Memory is a funny thing. I can’t remember what drugs we talked about at last month’s P&T meeting, but I remember that one of my friends likes showers so hot they are on the verge of being painful. I forgot my partner’s birthday in 2014—that was bad—but I remember an acquaintance in France once telling me, “Je ne sais pas résister aux fruits!” (“I can’t say no to fruits”), which struck me as the most French thing I had ever heard anyone say. I have no idea when my last tetanus shot was, but I still remember a magenta cactus flower I found on a hike in Sedona in 2006.

Several years ago, I was annoyed that I couldn’t remember all the side effects and interactions of the common anti-psychotics we use in the ED. Because our ED is a center of excellence for psychosis, I got our pharmacists to help me make a table where you could refresh your memory at a glance. My colleagues seemed to like it, and eventually it turned into one of the early “toolkits” on the CalACEP website. (You can see it here: [https://shorturl.at/rKLT0](https://shorturl.at/rKLT0))

One of my goals as CalACEP President was to augment and refresh our toolkits. The autumn of 2022 was a brief fallow season in between legislative sessions, so we spent it developing new resources and education for CalACEP members. If you look at our website, californiaacep.org, you’ll see an area called “Practice Forward,” which has a drop-down menu with many of the resources we’ve created.

New toolkits you can find there include a CPT coding guide which was posted in the Fall of 2022 to help members get ready for the new CPT coding rules that went into effect in January 2023. This guide should be required reading for any new grads coming into your practice, so they can optimize their documentation and avoid unnecessary documentation. You can find this CPT coding guide in this issue of Lifeline on pages 18-20.
We also added three new offerings from the California Bridge Program for treating substance use disorders—webinars on treating methamphetamine and polysubstance use disorder, and a guide with the latest evidence-based information on treating alcohol use disorder.

Our upcoming 2023-24 CalEMRA President, Nicole McAmis, created a toolkit with multiple resources for assisting victims of human trafficking, including posters and wallet cards that can be displayed and given out in your ED. Both of which are included on pages 10-12 of this issue.

CalACEP member, David Wang, MD, gave a well-received webinar about how to embed palliative care physicians into your ED with a huge return on investment in terms of reduced length of stay and improved patient satisfaction.

And CalACEP Board Member, Rebecca Ruiz, MD, created a toolkit called “Planning Ahead: Early-Career Physician Finances Guide” that is full of tips and tricks to save money and invest in your future at the start of your career (you can find her guide under the “Membership” tab and on page 14-17 of this issue.

Once the Legislature got back in session in January, we really got busy at CalACEP, pouring over scores of bills and looking for support for our sponsored bills. The session has gone well for us overall, and you can always read details in the Advocacy Updates in Lifeline and the Weekly Re-Cap emails. I’ll just call out one example—we are on the verge of never having to check CURES again when prescribing Suboxone!

Most recently, CalACEP staff scored a huge win by securing $200 million in the state budget specifically for Emergency Physicians! This will start in 2025 and will be funded by the Managed Care Organization (MCO) tax just passed by the Legislature. The MCO tax will direct hundreds of millions of dollars not only to EPs but also to other Medi-Cal providers, which should improve access to care for Medi-Cal recipients. We were the only specialty with its own line item in the budget, for which we have our talented staff to thank.

We estimate that this new funding may result in as much as a $40,000 average wage increase for EPs who serve a high proportion of Medi-Cal patients. That is a stunning success, akin to securing passage of the Maddy EMS Fund decades ago, in terms of its importance to the state-wide stability of our specialty.

Although I can’t claim any credit for pulling off the MCO tax win (other than cheerleading), I’m thrilled that it happened during my presidency. It has been my honor to work with the CalACEP Board of Directors and staff this year, and it has been my favorite “work thing” to spend time on. Advocacy work gets me fired up about our mission: making things better for Emergency Physicians and our patients. It truly is a wellness activity. I’ll remember the standout moments from this year, like our MCO tax win, as vividly as I remember that gorgeous magenta flower.

I want to thank all of you for your support and for honoring me with the opportunity to lead this amazing organization for a brief time. Every President’s goal is to get through the year without crashing the Cadillac, and I’m grateful that the CalACEP Cadillac is still zooming along.
ADVANCED

EvolvED: Redefining EM

CALIFORNIA ACEP’S ANNUAL CONFERENCE 2023

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

Friday, September 8, 2023
Hotel Dena
303 Cordova Street
Pasadena, CA
### Schedule

<table>
<thead>
<tr>
<th>TIME</th>
<th>EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00-09:00am</td>
<td>Continental Breakfast and Registration</td>
</tr>
<tr>
<td>09:00-09:10am</td>
<td>Welcome &amp; Program Overview</td>
</tr>
<tr>
<td>09:10-09:40am</td>
<td>Keynote</td>
</tr>
<tr>
<td>09:40-10:00am</td>
<td>Award Ceremony</td>
</tr>
<tr>
<td>09:50-10:00am</td>
<td>Human Trafficking</td>
</tr>
<tr>
<td>10:00-10:10am</td>
<td>Transgender Patients in the ED</td>
</tr>
<tr>
<td>10:10-10:30am</td>
<td>BREAK</td>
</tr>
<tr>
<td>10:30-12:05pm</td>
<td>Track Intro</td>
</tr>
<tr>
<td>10:35-10:45am</td>
<td>In Memoriam</td>
</tr>
<tr>
<td>10:45-10:55am</td>
<td>Emergency Medicine: A Lifestyle Specialty</td>
</tr>
<tr>
<td>10:55-11:05am</td>
<td>How to Evaluate DEI in Residency Programs</td>
</tr>
<tr>
<td>11:05-11:25am</td>
<td>Building Your Brand/Interview Prep</td>
</tr>
<tr>
<td>11:25-12:05pm</td>
<td>Q&amp;A</td>
</tr>
<tr>
<td>12:05-12:55pm</td>
<td>LUNCH</td>
</tr>
<tr>
<td>12:55-1:10pm</td>
<td>Presidents Message</td>
</tr>
<tr>
<td>1:10-1:15pm</td>
<td>CalEMRA</td>
</tr>
<tr>
<td>1:15-1:25pm</td>
<td>Award Ceremony</td>
</tr>
<tr>
<td>1:25-1:45pm</td>
<td>Featured Poster Presentations</td>
</tr>
<tr>
<td>1:45-2:30pm</td>
<td>Poster Session</td>
</tr>
<tr>
<td>2:30-4:05pm</td>
<td>Track Intro</td>
</tr>
<tr>
<td>2:35-2:45pm</td>
<td>Wellness</td>
</tr>
<tr>
<td>2:45-2:55pm</td>
<td>99 Decisions</td>
</tr>
<tr>
<td>2:55-3:05pm</td>
<td>The Deposition Whisperer</td>
</tr>
<tr>
<td>3:05-3:15pm</td>
<td>Get Out Of Your Own Way</td>
</tr>
<tr>
<td>3:15-3:25pm</td>
<td>Finding the Right Job for You</td>
</tr>
<tr>
<td>3:25-3:35pm</td>
<td>Teaching IS Equity</td>
</tr>
<tr>
<td>3:35-4:05pm</td>
<td>Finance Talk</td>
</tr>
<tr>
<td>4:05-4:15pm</td>
<td>BREAK</td>
</tr>
<tr>
<td>4:15-4:30pm</td>
<td>You, Me, and ChatGPT</td>
</tr>
<tr>
<td>4:30-4:40pm</td>
<td>CalACEP Advocacy</td>
</tr>
<tr>
<td>4:40-5:05pm</td>
<td>Awards Ceremony and Closing</td>
</tr>
<tr>
<td>5:05-6:00pm</td>
<td>Closing Reception</td>
</tr>
</tbody>
</table>

