Welcome to the first issue of EM ADVOCATE. This is a newsletter intended to address issues facing EM Residents in Massachusetts. We are a publication associated with the Massachusetts College of Emergency Physicians, created by, and intended for EM Residents in MA. Our goal is to focus on a variety of issues, including legislation and policy relevant to emergency medicine, preparedness for the job market, new advances in clinical medicine, and up to date information on how to get involved in advocacy.

Do you want to write for the EM Advocate?

The EM Advocate is looking for intelligent, creative, and interesting articles to highlight resident thoughts and opinions throughout the Commonwealth of MA. Subject matter can include topics of social responsibility, interesting cases, scientific advances, emergency medicine subspecialty issues, grass roots activism, and opinions regarding public or hospital policies, etc. Please contact your residency’s MACEP representative or the Editor for opinions, ideas, and article submission. We look forward to hearing from you!

Sam Licciardo, MD
Editor in Chief, EM Advocate
Samuel.Licciardo@umassmemorial.org
Reimbursement for Emergency Ultrasound (EUS) is an important factor in the development of the specialty and the growth of community emergency departments. Over the last decade emergency ultrasound has become a vital technology in patient care and residency education. When an emergency physician performs an ultrasound, insurance companies usually reimburse for the given emergency ultrasound, allowing continuing development of ultrasound utilization at that given program.

Changes in reimbursement can deeply influence a program’s success. Blue Cross, one of the largest insurers in Massachusetts has “routinely denies payment to ED physicians who perform bedside ultrasounds, based on internal policies”, says Romolo Gaspari, M.D., director of the ultrasound division at UMass Memorial Medical Center.

In fact, Blue Cross has not paid for ultrasounds performed by ED physicians at UMass since 1998. During meetings 4 years ago with Blue Cross executives, they admitted that their position on ED physician performed ultrasound needed updating. Since that time they continue to deliberate on their internal process for handling ED performed ultrasounds. In an interesting development, more recently Blue Cross has determined that they consider performance of the FAST exam “incidental to the ED visit”. This means that the procedure is no longer separately billable from the rest of the ED

“There is a national trend to avoid paying for ultrasounds performed by ED physicians.”

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10 questions to ask a prospective employer

As new generations of Board Eligible Emergency Physicians flood the market, employers are chomping at the bit to obtain their services. While these potential employers will have some key questions for us, there are some questions current EM Residents want, or should want, to ask them.

When residents think about their future job, they want to work in a place where they are happy, treated fairly, and surrounded by a strong group of providers. They want to practice in a safe environment with systems in place to ensure that patients receive the highest quality of care. They want to have a competitive salary. The key to

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In review, Massachusetts has enacted healthcare legislation as of 2006 that was the basis for the federal legislation recently passed in Washington, D.C. This legislation hoped to subsidize health insurance programs, require all state residents to obtain health insurance or else pay a monetary penalty, require employers with 21 or more full time workers (as of July 1, 2013) to meet a minimum standard of health coverage or pay assessment, and established ‘insurance exchange’. The laws that direct our healthcare system are constantly changing. As these changes take place, legislators need input from Emergency Physicians. The following questions and article pertain to the MA legislative updates or “Chapter 224 of the Acts of 2012”

Are Accountable Care Organizations (ACO’s) going to be held accountable? ACO’s are important because they are at the center of a new wave of payment reform using ‘global payments’, i.e., “1 payment per each patient, every month, of all patients in our ACO.” With this in mind, a center for health information and analysis was established, which will publicly report financial information regarding fiscal conditions of acute care hospitals, and monitor development of ACO’s.

Are paper charts here to stay? NO! The Mass e-Health Institute was established in order to move all providers in MA toward electronic health records (EHR), and will require doc’s to be proficient in use of health information technology in order to be licensed in MA. Further, those EHR’s will be readily accessible, electronically, by patients via a new Health Information Exchange, which will bring transparency full circle.

Equal and proper care for psychiatry patients. If you have worked in a community hospital, you know that patients with a psychiatric diagnosis tend to wait hours, days, or worse to get their definitive treatment at a psychiatric hospital. Furthermore, despite acute psychosis and depression being taught to EM Residents as being true emergency medical conditions, it appears as though they have not been considered as such by everyone else.

This means that psychiatric emergencies, according to legislators, don’t carry the weight and requirement of timeliness that other medical or surgical diagnosis have carried. Thanks to the hard work of some of your emergency physician colleagues in MA, the definition of ‘Emergency Medical Condition’ has been expanded under consumer protection statues to include behavioral and substance abuse disorders.

In addition, regulations will be required to enforce ‘mental health parity’ laws from private insurers and Medicaid. Parity laws ensure equal treatment for all emergency medical conditions, whether surgical, medical, or psychiatric. This problem stems from seeing cases every day show lack of parity between behavioral and medical complaints. Could you imagine, if when you picked up your C-Med phone, you told them couldn’t bring that STEMI in yet

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because your on hold with the insurance company on the other line to pre-authorize their coronary intervention? To help put this all together, a Health Care Workforce and Advisory Council within the Department of Public Health will work to improve access to behavioral and substance abuse services. Work is not nearly over, but hopefully heading in the right direction.

