THIS ISSUE’S TOPIC:

PERSPECTIVE

Addressing Social Determinants of Health from the Emergency Department through Social Emergency Medicine

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WELCOME new members!

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I am a proud graduate of Jefferson Medical College (now known as Sidney Kimmel Medical College of Thomas Jefferson University) in Philadelphia, PA. It was early in my first year of medical school when I was introduced to JeffHOPE (Health Opportunities, Prevention & Education). A student-run volunteer organization, JeffHOPE organized and executed free medical clinics for Philadelphia’s underserved, vulnerable, and homeless population. Started in 1991 by a group of Jefferson medical students, it has grown into an organization that helps over 5,000 patients per year. It gives future health care professionals (medical, nursing, and pharmacy students) the ability to witness and practice the transformative power of basic human decency provided through whole person medical care.

While I started as a random first-year medical student volunteer, I quickly became a staple attendee. I would leave each day with a profound feeling that I helped those who needed it and learned more than the lecture could provide. By my fourth year, I became the student medical director of the Ridge Clinic. The Ridge Clinic was one of the five sites run by JeffHOPE during my years of medical school. In cooperation with the Ridge Avenue homeless shelter, we would transform a large room into a medical clinic every Tuesday evening. It had everything from a check-in station, seven patient exam areas, a waiting room, an on-site pharmacy, and a social work area. Our nightly volume would range from 20 - 40 patients over three hours. Some we knew well, as they were recurring patients, and others were new, just trying to obtain any level of care in a crisis.

JeffHOPE challenged every stereotype and bias I had towards the homeless population. Before JeffHOPE, my exposure to the “homeless” population were those who lived on the street, asked for spare change, or maybe had a substance use disorder. While Ridge Avenue provided shelter for some of the patients we treated at the clinic, the majority worked seven days a week in multiple jobs across different parts of town. It became more apparent through my time there just how many people experiencing homelessness ended up without housing through no fault of their own, through unfortunate events such as a house fire, medical debt, or any number of circumstances out of their control. It was an awakening as to how much luck plays into all our lives and how the social construct keeps people and at-risk populations in a vicious cycle of housing instability.

But as it is for all of us, health is never forgiving or patient. At JeffHOPE and in my practice, I have seen countless examples of how societal constructs impact health. Diabetes control would become problematic for those racing from one job to the next, whose only affordable or feasible meal was fast-food or instant meals. Blood pressure would rise, as did financial stress or the continual worry of not knowing where to rest their head that night. Obtaining health care always resulted in fear. Fear of significant financial burden or the tragedy of making the choice to leaving all their worldly belongings unattended on the streets to go to a doctor’s appointment.

JeffHOPE also taught me that decency comes in many forms and that caring for another’s health could, at times, be as simple as providing flip flops for communal showers to prevent recurrent fungal infections or a toothbrush kit to stop dental decay. It could also be restarting a patient’s medications and preventing them from developing a life-threatening disease process, such as providing insulin to keep an episode of DKA from reoccurring.

I will be honest that for the last ten years, some of these teachings have gotten lost. At times, I have probably become jaded when the homeless alcoholic patient repeatedly presents for chronic complaints led by noncompliance and frustrated when the diabetic continues to wear improper footwear resulting in yet another ulcer and hospitalization. I do not believe in absolving anyone’s responsibility for any problem. It can be easy to pass judgment on others for what seems like poor...
choices or inappropriate decisions when, in fact, some factors are out of one's control. Many of us have realized through recent events the systemic injustices associated with gender and race in all aspects of life, including healthcare.

Factors that are entirely out of one's control can lead to severe and lasting impacts. Many of us know someone whose housing situation has become unstable, whether it be due to wildfires or COVID-19 financial constraints. This year has made all of us realize how easy it is to go from stability to chaos. This is a set up for failure, especially when compounded with any of the following: food insecurity, substance use disorder, evacuation from a disaster zone, abuse, human trafficking, incarceration, or sexual/gender orientation.

While my JeffHOPE experience only touched on the tip of social determinants and how they impact healthcare, CalACEP members and advocates continue to be leaders and experts in this field. A prime example is Dr. Omar Guzman, who started a street medicine program at Kaweah Delta which provides care on the streets of Visalia, CA to reach their unsheltered population. Later in this issue you will read more about the ways this multidisciplinary team highlights how emergency medicine can be applied beyond the wall of the hospital to heal a community. We welcome Dr. Guzman to the board of CalACEP as this year’s “At-Large Member” to help bring awareness and expertise on social determinants of health and how it impacts the delivery of emergency care.

Like everything we do in medicine, there must be science to support practice change. Members like Dr. Maria Raven and Dr. Harrison Alter are great examples of this; their research provides data and reproducible ideas that have shaped the decisions of medical and policy leaders. They challenge the dogmas and perceptions that exist including frequent users of the emergency department (ED) and best teaching methods to help physicians learn about intimate partner violence, among many others.

While social determinants of health had already been rising into the minds of many emergency physicians for the last few years, we know it has become a priority of legislators as they try to tackle homelessness, the opioid crisis, and the Medi-Cal budget. CalACEP will continue to partner with stakeholders to bring forward and execute a meaningful solution whenever possible. Our skill set as emergency physicians, to think outside the box, and the fact we see patients from all parts of society in EDs, make us ideal partners. But it must remain a partnership with an understanding that a lack of resources or true support sets us up to fail. CalACEP continues to ensure that, as those doing the work, we be at the table when the solutions are being discussed. When we help shape the future, we can do great things. We have already taken up the reigns as the State’s leaders in the effort to expand access to treatment for opioid use disorder with the development of a medication assisted treatment (MAT) toolkit, which is available on our website (https://californiaacep.org/page/MAT-ED), the release of the CalACEP MAT Podcast (listen here to get CME www.californiaacep.org/page/Podcast), and our collaborative work with the California Bridge Program (https://www.bridgetotreatment.org/).

I am proud to announce that CalACEP will be starting a new SocialEM committee where best practices and ideas can be discussed and solutions offered to the public, legislators, and the house of medicine. Through this committee and all our ongoing work, CalACEP will continue to shape emergency medicine and California to be better, more welcoming, and safer places for all.

SOURCES:
The 2019-20 Legislative Session wrapped up on September 30th when Governor Newsom took final actions on bills that reached his desk. The COVID-19 pandemic had a significant impact on the Legislative Session this year with Legislators not able to be in Sacramento for much of the session leading to a condensed timeframe for bills to be acted on. As a result, Legislators were forced to limit the number of bills they could move forward. To provide some perspective, there were 3,033 bills introduced in 2019, the first year of the two-year session. Of these 1,331 were sent to the Governor. The remaining 1,702 bills were still alive and eligible to move forward in 2020. In 2020 there were 2,390 new bills introduced. Out of the nearly 4,000 bills “alive” in 2020, only 513 made it to the Governor.
Below are the bills we took a position or sponsored. The first part of the report are the results of the bills and budget items that moved forward, and the second part of the report are those bills that did not move forward due to the COVID-19 pandemic.

### **Budget Request for $20 Million – Sponsor**
In 2019, we sponsored a request for $20 million which was included in the State Budget to create a grant program that would allow hospitals to apply for up to $50,000 to fund a position for an alcohol and drug counselor to be located in the emergency department (ED). The grant process was being developed and no money had been distributed when the COVID-19 pandemic hit and the economic impact to the state general fund became more severe. To help with the 2020-21 budget shortfall, there was a proposal to take back the $20 million from the grant program before it could even start. California ACEP fought for the funds to remain in place arguing that alcohol and drug counselors are needed more than ever with the impact of the pandemic. Our arguments resonated and the funds were maintained. In addition, we were able to negotiate new parameters for the program to allow hospitals to obtain up to $100,000, instead of only $50,000, and make other improvements to the grant program structure.

### **SB 793 (Hill) – Support – Signed by Governor**
This bill prohibits the sale of a flavored tobacco product or a tobacco product flavor enhancer.

### **AB 2265 (Quirk-Silva) – Support – Signed by Governor**
This bill clarifies that Mental Health Services Act (MHSA) funds are permitted to be used to fund treatment for individuals with co-occurring mental health and substance use disorders. It also requires counties to report information about the individuals treated to the Department of Health Care Services.

### **AB 2164 (R. Rivas) – Support – Signed by Governor**
This bill would have allowed a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) to establish a relationship with a patient who is located within their service area by synchronous or asynchronous (store-and-forward) telehealth. AB 2164 would sunset 180 days after the COVID-19 Public Health Emergency has been terminated by the state of California.

To the Members of the California State Assembly; I am returning Assembly Bill 2164 without my signature. This bill would authorize a Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) to establish a relationship with a patient who is located within their service area by synchronous or asynchronous (store-and-forward) telehealth. AB 2164 would sunset 180 days after the COVID-19 Public Health Emergency has been terminated by the state of California.

While I am supportive of utilizing telehealth to increase access to primary and specialty care services, the Department of Health Care Services is currently in the process of evaluating its global telehealth policy to determine what temporary flexibilities should be extended beyond the COVID-19 pandemic. Changes to FQHC and RHC telehealth is better considered within the context of a global assessment around telehealth in the state of California. Further, the cost of these changes is also more appropriately considered alongside other policy changes in the budget process next year. - Sincerely, Gavin Newsom

### **AB 1544 (Gipson) – Sponsor – Signed by Governor**
This bill expands paramedic scope of practice in certain settings that have been piloted, and allows transportation of 911 callers to sobering centers and mental health facilities rather than to the ED. The bill ensures that scope expansion authorization is evidence-based and informed by what was shown to be safe for patients in the pilot programs. It also ensures that the alternate destinations patients are taken to are licensed facilities. Additionally, the bill includes EMTALA non-discrimination protections, a core principle for emergency medicine. Lastly, the bill strikes an important balance between allowing local control and ensuring statewide standards to protect all Californians, regardless of county of residence.

