

## PRESIDENT'S LETTER

# March 7: The Day to Make Our Voices Heard in Springfield

Save the Date for ICEP Advocacy Day!



**Michael Wahl,  
MD, FACEP, FACMT**

Specialty associations such as the Illinois College of Emergency Physicians provide 4 major functions for members: Advocacy and public relations; educational programs; sharing of best practices; and convening conferences in order to advance the interests of members, in our

case, emergency physicians and the patients they serve.

On March 6 and 7, ICEP will hold EM Days in Springfield, a combined clinical and legislative conference. This conference will provide clinical education on March 6 and allow for networking and sharing of best practices. March 7 will be an advocacy day in which members will be taught the basics on speaking to legislators, and in the afternoon, they can meet with legislators to educate them on issues affecting the practice of emergency medicine and their effects on access to care.

ICEP has always been active in the realm of legislative advocacy on behalf of its members. The Patient and Physician Advocacy Committee (formerly Government Affairs) meets regularly with our lobbying firm, Illinois Strategies

to monitor and act upon legislation that may be helpful or harmful to the practice environment and ultimately to the patients who seek emergency care. The past couple of years have seen issues rise to the top in the areas of mental/behavioral health and out of network billing.

### **Mental Health**

The great recession has had a negative impact on public funding for patients with mental health problems. As the resources that provide outpatient care for these patients dry up, emergency departments become their safety net. Resources that provide for inpatient care are also limited, and as a result, placement of these patients can take several hours to several days. These prolonged stays create inefficiency in our workflow, increase the wait times for other emergent patients and consume resources that threaten the function of the vital service of emergency medicine; the safety net itself is breaking under the strain.

A few months ago, there was a move by the state to close several state mental health facilities — a move that further threatened our ability to disposition these patients. In response, ICEP:

- Worked with our lobbyists to educate legislators on the importance of the state facilities.
- Authored a letter to the editor that was printed in the Daily Southtown (part of

the Sun-Times) against the closure of state mental health facilities

- Sent out an e-mail advocacy alert from which 160 members sent e-mail letters to their state representatives, senators and Governor Quinn
- ICEP Past President Bill Sullivan spoke at a town meeting against the closure of Tinley Park Mental Health Center

These efforts, along with the efforts of many other organizations and individuals, led to stop-gap funding that maintained funding for mental health facilities through June 2012. On March 7, we will be speaking to our legislators as constituents, to educate them on the need for mental health funding in order to decrease the surge we are seeing in our emergency departments. This is the day to make our voice heard and improve the quality of care to our patients.

### **Out of Network Billing**

In the past two years, the legislature discussed and eventually passed a bill regulating payment for out of network patients by emergency physicians, radiologists, pathologists, and anesthesiologists. In the language of the bill, hospital-based physicians were singled out as having to accept payment for treatment of out of network patient (unlike elective office-based practices). This potentially leaves emergency physician groups that do not have a network

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# March 7: The Day to Make Our Voices Heard

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contract with an insurer at risk for markedly decreased reimbursement.

For many EM groups, self-pay, Medicaid and Medicare patients make up a substantial portion of their payor mix. These three populations are reimbursed at a level that often does not cover the cost of care. In our EMTALA-mandated specialty, privately insured patients provide the margin needed to care for all patients. The extra resources provided by the private insurers in essence fund the safety net. In the current funding model, without this revenue, the delivery of emergency medicine to all who need it is threatened. The safety net itself is at risk.