**COLOR KEY:**  
- Medical Student Track  
- Resident Track
The California Legislature passed the health budget trailer bill earlier this year, which includes the renewal of the state’s MCO Tax. This tax on managed care plans will provide an opportunity for the state to raise funds, match them with federal dollars, and provide resources to invest in health care infrastructure, including the largest Medi-Cal rate increase in California history. The initial proposal included rate increases for primary care providers and mental health providers to 87% of Medicare but did not include emergency physicians.

As you are painfully aware, your Medi-Cal reimbursement rates have not increased in 20 years, despite you caring for a disproportionate share of the Medi-Cal population. California ACEP staff and member physicians engaged in grassroots advocacy efforts to encourage the Governor and the Legislature to include emergency physicians in the final language. Your membership and our advocacy efforts literally paid off!

Starting in 2025, $200 million will be devoted annually to increase reimbursement rates for emergency physicians. This increase will take your Medi-Cal rates from somewhere between 55-60% of Medicare reimbursement to 80%!

We could not have done this work without you. Your grassroots efforts resulted in over 1,000 calls and emails to policy makers! The stories that you told, about the patients you see and the impact of low rates on your community, were incredibly impactful. California ACEP staff will continue to monitor and update you and the progress of MCO tax implementation, and to provide you with the tools you need to advocate on other legislation that impacts your patients and your practice.
She was inspired by a bad outcome for a young patient with substance use disorder. She did not just grieve for the patient, she set out to do something about these all too frequent tragedies. At that time, prescription medication, often from multiple doctors, was the primary source of substances used inappropriately. She organized the San Diego medical community to agree that one doctor and one pharmacy should be the providers of controlled substances for each patient. This was a pioneering innovation at the time and was later widely adopted.

California ACEP adopted a safe prescribing guideline under her leadership: [https://californiaacep.org/page/SafePrescribing](https://californiaacep.org/page/SafePrescribing). It is very well done, comprehensive, and even has a great tip on parenting. Take a look. It might improve your practice.

She went on to be Chief Medical Officer in The White House Office of National Drug Control Policy. While there she worked on Xing the x-waiver, getting insurers to pay for addiction medicine services, and ending the opioid prescription crisis among other things. She even still managed a few clinical shifts every month.

Dr. Lev has a podcast, High Truths on Drugs and Addiction, that educates anyone who wants to listen on substance use disorder. She has interviewed a wide range of experts, patients, and families on these podcasts, of which there are well over 100 episodes. [https://hightruths.com/](https://hightruths.com/)

Dr. Lev recently championed a bill that passed in California that requires drug screens to include fentanyl. Patients who are screened can now find out if they were unknowingly exposed to fentanyl. Also, the magnitude of the fentanyl epidemic can now be measured more accurately.

Dr. Fred Dennis, MD, MBA, FACEP and I, among others, were instrumental in the development of the ACEP award that Dr. Lev won. We recognized that in the past, substance use disorders and behavioral health were not well managed in the emergency department. It was treat and street. A dose of Narcan or a banana bag and out the door when the patient was deemed safe to walk. Fortunately, emergency medicine is doing much better now, with innovations such as buprenorphine, social workers, telepsychiatry, warm handoffs, Narcan scripts, and so on. The purpose of the award is to encourage and recognize the betterment of the treatment of these emergency patients. Dr. Lev is certainly deserving of the award.

Please see the interview I did of Dr. Lev about her involvement with addiction medicine on her podcast: [https://hightruths.com/?s=Lev+Interview](https://hightruths.com/?s=Lev+Interview).
If you or someone you know is being forced to engage in any activity and cannot leave, whether it is commercial sex, housework, farm work, or any other activity, call the National Human Trafficking Resources Center Hotline:

1-888-373-7888
Text: 233733 (BeFree)

Available 24/7, 7 days a week. Anonymous and confidential.

Victims of human trafficking are protected under U.S. and California Law.

Created by: Nicole E. McAmis, MD
DETENER EL TRÁFICO HUMANO

Si usted o alguien que conoce se ve obligado a participar en cualquier actividad y no puede irse, ya sea sexo comercial, trabajo doméstico, trabajo agrícola o cualquier otra actividad, llame al Centro Nacional de Recursos contra el Tráfico de Humanos:

1-888-373-7888
Text: 233733 (BeFree)

Disponible 24/7, 7 días a la semana.
Anónimas y confidenciales.

Las víctimas del tráfico de humanos están protegidas bajo las leyes de los Estados Unidos y California.

Created by: Nicole E. McAmis, MD
HISTORICAL QUESTIONS

• Do you feel safe?
• Have you been forced to engage in sexual acts for money or favors?
• Is someone holding your identification documents or passport?
• Has anyone threatened to hurt you or your family if you leave?
• Has anyone physically or sexually abused you?
• Do you have a debt to someone you cannot pay off?
• Does anyone take all or part of the money you earn?

SUSPECTING HUMAN TRAFFICKING?

• Call the National Human Trafficking Resource Center (NHTRC) hotline: 1-888-373-7888
• Ask for assistance with assessment and next steps
• Assess the current level of danger (trafficker present, what will happen if patient does not return, anyone else in danger, patient a minor)
• Consider law enforcement involvement for victim safety

RED FLAGS OF HUMAN TRAFFICKING

• Someone else is speaking for the patient and is reluctant to leave
• Patient exhibits fear, anxiety, or tension
• Patient reluctant to explain injuries or shares a scripted history
• Patient reports unusually high number of sexual partners, STDs, pregnancies, miscarriages, or terminations

WHEN APPROACHING CONVERSATIONS

• Ask others to leave for interview/exam
• Bring in a social worker or advocate whenever possible
• Use a professional, neutral interpreter if needed
• Assure confidentiality, unless the situation invokes state mandatory reporting laws (i.e. persons in grave danger, minors under 18, etc.)
MENTAL HEALTH & CRISIS SUPPORT RESOURCES FOR CALACEP MEMBERS

Physician Support Line:
• Call (888) 409-0141
• Open 7 days a week from 8am to 1am Eastern Time
• Psychiatrist volunteers; an anonymous and GREAT choice for crisis

Call the number on the back of your insurance card for a covered mental health referral or log onto your plan website to find a covered provider.

