THE ED FOLLOW-UP NURSE,

a great way to improve your department

Page 12
California ACEP
Board of Directors &
Lifeline Editors Roster

2018-19 Board of Directors
Chi Perlroth, MD,FACEP, President
Vivian Reyes, MD,FACEP, President-Elect
Vikant Gulati, MD,FACEP, Vice President
Sujal Mandavia, MD,FACEP, Treasurer
Lori Winston, MD,FACEP, Secretary
Aimee Moulin, MD,FACEP, Immediate Past President
Harrison Alter, MD,FACEP (At-Large)
Reb Close, MD, FACEP
John Coburn, MD, FACEP
Carrieann Drenten, MD, FACEP
Jorge Fernandez, MD
Michael Gertz, MD, FACEP
Doug Gibson, MD, FACEP
John Ludlow, MD, MBA, FACEP
Karen Murrell, MD, MBA, FACEP
Mitesh Patel, MD, MBA, FACHE, CPE
Hunter Pattison, MD (CAL/EMRA President)
Patrick Um, MD, FACEP, FAAEM

Advocacy Fellowship
Carrieann Drenten, MD, FACEP, Advocacy Fellowship Director
Sam Jeppsen, MD, Advocacy Fellow

Lifeline Medical Editor
Richard Obler, MD, FACEP, Medical Editor

Lifeline Staff Editors
Elena Lopez-Gusman, Executive Director
Kelsey McQuaid-Craig, MPA, Director of Policy and Programs
Lucia Romo, Membership and Education Coordinator
Lauren Brown, Government Affairs Associate
Meri Thresher, Administrative Assistant

JANUARY 2019
Index of Advertisers

Emergency Medical Specialists of Orange County Page 14
Independent Emergency Physicians Consortium Page 7
Mission Hospital Page 14
Philip Fagan, MD Page 14
St. Jude Med Center Page 14
Ventura Emergency Physicians Page 14
Welcome new members!

Julie Elizabeth Anderson, DO
Justin M. Arndt, MD
Joseph H. Chang, MD
Muamin Hamdani
Gina Hana

Sabrina Khan Harrell
John Hooge, MD
Brian Knight
Kerry Lamb
Vijay G. Menon, MD

Joel C. Miller, MD
Charles Ban Poon
Bushra Mazhar Syed
Allan Dean Winger
Josue Zozaya

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
Procedural Sedation

EMERGENCY DEPARTMENT
Since the 1990s, our emergency department (ED) colleagues, such as Dr. Steven Green, have been fighting for our specialty to gain access to sedation drugs - such as Ketamine, Etomidate, and Propofol - as we realized we needed more safe and effective drugs to take care of our unscheduled sick and injured ED patients. Some of us have made some headway in collaborating with our anesthesia colleagues and convincing our hospital administrators that we can provide reprieve for our patients during painful procedures at various levels of sedation (mild, moderate, dissociative, and deep) in both urgent and emergent settings.

Despite all the ED research and literature on safety and efficacy, all the training in our residencies and educational courses, and our ability to manage the airway and critically ill patients with these drugs, many of our hospitals and anesthesia colleagues still feel there should be restrictions on the level of sedation and the types of sedation medications we use in the ED. How fun or effective is strapping a toddler down with bed sheets or a papoose to suture a facial laceration? What if versed and fentanyl were your only options to titrate on an awake trauma patient before you inserted a chest tube? The sad fact is that this is still the case for some of our ED colleagues in California.

To assess the extent of these restrictions, California ACEP collaborated with Dr. Steven Green, and others, this year to survey medical directors for all licensed EDs in our state. Of the 328 California EDs, responses were obtained from 211 (64%). The survey quantified some of the suspicions we had, as 43% (91 EDs) reported conditional or total limitations on their ability to administer one or more of the following: moderate sedation, deep sedation, Propofol, Ketamine, or Etomidate. Further, local anesthesia directors were the most frequently cited creators and enforcers of these restrictions. And, not surprisingly, some respondents reported that due to these restrictions, they used less medications than desired.

How about we start this month’s message with a short quiz:

1. What medication would you use to sedate and reduce the 8 year old kid who fell off a skateboard and sustained a displaced fracture of his distal radius?

