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EMpulse

Official Publication of the Indiana Chapter of American College of Emergency Physicians

The 49th Annual INACEP Emergency Medicine Conference is

April 15, 2021

This will be a virtual event!

Registration is now open at inacep.org

Inside this Issue

A View from the Top

Lauren Stanley, MD, FACEP (INACEP Board President)

"2020, don't let the door hit you on your way out!"

This seems to be the overarching sentiment as we close out 2020 and move into a new year. 2020 hit hard from all angles, especially for emergency physicians working day in, day out during a pandemic, with all the associated physical and mental health downstream effects.

In the midst of all of this, there were some victories for our specialty in 2020, and ACEP has been at the leading edge of many of these. ACEP worked tirelessly to make the year-end Congres-sional legislative package (that funds the federal government and provides additional COVID-19 stimulus) EM-friendly. A key victory was that ACEP was able to eliminate 2/3's or more of the antici-pated cuts in Medicare reimbursements, such that EP's will receive a cut of 2% (at worst), and some may actually see increased reimbursement. You can read more about this later in this edition of *EMpulse*.

The 5,600-page piece of legislation also addresses "Surprise Medical Billing." It calls for an independent dispute resolution (IDR) process to help physicians more fairly resolve out-of-network disputes; includes a reasonable payment standard; and limits deductibles for out-of-network emer-gency care (to not exceed in-network). These EM-favorable stipulations establish a helpful precedent for us at the Indiana state level, as there are ongoing discussions about SMB legislation during the current state legislative session.

With some discreet victories in our pocket, it is time to look forward to how we as a specialty can tackle issues affecting our jobs and our patients. The job market in Emergency Medicine has be-come quite saturated, making it particularly difficult for new EM residency graduates to find their ideal job. This problem is multifactorial, including (but not limited to) the surge in residency programs in re-cent years. In the coming month, ACEP will be releasing a report from its EM Workforce Task Force, a multi-organizational task force that has been collecting and synthesizing data over several years in order to help us best understand and shape the EM workforce landscape going forward.

For those who have caught a bad case of cabin fever in the last year, get your luggage and vaccination record ready because there will be options for in-person conferences once again in 2021. For example, the Leadership and Advocacy Conference will have options for in-person and virtual attendance on July 25-27 in Washington, DC.

At the state level, as legislators kick off the 2021 legislative session, we at INACEP are work-ing to make sure that bills affecting Emergency Medicine are crafted in a way that supports us and our patients. We continue to work with the other physician societies in the Indiana Physician Coalition to fight back on scope-of-practice bills. Look for more action on this in 2021 as more and more non-physician providers vie for increased autonomy. Your training and board certification in Emergency Medicine are an irreplaceable asset to patients, and we will continue to advocate for physician lead-ership of the ED care team.

To my EM community across Indiana: I look forward to serving you in 2021, as we leave a profoundly challenging year behind us and keep our eyes set on the possibility of a healthier and happier year for our patients and for us.

Coping with Covid

by Heather Clark MD, FACEP (INACEP Board Member)

Did you know there are well described stages of disaster response, much like the stages of grief we learned in medical school? The graph above certainly reflects my experience and I suspect our collective experience as EM physicians working in this current COVID pandemic. As we approach the 1 year anniversary of COVID arriving at our doorstep, the disillusionment is strong. If you are like me, this valley seems even deeper and wider simply because COVID is an ongoing, daily disaster rather than a one-time event. Adding to the known systemic issues in our healthcare system that have already led to rampant pre-pandemic professional burnout, these anxieties and new realities are affecting many of us substantially. Job dissatisfaction, depression, suicide, family stress, and much more are "COVID adjacent" morbidities.

So what do we do? What can we do? If we wait on our circumstances to change, we are setting ourselves up for more disappointment and disillusionment. If we wait for our patients, family, and friends to finally "get it"; or for the hospital administration or the government to come rescue us, we will become more and more cynical and disabused. If our mindset, outlook, and emotional well-being depend on our external world to change, we give away all our power.

