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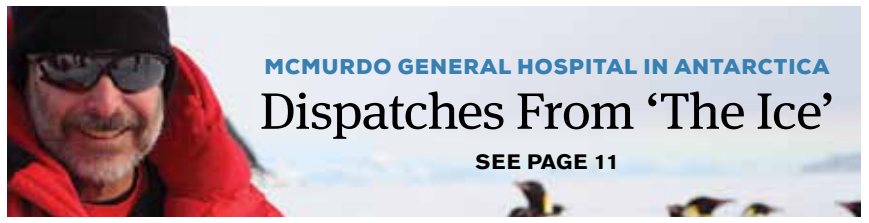

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WHY DO WE CARE ABOUT WELLNESS?

Emergency Medicine Wellness Week 2016 will focus on how emergency physicians can manage self-care

INTRODUCTION *by* JAY A. KAPLAN, MD, FACEP

In the early seasons of the TV show *ER*, Dr. Peter Benton is seen in the lead-in video doing a fist pump after he began an emergency surgery on his own. He had come of age.

I saw that on TV, and I got jealous because I asked myself how often, at the end of my day as I was leaving the emergency department, did I make that move, did I feel and say, "Yes, today was why I became an emergency physician." More often, my expression was one of relief, "Thank goodness that shift is over." I started thinking that if 75 percent of the time I did not feel fulfilled and thankful for my day, something was wrong.

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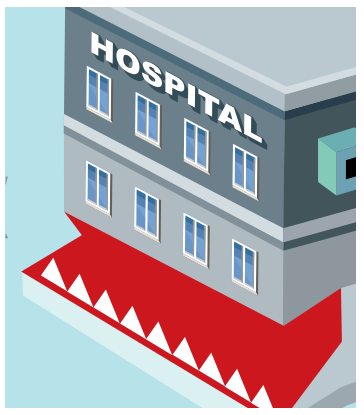

To Merge or Not to Merge

Highlights from the ACEP15 Council Town Hall Meeting on M&A: Part 1

Editor's Note: *The ACEP Council hosted a Town Hall meeting on mergers and acquisitions on Oct. 24, 2015, in Boston. Here is an edited transcript of the discussion, including the introduction by then-Council Speaker Kevin M. Klauer, DO, EJD, FACEP, chief medical officer–emergency medicine, chief risk officer for TeamHealth, and* ACEP Now *medical editor-in-chief.*

INTRODUCTION
by KEVIN KLAUER, DO, EJD, FACEP

This is our Town Hall meeting and should represent a topic that is really important to the practice of emergency medicine, our specialty, and beyond: mergers and acquisitions. Many of us may not know a lot about this process and how it could impact us, but I think it's time we discussed it so that we are all more informed about mergers and acquisitions in medicine. That's why I titled this "Mergers and Acquisitions: The Medical Shark Tank." I tried to get Mark Cuban; he still hasn't responded to the request. I've asked Ricardo Martinez, who has a wealth of broad health care knowledge, to moderate this session.

CONTINUED *on page 6*

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The Official Voice of Emergency Medicine

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UPDATES AND ALERTS FROM ACEP

NEWS FROM THE COLLEGE

Chaney Receives Lifetime Achievement Award From AMA

The American Medical Association (AMA) Board of Directors awarded a Medical Executive Lifetime Achievement Award to W. Calvin Chaney, JD, CAE, ACEP's former general counsel and associate executive director for policy and administration.

The award, which was given to Mr. Chaney during the opening session of the AMA's interim meeting in Atlanta in November, honors medical association executives who have "contributed substantially to the goals and ideals of the medical profession," according to the AMA.


Mr. Chaney

AMA President Steven J. Stack, MD, FACEP, said Mr. Chaney was honored "for his dedication and tireless work advocating for improved patient access to emergency health care."

Mr. Chaney joined ACEP in 1992 as its first state legislative director. He helped develop ACEP's initial advocacy resources and provided support and guidance to ACEP chapters, including drafting legislation, hiring and evaluating lobbyists, and providing advocacy training for members.

During his 22 years with ACEP, Mr. Chaney played a key role in advancing emergency medicine and patient access to care. One key accomplishment was his work on the prudent layperson standard legislation, which provided safeguards for patients seeking emergency care when health plans were denying coverage to those who ultimately were deemed to have a nonemergent diagnosis. In addition, the legislation prohibited requiring patients to seek preauthorization. As a result of his efforts, according to the AMA, legislation was passed in 47 states and included Medicaid, Medicare, federal employee health plans, and, most recently, the Affordable Care Act.

Mr. Chaney served as president of the American Association of Medical Society Executives, chaired several committees, and led trainings as part of the association's New Medical Executive Institute. He received an honorary membership award from ACEP at ACEP15 in Boston.

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Recent topics added to the site include:

- A Model of Cost-Effectiveness of Tissue Plasminogen Activator in Patient Subgroups 3 to 4.5 Hours After Onset of Acute Ischemic Stroke
- A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department
- A Performance Improvement Prescribing Guideline Reduces Opioid Prescriptions for Emergency Department Dental Pain Patients

'ACEP Frontline' Gives Voice to Key Issues in EM

The hottest topics in emergency medicine are now accessible online through free ACEP podcasts.

"ACEP Frontline," hosted by Ryan Stanton, MD, FACEP, features in-depth conversations with leaders in emergency medicine about important issues facing emergency physicians.

The podcasts will be posted throughout the year, and the first three episodes are already available: "Choosing Wisely" with Kevin Klauer, DO, FACEP; "Interventional Stroke Care" with Christian Ramsey, MD; and "Peds EM Update" with Al Sacchetti, MD, FACEP.

Future episodes will address the new tPA clinical policy, staffing models, endovascular therapy for stroke, and more.

The podcasts can be accessed at https://itunes.apple.com/us/podcast/acep-frontline/id1063793120?mt=2.

Nominations Deadline for Blue Jay Consulting/EMF ED Award Is Feb. 15

Nominations are being accepted for the Blue Jay Consulting/Emergency Medicine Foundation Emergency Department Director of the Year Award.

The award recognizes emergency physician leaders who have demonstrated exemplary collaborative skills in the emergency department. The deadline for submitting nominations is Feb. 15.

The nominee must be an active or life member of ACEP and must currently be in a leadership position in an emergency department. The nominee must show significant contributions in six categories: collaboration with nursing, quality patient care, operational effectiveness, education, community service, and a synergistic approach to leadership within the hospital or hospital system.

A member of ACEP may self-nominate or may nominate another ACEP member. ***For more information, visit www.emfoundation.org/directoraward.***

THE BREAK ROOM

Another EM Ninja

I read the article on the ED physicians participating on *American Ninja Warrior*. However, the list was not complete. One of my colleagues, Dr. Richard Shoemaker, not only participated in *American Ninja Warrior*, he advanced to the national competition in Vegas. He may not have received as much TV time as the perennials, but he too is a true warrior.

I just wish he was listed as well.

–Gregory Cuculino, MD, FACEP
Glen Mills, Pennsylvania

The Editors Respond

Thank you for letting us know about Dr. Shoemaker's participation. We regret the oversight and have updated the article online to include him. Congratulations to Dr. Shoemaker for his accomplishments as a warrior!

Split or Supertrack?

I found it somewhat difficult to empathize with Perth Amboy's ED dilemma (227 minutes discharge average, 3.2 percent LWBS) in a 36-bed ED with 17 percent admits and a 47,000 annual census ["Split for Success," Nov. 2016]. My ED (St. Francis Hospital in Federal Way, Washington) will see 55,000 patients, with 16 percent admits and transfers in 2015, with 3 percent LWBS and a 150-minute median for discharged patients—in a 24-bed ED.

The Perth Amboy ED has a very high low-acuity population (40 percent triage level 4 and 5) and would've probably been better served by developing a supertrack segmentation for these lowest-acuity patients.

–Jeffrey M. Cortazzo, MD, FACEP
Federal Way, Washington

Dr. Welch Responds

Dear Dr. Cortazzo,

It sounds like you work in a very efficient shop! Perth Amboy on the other hand was struggling ....

You are right—there were many options for them to consider that would improve workflow and patient flow. I might have put a provider in triage and employed vertical patient flow, for example. That said, ESI 3 patients dominate in every emergency department, and the management of this heterogeneous and diverse group of patients is becoming a universal challenge in emergency medicine.

That is why their story was attractive to me and, in my view, worth telling. It has widespread applicability and transferability to many other EDs and addresses a universal problem. It may provide a starting point for other EDs trying to manage the tidal wave of ESI 3 patients.

Hey, they did cut their door-to-physician time dramatically with the new model. Doesn't that earn them some kudos?

Thanks for your comments!

–Shari Welch, MD, FACEP
Salt Lake City

2016 Payment Update

CENTERS FOR MEDICARE & MEDICAID SERVICES RELEASES FEE SCHEDULE FOR 2016

BY MICHAEL A. GRANOVSKY, MD, FACEP, AND DAVID MCKENZIE, CAE

The Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (PFS) Final Rule on Oct. 30, 2015. It addresses changes to the PFS as well as other important Medicare Part B payment policies. The rule became effective Jan. 1, 2016, and was published in the Nov. 16, 2014, Federal Register.

Conversion Factor

At the conclusion of 2015, the Medicare conversion factor (the amount Medicare pays per Relative Value Unit [RVU]) was set at $35.9335. The 2016 rule is no longer governed by the Sustainable Growth Rate (SGR) formula, which had mandated continuing annual cuts to physician payments, resulting in year-after-year Congressional rescues with short-term fixes. Instead, with the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law on April 16, 2015, the draconian SGR cuts were permanently repealed and the conversion factor was stabilized. In addition to broad sweeping payment reform related to Physician Quality Reporting System (PQRS), the value-based payment modifier (VBM), meaningful use, and alternative payment models, MACRA provides positive annual payment updates of 0.5 percent through 2019. However, due to two additional pieces of legislation—Protecting Access to Medicare Act of 2014 (PAMA) and Achieve a Better Life Experience Act of 2014, which mandate net cost savings of 1 percent—the final 2016 conversion factor will actually be decreased by 0.3 percent. As a result, the 2016 Final Rule published a conversion factor of $35.8279 (see Table 1).

Merit-Based Incentive Program

The Merit-Based Incentive Payment System (MIPS) is a new payment mechanism that will provide annual updates to physicians starting in 2019 based on performance in four categories: quality, resource use, clinical practice improvement activities, and meaningful use of an electronic medical record (EMR) system.

Unlike the flawed SGR, the new system will adjust payments based on individual performance. Importantly, MIPS does not set an arbitrary aggregate spending target, which previously led to the need for annual patches to prevent SGR-mandated cuts. The three existing quality programs (PQRS, VBM, and EMR) will be consolidated under MIPS beginning in 2019. An overview of the evolution of the various federal quality programs is in Table 2.

Geographic Practice Cost Index Update

The Geographic Practice Cost Index (GPCI) is used by CMS to modify the RVU values based on regional differences relating to cost of living, malpractice, and practice cost/expense, which allows Medicare to adjust reimbursement rates taking into account regional and practice-specific factors. Some states have a permanently fixed work GPCI, including Alaska at 1.5 and the frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming) at 1.0. Other states are subject to a work RVU GPCI that ranges from 0.6 to 1.2. In past years, Congress passed single-year legislation, setting a GPCI work floor of 1.0 that then expired at the end of the year. Section 102 of PAMA allowed for another extension of the work GPCI floor, and the existing 1.0 floor on the physician work GPCI was extended through March 31, 2016.

ED E/M RVUs Stable for 2016

Emergency medicine's RVU values are stable for 2016, with only small decimal point–level changes. For 2016, the work RVUs for emergency medicine services remain unchanged. The total RVUs (work, malpractice, and practice expense RVUs) associated with ED E/M services 99281–99285 and 99291 will experience small changes driven by adjustments in practice expense and liability expense. The CMS-published specialty-specific impact analysis states that emergency medicine will experience a 0 percent update in overall RVU values for 2016. The 0 percent increase for emergency medicine as a specialty published by CMS contains moderate rounding. Though accurate for 99283, the RVUs for many of the other ED codes are minimally decreased at the hundredth of an RVU level (see Table 3).

