

lifeline

OCTOBER 2016

a forum for emergency physicians in california

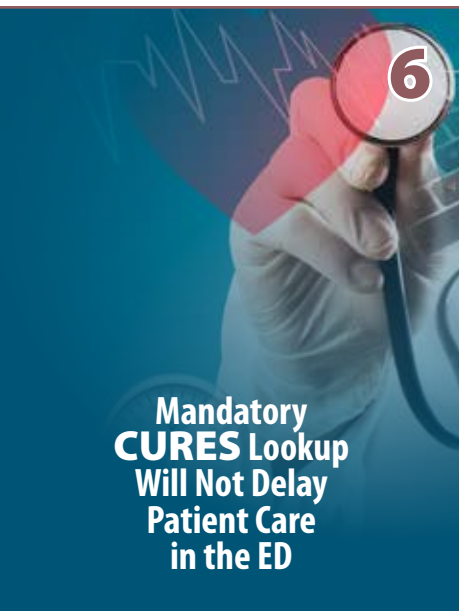
Are USUAL & CUSTOMARY CHARGES Reasonable?

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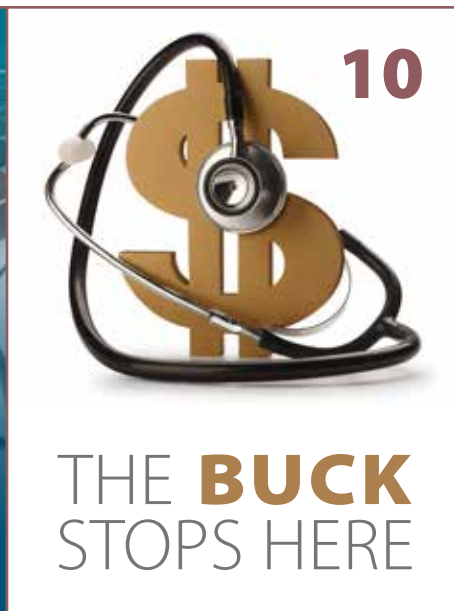
CALIFORNIA ACEP



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Will Not Delay
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By Larry Stock,
MD, FACEP

MY PAST, OUR FUTURE:

Emergency Medicine Residency Training

I had just completed my last shift at Harbor UCLA; it was a busy shift—fun with good energy and great residents. I started spending time at Harbor thirty years ago as a second year medical student. Our headquarters was a doublewide trailer on the Harbor campus adjacent to the wooden barracks that have served as patient wards starting in 1946 and still function as research labs and offices. We were taught by the dedicated UCLA faculty at Harbor in the classroom and on the wards.

As a fourth year student, unsure of myself and unclear where I was headed, I attended a lecture by Dr. Howard Bessen, the emergency medicine (EM) residency director at Harbor UCLA. It was Howard's sheer joy of teaching and his obvious love of being an EM physician, which captured my attention and prompted me to ask his advice about EM. This resulted in a clerkship at Harbor. During my first shift I instinctively knew EM was where I fit in and would be happy.

With hard work and good luck, I matched at Harbor for EM residency. It was at Harbor that I, and my newbie classmates, were inspired by Howard and our other academic faculty members and became the physicians that we are today. Our residency became our work family and our residency director a surrogate parent. Through the program we became inculcated with a sense of professionalism, an ownership mentality, and a duty to do the right thing for the patient.

Prior to and during the early 1960's the quality and safety of emergency care in the United States was highly variable and often poor.

Unsupervised interns and physicians trained in other specialties were ill prepared to deal with the range and acuity of pathology that EM physicians consider routine today. Patients died of illnesses and injuries because of lack of training to recognize and manage emergencies. We also lacked the well-developed systems of care that we take for granted today: the emergency medical services (EMS) system, the trauma system, intensive care units, and emergency cardiac care.

It was the creation of organized EM through ACEP, EM residency training, the development of board certification through the American Board of Emergency Medicine (ABEM), and the development of the Model of EM, that resulted in improved standards of patient care. In less than half a century the pioneers of EM, starting with the recognition of a societal need for accessible high quality emergency care for all, made that vision a reality. While the first generation of EM physicians became board certified via the practice track, it was the advent of EM residency training that created the growth and development of our specialty today.

California ACEP has been at the forefront of major EM care improvement since 1971. California ACEP and California physicians have been leaders in system development (EMS/Paramedics/911, Trauma, Mobile Intensive Care Nurse, Coronary Care Units as well as EM residency training development. Starting with LA County USC, California now has 16 outstanding EM residency training programs. The learning and growth that takes place when residents and faculty focus on patient care, teaching, and research has been nothing short of transformative for the specialty and for the US.

This *Lifeline* article is a thank you to those individuals who have dedicated their careers to teaching others the art and science of EM: EM residency directors and all academic emergency physicians. The cognitive, interpersonal, and procedural skills you have taught have resulted in safe, effective, high quality care being available virtually everywhere in California. This article is also to honor our EM residents. You are the future of our specialty. While we stand on the shoulders of those that came before us, you are the ones who will stand in the pit, teach, perform research, and determine the future course of EM.

