Illinois EPIC
Emergency Physicians Interim Communique

Illinois College of Emergency Physicians
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PRESIDENT'S LETTER

The Illinois SMART Act: Is the Devil In the Details?

Heather M. Prendergast, MD, MPH, FACEP

On May 24, 2012, SB2840, the Save Medicaid Access and Resources Together Act, also known as the SMART Act, passed both houses of the Illinois General Assembly and was signed into law by Governor Quinn on June 14, 2012. The SMART Act was the work product of the Legislative Medicaid Advisory Committee and represented a bipartisan effort.

There are several provisions contained within the act that will present challenges and threats to our practices, but ICEP was recently instrumental in achieving a victory for emergency physicians by amending the co-payments for non-emergent services.

Co-payments for "Non-Emergent" Services
Emergency physicians were notably concerned regarding the language of the act, which stated there would be mandatory co-pays for non-emergent services.

Whatever your philosophical point of view is regarding individual patient responsibility, having a statute in place that defines what is an emergency — either prospectively or retrospectively — is fraught with difficulty.

ICEP challenged this provision as a direct conflict with the prudent layperson standard and appealed to the Joint Committee on Administrative Rules (JCAR). JCAR responded to ICEP's request to exclude Level II emergency services from the Medicaid copayment provision under the new SMART Act. JCAR agreed with ICEP and objected to HFS's extension of the copayment to Level II service.

HFS agreed to modify the emergency rules regarding copayments. As of October 5, 2012, as ICEP requested and JCAR affirmed, the rules have been revised to exclude Level I and Level II ED services from the co-payment requirement. The co-payment for non-emergency services is $3.65.

Four-Prescription Rule
The four-prescription rule is a great example of a challenge to the practice of EM. SB2840 states: "On and after July 1, 2012, the Department shall impose limitations on prescription drugs such that the Department shall not provide reimbursement for more than 4 prescriptions, including 3 brand name prescriptions, for distinct drugs in a 30-day period, unless prior approval is received for all prescriptions in excess of the 4-prescription limit. Drugs in the following therapeutic classes shall not be subject to prior approval as a result of the 4-prescription limit: immunosuppressant drugs, oncolytic drugs, and anti-retroviral drugs."

With passage of the SMART Act, Illinois joins a list of 6 other states that have placed caps on the number of prescriptions that Medicaid patients can receive within the last 2 years. Here in Illinois, this puts an additional burden on a health system that is struggling with out-of-control health care costs by elevating cost containment over quality of care.

According to numbers published in a recent article in Crain's Chicago Business, while the average adult on Medicaid reportedly fills 23 prescriptions a year, the average senior on Medicaid fills 115 prescriptions annually. It is estimated that 200,000 Medicaid patients fill more than five prescriptions per month.

According to written testimony provided to the Illinois Health Care Reform Implementation Council by the Sargent Shriver National Center on Poverty Law, an estimated 700,000 Illinoisans (27% of Illinois uninsured) will be added to Medicaid under the Accountable Care Act.

It is likely that the brunt of this prescription cap ruling will disproportionally affect the most vulnerable patients in the system, the elderly and those with chronic medical and/or psychiatric illness.

As emergency physicians, we will find our-

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InsideEPIC

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The Illinois SMART Act: Is the Devil in the Details?

Impact of Legislation on Practice of Emergency Medicine Troubling

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selves in a real conundrum. When patients are discharged from our emergency departments, we expect that they will fill their prescriptions. The SMART Act adds an additional layer of uncertainty and complexity. Many patients will heed our advice and attempt to fill their prescriptions, only to be turned away if they have reached the monthly limit. At this point, patients are instructed to return to the prescriber to have a prior approval request submitted on their behalf. According to HFS guidelines, these requests can be submitted via telephone or fax and will be reviewed on a case-by-case basis.

How many repeat emergency department visits and readmissions will be directly related to these prescriptions limits is uncertain but likely to be significant. Emergency physicians cannot know their patients' prescription limit status, which creates a significant disadvantage in providing [optimal] patient care. It's likely that limiting prescription coverage will end up creating higher downstream costs.

While hospitals and emergency departments are working to develop collaborative transitions-of-care models that address 30-day hospital readmission rates and repeat ED visits, this ruling may have the effect of two steps backwards.

There is no reduction in fees for physicians, dentists, and Federally Qualified Health Centers (FQHCs) included in the SMART Act; however, there are several additional features to the act of concern to emergency medicine.