Critical Care Services

Critical care services were also revalued as part of the Final Rule and benefited from a small increase (see Table 4).

Physician Quality Reporting System

PQRS continues for 2016. Groups not reporting PQRS measures in 2016 will receive a 2 percent penalty assessed against their 2018 Medicare allowables. Additionally, failing to satisfy 2016 PQRS reporting requirements would trigger an additional 4 percent penalty for most groups under the VBM program for a total penalty of 6 percent in 2018.

For 2016, satisfactory PQRS reporting requires at least nine measures, involving three National Quality Strategy domains, for at least

Table 1. Calculation of the 2016 Conversion Factor

CONVERSION FACTOR IN EFFECT IN CY 2015	**35.9335**
Update Factor	0.5% (1.005)
CY 2016 RVU Budget Neutrality Adjustment	-0.02% (0.9998)
CY 2016 Target Recapture Amount	-0.77% (0.9923)
CY 2016 Conversion Factor	**35.8279**

Table 2. Transition of Federal Quality Programs

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026+
Base	0.5%	0.5%	0.5%	0.5%	0.5%	Based Conversation Factor Update of 0.0% Each Year						0.25%
EMR	Continues under current law				+/-5% MIPS	+/-5% MIPS	+/-7% MIPS	+/-9% MIPS				
PQRS	Continues under current law											
VBM	Continues under current law											
MIPS												

Table 3. 2016 ED E/M RVUs 99281–99285

CODE	2015 WORK RVUs	2016 WORK RVUs	2015 PE RVUs	2016 PE RVUs	2015 TOTAL RVUs	2016 TOTAL RVUs
99281	0.45	0.45	0.11	0.11	0.59	0.60
99282	0.88	0.88	0.21	0.21	1.16	1.17
99283	1.34	1.34	0.29	0.29	1.75	1.75
99284	2.56	2.56	0.53	0.53	3.33	3.32
99285	3.80	3.80	0.75	0.75	4.93	4.90
99291	4.50	4.50	1.43	1.42	6.33	6.31

Table 4. Critical Care Services

CPT CODE	2015 WORK RVUs	2016 WORK RVUs	2015 TOTAL RVUs	2016 TOTAL RVUs
99291	4.50	4.50	6.33	6.31
99292	2.25	2.25	3.16	3.16

Table 5. Predominant 2016 Potential CMS ED PQRS Measures Typically Applicable to ED Providers

MEASURE #	DESCRIPTION	DOMAIN
PQRS #54	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	Clinical Effectiveness
PQRS #76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	Patient Safety
PQRS #91	Acute Otitis Externa (AOE): Topical Therapy	Clinical Effectiveness
PQRS #93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Efficiency & Cost Reduction
PQRS #187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy (tPA)	Clinical Effectiveness
PQRS #254	Ultrasound Determination of Pregnancy Location for Pregnant Patients With Abdominal Pain	Clinical Effectiveness
PQRS #255	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure	Clinical Effectiveness

Table 6. 2016 PQRS Impact for Groups of 10 or More Providers

	QUALITY PROGRAM	PAYMENT IMPACT
1	**Traditional PQRS Penalty**	Potential 2.0% decrease in 2018 for 2016 performance
2	**VBM**	Potential 4.0% decrease in 2018 for 2016 performance
Total Potential Penalties		**6.0% decrease in 2017 for 2016 performance**

50 percent of the Medicare part B patients during the year. Additionally, the 2015 requirement for reporting on a cross-cutting measure continues for 2016.

The predominant 2016 potential CMS ED PQRS measures typically applicable to ED providers are listed in Table 5. There are also three new measures related to head CT utilization, including head CT for adult blunt head trauma, head CT use in the pediatric population, and use of neuroimaging in patients with a primary headache.

2016 Value-Based Payment Modifier

The Affordable Care Act requires CMS to apply a VBM to physician payments for all providers by 2017. CMS has been gradually phasing in the VBM program. For 2016, the VBM carries a potential penalty of 4.0 percent for groups of 10 or more providers (eligible providers include all physicians and advanced practice providers, full time and part time). The VBM penalty will be applied to 2018 payments based on 2016 dates of service. The VBM penalty will be avoided if at least 50 percent of the providers within a group satisfy the minimum PQRS reporting requirements in 2016.

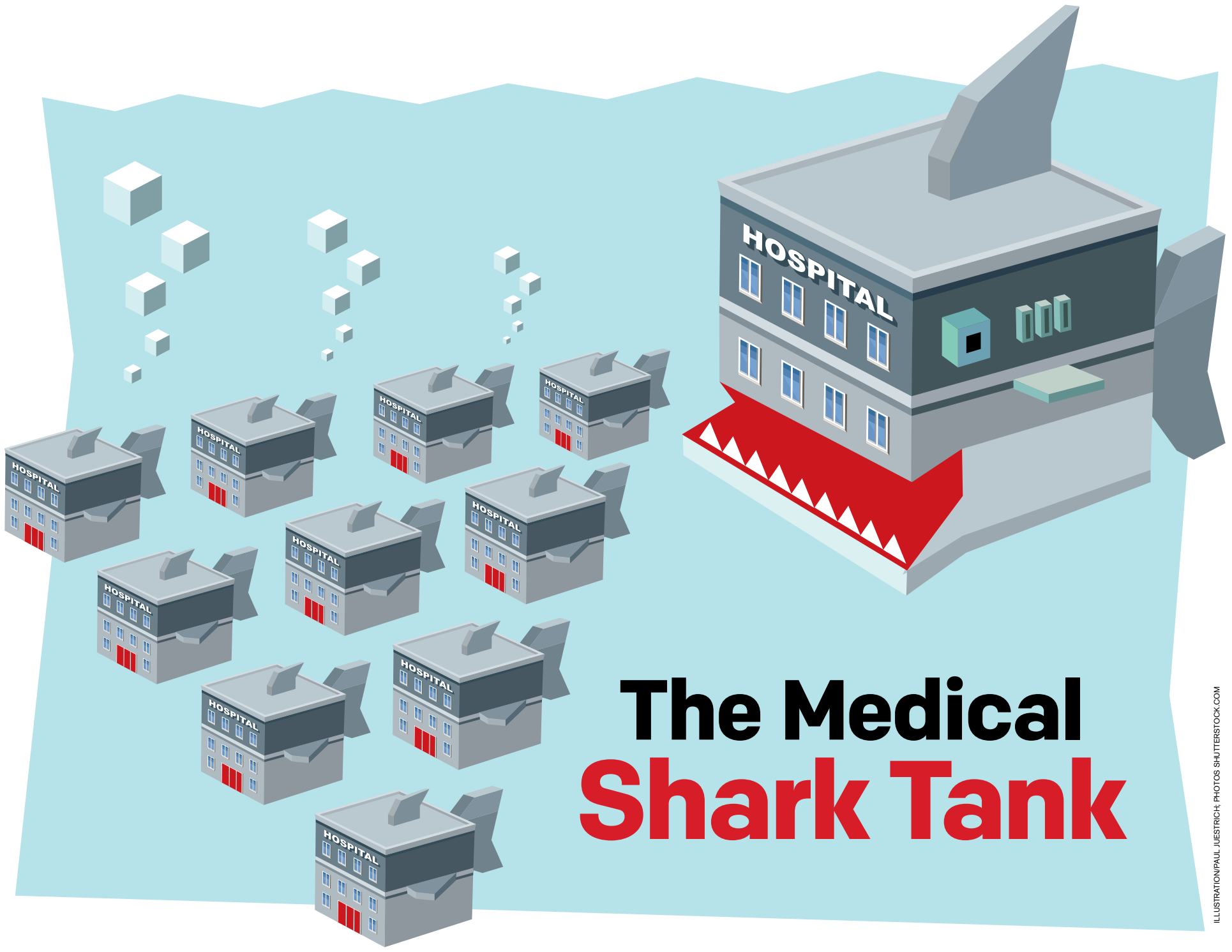
CMS is also continuing the VBM scoring methodology, which looks at both cost and quality scoring for individual providers and groups. Failing to meet the PQRS reporting requirements would trigger an automatic 4 percent penalty under the VBM program (see Table 6 for a summary of PQRS penalties). Groups satisfying PQRS reporting go on to the quality-tiering step and will be graded as below average, average, or above average and have the potential to earn a small bonus. Importantly, as MIPS takes over in 2019, VBM is being phased out after 2018.

Other Resources

Resources for these and other topics can be found on the reimbursement section of the ACEP Web site. Mr. McKenzie is also available to field your questions at 800-708-1822, ext. 3233. Finally, ACEP offers well-attended and highly recommended coding and reimbursement educational conferences each January.

Next month, we'll look at the CMS proposal to eliminate the global surgical package for procedures, 2016 coding changes, an ICD-10 update.

DR. GRANOVSKY is president of LogixHealth, an ED coding and billing company, and currently serves as the course director of ACEP's coding and reimbursement courses as well as the Chairman of ACEP's National Reimbursement Committee. **MR. MCKENZIE** is reimbursement director for ACEP.



The Medical Shark Tank

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MODERATOR

Ricardo Martinez, MD, FACEP, chief medical officer for North Highland Worldwide Consulting and assistant professor of emergency medicine at Emory University in Atlanta

PARTICIPANTS

Brent Asplin, MD, MPH, FACEP, chief clinical officer for Mercy Health in Ohio

Savoy Brummer, MD, FACEP, vice president of practice development at CEP America in Belleville, Illinois, and chair of the ACEP Democratic Group Section

Ray Iannaccone, MD, FACEP, president of EmCare

Jay Kaplan, MD, FACEP, President of ACEP; director of the patient experience for CEP America in Emeryville, California; and a practicing clinician in the emergency department at Marin General Hospital in Greenbrae, California

RM: I think we have a very good group to talk about mergers and acquisitions, which are happening fairly quickly. The United States is seeing a lot of consolidation in many different markets. I'll start with Dr. Asplin: what is driving hospital consolidation, and is that a good thing or a bad thing?

BA: The first thing to consider is that, relative to other industries, we're actually on the front end of a consolidation movement. We're really still quite fragmented in health care. The majority of primary care practices in the country are still using three providers or less. Look at other industries, like how many U.S.-based global airlines there are now. Look at telecommunications, and soon we may only have three large for-profit health insurers that are national in scope. There are three basic financial drivers: liquidity and balance sheet drivers, operational metrics, and purchasing power. It's about spreading fixed overhead costs to a larger base and gaining efficiency. It's about building a stronger balance sheet to be able to withstand shocks to that balance sheet. Even though the cost of capital is at a historical low, it's also about maintaining a strong rating to be able to access capital at rates that are favorable. You also want purchasing power in terms of supply chain and some asymmetry of negotiations. Those are the financial drivers, but I think uncertainty is one of the biggest drivers of consolidation. Even if all is going well for an independent community hospital, things can go from strong performance to the brink of solvency quickly, particularly with the dramatic swings we may be seeing in reimbursement. That is why you are going to see more hospital consolidation unless you have a compelling brand where you can continue to go at it as a single institution. Children's hospitals would be some of the classic examples of a single-institution compelling brand. I think consolidation is a good thing for the system overall because we will lose fewer access points in hospitals because of it than we would if those hospitals remained independent.

RM: Great, thank you. Two things to throw on your plate: one of those is a business concept called rule of threes that comes out of a Georgia Tech business school. Basically, everything consolidates down to three. Look at cellular companies. You mentioned the insurance companies consolidating to three. Secondly, everyone's figured out it is time to go after the children's hospitals, so they are under great stress right now. Savoy?

SB: I would completely agree with all those drivers. I think uncertainty has another more common name, which is fear, and a lot of hospital systems have a fear of obsolescence. They're looking to consolidate to eliminate much of their competition in other areas. They're looking for new sources of revenue to, perhaps, offset some of their losses in other areas. Obviously, increasing their market share allows them to do that.