California ACEP is dedicated to ensuring a sufficient EM workforce and having adequate resources for EM in California. We advocate for our specialty in the legislative, legal, and regulatory realms. California ACEP is here to support and engage our members. We are dedicated to protecting the current and future state of EM practice in California. The California Emergency Medicine Residents' Association (Cal/EMRA) president is a voting California ACEP board member. All EM residents can join California ACEP for FREE and we sponsor residents to attend our board meetings.

HERE IS THE ASK:

- **Join California ACEP**
- **Come to an event:** Board Meeting, Legislative Leadership Conference, AdvancED Annual Meeting
- **Get involved:** Visit our website, Facebook, Twitter, and read *Lifeline*

This is your organization for your professional future; join the conversation.

In closing, Drs. Bob Hockberger and Roger Lewis generously allowed me to stay on at Harbor as a clinical faculty member. While most EM residents spend three or four years training, I have stayed on an additional 25 years. I am now an R-28. While I have tried to teach something of value, I clearly learned something every shift. Life circumstances have made this the right time for me to finally graduate. I want to thank my colleagues, students, and teachers for exemplifying the best qualities in physicians: curiosity and kindness. Time for rounds. ■

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 The Model of the Clinical Practice of Emergency Medicine
<https://www.abem.org/public/publications/em-model/history>



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Mandatory CURES Lookup Will Not Delay Patient Care in the ED

By Elena Lopez-Gusman & Kelsey McQuaid, MPA

We have received many questions from our members regarding SB 482 by Senator Ricardo Lara. The bill was signed by Governor Jerry Brown on September 27, 2016 and will go into law on January 1, 2017.

When SB 482 was introduced, it required physicians to check the Controlled Substance Utilization Review and Evaluations System (CURES) any time they prescribed a Schedule II, III, or IV drug to a patient for the first time. In the emergency department (ED) this would have required a CURES look up on virtually every patient needing that level of pain treatment.

CURES is an effective resource to help facilitate appropriate prescribing decisions and to identify patients abusing controlled substances so they can receive assistance. However, as you know all too well, the CURES database can be slow and cumbersome to use and there are many instances in the ED where a requirement to look up a patient's history is unnecessary and takes away time that could use to treat a trauma victim or a patient in cardiac arrest. For example, you may decide you would prescribe your patient with a crushed femur an opioid, regardless

of what the CURES history contains, so a requirement in law to look in CURES only serves to divert your precious time from patient care.

The Chapter took an Oppose Unless Amended position when SB 482 was introduced and argued that the requirement to check CURES every time an emergency physician prescribes would lead to valuable time being taken away from treating patients in the ED. Staff was able to successfully negotiate amendments that state **health care practitioners prescribing, ordering, administering, or furnishing a controlled substance in the emergency department will not be required to check CURES if they write a non-refillable prescription for no more than a seven day supply.**

The ED exemption is a major victory for emergency physicians because it won't place additional stress on you and your department. You will be allowed to use clinical judgement in cases of severe pain, such as a teenager who was in a car accident or a patient passing a kidney stone, as long as you prescribe a seven day supply or less.

More than 20 states, including New York, require mandatory lookup of their Prescription Drug Monitoring Program. The Chapter's advocacy efforts ensure that SB 482 does not place additional stress on California's overcrowded EDs and allows emergency physicians to use their clinical judgment to determine when to access CURES.

In 2014, the Chapter decided to take action to reduce opioid overdoses and deaths by creating safe prescribing documents for the ED. Our safe prescribing guidelines have been adopted by over 70 stakeholders, including hospitals, medical societies, and community organizations. The Chapter has participated in numerous county safe prescribing coalitions spearheaded by the California Healthcare Foundation. To find out more about the Chapter's safe prescribing resources visit www.californiaacep.org/improving-health/safe-prescribing. Please contact Kelsey McQuaid at kmcquaid@californiaacep.org if your ED is interested in joining our efforts.

If you have any questions about CURES or California ACEP's legislative efforts, please contact us at info@californiaacep.org or by calling the Chapter office at (916) 325- 5455. ■



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Are **USUAL & CUSTOMARY CHARGES** Reasonable?

By Myles Riner, MD, FACEP

In State legislative offices throughout the country where the issue of out-of-network physician charges, balance billing, and plan benefits are being debated, the constant refrain from health plan representatives is that usual and customary charges are an 'unacceptable standard' for out-of-network benefits. Nope, won't consider it, won't even discuss it: U&C charges are "off the table". Aside from the fact that, when one side in a negotiation takes something off the table at the start, it really is no longer a negotiation: is it reasonable to eliminate usual and customary charges from consideration?

It wasn't that long ago that health plans would allow (pay) a benefit based on the lesser of the physician's full charge or the 70th or 80th percentile of usual and customary charges based on the Ingenix database. Things changed when the Attorney General of New York got wind of the fact that health plans were deliberately manipulating the claims data that generated this United Healthcare owned database in order to cheat enrollees out of hundreds of millions of dollars in benefits for out of network services; and sued several plans for this abusive tactic. Suddenly, having been caught with their fingers in the cookie jar, commercial health plans almost universally and simultaneously decided to abandon the usual and customary charge standard for OON benefits. The AG required several of these plans to fund the development of a new, independent usual and customary charge database called FAIR Health; but since these plans were limited in their ability to manipulate the new database, most decided to rely on other standards where state regulations allowed. Most of the new standards for OON benefits are either based on a percentage of Medicare rates or on the plan's own, highly arbitrary, black-box, "usual, customary and reasonable" rates, all of which are considerably lower than (often less than half of) the 70th percentile of U&C charges. The plans rationalize this new approach in the following ways:

- it is necessary to keep premiums down
- usual and customary charges are too high because there is nothing that keeps physicians from overcharging for their services, or consistently raising fees
- outlier physician charges distort usual and customary charge databases
- it is a way to encourage enrollees to preferentially use in-network physicians

Let's look at these arguments. Of course, limiting plan benefit payouts might keep premiums down, but so would limiting plan profits; yet profits and premiums have risen in lockstep. Also, there is no evidence that limiting OON benefits has kept premiums from increasing, and in many cases enrollees are not getting the benefits that their premiums are supposed to secure. The argument that there are no economic factors keeping physician charges in check ignores the very real competitive forces that constrain physician charges. Hospitals that contract with physicians for services want their physicians to be sensitive to their market. Physicians who charge high prices and refuse to contract with plans and discount their charges to health plan



enrollees will have difficulty filling their offices or surgery schedules unless their skills, reputations, and services are exceptional and in great demand. It is true that outlier charges can distort usual and customary charge databases when the survey areas are small, or when large, high charging physicians groups dominate in their market; but these impacts can be easily mitigated by expanding the size of survey areas and maximizing the number of claims included. Lastly, as plans shrink the size of their networks to include fewer providers; enrollees may be forced outside of these narrow networks to obtain needed services from the most qualified physicians, and they shouldn't be excessively penalized for doing so.

The concept behind using a usual and customary charge database for out-of-network benefits is that these charges reflect the various forces that define the reasonable market value of these services, including the cost of providing them. A physician who is providing services outside of a health plan network is usually not receiving any of the other considerations from a health plan in return for discounting their services to the plan's enrollees. These considerations might include a large referral base, faster payment, fewer denials of coverage, direct to provider payments, etc. Taking a large sampling of claims from physicians and looking at the range of charges (fees) for these services, then lopping off the highest 20 or 30 percent of these as 'too far above the mean', allows for the identification of a 'reasonable range of fees' that reflect the market value of these services. This is why this approach was

used by plans in the past to determine what the reasonable benefit should be for OON services. Some plans still do this, but now most plans have decided they need to redefine 'reasonable market value' to mean 'what ever we think is reasonable'.

You could argue that the market for physician services isn't really an open, fair, and competitive market, and you might be right in many areas of the country, but that this why the top 20% or 30% of charges are excluded from the 'reasonable' standard for OON benefits. There is nothing logical or reasonable about allowing plans to make this determination independently, especially if physicians are prohibited by law or regulation from seeking to recover more than what the plan 'allows' for out of network services. If plans want to set fees, they should be forced to go through the equivalent of a public utilities commission process, otherwise they are using the government to steal those services from providers at an unwarranted discount. If anything should be off the table in these negotiations for an OON benefit standard and balance billing legislation, it should be offering plans a license to steal. ■

NOTE: This article is reprinted with the permission of Dr. Riner. The views and opinions expressed in this piece do not necessarily reflect the views and opinions of California ACEP.



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By Andrew H. Selesnick

THE **BUCK** STOPS HERE



CA Supreme Court to Rule on Health Plans' Negligent Delegation of Payment Responsibilities

A disturbing trend has emerged within our health care system that places the financial interests of health plans over not only the livelihoods of physicians, but also the accessibility, affordability and quality of health care to patients. Rather than bearing the financial risks of providing coverage to their own enrollees, health plans delegate this risk to undercapitalized risk-bearing organizations ("RBOs"), such as medical groups and independent practice associations ("IPAs") which often cannot cover the costs of the medical services provided. In California, this issue recently came to a head in a case I argued before the state's Supreme Court.¹ Before the end of this year, the Court will decide whether emergency physicians can sue health insurance companies for negligently delegating payment responsibility to an IPA when the plan knew, or should have known, that the IPA was not financially stable.

The Case of the Insolvent IPA

The underlying case commenced in 2010 and involves La Vida Medical Group ("La Vida"), an IPA operating, at the time, in Southern California. La Vida served as an intermediary between providers and patients who were covered by a variety of health insurance companies, including among others: Aetna, Blue Cross, Blue Shield, Cigna, Health Net, and PacifiCare. The health plans compensate local groups like La Vida in exchange for the assumption of all financial risk for medical claims, as well as other administrative duties such as customer service. In exchange for accepting the delegated responsibilities, La Vida received money on a capitated or fixed periodic payment basis.

In California, non-contracted emergency physicians are particularly vulnerable to the health plans' compensation policies because Health and Safety Code §1317 obligates emergency physicians to treat all patients requiring emergency care regardless of the patients' insurance coverage or ability to pay, and these physicians have no contract that they can enforce against either the health plans or their delegated IPA. Moreover, since 2009, emergency physicians have been legally prohibited from balance billing patients for sums left unpaid by an HMO.² Unable to provide free medical care while remaining economically viable, many physicians are then forced to curtail their practices, resulting in reduced overall access to affordable, quality health care.