Our lobbyists have been working with state legislators to ensure that the needs of emergency physicians and their patients continue to be met. Currently being negotiated with the legislature and insurance companies is additional language

to amend the out of network bill:

- Usual and customary charges well defined
- Prudent layperson language maintained with possible EMTALA-related services exempted
- Explanation of benefits
- Arbitration well-defined process utilizing American Arbitration Association standards
- The Illinois Department of Insurance will be required to make an annual report to the General Assembly

While not as desirable as being exempt from the law due to our EMTALA requirements, it is a good first step to ensure we can continue to expect fair payment for services performed for out of network patients. The annual report to the state can track whether insurance companies are refusing to negotiate in good faith through reporting by EM groups and can also track the percentage of in-network contracts insurance companies have. For example, if an insurance company has a current out of network percent-

age of 15%, and over three years this goes to 25%, it is a pretty good indication that they are no longer negotiating with physicians due to the law.

March 7 is the day we can advocate in Springfield together on behalf of the practice of emergency medicine. I hope you will join us for the entire two-day conference, but it is imperative that each and every one of us makes the effort to be present on March 7 in Springfield. It is a day to make a difference.



— **Michael Wahl, MD, FACEP, FACMT**  
**ICEP President**

*For more about EM Days in Springfield on March 6-7, including registration information, please see the story on Page 4.*

## Last Call for ICEP Committee Members

Deadline to Submit Applications Friday, December 30

Friday, December 30 marks the deadline to submit applications to serve on ICEP committees in 2012.

Committee membership terms are one year, and most committees meet four times per year at the ICEP office in Downers Grove or by teleconference or videoconference.

Members who currently serve on committees must reapply if they wish to continue their committee membership. If reapplication is not received, members will be considered inactive on the committee and removed.

If you would like to be considered for a committee appointment, please download the Committee Member Application.

Descriptions for ICEP's committees are included in the Committee Member Application.

Applications must be completed electronically and should be sent to Ginny Kennedy Palys by email at [ginnykp@icep.org](mailto:ginnykp@icep.org) by close of business on December 30.

Notification of appointment will be made via email by the end of January.

### ICEP Committees 2012

- Awards/Nominating
- Bylaws
- Educational Meetings
- EM|MOREinFOUR Course
- EMS
- Finance
- ITLS Illinois Advisory
- Membership
- Patient & Physician Advocacy
- Practice Management
- Research



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# ICEP Submits Comments to House Task Force on EMS Funding for Consideration

*After conducting a series of hearings around Illinois this past fall, including one at the ICEP office on September 20, the state House Task Force on EMS Funding is developing recommendations for the Illinois General Assembly, to be translated into bills to go before the General Assembly in spring 2012.*

*In December, ICEP's EMS Committee finalized comments to submit to the Task Force for their consideration as they craft the recommendations. The following is the full text of the testimony submitted.*

The Illinois College of Emergency Physicians (ICEP) is the state medical specialty society representing over 1,250 physicians who practice emergency medicine in Illinois. Many of our members serve as EMS Medical Directors for Illinois' EMS Resource Hospitals and direct pre-hospital programs throughout the state.

Resource Hospitals are designated by the Illinois Department of Public Health to provide this vital voluntary service to their communities. Under the Illinois EMS Systems Act (210 ILCS 50/3.35), Resource Hospitals are mandated to provide essential EMS services to the community and the pre-hospital care providers in their region.

Some of these responsibilities include:

- Advocating and ensuring that EMS systems (and providers) adopt and maintain state-of-the-art pre-hospital medical protocols, equipment and pre-hospital medical training necessary to assure adequate pre-hospital medical care for its community
- Monitoring and supervising all aspects of the EMS System it oversees
- Updating Standard Operating Procedures (SOPs) on a regular basis to maintain a current level of the care provided by pre-hospital providers to their patients
- Regularly meeting with pre-hospital provider leadership to communicate functions, direction, and goals of the EMS System
- On a monthly basis, working with Infield Educators to create monthly Continuing Education (CE) sessions



**Members of the House Task Force on EMS Funding listen to testimony from Chief Mike Hansen during the meeting held at ICEP in September.**