National Suicide hotline:
• Call 988
• Chat at https://988lifeline.org/chat/

California Medical Association:
• Call: (650) 756-7787 (Northern California) or (213) 383-2691 (Southern California) you will get a call back from trained peer support physician to chat and provide support and referrals for physicians and Dentists.
• You can also visit https://www.cmadocs.org/confidential-line.

Crisis Text Line:
• Text HOME to 741741 to connect with a volunteer Crisis Counselor
• https://www.crisistextline.org/

Crisis phone line, online chat, text line, and LGBTQ specific resources are available at:
• https://www.thetrevorproject.org/get-help-now/
• To find care in any area visit https://findtreatment.samhsa.gov/ and input your zip code.

App based help:
• https://ginger.app.link/download-ginger

Free anonymous online for crisis therapists & counselors:
• https://www.7cups.com

National Domestic Violence Hotline
• (800) 799-SAFE (7233)
• https://www.thehotline.org

National Sexual Assault Hotline:
• (800) 656-HOPE (4673)

Organizational Help and promotion of well-being
• ACEP wellness https://www.acep.org/life-as-a-physician/wellness/
• AMA steps forward wellness: https://edhub.ama-assn.org/steps-forward/pages/professional-well-being
THE ROAD AHEAD

EARLY-CAREER PHYSICIAN

FINANCIAL CONSIDERATIONS

Compiled by
Rebecca Ruiz, M.D.
IN MEDICAL SCHOOL

Shared Housing

- Living at home
- Rental housing with friends
- Apply for jobs at your school: tutoring, lab assistants - some jobs may have tuition offsets
- Gig economy/e-commerce work: flexible scheduling
- Some housing options may include labor exchanges: pet-, baby-sitting, gardening, tutoring, BUT BEWARE OF SCAMS

Working

- Are you willing to join the military? Depending upon the service branch under consideration, there are many plans for full tuition coverage and post-military stipends after your commitment ends - a minimum of four years’ commitment

Military Service

Other Thoughts

- Look for student discounts on everything:
  - Car insurance
  - Computers
  - Mobile phones & plans
  - Food
- What is absolutely necessary?
  - If you live in a large city with good public transportation, do you need a car?
  - What’s the minimum amount of student loans that you can borrow?
- What situations or items are the lowest-cost that will also be least disruptive to your education?

Compiled by Rebecca Ruiz, M.D.
**PLANNING FOR RESIDENCY**

**Program Location**
- Consider only applying to programs that you rank highly.
- Consider applying to programs that are within reasonable driving distance from your medical school.
  - This can decrease the cost of moving and travel.
- Consider the cost of living in the program area.

**IN RESIDENCY**

**Money-Saving Tips**
- Live in an area that is safe, convenient and where housing is no more than 25% of your gross income.
- Live with roommates.
- Begin to pay back student loans.
- Research affordable insurance bundle.
  - Renters, car, homeowners.
- Eat at the hospital, don’t leave any unspent money on your meal account!
- Consider mobile phone family plans.
- Limit subscription services.
- Share internet costs with neighbors.

**Earning Extra**
- Moonlight.
- Gig economy/e-commerce work: flexible scheduling.
Investing

- Ask if your program has retirement plan options, and, if it does, SIGN UP!
- Consider opening your own Roth Individual Retirement Account (Roth IRA)
- Contribute to a Health Savings Account (HSA) if you have a High-Deductible Health Plan (HDHP)
- Consider opening a high-yield savings account and set-up automatic monthly deposits
- Consider opening an investment account

Money Matters

POST-RESIDENCY

- Apply to jobs that qualify for loan forgiveness and/or repayment plans
- Apply to higher-paying jobs that include monthly stipends while you’re still in residency to help defray/cover moving expenses
- Apply to jobs in areas with lower costs-of-living
- Obtain disability insurance before the end of your residency
- Avoid/delay big, less-necessary purchases:
  - Expensive cars
  - Luxury items
  - High-cost vacations
- Save money for practice-related costs
  - Boards
  - State licensure
- Aim to save three months’ of living expenses for emergency situations
# AMA 2023 E/M DESCRIPTORS AND GUIDELINES

## TABLE 1: ELEMENTS OF MEDICAL DECISION MAKING

Note: The LEVEL (left-most column) is determined by the highest of 2 out of 3 elements of these “Elements of MDM”

<table>
<thead>
<tr>
<th>Level of MDM</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Amount and/or Complexity of Data to Be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward 99282</td>
<td>Minimal 1 self-limited or minor problem</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
</tbody>
</table>
| Low 99283 | Low Need one of the following:  
- 2 or more self-limited or minor problems  
- 1 stable, chronic illness  
- 1 acute, uncomplicated illness or injury  
- 1 stable acute illness  
- 1 acute uncomplicated illness or injury requiring hospital inpatient or observation level of care | Limited (Need 1 out of 2 categories)  
Category 1: Tests and documents  
Any combination of 2 from the following:  
- Review of prior external notes  
- Review of the results of each test  
- Ordering of each test  
Category 2: Assessment requiring an independent historian | Low risk of morbidity from additional diagnostic testing or treatment |
| Moderate 99284 | Moderate Need one of the following:  
- 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment  
- 2 or more stable, chronic illnesses  
- 1 undiagnosed new problem with uncertain prognosis  
- 1 acute illness with systemic symptoms  
- 1 acute complicated injury | Moderate (Need 1 out of 3 categories)  
Category 1: Tests and documents  
Any combination of 3 from the following:  
- Review of prior external notes  
- Review of the results of each test  
- Ordering of each test  
Category 2: Independent interpretation of test performed by another HCP  
Category 3: Discussion of management or test interpretation with other HCP | Moderate risk of morbidity from additional diagnostic testing or treatment  
Examples only:  
- Rx drug management  
- Dec. regarding minor surgery with identified patient or procedure risk factors  
- Dec. regarding elective major surgery without identified patient or procedure risk factors  
- Dx or tx significantly limited by SDOH |
| High 99285 | High 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or  
1 acute or chronic illness or injury that poses a threat to life or bodily function | Extensive (Must meet the requirements of at least 2 of 3 categories)  
Category 1: Tests, documents, or independent historians  
Any combination of 3 from the following:  
- Review of prior external notes  
- Review of the results of each test  
- Ordering of each test  
- Assessment requiring an independent historian  
Category 2: Independent interpretation of test performed by another HCP  
Category 3: Discussion of management or test interpretation with other HCP | High risk of morbidity from additional diagnostic testing or treatment  
Examples only:  
- Drug therapy requiring intensive monitoring for toxicity  
- Dec. regarding elective major surgery with identified patient or procedure risk factors  
- Dec. regarding emergency major surgery  
- Dec. regarding hospitalization or escalation of hospital-level care  
- Dec. not to resuscitate or to de-escalate care because of poor prognosis  
- Parenteral controlled substances |
1. Billing is based on the number and complexity of problems, the amount or complexity of data, and risk of complications or morbidity and mortality of patient management.

