IEPC

Independent Emergency Physicians Consortium

IEPC Newsletter February 2023

In this issue:

Night Shifts

I used to love them

Written by Katren Tyler, MD Clinical Professor of Emergency Medicine, Medical Director of Physician Wellness, Age-Friendly Emergency Department Physician Lead, Geriatric EM Fellowship Director, Vice Chair for Geriatric Emergency Medicine and Wellness, UC Davis

Many of us started our EM careers as bright-eyed, twenty-somethings who had no problems with shift work, working multiple overnight shifts and rapid schedule transitions. And frankly, this is reasonably easy to keep up in our 30's as well, even as our external responsibilities get more complex. And then your 40's happens.

Ludicrously, I have done two residencies in Emergency Medicine – one in Australia and one in the USA. But in this regard, I am a bona fide expert - in my adult life, I have never not been a shift worker. As a resident in Australia, I spent more than 20 weeks in a year on a rotating night-float shift schedule and loved it. Night shifts: I used to love them. I was a night owl and proud of it. Until I didn't and wasn't.

I don't like night shifts anymore. I understand that we are a 24/7/365 business. But now, in my 50's, I am at my best early in the morning – the circadian opposite of being a nocturnist Night shifts are, without a doubt, my highest risk for a cognitive error at work, and I don't think I am alone.

Chronotypes are how sleep researchers describe your chronobiology. Your chronotype reflects your individual preference for going to sleep at night and getting up in the morning. As much as possible, you should estimate your chronotype when you are free of the external responsibilities of your life – work, kids, pets, all the business of modern life temporarily aside – ideally when you are on a vacation or at least on a non-work weekend. For the most part, researchers classify chronotypes as early, intermediate, and late. Sleep researchers recommend that we should try and make your work schedule match your chronotype. Obviously, this is a challenge in our specialty. For many people, our chronotype gets earlier as we get older and our tolerance for late and night shifts is reduced.

In healthcare, we place most of the responsibility for coping with shift work on the individual healthcare worker. System and department wide responses to the impacts of shift work as we age, or experience other physiologic challenges are limited. My call to arms for fatigue management systems is that our lack of protections for shift workers are also likely

NIGHT SHIFT con't from last page

harming our patients, and that surely makes it a systems issue.

We know that shift work is a burden for emergency physicians and their families in terms of circadian desynchronization and fatigue. The evidence is clear: shift work, especially night shifts, get harder as we get older; night shifts are associated with short-term cognitive impairment across all industries. Moreover, longer periods of duty, especially longer night shifts, are associated with short-term cognitive impairment and increased errors across all industries.

System suggestions

We have known for decades that sleep deprivation can be as serious as alcohol intoxication. It is unacceptable to be inebriated at work. Yet we idealize and reward being exhausted in medicine. We have socialized and normalized fatigue in medicine for decades, recent changes notwithstanding. Healthcare in general, and EM in particular, has not acknowledged the cognitive load and patient safety risks of shift work. There are very little systemic protections for physicians after training, and honestly, not that many protections during residency. We do not systemically evaluate if individuals tolerate shift work. Even if we acknowledge differences, we almost always put the responsibility on the individual. Multiple studies in healthcare and in other industries show people make more cognitive errors the longer that they have been awake. It will not surprise you to learn that other industries, especially the airline industry and some manufacturing industries have made stronger commitments to fatigue management than medicine has. Sleep is the only way to reverse sleepiness. Fatigue management systems promote a shared responsibility between the employee and the system. Sequelae of shift work include social jetlag / circadian desynchronization, cognitive impairment, and sleep disruption. Suggestions for protecting healthcare shift workers, and their patients, include evaluating the risks to ourselves and our patients, including pregnancy outcomes in health care workers, chronotype scheduling, access to sleep clinics, breaks on night shifts or extended shifts, access to food and water including cafeteria access, and the availability of call rooms or rideshare options. Driving home after a night shift is a significant risk for motor vehicle crashes. We have work to do on the systemic role of sleep and aging physicians; most literature acknowledges sleep deteriorates with age, especially in shift workers.

