

# lifeline

WINTER 2019

a forum for emergency physicians in california

THIS ISSUE'S TOPIC:

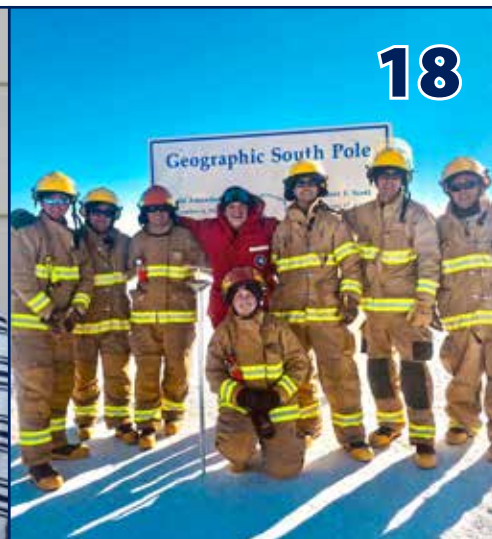
**EMERGENCY MEDICAL SERVICES**

## VISION FOR EMS IN CALIFORNIA

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**CALIFORNIA ACEP**

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# WELCOME new members!

Corbin Donham

Forrest Robert Hamlin

Madeleine Heller

Soroush Kazemi

Meg Maeda

Alina Mitina

Eric Nguyen

Mustafa Shakir

Jeremy William Sieker

Kristina Van De Goor

Corey Young



## 100% GROUPS

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Beach Emergency Medical Associates

Centinela Freeman Emergency Medical Associates

Central Coast Emergency Physicians

Coast Plaza Emergency Physicians

Emergency Medicine Specialists of Orange County

Hollywood Presbyterian Emergency Medical Associates

Huntington Park Emergency Medical Associates

Napa Valley Emergency Medical Group

Newport Emergency Medical Group, Inc at Hoag Hospital

Orange County Emergency Medical Associates

Pacifica Emergency Medical Associates

Pacific Emergency Providers, APC

Redondo Emergency Physicians

San Dimas Emergency Medical Associates

Shasta Regional Emergency Medical Associates

Sherman Oaks Emergency Medical Associates

Tarzana Emergency Medical Associates

Temecula Valley Emergency Physicians

Valley Presbyterian Emergency Medical Associates



Vivian Reyes,  
MD, FACEP

# THE EMS HANDOFF

The swing shift was slamming me. I was two patients behind and hustling to see the next in line, a 70-year-old woman suffering chest and shoulder blade pain. “Ms. Grace” had normal vitals but had been put in the code room. “*Strange. Are we out of beds?*”, I wondered. The nurse’s note read “R/O dissection.” Normally I’d check the EMR, but Ms. Grace was visiting from Denver. I walk in to meet a pleasant, well-appearing woman, who tells me she is a nurse practitioner. She is “embarrassed beyond belief because [her] daughter called the ambulance.” Her daughter picked her up at the airport and they went to dinner, where Ms. Grace had an episode of chest and shoulder blade pain that quickly resolved. Her daughter panicked and called 911.

Ms. Grace took BP meds and prednisone for rheumatoid arthritis. Her vitals were rock solid on the monitor and her pulses and blood pressures were equal bilaterally on all extremities. Her exam was normal. I left the room, perplexed by the “R/O dissection” comment. I searched for the EMS providers who had brought her in. They were gone and their report nowhere to be found. The nurse confirmed they feared a dissection.

*What did they see or hear that I didn’t?* I hedged my bets with a D-dimer, ECG, and chest X-ray and moved on to my next patient with the unsatisfying feeling I was missing a critical piece of information. I circled back to her on the computer and found I could access her Denver EMR. Jackpot! It confirmed her past medical history plus one thing she omitted. Aortic Aneurysm. Digging further revealed it was a small incidental finding and was just being monitored. Next step, CT.

The CT showed an aortic dissection extending from her ascending aorta down to her iliacs. The CT surgery team swooped her up to the OR and she did well.

A few hours later, Ms. Grace’s nurse grabbed me and pointed out her EMS providers were here dropping off another patient. I filled them in on Ms. Grace’s diagnosis and asked what made them worry about a dissection in the first place. They said “When we got to the

restaurant she just looked off. She looked gray.” They were surprised to find normal vitals but sensed something was very wrong. They were right.

EMS providers and the ED care team each play important, sequential roles in a patient’s journey through the health care system. EMS has first touch and sets the stage and pace of that journey. They witness what emergency physicians wish they could see – like Ms. Grace minutes after she dissected the entire length of her aorta. In other situations, they are often the only ones on the care team to see a patient’s home situation, both social and physical. This contextual information can not only reveal clues to diagnoses but is vital to seeing the patient as a human being, not just an “abdominal pain” or a “chest pain.” It is just as crucial to get a good handoff from our pre-hospital partners as it is for us to get good handoffs from one another during shift change. Yet, emergency physicians rarely ask for reports. Our California ACEP EMS liaison, Atilla Uner (practices emergency medicine at Antelope Valley Hospital ED and UCLA Ronald Reagan Medical Center and serves as CalACEP’s appointee to the California Commission on Emergency Medical Services and the Los Angeles County Emergency Medical Services Agency Health Services Commission) told me, “EMTs and paramedics are eager to participate. They want to be valued as a contributing part of the team. They are people just like us.” And, they can often give us information key to providing patients exceptional

care. If you could change one thing in your practice today, Atilla urges, "Please talk to your EMTs and your paramedics. Ask them for your patient's history." It will lead to better care.

Given the importance of this relationship between the pre-hospital team and the ED care team, it only makes sense that California ACEP work with organizations like the EMS Medical Directors Association of California (EMDAC) and the Emergency Medical Services Authority (EMSA). Therefore, it was my pleasure to meet with Dr. Dave Duncan, a CalACEP member, who was appointed in September by Governor Newsom to be the EMSA Director. He accepted our invitation to our November Board of Directors meeting, and actively participated in robust discussions on topics spanning from care coordination to e-bike and scooter safety to balanced billing. Together, we discussed areas in which CalACEP and EMSA are aligned.

## EMSA'S VISION STATEMENT

*EMSA is a leader in innovative, effective, and collaborative emergency medical services. We inspire EMS systems to advance the quality, safety, and satisfaction of healthcare in their communities.*

We share similar visions – we want our teams to provide safe and high-quality care to our patients and communities. Both of us are dedicated to finding innovative solutions to the barriers we face in today's emergency care system. There are plenty of overlapping issues we can collaborate on – wall time, patient handoffs, and disaster response, to name a few. The future is bright with opportunities to innovate jointly.

Health Information Exchange (HIE) has a long way to go before it is optimized, but it will benefit both emergency medicine providers and EMS providers. Working together on HIE would allow us to address data security and operational workflows. A better HIE system would have allowed Ms. Grace to be diagnosed and sent to surgery even faster. Care coordination is another area in which EMS providers are well positioned to improve the patient care journey. By working together, EPs and EMS providers can prevent the revolving door that patients sometimes get stuck in as they cycle in and out of the ED relying heavily on the EMS system. What this

looks like will depend on our collaboration. HIE and care coordination are two high priority areas for CalACEP this year.