The bill had been held on the Senate Floor at the request of the Governor’s office in 2019 to allow the new EMSA Director to engage in the discussion. After diligently working with the EMSA Director and the Governor’s Office we were able to work through the remaining concerns. The signing of the bill included a message from the Governor stating there is some “ambiguity” in the definition of sobering centers and mental health facilities and directs EMSA to work on legislation to clarify these terms.

### **AB 890 (Wood) – Oppose – Signed by Governor**
AB 890 allows nurse practitioners to practice without physician supervision when meeting certain qualifications. This same bill had been defeated multiple times over the past eight years. This year, Legislators seemed to be swayed by arguments the bill would help improve access to primary care in rural areas.

California ACEP attempted to secure an amendment that would exempt emergency medical services from the bill towards the end of the session when it was becoming more apparent the bill would not be defeated. The author rejected the amendment. Multiple Legislators expressed concerns with the bill, an understanding of the unique nature of the ED, and an openness to future legislation to clean up the bill.
The veto message from the Governor is as follows:

Governor and the Legislature regarding new state policies, programs, and actions on homelessness. Finally, the bill allows peers to practice in any county in the state, whereas currently peers may only practice in the county where they are certified. This bill had passed the legislature several times and was previously vetoed by Governors Brown and Newsom.

**SB 855 (Wiener) – Support – Signed by Governor** – This bill expands the ability of Californians to obtain treatment for a wide array of mental health and substance use disorders. It requires commercial health insurers to pay for medically necessary treatment of any behavioral health or substance use disorder listed in the DSM-5, the American Psychiatric Association manual that defines mental health conditions.

**AB 1845 (L. Rivas) – Support – Vetoed by Governor** – This bill would have created the Office to End Homelessness, which would be administered by the Secretary on Homelessness appointed by the Governor, and required that the Office serve the Governor as the lead entity for ending homelessness, making recommendations to the Governor and the Legislature regarding new state policies, programs, and actions on homelessness.

The veto message from the Governor is as follows:

To the Members of the California State Assembly: I am returning Assembly Bill 1845 without my signature. This bill would establish the Office to End Homelessness within the Office of the Governor and realign several of the state’s ongoing efforts related to homelessness. I sincerely appreciate the author’s leadership on this issue and the intent of this bill, but I do not support this particular vision of organizational restructuring at this time. Homelessness has been and remains one of my top priorities, commanding the dedicated attention of a Senior Counselor on Homelessness and Housing in the Governor’s office and the dedication of senior members of my Administration including multiple Agency Secretaries. Since taking office in January 2019, we have invested over $2 billion in new, direct aid for homelessness. I am also proud of our work to implement Project Roomkey and Homekey, which help to protect homeless Californians from COVID-19 during this pandemic. These initiatives and investments demonstrate our commitment to prioritizing this vulnerable population, no matter what other challenges we confront. And they serve as a proof point of the interagency coordination we have led to develop and implement them successfully. Homelessness must not be considered in a vacuum.

Our Administration has taken a demonstrably integrated approach to preventing and ending homelessness by empowering leaders in the health care and housing space to work together on coordinated solutions. Separating policy development on homelessness from that on health care or housing will lead to more fragmentation, not less. Looking at homeless spending through a separate lens, divorced from our health care and housing budgets, will lead to more duplication and inefficiency. There are certainly ways in which we can improve upon state government’s collective work in this area. However, I am not convinced that the approach outlined in this bill is the best path forward. I am committed to partnering with the author and the Legislature next year to continue making progress on this critical issue.

-Sincerely, Gavin Newsom

The bills below were all held due to the COVID-19 pandemic and lack of time for the Legislature to review.

**AB 451 (Arambula) – Sponsor – Held On Senate Floor** – This bill would require acute psychiatric facilities, psychiatric health facilities (PHFs), and general acute care hospitals to accept all patients with psychiatric emergencies when transferred from emergency departments, regardless of their ability to pay or insurance status.

**SB 65 (Pan) – Support** – This bill would require Covered California to issue quarterly public reports containing information on the individual health insurance market assistance program created in the 2019-20 Budget Act.

**AB 2449 (Berman) – Oppose** – This bill would require the California Department of Public Health (CDPH) to establish a Sepsis Advisory Committee for the purpose of gathering information regarding sepsis protocols in California hospitals and recommending best practices regarding sepsis care. California ACEP opposed this bill because national data on sepsis best practices already exist and additional best practices could create ambiguity with regards to ideal treatment recommendations.

**SB 1407 (Moorlach) – Oppose** – This bill would require CDPH to develop and make available to licensed physicians and surgeons...
written materials identifying specified federal resources on vaccine warnings, injuries, and deaths. The bill would require a physician and surgeon to provide those materials to a child’s parent or guardian before or at an appointment at which a vaccine is to be administered.

- **AB 2242 (Levine) – Oppose unless Amended** – This bill would require a health care service plan or a health insurance policy issued to approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health professional within 48 hours of the person’s release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services.

- **AB 2411 (Nazarian) – Oppose unless Amended** – This bill would require a healing arts licensee who receives remuneration from a drug or device company to disclose the amount and source orally and in writing to each patient before the intended use or prescription of a drug or device manufactured or distributed.

- **AB 2432 (Maienschein) – Oppose unless Amended** – This bill would require a surgical clinic or general acute care hospital, as part of the admissions process, to ask the patient whether the patient has a religious observation that requires the retention of human body parts and if the patient has a funeral home to which a human body part that is severed from the patient may be released. The bill would require a surgical clinic or general acute care hospital, when a patient requests retention of a severed human body part, to note that fact on the patient’s record, and to retain the severed human body part until releasing the human body part to the patient-specified funeral home.

- **AB 2786 (Nazarian) – Oppose unless Amended** – This bill would require CDPH to develop protocols for hospital EDs to implement an HIV testing program for ED patients. The bill would require the ED’s protocols to address the integration of opt-out HIV testing into the ED standard of care, streamlining HIV testing consent procedures, and structural strategies to minimize the need for provider intervention.

- **AB 2817 (Wood) – Oppose unless Amended** – This bill would create the Office of Health Care Quality and Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs, and create a strategy to control health care costs.

- **AB 2830 (Wood) – Oppose unless Amended** – This bill would delete provisions relative to the Health Care Cost Transparency Database and would instead require the office to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System, which would include health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multistate-insured plans, and other specified mandatory and voluntary submitters.

- **AB 2032 (Wood) – Support** – This bill would clarify that the medical necessity standards do not preclude coverage for, and reimbursement of, mental health and substance use disorder assessment, screening, or treatment prior to an official diagnosis.

- **AB 2158 (Wood) – Support** – This bill would delete the requirement in current law that a health insurer comply with the requirement to cover preventive health services without cost sharing to the extent required by federal law, and would instead require a group or individual health insurance policy to, at a minimum, provide coverage for specified preventive services without any cost-sharing requirements for those preventive services, thereby indefinitely extending those requirements.

- **AB 2159 (Wood) – Support** – Current law provides for the regulation of health insurers by the Department of Insurance. This bill would delete the requirement that a health insurer comply with the prohibition on lifetime or annual limits to the extent required by federal law, and would instead prohibit an individual or group health insurance policy from establishing lifetime or annual limits on the dollar value of benefits for an insured, thereby indefinitely extending the prohibitions on lifetime or annual limits.

- **AB 2239 (Maienschein) – Support** – Current law requires participants in the Steven M. Thompson Physician Corps Loan Repayment Program to have full-time status in an eligible practice setting. This bill would require $2,000,000 to be annually transferred from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians. The bill would define “practice setting” to additionally include a program or facility operated by, or contracted to, a county mental health plan.
**AB 2266 (Quirk-Silva) – Support** – This bill would establish a pilot program in up to 10 counties and would authorize funding from the MHSA to be used to treat a person with co-occurring mental health and substance use disorders when the person would be eligible for treatment of the mental health disorder pursuant to the MHSA.

**AB 2347 (Wood) – Support** – This bill, contingent upon an appropriation by the Legislature, would reduce premiums to zero for Covered California participants with household incomes at or below 138% of the federal poverty level, and would scale the premium assistance subsidy amount for program participants with household incomes of 139% to 600% of the federal poverty level.

**AB 3118 (Bonta) – Support** – This bill would require the State Department of Health Care Services to establish a pilot program for a 3-year period in the County of Alameda to provide medically supportive food, such as healthy food vouchers or renewable food prescriptions, as a covered benefit for a Medi-Cal beneficiary who has a specified chronic health condition.

**SB 55 (Jackson) – Support** – This bill would exempt emergency shelters or supportive housing projects from meeting certain requirements of the California Environmental Quality Act (CEQA).

**SB 175 (Pan) – Support** – This bill would delete the requirement that a plan comply with the prohibition on lifetime or annual limits to the extent required by federal law, and would instead prohibit an individual or group health care service plan contract from establishing lifetime or annual limits on the dollar value of benefits for an enrollee, thereby indefinitely extending the prohibitions on lifetime or annual limits regardless of federal changes.

**AB 2747 (Santiago) – Support if Amended** – This bill would expand the access to Office of Statewide Health Planning and Development (OSHPD) health data to include nonprofit health policy organizations and labor unions.