Beginning in 2007, La Vida failed to comply with multiple financial requirements. Specifically, La Vida did not meet Department of Managed Health Care ("DMHC") standards for sufficiency of working capital, tangible net equity, and cash to pay provider claims. The health plans were well aware of La Vida's deteriorating financial condition (e.g. La Vida submitted financial statements to the health plans on a quarterly and annual basis). The health plans failed to ensure that La Vida maintained sufficient capital to pay providers' claims. Years after La Vida first began openly demonstrating financial instability, the health plans finally discontinued their capitation payments to La Vida and terminated the relevant contracts. Shortly thereafter, La Vida closed its doors, laid off nearly every employee, turned off the telephone and effectively went out of business. And, predictably, providers were left in the lurch.

Seeking Justice for Emergency Providers

In 2010, a group of emergency physicians and radiologists filed a lawsuit against the HMOs arguing that if the HMOs negligently delegated their emergency service responsibilities to an IPA, the HMOs should be financially responsible. The HMOs countered that once they established contracts with the IPA delegating their reimbursement obligations, they could not be held liable. The trial court agreed with the HMOs and dismissed the case. The providers appealed, and in 2014 the California Court of Appeal issued a landmark opinion, reversing the trial court, and ruling that: when no contract exists between an emergency medical provider and an IPA, and the HMO that contracted with the IPA knew (or should have known) of its inability to pay, the HMO is financially responsible for reimbursing the emergency physicians.

The health plans appealed this decision to the California Supreme Court, and the appeal was argued in early September. The health plans essentially argue that, because they have the right under the Knox-Keene Act to delegate their statutory payment responsibilities to an IPA, they can have no liability - under any circumstances or under any theory - to pay the emergency physicians who treat the health plans' enrollees after the delegation transpires.

The providers' position is easy to summarize: by virtue of their inability and powerlessness to choose whether to provide any of the services at issue due to their status as non-contracted emergency service providers and the statutory mandate to treat all patients in need of emergency care, in addition to the recent prohibition on balance billing,

the health plans' right to delegate financial responsibility for emergency services provided to their enrollees is not absolute. Moreover, the provisions of the Knox Keene Act explicitly permit common-law causes of action against the health plans arising out of the health plans' own wrongful conduct.

Put simply, if the Legislature intended that emergency physicians absorb all risks of nonpayment for their services, regardless of the reason for the nonpayment, as a condition of holding themselves out as emergency physicians, then the Legislature would have included such language within the Knox-Keene Act. Ultimately, without a common law avenue for non-contracting physicians to obtain payment for services rendered, the physicians would be left without a remedy and, potentially, without a viable medical practice.

A Pressing Matter of Public Policy

The case before the California Supreme Court touches on a significant issue of public policy (which is no doubt why the Court requested

substantial *amicus* briefing, including from the DMHC, American College of Emergency Physicians and California Medical Association). The health plans told the California Supreme Court that state law and regulation shields them from post-delegation liability, and that the health care system would effectively collapse if health plans were held responsible for the financial health of the risk-bearing organizations with whom they contract. They argue that such exposure would not only run contrary to statutory intent, but also result in increased costs and reduced quality of care.

The providers counter-argument is simple; the statutory right to be compensated belonging to non-contracting physicians who have provided emergency services is meaningless if the right cannot be enforced. Thus, if a health plan, by its own negligence, interferes with this statutory right, it is only logical that the non-contracting physician who has provided emergency services has a negligence cause of action against the health plan -i.e., the entity that interfered.

It is ultimately the patients who suffer most when payers fail to honor their high-stakes bets on health care reimbursement. This case has real life and death implications for any California resident and/or visitor who may require emergency care. Further, California has a clearly expressed public policy supporting the proposition that professionals are not required to give away their services for free, but rather must be - and deserve to be - fairly paid as a matter of law and sound public policy. We will soon see whether the California Supreme Court agrees that this policy should extend to emergency physicians.

Andrew H. Selesnick is a partner at *Michelman & Robinson, LLP (M&R)*, a national law firm, where he leads the *Health Care Litigation Practice Group*, representing physicians, physician groups, hospitals, substance abuse treatment facilities, skilled nursing facilities and ambulatory surgery centers in reimbursement matters, provider-payor disputes, management and ownership disputes and fraud and abuse defense. ■

1 - The case is *Centinela Freeman Emergency Medical Associates et al. v. Health Net of California Inc. et al.*, case number S218497 in the Supreme Court of the State of California.

2 - *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, Inc.* (2009) 45 Cal.4th 497

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January 13th at 7:20 AM, Jessica Mason, M.D.

January 14th at 7:20 AM, Mel Herbert, M.D.*, EMRAP Founder

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The Center for Emergency Medical Education designates this live activity for a maximum of 14.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Wednesday, January 11th (Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler)