- On a monthly basis, providing continuing education sessions, including education, testing, and competency evaluations to all providers covering all shifts within the EMS System
- Notifying IDPH of pre-hospital providers who have successfully completed requirements for licensure testing and re-licensure
- Educating or coordinating the education of Emergency Medical Dispatchers (EMDs)
- Establishing or approving protocols for pre-arrival medical instructions to callers by EMDs
- Educating and evaluating the competency for Emergency Communications RN (ECRN) candidates to answer hospital telemetry radio calls from pre-hospital providers as required for medical oversight
- Reviewing pre-hospital run reports for Quality Improvement (QI) oversight
- Designing and implementing community outreach and education programs

Funding for Resource Hospitals is desperately needed. ICEP proposes that the Task Force consider the following to improve emergency medical services care in Illinois.

- **Recommendation:** During fiscal year 2011, \$4.5 million was distributed to 59 Illinois trauma centers. There are no designated funds, however, to support the functions of the current 67 EMS Resource Hospitals in their active goals of

oversight of all aspects of pre-hospital care by EMS personnel.

ICEP proposes the formation of an annual designated fund to support EMS Resource Hospitals in their functions and responsibilities as previously noted and to assist EMS Resource Hospitals in the implementation of ongoing and new programs to ultimately improve the quality of the care we provide to our patients in the pre-hospital setting.

- **Recommendation:** Medical equipment and devices are continually improving. We must be able to equip EMS personnel with new technology in order to improve patient care. One example is the capability of obtaining a 12 lead EKG and transmitting it directly to an emergency physician or cardiologist in order to activate the cardiac cath lab even before the patient arrives to the hospital.
- **Recommendation:** The National Scope of Practice new education standards consistent with national guidelines will be required to be incorporated into our educational programs by January 1, 2013. This is a large endeavor which will improve EMS providers' knowledge bases by applying updated evidence-based medicine to the care we provide to our patients.
- **Recommendation:** Development of an Expanded Scope of Practice model to equip EMS providers with advanced skills through specific protocol design and competency programs to apply those advanced skill sets to the critical needs of our patients and also to meet the needs of underserved areas of Illinois.
- **Recommendation:** Development, education, and implementation of electronic run reporting in order to submit National EMS Information System (NEMSIS) compliant data to state and national data banks. Allows for comparison data of all aspects of pre-hospital care between local EMS agencies, EMS systems, EMS regions, and Illinois and national data banks.
- **Recommendation:** Finally, we must protect any designated EMS fund to support EMS by not allowing it to be swept into general revenue funds.

# EM Days in Springfield on March 6-7 Combine Advocacy, Education

ICEP's EM Days in Springfield will bring together clinical and advocacy educational topics at the two-day revamped downstate meeting on March 6-7 at the President Abraham Lincoln Hotel and Conference Center in Springfield.

## Clinical

The first day of the conference, Tuesday, March 6, will focus on clinical education.

Nick Mohr, MD, of the University of Iowa Hospitals & Clinics, will explore the use of capnography in the ED with a keynote session that reviews sedation, intubation and beyond.

Christopher McDowell, MD, M.Ed. will examine the role of physician extenders in the emergency department, looking at innovative ways to incorporate physician assistants and nurse practitioners into daily operations.

More topics, including a literature review and an abbreviated emergent procedures simulation course, will be finalized shortly.

## Advocacy

To transition to a focus on advocacy efforts, registrants are invited to attend a special reception on Tuesday evening at the Abraham Lincoln Presidential Library and Museum. State legislators and ICEP's lobbyists will also be invited to the reception, which will be held from 5:30 to 7:00 p.m. Attendees will be able to network and explore the museum during the event.

Wednesday, March 7 kicks off ICEP Advocacy Day. Participants will attend sessions in the morning to learn how to effectively com-

## EMdays in Springfield ADVOCACY & EDUCATION

**March 6-7, 2012**

President Abraham Lincoln Hotel & Conference Center  
Springfield, Illinois

*Clinical*

ED capnography • Physician extenders in the ED • Literature review • High risk procedures simulation lab

Out of network legislation • Health care reform • State mental health closures • Legislative visits to the Capitol

*Advocacy*

Join ICEP for a  
*special evening reception with legislators*  
at the Abraham Lincoln Presidential Library and Museum  
5:30 - 7:00 PM Tuesday, March 6

municate with legislators and be briefed on important issues for emergency medicine, including out of network legislation, health care reform, and state mental health facility closures.