2. The History and Physical are NOT considered elements of the E/M codes. Past Medical History, Review of Systems, and Social History are NOT taken into account for elements of the level of service.

3. Document when obtaining history from an independent historian (e.g., parent, guardian, spouse).

4. Document your review of external notes (e.g., EMS, DC Summary, Clinic).

5. Document tests or treatment considered but not performed.

6. Document your independent interpretation of studies (e.g., XR, CT Scan), review of tests you ordered and/or interpreted (e.g. labs) and cardiac monitor interpretation.

7. Document discussion of management with external provider (e.g., hospitalist, consultant, case manager, social worker, primary care physician).

8. Document if social determinants of health (SDOH) affected choice of management (e.g. homelessness, food insecurity, unemployment, addiction).

9. Document the decision regarding hospitalization (when applicable).

10. Document that you addressed or managed patients’ existing chronic illnesses or conditions when appropriate (e.g. poor control of hypertension or diabetes).


2. In 2023, billing is NOT based on components of the history and physical exam though the HPI will help to establish problem complexity. Past Medical History, Review of Systems, Family History, and Social History are NOT taken into account for elements of the level of service.

a. This is perhaps the biggest change in 2023 from previous requirements for a certain number of elements in the history and physical exam.

b. The only requirement in the new release is “a medically appropriate history and/or exam.”

c. There is no requirement for documentation of these as separate parts of the history. They may be omitted entirely or included in context of the HPI only.

d. Family History will no longer be required for OBS care.

4. Document your review of external notes (e.g., EMS, DC Summary, Clinic Notes)

a. Any notes authored from a provider outside your group apply.

5. Document tests or treatment considered but not performed.

a. The ordering and review of the results of tests counts toward complexity of data.
b. A test considered but not ordered will count as credit for complexity of data interpreted (e.g., d-dimer for PERC rule, head CT for PECARN, etc.).

6. Document your independent interpretation of studies (e.g., XR, CT Scan, cardiac monitor) and review of tests you ordered and/or interpreted (e.g., labs).
   a. Note: If separately reporting or billing for a service (e.g., cardiac monitor), then its interpretation is not included as a data element ordered or interpreted.
   b. An interpretation of a complex study such as a CT scan need not conform to usual standards for interpretation (i.e., that which would be done by a radiologist). However, your interpretation counts as an element of data reviewed.
   c. You need not have ordered the test to interpret it and get credit; if a patient presents with lab work from an outside source, you can document your review and get credit.
   d. Documentation of order and review of 3 unique labs counts as 3 elements (as long as the labs are not grouped; e.g., review of WBC, HGB, PLT is one element of a CBC).

7. Document discussion of management with external provider. (e.g., hospitalist, consultant, case manager, social worker, primary care physician, pharmacist)
   a. This includes conversations which occurred in an asynchronous medium, or those which did not occur in person.
   b. Conversations through an intermediary are not included.

8. Document if social determinants of health affected choice of management. (e.g., homelessness, food insecurity, unemployment, addiction)
   a. SDOH are a big change in 2023, when properly documented as they pertain to management of the disease process, they add an element of risk of complications.

9. Document the decision regarding hospitalization (when applicable).
   a. A documented discussion about why a patient was discharged as opposed to being admitted speaks to the risk of complications and morbidity/mortality of a case.

10. Document that you addressed or managed patients’ existing chronic illnesses or conditions when appropriate (e.g., poor control of hypertension or diabetes).

11. Document a focused patient-specific differential diagnosis
   a. A non-templated differential with discussion will help to establish the patient risk complexity.

Additional points worth noting:

- Pulse oximetry is not considered a test. (Don’t waste your time formally “interpreting” it).
- A comprehensive history and comprehensive examination are nice and may be adequate; it will not be considered however in your level of service or billing.
- Translator services are not considered independent historians
- Time is no longer a component of consideration of level of service (for standard codes). (Critical Care is still a time-based service and the time requirements for the various levels will change in 2023).
- The “Level 1” LOS/Chart (99281) is expected to be so simple that it may not even require a physician or AHP to be involved. MDM does not apply at all to this LOS.

Example documentation:

- “Additional history was obtained through the patient’s daughter as an independent historian who reviewed the patient’s chronic medical issues and symptoms which prompted today’s visit.”
- “I reviewed prior external notes available to me in the EMR from when the patient was discharged from the hospital last month.”
- “The patient required continuous monitoring while receiving repeat doses of opiate medications to control his pain.”
- “In my independent interpretation of the CT scan of the head, I did not see evidence of a large intracranial bleed. I await the final interpretation from the radiologist.”
- “I considered the need for admission in this patient with chest pain, but feel that due to normal test results and given his ability to follow-up, he is stable to be discharged and evaluated as an outpatient this week by his PMD.”
- “I discussed with the patient the need for emergency surgery to remove her gallbladder due to active infection.”
- “I discussed the case with the social worker due to the history of domestic violence and my concern for the patient’s safe discharge.”
- “I discussed the case with case manager to ensure that her continuing medical needs could be met at her current residence.”
- “I am prescribing controlled substance pain medications to the patient to help with adequate analgesia while at home over the next few days.”
- “The patient was continuously monitored during fosphynothen infusion to make sure there his blood pressure remained stable and there were no adverse effects.”
- “The patient also has chronic hypertension and her blood pressure was elevated today, likely due to pain. Her blood pressure improved after administration of pain meds and I counseled her to discuss her HTN management at her next doctor’s appointment.”
- “The patient has chronic diabetes and his blood sugar was high today. I administered IV fluids to help lower the glucose and counseled the patient to discuss his diabetes management with his PMD.”
BUPRENORPHINE FOR HIGH-DOSE TRAMADOL DEPENDENCE: A CASE REPORT OF SUCCESSFUL OUTPATIENT TREATMENT

Leslie Mukau, MD*,†
Kadia Wormley, MD‡
Christian Tomaszewski, MD, MS, MBA*,†
Bushra Ahmad, MD§
Rais Vohra, MD¶
Andrew A. Herring, MD||

