EPIC

The Magazine of the
Georgia College of
Emergency Physicians

SPRING 2010

Legislating Healthcare

- tort reform
- trauma funding
- medicare reimbursement
- Georgia's Supreme Court decisions

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Not only is it safe, but patients treated via REACH are treated 20 minutes faster than the national average at major centers around the country. **Read the full story on page 18**

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We welcome your comments or suggestions for future articles. Call or write at:

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My problem

Robert Cox, MD, FACEP, President, GCEP

My problem with the published magazine is that as I go to write about news and happenings today, due to the production schedule, it may be old news by the time you read it! This week, the president signed the "jobs bill" into law which included another 30-day patch to the flawed Sustainable Growth Rate (SGR) formula, so we begin another countdown to a 21% cut in Medicare reimbursement. (As you know, in simple terms, as Medicare expenditures rise, the formula calls for reduction in physician reimbursement and Congress has been passing temporary 'patches' without paying for them for years.)

A "doc fix" was included in the original comprehensive healthcare reform legislation to gain the support of the AMA, but was removed later as one of the mechanisms to allow the Congressional Budget Office to score the bill as "not increasing the deficit." Even though the publication delay, I feel comfortable asking you to please call or write your congressman as well as Senators Chambliss and Isakson (links on GCEP.org) to let them know that a patch is not enough and the SGR must go.

Is the comfort cynicism from knowing that we have been asking for this ever since I've been involved in organized medicine and I don't expect a change? No, it's the reality that healthcare policy is in flux and they need to hear we are tired of going hat in hand every year (and more recently every month) begging for fair, adequate, enough federal reimbursement to cover our federally mandated service to this country. Reform is off, reform is on, they have enough votes, they don't have enough votes, public option is in, public option is out. I don't know what the outcome will be when this gets to press. As a wise emergency physician recently said to me, emergency medicine is the "public option."

Your GCEP leadership participates in the multidisciplinary Southeast Division, American Heart Association (AHA) Mission: Lifeline committee. The Mission: Lifeline* findings are Class I recommendations for treatment of STEMI patients. We're there to provide expertise from the standpoint of emergency medicine, ED operations, and medical direction of the EMS system. The committee is charged with reviewing the current system of care, developing the ideal implementation system, addressing the gaps and barriers, and formulating recommendations for research, programs, and policy.

You would think it would be a "no-brainer" (no offense to the stroke sub-committee) to implement the recommendations but as they say, all politics are local. Take the simple line: *Each EMS system should maintain a standardized reperfusion STEMI care pathway that designates primary PCI as the preferred reperfusion strategy if initiated within 90 minutes of first medical contact or fibrinolytic therapy in eligible patients when primary PCI within 90 minutes is not possible*. Our committee has identified more than 20 issues and barriers in just this section. This topic was a major discussion item at my group's last ED meeting since we're a non-PCI hospital with a county Fire-EMS system in suburban Atlanta. As the committee continues its work, I want to hear from you about the problems and solutions you've experienced working on improving the system of STEMI patient care. We'll give updates as work progresses.

Georgia is making headway on implementing the NHTSA EMS Education Agenda for the Future. The Education Agenda was developed by a task force representing the full range of professions involved in EMS education, including EMS administrators, physicians, regulators, educators and providers. The document proposes an education system with five integrated primary components: The National EMS Core Content, Scope of Practice Model, Education Standards, Education Program Accreditation and Certification.

The Georgia Emergency Medical Services Advisory Committee has recommended the adoption of the National EMS Core Content and Education Standards and the Georgia Emergency Medical Services Medical Directors Advisory Committee has recommended the adoption of the National EMS Scope of Practice Model. Accreditation rules are still being worked on and the National Registry Exam serves as the National Certification exam.

You may recall, the Georgia Association of EMS dropped SB233 last year with the intent of bypassing the NREMT exam with a Georgia homemade exam. We are opposed to the idea of a homemade exam for paramedic certification. The wording of the bill, which currently sits in the Sharon Cooper's House Committee, directs: *No later than July 1, 2010, the board shall administer or approve one or more examinations for purposes of certifying and recertifying paramedics and cardiac technicians which measure competency directly related to the scopes of practice for paramedics and cardiac technicians*

My problem: continued on page 6

*http://www.americanheart.org/presenter.jhtml?identifier=3061071

from the president

Robert Cox, MD, FAAEM, FACEP
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Dr. Cox is a practicing emergency physician.

Legislative Day Update

Matthew J. Watson, MD, FACEP, President Elect, GCEP

Matt Watson, MD, FACEP
president.elect@gcep.org

A partner in Northside Emergency Associates, Dr. Watson graduated from Jefferson Medical College, and completed his Emergency Medicine Residency at Geisinger Medical Center in Danville, Pennsylvania.

On February 9, 2010 the Georgia College of Emergency Medicine hosted its Annual Legislative Day at the Georgia Capitol. It was another successful year, thanks to all of the dedicated Physicians and Legislators that take the time to get together and update each other on their perspectives of the issues. Over 30 legislators and 50 Emergency Medicine (EM) physicians met throughout the day, culminating with the luncheon roundtable.

As in the past, EM physicians met over breakfast to discuss issues currently at the forefront that were the key issues to discussions through out the morning under the "gold dome." This was followed by an update on GEMPAC, and its importance in helping the EM community protect its positions with the legislature.

This year we had the special privilege of having Joe Cregan, Esq. and Carrie Lowe, Esq. from MAG Mutual and Page Powell, Esq. from Huff, Powell & Bailey update us on some very important cases before the Georgia Supreme Court. GCEP's EPIC reviewed these cases in depth in the last issue. Briefly, before the Supreme Court at this time (and due for a decision any day now) are cases that are trying the constitutionality of certain issues that have protected us since the passage of tort reform in Georgia in 2005 . These cases are determining the constitutionality of the "gross negligence" standard, the non-economic damages caps, and a case about HIPAA issues regarding the defense attorneys ability to discuss the care rendered with witnesses.

Our luncheon was very well attended again this year, by our elected officials from both the House and the Senate. Many of them updated us on issues that they are working on in committee and on the floor, with topics such as seat belt laws for pick-up trucks, laws to limit or prohibit cell phone usage and texting while operating a vehicle, ongoing trauma system funding, the "hospital-bed" tax, passage of the super-speeder law last year, and many others.

We strongly encourage all of you to try to attend this great opportunity to meet with your legislators, and have open discussions on how and why they business they conduct under the "gold dome" directly effects the health of their constituents that put them in office. But just as important are the ways you can keep them informed during the remainder of the year.

Call your Representative or Senator, and invite them to your Emergency department, or meet them in their office. Let them know how tort reform and other legislation impacts your ability to render care. Finally, contribute to GEMPAC. The lobbyists and leaders of GCEP that meet and discuss these issues with the legislators need your help to support those politicians that are moving forward on the right issues that protect our great specialty.

Thank you Legislative Day attendees

Representatives
Kathy Ashe
Leah Barnett
Elly Dobbs
Margaret Kaiser
Tom Knox
David Lucas
John Meadows
Billy Mitchell
Jay Neal
Tom Price
Jimmy Pruett
Tracy Webber
Joe Wilkinson

Senators
Buddy Carter
Greg Goggans
Johnny Grant
Judson Hill
Ralph Hudgens
Nan Orrock
Cecil Staton
Zack Johnson

GCEP Members
Clarence Carr, MD
Rob Cox, MD, FACEP
Ralph Griffin, MD, FACEP
Mike Hagues, MD, FACEP
Rob Higgins, MD, FACEP
Steve Holbrook, MD, FACEP
Ben Holton, MD, FACEP
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GE Malcolm Jr., MD, FACEP
James Nowakowski, MD, FACEP
Bob Risch, MD, FACEP
John Rogers, MD, FACEP
Stuart Segerman, MD, FACEP
Vida Skandalakis, MD, FACEP
Edd Thomas, MD
Matt Watson, MD, FACEP
K. Panch, MD, FACEP
Taj Adams, MD
Foyeke Adeyemo, MD
Karim Ali, MD
Ann Azcuy, MD
Jana Beckett, MD
Brad Bellard, MD
Ajay Bhatt, MD
Connie Chan, MD
Alan Chiem, MD
Jeremy Chou, MD
Brian Dougal, MD
Pat Eagleson, MD
Mark Fenig, MD
Miraim Fisher, MD
James Foster, MD
Kim Gardner, MD
Heather Gunn, MD
JP Hill, MD
Chichi Ikpe, MD
Melissa Jordan, MD
Jona Karlsonn, MD
Heidi Klein, MD
Eli Klovee-Smith, MD
Holly Krysiak, MD
Scott Kupriel, MD
George Leach, MD
John Lemos, MD
Sean Lowe, MD
Nidhi Mahendru, MD
Stephanie Marshall, MD
Jon Marti, MD
Chiatne McFarland, MD
Riddhi Merchant, MD
Wendi Miller, MD
Nicki Mlynski, MD
Nick Moseley, MD
Nee-Kofi Mould-Millman, MD
Vinh Ngo, MD
Rachel O'Malley, MD
Dave Powell, MD
Laurie Raborn, MD
Kelley Ralph, MD
Tiffany Sanders, MD
Seema Sharma, MD
Tyler Straach, MD
Trenae Thomas, MD
Laura Towater, MD
Anna Wasserstrom, MD
John Weston, MD
Hannah Woebkenberg, MD
Dan Wood, MD
John Woodruff, MD
Rebecca Wurster, MD
Dino Zaharis, MD
Joaquin Zalacain, MD

Get to know your Board of Directors: Mike Hagues, MD, FACEP

John J. Rogers, MD, FACEP, Secretary, GCEP

"My father owned his own medical advertising business and that then resulted in five to ten medical journals arriving in our home daily. In high school and college I did volunteer work with the National Ski Patrol. Perhaps that is how I got interested in medicine."

Mike did a rotating internship at Brooke Army Medical Center in 1979 and then was stationed at Fort Hood in Texas to complete his military obligation. He worked in both the ED and medical clinic, but in the summers was stationed at Fort Irwin with the 2nd Armored Division. Occasionally the excitement of a true emergency required a flight to Loma Linda Medical Center. "Arriving at a medical center in 'fatigues' during the early 80s was not something they were used to seeing in the ICU."

Working with PAs in the medical clinic afforded him a life long appreciation for what they do. At Fort Hood they handled the 50 plus patients who presented for 'sick call,' which allowed him the time to see the ones who required more care.

During this time the Army stared up its third emergency medicine residency program and he was invited to join. He was the first Chief Resident in EM at Darnall Army Community Hospital and completed his training in1982. Then was assigned to Martin Army Community Hospital at Fort Benning, Georgia. There he and his wife raised their three sons.

While moonlighting in the ED at the Medical Center in Columbus, he met Dr. Wally Griner, an early GCEP member. Through his influence Mike became active in GCEP. Eventually he served on the Board of Directors and was one of the original signers of the GCEP Articles of Incorporation. For six years he was the GCEP secretary/treasurer and has been a member of the Board or a Councillor for many years.

Once during the Democratic National Convention he had the pleasure of treating an excited delegate with SVT, all the while being televised nationally. He also was at courtside during the Olympic volleyball events.