- 9:30 AM **Brunch** (Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler):
Richard Stennes, M.D.: "My Travels Around the World—On and Off the Ship"
Jerry Hoffman, M.D.: A Few Remarks from the 'Skeptic.'
- 1:00 PM **Ranger Guided Group Hike: Mirror Lake** (Meet in The Majestic Yosemite Hotel Lobby – formerly Ahwahnee Lobby)
- 5:30-6:30 PM **Reception** (Half Dome Village - formerly Curry Village): It's A Party In Honor of Billy Mallon, M.D.
and A Number of the Elders of Emergency Medicine
Martha Chessie: Basketry
Shane Hendren: Navaho Metalsmith
Kathleen O'Hara: Photography
- 6:30 PM **Dinner** (Half Dome Village - formerly Curry Village)
- 7:00-7:15 PM **Welcome and Introductions:** (Half Dome Village - formerly Curry Village)
Ron Crowell, M.D. & Larry Stock, M.D., President of California Chapter
- 7:15-8:00 PM **Ryan McGarry, M.D.:** "The Making of 'Code Black,' the TV production"
- 8:00-9:30 PM **Jeremey Kittel:** American Fiddler, Violinist and Composer

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Thursday, January 12th (*Yosemite Valley Lodge Garden Terrace – formerly Yosemite Lodge Garden Terrace*)

- 7:45-8:45 AM **Paul Auerbach, M.D.:** “Leadership and Where Emergency Medicine Should Lead” (1 Hour CME)
- 8:45-9:45 AM **Ramin Tabatabai, M.D.:** “Managing the Unstable AFIB Patient” (1 Hour CME)
- 9:45-10:15 AM **BREAK: Visit Exhibitors & Sponsors** (*Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler*)
- 10:00 AM **Spousal Program** (*Yosemite Valley Lodge Bar*): **Judith Crowell, M.D., Dermatologist:**
Final Edition - “Part VII, How to Invest Intelligently in Your Ongoing Beauty”
- 10:15-11:15 AM **Christian Tomaszewski, M.D.:** “Cardiac Toxins: Beyond ACLS” (1 Hour CME)
- 11:15-12:15 PM **Dan Imler, M.D.:** “The Febrile Infant: Update 2017” (1 Hour CME)
- 1:30 PM **Ranger Guided Group Hike: Vernal Falls** (*Meet in Happy Isles parking lot*)
- 5:15 PM **Wine and Cheese Reception** (*Majestic Solarium – formerly Ahwahnee Solarium*):
Martha Chessie: Basketry
Annie Hoffman: Artist
Jeremy Kittel: Fiddler
- 5:45-6:45 PM **Pepper Trail, Ph.D.:** “Voyage to The Origin of Species: Reminiscences of Charles Darwin (in Person).”
- 6:45-7:00 PM **Annie Hoffman:** My Work
- 7:00-7:30 PM **Shane Hendrin, Navaho Metalsmith:** “My Family’s 300 Years in the West”

Friday, January 13th (*Yosemite Valley Lodge Garden Terrace – formerly Yosemite Lodge Garden Terrace*)

- 7:45-8:45 AM **Graham Billingham M.D.:** “ED Malpractice and Emerging Risk: Latest Update” (1 Hour CME)
- 8:45-9:45 AM **Dan Imler, M.D.:** “What’s New with Pediatric Sedation” (1 Hour CME)
- 9:45-10:15 AM **BREAK: Visit Exhibitors & Sponsors** (*Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler*)
- 10:00 AM **Spousal Program** (*Yosemite Lodge Bar*): **Martha Chessie:** “An Introduction to Basket Weaving”
- 10:15-11:15 AM **Ramin Tabatabai M.D.:** “Oncologic Emergencies” (1 Hour CME)
- 11:15-12:15 AM **Christian Tomaszewski, M.D.:** “Diagnostic Errors: Strategies to Avoid” (1 Hour CME)
- 1:00 PM **Ranger Guided Group Hike: Yosemite Falls Trail** (*Meet in Trailhead parking lot*)
- 5:00 PM **Wine and Cheese Reception** (*Majestic Solarium – formerly Ahwahnee Solarium*):
Charles Cramer: Photographer
Shane Hendren: Navaho Metalsmith
- 5:30-6:15 PM **Paul Auerbach, M.D.:** “Disaster Response: Preparing and Responding.
From Mega-disasters to Your Home.” (1 Hour CME)
- 6:15-7:00 PM **Stephen Ainlay, Ph.D., President, Union College:** “A College President’s Perspective
on the State of Higher Education in America: Where it is, Where it Needs To Go,
and How Can We Afford to Get There?”
- 7:00-7:45 PM **Thomas Lee, M.D.:** “Health Access in Complex Emergencies: Burma,” Documentary:
“The Black Zone” by Grace Baek (1 Hour CME)

Saturday, January 14th (*Yosemite Valley Lodge Garden Terrace – formerly Yosemite Lodge Garden Terrace*)

- 7:30-8:30 AM **Tommy Korn, M.D.:** “Spooky Eye Emergencies Not to Miss! - 2017 Update & Review” (1 Hour CME)
- 8:30-9:30 AM **Tsuyoshi Mitarai, M.D.:** “Ultrasound as a Stethoscope to Care for Critically Ill:
Its Clinical Applications” joint lecture with MyPhuong Mitarai, MD (1 Hour CME)
- 9:30-9:45 AM **BREAK**
- 9:45-10:45 AM **David Schrager, M.D.:** “The Emergent Shoulder, A Case Review” (1 Hour CME)
- 10:45-11:45 PM **David Schrager, M.D.:** “Literature Review” – “Relationship between Global and 1st World EM
and How That Relates to the EP’s Behavior and Self Worth” (1 Hour CME)
- 12:00-1:15 PM **Buffet Lunch: Onsite only** (*Yosemite Valley Lodge Garden Terrace – formerly Yosemite Lodge Garden Terrace*)
- 12:30-1:15 PM **David Paradis, M.D.:** “Emergency Physician Up Close and Personal: The Year I climbed
Shasta, Rainier and Denali”