Departmental suggestions

As people age, our chronotype typically gets earlier, meaning we generally need to go to sleep earlier and wake up earlier. We typically experience this change starting in our mid 40's. If you are lucky, you have some late chronotypes on your faculty. Physiologically, late chronotypes can tolerate later shifts, including night shifts, with more sleep before and between night shifts. Late chronotypes may struggle with early morning shifts. Some individuals keep the same sleep-wake patterns they had when they were younger, are better able to tolerate shift work as they get older and are referred to as healthy shift workers.

Many departments have night shift crews and incentivize the night shift: the night shift crews should be incentivized as much as possible in time or money. In our department, for some years, we have been able to opt out of night shifts at 55, and recently lowered the age to opt out of night shifts to 50 years of age. This earlier opting out of night shifts at age 50 added 2-3 nights shifts per year to those faculty less than 40.

Pregnancy

Pregnancy is a common physiologic challenge faced by healthcare workers and the health systems that employ them. Pregnancy outcomes are worse in shift workers and those working longer than a standard 40-hour week. It is harder to protect the first trimester because schedules are often in place before people know they are pregnant, but protecting the third trimester and parental leave periods should be more straightforward than many EDs make it. Our department has adjusted our shift requirements for pregnant faculty so that there are no required night shifts in the third trimester, and no clinical shifts in the emergency department after 36 weeks' gestation. As a department, we do have the option of telemedicine if pregnant faculty need to keep working clinical hours. Our health system provides 90 days of pregnancy leave for all faculty.

Moving forward, we should think about how we collectively protect ourselves and each other from the impacts of shift work - for ourselves, for our colleagues and for our patients.

IEPC Member Perspective

Should I Take an Emergency Physician Job With Kaiser?

Written by Anonymous IEPC member/contributor

Within the protected Kaiser bubble, will I thrive or burnout?

The relationship between Kaiser and non-Kaiser emergency physicians have deteriorated with lack of responsiveness and heavy cuts in reimbursement. This article reflects that frustration.

Emergency medicine residency is hard. Residents and interns work many days and long hours. The work is often at county or community hospitals that treat a challenging patient population with a myriad of medical and social problems. Being on the frontlines facing a constant influx of patients with multiple complex issues can be daunting. At the end of residency, many young emergency physicians are ready for a break. The task of trying to start and build a career, at the end of residency, brings even more stressors.

It is during this time that many residents are offered career options. One option, chosen by many young physicians, is Kaiser Permanente. Kaiser Permanente is an HMO, consisting of the Kaiser Foundation Health Plan (the Kaiser insurance), Kaiser Foundation Hospitals, and the Permanente Medical Group (the Kaiser doctors). Patients buy the Kaiser insurance and they are only allowed to see Kaiser doctors. The Kaiser doctors (though technically their own medical group) are paid their salary solely by Kaiser Health Plan from the pool of insurance premiums, and so essentially act as its employees.

Kaiser has a large presence in California and is aggressive at advertising and recruiting graduating residents. Many graduates are uncertain about their future and are given no education on how to go about job-seeking in California. They have little knowledge about how there are small independent democratic groups, large corporate-owned non-democratic groups (and everything in-between), and Kaiser. Trying to maneuver through this landscape and learn the nuances is challenging. It is during this time that Kaiser makes confused emergency medicine graduates their tempting offer.

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After what has been a physically and mentally taxing residency, and after giving so much acting as the very fabric of a health care and societal safety net within the ED, many residents look to downshift. Kaiser Permanente offers ED graduates a comfortable job, with a large increase in salary compared to residency, nice benefits, and employment in a large corporation where doctors can fill their role without the stress of running their own business. For a work-weary graduating resident, the idea of being a cog in the wheel in a relatively cushy job, while making a decent living, and receiving benefits, may be too hard to pass up. But, is the Kaiser offer all that it seems? Is the apple as sweet as it looks, or is there something inside the fruit unseen that is spoiled?

