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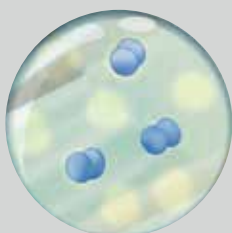
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THE COLD REALITY OF MERGERS AND MONEY

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STATE OF THE EM UNION

Dr. Jay A. Kaplan discusses his goals for
his year as ACEP's President

Each year brings new challenges for our specialty to face and a new President to lead the charge. Jay A. Kaplan, MD, FACEP, who took over as ACEP President in October, recently shared his views on a few of those challenges with *ACEP Now* Medical Editor-in-Chief Kevin Klauer, DO, EJD, FACEP. Here are some excerpts from their conversation.

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GET READY FOR NALOXONE

*Emergency
departments need
implementation
strategies for
distribution*

by ELIZABETH A. SAMUELS,
MD, MPH, JASON HOPPE, DO,
JOAN PAPP, MD, FACEP; LAUREN
WHITESIDE, MD, MS, ALI S. RAJA,
MD, MBA, MPH, AND EDWARD
BERNSTEIN, MD, FACEP

THE CASE

A 57-year-old man is brought in by family in a private vehicle after a "heroin overdose." The patient had just gotten out of rehab and was doing well until that day, when the family found him blue and unresponsive. The patient regains spontaneous respirations and normal oxygenation after two doses of naloxone in the ED. He is clinically stable after several hours of observation in the ED, and you think he is ready for discharge. What do you have available in your ED to prevent a recurrent overdose or overdose death?

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ACEP Now

The Official Voice of Emergency Medicine

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UPDATES
AND ALERTS
FROM ACEP

NEWS FROM THE COLLEGE

ACEP Construction Continues!

Amid obstacles, ACEP's new headquarters is on track to open its doors in September

by DIANNA HUNT

THE WALLS ARE UP, AND construction is moving forward toward a fall grand opening for the new ACEP headquarters building.

Despite fall rains, winter mud, and a narrow miss by December tornadoes, construction continued undeterred just a few miles from the existing ACEP headquarters near Dallas/Fort Worth (DFW) International Airport.

Construction is expected to be completed by August, with a grand opening to follow for the three-story, 57,000-square-foot headquarters, which is almost double the size of the existing headquarters.

Background: A beam signed by ACEP and EMF Board members is placed in ACEP's new headquarters. Inset left: An artist's rendering of the headquarters building. Inset right: ACEP Board members sign a beam for the building.



"I am thrilled with the progress of the construction of the new building," said ACEP President Jay A. Kaplan, MD, FACEP. "Despite the rainiest winter in recent history and losing 37 days of construction as a result, we are on track to inhabit the building by the beginning of September ... We are giving birth to a new era in emergency medicine based on the thoughtfulness and intelligence put into the design and functionality of our new headquarters."

In a special "topping out" ceremony in January, Board members of ACEP and the Emergency Medicine Foundation signed a large beam that had been painted white for the occasion. The beam was signed and put into place while the Board members were at ACEP headquarters for their January meeting.

The new building will allow consolidation of ACEP staff under one roof and provide greater efficiency for delivering services and benefits to members. It is designed to be energy-efficient and will include amenities for the visitors who attend meetings and conferences there each year.

"We have outgrown our current headquarters, which is more than 30 years old, and have had to put staff across the street in an adjacent facility," Dr. Kaplan said. "Not having all of our staff in one building has created inefficiencies despite excellent management by our leadership team. The new building has been designed with organizational alignment and our future in mind."

Bursting at the Seams

ACEP moved into its existing headquarters in the mid 1980s, when the organization's membership, finances, and activities were just about one-third the size they are now. The organization had about half the staff as today and delivered far fewer services.

After extensive review by ACEP management and the Board of Directors, the six-acre site, just a few miles from the existing headquarters, was purchased in June 2014. The existing building will be sold.



We are giving birth to a new era in emergency medicine based on the thoughtfulness and intelligence put into the design and functionality of our new headquarters.

—Jay A. Kaplan, MD, FACEP, ACEP President

Groundbreaking at the new site took place in April 2015, and the walls went up in January 2016. Work has already begun on adding internal structure beams to support the walls while the roof is completed.

Each concrete wall panel weighs between 60 and 100 tons, and the panels are nearly 10 feet thick. They are reinforced with rebar and constructed with a 5,000-pound concrete that is particularly strong and fast drying.

Looking Ahead

The next step in the construction is to enclose the building so that work can begin inside.

After the internal structure supports have been put in place, the roof will be installed. Then the supports will be removed to allow construction of the floors, starting with the third floor and working down.

At that point, work can begin on the interior of the building, unfettered by the notorious changes in the Texas weather.

The building will also incorporate a special area devoted to the history of the specialty, with art displays commemorating the mission of ACEP and the service of emergency physicians.

"It will be a testament to the importance of emergency medicine," Dr. Kaplan said. "Besides having the latest technology and communication capabilities, and space to expand as we continue to grow, the headquarters with our ACEP logo will be very visible from a main highway as well as from the air when planes land at DFW airport."

Floor plans, construction photos, and planned finishes are available online at www.acep.org/About-Us/New-Headquarters.

DIANNA HUNT is the ACEP communications manager.

AT A GLANCE

New ACEP Headquarters

What: Three stories, 57,000 square feet.

When: Expected completion date in August, with grand opening tentatively set for September.

Where: Just a few miles from the existing headquarters in Irving, Texas, near Dallas.

Why: Consolidate ACEP services into one building to increase efficiencies and savings.

More info: Follow the construction at www.acep.org/About-Us/New-Headquarters.

PAVE THE WAY

How to Contribute

It's not too late to donate a brick paver for ACEP's new headquarters to help "Pave the Way" for the future of emergency medicine. Bricks ordered by March 31, 2016, will be installed in time for the headquarters' grand opening, tentatively set for early September. Bricks will continue to be sold even past the deadline until space runs out for the pavers. Visit www.emfoundation.org/PavetheWay for pricing and donation information.

NEWS CONTINUES on page 4

Just What the Doctor Ordered: Emergency Medicine Wellness Week

The first-ever Emergency Medicine Wellness Week was a healthy success.

Hundreds of ACEP members participated in the effort Jan. 24–30 to focus on their own well-being, and engagement on Twitter and Facebook was high as members shared videos, photos, and tips of their own wellness efforts.

ACEP members knew what they wanted to do to improve their well-being: an informal online survey showed that members chose spending time connecting with family and friends as their top priority.

Focusing on healthy food choices came in second, with planning a vacation and learning to meditate being next in line for members' get-healthy priorities. Adding exercise, such as taking the stairs, to daily routines rounded out the top five.

Plans are already under way for next year's EM Wellness Week. Share stories and watch for regular updates at www.acep.org/emwellnessweek.

Interested in Volunteering? Apply Now to be a Member of an ACEP Committee

The selection process has begun for appointing members to serve on national ACEP committees during fiscal year 2016–2017, ACEP President-Elect Rebecca B. Parker, MD, FACEP, has announced.

Members interested in serving on a national committee are asked to submit an interest form and curriculum vitae by May 16, 2016. Dr. Parker also asks that members include specific information explaining qualifications and experiences relevant to the particular committee.

Members are also encouraged to contact their chapter to obtain a letter of support. Member interest and qualifications will be matched with the College's needs. A list of current national ACEP committees, members, objectives, and annual reports are located at www.acep.org/committees.

Most committee work will be accomplished through email and conference calls, but committee members are expected to attend the organizational meetings at the annual meeting Oct. 16–19 in Las Vegas. The appointment is contingent upon completion of a conflict-of-interest form.

Members interested in serving on a committee are asked to contact Mary Ellen Fletcher at 800-798-1822, ext. 3145, or mfletcher@acep.org. Committee interest forms are available online at <https://webapps.acep.org/Membership/committeeinterest.aspx>.

Committee appointments will be finalized in June.

ACEP Joins National Opioid Working Group

ACEP has joined dozens of other medical groups to participate in the U.S. Department of Health and Human Services' External Opioid Working Group.

ACEP President Jay A. Kaplan, MD, FACEP, attended a meeting on the White House grounds in January to kick off the working group. The group will meet bimonthly to share updates and best practices and learn about the Obama administration's opioid strategy. ➔

WHAT ARE YOU THINKING?

SEND EMAIL TO ACEPNOW@ACEP.ORG;
LETTERS TO ACEP NOW, P.O. BOX 619911,
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972-580-2816, ATTENTION ACEP NOW.

Emergency Nurse Practitioner Certification Exam Being Developed

AAENP and AANPCP will collaborate on the certification test expected to launch Jan. 1, 2017

BY KAREN "SUE" HOYT, PHD, RN, FNP-BC, CEN, FAEN, FAANP

The American Academy of Emergency Nurse Practitioners (AAENP) and the American Association of Nurse Practitioners Certification Program (AANPCP) are developing the first board specialty certification examination for nurse practitioners who practice in emergency care.

The AAENP and AANPCP collaboration will provide a certification program that aligns with the APRN Consensus Model for specialty nursing practice and meets national accreditation standards. Individuals practicing in the emergency care setting who seek certification are eligible to take the examination provided that they have completed an appropriate graduate degree and have primary certification as a family nurse practitioner.

The committee (composed of members of AAENP and AANPCP) held a conference call Jan. 20, 2016, and met in Dallas on Feb. 26–28 to discuss the next steps in the ENP certification process. The vendor for test certification is Professional Exam Service. The group has enlisted three panels:

- **Panel I:** Practice Analysis (Role Delineation)
- **Panel II:** Subject Matter Experts
- **Panel III:** Test Construction/Item Writers

While a specific launch date for the ENP certification examination has not yet been established, the anticipated timeframe will be Jan. 1, 2017. Eligibility to take the examination is based on the candidate meeting the following requirements:

- Current, active registered nurse license in the United States, US territories, or a Canadian province or territory.
- Current national certification as a family nurse practitioner.
- Emergency care specialty content that includes at least one of the following:



ILLUSTRATION/PAUL JUESTICH; PHOTOS SHUTTERSTOCK.COM

a minimum of 2,000 direct emergency care practice hours in the past five years and evidence of 100 hours of continuing emergency care education with a minimum of 30 of those hours in emergency care procedural skills within those five years; completion of an academic emergency care graduate or post-graduate nurse practitioner pro-

gram; or completion of an approved emergency fellowship program. ➔

DR. HOYT is chair of the NP Validation Committee for AAENP, a clinical professor at the University of San Diego, and an emergency nurse practitioner at St. Mary Medical Center in Long Beach, California. She is editor of the *Advanced Emergency Nursing Journal*.



Mt. Erebus as seen from a helicopter.