CEMAF *Donors*

The California Emergency Medicine Advocacy Fund (CEMAF) has transformed California ACEP's advocacy efforts from primarily legislative to robust efforts in the legislative, regulatory, legal, and through the Emergency Medical Political Action Committee, political arenas. Few, if any, organization of our size can boast of an advocacy program like California ACEP's; a program that has helped block Medi-Cal provider rate cuts, stop the \$100 million raid on the Maddy EMS Fund, and fight for ED overcrowding solutions – and that's just the last year! The efforts could not be sustained without the generous support from the groups listed below, some of whom have donated as much as \$0.25 per chart to ensure that California ACEP can fight for emergency medicine. **Thank you to our 2015-16 contributors (in alphabetical order):**

- Alvarado Emergency Medical Associates
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- Centinela Freeman Emergency Medical Associates
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- Coastline Emergency Physicians Medical Group
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ANNOUNCEMENTS |



OHIO ACEP EMERGENCY MEDICINE BOARD REVIEW

February 9-13, 2017, Irvine, California
 Register at www.ohacep.org
 *Approved for AMA PRA Category 1 Credits™

FREE ORAL BOARD EXAM PREP – EXAMINERS & EXAMINEES

Volunteer/Sign-up at: <https://www.surveymonkey.com/r/YM8Z5ST>

CALIFORNIA ACEP CO-SPONSORED CONFERENCES

- Emergency Medicine in Yosemite, January 11-14, 2017
 Yosemite, California

Award Recipient Acknowledgement

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EMS AWARD

Clement Yeh, MD, FACEP

HOUSE OF MEDICINE AWARD

Michael Luszczyk, DO, FACEP

HUMANITARIAN AWARD

John Brown, MD, FACEP



CALIFORNIA ACEP UPCOMING MEETINGS & DEADLINES

For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

OCTOBER 2016

6th at 10am	Council Delegation Conference Call
14th - 15th	ACEP Council Las Vegas, NV
16th - 19th	ACEP 2016 Scientific Assembly Las Vegas, NV

NOVEMBER 2016

1st at 9am	Reimbursement Committee Conference Call
10th at 10am	Government Affairs Committee (GAC) Conference Call
10th at 1pm	Practice Management Committee Conference Call
15th at 10am	CAPP Board of Director's Meeting Sacramento, CA
17th at 10am	Board of Directors Meeting Sacramento, CA
24th - 25th	Thanksgiving Holiday, Office Closed

DECEMBER 2016

5th - 6th	CHA ED Conference Riverside, CA
8th at 10am	Government Affairs Committee (GAC) Conference Call
9th at 10am	Member Services Committee Conference Call
26th - 1st	Office Closed for Holidays

OCTOBER 2016

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NOVEMBER 2016

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DECEMBER 2016

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CAREER OPPORTUNITIES |

ANAHEIM, CALIFORNIA: Anaheim Regional Medical Center's Democratic ED Physician group has immediate part time/full time positions available for BC / BE Emergency Physicians. We have a busy, high acuity department with 44,000 annual visits. Shifts are 9-10 hours long with night shift/holiday differential and double coverage during peak hours. We offer a competitive salary, paid malpractice and full partnership opportunities.

Interested physicians E-mail your CV and references to vijay4@aol.com, amit4ten@aol.com or call us at 714-999-5112.

BAKERSFIELD, CALIFORNIA: Pinnacle Emergency Physicians (2007-present) with 3 local ED's (10h shifts) seeking FT/PT, BC/BE docs (all trauma goes to the County Hospital)

- Memorial Hospital: 80k/y, STEMI, Stroke & Burn Receiving Center, currently 24/7 Peds, PICU, OB and adult hospitalist services...Peds ED opening 4/2017
- Mercy Downtown: 37k/y, Stroke Receiving Center w/ adult hospitalist services
- Mercy Southwest: 52k/y, Stroke Receiving Center w/ adult hospitalist services

Staffed by 40 FT/PT physicians and 40 FT/PT mid-levels. PT: \$230/h, hotel provided.

FT: 120h/mo, full profit sharing after 2 1/2y plus CME, health, retirement contribution, paid malpractice with no tail, quarterly bonus, sign on bonus, interest free loan for moving expenses.

Income in top 5-10% nationwide. Low cost of living, white water rafting, mountain biking/hiking, 2h to DTN LA or central coast beaches, 4h to Mammoth, Las Vegas, San Francisco, San Diego.

Contact: Les Burson, DO, Medical Director phogku@aol.com 661-332-1064 or Dr. Kian Azimian, MD, Assistant Medical Director kianazimian@yahoo.com 661-616-8930

CENTRAL COAST: MMC Emergency Physicians Medical Group at Marian Regional Medical Center-Santa Maria-seeking a qualified BC/BE Emergency Physician to join a stable, independent, single hospital, democratic group. Partnership opportunity available in this well-supported ED with growing census of >80,000 visits/year. New hospital/new ED opened in 2012. Practice alongside experienced colleagues at a STEMI receiving center, a Level III Trauma Center and a certified Stroke Center that offers 24/7 in-house hospitalists, OB laborists and intensivists in addition to a NICU, peds hospitalists and FP residents. Live on the beautiful Central Coast, anywhere from San Luis Obispo to Santa Ynez/ Solvang, with easy commutes to work and easy access to beaches/mountains/ wine country along with all types of outdoor recreation. This is the job your residency director told you to find.