Apologizing to patients for mistakes made. If I make a mistake… can I apologize to my patient?? YES! As a part of this year’s medical liability reform, provider apologies are inadmissible as evidence in judicial and administrative proceedings.

These are some of the changes to legislation in 2012 that are relevant to Emergency Physicians. They have been enacted because of the work that legislators, advocates, and ED docs just like you have done. Want to get involved and change Emergency Medicine for the better. Contact your residency MACEP representative!

This ‘Legislative Update’ was written using MACEP’s summary of the Chapter 224 of the Acts of 2012, the Legislative Update written by Ronna Wallace, Legislative Consul, and Gregory Volturo, MD, FACEP, Current MACEP President. MACEP Newsletter October, 2012

www.macep.org

EUS Reimbursement (continued)

visit. In other words, they do not reimburse ED physicians for performing a FAST exam.

Tuft’s Health Care as of 2012, similarly, determined that they would no longer reimburse non-radiologists for ultrasounds. According to Dr. Gaspari, “there seems to be a national trend to avoid reimbursing for ultrasounds performed by ED physicians.” The types of policies by Blue Cross and Tufts Health Care eventually lead to negative pressure on developing ED ultrasound programs, as there is less support for community ultrasound programs to fund quality improvement efforts as well as education.

Despite ultrasound being considered a core skill for emergency physicians, the lack of reimbursement for the work performed can seriously decrease the development of EUS in community ED’s. The loss of bedside ultrasound in community hospitals can contribute to substandard patient care and ED physician dissatisfaction. As emergency providers, we know bedside ultrasound is here to stay, and we need to continue to fight for its survival in the community setting. We welcome thoughts, opinions, and suggestions to solve this problem.

Please send submissions directly to the Editor.

Contributors to this article include Romolo Gaspari, MD, PhD, Director, Division of Emergency Ultrasound, UMass Memorial Medical Center.
feeling comfortable in your new job is knowing you’re cared for, covered in case the worse happens, and confident that your group wants a happy/healthy colleague.

The question becomes how will you be assured you will have comfort in your new job? Answer: by asking questions that give revealing answers about the group.

**Question 1:** How many hours of physician coverage do you have and what is the average daily patient volume? Will you be working with midlevel providers or residents? If so, what type of supervisory role will be expected?

**Question 2:** What process improvement (PI) projects are in place at your group? As of recently ABEM (your certifying board) has developed requirements for ongoing process improvement activities in order to maintain your board certification. Regular PI activities are the mark of a group that care about taking better care of patients and making you a better doctor. ABEM will also require that you demonstrate communication and professionalism, so whether you like it or not, patient satisfaction surveys are here to stay.

**Question 3:** How are lab tests and XR discrepancies followed up? If your shop has a process for following up on blood cultures and XR discrepancies, odds that you will named in a malpractice suit for missing a positive blood culture 2 days after your shift ends or that subtle fracture or lung nodule, will be much lower.

**Question 4:** What is the acuity mix? Its important to know the ED’s admission rate, (including %ICU/pediatric/OB), left without being seen, and transfer rate? Who else is in the hospital in the middle of the night to provide patient care, assist with deliveries, respond to codes on the floor – hospitalists, in-house pediatrician, anesthesia, obstetrician or L&D nurse?

**Question 5:** What is the payment structure like? Are there RVU/hour incentives? Does the group pay salary, salary + bonus, and is productivity tied to your salary and/or bonus?

**Question 6:** Are you expected to join committees or be involved in hospital in some way? Don’t forget that in order to esteem yourself with “FACEP” you will need to stay involved in hospital affairs, process improvement initiatives, resident/med student education, etc.

**Question 7:** Is there a requirement for physicians in the group to be Board Certified or Board Eligible (meaning you’ve completed EM residency)? How many of the current docs are not BC/BE? Your colleagues are the people you will be signing out to, taking sign out from, asking for help/advice from, and moving patients through the department with.

**Question 8:** Is malpractice covered? Is it claims made or occurrence and is the tail covered? Who covers the tail? Is there a cross indemnity clause or exclusivity clause? Does this shop cover disability, and if so, is it ‘own occupation’ disability coverage. What are the specific terms of coverage? Otherwise, if you are injured, you might find yourself back in residency, perhaps psychiatry.

**Question 9:** What is the average boarding time? Is there a dedicated multidisciplinary team that works to optimize patient flow?

**Question 10:** What type of record keeping is used? Do they use an electronic medical record, paper charts, and/or scribes?

This article was written with exceptional input from **Jeff Hopkins, MD, FACEP, Chair, Milford Regional Medical Center Emergency Department.**
Annually, MACEP provides three grant awards for up to $2,000 each to those recipients chosen after a review of all submitted applications by a panel of MACEP members. The purpose of these grant awards is to encourage emergency medicine residents to use their energy and creativity to advance the field of emergency medicine in our state and beyond. Residents can apply in areas that are not routinely funded to pursue projects in public policy, international emergency care or to initiate a research study.