DON'T EXPECT A WARM WELCOME
WHEN YOU ARRIVE IN ANTARCTICA

First Day on The Ice

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

“How do you get to Antarctica?” may be the third most common question I get when I tell people I’ll be spending the winter there. (The first, of course, is, “How cold is it?”

The answer? “Colder than a ... !” You get the idea.)

After several days’ delay in Christchurch, New Zealand, due to very bad weather on The Ice, I arrived at Antarctica’s McMurdo Station. The 2,180-mile trip took about five hours in a US Air Force C-17 plane. If we had taken the alternative, a C-130, the trip would have been an excruciating eight hours. Neither plane has the amenities you expect when flying. They do provide a bag lunch, but heating is minimal, there are few windows, most seats are webbing, and the “bathroom” is a bucket surrounded by drapes.

Antarctica, the continent I’ll be living on for the next seven months, has a surface area of 5.4 million square miles, 1.4 times the size of the United States. This makes it the fifth largest continent. Almost 98 percent of the continent is covered by an ice sheet that averages 6,000 feet (more than one mile) thick. Antarctica has 70 percent of the world’s fresh water, frozen as ice. Yet, to our knowledge, explorers only reported seeing it in 1820 and landed on the continent in 1821. Explorers first “overwintered” there in 1898, a tradition I will be continuing.

McMurdo Station sits at the southern tip of the volcanic Ross Island, at the edge of the Ross Ice Shelf and the Ross Sea. The 13,300-foot Mt. Erebus, an active volcano, towers above the station. Our plane lands on a constantly maintained airfield on the Ross Ice Shelf. It’s disconcerting to realize that this enormous cargo aircraft is setting down on ice covering the very deep Southern Ocean. I’m comforted in knowing that experts maintain this airfield—a huge undertaking given the extreme cold and frequent gale-force winds—throughout even the mildest (everything is relative) times of the year.

ANTARCTIC WELCOME

When do you *really* know you’ve arrived? As the plane descends toward the airfield, everyone receives the instruction to “bundle up,” meaning that they should don all of their extreme cold weather (ECW) gear. This sounds extreme until they open the passenger door and we’re

suddenly hit by the brutal cold.

Of course, you’re greeted by the indigenous population with native dances and flower leis. Just kidding! (The second most common Antarctica question I get is about the indigenous population.) The largest indigenous life forms in Antarctica are nematodes (roundworms) that are found in a few areas of the continent. Mostly, there are microorganisms but no insects. The only people on the continent are scientists and their support teams. The number varies, from around 4,400 in the “summer” months of October through February to around 1,100 during the Antarctic winter. Although many countries have Antarctic research stations, the only ones with at least 100 people during the peak months include Argentina, Australia, Chile, France, Italy,

for a quick meal before I crashed for the night.

Waking up is a bit tough since McMurdo time is four hours earlier (and one day later) than in my hometown of Tucson, Arizona. However, after my morning ablution, I climbed back into my ECW gear to make my way over to the dining hall for breakfast. The buildings we live and work in are warm enough, so wearing normal clothing plus some long underwear suffices to keep us toasty. To get from the building where I live to the medical building, I subscribe to the common McMurdo truism, “The shortest path from one place to another on the station is through a heated building.” This first morning’s breakfast is good, hot, and plentiful. We’ll see how it goes as the season progresses and fresh food disappears from the menu.



The hospital clinic at McMurdo Station.

To get from the building where I live to the medical building, I subscribe to the common McMurdo truism, “The shortest path from one place to another on the station is through a heated building.”

Japan, Russia, the United Kingdom, and the United States.

I bundled up and emerged from the plane to climb onto Ivan the Terra Bus, which takes us to general orientation in the dining hall. The dining hall, which also serves as the community center for group activities, is spacious enough to accommodate the large summer population. As the winter crew, we make a small dent in the space, spreading out to be comfortable and to sit with the people we know. Outgoing staff drone through the orientation that they’ve been giving at least twice a week throughout the summer. It sounds like every other orientation you’ve ever heard, with most people too tired even to take in the important information.

Then comes the vital stuff: getting room assignments and keys and doing the “bag drag” to get your luggage to your room. I met briefly with the outgoing summer medical-dental crew but started official on-Ice medical equipment and procedure orientation the following day. I went back to the building that houses my room and tried to unpack a few things. I was tired enough that I considered just lying down on the unmade bed and going to sleep, but I had enough stamina to make the bed and even go

GETTING TO WORK

From there, I headed over to the hospital/clinic to meet up with both my nurse practitioner partner and the South Pole crew to orient on the X-ray machine (we take our own films), the very modern ultrasound, the new defibrillator/monitors, the dental materials and equipment (I’m also the “dentist”), the pharmacy, and the maintenance equipment such as the medical sterilizer. We also learned the current procedures for obtaining telemedical consultations, completing the ever-present forms, and making periodic connections with our home base at University of Texas Medical Branch in Galveston.

Happily, the wind had not yet picked up enough to cover one entire side of our building or fill the clinic’s entryway with snow. We crunched easily across the ice as we walked through town, grateful for the thin gray light that was still available for a few hours each day. That won’t last long for, as they say in *Game of Thrones*, “winter is coming.” ☹

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



STATE OF THE **EM** UNION

CONTINUED FROM PAGE 1

KK: What do you think the biggest challenges facing emergency physicians are?

JK: I think the biggest challenge for emergency physicians, and for ACEP as well, includes continuing to show our value both to our patients and to those who pay for the care, the federal government and insurers. We continue to be labeled as the most expensive place to receive care. It is very clear that the major driver of health reform is not really quality—it's cost. I find it very interesting that what used to be called the Patient Protection and Affordable Care Act, passed in 2010, is now being called the Affordable Care Act. The greatest challenge is to give great care to our patients with the limited resources that we have. We are going to continue to be asked to do more with less.

KK: Congratulations on Emergency Medicine Wellness Week. What additional goals do you have for your presidency?

JK: Emergency physicians lead all specialties in terms of burnout. Burnout can be characterized as a loss of work fulfillment, emotional exhaustion, and a sense of disconnection or depersonalization. We have to continue to fo-

cus on that and helping physicians be more healthy. Wellness isn't a one-week thing; it's a yearlong thing.

Fair reimbursement. There was a bill in Congress and there are bills in multiple states that talk about "surprise billing." Insurance companies have been fairly effective in portraying physicians as greedy doctors, predatory billers, and that we are sending bills to patients over and above what the insurance company is willing to pay. Unfortunately, the concept of fair payment doesn't play well with regulators and legislatures because they think that doctors are already well paid. I think that we have to stop talking about surprise billing. We have to start talking about surprise coverage. As one insurance VP said at one of the American Medical Association meetings I recently attended, "The first and only thing which patients look at is the affordability of the premium." Insurance companies have hoodwinked patients by offering them "affordable premiums" but raising their deductibles. One of my top goals is to go after the insurance companies and portray them as more interested in profits than they are in patients.

There are a number of other areas we are also very focused on to provide better care for patients. One is the opioid crisis, where more

patients are dying from prescription drug overdoses than they are from motor vehicle accidents. In the age of terrorism, ACEP needs to take leadership, so I formed a high-threat, high-casualty task force that will look at what ACEP can do to be leaders in educating the public and physicians on how to deal with active-shooter incidents.

KK: Occasionally, people have been critical of you when you speak about experience of care so passionately, as you have done a fair amount of consulting work in that area. How would you respond to those criticisms?

JK: I have been a patient advocate for a long time, and as emergency physicians, we do ourselves harm if we try to separate ourselves from that. There is good evidence that the more patients trust us and the better their experience is, the more they are compliant with our recommendations, and they'll have better outcomes. I have never been one to say that you have to satisfy every patient. I think we need to give patients what we feel is in their best interest, not necessarily what they want. I would also respond that I have never been an advocate for patient satisfaction in the absence of being an advocate for creating a great place for doctors and nurses to work. Unhappy doctors don't make for happy patients. Whenever I travel to do consulting, those who experience the work find that I am an advocate for them to ensure they receive the adequate resources that they need to give great care to their patients. This year, I have dramatically cut down on consulting work. I've wanted to devote time to being President of ACEP. My wife and I planned for that, as my income would be significantly cut, and that's fine with me.

KK: Let's talk about ACEP and membership value. How would you explain to a member why ACEP is spending the College's money on a new headquarters?

JK: Membership value. We recently had a study of our membership and, within the next two months, are creating a plan to improve retention of our transitioning residents through the first 10 years of their practice. ACEP brings educational value with eCME, ACEP CME Tracker, and Portfolio Tracker that allows you to track all of your credentials.

Our current building is over 30 years old. We have outgrown it, with some staff having offices across the street. The building doesn't say, "You should have respect for the physicians who practice emergency medicine." Because we had a couple of good years in terms of ACEP14 and ACEP15 and have been able to save money, it makes all the sense in the world to create a new headquarters with new technology that will have all of our staff under one roof and is a place that says emergency medicine is a special specialty and physicians who prac-



I think the biggest challenge for emergency physicians, and for ACEP as well, includes continuing to show our value both to our patients and to those who pay for the care, the federal government and insurers. We continue to be labeled as the most expensive place to receive care. It is very clear that the major driver of health reform is not really quality—it's cost.

—JAY A. KAPLAN, MD, FACEP

tice emergency medicine are to be honored. We will have an area for the history of emergency medicine, and we will have an outside area sponsored by our Emergency Medicine Foundation that will have pavers with messages from emergency physicians.

KK: Will this expense have a negative impact on any programs that members currently benefit from?

JK: Absolutely not. Under the leadership of Dean Wilkerson, Craig Price, Bobby Heard, Michele Byers, and Gordon Wheeler in Washington, and the countless other staff members, there is not a specialty organization that could have a better staff. They're passionate about emergency medicine and represent us well. The new headquarters will not compromise any of our activities and, in fact, will help us be more efficient in addressing other issues.

KK: What are your thoughts about democracy, and how important

do you feel that is in the current emergency medicine climate?

JK: I've been part a democratic group for my entire emergency medicine career, with the exception of about two years when I was part of the health system. Democracy does not mean anarchy, that everybody is equal, or that you don't have leadership. I think the fundamentals of the best of democratic groups relate to physicians having a say in their practice environment and open books providing physicians some sense of where their compensation is coming from. If they work hard and they give their patients great care, they should be compensated more than those who do less. There's no one model that is best. In this age of consolidation of insurers and physician practices, and more doctors becoming employed, we are going to see those changes in emergency medicine. We need to maintain the sense of physicians as owners rather than renters. In other words, physicians should feel that they have some responsibility for their work

environment. Any model that promotes that is a model that we need to support.

KK: I have one last question for you, Jay. How do you see the role of the emergency physician changing in the near future and beyond?

