**WELCOME**

**New members!**

<table>
<thead>
<tr>
<th>Central Coast Emergency Physicians</th>
<th>Loma Linda Emergency Physicians</th>
<th>Tri-City Emergency Medical Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Medical Associates</td>
<td>Napa Valley Emergency Medical Group</td>
<td>University of California, Irvine Medical Center Emergency Physicians</td>
</tr>
<tr>
<td>Emergency Medicine Specialists of Orange County</td>
<td>Newport Emergency Medical Group, Inc at Hoag Hospital</td>
<td>Pacific Emergency Providers, APC</td>
</tr>
<tr>
<td>Front Line Emergency Care Specialists</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Jessica Andrusaitis  
Jessa Baker  
Travis Deuson MD  
Mayur M Kashi  
Grace Lee MD  
Christine J Licata  
Katie Maltester, Medical Student  
Matea Orlovic  
William Pho MD  
Sylvia A Pina Paz  
Daniel Sadoma  
Michael J Stone, Medical Student  
Morvarid Tavassoli  
Amanda Wagner  
Jay Yim
Access to care is a fundamental patient-centered emergency medicine concept. It is also part of the critical public health triangle of access, quality, and cost. Health care reform has set in motion plans and actions to reduce health care costs while expanding access to care. In California, the Emergency Medical Services Authority (EMSA) is piloting changes with respect to how patients who call 911 gain access to care.

On September 25, 2016 an article appeared in the Wall Street Journal (WSJ) that explored the profound changes taking place in Emergency Medical Services (EMS). The article touched on Alternative Destination programs for 911 callers. Alternative Destination is a hot topic in the EMS world as a component of Community Paramedicine (CP). CP is an evolving model of community-based healthcare that aims to provide value by creating new roles for paramedics beyond emergency field response, assessment, care, and rapid transport to 911 receiving hospital emergency departments (EDs). CP endeavors to deliver additional training to paramedics to fulfill a variety of roles including assessment, management, and support of tuberculosis patients, hospice patients, post-hospital discharge patients, and super users of the 911-system.

Alternative Destination programs are based on the premise that the community paramedic, in the field, can identify low-risk/non-emergency 911 callers, and that alternatives to transport to the ED can be safely utilized. These alternatives include: urgent care centers, clinics, or no transport. In November 2014 the California Office of
Southern California
JOB OPPORTUNITIES

- Excellent Opportunities for Emergency Physicians
- Very Competitive Compensation
- Hospitals include Arcadia Methodist & Glendale Memorial (Top heart programs).
- Available practice settings in the Greater Los Angeles area.

Contact Debbie Corn for more information (909) 634-3172 or email CV to dcorn@emmamd.com

Statewide Health Planning and Development (OSHPD) approved a proposal by EMSA for thirteen CP Projects, including four Alternative Destination pilots. EMSA’s goal is to go to the California Legislature to change the scope of practice of paramedics, permitting the development of CP in California, including 911 caller Alternative Destination programs. (1)

California ACEP strongly opposes Alternative Destinations for 911 callers. The key reason for the Chapter’s opposition relates to the absence of evidence showing patient safety and quality. Patients who call 911 are a high-risk population in terms of complexity, acuity, and vulnerability. By calling 911, patients are actively seeking access to emergency care, where their EMTALA rights can be realized. These rights include the right to receive a medical screening exam to search for emergency medical conditions. Alternative Destination programs interrupt this patient goal and right.

EMSA proposes changing a system that works for Californians who believe they may be experiencing an emergency. Currently EMS, with mobile intensive care nurse (MICN) and medical oversight, transports 911 callers to hospital EDs or higher levels of care including EDAP, STEMI, Stroke, Trauma, and Pediatric Trauma Centers. All these receiving centers are capable of providing an EMTALA medical screening exam. Alternative Destination programs propose making a field triage decision to transport to a lower level of care that is not capable of providing an EMTALA medical screening exam because many of them do not have the requisite lab or imaging capabilities, let alone cath lab or other resources necessary to immediately assess a patient.

EMSA hopes to reduce ED overcrowding through Alternative Destinations. However, emergency physicians know all too well that low acuity patients do not contribute to ED overcrowding. These patients have short lengths of stay, require few resources, and do not take up ED bed space.

There is currently no evidence that paramedics can reliably identify low-risk/non-emergency 911 patients who do not require transport to a hospital ED. The published literature on this topic identifies undertriage as a significant issue. In the absence of a validated triage tool, strong evidence of safety and quality is still needed. Unfortunately, the current EMSA Alternative Destination pilots are not designed to prove safety or quality. Until compelling evidence exists on safety and quality the Chapter will remain strongly opposed to Alternative Destinations.

In fact, the only evidence we do have - the early experience from the pilot project - has resulted in a patient being sent from the field to a clinic, and then sent to the ED where they went to the cath lab to have a coronary artery stented emergently, as well as another patient who was in a car accident and sent to urgent care where they missed a fracture.

The ED is the place with the time, tools, and team to identify who is sick and who is well. The following is my response to the WSJ article regarding Alternative Destinations for 911 callers.
In “A Revolution in EMS Care” (http://www.wsj.com/articles/the-revolution-in-ems-care-1474855802) (2) WSJ assistant managing editor Laura Landro describes the potential role of emergency medical services’ (EMS) community paramedics as decision makers in “alternative destination” programs. 911 callers would have an evaluation in the field to decide who needed to be sent to the emergency department (ED) and who could be sent to an alternative destination, such as an urgent care center, and who could be left at home. Ms. Landro argues cost savings could be realized.

But some of the cost savings would come from substituting people with less education and experience (paramedics) for people with more (doctors) because they’re cheaper. Those potential savings come at a great cost—both financial and human—when serious conditions are inevitably missed.