**AB 3224 (Rodriguez) – Support if Amended** – This bill would require CDPH to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health department infrastructure, and to make recommendations for future staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. CDPH would be required to report the findings and recommendations of the evaluation to the Legislature.

**SB 936 (Pan) – Support if Amended** – This bill would require the Department of Health Care Services to establish a stakeholder process for commercial Medi-Cal managed care contract procurement and would authorize the department to contract only with plans that can demonstrate their ability to meet specified criteria.

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**Thank You**

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CalEMRA Award

This award is given to an outstanding resident in recognition of their exceptional academic and/or advocacy efforts, or for exceptional efforts through, for, or on behalf of CAL/EMRA by a non-resident.

RECIPIENT: Daniel Udrea, MD

REASON: Dr. Udrea is a PGY-3 at Loma Linda and has been a relentless advocate for his fellow emergency medicine residents. He is a dedicated member of CalEMRA, serving as their Membership Director and running their social media presence for the last two years. He has also made an impact on CalACEP as a member of the Annual Conference Planning Committee, ensuring the resident perspective is well represented. Outside of CalEMRA, he has been doing innovative work with his residency when it comes to 3D printing face shields and supplies during the COVID-19 pandemic. Dr. Udrea is a hardworking, committed member who is selfless and truly gives to his co-residents and residency.

BIO: Daniel Udrea is a senior EM resident at Loma Linda University Health – Emergency Medicine Residency. He currently serves as California EMRA’s membership chair and is a California Medical Association Delegate to the American Medical Association. He will be pursuing a critical care fellowship to be completed in 2023. His current educational goals involve the development of high fidelity, low cost simulation models to further advance medical education around the world.

STATEMENT: I am grateful for the opportunity to receive this award. I want to thank my colleagues within CalACEP, CalEMRA, and my mentors within the Loma Linda University Emergency Medicine residency who have helped me become a better advocate for my patients. I also want to thank Dr. Anna Yap for encouraging me to get involved with leadership and advocacy as a medical student. Together, we have the voice to make a change to ensure our patients get the absolute best care.

Education Award

This award is given to a member who has made an outstanding contribution to the education of emergency medicine residents or who has made a significant contribution to emergency medicine research and education.

RECIPIENT: Stuart P. Swadron, MD, FACEP

REASON: Dr. Swadron has earned the nickname Captain Cortex because he is a clinical genius and can translate his skills as a clinician into education. Whether he is teaching at the bedside, on a stage in front of thousands, or on camera, he connects with his students and audience. He relates to the learner and advocates for their point of view. Dr. Swadron does not just teach facts and the “what,” he teaches the “why.” His casual way of approaching complex problems allows him to communicate the nuances of medicine in a way that makes it click and stick. Dr. Swadron is always willing to embrace students, residents, fellows, and junior faculty. There is no better example of a mentor.
**EMS Achievement Award**

This award is given to a member who has contributed significantly to the improvement of the quality and/or coordination of emergency medicine within the larger emergency medical system.

**RECIPIENT:** David Duncan, MD  
**REASON:** Dr. Duncan has dedicated his career to improving EMS care. He has served in a number of capacities, including: Aeromedical Representative for the EMS Medical Directors Association of California (EMDAC), Medical Director CALSTAR air ambulance, Medical Director for CAL Fire, CAL Fire Representative to Joint Advisory Committee for Public Health Emergency Preparedness, EMS Authority Directors Advisory Group, Assistant Secretary for Preparedness and Response (ASPR) – Committee on Mitigation of EMS Drug Shortages; REACH Medical, Holdings Executive Medical Director, and current EMS Agency Director for California. He was awarded California EMS Authority Medical Director of the Year in 2018 and led the California Shock Trauma Air Rescue (CALSTAR) to be awarded the “2016 Air Ambulance Program of the Year” out of more than 300 air ambulance services. Dr. Duncan has an unwavering commitment to California’s EMS system and those providing emergency care.

**BIO:** Dr. David Duncan was appointed as the Director of the California Emergency Medical Services Authority (EMSA) in September 2019. He is a member of the Society of Academic Emergency Medicine, American College of Emergency Physicians, and the American Medical Association. He has also been a member of the Emergency Medical Directors Association of California (EMDAC) from 2010 to 2020, representing both CAL FIRE and California air medical providers through 2019. Dr. Duncan earned his medical degree from the University of San Diego School of Medicine in 1991 and completed his emergency medicine training at the UC Davis Medical Center in 1994. He was appointed Chief Resident and then Assistant Residency Director at UC Davis from 1993 to 1996, following which he transitioned to community emergency medicine. Dr. Duncan’s career in emergency medicine has been diverse. He has held many Medical Director positions including the Placer County Corrections Medical Director from 2006 – 2019 as well as the CALSTAR Air Ambulance Medical Director from 2009 – 2017. He and others led that provider to earn the National Air Ambulance of the Year Award in 2016. In 2018, REACH Medical Holdings appointed Dr. Duncan as their Executive Medical Director, serving over 30 bases. Dr. Duncan also served as Medical Director for CAL FIRE – California Department of Forestry and Fire Protection from 2010 to 2019. He received the California “Medical Director of the Year” award in 2018. Additionally, Dr. Duncan remains on staff as an emergency physician at the Mather VA Hospital in Sacramento and finds time to do research, lecture, play the drums and develop medical devices. He holds 18 medical patents.

**STATEMENT:** I would like to thank the California Chapter of the American College of Emergency Physicians for recognizing me as the recipient of the EMS Achievement Award. It is a profound honor for which I am greatly appreciative and truly humbled.

We are certainly living in tumultuous times. It has been an privilege and a challenge to serve as the Director of the Emergency Medical Services Authority over the last year and I would be remiss if I did not also thank the EMSA team for such incredible dedication and hard work in assisting our California EMS systems through these events of 2020.

I know everyone in emergency medicine has been responding to similar disarray and pressures within their systems, hospitals and emergency departments. It has been incredibly inspiring to watch emergency physicians lead the way through this COVID pandemic - providing such amazing care for our Californians with among the lowest mortality rates in the country.

There are many battlegrounds facing us currently with COVID-19, socioeconomic turmoil and uncertain medical economics. We are in many ways fighting for our own welfare and it is my hope that we persist doing what we do so well in our EDs – and that is embrace these battles, collaborate and continue to fight for the best solutions we can provide. Strong democratic organizations like this provide us the means to move these issues forward with the most successful outcomes.

I am incredibly grateful and proud to be part of the California Chapter of the American College of Emergency Physicians.

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**House of Medicine Award**

This award is given to a member who has significantly improved the standing and influence of emergency medicine within the house of medicine and done so through their leadership within and among other organizations, especially other specialty societies, medical societies and state and national health care organizations.

**RECIPIENT:** Rais Vohra, MD, FACEP  
**REASON:** Dr. Vohra became the Interim Fresno County Health Officer in February of 2020. Little did he know he was assuming this key leadership role in the weeks leading into the COVID-19 pandemic. Dr. Vohra has worked tirelessly under these stressful circumstances to enable testing, communicate with local hospitals and clinics, expand medical care facilities to arenas and fairgrounds, develop plans to care for the homeless with COVID, work with local and state government officials, and communicate regularly with the local media to provide updates to the public. He has done all of this and so much more with limited resources and budget. He continued to work shifts in the emergency department and personally see patients. Dr. Vohra has done all of this and more with a smile and a calm, collected approach.

**BIO:** Rais Vohra is an emergency physician, medical toxicologist, and public health officer based in Fresno CA. Dr. Vohra grew up in Texas, and attended Baylor College of Medicine in Houston before completing emergency medicine residency at UT Southwestern Medical Center/ Parkland Hospital in Dallas, Texas. After that, he completed a medical toxicology fellowship at UC San Diego, and then accepted a faculty position at UCLA–Olive View Medical Center in Los Angeles County. Since 2009, Dr. Vohra has been a faculty member in the UCSF Fresno Department of Emergency Medicine, where he established an inpatient toxicology consultation service.

As a medical toxicologist, Dr Vohra has been involved at the intersection of emergency medicine, clinical research, and public health policy throughout his career. Dr Vohra currently serves as the Medical Director of the Fresno-Madera Division of the California Poison Control System, which serves the population and health care workforce of California with an always-available, toll-free hotline staffed by specialists trained in poisoning management. In addition, he leads the California Bridge
2020 CHAPTER AWARD RECIPIENTS

Humanitarian Award

This award is given to a member who has dedicated or volunteered a significant amount of their time and expertise to the service of underserved patients or those affected by disasters or significant world events.

RECIPIENT: Daniel B. Khodabakhsh, MD

REASON: After graduation Dr. Khodabakhsh joined the International Medical Corps in responding to the earthquake in Haiti in January 2010. He spent 2010-2012 working virtually every day. He spent half his time in Haiti and the other half in the United States attending as a fellow at Harbor-UCLA and working part time at Antelope Valley Hospital. Dr. Khodabakhsh’s work in Haiti included teaching, capacity building, developing innovative disaster response, and strengthening the prehospital system in areas that had been devastated by the earthquake. He was central to IMC’s response to the Cholera outbreak in Haiti, an emergency within a disaster. As impressive as his work product was, his resilience was even more impressive. He took his continuous contribution for three years in stride while those watching him could not be anything but deeply impressed by his integrity, commitment and energy. The common thread running through his tapestry of a life is his wisdom and kindness beyond his years and his embodiment of the qualities of the ideal physician.