Although he as worked at several hospitals in south Georgia and in Alabama, Mike has made Saint Francis Hospital in Columbus his professional home and has served as their ED medical director for the past 15 years. He now leads a group of 15 physicians in a democratic group. Teaching medical students who rotate through the ED is one of the benefits he enjoys.

Mike often serves as 'Doctor of the Day' at the State Capitol. "It is a fun diversion and every member of the Columbus delegation knows me. (See photo below).

He enjoys snow skiing, canoeing and participates in 'Paddle Georgia' every year. He also is the 'chief walker' during dog shows for his pedigree American Bulldogs. Mike has participated in nine marathon runs, though he now is happy to watch his son Roger in these races. Roger was a member of the UGA Cross Country team.

"Arriving at a medical center in 'fatigues' during the early 80s was not something they were used to seeing in the ICU."

Governor Sonny Perdue thanks Dr. Mike Hagues for his service as Doctor of the Day

breaking news

MAG says Georgia Supreme Court decision overturning tort reform is huge loss for patients

Tom Kornegay, Director of Communications, Medical Association of Georgia

ATLANTA – Gary C. Richter, M.D., the president of the Medical Association of Georgia (MAG), says Georgia's Supreme Court decision (*Nestlehutt v. Atlanta Oculoplastic Surgery*) overturning the 2005 tort reform law that put a $1 million limit on the damages that are associated with the "pain and suffering" that can be awarded during a medical liability lawsuit is a huge loss for patients in the state.

"Georgia's patients have enjoyed increased peace of mind because physician services have been far more accessible since Senate Bill 3 became law, so we are extremely concerned about this decision," says Dr. Richter, who also pointed out that there is no cap on "economic" damages (e.g., lost wages or medical expenses) in Georgia. He explains that tort reform has effectively reduced professional liability premiums and reinforced critical health care needs like obstetrical and general surgery services in the state.

"This decision is unacceptable and unsustainable, and I believe it's one that's going to energize and unify the physician community in Georgia," Dr. Richter says, adding that MAG has already begun assessing its legislative options. "I'm appealing to every physician in this state to join us in our advocacy efforts to mitigate the detrimental effects that this decision is going to have on our patients, as well as the practice environment."

He says that there are some 1,000 more physicians in Georgia since the tort reform law passed in 2005, according to a study of private practice physicians in the state by the Carl Vinson Institute of Government at the University of Georgia in Athens. The Atlanta-based gastroenterologist also explains that according to MAG Mutual Insurance Company, medical liability insurance costs are down by 18 percent in the state since 2005. Furthermore, he says that MAG Mutual has reported that its premiums have not increased since 2005. And Dr. Richter points out that the frequency of claims has decreased by 30 percent since 2004, according to MAG Mutual.

"Georgia's tort reform law has served as a catalyst for increased competition," Dr. Richter says. "There are now 18 insurance carriers writing $1 million or more in medical liability insurance policies for physicians in Georgia." He says this kind of free-market approach is consistent with MAG's efforts to promote "patient-centered" health care reform, adding that, "What's imperative is ensuring that patients have access to a physician in their time of need."

With more than 6,000 members, MAG is the leading voice for physicians in Georgia. Go to www.mag.org for additional information.

"I'm appealing to every physician in this state to join us in our advocacy efforts to mitigate the detrimental effects that this decision is going to have on our patients, as well as the practice environment."

—Gary C. Richter, M.D.
President, Medical Association of Georgia

Court's decision is a victory for state's physicians, citizens

MAG Mutual Insurance Company

ATLANTA, GA (March 15, 2010)

The Georgia Supreme Court today upheld an important provision of the tort reform legislation passed by the state's legislature in 2005. The decision upheld the law requiring a plaintiff to prove gross negligence by clear and convincing evidence in order to prevail in a lawsuit against a physician performing medical services in an Emergency Room or Department.

Darrell Grimes, President and Chief Operating Officer of MAG Mutual Insurance Company – the state's leading medical professional liability insurer – indicated that the decision is a victory for Georgia's physicians and patients. Mr. Grimes said, "We are pleased for the physicians and citizens of Georgia. The Court's opinion acknowledges the impact this law has had in preserving the availability and affordability of quality health care services. The ruling ensures that Georgia's patients will have a sufficient number of doctors staffing the state's emergency rooms."

In response to today's action by the Court, Dr. Roy Vandiver, the Company's Chairman of the Board, announced, "As a result of this decision, MAG Mutual intends to reduce its medical liability insurance rates for the state's Emergency Room physicians."

Formed in 1982 by Georgia physicians, MAG Mutual Insurance Company is headquartered in Atlanta and provides medical professional liability and other insurance, financial and practice management services to physicians throughout the state. MAG Mutual is the ninth largest medical liability insurer in the U.S. and is owned its physician-policyholders and led by its physician Board of Directors.

breaking news

MAG MUTUAL

Medical Association of Georgia protects us all

Earl Grubbs, MD, FACEP, MAG Delegate

Earl Grubbs, MD, FACEP
egrubbs777@comcast.net

Dr. Earl Grubbs practices Internal Medicine and Emergency Medicine at Paragon Emergency Physicians in Snellville, Georgia.

If you are not entirely happy with the AMA's blanket support of the healthcare bill just signed into law, YOU ARE NOT ALONE. The Medical Association of Georgia (MAG) sent its' delegates last November to the annual AMA House of Delegates meeting with a goal of passing a resolution to change the AMA's position. Unfortunately, they were unsuccessful in garnering the necessary support from the other states to pass that resolution.

"All politics is local." The fact that you are reading this demonstrates the fact that you are involved in "local" organized medicine. I would like to suggest that in addition to your involvement in GCEP that you also become a member of the Medical Association of Georgia. You can join MAG without the necessity of joining the AMA and yet still have your voice heard by the AMA through your MAG representatives.

Without the Medical Association of Georgia there would have been no Senate Bill 3 tort reform legislation. The passage of that law in 2005 has saved each of us tens of thousands of dollars on our malpractice premiums and saved many of us from hours of wasted time in frivolous litigation. MAG's diligence since 2005 has prevented introduction of legislation that would have diminished the positive impact of Senate Bill 3.

MAG is the main driving force behind efforts to improve our trauma system. Without MAG there would have been no monies distributed in 2009 and no future money from the "super speeder bill." We still have a long way to go and there are several bills currently being considered that address the long term financing of a statewide trauma system. MAG monitors the status of these bills and coordinates expert testimony when appropriate.

MAG is also there to protect us from the constant creep of non-physicians into treatment modalities originally limited to adequately trained doctors. Every year the chiropractor, mid-level provider, optometrist, and nursing associations attempt to expand their "scope of practice." MAG is there to protect our patients from those changes that might outwardly sound innocuous, but in reality could lead to disastrous outcomes.

MAG cannot succeed without your help; it needs your membership so it can claim to speak for Georgia's physicians, AND IT NEEDS YOUR MONEY. Membership is at a reduced rate of $275 the first year, gradually increasing over the next few years to a current maximum of $500. That kind of yearly investment to save tens of thousands of dollars and protect our patients through trauma and scope-of-practice legislation is MONEY WELL SPENT.

Log into www.mag.org and complete your application today (tell them "Earl sent you.") Don't let another day go by without membership; it's good for your patients, it's good for medicine, and it's GOOD FOR YOU.

My problem: continued

as established by the board; provided, however, that this shall not be construed to prevent the board from accepting other additional examinations for purposes of certifying and recertifying paramedics and cardiac technicians. Now, because of the Advisory Committee recommendations, we feel that the National Registry test is the only examination that meets the standards set. We will continue to work with the Georgia Association of EMS and support any legislation that promotes the Education Agenda.

Finally, I'd like to send a couple of shout outs: To John Rogers, MD, FACEP for organizing an excellent program in middle GA at the hand surgeons' castle, to Matt Watson, MD, FACEP for a superb job as emcee at the GCEP Legislative Day, and to Steve Davis from MAG Mutual for organizing our excellent legislative day speakers: esqs. Carrie Lowe, Joe Cregan from MAG and Page Powell from Huff, Powell and Bailey.

Looking forward to seeing you at the Summer Meeting at Hilton Head!

What MORE can I really do?

Rob Higgins, MD, FACEP, GEMPAC Chair

GEMPAC is asking for your help, five easy tasks. Please put them on your to do list.

1. Yes **DONATE** a minimum of $100 by checking the GEMPAC box on your ACEP dues annual statement. This is the easiest step and one of the most important. Politicians who support our causes need campaign donations to win. Our PAC almost doubled donations last year, this year we hope to reach $100,000 with everyone's help. Let me also add – in this partisan environment of national healthcare reform – that are donations are non-partisan, but pro-emergency medicine. We want people elected who understand our issues and push for our causes – from either party.
2. **ASK** your company, partnership, or group to match your donation. We'd like to see an easy doubling of every dollar you donate. Your company has saved thousands in malpractice premiums the past five years through Georgia tort reform. Pressure them to pass this savings on to GEMPAC. There are no state PAC corporate donation limits, so it's simple. This year GEMPAC will acknowledge all corporate donations in the December *EPIC*.
3. **ENCOURAGE** your partners in the ED to donate to GEMPAC too. They certainly will follow your trusted lead more than my simple requests. When everyone in the group has donated please let our office know so we can give you a well earned spot in our GEMPAC 100% Club.
4. **FIND** out who your Georgia Senator and Representative are and get their email addresses – if tort reform is overturned by the Georgia Supreme Court we will need their help.
5. **Schedule** a meeting with your legislators this summer. Talk about your issues in the ED and how they can help. Make them understand how and why we provide this safety net of healthcare for the public. If you have issues with Medicaid reimbursement let them know how it affects you. Tell them how tort reform has helped your ED. Give them a tour of your ED to explain access to care issues, on-call coverage gaps, and poor follow-up options.

Five simple tasks--please write them down and check them off as you complete them. You have plenty of time to do this. Too busy is not a valid excuse as we see our practice environment and pay slowly erode. This is not a task that we can ignore and expect things to improve. Don't let others carry the burden for you. We need 100% effort.

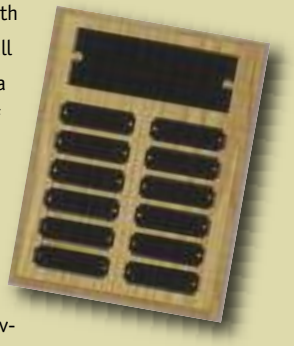
Rob Higgins, MD, FACEP
robhiggins@mac.com

Dr. Robert Higgins is the managing partner at Northside Emergency Associates.

Thank You GEMPAC Donors Jan/Feb 2010

Emma M. Watson
Rick A. Brewer
Kenneth J. Miller
Navin Patel
Carol Klingenberg
Wilfredo Rios
Cassandra B. Evans
Peter D. Steckl
Victor M. Camacho
Jacquelin M. Miller
Ulric A. Gilkes

GEMPAC 100% for Group Recognition



The Georgia College of Emergency Physicians in conjunction with the American College of Emergency Physician want to honor all practicing emergency physician groups who have demonstrated a commitment to excellence and recognized the importance of maintaining an active membership in their specialty organization. All professionals know the importance of ensuring strong leadership and high professional standards in their chosen field. Membership in your specialty organization provides you with up to date learning opportunities and conferences, allows the organization to remain vigilant and monitor the activities of government and how they effect our practice environment. The organization through yearly council meeting continues to strive for higher practice standards and supports state and local initiatives for research and improvement by providing grants to local chapters.