Medical interns and residents exist in a system where they are clearly subservient to the Chief Resident, the residency director, and all the attending physicians. Just like in medical school, they are told where to be and when to be there. This structure provides organization and comfort to the chaotic work environment of an intern or resident. Kaiser offers a similar employer-employee model which appears familiar to young physicians. ED physicians within Kaiser receive a predictable salary and financial decisions are taken care of by others. Initially, this may reduce stress, but with time the lack of control and transparency of the revenues generated by one's work can become frustrating. The comfort of the employed status is lost as one's career matures, and the lack of autonomy associated with just being a "clock-puncher" can be disheartening.

To a financially-challenged graduating resident, a Kaiser Permanente salary looks enticing. However, Kaiser ED physicians make significantly less than their colleagues in the more common fee-for-service model. What is also not advertised is that to achieve their full salary, Kaiser physicians must work full-time which is approximately 160 hours/month. Kaiser typically recruits new hires to their less desirable sites. This is similar to the other big groups like Envision, Team Health, Vituity, and USAHCS. Most of the highest paying sites at the best locations are run by independent groups (many members of IEPC) and Kaiser would like to keep this fact away from graduates.

Kaiser is known for its benefit program. The package is designed to entice young physicians to say, "Yes" and once they become employed there exists large disincentives to leave. It is widely known in the ED physician community that Kaiser is famous for its "golden handcuffs" benefit package. If you are a recent graduate, and a young physician, and you work your entire career until you retire working full-time with Kaiser, these golden handcuffs can pay off in retirement. But for those who have lost the taste for the "Kaiser Kool-Aid" and who leave early the penalty is harsh, and the loss of many of the benefits makes the taste of those years of taking less salary at Kaiser even more bitter.

Kaiser ED physicians primarily care for Kaiser members who are employed and well-adjusted. Overall, Kaiser members are savvy health care consumers and over-utilization of ED services is rare. Subsequently, though Kaiser ED docs have to work a lot of hours to make full pay, their day-to-day jobs are relatively easy. Kaiser avoids placing hospitals in poorer demographic areas to minimize walk-in Medi-Cal patients. Therefore, Kaiser ED docs mostly care for responsible members with perceived acute care issues. Patient flow is predictable and ancillary services relatively abundant. Therefore, a Kaiser ED doc can take on a minimalist approach and function as a temporary stabilizing provider, and triage agent arranging for inpatient definitive care by others, or much more likely, follow-up visits through Kaiser's network. Because most patients are employed and responsible community members the challenging social influences on a patient's health, and their ultimate deposition from the ED, are minimized. The allure of an alternative comfortable job to a resident who has functioned for years giving heart, soul, and body on the frontlines as a safety net provider is attractive.

But as many Kaiser ED physicians have experienced there are downsides to the minimalist approach to medicine seeing a healthier population. Kaiser ED physicians find their skills deteriorate not caring for the sickest patients. As a self-contained HMO, Kaiser is financially incentivized to discourage health care utilization, so Kaiser doctors are graded and financially rewarded or penalized based on test utilization. Admission rates are watched closely. Many patents talk about how Kaiser is a great health plan when you are healthy, just don't get sick.

A leading cause of burnout is the loss of feeling like one's work

is making a difference to other individuals and to society. All emergency physicians have an altruistic trait, and we chose our specialty because we know our work truly does change and save lives. Without the emergency safety net people truly would suffer and be lost. When an ED doctor chooses to join Kaiser, they carve themselves out of that world. Kaiser docs have chosen to practice medicine in a bubble buffered from seeing the poorest and sickest patients. After residency it is easy to think that it is time to take care of oneself and focus on supporting one's family. But as one's practice matures the loss of purpose and loss of satisfaction received when helping those most in need can be dispiriting and lead to burnout.

Kaiser Permanente has shunned its social responsibility and has had to settle a number of lawsuits where it removed coverage and shifted undesirable and poorer members to Medi-Cal. On rare cases in my ED, I find a challenging patient with socioeconomic problems with Kaiser insurance and my fellow ED docs and I always "joke" how long it will be until Kaiser figures this out and cuts them off. Ultimately this always happens and they are shifted to the county clinic and Medi-Cal. It is widely known that Kaiser discourages EMS providers from bringing homeless patients to their EDs while encouraging them to bypass closer hospitals when Kaiser members access the EMS system. Kaiser members are also instructed to go to Kaiser EDs possibly driving past a closer ED during an acute medical emergency.