Care Coordination Program Participation
The statute mandates that enrollees in certain counties are required to have a 50% participation rate in a care coordination program. Many managed care entities are lining up for this market. Given the irregular and sporadic payments from Illinois Medicaid, pursuing payments from a multitude of managed care entities is a daunting prospect for emergency physicians and their billing entities.

Limitations of Payment for Hospital Services
As our business partner, hospital payments have been targeted specifically in a number of ways:

1. A 3.5% reduction in base payments for all hospitals (excluding Safety Net or Critical Access Hospitals).
2. Reduction or outright denial of payment for hospital acquired conditions and potentially avoidable admissions.
3. Restriction of admissions for detoxification services within a 60 day period.
4. Outpatient physical therapy restricted to 20 visits per year.

Reduction in Enrollment
Patients on general assistance will be dropped from eligibility in certain communities, adding to our uninsured burden.

Program Integrity Enforcement
This is an initiative aimed at increasing audit activity.

Payment Reforms
The time limit for providers to submit a claim will be reduced to 180 days.

Sexual Assault Survivors Emergency Treatment Program
Payments for this program will be reduced.

Restrictions on Non-Emergency Adult Dental Services
This will undoubtedly increase the burden on EM physicians for care of dental emergencies as well as overall dental care.

All of these changes may have significant impact on our ability to care for our patients, and potentially add significant administrative burden to our practices.

As the only state organization committed to advocating for emergency physicians and their patients, ICEP must highlight when these new policies fail to deliver the intended results or (more importantly) create new problems.

Over the next several months, ICEP's strategic alliances with other organizations will continue to address our concerns and collectively achieve victories on behalf of our patients and speciality. **ICEP needs to hear from you — our membership** — about the real adverse affects of the SMART Act on your patients!

We will collectively deliver these stories to our elected officials. Early next year, ICEP will be organizing a 1-day trip to Springfield (transportation provided) dedicated solely to advocacy. As a specialty central to health care delivery across the state of Illinois, emergency physicians have a unique and powerful voice that is essential to better healthcare. Your voice has never been more important.

— Heather Prendergast, MD, MPH, FACEP
ICEP President

Illinois EPIC

Illinois College of Emergency Physicians
3000 Woodcreek Drive, Suite 200
Downers Grove, IL 60515
Phone 630.495.6400 Fax 630.495.6404
www.icep.org

Editor
Cai Glushak, MD, FACEP
ICEP President
Heather Prendergast, MD, MPH, FACEP
Executive Director
Virginia Kennedy Palys
Managing Editor
Kate Blackwelder

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ICEP Resolution on Mental Health Modified, Passed by ACEP Council

ICEP's resolution proposing a study on the effects of psychiatric boarding patients was passed by the ACEP Council after the Reference Committee recommended it be combined with a related resolution from the Pennsylvania chapter.

The resulting Substitute Resolution 22, Behavioral Health Patients in the Emergency Department, was approved by the Council.

Under the provisions of the approved Resolution 22, ACEP will convene a work group of appropriate stakeholders to explore and identify additional resources, technologies, and best practices that promote quality patient care for timely evaluation and disposition of behavioral health patients.

A report from the work group on behavioral health care will be delivered to the 2013 ACEP Council.

Representing ICEP at the Council Meeting were: E. Bradshaw Bunney, MD, FACEP; Shu B. Chan, MD, MS, FACEP; Marc Dorfman, MD, FACEP; Mila Felder, MD, FACEP; Cai Glushak, MD, FACEP; John Hafner, Jr., MD, FACEP; George Z. Hevesy, MD, FACEP; Chad Kessler, MD, FACEP; Valerie J. Phillips, MD, FACEP; Heather M. Prendergast, MD, MPH, FACEP; Derek Robinson, MD, MBA, FACEP; Edward P. Sloan , MD, MPH, FACEP; Deborah Weber, MD, FACEP; and John Williams, MD, FACEP.

ICEP's 2012 Councillors pose with ACEP Board Member Mark Mackey, MD, MBA, FACEP, at the conclusion of the Council Meeting.

ICEP authored its original resolution to ask ACEP to investigate the magnitude and any possible solutions to the problem of holding patients in need of psychiatric services. This problem is spiraling out of control, especially in Illinois. Not only do these patients place a burden on the ED in terms of their prolonged stays, but oftentimes they are violent and pose a risk to staff and other patients. With ongoing cuts in the budgets for state health services, this situation is certain to worsen.