2. What drugs could you use to perform synchronized cardioversion on an atrial fibrillation patient with an already low blood pressure?

3. What option would you use to reduce the dislocated shoulder on an athlete whose 250 pounds of contracting muscle will prohibit you from getting the humerus back if he’s not completely limp and, better yet, get him in and out of your really busy ED in no time flat?

Pretty straightforward, right? Well, it turns out, only for some of us…
effective sedatives or performed procedures without sedation when sedation would have been preferred, and as a consequence, they observed inadequate sedation and pain control.\textsuperscript{1}

Also from the California ACEP survey, “More than one-third of our EDs reported restrictions or prohibition of the emergency physician performing the procedure while simultaneously overseeing sedation. Although such a precaution may be considered optimal for elective procedures, there is a longstanding track record of emergency physicians simultaneously performing procedures while managing moderate, dissociative, and deep sedation and without evidence of any increased frequency of clinically important adverse events or outcomes. The presence of two emergency physicians is frequently a physical impossibility in many lower-volume EDs, and thus any restriction threatens the ability of the emergency physician to provide humane, effective relief of procedural pain and anxiety.” When our patients suffer because of these types of restrictions, we need to look beyond turf wars and look to the evidence to provide the best care for our patients.

Earlier this year, the American Society of Anesthesiologists (ASA) released their revised sedation guidelines which seek to restrict the use of Propofol and Ketamine outside of the hands of anesthesia. They also left out any guidelines on deep sedation, which is often used in the ED.\textsuperscript{2} Wait a minute, aren’t we moving backwards? Despite discussions and collaboration between ACEP and ASA leadership, ASA still made a decision to endorse guidelines that restricted the most commonly used medications in the ED. Hospitals vary on who dictates sedation policies, but many allow them to be developed exclusively by the Department of Anesthesia and, as such, anesthesia chairs may look to these ASA guidelines for direction on how to develop or revise hospital policy. Some anesthesia chairs may also believe one hospital policy on sedation fits all patients: preoperative versus emergency versus pediatric patients.

To make sure emergency physicians had the most up-to-date guidelines for our unique practice, ACEP released “Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline” on September 28, 2018. This was a coordinated effort by emergency and pediatric emergency physicians reaching out for other specialty input to develop evidence-based guidelines for our patients, who almost always arrive unscheduled and require all levels of sedation. For those of us who have worked hard to ensure we have our own sedation policies in the ED, please refer to these guidelines for your next revision. For the rest of us, please use this as a concise, evidence based, and well referenced tool for you or your medical director to start the conversation with your anesthesia colleagues to improve sedation care and change sedation policies for your ED patients. The big challenge is that changing these policies and access to medications in the ED happen at the local hospital level. But perhaps given ASAs even more restrictive national guidelines, we should look at this challenge instead as a silver lining.
A little bit more background information to start the conversation:

ED practice restrictions have been propagated not because they are required or even encouraged by the Joint Commission or by the Centers for Medicare and Medicaid Services (CMS). They instead result from sedation policies and protocols based on local preferences and unduly conservative interpretations of state regulatory compliance. The last California Department of Public Health (CDPH) All Facilities Letter referring to procedural sedation in the ED (AFL 13-17 dated July 5, 2013) describes requirements and specific provisions to sedation policies which are fairly open to interpretation. However, the AFL is helpful in recognizing that, “In general, the policies and procedures governing sedation practices should be specific to the unit of the facility in question, i.e. Emergency Department,” etc.

Further, CMS acknowledged the special situation and training of emergency medicine. “The ED is a unique environment where patients present on an unscheduled basis with often very complex problems that may require several emergent or urgent interventions to proceed simultaneously to prevent further morbidity or mortality.” They continue: “... emergency medicine–trained physicians have very specific skill sets to manage airways and ventilation that is necessary to provide patient rescue. Therefore, these practitioners are uniquely qualified to provide all levels of analgesia/sedation.”

Below are some highlights from ACEP’s “Unscheduled Procedural Sedation” Guidelines to help improve policies in your ED:

1. Make it Multidisciplinary: “Procedural sedation (whether elective or unscheduled) has always been administered by providers of different backgrounds working in diverse settings. This multispecialty experience fosters productive debate and innovation.” Consider adding Cardiology, Pulmonary Critical Care, Interventional Radiology, and Gastroenterology to the conversation with you and Anesthesia. Many of these specialty colleagues understand the urgent and emergent conditions in which your patients arrive and can attest to and confirm your unique challenges.