JK: What brought us to this dance ain't going to get us into the next one. Einstein said the best definition of madness is to do things the same way and expect different results. How do most of us approach change? Change is good; you go first. I think we have to go first, and so I think the role of emergency medicine will change. I think that retail clinics will have huge backing from venture capital. I think they and urgent care will continue to take the less-sick patients away. With the incidence of heart disease, diabetes, and obesity, and people living longer, we're going to have plenty of patients to see. Our practice is going to become more difficult because we're going to see sicker patients.

As emergency physicians, we need to own telehealth and telemedicine. I think we are the best specialists to provide video and over-the-phone consultation with patients. I think we're going to be utilizing advanced practice providers more and more because I think we're going to have to leverage our expertise and leverage our time. It will be incumbent upon us to be careful in regard to our supervision of our advanced practice providers to ensure that our patients continue to get great care while, perhaps, expanding their scope. Health care is a team sport, so I think we're going to need to learn more about managing complex systems and leading groups of people. I think we have a very bright future. Two F words: I think we need to be **fascinated** about the challenges that we face and **fight** for our patients.

Editor's Note: Read more about Dr. Kaplan's goals at www.acep.org/About-Us/2015-Year-in-Review---Dr--Jay-Kaplan (ACEP login required). ☺



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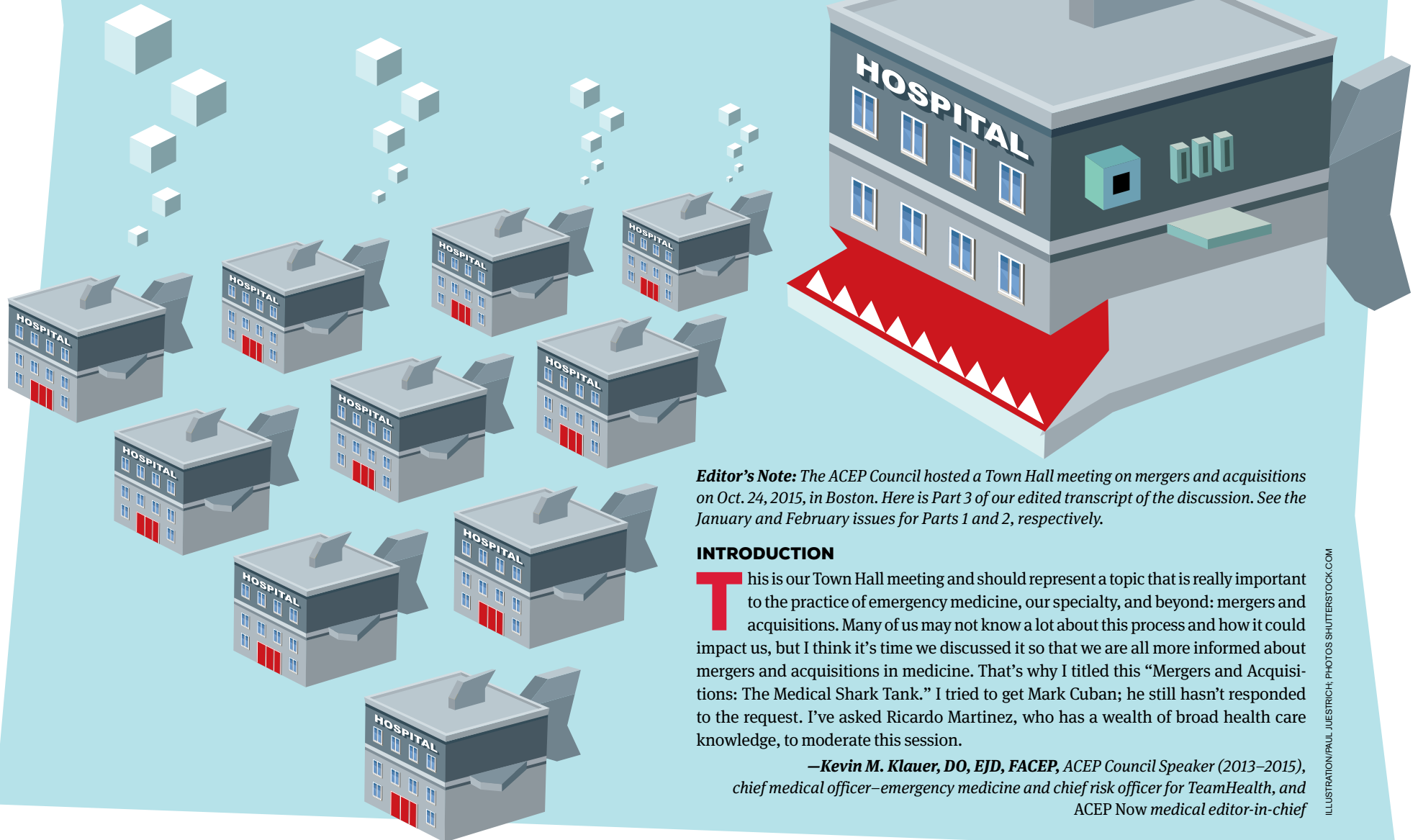
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The Cold Reality of MERGERS AND MONEY

Councillors weigh in during our highlights from the ACEP15 Council Town Hall Meeting



Editor's Note: The ACEP Council hosted a Town Hall meeting on mergers and acquisitions on Oct. 24, 2015, in Boston. Here is Part 3 of our edited transcript of the discussion. See the January and February issues for Parts 1 and 2, respectively.

INTRODUCTION

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.

—Kevin M. Klauer, DO, EJD, FACEP, ACEP Council Speaker (2013–2015), chief medical officer—emergency medicine and chief risk officer for TeamHealth, and ACEP Now medical editor-in-chief

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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

JK: Culture doesn't stand by itself. If it's a synergistic relationship and the quality of the organizations both improve, then that's a match made in heaven, and it becomes a win-win. On the other hand, if two organizations come together and the quality, outcomes, and revenue don't meet expectations and in fact suffer a little bit, that's when things fall apart.

SB: As important as culture is, it's less important to people outside of our market. How many random telephone calls does the C-suite of CEP get every month from private-equity or hedge funds, saying, "We'd like to purchase your organization for X multiple"? Again, as much as we talk about culture, there are those outside of our industry who really look at the numbers.

BA: I'll give you some great questions from Pat Lencioni, which are great questions to answer whether you're considering a merger or not. They are really helpful and powerful: Why do we exist? (What is your mission?) How do we behave? (What are your values?) What do we do? (What are we really trying to accomplish together?) How do we think we'll be successful together? If you are considering a merger with another entity and you don't have alignment at all in the first four, it might not be the best idea.

RM: Here's my last series of questions: How does emergency medicine best grow? Where are we going to be? Where do you see us being as a specialty in five years? What kind of structure do you see us operating in?

BA: There's a huge opportunity in alternative payment models to help at the interface of inpatient and outpatient care. Emergency medicine will always be at that interface. I think the groups that are helping systems get at value and lower their costs (avoid potentially avoidable admissions, creating alternatives to admission, providing care-transition support) are going to be a growth opportunity. The ability to do free pricing for freestanding centers is going to be eroded pretty quickly. Run your pro forma both ways under freestanding and hospital-based pricing because it could get pretty ugly on the hospital-based pricing front. Not all systems are interested, but the ones that are in virtual care are going to be in good shape.

SB: I'm going to quote Wes Curry. He tells me all the time, "I think we're at a tipping point." Those groups that will continue to demonstrate performance will succeed. Those who have tried to become the lowest-cost bidder yet deliver a very weak product will fail.

RI: There's a lot of business wisdom that says stick to your core, but there's a lot of exciting stuff going on with virtual medicine, navigation, population health management, and care management. I'd rather be the one providing those services, or at least providing the navigation through those services, rather than someone else. I do not want to be walking around five years from now with the same three tools in my toolbox: doctor, phy-

sician assistant, and scribe. I'd like to have 10 different tools.

JK: I have quoted Tom Peters for years: "If the other guy's getting better, you better be getting better faster. If that other guy's getting better, you're getting worse." This means, paradoxically, you can be getting better and getting worse at the same time if the other guy is getting better faster than you are. The only thing you ever have is a leading edge. We have to rebrand emergency medicine. Myles Riner did a study a number of years ago where he looked at over 6,000 claims. He found that if you took the 20 percent least-acute patients out of the system,

going to go away, and it's critical and adds tons of value to the system, but if I can get 4 percent on a \$730 million book of business, I'll take the \$29 million. I'm going to get the ED visits out that I can because not all of them do add value. I don't think it's a myth that the ED is a high-cost place. If it's an ankle sprain, do you want to write a \$1,200 check, or do you want to write a \$200 check?

JK: Brent, as a hospital administrator, are you and the American Hospital Association willing to sit with me as President of the College and have a discussion about why hospitals are shifting huge overhead to the emergency departments? Since over 75 percent of emer-

Brent, as a hospital administrator, are you and the American Hospital Association willing to sit with me as President of the College and have a discussion about why hospitals are shifting huge overhead to the emergency departments? Since over 75 percent of emergency hospital bills are related to hospital charges, could we have a conversation about making the visit cheaper for the patient?

—JAY KAPLAN, MD, FACEP

The ability to do free pricing for freestanding centers is going to be eroded pretty quickly. Run your pro forma both ways under freestanding and hospital-based pricing because it could get pretty ugly on the hospital-based pricing front.

—BRENT ASPLIN, MD, MPH

If you've got a lot of partners that are toward the end of their career and they have an idea that their lifelong investment now needs to be monetized, I think that's a very clear warning sign.

—SAVOY BRUMMER, MD, FACEP

If you're an owner, hopefully you have a voice. If you're in a group where you're not an owner but they have a culture of including physicians and they invite your opinions, then you should give them and ask for information. The other thing you should do is check your employment agreement. There may be protections or considerations included.

—RAY IANNACCONE, MD, FACEP

you'd save only 4 percent of the cost. If you decrease computed tomography scans by one out of 12, you would save that much money as well. We have to do away with the myth that the emergency department is the most expensive place to receive care. ACEP has an alternative payment model task force. We have one looking at Medicaid access. We also have one looking at out of network and balance billing.

BA: It's true that emergency medicine is not

gency hospital bills are related to hospital charges, could we have a conversation about making the visit cheaper for the patient?

BA: It's going to happen. It's hospital-based pricing, and I say to my colleagues all of the time, it's going to get cut. The hospital can't escape it, so if they can't reduce their costs, they're not going to be successful. I wanted to throw that in there because it was feeling more like a waiting room bubbler tank than a shark tank.

RM: It is a shark tank, so shark away. Prices are dropping now that it's becoming more visible to people. The average deductible is \$1,500 for hospital admission. The average person has less than \$1,000 in savings, so do the math. That's called bad debt, and it's a lot.

