School Bus
- Health Care Reform: Is Your ED Prepared? The Operations Management Perspective (Presented by the Operations Management Committee) — 2 day course

February 12, 2014

- High Risk Electrocardiography
- Living the Tactical Life: Lessons and Skills from Tactical Military Medicine (Jointly sponsored by USAAEM)
- Medical Student Track