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Welcome new members!

Linnea Lantz
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Tri-City Emergency Medical Group
University of California, Irvine Medical Center Emergency Physicians
Dear Fellow Members,
The men and women of emergency medicine (EM) save lives and reduce suffering every day and night for all who seek our care. We turn away no one and care for all, using our hard earned skills. We lead our emergency department (ED) teams. We teach and mentor to prepare the next generation of EM doctors to care for patients. You are my heroes. As we begin a new year it is a great opportunity to reassess our personal and professional priorities and to make sure our plans and actions are consistent with our goals. California ACEP can look to our mission and vision statements to help us refocus:

THE MISSION
California ACEP’s mission is to support emergency physicians in providing the highest quality of care to all patients and to their communities.

THE VISION
California ACEP’s vision is that all people in California have timely access to high-quality emergency care, which is recognized as an essential public service. The emergency physician is the recognized leader and coordinator of a healthcare team capable of a comprehensive response to the medical needs of our patients and community. We promote and protect the personal and practice rights, safety, wellness and longevity of emergency physicians.

Your California ACEP staff, board members, and other Chapter leaders seek to meet this mission and reach for this vision by working in the spheres of advocacy, member services, and education. I will focus primarily on advocacy, as it is here that I believe our most meaningful work is done on behalf of our members and patients. Advocacy is an activity, by an individual or group, which aims to influence decisions within a system. Consistent vigilance to protect our members’ interests: patient access to care, fair payment, adequate resources, and a risk environment that supports high quality and high value emergency medicine. CEMAF, the California Emergency Medicine Advocacy Fund, was created to support California ACEP’s comprehensive advocacy program that fights for emergency medicine through legislative, legal, and regulatory advocacy and through public relations and media outreach. CEMAF is funded through group contributions. If your group is not making an investment in your future by contributing, please contact the Chapter office. Our Executive Director, Elena Lopez-Gusman and one of our Board Members would like to visit your group to explain why your group investment in CEMAF is essential for Emergency Medicine in California.

To complement and assist in the work described above, the Chapter has formed committees, working groups, and task forces chaired by Chapter leaders. While only some of the committees are required by our bylaws, all help carry out needed functions of the Chapter. Committees include:
- Board of Directors
- Executive
- Government Affairs
- Finance
- Reimbursement
- Awards
- Nominating
- Officer Nominating

WORKING GROUPS AND TASK FORCES
Working groups and task forces are formed at the discretion of the Chapter President to focus on Chapter priorities and initiatives. Working groups tend to focus on complex, multiyear, and ongoing initiatives where as task forces tend to have a more specific, short-term focus and goal. This year we have formed four working groups and four task forces.

WORKING GROUPS (WG)
Our working groups are:
- Annual Assembly: This is our annual Chapter conference, currently named AdvancED. This WG will help create the conference’s educational, social, and logistical plans.
Care Coordination: The value of EM includes our ability to gather and use front-end visit information and history, patient oriented interventions, and back-end visit coordination for disposition and resources. This WG will focus on using health information resources, evidence based interventions, and coordination with next step visits and resources to best meet patient needs.

Mental Health: Patients with mental health problems are coming to the ED in ever increasing numbers, often due to lack of outpatient resources. Once in the ED we often lack the capacity and linkages to get them where they need to go after the ED work is completed. This WG will work on understanding and improving the care and flow of ED patients with mental health problems.

Public Health: Evidence based EM can often result in better care at a lower cost that is safer and more satisfying to the patient, family, and provider. The WG will seek to translate evidence-based knowledge for our members to use at the bedside with patients and families for shared decision-making.

TASK FORCES (TF)
Our task forces are:

ED Violence: All members of the ED team are at risk of being assaulted and injured while caring for patients. This TF will explore ED violence and what emergency nurses and physicians can do together with hospitals to mitigate this risk.

