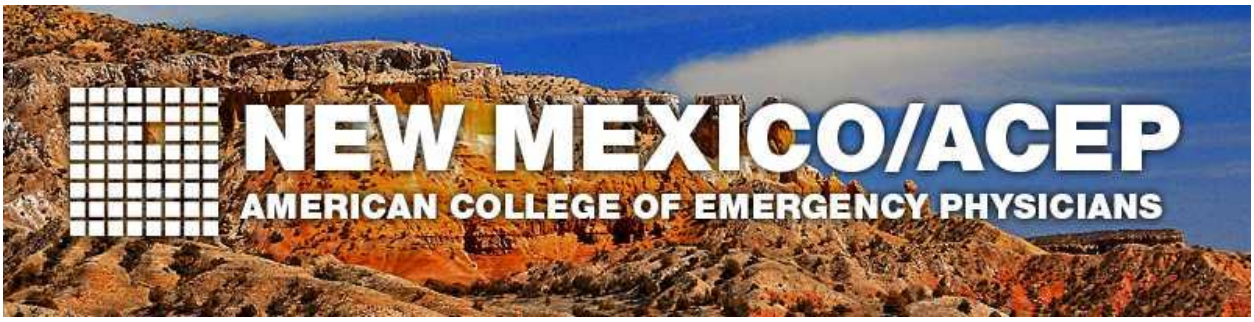
A Newsletter for the Members of the New Mexico Chapter - Fall 2020



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In this edition:

Resident's Corner
Practice Environments: RVU-Based Struture vs. Salaried Structure

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At this time last year, I was an intern undergoing my first competency review. The review included a dizzying spreadsheet including categories like procedure totals, conferences

attended, and number of course evaluations completed. Of the many metrics and checkboxes, there were two rows I was unfamiliar with: “Patients Seen” and “wRVUs,” which my program director told me will likely never leave me. The curve showed I was slightly below the average and my program director suggested ways to improve those numbers. After that meeting I developed better workflows, better charting techniques, and reached dispositions faster. The effect those metrics had on me was largely beneficial and in the spring I was happier with my place on the Gaussian curve.

However, as I approached my second competency review, I became aware of how these two metrics subconsciously and probably disproportionately colored my perception of how a shift went. I became curious where the metrics came from, whether they really are universal, and how much will they impact my practice environment after residency. To answer this question, I first had to figure out what an RVU is.

The RVU

For any resident who, like me, is unfamiliar with the RVU, or Relative Value Unit, it is a dollar value that is assigned to the more than eight thousand codes in the Current Procedure Terminology book. The value is determined by three components: i) the requisite time, effort, and expertise ii) the practice expense, and iii) the cost of the professional liability insurance. The dollar-value can be scaled by conversion factors to account for predictable, fixed factors like night shifts during which volumes are demonstrably lower or when the patient population consistently requires more complicated workups and dispositions. The impetus for the RVU’s adoption was an attempt to tie provider compensation to productivity. Prior to the RVU, a medical director’s appraisal of an EP’s productivity may have included subjective perceptions of the provider and nonspecific data like the number of patients the department saw during a shift. The performance of the second provider in the department was a common confounder. Assigning RVUs to a provider’s documentation was a way to reward providers who emptied the waiting room and at the same time tightened the screw on those who may have been found watching SportsCenter in front of a full rack. It also placed the burden of measuring productivity on the provider, as the providers themselves documented the billable codes. The RVU has now come to dominate the incentive structure of most emergency departments. But, the RVU has its own shortcomings. Adapting to the new rules, less productive providers performed gratuitous, RVU-rich workups without actually seeing more patients. Savvy EPs “poached” procedure-intensive patients that were guaranteed to generate high RVU’s while “Elderly woman with dizziness” was left sitting in the rack. One solution was to combine the RVU with a second metric, “number of patients seen per shift.” Under this model a physician could expect a guaranteed base pay provided they saw a predetermined minimum number of patients, while working for bonuses that were allocated proportionately to the RVUs they generated.