In the afternoon, participants will visit the state Capitol to sit down face-to-face with legislators and their staff to discuss the issues and work together toward common goals. A debriefing with all participants will end the day from 3:00 to 4:00 p.m.

A full course brochure and online registration will be available in January. Watch your email for more details coming soon!

ICEP hopes all members will join us in Springfield for this important event to help us shows Illinois legislators that the College is a powerful force for change.

# ICEP Seeks Nominations for Board of Directors

## Committee Also Calls for Councillor, Awards Noms

The Awards and Nominations Committee is seeking suggestions for nominations to the Board of Directors and Councillors.

Four members and one resident member will be elected to the ICEP Board in 2012. Board members are elected by the membership via electronic ballot. Voting will open on March 11.

All 13 councillor positions are also up for election. Councillors will be elected by the Board of Directors at its meeting following the Spring Symposium on April 26.

If you would like to be considered for a Board or councillor position (or both), send an email explaining your reasons for seeking nomination and a brief statement about your service to ICEP and emergency medicine to [ginnykp@icep.org](mailto:ginnykp@icep.org) by January 20.

Residencies are asked to spread the word to their residents about the Resident Member position. Resident Members serve a 1-year term on the Board.

The Awards and Nominating Committee is also seeking nominations for ICEP's annual awards that will be presented at the Spring Symposium.

If you know a colleague or other fellow member who deserves to be recognized for his or her accomplishments and dedication to our Chapter, now is the time to let ICEP know!

ICEP's awards are:

- Bill B. Smiley Award — ICEP's highest honor
- ICEP Meritorious Service Award
- Downstate Member Service Award
- Advocacy Award for legislators who have made a difference

Please submit your recommendations to Ginny Kennedy Palys at [ginnykp@icep.org](mailto:ginnykp@icep.org) by January 20 with a short explanation of your nomination.







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*Lynne E. Nowak, M.D., Internal Medicine  
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# State to Keep Mental Health Facilities Open Through June

The General Assembly has passed the supplemental funding bill, SB 2412, which will keep state operated psychiatric facilities open through the end of the fiscal year in June 2012. The supplemental bill also provided an additional \$30 million for community mental health services.

Earlier this fall, budget cuts prompted the State of Illinois to schedule the closing of several state psychiatric hospitals by the end of 2011. ICEP immediately launched a campaign among the membership to contact their state officials to urge keeping the facilities open. More than 160 ICEP members took action and contacted their state representatives, senators, and the governor about this threat.

ICEP will continue to work with our lobbyists to find a long-term solution to the state psychiatric facility funding issue. Closure of these vital institutions would force many mental health patients to remain in emergency departments while scarce treatment options are found. The impact will affect all ED patients whose care may be delayed due to exhaustion of resources.

ICEP Past President Bill Sullivan, DO, JD, FACEP was recently quoted in an article published by MSNBC.com about the issue of psychiatric patients in the emergency department. The national story has been picked up by more than 10 news outlets across the country, including the Chicago Tribune.

Read the Story Online

In the article, Dr. Sullivan related a story about a recently homeless patient he treated in the emergency department, who repeatedly threatened to kill himself.

"It seemed almost as if he was interested in being admitted," Dr. Sullivan told MSNBC about the patient, who also inquired if the ED had a meal tray.

The article focused on the trend of states slashing mental health services, and its effect of taxing already overburdened emergency rooms.