For more details, contact David Ketelaar, MD at dketelaar62@gmail.com Phone (805) 440-0837

DOWNTOWN LOS ANGELES: Emergency Physician needed. \$350,000 + incentive per year, malpractice paid, half days, half nights. ABEM ABOEM with experience. Present core group average 23 yrs tenure. 36,000 annual visits, paramedic receiving (no peds) STEMI Stroke, physician coverage 36-40 hrs/day, NP & PA coverage 12-20 hrs/day

FAX CV to 213 482 0577 or call 213 482 0588 or neubauerjanice@gmail.com

LOS ANGELES – CULVER CITY: Southern California Hospital at Culver City Rare opportunity to join a Westside LA ER group. Group seeks BC/BE emergency physician to work Part-Full Time as an independent contractor. Excellent compensation with malpractice paid. Nine hour shifts with 11 hours of PA double coverage. 90% nights shifts are covered by night doctors. A complete ED refurbishment has been completed with an ER rebuild and expansion in the future. Computerized Charting and PACS!

Email CV and references to cclark@epmg.org. Phone 951-898-0823.

NORTHERN CALIFORNIA, NAPA - Independent Medical Group is seeking qualified candidates to staff their minor emergency department. Candidates include: near retirement Emergency Physicians, Family Practice physicians, Urgent care Physicians or Emergency department Nurse Practitioners.

If interested, forward C.V. to Tony Mottalei M.D. mottalei@gmail.com

NORTHERN & CENTRAL CALIFORNIA: Kaiser Permanente is looking for excellent BE/BC Emergency Medicine physicians interested in full time or less than full time position with dynamic physician group throughout Northern and Central California.

The Permanente Medical Group, Inc. offers:

- Competitive salary
- Recruitment bonus
- Mortgage loan program (approval required)
- Comprehensive benefits package, including excellent retirement plans
- Malpractice insurance coverage
- Cutting-edge technology

TPMG, Inc. allows you to combine a medical practice of which you can be proud and a quality of life you deserve.

To apply, send your curriculum vitae to Narlyn Villaruel at Narlyn.Villaruel@kp.org or call (800) 777-4912. <http://physiciancareers-ncal.kp.org>

RIVERSIDE, CA: Parkview Medical Center – Great opportunity to join a 14 year ER group. Group seeks BC/BE Emergency Physician to work Part/Full Time as an independent contractor. Excellent Top Tier Compensation based on productivity with malpractice paid. Ten hour shifts with MD double coverage and 12 Hour PA. Computerized equitable shift scheduling. Efficient Computerized Charting and PACS! A brand new ER expansion will break ground soon tripling the size of the ER!

Email CV and references to cclark@repmg.com Phone (951) 898-0823

SAN DIEGO, CALIFORNIA: Coastal San Diego emergency department seeking qualified, board-certified/eligible emergency medicine physician to join our independent, democratic group. Location is by the beach in Northern San Diego with year round outdoor life and outstanding schools. Tri-City Medical Center Emergency Department is a dynamic, high-acuity department with an excellent specialty call-panel, PGY3&4 Emergency Medicine Residents, and advanced practice PA's. Practice is designed with quality of life in mind, including 8 hour shifts with overlap and extensive provider coverage. Salary potential reaches top 3% nationally. "A"- Rated malpractice insurance with tail coverage provided.

Forward CV to Teresa Riesgo email: triesgo@tcemg.net phone: 760-439-1963

SAN FRANCISCO: Live in one of America's finest cities! Join our established, independent, democratic, physician-owned emergency group at a multi-hospital system with 2 new facilities pending. Stable, long-term contract. Immediate openings for PT/FT physicians. Excellent compensation/benefits.

Email CV to leilanig@farallonmed.com.

SOUTHERN CALIFORNIA OPPORTUNITIES:

- Tustin, CA - Orange County - 73-bed community hospital, 8-bed ER, paramedic receiving, low volume. 10 x 24hr = \$240,000/yr + incentive
- East Los Angeles - 120-bed community hospital urgent care (non paramedic receiving) volume 700/mo. Guarantee \$100/hr.
- Norwalk, CA - 60-bed hospital. 500-600 patient/mo. Paramedic receiving. \$110/hr.

FAX CV to 213 482 0577 or call 213 482 0588 or email neubauerjanice@gmail.com

SOUTHERN CALIFORNIA – ORANGE COUNTY: Full time and part time independent contracting emergency physicians needed for high volume, high acuity practices. Chest Pain Center, Stroke Center, Pediatric Level II trauma center - large independent group with forty years of clinical excellence for two acute care facilities. Expanding group needs BC/BE emergency physicians and pediatric emergency physicians. Excellent compensation, malpractice paid, scribes, midlevel providers, 8 – 9 hour shifts, excellent call panel coverage.