AUDIENCE: For a lot of us, getting merged or acquired is a contract of adhesion. We don't have a lot to say about it. What are the warning signs? When do you stay, and when do you start pulling up stakes and looking for someplace else?

RI: Four years ago, Emergency Medical Associates (EMA) looked at, "Should we do something?" We decided, no, we shouldn't. We ended up having these big meetings with 200 partners. This time when we did it, the board came to me and said, "We're just going to do this as a board because it was very disruptive doing it the other way." The board did a lot of deliberation, and the partners of EMA voted yes or no. Was it a secret that we were having these discussions? No. What were the warning signs? There were lots of meetings that don't normally take place and parking lots filled with cars that you don't recognize. If you're an owner, hopefully you have a voice. If you're in a group where you're not an owner but they have a culture of including physicians and they invite your opinions, then you should give them and ask for information. The other thing you should do is check your employment agreement. There may be protections or considerations included.

JK: You should look around and start seeing if there is an option for you that will allow you to get something from your years of service. There are some groups where they will give you a certain amount of partnership for years that you've been practicing with them. There are some options where you may be able to retain local control and still be part of a larger group.

SB: I think one problem with many groups is that they originated and began without the end in sight. Many times, independent practices will see there's an issue but will be too paralyzed because of their structure to actually do something about it. If you've got a lot of partners that are toward the end of their career and they have an idea that their lifelong investment now needs to be monetized, I think that's a very clear warning sign. When groups are using creative financing to deal with some of their financial obligations, clearly that's a problem. If there are any preferred partner arrangements or joint-venture agreements, I would immediately consider that a threat as well.

AUDIENCE: When does an acquisition become predatory? I have a very close friend. His CEO tapped him on the shoulder and said, "You know, we want you to joint venture with this particular organization. It's going to be such a great deal for you. You're going to give them all your revenue; they're going to split the profit with us, the hospital, and we're going

CONTINUED on page 10

to pay you less because you're paid too much. We want to keep you because we love you, but you know that Tesla that's in the parking lot is too much."

BA: You just answered your own question. I think that's a description of when it's predatory, and ACEP should take a stand on that. I don't know whether or not you'll be able to stop it, but I think that's a pretty clear example of when it gets predatory.

JK: If hospitals are coming and saying to physician groups, "You have to joint venture with us, and in return, we're going to take some of your professional fee and feed it back to the hospital," then that's fraud, and ACEP should take a strong stance with regard to that.

AUDIENCE: I learned in business school there's no such thing as a merger. They are always acquisitions. My question is, what are you seeing, and are there any activities about expansions beyond the usual SNF-ist [skilled nursing facility], hospitalist, acute care model to partnering?

JK: We have a task force on alternative payment models. With the whole concept of bundled payments, we think they are going to carve out emergency medicine, and I

think the carve out is going away sooner than we expected. **[Editor's Note:** See page 16 for a 2016 update on bundled payments.]

RI: Over the last five to seven years, we've gone from a situation where hospital administrators would never consider putting more than one service line under one contract to the exact opposite.

SB: We're seeing that universally across the market. Hospital CEOs will say, "You've done such a great job in the ED. Will you take a look at the hospitalists? Can you take a look at cardiologists?"

RM: I'm going to tell you from my days in capitated care that when the pie gets smaller, the table manners change.

AUDIENCE: A large part of our income comes from private insurance companies, and there are high-profile planned mergers of four of the five largest insurers in the United States. What is the marginal value of private for-profit health insurance vis-à-vis a public payer like Medicare?

JK: The term health insurance company is an oxymoron because health insurance companies do not exist for the health of their patients and their clients. They exist to make profits for their shareholders. We

need to go after the insurance companies and have them show their true colors as best we can, and we need to ally with our patients.

AUDIENCE: I'm representing the Section on Medical Humanities. This was not a very humanistic discussion, not much poetry, but my question is actually concerning what happens to academic medical centers [AMCs] in all of these changes. AMCs are more expensive than typical community hospitals. My question is, what's the role of emergency medicine in helping academic medical centers to successfully navigate some of the changes that are coming down the road?

BA: There will be fewer AMCs, and that's a larger dilemma for the educational needs of the country than it is for the clinical needs of the country. Community systems that can partner with AMCs on an educational mission are going to be needed. I don't know that all of the AMCs we have currently are going to be needed for the quaternary needs of the population. In emergency medicine, we're systems experts. To the degree that we can help strengthen those community and academic partnerships in our markets, that's the area that's going to help academic medicine the most.

RM: Academic hospitals lose money on teaching, they lose money on research, and they have very high fixed costs. They have a problem.

AUDIENCE: The evidence that I've seen out there suggests that consolidation raises prices. It may decrease costs, but those costs are often pocketed by the institutions they're consolidating, and there's very little evidence the consolidated institutions actually have increased quality. I'm wondering what the case is for the nation and for our patients to encourage consolidation under those circumstances.

BA: These are market forces, and you're not going to be able to stop the market forces from doing it. Your points are well taken. The successful consolidations will be those that are able to lower total cost of care for populations and be able to tell a quality and value story associated with it. Having the infrastructure to do this new work is so expensive. We'll spend \$30 million next year on care management, IT, analytics, new resources, clinical pharmacists, call centers, and data aggregation tools to try to be successful in a population health framework. You can't duplicate that without having scale. 📌



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THE LATEST ON EMERGENCY PHARMACEUTICAL SHORTAGES

Emergency physicians should act to draw attention to the problem

BY JEFFREY GOODLOE, MD, NRP, FACEP

Although many ACEP members have forgotten about times when medications were consistently plentiful, it's really been just a little longer than a decade that never-ending shortages have plagued patients and physicians alike. Since 2010, clinicians have been facing more than 150 active shortages at any given time. In fact, 10 of the most basic medicines have combined for more than 50 shortages in the past decade: dextrose, diazepam, epinephrine, fentanyl, lorazepam, morphine, ondansetron, nalbuphine, naloxone, and promethazine.

There are solutions beyond just tracking shortages. Although the U.S. Food and Drug Administration (FDA) is taking interest, many emergency physicians sometimes wonder if the government is problem solver, problem creator, or perhaps both. Emergency physicians may be unaware of these facts:

- The FDA has a drug-shortage team, further empowered by Congress's passage of the FDA Safety and Innovation Act (FDASIA) of 2012.
- Pharmaceutical companies are now required to let the FDA know as soon as possible if actual or potential shortages are noted or expected.
- The FDA drug-shortage team has a "prevention tool kit" ranging from prioritizing manufacturing approvals to asking additional pharmaceutical companies to join in a particular generic medication's production.
- The FDA can allow imports of foreign products to alleviate shortages. Recent examples of imports include propofol and normal saline.

All of these points considered, the FDA and Congress can't compel any company to supply a medication, no matter how critical or lifesaving it may be. Pharmaceutical manufacturing is a business; companies choose to make products or not.

While the cause of most shortages is some kind of manufacturing deficit, either in quality or capacity, the root cause of how those deficits come about is often unclear. Many of these products are generic and inexpensive in both wholesale and retail markets. When profit margins are slim, manufacturers may not have cash on hand or incentive to invest in manufacturing equipment dedicated to that product. Many companies have chosen to add more products to manufacturing schedules without corresponding additions in capacity. Overall, we're left with a combination of economics, infrastructure, and business-model conflicts that is at the root cause of most shortages.

ACEP's Emergency Medical Services (EMS) Committee leaders, Craig Manifold, DO, FACEP, and I, recently consulted with Erin Fox, PharmD, adjunct associate professor at the University of Utah School of Medicine in Salt Lake City, about these shortages. If you haven't heard of Dr. Fox's passion about the shortage of emergency medications in the United States, you should know we have a real ally.

Dr. Fox has been intricately involved in tracking shortages for more than 15 years. The American Society of Health-System Pharmacists (ASHP) maintains a very useful resource at www.ashp.org/shortage. Dr. Fox leads a team at the University of Utah Drug Information Service in close partnership with ASHP. She works on contingency strategies continuously and takes a particular interest in

Dr. Fox predicts ongoing shortages of generic injectable medicines. She admits that predictions are particularly difficult as drug manufacturers do not disclose exactly which medicines are manufactured in specific facilities. Even if you follow the quality data that the FDA provides about a facility's inspection, the medicines manufactured there remain secret.

Dr. Fox advises us of the benefits in partnering with pharmacists in both EMS and ED settings to help emergency physicians remain up to date about what shortages will be affecting their practices. The University of Utah Drug Information Service contacts manufacturers directly to verify contents of the ASHP Drug Shortages Resource Center. Emergency physicians can consider the alternatives and management suggestions made available on that Web site. The shortages

TEN OF THE MOST BASIC MEDICINES have combined for more than 50 shortages in the past decade: dextrose, diazepam, epinephrine, fentanyl, lorazepam, morphine, ondansetron, nalbuphine, naloxone, and promethazine.

shortages impacting critical patient encounters, the encounters we face daily in EMS and emergency medicine.

For example, how is it that, with saltwater being so abundant on Earth, we can be in short supply of normal saline? Dr. Fox shares that it's actually quite complicated to take large amounts of saltwater, make it sterile and particle free, and package it. This shortage comes down to capacity. With only three suppliers of fluids in the United States, there simply isn't capacity to make up shortfalls in case of even a small recall or when a manufacturer needs to close a facility for cleaning. We also have other issues straining the supply of fluids, such as new medications that need dilution. Finally, companies increasingly manufacture on a just-in-time basis. When even a small glitch occurs, the supply chain is so fragile that it results in a shortage in your ED.

considered particularly serious can be found by filtering on the "No Commercially Available Preparations" tab.

Dr. Fox encourages emergency physicians to do the following:

- Talk to the media about the impact of medication shortages in their individual practices.
- Remember that working around the shortages but not talking openly about them paradoxically makes the shortages invisible to policy makers and the public alike.
- Advocate that Congress create and pass legislation to mandate that pharmaceutical manufacturers disclose the location and the actual company that manufactures their products. Increased transparency in labeling helps identify shortage causes and helps in making quality purchasing decisions. ➕

DR. GOODLOE is medical director, medical control board, for the EMS system for Metropolitan Oklahoma City and Tulsa and professor and EMS section chief in the department of emergency medicine at the University of Oklahoma School of Community Medicine in Tulsa.





EMERGENCY PHYSICIAN BECOMES THE PATIENT when he experiences a subarachnoid hemorrhage during a bike ride

Nonaneurysmal perimesencephalic subarachnoid hemorrhage:

1. Hemorrhage restricted to the perimesencephalic or prepontine cistern
2. Normal angiogram
3. Excellent outcome



WHEN EMERGENCY PHYSICIAN Michael J. Jarosick, DO, decided to go for a mountain bike ride in Ohio's Mohican State Park on Aug. 20, 2013, he didn't expect to end up as a patient in the emergency department—or know that his decision to ride with two friends, Rabbit and Jamieson, instead of riding solo would be a critical one. During the ride, he experienced a subarachnoid hemorrhage.