2. Ventilatory Adequacy versus Responsiveness: “Modern procedural sedation practice is best served by focusing on patient responsiveness when the intent is to ensure effectiveness, while focusing on ventilatory adequacy when the intent is to ensure safety.” If available, use capnography to monitor ventilatory adequacy. Waking a patient up every few minutes does not help with monitoring safety; in fact, it may decrease efficacy causing higher requirements of sedatives because the patient may be too alert to fully receive the benefits of sedation.

3. Procedural Sedation Depth, not Drug: “A longstanding hallmark of procedural sedation guidelines is the concept of a sedation continuum,” that most sedatives are capable of producing any sedation depth along the scale of minimal sedation to general anesthesia. “Accordingly, it is more meaningful to focus clinical decisions and management upon sedation depth and ventilatory adequacy rather than the specific drug itself,” meaning restricting drugs from various departments does not make sense. “There is no evidentiary or pharmacological basis for the designation of specific procedural sedation agents as intended or not intended for general anesthesia, or for restricting them on this basis.”

4. Sedation Staffing: Two-person Sedation Team: “Safe procedural sedation requires a minimum of two trained health care practitioners at the bedside: the sedation provider who takes responsibility for oversight of the procedural sedation encounter and a sedation monitor (commonly a registered nurse or respiratory therapist) whose primary duty is continuous patient monitoring and documentation.”

5. Nurse Administration of Sedatives: “Just as qualified registered nurses routinely administer sedatives and paralytics for intubation under direct supervision of an ordering provider, they are similarly qualified and capable of administering medications for procedural sedation while under the direct supervision of the ordering provider...Nurses with the required skills to serve as sedation monitors should be permitted to administer any and all medications used for unscheduled procedural sedation while under the direct supervision of the ordering provider, with the ordering provider specifying the dosing and administration.” Yes, the Propofol debate.

6. Pre-sedation Patient Evaluation: ASA Classification I and II (healthy and with mild systemic disease) are generally excellent candidates for procedural sedation. Those with severe systemic disease (ASA III or greater) are at greater risk of adverse events. Interestingly, there is no evidence that Mallampati score has any impact on clinical outcomes, so it is not recommended. That being said, it is important to assess for anatomic or physiologic variants that put them at greater risk of airway or ventilatory compromise or that might complicate assisted ventilation (i.e. micrognathia, macroglossia, laryngomalacia), short neck, severe obesity, history of obstructive sleep apnea, premature birth in infants.
Pre-sedation Oral Intake: “The combination of vomiting and loss of airway protective reflexes is rare during procedural sedation, and resulting aspiration is extremely rare.” To date, only nine reports of aspiration-associated deaths have been reported in the post-1984 procedural sedation literature, of which eight were during upper gastrointestinal endoscopy. None of these occurred in children or healthy adults. Currently, there is no evidence that non-compliance with elective fasting guidelines increases the risk of aspiration or other adverse events.

Please feel free to contact me at info@californiaacep.org with any questions. I hope to continue the discussion.

Chi Perlroth, MD FACEP

REFERENCES

The first California ACEP sponsored budget request asked the State to provide $20 million for a grant program to place alcohol and drug counselors in emergency departments (ED) throughout the state. Unfortunately, our precise proposal was left out of the final budget deal made with the Governor.

However, sometimes ideas floated in the public policy arena take shape in different ways. We are pleased to report this is the case with our alcohol and drug counselor proposal. The State recognizes the important role emergency medicine can play in getting patients the treatment they need and has allocated $15 million in funding for use in the ED.

The funding will be administered through the Public Health Institute’s California Bridge Program to increase access to evidence-based treatment for substance use disorders. The program seeks to increase access to Medication Assisted Treatment (MAT) at sites where patients with opioid use disorder (OUD) receive much of their healthcare: the urgent care, emergency department, inpatient hospital wards, and hospital-based specialty clinic settings.