Human Trafficking: Present day slavery manifests itself throughout the world, including the United States, in persons who are trafficked. Akin to child abuse, domestic violence, and elder abuse, human trafficking can be recognized and managed. The ED is the place within the health care system most likely to encounter those who are victims of human trafficking. This TF will provide members with the tools to recognize and address this issue.

Community Paramedicine: This TF will address the issues of Community Paramedicine, (i.e. paramedics with additional training who take on community provider roles). Specifically, the Chapter’s patient safety concerns with alternative destination programs for 911 callers will be explored.

Maddy Fund Implementation: After the huge victory of sustaining the Maddy Fund intact for another ten years, this TF of the Reimbursement Committee will work to provide tools to help implement Maddy Fund programs in counties that have not implemented the second portion of the Maddy Fund.

We have an ambitious agenda but are armed with the best team of any ACEP Chapter. If you are passionate about working on any of these topics, please contact the Chapter office at info@californiaacep.org and get involved.

Sincerely,

Larry
POTENTIAL CHANGES TO THE AFFORDABLE CARE ACT: What Experts are Saying After the 2016 Election

By Elena Lopez-Gusman & Kelsey McQuaid, MPA

In response to the many questions we’ve received from our members about the impact of the 2016 Election on healthcare in California, we’ve assembled the information and rumors we’ve heard as of mid-December.

During the 2016 campaign, President-elect Donald Trump supported a repeal of the Affordable Care Act (ACA). Republicans in Congress have sought to repeal the ACA since gaining majorities in both houses, but all attempts were vetoed by President Barack Obama. At the time this article was written, there were no clear proposals in place for how Congressional Republicans intend to repeal the ACA and replace it.

On December 12, 2016, Senate Majority Leader Mitch McConnell (R-KY) told reporters that “[Republicans] will move right after the first of the year on an Obamacare repeal resolution.”

One possibility is a repeal of the law, but with delayed implementation, so as to have made good on a campaign promise while buying time to figure out how to actually make policy changes that work and that their constituents will like. It is unlikely that the entirety of the ACA will be permanently repealed. Democrats in the Senate will be able to filibuster and block any legislation that proposes an outright repeal. The more likely option, as alluded to by Sen. McConnell, is that funding for ACA subsidies and Medicaid expansion will be cut during the budget reconciliation process. Cutting funding through the budget process cannot be filibustered and only requires 51 votes; Republicans hold 52 seats in the Senate.

One ACA replacement plan that has people talking in Washington, DC is what’s known as the Patient Freedom Act, which was originally introduced by Senator Bill Cassidy (R-LA) in 2015. Under this bill, states would receive a sum of money to distribute to residents in the form of health savings accounts. These funds, intended to go toward paying insurance premiums, would be allocated based on age, not income. The Patient Freedom Act would also abolish the individual mandate to purchase insurance and the requirement that employers offer health insurance to their employees. Many health policy experts project that this plan would harm low income individuals.

California has benefitted from the ACA and, quite possibly, has the most to lose of any state if the ACA is repealed. Following the passage of the ACA, California fully embraced Medicaid expansion and created its own insurance exchange, Covered California. As a result, 3.7 million Californians who were not previously eligible for Medi-Cal are now covered by the program. Additionally, 1.4 million Californians have purchased private insurance through Covered California; nearly 89 percent of those people receive federal subsidies to help pay their premiums. Between Medi-Cal and Covered California, approximately 5 million Californians receive health insurance as a result of the ACA.

Covered California has continued to make clear they are open for business and to urge Californians to purchase health insurance for 2017. So far, their efforts have paid off. In mid-December over 25,000 new enrollees purchased health insurance from Covered California in the span of two days, bringing the total to 153,000 sign-ups and 1.2 million renewals as of December 14th.

According to the UC Berkeley Center for Labor Research and Education, California is expected to lose over $20 billion a year in federal funding for Medicaid expansion and Covered California subsidies if the ACA is repealed. Governor Jerry Brown and other state officials have not said how they will deal with that type of loss in revenue and the Governor is not likely to include cuts in his initial draft of the State Budget that will be released on January 10, 2017, prior to the inauguration.