Here is something that might surprise you. Every emotion we experience is because of a thought in our brain. Inversely, the thoughts we have in our brains, both conscious and subconscious, create our emotions. Our brains are both sneaky and powerful.

Our brains love to be busy and they love to be right. If we feed our brains thoughts that life is awful and people are stupid, they will find all the available evidence to reinforce those beliefs. If we tell our brains that life is beautiful and people are resilient, they will find us evidence to support those beliefs. If we don't consciously, and purposefully, choose our thoughts, our brains

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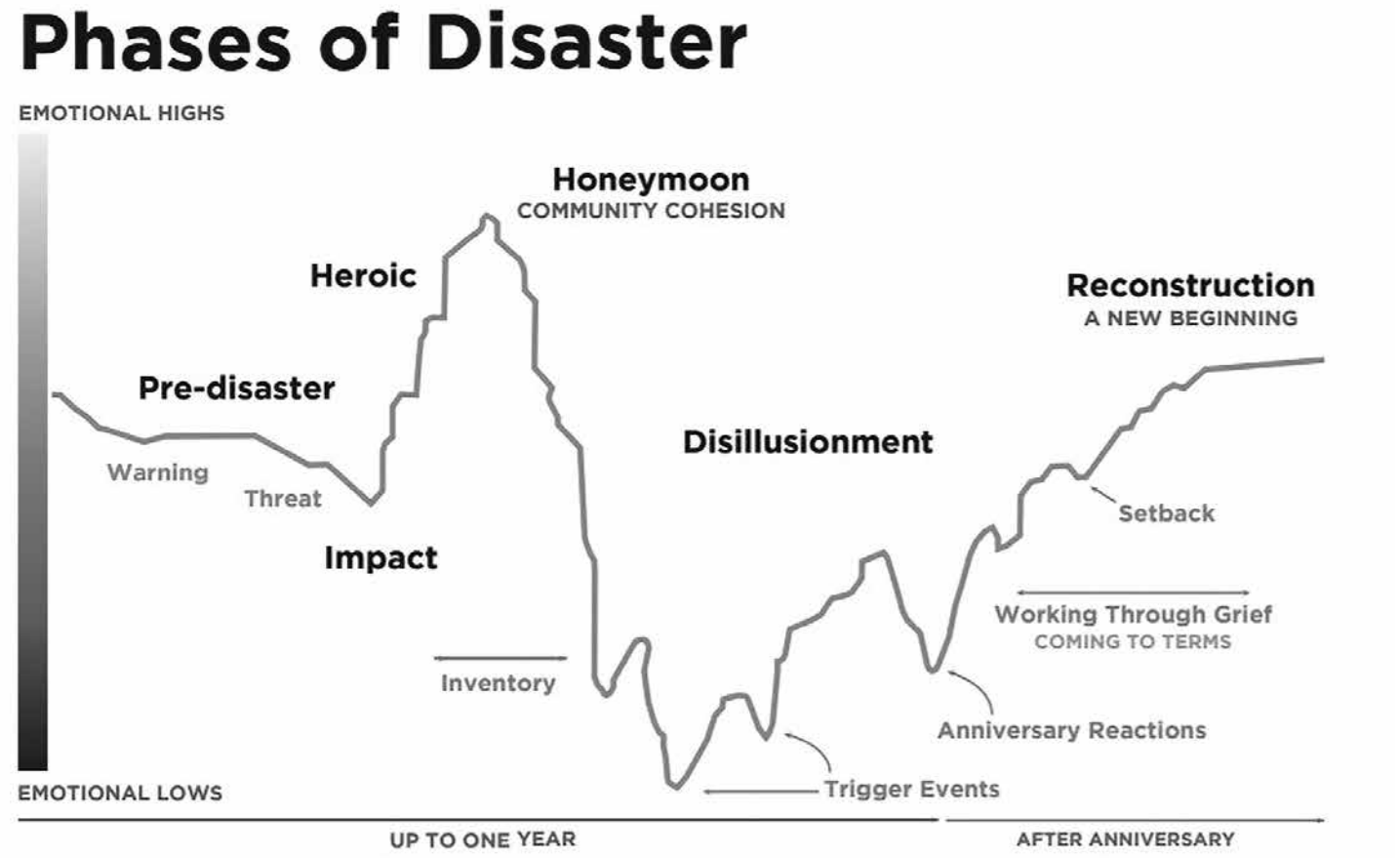

Source: Zunin/Meyers, as cited in Training Manual for Mental Health and Human Service Workers in Major Disasters, U.S. Department of Health and Human Services (2000).