One of the most grievous offenses Kaiser commits is the way it handles transfers. All hospitals that participate in the Medicare program are required to follow EMTALA. Sadly, legislators and regulators have looked the other way allowing Kaiser to violate EMTALA on a daily basis. Kaiser has designed the EPRP system so that it only handles member repatriation transfers. Even though Kaiser hospitals have a robust on-call panel with multiple specialties they have shielded access to these physicians. On one occasion when I had a sick GI bleeder and no GI on-call I found the secret back-line to the nearby Kaiser ED where I knew they had GI available. After explaining the patient's situation, the Kaiser ED doctor said they had GI and a bed but he wasn't sure if he was allowed to accept a non-Kaiser patient. I was placed on hold and transferred to the house supervisor who hung up on me. When I called back the ED charge nurse hung up on me. The EPRP ED physician refused to discuss the patient's case. Eventually the patient had to be transferred 100 miles away, driving past that Kaiser hospital to get there. Throughout the state, Kaiser hospitals refuse to participate in EMTALA and restrict access to some of the sickest patients needing medical care. This behavior is unlawful and unethical.

Kaiser emergency physicians are required to take phone calls as part of EPRP (Emergency Prospective Review Program). California EMTALA law is clear that only a treating physician at the bedside can determine a patient's medical stability. In violation of that law, and because of built-in financial incentives, Kaiser EPRP doctors frequently argue over the phone with treating ED physicians about a Kaiser patient's stability while being treated at a non-Kaiser ED. These EPRP physicians (who have never seen nor laid hands on the patients) threaten to not pay for the medical care given to their members at the non-Kaiser hospitals. Even more unethical, Kaiser EPRP doctors threaten their own patients with large medical bills unless they agree to be transferred to a Kaiser hospital. These financial threats have forced emergency physicians to transfer patients against their will and despite the treating physicians' medical judgment. These EPRP physicians violate the Hippocratic Oath to "first do no harm" and should be held accountable by the Medical Board and ACEP. Recently a Kaiser EPRP ED physician refused to authorize admission on a patient I saw with chest pain, arguing they were "stable", threatening not to pay their medical bills and sending a fax saying they would stick the patient with the bill. Not longer after this infuriating phone call, the patient went into VFib and

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coded. We brought him back, but there was no guarantee that he would, especially if he was in the back of an ambulance or on a gurney mid-transport.

Despite what Kaiser has tried to engrain into residents and doctors, there is nothing in California law that states non-Kaiser physicians have to waste time reading off labs and discussing cases with EPRP physicians. We did this as a courtesy. We are required to inform them of our working diagnosis and disposition decision (e.g., stable requires transport, unstable require admission). Hospitals are required to make one phone call to Kaiser when the decision is made by the treating physician. According to the California Health & Safety Code Section 1262.8 Kaiser then has "30 minutes" to call back. If they do not then even stable patients can be admitted to the non-Kaiser hospital and Kaiser must pay for both stabilizing and post-stabilization care. If EPRP agrees to accept the patient in transfer they must arrange for a "prompt" transfer. If they do not and they fail to transfer the patient in a "reasonable" time then the patient can be admitted and Kaiser must pay.

The latest example of Kaiser's refusal to play its part in the health care safety net is its drastic payment cuts to emergency physicians. Kaiser is well-known for refusing to pay or underpaying safety net hospitals leading to ongoing litigation. But Kaiser previously compensated non-Kaiser emergency physicians fairly when they provided life or limb-threatening stabilizing emergency care to Kaiser patients. This ended in June of 2022. Kaiser has slashed reimbursement to non-Kaiser ED docs in half without providing any justification. Fair payments to less-advantaged emergency departments was the very least wealthy Kaiser Permanente should do, and siphoning off these dollars to increase its profits will tear another hole in the fabric of the emergency care safety net.

