IEPC Newsletter
September 2021

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2021 Speaker Series

Presented by the Independent Emergency Physicians Consortium
Time & Date: 9:00AM - 9:30AM Pacific on the fourth Monday of the month May - Nov.
Advance registration is required. After registering, you will receive a confirmation email containing information about joining the meeting.

This free speaker series will welcome leaders in the field to cover timely and engaging topics that are important to independent emergency physicians. The sessions will precede each monthly conference call and are open to all IEPC members and those who may be interested in joining.

- **May 24** - Elena Lopez-Gusman, Executive Director, California ACEP to discuss Cal-ACEP priorities for 2021
- **June 28** - Laura Wooster, ACEP Associate Director, Public Affairs and Jeffrey Davis ACEP Director of Regulatory Affairs to discuss national ACEP priorities for the independent emergency physicians
- **August 23** - Sandy Schnieder, MD, ACEP Director of EM practice to discuss the emergency physician workforce
- **September 27** - Mark Reiter MD, MBA MAAEM CEO, AAEM to discuss AAEM priorities for the independent emergency physician
- **October 25** - BJ Bartelson, RN MS, NEA-BC, CHA VP, Nursing & Clinical Services to discuss the California Hospital Association and independent emergency physicians
- **November 22** - Andrew Selesnick - Shareholder, Chairman of the Healthcare Litigation Practice Group to discuss legal billing issues affecting independent emergency physician groups

Visit www.IEPC.org for more information.

The Deadly Cost of Psychiatric Boarding

Roneet Lev, MD
Executive Director, IEPC

Avi had a little chest pressure while at work and could ignore it as he finished up his day. Once home, his wife Jill convinced him to check it out, and they drove together to the emergency department (ED). The ED was packed, lots of people needed tending to for physical ailments, but mental health and substance abuse patients also occupied many beds. Avi was directed to a waiting room until a bed opened up.

It was July 2020 in Southern California – the COVID surge had not yet hit - but no visitors were allowed in the hospital. Jill waited in the hospital parking lot in the car. The plan was for Avi to text her when he was ready to leave. His text never arrived.

An hour into the wait, Avi had collapsed. A code blue was called for the waiting room– never a smooth event. Emergency workers did CPR on the floor, and as a big guy, it took time to get him on a proper gurney and attach him to a monitor. A few rounds of unsuccessful ACLS, and it was over. Avi was dead. The triage nurse did not take down Jill's number to call her because no one expected this tragedy. Instead of a text from Avi, four hours later, Jill received the worst call of her life from the medical examiner. "Avi" was dead.

Avi and Jill were friends of mine. When I learned of Avi's passing, I joined the family at the hospital. Jill and her two daughters were accompanied to the ED and allowed to wait for the medical examiners' transport team to take Avi. I am an emergency physician, typically on the other side of the curtain to one of these extreme events. I see the juggling of multiple patients spread all over a large emergency department all the time. Now, as a quiet observer, the sounds of the ED were remarkable – patients scream, orders barked, occasional laughter, and steady ambient chatter. The place was packed. We were situated in a room near the ambulance door and witnessed the lineup of paramedics and their patients waiting for an open bed. In the EMS (Emergency Medical Services) community, this is known as "offload delays" or "wall time" because ambulances wait along a wall waiting to turn over their patients. Now I sat quietly, waiting, absorbing the sights and sounds of the hospital, wondering why Avi had to die.