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Case Study: A Case of Scrofula Diagnosed in the Emergency Department

by Mary Blaha, DO, PGY-3, Indiana University Emergency Medicine Residency

Overview

A 68-year-old female with no past medical history presented to the emergency department (ED) with a neck mass that had been present for many months. The chief complaint was listed as "abscess" on the tracking board. She emigrated from Africa two years prior. The patient denied any current fevers, cough, weight loss, night sweats, or other infectious symptoms. She was not a smoker or an intravenous drug user. When asked, on further review of systems, the patient had been partially treated for tuberculosis (TB) upon her arrival to the United States two years ago, but she never completed treatment.

Findings and Workup

Physical exam: Physical exam was remarkable for a well-appearing woman with an isolated, right-sided neck lesion. The lesion was a firm mass without tenderness to palpation, drainage, or fluctuance.

Labs: Basic labs were within normal limits.

Imaging: Chest x-ray and CT chest were unremarkable.

Management

The patient was appropriately triaged to the low acuity side of the ED upon her arrival. She was very well-appearing and was hemodynamically stable. Given the appearance and the location of the lesion as well as patient's history of untreated TB, there was concern for TB cervical lymphadenitis, also known as scrofula. Basic labs were within normal limits and chest imaging did not show any signs of active TB. The patient was placed on airborne precautions and she was admitted to the hospital for further workup. She was admitted to the hospitalist team with an infectious disease (ID) consult. While inpatient, a biopsy of the lesion was performed that confirmed TB lymphadenitis. In coordination with ID consultation, the patient was started on TB treatment. The plan at discharge was for the patient to take multi-drug therapy for six months.

Discussion

This is a case of TB cervical lymphadenitis, also known as scrofula. Lymphadenitis is the most common presentation of extra-pulmonary TB and the cervical nodes are the ones most commonly involved. It is usually caused by reactivation of latent TB infection. This lymphadenitis tends to be unilateral and it is uncommon to have more than one lymph node involved. Typically, the anterior and posterior cervical chains are involved. Patients usually present with a chronic, non-tender lymph node without systemic symptoms and without fluctuance or drainage. This disease process can be somewhat difficult to diagnose as it can be confused with a typical abscess or with other causes of lymphadenopathy. Appropriate history-taking is a key component in making this diagnosis. As with this patient, most patients with TB lymphadenitis do not have signs of active pulmonary TB on chest imaging. Treatment for TB lymphadenitis should be done in coordination with infectious disease consultants and with close outpatient follow-up. Immunocompetent individuals typically receive treatment for six months. High-risk patients presenting with TB lymphadenitis should be tested for HIV co-infection. These co-infected individuals may require longer treatment.

Conclusion

TB cervical lymphadenitis, also known as scrofula, is the most common presentation of extra-pulmonary TB. Patients usually present with a chronic, isolated, non-tender cervical lymph node without systemic or infectious symptoms. The diagnosis can be difficult to make and requires thorough history-taking. Emergency medicine physicians should have a high index of suspicion in high-risk patients. Patients should be screened for active pulmonary TB infection. They should be admitted to the hospital with ID consultation where biopsy and treatment can be initiated.

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2020 was some year.

Now that we're finally looking at it in the rear-view mirror, what did we learn? How are we different? How are **you** and **your practice** different? And what will you change going forward?