A plaque will be awarded to each group who has 100% membership of all eligible physicians in GCEP/ACEP. A yearly plate will be added for every year that 100% membership is maintained. This can be displayed in your hospital waiting room to make your patient population aware of the high standards of your group. Any application will be sent out for you to fill out if you have met this requirement. For groups that serve more than one hospital, a plaque for each department will be sent.

Applications for ACEP committees now open

American College of Emergency Physicians

Recently Dr. Sandra Schneider, the ACEP President Elect, sent a letter to ACEP members soliciting their application to serve on an ACEP national committee. Committee Interest Forms must be submitted to Rochelle Ross at ACEP (rross@acep.org) and must be postmarked no later that May 17, 2010. A copy of your CV should be included. The online application form is available at http://www.acep.org/CommitteeInterest.aspx. EMRA members who are interested in serving as that organization's representative on an ACEP committee should also apply.

ACEP Committee List

- Academic Affairs
- Audit
- Awards
- Bylaws
- Clinical Policies
- Coding and Nomenclature Advisory
- Compensation
- Disaster Preparedness and Response
- Education
- Emergency Medicine Practice
- EMS
- Ethics
- Federal Government Affairs
- Finance
- Medical Legal
- Membership
- National Chapter Relations
- Pediatric Emergency Medicine
- Public Health and Injury Prevention
- Public Relations
- Quality and Performance
- Reimbursement
- Research
- State Legislative – Regulatory
- Well-Being

Applicants will be notified by the end of July if they are selected. Members who are chosen will serve a minimum of one year beginning with the Committee's organizational meeting during the ACEP Scientific Assembly in Las Vegas this fall. Committee members will be asked to attend the organizational meeting.

Sandra Schneider, MD, FACEP
sschneider@acep.org

Dr. Sandra Schneider is the ACEP President Elect.

ACEP Looks Back at 2009

Dear Members:

As I reflect on 2009, I realize that together - the American College of Emergency Physicians (ACEP) and its individual members - achieved some significant accomplishments.

For example, when CMS announced a 21% cut in Medicare payments, ACEP increased its efforts to persuade the government to permanently replace the flawed Medicare payment system and adopt a fair and equitable model. When crowding and boarding impacted our practices, ACEP and its Boarding Task Force went on the

offensive, suggesting solutions and making sure the public and Congress knew that patient safety was being affected.

As your specialty organization, ACEP is your voice and responds to your needs as an emergency physician, every day.

Take a look at what we've accomplished together in 2009. Then, imagine what you as an emergency physician and we, as your specialty organization, will be able to accomplish in 2010. I look forward to it!

Angela F. Gardner, MD, FACEP
President

Angela F. Gardner, MD, FACEP
agardner@acep.org

Dr. Angela Gardner is the ACEP President.

We Fought for Equitable Reimbursement for Your Services

If you belong to ACEP for no other reason than to support its reimbursement efforts, then your membership paid for itself, and then some. That's because ACEP is emergency medicine's only representative on the AMA committees that determine physician reimbursement, fighting for fair reimbursement every day.

- ACEP's work on the AMA Physician Practice Inventory Survey produced a 2% increase in ED payments, transitioned over four years, replacing a projected decrease.
- ACEP successfully protected the CPT code for interpretations of 3-lead ECGs that will positively impact Medicare payments.
- ACEP representatives gained a favorable CPT clarification on the use of soft tissue ultrasound codes that broadened their availability for emergency physicians.
- ACEP filed compliance disputes against Anthem/Wellpoint and Humana to stop the practice of bundling separately billable services in the ED E/M codes. ACEP is contemplating future actions with payors.
- After California prohibited balance billing, ACEP rapidly created model legislation and support documents for states to use in fighting balance billing prohibition laws. The fiscal impact to emergency physicians: About 30% of revenue comes from balance billing charges for non-contracted payers.
- ACEP and all of organized medicine are united in efforts to permanently replace the flawed Medicare payment formula currently in use. We are urging Congress to enact stable and annual Medicare physician payment updates.

We Put Your Role as an Emergency Physician in the Media

Public support for, and the recognition of, emergency care as an essential community service is an important part of ACEP's advocacy agenda. To help generate grassroots support for emergency medicine in your community and throughout the country, ACEP continues to bring your story to the public.

- *USA Today*, working with ACEP members, published a 2-part cover story that showed millions of readers how emergency medicine positively impacts their lives.

- ACEP statements promoting emergency physicians as highly skilled and compassionate physicians were released in response to congressional and Obama administration misrepresentations that emergency care is expensive/inefficient.
- ACEP's strong, principled stand on the accusation that the University of Chicago engaged in "patient dumping," showcased emergency physicians and ACEP as patient advocates. The University of Chicago has since rescinded those policies.
- ACEP emphasized the impact of long wait times and emergency department crowding on patient safety to media outlets including CNN, Fox News, MSNBC, the *New York Times*, the *Wall St. Journal*, the *Washington Post* and the *Los Angeles Times*.
- ACEP's national public awareness campaign, "The Myths and Realities of Emergency Care," showcased EM as an essential community service that provides lifesaving care around the clock to communities throughout the country.

We Helped You Respond to a Growing Pandemic

H1N1 affected emergency departments throughout the country as patients crowded hospitals seeking care. ACEP developed a number of timely resources to help you manage this unexpected patient surge.

- ACEP's CDC-endorsed, "National Strategic Plan for Emergency Department Management of H1N1" was used by hospitals and clinicians throughout the world to help manage the tremendous patient surge caused by the virus.
- To help people who might have gone to the emergency department determine whether they needed emergency care, ACEP worked with experts on a self-assessment tool that was used by tens of thousands of potential patients, and according to Google, was one of the most searched for H1N1 items.

We Had New Insights on Critical Issues Affecting Your Practice

The development of evidence-based clinical policies that you can use in your everyday practice is a core mission of ACEP. In 2009, ACEP published two new clinical policies to help you manage high volume, high-risk complaints, and numerous other resources important to your practice.

- More than 10% of closed malpractice claims involving emergency physicians include the missed diagnosis of abdominal pain. ACEP's new clinical policy on suspected appendicitis was developed to help you manage those patients.
- Community-acquired pneumonia is a major health problem that has recently become the focus of The Joint Commission and CMS. ACEP's clinical policy critically evaluates the available evidence involving two often controversial critical issues in the care of CAP.
- ACEP developed new policy statements and information papers to advance the knowledge base in critical areas such as medical records in the ED, the impact of boarding patients on public health, staffing and production in the ED, free standing emergency care centers, and others.

We Gained Support for Emergency Care Legislation

To assure the unique interests of emergency physicians were included in health care reform legislation, ACEP members provided testimony to congressional committees while ACEP staff reviewed and provided suggestions on the various bills being considered.

- Because of ACEP's efforts, the bills under consideration in Congress include emergency medical care as an essential component. They also base payment on ACEP's prudent layperson standard.
- The ACEP-supported "Access to Emergency Medical Services Act" was reintroduced and quickly gained traction as both House and Senate members signed on to this legislation. The bill calls for a 10% increase in Medicare reimbursement for EMTALA-related care and directs the CMS to create quality measures to address boarding.
- Because every emergency physician could not be there, more than 350 ACEP members descended on Capitol Hill to urge their House and Senate members to pass ACEP-supported legislation.

We Worked for Regulatory Relief

ACEP is organized medicine's leading proponent for regulatory relief for emergency medicine. We work with Congress and regulatory agencies to reduce costly and counterproductive administrative burdens and modify or eliminate regulations that do not take into account the unique aspects of emergency medicine.

- The range of issues addressed in 2009 includes EMTALA, physician and hospital payment policies, Medicaid regulations for payment of GME, and many more.
- ACEP represents the specialty to the Joint Commission and in 2009 submitted comments on issues including standards for contracted

services, credentialing, privileging, medication management, patient safety goals, and others.

We Opened Doors for Our Specialty on Capitol Hill

ACEP's political action committee, NEMPAC, provides much needed access on Capitol Hill to ensure the voice of emergency medicine is included in the legislative process.

- Because of NEMPAC's size and influence, ACEP and emergency physicians are recognized by legislators as leaders in both the political process and in the development of sound health care policy.
- In the last election NEMPAC contributed to the campaigns of more than 200 successful candidates.
- NEMPAC heads into the 2010 elections as one of the largest and most influential physician specialty PACs and, with the continued support of ACEP members, is well-positioned to participate in the November congressional elections
- Recognizing health care reform as the top domestic issue of the Obama Administration and Congress, ACEP members donated more than $1,150,000 to NEMPAC.

You Received Free Access to all ABEM LLSA Articles

ACEP not only helps you prepare for the LLSA exam, it helps you strengthen your knowledge of emergency medicine with free access to the ACEP LLSA Resource Center.

- As an exclusive member benefit, ACEP has made all 69 LLSA articles available at no charge. Included for the first time are the articles published in JAMA. Members also have free access to LLSA article summaries as published in Critical Decisions in Emergency Medicine.

We Influenced Your Practice at the State Level

Membership in your state chapter assures you are properly represented in important local issues such as balance billing and malpractice caps.

- Results from the National Report Card on the State of Emergency Medicine allowed ACEP's chapters to pursue state advocacy initiatives on issues such as the development and funding of statewide trauma systems, support of residency programs and legislation to cap to liability awards.
- ACEP provided additional funding to chapters so they could influence important local and statewide issues such as balance billing and emergency care in rural areas.
- ACEP's free legislative tracking system gives your state leaders the tools they need to be more effective, while our electronic newsletter service lets your chapters keep you up to date on state activities.

Annals, Your EM Journal*, Is Honored as One of the Best*

ACEP Members receive one of the best and most influential medical journals free every month. Annals has not only changed the practice of emergency medicine, it has influenced the way other specialties think about emergency medicine.

- On June 16, 2009, Annals of Emergency Medicine was honored as one of the 100 most influential journals of the past 100 years by the Biomedical and Life Sciences Division of the Special Libraries Association of the US.

Scientific Assembly Helps You Provide the Best in Patient Care

The emergency medicine practice environment is changing rapidly, and there's no better place to improve your practice skills than ACEP's Scientific Assembly.

- The October meeting in Boston was the largest ever, with more than 5,000 emergency physicians, guests and exhibitors showcasing the very best the specialty has to offer.

We Improved Patient Care Through Research

The Emergency Medicine Foundation helps improve patient care by funding research in areas that are important to your practice.

- In 2009, the foundation awarded $384,000 in grants to fund research in important areas such as improved triage protocol, ultrasound, quality improvement, ED crowding, rural recruitment and other critical areas.