Dr. Jarosick, currently a physician at a privately owned urgent care and occupational medicine clinic in Findlay, Ohio, recently sat down with *ACEP Now* Medical Editor in Chief Kevin Klauer, DO, EJD, FACEP, to talk about his experience diagnosing his own medical situation and being on the receiving end of lifesaving emergency care.

KK: What were you doing that day?

MJ: I was mountain biking. I was preparing for a trip to Washington State to stay with a friend and do some mountain biking out there with him. I had all of my stuff packed. I was busy all day tying up loose ends before I was going to leave town for a week and knew that I wanted to get in one more ride.

KK: Was this was an average training day, and did you feel normal?

MJ: I was going to ride by myself, like I often do. I thought at the last minute, "Why don't I call my one friend Rabbit and see if he wants to ride?"

KK: When did you know that something was not right?

MJ: We were about an hour into the ride, starting to do this one hill climb, when I noticed my neck was a bit sore and I was getting pressure in the temples. I thought, "This is my backup helmet, and I can never get it adjusted just right." This built for about 20 minutes gradually. The thing about [feeling a] thunderclap coming from out of nowhere? Not really.

KK: Your first response, just like every good patient, was denial of your symptoms?

MJ: Yes, but then I looked at my buddies and said, "I'm having a subarachnoid hemorrhage."

KK: Are they physicians?

MJ: No. One guy is a total layman, and the other one is an athletic trainer. They said, "You're having a what?" I said, "A blood vessel broke in my brain, and it's bleeding." Within a matter of minutes, we shifted into rescue mode. I was overcome with pain right there. The nuchal rigidity was unbelievable. I tried to sit down, but any little movement of my head when I was seated upright was too much pain for me to take. It was nuchal rigidity as I imagined it would be.

KK: Absolutely. Did you have any of the classic symptoms like photosensitivity, nausea, or vomiting?

MJ: I did get some nausea, and I vomited once.

KK: When this happened, how far away from civilization were you?

MJ: We would have had to go at least two miles in either direction to get to one of the main roads.

KK: Were you going to try to ride out, or were you going to have someone come up and get you?

MJ: They asked me, "Can you ride out of here?" and I said, "No, there's no way I can do that." It just so happened that we were at a junction in the trail that crosses a hiking trail. I knew that if they could just get me up to that parking lot, I'm basically at the ambulance.



Dr. Jarosick on a bike ride.

KK: Did you experience any fear or other emotions?

MJ: I saw myself as patient and rescuer at the same time. I couldn't effect the rescue by myself, but I had to participate in it. I was in a survival mode.

KK: What kind of thoughts were you having? Were you starting to think about how bad this would be? What if you didn't make it out?

MJ: I stayed pretty positive because I'm thinking I've seen some subarachnoid hemorrhages in the ED; they get treatment, and some of them do all right. I used to never carry a cellphone because I believed in rugged self-reliance. I always carry a cellphone now. Between the three of us, one guy had a cellphone. There are valleys there where you really can't get a signal. My friend Jamieson, the athletic trainer, rode up that trail to the open parking lot, and he was able to call 911.

KK: Did they transport you by ground, or did they fly you?

MJ: I was in the submissive baboon position with my butt in the air, my hands on the ground, and my head in my hands. It was the most comfortable for my neck. As I was in that position, the paramedic [Tom Gallagher] walked up to me and said, "We have the stretcher and the rig. Want us to go get it?" I said, "Can you carry me out in this position?" I knew I didn't want to lie on my back. He said, "No, we'd have to lay you on your back." So I said, "Get me up, and let's see if I can walk out of here." At that moment, I had to push the guy away so I didn't puke on his shoes.

KK: Were you a good patient and let them do their work? Or did you tell them exactly what was going on and exactly what you wanted done?

MJ: I was a good patient. I certainly would have put up a fight if I disagreed with them, but I didn't have to because they had it under control. There was a well-intentioned nurse who walked in and said, "I heard you have a bad headache." I replied, "It's a subarachnoid hemorrhage." That really threw her off guard. She said, "Do you have a history of migraines?" and I said, "No, and this is a subarachnoid hemorrhage."

KK: The nurse was your first contact when you came in.

MJ: Yes. She was doing what she was supposed to do. I was just a little ahead of her.

KK: Did you have a CT scan or lumbar puncture?

MJ: The doc walked into the room, and I basically told him the short version of what happened. I don't remember the exact words of the conversation, but he did a very appro-

appropriate 30-second exam. Why spend more time? He gave me something for pain and ordered the CT, just like that.

KK: So the CT was positive. How did he deliver that information to you?

MJ: He came in and said, "Your CT scan shows subarachnoid hemorrhage," matter-of-factly. He already had a plan, which was good. We did have a very good neurosurgeon there at the hospital, Boh Chopko. He said, "I called Chopko, and he's only going to be here for another week and doesn't think he should be involved in your care since he's not going to be here to finish it," so I was transferred.

KK: How did they fix you? What did they do?

MJ: The very next day, they did an angiogram and saw that there was no aneurysm. There was nothing to fix. It's what they call a perimesencephalic subarachnoid hemorrhage, also known as a prepontine, which are venous leaks in the brain stem. It often happens to young, healthy folks who are exercising, but they don't say that exercise caused it, if that makes sense. I saw the attending neurosurgeon the next morning, and I was feeling a lot better. I was thinking, "I've got this thing beat. I was looking down the barrel of the gun last night, and now I'm just going to have to hang around the hospital for a couple of weeks." Then things changed. I got a very severe headache that night. It was 24 hours later. That's when I was really scared. I was a lot more scared than when it first happened. Knowing that I don't have an aneurysm, there's nothing to fix. If the return of my severe headache meant that I was bleeding again, now what was going to happen? What were they doing to do? I was much more scared than when it happened originally.

KK: What did they do next?

MJ: They ran me down for an emergency CT and showed that



Tom Gallagher, the paramedic/fire chief who met Dr. Jarosick in the park and initially assessed his condition.

there was no more bleeding. That was all I needed to know. The explanation that I was satisfied with is, "This is just a process. You're going to have bad headaches for a while." As long as I knew I wasn't bleeding and wasn't going to die, I was OK. They had to keep me in for two weeks because there's a danger period of arterial vasospasm that lasts two weeks from the initial bleed. I was treated with nimodipine. One of the things they did for me, which ate up a lot of the two weeks, was to perform arterial dopplers every day for a week. They would take a ratio of the velocity in my carotid and one of the cerebral arteries. If the ratio of the cerebral to carotid was too high, high velocity in the cerebral circulation, it was an indication that the artery was narrowing down a bit. They were using that monitoring technique to determine how long to have me on hyperhydration therapy. The theory was if you keep an artery stuffed full of fluid, it can't close down. They started off with saline. Then they moved

up to albumin. I was having these incredibly wild vivid hallucinations. It took me a couple of days to figure it out. I was sitting there going, "Steroid psychosis! I remember hearing about that." They had me on high-dose Decadron for the inflammatory changes, which were presumably making my headache worse. That was my diagnosis, and I was right. They stopped the steroid, and the hallucinations went away.

KK: Any long-term sequelae?

MJ: It took me several months to realize it, but I have a bit of fine-motor left-right confusion that only manifests with quick fine-motor skills. The only time I notice it is when I type. Examples: typing "fro" when I try to type "for" and "symptomts"

when I try to type "symptoms" and "dya" when I try to type "day." If you look at a keyboard, you can see that the transposed letters are always opposing sides of the left/right finger position. I am usually immediately aware of the error when I make it, but I can't stop it from happening.

KK: How long did it take you to recover?

MJ: I was on a mission to feel normal again, and I wanted to prove to myself that I was normal. I went home and started mountain biking the next day. I got myself back in shape. My goal was to ride a 100 km mountain bike race within a year of the event. There was a race I'd done once a couple of years previously in New Hampshire called the Hampshire 100, so that's the one I aimed for. Nearly a year after my subarachnoid hemorrhage, I finished the race going hard, and I'd like to think of it as a punctuation of my recovery. It was a wonderful day. ☺

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Criticaldecisions
in emergency medicine

ACN_0316-0070-0216

Given the high prevalence of opioid dependency and abuse among emergency department patients and the increasing frequency of overdose-related ED visits, emergency physicians have an opportunity to prevent opioid overdose deaths.¹⁻³ ED naloxone distribution is a simple, cost-effective way to provide a lifesaving intervention.⁴⁻⁷ In August 2015, the ACEP Trauma & Injury Prevention Section organized a webinar on practical considerations when starting a program. Key considerations every ED naloxone program must consider include program implementation and utilization, policies and regulations, means of distribution, cost, and patient education.

PROGRAM IMPLEMENTATION AND UTILIZATION

Primary factors influencing program utilization include knowledge of literature-based evidence; policies and laws; ED/hospital support, policies, and procedures; professional organizations’ policies and guidelines; and cost/payment mechanisms. Program incorporation into normal work routines can diminish utilization barriers and facilitate support. Policies, procedures, and expectations should be easy to understand and readily accessible.

Patient barriers to naloxone—including stigma, mistrust of medical providers, fear of legal consequences for possession or use, and fear of withdrawal after receiving naloxone—should be addressed. Building patient trust and soliciting feedback will improve program acceptability and quality.

Prominent provider barriers include negative attitudes toward addiction, lack of knowledge about naloxone, and lack of clarity about who should receive naloxone. We recommend naloxone for patients who use heroin, exceed 100 mg morphine equivalents daily, have opioid abuse/dependency, or have had an opioid overdose. Staff training, program monitoring, and staff feedback should be data driven and provided on a regular basis.

POLICIES AND REGULATIONS

There is significant regulatory variability among states.⁸ Thirty-seven states have successfully amended legal regulations to eliminate legal barriers to naloxone distribution.^{9,10} Access to naloxone is the main barrier faced by patients and programs, as there are few providers willing to prescribe or distribute naloxone. State emergency medical services (EMS) laws also can restrict which first responders can carry naloxone.¹¹ Liability, real or perceived, is also an important barrier for prescribers, pharmacists, and bystanders. Regulatory solutions include third-party prescribing, standing naloxone orders, collaborative practice agreements, pharmacist-as-prescriber policies, Good Samaritan laws, and increasing EMS/first responder access. Information about these types of legislation and what is present in your state can be found at lawatlas.org/query?dataset=laws-regulating-administration-of-naloxone. (See Figure 1, pg 15 for a map of states that have legislation preventing prescribers from being criminally liable for prescribing, dispensing, or distributing naloxone to laypeople.)