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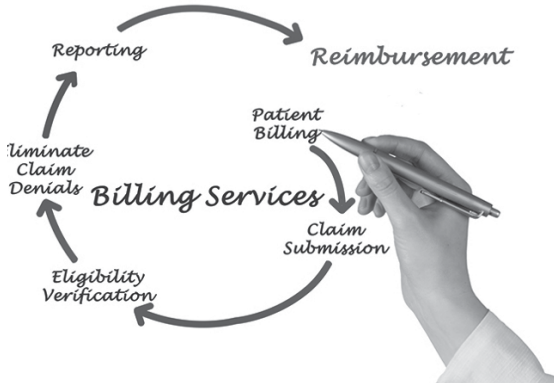
Major Crisis Averted (for Now): Medicare Reimbursements

by Jeff Davis MD, FACEP (ACEP Director of Regulatory Affairs)



ACEP's advocacy efforts on behalf of its members paid off with end-of-year legislation affecting Medicare reimbursement. Heading into 2021, emergency physicians faced a threatened 10% cut to Medicare payments, which could have been devastating to many groups. This was ultimately avoided, largely due to the efforts of ACEP, working alongside organizations including the AMA. Moreover, many ED's stand to receive increased reimbursement. Read more information below, from Jeff Davis (ACEP Regulatory Affairs Director).

This is just another way your dues have been put to good use!

Major Crisis Averted (for Now): Rather than Medicare Payment Reductions, a Raise May be Coming Your Way In 2021

As emergency physicians, you can breathe a little easier now. Instead of a cut to Medicare reimbursement in 2021, now, with the passage of the major omnibus bill at the end of 2020, many of you will actually see an increase in your Medicare reimbursement this year. And since many private payors use Medicare payment levels to set their rates, you hopefully will receive some much needed financial security during this very difficult time.

So what exactly happened? As you may recall from my Regs & Eggs post on the 2021 Medicare physician fee schedule (PFS) final regulation, the Centers for Medicare & Medicaid Services (CMS) finalized a 10.2 percent cut to the PFS conversion factor. Since the PFS conversion factor converts all PFS codes to a dollar amount, this major cut would have impacted every health care practitioner that bills Medicare. ACEP therefore joined with the American Medical Association (AMA) and other medical associations in fiercely opposing this cut and urging Congress to pass legislation that would eliminate the reduction.

While Congress did not completely eliminate the cut to the conversion factor in the omnibus bill, the legislation did include two provisions that, taken together, had the overall effect of offsetting around two-thirds of the 10.2 percent reduction. First, the bill granted CMS enough funding to add 3.75 percent back to the PFS. Second, it delayed the implementation of the add-on code for complexity (G2211) for three years until 2024. This single code had initially accounted for around 3 percent of the conversion factor cut.

CMS recently updated the PFS conversion factor to incorporate these legislative changes. Instead of the 10.2 percent cut that was initially calculated, the conversion factor will now be reduced by only 3.3 percent in 2021 compared to 2020.

Now, how does that impact you specifically? It is important to remember that your total Medicare reimbursement depends on both the conversion factor and the codes that you typically bill. As seen below, the total payment any health care practitioner receives for a service is based on the amount of relative value units (RVUs) for the service (which include work, practice expense, and malpractice RVUs), the size of the conversion factor, and a geographic adjustment.

Total payment under the PFS =
Total RVUs x Conversion Factor x Geographic Adjustment

Knowing ahead of time that the conversion factor would likely be cut in 2021, ACEP took action early to ensure that you as emergency physicians would receive an appropriate level of reimbursement for the services you deliver. When CMS announced last year that it was seeking to revalue the

Code	2020 Total RVUs	2020 CF	2020 Total Payment	2021 Total RVUs	2021 CF	2021 Total Payment	Difference in Payment 2021 - 2020	% Change in Payment 2021 to 2020
99283	1.84	36.09	$66.40	2.09	34.89	$72.93	**+$6.52**	**+9.82%**
99284	3.38	36.09	$121.98	3.55	34.89	$123.87	**+$1.89**	**+1.55%**
99285	4.91	36.09	$177.20	5.18	34.89	$180.75	**+$3.55**	**+2.00%**

office and outpatient evaluation and management (E/M) codes for 2021, ACEP advocated strongly for corresponding increases for the ED E/M codes levels 3 through 5 (CPT codes 99283, 99284, and 99285)—the most commonly billed codes for emergency medicine. These efforts built on our advocacy to the AMA's RVS Update Committee (RUC). ACEP also provided data and a solid policy argument directly to CMS and the White House to help strengthen our case. That advocacy paid off, and CMS adopted our increased code values for the ED E/M codes in 2021.