*University of California, San Diego, Department of Emergency Medicine, San Diego, California
†El Centro Regional Medical Center, Department of Emergency Medicine, El Centro, California
‡Highland Hospital – Alameda Health System, Department of Emergency Medicine, Oakland, California
§Imperial County Behavioral Health Services, Division of Substance Use Disorder Treatment Program, El Centro, California
¶University of California, San Francisco-Fresno, Department of Emergency Medicine, Fresno, California
||University of California, San Francisco, Department of Emergency Medicine, San Francisco, California

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INTRODUCTION: During the coronavirus disease 2019 pandemic caused by the severe acute respiratory syndrome coronavirus 2, deaths from opiate drug overdoses reached their highest recorded annual levels in 2020. Medication-assisted treatment for opiate use disorder has demonstrated efficacy in reducing opiate overdoses and all-cause mortality and improving multiple other patient-centered outcomes. Treatment of tramadol dependence in particular poses unique challenges due to its combined action as opioid agonist and serotonin-norepinephrine reuptake inhibitor. Tramadol puts patients with dependence at risk for atypical withdrawal syndromes when attempting to reduce use. Little evidence is available to guide treatment of tramadol dependence.

CASE REPORT: We present a case of high-dose tramadol addiction that began with misuse of medically prescribed tramadol for treatment of musculoskeletal back pain. The patient’s use reached oral consumption of 5000-6000 milligrams of illicit tramadol daily. She complained of common complications of tramadol use disorder including memory impairment, excessive sedation, and tramadol-induced seizures. The patient was referred to the emergency department in a withdrawal crisis seeking treatment where she was successfully managed with buprenorphine and phenobarbital and then linked to ongoing outpatient treatment.

CONCLUSION: Our report adds to the limited guidance currently available on the acute management of tramadol withdrawal and treatment of tramadol use disorder. Our case suggests the initiation of high-dose buprenorphine may be an effective and feasible option for emergency clinicians. [Clin Pract Cases Emerg Med. 2022;6(1):71-74.]

KEYWORDS: case report; tramadol addiction; serotonin-norepinephrine reuptake inhibitor (SNRI) withdrawal symptoms; buprenorphine induction.

INTRODUCTION

In the midst of the coronavirus disease 2019 pandemic caused by the severe acute respiratory syndrome coronavirus 2, drug overdose deaths rose nearly 30% to a record 93,000 in 2020, representing the most drug overdose deaths in a year, the most deaths from opioid overdoses, and the most overdose deaths from synthetic opioids. Treatment of opioid use disorder with buprenorphine or methadone has been shown to decrease opioid overdose, reduce all-cause mortality, improve quality of life, decrease human immunodeficiency virus/hepatitis C transmission, and reduce drug cravings and criminality.

Tramadol is a centrally acting opioid agonist and serotonin/norepinephrine reuptake inhibitor (SNRI) used for the management of moderate to severe pain in adults. Tramadol differs from other traditional opioid medications in that it doesn’t just act as a μ-opioid agonist, but also affects monoamines by modulating the effects of neurotransmitters involved in the modulation of pain such as serotonin and norepinephrine, which activate descending pain inhibitory pathways. Unlike other opioid medications, tramadol use, especially at sustained high doses also carries a risk of seizure and serotonin syndrome, especially if used with other serotonergic medications.

Unfortunately, there is little in the literature to guide emergency treatment of tramadol addiction. Although attempts to treat tramadol withdrawal with buprenorphine have been published, this is the first case of high-dose tramadol addiction and dependence successfully managed with buprenorphine in an emergency department (ED) setting. Given the increased interest and use of ED-initiated buprenorphine we believe cases like this one could be a useful guide for other clinicians confronted by similar cases.

CASE REPORT

A 29-year-old Latina female with a past medical history of post-traumatic stress disorder (PTSD), depression, and anxiety self-referred to a behavioral health center seeking treatment for severe tramadol use disorder. She had a remote history of marijuana use, without other...
recreational drug or alcohol use. She had no history of any other opioid use, apart from tramadol. At age 24 she first began taking tramadol 50 milligrams (mg) daily as prescribed by her primary care physician for treatment of back pain but continued use after this pain had resolved. She began crossing the border into Mexico to purchase tramadol in increasing quantities and slowly increased her dose to approximately 5000-6000 mg daily, costing her $200 US dollars monthly.

Complications of her tramadol use included memory impairment, excessive sedation, and tramadol-induced seizures, occurring about every two weeks. Prior to presentation for care, she had independently tried numerous times to quit by tapering but was limited by intolerable withdrawal symptoms, never dropping usage below 4000 mg daily.

At time of presentation, she had not yet participated in any formal detoxification program. Withdrawal symptoms began two hours after her last use and included anxiety, restlessness, diaphoresis, and arthralgias. During this time, she was concomitantly experiencing hopelessness and passive suicidality in the setting of untreated depression, anxiety, and PTSD from childhood sexual, physical, and emotional abuse. Her family history was notable for active substance dependence in multiple members, including a sister who had recently died from a heroin overdose four months prior to presentation. Her mother had a history of methamphetamine abuse, and her brother was actively abusing multiple illicit drugs including fentanyl.

Given tramadol’s combined action as a mu-receptor agonist and SNRI, the patient was at risk for an atypical opioid withdrawal syndrome. For this reason, inpatient detoxification with tramadol tapering and buprenorphine induction was preferred. Ultimately, given limitations of local resources and in consultation with addiction specialists, a plan was made to coordinate outpatient buprenorphine induction from the ED. Seven days following initial presentation to the behavioral health facility the patient was asked to go to the ED but did not and decided to taper the tramadol dose herself. She went down to 4000 mg of tramadol per day but started having withdrawal symptoms and went back up to 5000-6000 mg a day. Three days later she finally showed up for her first ED visit.

At her first outpatient induction attempt, she presented to the ED and was given sublingual buprenorphine 8 mg with phenobarbital 200 mg added to prevent withdrawal seizures. She was discharged home.
on buprenorphine/naloxone 8/2 mg twice a day with instructions to return the next day for followup. On the night of discharge, she noted significant withdrawal symptoms, reported difficulty with sleep and anxiety, and ultimately resumed tramadol use. The patient never filled her prescriptions. She received additional counseling regarding her available treatment options: slowly tapering use vs medication-assisted treatment.