During the 2018 Legislative Session, California ACEP worked on two budget items: one on expanding access to substance use disorder treatment and the other on Proposition 56 residency program funding. While not everything went according to the original plan, the end result is an additional $22.6 million in funding for emergency medicine. This is a great victory for emergency medicine and your patients!
Through this Request for Applications, PHI seeks to identify up to 30 hospital/healthcare sites to participate in the California Bridge Program (CA Bridge) activities. Of the $15 million in available funds, successful applicants may be eligible to receive $100,000–$300,000 of funding to implement MAT programmatic activities at their site for up to an 18 month period; funding amounts will vary by site.

The application deadline was December 17th and 74 facilities applied for the 30 funding opportunities! Grant recipients will be notified in mid-January. We are excited by the level of interest across the state and to expand on this funding in the years to come. For other ways to expand MAT in your ED, visit the MAT page on the California ACEP website: https://californiaacep.site-ym.com/page/MAT-ED.

The second budget item California ACEP worked on was Proposition 56. California ACEP ensured the $40 million in Proposition 56 funds for GME for emergency physicians and primary care physicians was properly allocated. You may recall, last year the Governor stole the money by reducing the UC budget and filling it with the Proposition 56 funds intended for GME programs. This year we were successful in having the funds allocated correctly to GME programs even though the Governor once again tried to redirect the funds. This is a great victory for emergency medicine residency programs, enabling them to expand the number of residency slots in California.

The $40 million in Prop. 56 funding will be administered by Physicians for a Healthy California (PHC) through a new grant program, CalMedForce, which will award funding to primary care and emergency medicine residency programs in California. The application was released on December 12, 2018, and is due by January 15, 2019, at 11:59 p.m. (PST).

To be eligible for funding, residency programs must meet the following criteria:

- Located in California
- Osteopathic or allopathic
- Primary care (family medicine, internal medicine, obstetrics/gynecology and/or pediatrics) or emergency medicine
- Accredited by the Accreditation Council for Graduate Medical Education (ACGME), and/or the American Osteopathic Association (AOA) Council on Postdoctoral Training
- Serving medically underserved areas and populations

Available funding* per discipline:

- Family Medicine: $9.5 million
- Emergency Medicine: $7.6 million
- Internal Medicine: $7.6 million
- Ob/Gyn: $5.7 million
- Pediatrics: $7.6 million

*Funding is approximate and will be disbursed based on scoring criteria.

California ACEP is pleased to have secured $7.6 million for emergency medicine through the PHC stakeholder process. We would like to thank Lori Winston, MD, FACEP and Aimee Moulin, MD, FACEP for participating in the PHC stakeholder process and making our case for additional funding for emergency medicine.

We hope California’s emergency medicine residency programs will take advantage of these funds!

California ACEP will continue to fight for additional funding for emergency medicine, including innovative programs that will help you connect your patients to much-needed services. We look forward to building on our 2018 successes in the years to come.
Since approximately 2002, Queen of the Valley Medical Center Emergency Department has employed a Registered Nurse in the role of Follow-up Nurse (FUN). This person usually works a dayshift from 9a-5p with some variation, 7 days a week. This timeframe serves two purposes; being available to process the lab culture results and radiology over-reads, and provide the emergency department (ED) dayshift surge capacity needs to cover breaks and lunches when ED volume swells.

The value of this position cannot be overstated, as their work serves to protect the Med-mal exposure of both the hospital and the physicians by following up on all culture results and next day radiology discrepancies. These important results are acted upon almost immediately by the FUN. Their flexible role is the most immediate staffing surge response available within the hospital staffing model. The FUN also performs day after care phone calls to patients and families based on selected criteria; Trauma activated patients that were discharged from the ED, positive cultures, missed fractures. They also call patients based on emergency physician request; complex patients with need for close follow-up, out of town visitors without follow-up, borderline admitable patients (weak and dizzy). These calls generate overwhelmingly positive feedback for the caregivers that improves morale, empathy, and job satisfaction. The rare negative feedback serves to inform on process improvement. It is highly suspected that these calls also improve our patient satisfaction scores, although this has not been formally studied in our facility.