MEANS OF DISTRIBUTION

Providers can provide naloxone directly to patients, write a prescription, or refer patients to a community organization or pharmacy participating in a collaborative practice agreement. Prescribing is low-impact to the system and can be implemented immediately.

Naloxone is offered in intramuscular (IM) and intranasal (IN) formulations. IM can be delivered in the lateral arm or thigh. IN is given as a spray in each nostril with similar efficacy and safety.^{12,13}

IM naloxone can be dispensed as two single-dose vials, 0.4 mg/mL, with syringe and needles. Approved by the US Food and Drug Administration (FDA), Evzio is a prefilled auto-injector that contains a single dose of naloxone 0.4 mg.¹⁴ IN naloxone is prescribed as a 2 mL prefilled luer-lock needleless syringe with an IN mucosal atomizing device.¹⁵ The recently FDA-approved Narcan is a preloaded nasal atomization device that delivers a single 4 mg dose. This higher dose is necessary for IN route of delivery and for patients who do not respond to the lower dose (e.g., after

fentanyl overdose). With the exception of the preloaded IN device, it is recommended that you prescribe two naloxone doses.

COST

ED naloxone programs may be funded through your hospital, grants, or local governmental agencies. Public health departments and community-based naloxone programs can also be key allies. Depending on your state, Medicaid may reimburse for the naloxone kit and/or overdose education.

The cost of naloxone ranges by manufacturer (see Table 1 below). The Evzio auto-injector may also be covered by insurance or Kaléo’s patient assistance program.¹⁶ To accurately estimate cost, first estimate need and then select items for your naloxone kits. Take-home naloxone kits are given to patients or their loved ones for out-of-hospital use in case of an overdose and may include educational materials, nasal atomizers or needle and syringes, gloves, face shield, and two doses of naloxone.

PATIENT EDUCATION

Patient education should cover overdose risk factors, avoiding overdose, recognizing and responding to an overdose, and administration of naloxone. A combination of in-person counseling and an educational video or handout is best, if feasible. Family and friends should be included in the training, as they may be administering naloxone in an out-of-hospital overdose.

In-person education by staff or a drug counselor is interactive and can be combined with a referral to treatment. If in-person education is not feasible, video and handout materials are cheaper, portable, and uniform and can be referenced at home. However, they are less personal and less engaging and may miss an opportunity for referral to treatment. PrescribeToPrevent.org has educational materials tailored to different patient populations.¹⁷

BACK TO THE CASE

Before the patient is discharged, he and his family are counseled on the dangers of heroin use, how to recognize an overdose, and the proper technique for administering naloxone. They are given some written educational materials and a naloxone kit to use if the patient overdoses again.

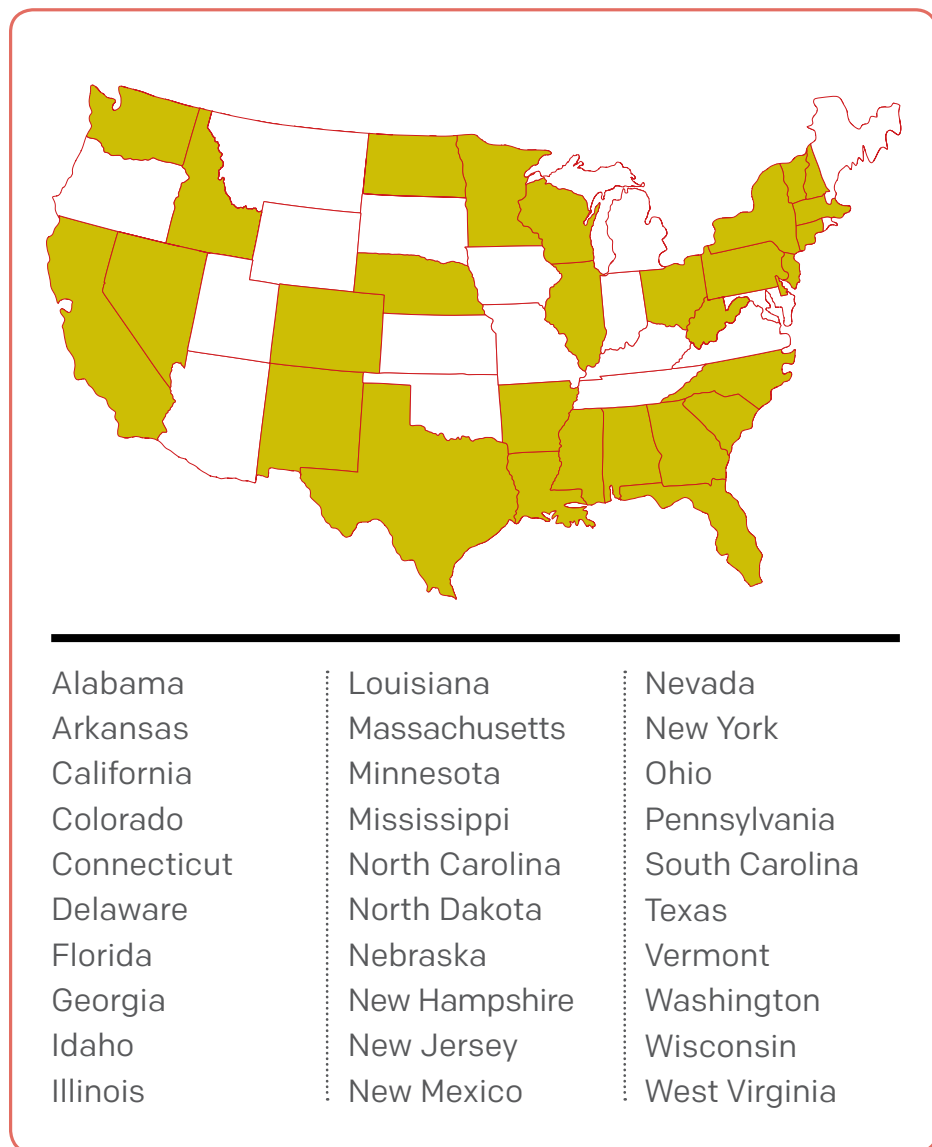
CONCLUSION

Emergency physicians treat patients with addiction and opioid overdose every day. Increasing access to naloxone is one strategy ED providers can use to reduce deaths due to opioid overdose. For more information about how to set up a program and to access the full ACEP TIPS webinar report, go to www.acep.org/traumasection. ☛

Table 1. Average Cost of Naloxone by Type and Dose

MANUFACTURER	TYPE	AVERAGE COST/DOSE
Adapt Pharma	IN, preloaded, 4 mg dose	\$33/dose
Amphastar	IN, self assembly, 2 mg dose	\$33/dose
Hospira	IM, self assembly, 0.4 mg vials	\$15.83/dose
Kaléo	IM, auto-injector, 0.4 mg	\$287.50/dose

Figure 1. States With Legislation Preventing Prescribers From Being Criminally Liable for Prescribing, Dispensing, or Distributing Naloxone to Laypeople



SOURCE: Law Atlas, <http://lawatlas.org/query?dataset=laws-regulating-administration-of-naloxone>.

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WILEY



BENEFITS OF BUNDLING UP

New CMS payment rules introduce bundled payments for observation care

BY CHRISTOPHER BAUGH, MD, MBA, FACEP, AND MICHAEL GRANOVSKY, MD, FACEP

Last November, the Centers for Medicare & Medicaid Services (CMS) published its 2016 final rule for the Outpatient Prospective Payment System (OPPS). Because observation care is considered an outpatient service, the new rule included important changes to observation billing. Most notably, it retired facility payment observation code APC 8009 and introduced C-APC 8011—the first “C” stands for “comprehensive.”¹ Payment increased from \$1,234 to \$2,174, which is reflective of the new bundled payment for most facility charges previously paid separately (ie, diagnostic imaging, stress testing, and medication infusions). Updates to the professional evaluation and management codes (CPT) for observation care were minor, as illustrated in Table 1.

This major change to bundled facility payments will provide incentives to hospitals to minimize diagnostics and lengths of stay,

which favors protocol-driven care and early discharge, features of most emergency medicine-run observation units. For example, in 2007, Ross and colleagues showed that for ED patients with transient ischemic attack randomized to an ED-run observation unit or an inpatient neurology team, the observation unit followed its protocol 97 percent of the time versus 91 percent for the neurology team, with the former having less than half the hospital length of stay and a greater rate of reaching a defined clinical endpoint.² A 2013 study by Pena and colleagues also found shorter lengths of stay with an ED-run unit versus an open unit run by various services.³ Of note, the new rule does not address long-standing observation-related issues, including lack of coverage for self-administered medications and the vexing requirement for three inpatient nights in the hospital to qualify for a skilled nursing facility benefit.

Table 2 compares payments for an observation stay with a short inpatient admission

for a patient with traditional Medicare and no second payer, which is the most straightforward example. In this scenario, an elderly patient presents to the ED with syncope and is deemed at intermediate risk. Assuming the patient’s actual hospital visit spanned exactly two midnights, out-of-pocket costs for the observation stay would be around half of the inpatient costs (\$640.65 versus \$1,398.21), driven largely by the Medicare Part A deductible, a patient expense for inpatient care that should be strongly considered when comparing the expense of observation care to alternatives. Additionally, even in the scenario where a patient begins hospitalization as an observation patient and transitions to inpatient care (an expected outcome in about 20 percent of cases), the facility charges roll into Part A and the observation facility coinsurance liability disappears.⁴ The only additional costs to the patient would be the self-administered medication costs and professional fee coinsurance during the brief

observation stay, which is typically a small fraction of the facility payment.

