THE BURNOUT BURDEN:
Why Doctors Need Help From Leadership

Page 10
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APRIL 2019
Index of Advertisers

| Emergency Medical Specialists of Orange County | Page 18 |
| Independent Emergency Physicians Consortium | Page 5 |
| Mission Hospital | Page 18 |
| Philip Fagan, MD | Page 18 |
| St. Jude | Page 18 |
| Ventura Emergency Physicians | Page 18 |
| Vituity | Page 15 |
**WELCOME new members!**

<table>
<thead>
<tr>
<th>Central Coast Emergency Physicians</th>
<th>Loma Linda Emergency Physicians</th>
<th>Tri-City Emergency Medical Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jamal Yosuf Alam</td>
<td>Alexandra N. Grossman, MD</td>
<td>Melanie Lanchi Pham, MD</td>
</tr>
<tr>
<td>Eric Mihael Arnold</td>
<td>Daniel Iancu</td>
<td>Michael Plantak</td>
</tr>
<tr>
<td>John Campo, MD</td>
<td>Jared Johns, DO</td>
<td>Tamy Rojas</td>
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<tr>
<td>Esteban Casasola</td>
<td>James Ko</td>
<td>Antonio Hernandez Saenz</td>
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<tr>
<td>Bryce Chavez</td>
<td>Joel Labha, DO</td>
<td>Thomas Shank</td>
</tr>
<tr>
<td>Lea Monique Cohen</td>
<td>Anthony Lim, MD</td>
<td>Nishelle Elizabeth Smith</td>
</tr>
<tr>
<td>Jared Curtis</td>
<td>Nana Yaa Y. Misa, MD, MPH</td>
<td>Dale Till</td>
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<tr>
<td>Inbal Sarah Epstein</td>
<td>Nicole J. Munz, DO</td>
<td>Vinson Vong</td>
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<tr>
<td>Andrew Lazaro Fonticiella</td>
<td>James W. Murphy, MD</td>
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<tr>
<td>Matthew David Fukuda</td>
<td>Carolina Ornelas</td>
<td></td>
</tr>
</tbody>
</table>

100% GROUPS

- Central Coast Emergency Physicians
- Emergency Medicine Specialists of Orange County
- Emergent Medical Associates
- Front Line Emergency Care Specialists
- Loma Linda Emergency Physicians
- Napa Valley Emergency Medical Group
- Newport Emergency Medical Group, Inc at Hoag Hospital
- Pacific Emergency Providers, APC
- Tri-City Emergency Medical Group
- University of California, Irvine Medical Center Emergency Physicians
Did you know that as part of the Affordable Care Act (ACA), all tax-exempt hospitals and health systems were challenged to improve the health of the communities they serve? Actually, the ACA required that all tax-exempt hospitals conduct a community health needs assessment (CHNA), which was supposed to serve as a catalyst for new or augmented hospital-community collaborations. Not surprisingly, of 300 CHNAs in 2014, Lack of Access to Care was reported in 67% of hospitals, Preventive and Screening Services in 36%, Inadequate Chronic Conditions Management in 32%, Socioeconomic Factors in 27%, Lack of Insurance Coverage in 27%, Obesity in 70%, Behavioral Health in 64%, Substance Abuse in 44%, and Diabetes in 36%.

If you work for a non-profit hospital, your hospital has likely already performed a CHNA and may even publish an ongoing Community Benefits flier that lets you know what they have done to help our communities and even how many dollars are going to each endeavor. Now, assess whether you as ED leaders were involved in these needs assessments and think about those patients we see over and over again in our EDs who may not be captured by those assessments? Who are the patients that bring on our sense of frustration (and even contribute to our burn out), whose symptoms worsen despite your thorough care and specific discharge instructions? What types of patients land in our EDs repeatedly with the same complaints or don’t seem to have any complaints at all but show up again and again with various presentations (think falls, confusion, dehydration, intoxication)? Do we judge them or, almost worse, do we resolve ourselves to just go through the motions to “rule out the emergencies” (you know, the CTs, EKGs, UAs, etc.), referring them back to their primary care doctor whose job it is to deal with those social issues? And, we even asked the social worker to see them before they left, right?