RM: Thank you very much. Dr. Iannaccone, in your role, you have a large perspective across the country.

RI: The only thing I would add is that as hospitals and health systems are looking at what they have to do over the next few years to maintain what thin margin they have, a small community hospital looks at the daunting task in terms of IT, purchasing, upkeep, or putting together a robust physician network. I think they recognize they need a certain amount of scale to do that. I've been told by health system CEOs that they know that the number of patients admitted to their hospitals is going to go down. They're going to need a bigger, broader base of people to fill the beds while they're in the gap years until they're getting paid for quality.

RM: Thank you. Jay?

JK: Well, the single biggest driver of health care reform is cost. As organizations look to decrease their expenses, two of the ways they do that is to eliminate competition and to eliminate unnecessary expenses. One of the ways they can eliminate those items is through purchasing power, which Brent mentioned. Another strategy is to develop what are being called HROs, or highly reliable organizations. You can't have 15 doctors with each wanting to do things their own way. You have to figure out what's the one "our way." When I was chief of emergency medicine for a 10-hospital health care system, we looked at the number of antibiotic prescribing regimens we had for community-acquired pneumonia; we had 37. By narrowing it to 10, we were able to save the system a couple of million dollars. I think that's what organizations are doing as they are merging. They are looking to develop more consistency across all their different facilities and, by doing so, they reduce costs.

RM: Let's turn it to emergency group consolidation. I wanted to separate those because they are two different things. I'll ask the same question, and I'll start with Jay. What's driving that emergency group consolidation, and is that a good thing or a bad thing?

JK: There are a couple of things driving emergency medicine group consolidation. One of the most important things is physicians must have a say in terms of their practice environment, in terms of their pay, how hard they're working, and the resources they have. What's driving emergency medicine group consolidation is those same hospitals that are now consolidating are looking at their costs and seeing that they have some product lines that are money makers and others that are losers. They're thinking about their groups, which offer not only emergency medicine services but hospitalist services and maybe anesthesia, and asking, "Through consolidating those services, can I improve quality and decrease cost?" That is, from my perspective, what's driving acquisitions and consolidation. A lot of smaller groups are saying, "We see the writing on the wall. What can we do to protect our lifestyle and to protect our practice environment? We do not want to get swallowed up where we are going to lose control." Interestingly enough, if you look at physicians nationwide, by 2025, 70 percent of physicians will be employed. That's changing the whole paradigm for physicians who went into practice. Is it a good thing or a bad thing? I'm going to put on my ACEP hat and say that it's good as long as we can maintain a sense where physicians have some control over their practice environment.

Well, the single biggest driver of health care reform is cost. As organizations look to decrease their expenses, two of the ways they do that is to eliminate competition and to eliminate unnecessary expenses.

—JAY KAPLAN, MD, FACEP

I don't care what the payment model is: modified fee for service, alternative payment model, or value-based purchasing. If it doesn't lead to taking costs out of the system, it's not sustainable. Period.

—BRENT ASPLIN, MD, MPH, FACEP

RM: Dr. Iannaccone?

RI: Well, I think I'll answer that question by telling you briefly about the experience my group, Emergency Medical Associates, went through because we just did it less than a year ago. We had 37 years as a fiercely independent democratic group. We were painfully democratic in terms of how we did things. So why would we feel we have to make a decision like this? When I say "we," I mean that as the CEO, I reported to a board of nine physicians, partners who worked and owned the group. It was all run by physicians. Together, we put together a strategic plan, looked at it, and said, "Holy cow, we're not going to be able to get that done. We don't have enough money, we don't have the size, and we don't have the speed to compete or to solve the problems." The problems seemed to be coming quicker than our solutions were, so we needed to find a partner that would allow us to have some of the things that Jay just mentioned to retain some of the autonomy that we had without the ownership. I think that's what groups are looking for when they consolidate: a pooling of resources.

RM: Great. Savoy?

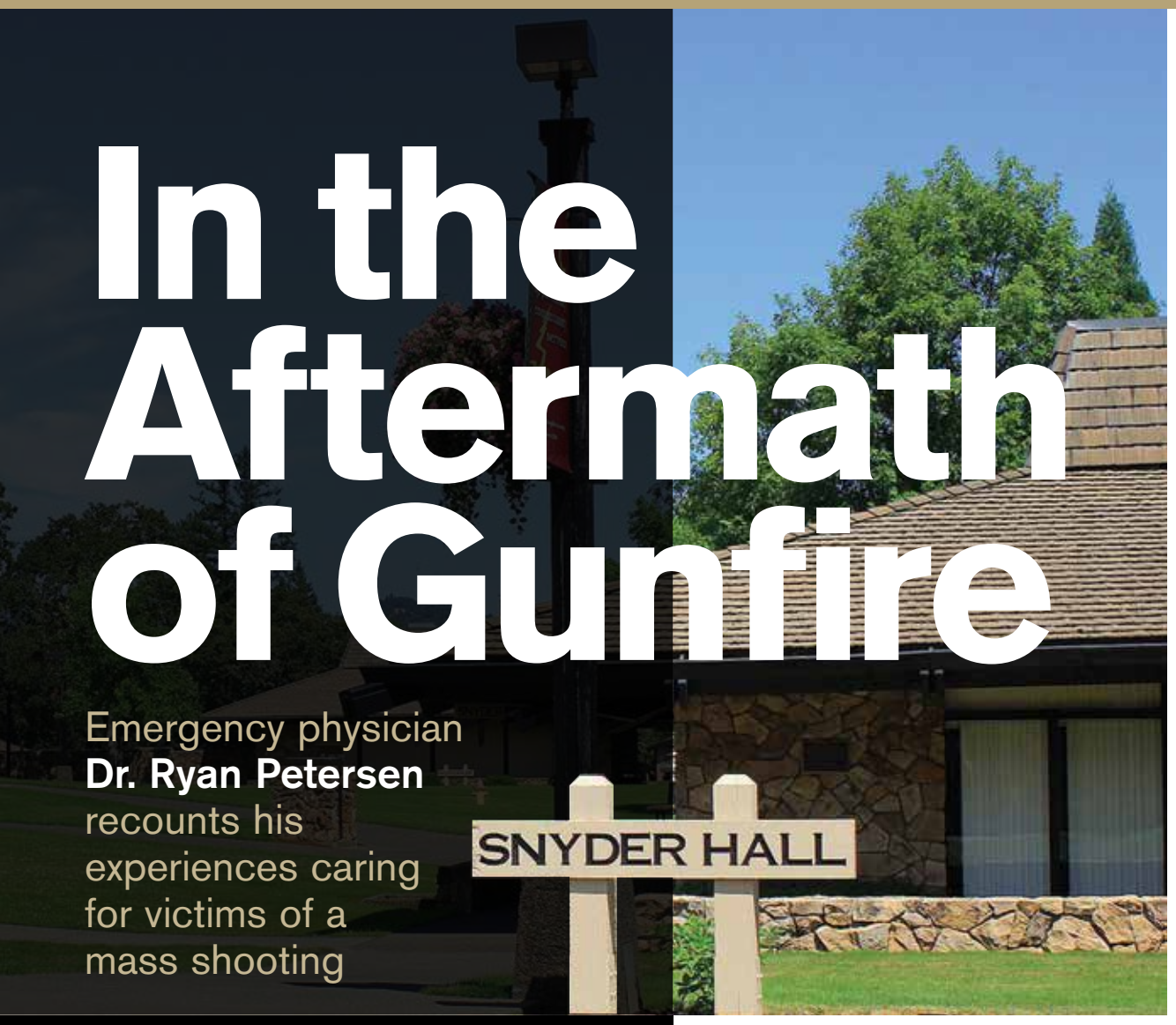
SB: I think ideally most people would look at consolidation among professional services in a positive way if you are going to improve overall performance for patient care, if you're going to improve the patient experience, and lastly, if you can do so in a setting maintaining or decreasing the cost curve. However, the majority of times we're seeing many groups, especially independently owned groups, consider consolidation because of a failure, at least a perceived failure, of their ability to compete in the marketplace. I think, again, that there's a large amount of fear from the eyes of the smaller independent groups. Lastly, I do believe that there's a generational component in which there are many folks around retirement, and they're looking for different means to monetize their practice. If you look at how Wall Street and private equity have subsequently performed after many of those acquisitions, you'll see that performance hasn't necessarily been ideal. I know that within my particular democratic group, we see over 5 million visits a year, but $100 million of our annual revenue comes from private equity or publicly held practices that had ultimately failed.

RM: Thank you. Dr. Asplin?

BA: I'm going to answer this from a hospital system perspective. We have 23 hospitals in seven markets across Ohio and one market in western Kentucky. Many of you are familiar with W. Edwards Deming, one of the most important quality-improvement process engineers of the 20th century. One of my favorite quotes of his is, "Uncontrolled variation is the enemy of quality." I don't know what the right answer is in terms of the right number of groups for a system like ours to work with, but I know it's not 23 different groups. The answer, at least for the near term for us, isn't to employ everyone, but we can't work and get to scale fast enough if we have too many partners to work with. From a hospital system perspective, how can we get at the next level of quality, safety improvement, and cost reduction? I don't care what the payment model is: modified fee for service, alternative payment model, or value-based purchasing. If it doesn't lead to taking costs out of the system, it's not sustainable. Period. We have to get at cost, and there are tens of millions of dollars of unnecessary costs and quality failures in our system due to uncontrolled clinical variation. You can't get at those without clinician and physician engagement. That's why if it's leading to costs coming out, uncontrolled variation coming down, and quality improving, then I think the consolidation of hospital-based groups—emergency medicine being one of them—is a good thing.

Council Town Hall highlights will continue in the February issue.

In the Aftermath of Gunfire



LEFT: Snyder Hall at Umpqua Community College, Oregon. This was the scene of the Umpqua Community College shooting on October 1, 2015. INSET: Mercy Medical Center, a hospital located in Roseburg, Oregon.

Emergency physician **Dr. Ryan Petersen** recounts his experiences caring for victims of a mass shooting

Although it is no longer unusual to see mass shootings in the news headlines, most people don't expect one to happen in their hometown. As mass shootings become more common—and more deadly—though, emergency physicians increasingly may face the grim challenge of caring for multiple shooting victims while wondering how something like this could happen in their town.

Ryan Petersen, MD, an emergency physician at Mercy Medical Center in Roseburg, Oregon, was enjoying an ordinary day of running errands when he got a call from his hospital that there had been a shooting at Roseburg's Umpqua Community College,and that he was needed at Mercy to care for the victims. Ten people, including the gunman, died from the shooting, and nine others were injured. Ten of the victims were taken to Mercy Medical Center for treatment.

Dr. Petersen recently sat down with *ACEP Now* Medical Editor-in-Chief Kevin Klauer, DO, EJD, FACEP, to talk about his experiences caring for those injured in the shooting and how the event has affected both him and his community. Here are some excerpts from their conversation.

KK: Although it weighs heavy on people's minds and hearts, I appreciate your being willing to talk about this. Where were you on the date of that event?

RP: I was actually driving to the store to pick up my 4-year-old's birthday gift. I was about a half mile away from the hospital.

KK: What altered your course that day?

RP: I got a phone call from Melissa Norris, our on-site assistant, and she told me the initial report was there were up to 30 victims in a shooting at Umpqua Community College (UCC).

KK: Did you have your children in the car with you then?

RP: No, my wife was in Utah with both of my kids. I told Melissa, "I'll be at the emergency room in a second," hung up, called my wife, and I said, "There's been a shooting at UCC. I want you to know that I'm OK, but I'm going to try to help out with it."

KK: When you got there, how did the department look? Was it business as usual?

RP: The climate was definitely different. You could tell everybody was very tense. The entire emergency department was full of nurses, general surgeons, orthopedic surgeons, as well as the majority of the ER staff.

KK: What did you do with your existing patients?

RP: The existing patients basically were moved to the other side of the ER just to open up the main department so that we'd have the first 10 rooms open to take patients.

KK: Were people understanding when you told them that they were in the waiting room and that you wouldn't be able to see them right away?