Lastly, the most promising area in which CalACEP and our EMS partners can collaborate is community paramedicine. Community paramedicine has been growing successfully outside of California in both the number and variety of patient care programs. In California, we are eagerly watching a range of pilots focusing on alternate destinations, including sobering centers and mental health facilities; on frequent EMS users; and on post-discharge management, hospice, and tuberculosis treatment. Because community paramedicine is such a new and evolving care model, it is important we proceed in a manner that maintains the level of safety we would expect to provide to all our patients all the time. This specific topic of safety as it pertains to scope of practice for EMS providers is addressed by Dr. Kristopher Lyon and Dr. Kevin Mackey later in this issue. Dr. Marc Gautreau also discusses unique ways in which paramedics may provide care to our patients in his article "Visions for EMS in California". While we want to innovate and challenge our current models of care we need to move forward in a deliberate manner – collaborating as a unified care team, using data to assure we are keeping our patients safe and delivering high quality care, testing workflows and using quality improvement to strive for efficiency and ability to scale, and creating system-based approaches – not person dependent or hero-dependent programs. If we take the time up front to do these things, I have no doubt that together we will successfully transform the way we provide emergency care in California. ■

Dr. Reyes (left) and Dr. Duncan (right)





# California ACEP Co-Sponsoring Effort to Authorize

By Elena Lopez-Gusman and Kelsey McQuaid-Craig, MPA

## COMMUNITY PARAMEDICINE

**“If you have seen one EMS system, you have seen one EMS system.”** The saying goes. Reflecting the commonly held notion that no two EMS systems are alike. California is divided into 33 Local Emergency Medical Services Agencies (LEMSAs), 7 regional agencies, and 26 single county agencies. California’s broad geographic diversity often creates tension between adaptive systems that meet local needs and standardized practices.

In 2014, the State of California embarked on an innovative pilot to explore the expansion of paramedic scope of practice through the Office of State Health Planning and Development (OSHPD). The project initially looked at 13 different pilots across the state. Paramedics were specially trained in several different models: assistance for patients recently discharged from hospitals transitioning to at home care, hospice support, field identification and diversion of patients with psychiatric illness and intoxication, case management of high utilizers, field identification and diversion of patients to urgent care or primary care, and community support for directly observed therapy for Tuberculosis.

In 2018, State Senator Robert Herzberg introduced SB 944, which sought to authorize the models tested by the pilot project, to expand paramedic scope of practice, and to change California law to allow 911 callers to be transported to sobering centers and mental health facilities. After multiple meetings and discussions with the bill’s sponsor, the California Professional Firefighters, to understand our principles and ensure the bill included patient safety protections, California ACEP supported SB 944. Unfortunately, the bill did not make it out of the Assembly. The provisions of the bill were later amended into AB 3115 (Gipson). While that bill successfully passed both houses of the Legislature, it was vetoed by then-Governor Brown.

During the 2019 Legislative Session, we again worked with the California Professional Firefighters to reintroduce the language in SB 944 and AB 3115 and authorize community paramedicine. AB 1544 by Assembly Member Mike Gipson seeks to permanently expand EMT scope of practice to authorize several of the concepts tested in the pilots, including post-discharge follow-up care and directly observed therapy to persons with tuberculosis, as well as transporting patients to sobering centers and mental health facilities rather than emergency departments (EDs).

The approach outlined in AB 1544 is consistent with CalACEP’s values and maintains our approach to prior Community Paramedicine bills in 2017 and 2018. We believe AB 1544 builds a framework to address local needs, while ensuring quality patient care. Specifically:

- Scope expansion authorization must be evidence-based and replicate the data and experience gathered from the pilot programs
- Destinations must be defined and licensed
- EMTALA non-discrimination protections must be included
- Data collection must be required

AB 1544 is well crafted to meet these important patient safety protections.

Specifically, the bill requires that the local EMS agencies develop programs that are based upon and informed by the pilots. AB 1544 additionally requires EMSA to promulgate regulations, based upon and informed by the pilots, for the formulation of these programs. The local programs must be approved by EMSA to ensure that they meet these standards. AB 1544 strikes an important balance between allowing local control and ensuring statewide standards to protect all Californians, regardless of county of residence.

A critical component of ensuring a patient can safely be transported to an alternate destination is to ensure that the destination itself is safe. EMS providers can't reliably determine where it is safe and appropriate to take a patient if the destination does not have clearly defined and regulated capabilities and capacity. The healthcare provider and facility on the other end must be equipped to meet the patient's healthcare needs and identify potential problems. AB 1544 ensures patient safety by requiring both mental health and sobering center destinations to be licensed facilities.

EMTALA is a core tenet for emergency physicians – the fundamental principle that patients should not be discriminated against in the provision of emergency care. Access to emergency services and the quality of that care should be the same for all people, regardless of the person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, or ability to pay for medical services. Critical to the creation of community paramedicine programs in California is that they do not create a two-tiered system of healthcare. AB 1544 ensures that the triage criteria used to determine what care a patient will receive be non-discriminatory, and that their ultimate destination cannot refuse to accept patients based on discriminatory criteria.

The safest and best way to reduce the number of people who seek care in the ED is to keep them well, rather than to divert them from the ED when they find themselves in crisis. AB 1544 authorizes a statewide expansion of the pilots that provide post-discharge follow-up, directly observed therapy to patients with tuberculosis, and intensive case management for frequent users of the EMS system –excellent ways to keep patients healthy and to manage the social determinants of health. AB 1544 includes expansion of pilots that aim to reduce ED visits by keeping people well.

CalACEP believes in research and evidence-based change. To this end, new concepts must continue to collect data as they expand to ensure safety and allow for the development of best practices as these models expand across the state. As we embark on this new healthcare pathway, local EMS agencies must be required to collect and report their data to the State to evaluate the safety of all programs, just as they do with other EMS and pre-hospital-initiated procedures. The public and the Legislature must have the information to adequately review whether California has been able to effectively take the pilots to scale. AB 1544 requires data collection, reporting, and public transparency to ensure these programs are adequately meeting patient safety goals.

AB 1544 was held in the State Senate at the request of the Governor's Office who asked that we delay the bill until 2020 in order to provide the opportunity for a new EMSA Director to be appointed and engage in the discussion. We are pleased Dr. Duncan has been appointed and have already begun conversations about how to further refine this legislation.

Meanwhile, CalACEP is involved with the California Advancing and Innovating Medi-Cal (CalAIM) initiative. CalAIM is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reform. The goals of case management for high utilizers, as well as alternate destinations to sobering centers, have also been raised in this context. We will be actively engaged in the CalAIM stakeholder process on the wide variety of Medi-Cal issues raised and, with regards to the EMS issues, we will continue to advocate for our patients to ensure that research is used to set certification standards for sobering centers, rather than the conflicting motivations of insurance companies.

