

# President's Message

## The Future of CALAAEM, PART II

### CalAAEM Statement of purpose

**It is my belief that CalAAEM exists to support individual physicians, clinically and legally and as an advocate for improvements in the clinical practice of emergency medicine for both patients and physicians.**

**The maturation of our professional organization is dependent on the members who dedicate themselves over time to finding ways to advance the organization's mission.**

### Advancing the mission

I am proposing that we address this mission with a newly defined focus on individual physicians and their needs combined with an effort to improve patient care through CalAAEM-branded educational activities and practice support. These activities would be designed to generate revenue for CalAAEM through nominal fees collected from a large number of physicians. The revenue generated would be used for advocacy, investment in other support activities and to put us on a more even footing with Cal/ACEP financially.

These efforts would be designed to generate income for CalAAEM on several fronts. The ultimate goal is to increase the impact of CalAAEM as a political force, a support organization for physicians, and a channel for the dissemination of a compendium of best practices based on principles of evidence-based medicine generated through a collaborative academic effort.

### Expansion of the Board

I am proposing an expansion of the Board to include at least one faculty representative and one resident representative from each residency program in the state. These members would be selected by the programs themselves and seated by appointment of the elected board. I would like to see major provider organizations represented on the board as well, including representatives from major contract groups and Kaiser. Non-affiliated physicians and any other interested members are of course welcome to participate. The larger board will be managed by an executive committee of the larger board to be elected by the membership. This strategy provides the organization with involved members at each program receiving Board communications, able to participate in Board activities, and as a liaison to the organization and the residency programs.

### Board operations

Going forward I favor greater use of the internet to manage Board business and the use of the full spectrum of twenty-first century communication tools. Getting people together and making the telephone meetings efficient has proved to be somewhat problematic. Specific proposals, initiatives, issues and themes

deserving of action by CalAAEM would be discussed via email and through internet-based groups over periods of time defined by the board. Feedback would be collated by the president and the Board into specific proposals that can be voted on by email as well. Perhaps a board retreat or a series of Board meetings in different parts of California this year will allow for more extensive face-to-face planning and discussion. Face-to-face meetings seem to create more enthusiasm and purpose, accelerating transformation and engendering more participation.

### Alliance with California academic medicine

#### The Future Leaders of EM

CalAAEM seeks a permanent alliance with academic medicine. We hope that CalAAEM will become synonymous with academic and performance excellence. The strategy involves using both the organization and *CalJEM*, our academic journal, to source the development of accessible, up-to-date tools to support clinical practice, distribute that information and create a vehicle to showcase the academic achievements of medical students interested in EM, EM residents and faculty research. We see stratification within the journal with sections devoted to each group's research activities. In fact, we have invited California EM residency programs to submit their senior project abstracts for publication in *CalJEM*, with six abstracts appearing in this issue. We have already assigned abstract development for the LLSA project to a cadre of faculty-directed USC medical students and are very close to publishing the 2005 abstracts. With completion of this phase we are hoping for accelerated completion of the remaining years by using medical students throughout California.

#### Management training for EM residents

With the maturation of Emergency Medicine, the end of the era of the grandfathered board-certified MD is on the event horizon. The torch of leadership for all aspects of EM is going to be passed to a younger generation of academic, residency-trained MDs.

With this transformation the business leaders of EM, most of whom fall into this maturing category, will pass along the management of EM to younger physicians. If past patterns recur the current entrepreneurs in control will be offering their organizations to larger CMGs for very large sums of money, money for the most part created by the good will and hard work of front line EPs. Unfortunately, without intervention most of this money will flow to very few entrepreneurs, and working physicians will be excluded from the equity cash out.

As the process continues, the trend to consolidate more contracts into fewer corporate hands will grow. The issue of corporate practice of medicine will grow with it. AAEM has begun to address this issue specifically now. CalAAEM wants to identify such transactions within the state and consider interventions to promote alternatives to the reconfiguration of large CMGs.

We believe in local and physician-owned single hospital groups or smaller regional based groups with local interests, local physician control and member physician control over group operations. The embrace of a profit-sharing model will reduce or eliminate the drain on revenue by shareholders and overpaid executives profiting illegally from the work of other physicians. These

corporate practices are most likely illegal, yet through political maneuvering, bribery disguised as political contributions and marginal business practices based on faulty rules, they have continued for the most part unabated. CalAAEM is dedicated to identifying these situations and intervening when possible.