# ACEP President Shares Vision for Future of EM

## Dr. David Seaberg Addresses ACEP Council at 2011 Scientific Assembly in San Francisco



David Seaberg, MD, FACEP

*If you weren't able to attend the 2011 Scientific Assembly or Council meeting in San Francisco in October, you probably missed ACEP President David Seaberg's address about the future of emergency medicine. The text of his presentation follows.*

The best way to predict the future is to create it. Though often repeated, this sentiment is just as relevant today as it was when economist Peter Drucker first wrote it many years ago. The question I pose to all of you is -- what future will we create for emergency medicine?

As your new president, I am honored and thankful for the support of the Council as we continue to fight for our specialty, to ensure a bright future for all emergency physicians. There is no other group I would want next to me in our battle, than my emergency medicine colleagues. The Councillors in this room represent the very best our specialty has to offer. Yet, the next three years of healthcare reform will likely affect the next 30 years of our practice. It will touch all aspects of what we do: how we work, how we are paid, and how we interact with our patients. In short, it will redefine the specialty of emergency medicine.

By 2025, an average family of four will have to spend up to 40 percent of its income on health insurance. By that same time, Medicare and Medicaid will account for nearly 40 percent of the federal budget. This is what bending the cost curve in medicine is all about. Now is our time to act -- to shape the way we will practice and to determine our future.

As you know, there are three pillars of healthcare reform: Access, Quality, and Cost. The first goal of the Accountable Care Act was to provide insurance to those who do not have any. This aspect of the legislation has sparked great

controversy and will most likely be settled by the Supreme Court. But this country must still face the issue that those of us in emergency medicine have always known. Insurance coverage does not equal access to care. Regardless of insurance status, emergency department visits increase every year and now account for nearly 136 million encounters.

The two other pillars of healthcare reform -- Quality and Cost -- comprise the value equation. To enhance value, one must improve quality at the same or lesser cost. The federal government sees integrated care delivery systems, such as accountable care organizations, bundled payments and episodes of care, as viable solutions to reduce costs while improving the quality of care delivered to patients.

Just how will emergency medicine fit into this new paradigm? In my travels representing ACEP over the last year, I have heard insurance companies state over and over their desire to get patients out of the emergency department. I have heard their vision of emergency medicine as acute care gatekeepers. We have seen a movement of state Medicaid programs to reduce what they perceive to be unnecessary ED visits or only pay for a certain number of visits. It is problematic that insurance companies and policy makers do not see the value of emergency medicine. A visit to the ED has now somehow been inappropriately characterized a failure of the system. But remember, emergency medicine only accounts for two percent of all health care expenditures each year however, emergency physicians provide 28 percent of all ambulatory care visits and nearly two thirds of all visits after hours. This is true value, indeed.

I believe it is incumbent on our organization to highlight the value of emergency medicine. We have value today in being the rapid diagnostic center, of reducing patient cycle time and returning patients back to work sooner, we reduce readmissions and

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# Short-Term SGR Fix Signed by Obama

By Denise Fulton  
Elsevier Global Medical News

After several weeks of partisan debate between the U.S. Senate and House of Representatives, both chambers finally approved a two-month extension of payroll tax breaks and the Medicare sustainable growth rate.

Prior to the extension, physicians faced a 27% cut in their Medicare payments beginning January 1 based on the Sustainable Growth Rate (SGR) formula, which controls total spending on physicians' services based on the gross domestic product.

The measure passed by Congress and signed by President Barack Obama keeps the 2 percent payroll tax cut and unemployment benefits through February 2012, and Medicare payments for physicians will remain at current rates.

Obama urged Congress to come up with a full-year agreement on payroll tax breaks and an SGR fix — “without drama” and “without delay,” according to the report.

On December 22, bowing to pressure from all sides, House Republicans agreed to pass a Senate-authored bill to extend the two key provisions. The Senate passed an amended version of its extension bill by unanimous consent on December 23 and the House quickly followed suit.

By using the unanimous consent vote, congressional leaders were able to move the bill forward even though many members had already traveled home for the holidays.