California voters approved two ballot propositions in November that intended to raise Medi-Cal provider reimbursement rates, Propositions 55 and 56.

Proposition 55 extends existing tax rates that were enacted in 2010. Prop. 55 creates a new state budget formula that requires 50 percent of excess General Fund revenues be allocated to Medi-Cal, up to $2 billion. These funds are meant to supplement, rather than replace, existing General Fund monies that go to Medi-Cal. However, the first priority for funds is education and rumors among insiders suggest that all of the Proposition 55 funds will likely go to education with none remaining for health care.

Proposition 56 increases the tobacco tax in California. The funds are distributed to existing tobacco tax funded programs, administration of the tax, enforcement, physician training, treatment of dental diseases, and audits of funds collected under the new tax. After those programs are funded, 82 percent of remaining funds go toward funding Medi-Cal services, tobacco use prevention, disease prevention, and school programs aimed at reducing tobacco use.

Most health policy experts in California anticipated a small increase in Medi-Cal provider reimbursement rates as a result of these two measures, but loss of federal funding could eliminate these anticipated reimbursement increases. Insider rumors suggest it is highly likely that this revenue stream will be diverted to help offset the potentially devastating federal cuts. Officially, the state is waiting to see what happens at the federal level with the ACA and Medicaid expansion before they say what impact these initiatives will have on provider rates.

We will keep our members updated on changes at the federal and state levels as we get more information in the coming months.
OH DEER!

IS IT TIME TO RENEW?

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Introduction: Alternative destination transportation by emergency medical services (EMS) is a subject of hot debate between those favoring all patients being evaluated by an emergency physician (EP) and those recognizing the need to reduce emergency department (ED) crowding. This study aimed to determine whether paramedics could accurately assess a patient’s acuity level to determine the need to transport to an ED.

Methods: We performed a prospective double-blinded analysis of responses recorded by paramedics and EPs of arriving patients’ acuity level in a large Level II trauma center between April 2015 and November 2015. Under-triage was defined as lower acuity assessed by paramedics but higher acuity by EPs. Over-triage was defined as higher acuity assessed by paramedics but lower acuity by EPs. The degree of agreement between the paramedics and EPs’ evaluations of patient’s acuity level was compared using Chi-square test.

Results: We included a total of 503 patients in the final analysis. For paramedics, 251 (49.9%) patients were assessed to be emergent, 178 (35.4%) assessed as urgent, and 74 (14.7%) assessed as non-emergent/non-urgent. In comparison, the EPs assessed 296 (58.9%) patients as emergent, 148 (29.4%) assessed as urgent, and 59 (11.7%) assessed as non-emergent/non-urgent. Paramedics agreed with EPs regarding the acuity level assessment on 71.8% of the cases. The overall under- and over-triage were 19.3% and 8.9%, respectively. A moderate Kappa=0.5174 indicated moderate inter-rater agreement between paramedics’ and EPs’ assessment on the same cohort of patients.

Conclusion: There is a significant difference in paramedic and physician assessment of patients into emergent, urgent, or non-emergent/non-urgent categories. The field triage of a patient to an alternative destination by paramedics under their current scope of practice and training cannot be supported. [West J Emerg Med. 2016;17(6)690-97]
INTRODUCTION

Expanding the role of emergency medical services (EMS) has become an emerging topic of conversation given the need to expand local access to healthcare resources for communities and their residents. It is estimated that in 2011, national emergency department (ED) visits totaled 131 million, or 421 ED visits per 1,000 population. The total number of these ED visits that could be considered non-urgent has been difficult to determine, with numbers ranging from 4.8% to 90% of visits. The criteria used to determine non-urgent of a patient presentation have proven difficult to establish with multiple reports using different definitions.