Initially, the large, 10.2 percent across-the-board cut to the conversion factor totally wiped out the increases to the ED E/M code values—resulting in an estimated 6 percent reduction to your payments. Now, with a smaller cut to the conversion factor, these increases will show through. **In fact, we have calculated that you will see an increase of 9.8 percent for ED E/M level 3 services, 1.6 percent for ED E/M level 4 services, and 2.0 percent for ED E/M level 5 services in 2021.**

While this is great news, we are not totally out of the woods yet. A 2 percent reduction to Medicare reimbursement instituted in 2013, called sequestration, continues to rear its ugly head. Although Congress temporarily halted sequestration during the COVD-19 public health emergency, it is now scheduled to come back in full force on April 1, 2021. Further, looking past 2021, the additional PFS spending caused by the large increases to the office and outpatient E/M codes will continue to result in across-the-board cuts to the conversion factor. While Congress intervened in 2021 to offset a large proportion of the conversion factor cut, it may need to act again before January 1, 2022 to prevent another reduction from occurring. Finally, CMS could decide in 2024 to institute G2211—the add on code for complexity. As previously mentioned, the implementation of that code would result in a significant cut to the conversion factor.

ACEP knows that we have more work to do to prevent future cuts, but for now, I am happy to say: crisis averted, and we will continue to fight another day.

Jeffrey Davis

Director of Regulatory Affairs at ACEP

He manages ACEP's formal response to federal policies and works with federal agencies and other stakeholders to help advance ACEP's federal affairs agenda. Prior to that, Jeffrey worked in the Budget Office at the U.S. Department of Health and Human Services for nearly eight years. Jeffrey came to the Government as a Presidential Management Fellow, and in his position in the Budget Office, he advised top level officials on major budgetary and policy considerations within Medicare and prepared detailed analyses of Medicare regulations and legislation. Jeffrey has a Masters of Science in Health Policy and Management from the Harvard T.H. Chan School of Public Health and a Bachelors of Arts degree from Duke University.

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Reimbursement Battle Part 3 – Medicare, Medicaid & Government Related Reimbursement Updates

by Bart Brown MD, FACEP (INACEP Immediate Past President)

Out of Network (OON) Billing Legislation

1. National OON Billing Legislation in the Year End Package

Surprise Bills vs. Surprise Insurance Gaps? Require insurers to fairly reimburse providers and appropriately cover their customers (the patients) vs. Subsidizing insurer mega-profits? DC lawmakers surprisingly completed bipartisan legislation addressing "Surprise Billing". Persistent advocacy by national and local ACEP members and allies led to drastic improvement from the "in network median benchmark proposals" that were initially favored in 2019.

The final version includes many provider friendly changes including independent dispute resolution (IDR), deductibles limits for out-of-network emergency care to be no higher than in-network, utilizes a reasonable payment standard, and requires insurers to print a policyholder's deductibles on their insurance card. While the insurer's median in-network will be considered as part of the IDR process, it will be based on the amount it was in January 2019 with annual increases for inflation—preventing insurers from gaming payments by dropping their higher-cost contracts.

2. OON Billing in Indiana's 2021 Session

Legislation passed in last year's session was ambiguous and heavily favored Insurers. Fortunately, an unprecedented multi-front advocacy campaign led by INACEP and our members successfully exempted Emergency Medicine from this bill.