New technologies deployed in the field can improve the opportunities for diagnosis and treatment. But they cannot replace the judgment and experience of the person who makes the diagnosis or chooses the treatment. It’s easy to see with hindsight which patients didn’t need life-saving intervention. It’s much harder to see who they are when confronting the confusing picture at the beginning of an episode of illness. There are dozens of seemingly minor symptoms that are actually signs of major conditions.

The article describes shortness of breath and abdominal pain as non-emergency 911 calls. In my years as an emergency physician, I have treated hundreds of patients suffering from life-threatening asthmatic attacks, heart attacks, pulmonary emboli, abdominal aortic aneurysm, ischemic bowel, and acute abdomen with perforated viscus—all conditions with symptoms of shortness of breath or abdominal pain. Those people’s lives were saved because they came straight to the emergency department.

Patients who are worried enough to call 911 are frequently patients with high-risk complaints and illnesses that may be difficult to diagnose, many of whom are at the extremes of age, fragile, and in poor health. If there was evidence that a low risk group of 911 callers could be reliably identified, the plan Ms. Landro admires might be of value. However no such evidence exists. The published scientific studies on this question all point to the issue of under-triage, wherein a significant number of patients are wrongly diagnosed as being well enough not to be sent to the ED. The Institute of Medicine has emphasized the need for more high quality research evidence for EMS. (3)

We have spent years building a world-class 911 system that saves lives—routing people quickly and effectively to the closest emergency department. The practice of EMS transport of 911 callers to hospital EDs exists to protect the public’s health and to help ensure that if someone thinks they are having an emergency they can get immediate medical attention. Safety and quality need to be front and center when dealing with high-risk 911 patient complaints such as shortness of breath and abdominal pain. While the national discussion on healthcare value is important, the issue of cost needs to be balanced against the issues of quality and safety.

Emergency Medicine physicians are the leaders of the professional emergency care team. While we support innovative programs that can prevent emergencies, or those that provide more support to patients, we cannot support those that place patients at risk. We remain patient centered and vigilant 24/7/365 to care for emergencies big and small.

Lawrence Stock, MD, FACEP
President, California Chapter
American College of Emergency Physicians
Sacramento, California

CITATIONS

CONGRATULATIONS TO OUR NEWEST FELLOWS!
The major focus of the 2016 General Election centered on the Presidential Election, but there were also a number of important local elections and a slew of initiatives on the ballot. Voter turnout in the general election was over 75% in California – the highest rate since 2008, and had a resounding effect on State Assembly and Senate races.

Democrats felt they had a great opportunity to secure a supermajority in both the State Senate and Assembly. A supermajority would allow Democrats to pass any measure requiring a two-thirds vote such as tax measures without having to reach across the aisle for compromise. To achieve this, the Democrats would need to win over two seats in the Assembly to get them to 54 and one seat in the State Senate to get them to 27. The Democrats targeted seven Assembly races and five State Senate races. They were successful in picking up enough seats in both houses to obtain a supermajority. While significant, since the passage of Proposition 25 lowered the vote threshold for passage of the state budget to a simple majority, achieving a supermajority is not as significant. Additionally, a supermajority does not necessarily make achieving a 2/3 vote on legislation easier. It simply moves the power base from the Republican Party to the so-called "moderate" or "business" Democrats who now have greater influence.

As a part of the process in determining which candidates EMPAC should support, your advocacy staff interviewed a wide array of candidates for statewide office and toured numerous others in emergency departments around the state. In total, EMPAC contributed to twelve candidates during the general election. Of those twelve candidates, eleven were elected! That’s a success rate of 91.7%.

Building relationships with elected officials early in and throughout their careers is extremely important. While we don’t have a crystal ball, we endeavor to support allies who will be elected to leadership or become a vocal champion of our causes in committee and on the floor of the legislature. For example, EMPAC has been a long-time supporter of Assembly Members Wood and Maienschein, who now serve as the Chair and Vice-Chair, respectively, of the Assembly Health Committee.

From San Diego to Los Angeles to the North Coast, EMPAC supported candidates for the Assembly and State Senate had strong showings. Incumbent elected officials Assembly Members Jim Wood, Matt Dababneh, Miguel Santiago, Sebastian Ridley-Thomas, and Brian Maienschein were all reelected. Earlier in 2016, Dr. Joaquin Arambula won his very competitive special election race for State Assembly, becoming the first emergency physician elected to the California State Legislature. Dr. Arambula won his general election race and will be headed back to the Assembly in 2017.

In addition to our support of candidates, California ACEP endorsed two ballot initiatives – Proposition 56 and Proposition 63. Prop. 56 increases the tobacco tax by $2 per pack and also applies the tax to electronic cigarettes. Prop. 63 requires individuals who wish to purchase ammunition to first obtain a permit, mandates dealers to check this permit before selling ammunition, and eliminates several exemptions to the large-capacity magazines ban and increases the penalty for possessing them. Both propositions passed by resounding margins.

Thanks to generous contributions to EMPAC by California ACEP members like you, emergency physicians have become a force to be reckoned with in California politics. As strong as our results have been in the 2016 election cycle, the strength and influence of our opponents in Sacramento cannot be underestimated. Without member involvement and contributions from all of our donors, we will not be able to continue to develop and elect emergency medicine champions.
CANDIDATES SUPPORTED BY EMPAC IN THE 2016 ELECTION CYCLE INCLUDE:

<table>
<thead>
<tr>
<th>Candidate</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>Assembly Member Jim Wood (AD 2)</td>
<td>Won with 73.1% of the vote</td>
</tr>
<tr>
<td>Assembly Member Joaquin Arambula (AD 31)</td>
<td>Won with 63.8% of the vote</td>
</tr>
<tr>
<td>Monique Limon (AD 37)</td>
<td>Won with 63.8% of the vote</td>
</tr>
<tr>
<td>Assembly Member Matt Dababneh (AD 45)</td>
<td>Won with 66.4% of the vote</td>
</tr>
<tr>
<td>Assembly Member Miguel Santiago (AD 53)</td>
<td>Won with 58.2% of the vote</td>
</tr>
<tr>
<td>Assembly Member Sebastian Ridley-Thomas (AD 54)</td>
<td>Won with 81.6% of the vote</td>
</tr>
<tr>
<td>Randy Voepel (AD 71)</td>
<td>Won with 65.9% of the vote</td>
</tr>
<tr>
<td>Assembly Member Brian Maienschein (AD 77)</td>
<td>Won with 57.9% of the vote</td>
</tr>
<tr>
<td>Assembly Member Lorena Gonzalez (AD 80)</td>
<td>Won with 77.8% of the vote</td>
</tr>
<tr>
<td>Steve Fazio (SD 27)</td>
<td>Lost with 44.1% of the vote</td>
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</table>

OUTCOME OF BALLOT PROPOSITIONS:

<table>
<thead>
<tr>
<th>Proposition</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROPOSITION 51 (School Bonds.)</td>
<td>Passed with 55.1% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 52 (Medi-Cal Hospital Fee Program.)</td>
<td>Passed with 70.1% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 53 (Revenue Bonds. Statewide Voter Approval.)</td>
<td>Failed 49.4% to 50.6%</td>
</tr>
<tr>
<td>PROPOSITION 54 (Legislature. Legislation and Proceedings.)</td>
<td>Passed with 65.4% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 55 (Tax Extension to Fund Education and Healthcare.)</td>
<td>Passed with 63.2% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 56* (Cigarette Tax to Fund Healthcare, Tobacco Use Prevention, Research, and Law Enforcement)</td>
<td>Passed with 64.4% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 57 (Criminal Sentences. Parole. Juvenile Criminal Proceedings and Sentencing.)</td>
<td>Passed with 64.4% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 58 (English Proficiency. Multilingual Education.)</td>
<td>Passed with 73.5% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 59 (Corporations. Political Spending. Federal Constitutional Protections.)</td>
<td>Passed with 53.2% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 60 (Adult Films. Condoms. Health Requirements.)</td>
<td>Failed 46.3% to 53.7%</td>
</tr>
<tr>
<td>PROPOSITION 61 (State Prescription Drug Purchases. Pricing Standards.)</td>
<td>Failed 46.8% to 53.2%</td>
</tr>
<tr>
<td>PROPOSITION 62 (Death Penalty.)</td>
<td>Failed 46.9% to 53.1%</td>
</tr>
<tr>
<td>PROPOSITION 63* (Firearms. Ammunition Sales.)</td>
<td>Passed with 63.1% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 64 (Marijuana Legalization.)</td>
<td>Passed with 57.1% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 65 (Carryout Bags. Charges.)</td>
<td>Failed 46.1% to 53.9%</td>
</tr>
<tr>
<td>PROPOSITION 66 (Death Penalty. Procedures.)</td>
<td>Passed with 51.1% of the vote</td>
</tr>
<tr>
<td>PROPOSITION 67 (Ban on Single-Use Plastic Bags.)</td>
<td>Passed with 53.3% of the vote</td>
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For more information on how to make a contribution to EMPAC, please contact us at info@californiaacep.org or by calling the Chapter office at (916) 325-5455.

*California ACEP endorsed
How Gratitude Can Change Your Life for the Better

Imagine a drug that promises to help people exercise more, sleep better, feel more optimistic, and increase overall happiness with life. In a large clinical trial, patients assigned to receive the drug in question significantly outranked the control group in all of these categories in as little as 9 weeks. The cherry on top? There were no adverse effects.

This study was a reality, but the drug was not. It wasn’t a pill, it was a practice: Gratitude. In the 2003 study, psychologists Emmons and McCullough asked university students to submit weekly lists of things they were grateful for. By the end of the study, it appeared their lives had changed for the better.

An “attitude of gratitude” has long been associated with positive psychological outcomes. As early as 1924, philosopher and writer G.K. Chesterton extolled gratitude for its ability to produce “the most purely joyful moments that have been known to man.” In the 1980s, gratitude, along with other positive psychological constructs, caught the attention of academic psychologists. It’s since been shown to lead to increased happiness, emotional well-being, and satisfaction with life, as well as decreased stress, depression, and anxiety.

IT’S NOT JUST IN YOUR HEAD
More recent evidence has pointed toward gratitude’s beneficial effects on physical health. In the Emmons and McCullough study, for instance, the college students who were instructed to practice regular expressions of gratitude self-reported lower rates of physical ailments, like headaches and stomach upset. Researchers in Switzerland found that grateful individuals experience higher levels of physical well-being, are significantly more likely to engage in health care, and have a greater propensity to perform health-promoting behaviors like choosing healthy foods and abstaining from drugs.

Grateful people even appear objectively healthier than those who don’t regularly express appreciation. Increased heart rate variability—a measure that has repeatedly predicted decreased mortality in patients with coronary artery disease and heart failure—has been observed in research subjects who were asked to focus on a feeling of sincere appreciation. Gratitude has been related to improved sleep, measured not only by subjective sleep quality, but also by sleep duration, sleep latency, and daytime dysfunction attributed to fatigue. Researchers from the University of California, San Diego reported lower levels of inflammatory markers in patients with heart failure who scored highly on a gratitude questionnaire. A wealth of data shows that gratitude and other positive psychological constructs are even associated with decreased all-cause mortality in both healthy and medically diseased populations.

IS GRATITUDE THE CHICKEN OR THE EGG?
None of this research addresses the issue of whether gratitude is a cause of well-being, per se, or merely a positive emotion that people with high well-being frequently experience. Experimental studies have begun to answer this question.

One of these studies asked 119 women to keep a daily record of their lives for two weeks. Half the women were told to record specifically those things they were grateful for. The other half were told to objectively record events without any emotional associations. At the end of the 2-weeks, those in the gratitude group had significantly higher levels of well-being, increased sleep quality, and even decreased blood pressure.