California Health and Safety Code Division 2.5, section 1797.52, requires that all patients who call 911 be taken to an acute hospital with a basic or comprehensive ED to receive further evaluation by medical staff. However, it has been proposed that some 911 calls for low-acuity conditions could potentially be diverted to non-ED settings such as urgent care clinics or primary care offices, possibly reducing the crowding and long wait time seen in many EDs and, as a result, reduce the cost of healthcare.

In July 2013, a report published by the Institute for Population Health Improvement, University of California Davis Health Systems underlined possible changes to the current California EMS system. Included in this report was the proposal that patients with specified conditions not needing emergency care could be transported to non-ED locations or alternative destination transport. The alternative destination locations listed included mental health facilities, urgent care clinics or primary care offices. Multiple published national reports estimate that 11% to 61% of ambulance transports may not require immediate care in the ED. Based on this report, the Emergency Medical Services Authority (EMSA) has initiated pilot programs in California to study the feasibility of alternative transportation. As of 2016, four pilot programs have been approved to study alternative transportation destinations in California.

In those circumstances where EMS providers encounter patients who do not need advanced life support (ALS) level of care or evaluation at an ED, transportation to an alternative destination may be more cost effective. EMS systems with proper resources along with close medical oversight may be good candidates for implementation of such a program. However, the majority of research in this area has concluded that there is currently insufficient evidence to support widespread implementation of non-transport and alternative destination protocols.

This pilot study aims to assess the accuracy of the paramedic’s assessment of a patient’s acuity level and identify areas of improvement in prehospital patient care. In addition, the findings from this pilot study could be used to address any deficiencies in paramedic training, which in turn could strengthen the programs for alternative transport destinations.

METHODS

Study Design and Setting and Selection of Participants

This is a prospective double-blinded study analyzing the responses recorded by paramedics versus licensed emergency physicians (EP) of patients transported to Arrowhead Regional Medical Center (ARMC) by licensed paramedics with Rialto Fire Department (RFD) between April 2015 and November 2015. RFD’s California state-licensed paramedics serve a population of 101,109 in a 22.37 square mile urban setting located in San Bernardino County, the largest county in the United States. RFD responded to 7,617 calls for medical assistance in 2015. The RFD has 45 paramedics trained to provide ALS, including administering medications, establishing vascular access, advanced airway placement, cardiac rhythm interpretation and defibrillation. During the study period, RFD ambulances transported 1,720 patients to ARMC, of which 505 were randomly selected for this study.

ARMC is a 456-bed acute care hospital in Colton, California. ARMC is the only American College of Surgeons-verified Level II trauma center serving San Bernardino County. ARMC ED is the second busiest in California and has an annual volume of more than 116,000 visits. Additionally, more than 12 ground and air providers transport patients to ARMC. These providers operate within the 20,000 square miles of San Bernardino County and provide coverage for a mix of urban and rural communities with a total population of over 2.1 million.

The EPs responsible for collecting data were board-certified in emergency medicine or senior level emergency medicine residents with completion of three or more years of training. The institutional review board of ARMC approved this study.

Data Collection and Processing

We calculated the degree of agreement between the paramedics’ and EPs’ evaluation of emergent, urgent, and non-emergent/urgent patient presentations transported by paramedics. Emergent conditions were defined as requiring immediate attention with threat of life. Urgent conditions were defined as requiring immediate attention without threat of life that could go to a non-ED facility. Lastly, non-emergent/non-urgent was defined as patients not requiring transportation.

The primary outcome was agreement on the acuity level assessed by paramedics and EPs, respectively. Agreement was defined as the same acuity level being assessed by paramedics and EPs. Under-triage was defined as a lower acuity assessed by paramedics but a higher acuity by EPs. Over-triage was defined as a higher acuity assessed by paramedics but a lower acuity by EPs. To decrease the variability of the outcome, this study was limited to one group of paramedics with similar education, regulatory oversight, and medical supervision. Furthermore, the geographic region and population sampling was also limited to one particular area.