BIO: Daniel Khodabakhsh, MD is an Emergency Medicine physician at Antelope Valley Hospital (AVH) in Lancaster, California in the Mojave Desert. He is a Clinical Professor (Volunteer) at UCLA School of Medicine for his work in training UCLA EM residents. Previously, he received his education at UC San Diego in Biology and Anthropology. He completed medical school at UC Davis and residency training in Emergency Medicine at Harbor-UCLA. Staying at Harbor-UCLA as the Global Health Fellow, he was deployed for a total of 9 months in Haiti as part of the rebuilding effort after the devastating earthquake of 2010. He trained hundreds of Haitian first-responders, nurses and doctors in emergency care and also helped organize one of the first cholera treatment centers on the island at the start of the epidemic. Daniel’s global health deployments have also included in the Philippines, Thailand and Panama. Returning home from work abroad, he focused on the epidemic of healthcare worker burnout and became a trained mindfulness teacher to provide freely available stress reduction courses to hospital staff. In addition, he helped create the AVH Palliative Care service 5 years ago and has served as the Palliative Care Medical Director after seeing patients and families in the ER that were receiving inadequate palliative support. More recently Daniel helped found AV Supportive Care and Hospice, currently serving as its medical director, with the intention to provide high quality, locally based Palliative Care and Hospice services to the AV community. In addition, for the COVID-19 response, he helped form a working group with NASA and other aerospace engineers to develop positive pressure helmets as a safe delivery system for respiratory support, with a model undergoing Emergency Use Authorization (EUA) review. Moving forward he hopes to blend his clinical work in both Palliative Care and Emergency Medicine to perform research and provide education in this emerging nexus of medicine.

STATEMENT: I wish to extend my heartfelt thanks to Awards Committee of the California Chapter of the American College of Emergency Physicians for this honor. It is humbling to be recognized in this way, especially when considering previous recipients, many of them my heroes. One of them being Larry Stock, MD, who has been a friend and mentor throughout my life and career. It is in working alongside all of my colleagues at Antelope Valley Hospital that I have grown as a person and physician, learning that when it comes to providing clinical care, ‘how we are’ with patients at the

Program at Community Regional Medical Center. The California Bridge Network of sites trains health care providers across the state and advises the California Department of Health Care Services (DHCS) on best practices related to improving access to treatment for patients with substance use disorder and opioid withdrawal.

In his various capacities, Dr. Vohra has played an important role at the intersection of clinical medicine and public health locally, regionally, and globally. Since 2009, Dr. Vohra has been a faculty member at UCSF Fresno Department of Emergency Medicine, where he established an inpatient toxicology consultation service and also directed the UCSF Fresno Global Health Curriculum, serving as the first ACEP Ambassador to Nepal, as a volunteer for earthquake relief in Haiti, and as a toxicology educator and researcher at multiple international locations. All of these experiences allowed unique insights into how health care systems are structured, and how they can be improved and expanded given their diverse resources and goals. Dr. Vohra’s dedication and interest in public health was solidified in January 2020, just weeks before COVID-19 was declared a worldwide pandemic, when he was appointed as Interim Health Officer for the Fresno County Department of Public Health. Since that time, Dr. Vohra has been at the forefront of the pandemic response in Central California’s San Joaquin Valley, a largely agricultural and medically underserved region of the state. In this new position, Dr. Vohra continues to help foster important connections and partnerships between agencies and institutions within Fresno County, the central valley, and the California Department of Public Health. While these relationships are most urgently required for the current coronavirus response effort, the collaborations being formed will hopefully last beyond the pandemic to leave Fresno County a stronger, healthier, and more resilient community.

STATEMENT: It is both humbling and inspiring to receive the House of Medicine Award, and I am sincerely grateful to California ACEP for this special recognition. I consider myself so fortunate to have had colleagues, mentors, residents, and staff who have advised, instructed, and challenged me throughout my career. Most of all, I am thankful for my wonderful and supportive family and for my wife, Stacy, who inspires me each day with her patience, kindness, and fierce dedication to me throughout my career. Most of all, I am thankful for my wonderful and supportive family and

All of which gives me great hope, because while we are tasked with difficult decisions every day, I am optimistic that this pandemic will ultimately leave our health care system stronger and more resilient for the great work we will still have left to do. We are all in this together, and together we are stronger during this unprecedented time. Stay strong, stay safe, stay positive—the best is yet to come for the House of Emergency Medicine!
efforts. Important contacts, especially those related to Chapter advocacy for meetings and outreach with outside organizations and other important contacts, especially those related to Chapter advocacy efforts.

**Key Contact Award**

This award is given to a member who has contributed significantly to Chapter activities by serving as a primary contact or facilitator for meetings and outreach with outside organizations and other important contacts, especially those related to Chapter advocacy efforts.

**RECIPIENT:** Atilla Üner, MD  
**REASON:** Dr. Üner serves as CalACEP’s appointee to the Los Angeles County EMS Commission and the California EMS Commission. He has served on the California EMS Commission since 2016 and currently serves as Vice-Chair of the California EMS Commission. He has been an outstanding source of leadership and guidance on EMS within CalACEP. Dr. Üner’s work representing CalACEP on the LA County and California EMS Commissions and insights have been exceptional.

**BIO:** Dr. Atilla Üner worked as an EMT-I for the Bavarian Red Cross in Munich, Germany before attending medical school at the Free University of Berlin (West) from 1984 to 1991 and completing his medical doctorate in 1992. After internships at the University of Hamburg, Germany, and St. Luke’s Medical Center in Milwaukee, WI, he completed his residency in Emergency Medicine at UCLA and graduated as a chief resident in 1997. He then completed an EMS fellowship at UCLA, obtained a Master’s degree in Epidemiology at the UCLA School of Public Health in 2002, and completed a fellowship in Undersea and Hyperbaric Medicine at UCLA in 2009. Dr. Üner is board-certified in Emergency Medicine, and subspecialty board-certified in Emergency Medical Services and in Undersea and Hyperbaric Medicine.

Dr. Üner served as associate medical director for the UCLA Center for Prehospital Care from 1999 to 2020 and is now the medical director for the UCLA Paramedic Education Program. He is the medical director for the UCLA and Antelope Valley Hospital EMS base hospitals, a commissioner with the Los Angeles County EMS commission, and Vice Chair of the California EMS Authority Commission on EMS. He is a Medical Team Manager with FEMA Urban Search and Rescue team CA TF-2 / USA2 and serves on the EMS Medical Director Association of California Paramedic Scope of Practice committee.

Dr. Üner is a Health Science Clinical Professor of Emergency Medicine at the David Geffen School of Medicine at UCLA, an Adjunct Professor of Nursing at the UCLA School of Nursing, an attending emergency physician at both Ronald Reagan UCLA Medical Center in Los Angeles and at Antelope Valley Hospital in Lancaster, California, and the Southern California Regional Medical Director for REACH Air Medical Services.

**STATEMENT:** I am humbled and honored to receive this award and thank CalACEP members and leadership for their trust and support. The EMS Commissions provide oversight and stakeholder feedback to decisions and policies issued by the local EMS agencies and the California EMS Authority.

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**Media Award**

This award is given to a member who has made significant contributions to the improvement of the awareness, education, understanding and influence of emergency medicine and the Chapter through all forms of media.

**RECIPIENT:** Nicolas Sawyer, MD, MBA, FACEP  
**REASON:** Dr. Sawyer has been an advocate for CalACEP and emergency medicine on social media, especially sharing personal experiences and dispelling misinformation during the COVID-19 pandemic. His video detailing his experience volunteering in New York went viral on Twitter. He has also been quoted in multiple news articles because of his tweets dispelling myths about COVID-19. While Dr. Sawyer’s social media advocacy focuses on more than just COVID-19, he has had a substantial impact educating the public during the pandemic.

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**Senator Ken Maddy Political Leadership**

This award is given to a person who, like Senator Maddy, has made a lasting and indelible contribution to emergency medicine through significant legislative and/or political efforts.

**RECIPIENT:** Senator Richard Pan, MD  
**REASON:** Dr. Pan has been a tireless defender of the practice of medicine as a State Legislator and Chair of the Senate Health Committee. He has been an ardent supporter of public health, especially vaccinations. Despite receiving death threats for authoring a bill mandating vaccination, he has succeeded in passing that legislation and others that have increased California’s vaccination rates. During his time in the Assembly and Senate, he has stood by physicians in every debate over scope of practice even when he was the only vote. Dr. Pan is a defender of medicine and emergency medicine and has shaped the debate in the California Legislature.

**BIO:** Dr. Richard Pan is a pediatrician, former UC Davis educator, and State Senator proudly representing Sacramento, West Sacramento, Elk Grove, and unincorporated areas of Sacramento County.

Dr. Pan chairs the Senate Committee on Health and the Budget and Fiscal Review Subcommittee on Health and Human Services. He also chairs the Senate Select Committee on the 2020 United States Census and serves as Chair of the Senate Select Committee on Asian Pacific Islander Affairs and Vice-Chair of the Asian Pacific Islander Legislative Caucus. He serves on the Senate Committees on Budget and Economic Opportunity and Finance and Revenue and Taxation.

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First elected to the State Assembly in 2010, Dr. Pan strives to keep our communities safe and healthy. TIME magazine called Dr. Pan a “hero” when he authored landmark legislation to abolish non-medical exemptions to legally required vaccines for school students, thereby restoring community immunity from preventable contagions. Dr. Pan also authored one of the most expansive state laws regulating health plans eliminating denials for pre-existing conditions and prohibited discrimination by health status and medical history.

Special Recognition Award

This award is given to a member who has made an important contribution to the Chapter or advanced specific Chapter objectives and/or priorities by leading or directing an independent effort or initiative.