NPR recently reported the early findings of a yet unpublished study in which patients with heart failure were asked to keep a gratitude journal most days of the week, noting 2 or 3 things they were thankful for. After 2 months of this practice, patients had higher levels of heart rate variability and decreased levels of inflammatory markers as compared to pre-intervention testing, suggesting a lower risk of adverse cardiac events.

ADOPT A PRACTICE OF GRATITUDE
Good news for anyone who wasn’t born with a grateful disposition: The benefits of gratitude seem to be attainable through a directed practice of thankfulness. Intentionally establishing an attitude of appreciation likely leads to the same health benefits that naturally grateful people already enjoy.

An even more welcoming news is that cultivating gratitude is surprisingly simple. In fact, one study demonstrated that positive psychological effects of writing just one thank you letter lasted for up to one month.

To harness the benefits of appreciation, try keeping a daily gratitude journal. Write a hand-written thank you note. Make a point to express your appreciation for someone who helps you—the barista, the bus driver, the bank teller—every day. You can even incorporate gratitude in mindfulness-based meditation by focusing on what you’re grateful for, even things as simple as warm sunlight or a pleasant sound. Committing to these free, easy, and simple practices will create a ripple effect of improved health, happiness, and well-being throughout your life.

About the Author
Nicole Van Groningen is a third-year internal medicine resident at NYU, where she has been involved in high-value quality improvement projects as part of the national ACP/ABIM Choosing Wisely High Value Care In Action Fellowship. She also has a passion for medical innovation, which she blogs about at AvantMed. She is an avid tweeter at @NVanGroningenMD.
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All my life, I’ve had a passion for working with our elders. As a teen, I loved volunteering in our church’s senior fitness program. And I gained even greater empathy by caring for each of my parents through a serious illness.

Today, I’m an assistant ED medical director at the Saint Agnes Hospital in Baltimore. Like most large EDs, ours can be a loud, busy, bewildering place. This is especially true for the large population of elders who visit us each year. When I learned that CEP America and Saint Agnes were collaborating on the development of a new Senior ED, I jumped at the chance to get involved. In today’s post, I’ll describe how we created a setting that helps elders feel safe and empowered while boosting our hospital’s quality metrics.

A GROWING NEED

Over the past few years, geriatric emergency medicine has emerged as an important specialty. Patients over 65 are more likely to utilize the ED, and their average cost per visit is far above the national average. They’re also about three times more likely to be admitted to the hospital. Despite being well represented among ED patients, elders face some significant barriers to emergency care:

- **Physical.** Elders with hearing impairment may have difficulty understanding discharge instructions in the noisy ED environment. The layout of the department may require patients who are at risk for falls to walk long distances.

- **Psychological.** Older adults who are fearful of losing their independence may withhold information about their medical history or living situation.

- **Cultural.** Prejudices and stereotypes about older adults can impact the care they receive. For example, providers might assume that an older adult “doesn’t really know what happened” or “can’t understand” rather than making an extra effort to communicate.

As a result, many elders end up feeling distressed, lost, and helpless in most EDs. This stress can reduce satisfaction and escalate symptoms, particularly in patients with delirium or dementia.

These issues are particularly salient to Saint Agnes, which serves a large geriatric population. About 10 percent of our ED patients are age 65 and over. While many come from the multiple nursing homes and rehab facilities in the area, others are living at home and value their independence.

About two years ago, Saint Agnes received a generous donation for the enhancement of geriatric care. The hospital had recently created a successful pediatric ED in partnership with CEP America, so a Senior ED seemed like a logical next step.
TRANSFORMING EMERGENCY CARE

The Senior Emergency Department at Saint Agnes Hospital is the 73rd geriatric ED in the United States, the second in Maryland, and the first in Baltimore. The hospital and CEP America collaborated in its creation with valuable guidance from the Schumacher Group and The Erickson School of Aging Studies at the University of Maryland, Baltimore County.

In order to better serve our older adult patients, we first needed to create a culture that was sensitive to their needs and preferences. This would require each of us in the department to evaluate our attitudes, beliefs, and prejudices.

Early in the planning process, we held an integrated planning meeting for all providers and staff who touch the ED patients. Our group created two word clouds:

How older patients feel in a typical ED:

Powerless
Anxious
Angry
Threatened
Disrespected
Confused

How we want them to feel:

Confident
Respected
Heard
Empowered
Understood
Protected

Throughout the planning process, we worked to replace the negative feelings from the first cloud with positive feelings from the second.

Next it was time to assemble our team. Research suggests that the complex health needs of seniors can best be met through a multidisciplinary approach. All ED physicians, PAs, NPs, and nurses received training in geriatrics. In addition, we invited nutritionists, social workers, and pharmacists to participate.

We also oversaw the renovation of a small section of the existing ED to create a safe and inviting environment for elders. The new layout consisted of seven walled treatment bays around a central nursing station with alcoves for pharmacy and nutrition consults. Safety features included no-slip flooring and handrails. Walls were soundproofed and painted soothing colors. Beds were fitted with softer mattresses, thicker blankets, and pillow speakers. Even the lights and TVs were adjusted to reduce glare.

Finally, we developed screening tools to address common health issues among older adults, including falls risk, delirium, in-home safety, and medication interactions. These assessments are usually administered at triage, which allows us to begin discharge planning immediately. They also help us to pinpoint the underlying causes of our patients’ health issues.

NO AGE LIMIT ON QUALITY

The Saint Agnes Hospital Senior ED opened in 2015. Just one year later, our patients and hospital are reaping many benefits:

Patient satisfaction. The service has developed a positive reputation in the community. Older patients will actually tell their referring physicians to send them to the “geriatric side” of the ED.