The best data available on Medicare beneficiary out-of-pocket expenses arise from a 2013 report from the Office of the Inspector General, which shows that the patient expense for an observation stay was less than the expense for a short inpatient stay 94 percent of the time.⁵ Additionally, the percentage of patients caught in the scenario where they were hospitalized for three or more nights but didn’t have three inpatient overnights (ie, start in observation, then transition to inpatient for a couple more days) and needed subsequent skilled nursing facility care that Medicare did not pay for was 0.6 percent of all observation visits.⁵ In the lay press, stories from this small fraction of visits make for very compelling news, and as a result, the headlines featuring these visits highlight a real but exceedingly rare consequence of observation care.⁶

In conclusion, Medicare’s shift to a bundled facility payment this year creates an incentive to use evidence-based protocols for observation care while also effectively capping the patient out-of-pocket costs for observation facility charges. The new rule still does not address previous patient financial issues, such as shifting the burden of self-administered medications onto patients (or providers) or the lack of time counting toward a skilled nursing facility benefit for nights spent in the hospital while in observation status. However, this new rule helps to clarify and cap the patient expense for an observation visit, a seemingly positive development in observation care. ☺

Table 1. 2015 and 2016 Observation Professional Total Relative Value Unit (RVU) Values

SAME-DAY OBSERVATION			MULTI-DAY OBSERVATION (INITIAL DAY)			MULTI-DAY OBSERVATION SERVICES (DISCHARGE DAY)		
CPT Code	2015 Total RVUs	2016 Total RVUs	CPT Code	2015 Total RVUs	2016 Total RVUs	CPT Code	2015 Total RVUs	2016 Total RVUs
99234	3.78	3.76	99218	2.83	2.81	99217	2.05	2.05
99235	4.77	4.76	99219	3.83	3.81			
99236	6.15	6.13	99220	5.25	5.22			

Table 2. Sample Medicare Fees and Payments for a Typical Hospitalization for Syncope

SERVICE	INPATIENT	OBSERVATION
Facility Fees	Patient pays Part A deductible: \$1,288 Medicare Part A pays Diagnosis Related Group (DRG) 312: \$4,101* (pre deductible \$2,813)	Patient pays 20% of C-APC 8011: \$434.83 Medicare Part B pays 80% of C-APC 8011: \$1,739.31
Professional Fees <ul style="list-style-type: none">Initial evaluationSubsequent evaluationDischarge evaluationComputed tomography (CT) interpretationEchocardiogram (ECG) interpretationECG interpretation x3	Patient pays 20% of fees: \$110.21 Medicare Part B pays 80%: \$440.83 CPT 99223: \$204.22 CPT 99233: \$104.98 CPT 99239: \$108.20 HCPCS 70450: \$43.35 HCPCS 93306: \$64.49 CPT 93010: \$8.60 x3 (\$25.80)	Patient pays 20% of fees: \$78.82 Medicare Part B pays 80%: \$315.29 CPT 99220: \$187.02 — CPT 99217: \$73.45 HCPCS 70450: \$43.35 HCPCS 93306: \$64.49 CPT 93010: \$8.60 x3 (\$25.80)
Medications	Patient pays \$0 Medicare Part A pays DRG payment	Patient pays entire cost: \$127** Medicare Part B pays \$0
Laboratory	Patient pays \$0 Medicare Part A pays DRG payment	Patient pays \$0 Medicare Part B pays C-APC payment
Facility Diagnostics <ul style="list-style-type: none">Cardiac monitoring x48 hoursCT of the brainTrans-thoracic echocardiogramECG x3	Patient pays \$0 Medicare Part A pays DRG payment	Patient pays \$0 Medicare Part B pays C-APC payment
Total Payments:	Patient: \$1,398.21 Medicare Part A: \$2,813 Medicare Part B: \$440.83	Patient: \$640.65 Medicare Part A: \$0 Medicare Part B: \$2,054.60
Total Revenue:	Hospital: \$4,101 Professional: \$551.04	Hospital: \$2,301.14 Professional: \$394.11
TOTAL COST:	\$4,652.04	\$2,695.25

These calculations are for traditional fee-for-service Medicare without a secondary payer. Part B payments assume the \$166 annual deductible has already been paid. Part A payments assume the patient has not paid for any qualifying Part A services in the prior 60 days.
*DRG payment calculated as mean unadjusted 2013 Medicare payment amount.
**Average out-of-pocket medication costs based on 2013 Office of the Inspector General Report.⁵

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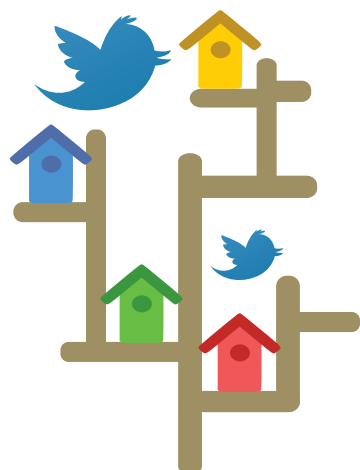
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Twitter Abuzz With Sepsis News

New sepsis definitions spark online debate



by JEREMY SAMUEL FAUST, MD, MS, MA

If free open access medical education (#FOAMed) has a single greatest strength, it is that it cuts the gap between knowledge acquisition and knowledge translation significantly. February proved that once again.

First, *The New England Journal of Medicine* (NEJM) announced that metrics for all articles published since July 2010 will now be available to everyone, not just authors. This will actually give FOAM a boost. Even a superficial browsing of its newly updated @NEJM website, www.NEJM.org, demonstrates that the articles that received Twitter attention were more likely to have substantially higher page views. While formal studies to assess that contention will be necessary, it will now be easier than ever to do so. Further, it was immediately apparent that some—though not all—articles in NEJM receive fewer page views than many popular FOAM blog posts and podcasts. If this is the case for the leading medical journal in the world, that contrast will certainly be magnified in the lesser-read journals. This will continue to underscore the importance of FOAM quality. Some, like Teresa Chan, MD (@TChanMD), of Canadiem.org (formerly BoringEM.org), will likely see this as further evidence that some formal structures in the FOAM movement seeking to assure quality are important, if not necessary. (See her much discussed article “Waves of FOAM” on Canadiem.org.) Others like Scott Weingart, MD, FCCM (@emcrit), argue that the massive number of FOAM site visits ensures its own quality in ways that even journals can’t match. Active FOAM audiences frequently catch mistakes large and small, and they have a direct line to the content creators, who are likely to make corrections and comments instantly.

But the biggest news in #FOAMed was, once again, sepsis. After months of anticipation, the Society of Critical Care Medicine and the European Society of Intensive Care Medicine announced their new consensus definitions of sepsis on Feb. 22 from its 45th annual critical care conference, held in Orlando, Florida (#CCC45 on Twitter). To say that the new sepsis definitions went viral would be an understatement. Of the 15,000 tweets, by far the most buzz centered around the new sepsis definitions, known as Sepsis 3 and published in *The Journal of the American Medical Association* (JAMA). An online debate erupted within minutes of the announcement.

The new definitions, which have not been endorsed by ACEP, define sepsis as “life-threatening organ dysfunction caused by a dysregulated host response to infection.” The criteria for organ dysfunction are defined as any acute increase in the Sequential/Sepsis Related Organ Dysfunction Scale (SOFA). However, because a SOFA scale involves a significant slew of laboratory results, the committee sought to develop a proxy that would

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help emergency and prehospital providers identify at-risk patients. Thus, from retrospective chart data, the quickSOFA, or qSOFA, was derived. qSOFA is meant to replace systemic inflammatory response syndrome (SIRS), which was deemed unhelpful for identifying sepsis patients and criticized both for being too big a net while having significant holes in it, causing some septic patients to escape notice. Further, unlike SIRS, the qSOFA score can be calculated in triage without laboratory results. To have a “positive” qSOFA, a patient must have two of the following: respiratory rate ≥ 22 , altered mental status (defined as a Glasgow Coma Scale ≤ 13), and a systolic blood pressure ≤ 100 mm HG. In the newly published, albeit retrospective, studies, qSOFA outperformed SIRS in detecting patients at risk of having life-threatening organ dysfunction due to infection. Septic shock was also redefined as the “subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone.” After identifying the cohort of patients in the medical records who were most likely to die, the clinical criteria were derived. This “reverse engineering” was done in order to develop a tool that clinicians could use to help risk-stratify patients.

Of the various aspects of the new definitions, the biggest attention getter online has certainly been the qSOFA score. My podcast cohost Lauren Westafer, DO, MPH (@LWestafer, @FOAMpodcast), immediately tweeted a JPEG of a silhouetted man in a hat with the three qSOFA criteria listed. That’s “HAT” for hypotension, altered mental status, and tachypnea. Not bad. Not to be outdone though, Natalie May, MBChB, MPHe, MCEM, FCEM (@_NMay), of the St. Emlyn’s emergency medicine blog (stemlynblog.org) in Manchester, UK, tweeted a JPEG of the DC Comics

bat signal: “the BAT score: Blood pressure, AMS, Tachypnoea.” Oh, the British with their extra vowels.

Others commenters, however, were less enthusiastic about the new definitions and criteria. Intensivist Flavia Machado, MD, PhD (@FlaviaSepsis), tweeted a JPEG summing up her feelings: “Keep Calm and Don’t Change Sepsis Definitions.” In a link to a statement from the Latin American Sepsis Institute (LASI), Dr. Machado and others in low- and middle-resource settings expressed concern that the new definitions might not have enough sensitivity. The 19 coauthors also expressed concern that the definitions were made without consulting important stakeholder organizations such as LASI. Last year, ACEP lodged a similar complaint regarding the lack of emergency medicine representation on the task force that developed the new definitions.

That being said, uptake of the definitions online seemed brisk and enthusiastic. On his free online medical calculator, MDcalc (www.mdcalc.com), Graham Walker, MD (@grahamwalker), rolled out a new SOFA and qSOFA score tool within days of the announcement. Salim Rezaie, MD (@srrezaie), used the relatively new Twitter poll function to ask the #FOAMed community, “Is Sepsis-3/qSOFA/SOFA ready for primetime clinical use?” Out of 139 responses, 22 percent said, “Yes, SIRS is Dead,” 28 percent said, “No, SIRS is NOT dead,” while 50 percent said, “Maybe, Use SIRS & SOFA.” Not a bad start for five days after liftoff.

Dr. Westafer and I also released a 20-minute summary of the definitions on our podcast, FOAMcast (www.foamcast.org). In that episode, we cover how the definitions were made as well as some strengths, weaknesses, criticisms, and defenses of the new definitions.

The conversation will no doubt continue online and likely in person at the 36th International Symposium on Intensive Care and Emergency Medicine, March 15–18, in Brussels, Belgium, so watch for tweets coming from #ISICEM16. 🗳

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**DO YOU HAVE ANY
FAVORITE FOAMED
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1) CSF Sterilization & 2) CT Angiograms



Recent research provides guidance when dealing with meningitis and palatal wounds in children

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While not the aim of the paper, it did demonstrate that no patient receiving an LP more than five hours after antibiotic administration had a positive culture for *Neisseria*, suggesting that the CSF is sterilized by five hours.

by LANDON JONES, MD, AND RICHARD M. CANTOR, MD, FAAP, FACEP

The best questions often stem from the inquisitive learner. As educators, we love—and are always humbled—by those moments when we get to say, “I don’t know.” For some of these questions, some may already know the answers. For others, some may never have thought to ask the question. For all, questions, comments, concerns, and critiques are encouraged. Welcome to the Kids Korner.

Question 1: After administration of IV antibiotics for suspected meningitis in children, how long do you have before sterilizing the cerebrospinal fluid (CSF), yielding a negative CSF culture?