RECIPIENT: Vik Gulati, MD, FACEP
REASON: Dr. Gulati felt that he had to do something more when the COVID-19 pandemic hit. He partnered with others to develop a nonprofit organization called CHARGE, which collects donations from the community of cell phone chargers of various types, labels them, packages them, provides flyers and instructions, and distributes them to healthcare facilities. The phone chargers are given to patients who are isolated due to COVID-19 and have no other means of contacting their family and friends if they cannot charge their cell phone. Dr. Gulati took an idea and made it a reality, playing an important role in combating the loneliness epidemic of COVID-19 patients.

Walter T. Edwards Meritorious Service Award

The Chapter’s highest honor, this award is given to a Chapter leader who, like Dr. Edwards, has distinguished themselves among their peers in the Chapter as demonstrating the highest commitment to emergency medicine and the Chapter, and who has made contributions to the Chapter that have significantly shaped its mission, vision, objectives or priorities.

RECIPIENT: Andrew Fenton, MD, FACEP
REASON: Dr. Fenton’s years of service to the Chapter including one year as one of the Chapter’s first advocacy fellows, eight years on the Board Directors, and one year as President. During his time on the Board and as President, he brought a heightened awareness to the issue of firearm injury prevention, ushering in CalACEP’s Firearm Policy in 2016. This was before many were comfortable taking a position on firearms, but Dr. Fenton believed a science-based approach to firearm violence prevention was the right thing to do to save lives. He also championed other public health issues including drug overdose prevention and pediatric trauma care. Even after his presidency, Dr. Fenton has been an active champion of emergency medicine and CalACEP and his leadership has had a profound impact on the organization and the patients of California.

Thank You to the AdvancED 2020 Technology Partner!

EM:RAP provided video services for the Keynote, President’s Message, and live components. They also created the COVID heroes, Awards, and Advice to Residents compilation videos. Thank you to EM:RAP’s staff!
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GUEST ARTICLE

Addressing Climate Change as An EMERGENCY PHYSICIAN

By Marc Futernick, MD, FACEP
It’s getting hotter. Our planet has been warming for decades, and this year is the hottest on record so far. When it is hotter than normal, more people die. Heat waves kill more people each year than all other natural events combined. These are facts. And that’s just the tip of the iceberg as these statistics only include heat stroke and obvious heat-related mortality. Studies reveal that when it is hotter than usual, especially for a few days in a row, more people have heart attacks, strokes, and respiratory ailments; more people stab and shoot each other, with increased severity; more people kill themselves; and more premature babies are born. These are facts.

I have been educating myself about our environment for decades. Initially, this consisted of reading books like Earth in the Balance by Al Gore back when I was in college. I also joined environmental advocacy groups to stay informed and take action. I started doing my own recycling, out of my garage, long before curbside recycling came to be. A more recent example is that I’m eating less meat and dairy, which is good for the environment and my health. My family teases me whenever I try to claim I’m vegan, but there are indeed days that I am! I believe that we can send a powerful market signal every time we order a vegan meal, telling restaurants and markets that customers want more of these options. I was pleasantly surprised on my last trip to New Orleans, long known for amazing food, to see vegetarian or vegan dishes at every restaurant we visited.

I share my environmental journey with others through a regular email blast. I have about 300 people on the list. These e-mails always lead to good discussions and I feel like I’m learning as much as educating on this topic. Based on those and other discussions, I know that people value my opinion, in part, because I am an emergency physician.

Sometimes I hear from physicians that climate change and environmental issues are not our space, that they are too big a problem for physicians to solve, or even that they are not specific to our specialty. I think we need to look at the bigger picture and examine our role in the healthcare system. Emergency physicians have always been involved in prevention, advocating for helmets and seat belts, robust 911 access and trauma systems, and more recently the push to prevent opiate overdoses by treating opiate use disorder in our departments. We have also led the charge in disaster preparedness and management. This is exactly our space and expertise.

Victims of the impacts of climate change present in many different ways, but they all come to our EDs. We may not always be aware of the connection between poor air quality and the heart attacks, strokes, and respiratory exacerbations we treat on a daily basis, but rest assured we will see fewer of these serious illnesses if we clean up our air. This was proven in studies done in Los Angeles in the 80’s and 90’s, with decreased incidence and severity of childhood asthma as the smog problem improved. When heat waves strike, our ED volumes surge and our patients suffer in ways we don’t consciously connect to the temperature outside, but we should. When wildfires, storms, and floods occur, where do the impacted patients go for help?

I also frequently hear that this problem is just too big, and our impact too small, either as individuals or through our organizations. We must not underestimate the power of our trusted voices. When physicians talk, people really listen. The key to engaging people is to deliver a clear message, frequently, from a trusted source. We are that trusted source, and we have been silent far too long.

Dr. Marc Futernick is Chair of the Board for VEP Healthcare and a practicing emergency physician in Los Angeles. He is a Past President and currently serves on the California ACEP Board of Directors.
A mysterious new illness appears. It seems to spread without symptoms, but nobody knows for sure. Theories emerge about how it’s transmitted. Is it on surfaces? In the air? In our water? Children are pulled out of schools for fear of contracting the illness. There is discussion of quarantines for those afflicted. There is no known treatment. There is no cure. The public is panicked. People are dying. Sound familiar?

Today there are 180,000 Americans who are unaware that they are living with this illness and could spread it to others. No, I’m not talking about COVID-19: I’m talking about HIV. Almost 40 years after the original outbreak, HIV is still here and continues to spread. Half of all Americans who are newly diagnosed with HIV had been living with it for three years without realizing it, and those people who are unaware of their HIV-positive status are the source of 40% of all new cases. There is a clear lesson to be learned here: you can’t stop an infectious disease if you don’t test for it.

Nowhere is this more evident than in Austin, Indiana, a small community with a population of 4,295. On the surface it seems like any other midwestern town, but there’s one thing that sets it apart: its HIV incidence is higher than any country in sub-Saharan Africa. In January 2015, as a surge of new HIV cases were discovered in the Austin area, it was thought that the infection was spreading through the community via IV drug use. In response, public health experts called on then Governor Mike Pence to lift the ban on needle exchanges in

‘Tis The Time’s Plague

By David Terca, MD

‘Tis the time’s plague, when madmen lead the blind.”

– King Lear, Act IV, Scene 1
the state. While the lack of needle exchanges certainly exacerbated the problem, there was another critical, less-discussed issue at play: the only HIV testing center in the area was a Planned Parenthood clinic that had been closed two years prior by state budget cuts. Not only was it difficult for residents of Austin to obtain clean needles, it was nearly impossible for anyone in Austin to get tested for HIV. We know what happened next.

Indiana’s failure is in sharp contrast to what has happened in New York in the past decade. In 2010, New York state passed legislation requiring all healthcare providers to offer an HIV screening test for all patients aged 13 to 64. At first this might seem like overkill, but the success of this legislation is hard to ignore. From 2010 to 2017, since implementing widespread HIV testing, New York state has seen a reduction of 30% of new cases. Compare that to the 15% reduction in California over the same time frame and 12.5% reduction nationally, and you should begin to ask what we can do better here in the Golden State.

Through 2016 and 2017, the California Department of Public Health implemented a pilot program to assess the effectiveness of expanded HIV screening in select EDs across the state. The summary report given to the Legislature in 2019 found a yield of 1.7% of new HIV diagnoses through expanded screening. Put another way, the pilot project found that for every 59 HIV screening tests offered in the ED, one positive case was identified that otherwise would not have been. Of course, there are many logistical hurdles that come with implementing such a program, and it’s really only the first step in public health outreach. Patients still need to receive treatment and have access to follow up care. On top of that, a one-size-fits all government approach is problematic: what works well in San Francisco might not work as well in Chico.

The fact remains, however, that this issue is tremendously important here in California: we rank second in the nation in number of new HIV cases—with 4,720 patients newly diagnosed across the state in 2015. On top of that, HIV-infected patients visit the ED at a rate more than twice of the general population. This is a tremendous opportunity for us, and the time for action is now. HIV does and will continue to affect our most vulnerable patient populations, which in turn will put them at risk for worse outcomes in the current pandemic. Through broadened screening, we can eliminate new HIV cases in the state. With inaction, however, we will continue to miss new cases, as nothing will come of nothing.

REFERENCES:

Dr. Terca is a practicing emergency physician in Sacramento, CA. He currently serves on the California ACEP Board and previously served as an Advocacy Fellow.
I started taking medical students out into the streets in a van loaded with supplies. We take a small team carrying backpacks, bags, and buckets of supplies to the makeshift shelters of the dozens of people living in large homeless encampments along the St. Johns River and other locations in the region. The team stops and meets with each and every person, offering food, water, hygiene supplies, first aid, medicine, preventive screenings, disease information, and referrals to social services.

Kaweah Delta Street Medicine is a committed group of physicians, residents, and community volunteers who travel the roads of Tulare County, reaching out to its most vulnerable residents with empathy and a desire to reach those who may be living outside of the system that many of us take for granted.

I serve as Director of Kaweah Delta Street Medicine, but I am aided by an amazing team that includes Dr. Chadi Kahwaji and Krystal De Azevedo.

Our goal is simple: bring medical care to the people who need it most and serve them where they live. We even bring a mobile pharmacy and offer wound care.

ED visits by homeless has increased steadily over the last 5 years, both lack of care and...
ineffective care have resulted in recurrent ED visits and hospital stays, increasing healthcare costs, overcrowding, and wait times in the ED. As emergency physicians, we are well equipped to address any health issue that walks through the door, but we never receive training for addressing the complex social issues that afflict our communities.