What interests me about these systems, having only been a resident, is how each reimbursement structure and its respective nuances impact a practice environment. Specifically, in an RVU-based system, in which multiple providers see the same patient, how are RVU’s most equitably distributed? Do systems that assign full RVU credit to the dispositioning doctor, and therefore discourage seeing patients later in a shift, have longer wait times, but possibly better outcomes? Do systems that assign full credit to the initiating provider clear the waiting room, but increase sign-outs? In essence, how do reimbursement structures address healthcare’s quadruple aim of providing quality, improving population health, reducing cost, and improving physicians’ work-life balance. To spoil the ending, I was not able to answer any of these questions or even find studies that addressed the topic. To paraphrase a UNM faculty member, a study of this nature would be very difficult given the number of confounders, the inability to define a control

versus experiment arm, and the fact that most EM groups have only one compensation model. So to at least generate hypotheses I reached out to New Mexico providers to elicit their experiences working within different practice environments.

RVU-Based Structures

Most respondents were skeptical of RVU-only based models, often on the grounds that the incentives redirect the aim of medicine from the patient to the procedure. A Medical Director of a Pediatric ED who now works in a hybrid system wrote,

"[The RVU-only system] makes providers order more tests. For example, is it better to observe a pediatric head trauma patient for three hours or just order the CT so you get RVUs and turn the room over faster? I know most providers try and do the right thing but it could incentivize the opposite."

A rural adult ED provider who had previously worked in a more incentive-based setting echoed this sentiment,

"Even if you don't mean it, you provide different patient care. It's not necessarily bad patient care but it is driven by financial incentives."

Other respondents had witnessed and were discouraged by "poaching behavior." One recalled a colleague who would disappear to the bathroom every time he was next up for a "colicky baby" chief complaint. Another worked with an EP who monitored the EMS radio for high-RVU patients then swiped the chart before it even entered the rack. However, the doctor I spoke with who is still working in an RVU-based adult ED was largely positive,

"[The RVU-only] compensation structure has many benefits. For starters when the work is all incentivized it increases the efficiency of the department. You would be hard pressed to find a more streamlined ED…We see on average two to three patients per hour, even during COVID with the drastically decreased volumes… knowing you will be compensated for what you do definitely helps."

The physician group in which he works includes some modifications to a pure-RVU system including increased compensation for night shifts and adjustments to encourage compassionate bedside manner,

"Overall physician satisfaction scores are tied to our income. It is actually withheld from our RVU rate and paid to us on a quarterly basis based on a percentage of these scores. This balances out the need for speed only, you still have to be nice and provide great care."

"Poaching," he said, is addressed by self-policing at the group level and typically does not become an issue unless volumes are high. In that situation any encounter becomes fair game if the patient has been unseen in a room for over fifteen minutes. Of note, this practice had at one point switched to a salary based pay, and the result was undesirable,

"It was definitely evident that we are all human and when the incentive went away the desire to see the high volume went away. This resulted in a less efficient ED and throughput was prolonged."

Afterward, the practice returned to a fully RVU-based structure.

Salaried Structures
The respondents who worked in salaried structures were universally positive and in many cases had arrived in their position after having a less positive experience in an incentivized structure. They endorsed much lower rates of burnout and turnover among their colleagues, and emphasized a sense of connection to their patients.

"…it is mission driven work and meaningful…I feel I have less pressure to make decisions based on bottom line. For me, this is purposeful," wrote an Adult ED provider in rural New Mexico

Yet, if RVU-based structures encouraged "poaching" behavior, salaried structures seemed to allow unmotivated providers to take advantage of guaranteed pay. Several respondents recalled EPs who saw fractions of what their colleagues saw and for a long time suffered no consequences. In this instance, the solution was to gradually build an ED team with a shared vision. The director I spoke with achieved a healthier, more productive department via careful selection of mission-driven providers rather than shifting to an incentivized structure.

How to Split RVUs
Regarding the question of RVU allocation when providers split an encounter, most respondents expressed that this was a significant issue, but from the responses there was no one model that completely resolves the issue of sign-outs. A PEM provider who had worked in an RVU-only setting was part of a group that switched from 100% credit to the initiating provider to a "40/60 method" where 40% was allocated to the doctor who started the chart and 60% to the doctor who provided the ultimate disposition. The greater proportion of the RVU was given to the dispositioning doctor as they assumed greater liability. The problem prior to the switch was that when providers were compensated for initiating charts, many picked up a disproportionate amount of patients in the last hour of their shift. Those incomplete encounters were then signed out to the oncoming shift. Other respondents echoed this sentiment. However at least one provider who had worked under a similar "40/60" model had the opposite experience.

"We had huge volumes of patients sit in Obs because there was a less incentive for the provider who initiated the encounter to provide a disposition."