For the 2021 session, some have expressed desire to "fix" the 2020 Surprise Billing law. It is too early to know the specifics or how this will interact with the Federal bill just passed. We are closely monitoring this with our lobbyist Lou Belch. We will use the Engaged platform to send important updates or calls to action similar to the past 2 years.

2020 Medicare Reimbursement Updates – Successful Advocacy Efforts and Crisis Aversion

Since early 2020, ACEP advocated strongly for increases for the ED E/M codes levels 3 through 5—the most commonly billed codes for emergency medicine. These efforts built on ACEP's ongoing advocacy to the AMA's RVS Update Committee (RUC), with INACEP's own Jamie Shoemaker leading the effort. ACEP also provided data and a solid policy argument directly to CMS and the White House. That advocacy paid off, and CMS adopted our increased code values for the ED E/M codes in 2021.

Unfortunately, this was followed by CMS announcing they finalized a 10.2 percent cut to the PFS conversion factor. Since the PFS conversion factor converts all PFS codes to a dollar amount, this major cut would have impacted every health care practitioner that bills Medicare. ACEP joined with the American Medical Association (AMA) and other medical associations in fiercely opposing this cut and urging Congress to pass legislation that would eliminate the reduction. Led by Lauren Stanley, INACEP assisted by speaking with many local and national leaders to oppose these drastic cuts during a pandemic. I would like to thank the many INACEP members that contacted their legislators to oppose these cuts.

The large Omnibus bill at the end of 2020 granted CMS enough funding to add 3.75 percent back to the PFS. It also delayed the implementation of an add-on code for complexity (G2211) until 2024. CMS recently updated the PFS conversion factor to incorporate these legislative changes. The conversion factor will now be reduced by only 3.3 percent in 2021 compared to 2020. ACEP leaders calculate that we will see an increase of 9.8 percent for ED E/M level 3 services, 1.6 percent for ED E/M level 4 services, and 2.0 percent for ED E/M level 5 services in 2021.

Upcoming Issues --- a 2 percent reduction to Medicare reimbursement instituted in 2013, called sequestration, is scheduled to return on April 1, 2021. While Congress intervened in 2021 to offset a large proportion of the conversion factor cut, it may need to act again before January 1, 2022 to prevent another reduction from occurring. Another issue further down the line is whether CMS will decide in 2024 to institute G2211—the add on code for complexity referenced above.

Indiana Managed Medicaid Updates

1. Previous INACEP actions

A. INACEP leadership participated working group with FSSA, Legislators, and Managed Care Entities (Insurers that contract with FSSA to provide and manage benefits to Medicaid enrollees) to address multiple significant reimbursement issues with Medicaid plan providers. The main issues include frequent unsupported downcodes and denials, Prudent Layperson disregard, and

B. FSSA made changes requiring MCEs to consider the 1st six diagnoses, ending their manipulation of only looking at the 1st listed diagnosis. The Autopay Diagnosis list was expanded to include many commonly seen conditions.

C. INACEP leadership met with MHS and MDwise to successfully reverse unfair downcode/payment reduction policies.

2. Continuing Issues with Indiana Medicaid Payers

A. The FSSA changes decreased the frequency of this behavior, but we continue to see downcoding and underpayment, the majority from one Indianapolis based MCE. The autopay list misses many commonly seen diagnoses, especially those related to substance abuse and mental health.

B. These ongoing issues have resulted in significant cumulative losses for those providing care for a vulnerable patient population.

3. Plans to Address Ongoing Issues

A. Continue to work with FSSA to push for a permanent solution to this recurring problem and/or consider Alternate Payment Methods (APM).

B. Working with our lobbyist, medical society allies, and representatives to legislate a permanent solution such as a "2-tiered Case Based Reimbursement Rates Plus Procedures" to simplify and expedite the reimbursement process and eliminate downcodes, denials, and diagnosis dependent payments. Providers would receive one rate for discharged patients and another rate for admitted patients. This has worked well in other states including Michigan.

C. We are collaborating with National ACEP leadership and the ACEP Reimbursement Fellows to evaluate new Alternate Payment Methods (APM) for Medicaid patient care.