### **Taking Advantage of Academic Resources**

The academic community is literally bursting with energy to advance EM and increase the impact of EM within the health care system. CalAAEM's efforts with *CalJEM* and the growth of the Academic Task Force, integral to the enhancement of *CalJEM*, are under way.

The number of people dedicated to elevating EM within academia and the community is staggering and awe-inspiring to me. So many good people, so devoted to training the next generation of EPs and at the same time working tirelessly to develop evidence-based clinical practices through research and self effort is something that is affecting the way that EM is perceived by both our colleagues and our patients.

The emerging recognition of the importance of developing business-savvy future leaders is something that we at CalAAEM have recognized as a necessity and something that we seek to promote by expanding the scope of *CalJEM* to include materials that study and address these important issues that affect our practices in many, many ways. CalAAEM supports the expansion of business awareness for the future leaders of EM and will be looking for material to publish in *CalJEM* on this subject.

I believe the more formal alignment of CalAAEM with academic medicine supports CalAAEM and *CalJEM* and provides increased opportunities for residents to participate in writing, research activities and the presentation of organized clinical information now and in the future. This association also will provide continuous exposure of new physicians to what CalAAEM is doing for emergency physicians, emergency medicine and patient care.

### **Legal defense fund**

I am proposing that some portion of our revenue be devoted to participation in the defense of California emergency physicians dealing with legal issues that impact emergency medicine. That role could be expansive or narrow and range from providing documents in support of people and issues to increased contact with national on legal issues raised in California but applicable across the country. In a more advanced state of revenue generation we could move toward retainer agreements with legal resources that could help members with problems that might play out legally. Issue definition and strategic planning in the early stages of a dispute often resolve problems sooner. As the opportunity arises to participate in litigation that could have a long term or permanent impact on the practice of emergency medicine and individual members, we would assume a supportive posture when possible. Our exact role in any situation would be determined on a case-by-case basis.

### **Physician rights**

In the area of physician rights there are five issues I would like to focus on with the intent that CalAAEM becomes identified with these issues in California. The framework for support of these issues is a legal and advocacy-based construct. We would support California physicians forced into litigation to defend their rights. The goal would not be local fixes but permanent changes in the way that business is done, either by taking cases to judicial judgment or by seeking commitments from the litigants as part of any settlement to change policies that will impact a wider group of physicians. There would be an intention within any effort to resolve these issues permanently and in the best interests of Emergency Medicine.

#### **1. Medical staff rights**

It is absurd that emergency physicians, who must qualify for medical staff privileges and participate in medical staff activities, have no rights with respect to medical staff due process. At times one angry medical staff physician has the clout to get any ED physician removed, and there seems to be no one to defend that MD, especially the CMG. When EM MDs are let go over conflicts with medical staff over patient care issues in which the EM physician is right, CalAAEM will, if asked, attempt to use its power to intervene in favor of an alternative resolution. Emergency physicians, as all other medical staff members, are entitled to due process resolution of medical staff conflicts and issues. CalAAEM should and will stand up for physicians denied these due process rights.

#### **2. Corporate practice of medicine and fee splitting**

The ACEP leadership expends the majority of its political capital on reimbursement issues and protecting the revenue streams flowing for the most part into corporate bank accounts. There, via trickle down, the working EM MD' get some portion of that income. The issue becomes contentious when the amount of money that remains in the corporate account is more than the cost of the services provided. Dressed up any way you want, corporate interests are sharing revenue with practicing physicians at rates that can be 25% or more of total revenue and far in excess of actual costs of practice management. The providing of practice management services is the rationale and the quasi-legal excuse, for this fee splitting. Fee splitting is already against the law in California, but a careful legal examination of the issue has been repressed when raised legally, primarily through settlement. Opportunities to define contract management from the perspective of the working physician, not the contract holder, should be sought.