Fewer repeat visits. Our screening process enables us to treat the root causes of health problems, which really makes a difference in the lives of our patients.
For example, a man in his late 80s came in after a fall and screened at high risk for future falls. He was very independent, and we couldn’t imagine him in a nursing home. Within a few hours, our social work team had set him up with home health services and arranged to have some simple safety equipment installed in his house. The patient was discharged that day to a safe home situation.

**Reduced admissions and readmissions.** Another patient came in after falling repeatedly. She was very undernourished, which was causing her to feel weak. One option was to admit her in order to place a feeding tube. However, we felt we could provide the resources to correct the problem.

And we did. Our social worker set up home meal delivery. The consulting pharmacist recommended supplements. And the physician followed up with the patient’s primary care doctor to ensure continuity. As a result, the patient avoided a hospitalization and maintained her independence and dignity.

**WHAT’S NEXT?**

While our senior ED is now up and running, it’s still a work in progress. We’re currently collecting outcome data for this setting so we can further refine our approach to care. We also hope to incorporate telehealth into the program in order to assist outlying EDs in caring for elders.

Geriatric emergency medicine is quite intellectually challenging, and the field is advancing rapidly. One of our biggest challenges is providing team members with the educational opportunities they need to stay on top of the latest research and recommendations.

For myself, this journey has been incredibly rewarding. Now that the Senior ED is up and running, I’m beginning to share our story with the community through speaking engagements. I tell my audience about the wonderful patients I’ve met, and how they’ve challenged my own views on aging.

In both my personal and professional lives, I’ve seen how the needs of elders can fall by the wayside in healthcare settings. As providers, we can ensure that their voices are heard and that each person is treated with respect and dignity.

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**Note:** This article is reprinted with the permission of CEP America and does not necessarily reflect the views and opinions of California ACEP.
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Join our 40th Annual Emergency Medicine in Yosemite
January 11-14, 2017

Come participate in a unique experience: fabulous lectures, special features, afternoon Park Ranger hikes, a mini-TED non-medical program over Wednesday brunch, Wednesday dinner and reception, Thursday and Friday evening cocktail receptions and entertainment.

Just added
EMRAP Live From Yosemite:

January 13th | 7:20 AM
Jessica Mason, M.D.

January 14th | 7:20 AM
Mel Herbert, M.D.*, EMRAP Founder
*Schedule permitting

Registration is now open online at
www.yosemitemef.org
Early Bird closes November 15, 2016
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Center for Emergency Medical Education (CEME) and Yosemite Medical Education Foundation. The Center for Emergency Medical Education is accredited by the ACCME to provide continuing medical education for physicians.

The Center for Emergency Medical Education designates this live activity for a maximum of 14.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Sponsored by Yosemite Medical Education Foundation (YMEF)

Co-sponsored by California ACEP
American College of Emergency Physicians California Chapter

WEDNESDAY, JANUARY 11TH
(Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler)

9:30 AM  Brunch (Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler):
Richard Stennes, MD: “My Travels Around the World—On and Off the Ship”
Jerry Hoffman, MD: A Few Remarks from the ‘Skeptic’

1:00 PM  Ranger Guided Group Hike: Mirror Lake (Meet in the Majestic Yosemite Hotel Lobby – formerly Ahwahnee Lobby)

5:30-6:30 PM  Reception (Half Dome Village - formerly Curry Village):
It’s A Party In Honor of Billy Mallon, M.D. and A Number of the Elders of Emergency Medicine
Martha Chessie: Basketry
Shane Hendren: Navaho Metalsmith
Kathleen O’Hara: Photography

6:30 PM  Dinner (Half Dome Village - formerly Curry Village)

7:00-7:15 PM  Welcome and Introductions: (Half Dome Village - formerly Curry Village)
Ron Crowell, MD & Larry Stock, MD, President of California Chapter

7:15-8:00 PM  Ryan McGarry, MD: “The Making of ‘Code Black,’ the TV production”

8:00-9:30 PM  Jeremy Kittel: American Fiddler, Violinist and Composer
### Thursday, January 12th

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:45-8:45 AM</td>
<td>Paul Auerbach, MD: “Leadership and Where Emergency Medicine Should Lead” (1 Hour CME)</td>
</tr>
<tr>
<td>8:45-9:45 AM</td>
<td>Ramin Tabatabai, MD: “Managing the Unstable AFIB Patient” (1 Hour CME)</td>
</tr>
<tr>
<td>9:45-10:15 AM</td>
<td><strong>Break: Visit Exhibitors &amp; Sponsors</strong> (Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler)</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Guest Program (Yosemite Valley Lodge Bar):</td>
</tr>
<tr>
<td>10:15-11:15 AM</td>
<td>Christian Tomaszewski, MD: “Cardiac Toxins: Beyond ACLS” (1 Hour CME)</td>
</tr>
<tr>
<td>11:15-12:15 PM</td>
<td>Dan Imler, MD: “The Febrile Infant: Update 2017” (1 Hour CME)</td>
</tr>
<tr>
<td>1:30 PM</td>
<td>Ranger Guided Group Hike: Vernal Falls (Meet in Happy Isles parking lot)</td>
</tr>
<tr>
<td>5:15 PM</td>
<td><strong>Wine and Cheese Reception</strong> (Majestic Solarium – formerly Ahwahnee Solarium):</td>
</tr>
<tr>
<td></td>
<td>Martha Chessie: Basketry</td>
</tr>
<tr>
<td></td>
<td>Annie Hoffman: Artist</td>
</tr>
<tr>
<td></td>
<td>Jeremy Kittel: Fiddler</td>
</tr>
<tr>
<td>5:45-6:45 PM</td>
<td>Pepper Trail, PhD: “Voyage to The Origin of Species: Reminiscences of Charles Darwin (in Person)”</td>
</tr>
<tr>
<td>6:45-7:00 PM</td>
<td>Annie Hoffman: My Work</td>
</tr>
<tr>
<td>7:00-7:30 PM</td>
<td>Shane Hendrin, Navaho Metalsmith: “My Family’s 300 Years in the West”</td>
</tr>
</tbody>
</table>