We created the incentive for the hospital to fund this position through shared risk reduction with the radiology department budget. Medicare QA monies from Part A include indications of Radiology QA. Like many changes, it took a bad outcome years ago to be the catalyst which helped prioritize the need. In this era of hospital budget squeeze, we have had to advocate & defend this position on a regular basis. Absence of Med-mal cases is a hard point to argue, but it is very real when you have experienced a lawsuit. Also, in the era of ED boarding, nursing staff shortages, and last minute RN sick calls, this FUN role has been one of the only reservoirs of RN staffing support on really busy days when more help is needed; summer weekend shifts, Flu season, etc.

The FUN is typically filled by an experienced ED nurse who has served in many different roles such as triage, shift lead, etc. Sometimes this position is filled by and RN who is out on disability from an injury where they cannot perform usual ED nursing duties, but can perform computer/cognitive tasks. This is very helpful for the nurse who wants to get back to work, but is not cleared for full duty. They often report...
that they really enjoyed the time spent with patients and families and genuinely connect with people in a different way regarding their ED care that is meaningful. They have the time, not often available in the ED setting to answer questions that may have developed since discharge. They reiterate the need for filling the given prescriptions and following discharge instructions. These calls result in increased compliance with home care directions, another hard to measure metric that has tremendous patient care value. Serving in this position is often very educational for the ED nurses, stepping outside their usual role, to hear how patients are doing after their encounter and to receive feedback about their visit. This dual function can prevent unnecessary return trips to the ED and also recommend immediate return for further treatment; i.e. bacteremia. These nurses also serve an important reporting function to the public health department for positive cultures.

I have also noticed a positive effect on the physicians and PA/NP’s when receiving the FUN notes. The positive feedback seems to lift spirits, increase empathy and improve job satisfaction. This has immeasurable value in a busy department doing a challenging, often thankless job with difficult circumstances. The caregivers who don’t utilize this service, often come around after the positive feedback is tangible amongst their colleagues, and jealousy peaks their interest. Our department has received high satisfaction scores compared to sister hospitals and the FUN is a significant part of that. Patients and families often report that they have never been called after a visit to the ED, and are generally effusive about their care experience. We have begun to expand this positive vibe to include nurses and techs whom were in contact with the patient during their ED care. Highlighted names are often displayed on the bulletin boards in the ED lounge and broadcast within monthly meetings. This has resulted in staff taking visible pride in their work.

Having previously served as our ED medical director, I wish I would have taken advantage of the FUN role. It is one of the best ways to improve many aspects of the department functions, safeguard against difficult cases and missed findings falling through the cracks, minimizing QA and Med-mal, and reducing bounce backs. All that plus increasing nursing staff surge capacity and improving patient satisfaction is a Win - Win for all. Your hospital administration will not easily want to support the increased FTE, but the benefits are many. Discussion may circle around improving LWOBs on busy shifts or when multiple sick calls occur during Flu season.
Emergency physicians stand in a unique position in medicine. We are the gateway to healthcare. We provide treatment to anyone at any time. People come to us in times of emergency and entrust in us to do what is right for them, and in alignment of their treatment wishes. During emergencies, patients are often unable to speak for themselves, leaving family members or physicians to make critical decisions, possibly without fully understanding a patient’s desires.

There have been several pieces of legislation in California, supported by California ACEP, to create an ePOLST. However, the costs for such a project have kept policy makers from adopting a statewide POLST e-registry. In 2015, SB 19 (Wolk) was signed into law creating a POLST eRegistry pilot program. This legislation authorized the piloting of health information technology to retrieve a valid, completed POLST form in order to understand in real-time a patient’s end-of-life treatment wishes. The provisions of that law are set to sunset January 1, 2020, unless a bill is passed in 2019 to continue the pilot.

Emergency physicians often jump in to solve problems when others have not. Seeing a need here, and no technology on the horizon, I began looking at starting an ePOLST registry. I’m proud of the result, HealtheMedRecord (HEMR), which has a health IT platform, Medcordance, a cloud-based HIPAA secure ePOLST Registry and advance care planning platform that connects treatment teams, families, caregivers, EMS, and hospitals to focus on memorializing and honoring treatment wishes for patients with a terminal illness.

Medcordance is built from the ground up to incorporate both user-centered design and patient centered concepts in its electronic workflows. These workflows harmonize with existing clinical workflows to ensure a high measure of adoption and user satisfaction, while using latest mobile technology to assist treatment teams to efficiently complete new and updated ePOLSTs, and allow viewing them during patient emergencies. HEMR has been vetted by National POLST (polst.org), and is acknowledged to be in alignment with the National POLST paradigm.