The most common structure I found, admittedly based on a small sample size, was one in which the dispositioning provider receives the credit. While some EPs described negative prior experiences under such a system, those currently working in that environment were largely positive. An adult ED provider in Albuquerque wrote,

"Our 'patients seen' is actually counted by patient dispositions you make during your shift. I like this because it encourages everyone to try and dispo the patients they pick up, and discourages signing out a lot of active patients. I think this helps a lot with the culture and collegiality."

However, the doctor in the high-efficiency RVU-based environment had an equally positive experience under the opposite system, suggesting other factors like the efficiency of the department and the culture of the practice are as important as the compensation structure,

"The physician that did the majority of the work up and evaluation will keep the RVUs. If we need to intervene and make some emergent decision or change the dispo there is the capability to take over care and receive the RVUs. With this model physicians are more

than willing to perform procedures that other places might defer to the specialist such as ortho reductions, central lines, regional blocks, complex lacerations, paracenteses and thoracenteses. They all are assigned RVUs."

No Size Fits All

The two remaining common themes were that the individuals who comprise the group matter and most respondents were satisfied in their current practice environment. The physician who saw high-volumes in a fully RVU-based structure described functional self-policing and collegiality within the physician group. There was a willingness to transfer RVUs when a dispositioning doctor ended up performing more work and a cooperative understanding about how the department needs to function. A physician in a smaller, rural hospital noted the shared sense of purpose in providing quality care to their community.

"It's crucial to work as a team if you have a sick patient that demands a lot of critical care. Fortunately, I work in an environment where coworkers have your back…sometimes there is slack to pick up but because of our size, sometimes there aren't enough rooms for me to see more patients. Sitting around frustrates me more than having to see more patients. That's why we're doctors - we like taking care of patients and in my ED environment, I don't mind the work."

After having this discussion with all the respondents my own conclusion is that one size does not fit all and some sizes do not fit anybody. A certain compensation structure and practice environment may suit some physicians better than others and that compensation structure needs to function within its own setting. From the responses, it seems a shared sense of mission, whether that is efficiency, service, or something else, seems to be a critically important factor. The objective outcomes of these systems haven't yet been measured so correlations to productivity, left-without-being-seen, bounce-backs, and physician burnout cannot yet be made. However, what stands out to me is that each respondent seemed to be working within the environments that suited him or her best.

Thank you to all the physicians who contributed to this article and I hope this provides some insight to my fellow New Mexico residents in seeking their own ideal practice environments.

Welcome New Members!

Tanya Belle, MD
Mitchell Byrd
Richard R. Capone, II
Tushank Chadha
Zachary Coffman
Darbi Cox, MD
Dominic DiDomenico, DO
Bryan Thomas Jarrett, MD

Sandra LeNguyen, ATC
Nathaniel Link, MD
Miryam E Miller, MD

Valeria Nunez Martinez
Michelle Reyes
Emma A. Robertson
Jimmy To

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ACEP COVID-19 ALERT

Stay current with the COVID-19 Center. It's your one-stop-shop for clinical and legislative updates. **Quick Links:** Physician Wellness Hub | COVID-19 Field Guide | COVID-19 Severity Classification Tool

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HHS: 'Imminent' EUA for COVID-19 Antibody

In a special call on Friday, Nov. 6, the HHS announced that they anticipate an 'imminent' Emergency Use Authorization (EUA) for the Lilly COVID-19 antibody. Learn more.

HHS Issues Regulations and Guidance on COVID-19 Therapeutics and Vaccines

The Department of Health and Human Services (HHS) has already issued some useful regulations and guidance around vaccines and therapeutics. With respect to vaccines, the Centers for Medicare & Medicaid Services (CMS) within HHS announced a series of actions at the end of October to ensure that many Americans have access to the COVID-19 vaccine at no cost when it becomes available. CMS released a regulation that allows for Medicare coverage of any vaccine that the FDA authorizes without beneficiary cost sharing. The reg also implements CARES Act requirements providing private health plan coverage of a COVID-19 vaccine without cost sharing from in- and out-of-network providers during the public health emergency. Read More.

Advocacy Alert: Halt Impending Medicare Cuts for EM Physicians

Urge Congress to co-sponsor H.R. 8702 to halt impending Medicare cuts for emergency physicians. EM physicians will face a 6% cut to Medicare reimbursements in 2021 unless Congress acts. H.R. 8702 would hold physicians harmless from any reductions that would be less than what they were reimbursed in 2020, while keeping in place the scheduled pay increases for primary care. For physicians who do receive a cut, this bill authorizes a temporary additional payment for 2021 and 2022 equal to the amount lost. Contact your representatives today.