Doctors' groups expressed relief that the pay cut was averted, as well as dismay at Congress' continued short-term fixes to the SGR problem.

Peter W. Carmel, MD, president of the American Medical Association, said in a statement: “Congress now has to enact a real and fiscally responsible solution to this sorry cycle of scheduled cuts and short-term patches that compromises access to care for patients and drives up costs for taxpayers.”

Dr. Carmel encouraged members of Congress

to “use this time to work in a bipartisan manner to provide long-term stability for seniors, military families and the physicians who care for them.”

The American Academy of Family Physicians, also issued a statement in response. Glen Stream, MD, the organization's president, said: “Eleventh-hour legislation that fails to meet the needs of constituents is no way to conduct the nation's business. That is particularly true when millions of Americans' health and welfare are at stake.”

“Americans are tired of short-term, insufficient answers to long-standing problems,” Dr. Stream continued. “Americans want a permanent solution. They want Congress to look beyond the next few months or the next year. They want health security. Instead, they got a bitter holiday gift — an extra 60 days before health insecurity again sets in.”

— Reprinted from a story published by ACEP News on December 23, 2011.

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# ACEP President Shares Vision for Future

*from Page 6*

potentially avoidable admissions through our observation units, and we help prepare our nation for disasters and provide syndromic surveillance.

Yet, I want to promote another vision of the value of emergency medicine. Emergency physicians must consider stepping out of our perceived comfort zone and perception of only providing acute care. As we all know, the primary care medical home is wonderful in theory but in practicality, it does not exist today. Nor will it in the near future. We do not have enough primary care physicians to fulfill this role but we have a need for the integration of medical care for the patient.

In preparing for this speech, I re-listed to Greg Henry's ACEP President's address to this very Council 16 years ago. In his speech, Dr. Henry called for the emergency department to serve as the central hub. I am renewing this call, one in which the ED is not only the central hub but a bridge to an integrated delivery system.

Could the emergency department, with its 136 million visits each year, with another 100 million visitors who come with patients, be a conduit or bridge to an integrated delivery system? I feel the ED and emergency medicine should consider the benefits of redesigning itself with support from the hospital and third party payers to provide an additional team of health providers – physicians, mid-levels, nurses, techs, case managers, and social workers – who could provide preventative care – such as immunizations and health care screenings; who could promote wellness through education on exercise, diet and other lifestyle choices; who could enhance our observation units to further reduce readmissions and potentially avoidable admissions; and who could develop better disease management and palliative care protocols to prevent these patients from their continual cycle of ED visits and admissions.

We can use our access to patients as a vehicle to enhance emergency medicine's value by serving as a bridge to integrated medical care – saving cost to the system and promoting quality care that keeps patients well. Just think how powerful emergency medicine could be as a leader and key contributor in the integrated health care delivery system. That is a future worth creating.

To accomplish the goal of enhanced value, we need medical liability reform. Defensive medicine continues to hinder our ability to practice

efficient emergency care, but we have the opportunity to push federal tort reform as a larger part of the healthcare reform movement. At a minimum, we should be protected when we follow identified best clinical practices. And with EMTALA as one of the largest unfunded mandates in history, we must have medical-liability for EMTALA-related services.

I think I'm in a room where I can safely say that emergency physicians deserve fair payment for their services.

ACEP has had major successes in this area over the years, but we still have many battles ahead. Congress has not found a fix to the sustainable growth rate formula, which could lead to a nearly 30 percent cut in Medicare payments as of January. ACEP also continues to push the issue of balance billing. Our members have worked with the National Commission of Insurance Legislators to draft model legislation for balance billing in emergency medicine.

We also must monitor and advocate against the impending state Medicaid program cuts. If emergency medicine continues to serve as the health care safety net, we must work innovatively with states to ensure adequate reimbursement for their Medicaid enrollees. Programs that limit ED visits must be actively fought, and the prudent layperson standard must be upheld for emergency visits.