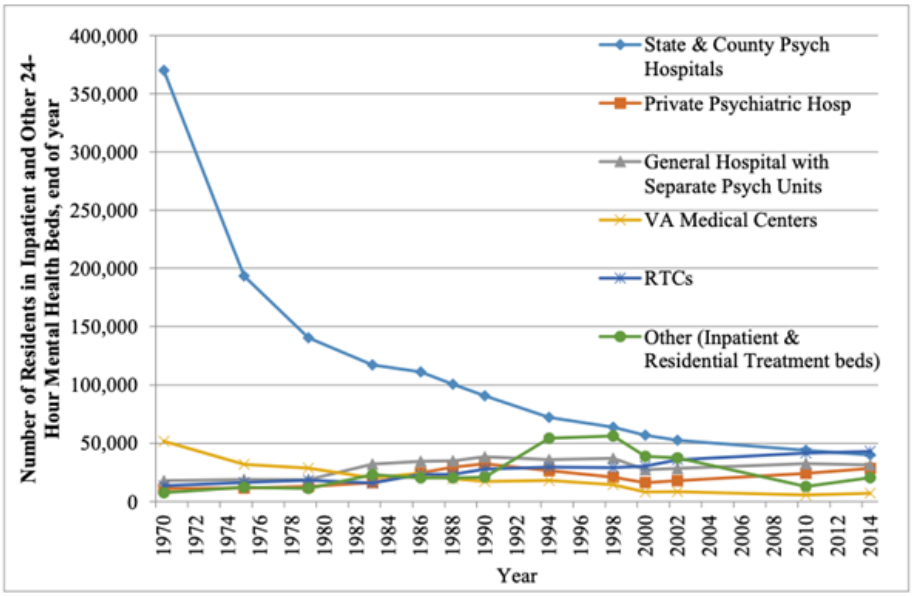
The situation was familiar. At that time, COVID patients were rare, but ED's are almost always at capacity. On top of that, more and more are default psychiatric boarding locations. I work at the other side of town, but we too could have 15 or more ED beds used at any one time to house mental health and intoxicated patients for hours and even days as they await placement or the urge to leave. Was this the reason a would-be healthy 55-year-old man would drop dead in an ED waiting room?

A few months earlier, Avi was dancing at my son's wedding and lifting him onto a chair. Why did Jill get a call from the medical examiner and not a nurse or doctor? I wanted to find out.

The ED physician was appropriately apologetic and showed me the triage EKG with the family's permission. Avi had some mild chest pain, and the EKG had nonspecific findings. Still, hospital personnel sent him to a waiting room with active chest pain until a bed became available.

After receiving the medical brief, I traversed the hallways of this overflowing ED to report to the family. I didn't share what I was thinking: could Avi be alive now if he was in an ED bed on a monitor? Could he have suffered

Psychiatric Boarding continued from last page



Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014. August 2017. National Association of State Mental Health Program Directors.

V-fib and quickly shocked out of it? Did Avi get a fair chance? What's the point of upsetting an already grieving family? It doesn't change anything. These were the thoughts I kept to myself, and a year later, it still haunts me.

Proper flow of an emergency department is a matter of life and death. Across our nation, our society prioritizes ED beds for mental health and substance abuse over patients like Avi. As an emergency and addiction physician, I get satisfaction treating patients with substance use disorder and those with a mental health crisis. However, the ED is a loud, busy environment is not the best place to treat these disorders.

The problem is classic supply and demand. We have an increased volume of mental health and intoxication cases and a decreased supply of psychiatric beds. According to Mental Health America, 19% of adults, or 47 million Americans, experience Any Mental Illness (AMI), and 4.55% have a severe mental illness. Substance Use Disorder is reported in 7.67% of adults in the past year. The percent of adults reporting serious thought of suicide is 4.32%, or 10.7 million people, increasing by 460,000 from the previous year.

From 1970 to 2014, the number of patients in psychiatric beds declined from 236.8 patients per 100,000 population to 53.8 patients in beds per 100,000, a 77% percent reduction, according to the National Association of State Mental Health Program Directors (NASMHPD). With increased patients and decreased beds, where did over 300,000 mental health residents go? Did their chronic disease resolve? Are they adequately treated on an outpatient basis? California passed a millionaire's tax in 2004 to resolve the mental health crisis. Did that make a difference at the front lines?

Psychiatric boarding has become standard in our emergency departments at 6 a.m. I can predict that 50% of our ED patient volume is patients waiting for placement. I have been told of a man who lived in the ED for 17 days remaining for a mental health bed. Patients routinely spend 2-3 days in the ED detoxifying from drugs.