When speaking with my primary care colleagues, they too are also fraught with clinical and documentation demands in their clinics, trying to hit their volumes to keep up their reimbursements to keep the lights on. For those patients lucky enough to have fair access to a primary care physician, we hope their doctors are able to afford the time to address their social issues. But how are we doing in assessing WHY our patients are coming back to the hospital?

There are various social screening tools developed to help us assess individual needs. In the realm of primary care, there has been a movement to use these tools to help refer individuals to the proper resources. But couldn’t we use social screening to better assess our local needs and local patterns as well? A great summer project for a college student interested in medicine would be to sit in your waiting room, handing out surveys to your patients, to do just that. Is there food and nutrition insecurity, homelessness or the threat of homelessness, addiction, lack of transportation fitting their mobility, sexual history including sexual abuse, depression or suicidal risk including access to
guns, work history, and possible environmental exposures, just to name a few? There are various validated screening tools including PRAPARE (Protocol for Responding to and Assessing Patient’s Assets, Risks, and Experiences) developed by the National Association of Community Health Centers (www.nachc.org), The EveryONE Project by the American Academy of Family Physicians, and the Center for Medicare and Medicaid Services (CMS) Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool. None are tailored to the ED but the AHC Health-Related Social Needs Screening Tool, although weak on assessing housing needs, may help you better understand what our local patients struggle with, which can ultimately influence their health and outcomes.

Of course, even without the need for any screening tools, many emergency physicians have already worked with their community leaders to fund homeless shelters and respite centers to be open for intake on Saturdays and Sundays because, as we all know, homelessness does not limit itself to weekdays and bankers’ hours. Other ED leaders have raised money and worked with their hospital and county officials to build psychiatric services sorely needed in their communities. Yet other emergency physicians have developed intricate hospital and community programs to identify, shelter, and protect victims of human trafficking. Some Trauma Centers have developed violence intervention programs for when victims of gang violence arrive injured because, as the ED literature shows, if we intervene after an injury, they have a much higher likelihood of changing their lives.

Now, imagine what we could learn if we actually ask our patients when they come to our EDs what social issues they struggle with? During one of my recent conversations with Dr. Harrison Alter, who started the Social Emergency Medicine section of ACEP and serves as the Founding Executive Director and Director of Research at the Andrew Levitt Center for Social Emergency Medicine, he astutely remarked, social needs and social determinants of health don’t always overlap 100%. Social determinants of health respond well to screening tools. Social needs are local, and these are the needs that move us and make us want to help. Luckily, there is great overlap between the two. I distinctly recall a patient I saw in the ED several days in a row, with over 10 visits in one month. He was an elderly pleasant gentleman, daily drinker, always arrived after a neighbor would come to visit him who himself had mental disabilities who called 911 for him. It turns out, the patient had no access to food and was coming for the dry turkey sandwiches. If we screened him, we might have found out earlier why he ended up here. Many of our patients are ashamed to tell us about their social needs, and these needs are not always obvious. But if we ask, it may reveal what impacts them, and finally sidestep the health care systems’ “blind side.”

Where do we go from here? These discussions have made me start thinking about how we can begin applying these concepts in my own ED. I will be speaking with our department and clinical hospital leaders, including social workers and case management, about doing an ED summer project with a screening tool. I am thinking about looking at coordinating local and county resources (and maybe even enlist my husband an infectious disease doctor) for the treatment and counseling of HIV/HCV patients that could get diagnosed in the ED if we are able to screen them and take care of them holistically in our community. I would like to coordinate with local cardiologists to see if they might be willing to provide some charity care for those who cannot get follow up because of their insurance or documentation status. I am inviting experts like Dr. Aimee Moulin with the CA-Bridge Program to educate our department on Medication Assisted Treatment for opioid use disorders and show us how easy it can be to begin a patient on the road to recovery, starting right in our EDs. I have joined my hospital’s Community Benefit Oversight Committee so I can contribute to the conversations about how we are using our monies and resources to help our community. These are just some brewing ideas of how we can help our community; what are your ideas to start helping yours?