On one of her trips from Mexico the patient was apprehended for illegal drug possession, and all her tramadol pills were confiscated. She returned to the ED eight days later after her initial visit. Before coming to the ED, the patient had taken buprenorphine/naloxone (8/2) mg. After examination she was given an additional 8 mg buprenorphine. About an hour later she was feeling slightly better but still having some residual withdrawal symptoms. She was given another 8 mg of buprenorphine. She felt much better and was discharged after spending slightly less than four hours in the ED. She was discharged with a prescription for buprenorphine/naloxone 16/4 mg twice a day. Venlafaxine, a SNRI, was concomitantly prescribed to forestall possible SNRI withdrawal symptoms. Ten days post induction, she was still taking prescribed buprenorphine/naloxone at the same dose and was not having withdrawal symptoms, drug cravings or using tramadol. She had not yet started taking venlafaxine. Almost a year out after induction, she reported stable abstinence from tramadol with buprenorphine/naloxone 16/4 mg twice a day. She had also started treatment for depression and anxiety with buspirone 10 mg and sertraline 150 mg once daily.

DISCUSSION

We present a complicated case of high-dose tramadol addiction and dependence successfully treated with high-dose buprenorphine induction and high-dose buprenorphine maintenance initiated in the ED setting. Previous case studies have shown some success with transitioning tramadol-dependent patients to buprenorphine. Using a residential inpatient treatment facility, a patient with a dependence of 1400 mg of tramadol a day was transitioned successfully over 28 days to stable treatment with buprenorphine 8 mg/naloxone 2 mg orally daily. The biggest hindrance was complications with antidepressant discontinuation syndrome, which was due to tramadol's serotoninergic activity. Hence, we offered the patient a prescription for venlafaxine, which she did not fill, in addition to the buprenorphine.

After hydrocodone and oxycodone, tramadol is the third highest used and misused opioid per data from the Drug Abuse Warning Network, a nationwide public health surveillance system that improves ED monitoring of substance use crises, including those related to opioids, with over a million cases of misuse reported annually.11 Tramadol abuse accounts for over 20,000 ED visits annually.8 The effect of rescheduling hydrocodone from schedule III to II in 2012 has been associated with an increase in tramadol prescribing based on data available in four states.9 In addition to opioid dependence and adverse effects, such as seizures and serotonergic syndrome associated with tramadol, its use naively for postsurgical pain is associated with an increased risk of prolonged opioid use when compared to other short-acting opioids.10 Its use has also been associated with increased all-cause mortality compared to non-opioid pain medications, suggesting it is no safer than traditional opioids.11 Therefore, in addition to preventing opioid dependence, it behooves clinicians to wean patients off tramadol, especially when they are using excessively high levels, since toxicity of this drug is high.

In the case of our patient there were concerns for unpleasant SNRI discontinuation syndrome and withdrawal seizures due to tramadol dose tapering, but we managed without inpatient admission. Since tramadol is also an SNRI we were uncertain whether we should be
concerned about SNRI withdrawal syndrome and whether the patient should also have been concomitantly started on an antidepressant in addition to buprenorphine. We prescribed an antidepressant, venlafaxine, but she did not take it. The patient reported that initial attempts with lower doses of buprenorphine did not adequately treat withdrawal symptoms and craving. High-dose buprenorphine appears to have been successful for this patient.

Physical dependence on tramadol can occur at doses as low as 200 mg/day. In addition to the usual opioid withdrawal symptoms tramadol may have atypical opioid withdrawal syndrome symptoms that may include unusual extremity sensory experiences including numbness and prickling, hallucinations, confusion, intense paranoia, high anxiety and panic attacks, and disorientation and depersonalization. Although these atypical symptoms may not be generally life-threatening, they may be uncomfortable or put the individual in dangerous situations or at high risk of making bad decisions.

Literature is sparse regarding how to treat such individuals short of an inpatient, medically supervised detox center. Herring et al have recently shown that high-dose buprenorphine (high-dose induction dose defined as greater than 12 mg) is both efficacious and safe in treating patients with opioid use disorder in the ED. Extended-release (ER) tramadol has been shown to be as effective as buprenorphine for treating opioid withdrawal in two randomized controlled trials. Doses up to 600 mg/day of tramadol ER were used successfully in one randomized controlled trial, but the drug was quickly tapered over one week during their residential treatment. Another study showed that buprenorphine results in lower withdrawal symptoms within two to three days of detoxification vs tramadol. The downside in that trial was that three patients (10%) sustained seizures, limiting tramadol’s use for severe opioid dependence long term. Therefore, substituting high-dose buprenorphine for opioids, including tramadol, may be more efficacious for induction and sustainability in patients with high-dose opioid dependence, particularly those who are trying to end tramadol dependence.

**CONCLUSION**

Little has been written about specific treatment for patients with tramadol use disorder. This case illustrates that buprenorphine induction and maintenance without concomitant use of an SNRI agent may be all that is needed in high-dose tramadol detoxification and or treatment of withdrawal symptoms in an outpatient setting.

The authors attest that their institution requires neither Institutional Review Board approval nor patient consent for publication of this case report. Documentation on file.
REFERENCES


Firearm-related deaths and injuries are a serious public health problem in California and the United States. The rate of firearm-related deaths is many times higher in the US than other democratic, industrialized nations, yet many of the deaths and injuries are preventable. The California American College of Emergency Physicians Firearm Injury Prevention Policy was approved and adopted in 2013 as an evidence-based, apolitical statement to promote harm reduction. It recognizes and frames firearm injuries as a public health epidemic requiring allocation of robust resources, including increased governmental funding of high-quality research and the development of a national database system. The policy further calls for relevant legislation to be informed by best evidence and expert consensus, and advocates for legislation regarding the following: mandatory universal background checks; mandatory reporting of firearm loss/theft; restrictions against law-enforcement or military-style assault weapons and high capacity magazines; child-protective safety and storage systems; and prohibitions for high-risk individuals. It also strongly defends the right of physicians to screen and counsel patients about firearm-related risk factors and safety. Based upon best-available evidenced, the policy was recently updated to include extreme risk protection orders, which are also known as gun violence restraining orders. [West J Emerg Med. 2021;22(2)266–269.]

Firearm-related injuries and deaths are a serious public health problem in the United States (US), yet the idea of regulating firearm ownership and access is complicated, politically charged, and potentially conflicts with US Constitution 2nd Amendment rights. The rate of firearm-related deaths is many times higher in the US than in other democratic, industrialized nations. In 2015, there were 113 firearm deaths per million individuals in the US as compared with 0.8 in the United Kingdom. Despite this disparity, and largely due to politics, firearm violence prevention research receives significantly less US federal funding compared with other leading causes of death; yet available research suggests that many firearm-related injuries and deaths are preventable. A 1993 study published in the New England Journal of Medicine and funded by the US Centers for Disease Control and Prevention (CDC) identified an association between elevated homicide risk within homes with guns. In response, the National Rifle Association (NRA) successfully lobbied US Congress in 1996 to include the “Dickey Amendment” in the federal omnibus spending bill. That amendment stripped $2.6 million from the CDC’s budget (the amount it had spent on firearm research the previous year) and added the following language: ‘none of the funds made available for injury prevention may be used to advocate or promote gun control.’ Thereafter, federal firearm safety and violence research funding at the CDC, and later the National Institutes of Health (NIH), was effectively eliminated. A 2013 report from the Institute of Medicine concluded, “the scarcity of research on firearm-related violence limits policymakers’ ability to propose evidence-based policies that reduce injuries and deaths and maximize safety.” Using a methodology that calculated expected levels of research investment based on mortality rates, one study estimated that between 2004 and 2015 firearm violence prevention research received just 1.6% of the federal research support projected, and had just 4.5% of the volume of publications anticipated. Congress in 2018 clarified that the CDC can conduct research into firearm injury prevention, but again cannot use government funds to specifically advocate for gun control. Subsequently, the 2020 federal omnibus spending bill specifically allocated $25 million to the CDC and NIH toward firearm violence prevention research.