#### **3. Continuity of practice rights**

All physicians are entitled to continuity of practice rights regardless of who is managing an ED contract at a given facility. When change in contract management groups occurs, physicians with standing at a facility should have certain rights to maintain the continuity of practice that should be negotiated as part of the change in management. The summary dismissal of groups of MDs by CMGs or hospital administrators cleaning house, is an issue

that impacts many of us and one that I feel we can take a position on. We can and should work with members to minimize the impact on EPs, medical staff physicians and patients when these changes take place.

#### **4. Advocacy for improvements in the healthcare work environment and reductions in the workload of the healthcare provider**

The ever increasing overload conditions that individual physicians are forced to suffer with must be opposed in the interests of patients and providers. I believe we can work (perhaps with Cal/ACEP) in creating regulatory guidelines that we as an organization develop, support and promote to improve the work environment for emergency medical providers. The emphasis is to enhance the practice of EM as experienced by individual physicians and long-suffering patients sitting in the waiting room. Recognition of the negative impact of cost cutting in health care on emergency medicine is the first step. Proposals to increase EM revenue and increase EM resources throughout California (like the 2005 effort with the 911 surcharge that failed due to opposition from phone companies) are necessary to promote the health of providers and optimize the health care system. Perhaps other initiatives identifying other sources of revenue can be looked for.

We should support a system in which EMS is elevated to the position of respect and financial support commensurate with the awesome responsibility we all so willingly assume. We should seek to transform EM from an overwhelmed legislated last resort to a fully funded, key component of an outpatient provider network growing ever more dependent on EM for patient care. The emphasis should be on EMS funding, not physician income.

#### **5. Mandatory ACEP membership... is it legal?**

It is clear that many physicians are forced to join Cal/ACEP and ACEP as a condition of employment. This may not be legal. While we should support physicians joining professional groups and the use of funds to promote the specialty and the interests of members, it is not clear that all members benefit equally from the monies collected by ACEP or that all physicians forced to join ACEP, do so voluntarily. We should favor choice with a continued commitment to advocacy to be shared between CalAAEM and Cal/ACEP and perhaps an equalization of dues with Cal/ACEP, something they suggested to us. The precise framework for pursuing this issue has been discussed but not resolved. Some advocate mandatory membership in one group or the other. Some have discussed creating a professional paradigm in which membership in both might be considered appropriate. The issue is really the lack of choice and control over the use that these funds collected from the unwilling.

#### **Practice support**

There are many academic projects that can help enhance the practice of EM in California.

CalAAEM is in a position to financially support the development and implementation of such products through grant programs to developers. CalAAEM through advisory boards can participate in the development and distribution of such projects. The efforts

of the developers of such content would be considered as these projects evolve and revenue is generated.

If an alignment between CalAAEM and California academic emergency medicine can be achieved, CalAAEM is in a position to be the source of educational materials developed by the California emergency medicine community. Our purpose is the edification of all physicians within California and elevating the practice of all physicians. The support and products would be available for nominal fees and used also as an inducement to further participation in CalAAEM.

These practice-support efforts could in effect help define and project a standard of care of EM practice in California that would have both clinical and legal implications.

I am proposing a number of academic projects to be completed through the combined efforts of the California emergency medicine residencies.

#### **Templates**

AAEM has templates that are excellent but somewhat inaccessible and definitively not nominal in cost. CalAAEM could consider a sublicense of this product (not likely) or the development of similar templates to be used instead of the single, general content template used in many places already. I would like to develop templates that we own, and brand, that can be used by our members in every day practice, again at nominal costs. CalAAEM can be an ever-present part of ED documentation and practice.

As most of us know these templates can be powerful tools to match a particular chief complaint with standard of care content. Through updates and revisions we not only could help define the standard of care at the point of care, but maintain control over the evolution of the standard. Through these content managed tools we can help with the implementation of new technologies and the decimation of new information derived from research and academic scrutiny.

#### **Electronic templates**

These tools marketed as the T-System EV, and other such products, are valuable tools in converting the content of the template charting to text with many other features and benefits. They are very expensive to the point of being prohibitive in most financially stressed environments. The challenge of low cost electronic templates married to content from the academic efforts was envisioned as a project I began to study three years ago. The efforts I have made have evolved to the point of being cost effective, useful and testable. An architecture designed for standard of care content has been developed and has been offered to CalAAEM for study and promotion as a cost effective alternative to expensive computer systems.