Upon evaluation of each patient in the field, RFD paramedics completed an evaluation form (Figure 1) indicating the chief complaint of the patient being transported, the body system affected, and the decision as to whether there was an emergent/urgent versus non-emergent/non-urgent condition. Each form was then placed in a sealed envelope and handed to the receiving EP along with a corresponding blank evaluation form (Figure 2). The receiving EP would then complete the form immediately after physical evaluation and place both surveys in a large sealed envelope. The receiving EP had no knowledge of the responses recorded by RFD paramedics.

Statistical Analysis

We conducted all statistical analyses using the SAS software for Windows version 9.3 (Cary, NC). Descriptive statistics were presented as frequencies and proportions for categorical variable. We performed a crosstab analysis to assess the inter-rater reliability (Kappa statistic) between paramedics’ and EPs’ assessment on patients’ conditions. All statistical analyses were two-sided. We considered p-value < 0.05 to be statistically significant.
**RESULTS**

A total of 503 patients transported by EMS had surveys completed by both a paramedic and an EP who evaluated their acuity level and presenting chief complaint with the corresponding body system affected. Two surveys were excluded due to missing acuity evaluations by paramedics, which led to a final sample size of 503. Among these 503 patients, 251 (49.9%) were assessed to be emergent, 178 (35.4%) as urgent, and 59 (11.8%) non-urgent by paramedics, which led to a final sample size of 503. Among these patients, 224 (89.2%) were assessed as emergent, 25 (10%) as urgent, and 2 (0.8%) as non-urgent by the EPs.

We conducted three subgroup analyses to identify the discrepancy between paramedics’ and EPs’ assessment on patients’ acuity level. The first subgroup analysis is considered as “over-triage,” in which paramedics evaluated patients at a higher acuity level but the EPs’ evaluation of the same cohort of patients were at a lower acuity level (Table 2). The four systems most frequently over-triaged by the paramedics were neurological (n=10, 22.2%), musculoskeletal (n=8, 17.8%), cardiovascular (n=6, 13.3%), and gastrointestinal (n=5, 11.1%). The second subgroup analysis was considered as under-triage, in which paramedics evaluated patients as lower acuity level but EPs evaluated the same cohort of patients as a higher acuity level (Table 3). The four systems most frequently under-triaged by paramedics were neurological (n=14, 14.4%), musculoskeletal (n=8, 13.3%), cardiovascular (n=6, 13.3%), and gastrointestinal (n=5, 11.1%). The third and last subgroup analysis was considered as correct triage, where paramedics and EPs made the same assessment on the patient’s acuity (Table 4). The four systems most frequently correctly triaged systems assessed by paramedics were neurological (n=73, 20.2%), musculoskeletal (n=68, 20.6%), cardiovascular (n=59, 16.3%), and gastrointestinal (n=54, 17.8%).

**DISCUSSION**

The study aimed to determine the level of agreement between paramedics and EPs in their evaluation of the acuity of the patient and presenting condition.
the physiological systems involved. Paramedics agreed with EPs on 71.8% of the patient cohort regarding the assessment of the acuity level. The overall over-triage rate was 8.9% and the under-triage rate was 19.3%. There is significant difference in paramedic and physician classification of the alternative destination for emergency evaluation. Based on this pilot study, there is room for improvement in evaluation of those urgent and non-emergent/non-urgent patients as assessed by paramedics.

Morganti et al explored the topic of expanding the range of EMS transport options and the difficulties posed by such a change in current policy.5 This included the question of whether EMS providers can accurately identify patients who can be safely managed in a non-ED setting. Of special concern was the under-triaging of patients seeking access to emergency medical care. The reported under-triage rate in the current study was 19.3%, which was consistent with previous findings by Morganti et al, where they reported a wide range of rates (3% to 32%) of EMS personnel failing to recognize the severity of patients’ problems.5 This current study contributes to the literature by listing the four most frequently under-triaged systems by paramedics. It is our goal to use the data from this pilot study to attempt to institute further training for paramedics to distinguish potentially emergent conditions from the urgent or non-emergent/non-urgent to prevent under-triaging. For example, this may include decision rules depending on patient's chief complaint, medical history, and age, which paramedics could use prior to labeling a patient as not requiring emergency room care.