In 1980, CalACEP sponsored SB 125 by Senator Garamendi that created the statewide EMS system, including a strong state oversight Commission with emergency physician representation. In the almost 40 years since then, our members have trained thousands of paramedics, served as EMS medical directors, and have been integral to the successful evolution of a world-class EMS system. Innovation, quality, and patient safety in the pre-hospital setting have been ongoing values of the organization and its members. We are pleased to continue that proud tradition by ensuring our patients receive high-quality EMS care. ■



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# 2019

## CHAPTER AWARD

## RECIPIENTS

**RECIPIENT:**

**Gus Garmel, MD, FACEP**

**AWARD:**

**Distinguished Service Award**

**DESCRIPTION:**

This award is given to a member who has made a significant contribution to emergency medicine throughout their career either through Chapter-specific activities or through activities aligned with the Chapter mission, vision and priorities and objectives.

**PERSONAL  
STATEMENT:**

Thank you CalACEP, the Board of Directors, the Awards Committee, and its members for this honor. I am tremendously proud of being selected to receive the 2019 California Chapter of ACEP's Distinguished Service Award. Those who know me know my passion about all things emergency medicine.

I am personally grateful for the professional opportunities have been afforded with CalACEP as an educator, mentor, academician, and supporter.

I must acknowledge my colleagues at Kaiser Permanente Medical Center - Santa Clara and my Stanford colleagues, with whom I share tremendous dedication to our specialty.

One of the greatest pleasures of my career has been mentoring medical students, residents (both EM and non-EM), and junior faculty. It gives me incredible joy to realize that I have made a difference in their lives and careers.

I feel this award also honors my family and friends who encourage me to care for those desiring medical attention for whatever reason at any time of the day or night. This is especially true of my spouse and best friend, who understands the challenges we face as emergency providers.

I humbly accept CalACEP's award on behalf of emergency personnel throughout California. This recognition inspires me to work even harder, smarter, and better for my patients and for my colleagues.

**NOMINATION  
STATEMENT:**

Throughout Dr. Garmel's 28 years as a practicing Emergency Physician in California, he has been an outstanding educator, residency director, author, and most importantly, advocate for and mentor to hundreds of Emergency Physicians in training. Dr. Garmel has been extremely influential in the development of our specialty and warrants special recognition from our chapter. In his final year of residency as a Chief Resident, Dr. Garmel was recruited to found the Stanford/Kaiser Emergency Medicine residency program. Dr. Garmel worked for over two decades to develop the program into one of the premier residency programs in the country, training hundreds of residents in this specialty. He was instrumental in exposing residents to Emergency Medicine in community settings and preparing to practice sustainable, patient-centered medicine in any practice setting. He has served as a consultant to help establish several other EM programs in California, including UCSF/SFGH, Kaiser San Diego, Kaweah Delta, and the new Kaiser Central Valley Emergency Medicine residency. In addition to his educational efforts to residents, Dr. Garmel has been an active educator to faculty as an author and lecturer. He is frequently invited to give Grand Rounds at EM residency programs around the country, where he donates his honorarium back to the program to support resident wellness activities. Dr. Garmel has provided service to California ACEP in many ways. He was chair of the California ACEP Academic Assembly from 2001 to 2004. He has lectured at chapter conferences, including the Yosemite Conference (when it was a chapter function) and the Annual Assembly. Most importantly, he has mentored many chapter leaders and board members, including several California EMRA presidents.

His nominator said, "I can say that the mentorship Gus has provided me throughout residency and post-graduation has been an essential piece of my ongoing career development and has made me a better Emergency Physician."





**RECIPIENT:** Peter Acker, MD, MPH, FACEP

**AWARD:** Humanitarian Award

**DESCRIPTION:** 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.

**PERSONAL STATEMENT:** I am incredibly honored to receive this award and owe a heartfelt thank you to my colleagues within the Stanford Emergency Medicine International group who have provided amazing support, mentorship, guidance, and advocacy. In truth, none of the work I've had the opportunity to carry out would have been possible without them, so perhaps it would be more appropriate for me to accept this award on the entire group's behalf.

I owe a similar debt to all of our international partners and collaborators. Through their patience, dedication and willingness to share knowledge and perspectives, we've had the chance to learn together and catalyze positive change synergistically.

**NOMINATION STATEMENT:** Dr. Acker has substantially advanced the provision of acute/emergency care across Cambodia and raised the stature of emergency medicine as a specialty within the medical community.

Decades after the fall of the Khmer Rouge, Cambodia's healthcare infrastructure, workforce, and education system are still reeling from the consequences of the genocide. Substantial development efforts from numerous countries and organizations have begun to move the healthcare needle in the country, but emergency medicine and acute care remained an unrecognized need until recently. Dr. Acker has worked in Cambodia for the past half-decade residing there for over one year. During this time, he has led a number of efforts that have dramatically improved Cambodia's healthcare system and elevated the role of emergency medical care in the country.

The nominator said "Dr. Acker represents the best of global health and global emergency care. He tirelessly strives to improve access to emergency and acute care across the globe via a partner-oriented approach to local health system strengthening. Dr. Acker does not seek the spotlight or recognition for his work however, he is extremely deserving of such recognition."

**RECIPIENT:** Pankaj Patel, MD, FACEP

**AWARD:** Special Recognition Award

**DESCRIPTION:** 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.

**PERSONAL STATEMENT:** I am grateful for this award. We have accomplished much over the years and I have been very fortunate and blessed to have been involved with so many wonderful colleagues over the years who have helped make this all possible.

**NOMINATION STATEMENT:** Dr. Patel is among the pioneers of our specialty, and he is nominated in recognition of countless contributions in service to our patients, the communities we live in and our profession as our specialty has grown and the expectations of our emergency departments have broadened and deepened in an exponential fashion over the three decades spanning his career. Dr. Patel led the very large North Valley Kaiser Permanente emergency physician group as the Department Chief for the Kaiser Permanente facilities in Sacramento and Roseville throughout the exponential growth and maturation of the specialty of emergency medicine and expansion of the group, ultimately supervising over 85 board certified emergency physicians and over 250 nursing and ancillary staff.

# 2019 CHAPTER AWARD RECIPIENTS



**RECIPIENT:** Anna Yap, MD  
**AWARD:** CAL/EMRA Award

**DESCRIPTION:** 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.

**PERSONAL STATEMENT:** I am honored and humbled by this award. Thank you to my co-residents and faculty at UCLA and at Olive View who have supported and mentored me, finding ways to allow me to still pursue my interests while working in a busy residency. I want to also acknowledge my friends and colleagues in organized medicine who have become my second family, inspiring me with their vast policy knowledge and ideas, proving that it is never too early to challenge the status quo; that medical students and residents can be effective advocates and make an impact. She would like to thank her parents and her partner Michael.

**NOMINATION STATEMENT:** Dr. Yap is a true inspiration as an emergency medicine resident. She is a tireless advocate for her community, whether she is finding ways to make a difference in the lives of our patients or pushing to create a better educational environment for her fellow residents. Anna is successfully dedicated, unflappable, and effective. She led a negotiation team that got a raise for UCLA residents across all specialties, as well as bringing in wins on other important issues like doubling the time for maternity leave for residents, guaranteeing accommodations for lactating mothers, and a well-funded a resident wellness committee to keep working to make life better for her fellow residents.

Dr. Yap deserves this award, because she is the best of what CalEMRA offers. She is a dedicated resident, learning the skills of clinical medicine, but she gives all of herself to the service of her patients and our specialty, so that we can all live a better life.