Anecdotally, the problem appears to be widespread. In a 2010 survey of hospital emergency department administrator conducted by the Schumacher Group, 86% of ED administrators indicated they are unable to transfer psychiatric patients, with 70% reporting stays of greater than 24 hours and 10% reporting average stays over a week. More than 90% of survey respondents reported that this boarding reduces the availability of ED beds, and 67% of respondents reported a decrease in the number of psychiatric beds.

ICEP member Dr. Rebecca Parker was elected to her second term on the ACEP Board of Directors.

Dr. Rebecca Parker Reelected to ACEP Board of Directors

ICEP member Rebecca B. Parker, MD, FACEP was reelected to the ACEP Board of Directors during the 2012 Council Meeting at Scientific Assembly in Denver. This will be her second term on the Board.

Dr. Parker is a former member of ICEP's Board of Directors. She is one of two Illinois members seated on the ACEP Board: Mark Mackey, MD, MBA, FACEP was elected to the Board in 2011.

Also elected to the Board at the 2012 Council Meeting were: Vidor Friedman MD, FACEP, of Florida; William Jaquis, MD, FACEP, of Maryland; and Jay A. Kaplan, MD, FACEP, of California.

Alexander Rosenau, DO, FACEP, of Pennsylvania, was elected to the position of President-elect for the term. Andrew Sama, MD, FACEP, of New York, has assumed his role as ACEP President.

Heart Rescue Program in Illinois Aims to Educate Public on Cardiac Arrests

The University of Illinois Hospital and Health Sciences System has received a $2.5 million grant from the Medtronic Foundation to coordinate Illinois Heart Rescue, an ambitious statewide all-volunteer effort to more than double survival from sudden cardiac arrests in Illinois.

Gov. Pat Quinn launched Illinois Heart Rescue at the end of August.

ICEP members Terry Vanden Hoek, MD, FACEP, and Eric Beck, DO, EMT-P are serving as the project's team leaders. Numerous other ICEP members are also involved in advisory and hospital liaison roles.

"In sudden cardiac arrest, a few seconds of time can make a lifetime of difference," said Dr. Vanden Hoek, professor and chair of emergency medicine at the University of Illinois Hospital. "The Medtronic Foundation has given us an opportunity to help the people of Illinois make that difference."

The all-volunteer leadership team for Illinois Heart Rescue represents an unusually broad collaboration between physicians, health professionals, community organizations, hospitals, EMS systems, fire departments and governmental agencies across the state.

Leaders in the initiative include the Chicago Fire Department, Chicago EMS System, the Illinois Department of Public Health, the Chicago Cardiac Arrest Resuscitation Education Service (CCARES) and the University of Illinois Hospital and Health Sciences System.

"Currently, one of the missing links in the 'chain of survival' is data," said Joseph Weber, MD, Chicago EMS director, emergency medicine physician at John H. Stroger Jr., Hospital of Cook County and assistant professor at Rush Medical College. "This grant will allow us to quantify cardiac-arrest survival across the state. We can then use this data to direct quality improvement initiatives and track progress on our ultimate goal of improving cardiac arrest survival in Illinois."

Illinois Heart Rescue aims to double survival from sudden cardiac arrest by strengthening three key links in the chain of survival: bystander CPR, pre-hospital resuscitation by EMS, and post-arrest care through hospital interventions.

In the first moments, a knowledgeable bystander who can begin CPR can save a life. Illinois Heart Rescue's community initiative will aim to improve bystander CPR in Illinois through free instruction.

"If you see someone collapse, the message is simple: Call 911. Start doing chest compressions, 100 beats per minute and two inches deep. Call for someone to bring an AED and use it. These actions alone can save someone's life," said Amer Aldeen, MD, FACEP, assistant professor of emergency medicine at Northwestern University, co-director of CCARES and Illinois Heart Rescue community liaison.

The Illinois Heart Rescue team will use social media, multi-lingual and culturally sensitive messaging, athletic events, and community health fairs to reach the diverse population of Illinois.

"We plan to spread the message of bystander CPR and AEDs throughout Illinois, especially in our relatively underserved urban and rural areas," Dr. Aldeen said.

Evidenced-based best practices for pre-hospital care will be taught to 911 dispatchers, EMTs, firefighters, and paramedics in simulator training at the Chicago Fire Academy Simulation Center and later at simulation centers in Peoria and Evanston.

"We will bring the science of cardiac arrest resuscitation to the streets through simulation training," said Dr. Beck, EMS Medical Director for Chicago and assistant professor of medicine at the University of Chicago. "Simple things like high-quality, uninterrupted chest compressions and limiting patient movement during cardiac arrest have been shown to dramatically improve survival."

