IEPC

Independent Emergency Physician Consortium

IEPC Newsletter
November 2021

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Stop Calling It Boarding – It's ED Psychiatric Care

Roneet Lev, MD
Executive Director, IEPC

I had the honor of discharging a 23-year-old patient with autism, let's call him Austin, who presented to the emergency department on a 5150 psychiatric hold due to violent behavior. There were no locked mental health beds in the area and so Austin remained in our emergency department for two weeks. Austin awoke and went to sleep day after day in the Emergency Department - eating, drinking, and I imagine brushing his teeth. In total he was in the ED more shifts than I was. Some call this psychiatric boarding. I don't like that term – it's misleading, it sounds like no medical care was delivered.

During those two weeks Austin had a sitter next to him 24/7. He received regular vital signs, medications, counseling, rounding by the psychiatric team, consultation and orders by different emergency physicians, and daily consultation by a psychiatrist. He received successful medical and psychiatric treatment over those weeks. The treatment, in fact, was so good that Austin was safely discharged home. A mental health bed never opened. Austin was not just boarding in the ED, Austin received Emergency Department based psychiatric treatment. ED psychiatric treatment works, but unfortunately it is not the best place for mental health patients and disastrous for overall ED flow.

Now picture yourself as the health insurer who needs to pay for Austin's care. Austin's bill would include one hospital ED visit, one ED physician visit, perhaps an observation code, some medications, and a psychiatrist bill. What a bargain! That beats a two week stay in a mental health facility. Health plans must love ED "psychiatric boarding"! What is the incentive to transfer a patient or create new mental health beds if care is provided in the ED for less? What if the health plans were charged a daily ED hospital and ED physician rate for every day that their patient cannot be placed? Now that would align incentives.

California ACEP 2021 Legislative Review

Valerie Norton
IEPC Member and President-Elect, California ACEP
Elena Lopez-Gusman
Executive Director - California ACEP

California ACEP had a busy year with critical issues of pandemic, workforce, payment threats, and mental health boarding. Here is a summary of some of the legislative activity that was discussed during an IEPC Speaker Series.

Improve the safety and quality of care for patients across California

- AB 451 Arambula: Requires free-standing psychiatric hospitals to accept patients in transfer under the same rules as other EMTALA-bound facilities, without regard to ability to pay. Signed by the Governor.
- AB 685 Maienschein: Would require Emergency Physician review before a health plan or insurer could down code a claim. This is a two-year bill and will be heard in January.

Improve EM practice

- AB 1113 Medina: Gives free college tuition at state schools for children of healthcare workers who died of COVID. We worked with the authors to have independent physicians included, not just

LEGISLATIVE REVIEW

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hospital employees. Signed by Governor.

- SB 104 McGuire: Would provide a pass-through credit on state and local taxes (SALT) to S corporation physician groups. This bill is held on suspense but was enacted by AB 150 which was a budget trailer bill. While we were hoping to expand the applicability of the pass-through to more EP entities, we were pleased to see this signed into law.
- SB 250 Pan: CMA sponsored bill that would require insurers to collect co-pays and deductibles directly from patients instead of making physicians do that. Will be heard again in January.
- $40 million budget allocation for grants to EDs to provide behavioral health navigation services. This is modeled after the $40 million we successfully got last year for substance use navigators. This was passed and signed and there will be a grant process in 2022 to distribute the additional funds.

Oppose or try to amend legislation that would be detrimental to ED practice

- SB 447 Laird: would allow pain and suffering awards for heirs of decedents who get a malpractice award. Essentially doubles possible MICRA pain and suffering award from $250,000 to $500,000. Signed by the Governor.
- AB 835 Nazarian: Would require all EDs to test for HIV on all patients undergoing a blood draw unless they opted out. After energetic lobbying efforts to oppose

different versions of this bill over several years, the current version was kept in the "suspense file" this year due to the cost to the state (Medi-Cal, UC system). It would have been an unfunded mandate for all hospitals.