**RECIPIENT:** Hunter M. Pattison  
**AWARD:** House of Medicine Award

**DESCRIPTION:** 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.

**PERSONAL STATEMENT:** Hunter Pattison, MD, is a current chief resident in Emergency Medicine at the University of California Davis Medical Center in Sacramento, CA. He earned his medical degree at the University of Florida College of Medicine where he was extensively involved with organized medicine on a local, state and national level. He previously served this past year as the CAL/EMRA President and resident representative to the California ACEP Board of Directors, as well as nationally on the American Medical Association Resident & Fellows Section Governing Council.

**NOMINATION STATEMENT:** Dr. Pattison has improved the standing and influence of emergency medicine through his active leadership in CalEMRA, CalACEP, California Medical Association, and the American Medical Association. He represents the CMA at the American Medication Association, is a member of the Governing Council of the Resident/Fellow section of the AMA, and serves on the AMA Advisory Committee on LGBTQ Issues. He served as CalEMRA President-Elect from 2017-2018, and as President from 2018-2019.



**RECIPIENT:** Jessica Mason, MD

**AWARD:** Education Award

**DESCRIPTION:** 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.

**PERSONAL STATEMENT:** I am incredibly humbled to be receiving the Chapter's Education Award from California ACEP. What an honor! I am grateful to the many mentors who continue to guide my path: Mel Herbert, Stuart Swadron, the team at EM:RAP and her mentors, department and program leadership, and colleagues at UCSF Fresno who have trusted and supported my non-traditional path. The outstanding residents at UCSF Fresno constantly remind me of the value in working in an academic department. They inspire and challenge me in the best ways possible. California ACEP and the talented EM physicians on our planning committee have been wonderful partners in planning the AdvancED conference and a pleasure to work with. Most of all, my husband Dave Mason believes in me, encourages me to be my best self, is my unwavering partner and best teacher.

**NOMINATION STATEMENT:** "No other name resonates with outstanding contribution to the education of emergency medicine residents quite like Jess Mason."

Dr. Mason is part of medical podcasts, EM:RAP C3 and This Won't Hurt a Bit. EM:RAP C3 is focused on medical education within the medical community. This Won't Hurt a Bit, on the other hand, is an entertaining podcast for the general public. Both highlight patients describing their experiences dealing with medical conditions and going through treatments. When I go to medical conferences or interview senior residents looking for a fellowship position in our Fresno program, often the first words out of their mouth are: "you know I saved a life after listening to Jess Mason on how to put in a Blakemore tube" or "I couldn't have gotten through residency without all those procedure videos available online for free on YouTube, she is like a faculty to me even though I didn't train in Fresno." Jess's impact isn't just national either, the educational content she creates is so engaging and creating, she is having international impact. I cannot think of an unsung hero- the Woman behind the curtain- more deserving of her educational impact on our specialty.



**RECIPIENT:** Aimee Moulin, MD, FACEP

**AWARD:** Walter T. Edwards Award

**DESCRIPTION:** 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.

**NOMINATION STATEMENT:** Dr. Moulin's years-long contribution to our Chapter makes her overwhelmingly deserving of this award. She has served formally as a President of the Chapter, as well as Director of the CalACEP Advocacy Fellowship. However, her commitment and involvement span well beyond the titles she held. She has been a driving force in the Chapter's advocacy efforts and is responsible for our huge legislative successes in the areas of mental health and the treatment of substance use disorders. Not only did she help shape the mission, objectives and priorities of the Chapter, she saw them to successful fruition to the benefit of patients and physicians. Without her we would not have secured 20 million dollars in the state budget for substance use counselors in EDs across California. She has passed her enthusiasm for the specialty, for advocacy, and the Chapter onto the next generation of emergency physicians through her leadership of our Advocacy Fellowship and her years of mentorship as Assistant Residency Director at UC Davis. She is passionate about improving the practice environment for her colleagues and for delivering better care to patients. ■





# VISION FOR EMS IN CALIFORNIA

By Marc Gautreau, MD, MBA, FACEP, FAEMS

In 2018, the acceptance rate for the recruit fire academy at the San Jose Fire Department was 1.9%. For Stanford Medical School, the second most competitive medical school in the United States, it was 4.29%. Now one may argue that each is recruiting from a different population base, and this is true. Medical students are universally top tier graduates of colleges and universities, while most fire departments require only a high school education and completion of an accredited paramedic program. Many highly encourage and prefer college graduates, however, the high pay, job security, and a flexible work schedule that permits the pursuit of other interests makes the fire service highly attractive to motivated, highly intelligent individuals with a strong work ethic and a dedication to their communities that is unsurpassed. The San Jose Fire Department includes in its ranks: college educated engineers, economists, and physician assistants, as well as one medical school graduate who fell in love with the fire service during a medical school ride along. They are not just hose jockeys, not in California.

So, what does this mean? EMS paramedics represent the most underutilized segment of the health care system. Traditionally advanced life support was intended to improve survival in cardiac arrest, with additional utility in reducing morbidity from hypoglycemia and anaphylaxis and reducing time to treat respiratory events, such as asthma exacerbations and CHF. However, treatment for these entities has progressed so well that CHF exacerbations and acute hypoglycemia due to insulin overdose are comparatively rare, and cardiac arrest has always represented a small fraction of EMS calls.

In the meantime, emergency departments have become overcrowded with many patients who require no imaging or laboratory analysis, but only a good history and exam and relatively simple management. On the other spectrum, emergency physicians are increasingly caring for highly complex patients consuming greater amounts of time and energy in reviewing their previous records, obtaining advanced imaging, and sometimes numerous consultations. It is in the management of these patients that physicians offer the greatest value for their time.

Can we offload some of the care currently provided in the emergency department to some of the more frequent EMS patients to EMS providers? Can a paramedic unit become the alternate care center for

patients with simple problems that often result in 911 calls? How many patients of automobile crashes can be discharged without imaging after their c-spine is clinically cleared? How many athletic injuries can be managed as sprains based on the Ottawa ankle rules? These exams can easily be taught to EMS providers (and have been in many states), reducing unnecessary and costly transport and emergency department evaluations and reserving the emergency physician's time for more value-added activities. It is this, and not performing post-operative wound checks, that offer the most value from the EMS system.

EMS paramedics operating under the supervision of EMS medical directors could become essentially the physician's assistants of the pre-hospital environment. Defaulting to transport of many patients is expensive and wastes both emergency department resources and ambulances. Developing strategies for increasing the value of the pre-hospital care system can proceed in a cautious, stepwise fashion, as data regarding the safety and efficacy of treatment without transport becomes available.

We are not making new emergency physicians at the same rate we are seeing new emergency patients, and the unlikelihood of significant increases in residency positions, as well as the increasing complexity of patients and the economic advantages the ED offers patients with complications of cancer therapy, transplant surgery, and the myriad serious diseases once fatal but now essentially chronic, means this will not change any time soon. It is time to focus the emergency physician's time on the patients for whom they add the most value and delegate care of those who need only a good evaluation and relatively simple management to our pre-hospital paramedic colleagues. ■

**DR. GAUTREAU** is the Director of Pre-Hospital Care for Stanford Emergency Medicine and is the Medical Director of the San Jose Fire Department.