We Showcased a Real Need Through the Workforce Study

- The ACEP Workforce Study – the first in more than 10 years – was published in July 2009. The study highlighted the critical shortage of emergency physicians and its results will be used as ACEP pushes for more emergency medicine residency slots.

We Increased Membership and Advanced the Specialty

More emergency physicians than ever see the value in belonging to the most influential organization in the specialty.

- In 2009, ACEP's membership continued to grow, with more than 27,500 emergency physicians now part of the ACEP family.

We Prepared for the Unthinkable

ACEP is a leader in the development of disaster preparedness and response resources affirming that emergency physicians are setting the standard, not other organizations or agencies.

- ACEP revised Bombings: Injury Patterns and Care, a curriculum that is used throughout the world and has been credited with saving countless lives.
- ACEP led a task force to develop the core competencies for all-hazards disaster training for emergency physicians, emergency nurses and EMS personnel. The project will set a national standard for training acute care medical professionals to care for patients during disasters.
- ACEP is developing an online training course to improve preparedness, communication and cooperation between those responding to mass casualty disasters.

Non-compete agreements for physicians: Why does Georgia treat its doctors differently than it treats its lawyers?

David A. Olson, Attorney at Law
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Georgia courts, by and large, are on the vanguard when it comes to contemporary approaches to traditional issues. The same is not true, though, when it comes to restrictive covenants, or, more specifically, non-compete agreements. Generally, our courts disfavor any contract which imposes a restraint on trade, but they will allow an employer to restrict a former employee's competition subsequent to separation so long as those restrictions remain reasonable. The same courts, however, have established such an intricate and fragile web of rules when it comes to construction of these agreements that it has become near-impossible to enforce one that has not been drafted by a knowledgeable attorney. How does this affect physicians?

For ages, the law has been that covenants not to compete in physicians' employment contracts do not per se violate the state's public policy. If the restrictions are sufficiently limited and are reasonable in light of the business interest to be protected they will be upheld. This is an interesting contradiction to how Georgia treats non-compete agreements for lawyers, which will be discussed more below.

Employers of physicians and physicians themselves should demonstrate equal concern regarding the proper drafting of physician non-compete agreements. Employers must guard against common drafting errors such as failure to include an express, reasonable geographical description of the territory covered, or failure to specify clearly which specialties a physician is prohibited from practicing. On the other hand, a physician should closely review his or her non-compete agreement to ensure that its terms provide adequate security in the event his or her employment is terminated.

From an employer's prospective, ensuring that the restrictive covenants within the agreement are reasonable is imperative. In determining reasonableness, a three-part test is applied by Georgia courts, examining duration, territorial coverage, and the scope of the prohibited activity. Pittman v. Harbin Clinic Professional Assoc., 210 Ga. App. 767 (1994); See Azzouz v. Prime Pediatrics, P.C., 296 Ga. App. 602 (2009). These cases stand for the proposition that a restrictive covenant within an employment contract will be upheld if the restraint on trade is not unreasonable, is founded on a valuable consideration, is necessary to protect the interest of the party who is seeking to impose it, and does not unduly prejudice the interest of the public. Accordingly, it would behoove employers to hire legal counsel to draft or review the employment contract, as to ensure adherence to the above dictates, for failure of any single requirement invalidates the entire agreement. Georgia is one of the few states that will not "blue pencil" an employment contract, meaning the court will not modify or edit your contract to make it reasonable. Thus, if one part of a non-compete agreement is unenforceable, then any other restrictive covenants contained in that agreement become unenforceable, even if those other restrictions would withstand scrutiny standing alone. A single omission or drafting error by the employer can completely defeat the non-compete agreement in its entirety, leaving the employer jaw-dropped and empty-handed.

On the flip side, for the practicing physician, the importance of scrutinizing his or her employ-

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ment contract before putting pen to paper cannot be overstated. Imagine you signed a two-year employment contract with "ABC Medical Clinic." You are one year into your contract when the clinic decides it must reduce your pay as a result of current financial constraints. Unfortunately, your adjusted salary is not enough to cover your current expenses. A nearby medical clinic offers you a position with a comfortable salary. You let out a sigh of relief. But wait….regrettably, you signed a non-compete agreement with "ABC Medical" that prevents you from practicing within a 50-mile radius of "ABC's" facility, and your new job is located only 28 miles away. The only other position available is at a clinic 84 miles away. What do you do?

The key is to prevent this situation from ever occurring. At the outset of obtaining employment, you should approach the employment contract with the same degree of seriousness as you approach medicine. You could avoid the above scenario if you obtain legal advice on all restrictions in a non-compete clause. Additionally, your lawyer might have negotiated a buyout option or a reduced buyout amount, time period or geographic scope.

As stated, Georgia courts routinely hold physician non-compete agreements as valid. There is, however, a palpable trend occurring across the nation. Many states are beginning to hold physician non-compete agreements void as against public policy. For years, the American Medical Association ("AMA") stated that physician non-compete agreements are not "in the public interest." Further, the AMA states that non-compete clauses "restrict competition, disrupt continuity of care and potentially deprive the public of medical services." Georgia, however, has yet to adopt this approach with respect to physicians.

Contradictorily, current Georgia law prohibits attorney non-compete agreements. The comments to Rule 5.6 of the Professional Rules of Conduct governing attorneys states, in part, "[a]n agreement restricting the right of [a lawyer] to practice after leaving a firm not only limits their professional autonomy but also limits the freedom of clients to choose a lawyer." Does an agreement restricting the right of physicians to practice not limit their professional autonomy? Does it not limit the freedom of patients to choose a physician? Certainly we should not allow this incongruity to exist. Two cousin-professions being so disparately treated in the face of such similar rationales should clearly be found to be against public policy.

This apparent dichotomy seemingly presents avenues by which a skilled lawyer may argue the invalidity of non-compete covenants as violating public policy. While we may be on the cusp of a new era in physician non-compete agreements, the best advice presently is for employers, physicians, and their respective attorneys to sit at the table together in the spirit of compromise and draft a non-compete agreement that is reasonable for both parties. After all, the practice of medicine is about helping people, and that motivation should be present in all aspects of your highly esteemed profession, even in the employment contract.

Protecting your most valuable asset

Setu Mazumdar, MD, President and Wealth Manager, Lotus Wealth Solutions

Most physicians think of asset protection as shielding financial and physical assets from potentially catastrophic lawsuits, but there is actually a much larger asset we should be protecting first—our future income.

During every shift we see patients who have suffered an unexpected major injury or illness which requires them to miss work and substantially reduces their income: the 25-year-old who sustains multiple fractures from a motorcycle accident, the 40-year-old with no cardiac risk factors who has an acute MI, the 35-year-old with new onset seizure who has a brain mass. While most physicians have the "it can't happen to me" attitude, the statistics show otherwise. The best way to protect your future income stream is to buy individual disability income insurance.

The statistics

Data from the U.S. Census Bureau reveals that over 18 percent of working-age people have a disability and that almost half of these are classified as severe disabilities. Most estimates claim that the chance of disability before age 65 is nearly one in eight! For a 35-year-old male there is a 20 percent chance of becoming disabled, even higher for females. While a lot of physicians think they can continue working through a disability, the reality is that only about 26 percent of working people with a severe disability actually are employed. Even accounting for years of education, only about half of people with 16 or more years of education and a work disability are actually participating in the labor force. In 1992 almost 20,000 physicians and dentists had a disability according to the U.S. Census Bureau. While most physicians may have life insurance, at any working age, it is more likely that you will become disabled than die. For emergency medicine physicians in particular, we are also subject to the health effects of shift work, which increases our chances of injury after nightshifts and increases cardiovascular disease risk.

Amount and type of disability insurance

So, what should you look for in a disability insurance policy? The amount of coverage is fairly straightforward, since insurance companies limit the amount of coverage to roughly two-thirds of your monthly income to a maximum of about $15,000 for emergency medicine physicians. In other words in order for you to receive a disability benefit of $15,000 per month, you would have to make an income of $25,000 per month (or $300,000 per year). You should compare your current monthly spending habits to your disability benefits and make sure that you have adequate disability insurance to cover your expenses.

There are two basic types of disability coverage—group and individual. While it's great to have group benefits, realize that if your group is paying for your group disability policy, benefits from a group policy are taxable whereas benefits from an individual policy are not. Your income from a disability will already be lower than your emergency medicine income. Don't make this worse by just having a group policy for which you pay taxes on the benefit. This is why purchasing an individual policy is critical, but realize that there will be a limit on the combined amount of group and individual coverage.

Policy features

There are numerous provisions, options, and riders on disability insurance policies, but certain ones are essential. When you purchase individual disability income insurance, the most crucial decision is to define what

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Bylaws revision to be considered at annual meeting

John J. Rogers, MD, FACEP, Secretary, GCEP

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Dr. Rogers is the Secretary-Treasurer of GCEP.

A Bylaws Revision was undertaken to ensure GCEP followed the ACEP Model Chapter Bylaws, was compatible with the ACEP Bylaws, and was internally consistent. There were some areas of our currently Bylaws that required further clarification. It was also felt that the document should reflect what was our actual practice. Since this is a revision it must be considered as a whole. It is not a series of amendments to the previous version. A revision will only require a simple majority whereas amendments require approval by 2/3s. A copy of the current Bylaws, the ACEP Model Chapter Bylaws, and the proposed Revised Bylaws may be found on the GCEP Website, www.gcep.org. The ACEP Bylaws are available on the ACEP website, www.acep.org.

A brief outline of the major changes follows:

1. Terms of Office for all Officers are two years (previously one year)
2. President may only serve one term (previously could serve two terms)
3. The Office of Secretary and Treasurer MAY be combined or divided (currently they are combined)
4. Secretary/Treasurer may serve an unlimited number of terms (currently all Officers serve one year terms with a two term limit)
5. Directors may serve an unlimited number of terms (currently limited to two consecutive terms)
6. Councillors are elected by the BOD (currently elected by the members)
7. The composition of the BOD is clarified
8. Allows for official communication and notice by email etc. (currently notice is only by US Mail)
9. Shortens the notice requirements to not less than 30 days (currently 90 days)
10. Establishes a Tellers Committee to oversee elections

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constitutes a disability. Always buy disability insurance which has a very liberal definition of disability, commonly referred to as an "own occupation" policy. Essentially this means that if you are unable to work as an emergency medicine physician, you can still work in some other occupation, whether it's family practice or even some nonmedical career, and still collect disability benefits. These policies are much less common than they used to be and now insurance companies will modify this definition to mean own occupation for a limited amount of time, after which point the definition of disability changes to any occupation, meaning that you cannot receive benefits if employed in any other occupation.

It's been shown in several studies that over the past decade physician income does not keep pace with inflation, so it's vital that you purchase a policy with a cost of living adjustment. Essentially this feature increases your monthly benefit every year you are disabled to adjust for loss of purchasing power due to inflation.

A policy that is non-cancelable and guaranteed renewable is a must for physicians. This means that the insured physician can automatically renew the policy every year and that the insurance company cannot change the monthly benefit or the premium. For younger physicians just out of residency, having a policy that automatically increases your benefits (you must pay higher premiums) is also key because it forces you to purchase more insurance as your income increases and as you can afford it.