- SB Roth 806: This bill is an omnibus bill that reauthorizes the CA Medical Board. Among its provisions, it would have continued the post-graduate training license that was established 5 years ago by the medical board reauthorization bill and prevented moonlighting. We worked hard to fix this and were successful. Signed by Governor.
- AB 1204 Wicks: Would have required physicians to report redundant demographic data on their patients already being reported by hospital. We were able to work with the author to have physicians removed.
- AB 1105 Rodriguez: Would have required physician employers to provide COVID testing to their employees, duplicative of hospital testing. We were able to work with the author to remove the requirement for emergency physicians.
- AB 789 Low: Would have required Hepatitis B & C screening in the emergency department when primary care services were being provided. We were able to work with the author to exclude the ED.
- SB 306 Pan: Would have required syphilis screening on patients who delivered in the ED. Worked with author to make this a recommendation rather than a requirement.
- SB 744 Glazier: Would have added housing, address and other demographic patient information to the mandatory reporting already required of physicians for communicable respiratory illnesses. Worked with author so that this is only required to be reported if the information is known.

Work in the regulatory process to implement recent laws in sensible ways that will protect EM and ED patients

- AB 1544 Community Paramedicine: AB 1544 was signed into law in 2020 allowing paramedics to expand their scope of practice in certain settings and to allow paramedics to transport patients to certain alternate destinations (sobering centers and mental health facilities). We serve on the advisory committee drafting regulations to provide guidance to LEMSAs to implement this law.
- AB 890 Wood NP scope of practice: we are engaging with the BRN advisory committee and in process of creating a position statement from California ACEP regarding our opinions about transition to independent practice in an ED setting, and what additional requirements NPs should have to meet for this.

California Hospital Association 2021 Update

BJ Bartleson, RN, MS, NEA-BC
VP Nursing & Clinical Services

The follow is a summary from the IEPC lecture series given by BJ Bartleson in October 2021. She reviewed a challenging year for the California Hospital Association and accepted feedback and suggestion from the IEPC audience.

Massive Financial Loss from COVID-19

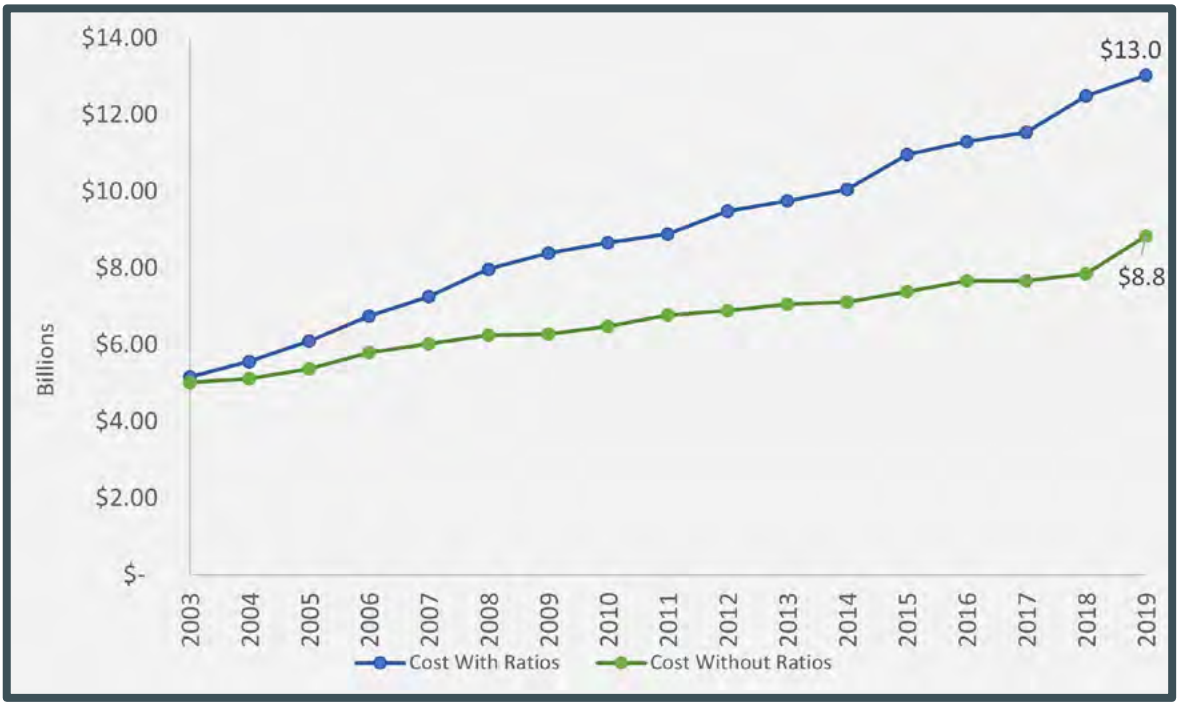
California hospitals endured a loss of $14.3 billion in 2020 without federal CARES Act funding, which was caused both by a loss in revenue and expenses tied to the pandemic. Even with CARES Act funding, California hospitals sustained a loss of $8.4 billion. Hospitals experienced a decrease in utilization of over 4 million adjusted patient days in 2020, an 11% drop. Due to this dip in utilization, as well as increases in expenses related to pandemic response (e.g., additional personal protective equipment purchases and non-traditional hospital space modifications), it's estimated that hospitals lost over $14 billion dollars in 2020. Under an optimistic scenario, hospitals will lose $600 million more in 2021. If a more negative scenario occurs, losses may reach $2 billion in 2021.