However, many issues must be addressed to ensure the quality of alternative transportation and destination programs with patient safety as the upmost priority. EMS programs need to ensure implementation of continuous quality improvement of policies and procedures. One of the most essential steps is to develop educational programs for EMS personnel, physicians, and the community that encourage teamwork and improve compliance with established emergency medical dispatch criteria, particularly among the four systems most frequently associated with the 8.9% over-triage and 19.3% under-triage rate. Furthermore, any future studies and educational programs must ensure that alternative transportation and destination decisions are consistent with medical necessity and with consideration for patient preference and when the patient’s condition allows. This may call for more oversight and supervision of paramedics if alternative destination becomes a reality. EP supervision could be also implemented by using new technologies such as telemedicine.

A reduction in the use of EDs for non-emergency conditions, a practice that has often been suggested as contributing to the rising costs of healthcare, will ultimately require a multi-disciplinary approach. Diverse demographic and socioeconomic characteristics influence patients who contact 911 for ambulance transport, including a patient’s perception of his own acuity level and of how quickly an urgent care or primary care physician could address his complaint.1,5,13,14 Ultimately, the ED is a safety net for patients, especially for those without a primary care physician or patients with chronic medical problems who require treatments best addressed in the ED. Part of the solution will require the involvement of case management, individualized care plans and information sharing.8,14,15 Telemedicine services may also offer opportunities for supporting patient management in prehospital care. With the introduction of smartphones over the past decade, telemedicine services have grown...
in the U.S. and many hospitals have implemented their use. The ability to interact remotely with patients and EMS personnel is applicable in many ED settings. Because this method of communication provides instant, high-quality medical consultation, the result is an improvement in prehospital patient care. It is well recognized within the medical community, including professional emergency medicine organizations, that scientifically supported introduction of telemedicine services may improve quality of care. Adoption of this technology, however, has been slow and in some cases impeded by resistance from some state licensing boards and the reluctance of some private and government payers to reimburse for such services.16-18

Lastly, legislators will also have to support appropriate compensation for EMS systems based on patient evaluation and treatment as well as on alternative destination transport. Currently, the Centers for Medicare & Medicaid Services (CMS) only reimburses transport that is both “reasonable” and “medically necessary,” with the majority of Medicare-reimbursed ambulance calls involving transport to the ED.5 Additionally, payment for 911 service EMS ground transport is tied to level of service (BLS versus ALS), with private insurances following the lead on reimbursements made by CMS.5

LIMITATIONS
This pilot study was subject to a few limitations that could potentially alter the outcome of our findings. We attempted to design a system that would allow EMS providers to make their evaluations without physician influence by having paramedics complete their forms prior to arrival to the ED. However, the current study does not take into account the influence on paramedics by the base station’s contact with the mobile intensive care nurse and/or EP. Even if prehospital influence from base contact were removed, there were instances when paramedics were unable to complete their forms prior to arrival due to patient acuity, shorter travel times, and need for patient treatments and interventions. The result was that paramedics may have filled out the forms after being directed by a nurse or physician to a specific area of the ED based on acuity. This initial evaluation by a nurse or physician would likely influence (bias) the paramedic’s evaluation of the patient. Additionally, although EPs were directed to complete their evaluation forms after their own initial evaluation of the patient, many factors could alter their determination of acuity. The EP’s evaluation could have been influenced by the paramedic’s report and potential differential diagnoses offered, as well as by treatments administered (which may or may not have been necessary). The paramedic’s framing of his patient encounter could also have influenced the EP. Other factors that could have caused a discrepancy between paramedics and EP evaluation include changing chief complaints by the patients and evolving symptoms/signs. Clearly if a patient presents early on with minor symptoms in the field, a paramedic may determine a patient did not need emergent evaluation. However, during the transportation and waiting in the ED for a bed, the patient’s condition might evolve into a more serious condition. By the time the patient is evaluated by a physician, the acuity status and/or chief complaint could drastically change through no fault of the paramedic or his/her training. Language barriers between the patients and paramedics may have also contributed to discrepancies between the acuity level evaluations. EPs have access to translation services that paramedics do not.
not, which allows for additional information gathered on the patient’s chief complaint and medical history.