When we consider all of these issues and what they mean for the future of emergency medicine, we can't lose sight of those physicians coming up behind us. Current budget negotiations are underway to limit funding for graduate medical education, and this comes at a time when we are facing a potential shortage of emergency physicians and emergency care providers over the next 20 years. Emergency medicine residency programs could be at risk, so we must devote resources to fight these cuts.

We also know that rural areas are particularly vulnerable to physician shortages. This highlights the obvious need for innovative solutions to providing emergency care to all areas.

I feel the time has come for ACEP to open its doors to collaborative efforts to provide quality emergency care for everyone. We will need to work with non-board certified physicians who practice emergency care to provide them education and advocacy so they can effectively

and efficiently take care of their patients. We also need to work with our advanced practice practitioners and mid-level providers to create efficient emergency care teams. The emergency department of the future will have a patient-centered team approach involving many practitioners dedicated to quality and efficient emergency care.

I am encouraged for the future of emergency medicine. Along with the ACEP Board of Directors, I will spend this next year tackling the very issues I have just outlined. One important step in creating a strong future for our specialty was the recent creation of the Emergency Medicine Action Fund.

The Action Fund is a historic collaboration of emergency medicine organizations and leaders that will enhance emergency medicine's advocacy efforts on the regulatory front. Our voices must be heard to protect our practice and our patients, and the work of the Action Fund Board of Governors in conjunction with ACEP's ongoing advocacy efforts, will be essential in making that happen.

I want to challenge all of you to help us create the future we want to see for emergency medicine. In addition to supporting the Action Fund, your contributions to NEMPAC make all the difference in impacting our advocacy efforts. We truly appreciate your continued support.

I recently led an emergency medicine delegation to Rwanda. The Rwandan people have suffered much hardship yet they greeted us each day with a saying:

Neweeno uryebey, aharee ubushakey, beoseye birashowbokah -- which means come and see, where there is will, everything is possible

As I enter my 25th year in emergency medicine and ACEP, I realize I must double my efforts for change – less for my career, but more for our younger members, residents and patients. We must focus on value and value-added services in emergency medicine. We must strive to provide the highest quality medical care to our patients. These next few years will be crucial for all of medicine. I ask you to join me in laying the foundation for our future. Let's demonstrate why we are, and will continue to be, true leaders in the House of Medicine.

— **David Seaberg, MD, FACEP, President**  
*American College of Emergency Physicians*





## Unique Opportunity for Emergency Medicine Board-Certified Physicians (ABEM, AOBEM or BCEM) in central Illinois

**What:** Due to the relocation of one full time member of our group, we are seeking 1 full-time physician or 2 part-timers to fill this position. Full time is 6 shifts per month of 24 hour each. This is a small group practice at a downstate hospital emergency department. The hospital is also considering development of a hybrid hospitalist program using NP's/ PA's with us as their supervising physicians. The ED has a volume of ~10,500 and is a very satisfying practice environment.

**Where:** Approximately 100 miles south of Chicago within comfortable driving distance of the Chicago area.

**Qualifications:** Experienced emergency physicians with outstanding clinical skills and a desire and enjoyment of communicating with patients, BC/BP in EM (primary care boards additional would be a plus because of future possible hospitalist role).

**Pay/Benefits:** \$125/hour on weekends/holidays and \$118/hours on weekdays (ED volume 10,500). Pay will increase by \$10/hour if hospitalist program begins next summer. Full-time benefits (>144 hours/ month): health insurance, 401K, \$3,000 per year CME, paid malpractice insurance (including tail) and pre-tax business expense deductions.