- 39% of hospitals had negative operating margins in 2019, up from 33% in 2015.
- 28% of hospitals have operating margins less than -3%.
- $323 billion projected losses nationally, $8 billion for California
- 56% decrease in outpatient visits (early COVID, national data)
- 41% of US adults avoided medical care as of June 30, 2020

More information on hospitals' COVID-19 losses can be found here.

Financial Wins for Behavioral Health

AB 133 – Omnibus Health Trailer Bill- recorded breaking $76 billion state budget surplus and $27 Billion in federal aid. The bill invests more dollars in Medi-Cal, case management, telehealth and other virtual modalities. This is a big win for behavioral health and CHA's sponsored request of $40 million to support the CalBridge Behavioral Health Pilot Program- behavioral health navigators in ED's to screen and offer intervention and



Mandatory Staffing Ratios Cost Billions Per Year

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referral for mental health or SUD. The bill adds Behavioral Health Continuum Infrastructure Program for competitive grants to increase capacity in crisis stabilization, establishes the Children and Youth Behavioral Health Initiative.

- $50 million to Song-Brown program to fund new primary care residency programs
- $10million to fund pre-licensure RN programs

Supply Chain Unpredictability
The US normally spends $5 billion on PPE, and 90% of N95 respirator masks are imported from China.

- 25 million PPE were used in US in 2019
- 3.5 billion N-95's plus will be needed by the end of the year

The federal national reserve for masks had only 1% of the required supply. Manufacturing Lab Testing Supplies have been constrained since day one, now hospitals are facing rolling shortages of reagents, plastics, test kits, etc. Without any support from the state or federal government

Workplace Unpredictability
Some estimates tout clinicians account for 20% of the COVID infected. Hospitals have faced pressure and inconsistent and changing regulatory requirements from CalSHA, CDPH, CMS, and CDC. The workforce is dealing with childcare and education constraints, workforce fatigue, and early retirement. Labor costs comprise the majority of hospitals' total operating expenses and have increased 61% in 10 years.

Mandatory Staffing Ratios Cost Billions Per Year
In 2019, mandatory staffing ratios cost hospitals $4.2 billion. The cost of mandatory ratios has increased every year since 2004.