Please feel free to reach out to me chiperlroth@gmail.com, Dr. Harrison Alter harrison.alter@levittcenter.org, or our CAL-ACEP staff info@californiaacep.org with any questions about how you can start looking at the social needs of the patients in your community and actually find ways to start changing their health outcomes.

From My Community to Yours,

Chi Perlroth
The Dynamex case dates back to 2004, when Dynamex, a package and documents delivery company, converted all of its drivers to independent contractors after management concluded the move would save money. A group of drivers sued, claiming they performed essentially the same tasks in the same manner as when they were employees, but without the protections of the California Labor Code and wage orders. Last year, the California Supreme Court ruled in favor of the drivers. While many observers agree that the facts in the Dynamex case were egregious, lawyers disagree on the limitations of the case and many argue that the ruling is not limited to that one company, or even that one industry, that it in fact it applies to all businesses in every sector of the California economy.

Prior to Dynamex, California courts and state agencies had long applied what is known as the Borello test for determining whether a worker was an independent contractor for labor and employment purposes. Notably, the Borello decision was also a California Supreme Court decision and was referenced by the California Labor Commissioner as the model to utilize for determining independent contractor status. See S.G. Borello & Sons, Inc. v Dept. of Industrial Relations (1989). This flexible, multi-factor approach looked primarily at whether the hiring entity had a “right to control” the manner in which the worker performed the contracted service, along with eight other “secondary” factors, such as whether the worker was engaged in a distinct occupation or business, the skill required in the particular occupation, and whether the worker or the hiring entity supplied the tools used to perform the work and the place where the work was performed.

The California Supreme Court made a surprising and unprecedented departure from decades of employment law and announced a significant change, adopting the “ABC” test for determining whether an individual is an employee under the Wage Orders in question under Dynamex. Notably, this test has never existed in any form of California law, either in statute or by regulatory action. Additionally, while other state legislatures have enacted similar tests, this is the first time that such a test has been imposed by a court without legislative approval.

As you likely know, on April 30, 2018 the California Supreme Court dramatically changed employment law through their ruling in Dynamex Operations West v. Superior Court (Dynamex).
Under this new "ABC" test, a person will be considered an independent contractor only if the hiring entity can prove all three of the following:

A. That the worker is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance of the work and in fact;

B. That the worker performs work that is outside the usual course of the hiring entity’s business; and,

C. That the worker is customarily engaged in an independently established trade, occupation, or business of the same nature as the work performed.

This new test places in doubt the sustainability of a significant portion of independent contractor relationships in California and has the potential to cause substantial economic harm to hundreds of thousands of working Californians. Because of the rigidity of the test, specifically factors "B" and "C", most individuals who control their own schedule, control the projects or tasks they take on, and control the way in which they perform the tasks or projects, will likely lose existing contracts and work opportunities because they perform work that is similar to that of the business entity retaining their services and/or are not in an independent business or trade of the same work being performed.

We heard from many of you raising serious questions about its implications for yourselves and your groups. As a result, California ACEP’s advocacy team has worked hard to seek legislative clarification around the implications of Dynamex.

As you know, many emergency physicians are independent contractors and many work at multiple hospitals. We have made it clear
to stakeholders, including organized labor, that this structure is crucial to ensuring rural and safety net hospitals have enough physician coverage in their emergency departments (ED). The ban on the corporate practice of medicine has also been part of our discussions and has proven to be a compelling argument as to why emergency physicians must be exempted from the ruling.

