n 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.

INTRODUCTION by JAY A. KAPLAN, MD, FACEP

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.

‘PAVE THE WAY’ Brick by Brick

Donate a brick paver for ACEP’s new headquarters and help “Pave the Way” for the future of emergency medicine. Bricks ordered by March 31 will be installed in time for the headquarters’ grand opening later in the year. Bricks will continue to be sold until space runs out for the pavers. Visit www.emfoundation.org/PavetheWay for pricing and donation information.

CONTINUED on page 16
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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.

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 Medicare, 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 Klauser, DO, FACEP; “Interventional Stroke Care” with Christian Ramsey, MD; and “Peds EM Update” with Al Sacchetti, MD, FACEP.

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


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.

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

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

<table>
<thead>
<tr>
<th>MEASURE #</th>
<th>DESCRIPTION</th>
<th>DOMAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS #54</td>
<td>Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain</td>
<td>Clinical Effectiveness</td>
</tr>
<tr>
<td>PQRS #91</td>
<td>Acute Otitis Externa (AOE): Topical Therapy</td>
<td>Clinical Effectiveness</td>
</tr>
<tr>
<td>PQRS #93</td>
<td>Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use</td>
<td>Efficiency &amp; Cost Reduction</td>
</tr>
<tr>
<td>PQRS #187</td>
<td>Stroke and Stroke Rehabilitation: Thrombolytic Therapy (tPA)</td>
<td>Clinical Effectiveness</td>
</tr>
<tr>
<td>PQRS #254</td>
<td>Ultrasound Determination of Pregnancy Location for Pregnant Patients With Abdominal Pain</td>
<td>Clinical Effectiveness</td>
</tr>
<tr>
<td>PQRS #255</td>
<td>Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure</td>
<td>Clinical Effectiveness</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>QUALITY PROGRAM</th>
<th>PAYMENT IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Traditional PQRS Penalty</td>
<td>Potential 2.0% decrease in 2018 for 2016 performance</td>
</tr>
<tr>
<td>2 VBM</td>
<td>Potential 4.0% decrease in 2018 for 2016 performance</td>
</tr>
<tr>
<td>Total Potential Penalties</td>
<td>6.0% decrease in 2017 for 2016 performance</td>
</tr>
</tbody>
</table>
TO MERGE OR NOT TO MERGE | CONTINUED FROM PAGE 1

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

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
**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 speaking a common language. Everything consolidates down to being 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.

**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.

**RM:** Dr. Lannaccone?

**SB:** I 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. Lannaccone, 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 Brentians 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 anesthesiology, 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 —BRENT ASPLIN, MD, MPH, FACEP

**RM:** 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 report 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 speed, 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 at when they consolidate: a pooling of resources.

**RM:** 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 speaking a common language. Everything consolidates down to being 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:** I think ideality 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 going into 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.

**BA:** We’re looking at emergency group consolidation. I wanted to separate those two different things. I’ll mention another strategy is to develop physician networks. Together, we put together a strategy 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.

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A

In the Aftermath of Gunfire

Emergency physician Dr. Ryan Petersen recounts his experiences caring for victims of a mass 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: What altered your course that day?
RP: I got a phone call from Melissa Norris, our onsite 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 entire emergency department was full of nurses, general surgeons, orthopedic surgeons, as well as the majority of the ER staff.

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 could 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 callous. 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 combated 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**

<table>
<thead>
<tr>
<th>Total fatalities</th>
<th>Total mass shootings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: Mother Jones</td>
<td></td>
</tr>
</tbody>
</table>

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.
INTRODUCTION

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?

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.

NJ: Does a lack of democracy mean you will not be treated fairly? (Is fair treatment confused with democracy?)

RM: I think that 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 that 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.

What is the definition of “democracy”?

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.

What role will democratic groups have in the future of emergency medicine?

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.

NJ: What is the definition of “democracy”?

RM: 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 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?”

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.

Questions about democracy in emergency medicine.
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. 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.

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 EKG 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.

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.

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

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.” A second vignette went beyond discussing the potential errors that reportedly lead to a missed pulmonary embolism: “The emergency physician signs up to see the patient it 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 in-patients and 0 to 16.5 percent in emergency department patients (Callen et al., 2011).”

The number (16.5 percent) in the Callen article was obtained from Kachalia et al. 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).” 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 EMRALA: zero. In today’s environment of increased ED volumes and cost containment, “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 is not one. 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 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.

References

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.
Counting the Hours
EDBA data can help EDs improve productivity

by JAMES J. AUGUSTINE, MD, FACEP

There is considerable variation in the staffing 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. 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 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.

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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), equating 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.