D. Look into options for the recovery of considerable cumulative losses resulting from the above-mentioned issues with Medicaid Plan Providers.

E. Advocate for insurers to fairly compensate providers for mental health and substance abuse related visits, particularly during the pandemic and ongoing substance abuse crisis.

This ends the three-part reimbursement series. Hopefully this helped to untangle the complexities and clarify current and upcoming issues and how we plan to address them. We are fortunate to have access to National ACEPs arsenal of resources and expert consultants, including newly elected board member Jamie Shoemaker. We have all seen the positive benefits of advocacy, at both the state and federal level. INACEP leadership will continue to fight for our members and specialty.

I would like to thank INACEP members and our allies for their impressive response to calls for action by contacting their representatives and coming to the Statehouse over the past few years. We would not have had success without your presence. Please share this with non-ACEP member and encourage them to join. Strongly consider donating to IEMPAC.

Please feel free to contact INACEP leadership if you have recurrent reimbursement issues with payors and/or unclear or unfair reimbursement policies.

UPCOMING EVENTS

Indiana ACEP Emergency Medicine Conference

Virtual • April 15, 2021

Leadership & Advocacy Conference

Washington DC • July 25—27, 2021

Scientific Assembly

Boston, MA • October 25—28, 2021

Legislative Update

by Lou Belch, Lobbyist for INACEP

The Indiana General Assembly began the 2021 Session on January 4, 2021. The first day signaled the start of what will be a very different Session. In 2021 there are only two tasks that must be completed: passing a 2 year budget, and drawing new congressional and legislative district lines (a once in a decade duty). All other bills are technically unnecessary, although every bill filed is important to someone.

Legislative rules and procedures were modified to operate in a safer environment due to COVID concerns. Committee members and members of the public would be in different rooms for committee hearings and both rooms would be sanitized between hearings. Legislators were limited in the number of bills they could file, and committee chairs were encouraged to only move bills that were necessary, other issues would have to wait. A great deal of posturing and promises made occurred on the first day. Democrats in both the House and Senate offered a resolution, that was defeated, to require all members to wear masks while in the government complex. All others are required by order of the Governor, but the separation of powers provision of the Constitution prohibits the application of those rules on members of the Legislature.

There were several bills last session to address health care costs and there are few this year. Legislators are aware of the fiscal and emotional strain that COVID has put on the health care deliver system. There are bills filed in both the House and Senate that address telehealth and other bills in both chambers that will create some immunity for health care providers during the declared Public Health emergency. As this article is being written, the details of those bills are not available. INACEP leadership will continue to monitor them and act according to the interests of emergency medicine.

Also, not prevalent this year are bills that will change the scope of practice of non-physician providers. In previous sessions, APRNs have been seeking independent practice, that issue will not be considered this year.

INACEP lobbyists are involved in discussions with legislative leadership to determine if the surprise billing law passed at the Federal level results in the need to modify the Indiana law that was passed last year. The Indiana law does not apply to emergency situations, the Fed will govern those.

Conference Update

The INACEP 49th Annual Indiana Emergency Medicine Conference will be held virtually **Thursday April 15, 2021** – Login instructions will be provided when they become available after you register on-line for this event at https://inacep.org/.

Here is the line-up for this event.

TIME	EVENT	SPEAKER
9:00 – 10:00 AM	*Hospital Police Innovations*	Tom Rhoades, Parkview Health Director of Public Safety
10:00 – 11:00 AM	*Heart Failure*	Peter Pang MD, FACEP
11:00 AM – Noon	*COVID and the Opioid Epidemic*	Ryan Stanton MD, FACEP
Noon – 1:00 PM	*Healthcare and Emergency Department Innovations*	Mark Rosenberg DO, MBA, FACEP
1:00 – 1:30 PM	*ACEP Update*	Mark Rosenberg DO, MBA, FACEP
1:30 – 2:30 PM	*INACEP Update*	Annual Meeting
2:30 – 3:30 PM	*The Unstable Young Infant: Interventions That Save Lives*	Richard Cantor MD, FAAP, FACEP
3:30 – 4:00 PM	*ISDH Update & COVID Response*	Lindsey Weaver MD, FACEP

Coping with Covid

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are like unsupervised toddlers wreaking havoc day in and day out and we are the ones left to clean up the mess.