Finally, in the event that you can still work part time but with a reduced income, a policy which pays residual disability benefits will pay you a benefit equal to the lost income. So, for example an EP normally making $10,000 per month who becomes disabled but later can work part time making $ 5,000 per month would receive a residual disability benefit of $ 5,000 per month.

Conclusion

As emergency medicine physicians we've spent over a decade and well over six figures for our education and training. Purchasing individual disability insurance is a small price to pay in order to protect our single greatest asset.

Parental refusal of care in the seriously ill child

Peter Steckl, MD, FACEP

Scenario:

HPI: 7-year-old female with a history of chronic asthma presents with complaints of cough and increasing shortness of breath over the past two weeks. She has been admitted several times in the past with severe asthma attacks and was nearly intubated on the last visit six months ago but "pulled through."

PE: VS: P 154 RR 30 and labored, T 100.7. Pulse ox- 91% on Room Air.

Awake, alert and in moderate respiratory distress

Lung exam: Audible wheezes throughout and patient is moderately retracting.

EDC: She is placed on oxygen, given three aerosol nebulizer treatments and 2 mg/kg of Solumedrol IV with mild but incomplete improvement.

Reexam: Shows some diminution in the wheezes and improved air movement but tachypnea and retractions persist. Pulse ox is now 92% on RA, but when she walks to the bathroom she becomes grossly dyspneic and pulse ox is at 87% RA.

Disposition: You appropriately recommend admission for this patient, but the parents have grown tired of the ED experience and feel their daughter looks OK and would prefer she be discharged and give a try of therapy at home. You argue stridently against this plan, but to no avail. The family now is losing their patience and demands that the IV be discontinued so they may leave. You are torn.

A situation such as this can be one of the more trying experiences that an ED physician can endure. He/she is understandably conflicted between respecting the autonomy of the parents in decision making regarding their child and doing what is safe and right for the patient. In these circumstances, it is imperative that the physician understands the rights and responsibilities of all involved parties.

At times frustratingly ambiguous, the law is very clear in defining who is responsible for consent in the pediatric patient. As children are not considered of legal age to accept or refuse care, we normally look to the parents for guidance. However, if parental decisions can be expected to result in a threat to life, physicians are empowered to act in the defense of the child. Though such action can be uncomfortable, we can feel protected from liability by the legal principle of *parens patriae* which codifies the state's interest in assuring the well being of children. In the view of the courts the parents serve as guardians for the child, but they do not own him and thus cannot proceed down a path that is clearly detrimental to his ultimate wellbeing. Under this doctrine, when a child's health is seriously jeopardized the ED physician is authorized to take protective custody of the child as they would in any neglect case and perform procedures and/or disposition them in a manner that is safe and appropriate.

Though not desirable, in rare cases taking custody may be the only option. When necessary, the ED physician should take great care to explain to the parents that what is being done is in the best interest of their child and the rationale for taking such a drastic step. Explain that the action is a medical obligation under the law and it will be reported to the proper authorities including the hospital administrator, hospital attorney and child protective services. In many cases this discussion will be enough to cause the parents to stand down and allow one to proceed with planned treatment. If not, then one should feel comfortable proceeding in that legal protection from liability exists under child abuse and neglect statutes.

In noncritical cases, where the parents appear competent and there appears to be little danger to the wellbeing of the child, refusal of care by the parents is acceptable and typical AMA procedures should be initiated along with associated documentation of discussion of risks and competence of at least one parent.

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Dr. Pete Steckl is the Risk Management Director for Emerginet, LLC, Atlanta, GA and member of the MAG Mutual Claims Committee and a member of ACEP Medical Legal Committee.

Emory emergency medicine residency update

Phillip Shayne, MD, FACEP

Phillip Shayne, MD, FACEP
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Dr. Phillip Shayne is Associate Professor, Residency Director and Vice Chair for Education at Emory University School of Medicine.

Heading into the final stretch of residency, the Emory senior residents are busy finalizing their career plans. In a typical year about a third of our residents obtain academic positions and about two-thirds stay in Georgia – this year is no different. In a class of 18, three have accepted faculty position in ED's with residency programs – in Detroit, New York City and Wake Forest. Another three have secured fellowship positions, one each in ultrasound and sports medicine, and one will be Emory's first Academic Fellow. Those going into community practice are equally split between staying in Georgia and moving around the country. Fortunately, despite difficult economic times, none have had a problem getting great offers. And they deserve it, having worked hard for three years in difficult circumstances, surviving the near-closing of Grady and then this last more fun, but frenetic year of re-building and change.

Rachel O'Malley will be the department's first Academic Fellow upon graduation from the residency in June. She will join the faculty as a clinical instructor with protected time to develop her education interests. The fellowship year will include participating in the ACEP Teaching Fellowship, and the Medical Education Research Certificate (MERC) program at CORD. The teaching fellowship will form the structure for an academic project and she will spend the year focusing on simulation and observational medicine.

The rank list for the class of 2013 is now in and certified. This will be another banner year for Emergency Medicine with a record number of applicants and programs. Emory received 925 applications and interviewed about 190 students for 19 intern positions. Students are selected based on their academic record, real-life experience, history of community service, and sense of fit into an urban, academic program. We look forward to another stellar class.

The biggest programmatic change in the past year was the development of a dedicated ultrasound rotation in the first year. The recruitment of William Manson to join Mary Ann Edens in leading our ultrasound program allowed us to aggressively advance ultrasound training in the intern year. While the old curriculum had the residents obtaining their U.S. certificates by graduation, the class of 2012 will be finished with all of their U.S. requirements by the end of their intern year. The department is currently recruiting its first U.S. Fellow for the summer of 2010 and looks forward to an even more dynamic program next year.

The program is also looking forward to the successful implementation of a full scale EMR at Grady. On March 17 the EPIC tracking system went live for the ED, with the full system expected to be functional by the end of October. EPIC joins our new PACS system and new ultrasound machines as part of the capital improvements brought into Grady by the new Board. While a busy year, it has been a great time to be at Emory.

If you are wondering what happened to Emory's Crawford Long Hospital on the Atlanta connector across from Georgia Tech; it is now Emory University Hospital Midtown. The brand new facility has a beautiful ED which will see close to 60,000 patients this year. Since this type of urban, community setting most resembles the type of practice a majority of our residents enter, Midtown is an important and popular rotation in each year of the training program.

Nationally, the Emory program continues to be well represented. Kate Heilpern, chair of Emergency Medicine, is the immediate past president of the Society for Academic Emergency Medicine, and will step off the Board in June. Debra Houry, vice chair for Research is currently on the SAEM Board and is running for president. I will become the president of the Council of Emergency Medicine Residency Directors (CORD) in June, and Douglas Ander, assistant dean for Medical Education and Director of the Emory Center for Experiential Learning is slated to chair the CDEM (Clerkship Directors of Emergency Medicine).

And finally, we are excited for Arthur Kellermann, our founding chair, as he moves to his next venture. Dr. Kellermann has accepted a position with the RAND Corporation to lead their Washington, DC-based program in preparedness and public health systems. In addition to serving as a senior principal researcher, he will hold RAND's Paul O'Neill/Alcoa chair of Policy Analysis. Dr. Kellermann started with RAND on March 1; we very much miss his presence but appreciate his legacy.

MCG emergency medicine residency update

Stephen A. Shiver, MD, FACEP

I guess Augusta has not heard about the global warming phenomenon. We have had an unusually cold winter highlighted by 5-6 inches of the white stuff in February. It was of the wet variety, perfect for snowball fights and building snowmen, and was the biggest snowfall here in several decades. Despite an expected run on milk and bread by the Augusta citizenry, everyone survived and enjoyed the rarely encountered winter scenery. Perhaps I should modify the portion of my residency recruitment speech referencing the mild Augusta winters.

Can the Masters really be around the corner? Despite the weather, the calendar doesn't lie. Always a defining event for the city of Augusta, Masters week has become a favorite time of the year for our residents as we are fortunate to be able to provide medical support for the tournament. It is an excellent opportunity for the residents to gain valuable exposure to event medicine and to get a firsthand glimpse of the most famous layout in all of golf. Augusta is abuzz about the possibility of a Tiger sighting this spring.

We are currently undergoing a major ED renovation/expansion project. The expansion will add 16 additional acute care beds and enable us to continue to grow our volume, already at 76,000 patient encounters for the last fiscal year. Following this year's match, we will be up to our full complement of 10 residents per EM level. Given our ED expansion and growing volume, we are in the early stages of querying the RRC about further complement expansion in coming years.

Our weekly lecture series is in a period of transition. We are rapidly moving away from predominantly powerpoint presentations towards a more interactive format. Simulation is playing a key role and we continue to expand its usage. In addition, we are increasingly utilizing technology that allows our residents, faculty, and alumni to access core content on the web. The site can be accessed by clicking on the 'Lectures' link located on our new residency home page www.mcg.edu/ems/residency/. Interested alumni may contact us for further access information.

We welcome any questions or comments you may have concerning our residency program. Our Program Coordinator, Courtney Buckner, may be reached at (706) 721-2613.

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Dr. Shiver is Associate Professor of Emergency Medicine and Residency Program Director at the Medical College of Georgia. Clinical and research interests include resident education, emergency ultrasound, airway, and trauma. In addition to his emergency medicine training, he completed a general surgery residency at Wake Forest University Baptist Medical Center and is board certified by the American Board of Surgery.

The lecture series can be accessed by clicking on the "Lectures" link on the new residency home page, www.mcg.edu/ems/residency/

REACH: the Georgia telemedicine project

Hartmut Gross, MD, FACEP

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Dr. Gross is Professor of Emergency Medicine, Professor of Neurology and Assistant Professor of Pediatrics at the Medical College of Georgia.

In 2002, faculty from the departments of Neurology and Emergency Medicine at the Medical College of Georgia collaborated to facilitate acute stroke management in rural EDs and developed a tool to assist physicians in those EDs in identifying to which patients tissue Plasminogen Activator (tPA) should be offered. The result was REACH (Remote Evaluation of Acute isCHemic stroke), a simple Internet-based system which is wireless on either end with video capability to see and examine the patient in the remote ED and perform an NIH stroke assessment, as well as view the patient's CT scan. The patient's family could be given accurate information about the risks and benefits of thrombolytic therapy. tPA could be administered right in the rural ED, enabling the patient to be transferred leisurely and safely, now that time sensitive assessments and treatment options had been addressed. The system is staffed 24/7/365 by rotating faculty neurologists and one EM attending.

Since its humble beginnings, MCG has grown to be the hub for 14 spoke hospitals, from in the same county to 150 miles away with two more sites planned to start up in January. Just under 1,000 consultations have been performed in our network alone and tPA has been given just under 200 times, right at 20 percent which is comparable to only a few leading sites' on-site treatment. Complication rate from hemorrhage rate has been under the national average at 2.5 percent and have been minor, making it clear that treating patients via telemedicine is as safe as treating in-house. Not only is it safe, but patients treated via REACH are treated 20 minutes faster than the national average at major centers around the country.