The medicine part is simple. It’s breaking down the human part that is difficult. Humanizing folks again who are marginalized and outside of the system is the challenge. That is why Kaweah Delta Street Medicine partners with local agencies such as Kings/Tulare Homeless Alliance and Tulare County Health and Human Services Agency to offer holistic support. Both organizations work extensively with the homeless population and provide an important key to the program’s success.

Like many similar programs across the US, we provide undocumented workers, uninsured individuals, and the homeless population medical care free of charge and delivered on-site. Street medicine is the first step in achieving higher levels of medical health, mental health, and social care through coordinated and collaborative outreach.

In late May and early June of this year, our Street Medicine team made sure that no corner of the community was forgotten by visiting homeless encampments to offer free COVID-19 testing.

When I left high school and moved away for college, I knew that I wanted to come home someday to Visalia and help the community in some way. My parents always told me that your community is your family, so I wanted to come back and serve those most in need, the underserved, and be there 24/7. I know that I have reached that place now and it is my honor to bring medical students and residents along on that journey.

Dr. Omar Guzman is the Director of Undergraduate Medical Education at Kaweah Delta and an Emergency Physician. He is the 2020-21 At-Large Member of the California ACEP Board of Directors.
Addressing Social Determinants of Health from the Emergency Department through SOCIAL EMERGENCY MEDICINE

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Edward Bernstein, MD‡ Harrison J. Alter, MD, MS*
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Dialogue and policy surrounding healthcare reform have drawn increasing interest to the social factors, accountable for nearly one-third of annual deaths in the United States, that affect the health of populations. The Affordable Care Act (ACA) includes provisions for health systems to address social determinants of health, but how this is to be accomplished remains uncertain. If we are to make progress as a health system in addressing social determinants of health, we must open a dialogue and practice that reaches patients at the front lines of the medical system and population health— including in the emergency department (ED). The fact that emergency physicians care for patients who are complicated both medically and socially is no surprise, but the idea that we have an important role to play in the social determinants of health of our patients is, while controversial, gaining increasing attention among emergency physicians across the country. This interest comes largely from necessity, as we face a daunting task of providing care to the large volume of vulnerable patients who seek refuge in our EDs.

The ED is a window into the community, which starkly frames the contributions of the social determinants underlying the trauma resuscitations, repeat child visits for asthma exacerbation, or sepsis due to delay in seeking care. In the ED, we diagnose and treat the medical problem—but in order to improve the health of our patients we need to expand our role to diagnose and treat their social determinants of health as well. We urge our colleagues to not only consider the social determinants underlying health and illness, but to also develop systematic interventions, measure their effects, collaborate with others, and advocate for policies that will improve the health of our patients. We advocate physicians to address the social determinants of health from the ED, in other words, to practice Social Emergency Medicine.

The World Health Organization defines the social determinants of health as “conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.” It seems obvious that poverty, racial and ethnic inequities, and lack of preventive care, would lead to poor health. But the social determinants of health extend beyond these more tangible aspects of our lives. Every aspect of how we live, including social class, influences health profoundly. Even among London-based British civil servants leading relatively stable lives with guaranteed employment, salary and health insurance, there is a steep and inverse correlation between job classification level, morbidity and death. From a policy standpoint, this gradient is compelling, as it affects all of our patients, not just those living in poverty, but the middle class as well.

Given that the structure of our daily lives are the social determinants of health, doing something about them requires moving our focus from the single patient to the population level, from diagnostics and medications to environmental and social structures and the policies that create them. While it would be clear to most emergency physicians that a patient’s frequent visits for hyperglycemia reflect poorly managed diabetes, what is easily labeled willful noncompliance might instead be a lack of access to healthy foods, and ultimately insufficient social and technical support for the entire community. Thus, medical treatment of a disease such as diabetes, without regard to the social determinants of health, suffers the danger of being ineffective. Just as we cannot treat volume overload without understanding the physiology of the kidney, heart, lungs and their interaction, we cannot begin to treat a patient’s medical problems without understanding the social factors, the life he lives.

Necessity mandates action. While the ACA tasks primary care with managing these social determinants, access to medical care increasingly occurs through the ED for insured, as well as poor and marginalized populations. The ED is the only door open to anyone for comprehensive medical and social services, 24 hours a day, 7 days a week, regardless of acuity or complaint, age, or insurance status. The status of the ED as society’s “safety net” is reinforced by a legal imperative, embodied in the Emergency Medical Treatment and Labor Act of 1986, which requires Medicare-participating hospitals offering emergency services to provide a medical screening examination and stabilization of emergency conditions regardless of ability to pay. What we face practicing in this safety net is an imperative to act. We must embrace this role and adopt our practice to our de facto environment, as a critical part of our healthcare safety net. Applying knowledge about social determinants of health to the bedside and developing effective, systematic interventions that reach out into the community is the practice of Social Emergency Medicine.

With increasing ED volumes and ED crowding in the headlines, some argue that taking on this burden would interfere with the ED’s primary mission of caring for the acute and emergent medical problems of the patients, and only when funded appropriately, should EDs take on this mammoth task. However, practically speaking, patients inadequately treated will continue to return to the ED. Many EDs already screen for vulnerable patients and offer some preventive services. ED directors are not philosophically opposed to offering these services within the ED, but are concerned with added costs, effects on ED operations, and potential lack of follow up. We believe that to ignore the contribution of social determinants on disease simply because addressing them requires unbudgeted resources, including sophisticated coordination of clinical, statistical, social and policy expertise, is as great an omission as ignoring the contribution of genetics simply because we do not yet have the tools to reliably control gene expression. EDs are beginning to take ownership of social determinants of health for their patients. Recent examples of successful Social Emergency Medicine interventions have focused on the development of coordinated care models providing ED patients in need with comprehensive medical and social services. Emergency medicine researchers worked with the Housing First partnership between...
the Centers for Medicare and Medicaid Services and New York City, which provided housing for high-risk homeless patients, resulting in improved health and cost savings for the city. A Boston Medical Center has a robust youth violence intervention program integrated into ED clinical care. Emergency medicine has advocated for policies and programs to improve the care of patients with substance use disorders such as implementing screening, brief intervention, and referral to treatment programs and providing take-home naloxone to prevent opioid overdose.

A fundamental step towards making the practice of Social Emergency Medicine more feasible requires integrating the study of the social determinants of health into our education. Medical training in the social determinants cannot be relegated to a single lecture or seminar, but rather requires a proportional emphasis along with anatomy, pharmacology and pathophysiology of disease. Similarly, we must not only teach the relationship of social determinants and health, but also teach the tools to translate theory into practice. We should teach methods to collaborate with community groups and design interventions so that young doctors do not segregate their medical and social diagnoses and interventions.

A fitting consequence of developing a subspecialty of Social Emergency Medicine would be that while all medical practitioners must know some theory, basic diagnostics and treatment; complicated cases require expert consultation and a systemwide effort. A single physician recognizing that a patient’s unstable housing is an impediment to proper management of his health is important, but the next steps can feel daunting — especially in the face of a full waiting room and critically ill patients. This burden cannot fall on the individual clinician; isolated interventions will fail. Although a physician can recognize that her patient is suffering an ST elevation myocardial infarction, she requires a system to achieve timely medical and procedural intervention resulting in favorable outcomes. Accordingly, successful Social Emergency Medicine interventions require specialty training, resources, and a multidisciplinary team.

Physicians practicing Social Emergency Medicine must also network, establish, and foster collaborations. Screening programs and innovative interventions cannot be solely well intentioned, but must be needs based and proven effective. Sharing of resources, best practices, standardization of data collection, and research networks with the dissemination of findings are imperative. Social Emergency Medicine initiatives should culminate in advocacy for policies to combat the adverse health impacts that stem from the vastly disparate conditions in which people are born, grow, live, work, and age.

One can view the ED (by law, the most accessible door into our healthcare system) as the social barometer of its community. Within the waiting room the emergency physicians witness the confluence of social determinants of health and their deconstruction into pathology. Our daily practice compels us to act, to systematically and collaboratively act on upstream social factors to positively and comprehensively influence downstream health outcomes. This paradigm shift is critical to effectively care for our patients. In the words of Rudolph Virchow, “Medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time.”

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Conflicts of Interest: By the WestJEM article submission agreement, all authors are required to disclose all affiliations, funding sources and financial or management relationships that could be perceived as potential sources of bias. The authors disclosed none.

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INTRODUCTION: Frequent users of emergency departments (ED) account for 21–28% of all ED visits nationwide. The objective of our study was to identify characteristics unique to patients with psychiatric illness who are frequent ED users for mental health care. Understanding unique features of this population could lead to better care and lower healthcare costs.

METHODS: This retrospective analysis of adult ED visits for mental healthcare from all acute care hospitals in California from 2009–2014 used patient-level data from California’s Office of Statewide Health Planning and Development. We calculated patient demographic and visit characteristics for patients with a primary diagnosis of a mental health disorder as a percentage of total adult ED visits. Frequent ED users were defined as patients with more than four visits in a 12-month period. We calculated adjusted rate ratios (aRR) to assess the association between classification as an ED frequent user and patient age, sex, payer, homelessness, and substance use disorder.

RESULTS: In the study period, 846,867 ED visits for mental healthcare occurred including 238,892 (28.2%) visits by frequent users. Patients with a primary mental health diagnosis and a co-occurring substance use diagnosis in the prior 12 months (77% vs. 37%, aRR [4.02], 95% confidence interval [CI] [3.92-4.12]), homelessness (2.9% vs 1.1%, odds ratio [1.35], 95% [CI] [1.27-1.43]) were more likely to be frequent users. Those covered by Medicare (aRR [3.37], 95% CI [3.20-3.55]) or the state’s Medicaid program Medi-Cal (aRR [3.10], 95% CI [2.94-3.25]) were also more likely to be frequent users compared with those with private insurance coverage.