# ON EMS

By Atilla Uner, MD, FACEP

Emergency Medical Services (EMS) is the science of providing medical care in an out-of-hospital setting. And an actual science it is. In order to give life-saving treatment to the acutely ill and injured, with the limited supplies and diagnostics we can carry to the scene, we must distill emergency medical care down to its most essential components. It requires the utmost expertise and skill to know what to do when, and what to leave out. EMS is to in-hospital medicine what a poem is to a novel: less complex, but an equal art form, nonetheless. Despite its hands-on nature, EMS medicine is at its core an intellectual adventure.

EMS physicians have adopted an evidence-based approach to EMS medical care. Yet, there is a persistent and growing disconnect between the EMTs and paramedics actually doing the work and the physicians in EMS leadership positions. EMS interventions are added and removed based on aggregate study data on large populations. Involvement of front-line EMS personnel in this process is minimal or absent. Ecological fallacy is defined as the failure in reasoning that arises when an inference is made about an individual based on aggregate data for a group. A statistical truth about a large population, no matter how well proven, does not help the individual EMS practitioner, or their patient, when they need an intervention that they are no longer allowed to provide. Adding insult to injury, while California EMS leadership rightfully insists on detailed data acquisition and QI when an intervention is added to the paramedic scope of practice, they have never expended any effort to obtain even minimal data on complications and outcomes when an intervention has been taken away, completely ignoring the fact that omission and commission in medicine can have equally grave consequences for the patient. This leads to bitterness and withdrawal of professional engagement among front-line providers. EMS providers all have the shared experience that nothing they say or do matters, and even though they have eyes and hands on the patient, distant and detached EMS leadership will explain their profession to them. Not all is well in California EMS.

EMS has become the largest subspecialty within Emergency Medicine. Fellowships and academic appointments have followed, leading to a welcome and refreshing spirit of innovation and exploration. Transport of EMS patients to destinations other than a 911-receiving Emergency Department (ED) for psychiatric complaints and substance abuse are popular pilot projects. One can argue that these patients' needs are not being met in a busy ED and that they are better off being brought to a sobering center or psychiatric clinic, without ED wait or patient boarding. A different explanation would be that these patient groups were chosen

because they have no lobby, and hospitals will not complain when they have less of them in their care. EDs are subject to extensive inspection, quality control, and review by multiple certifying bodies. Alternate destination clinics are under far less scrutiny. Does a patient who is intoxicated or psychotic enough to require immediate care and observation really have the capacity to agree to participate in these studies? If this proceeds, why not bring isolated hip fractures directly to an orthopedic hospital or chest pain patients to a chest pain center? After all, the argument will go, these centers specialize in this exact disease or injury, and there is no ED wait, EMS wall time, or patient boarding. Once the concept is instituted with an underinsured and vulnerable patient population, other, more lucrative alternate destination models will follow, and the precarious revenue model of 911-receiving EDs will be threatened as models to bypass the ED with high paying diagnoses will be attempted. Let's be careful whose bidding we are doing. New is not always better.

I hope and trust that our newly founded EMS subspecialty will refocus on its core mission: to educate and support the EMT's and paramedics who are actually doing the work, to set high expectations in their clinical skills and professionalism and hold them and their employers to it, to set an example ourselves and act with the highest level of integrity and clinical excellence, to critically review the status quo and come up with new ways of administering EMS medicine while involving and partnering with front-line EMS providers, and to be physician servant-leaders to the EMS professionals who serve California. ■

**DR. UNER** is the Associate Medical Director of the UCLA Center for Prehospital Care and UCLA Paramedic Education Program. He also serves as CalACEP's appointee to the California Commission on Emergency Medical Services and the Los Angeles County Emergency Medical Services Agency Health Services Commission.

# So, You're Thinking About an EMS Fellowship?

By Puneet Gupta, MD, FACEP and Tiffany M. Abramson, MD

**Are you interested in a career in Prehospital Medicine? Are you considering an EMS fellowship?** In this article, we will provide you with insight into the benefits of undertaking a fellowship and the life of an EMS Fellow. There are numerous benefits to be found in fellowship, some obvious, some less so; however, as with all fellowship training, it comes at a cost - your time. **So, is an EMS fellowship worth it for you? Well, read on and decide for yourself.**

The benefits of an EMS fellowship are similar to those of most emergency medicine fellowships - becoming a subject matter expert, developing a specific niche, and potentially becoming board certified in your sub-specialty. An EMS fellowship will provide you the skills and background needed to become a successful prehospital medical director, educator, or researcher. The fellowship will cover the core curriculum of EMS and prepare you for the EMS board exam, provide the opportunity to give medical direction and patient care in the prehospital environment, and complete a scholarly project. Additionally, studying under dedicated mentors will not only increase your knowledge base and skill set, but it will also help you become part of the local and national EMS communities. Being a member of the community will increase your opportunities for jobs and academic endeavors, expand your professional network, and will make you a stronger candidate for future EMS positions. Note, since the practice pathway is now closed, an ACGME accredited fellowship is the only way to become eligible to sit for the ABEM EMS subspecialty certification exam. Board certification will attest to your dedication to the subspecialty and provide you an advantage when applying for more competitive positions.

That being said, a year of dedicated EMS study is incredibly fun! If you're thinking about fellowship you are probably as excited about this field as we are. Imagine a year where you get to immerse yourself in the craft. From spending time in the air to responding to calls on the ground. From tactical training to becoming part of a search and rescue crew. From lecturing to prehospital providers to delving into the intricacies of EMS policies and regulations. Being exposed to the multiple aspects of EMS is essential to EMS training but also a unique experience that can be obtained through fellowship.

To be facile at Prehospital Medicine, you must understand the politics of working in an EMS environment with unique environments and multiple stakeholders, many of which are different from the hospital setting. To be competent, you must have an understanding of the vast body of knowledge required to advise on prehospital medicine, much of which is not touched upon during traditional Emergency Medicine

training. As your experiences grow, so will your skill with dealing with these out of hospital emergencies that you may be called to advise upon with the support of an experienced mentor to guide you along the way.

Now that you've established that you want to apply for an EMS fellowship, which fellowship do you choose? EMS systems differ significantly as they grow to fit the community that they serve. As an EMS fellow, your system will be your training arena. If you know what system you want to work in, consider going there to establish a foundation. You may also want to choose your fellowship based on your specific interest - many fellowships have areas of focus (i.e., disaster, tactical, mobile integrated health, search and rescue, wilderness, event medicine, or prehospital research). If you know what type of practice you're looking for, consider looking for an EMS system that exemplifies those traits and EMS faculty who can mentor you in those areas to optimize your training. If you don't know, don't panic! You'll have so many experiences in fellowship training that you don't need to choose. By the time you've finished, you'll have a better idea of where you want to go.

Thank you for reading our words. If you are drawn to Prehospital Medicine, we highly recommend considering a fellowship year. As the body of experience and knowledge of Prehospital Medicine grows, there is more and more information to know and more ways to impact a prehospital system. From developing political savvy to providing evidence-based online medical direction, the skills in an EMS physician's toolbox must grow beyond that of an Emergency Physician. While an EMS fellowship is full of exciting experiences, it also harbors a structured way to become competent.