In order to meet a request from the New York State Health Department to build a telestroke network in their state, a company, REACH Call, Inc. was created. Twenty-seven hubs and spokes now cover much of the state using the REACH system. Other states have one or more hubs and spokes in place including South Carolina, Tennessee, Florida, Wyoming, Louisiana, and Alaska. Additionally, Georgia has a second hub at Candler in Savannah with six spokes of its own which are REACH-based. All this makes the REACH system the busiest stroke network in the U.S. Stroke Belt and amongst the most prolific in the world.

Our REACH group has learned a lot as we've expanded the program, from where the interest needs to originate to have a successful program, to financing, to on-call coverage and its costs to make the program work, to the fact that rural hospitals can actually out perform the big multi-specialty centers with a telemedicine backup.

So now what? Even though the original premise in the system design was to do one thing and do it well, REACH is far from sitting on its laurels. The program has undergone several software renovations and is currently upgrading its installed base to REACH 3.0. This comes even before the wake of the legislation passed to develop a stroke network across all of Georgia. The complete overhaul to the system is in answer to a request by many customers to expand and have more consultation modules available. While a general consult module has been available for some time, cardiology, psychiatry, trauma, and orthopedic modules are among the most commonly requested. For that, software has to be rewritten. The new system is designed to be more of a plug and play system with new modules being designed, prototyped, and ready to integrate within a few months.

We have also determined that rural sites are a fertile ground for research opportunities. While we have enrolled many patients who were initially evaluated at a rural site via REACH in various research studies, one of our plans is to start

Dr. Gross at home providing a consultation.

recruiting patients for studies while they are still at the rural site. Even with these plans, we suspect the potential of the rural sites is still far underutilized, but with a little stretch (and a little you know what), we expect the REACH telemedicine system will continue to have an expanding positive impact on healthcare in the state of Georgia as well as the rest of the US.

REACH Sites in Georgia

1 Ty Cobb Memorial Hospital, Royston
2 Elbert County Hospital, Elberton
3 Emanuel County Hospital, Swainsboro
4 Jefferson County Hospital, Louisville
5 Jenkins County Hospital, Millen
6 McDuffie Regional Hospital, Thomson
7 Morgan Memorial Hospital, Madison
8 Washington Regional Medical Center, Sandersville
9 Wills Memorial Hospital, Washington
10 Tift County Hospital, Tifton
11 Doctor's Hospital, Augusta
12 Burke County Hospital, Waynesboro
13 St. Mary's Hospital, Athens
14 Fairview Park hospital, Dublin
15 Coliseum Hospital, Macon
16 Palmyra Hospital, Albany
17 Medical College of Georgia, Augusta (hub cart)

Emergency medicine resident's association: promoting excellence in patient care

Edwin Lopez, MD, President, EMRA

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Dr. Lopez is President of the Emergency Medicine Resident's Association and Clinical Instructor in the Department of Emergency Medicine at Loma Linda University Medical Center.

The Emergency Medicine Residents' Association (EMRA) promotes excellence in patient care through the education and development of emergency medicine residency-trained physicians. Founded in 1974, EMRA is the largest and oldest independent resident organization in the world. In fact, it now has a membership of more than 9,000 residents, medical students and alumni.

The main goals of the EMRA leadership in the 2009-2010 academic year have been centered around:

- Increasing membership value by offering new grants and scholarships, *EM Resident* Magazine features, new publications, reference material and affinity partnerships
- Developing educational resources for members using new technologies and applications
- Promoting local involvement and advocacy efforts and fostering future leaders, particularly through emergency medicine interest groups and residency program representatives

Stay updated with EMRA by looking through your monthly, "What's up in Emergency Medicine" E-newsletter, reading through the upcoming events in the front of each *EM Resident*, and familiarizing yourself with www.emra.org. Using the resources available to you from EMRA, being aware of leadership opportunities, and determining where you fit in the valuable network of emergency physicians-in-training will enhance your education and career.

Most EMRA members are familiar with some of our "big name" products and resources. Such is the case with the *EMRA Antibiotic Guide* and *EM: Reviews and Perspectives* (EM:RAP) from the Center for Medical Education. Here are a few lesser-known offerings you might want to check out as well:

- The *Emergency Medicine Advocacy Handbook*, a great health policy overview with issues specific to emergency medicine as well as healthcare as a whole.

$15 in the EMRA Bookstore

- EMRA Cast: Medical Student Podcasts designed to help with the process of applying to EM, surviving rotations, interview tips, and other pearls of wisdom

Free, available on www.emra.org and in iTunes podcasts

- EM Post-Call : EMRA's new blog, featuring all topics in life and training of EM Physicians by residents, attendings, medical students and guest bloggers.

www.empostcall.com

- Other free and discounted online resources at your fingertips, including: free subscriptions to three publications from EM Practice and a 20% discount on your subscription to video downloads on www.emcorecontent.com.

Visit the member benefits section of www.emra.org to browse all member offerings.

- *EM Career Central*: EMRA's official online job bank, with new functionality and enhanced features on their recently-overhauled website.

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- Meeting Scholarships, Local Action Grants and Research Grants: along with our long list of awards and scholarships available throughout the year, EMRA supports several projects per year with our Local Action and Research Grants and helps pay travel costs for several members attending national meetings, including CORD Academic Assembly, the SAEM Annual Meeting, and ACEP's *Scientific Assembly*. See www.emra.org for deadlines and application criteria.
- EMF/EMRA co-sponsored research grants to support EM research, education and young investigators.

EMRA leaders continue to seek out new and exciting ways to bring useful, valuable benefits and leadership opportunities to members, and always welcome suggestions and input from you. In fact, EMRA is at its best when members take initiative and interest in the organization that's all about them. As members of the Georgia chapter of ACEP, take pride in your residency training and continue to be proactive in your career in emergency medicine.

PAs in the ED: Supervision and Utilization

Cary J. Stratford, PA-C, Vice President, SEMPA

Since the earliest days of the physician assistant (PA) profession in the mid-1960's, PAs have practiced in the field of emergency medicine. Of the estimated 70,000 clinically practicing PAs, almost 10 percent work in emergency medicine.[3] In fact, the evolution of EM as a specialty, ACEP, and the PA profession paralleled each other.

In Georgia, according to AAPA data, there were 264 PAs practicing in emergency medicine in 2008, accounting for over 1.04 million patient visits.[1] Given the exponential increases in ED volumes in just the past few years, those numbers are likely larger today.

PAs practice medicine with the supervision of licensed physicians. Their work is not limited to emergency departments. PAs serve in pre-hospital patient care, patient triage, fast track, trauma, and selective administrative functions. They also provide emergency care for patients in pre-hospital situations, and ground or air transport.[1]

The visionaries of the PA role were right. A physician can more effectively care for patients when working as part of a physician-PA team. The efficiency of this model has led to its utilization in all medical and surgical specialties. The physician-PA team is effective because of the similarities in physician and PA training, the PA profession's commitment to practice with supervision, and the efficiencies created by utilizing the strengths of each professional in the clinical practice setting.[3]

Although by law PAs are dependent practitioners, typically they exercise considerable autonomy in clinical decision-making. The relationship between the physician and PA is one of mutual trust and reliance. The physician trusts the PA to provide physician-quality care to patients, and to consult with the physician on those cases that are outside the PA's expertise or scope of practice. The PA trusts the physician to be available for supervision, to provide learned advice, and to accept the care of patients with serious or complex problems.[3]

PA education – training in the medical model

The relationship between PAs and physicians begins in PA school where physicians, PAs, and others provide instruction in a curriculum following the medical school model. PA students typically share classes, facilities, and clinical rotations with medical students.

Because they train using similar curricula, training sites, faculties and facilities, physicians and PAs develop a similarity in medical reasoning during their schooling that eventually leads to homogeneity of thought in the clinical workplace.[5]

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Supervision – the EP's role:

The scope of practice of a PA is created by the EP/PA team and defined by Georgia state law and regulation. In addition, it is shaped by facility policy, by the education, experience, and expertise of the PA; and by the determination of the supervising physician(s) about what tasks will be delegated. Emergency physicians are given the ultimate control over delegation, within the limits of their own practice, and can tailor the PAs practice to the needs of the department.

The medical director of the emergency department or other EPs can serve as supervising physicians.

In Georgia, a supervising physician can supervise up to two PAs functioning simultaneously,

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and four in total. Georgia also requires an alternate physician supervisor. As a result, larger EDs utilize multiple MDs in this capacity.[1] Physicians functioning as a supervisor should familiarize themselves fully with Georgia statute and regulations.

Because medical practice and physician-PA practice are dynamic, specific lists of approved tasks that physicians can delegate to PAs are not practical. There are not any "typical" restrictions on what a PA does in the ED.[4]

ED PAs – where are they, and what are they doing?

In a comprehensive 2009 survey commissioned jointly by ACEP and SEMPA (Society of Emergency Medicine PAs) and completed by the NCCPA (National Commission on the Certification of PAs) we learn that over 68 percent of PAs in EM identify themselves as working in the main ED and less than 20 percent identify practice limited to Fast Track.[2]

While PAs provide all the evaluation and procedures typically associated with Fast Track acuity, this survey demonstrates that many are engaged in advanced procedures and higher acuity patients. Over 70 percent of PAs in EDs indicated they do multi-layer wound closures, major joint dislocation reductions and arthrocentesis. Over 50 percent indicated that procedural sedation, slit lamp examination, and LP were among the tasks assigned to them. Just under half are experienced in Rapid Sequence Intubation. These skills further enhance the value of PAs to the busy emergency physician.

The NCCPA survey also demonstrates that 75 percent of PAs in EM work in departments with 100 percent attending EP coverage, the remaining 25 percent work in remote or rural systems or outside the ED, with varying levels of EP presence.[2] In these situations the same rules and regulations on PA supervision apply.

While the variation in PA responsibilities, from ED to ED is wide, this simply reflects the versatility and effectiveness of PAs. Emergency physicians are given the delegatory latitude by Georgia law and regulation to develop a system that provides for the highest levels of quality and efficiency in emergency care delivery. *For more information go to the Society of Emergency Medicine PAs website: www.sempa.org.*

References:

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3. Physician Assistants in Emergency Medicine Issue Brief: American Academy of Physician Assistants, September 2004
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5. Issue Brief: The Physician-PA Team, American Academy of Physician Assistants, May 2009

The PA profession remains committed to the concept of the supervising physician-PA team. This is reflected in the AAPA's description of the profession: The AAPA believes that the physician-PA team relationship is fundamental to the PA profession and the delivery of high quality care. As the structure of health care system changes, it is critical that this essential relationship be preserved and strengthened.[5]

Pulmonary Embolus

Stephen A. Shiver, MD, FACEP
Ben Holton, MD, FACEP

Mrs. Jones is a 66-year-old female who presents to the ED complaining of chest pain and progressive dyspnea. She was in her usual state of health until approximately 2 days ago when she returned from a trip to Europe to visit her daughter. She has a difficult time describing and localizing her chest pain but states that it is worse with breathing. There has been no associated nausea/vomiting, diaphoresis, or radiation. Her past medical history is significant for hypertension, mild obesity, and a remote myocardial infarction.