There is also the question of the difference in the definitions for acuity used by physicians and paramedics. While we attempted to use the same language for emergent, urgent and non-emergent/non-urgent by including these definitions on the surveys, either the physician or paramedic could have relied solely on experience when treating a patient presenting with a seemingly benign complaint that then resulted in a critical diagnosis made by the EP. Unfortunately, given that the paramedics’ job duties limit them to stabilizing and transporting patients to the ED for further evaluation, there is little opportunity for them to learn whether the patients ended up going home without any diagnostic testing or if their condition further deteriorated in the ED.

CONCLUSION

This pilot study demonstrates that there is a significant difference in paramedics’ and physicians’ assessment of patients into emergent, urgent, or non-emergent/non-urgent categories. Targeted education on field triage, strict protocols, direct supervision with medical monitors and utilization of telemedicine may improve EMS providers’ triage diagnostic ability. Additionally, supervision by emergency physicians using new technologies, such as telemedicine, and a resolution to the issue of lack of language translation services in the field may also improve paramedics’ triage of patients.

ACKNOWLEDGMENTS

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Lastly, although paramedics and physicians may have disagreed on their initial evaluations of patients, this may not have correlated with actual patient outcomes. No patient identifiers were included on either form completed by paramedics and physicians. This prevented tracking of a patient’s hospital course, admission versus discharge, and overall determination of the actual etiology and acuity of the patient’s chief complaint.

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

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TO THE BEST MEMBERS IN THE WORLD

happy new year!

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Registration is now open online at
www.yosemitemef.org
Early Bird closes November 15, 2016
2017 Emergency Medicine in Yosemite

January 11 - 14, 2017

“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

CME FACULTY

Paul Auerbach, M.D.
Ramin Tabatabai, M.D.
Christian Tomaszewski, M.D.

Dan Imler, M.D.
Graham Billingham, M.D.
Thomas Lee, M.D.

Tommy Korn, M.D.
Tsuyoshi Mitarai, M.D.
David Schriger, M.D.

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 Jeremey 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><strong>Guest Program</strong> (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><strong>Ranger Guided Group Hike</strong> (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>
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<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>
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### 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 Billingame 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><strong>Guest Program</strong> (Yosemite Lodge Bar):</td>
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<tr>
<td></td>
<td>Martha Chessie: “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><strong>Ranger Guided Group Hike</strong> (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>
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<tr>
<td></td>
<td>Charles Cramer: Photographer</td>
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<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>
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</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 III: 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 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
- 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
- VEP Healthcare, Inc.
- Valley Presbyterian Emergency Medical Associates
- 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.

### JANUARY 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>9th at 10am</td>
<td>Government Affairs Committee Conference Call</td>
</tr>
<tr>
<td>10th at 9am</td>
<td>Reimbursement Committee Conference Call</td>
</tr>
<tr>
<td>11th - 14th</td>
<td>Emergency Medicine in Yosemite Yosemite National Park, CA</td>
</tr>
<tr>
<td>11th at 2 pm</td>
<td>Mental Health Work Group Conference Call</td>
</tr>
<tr>
<td>16th</td>
<td>Martin Luther King, Jr. Day Chapter Office Closed</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 Sacramento, CA</td>
</tr>
<tr>
<td>9th-13th</td>
<td>Ohio ACEP Emergency Medicine Board Review (Co-Sponsored by California ACEP) Irvine, CA</td>
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<tr>
<td>20th</td>
<td>Presidents’ Day Chapter Office Closed</td>
</tr>
</tbody>
</table>