### Friday, January 13th

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:45-8:45 AM</td>
<td>Graham Billingham MD: “ED Malpractice and Emerging Risk: Latest Update” (1 Hour CME)</td>
</tr>
<tr>
<td>8:45-9:45 AM</td>
<td>Dan Imler, MD: “What’s New with Pediatric Sedation” (1 Hour CME)</td>
</tr>
<tr>
<td>9:45-10:15 AM</td>
<td><strong>Break: Visit Exhibitors &amp; Sponsors</strong> (Yosemite Valley Lodge Mountain Room Restaurant – formerly Yosemite Lodge Mountain Broiler)</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Guest Program (Yosemite Lodge Bar): An Introduction to Basket Weaving</td>
</tr>
<tr>
<td>10:15-11:15 AM</td>
<td>Ramin Tabatabai MD: “Oncologic Emergencies” (1 Hour CME)</td>
</tr>
<tr>
<td>11:15-12:15 AM</td>
<td>Christian Tomaszewski, MD: “Diagnostic Errors: Strategies to Avoid” (1 Hour CME)</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>Ranger Guided Group Hike: Yosemite Falls Trail (Meet in Trailhead parking lot)</td>
</tr>
<tr>
<td>5:00 PM</td>
<td><strong>Wine and Cheese Reception</strong> (Majestic Solarium – formerly Ahwahnee Solarium):</td>
</tr>
<tr>
<td></td>
<td>Charles Cramer: Photographer</td>
</tr>
<tr>
<td></td>
<td>Shane Hendren: Navaho Metalsmith</td>
</tr>
<tr>
<td>5:30-6:15 PM</td>
<td>Paul Auerbach, MD: “Disaster Response: Preparing and Responding. From Mega-disasters to Your Home.” (1 Hour CME)</td>
</tr>
<tr>
<td>6:15-7:00 PM</td>
<td>Stephen Ainlay, PhD, President, Union College: “A College President’s Perspective on the State of Higher Education in America: Where it is, Where it Needs To Go, and How Can We Afford to Get There?”</td>
</tr>
<tr>
<td>7:00-7:45 PM</td>
<td>Thomas Lee, MD: “Health Access in Complex Emergencies: Burma;” Documentary: “The Black Zone” by Grace Baek (1 Hour CME)</td>
</tr>
</tbody>
</table>

### Saturday, January 14th

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30-8:30 AM</td>
<td>Tommy Korn, MD: “Spooky Eye Emergencies Not to Miss! - 2017 Update &amp; Review” (1 Hour CME)</td>
</tr>
<tr>
<td>8:30-9:30 AM</td>
<td>Tsuyoshi Mitarai, MD: “Ultrasound as a Stethoscope to Care for Critically Ill: Its Clinical Applications” joint lecture with MyPhuong Mitarai, MD (1 Hour CME)</td>
</tr>
<tr>
<td>9:30-9:45 AM</td>
<td><strong>Break</strong></td>
</tr>
<tr>
<td>9:45-10:45 AM</td>
<td>David Schriger, MD: “The Emergent Shoulder, A Case Review” (1 Hour CME)</td>
</tr>
<tr>
<td>10:45-11:45 AM</td>
<td>David Schriger, MD: “Literature Review” – “Relationship between Global and 1st World EM and How That Relates to the EP’s Behavior and Self Worth” (1 Hour CME)</td>
</tr>
<tr>
<td>12:00-1:15 PM</td>
<td><strong>Buffet Lunch: Onsite only</strong> (Yosemite Valley Lodge Garden Terrace – formerly Yosemite Lodge Garden Terrace)</td>
</tr>
</tbody>
</table>
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 2015-16 contributors (in alphabetical order):

- Alvarado Emergency Medical Associates
- Antelope Valley Emergency Medical Associates
- Beach Emergency Medical Associates
- Berkeley Emergency Medical Group
- Centinela Freeman Emergency Medical Associates
- CEP America
- Chino Emergency Medical Associates
- Coastline Emergency Physicians Medical Group
- Culver City Emergency Medical Group
- Eden Emergency Medical Group
- Hollywood Presbyterian Emergency Medical Associates
- Mills Peninsula Emergency Medical Group
- Montclair Emergency Medical Associates
- Napa Valley Emergency Medical Group
- Orange County Emergency Medical Associates
- Pacific Coast Emergency Medical Associates
- Pacific Emergency Providers
- Pacifica Emergency Medical Associates
- Riverside Emergency Physicians
- San Dimas Emergency Medical Associates
- San Francisco Emergency Medical Associates, Inc.
- Sherman Oaks Emergency Medical Associates
- South Coast Emergency Medical Group, Inc.
- Tarzana Emergency Medical Associates
- TeamHealth
- Temecula Valley Emergency Physicians, Inc.
- US Acute Care Solutions
- Valley Emergency Medical Associates
- Valley Presbyterian Emergency Medical Associates
- VEP Healthcare, Inc.
- West Hills Emergency Medical Associates
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