RP: That's actually a very interesting story. The waiting room at that time was pretty full. The nursing supervisor went out and said, "I wanted to let you all know there's been a shooting. There's a number of very sick victims that are going to be coming in, and it's probably going to be a one- to two-hour delay before we are able to bring anybody back." All the people in the emergency department volunteered to leave and come back later.

KK: From the time you got to the department, how long before you started seeing some patients?

RP: Less than a minute. I got to the car, ran back, threw some scrubs on, and walked out. Lisa Beth Titus is our trauma coordinator. She was in the front doing triage, and she said, "You have 30 seconds or so. I'm going to send the first victims to the trauma rooms, and the third one I'll send to you." I popped into the room and introduced myself. I said, "We'll be the team. We'll assess this as fast as we can. If there's something we can do for this patient, we'll do it. And if we can't, we'll have to move on."

KK: How many total patients did your department receive?

RP: We ended up getting 10. I think there were 20 total, with 10 deaths, and we ended up getting 10 of those in the ER.

KK: How many did you personally take care of?

RP: I took care of four.

KK: That's plenty.

RP: The initial patient I got unfortunately sustained injuries that weren't compatible with life, so we had to move on to the next one. The next three I got were all extremity injuries. The really ill patients had moved into the trauma bays and were being taken care of by Wade Fox, DO, FACEP, and Jennifer Bodenhamer, DO.

KK: If you care to share one moment from this whole event that weighed on you emotionally, I'd be interested to hear what that was.

RP: I think as ER docs, we're pretty calloused. If you see terrible things on a daily basis, you're really able to build up walls and deflect a lot of the stuff you see on a daily basis. You have someone who comes in, and they've been shot or stabbed. There's always a degree of culpability with these patients, whether that's imagined or true. You'll find out that they'd probably not been doing the right thing at the right time, and so for me, that's a coping mechanism. In this case, that just fell right on its face. These were just innocent kids who were assassinated, and that took a huge emotional toll on the physicians. It really hurt.

KK: In a 30-minute time frame that day, tell me about the gamut of injuries you saw, both for the patients who survived and those who did not.

RP: The first patient was a gunshot wound to the head. She was in asystole and was receiving CPR when she came through the door. You're in triage mode at that point because you're not sure what else is coming in. We took her pulse quickly, and she obviously had injuries that were not survivable. I moved from that team to the next room. That was a gunshot wound to the thigh; it was a superficial through and through. She was an 18-year-old whose mother actually was working in the hospital. The next two were both gunshot wounds to the hand, and I was able to pass those off to additional ER docs that came in.

KK: We all hear about these events, but we may feel insulated from them. That's someone else's community. How surprised were you that this was happening in your community?

RP: It's really mind-blowing. I think President Obama talked about how we've become numb to this. You hear about all these tragedies around the country, and you really do become numb. You're subjected to it constantly, but you always feel like that's not going to happen here in this small, isolated, beautiful wilderness community. Everyone here was really shocked.

KK: When you have an event like this, we would like to believe this is just a day in the life of an emergency physician, but how has this changed you?

RP: I feel uneasy. I used to feel pretty isolated from this sort of stuff, and once it happens, you have a degree of uneasiness with the world. It's hard to describe, but you worry about your kids and your family. I honestly don't know if it will ever go away. Time heals all wounds, so I suspect with time you'll lower this level of alertness, and things will come back to at least a degree of normalcy. This tragedy has had a profound effect on the doctors and nurses here, and I hope at some point in time that a degree of security comes back to me as well as the community.

KK: Despite the fact that it was difficult and challenging, it would have been worse not being able to participate and help.

RP: I felt fortunate that I was here and was able to help out with all the docs.

KK: Did you have any personal interaction with the families?

RP: Unfortunately, two of the kids who were killed I personally know. Anspach is one of the guys who works on the fire department that I'm the director for; his son Treven Anspach was killed. My family friends were involved as well. I'm not best friends with these guys, but we were closely associated with two of the kids who were killed.

KK: So it became even more personal for you. Do you think from an interpersonal perspective you were able to provide some guidance and some support for them?

RP: Honestly, I don't know if I did. I think I was overtaken by all of this. I know that my wife was able to go to some of the families and provide dinners, but personally, I was overwhelmed with the aftermath and didn't have a lot of time to go and spend with the victims' families unfortunately.

KK: I don't blame you. You shouldn't be expected to. I'm glad your wife was able to support those that you knew.

RP: The community really rose up in terms of that. They set up a number of donations and sponsorships. I think the one gentleman who combatted the shooter had $700,000 within a couple of days in an account that they had set up. The community has had an amazing response.

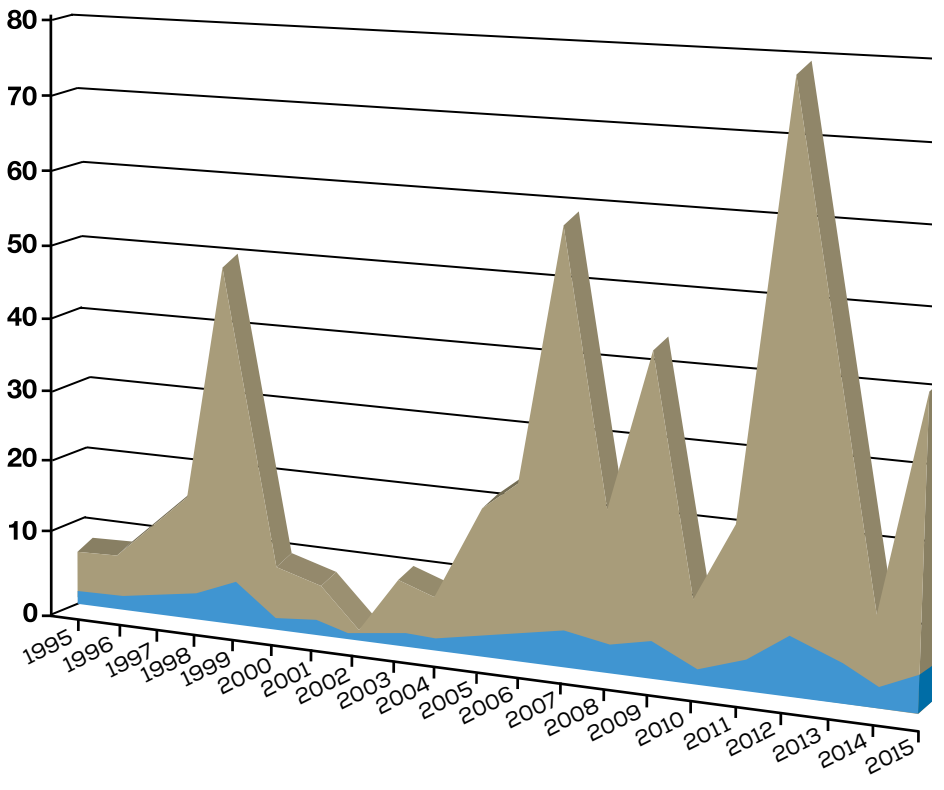
KK: Thank you, Ryan, for sharing your thoughts. I know it's got to be a sensitive topic.

RP: It's kind of hard to talk about.

KK: Maybe your story can help prepare others down the road if they find themselves in a similar situation.

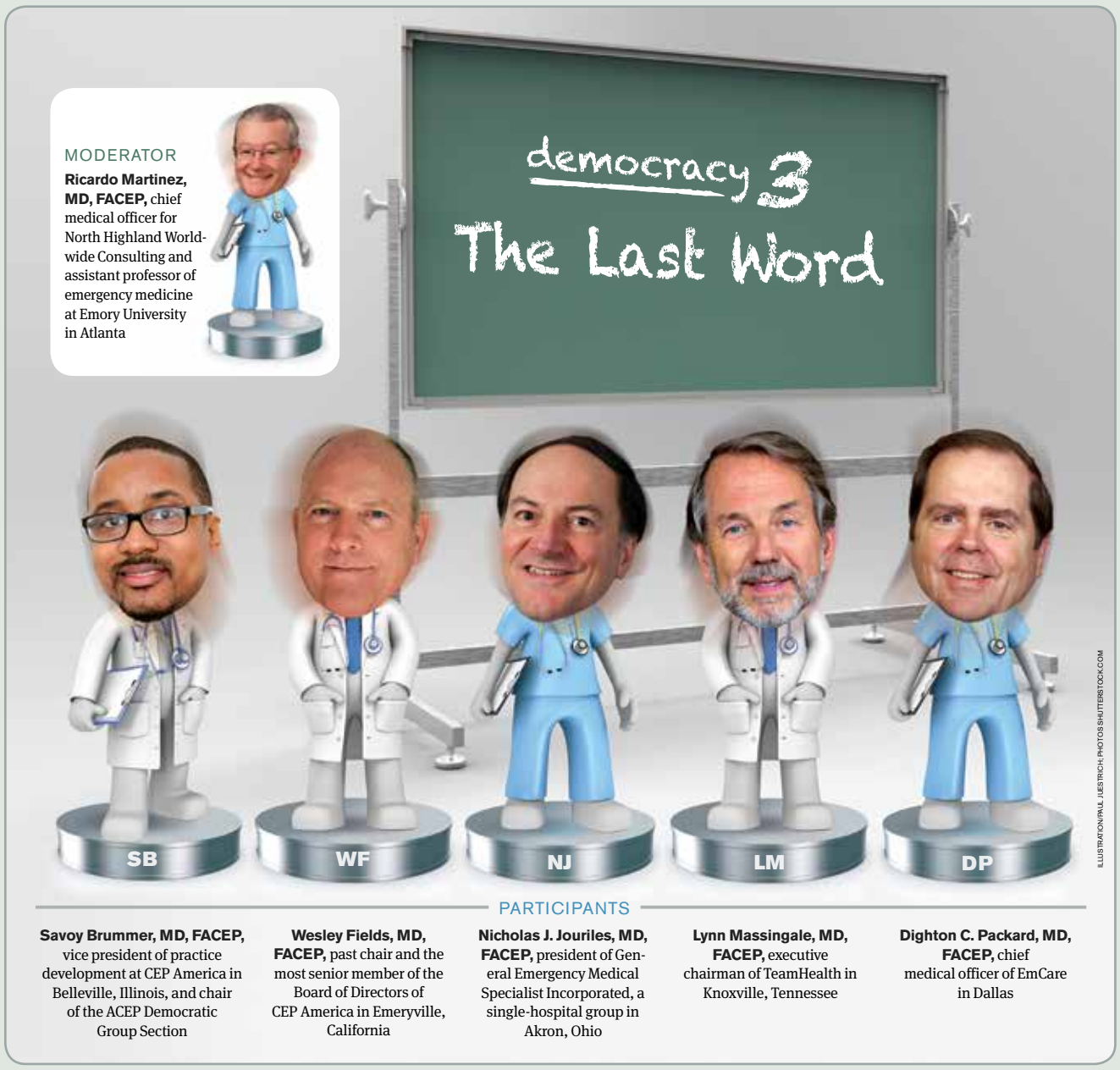
RP: Absolutely.

20 YEARS OF MASS SHOOTINGS IN THE UNITED STATES, 1995–2015



Source: *Mother Jones*

For this chart, a mass shooting is defined as an attack in a public place with four or more people killed. Mass murders in private homes related to domestic violence and shootings tied to gang or other criminal activity are excluded.



ILLUSTRATION/PAUL JUESTRICH; PHOTOS/SHUTTERSTOCK.COM

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Dighton C. Packard, MD, FACEP, chief medical officer of EmCare in Dallas

The Future of Democracy

Emergency medicine leaders weigh in for this democracy roundtable discussion

INTRODUCTION *by* KEVIN KLAUER, DO, EJD, FACEP

For decades, the concepts of democracy and democratic group practice have been held as the standard to strive for in emergency medicine, but with the evolving landscape of health care, is it time to revisit these concepts? What role will democratic groups have in the future of emergency medicine? In Part 3 of this three-part series, EM leaders from different walks of life weigh in on the following questions. Check out the October and November 2015 issues or visit ACEPNow.com to read Parts 1 and 2.