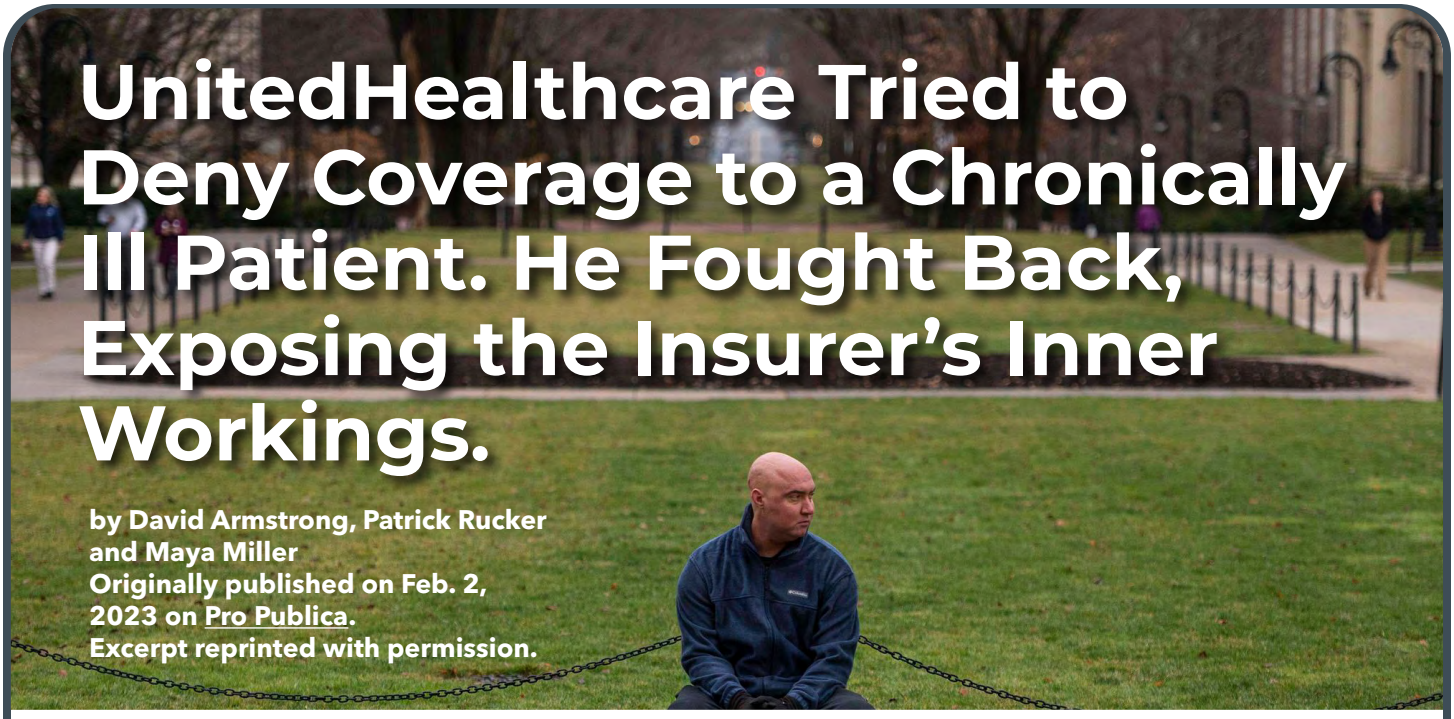
Kaiser Permanente is one of the largest health care entities in California and is growing. They have been touted as a model HMO/ACO in the era of the Affordable Care Act. But Kaiser's success is dependent on their model of caring only for the more fortunate members of society while shunning the poor. Graduating emergency residents in California are some of the best-trained in the country and have often endured a grueling residency. An employment offer from Kaiser Permanente, promising an easier job, carefree employee role, and a decent salary with benefits is very tempting. These young physicians should realize, however, that when they don the Kaiser golden handcuffs they sacrifice a higher salary, the autonomy of controlling one's business, and the career satisfaction that comes with providing the expert care to those who need it most and only we can give. By joining Kaiser, emergency physicians also partner with an organization that behaves unethically, underfunds the emergency safety net, underpays its colleagues, and pressures its doctors to violate the Hippocratic Oath. The Kaiser apple may look sweet, but in fact the fruit has spoiled.