HEMR launched in Ventura county early 2018, and we also partnered with Colorado’s state-wide HIE, the Colorado Regional Health Information Organization (CORHIO), and will be the first fully functioning state-wide HIE-integrated electronic ACP platform beginning in the 2nd quarter next year. It has been rewarding to work with CORHIO and their CEO, Morgan Honea, to move the process of health information exchange forward in Colorado.

We worked hard to make Medcordance the first (and thus far only) ePOLST and Advance Care Planning platform certified by Medicare for reporting under Medicare’s Merit-based Incentive Payment System. Through a collaboration between HEMR and the Ventura County Medical Association, the VCMA-HEMR Qualified Clinical Data Registry allows physician groups access to the Medcordance ePOLST Registry after subscribing to the QCDR. The VCMA-HEMR QCDR authored the first MIPS measure devoted to electronic POLST submissions into a registry.

I am pleased the State of California chose to pilot this opportunity to use technology to improve patient care and create system efficiencies. I hope providers take advantage of the opportunity.

About Carlo Reyes:

Carlo Reyes is a board-certified emergency physician, pediatrician, and a healthcare attorney. He is the CEO and a founder of Health-e-MedRecord. He is the Assistant Medical Director in Emergency Medicine at Los Robles Hospital in Thousand Oaks, California, a Board Member of the Ventura County Medical Association, and a Steering Committee Member of the Ventura County Coalition for Compassionate Care. He is a featured columnist for Emergency Medicine News, writing AT YOUR DEFENSE, focusing on advocating for emergency physicians. He also started a non-profit, Health-e-Charity, which builds international multi-specialty medical mission teams. He can be reached at: ---
Wishing you and yours a cheerful holiday season and an even happier new year!
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 2017-18 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.
- US Acute Care Solutions
- Valley Emergency Medical Associates
- Valley Presbyterian Emergency Medical Associates
- Vikant Gulati, MD
- Vituity
- West Hills Emergency Medical Associates

Thank you to our 2017-18 contributors (in alphabetical order):

SAVE THE DATE

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

CALIFORNIA ACEP SPONSORED & CO-SPONSORED COURSES

41st Annual Emergency Medicine In Yosemite
January 16-19, 2019 | Yosemite, CA

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.

## JANUARY 2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>New Year's Day&lt;br&gt;Chapter Office Closed</td>
</tr>
<tr>
<td>7th</td>
<td>California State Legislature Reconvenes&lt;br&gt;Sacramento, CA</td>
</tr>
<tr>
<td>8th at 9 AM</td>
<td>Reimbursement Committee&lt;br&gt;Conference Call</td>
</tr>
<tr>
<td>16th – 19th</td>
<td>Emergency Medicine in Yosemite&lt;br&gt;Yosemite Lodge</td>
</tr>
<tr>
<td>17th at 10 AM</td>
<td>Government Affairs Committee (GAC)&lt;br&gt;Conference Call</td>
</tr>
<tr>
<td>21st</td>
<td>Martin Luther King, Jr Day&lt;br&gt;Chapter Office Closed</td>
</tr>
</tbody>
</table>

## FEBRUARY 2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Board of Directors Nominations Open&lt;br&gt;Online</td>
</tr>
<tr>
<td>7th at 10 AM</td>
<td>Board of Directors Meeting&lt;br&gt;Sacramento, CA</td>
</tr>
<tr>
<td>18th</td>
<td>President's Day&lt;br&gt;Chapter Office Closed</td>
</tr>
</tbody>
</table>