CalAAEM should support the use of such products in general and the increased use of technology in EM practice. This product and the other discussed herein are the building blocks of such a technological transformation. These efforts will be discussed going forward.

### **Computerized point of care practice guidelines**

A computerized quick guide to Emergency Medicine information for all EM physicians, residents and medical students is a very valuable product. The product would be designed so that the first three or four letters of a topic will take you to a single page of information, designed to be useful at the point of care. New medications, diagnostic strategies, procedure guidelines, etc. would be available for ED physicians across the full spectrum of practice. A product such as this would be both convenient and appreciated. Easy access to info for ED physicians created by ED physicians can increase the quality and consistency of patient care and reduce errors. With the cooperation of the California academic community, the maintenance of the project would be passed to each succeeding collective resident class as an ongoing resident activity.

To implement such a project under the auspices of CalAAEM, we would develop our own topics and content and use generic web page presentation schemes to create a product branded by CalAAEM representing the organization and the creators of the content.

I believe we have funds available to support the development of a content outline, writing and editing and the production of the different computer versions of the product. The product would be available to members for a nominal amount of money and to others at a higher cost. The intention is in part to define the practice standards and make those standards easily available throughout the Emergency Medicine community and increase the mind space of CalAAEM among emergency physicians and other primary care MDs.

The development of these materials will be properly resourced and continuously updated to provide leading edge, consensus and evidenced-based practice guidelines that will be available to all emergency physicians. A committee of editors will ensure the quality and consistency of the content.

This is a big project and one that will take time and further development of the relationship between CalAAEM and the residency programs. Yet when completed would represent a real accomplishment that can be updated yearly perhaps by a resident division of AAEM.

### **LLSA**

We are currently developing our own LLSA study program, again branded by CalAAEM, offering the study materials to members. That too will be completed by a coordinated effort of the residency programs, medical students and their directors. The costs of collecting materials, packaging and marketing them can be borne by CalAAEM until such time as the effort is self-sustaining.

### **Web-Based CME**

There are several programs that have already been developed and presented that I believe can be converted to web-based CME. End of life, pain management and trauma programs can be used to provide educational opportunities for all physicians at not-for-profit rates.

With moderate acceptance of such programs, CalAAEM can generate ongoing revenue and allow the organization to remain focused on the evolving educational needs of the members and provide the resources to maintain the content of such materials.

Through hard work, research, writing, coordination and dissemination of the evolving standard of care information, CalAAEM would become synonymous with practice excellence and meeting the clinical, educational and CME needs of its members. These efforts will be a direct reflection of the excellence of the membership and the California academic community. CalAAEM can be the collective thought leader for the practice of emergency medicine.

### **Advocacy**

Advocacy has been part of the plan for CalAAEM. The use of existing email and faxed-based advocacy products was explored in 2005 and found to be prohibitively expensive. Low-cost alternative for such advocacy are being sought by CalAAEM.

### **Support for practice protocols through partnership with legislators**

Another program I am hoping we can explore is to enlist the support of legislators in the development and use of practice protocols COUPLED WITH an indemnification from litigation of providers who follow those protocols. While protocols are presented in the literature with good intentions, without formal regulatory support through indemnification they are impractical and rarely used. Literally millions of dollars can be saved if the risk of a lawsuit were removed when various common and tested practice protocols are applied and documented.

CalAAEM can start a project to both develop specific practice protocols and seek to establish a pipeline to the legislature to have the protocols codified and indemnification guaranteed to the diligent followers of the protocols. For the small percentage of cases that are missed by protocols other remedies can be offered including a no-fault settlement strategy. The overall benefit would be tremendous and the legislature I believe would be receptive to such a paradigm that could be used over and over, and with increasing benefit through decreased costs with each successive application of the model.

### **Conclusion**

It is my belief that the possibilities for growth are substantial. The opportunities to contribute to EM healthcare are significant. The process of redefining CalAAEM as a resource for the needs of its membership both practically and educationally can be part of the new direction we embark upon. As we go forward, we can differentiate ourselves in ways that are both needed and appreciated by our peers. Each of us can contribute to this program by using this material as a stepping stone to other ideas and finding a niche in this spectrum of ideas where you feel you can contribute. I welcome your participation and collegiality.

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