No More Emergencies

Listen to the comic reality of emergency billing with No More Emergencies.

From the creator: Like all of my health insurance content, this is completely true. This is one of the more egregious examples from Anthem of blatant criminal activity, and it's been going on for years. Remember, they don't care about you. They just want to extract money from you any way they can. You can read more here.

UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings.



by David Armstrong, Patrick Rucker and Maya Miller
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Excerpt reprinted with permission.

Note from the Editor: What is wrong with this picture?

- *On one hand health plans are reporting record profits but on the other hand hospitals are closing.*
- *On one hand 7 health insurance CEOs raked in a record $283 million last year but on the other hand emergency physician reimbursement is headed for a record decline in 2023.*
- *On one hand medical billing can run $2 million a year yet on the other hand a level 5 emergency physician fee is around $500.*

Emergency doctors, not hospitals are targeted for non-payment by health plans. Is it time for us to revolt.

In May 2021, a nurse at UnitedHealthcare called a colleague to share some welcome news about a problem the two had been grappling with for weeks.

United provided the health insurance plan for students at Penn State University. It was a large and potentially lucrative account: lots of young, healthy students paying premiums in, not too many huge medical reimbursements going out.

But one student was costing United a lot of money. Christopher McNaughton suffered from a crippling case of ulcerative colitis – an ailment that caused him to develop severe arthritis, debilitating diarrhea, numbing fatigue and life-threatening blood clots. His medical bills were running nearly $2 million a year.

United had flagged McNaughton's case as a "high dollar account," and the company was reviewing whether it needed to keep paying for the expensive cocktail of drugs crafted by a Mayo Clinic specialist that had brought McNaughton's disease under control after he'd been through years of misery.

On the 2021 phone call, which was recorded by the company, nurse Victoria Kavanaugh told her colleague that a doctor contracted by United to review the case had concluded that McNaughton's treatment was "not medically necessary." Her colleague, Dave Opperman, reacted to the news with a long laugh.

"I knew that was coming," said Opperman, who heads up a United subsidiary that brokered the health insurance contract between United and Penn State. "I did too," Kavanaugh replied.

The pair agreed that any appeal of the United doctor's denial of the treatment would be a waste of the family's time and money. "We're still gonna say no," Opperman said.

More than 200 million Americans are covered by private health insurance. But data from state and federal regulators shows that insurers reject about 1 in 7 claims for treatment. Many people, faced with fighting insurance companies, simply give up: One study found that Americans file formal appeals on only 0.1% of claims denied by insurers under the Affordable Care Act.

Insurers have wide discretion in crafting what is covered by their policies, beyond some basic services mandated by federal and state law. They often deny

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claims for services that they deem not "medically necessary."

When United refused to pay for McNaughton's treatment for that reason, his family did something unusual. They fought back with a lawsuit, which uncovered a trove of materials, including internal emails and tape- recorded exchanges among company employees. Those records offer an extraordinary behind-the-scenes look at how one of America's leading health care insurers relentlessly fought to reduce spending on care, even as its profits rose to record levels.

As United reviewed McNaughton's treatment, he and his family were often in the dark about what was happening or their rights. Meanwhile, United employees misrepresented critical findings and ignored warnings from doctors about the risks of altering McNaughton's drug plan.

At one point, court records show, United inaccurately reported to Penn State and the family that McNaughton's doctor had agreed to lower the doses of his medication. Another time, a doctor paid by United concluded that denying payments for McNaughton's treatment could put his health

at risk, but the company buried his report and did not consider its findings. The insurer did, however, consider a report submitted by a company doctor who rubber-stamped the recommendation of a United nurse to reject paying for the treatment.

United declined to answer specific questions about the case, even after McNaughton signed a release provided by the insurer to allow it to discuss details of his interactions with the company. United noted that it ultimately paid for all of McNaughton's treatments. In a written response, United spokesperson Maria Gordon Shydlo wrote that the company's guiding concern was McNaughton's well-being.