QUESTIONS

1. What is the definition of "democracy"?
   a. How do you measure democracy?
2. Is democracy a group structure or an ideal?
3. Do you think there is confusion about what democracy offers in EM?
4. Is this just marketing or substance in emergency medicine?
5. In a democratic group, do physicians get to vote on everything or just certain things?
6. Does democracy have obligations/responsibilities associated with it (eg, financial, covering additional shifts, etc.)?
7. Does a lack of democracy mean you will not be treated fairly? (Is fair treatment confused with democracy?)
8. What are the pros and cons of democratic groups and nondemocratic groups?

RM: Is the democratic model that we have articulated in the past going to be the most successful structure in the future, or do we all have to begin to give up a little something to get something bigger?

DP: The silence probably speaks for itself. I'm not sure that it's a matter of democratic versus nondemocratic. Regardless of whether you're democratic or nondemocratic, I think a larger group actually gives you the opportunity to take some risk, to try different models. I don't know if they're all going to win or all going to lose, but if you're large enough, you can take a risk and you can try different things and then, hopefully, spread that success across your system. If the democratic group has the willingness to invest in itself, to take those risks, then I think they can be as successful as a nondemocratic group.

SB: I would tend to agree. Having scale and having a sound financial base does allow you the flexibility to invest and experiment and even make mistakes. I think that, again, having those types of resources allows you to evolve, and democratic groups cannot be afraid to experiment to make investments in themselves and to change to meet those expectations of our hospital partners. It is more challenging when you have to service a certain amount of debt, or you have to make your shareholders at a smaller individual site happy.

LM: There are such pressures to move toward models that lower costs and, perhaps for the first time ever, really pay us for quality and outcomes. I do believe, regardless of size or structure, any of us can succeed if we're meeting the needs of our hospital clients/hospital customers. If the hospital is well-served, they will never call Dighton or us. On the other hand, if we serve their needs well, then I think they will call us. Ultimately, if you're meeting the needs of the hospital, your contract is probably not going to go out for bid.

NJ: I agree with Lynn and might take it a step further. The groups that are taking care of the patients are also helping the hospital system. That's what's been good about our group; we've been able to take care of the patients and keep the hospital happy. As long as you take care of your hospital and your patients, the group, no matter what size, is going to survive no matter what the structure.

RM: What would be the one or two things people should start thinking about now in order to ensure success?

WF: I think the thing that won't work is the concept that you train, you get board certified, and that you can spend the rest of your career practicing at Fort Apache. I think the folks that are going to be adding value, improving patient care, and improving population health are going to see themselves as being part of teams providing systems of care and improving processes of care, and are more likely to succeed.

NJ: What Wes said was brilliant. We've seen a change in how we define medical excellence. Back in the day, it used to be, "Did you order one of everything?" Now, it is not only, "Is your clinical care focus on the evidence and research to support your care?" but, "Is it also as efficient as possible?"

SB: Specifically for democratic practices, I think in the next five to 10 years we're going to see increased integration across the acute-care continuum. I think that you will likely also see an increase in the scale of democratic practice compared to what has traditionally been known. I think that all practices are going to have to demonstrate value for their patients, and this will require a certain amount of innovation.

DP: I think the next two to three years are going to be tumultuous. Five years from now, I think emergency medicine will be known for three things. First, the traditional: if you're really sick or hurt, it's the only place to go. Second, we will be noted to be the best urgent care diagnosticians in the world. Third, I think we will be experts on transitions of care, particularly in those transitions not only into the hospital to decrease length of stay but also transitions into the community. I think it's a great future.

LM: I think the emergency department will see much higher acuity. I do think there will be a lot of success with moving patients out to urgent care and providing care by telemedicine. If you look at the percentage of patients on the exchange that are picking high-deductible health plans and knowing that many of those patients are going to have a really hard time paying those bills, we think more and more people are going to go toward places that they perceive as best value. Additionally, emergency medicine will have greater and greater responsibility for cost. The last thing is integration, both in hospital medicine and with post-acute care.

RM: I really want to thank you for sharing your insights, experience, and perspectives for our readers. Thank you very much.

Dr. Iserson with emperor penguins in Antarctica. Above: Embroidery design for McMurdo General Hospital in Antarctica.

Dispatches From 'The Ice'

GETTING READY TO GO

BY KENNETH V. ISERSON, MD, MBA, FACEP, FAAEM

This winter, I'll be practicing emergency medicine on the beach. Sound sweet? Well, "beach" may not quite set the scene. While I will be living on the coast, I may only see open water for a couple of weeks and then only after a heavy-duty icebreaker laboriously opens a narrow channel to the Southern Ocean for the two cargo ships that make annual visits. The rest of the year, the ice stretches far beyond the horizon, covering the ocean so thickly that enormous U.S. Air Force C-17 cargo planes (maximum gross takeoff weight of 585,000 pounds) can use it as a runway. This "coastal" town will be my home for the next seven months: McMurdo Station, Antarctica, the continent's largest population center.

This will be my second tour on "The Ice." My first was the 2009–2010 Antarctic summer at McMurdo Station. When I told physician colleagues I met on that first trip that I would be returning for another season, I heard a variety of comments: "Wow!" "You're braver than me." "You're crazy." Returning for the winter season dovetails with my interest in remote and improvised medicine and my current global emergency medicine career. The station is far from civilization (an eight-hour military flight), making even the most critical evacuations extremely problematic in the winter months, when the winds can be hurricane force and -40 ° F is considered warm.

There's a common saying on The Ice: "You go the first time for the adventure, the second time for the money, and the third time because you no longer fit in anywhere else." For me, it's the adventure again. The isolated posting presents an interesting challenge: an extremely hostile environment with a relatively small community, about 200 people including those at New Zealand's Scott Base three kilometers away, involved in light industrial work.

The winter season will be significantly different from my summer experience. I led a team with up to three other physicians, a physician assistant, a physical therapist, a laboratory technologist, a dentist, a radiology technician, and up to five nurses. We were responsible for the medical care of 1,200 workers and scientists spread over the continent at remote science stations, and we could organize both routine and emergency evacuations without great difficulty unless the weather didn't cooperate. This time, an experienced nurse practitioner and I will not only provide basic medical and surgical care but also act as dentist, radiology tech, pharmacist, and lab tech for the community.

There's a common saying on The Ice: "You go the first time for the adventure, the second time for the money, and the third time because you no longer fit in anywhere else." For me, it's the adventure again.

Just to qualify for the position meant that I had to undergo the extensive, and usually dreaded, medical testing called "physical qualifying," or PQ. Similar to a pilot's annual medical exam, the PQ includes a detailed physical and dental exam, a long list of laboratory tests, dental and chest radiographs, and, since I am now of Medicare age, an ECG and cardiac stress test. I passed, but not everyone is that fortunate.

By the time you read this, I'll be on my way to The Ice via Christchurch, New Zealand, our gateway to McMurdo and the Pole. In the coming months, I'll update you about travel, extreme cold-weather clothing, and living and eating on The Ice. I'll also detail how we train our mostly lay "trauma team," the adventures and misadventures we experience, and how we're tolerating total night 24 hours a day.

DR. ISERSON is professor emeritus of emergency medicine at The University of Arizona in Tucson.

A NEW SPIN

What's on *My* Mind

Should we focus on the diagnosis or the decision-making process?

DIAGNOSING THE PROBLEM

"The delivery of health care has proceeded for decades with a blind spot: Diagnostic errors—inaccurate or delayed diagnoses—persist throughout all settings of care and continue to harm an unacceptable number of patients. For example:

- **A conservative estimate found that 5 percent of U.S. adults who seek outpatient care each year experience a diagnostic error.**
- **Postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10 percent of patient deaths.**
- **Medical record reviews suggest that diagnostic errors account for 6 to 17 percent of hospital adverse events.**
- **Diagnostic errors are the leading type of paid medical malpractice claims, are almost twice as likely to have resulted in the patient's death compared to other claims, and represent the highest proportion of total payments."[1]**

"The [Committee on Diagnostic Error in Health Care] definition of diagnostic error is the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient. ...

Timeliness means that the diagnosis was not meaningfully delayed; however, timeliness is context-dependent. While some diagnoses may take days, weeks, or even months to establish, timely may mean quite quickly (minutes to hours) for other urgent diagnoses. A diagnosis is not accurate if it differs from the true condition a patient has (or does not have) or if it is imprecise and incomplete."[1]

Source: *Institute of Medicine*

by KEVIN KLAUER, DO, EJD, FACEP

The 2015 Institute of Medicine (IOM) publication "Improving Diagnosis in Healthcare" takes an important step in the right direction with respect to identifying and avoiding medical error.[1] I suspect many have adopted this document in toto based on its credible source and its premise of improving diagnostic accuracy in medicine. I do agree that the IOM has produced another powerful and important document overall, but I feel it did so, to a certain degree, at the expense of emergency medicine.

What I think is being missed in this whole discussion is that as more pressure is placed on diagnosing accurately and in a "timely" manner, the more likely we are to become experts at creating diagnostic error. Although diagnostic error expert Patrick Croskerry, MD, PhD, professor of emergency medicine at Dalhousie University in Halifax, Nova Scotia, and his work were both included in this paper, aren't the heuristics, mental shortcuts, that Dr. Croskerry and others caution us to avoid only amplified by this additional pressure?

The IOM has clearly identified the emergency department as a high-risk environment. I certainly can't disagree. However, from my perspective, an overemphasis has been placed on the ED, suggesting an overgenerous share of responsibility belongs to emergency physicians. As a matter of fact, the emergency department is mentioned no fewer than 48 times in its 369-page document. "For example, analyses of claims data could be used in 'look back' studies to identify the frequency with which acute coronary syndrome is misdiagnosed ... explore how frequently these beneficiaries were seen by health care professionals in the week prior to ultimate diagnosis (either in outpatient, emergency department, or hospital settings), the incorrect diagnoses that were made, and the factors associated with the diagnostic error."[1] I don't dispute that the ED should be involved in such programs, but I do question why others are omitted. Isn't the ED an outpatient department, and aren't most EDs part of a hospital? Then why is the ED singled out while other outpatient and hospital departments are not even mentioned?

Although it seemed that the majority of those 48 mentions were providing facts about the ED and diagnostic error, others seemed unnecessarily sensationalistic and harsh. For instance, "the diagnostic error of Ebola in a Dallas emergency department" was mentioned in four different sections. Who could have been expected to make this diagnosis, the first ever to arrive at an ED in the United States? One case vignette reflected an alleged acute coronary syndrome misdiagnosis: "When she asked the ED doctor about the pain in her arm, he was dismissive of the symptom. Privately, a nurse in the ED asked Carolyn to stop asking questions of the doctor, noting that he was a very good doctor and didn't like to be questioned.'"[1] A second vignette went way beyond discussing the potential errors that reportedly lead to a missed pulmonary embolism: "The emergency physician who signs up to see the patient is well known for his views on 'addicts' and others with 'self-inflicted' problems ... He appears angry, and verbally expresses his irritation to the nurse. When the patient returns [she had been smoking], he admonishes her for wasting his time and, after a cursory examination, informs her she has nothing wrong with her heart and discharges her with the advice that she should quit smoking. His discharge diagnosis is 'anxiety state.'" There were 12 vignettes in Appendix D, "Examples of Diagnostic Error." Six of them involved the ED.

Let's discuss the "facts." In the section titled "What is known," the following was stated: "A systematic review of the literature on follow-up of test results in the hospital found failure rates of 1 to 23 percent in inpatients and 0 to 16.5 percent in emergency department patients (Callen et al., 2011)."[1] The number (16.5 percent) in the Callen article was obtained from Kachalia et al.[2] The 16.5 percent refers to errors made in "test results transmitted to and received by the provider." Thus, these are not errors made by emergency providers. In addition, the data are based on 79 malpractice claims from 1979 through 2001.

Following up on diagnostic data is critically important, and the ED plays a significant role, but we are reliant on our radiology, laboratory, and primary care colleagues to ensure that appropriate communication of critical data occurs.