Founded in 1971, the California Chapter of the American College of Emergency Physicians (California ACEP) is a 501(c)(6) non-profit, non-partisan, association representing California’s board-certified emergency physicians (EP). California ACEP’s mission is to support EPs in providing the highest quality of care to all patients and to their communities. In 2000, the California ACEP board of directors (BOD) voted to make firearms injury prevention one of the organization’s legislative priorities and approved a position statement concerning firearm injury prevention. In 2013, multiple bills regarding mandatory
firearm restrictions were proposed to the California State Senate and Assembly. The California ACEP BOD tasked a subcommittee with reviewing the chapter’s position statement and available research, updating the chapter’s official policy, and guiding its legislative and advocacy efforts. The California ACEP Firearm Injury Prevention Policy (Firearm Policy) was approved and adopted in 2013 as an evidence-based, apolitical statement to promote harm reduction. The Firearm Policy recognizes and frames firearm injuries as a public health epidemic requiring allocation of robust resources, including increased government funding of high-quality research and the development of a national database system of firearm injuries. The policy further calls for legislation to be informed by best evidence and expert consensus, and advocates for legislation focused on the following:

1. Mandatory universal background checks
2. Mandatory reporting of firearm loss/theft
3. Restrictions against law-enforcement or military-style assault weapons and high capacity magazines
4. Child-protective safety and storage systems
5. Prohibitions against gun possession or purchase for high-risk individuals
6. The right of physicians to screen and counsel patients about firearm-related risk factors and safety.

In 2016, in response to recent highly publicized mass shootings including San Bernardino and Sandy Hook, the state of California overwhelmingly passed Proposition 63 (63% in favor vs 37% opposed). Proposition 63 focused mainly on the regulation of ammunition. It mandated a universal background check and California Department of Justice authorization to purchase ammunition (in addition to firearms, which was already regulated), and it specifically prohibited possession of large capacity magazines (LCM), which hold more than 10 rounds of ammunition. Prior to Proposition 63, it had been illegal in California to manufacture, purchase, receive, import, keep, sell, give, or lend LCMs. Proposition 63 also levied fines against firearm owners who fail to report the theft or loss of their firearm. Several regulations in Proposition 63, including a ban on LCM possession and mandatory reporting of firearm loss or theft, were advocated by the Firearm Policy. The NRA subsequently sponsored a legal challenge to Proposition 63 (DUNCAN v BECERRA), and in March 2019, the District Court for the Southern District of California ruled that Proposition 63 was unconstitutional, despite testimony by EPs on behalf of California ACEP. On August 14, 2020, a divided three-judge panel of the Ninth District Federal Court of Appeals upheld the federal district court’s ruling. That decision is currently being further appealed, and the case is being closely tracked by California ACEP’s BOD and staff.

Another crucial firearm-related violence prevention policy topic recently reviewed by the California ACEP BOD concerns extreme risk protection orders (ERPO), which are also known as gun violence restraining orders. In many states including California, medical professionals, law enforcement officers, coworkers, teachers, and family members may petition a court for ERPOs, which preemptively and temporarily authorize law enforcement officers to remove...
firearms from individuals deemed high risk for self-harm or violence against others. ERPO laws often allow formal court appeal and forbid harassment, to prevent misuse of ERPOs that could restrict access to firearms for defense, hunting, or recreation. Several studies examining ERPOs in states outside of California suggest that they are modestly effective in reducing firearm-related suicides. Per a RAND analysis, there were limitations in these studies, including the extrapolation of suicide attempts, rather than observed data, and a lack of comparison groups. However, the data was convincing enough to move the chapter’s BOD in 2020 to include ERPOs in an update to the Firearm Policy.

California ACEP strongly believes that it should advocate for evidence-based solutions to public health and policy issues, including firearm violence prevention and safety. Clearly, preventing injuries and deaths is more effective than, and preferable to, heroic saves in the emergency department or trauma bay. The Firearm Policy promotes evidence-based legislative recommendations and highlights the urgent need for more robust government funding, data, and evidence to effectively address the firearm violence epidemic in California and the US.

**California ACEP Firearm Injury Prevention Policy:**

It is the position of the California Chapter of the American College of Emergency Physicians that:

1. Emergency Medicine is well positioned, as a profession and specialty, to appreciate the multifaceted ramifications of firearm injuries in our society. Firearm violence is a public health epidemic that can only be effectively cured by deploying necessary and appropriate resources.

2. California ACEP deplores attempts to politicize or silence physicians and science on firearm violence. We recommend robust funding (federal and otherwise) of research on firearm injury and evidence-based prevention as well as its impact on public health and safety. It is our hope and belief that such research will guide better future legislation and lead to well-informed public policy.
3. Legislative measures and policies to curb or reduce firearm violence should be informed by evidence-based consensus. We advocate for continued research and implementation of programs focused on the safe storage of legitimate firearms, development of childproof or personalized guns, prevention of both interpersonal and self-directed violence by firearms, including the prevention of gang-related and domestic violence.

4. We support mandatory, comprehensive, and universal background checks for the purchase of firearms. Background checks should be required for essentially all firearm transfers, including at gun shows and auctions and from private sellers. Prohibited straw purchases of firearms should be recognized as serious crimes and be treated as such, and all secondhand gun sales and firearm transfers should be regulated. We support continued efforts to improve the quality of the data on which background checks are performed, such that all prohibited persons can be detected.

5. We support requiring that all firearm owners of record be required to report the theft or loss of their firearm within a timely period of becoming aware of such a loss.

6. We recommend legislation banning civilian purchase or access to assault weapons, large-capacity ammunition magazines, and any munitions specifically designed for the use by military and law enforcement agencies.

7. We encourage all healthcare providers, including emergency physicians, to screen and counsel patients with diagnosed mental illnesses or believed to be at risk of harming themselves or others for their potential access to firearms, and to refer such patients to appropriate mental health services in a timely manner. Policies and procedures for this process need to be validated and standardized.