### DECEMBER 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>5th</td>
<td>Legislature Convenes 2017-18 Session</td>
</tr>
<tr>
<td></td>
<td>Sacramento, CA</td>
</tr>
<tr>
<td>8th at 10am</td>
<td>Government Affairs Committee</td>
</tr>
<tr>
<td></td>
<td>Conference Call</td>
</tr>
<tr>
<td>24th</td>
<td>Christmas Eve</td>
</tr>
<tr>
<td>25th</td>
<td>Christmas Day</td>
</tr>
<tr>
<td>25th – Jan. 1st</td>
<td>Hanukkah</td>
</tr>
<tr>
<td>26th – Jan. 2nd</td>
<td>Winter Holiday</td>
</tr>
</tbody>
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### JANUARY 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th</td>
<td>Legislature Reconvenes</td>
</tr>
<tr>
<td></td>
<td>Sacramento, CA</td>
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<tr>
<td>9th at 10am</td>
<td>Government Affairs Committee</td>
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<tr>
<td></td>
<td>Conference Call</td>
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<tr>
<td>10th at 9am</td>
<td>Reimbursement Committee</td>
</tr>
<tr>
<td></td>
<td>Conference Call</td>
</tr>
<tr>
<td>11th – 14th</td>
<td>Yosemite Medical Education Foundation’s Emergency Medicine in Yosemite</td>
</tr>
<tr>
<td></td>
<td>Yosemite National Park, CA</td>
</tr>
<tr>
<td>16th</td>
<td>Martin Luther King, Jr. Day</td>
</tr>
<tr>
<td></td>
<td>Chapter Office Closed</td>
</tr>
<tr>
<td>22nd – 28th</td>
<td>ACEP Wellness Week</td>
</tr>
</tbody>
</table>

### FEBRUARY 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>2nd</td>
<td>Board of Directors Meeting</td>
</tr>
<tr>
<td></td>
<td>Sacramento, CA</td>
</tr>
<tr>
<td>9th – 13th</td>
<td>Ohio ACEP Emergency Medicine Board Review Course (Co-Sponsored by California ACEP)</td>
</tr>
<tr>
<td></td>
<td>Courtyard Irvine Spectrum, Irvine, CA</td>
</tr>
<tr>
<td>17th</td>
<td>Legislative Bill Introduction Deadline</td>
</tr>
<tr>
<td>20th</td>
<td>Presidents’ Day (Observed)</td>
</tr>
<tr>
<td></td>
<td>Chapter Office Closed</td>
</tr>
</tbody>
</table>
ANAHEIM, CALIFORNIA: Anaheim Regional Medical Center’s Democratic ED Physician group has immediate part time/full time positions available for BC / BE Emergency Physicians. We have a busy, high acuity department with 44,000 annual visits. Shifts are 9-10 hours long with night shift/holiday differential and double coverage during peak hours. We offer a competitive salary, paid malpractice and full partnership opportunities.

Interested physicians E-mail your CV and references to vijay4@aol.com, amit4ten@aol.com or call us at 714-999-5112.

BAKERSFIELD, CALIFORNIA: Pinnacle Emergency Physicians (2007-present) with 3 local ED’s (10h shifts) seeking FT/PT, BC/BE docs (all trauma goes to the County Hospital)
- Memorial Hospital: 80k/y, STEMI, Stroke & Burn Receiving Center, currently 24/7 Peds, PICU, OB and adult hospitalist services… Peds ED opening 4/2017
- Mercy Downtown: 37k/y, Stroke Receiving Center w/ adult hospitalist services
- Mercy Southwest: 52k/y, Stroke Receiving Center w/ adult hospitalist services

Staffed by 40 FT/PT physicians and 40 FT/PT mid-levels. PT: $230/h, hotel provided.

FT: 120h/mo, full profit sharing after 2 1/2y plus CME, health, retirement contribution, paid malpractice with no tail, quarterly bonus, sign on bonus, interest free loan for moving expenses.

Income in top 5-10% nationwide. Low cost of living, white water rafting, mountain biking/hiking. 2h to DTN LA or central coast beaches, 4h to Mammoth, Las Vegas, San Francisco, San Diego.

Contact: Les Burson, DO, Medical Director phogku@aol.com 661-332-1064 or Dr. Kian Azimian, MD, Assistant Medical Director kianazimian@yahoo.com 661-616-8930

DOWNTOWN LOS ANGELES: Emergency Physician needed. $350,000 + incentive per year, malpractice paid, half days, half nights. ABEM ABOEM with experience. Present core group average 23 yrs tenure. 36,000 annual visits, paramedic receiving (no peds) STEMI Stroke, physician coverage 36-40 hrs/day, NP & PA coverage 12-20 hrs/day

FAX CV to 213 482 0577 or call 213 482 0588 or neubauerjanice@gmail.com

LOS ANGELES – CULVER CITY: Southern California Hospital at Culver City
Rare opportunity to join a Westside LA ER group. Group seeks BC/BE emergency physician to work Part-Time as an independent contractor. Excellent compensation with malpractice paid. Nine hour shifts with 11 hours of PA double coverage. 90% nights shifts are covered by night doctors. A complete ED refurbishment has been completed with an ER rebuild and expansion in the future. Computerized Charting and PACS!

Email CV and references to cclark@repmgt.org. Phone 951-898-0823.

NORTHERN CALIFORNIA, NAPA: Independent Medical Group is seeking qualified candidates to staff their minor emergency department. Candidates include: near retirement Emergency Physicians, Family Practice physicians, Urgent care Physicians or Emergency department Nurse Practitioners.
If interested, forward CV. to Tony Mottalei M.D. mottalei@gmail.com

RIVERSIDE, CALIFORNIA: Parkview Medical Center – Great opportunity to join a 14 year ER group. Group seeks BC/BE Emergency Physician to work Part/Full Time as an independent contractor. Excellent Top Tier Compensation based on productivity with malpractice paid. Ten hour shifts with MD double coverage and 12 Hour PA. Computerized equitable shift scheduling. Efficient Computerized Charting and PACS! A brand new ER expansion will break ground soon tripling the size of the ER!

Email CV and references to cclark@repmgt.com
Phone (951) 898-0823

SAN DIEGO, CALIFORNIA: Coastal San Diego emergency department seeking qualified, board-certified/eligible emergency medicine physician to join our independent, democratic group. Location is by the beach in Northern San Diego with year round outdoor life and outstanding schools. Tri-City Medical Center Emergency Department is a dynamic, high-acuity department with an excellent specialty call-panel, PGY3&4 Emergency Medicine Residents, and advanced practice PA’s. Practice is designed with quality of life in mind, including 8 hour shifts with overlap and extensive provider coverage. Salary potential reaches top 3% nationally. “A” Rated malpractice insurance with tail coverage provided.