The same article is quoted in two different portions of the IOM report, stating, "Studies have shown that an incorrect interpretation of diagnostic tests occurs in internal medicine (38 percent reported in Gandhi et al., 2006) and emergency medicine (37 percent reported in Kachalia et al., 2006)," and "Failure to order appropriate diagnostic tests has been found to account for 55 percent of missed or delayed diagnoses in malpractice claims in ambulatory care (Gandhi et al., 2006) and 58 percent of errors in emergency departments (Kachalia et al., 2006)."[1] Such interpretations are both overly broad and inappropriately based on limited, outdated malpractice data.

As the pressure mounts to select a diagnosis so that we can order a test, code and bill our charts, meet patient expectations, provide a diagnosis to follow-up and admitting physicians, and now meet the goals of the IOM, the likelihood of misdiagnosis may be even greater than before. Despite our 48 mentions, it is surprising to me how few times they mentioned EMTALA: zero. In today's environment of increased ED volumes and cost containment, "do more with less and do it better than you did before" is a recipe for diagnostic disaster.

Doing the right thing on behalf of our patients is the key, not assigning an arbitrary, and often premature, diagnostic label. We are so focused on how well we diagnose, we sometimes lose sight of the fact that diagnoses may not be possible at certain junctures in a patient's illness; we will never reach diagnostic perfection. Furthermore, the house of medicine has manufactured the concept of diagnosis as opposed to signs, symptoms, and pathology, which are real.

We seek the elusive "diagnosis" because that's what we have done for as long as we can remember; it's an expectation we've created. I propose we put that concept in the circular file. Based on the clinical circumstances, there are good decisions, bad decisions, acceptable decisions, and unacceptable ones, but frequently, there isn't just one answer. When a presentation is too complex to "diagnose," why don't we concede that fact, defaulting to the way medicine should be delivered in the first place, by us for our patients, with shared decision making? Don't diagnose; just make a reasonable decision that will lead you to the next diagnostic or therapeutic question where you should make another reasonable choice. When the diagnosis is evident, we'll declare it.

The IOM's report highlights many important issues; there is tremendous value in its work. I know my concerns may seem over critical. However, from my perspective, so is its characterization of emergency medicine. We need to be recognized as the safety net of the health care system, often with little control over our environment, and be allowed to deliver care free from the pressure of getting every diagnosis "right." The IOM report speaks to many of the issues that we have fought for but have gone largely unrecognized for years, maybe even decades. Perhaps the IOM report will raise awareness, resulting in provision of the necessary resources our nation's emergency departments so desperately need.

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DR. KLAUER is the chief medical officer–emergency medicine and chief risk officer for TeamHealth as well as the executive director of the TeamHealth Patient Safety Organization. He is an assistant clinical professor at Michigan State University College of Osteopathic Medicine and medical editor-in-chief of *ACEP Now*.

BRINGING DATA TO THE BEDSIDE

BENCHMARKING ALLIANCE

JAMES J. AUGUSTINE, MD, FACEP, is director of clinical operations at EMP in Canton, Ohio; clinical associate professor of Emergency Medicine at Wright State University in Dayton, Ohio; vice president of the Emergency Department Benchmarking Alliance; and on the ACEP Board of Directors.

Counting the Hours

EDBA data can help EDs improve productivity

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

by JAMES J. AUGUSTINE, MD, FACEP

There is considerable variation in the staff that provide patient care in American EDs. The Emergency Department Benchmarking Alliance (EDBA) has hosted three summits to develop the most effective definitions of staffing and markers of care. The definitions are completed and published and are being used in the annual EDBA survey.[1] The definitions developed by the EDBA consider four classes of ED staff: physicians, advanced practice providers (APPs), nurses (not differentiating the various levels of staff nurses), and the group composed of personnel who function in technical and clerical roles. For the computation of clinical performance, the EDBA collects data on daily staffing of these groups only counting those who are in a patient-care function.

For the last five years, the data have tallied the scheduled number of work hours in an average day for nurses, techs, clerks, physicians, and APPs. Counting the hours allows a calculation of productivity for each of these groups. All have been calculated using the same mathematical formula: number of ED patients visiting the ED on an average day divided by the number of scheduled hours for persons in a clinical role in an average day. It's a common calculation for physician productivity.

At the initiation of the EDBA studies 21 years ago, it was necessary to develop a formula that allowed comparison of staffing ratios where APPs were working in collaboration with emergency physicians (most patients seen with a physician rather than without). At that time, the shared role of ED patient management by physicians and APPs did not allow the same level of productivity of APPs as physicians. So in calculating the overall productivity of the licensed independent practitioners (physicians plus APPs) in an ED, the APP hours were assigned a factor of 0.5 the number of physician hours.

Example: An ED sees an average of 100 patients a day and uses 40 scheduled physician hours and 20 scheduled APP hours.

The calculation of physician productivity is 100 patients divided by 40 hours, or 2.5 patients per physician hour.

> Many emergency physicians have documented the loss of productivity and difficulties in patient flow when information systems do not support the role of physicians and APPs.

The calculation of licensed independent practitioner productivity is 100 patients divided by (40 physician hours + 20 APP hours multiplied by a factor of 0.5), or 100 divided by (40 + 10), equaling 2.0 patients per hour.

Through the last 20 years, APPs have assumed more independence in patient management in the ED, and in some EDs, it is now possible to measure patient care separately for the two types of practitioners. However, to maintain consistency, the EDBA productivity formula has not changed.

The results of the 2014 EDBA data survey are presented in Table 1.

Staffing Ratios

Nurse staffing ratios indicate there are about 0.62 patients managed per nurse-staffed hour per day. That ratio has been very consistent over five years and also across the different volume and types of EDs. Table 2 presents the staffing ratios of all groups of ED staff since 2010.

The second columns of Table 1 and Table 2 reflect the use of support staff in the ED. Combining tech and clerk hours, the service ratio averaged about 1.7 patients per scheduled hour. There has been an increase in this ratio over the last five years. This may reflect the decreased number of hours staffed by clerks as the use of physician computerized order entry and other technologies has expanded.

Emergency physician staffing produced an average of 2.48 patients seen per hour. When attending physician coverage was supplemented by APPs and the APP hours were given a factor of 0.5 (as above), the staffing ratio averaged 1.97 patients per hour.

CONTINUED *on page 19*

Table 1. Patients Seen Per Hour in the EDBA Data Survey for Calendar Year 2014

ED TYPE	NURSE STAFF	TECH/CLERK STAFF	PHYSICIANS	PHYSICIANS + APPs
All EDs (N=1,137)	0.62	1.7	2.48	1.97
Under 20K volume	0.56	1.6	1.4	1.3
20–40K	0.66	2.0	2.7	2.1
40–60K	0.62	1.7	2.9	2.2
60–80K	0.61	1.4	3.1	2.4
80–100K	0.60	1.4	3.1	2.4
Over 100K volume	0.65	1.2	3.1	2.4
Pediatric EDs	0.62	1.9	2.4	2.0
Adult EDs	0.56	1.3	2.8	2.2

Table 2. Patient-Per-Hour Staffing Ratios Over the Last 5 Years of EDBA Surveys

ALL ED TYPES	NURSE STAFF	TECH/CLERK STAFF	PHYSICIANS	PHYSICIANS + APPs
2014	0.62	1.7	2.48	1.97
2013	0.62	1.6	2.52	2.06
2012	0.62	1.7	2.55	2.07
2011	0.65	1.5	2.5	2.2
2010	0.65	1.4	2.4	2.2

DR. MILNE is chief of emergency medicine and chief of staff at South Huron Hospital, Ontario, Canada. He is on the Best Evidence in Emergency Medicine faculty and is creator of the knowledge translation project the Skeptics' Guide to Emergency Medicine (www.TheSGEM.com).

Diltiazem or Metoprolol for Rapid Atrial Fibrillation?

Beta blockers and calcium channel blockers compete for rate control in atrial fibrillation

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There has been controversy as to whether rhythm control is better than rate control for these dysrhythmias.

by KEN MILNE, MD

CASE: A 49-year-old man with no past medical history presents to the ED with palpitations for five days. He feels tired and a little short of breath but has no chest pain. His vital signs are normal except for a heart rate of 142 beats per minute (bpm). You palpate his pulse and find it irregularly irregular. An ECG confirms rapid atrial fibrillation.

QUESTION: In patients with rapid atrial fibrillation, what medication will obtain rate control faster: a beta blocker or a calcium channel blocker?

BACKGROUND: Atrial fibrillation is a common presentation to the ED, with atrial flutter being less common. There has been controversy as to whether rhythm control is better than rate control for these dysrhythmias. An aggressive rhythm control protocol demonstrating efficacy and safety for early-onset atrial fibrillation or flutter (AFF) has been published. [1]

Rhythm control would not be an option in this case because this man's symptoms have been present for five days. Rate control is the treatment of choice for stable patients with atrial fibrillation >48 hours or an unknown time of onset with a rapid ventricular response.[2] However, there is limited evidence on whether beta blockers or calcium channel blockers are better for achieving rate control.[3]

RELEVANT ARTICLE: Fromm C, Suau SJ, Cohen V, et al. Diltiazem vs. metoprolol in the management of atrial fibrillation or flutter with rapid ventricular rate in the emergency department. *J Emerg Med.* 2015;49(2):175-182.

- **Population:** Adult patients ≥18 years old presenting with atrial fibrillation or atrial flutter. There were many exclusions listed in the paper.
- **Intervention:** Diltiazem 0.25 mg/kg (max dose of 30 mg) or metoprolol 0.15 mg/kg (max dose of 10 mg) IV.
- **Comparison:** As above.
- **Outcome:**
  - **Primary:** Heart rate <100 bpm within 30 minutes.
  - **Safety:** Heart rate <60 bpm and systolic blood pressure <90 mmHg.

AUTHORS' CONCLUSIONS: "Diltiazem was more effective in achieving rate control in ED patients with AFF and did so with no increased incidence of adverse effects."

KEY RESULTS: There were 28 patients randomized to the metoprolol group and 24 in the diltiazem group. About two-thirds of the patients were new-onset atrial fibrillation. The mean age was 66 years, and 47 percent were men.

PRIMARY OUTCOME: HR<100 BPM AT 30 MINUTES

96 percent diltiazem vs. 46 percent metoprolol (number needed to treat=2)

No difference was noted between the groups in terms of bradycardia or hypotension.

EBM COMMENTARY:

1. **Convenience sample:** This was a convenience sample of patients, not consecutive patients, presenting to the ED with rapid atrial fibrillation, which could introduce selection bias.
2. **Stopped early:** The trial was stopped early after recruiting only 54 of the 200 patients required based on their power calculation for a noninferiority trial. There are differences between noninferiority, superiority, and equivalence trials.[4] Concerns have been raised in the literature about the ethics and problems of stopping trials early.[5,6]
3. **Medication dose:** The diltiazem was dosed at 0.25 mg/kg (max of 30 mg), and the metoprolol was given at 0.15 mg/kg (max of 10 mg). This may not be an equivalent comparison with underdosing of the metoprolol.
4. **Physician-oriented outcome:** The primary outcome of heart rate <100 bpm at 30 minutes may have been more of a physician-oriented outcome rather than a patient-oriented outcome. Physicians' priorities are to get the heart rate down and disposition the patient. However, the priorities of the patients could have been different and were not explored in this study.
5. **Single center:** This was a single-center study of an inner-city population. A multicenter study with a diverse population would have made the results more robust.

BOTTOM LINE: Despite the limitations of the study, it appears that diltiazem will achieve more rapid rate control in patients with atrial fibrillation than metoprolol.

CASE RESOLUTION: A slow push of diltiazem 0.25 mg/kg was given, and his rate dropped to 89 bpm. The patient was started on oral diltiazem to continue his rate control. His CHA2DS2-VASc score was found to be very low risk for stroke. Therefore, he was started on aspirin alone and discharged home with follow-up with a cardiologist in a couple of days.