"Mr. McNaughton's treatment involves medication dosages that far exceed FDA guidelines," the statement said. "In cases like this, we review treatment plans based on current clinical guidelines to help ensure patient safety."

But the records reviewed by ProPublica show that United had another, equally urgent goal in dealing with McNaughton. In emails, officials calculated what McNaughton was costing them to keep his crippling disease at bay and how much they would save if they forced him to undergo a cheaper treatment that had already failed him. As the family pressed the company to back down, first through Penn State and then through a lawsuit, the United officials handling the case bristled.

"This is just unbelievable," Kavanaugh said of McNaughton's family in one call to discuss his case. "They're just really pushing the envelope, and I'm surprised, like I don't even know what to say."

To read the full text of the article please visit ProPublica here.

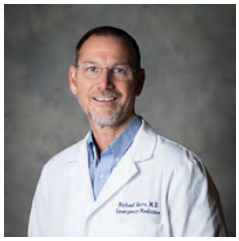
Congratulations to the Newly-Elected IEPC Board Officials

IEPC is excited to announce the new Board of Directors members for 2023-2024.

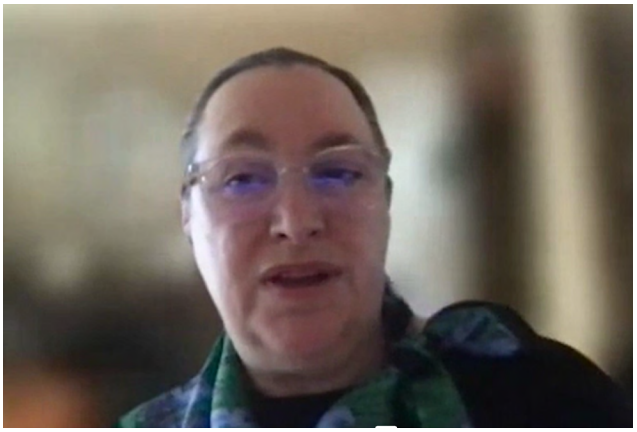
Newly-Elected IEPC Officials

- President: John Wallace
- Secretary: Mike Gertz
- Vice President: Sameer Mistry
- Vice President: Don Shook
- Vice President: John Ellison

Each official was sworn in at the January Board meeting, commencing their one-year terms. To all IEPC members - thank you for taking the time to cast your ballot. We appreciate your support in keeping the Consortium strong and moving forward in a positive direction.


November Session with Andy Selesnick



January Session with Katren Tyler

2023 IEPC SPEAKER SERIES

FREE TO ALL FRIENDS OF IEPC!

Presented by the Independent Emergency Physicians Consortium
Time & Date: 9:00AM - 9:30AM Pacific on the fourth Monday of the month.
Membership in IEPC is not required to attend. Advance registration for the meeting is required. After registering, you will receive a confirmation email containing information on how to join the call.

IEPC is proud to present the 2023 Speaker Series! This free speaker series has welcomed leaders in the field to cover timely and engaging topics that are important to independent emergency physicians. The sessions precede each monthly conference call and are open to all IEPC members and those who may be interested in joining. Upcoming sessions include:

- **February 27** - Mike Granovsky, MD, CPC, FACEP - 2023 Documentation Guidelines: Best Practices and Strategies for Success
- **March 27** - Sheree Lowe, MD - Emergency Medicine Practice Revenue Challenges Yesterday and Today with Proposed Solutions for Tomorrow
- **April 24** - Sandy Schneider, BSPharm, PharmD - ACEP - Boarding
- **May 22**- Elena Guzman, MD - California ACEP
- **June 26**- Bob McNamara, PharmD, MSPH, FAHA, FHFSA, FCCP - American Academy of Emergency Medicine
- **July 24**- Scott Adler, Cand. philol - Insight Strategies, LLC

This series is presented on the fourth Monday of the month January - November year. Advance registration is required and can be completed by registering through the monthly email invitation. After registering, you will receive a confirmation email containing information about joining the meeting. If you would like to join the IEPC mailing list, or want to invite a colleague, please click below.

Visit www.IEPC.org for more information and to register.

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