There are so many unanswered questions and potential unintended consequences created by the Dynamex ruling. Questions and consequences for engineers, software developers, designers, technicians, lawyers, therapists, insurance agents, realtors, accountants, financial advisors, professional consultants, small businesses, writers, editors, drivers, artists, and other professions. California ACEP participated in a legislative hearing on the issue with a number of other organizations representing workers in these industries. We made clear the experience of an emergency physician is not the same as that of the delivery drivers at the heart of the Dynamex decision.

The Court was limited in the information it considered in its opinion, but the Legislature is not. Legislative discussions and hearings that invite all stakeholders from all sides of this discussion together could better identify a test for independent contractor versus employee that provides a comprehensive and clear solution.

We are pleased to announce that emergency physicians are included in the legislative solution, AB 5 by Assembly Member Lorena Gonzalez Fletcher. AB 5 is backed by organized labor, who worked extensively with us to ensure California’s emergency physicians can practice without ambiguity and patients can continue to receive quality emergency care in their communities.

You may have seen that a number of bills relating to Dynamex have been introduced by the State Legislature this year. AB 5 has the most viable path forward and we are pleased that emergency physicians have been included.

While it is early in the legislative calendar, we are optimistic that AB 5 will reach the finish line so that emergency physicians can continue without risk to serve patients as they have for decades – through different employment models that allow the best access to care for their patients.

We hope that you will join us in Sacramento on April 23rd for our 30th annual Legislative Leadership Conference, where we will advocate on the important issues impacting emergency physicians and their patients.

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APRIL 23, 2019 SACRAMENTO
THE BURNOUT BURDEN:

Why Doctors Need Help From Leadership

By Steve Jackson
By now, it’s not news to anyone that physicians are feeling burnt out. But the scale of the problem may be worse than you think. “Burnout” describes the cluster of cynicism, depression, and exhaustion that overcomes people who struggle in their work. While burnout appears in every profession, physicians experience the worst of it: 54% of them are currently experiencing at least some burnout symptoms.

This is not a new issue. Physician burnout has been a well-documented phenomenon since 1981. Despite that, researchers and healthcare organizations have made little progress in curbing it. In fact, the burnout rate has been consistently rising every year.

What toll does this take on healthcare organizations? And what should leaders do about it?

The Uncounted Cost of Burnout

Taken together, the costs of physician burnout can be staggering. The most obvious financial drain is from turnover—burnt out physicians tend to quit. Christine Sinsky, MD, FACP, is the Vice President of Professional Satisfaction at the American Medical Association. She points out that replacing just one physician costs an organization between $500,000 and $1 million. This means that, if a health system with 500 physicians in its roster experiences average yearly rates of burnout (54%), they will have to spend $12 million every year recruiting new doctors.

For any organization, $12 million is a significant loss. But Dr. Sinsky clarifies that the financial fallout is more complicated than that. That’s because doctors all express burnout differently. They may not always quit their jobs; some scale back to part-time work, which, while expensive, is more tolerable than a resignation.

However, other doctors will simply grit their teeth and push through their burn out—and that’s not always a good thing. Burnt-out doctors see a consistent drop in their productivity, and even worse, their care quality tends to suffer. As Dr. Sinsky puts it,

“[Doctors with burnout] may respond by providing less-safe care. We know that care is safer when physicians are satisfied with their work.”

Healthcare organizations should note how this can affect care volumes. Patients notice when care quality dips, and they’re not afraid to switch providers over it.

But the far more important implication is to patient safety. The research is clear: burnt-out doctors put patients at risk.
Misdirected Burnout Cures

Because burnout’s symptoms can be so private and emotional, interventions for it—like mindfulness meditation—tend to focus on individual physician behavior. In theory, these boot-strap approaches promote physician “resilience.” While there’s some evidence that these interventions can help, they also put the burden on doctors to restore their own work-life balance. That overlooks burnout’s structural causes, over which physicians have little control.