The problem is now new. The Pew Foundation published an article in 2016 on the critical shortage of state psychiatric beds forcing mentally ill patients with severe symptoms to be held in emergency departments sometimes for weeks. The Treatment Advocacy Center published "Delayed and Deteriorating" in November 2017, highlighting an increase in ED boarding of psychiatric patients and blaming the lack of affordable, comprehensive psychiatric treatment services.

I am proud that the ED is the safety net for all medical and social problems of society. That's our job, and I own it. But as a system, it is not an intelligent utilization of resources. Avi's death is not the fault of the doctor, the hospital, or the county. Our health system is broken. There must be a better way.

It may have been Avi's time - but no, I don't think he received a fair chance.

Have an idea for an upcoming IEPC guest speaker or topic? Interested in contributing an article for an upcoming issue of the IEPC newsletter? Email admin@iepc.org

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Emergency Personnel Are Scared Not of COVID, But of Violence

"We are sitting ducks. Police will put yellow tape around our dead bodies."
"In the past 2 years we had a gun threat, a man with a machete and many other violent patients."
"We are under prepared."

These are some of the comments obtained by IEPC physicians in an internal survey about violence in the emergency department. Emergency physicians and staff may be justifiably concerned for their safety at work. The survey was completed by 23 IEPC member emergency departments in California.

When asked about whether the degree of violence has increased, decreased, or stayed the same, 9 doctors reported increased incidence of violence while 14 reported no change. The location of violent incidents included the main ED treatment area (9), Triage (10), and Both (4). Physicians reported findings knives (21), guns (5), machete (1), nun chucks (1) and hand axe (1).

Security measures at IEPC emergency department varied. All but one ED reported having hospital security. Placing mental health patients in gowns is policy at 11 of the ED s. Two hospitals had a canine unit and one hospital had a metal detector. "911 doctor down." I was assaulted at work. A young woman came to our fast-track area for a chief complaint of weakness. She was groggy, and I was trying to wake her up to obtain a history. I notice that she was hiding something in her shirt, and I asked her about it. She suddenly got him, shoved me in the abdomen and ran out. I had the wind knocked out of me as hospital security was called. I heard screaming all around. The patient was caught by security and was screaming. Security was yelling out whether I am pressing charges to keep her or should they let her go. I was trying to catch my breath as I was watching my patient to decide if she has the capacity to leave. She presented with weakness and possible altered mental status. I was watching her and listening to her to determine if she has capacity to leave safety. I saw her walk well, yell out if full comprehensive sentences, so I said she could go. Only later did I stop and think what I would advise my staff in a similar situation: "Press charges. Do it for yourself and for future medical staff who may be assaulted."

IEPC's survey is consistent with reports from ACEP, the American College of Emergency Physicians, and ENA, Emergency Nurses Association. ACEP report nearly 50% of emergency physicians have been assaulted at work and 70% of emergency nurses reported being hit and kicked while on the job. That is why both ACEP and ENA support the Workplace Violence Prevention Act.

I don't understand why it's ok to assault medical staff. Assault against medical staff should have legal implications just as much if not more than assault against law enforcement.

https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/02/amid-shortage-of-psychiatric-beds-mentally-ill-face-long-waits-for-treatment

Emergency Physician Staffing in the Wake of COVID

Emergency physicians are masters at multi-tasking, managing chaos, and dealing with the unpredictable. The COVID pandemic threw us a new challenge – decreased patient volume. At the beginning of the pandemic, we staffed up expecting a tsunami of patients, but many ED s did not see this volume. People stayed at home and feared the emergency department. ED s went from staffing up to staffing down. This summer we are once again experiencing increased volume and some of us and once again adjusting our staff to meet the demands.

IEPC survey the doctors in July 2021, before the late summer rise of COVID cases. Physicians were asked whether they are hiring new physicians, 13 out of 23 hospitals answered in the affirmative. 12 groups were hiring allied providers. However, 75% of groups reported decreased physician shift, either shorter or fewer shifts, and 9 groups decreased allied provider shifts. In July the ED volume was described as 75% of pre-COVID volume.