**Shifts:** We have 24 hour shifts available.

**Availability:** December 1st - we have 4 full-time physicians currently and are looking for 1 more full-time physician. If you have an interest in part-time, that is also acceptable

**If interested, send message and CV to:**  
**[jtbasketballmd@msn.com](mailto:jtbasketballmd@msn.com) or call 708-846-4329**



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**Carle Physician Group** in Urbana, Illinois is excited to announce a new partnership with Kirby Hospital in Monticello, Illinois and is seeking 4 **BE/BC Emergency Medicine** physicians to join our stable and experienced quality-oriented group of 18 physicians. ● Time will be split providing services to Carle Foundation Hospital, a Level I Trauma Center, and Kirby Hospital, a critical-access regional hospital with newly constructed facilities that opened in September ● Ideal candidate will be comfortable working in a high-volume, high-acuity emergency department (65K visits) and a slower-paced rural emergency department ● Emergency Department physicians are supported by a 18-physician Hospitalist Department and 24-hour in-house coverage provided by Anesthesiology, Hospitalists, OB-GYN, and Trauma Surgery ● Opportunity to teach medical students/residents through the **University of Illinois College of Medicine** ● **Superior compensation package, paid malpractice insurance with 100% tail coverage** ● Vacation, CME/meeting and holiday time with equitable distribution of holiday/weekend shifts ● Home to the Big Ten University of Illinois, Champaign-Urbana is a diverse community of 195,000 offering cultural, sporting and entertainment options usually associated with much larger cities; Monticello is a vibrant bedroom community; both are centrally located two hours from Chicago/Indianapolis and three hours from St. Louis. **For more information, contact Karen Uden at (800)436-3095, extension 4112, email your CV to karen.uden@carle.com or fax it to (217) 337-4181.**

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## ICEP Calendar *of* Events 2012

**January 2, 2012**

**ICEP Office Closed**  
New Year's Holiday  
Observance

**January 6, 2012**

**LEAD Program Meeting**  
ICEP Conference Center  
Downers Grove

**January 24-25, 2012**

**APLS\*PALS Combined  
Course**  
ICEP Conference Center  
Downers Grove

**February 8, 2012**

**EMS Committee**  
11:00 AM - 1:00 PM  
ICEP Board Room  
Downers Grove

**February 8, 2012**

**EMS Forum**  
1:00 PM - 3:00 PM  
ICEP Conference Center  
Downers Grove

**March 1, 2012**

**2009 EM4LIFE LLSA Article  
Review Course**  
ICEP Conference Center  
Downers Grove

**March 6-7, 2012**

**EM Days: Advocacy &  
Education in Springfield**  
President Abraham Lincoln  
Hotel & Conference Center  
Springfield

**March 6, 2012**

**ICEP Board of Directors**  
3:00 PM - 5:00 PM  
President Abraham Lincoln  
Hotel & Conference Center  
Springfield

**March 6, 2012**

**EM Days in Springfield  
Reception with Legislators**  
5:30 PM - 7:00 PM  
Abraham Lincoln Presidential  
Library & Museum, Springfield

**April 3-4, 2012**

**Oral Board Review Courses**  
Chicago O'Hare Marriot  
Chicago

**April 20, 2012**

**Emergent Procedures  
Simulation Skills Lab**  
NorthShore University  
HealthSystem Evanston Hospital  
Evanston

**April 26, 2012**

**Spring Symposium & Annual  
Business Meeting**  
Advocate Christ Medical Center  
Oak Lawn

**May 15, 2012**

**2010 EM4LIFE LLSA Article  
Review Course**  
ICEP Conference Center  
Downers Grove

**May 18, 2012**

**2011 EM4LIFE LLSA Article  
Review Course**  
ICEP Conference Center

**September 7, 2012**

**Emergent Procedures  
Simulation Skills Lab**  
NorthShore University  
HealthSystem Evanston Hospital  
Evanston

**September 27-28, 2012**

**Oral Board Review Courses**  
Chicago O'Hare Marriot  
Chicago

**November 2, 2012**

**Emergent Procedures  
Simulation Skills Lab**  
NorthShore University  
HealthSystem Evanston Hospital  
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