Forward CV to Teresa Riesgo email: triesgo@tcemg.net phone: 760-439-1963


Email CV to leilani@farallonmed.com

SOUTHERN CALIFORNIA OPPORTUNITIES:
- Tustin, CA - Orange County - 73-bed community hospital, 8-bed ER, paramedic receiving, low volume. 10 x 24hr = $240,000/yr + incentive
- East Los Angeles - 120-bed community hospital urgent care (non paramedic receiving) volume 700/mo. Guarantee $100/hr.
- Norwalk, CA - 60-bed hospital, 500-600 patient/mo. Paramedic receiving. $110/hr.

FAX CV to 213 482 0577 or call 213 482 0588 or email neubauerjanice@gmail.com

SOUTHERN CALIFORNIA – ORANGE COUNTY: Full time and part time independent contracting emergency physicians needed for high volume, high acuity practices. Chest Pain Center, Stroke Center, Pediatric Level II trauma center - large independent group with forty years of clinical excellence for two acute care facilities. Expanding group needs BC/BE emergency physicians and pediatric emergency physicians. Excellent compensation, malpractice paid, scribes, midlevel providers, 8 – 9 hour shifts, excellent call panel coverage.

Email CV and references to EMSOC@emsoc.net, fax to 714-543-8914

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

EMREF offers the following California providers list:

**American Health Education, Inc**
Perry Hookey, EMT-P
7300B Amador Plaza Road, Dublin, CA 94568
Phone: (800) 483-3615
Email: info@americanhealtheducation.com
Web: www.americanhealtheducation.com

**American Medical Response (AMR)**
Ken Bradford, Operations
841 Latour Court, Ste D, Napa, CA 94558-6259
Phone: (707) 953-5795
Email: ken.bradford2@gmail.com
Web: www.americanhealtheducation.com

**American Medical Response (AMR)**
Ken Bradford, Operations
841 Labour Court, Ste D, Napa, CA 94558-6259
Phone: (707) 953-5795
Email: ken.bradford2@gmail.com
Web: www.americanhealtheducation.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
Web: www.cce.csus.edu

**CSUS Prehospital Education Program**
Derek Parker, Program Director
3000 State University Drive East, Napa Hall, Sacramento, CA 95819-6103
Phone: (916) 278-4846
Mobile: (916) 316-7388
Email: dparker@csus.edu
Web: www.winecountrycpr.com

**CSUS Prehospital Education Program**
Derek Parker, Program Director
3000 State University Drive East, Napa Hall, Sacramento, CA 95819-6103
Phone: (916) 278-4846
Mobile: (916) 316-7388
Email: dparker@csus.edu
Web: www.cce.csus.edu

**EMTS – Emergency Training Services**
Mike Thomas, Course Coordinator
3050 Paul Sweet Road, Santa Cruz, CA 95065
Phone: (831) 476-8813
 Toll-Free: (800) 700-8444
Fax: (831) 477-4914
Email: mthomas@emergencytraining.com
Web: www.emergencytraining.com

**Fast Response School of Health Care Education**
Lisa Dubnoff, MICP/RN, Paramedic Director
2075 Allston Way, Berkeley, CA 94704
Phone: (510) 809-3646
Fax: (866) 628-5876
Email: ldubnoff@fastresponse.org
Web: www.fastresponse.org

**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: L.Jones@ahs.llumc.edu
Web: www.llu.edu

**Medic Ambulance**
James Pierson, EMT-P
506 Couch Street, Vallejo, CA 94590-2408
Phone: (707) 644-1751
Fax: (707) 644-1784
Email: J.Pierson@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.napa-valley.edu

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

**Oakland Fire Department**
Sheehan Gillis, EMT-P, EMS Coordinator
47 Clay Street, Oakland, CA 74607
Phone: (510) 238-6957
Fax: (510) 238-6959
Email: sean@baycj.com
Web: http://www.oaklandnet.com/fire/

**PHI Air Medical, California**
Graham Pierce, Course Coordinator
801 D Airport Way, Modesto, CA 95354
Phone: (209) 550-0884
Fax: (209) 550-0885
Email: gpierce@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
Web: www.riggsambulance.com

**Rocklin Fire Department**
Chris Wade, Firefighter/Paramedic
3401 Crest Drive, Rocklin, CA 95665
Phone: (916) 625-5311
Fax: (916) 725-7044
Email: Chris.Wade@rocklin.ca.us
Web: www.rocklin.ca.us

**Rural Metro Ambulance**
Brian Green, EMT-P
1345 Vander Way, San Jose, CA 95112
Phone: (408) 645-7345
Fax: (408) 275-6744
Email: brian.green@metro.com
Web: www.metro.com

**Santa Rosa Junior College Public Safety Training Center**
Bryan Smith, EMT-P, Course Coordinator
5743 Skyline Blvd, Windsor, CA 95492
Phone: (707) 836-2907
Fax: (707) 836-2948
Email: medic9001@comcast.net
Web: www.santarosa.edu

**WestMed College**
Brian Green, EMT-P
5300 Stevens Creek Blvd., Suite 200, San Jose, CA 95129-1000
Phone: (408) 977-0723
Email: jonesbs777@hotmail.com
Web: www.westmedcollege.com

**Verihealth/Falck Northern California**
Ken Bradford, Training Coordinator
2190 South McDowell Blvd, Petaluma, CA 94954
Phone: (707) 766-2400
Email: ken.bradford@falck.com
Web: www.verihealth.com

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EMREF is a proud sponsor of California ITLS courses.

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

Please call 916.325.5455 or E-mail Lucia Romo: lromo@californiaacep.org for more information.
The course physicians have trusted for 32 years!

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*Boost Confidence! Reduce Stress! Pass the Exam!*

February 9 - 13, 2017
Irvine, California

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