Illinois Heart Rescue will include a demonstration project, linking hospitals to postcardiac arrest care experts, modeled on the highly successful Illinois Poison Control Center, which links hospitals to expert advice.

"We are especially pleased to partner with Illinois Heart Rescue in this important initiative to eliminate disparities in sudden cardiac arrest and to improve cardiac arrest outcomes in our state, particularly in Chicago and underserved rural areas of the state," said Derek J. Robinson, MD, MBA, FACEP, executive director, Illinois Hospital Association's Quality Care Institute. Thirty partners throughout Illinois will collaborate initially to collect outcome data and champion state-of-the-art care for patients post-resuscitation.

Other grant partners include the American Heart Association, the Chicago Cubs, the American Red Cross, the Chicago Department of Public Health and many community organizations that include local health clinic systems and neighborhood groups.

"Illinois Heart Rescue has an enormous potential to save lives in Chicago and suburban and rural communities throughout the state," Dr. Vanden Hoek said. "The unprecedented collaboration from so many Illinois institutions gives us a foundation we believe can be sustained and serve as a model for other states."

Contact Illinois Heart Rescue:

C/O University of Illinois at Chicago
808 S. Wood Street, MC 724
Room 471-H
College of Medicine East
Chicago, IL 60612-7354
Phone (312) 355-0333
Email: ilheartrescue@gmail.com
Website: www.illinoisheartrescue.org

Physicians Encouraged to Register for Peripheral IV Workshop to Hone Skills

Physicians who are looking for practice in emergency medicine ultrasound and peripheral IV placement are encouraged to attend one of ICEP's upcoming half-day workshops.

Although the course was originally developed for all levels of nurses and emergency providers, many physicians have expressed an interest in attending to refine or refresh their skills. All are invited to attend. Physicians should note that no CME hours are available for the workshops.

Courses will be held at the ICEP Conference Center on Wednesday, October 24 and Thursday, November 29. The course of the course is $95 for the 4-hour program.

Each course will cover:

- Ultrasound basics of probe selection, knobology, image quality and more
- Getting started with ultrasound-guided peripheral IV
- FAST Exam overview
- Skills stations: Normal vasculature, transverse and longitudinal approaches to peripheral IV placement, normal and abnormal FAST exam, central line target practice, and more

ICEP has partnered with Advocate Christ Medical Center and the Illinois Emergency Nurses Association to present the workshops. ICEP member Laura Oh, MD, of Loyola University Medical Center is the program's course director, and the workshops will be taught by expert physician faculty from ACMC's Department of Emergency Medicine utilizing phantoms and a live model. The hands-on component of the course will be more than 2.5 hours of practice in small groups.

Physicians are also urged to send their emergency nurses and physician assistants to one of the upcoming courses. Help ICEP by getting the word out at your emergency department or group. The program includes an hour of didactic review in addition to the hands-on practice.

Register online now at ICEP.org. Space is limited due to the intensive hands-on nature of the workshop, but spaces are still left for both course dates. Each workshop will provide contact hours from ENA.

Make your own schedule.

After years of crazy hours and jumping through hoops, you've earned some flexibility. It's time to enjoy life.

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Visit us at booth 1309.

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IDPH Recommends Use of Tdap Vaccine in EDs

In 2012, more than 1,400 persons have received a diagnosis of pertussis in Illinois. In response to this increase, the Illinois Department of Public Health (IDPH) and the Chicago Department of Public Health recommend that whenever tetanus toxoid is indicated for wound management, hospital emergency department and urgent care center staff administer tetanus, diphtheria, and acellular pertussis (Tdap) vaccine.

Tdap is recommended instead of tetanus and diphtheria (Td) toxoids or tetanus toxoid (TT) to all patients 7 years of age and older, including pregnant women, who have not had a previous dose of Tdap. (If immunization records are not available, assume that the patient has not received a prior dose of Tdap.)

Pertussis is typically spread to young infants by adolescents or adults, usually household members. Infants too young to be immunized against pertussis are particularly vulnerable to severe pertussis disease. Increasing population immunity to pertussis should reduce opportunities for pertussis transmission.

Tdap vaccine, which was first licensed in the U.S. in 2005, is the only product available to protect older children, teens and adults against pertussis. Two Tdap formulations are available. Adacel® is currently licensed for those who are 11-64 years of age and Boostrix® is licensed for those 10 years of age and older (including those older than 64 years of age).