So how do we "tune in" to see what our brains are doing? How do we begin to supervise our brains? How can we begin to understand and control our thoughts to get more rewarded emotions? One way is to do something called a thought download. The idea is to grab a pen and paper and literally vomit every thought you are having onto the page as fast as you can. It is most effective to do this without editing, modifying, or judging so you can actually see the thoughts running wild in your brain. Once they are visible, you can decide whether you want to keep thinking those thoughts or not. Another way is to start with an emotion you are having and try to figure out the thought that is triggering that emotion. Either way, once written down and explored, you can then figure out if the words you are writing are all thoughts or if they reflect circumstances or feelings.

What does this look like in the real world?

CTFAR: Circumstance, Thought, Feeling, Action, Result.

Circumstances are neutral until we have a thought about them. "There are X number of patients in the waiting room." Then we have a thought: "I knew it; it's going to be a horrible night. I bet most of those people don't even need to be here." That thought creates feelings of overwhelm, stress, and cynicism. Those feelings drive our decisions, which ultimately create our results. In this case, feelings of stress and overwhelm might drive us to be short with the nurses, patients, and staff; or even do avoidance behaviors such as email or social network scrolling rather than going and seeing the next patient. We may act aloof and cynical with patients instead of kind and ready to help. Short term results include difficult interactions with the ED team, ED patients, perhaps poor patient outcomes due to missed history and data, and ironically, longer ED wait times as energy and motivation to go see those patients and clear out the waiting room is low. Long term, this pattern of thinking will drive burnout, job dissatisfaction, and can even negatively impact patient care.

How else could this play out? Remember that our external circumstance is neutral and not necessarily "changeable". In this example, the circumstance is "There are X number of patients in the waiting room." You can not change that circumstance at the moment. What if we tried a different thought? "I guess a lot of people need my help today. Job security!" This thought likely creates feelings of compassion, gratitude, and contribution. These feelings would cause our actions to be more cheerful, be approachable, and understanding with the ED staff and patients, and improve our motivation to go see the patients instead of exercising avoidance behaviors. As a result, the waiting room empties faster, our relationships with ED staff thrive, we are seen as compassionate leaders in the ED rather than ticking time bombs, and our patients receive more efficient and effective care.

The thought download exercise is a way to explore and discover your circumstances, thoughts, and feelings. Pick a circumstance or thought and just ask yourself 'Why? Why? Why?' until you've written down every sentence in your brain on the subject. Now go back through and label each phrase or sentence as a circumstance, thought, or feeling. Let GO of the circumstance you can't change and identify the thoughts that are creating adverse feelings and results. Brainstorm new thoughts that you could choose to think until you find a true, believable thought on the subject that would lead to more positive feelings and results. Decide to think those new thoughts and practice, practice, practice. Actively and consciously choose your new thoughts on the subject each time you feel the old, familiar negative ones arise. At first, it may feel like faking it til you make it, but soon you will be able to rewire your neural pathways to get new subconscious thoughts that are helpful rather than harmful and your new thoughts will start to become second nature. Positive feelings, actions and results will inevitably follow. This is NOT to say that a difficult work environment or social situations are your fault or that positive thinking will fix every problem. We all know there is much systemic change that needs to happen to support us as Emergency Physicians. However, taking control of our thoughts gives us back our power to think and respond and grow more often in the way that we wish, both personally and professionally.

COVID is our reality for the foreseeable future. Changing our circumstances, when possible, is usually a long term solution rather than an immediate one. Changing our thoughts about the circumstances can be an absolute game-changer in our day-to-day lives. So, the next time you are experiencing a strong emotion, remind yourself, "I am feeling this way because of a sentence in my brain." Tune in, listen up, and begin to actively choose the thoughts that you want to think.

EMpulse

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