**Is fellowship worth it? Well, that's for you to decide. ■**

**DR. GUPTA** completed an EMS Fellowship at Harbor UCLA in June 2019 and **DR. ABRAMSON** completed an EMS Fellowship at LA County/USC in June 2019.



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# EMS Medical Directors Association of California

★ By Kristopher Lyon, MD, FACEP and Kevin Mackey, MD, FACEP ★

The California Emergency Medical Services (EMS) system is comprised of 33 Local Emergency Medical Services Agencies (LEMSAs) providing EMS services to the 58 counties in California. Throughout the state there are over 64,000 certified Emergency Medical Technicians and over 23,500 licensed Paramedics who provide care on over 5.4 million calls for service every year. The state Emergency Medical Services Agency (EMSA) establishes the laws and regulations for EMS in California. EMSA also establishes the scope of practice for prehospital providers with input from stakeholder and advisory groups, such as EMS Medical Directors Association of California (EMDAC). The California EMS system is constantly evolving to improve the care of our patients.

EMDAC is made up of LEMSAs Medical Directors and prehospital care agency medical directors. Most of these medical directors are Emergency Medicine trained physicians and members of ACEP. Many are board certified in EMS Medicine through the American Board of Emergency Medicine. EMDAC serves as an advisory group to EMSA and provides recommendations for additions and deletions from the scope of practice through the review of the existing evidence and expert consensus.

For example, in 2018 EMDAC recognized that the preponderance of evidence demonstrated that pediatric intubation by paramedics did not improve outcomes. This then led EMDAC to recommend that EMSA remove pediatric intubation from the state scope of practice. As an alternative, pediatric supraglottic airways are allowed to provide paramedics a tool by which they can continue to manage pediatric airways in critical situations. Removal of pediatric intubation from the paramedic scope, however, had the unintentional consequence of disrupting the team dynamics of ground and helicopter critical care transport teams. These teams are frequently comprised of a nurse and a paramedic and they use their skills in a complementary team approach to care. Removing pediatric intubation led to task overload for the nurse in situations requiring rapid sequence intubation of pediatric patients, as the nurse would be required to administer the medications and intubate without the assistance of his or her paramedic partner.

Recognizing this as a potentially dangerous situation, EMDAC developed a Unified Scope of Practice (USOP) to address this scenario. Through an expert workgroup and the consensus of the entire EMDAC membership, an optional scope of practice was developed that could be implemented by individual LEMSAs. The USOP was

adopted identically by every LEMSAs so that crews that transition between LEMSAs work under the same protocol. For the USOP to apply, the paramedic must work on a Critical Care Transport (CCT) ambulance or air ambulance that is Commission on Accreditation of Medical Transport Systems (CAMTS) certified and complete extensive training to become a certified flight paramedic or critical care paramedic. Rigorous, continuous training and quality improvement requirements are a key part of this program. After adoption, this USOP allows qualified paramedics to perform pediatric intubation, rapid sequence intubation of adults and pediatrics, video laryngoscopy, utilize supraglottic airways, utilize ventilators, and provide intraosseous access. The USOP will allow the paramedic/nurse teams to treat their patients in the safest, most effective manner possible.

EMDAC continues to recommend expansions to the scope of practice as new evidence is published. After the recent CRASH 2 trial on tranexamic acid (TXA) showed a decrease in trauma-related mortality, several California LEMSAs conducted a trial to demonstrate the use and safety of paramedics administering TXA in the prehospital environment. TXA has been added to the optional scope of practice because of the success of this trial. As further evidence is published, TXA may be added for additional uses such as post-partum hemorrhage (WOMAN trial), traumatic brain injury (CRASH 3), and epistaxis.

EMDAC continues to address the opioid crisis in multiple ways. Narcan has been expanded to basic scope of practice so EMTs, law enforcement officers, and first responders can administer this life saving medication. Numerous non-opioid analgesics have been approved for prehospital use as well, including ketamine, ketorolac, and acetaminophen.

EMDAC and the California EMS system will continue to advance the delivery of care to the patients we serve. Peer-reviewed, published studies focused on the safety of alternate destination options for psychiatric patients and intoxicated patients will change the future of where prehospital patients are transported. Additional programs centered on community paramedicine will bring alternative options for treating patients in need. EMDAC is committed to helping our prehospital providers provide safe and effective care, to improve the quality of life for our patients, and to prevent needless deaths. ■

**DR. LYON** is the Immediate Past President of EMDAC, and **DR. MACKEY** is a Past President of EMDAC.





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# SUMMER ON ICE:

## *Medical Care at the South Pole*

By John S. Rose, MD, FACEP, FAEMS

“Going to Pole”! That is the colloquialism for deploying to the geographic South Pole used by the National Science Foundation (NSF) Antarctic Program personnel. I was fortunate to be selected as the physician for the Amundsen-Scott South Pole Station during the austral summer of 2018-2019. This was a 4-month deployment “on ice” by the NSF to care for the 140 scientists and support personnel at the South Pole. The station supports full-time research by the NSF. Three deep space telescopes and numerous other experiments are located at the station. Amundsen-Scott Station is operated by the NSF as part of the U.S. Antarctic Program (USAP) under the Antarctic Treaty. The Antarctic Treaty, originally signed in 1959 by 12 nations, is an international cooperative agreement that the Antarctic continent is to be used exclusively for scientific research. The USAP has operated a scientific station at South Pole continuously since 1956. This most recent station was completed in 2008. It is a state-of-the-art facility that mimics a space station given the extremely harsh Antarctic environment (average summer temperature is -56 F, 2% absolute humidity, and intense UV exposure during the 24 hours of sunlight during the summer). In fact, NASA classifies the facility as a “space station” because it shares communication satellites with the International Space Station. The station supports numerous scientific groups including NSF, National Oceanographic and Atmospheric Administration (NOAA), NASA, and the U.S. Air Force.



dispensing, nursing tasks, and everything else. In addition, I was the acting dental professional. I had access to a full array of consultants through the UTMB Polar Operations Support Center, though it could take some days to get a response given the very limited communication at the station.

Amundsen-Scott South Pole station sits on the Antarctic plateau at about 9,300 feet. However, the daily physiologic altitude is much higher because the barometric pressure at the South Pole is less than near the equator. Altitude would vary during the day ranging from 10,000 feet to 11,500 feet consequently, personnel were at risk for altitude illness. Personnel were airlifted by the US Air Force on an LC-130 Hercules from McMurdo station on the coast to the South Pole in a 4-hour flight. Given the rapid altitude change, personnel were instructed to follow an evidence-based protocol, which included acetazolamide, to minimize the risk of altitude illness once arriving at the station. Needless to say, for varying reasons, some personnel did not always follow the protocol and experienced altitude illness. During my deployment, three cases of altitude illness (one case of severe acute mountain sickness and two cases of high-altitude pulmonary edema) required med evac. Luckily for me though, during my deployment, most of the medical care involved minor illness or injuries.