### MARCH 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>7th at 9am</td>
<td>Reimbursement Committee Conference Call</td>
</tr>
<tr>
<td>8th at 10:30am</td>
<td>GAC: Practice Management Subcommittee Conference Call</td>
</tr>
<tr>
<td>8th at 12:30pm</td>
<td>GAC: Reimbursement Subcommittee Conference Call</td>
</tr>
<tr>
<td>8th at 2:30pm</td>
<td>GAC: Injury &amp; Illness Prevention Subcommittee Conference Call</td>
</tr>
<tr>
<td>12th - 15th</td>
<td>ACEP Leadership &amp; Advocacy Conference Washington, DC</td>
</tr>
<tr>
<td>16th at 10am</td>
<td>Government Affairs Committee Conference Call</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

CALIFORNIA, CENTRAL COAST SAN LUIS OBISPO: A fantastic job opportunity. Seeking residency trained, BC/BE Emergency Physician. Democratic, established group with equal partnership and full benefit package. Progressive hospitals on the beautiful Central California Coast, half way between LA and SF. A spectacular place to live, work and play. The perfect place to build your career and raise your family.
Call 805-434-1869. E-mail: ccep@tcsn.net.

DOWNTOWN LOS ANGELES: Emergency Physician needed. $350,000 + incentive per year, malpractice paid, half days, half nights. ABEEM 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

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. Guaranteed $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
Looking for an ITLS course?

EMREF offers the following California providers list:

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

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

Compliance Training
Jason Manning, EMS Course Coordinator
3188 Verde Robles Drive, Camino, CA 95709
Phone: (916) 429-5795
Fax: (916) 256-4301
Email: Kurgan911@comcast.net

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

EMS Academy
Nancy Black, RN, Course Coordinator
1170 Foster City Blvd #107, Foster City, CA 94404
Phone: (866) 577-9197
Fax: (650) 701-1968
Email: nancy@caems-academy.com
Web: www.caems-academy.com

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

Loma Linda University Medical Center
Lynn 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@ahslumc.edu
Web: www.llu.edu

Medic Ambulance
James Pierson, EMT-P
506 Couch Street, Vallejo, CA 94590-2408
Phone: (707) 644-1761
Fax: (707) 644-1784
Email: jpierson@medicambulance.net
Web: www.medicambulance.net

Napa Valley College
Gregory Rose, EMS Co-Director
2277 Napa Highway, Napa CA 94558
Phone: (707) 256-4596
Fax: (916) 960-6296
Email: grose@napanavalley.edu
Web: www.winecountrycpr.com

NCTI – National College of Technical Instruction
Len Ruhtraub, Course Manager
333 Sunrise Ave Suite 500, Roseville, CA 95661
Phone: (916) 960-6284 x 105
Fax: (916) 960-6296
Email: jliass@csu.edu
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 Airport Way, Modesto, CA 95354
Phone: (209) 550-0884
Fax: (209) 550-0885
Email: gpierece@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
3001 Crest Drive, Rocklin, CA 95665
Phone: (916) 625-5311
Fax: (209) 725-7044
Email: Chris.Wade@rocklin.ca.us
Web: www.rocklin.ca.us

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

Santa Rosa Junior College Public Safety Training Center
Bryan Smith, EMT-P, Course Coordinator
5743 Skyline Blvd, Windsor, CA 95492
Phone: (707) 536-2907
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: jonesds777@hotmail.com
Web: www.westmedcollege.com

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

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

EMREF is a proud sponsor of California ITLS courses.

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

Ohio ACEP Emergency Medicine Board Review

Boost Confidence! Reduce Stress! Pass the Exam!

February 9 - 13, 2017
Irvine, California

Ohio ACEP in partnership with California ACEP is offering a course in February 2017 in Irvine, CA!

www.ohacep.org    |    (614) 792-6506