Tdap need not be deferred if the patient cannot recall whether they have had a prior dose of Tdap vaccine and Tdap can be given regardless of the time elapsed since the last vaccine containing tetanus or diphtheria toxoids.

The only contraindications to immunization with Tdap, are a documented history of anaphylaxis after receipt of Tdap, DTaP or their ingredients; or encephalopathy occurring within seven days after immunization against pertussis that was not due to another identifiable cause.

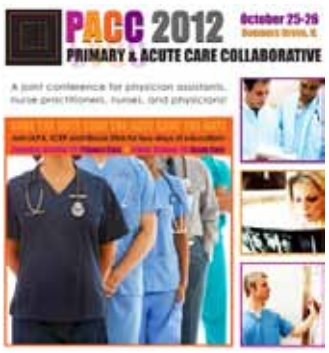
The cost differential between Td and Tdap vaccine is approximately $10 to $15 dollars depending on the vaccine manufacturer.

If you have any questions about tetanus vaccine recommendations for wound management or about pertussis, contact your local health department. For list of local health departments visit http://www.idph.state.il.us/local/alpha.htm.

Spread the Words to PAs, RNs about PACC 2012

PACC 2012, a joint conference for physician assistants, nurse practitioners, and nurses held by ICEP and IAPA, is next week!

ICEP encourages its members to spread the word to the PAs, APNs, and nurses in your emergency department or group. The two-day program covers 18 primary and acute care topics.



ICEP member Helen Straus, MD, MS, FACEP is serving as the program's course director. Acute care topics are presented by ICEP's expert faculty.

PACC 2012 will be held Thursday and Friday, October 25-26 at the ICEP Conference Center in Downers Grove. Registrants may opt to come to both days or one day. A Suturing Workshop is also scheduled.

Members Appointed to National Committees

Twenty-five ICEP members have been selected to serve on national ACEP committees for the current committee cycle:

Academic Affairs Committee
David S. Howes, MD, FACEP
Chad Kessler, MD, FACEP

Education Committee
John Bailitz, MD, FACEP
Morris Kharasch, MD, FACEP
Christopher Ross, MD, FACEP
Jeff Schaider, MD, FACEP
Michelle Sergel, MD
Ernest Wang, MD, FACEP

EMS Committee
Eric Beck, DO, EMT-P

Federal Government Affairs Committee
Susan Nedza, MD, MBA, FACEP

Membership Committee
William Burns

Research Committee
Jesse Borke, MD
Shu Boung Chan, MD, FACEP
D. Mark Courtney, MD, FACEP

Ethics Committee
Michaelina Bolton, MD
Aasim Padela, MD

Public Relations Committee
Archana Reddy, MD
Valerie Roth, MD

Medical Legal Committee
James Hubler, MD, JD, FACEP
Daniel Sullivan, MD, JD, FACEP
William Sullivan, DO, JD, FACEP

Quality & Performance Committee
Christopher Beach, MD, FACEP
Rahul Khare, MD, FACEP
Meredith Williams, MD

Disaster Preparedness & Response Committee
Bhakti Hansoti, MD

Clinical and Core Faculty Physician Opportunities in Illinois

Peoria, Illinois - OSF Saint Francis Medical Center, the major teaching affiliate of Emergency Medicine -University of Illinois College of Medicine -Peoria is seeking clinical and core faculty physicians for full and part-time opportunities. Exceptional opportunities available with an experienced and progressive hospital. A new ED was opened in 2010. EM residency, Level 1 Trauma Center, flight program, base station, and 88,000 emergency department visits annually.

Greater Peoria has a metro population of 350,000, offers a vibrant, energetic community, has an active riverfront, and a civic center, with cultural activities and sporting events.

Please contact: Stacey E. Morin
OSF Healthcare System
1420 West Pioneer Parkway | Peoria, IL | 61615
p (309) 683-8354, stacey.e.morin@osfhealthcare.org

www.osfhealthcare.org

OSF HealthCare

Studies Look at Frequent ED User Behavior

"Frequent flyers," or frequent users of the emergency department, do not have higher rates of non-urgent visits than typical ER patients, according to several new studies released during ACEP's Scientific Assembly. Despite being demonized as abusers of the health care system, the studies find that frequent users represent a small percentage of the total number of emergency patients and that most seek emergency care appropriately.