Innovations
Workforce innovations include employee wellness activities,increase student simulation training, large scale remote work when possible, competency based cross training, deployment of clinicians to new settings, advocacy for childcare funding and access, telenursing, and ability to treat patients at home.

Patient care innovations included telehealth and virtual care.

- 24% of health care office visits and outpatient visits were delivered virtually.
- 35% of home health visits could be virtual.

American Academy of Emergency Medicine Highlights of Legal Advocacy For Independent Emergency Physicians

Mark Reiter, MD MBA MAAEM
AAEM Past President
CEO of AAEM Physician Group
Robert McNamara, MD MAAEM
AAEM Past President
CMO of AAEM Physician Group

The following is an abridged article written by Dr. Reiter and Dr. McNamara. Dr. Reiter was featured in an IEPC speaker series followed by an interesting discussion with the participants.

In the 28 years since AAEM's founding, the Academy has been very active in advocacy and legal efforts on behalf of individual emergency physicians and independent groups. AAEM continues to be the only emergency medicine (EM) professional society ever to take legal action against contract management groups (CMGs) in defense of emergency physicians.

Catholic Healthcare West (CHW) and Emergency Physician Medical Group (EPMG) - CPOM
In 1997, CHW, one of the largest hospital chains in the country, announced the purchase of EPMG, a privately held emergency medicine (EM)

AAEM Highlights con't from last page

group. For the first time, a large hospital system had taken over a large EM group, converting hundreds of private practice emergency physicians into hospital employees. The $36 million purchase price was to be recouped by CHW from revenue taken from the professional fees of those emergency physicians. EPMG's principal owners earned millions of dollars on the sale and were then given jobs in the new CHW managed services organization, Meriten, which was essentially a contract management group. All current EPMG physicians – staffing eight of the 37 CHW hospitals – immediately became part of Meriten. Even more concerning, the independent emergency physician groups staffing the 29 CHW hospitals that were not part of EPMG were to be forced under the control of Meriten, which planned to take a 28% fee from its emergency physicians' fees for expenses and profit.

With 29 contracts at risk, the regional implications were profound. AAEM also recognized national implications, as every large hospital system would see the opportunity to control and profit from their emergency physicians. After AAEM wrote letters of concern to the board of CHW, CHW in turn threatened AAEM. Undeterred and with AAEM's help, the practicing emergency physicians of CHW organized into the Affiliated Catholic Healthcare Physicians (ACHP). With the support of AAEM, ACHP – along with the California Chapter of AAEM and the California Medical Association (CMA) – filed a lawsuit alleging violations of corporate practice of medicine (CPOM) and fee-splitting laws. The CMA recognized both the threat to emergency physician autonomy and the wider threat, as Meriten would also be positioned to control other hospital-based specialists.

Results

After initial court hearings seemed to go against it, CHW sold EPMG back to its original owners, who then reorganized EPMG into a fairer, independent, physician-owned group. If CHW had been successful in this endeavor it would have opened the door to other hospital chains taking over emergency physician groups large and small, dipping into emergency physicians' professional fees as a new source of revenue, and dramatically reducing the number of private EM groups.

Mount Diablo Hospital (MDH), California Emergency Physicians (CEP), and TeamHealth – Restrictive Covenants

In 2003, Quantum Health, a subsidiary of TeamHealth, the second largest EM contract management group (CMG) in the United States, lost its contract at Mount Diablo Hospital in Concord, California to CEP. Three of the emergency physicians there wanted to continue working at MDH, where they had each been on staff for years. One was even a former Medical Staff President. In response, Quantum Health filed suit against these doctors, seeking damages from them for their supposed role in the loss of the contract. The emergency physicians went to

AAEM Highlights con't from last page

ACEP for help and were told, as in the CHW matter, that it was a private business matter. They then came to AAEM and were provided advice, support, and legal assistance. The doctors joined AAEM in a counter-suit against TeamHealth, alleging that TeamHealth was using corporate subsidiaries to hide its violation of California's prohibition on the corporate practice of medicine (CPOM). AAEM sought a declaratory judgment, requesting that all ED staffing contracts held by TeamHealth subsidiaries in California be voided, in light of California's CPOM laws. This counter-suit was the first legal action ever taken against a CMG by an EM professional society.