Project descriptions should be concise on what is planned and why this research project would be important. All completed applications should be submitted by **November 15, 2013**. Applications will be blinded for the review with final decisions to be made by December 16, 2013. In addition, grant recipients should seek IRB approval and inform MACEP when that process has been completed. MACEP is committed to advancing emergency medicine and supporting the future leaders of our specialty.

Specific requirements for the Resident Grant Program include:

1. **Public Policy and Emergency Medicine.**

An application should address a current topic of importance to emergency medicine in Massachusetts. The award recipient will identify a topic that could include such areas as emergency department crowding, care of those with behavioral health issues, disaster preparedness, access to care and “liability.” A grant could provide support in order to work with an appropriate state government official appropriate for the selected topic. Appropriate mentorship from the MACEP Chair of the Legislative Committee and the MACEP Lobbyist is encouraged. The proposal will define a topic, planned work product (legislation, policy report appropriate for distribution to key policy makers, etc).

2. **International Emergency Medicine:**

Applicants should define a project that will advance the field of emergency medicine in a developing country or similar setting. The proposal should include explicit goals and objectives (example: educational program on pre-hospital care evaluation and treatment, resuscitation, injury prevention etc) as well as a letter of support from the proposed site of the project. If formal data are gathered, the grant will require approval from the host IRB and institutional IRB. The proposal must define a specific objective. Support for clinical rotations will not be considered.

3. **Emergency Medicine Research**

A resident can submit an application for an original research project. Such an application should follow standard grant applications (EMF, NIH) and include a detailed budget for the use of the award. Analyses of existing data as well as pilot studies to explore novel research hypotheses will be considered. Award is contingent on IRB approval from the institution. The proposal (2 pages max) should indicate the hypothesis, methods, planned analysis and required resources.

If you have any questions in regards to the application process please contact Tanya Pearson, MACEP Executive Director, tpearson@macep.org or 781-890-4407.

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### 2013 Resident Grant Recipients

**Emily Aaronson, MD**
Evaluation of the Implementation of Triage at an Academic Hospital in Post-Earthquake Haiti

**Brian Geyer, MD**
Shared Decision Making in the Workup of Pulmonary Embolism in the ED

**Brian Yun, MD**
Comparison of Advanced Airway Management Techniques by Tactical EMS Providers in a Simulated Tactical Setting
Advocate for your patients and colleagues

Topics in public health and policy require special attention and special skills in order to accomplish change for our patients and us. The Leadership and Advocacy Conference hosted by national ACEP plays an important role in our education to become leaders on the state and/or national level. Attendance promises “thought-provoking, inspiring and challenging sessions by nationally recognized speakers and key decision makers.”

The event includes education regarding specific legislation being discussed on Capitol Hill and subsequent discussion of specific bills with elected officials, lawmakers, and advisors all done in the seat of our government.

Walk the halls of the Capitol Building with mentor physicians and discover what making change really feels like.

“Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.”

-From the AMA’s Declaration of Professional Responsibility: Medicine’s Contract with Humanity

MACEP 2013 Calendar

January 29, 2013
MACEP Governmental Affairs Meeting
Marriott Courtyard Hotel
Marlboro, MA
3:30 - 4:30 PM
To be followed by:
MACEP Monthly Meeting
4:30 - 6:30 PM

February 26, 2013
MACEP Monthly Meeting
Marriott Courtyard Hotel
Marlboro, MA
4:30 - 6:30 PM

March 19, 2013
MACEP Monthly Meeting
Marriott Courtyard Hotel
Marlboro, MA
4:30 - 6:30 PM

April 23, 2013
MACEP Monthly Meeting
Marriott Courtyard Hotel
Marlboro, MA
4:30 - 6:30 PM

May 8, 2013
MACEP Annual Meeting
MMS Conference Center
Waltham, MA
9:00 AM - 3:00 PM

June 25, 2013
MACEP Monthly Meeting
Marriott Courtyard Hotel
Marlboro, MA
4:30 - 6:30 PM

November 9, 2013
Annual EM Ultrasound Course
MMS Conference Center
Waltham, MA
7:30 AM - 6:30 PM

November 22, 2013
Reimbursement & Coding Course
MMS Conference Center
Waltham, MA
7:30 AM - 3:30 PM

The EM Advocate is an Emergency Medicine Resident run newsletter, published in conjunction with the Massachusetts chapter of the American College of Emergency Physicians
Have you visited www.macep.org lately?

Visit MACEP’s website to find useful information:

**Home Page**
- current programs sponsored by MACEP/ACEP
- important events you should take notice

**What’s New?**
- the latest news affecting Emergency Medicine
- important news from ACEP
- section especially for Emergency Medicine Residents
- legislative happenings

**MACEP News**
- check here for the current & past issues of MACEP News

**Education for EM Physicians**
- the latest information on upcoming courses

Also, you will find information on who is representing you on the MACEP board of directors and various committees. Take a look at the various ways you can get more involved with MACEP.

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RETURN SERVICE REQUESTED