The issue of ED staffing is a concern for graduating ED residents applying for jobs. The issue is at the forefront of discussion by ACEP and the EM Physician workforce of the future.

Conflict of Interest of United Healthcare and Yale's Study on Surprise Billing

Conflict of interest is well known to inject bias into research. Who knows that more than experts who do research for a living? Researchers go to great lengths to disclose conflicts and avoid bias in publishing science. And yet, the researchers at Yale published a study on out of network billing with data from the insurance giant that worked behind the scenes to influence the paper and their own self-serving talking points. This finding was uncovered in a recent news story on The Intercept. The story demonstrates that everyone can have a conflict of interest. United Health was interested in increased revenue and decreased complaints about out of network bills; and Yale had a conflict of wanting exclusive rights to data that would result in a prestigious study.

No one wants "surprise billing," a catchy phrase that means patients are stuck with an ED bill because their insurance won't pay. Everyone agrees that patents should not be stuck in the middle. The problem is giving giant corporate health plans all negotiating power over the doctors. No, surprise billing should not mean that health plans unilaterally decide whether they should or should not pay for emergency care and what they feel like reimbursing. That simply screws the doctors and the patients. IEPC ran a campaign, AT RISK, docs at risk means patients at risk. We joined ACEP's effort to STOP surprise billing, SUPPORT full price transparency, and DON'T destroy small business emergency physicians.

UnitedHealthcare®

Yale University

The Yale study failed to disclose their conflict of interest, but they also failed to look at the consequences of siding with big corporation over independent physicians doing their best to run a small business. Unfortunately, the fight on surprise billing involved several goliaths: United Health Care, Team Health, Yale. There was little consideration to the people who are on the ground providing emergency care – the doctors. While much of healthcare is going to big corporation, we should preserve the independent physicians who dedicate their career and lives to serving patients.

$3.8 Million Awarded to Physician Serves as Important Reminder About Fair Hearing Rights

Written by Rebecca Hoyes for Nossaman LLP. Originally posted to www.JDSupracom on February 20, 2019.

In a decision affecting California hospitals, medical groups, medical staffs, and physicians, the California First District Court of Appeal has concluded that a physician's notice and hearing rights apply to situations where a hospital directs a medical group of a "closed" department to remove a physician from the hospital schedule.

In Economy v. Sutter East Bay Hospitals, Sutter Hospital operated a closed anesthesia department pursuant to a contract with East Bay Anesthesiology Medical Group ("East Bay Group"). The exclusive contract required all physicians providing anesthesia services at the hospital to be employed by East Bay Group. The contract also permitted the hospital to require East Bay Group to immediately remove from the schedule any of the anesthesiologists who performed "an act or omission that jeopardizes the quality of care provided to [the] hospital's patients."

In 2011, California Department of Public Health conducted an unannounced survey and placed the hospital in "immediate jeopardy" upon finding numerous deficiencies attributed to one of East Bay Group's anesthesiologists, Dr. Economy. At hospital administration's direction, East Bay Group removed Dr. Economy from the schedule pending further investigation. In the weeks that followed, the medical staff peer review committees reviewed the issue and recommended to East Bay Group that Dr. Economy complete a continuing education course through Physician Assessment and Clinical Education (PACE) program prior to returning to clinical practice. Dr. Economy did not receive an opportunity to meet with any medical staff peer review committees to discuss the matter.

Dr. Economy eventually completed the PACE program and returned to practice. After being alerted by the pharmacy manager of problems with Dr. Economy's chart, hospital administration contacted East Bay Group and asked them to "address the issue immediately." Dr. Economy once again was taken off the anesthesia schedule and asked by East Bay Group to resign. When he refused, they terminated his employment.

Dr. Economy thereafter filed a complaint alleging the hospital had violated his right to notice and a hearing under Business & Professions Code § 809 and his common-law right to fair procedure. He also filed suit against East Bay Group, which were resolved on summary judgment or settled prior to trial.