Dan Ariely, Ph.D., and William L. Lanier, MD, described three of these forces at work:

- **ASYMMETRIC REWARDS.** While doctors enjoy a prestigious and remunerative career, they’re also exposed to tremendous risk in the event that they ever make a mistake. The fear of the pain and expense involved makes many doctors unable to enjoy their work.

- **LOSS OF AUTONOMY.** Doctors are micro-managed continuously and often have little say in how they spend their days. One colleague of Dr. Ariely’s confided that he wasn’t even allowed to take unscheduled bathroom breaks. That would be hard for anyone to stomach—let alone a highly trained professional.

- **COGNITIVE SCARCITY.** Doctors have to carefully weigh every choice they make against its alternatives and consequences. That’s the essence of clinical work. But it takes a toll. Researchers have found that a stream of difficult decisions induces a cognitive deficit, one roughly equivalent to losing a night of sleep, being slightly intoxicated, or losing about 13 IQ points.

Doctors have next to no ability to change these pernicious influences on their work. No amount of “resilience” can overcome them. The implication that doctors should be solely responsible for resolving these issues, then, is worse than ineffective—it’s insulting.

What Organizations Can Do

But while the pursuit of individual resilience is almost a farce improving institutional resilience can be an effective strategy. Systematic solutions can succeed where small-scale interventions cannot.

It’s up to healthcare leaders to cultivate the kind of culture that responds to physicians’ needs and prioritizes their health. Here are some good first steps for healthcare leaders to take:

1. **LEARN.** Burnout is a complex and evolving problem. It’s important for leaders to understand the latest developments, which means reviewing the clinical literature on the subject. (The links in this article are a good place to start, but are by no means exhaustive.)

2. **LISTEN.** As mentioned above, burnout is also a highly personal experience. The literature won’t tell leaders how their workforces go through it. Leaders should, therefore, spend time listening to how physicians feel about their work.

3. **MEASURE.** Some healthcare leaders hesitate to measure how burnout has affected their organizations—perhaps because they’re not sure what to do about it. But Dr. Sinsky observes that measuring burnout’s impact is an important step toward resolution. “First measure,” she says, “and then, second, weigh the costs of burnout to your organization.” This will not only show leaders the true extent of the problem but will also point the way toward the most promising solutions.
4. **RETHINK.** Resolving workplace burnout demands a shift in approach to clinical work. Larry McEvoy, MD, president and CEO of LCI Group, points out that organizations must make physician vitality and wellbeing an explicit institutional priority. Once this becomes a staple of C-suite discussions, opportunities for intervention emerge—like giving physicians extra time to maintain their certifications, taking efforts to reduce clerical workload, finding new practice models that ease pressure on physicians, or improving processes for efficiency.

**Physician, heal thyself is not a tenable stance**

The solutions, of course, will vary by institution. But leaders will go a long way toward resolving burnout if they embrace a considerate attitude toward their clinical staff.

“Physician, heal thyself” is not a tenable stance to take against physician burnout. But leaders can heal institutions—and promote wellbeing for their doctors, their patients, and their organizations along the way.

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This article was originally published on The Doctor Weighs In (www.thedoctorweighsin.com) on July 24, 2018.

**Steve Jackson**

Steve Jackson serves as President of NRC Health. He joined NRC in September 2014, bringing nearly 20 years of experience advising health systems in a variety of terrains including, patient experience, physician engagement, and patient access. As President, Steve oversees company strategy and NRC’s portfolio of solutions that bring human understanding to healthcare. Today, NRC enables more than 75% of the Top 200 U.S. health systems to better understand the people they care for and design experiences that inspire loyalty. Prior to joining NRC, he held roles of increasing responsibility at Vocera Communications, The Advisory Board Company, Neoforma, and Stockamp & Associates. Steve graduated with honors from the University of California, Davis. Outside of the office, he serves as his family’s chief transportation officer, short order cook, and food and wine critic.
YOUR LIFE IN EMERGENCY MEDICINE

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Education is targeted to Medical Students and Residents, but all are welcome to attend.