## MARCH 2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7th at 11 AM</td>
<td>Government Affairs Subcommittee #1&lt;br&gt;Conference Call</td>
</tr>
<tr>
<td>7th at 1 PM</td>
<td>Government Affairs Subcommittee #2&lt;br&gt;Conference Call</td>
</tr>
<tr>
<td>7th at 3 PM</td>
<td>Government Affairs Subcommittee #3&lt;br&gt;Conference Call</td>
</tr>
<tr>
<td>14th at 2 PM</td>
<td>Government Affairs Committee (GAC)&lt;br&gt;Conference Call</td>
</tr>
<tr>
<td>15th</td>
<td>Board of Directors Nominations Close&lt;br&gt;Online</td>
</tr>
<tr>
<td>15th</td>
<td>CMA Council on Legislation&lt;br&gt;Sacramento, CA</td>
</tr>
</tbody>
</table>
FULLERTON, CALIFORNIA: Join our ED team in beautiful north OC at St Jude Med Center. Our 36 bed ED serves >70K pts/yr with 54-60 hrs MD, 44 hrs PA and 100% scribe coverage per day, 9-10 hr shifts. We have held this stable contract for >36 years, have excellent back-up, 24hr in house Critical Care, OB, neonatologist and hospitalists. We are a STEMI receiving center, “Advanced Comprehensive Stroke Center” and provide excellent compensation with night differential. Partnership track negotiable. EM BC/BE mandatory.

Send CV to kohparker@gmail.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.
• San Fernando Valley - 18000 visits $350000 per year with incentives Med surg with psyche beds. Overlap or NP or PA for busy times.

SOUTHERN CALIFORNIA – ORANGE COUNTY: Positions available for full and part time BC/BE EM and Peds EM physicians. Partnership track is available for full time physicians. We are a stable, democratic group established in 1976 serving two best in class hospitals, St. Joseph Hospital is a STEMI center and Stroke Center with 80,000 visits per year. CHOC Children’s Hospital is a Level II trauma center, tertiary referral center and teaching hospital (several residency and fellowship rotations) with 80,000 visits per year. Excellent call panel coverage, excellent compensation, malpractice and tail coverage, and scribe coverage. Sign on bonus for full time hires.

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. We seek an EM residency trained physician for a partnership track. Excellent coverage and midlevel provider support allow for high job satisfaction. UC Irvine EM residents on rotation allow for teaching opportunities. Two full-time, dedicated nocturnists work 6 nights a week. All other physicians average 6 overnight shifts per year!

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.

Send CV to: MaryAnn.Hubbard@StJoe.org

VENTURA CALIFORNIA: New hospital under construction and scheduled to open in the Spring of 2018. Central coast of California and 70 miles from LAX. Positions available in two facilities for BC/BE emergency physician. STEMI Center, Stroke Center with on-call coverage of all specialties. Teaching facility with residents in Family Practice, Surgery, Orthopedics and Internal Medicine. Admitting hospital teams for Medicine and Pediatrics. Twenty-four hour OB coverage in house and a well established NICU. Physician’s shifts are 9 hrs and 12 hours of PA/NP coverage. All shifts and providers have scribe services 24/7. Affiliated hospital is a smaller rural facility 20 minutes from Ventura in Ojai. Malpractice and tail coverage is provided. New hires will work days, nights, weekends and weekdays.

Send resume to Alex Kowblansky MD FACEP at kowblansky@cox.net

To advertise with Lifeline and to take advantage of our circulation of over 3,000 readers, including Emergency Physicians, Groups, and Administrators throughout California who are eager to learn about what your business has to offer them, please contact us at info@californiaacep.org or give us a call at (916) 325-5455.
Looking for an ITLS course?
EMREF offers the following California providers list:

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

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
Thomas Oakes, Program Director
3000 State University Drive East, Napa Hall, Sacramento, CA 95819-6103
Office: (916) 278-4846
Mobile: (916) 316-7388
Email: thomasf 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: L.Jones@llhs.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: grosse@napavalley.edu
Web: www.winocountrypcr.com

NCTI – National College of Technical Instruction
Lena Rohrabaugh, Course Manager
333 Sunrise Ave Suite 500, Roseville, CA 95661
Phone: (916) 960-6284 x 105
Fax: (916) 960-6296
Email: jicros@caltel.com
Web: www.ncti-online.com

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

If you are an EMS Director and would like to provide chest, head shock-injury training to your team, contact California ACEP to get started!

ITLS is the only pre-hospital trauma program endorsed by ACEP, since 1986, and is accepted internationally as the standard training course for pre-hospital trauma care.

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.
30 YEARS OF

LEGISLATIVE LEADERSHIP CONFERENCE

APRIL 23, 2019
SACRAMENTO