CONCLUSION: Patients with substance use disorders, homelessness and public healthcare coverage are more likely to be frequent users of EDs for mental illness. Substance use and housing needs are important factors to address in this population. [West J Emerg Med. 2018;19(6)902-906.]
INTRODUCTION

Mental illness is widespread and has high medical and socioeconomic costs.\(^1\) Emergency department (ED) visits for mental healthcare are growing in the United States (U.S.).\(^6\) Many patients continue to face significant barriers to consistent mental healthcare.\(^2\) ED visits increase when mental health services are unavailable or uncoordinated.\(^12-14\) Nationally, frequent ED users for all diagnoses account for 3–8% of all ED patients and 21–28% of all ED visits.\(^15-17\) High ED utilization is often seen as a marker of unmet healthcare needs as well as an opportunity to decrease healthcare costs and improve resource utilization.\(^15,18,19\)

Yet prior research on frequent ED users found that these patients have multiple chronic conditions and high rates of primary and specialty care outside the ED.\(^17,20\) Studies of patients with high ED use for any diagnosis show that they have insurance coverage and are more likely to have private insurance or Medicare insurance.\(^17,20,21\)

Patients with mental illness face barriers to consistent outpatient care. Mental health services tend to be difficult to access and poorly integrated with primary care.\(^22-24\) Studies on ED utilization in patients with mental illness have focused on large urban populations and may not be generalizable to broader areas. Studies have evaluated ED utilization by patients with mental illness but are limited by the sample being either a single hospital or across a single urban area.\(^23,25-27\) A study of ED visits in San Diego by patients with psychiatric diagnosis found that frequent users were more likely to have lower socioeconomic status, homelessness, and co-occurring substance use disorders.\(^28\)

Our study examined ED utilization for patients with a primary mental health diagnosis over a six-year period across California, using data that included the geographic and socioeconomic diversity of the entire state. We hypothesized that patients with mental illness covered by Medicare or Medi-Cal (the state’s Medicaid insurance program), those who were concurrent substance users, and homeless patients would be more likely to have high ED utilization. Understanding factors associated with high ED utilization across a large, diverse state has clinical and policy implications as systems attempt to address ED utilization and healthcare costs.

METHODS

We conducted a retrospective analysis of all adult ED visits to acute care hospitals with a primary mental illness in California from 2009–2014 using a cohort defined from patient-level data for all ED visits, reported to California’s Office of Statewide Health Planning and Development (OSHPD). Each patient discharged from inpatient admission or ED treatment encounter in a licensed hospital in California is included in the OSHPD data. Our analysis included data on all ED visits from patients discharged or admitted through the ED from 2009–2014. These data do not represent a sample but rather surveillance with 100% coverage. The University of California Davis Institutional Review Board Administration as well as OSHPD’s Committee for the Protections of Human Subjects approved this study.

Data used for the study included a unique patient identification number, patient demographic information to the level of Zip Code, date of service, expected source of payment, disposition, and up to 25 International Statistical Classification of Diseases and Related Health Problems, version 9 (ICD-9) diagnosis codes. We defined a surrogate marker for ED encounters of patients with a primary mental illness diagnosis as visits with mental health diagnosis in the first diagnosis position, using ICD-9 codes. Patients with a substance use disorder were defined as patients with a substance use diagnosis using ICD-9 codes in any one of the 24 secondary diagnosis positions. We defined patients with four or more ED encounters for a primary mental illness diagnosis in a 12-month period as frequent ED users. In the OSHPD database patients who were “homeless” were specifically assigned a zip code of “ZZZZZ.” This designation is distinct from patients with an unknown Zip Code reported as “XXXX” and patients who do not reside in the U.S. reported as “YYYY.”

We calculated descriptive analyses of patient demographic and visit characteristics (Table 1). Multivariate log-linear model with Poisson distribution was used to assess the association between patient factors such as age, sex, payer, homelessness, substance use disorder, and classification as an ED frequent user. We used adjusted rate ratios (aRR) to account for variations in person/time using the Poisson log-linear model. aRR and 95% confidence interval (CI) are reported in Table 2. Data analyses were performed using SAS (V9.4) software.

RESULTS

During the study period, a total of 846,867 visits were made to California EDs by adult patients with mental illness and a valid record linkage number. This total includes patients admitted, transferred, or discharged from the ED. Mean age was 54.0 (standard deviation 21.1) and 55.8% were male. Insurance status was 20.4% Medi-Cal, 31.5 Medicare, 12.4 private insurance, 10.2 % self-pay and 25.5% other (Table 1). Overall 238,892 (28.2%) of ED visits for mental illness were by frequent users. Frequent users with mental illness had different characteristics than non-frequent users. Patients with a primary mental health diagnosis and a co-occurring, substance use diagnosis in the prior 12 months (77% vs. 37%, aRR [4.02], 95% CI [3.92-4.12]), homelessness (2.9% vs. 1.1%, odds ratio [1.35], 95% CI [1.27-1.43]) were more likely to be frequent users. Those covered by Medicare (aRR [3.37], 95% CI [3.20-3.55]) or Medi-Cal (aRR [3.10], 95% CI [2.94-3.25]) were also more likely to be frequent users compared with those with private insurance coverage.

DISCUSSION

Frequent ED users are a focus point for many health service agencies and policymakers because of the cost incurred from such patients on healthcare systems. Mental healthcare needs are often identified in the literature as a reason for high ED utilization.\(^23,25-27\) However, in many other studies this conclusion is based on including all patients for whom a mental health diagnosis code appears in the case file, i.e., a
When a mental health diagnosis from any position is included, mental illness may be a factor in the ED visit but not the primary reason for seeking care. We limited analysis to patients specifically seeking mental health treatment. Using this focused approach we noted several differences between patients who are frequent users of the ED for mental illness and those who are not frequent users, including medical and social conditions that complicate treatment.

In our analysis concurrent, substance use diagnoses had a strong association with frequent ED visits for mental illness. This association between substance use disorders and mental illness highlights the importance of medical treatment that addresses both disorders. According to the Substance Abuse and Mental Health Services Administration's 2014 National Survey on Drug Use and Health, 7.9 million American adults have co-occurring, substance use disorders and mental illness.28 Twenty percent of individuals with a serious mental illness develop a substance use disorder in their lifetime, yet only 7.4% receive treatment for both disorders and 55% receive no

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<td>Substance use in past 12 months</td>
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*Medi-Cal is the Medicaid healthcare program serving low-income people in California.

| Table 1. Descriptive statistics for mental health emergency department users. |
|-------------------------|-------------------------|-------------------------|
| Patient characteristics | Less than 4 visits/year | 4 or more visits/year |
|                         | N  | %   | N   | %   |
| Total                   | 607975 | 71.8 | 238892 | 28.2 |
| Gender                  |                |     |                |     |
| Male                    | 238463 | 50.1 | 22592 | 61.5 |
| Female                  | 237502 | 49.9 | 14129 | 38.5 |
| Age                     |                |     |                |     |
| 21-25                   | 55992 | 11.8 | 3916 | 10.7 |
| 26-30                   | 52316 | 11.0 | 4922 | 13.4 |
| 31-35                   | 47057 | 9.9  | 4700 | 12.8 |
| 36-40                   | 42947 | 9.0  | 4123 | 11.2 |
| 41-45                   | 47306 | 9.9  | 4493 | 12.2 |
| 46-50                   | 51478 | 10.8 | 4815 | 13.1 |
| 51-55                   | 47985 | 10.1 | 4277 | 11.6 |
| 56-60                   | 36224 | 7.6  | 2752 | 7.5  |
| 61-65                   | 24586 | 5.2  | 1512 | 40.1 |
| 66+                     | 70074 | 14.7 | 1211 | 3.3  |
| Payer                   |                |     |                |     |
| Medi-Cal*               | 116373 | 24.4 | 14795 | 40.3 |
| Medicare                | 119080 | 25.0 | 10971 | 29.9 |
| Other                   | 106354 | 22.3 | 5001 | 13.6 |
| Private                 | 54571 | 11.5 | 1737 | 4.7  |
| Self pay                | 79587 | 16.7 | 4217 | 11.5 |
| Homeless                | 5079 | 1.1  | 1074 | 2.9  |

| Table 2. Adjusted rate ratio for higher mental health emergency department use. |
|-------------------------|-------------------------|-------------------------|
| Adjusted rate ratio     | 95% CI                   |                         |
| Gender                  | Male vs Female | 1.25 | 1.22-1.28 |
|                         | Payer                  | 2.94-3.25 | 2.90-3.55 |
|                         | Other vs Private       | 1.54-1.71 |
| Age                     | 20-25 vs 51-55 | 0.97 | 0.93-1.01 |
|                         | 26-30 vs 51-55 | 1.13 | 1.08-1.18 |
|                         | 31-35 vs 51-55 | 1.15 | 1.10-1.19 |
|                         | 36-40 vs 51-55 | 1.11 | 1.07-1.16 |
|                         | 41-45 vs 51-55 | 1.08 | 1.03-1.12 |
|                         | 46-50 vs 51-55 | 1.04 | 1.00-1.09 |
|                         | 56-60 vs 51-55 | 0.91 | 0.87-0.96 |
|                         | 61-65 vs 51-55 | 0.81 | 0.77-0.86 |
|                         | 66+ vs 51-55 | 0.32 | 0.30-0.35 |
|                         | Homeless               | 1.35 | 1.27-1.43 |

CI, confidence interval.