8. We recommend the creation of a national database and surveillance system to track firearm-related injury and mortality, including mandatory reporting of firearm injuries and fatalities by all hospitals and healthcare centers.

9. We support restraining orders that allow for the removal of a firearm to provide a rapid, focused response when risk for imminent firearm violence, including suicide and homicide, is high. We support restraining orders that rely on actions by judicial officers and include due process protections and provide for immediate firearm recovery and include a prohibition on possession and purchase of firearms and ammunition. We support allowing petitions for such orders to be submitted by family members, law enforcement officers, physicians, and other mental health professionals including school counselors.

10. We recommend prohibiting firearm purchases by individuals in high-risk categories that include but are not limited to habitual criminals, drug traffickers, persons with mental illness who are suicidal or high risk, those with violent misdemeanors, persons with multiple convictions for alcohol-related offenses, those with a history of domestic violence, juveniles convicted of violent crimes, and violators of parole and restraining orders.

11. We believe in the protection of healthcare providers’ rights to educate patients regarding firearm safety. We encourage all healthcare providers, including emergency physicians, to counsel patients about firearm safety when appropriate including discussing with parents safe storage of firearms in homes with children.
REFERENCES


2023 ACEP AWARD WINNERS

COUNCIL AWARDS

CURMUDGEON AWARD
JOHN D. BIBB, MD, FACEP

LEADERSHIP AND EXCELLENCE AWARDS

JOHN G. WIEGENSTEIN LEADERSHIP AWARD
PAUL D. KIVELA, MD, MBA, FACEP

JUDITH E. TINTINALLI AWARD FOR OUTSTANDING CONTRIBUTION IN EDUCATION
STUART P. SWADRON, MD, FACEP

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OMAR GUZMAN, MD, FACEP
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NATIONAL EMERGENCY MEDICINE JUNIOR FACULTY TEACHING AWARD
Lisa Rapoport, MD received the ACEP 2023 National Emergency Medicine Excellence in Bedside Teaching Award.

Craig Smollin, MD and Sara Krzyzaniak, MD, FACEP received the ACEP 2023 National Emergency Medicine Faculty Teaching Award.

Moises Gallegos, MD and Nida Degesys, MD, FACEP received the ACEP 2023 National Emergency Medicine Junior Faculty Teaching Award.

Cameron Fisk, MD; Mariame Fofana, MD; Laurel Gardner, MD; William Gibb, MD; Alana Harp, MD; Steven Ignell, MD; Rana Kabeer, MD, MPH; Lauren Klingman, MD; David Li, MD; Erin Liang, MD; Dylan Lukato, MD; Anastasia Markovtsova, MD; Elan Small, MD; Jessica Smith, MD; Andrew Stromberg, MD; and Jonathan Woo, MD graduated from the Stanford Emergency Medicine Residency Program.

Pranjal Gupta, MD joined Stanford University’s Critical Care Fellowship Program.

John Bibb, MD, FACEP, Paul Kivela, MD, MBA, FACEP, and Stuart Swadron, MD, FACEP received ACEP 2023 Leadership & Excellence and Council Awards.

Sebastian Hernandez, MD received the University of California Davis Department of Emergency Medicine Resident MVP award.

Subarna Adhikari, MD received the University of California Davis Department of Emergency Medicine Thomas Brofeldt award and the Health Equity Advocate Award.

Joseph A Yoon, MD and Sebastian Hernandez, MD received the Gloden Probe US award.

Patrick Cassiday, MD, PHD, received the Aaron Bair Airway Award.

Brennan Gibs, MD; Subarna Adhikari, MD; and Joseph A Yoon all received the Global Health Distinction Award.

Michael Gisondi, MD was named assistant dean for academic advising for Stanford School of Medicine.

Did you get a new job? Get promoted? Get published? Achieve a goal?

Let California ACEP know and we will include it in this new section of Lifeline. Tweet your accomplishment or post it on Instagram and tag @californiaacep or submit your accomplishments at: https://californiaacep.site-ym.comsurveys/?id=Accomplishments.
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, organizations of our size can boast of an advocacy program like California ACEP’s; a program that has helped locked in $500 million for the Maddy EMS Fund over a 10-year span, fought for ED boarding solutions, and secured an increase in Medi-Cal reimbursement rates to emergency physicians by $200 million annually beginning in 2025! 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 ED visit to ensure that California ACEP can fight on your behalf. Thank you to our 2022-2023 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
- Vituity

ANNOUNCEMENTS

CALIFORNIA ACEP SPONSORED & CO-SPONSORED COURSES

AdvancED 2023 Conference
Friday, September 8, 2023
Hotel Dena (formerly The Sheraton Pasadena)
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Save the Dates!
2024 Legislative Leadership Conference
Tuesday, April 9, 2024
Sacramento, CA

AdvancED 2024
Friday, September 6, 2024
TBD

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

Volume 1 – Who is CalACEP?
Volume 2 – System Capacity and Capability
Volume 3 – Reimbursement and Medi-Cal
Volume 4 – To be determined
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

### SEPTEMBER 2023

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NAPA, CALIFORNIA: NAPA VALLEY EMERGENCY MEDICAL GROUP;

We are an established democratic group staffing Queen of the Valley Medical Center 30K visits/yr, Level III Trauma Center, STEMI Center, Stroke Center. ACEP 100% club, Excellent on-call panel, malpractice paid. Two full time EM nocturnists, generous coverage, 4 Physician shifts per day and mid level support facilitates high workplace satisfaction.

We seek an EM residency trained physician for a partnership track. Send CV to Drsmith@nvemg.com
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Website: www.Lifewestambulance.com

**Medic Ambulance**
James Pierson, EMT-P & Helen Pierson
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

**GMR Learning (formerly NCTI)**
Lena Rohrbaugh, Course Manager
2995 Foothills Blvd Suite 100, Roseville, CA 95747
Phone: (916) 960-6284 x 105
Fax: (916) 960-6296
Email: ljcas@calltel.com
Web: www.ncti-online.com

**NorCal MedTac**
Brian Green, EMT-P
3107 Scotts Valley Dr, Scotts Valley, CA 95066
Phone: (831) 970-0440
Email: bschell9@hotmail.com
Web: www.norcalmedtac.com

**Rural Metro Ambulance**
Byron Ayllon EMT-P
1345 Vander Way, San Jose, CA 95112
Phone: (408) 275-6744
Fax: (408) 275-6744
Email: brian.green@rmetro.com
Web: www.rmetro.com

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

**(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.phiarmmedical.com

**Rocklin Fire Department**
Chris Wade, Firefighter/Paramedic
100 Riggs Ave, Merced, CA 95340
Phone: (916) 625-5311
Fax: (916) 625-5311
Email: adrianayllon@yahoo.com
Web: www.rmetro.com

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