Deployment to an austere environment, such as the South Pole, was a unique experience that tested all of my training and experience in emergency medicine. I would deploy again to this beautiful and harsh environment if given another opportunity. My experience in the South Pole is an example of how our great specialty is needed in so many different environments. ■

**DR. ROSE** is the Prehospital/EMS Medical Director and Program Director of the EMS Fellowship in the University of California Department of Emergency Medicine. He is also the Medical Director of the Yolo County EMS Agency.

The health care services on Antarctica are contracted through the University of Texas Medical Branch Polar Operation (UTMB). There are three stations on the continent that are staffed year-round and require medical support: McMurdo station, Palmer station, and Amundsen-Scott South Pole station. South Pole is staffed with a physician and an advanced practice provider. They prefer emergency physicians for the deployments when possible as the specialty has the required skill set for delivering care in austere and dangerous environments. In fact, the Chief Medical Officer for UTMB Polar Operation is an emergency physician from Northern California, Dr. Jim McKeith. He is an exceptional medical director who oversees all the medical care for the three stations.

As the physician at the South Pole, I was on call 24 hours/day. The medical clinic was very well equipped with a large treatment room and a small 2 bed unit for any limited inpatient requirements. I had to perform my own tasks and procedures including x-rays-both acquiring and developing, ultrasounds, EKG, lab draws, pharmacy





## *Crashing the Party:*

# WOMEN OF EMS

By Kathy Staats, MD

Before medical school, I had the joy and privilege of working as a prehospital provider. And during my years as an EMT, I was lucky to have a few adept female mentors on my volunteer service in rural Virginia. I looked to them for examples of how to move up the leadership ladder. Looking back, having only a fifth of our personnel be women was not outside the norm in EMS (Emergency Medical Services). **In fact, today only 34% of EMTs and 21% of paramedics are women.**

As I advanced onto my career in medicine, I noticed female representation trailed, especially at the level of medical directorship. As of September 2017, only 18% of EMS fellowship directors were women, and only 15% of our national board, the National Association of EMS Physicians, are currently female. Of the ten largest cities in the US in 2017, only 6% of the medical directors are women.

Despite the numbers, it quickly becomes apparent women have played vital roles in the advancement of prehospital care. Indeed, the entire concept of care in the field began with Clara Barton. During the Civil War, Barton, a nurse from the North, watched many soldiers dying before getting to the medical tents. In response, she coined the term, "Treat them where they lie," becoming the first to encourage in-the-field care.

Fast forward to 1966 when the paper, "Accidental Death and Disability: The Neglected Disease of Modern Society" was published. This study was a wake-up call; thousands of citizens were dying from car accidents, and these deaths were preventable. Throughout the country, multiple

agencies blossomed to meet this need for prehospital care and trauma prevention.

Leading the charge in Pittsburgh was one of the first female medical directors, Dr. Nancy Caroline. Through training her paramedics, Dr. Caroline developed the first comprehensive EMS textbook, called "Emergency Care in the Streets." From the oversight of Drs. Caroline and Peter Safar, the Pittsburgh's paramedic and resuscitation models spread as standards to use for the new programs beginning throughout the US.

The next few years were an uphill battle for women serving in the prehospital realm. Initially, EMS and Fire Departments served out of the same stations, and to be a paramedic, you needed to be a firefighter as well. Fire departments did not want to hire women, and they were not shy about their bias. Women were failed out of fire academy in spite of successful completion. The aversion to hiring women was so strong, it often required a court decision to allow women to be hired. The first official record of a female paramedic in the U. S. is from 1972, Dianne Rechle of Palm Springs, California, six years after medic programs were begun in the US.

As EMS was gaining footing in the prehospital arena, EMS physicians were working to establish themselves as a subspecialty. After beginning advocacy efforts in the 1990s, in 2010 EMS secured its own board certification. This herculean effort required a team endeavor and could not have been achieved without the labors of Drs. Debra Perina, Sandy Bogucki, and Jane Brice.



Female medical directors in EMS are increasingly garnering national distinction. Recognized for their oversight under the great significance of mass casualty incidents, Drs. Juliette Saussy and Sophia Dyer have been commended for leading their EMS agencies during Hurricane Katrina and the Boston Marathon Bombing respectively. And currently, the list is growing of women that are medical directors of major metropolitan areas, including Dr. Marianne Gausche-Hill of Los Angeles County, Dr. Katie Tataris of Chicago, Dr. Kathleen Schrank of Miami, Dr. Elizabeth Char of Honolulu, Dr. Kristi Koenig of San Diego County, and many of those mentioned previously for other achievements.

In a climate that has sometimes been known as “an Old Boy’s Club,” I wondered what methods have allowed certain women to thrive? I interviewed a few of today’s leaders, and I shared their recommendations for success at FIX 2017, which you can watch on [www.feminem.org](http://www.feminem.org).

How can we otherwise increase women’s representation in EMS leadership? First, we need to quantify how many women are in EMS. If we want to identify areas to improve upon, we should first know where we are beginning at. Currently, there is no national organization that gathers this data. Second, we should aim to increase women providers in the field. As many EMS medical directors pursue the

prehospital subspecialty after working in the ambulance themselves, it is not surprising, that with a lower percentage of prehospital providers being female, that leads to fewer female physicians being involved in EMS. Finally, women that aspire to enter the EMS world should seek out mentors, male and female, for guidance. Those already established should develop their own mentor-mentee opportunities.

Overall, advocacy efforts are increasing, evidence-based protocols are growing in number, and the interest in EMS is expanding. The future of EMS is bright! We can be the leaders we aspire to be, if we **#CrashTheParty**. ■

**DR. STAATS** is the Imperial County EMS Interim Medical Director and an advisor to the Santa Clara County Fire Department.

This article was originally published on FemInEM on February 20, 2018. Read more at [www.feminem.org](http://www.feminem.org).



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# MEMBER Accomplishments

Kashmir Singh, MD, FACEP received the 2019 Tenure Award from the ACEP Careers in EM Section in recognition of working 30 consecutive years in the same emergency department.

Shyam Sivasankar, MD became a Clinical Assistant Professor at Stanford Department of Emergency Medicine.

Gary Tamkin, MD, FACEP presented on Drugs of Abuse at the Annual Meeting of International Association of Chiefs of Police.

Alicia Kurtz, MD launched her new wellness podcast, Real Talk.

Christian Dameff, MD, MS; Alicia Kurtz, MD; Jessica Mason, MD; and Ryan Ribeira, MD, MPH were named EMRA 45 under 45.

Alan Chiem, MD, MPH, FACEP was elected Councilor of the Society of Clinical Ultrasound Fellowships.

Breena Taira, MD, MPH, FACEP presented "Language Justice in the Emergency Department" at FIX19.

Emily Sbiroli, MD presented "On the Frontlines of Climate Change" at FIX19.

Sean Oldroyd, DO was voted the Poster Most Likely to Implement at the CalACEP AdvancED 2019 conference for his poster "What would she want? is not the question to ask about end-of-life care".

Haley Manella, MD was voted the Best Educational Innovation Poster at the CalACEP AdvancED 2019 conference for her poster "Standardizing and Improving Procedural Informed Consent Through Patient-Centric Videos".