Email CV and references to EMSOC@emsoc.net, fax to 714-543-8914

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American Health Education, Inc

Perry Hookey, EMT-P
7300B Amador Plaza Road, Dublin, CA 94568
Phone: (800) 483-3615
Email: info@americanhealtheducation.com
Web: www.americanhealtheducation.com

American Medical Response (AMR)

Ken Bradford, Operations
841 Latour Court, Ste D, Napa, CA 94558-6259
Phone: (707) 953-5795
Email: ken.bradford2@gmail.com

A Work Safe Environment

Steve Bristow, EMT-P
3140 Aldridge Way, El Dorado Hills, CA 95762
Phone: (925) 708-5377
Email: worksafeenvironment@yahoo.com
Web: www.worksafeenvironment.com

Compliance Training

Jason Manning, EMS Course Coordinator
3188 Verde Robles Drive, Camino, CA 95709
Phone: (916) 429-5895
Fax: (916) 256-4301
Email: Kurgan911@comcast.net

CSUS Prehospital Education Program

Derek Parker, Program Director
3000 State University Drive East, Napa Hall, Sacramento, CA 95819-6103
Office: (916) 278-4846
Mobile: (916) 316-7388
Email: dparker@csus.edu
Web: www.cce.csus.edu

EMS Academy

Nancy Black, RN, Course Coordinator
1170 Foster City Blvd #107, Foster City, CA 94404
Phone: (866) 577-9197
Fax: (650) 701-1968
Email: nancy@caems-academy.com
Web: www.caems-academy.com

ETS – Emergency Training Services

Mike Thomas, Course Coordinator
3050 Paul Sweet Road, Santa Cruz, CA 95065
Phone: (831) 476-8813
Toll-Free: (800) 700-8444
Fax: (831) 477-4914
Email: mthomas@emergencytraining.com
Web: www.emergencytraining.com

Fast Response School of Health Care Education

Lisa Dubnoff, MICP/RN, Paramedic Director
2075 Allston Way, Berkeley, CA 94704
Phone: (510) 809-3646
Fax: (866) 628-5876
Email: ldubnoff@fastresponse.org
Web: www.fastresponse.org

Loma Linda University Medical Center

Lyne Jones, Administrative Assistant
Department of Emergency Medicine
11234 Anderson St, A108, Loma Linda, CA 92354
Phone: (909) 558-4344 x 0
Fax: (909) 558-0102
Email: LJones@ahs.llumc.edu
Web: www.llu.edu

Medic Ambulance

James Pierson, EMT-P
506 Couch Street, Vallejo, CA 94590-2408
Phone: (707) 644-1761
Fax: (707) 644-1784
Email: jpierson@medicambulance.net
Web: www.medicambulance.net

Napa Valley College

Gregory Rose, EMS Co-Director
2277 Napa Highway, Napa, CA 94558
Phone: (707) 256-4596
Email: grose@napavalley.edu
Web: www.winecountrycpr.com

NCTI – National College of Technical Instruction

Lena Rohrbach, Course Manager
333 Sunrise Ave Suite 500, Roseville, CA 95661
Phone: (916) 960-6284 x 105
Fax: (916) 960-6296
Email: jlcasa@caltel.com
Web: www.ncti-online.com

Oakland Fire Department

Sheehan Gillis, EMT-P, EMS Coordinator
47 Clay Street, Oakland, CA 94607
Phone: (510) 238-6957
Fax: (510) 238-6959
Email: sean@baycj.com
Web: http://www.oaklandnet.com/fire/

PHI Air Medical, California

Graham Pierce, Course Coordinator
801 D Airport Way, Modesto, CA 95354
Phone: (209) 550-0884
Fax: (209) 550-0885
Email: gpierce@philhelico.com
Web: http://www.phiairmedical.com/

Riggs Ambulance Service

Greg Petersen, EMT-P, Clinical Care Coordinator
100 Riggs Ave, Merced, CA 95340
Phone: (209) 725-7010
Fax: (209) 725-7044
Email: Gregp@riggsambulance.com
Web: www.riggsambulance.com

Rocklin Fire Department

Chris Wade, Firefighter/Paramedic
3401 Crest Drive, Rocklin, CA 95765
Phone: (916) 625-5311
Fax: (209) 725-7044
Email: Chris.Wade@rocklin.ca.us
Web: www.rocklin.ca.us

Rural Metro Ambulance

Brian Green, EMT-P
1345 Vander Way, San Jose, CA 95112
Phone: (408) 645-7345
Fax: (408) 275-6744
Email: brian.green@rmetro.com
Web: www.rmetro.com

Santa Rosa Junior College Public Safety Training Center

Bryan Smith, EMT-P, Course Coordinator
5743 Skylane Blvd, Windsor, CA 95492
Phone: (707) 836-2907
Fax: (707) 836-2948
Email: medic9001@comcast.net
Web: www.santarosa.edu

WestMed College

Brian Green, EMT-P
5300 Stevens Creek Blvd., Suite 200, San Jose, CA 95129-1000
Phone: (408) 977-0723
Email: jonesds777@hotmail.com
Web: www.westmedcollege.com

Verihealth/Falck Northern California

Ken Bradford, Training Coordinator
2190 South McDowell Blvd, Petaluma, CA 94954
Phone: (707) 766-2400
Email: ken.bradford@falck.com
Web: www.verihealth.com

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