Results
All parties reached a settlement whereby TeamHealth dropped its lawsuits against the emergency physicians, who were able to continue working at MDH, and AAEM dropped its lawsuit against TeamHealth for violating California CPOM laws. In 2005, AAEM assisted in similar cases in Rhode Island and Indiana, also with favorable outcomes.

PhyAmerica Bankruptcy – CMGs and Malpractice Coverage
In 2003, PhyAmerica, one of the largest CMGs, went bankrupt. In 2004, Sterling Healthcare, another large contract management group, purchased PhyAmerica's bankrupt assets, including its ED contracts. PhyAmerica then told its emergency physicians that their self-insured medical malpractice/ legal defense fund had been exhausted. 200 PhyAmerica emergency physicians who had already been sued were told they no longer had malpractice coverage and must pay all attorney fees and legal judgments out of their own pockets. And of course, PhyAmerica emergency physicians had no malpractice coverage for future suits. In response, AAEM organized a Working Group from among the affected emergency physicians, handled logistics, and offered free legal counsel. The Academy also filed an amicus curiae brief before the Baltimore Bankruptcy Court.

Results
In April of 2005 a court order guaranteeing the protection of the physicians' personal assets was handed down. AAEM also negotiated with Sterling Healthcare for partial reimbursement of the emergency physicians' legal costs.

Emergency Physicians Professional Association (EPPA) and EmCare - CPOM
In 2004, EmCare, the largest emergency medicine CMG, acquired the contract at Methodist Hospital in St. Louis Park, Minnesota. EPPA, a private democratic group serving the hospital since 1969, was not even told the contract was up for bid until after the contract was awarded to EmCare. No request for proposals was issued. In December of 2004, AAEM and EPPA jointly filed suit against EmCare for violating CPOM and fee-splitting laws, and filed suit against the hospital for breach of contract.

Results
Three weeks later, Methodist Hospital terminated its relationship with EmCare and re-contracted with EPPA. EPPA continues to serve Methodist Hospital and several other local hospitals.

TeamHealth and the Memorial Hermann Hospital System (MHHS) - CPOM
In 2007, MHHS, a large hospital network in Houston, awarded 8 emergency department contracts to TeamHealth. Several emergency physicians contacted AAEM for assistance in this matter, including a private group with a 20-year history with MHHS, which was ousted in this move. AAEM and the private group – with AAEM's financial assistance – filed suit against TeamHealth and MHHS, citing violation of Texas CPOM laws. AAEM felt the case had substantial footing, as the Texas Medical Practice Act prohibits physicians from being employed by lay corporations for the practice of medicine. Additionally, previous Texas case law (Flynn Brothers, Inc. v. First Medical Associates, Dallas 1986) held that lay persons could not profit from an ED contract. AAEM's efforts were funded through donations to the AAEM Foundation.

Results
Unfortunately, a state district court held that it did not have jurisdiction to hear the case. Despite an amicus curiae brief filed in support of AAEM by the Texas Medical Association, a state appeals court affirmed the district court's decision. The court of appeals held that AAEM lacked standing to challenge the contract between MHHS and TeamHealth, as well as the contracts between TeamHealth and its emergency physicians. AAEM then appealed to the Texas Supreme Court, which refused to hear the appeal.