Friday, September 20, 2019
Hyatt Regency, Orange County, CA
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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, lock in $500 million for the Maddy EMS Fund over the next 10 years, and fight for ED overcrowding solutions! 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 on your behalf. Thank you to our 2018-19 contributors (in alphabetical order):

- Alvarado Emergency Medical Associates
- Antelope Valley Emergency Medical Associates
- Beach Emergency Medical Associates
- Chino Emergency Medical Associates
- Coastline Emergency Physicians Medical Group
- Culver Emergency Medical Group
- Hollywood Presbyterian Emergency Medical Associates
- Las Cruces Emergency Medical Associates
- Los Alamos Emergency Medical Associates
- Mills Peninsula Emergency Medical Group
- Orange County Emergency Medical Associates
- Pacific Coast Emergency Medical Associates
- Riverside Emergency Physicians
- San Dimas Emergency Medical Associates
- Sherman Oaks Emergency Medical Associates
- South Coast Emergency Medical Group, Inc.
- Tarzana Emergency Medical Associates
- TeamHealth
- Temecula Valley Emergency Physicians, Inc.
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SAVE THE DATE

Legislative Leadership Conference (LLC)
April 23, 2019 | Sacramento, California

AdvancED 2019
September 20, 2019 | Garden Grove, California

CALL FOR PROPOSALS

California ACEP invites you to submit a Lightning Talk proposal and/or submit a poster presentation proposal for our annual conference, AdvancED 2019! The theme of this conference is “Your Life in Emergency Medicine”. The conference is tailored to residents and medical students, but all are welcome to submit proposals.

More information at californiaacep.org/event/AdvancED2019

SUBMIT A LIFELINE ARTICLE

Looking for a way to share your emergency medicine experience? Want to share a story from your last shift? Or maybe career or life advice? We’re looking for member and guest articles, including letters-to-the-editor. Please note that all articles and letters are reviewed and may be edited for grammar and content.

If you would like more information or would like to submit a guest article, email info@californiaacep.org.
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

**APRIL 2019**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</tr>
</thead>
<tbody>
<tr>
<td>12th – 21st</td>
<td>California Legislature: Spring Recess</td>
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<tr>
<td>23rd at 9 AM</td>
<td>Legislative Leadership Conference (LLC)</td>
<td>Sacramento, CA</td>
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<tr>
<td>24th at 9 AM</td>
<td>Board of Directors Meeting</td>
<td>Sacramento, CA</td>
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<tr>
<td>24th</td>
<td>CMA Legislative Advocacy Day</td>
<td>Sacramento, CA</td>
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</tbody>
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**MAY 2019**

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<thead>
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<td>5th – 8th</td>
<td>ACEP Leadership and Advocacy Conference</td>
<td>Washington, DC</td>
</tr>
<tr>
<td>14th at 9 AM</td>
<td>Reimbursement Committee</td>
<td>Conference Call</td>
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<tr>
<td>15th – 31st</td>
<td>Board of Director Elections</td>
<td>Online</td>
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<tr>
<td>16th at 10 AM</td>
<td>Government Affairs Committee (GAC)</td>
<td>Conference Call</td>
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<td>27th</td>
<td>Memorial Day – Chapter Office Closed</td>
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**JUNE 2019**

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<td>6th at 10 AM</td>
<td>Board of Directors Meeting</td>
<td>Sacramento, CA</td>
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Email CV and references to EMSOC@emsoc.net, fax to 714-543-8914

SOUTH ORANGE COUNTY: Mission Hospital and Children’s Hospital at Mission, a CMS 5-Star rated full service hospital. We are an established, independent, democratic group staffing this ED for 22 years. Excellent compensation; malpractice paid; scribes; midlevel providers.

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The department serves both a pediatric and adult base station hospital serving all of south OC. High acuity, 70,000 patients a year, comprehensive referral center, outstanding adult and pediatric sub specialty coverage, adult and pediatric trauma center, STEMI Center, and Stroke Center.

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