Recapped Capital (30) Minutes - November 18

In case you missed it, you can watch the last edition of Capital (30) Minutes, recorded on Wednesday 11/18, during which ACEP's Associate Executive Director for Public Affairs, Laura Wooster, covers 2020 election results & NEMPAC activity; legislative updates; regulatory updates; and ACEP's COVID-19 advocacy efforts.

CMS Finalizes Health Plan Price Transparency Regulation

On October 29, the Trump Administration finalized another major regulation that doubles down on its ongoing effort to promote price transparency in health care. As you may recall, the administration had already finalized requirements targeting hospitals. The new reg released last week is focused on health plans. It requires most health plans—including self-insured plans—to disclose pricing and cost-sharing information such as information on negotiated provider rates. Read more.

Sickle Cell & COVID-19 Webinar Coming Up Nov. 20

ACEP, the American Society of Hematology & ED Sickle Cell Care Coalition are hosting "Sickle Cell Disease & COVID-19 Management in the ED" on Nov. 20 at 11 a.m. ET. This webinar will provide education on how to evaluate SCD patients in the ED presenting with symptoms concerning for COVID-19 and/or complications of SCD, with SCD-specific considerations for evaluation and treatment.

EMF Has Two New Grants Available - **Apply Here**

- EMF/LifeFlow Resuscitation Research Grant letters of intent are due Nov. 20.
- EMF/NIDA Mentor-Facilitated Training Award in Substance Use Disorders Science Dissemination Solicitation proposals are due Nov. 30, 2020.

ACEP20 Access Continues, New Option Available for Non-Attendees

If you participated in ACEP20, remember that you continue to have access to the education, Research Forum, exhibit showcase and more. This content will remain on the ACEP20 platform for 90 days post-conference before moving to the ACEP Online Learning Collaborative for the remainder of your three-year access period. This is how you claim CME.

Those who were unable to attend can still can still get the education you missed from ACEP20 Unconventional and earn up to 276 CME hours for three years with the Virtual ACEP20 component. One new element of Virtual ACEP20 compared to previous years is that it includes highlights from Research Forum, including State of the Art and Plenary presentations.

New Podcast Focuses on Hepatitis A Outbreak in the U.S.

A recent episode of ACEP Frontline features host Dr. Ryan Stanton talking with Dr. Frank Lovecchio about what EM physicians need to know to protect themselves and their patients. Listen in.

While you're at it, catch up on all the latest podcasts:

- ACEP Frontline: COVID-19 & Stroke Overview with Dr. Aisha Terry
- *JACEP Open*: Is Three Minutes Enough?
- ACEP Frontline: Returning to Racing: Professional Sports & COVID-19
- *ACEP Nowcast*: Physician suicide, COVID-19 career impact and more
- *Annals of EM:* September 2020 Issue Recap

ACEP Leadership and Excellence Awards

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. Nominations will open in December and be accepted until March 1, 2021. Some of the newest awards include the Community Emergency Medicine Excellence Awward, the Innovative Change in Practice Management Award, the Pamela P. Bensen Trailblazer Award and the Policy Pioneer Award. Check out all Leadership and Excellence Awards.

JACEP Open is the official Open Access journal of the American College of Emergency Physicians (ACEP). Complementing ACEP's flagship journal, *Annals of Emergency Medicine*, *JACEP Open* welcomes high quality reports representing the full spectrum of emergency care.

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JACEP Open is always looking for qualified reviewers. Please send your CV to Stephanie Wauson, Managing Editor, swauson@acep.org.

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EMRA Opportunities for Residents and Medical Students

EMRA Committee Leadership applications are due December 1 for Chair Elect and Vice Chair positions for EMRA's 19 Committees.

EMRA Medical Student Council applications are due December 1 to lead our medical student efforts.

Applications are due for the Class of 2022 for the EMRA/ACEP Leadership Academy on December 31. The EMRA and ACEP Leadership Academy is a leadership/professional development program and virtual community for emerging leaders in emergency medicine.

EMRA Winter Awards Deadline: January 10. Awards and scholarships include a travel scholarship for ACEP21, Resident of the Year, Fellow of the Year, Medical Student of the Year, Chair of the Year, Residency Director of the Year, APD of the Year, Residency Coordinator of the Year and more.

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