Tenet Health – Cross Subsidization, Fee Splitting, CPOM

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In 2014, Tenet Health, one of the largest hospital networks in the country, put the contracts out for bid at 11 of its hospitals in California, to replace their emergency medicine, anesthesiology, and hospitalist groups. Many of these groups had served their hospitals and their communities well for decades. Most of the hospitalist contracts and some of the anesthesiology contracts included a subsidy from Tenet, while most of the EM contracts generated enough revenue through collected professional fees to be entirely self-supporting and quite profitable. Tenet solicited several large CMGs seeking a no-subsidy arrangement for all contracts. Essentially, Tenet wanted the profits from the emergency medicine contracts to cover its losses on the hospitalist and anesthesiology contracts. Federal fee-splitting laws, enacted to prevent kickbacks and abuse, prohibit the distribution of part of a physician's professional fee to any entity, in excess of the fair market value of services provided to that physician. When part of a physician's professional fee is being distributed to a hospital or CMG, the parties involved may be in violation of those laws. If an emergency physician's professional fees were to go towards subsidizing other hospital-based specialists, or to pad the bottom line of a for-profit corporation, this would appear to be an extreme violation of federal fee-splitting laws. It is also important to recognize that California has some of the strongest corporate practice of medicine (CPOM) laws in the country. These laws, drafted to protect the public due to the potential for abuse when a corporation's fiduciary duty to its shareholders is in conflict with a physician's duty to his or her patients, prohibit non-physician, lay corporations from owning or controlling physician practices.

Results

The leaders of several groups affected contacted AAEM and asked for our assistance. AAEM and its California chapter provided advice to the affected groups, sent letters outlining AAEM's concerns to the relevant hospital leaders, hospital boards, and medical staffs; and engaged in discussions with Tenet Health leadership. Soon after, Tenet's leadership informed AAEM that they were no longer considering this course of action, and that the local groups would remain.

Trigger Point Injections

Less Pain, Less Opioids

Roneet Lev, MD
IEPC Executive Director

How do you treat acute back pain in the ED after ruling out red flags? A shot of dilaudid? That's so 2013. Toradol and a lidocaine patch? Eh, not bad. How about a trigger point injection? Inject and massage lidocaine and bupivacaine right into the area that hurts. Lidocaine is for me, the inpatient doctor who want to see results instantly, and bupivacaine for the patient for 6 hours of anesthesia. The same technique works for fibromyalgia pain. Try it – you may like – and your patients may love you for it.

Video - How to do a trigger point injection

Viewpoint In Emergency Medicine News

Casey Grover, MD
IEPC Member

Dr. Grover is a member of IEPC who is active in his community promoting solutions of substance use disorder. Read his full article in EM News here.

Giving Buprenorphine for Opioid Use Disorder No Different From Prescribing Albuterol for Asthma

About 3500 Americans died from asthma in 2019 and nearly 90,000 Americans died from a drug overdose between August 2019 and August 2020, yet many physicians are not willing to prescribe buprenorphine for MAT in the ED, which is the equivalent of an inhaled corticosteroid/long-acting beta agonist for asthma. I use the term "willing" very carefully. The training for the DATA 2000 waiver (X-waiver) is now gone,

so all any doctor or non-physician provider must do is send a form to the DEA to request the ability to prescribe buprenorphine. The barrier to doing this is so small that it truly comes down to being willing to do it.

Medication-assisted treatment for opioid use disorder saves lives and is one of the most effective treatments for one of the most fatal illnesses in America right now. One study showed that starting patients on medication-assisted treatment for opioid use disorder can reduce mortality from overdose by as much as 80 percent. (BMJ. 2017;357:j1550) Try to find any other intervention for any illness that is that effective at saving lives.

IEPC Speaker Series

By popular demand, IEPC Speaker series will continue in 2021 and into 2022. The speaker series is free and open to all friends of IEPC - Membership not required. Subscribe to the IEPC mailing list at www.IEPC.org to receive communication on upcoming events.

- Nov 22, 2021 - Andrew Selesnick, JD *(top left)*
- January 24, 2022 - Dr. Robert McNamara *(right)*
- February 28, 2022 - John Holstein *(bottom left)*