Stephanie Benjamin, MD was voted the Most Creative Poster at the CalACEP AdvancED 2019 Conference for her poster "Writing for Wellness".

The UC Riverside team won the Escape Room challenge at the CalACEP AdvancED 2019 conference.

Rana Kabeer, MD, MPH received a grant to continue the MENTOR Video Series: Medical Education Novel Teaching On-Demand Resource.

Ryan Ribeira, MD, MPH and Nick Sawyer, MD, MBA were selected to this year's American Medical Association Health Systems Science Scholars Program.

Puneet Gupta, MD, FACEP passed the EMS Boards.

Breena Taira, MD, MPH, FACEP and Todd Schneberk, MD published their article "Undocumented Patients in the Emergency Department: Challenges and Opportunities" in WestJEM.

Luz Silverio, MD was named the 2019-20 Deputy Editor in Chief of ALiEM.

Marianne Gausche-Hill, MD, FACEP was awarded the American Academy of Pediatric's Jim Seidel Service award.

Anna Yap, MD received the Rising Star of Physician Leadership Award from the Los Angeles County Medical Association.

Ray Johnson, MD, FACEP received ACEP's James D. Mills Award.

Charlotte Wills, MD was named EMRA's Residency Director of the Year.

Al'ai Alvarez, MD, FACEP was the inaugural winner of the ACEP Diversity, Inclusion, and Health Equity Distance and Impact Award.

CalACEP Executive Director, Elena Lopez-Gusman, received the inaugural ACEP Diane K. Bollman Chapter Advocate Award.

Eric Gross, MD, FACEP received ACEP's National Faculty Teaching Award.

Dennis Hsieh, MD, JD received ACEP's National Junior Faculty Teaching Award.

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# CEMAF DONORS

The California Emergency Medicine Advocacy Fund (CEMAF) has transformed California ACEP's advocacy efforts from primarily legislative to robust efforts in the legislative, regulatory, legal, and through the Emergency Medical Political Action Committee, political arenas. Few, if any, organization of our size can boast of an advocacy program like California ACEP's; a program that has helped block Medi-Cal provider rate cuts, lock in \$500 million for the Maddy EMS Fund over the next 10 years, and fight for ED overcrowding solutions! The efforts could not be sustained without the generous support from the groups listed below, some of whom have donated as much as \$0.25 per chart to ensure that California ACEP can fight on your behalf. **Thank you to our 2018-19 contributors (in alphabetical order):**

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- Temecula Valley Emergency Physicians, Inc.
- US Acute Care Solutions
- Valley Emergency Medical Associates
- Valley Presbyterian Emergency Medical Associates
- VEP Healthcare
- Vituity
- West Hills Emergency Medical Associates

## ANNOUNCEMENTS |



### CALIFORNIA ACEP SPONSORED & CO-SPONSORED COURSES

#### Save the Date! 2020 Legislative Leadership Conference

April 14, 2020 | Sacramento, California

### SUBMIT A LIFELINE ARTICLE

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

The Spring Issue of *Lifeline* will be about Reimbursement and Surprise Billing. We welcome your thoughts on the topic.

If you would like more information or would like to submit a guest article, email [info@californiaacep.org](mailto:info@californiaacep.org).

### NOMINATE A CAL/EMRA 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](https://bit.ly/nominate4calemra).

### WE MOVED!

The Chapter moved suites on October 1st. Please update your records with our new address:

**California ACEP**  
**1121 L Street, Suite 401**  
**Sacramento, CA 95814**



## CALIFORNIA ACEP UPCOMING MEETINGS & DEADLINES

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

### DECEMBER 2019

<b>24th–31st</b>	<b>Winter Holidays</b> Office Closed
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### JANUARY 2020

<b>1st</b>	<b>New Year's Day</b> Office Closed
<b>7th at 9am</b>	<b>Reimbursement Committee</b> Conference Call
<b>9th at 10am</b>	<b>Government Affairs Committee (GAC)</b> Conference Call
<b>20th</b>	<b>Martin Luther King, Jr. Day</b> Office Closed

### FEBRUARY 2020

<b>1st–March 15</b>	<b>Chapter Board Nominations Open</b> Online
<b>6th at 10am</b>	<b>Board of Directors Meeting</b> Sacramento, CA
<b>17th</b>	<b>President's Day</b> Office Closed

### DECEMBER 2019

SUN	MON	TUES	WED	THURS	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

### JANUARY 2020

SUN	MON	TUES	WED	THURS	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

### FEBRUARY 2020

SUN	MON	TUES	WED	THURS	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

## CAREER OPPORTUNITIES |



**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](mailto: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](mailto: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](mailto: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](mailto:info@americanhealtheducation.com)  
Web: [www.americanhealtheducation.com](http://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](mailto: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](mailto: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: [thomasfp@sbcglobal.net](mailto:thomasfp@sbcglobal.net)  
Web: [www.cce.csus.edu](http://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](mailto:nancy@caems-academy.com)  
Web: [www.caems-academy.com](http://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](mailto:mthomas@emergencytraining.com)  
Web: [www.emergencytraining.com](http://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) 558-4344 x 0  
Fax: (909) 558-0102  
Email: [LJones@ahs.llumc.edu](mailto:LJones@ahs.llumc.edu)  
Web: [www.llu.edu](http://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](mailto:jpierson@medicambulance.net)  
Web: [www.medicambulance.net](http://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](mailto:grose@napavalley.edu)  
Web: [www.winecountrycpr.com](http://www.winecountrycpr.com)

### NCTI – National College of Technical Instruction

*Lena Rohrbaugh, Course Manager*  
333 Sunrise Ave Suite 500, Roseville, CA 95661  
Phone: (916) 960-6284 x 105  
Fax: (916) 960-6296  
Email: [jlcasa@caltel.com](mailto:jlcasa@caltel.com)  
Web: [www.ncti-online.com](http://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](mailto: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: [Gregp@riggsambulance.com](mailto:Gregp@riggsambulance.com)  
Web: [www.riggsambulance.com](http://www.riggsambulance.com)

### Rocklin Fire Department

*Chris Wade, Firefighter/Paramedic*  
3401 Crest Drive, Rocklin, CA 95765  
Phone: (916) 625-5311  
Fax: (209) 725-7044  
Email: [Chris.Wade@rocklin.ca.us](mailto:Chris.Wade@rocklin.ca.us)  
Web: [www.rocklin.ca.us](http://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](mailto:brian.green@rmetro.com)  
Web: [www.rmetro.com](http://www.rmetro.com)

### Defib This (ERT)

*Brian Green, EMT-P*  
1543 Pacific Avenue, Suite 104, Capitol CA 95060  
Phone: (831) 426-9111  
Web: [www.defibthis.com](http://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](mailto:ken.bradford@falck.com)  
Web: [www.verihealth.com](http://www.verihealth.com)

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

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

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

**EMREF is a proud sponsor of California ITLS courses.**

Please call **916.325.5455** or  
E-mail **Lucia Romo: [Iromo@californiaacep.org](mailto:Iromo@californiaacep.org)** for more information.

**lifeline**

California Chapter, American  
College of Emergency Physicians

1121 L Street, Suite 401  
Sacramento, CA 95814



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