"Frequent users are equally justified in seeking emergency care as non-frequent users because they have serious medical problems that demand emergency care," said Andy Sama, MD, FACEP, ACEP's president. "If one certainty emerges here, it is that patients with mental illnesses and psychiatric emergencies are coming to the ER because other resources are simply not available to them. Frequent users are also more likely to be insured by Medicare or Medicaid and to be chronically ill."

The definition of "frequent user" varies widely, from a patient who visits the emergency department four times a year to one who is there more than seven times a year. They are responsible for anywhere from 11.5 percent to 39.7 percent of all ER visits, depending on the definition of frequent user.

Studies in both Virginia and Wisconsin found that patients who visit the emergency department frequently do so for a relatively brief period – only a year or two. Results were mixed on whether frequent users were more or less likely to be admitted to the hospital from the ER. However, high repeat users in a Virginia emergency department, once admitted to the hospital, were significantly more likely to be re-admitted after 30 days.

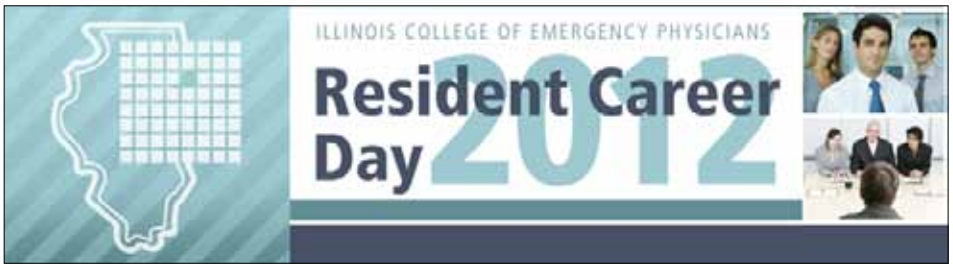
Robert E. O'Connor, MD, MPH, FACEP, one of the study authors from Virginia, noted that "federal programs designed to penalize providers for 30-day readmissions may be dangerous for high-risk patient populations. Our data show that patients who were frequent users of emergency department services following hospital discharge were more likely to require readmission for unstable health conditions that could not be managed in an ambulatory setting."

Repeat users, when defined as having two or more visits in a six-month period, represented 19.7 percent of all patients and 39.7 percent of all visits to the Virginia ER. In this study, patients who visited most often – more than nine visits in a 6-month period – represented less than 2 percent of all emergency department visits. These patients were more likely to be on Medicare and had significantly greater odds of having psychiatric illnesses.

In Massachusetts, frequent users were defined as patients who visited the emergency department five or more times in a year. They represented 2.1 percent of patients and 11.5 percent of visits. Like their counterparts in Virginia, they were more likely to be on Medicare and more likely to have mental illness-related visits.

So-called "super users," defined as patients who visit the ER 21 or more times in a year, in California were more likely to visit multiple hospitals for care. Although they represented only 0.2 percent of all patients, they accounted for 4.5 percent of all emergency department visits in the region. Frequent psychiatric patients in the California study were also more likely to visit multiple hospitals for care.

Resident Career Day Podcasts Online



ICEP has a valuable new career planning resource available online: Podcasts of each of the educational sessions from the 2012 Resident Career Day program.

Whether you were unable to attend Resident Career Day or just want to listen to one of the lectures again, visit ICEPBlog.org to get started.

You'll also be able to view the presentation PowerPoints from the site to follow along during the audio recording.

Five key topics were presented by expert faculty at the meeting in September and are now available for listening online. Each topic is approximately 30 minutes to 1 hour in length and puts an emphasis on real-world advice to help residents prepare for the job search. Topics are:

- Edward P. Callahan, MD, MS, FACEP, on fostering resilience.
- Dino P. Rumoro, DO, FACEP, on determing what type of practice fits you best.
- William Sullivan, DO, JD, FACEP, on interviewing and contract negotiation.
- Rebecca Parker, MD, FACEP on getting your personal finances in order.
- Jeffrey Graff, MD, FACEP on finding your emergency medicine niche.

Log on to ICEPBlog.org today to start listening!

CDC Reminds Providers of Guidelines for Safe Use of Single-Dose/Single-Use Vials

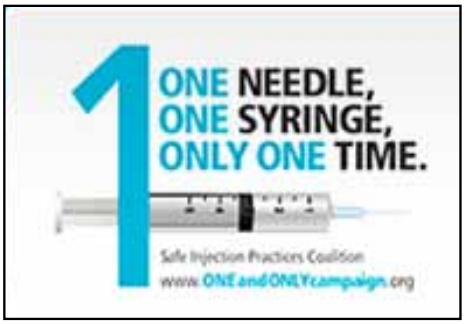
With certain drugs in short supply, some health care professionals may be tempted to use single-dose/single-use medication vials for more than one patient, a practice that goes against the Centers for Disease Control and Prevention's (CDC) 2007 Standard Precautions.