The trial court entered judgment in favor of Dr. Economy, finding that the action taken by the hospital in removing him from the anesthesia schedule was indisputably for a medical disciplinary cause or reason, and constituted a summary suspension of Dr. Economy's right to exercise his privileges and use the facilities of the hospital. Dr. Economy received an award $3,867,122 in damages for past and future income, emotional distress, and "tax neutralization."

In finding that the hospital violated Dr. Economy's common law and statutory due process rights, the trial court rejected the hospital's contention that the Easy Bay Group made the decision to suspend and terminate Dr. Economy's employment – not the hospital – and therefore, no hearing right had been triggered. The court found the hospital's approach untenable, as it would effectively allow a hospital to avoid complying with the notice and hearing requirements of 805 and 809 simply by relying on its contracts with third-party employers as a way to terminate the services of physicians. Rather, the court found that the "request" for Dr. Economy to be removed from the hospital schedule, first temporarily and then permanently, was the functional equivalent of a decision to suspend and later revoke his clinical privileges.

The Court of Appeal upheld the trial court's decision. Furthermore, the Court of Appeal rejected the hospital's argument that Dr. Economy had no entitlement to lost wages since he had not shown he would have been exonerated at a peer review hearing. Relying on a case involving a civil service employment case, the court determined that even if Dr. Economy would not have prevailed, he still would have been "entitled to back pay for the period during which the discipline was invalid." (See Skelly v. State Personnel Board (1975) 15 Cal.3d 194, holding that civil service employees held a property interest in the continuation of their employment which is protected by due process.)

Despite siding with the Plaintiff on most issues, the court ruled

FAIR HEARING RIGHTS con't from last page

for the hospital in rejecting Dr. Economy's claim for attorney fees under Business & Professions Code § 809.9, finding that the hospital's defense of the litigation could not be found to be "frivolous, unreasonable, without foundation, or in bad faith" as the evidence supported their factual assertions, and the hospital's argument that it had no duty to prepare an 805 report had "some support."

While the court in Economy focused on removal of a physician for competency reasons, which plainly met the definition of "medical disciplinary cause or reason," it remains to be seen how a court would respond if a hospital directs a medical group to remove a physician when the jeopardy to quality of care is not as obvious, such as when the physician engages in behavior that does not align with the professionalism standards of the hospital.

Medical staffs, as well as other peer review bodies, should also analyze their Bylaws to ensure they reflect the hearing rights afforded to physicians restricted from practicing for a medical disciplinary cause or reason in a similar situation. This case also serves as an important reminder for medical staffs and hospitals to assure that they meet their own peer review and fair hearing obligations, rather than relying on the actions of a medical group.

Hospitals and medical groups should review their current contracts to determine whether their contracts run afoul of Economy

or Business & Professions Code § 809.6 (prohibiting the waiver of hearing rights by contract). As an example, since the court equated the removal of a physician to a summary suspension, hospitals should consider whether similar contractual language allowing removal for "an act or omission that jeopardizes the quality of care provided to hospital's patients" is moot and should be replaced with language mirroring the standards for summary suspensions (i.e., when the failure to take such action may result in an imminent danger to the health of any individual).

NEW IEPC Member Insurance Benefits Now Available!

Independent Emergency Physician Consortium (IEPC), is an association of independent emergency physician groups whose purpose is collaborating on best business and clinical practices, sharing resources, and protecting the independent physician practice model.

In keeping with these objectives, IEPC has identified that one of the major business expenses for independent emergency physician practices are the various insurance products required to protect the group's entity, shareholders, employees, and independent contractors from risks on and off the job. This said, IEPC has decided to leverage the consortium's group purchasing power by partnering with two healthcare specialist insurance agencies to provide members with comprehensive and competitive options for both commercial and personal insurance products. In so doing, we expect that the program arranged by IEPC will be a cost-saving for your group, and a return on investment of your membership dollars.
Click here for details regarding each partner agency, and the insurance products they offer. Please note that utilization of either agency, or any of their products, is completely voluntary. IEPC is providing this networking opportunity to enhance your membership, and help you better insure your practice for lower premiums.

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