Thank you to Dr. Anand Swaminathan, assistant residency director of the NYU/Bellevue Emergency Medicine residency program (CoreEM), for his help with this review.

Remember to be skeptical of anything you learn, even if you heard it on the Skeptics' Guide to Emergency Medicine.

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

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NEW COLUMN

FOAMcast

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DR. WESTAFER is chief resident at the Baystate Medical Center at Tufts University in Springfield, Massachusetts. Follow her @LWestafer.

Don't FOAM It Alone

Columnists introduce readers to benefits of multimedia learning

by JEREMY SAMUEL FAUST, MD, MS, MA AND LAUREN WESTAFER, DO, MPH

Since 2014, we have been writing and producing FOAMcast, a podcast on a mission to bridge the cutting-edge content frequently favored in popular blogs and podcasts with essential emergency medicine core content that tends to get less attention in the world of free open access medical education (FOAM). We started small. At first, we were just a couple of EM residents armed with our smartphones, a couple of microphones, Skype accounts, some shared Google docs, and a handful of dusty textbooks. Now, we are... Wait, nothing has changed.

The format of our podcast is simple. In each episode of FOAMcast, we summarize a recent FOAM blog or podcast for a few minutes. We then spend the remainder of the show on related "bread-and-butter" topics covered by the major EM textbooks—which we fondly refer to as "Rosenalli" (a word we unabashedly made up as an amalgam of Rosen and Tintinalli, though we refer to other major texts as well).

In our first 40 episodes, we've covered the EMCrit podcast, SMART EM podcast, the EM Literature of Note blog, the Skeptics' Guide to Emergency Medicine, The St. Emlyn's podcast, and many more. Finally, we end our show with a boards-style multiple-choice question, which is donated to the show by the Rosh Review. In this recurring *ACEP Now* column, we'll highlight some of the best material from our most recent episodes of FOAMcast (which can be downloaded for free on iTunes or at www.foamcast.org). We'll also discuss what's going on in the world of FOAM and occasionally interview each other on emergency medicine and medical education topics. Let's start with that for this inaugural entry.

JF: From an educational perspective, what has been the most surprising part of making FOAMcast?

LW: Definitely that the stereotypes about the different formats of medical education just don't hold up. I think there's this misconception that textbooks are old, out-of-touch fossils that are hard to use and are basically dying a slow death. On the other end, I think some people still think of blogs and podcasts as thrown-together shoddy resources that can't be trusted. And I'd say that neither of those misconceptions is remotely true. Let's look at textbooks. If you ask people how far behind textbooks are, you'll get a range of answers. Five to 10 years? But in reality, the textbooks are surprisingly inconsistent. Some things in Rosenalli sound like they came right out of a podcast. Very progressive and current. Other times, you're wondering, "OK, how long until they update this thing?"

JF: We recently covered thoracic trauma algorithms on the show, and since then, I often ask interns and medical students to guess, "What do you think Rosen's says about routinely getting a rib series X-ray in cases of mild blunt trauma to the chest?" And they just assume that the textbooks are conservative and recommend to get that rib series. But in truth, they don't. Rib series films are a pretty unhelpful test in most situations, and the so-called old-school textbooks are on it.

LW: That's called pimping, my friend.

JF: I prefer to call it enhanced medical interrogation techniques. There's no actual torture involved.

LW: Then on the other hand, there's the misconception that podcasts and blogs are these thrown-together things that have not been researched or are presenting knowledge that is somehow inferior to what's found in Rosenalli.

JF: What we find is quite often the opposite. The most popular FOAM resources are often quite rigorously researched. And, in fact, the bibliographies are not only thorough, the quality of the papers cited is consistently excellent.

LW: One of my favorite things is to notice the studies that are cited in Rosenalli. If you look, some of it is frankly not strong. Some borders on hilarious, as we've covered on the show. But of course, some of it is high quality. But then take something like SMART EM podcast—the literature cited in the bibliography is uniformly superb. Another misconception is that using FOAM is some kind of shortcut. The appeal of FOAM for many is that the products are slick, refined, entertaining, and, above all, brief (SMART EM podcast notwithstanding). I know you recently had a chance to sit and talk with Lewis Goldfrank, MD, Herbert W. Adams professor and chair of the department of emergency medicine at New York University, about FOAM versus traditional medical education, and he expressed concern over the perceived shortcut to excellence by using FOAM.

JF: Thanks for dropping Goldfrank's name in there so I didn't have to.

LW: No prob.

JF: But yes, he's a methodical, deliberate, and truly intellectual person. My argument to him was that FOAM, when done correctly, is not a shortcut to learning but actually a springboard to deeper learning. It's actually a long cut! Instead of reading a chapter on, say, ENT emergencies and being done, our hope is that they'll listen to our show for 20 minutes and then be inspired to go read some of the chapters in Rosenalli or even some of the primary literature. Instead of one-and-done, now the learner is checking in with multiple resources and platforms.

LW: The reason this works is that people are actually attracted to things that they already find familiar. Our approach is to clue people in to what's hot in FOAM and then highlight what the texts say or what the boards want you to know. That way when they go to open that intimidatingly large textbook, it already seems friendly and familiar because we've taken a bite out of it already. Nice plug for our recent episode where we covered ENT emergencies after discussing the hotly debated recently published FELLOW trial that assessed the role of apneic oxygenation during rapid sequence intubation.

JF: Definitely a topic that got tons of attention in the FOAM world. Ultimately, though, I agree. We use FOAM, and you and I specifically create our brand of FOAM in an attempt to try to get ourselves—and, of course, our listeners—to do more work and studying, not less. That's probably our main motivation for even doing the show. We're not experts on very much, but I often refer to us as "public learners."

LW: I thought you mainly do the show as a platform for promoting your collection of made-up words. Rosenalli and SIRSycardia [heart rate between 90–99 bpm], come to mind.

JF: That's merely a fringe benefit.

LW: In all seriousness though, our motto is that people should not "FOAM it alone." Which is another way of saying: "Here's what's out there now. Here's what's hot. Now go and check it out for yourself and draw your own conclusions. Dig in to it."

JF: Because that's what all the "cool" kids are doing.

Next time, we'll delve into some recent episodes of FOAMcast. In the meantime, feel free to catch up on back episodes on iTunes or at www.FOAMcast.org. See y'all online.

Follow FOAMcast @FOAMpodcast.

INTRODUCTION *continued from page 1*


Dr. Kaplan

In recent published studies, emergency physicians outpace all other physicians in the rate of burnout.[1,2] We practice medicine in a highly unpredictable environment with patients and families who did not expect to need our services and who themselves are placed in a bewildering, highly stressful environment. No wonder emergency physicians have difficulty handling all that comes our way.

ACEP is the first national medical specialty to focus on the well-being of its members by creating an Emergency Medicine Wellness Week. We hope to do this annually as a way to remind ourselves that there are steps we can take to remain healthy and connected to what is important. I invite you to participate and lead ACEP in becoming a trailblazer in the house of medicine in preventing burnout, dealing with it when it occurs, and promoting well-being among ourselves and our colleagues.

DR. KAPLAN is President of ACEP, director of the patient experience for CEP America in Emeryville, California, and a practicing clinician in the emergency department at Marin General Hospital in Greenbrae, California.

EMERGENCY MEDICINE wellness week™
JANUARY 24 - 30, 2016

Sponsored by ACEP

WHY DO WE CARE ABOUT WELLNESS?

BY RITA A. MANFREDI, MD, FACEP

ACEP views wellness as so critical to the success of an emergency physician that Emergency Medicine Wellness Week 2016, sponsored by ACEP, will take place Jan. 24–30, 2016.

As human beings and emergency physicians, we all hope to be well, but wellness is more than just the absence of sickness. Many people and organizations have attempted to define wellness more precisely. The World Health Organization has distilled wellness to "a state of complete physical, mental, and social well-being."[3] The National Wellness Institute sees wellness as an evolving process through which people achieve their full potential.[4] *(See chart on page 17.)*

We can think of wellness as multidimensional with many spokes. Each spoke is critical to maintaining balance and achieving wellness. By looking at wellness this way, we can see how these elements are interconnected and contribute to how we live. However, emergency physicians may choose to prioritize these spokes in different ways.

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DR. MANFREDI is associate clinical professor in the department of emergency medicine and a Milliken Fellowship Graduate, George Washington Institute for Spirituality & Health, at the George Washington University School of Medicine in Washington, D.C., and a member of ACEP's Well-Being Committee.

Sign Up for **Special Emergency Medicine Wellness Week Activities**

Emergency Medicine Wellness Week 2016, Jan. 24–30, is an opportunity for emergency physicians and their colleagues to take the time to self-renew while staying dedicated to the highest quality patient care.

To participate, visit the website, www.acep.org/EMWellnessWeek, and sign up for daily wellness tips, print a personal pledge card, find resources and videos about better wellness, and share your stories of personal improvement.

"As emergency physicians, we care a lot about our patients. That's why we chose this specialty. But all too often we are so busy caring for others, we forget to care about ourselves," said ACEP President Jay A. Kaplan, MD, FACEP. "We want this week to be about action rather than just ideas. Everyone makes resolutions around the New Year; we hope that this week will help us and our colleagues make commitments to become more healthy, less burned out, and more resilient."

First, fill out an anonymous pledge card from the website, selecting areas that you will focus on for the week. Print it out and stick it on your refrigerator, your mirror—anywhere you'll see it every day. There will be suggested improvements in three major areas, such as physical (eating, health, exercise); connections (spending time with family and friends, doing a community project); and career enhancement (recognizing burnout, planning your next career move).

Next, sign up to receive daily messages about wellness for that week to help you keep on track, and introduce resources that will help improve your wellness that week and beyond. At the end of the week, ACEP will ask you how you did and what worked for you.

Each spoke is critical to maintaining balance and achieving wellness.

THE OCCUPATIONAL SPOKE

1 Are you satisfied with emergency medicine and the job you do in your own department? Remember why you chose emergency medicine as your career. There was something very compelling about becoming an emergency physician. Can you recall what that was? Your aim is to enrich your life through your work in emergency medicine.

THE EMOTIONAL SPOKE

2 Emergency medicine is fast-paced and stressful. As emergency physicians, we have to acknowledge what we are feeling rather than deny our emotions. We may be annoyed with consultants or difficult patients, but we have the power to choose how we will behave and manage these feelings. Being optimistic and maintaining satisfying relationships with others are key to wellness.

THE PHYSICAL SPOKE

3 Exercising enough, eating well, getting adequate sleep, and paying attention to the signs of illness and getting treatment when needed all play a big role in physical wellness. Emergency physicians who are in good shape will reap the psychological benefits of greater self-esteem and self-control.

THE FINANCIAL SPOKE

4 Being financially secure is a key component to your effectiveness as an emergency physician. Part of financial wellness is to develop a plan by establishing goals such as providing for your family, paying your monthly bills, planning for your children's education, and creating a nest egg that provides for a comfortable retirement and your future.

THE SPIRITUAL SPOKE

5 What gives you meaning and purpose in emergency medicine? Is it the art of helping and healing? The spiritual dimension will be characterized by times of peaceful harmony interspersed with rocky times of disappointment, doubt, and fear. In emergency medicine, every day we have these experiences that cause us to adapt and bring meaning to our existence.

THE SOCIAL SPOKE

6 How are you relating to others in the emergency department and in your life outside of work? Developing effective relationships with colleagues, patients, friends, and our families indicates social wellness.

THE INTELLECTUAL SPOKE

7 As our specialty changes and evolves, having an open mind in emergency medicine is critical. Sharing what you know with others in the emergency department can be stimulating and serve as a way to challenge yourself.

TAKE PART IN WELLNESS WEEK

8 Developing a personal approach for wellness is valuable to every emergency physician. Emergency Medicine Wellness Week 2016 will be seven days of virtual events addressing all seven spokes of wellness, with special offers designed to engage emergency department caregivers in self-care. You can choose which wellness spoke you want to focus on during the event by filling out a pledge card. Electronic articles, daily tweets, and email wellness tips will be showcased during the week.