Vital Signs T37.4 P120 BP150/90 RR24

She appears uncomfortable and is tachypneic with mildly increased work of breathing. Cardiovascular examination reveals a regular rhythm without any murmurs or gallops. Pulmonary examination reveals clear lungs bilaterally.

EKG is shown.

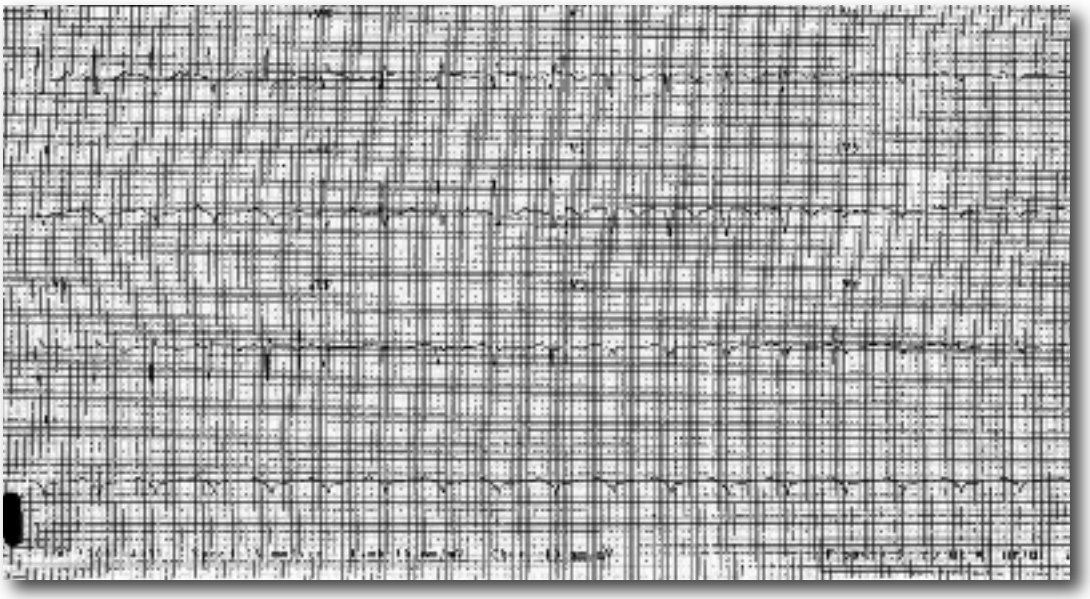
Diagnosis: Massive Pulmonary Embolism (PE)

The EKG shows a narrow complex sinus tachycardia with a rate of 109. There are numerous features suggestive of the diagnosis of PE, including the often described S1Q3T3 pattern. The pattern was first described in the 1930's in a series of patients with severe PE and consists of an S wave in Lead I, Q wave in Lead III, and an inverted T wave in Lead III. Unfortunately, the association is not universal and there are a wide range of numbers reported in the literature (<20% to >50%).

PE is known to cause right heart strain and it is this strain that results in many of the EKG findings associated with PE, including the S1Q3T3 pattern noted above. Other common findings presumably due to strain include inverted T waves in the anterior leads, demonstrated nicely in the pictured EKG, and the presence of right bundle block pattern, which may be complete or incomplete.

The presented patient was initially thought by the treating physicians to have myocardial ischemia. Such an assumption is not unreasonable given her clinical history and the presence of multiple ST/T changes on the EKG. She underwent a cardiac work up in the ED including laboratory studies, which were negative. A cardiology consultant suggested PE and subsequent CT angiography of the chest confirmed the diagnosis of bilateral PE. She was admitted to the Medicine service and treated with anticoagulation.

In summary, careful evaluation of the EKG can provide important clues as to the presence of PE. The EKG is not diagnostic, however, as exemplified by the fact that the simple presence of sinus tachycardia is considered by many to be the most common rhythm seen in the setting of PE. Given that PE can be extremely difficult to diagnose and the consequences of missing the diagnosis can be severe, we should use everything possible to assist us and need to keep the often subtle EKG findings associated with PE in our armamentarium.



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Dr. Shiver is Associate Professor of Emergency Medicine and Residency Program Director at the Medical College of Georgia. Clinical and research interests include resident education, emergency ultrasound, airway, and trauma. In addition to his emergency medicine training, he completed a general surgery residency at Wake Forest University Baptist Medical Center and is board certified by the American Board of Surgery.

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Detecting Aortic Aneurysm with Bedside Ultrasound

Mary Ann Edens, MD, FACEP
Matt Lyon, MD, FACEP

How many times have we heard the words, "back pain in room six" and cringed thinking to ourselves, "not another one." Most presentations of back pain are indeed benign. On occasion, this symptom can be the harbinger of serious, underlying and sometimes even fatal, disease processes. Take the case below for example.

A 55-year-old male presents to the ED with complaints of severe lower back pain. He reports that he was seen at an outside ED yesterday after developing sudden onset of severe back pain after helping a friend push his stalled car to the side of the road. He states that he was treated with ibuprofen and flexeril, but the pain has gotten progressively worse and now he is starting to feel dizzy. The nurse tells you that his pulse rate is 120 and his blood pressure is 80/40. What comes next?

In my world, you grab the ultrasound probe. The probe is placed on the abdomen to evaluate the patient's aorta and a picture is obtained (Figure 1).

This patient has an aortic aneurysm and is hypotensive. This is suggestive of a ruptured aneurysm. The patient was taken immediately to the operating room by the vascular surgery service and unfortunately died in the operating room from his ruptured abdominal aortic aneurysm.

Ruptured abdominal aortic aneurysm is a vascular emergency carrying both a high morbidity and mortality. Use of the bedside ultrasound by emergency medicine physicians has been shown to decrease the time to the operating room, which helps decrease both morbidity and mortality. There are studies that show that the use of ultrasound by emergency physicians in this scenario has 100% sensitivity.

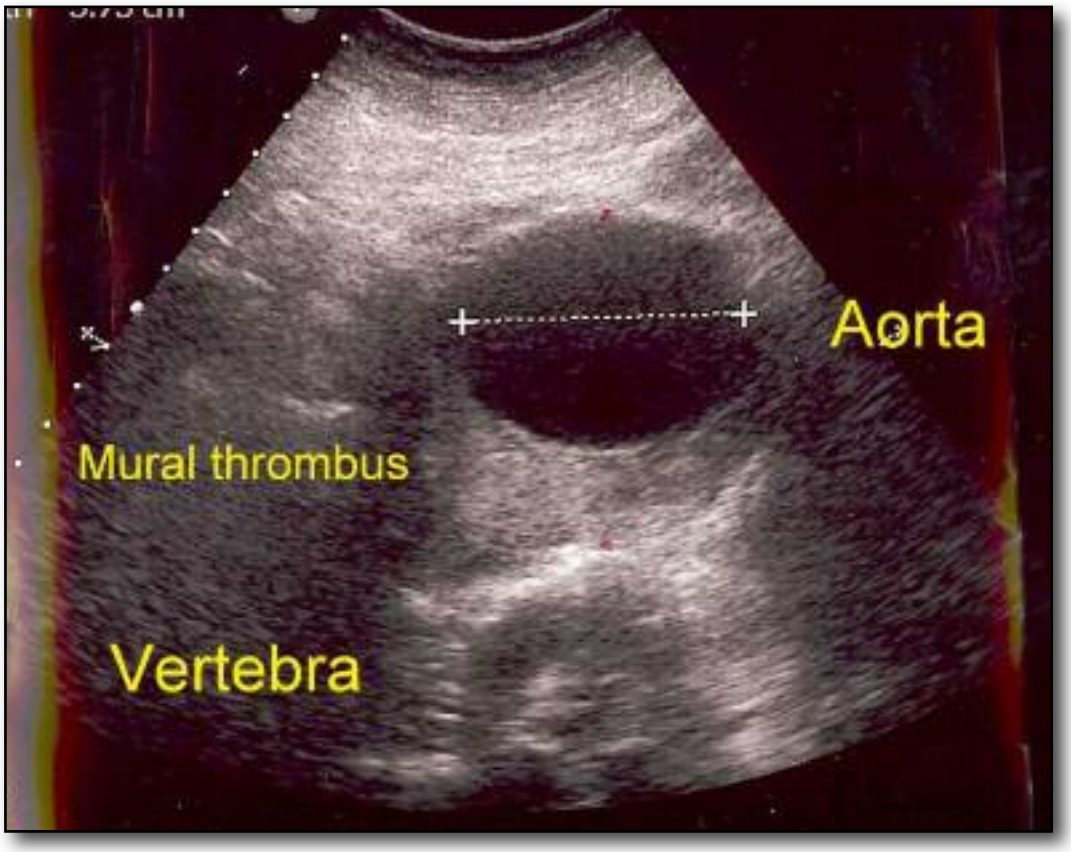

Figure 1. This picture demonstrates an aortic aneurysm with mural thrombus. The vertebra is used for reference. The measurement of the aorta is 5.75 cm. However, there is mural thrombus between the lumen of the aorta and the vertebra. If we measured perpendicular to our other measurement, the aorta measures about 7 cm.

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Dr. Edens is an Assistant Professor of Emergency Medicine at Emory University School of Medicine. She serves as the Director of Emergency Ultrasound Services. She will soon be moving to Shreveport, Louisiana to become the Associate Residency Director and Ultrasound Director for the Emergency Medicine Program at LSU-Shreveport. Dr. Edens has coauthored several ultrasound chapters in Adams' Emergency Medicine.

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Dr. Lyon is associate professor of Emergency Medicine at the Medical College of Georgia. He serves as the director of the Section of Emergency and Clinical Ultrasound as well as the director of the Emergency Department Observation Unit. He has significant educational experience, lecturing both nationally and internationally, and has published over 30 peer-reviewed articles on the use of ultrasound in clinical practice.