New outbreak reports provide a frightening reminder of these critical recommendations: medications labeled 'single-use' or 'singledose' must be used for one—and only one—patient.

The CDC reported in the July 13 issue of Morbidity and Mortality Weekly Report (MMWR) that 10 patients in Arizona and Delaware contracted severe methicillin-susceptible Staphylococcus aureus (staph) or methicillin-resistant S. aureus (MRSA) infections at outpatient facilities where practitioners reused medication from single-dose/single-use medication vials for multiple patients.

This report serves as a stark reminder that safe injection practices must be adhered to at all times, in all health care settings, and even during times of medication shortages. Health care providers are encouraged to double check their practices against the CDC's Injection Safety Recommendations.

In Arizona, three patients contracted invasive



MRSA infections following injections from the same single-dose/single-use vial at an outpatient pain management clinic. Patients were treated for acute mediastinitis, bacterial meningitis, epidural abscess and sepsis. A fourth patient who received an injection from the same vial was found dead at home six days after treatment at the clinic. Cause of death was reported as multiple drug overdose; however, invasive MRSA could not be ruled out.

Seven patients in Delaware were diagnosed with severe staph infections after receiving joint injections at the same outpatient orthopedic practice. Staff at the clinic had recently started to use single-dose/single-use vials for multiple patients after their supply of a smaller vial size (which they had previously dedicated for single –patient use), was disrupted as part of a national shortage. Two staff members who were responsible for preparing injections were found to be colonized with S. aureus, and one was an identical match to the strain that infected the seven patients.

Since 2007, the year that injection safety was included as part of Standard Precautions, there have been at least 20 outbreaks associated with the use of single-dose or single-use medication vials for more than one patient. Medication in single-dose/single-use vials is typically preservative-free, which makes it unsafe to use for more than one patient.

The One & Only Campaign is a public health campaign, led by the Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition (SIPC), to raise awareness among patients and healthcare providers about safe injection practices. The campaign aims to eradicate outbreaks resulting from unsafe injection practices.

The One & Only Campaign website, www.oneandonlycampaign.org, contains resources for health care professionals, including the CDC Guidelines, FAQs, communications checklists, links to social media sites, injection safety toolkits, and a wealth of print, audio, and video materials available for organizations who wish to help spread the word about safe practices related to single-dose/single-use vials.

ecps

Emergency Care Physician Services

Job Opportunities for Board Certified EM Physicians

Emergency Care Physician Services™ is a Chicago-based, physician-owned, financially democratic Emergency Medicine group with Full & Part Time Positions available for Board Certified EM physicians.

The unique business model of ECPS is based on full transparency with profit sharing opportunities for those physicians who make a defined commitment on a full or part time basis. Newly renovated ED facilities of MetroSouth Medical Center in Blue Island, IL offer 30 state-of-the-art medical exam rooms with integrated LCD televisions plus Empower Systems™ ONC Certified EHR hospital-wide. 42,000 patients are evaluated annually by double to triple staff coverage, with 43 hours of physician coverage.

Physician Requirements [Full Time, Part Time, or Moonlighters]

To be considered a Top ER Doctor and be guaranteed profit sharing opportunities, candidates must:

+ **Deliver High Quality, Expedient (Fast) Medical Care**
  All patients are evaluated "immediately" upon being placed in an exam room. Avg time equal or greater than 10 minutes. At the time period "Physician Change of Shift," all patients are evaluated immediately upon being placed in exam room to start diagnostics and medical orders.
+ **Deliver Customer Service Focused Medicine to Patients, Family Members, Hospital Employees, Medical Staff, and Senior Administrators.**
+ **Meet Patient and Customer Satisfaction Scores equal to or greater than the ECPS benchmark score.**
+ **Ensure Expedient Disposition of Hospital Admissions.**
+ **Ensure that all hospital admissions meet Medical Necessity Criteria with supporting clinical documentation and Diagnosis on the ED chart.**

Compensation

Base Salary is $175/hour for Day Shifts, $185/hour for Night Shifts.
Profit Sharing for those who make a defined commitment.
Malpractice Insurance is provided by ECPS.