JOIN EVERYONE IN ACEP FOR A FULL COURSE OF WELLNESS THAT WILL HOPEFULLY CONTINUE LONG AFTER EMERGENCY MEDICINE WELLNESS WEEK 2016 IS OVER.

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

WHAT I WISH I KNEW...

DR. KAPLAN is President of ACEP, director of the patient experience for CEP America in Emeryville, California, and a practicing clinician in the emergency department at Marin General Hospital in Greenbrae, California.

Dealing With Dark Times

How to handle depression, burnout, and thoughts of suicide

by JAY A. KAPLAN, MD, FACEP

When I was an intern in 1976, I invited a good friend over for dinner. She had been having some trouble with her boyfriend, and I was hoping to cheer her up. I cooked dinner, and we talked. The evening was a connected one, and at its end, I offered her a plant cutting, which I had made for her. This was my way of saying I care. She declined my gift. The next day, I was told that she had committed suicide the morning following our evening of friendship. I felt so guilty. I almost quit my internship that week.

Nathaniel Mann, MD, is a resident in the department of emergency medicine at the University of Cincinnati in Ohio. Jordan Celeste, MD, is president of the Emergency Medicine Residents' Association and an emergency physician in Florida.

HERE IS WHAT I WISH I KNEW

Depression is insidious. It sneaks up and can take you down in an instant.

We as physicians, and other health care professionals, are not good at recognizing burnout and depression in ourselves. We are perfectionists and expect ourselves to be experts from day one, which is unrealistic.

The most difficult task, and the most important when you believe a friend or colleague is depressed, is to reach out and offer your help. If your assistance is refused, share your concern with another friend and ask again.

The most difficult task, and the most important when *you* are having difficulty, is to reach out and ask for help. Admitting your own struggle and powerlessness is a big first step in helping yourself. It takes courageous humility.

Seeking to establish a relationship and talk with a therapist is not something to be ashamed of. It should be something to be proud of. We all have our strengths, things we are good at, and we all have our opportunities, areas where we are weak. We need to seek out those who appreciate our strengths and assist us to get better in those areas where we fall short.

Time passes very quickly. There is always more work. There is not always more time. We need to treasure our families and our friends. We will never regret bringing more love to who we are and what we do.

BY THE NUMBERS

PHYSICIANS AND BURNOUT

46%
of physicians report burnout.

52%
of emergency physicians report burnout.

50%
of male emergency physicians report burnout.

58%
of female emergency physicians report burnout.

53%
of physicians age 46–55 report burnout. This group is most likely to feel burned out.

22%
of physicians age 66 and older report burnout.

Source: Medscape 2015 Physician Lifestyle Report

DEPRESSION AND SUICIDE

400
Average number of physicians who die from suicide each year.

15–30%
of medical students and residents screen positive for depression.

Source: Physician suicide[3]

WHERE TO TURN FOR HELP AND INFORMATION

National Suicide Prevention Lifeline: www.suicidepreventionlifeline.org, 1-800-273-TALK (8255)

American Foundation for Suicide Prevention: www.afsp.org

Black-Bile, a website for physicians with depression: www.black-bile.com

American Association of Suicidology: www.suicidology.org

Federation of State Physician Health Programs: www.fsphp.org/State_Programs.html

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

THE BURDEN OF BURNOUT

Physicians experience a higher rate of burnout than the general population—37.9 percent versus 27.8 percent, according to a recent study in *Archives of Internal Medicine*—and emergency physicians report more burnout than all other medical specialties.[1] Physicians also have higher suicide rates than the general population—70 percent higher for men and 250 to 400 percent higher for women—even though rates of depression are about the same for physicians and nonphysicians.[2] Suicide is the most common cause of death among medical residents.[3] Despite this increased risk, one study found that only 26 percent of surveyed physicians who had suicidal ideation sought help.[3]

The effects of health care modernization also play a role in burnout: computerization was ranked 3.68, and the Affordable Care Act's impact was 3.65.

CAUSES OF BURNOUT

According to Medscape's 2015 Physician Lifestyle Report, bureaucratic tasks are the top cause of burnout, at 4.75 on a scale of 1 to 7.[4] Long work hours and insufficient compensation came next at 3.99 and 3.71, respectively. The effects of health care modernization also play a role in burnout: computerization was ranked 3.68, and the Affordable Care Act's impact was 3.65. Patient concerns also contribute to burnout, with difficult patients at 3.37 and too many patients at 3.34. Lack of professional fulfillment was lower on the list, ranked at 3.05.

WHAT CAN YOU DO TO COMBAT BURNOUT AND SUICIDE?

A 2015 Cochrane Review found that cognitive-behavioral training, mental relaxation, and physical relaxation can all reduce workplace stress moderately.[5] With the exception of being able to control work schedules, workplace interventions (improving support, mentoring, communication skills training, etc.) didn't have a noticeable effect on employees' stress levels.

Recognizing the warning signs for suicide is an important first step to preventing it. The American Association of Suicidology offers this mnemonic for the warning signs of suicide:

IS PATH WARM?

I IDEATION	P PURPOSELESSNESS	W WITHDRAWAL
S SUBSTANCE ABUSE	A ANXIETY	A ANGER
	T TRAPPED	R RECKLESSNESS
	H HOPELESSNESS	M MOOD CHANGES

See "Where to Turn for Help and Information" for more resources to learn about suicide and to seek help for substance abuse, depression, and suicidal thoughts.

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BENCHMARKING ALLIANCE

CONTINUED FROM PAGE 13

Table 3 focuses on the productivity of physicians and APPs in all the cohorts of EDs over the last four years. There has been an increasing number of EDs utilizing APP staffing. Those that use APPs appear to be increasing the number of hours relative to physician staffing. This staffing change may facilitate the continued increase in ED volume across all cohorts. But APP staffing has the greatest impact on the relative productivity of emergency physicians in EDs with over 20,000 volume per year.

From the data, it appears that emergency physician productivity is slowly increasing. This could be attributed to increasing ED presence of APPs, who assist in overall patient flow. But many EDs appear to be better able to accommodate the loss of physician productivity from the implementation of electronic tools in the ED. Many emergency physicians have documented the loss of productivity and difficulties in patient flow when information systems do not support the role of physicians and APPs. There are perhaps now some signs that providers have adapted to the use of those systems.

The use of APPs allows a reduction in time to provider and allows the staff to implement programs that reduce patient walkaway rates.

It is critical that emergency physicians and APPs be able to see patients, place orders in their electronic medical record, and provide documentation of patient care. The technologies must be simplified to improve the work capabilities of all providers and, in particular, must facilitate the work of physicians, who serve at the highest level of decision making. Emergency physicians must fill the important role of overseeing patient care and the work of APPs for certain patients.

The EDBA data have followed the trend toward increasing use of APPs in the ED. This has been correlated with improved intake processing of patients and reduced walkaway rates.

Table 3. Licensed Independent Practitioner Patient-Per-Hour Staffing Changes Through the Years

ED TYPE	2011 PHYSICIANS	2011 PHYSICIANS + APPs	2012 PHYSICIANS	2012 PHYSICIANS + APPs	2013 PHYSICIANS	2013 PHYSICIANS + APPs	2014 PHYSICIANS	2014 PHYSICIANS + APPs
All EDs	2.5	2.2	2.5	2.1	2.5	2.1	2.5	2.0
Under 20K volume	1.7	1.5	1.5	1.4	1.5	1.4	1.4	1.3
20–40K	2.6	2.1	2.6	2.1	2.6	2.1	2.7	2.1
40–60K	2.9	2.7	2.9	2.3	3.0	2.4	2.9	2.2
60–80K	2.6	2.3	3.0	2.4	2.9	2.3	3.1	2.4
80–100K	2.9	2.3	3.0	2.4	2.9	2.3	3.1	2.4
Over 100K volume	2.7	2.2	2.9	2.4	3.0	2.4	3.1	2.4
Pediatric EDs	2.1	1.9	2.3	2.0	2.4	2.1	2.4	2.0
Adult EDs	2.5	2.2	2.6	2.1	2.6	2.1	2.8	2.2

References

1. Wiler JL, Welch S, Pines J, et al. Emergency department performance measures update. *Acad Emerg Med.* 2015;22(5):542-553.

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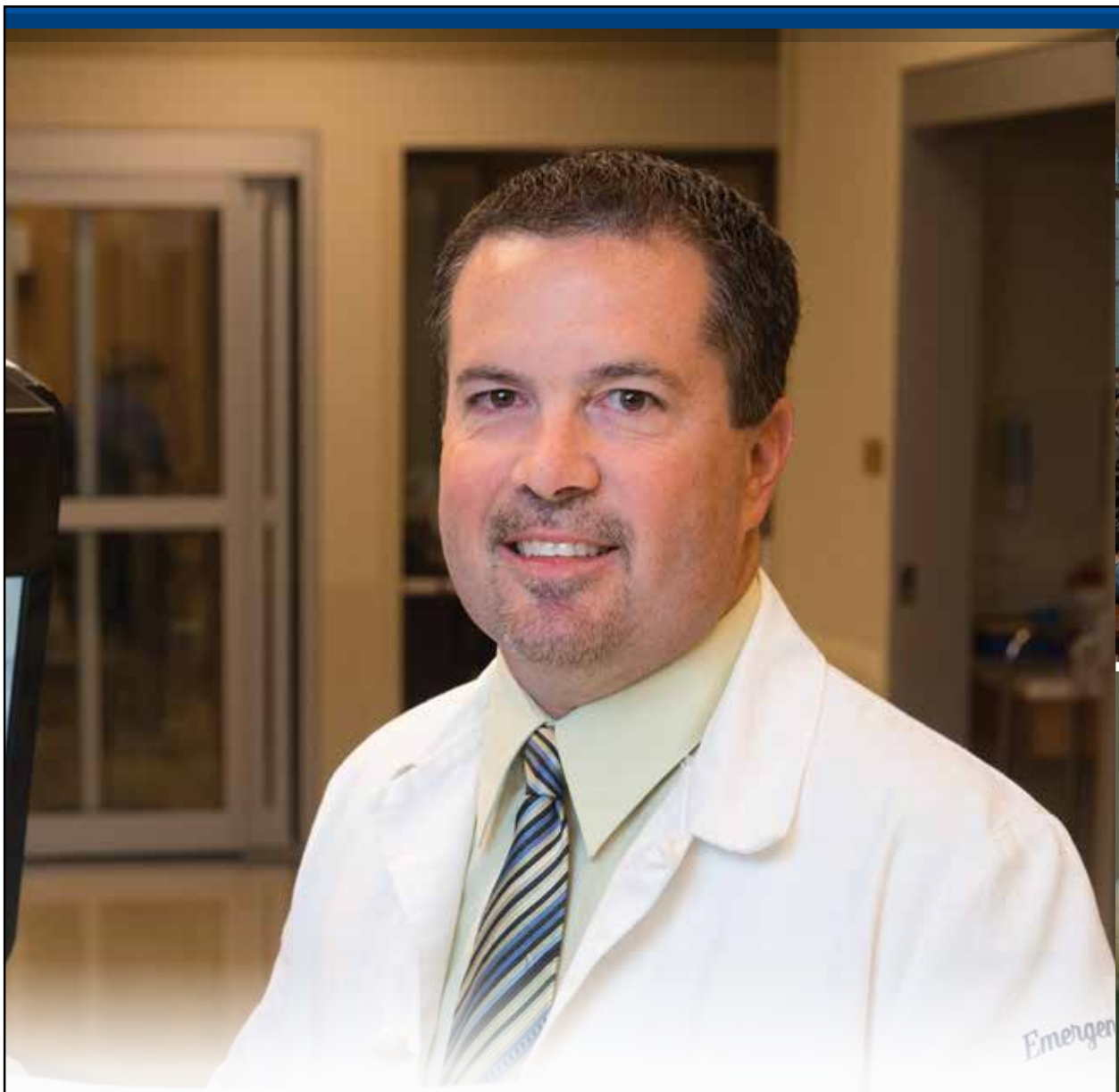

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