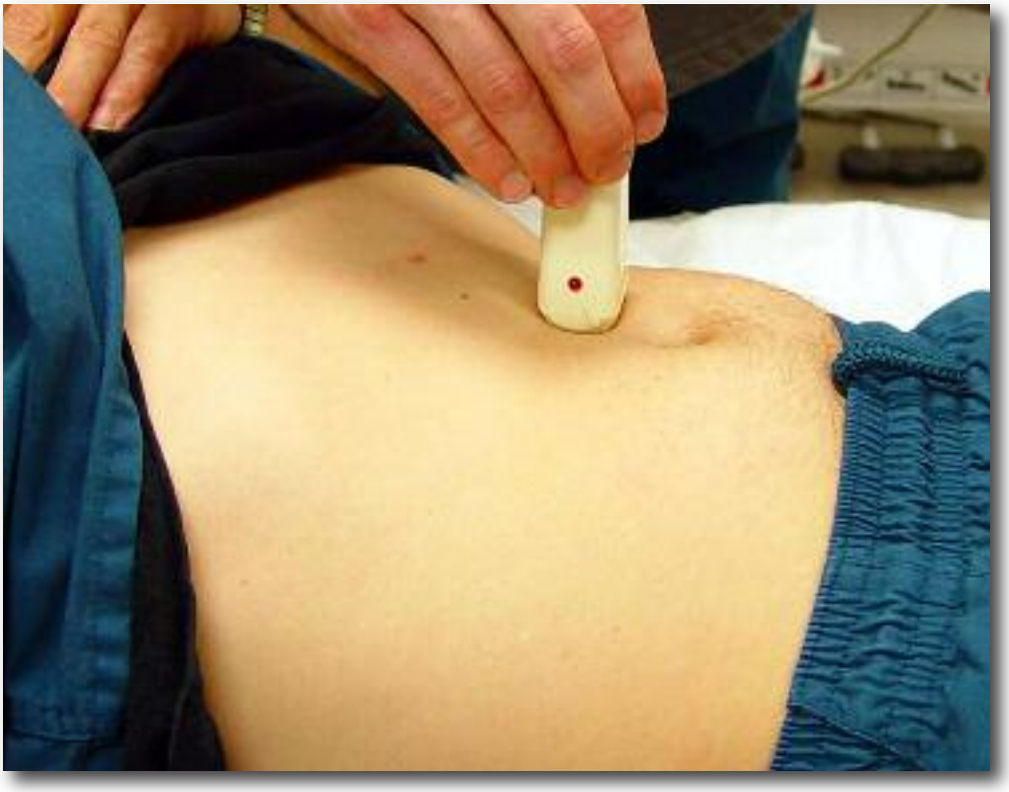

Figure 2. Placement of probe for transverse view of aorta

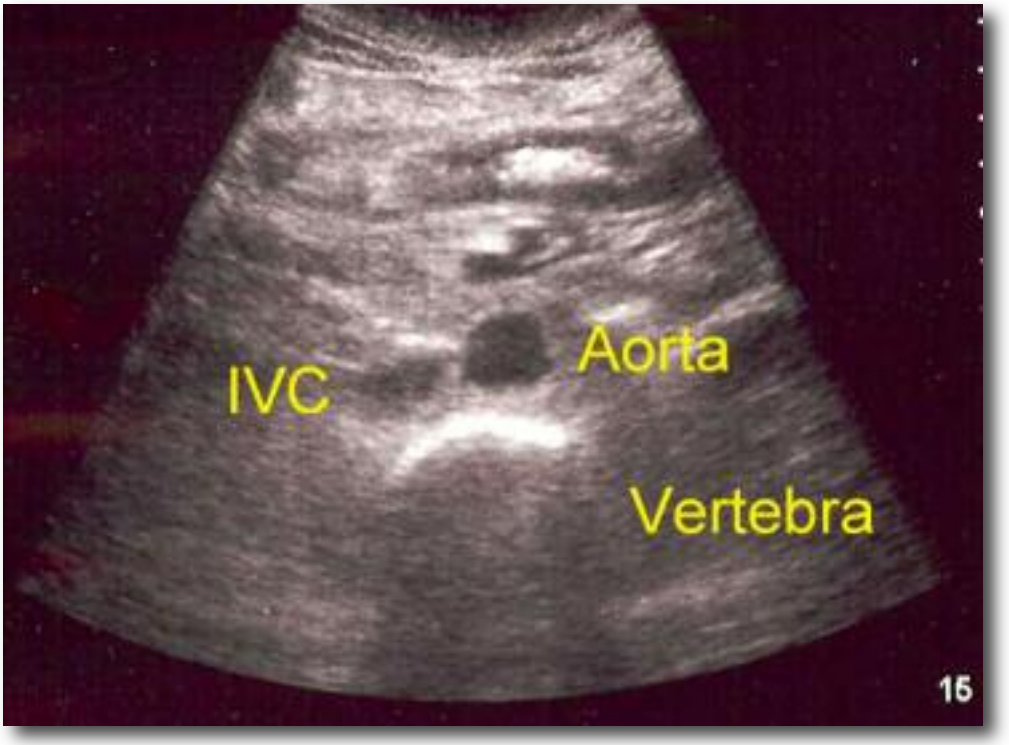

Figure 3. Normal aorta

The technique is not difficult. The probe is placed in the subxiphoid space with the probe indicator to the patient's right side (Figure 2). The aorta is often easier to find in this transverse plane because of its position just anterior to the vertebral body. The aorta should be just to the left of the patient's midline and non-compressible. The IVC will be just to the right of midline and should be at least partially compressible. Once the aorta is identified, the probe should be slowly moved down the abdomen, following the path of the aorta. Steady pressure will help move any bowel loops out of the way of the image. The aorta should be followed all the way down to the bifurcation. The bifurcation will usually occur around the area of the umbilicus.

Measurement of the aorta should occur in this transverse plane. The normal aorta measures less than 3 cm (Figure 3). Any dilation greater than 3 cm indicates an aneurysm (Figure 1). Most aneurysms occur in the infrarenal aorta, however, aneurysms can occur anywhere along the aorta. It is for this reason that the entire abdominal aorta should be visualized during the scanning process. Additionally, we must take care to appreciate any mural thrombus within the aorta. Mural thrombus may cause the lumen to appear smaller than it actually is (Figure 1).

If you found this interesting, come practice the technique in person at the GCEP summer meeting. We will be holding a hands on ultrasound session where this and other techniques will be demonstrated and models available for you to practice the techniques.

Hospital Spotlight: Dorminy Medical Center

Naomi Kirkman-Bey, MD, FACEP

Dorminy Medical Center (DMC) celebrates over 34 years of healthcare excellence in Fitzgerald, a small town in South Georgia, located in Ben Hill County with a population of approximately 18,000. This hospital is vital to the economic structure of our community employing over 300 employees with an annual payroll of over $9 million and an annual economic contribution of $56 million to our community.

Our mission statement is that Dorminy Medical Center will provide patient centered, physician driven, personalized healthcare services that exceed the expectations of our community. The vision of DMC is to offer a broad scope of healthcare and wellness services to our community through progressive, consistent, and compassionate care.

Today, Dorminy Medical Center is a 75-bed; acute-care facility offering highly trained staff and state-of-the-art diagnostic and treatment equipment. Dorminy Medical Center continues to meet the needs of the community through the vision of our leader, Warren Manley, CEO. We have an emergency department (ED) staffed around the clock with highly trained emergency physicians. We also have a complete support staff in addition to a walk in after hour clinic for non-emergency care. DMC also provides Intensive Care and Step-down units, OB and newborn nursery services, an operating suite with inpatient and outpatient surgeries, specialty clinics staff by specialists in a hometown setting. In this small southern Georgia town we are please to provided a full range of diagnostic services which includes medical imaging, clinical laboratory, cardiopulmonary services, swing bed unit, wound care center, dietetic and nutritional services, as well as in-house and community based education programs.

Dorminy Medical Center recently underwent a facility expansion in 2008 by adding 25,000 feet. The $9.5 million renovation included an addition to the surgery area for outpatient surgery, laboratory services, medical imaging including with a new reception area and waiting room. The renovation extended to patient access/registration area, the Birthing Place and the front entrance.

The Emergency Department is a huge focus for our hospital; the emphasis has not been strong enough to renovate the ED facility at this point however it is on the horizon. The gateway to our community is through the Emergency Department, due to the extraordinary opportunities that our ED has with the complexity of the dynamics with trauma, basic healthcare, behavioral health, mental health and pediatric care. With the economic downturn in our nation today, this has trickled down to our small town with company shut downs and over 16 percent of our community unemployed and without healthcare coverage. This change in socioeconomic demographic had a drastic affect on our ED. With our citizens becoming uninsured or underinsured, they no longer have the means to see their physician, thus utilizing the ED as the site for primary care. Our Emergency Department had become not only a place for true traumatic emergencies but a place our community utilized for basic healthcare. We had problems! The medical staff was not happy, the community was not happy and the emergency department personnel were not happy. There were many complaints!

The new front entrance to Dorminy Medical Center

We had the opportunity to begin with new directions and new solutions. Therefore DMC signed a contract with the Schumacher Group. This group of highly trained physicians came to our community bringing with them a vast wealth of knowledge. All of the physicians are board certified and the majority are emergency trained and board certified in Emergency Medicine. This group brought promise to the administration, active physicians and this community that DMC's ED was moving in the right direction. Our Emergency Director was well supported by the Schumacher Group with a monthly directors meeting reviewing and implementing best emergency practices throughout the Southeast. There are challenges which include the physical plant

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Emergency Department Staff at Dorminy Medical Center celebrates Fourth Place in Georgia for Best Patient Satisfaction.

of the Department which consists of six rooms with the sixth room designated as our trauma room. The volume is 13,000 per year with 14 percent admission rate, approximately 5 percent transfer rate and 15 percent acuity. There were also complaints from the community with long wait times, miscommunications between patient and physician, and lack of education of what an emergency department's role is in the healthcare sector. The Schumacher Group of physicians, lead by Dr. Naomi Kirkmen-Bey had multiple challenges in the Emergency department:

1. Develop a stable Emergency physician group
2. Decrease our wait time from a couple of hours to less than 20 minutes from the time the patient signs into the department.
3. Increase patient satisfaction and decrease complaints.
4. Implement the Medical Screening Exam with buy in from the community.
5. Limited space with no renovation in the foreseeable future.
6. Develop a rapport with active staff, hearing their views and earning their trust for the care of the patients and the community.
7. Decrease turnaround time for patients and their families with the average length of stay in the Emergency Department being greater than five hours at baseline.

DMC has been able to achieve a high level of customer satisfaction through the acquisition and retention of emergency board certified physicians. DMC ED staff has established a progressive environment of teamwork. We are able to accomplish much with limited resources through shared experiences, reliable support, trading and covering for one another and an over confidence in the excellence of our fellow professionals. Leadership reflects a common bond of trust and responsibility that provides our ED's continued success. We are progressive and consistent in our approach to the changing economic and social conditions of our community. This environment helps to attract and recruit experienced physicians with emergency training, which supports our overall level of patient satisfaction and trust.

Today, the ED has limited the challenges through hard work and dedication. Our wait time is down to 17 minutes and the turnaround time is two hours with transfer time less than 3.5 hours. The staff has trust in the physicians and the community has been educated to the role of the ED. The Emergency Team is essential to our community in many ways, however its value increased because they are not only physicians treating a healthcare problem, but are leaders in our community teaching people how to care for themselves. This education is important to prevention, treatment and long-term success in this community.

Dorminy Medical Center was awarded the 2009 VHA Leadership Award in Clinical Excellence for Patient Experience- Superior System Performance. The criteria for receiving this award is based on achievement of at least 70 percent "always" score in all six of the HCAPS composite categories for the most recent rolling 12-month period released by CMS (Center for Medicaid & Medicare Services). The six categories are as follows: Doctor Communication, Nurse Communication, Responsiveness of Hospital Staff, Pain Management, Communication about Medications, and Discharge instructions.

Also, Dorminy Medical Center was tied for 4th place in the State of Georgia through Hospital Compare website for the one of the highest scores on the CMS HCAPS survey. DMC has an 82% rating. The average of all reporting hospitals in the United States is 64% and the average of all reporting hospitals (129 hospitals total) in Georgia is 64%. Dorminy Medical Center is ecstatic with the accomplishments that we have made, especially within the Emergency Department in the last two years. We will continue to grow through this ever-changing healthcare environment.

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