This question is dependent on the antibiotic used to treat a patient’s suspected meningitis. A retrospective pediatric study by Blazer et al found that after 44–68 hours of IV treatment for known meningitis, the CSF culture was negative in 66/68 (97.1 percent) on repeat lumbar puncture (LP).¹ While the CSF culture was negative at the time of repeat LP, there was no significant difference between the cell counts and CSF differential when comparing the admission LP results with the repeat LP results 44–68 hours later. Of note, the drugs in this retrospective study were ampicillin, chloramphenicol, and penicillin. While these results do not specifically answer the above question, they do suggest that, even after 44–68 hours of antibiotics, the CSF cell count and differential will not significantly change.

A more recent retrospective study by Crosswell et al looked specifically at CSF sterilization time in pediatric cases of confirmed meningococcal meningitis after pretreatment with the third-generation cephalosporin cefotaxime.² This study’s aim was to determine how long children needed continued antibiotic treatment and included 48 children ages 0–14 years. While not the aim of the paper, it did demonstrate that no patient receiving an LP more than five hours after antibiotic administration had a positive culture for *Neisseria*, suggesting that the CSF is sterilized by five hours.

Finally, Kanegaye et al performed a retrospective study of 128 pediatric meningitis patients ages 0–16 years.³ Meningitis was defined as: 1) a CSF culture positive for a known bacterial pathogen, 2) a positive CSF antigen study, 3) a CSF pleocytosis and positive gram stain, 4) a positive blood culture combined with CSF white blood cells (WBCs) greater than 100/mL, or 5) CSF WBCs greater than 4,000/mL alone. Ninety-two percent (82/89) of the CSF cultures were positive if the LP was performed prior to antibiotic administration. Only 56 percent (22/39) of CSF cultures were positive in the group that was pretreated with antibiotics before the LP, and



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in this pretreatment group, the LP was delayed up to 72 hours in some patients. The three most common meningitis pathogens were *N. meningitidis*, *S. pneumoniae*, and group B streptococcus (GBS). With the exception of *N. meningitidis*, CSF cultures for pneumococcus and GBS were not sterile (negative) until four hours of antibiotic pretreatment. *Neisseria* cases were all sterile beyond three hours following pretreatment. Ninety-eight percent of these patients were treated with a third-generation cephalosporin.

SUMMARY

Sooner is better, but retrospective studies suggest that you probably have three to four hours after antibiotic administration before CSF sterilization in cases of *S. pneumoniae* and GBS. For potential *N. meningitidis* cases, though, you probably have a much smaller window of one to two hours before CSF sterilization.

Question 2: After a palatal puncture wound by a sharp object, is computed tomography angiography (CTA) necessary to evaluate for a carotid injury in children?

Current literature includes retrospective and case studies. A retrospective study by Hennelly et al looked at 205 well-appearing children between ages 9 months and 18 years with a normal neurological exam.⁴ The primary goal of the study was to identify any stroke or infection. Exclusion criteria included operative intervention for a retained foreign body, persistent bleeding, expanding hematoma, or intubation. Secondary goals of the study looked at CTA use, any positive CTA findings (excluding air), and any intervention (anticoagulation, operative, and admission for observation). The lateral soft palate was involved in 71 percent of the cases, and infection developed in 3/205 (1.4 percent)

cases. No patients developed stroke. Ninety (44 percent) of the patients got a CTA, and 10 percent (9/90) of these scans were interpreted as positive, with one intimal tear and eight cases of edema. None of the positive CTA results led to any significant interventions like surgical intervention or anticoagulation. The authors were unable to draw any definitive conclusions about antibiotic prophylaxis and its relationship to infection. Other retrospective studies by Hellmann et al (n=131) and Radkowski et al (n=23) found no neurologic complications as well.^{5,6} To be fair, there are rare case reports that talk about carotid injuries that manifest more than 24 hours after the injury. They are very rare but do exist.

SUMMARY

The likelihood of a carotid injury following penetrating trauma to the soft palate is very low, suggesting that imaging may not be necessary in neurologically normal well-appearing children. However, there are no prospective studies on this topic. ☺

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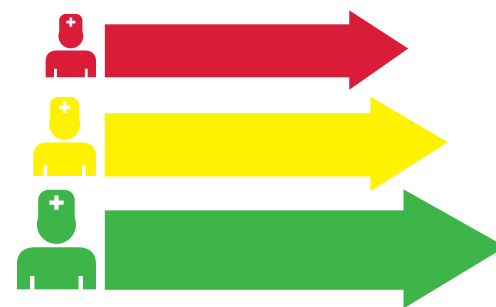


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Inno-Great!

An innovative physician-staffing paradigm

by SHARI WELCH, MD, FACEP



Texas Health Harris Methodist Hospital Fort Worth is part of a 25-hospital system and one of the busiest emergency departments in the country. With 635 inpatient beds, the hospital houses a 100-bed ED, which treated approximately 120,000 patients last year. Its admission rate is high at 24 percent, and it has a high ambulance arrival rate of 30 percent. The ED leadership and staff moved into their new facility approximately two years ago, and it boasts five zones and 75,000 square feet. Even before moving to the new facility (the old one was only a third of the size), the department had a reputation for service quality and efficiency.

The Texas Health Fort Worth ED has unrivaled performance in both clinical and operational metrics. Most of its core measure metrics (pneumonia, stroke, ST elevation myocardial infarction, sepsis) had performance above 95 percent, with many at 100 percent. Further, its operational performance is un-

heard of in EDs seeing more than 100,000 patients a year:

- Door-to-doctor time is 20 minutes.
- Overall length of stay is 185 minutes.
- Length of stay of admitted patients is 291 minutes.

What are some of its strategies for such outstanding workflow, patient flow, and clinical quality? This department is staffed by an extremely stable physician group with strong leadership and a long history of service quality. The ED group was founded and led by John Geesbreght, MD, FACEP, who was formerly in the military and is, by all accounts, a visionary and a gifted operational thinker. He was joined early on by Elliott Trotter, MD, and Ralph Baine, MD (who was a nurse when he initially joined the group), who shared his vision for an efficient and patient-centric emergency medicine practice. Interestingly, Texas Health Fort Worth has some half a dozen physicians who came up through the ranks as nurses or scribes

Physicians ... move from the highest-acuity area to the lowest-acuity area during a shift.

and then returned to the group after completing medical training.

Dr. Geesbreght and his leadership team have designed one of the most unique and original physician-staffing models in use. Despite promoting individual physician efficiency, this physician group recognizes that there are fast physicians and slow physicians. Though the group tracks efficiency metrics on all physicians and inspires them to work as efficiently as possible, it realizes that there are intrinsic differences. Doctors

are monitored for productivity and classified as green, yellow, or red, indicating the highest to lowest productivity, respectively. This is not used in a punitive fashion because this group recognizes that each physician member contributes to the good of the group in some way: some are researchers, some are teachers, some are IT experts, and some play a role in the EMS community, etc. However, when the clinical schedule is crafted, there is careful effort not to schedule consecutive or concurrent red physicians.

The ED at Texas Health Fort Worth was designed as an I-beam configuration, with five zones that care for patients based on triage acuity (see Figure 1). The most recently arrived physician treats the sickest, least stable patients in the critical care area.

Physicians progress through a schedule that has them move from the highest-acuity area to the lowest-acuity area (Critical Care → Medical A & B → Quick Care) during a

CONTINUED on page 20

Figure 1. The care zones at Texas Health Fort Worth emergency department.



shift. Procedures are handed off to a procedure physician who only does procedures. This will probably be the most controversial aspect of this scheduling paradigm, but it's explained by Terence McCarthy, MD, in a way that every emergency physician understands. If you're intensely involved with a patient who may be septic but you also have a three-layer facial laceration to close and are interrupted and distracted, you may feel afterward that you did not do your best. Imagine if all you had on your plate were procedures done in series. Since every physician works through the progression, every

physician has the opportunity to perform procedures. The model is also noteworthy for placing the most rested physicians in the area with the most clinically complex and ill patients. The shift finishes in the minor care area, which excludes patients with abnormal vital signs. Physicians are encouraged to make efficient and rapid dispositions of these patients because if they are unable to tidy up a zone as they progress through it, then they may have active patient care going on over a large ED footprint. The physicians admitted that, on occasion, the geography and the physician-progression model seem

at odds and a physician is doing a lot of running, but the doctors explained that their model had many advantages viewed as, "what is good for the patients."

The proof of physician satisfaction is in the retention pudding. Texas Health Fort Worth has very low staff turnover. When asked about the last time a physician left the group, Richard Dixon, MD, and Dr. McCarthy scratched their heads. "Remember in 2002?" Both physicians and nurses are screened for a high work ethic and standard and good teamwork skills. The glue that seems to hold it all together is a genuine

commitment to the patient.

This innovative model for staffing and the delivery of patient care goes against the conventional wisdom of med teams in a geographic zone, but it clearly works. That said, it requires a high level of teamwork and collaboration, a culture of putting patients first, and a commitment to continuous improvement. If you have all of this going for you, this is a care-delivery model that is worth exploring.

Hats off to the ED at Texas Health Fort Worth. It is living proof of what a well-run ED can accomplish! ☺

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Editor's Note: Cutting through the red tape to make certain that you get paid for every dollar you earn has become more difficult than ever, particularly in our current climate of health care reform and ICD-10 transition. The ACEP Coding and Nomenclature Committee has partnered with ACEP Now to provide you with practical, impactful tips to help you navigate through this coding and reimbursement maze.

Fact #2: Abscess I/D Pearl

by JASON ADLER, MD, FACEP, AND HAMILTON LEMPERT, MD, FACEP, CEDC

An incision and drainage (I/D) of an abscess (or paronychia, furuncle, carbuncle, or suppurative hidradenitis, for that matter) is one of the top 20 procedures performed by emergency providers. Did you know there are actually two different codes for this procedure? A *simple* I/D, 10060, is one that is performed by lancing the lesion or using needle aspiration. In 2016, this is worth 2.77 relative value units (RVUs). On the other hand, a *complex* I/D is one

that may require you to probe the lesion, break up loculations, and pack the wound after irrigation.¹ This is worth 5.12 RVUs in 2016.

The RVU difference is large. Without the proper documentation of packing, probing, or breaking up loculations, a complex I/D becomes a simple one. Understanding simple documentation principles can have a dramatic effect on your group practice. If you do the work, you should get credit. For more documentation pearls like this, please visit www.acep.org/reimbursement. 

Reference

1. *Coders' Desk Reference 2011*. Salt Lake City, UT: Ingenix; 2010.

DR. ADLER is assistant medical director of the emergency department at MedStar Montgomery Medical Center and chief coding and reimbursement officer for Emergency Medicine Associates in Olney, Maryland. **DR. LEMPERT** is vice president and medical director, health care financial services, at TeamHealth, based in Knoxville, Tennessee.

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