In any of the diagnosis lines in a patient file. When a mental health diagnosis from any position is included, mental illness may be a factor in the ED visit but not the primary reason for seeking care. We limited analysis to patients specifically seeking mental health treatment. Using this focused approach we noted several differences between patients who are frequent users of the ED for mental illness and those who are not frequent users, including medical and social conditions that complicate treatment.

In our analysis concurrent, substance use diagnoses had a strong association with frequent ED visits for mental illness. This association between substance use disorders and mental illness highlights the importance of medical treatment that addresses both disorders. According to the Substance Abuse and Mental Health Services Administration's 2014 National Survey on Drug Use and Health, 7.9 million American adults have co-occurring, substance use disorders and mental illness. Twenty percent of individuals with a serious mental illness develop a substance use disorder in their lifetime, yet only 7.4% receive treatment for both disorders and 55% receive no
Studies looking at single institutions have found high ED utilization in patients with co-occurring, substance use disorders. Such dual-diagnosed patients have low rates of access to treatment for their substance use disorders. Despite evidence that integrated treatment is considered best practice, there are barriers to widespread adoption. Given the high demand for mental healthcare and substance use treatment identified in this study of California, future research should assess availability and impact of integrated mental health/substance use treatment programs.

Although less strong than the association between co-occurring, substance use disorders, we also found an association between homelessness and frequent ED visits for mental illness. Homeless patients had higher rates of ED visits and hospitalizations than non-homeless patients for all diagnoses, and they reported barriers accessing outpatient care. Interventions designed to address homelessness such as supportive housing have shown to impact healthcare utilization and expenditures.

National databases have shown that Medicaid recipients have a high prevalence of psychiatric disorders, and psychiatric disorders are a driver of healthcare costs. Indeed, we found a high proportion of patients entering the ED with mental illness were covered by the state’s Medicaid program Medi-Cal. This finding is consistent with other studies that have noted that patients covered by public insurance are more likely to use the ED when compared with those covered by private insurance. Additionally, California extends its Medi-Cal eligibility to the largest extent feasible under federal law. Yet barriers to consistent primary care or lack of access to regular outpatient mental healthcare could explain the higher ED visit rates.

**LIMITATIONS**

Studies that rely on retrospective data can be subject to a set of limitations such as selection, classification, and other forms of bias and confounding. Because our data cover the complete, documented population of ED visits in California, selection bias is mitigated. However, this study was dependent on diagnosis codes assigned by the ED provider and was subject to misclassification bias within and across the many hospitals from which patients were included. Further, choosing to identify those visiting the ED for mental health concerns by those with a mental health diagnosis in the first position served only as a proxy and risked missing patients. While individual chart review might have produced less concern, the volume of records made that infeasible. Prior work on ED populations and undiagnosed mental illness suggest that undercounting is more common. We report on healthcare utilization, but the data cannot speak to health outcomes nor can we definitively identify the causes of high ED utilization. Despite its shortcomings, this study reports and identifies important characteristics of patients who visit EDs for mental illness frequently across a large, diverse population, information that suggests areas for further study.

**CONCLUSION**

Patients with substance use diagnoses, patients who are homeless and those who are covered by Medi-Cal, the state’s Medicaid program, are more likely to be frequent users of the ED for mental illness. This suggests substance use and housing needs are important factors to address in patients with high ED use for mental health needs.

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Accomplishments

Manpreet Singh, MD was promoted to Medical Student Clerkship Director at Harbor University of California Los Angeles Emergency Medicine.

Nathan Kuppermann, MD, FACEP received the Faculty Distinguished Research Award from University of California Davis Emergency Medicine.

Elaine Hsiang was the recipient of the 2020 American College of Emergency Physicians’ Emergency Medicine Residents’ Association National Outstanding Medical Student Award.

James Delgadillo, MD was awarded the best research presentation on Airway Barrier Device Validation at the Society for Academic Emergency Medicine Stimulation Academy’s Fellow’s Forum.

Ashley Rider, MD’s presentation was recognized for Best Innovation at the Society for Academic Emergency Medicine Stimulation Academy’s Fellow’s Forum.

Christopher Bennett, MD, MA joined Stanford Emergency Medicine as Assistant Professor.

Marc Gautreau, MD was promoted to Emergency Medical Services Fellowship Director for Stanford Emergency Medicine.

Lauren Fryling, MD was awarded a Society for Academic Emergency Medicine Resident Research Grant for her study Effect of SB1152 (Safe Homeless Discharge Legislation) on Emergency Department Length of Stay and Recidivism.

Jeanne Noble, MD received the 2020 National Emergency Medicine Excellence in Bedside Teaching Award from the University of San Francisco Emergency Medicine.

Andrea Quiñones-Rivera, MD received a “Shining Star” commendation from one of her patients for providing stellar patient care.

Phillip Harter, MD, FACEP and Christopher Colwell, MD, FACEP received the 2020 Emergency Medicine Faculty Teaching Award from Stanford Emergency Medicine.

William Shyy, MD, FACEP received the 2020 National Emergency Medicine National Junior Faculty Teaching Award.

William Dixon, MD; Wei David Hao, MD; Michael Losak, MD; and James Marvel, MD transitioned from fellows to Clinical Assistant Professors at Stanford Emergency Medicine.

Larissa May, MD, FACEP was named Interim Health Officer for Yolo County.

Michael Gisondi, MD, FACEP received the Franklin G. Ebaugh Award Jr. Advising Award from the Program Teaching Awards Student Selection Committee from Stanford Emergency Medicine.

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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 2019-20 contributors (in alphabetical order):

- Antelope Valley Emergency Medical Associates
- Culver Emergency Medical Group
- Emergent Medical Associates
- Mills Peninsula Emergency Medical Associates
- Napa Valley Emergency Medical Group
- Pacific Emergency Providers, APC
- Riverside EP
- Temecula Valley Emergency Physicians
- Torrance Emergency Physicians
- US Acute Care Solutions
- VEP Healthcare Inc.
- Vituity

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 2019-20 contributors (in alphabetical order):

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- VEP Healthcare Inc.
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CALIFORNIA ACEP SPONSORED & CO-SPONSORED COURSES

Save the Date! 2021 Legislative Leadership Conference (LLC)
April 13, 2021 | Sacramento, CA

AdvancED 2021 Annual Conference
September 10, 2021 | The Westin San Diego Gaslamp | San Diego, 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 are 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.

UPCOMING LIFELINE TOPICS

Winter – Practicing Outside the ED (telehealth, wilderness, urgent care, etc.)
Spring – Health Equity/Diversity and Inclusion
Summer – Leadership Development (mentorship strategies, C suite, group leadership, etc.)

NOMINATE A CALEMRA ALL-STAR

Do you have an EM all-star hiding in your program and want to get their name out there? We’re looking for residents or medical students that deserve recognition!

Nominations can be submitted at bit.ly/nominate4calemra.
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

### NOVEMBER 2020

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>3rd at 9am</td>
<td>Reimbursement Committee Conference Call</td>
</tr>
<tr>
<td>11th</td>
<td>Chapter Office Closed Veteran’s Day</td>
</tr>
<tr>
<td>12th at 10am</td>
<td>Board of Directors Meeting Virtual</td>
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### DECEMBER 2020

<table>
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<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>2nd at 1pm</td>
<td>Executive Committee Conference Call</td>
</tr>
<tr>
<td>24th – 31st</td>
<td>Chapter Office Closed Winter Holidays</td>
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### JANUARY 2021

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<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>1st</td>
<td>Chapter Office Closed New Year’s Day</td>
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<tr>
<td>12th at 9am</td>
<td>Reimbursement Committee Conference Call</td>
</tr>
<tr>
<td>14th at 10am</td>
<td>Government Affairs Committee Conference Call</td>
</tr>
<tr>
<td>20th at 9am</td>
<td>Executive Committee Conference Call</td>
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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

VENTURA CALIFORNIA: We have moved into our brand new Hospital and Emergency Department as of December 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 two 12 hour shifts 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: thomasffp@sbcglobal.net
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

Loma Linda University Medical Center
Lyne Jones, Administrative Assistant
Department of Emergency Medicine
11234 Anderson St., A108, Loma Linda, CA 92354
Phone: (909) 556-4344 x 0
Fax: (909) 556-0102
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: grose@napavalley.edu
Web: www.winecountrycpr.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: ljossa@caltel.com
Web: www.ncti-online.com

PHI Air Medical, California
Eric Lewis, Course Coordinator
801 D Airport Way, Modesto, CA 95354
Phone: (209) 550-0884
Fax: (209) 550-0885
Email: elewis@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: Gregg@riggsambulance.com
Web: www.riggsambulance.com

Rocklin Fire Department
Chris Wade, Firefighter/Paramedic
3401 Crest Drive, Rocklin, CA 95765
Phone: (916) 625-5311
Fax: (916) 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

Defib This (ERT)
Brian Green, EMT-P
1543 Pacific Avenue, Suite 104, Capitol CA 95013
Phone: (831) 426-9111
Web: www.defibthis.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

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

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.

EMREF is a proud sponsor of California ITLS courses.
Please call 916.325.5455 or E-mail Lucia Romo: lromo@californiaacep.org for more information.
DO YOU WANT TO ADVERTISE TO EMERGENCY PHYSICIANS?
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Information on Sponsorships and EmployED online job postings can be found at www.californiaacep.org