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

<table>
<thead>
<tr>
<th>ED TYPE</th>
<th>NURSE STAFF</th>
<th>TECH/CLERK STAFF</th>
<th>PHYSICIANS</th>
<th>PHYSICIANS + APPs</th>
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</thead>
<tbody>
<tr>
<td>All EDs (N=1,137)</td>
<td>0.62</td>
<td>1.7</td>
<td>2.48</td>
<td>1.97</td>
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<tr>
<td>Under 20K volume</td>
<td>0.56</td>
<td>1.6</td>
<td>1.4</td>
<td>1.3</td>
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<tr>
<td>20–40K</td>
<td>0.66</td>
<td>2.0</td>
<td>2.7</td>
<td>2.1</td>
</tr>
<tr>
<td>40–60K</td>
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<td>1.7</td>
<td>2.9</td>
<td>2.2</td>
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<tr>
<td>60–80K</td>
<td>0.61</td>
<td>1.4</td>
<td>3.1</td>
<td>2.4</td>
</tr>
<tr>
<td>80–100K</td>
<td>0.60</td>
<td>1.4</td>
<td>3.1</td>
<td>2.4</td>
</tr>
<tr>
<td>Over 100K volume</td>
<td>0.65</td>
<td>1.2</td>
<td>3.1</td>
<td>2.4</td>
</tr>
<tr>
<td>Pediatric EDs</td>
<td>0.62</td>
<td>1.9</td>
<td>2.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Adult EDs</td>
<td>0.56</td>
<td>1.3</td>
<td>2.8</td>
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Table 2. Patient-Per-Hour Staffing Ratios Over the Last 5 Years of EDBA Surveys

<table>
<thead>
<tr>
<th>ALL ED TYPES</th>
<th>NURSE STAFF</th>
<th>TECH/CLERK STAFF</th>
<th>PHYSICIANS</th>
<th>PHYSICIANS + APPs</th>
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<tr>
<td>2014</td>
<td>0.62</td>
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<td>1.97</td>
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<td>0.65</td>
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</tr>
<tr>
<td>2010</td>
<td>0.65</td>
<td>1.4</td>
<td>2.4</td>
<td>2.2</td>
</tr>
</tbody>
</table>

CONTINUED on page 19
Diltiazem or Metoprolol for Rapid Atrial Fibrillation?

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

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 EKG 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


• 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 planned patients

3. 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.

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 CHADS2/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 Drs. 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. ♦

References


Don’t FOAM It Alone

Columnists introduce readers to benefits of multimedia learning

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

S
ince 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 Ros- enblatt’s texts). I think some people still think of blogs and podcasts as thrown-together shoddy representations of the different formats of medical education and don’t hold up. I think there’s this misconception that podcasts and blogs are just for the masses as well as textbooks that are old, out-of-date, and torture involved.

In our first 40 episodes, we’ve covered the EMGfit podcast, SMART EM podcast, the EM Literature of Note blog, the Skeptics’ Guide to Emergency Medicine, The St. Em- lyn’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 epi-

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 sit-

LW: Definitely that the stereotypes about emergency physicians have the second highest rate of burnout (just 1% less than critical care physicians) and that burnout has been shown to negatively affect patient care.*

Dr. Faust is a senior emergency-medicine resident at Mount Sinai Hospital in New York. He tweets about #FOAMed and classical music @jeremyfaust.

Dr. Westafer is chief resident at the Baystate Medical Center at Tufts University in Springfield, Massachusetts. Follow her @LWestafer.
EMERGENCY MEDICINE WELLNESS WEEK 2016

INTRODUCTION continued from page 1

In recent published studies, emergency physicians outpace all other physicians in the rate of burnout.1 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.

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. 26–30, 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.”2 The National Wellness Institute sees wellness as an evolving process through which people achieve their full potential.3 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.

References
4. The six dimensions of wellness model. National Wellness Institute website. Available at: www.nationalwellness.org/?page=Six_Dimen-

DR. MANFREDI is associate clinical professor in the department of emergency medicine and a Milken 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. 26–30, 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.
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.

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.

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.

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.

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.

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.

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.

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.
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.

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

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

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.
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. 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. Suicide is the most common cause of death among medical residents. Despite this increased risk, one study found that only 26 percent of surveyed physicians who had suicidal ideation sought help.

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. 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 3.88, 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. 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 for Suicidology offers this mnemonic for the warning signs of suicide: IDEATION, SUBSTANCE ABUSE, ANXIETY, TRAPPED, HOPELESSNESS, WITHDRAWAL, ANGER, RECKLESSNESS, 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.

References

BENCHMARKING ALLIANCE

Table 1 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 presence of APPs, who assist in overall patient flow. Many emergency physicians have documented the loss of 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.

References

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

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<td>Adult EDs</td>
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Bayfront Spring Hill & Brooksville, 2 hospital system (Spring Hill)
Oak Hill Hospital (Spring Hill)
St. Petersburg General Hospital (St. Petersburg)
Northside Hospital (St. Petersburg)
Medical Center of Trinity (Tampa) Medical Director and Staff
Citrus Park ER (Tampa Bay)
Brandon Regional Hospital (Tampa Bay)
Tampa Community Hospital (Tampa Bay)

The Villages Regional Hospital (The Villages)
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South Georgia Medical Center (Valdosta) Smith Northview Urgent Care Center (Valdosta)
Mayo Clinic at Waycross (Waycross)

KANSAS OPPORTUNITIES
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CHRISTUS Spohn Hospital - South (Corpus Christi)
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West Houston Regional Medical Center (Houston) Medical Director
CHRISTUS Jasper Memorial Hospital (Jasper) Medical Director and Staff
CHRISTUS Spohn Hospital - Kleberg (Kingsville)
Pearland Medical Center (Pearland)
CHRISTUS Hospital - St. Mary (Port Arthur)
CHRISTUS Santa Rosa Hospital - Westover Hills (San Antonio)
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