Contact

Those interested in participating in a financially democratic EM physician group should contact **Eric Nussbaum, MD FACEP at (708) 824-4880 or enussbaum@ecps.md**

www.ecps.md

Classified Ads

MICHIGAN CITY, INDIANA: Franciscan St. Anthony Health is a 30,000 annual volume facility located 60 miles from Chicago, IL. Staff EM physician opportunities are available. EPMG cares about allowing clinicians to live life and do the work they love. We care about providing exceptional compensation and benefits, including a brand new partnership program. To learn more contact Heather Smith at 734.686.6326 or hsmith@epmgpc.com. Visit us at www.epmgpc.com.

CHICAGO, ILLINOIS: Thorek Memorial Hospital is a low volume facility in the heart of Chicago. 12 or 24 hour shifts are available daily. The ED environment is supported with a highly-skilled and efficient nursing staff. EPMG cares about allowing clinicians to live life and do the work they love. We care about providing exceptional compensation and benefits, including a brand new partnership program. To learn more contact Sarah Hysell at 734.686.6327 or shysell@epmgpc.com. Visit us at www.epmgpc.com.

MOUNT SINAI HOSPITAL emergency department, community teaching hospital on the southwest side of Chicago, has full and part-time positions for EM board certified or prepared physicians. Level I Pediatric and Adult Trauma Center and Fast Track with 58,000 visits and EM residents from the University of Chicago. Competitive salary and benefits. Contact Leslie Zun, MD, Chairman, Department of Emergency Medicine, Mount Sinai Hospital, 15th and California, Chicago, IL 60608. Phone 773-257-6957, fax 773-257-1770 or e-mail zunl@sinai.org.

BARRINGTON, ILLINOIS. Tri-County Emergency Physicians, LTD seeks a full-time or part-time Emergency Department Physician at Good Shepherd Hospital in Barrington, Illinois. Must be board certified or board eligible in Emergency Medicine. Please send your CV to Dr. Joseph Giangrasso, 450 W. Highway 22, Barrington, IL, 60010, 847-842-4231 or email joe.giangrasso@advocatehealth.com. We offer flexible hours and a competitive salary with bonus.

HOBART, INDIANA: St. Mary Medical Center is located 35 miles south of Chicago. The emergency department is newly renovated and is a designated Level II Trauma Center. The current annual volume of the 22-bed department is approximately 40,000 visits. EPMG cares about allowing clinicians to live life and do the work they love. We care about providing exceptional compensation and benefits, including a brand new partnership program. To learn more contact Heather Smith at 734.686.6326 or hsmith@epmgpc.com. Visit us at www.epmgpc.com.

WANT TO REACH 1,250 ILLINOIS EMERGENCY PHYSICIANS?
Advertise in the Illinois EPIC. Targeted. Affordable. Effective. If you have a professional opportunity, product or service you want emergency physicians to know about, the Illinois EPIC will get you noticed. A great value for your marketing dollar, the EPIC helps you reach your audience by providing a complete line of advertising services. Contact Kate Blackwelder at 630.495.6400, ext. 205, or kateb@icep.org for an EPIC rate sheet and list of closing dates.

emergent procedures SIMULATION Skills Lab

SPACES STILL REMAINING!

Friday, November 2

NorthShore Center for Simulation & Innovation Evanston Hospital

ICEP.org

SWEDISH
Emergency Associates

Swedish Emergency Associates has full and part time positions available in the ED and Fast Track! Located on Chicago's dynamic north side, Swedish Covenant is a high acuity level II community teaching hospital with ED resident coverage and 49 hours of ED coverage & 14 hours of FT coverage. Benefits include malpractice insurance with tail coverage, competitive compensation, flexible scheduling, health/dental/disability insurance & productivity bonus opportunities. For consideration, please email your CV to Bruce McNulty MD, Chairman Emergency Medicine at Swedish Covenant Hospital: bmcnulty@seahealthcare.com or call 773-878-8200 x 5475.

Looking for a locally owned, well-established democratic group where every doctor's voice can be heard?

Emergency Medical Associates of Palos (EMAP) is offering an exceptional career opportunity for one or more full-time Emergency Medicine Physicians to practice compassionate, high-quality emergency medicine in a rewarding and stable environment.

Our Emergency Department treats an average of 46,000 patients annually, has a Fast Track program, and a full and responsive on-call referral board. EMAP will offer qualified physicians top-tier professional pay, including night and holiday differentials, a generous CME/professional fund, productivity incentives, 401k profit-sharing, and paid healthcare and malpractice insurance. The monthly schedule process is both innovative and fair, providing for overlapping shifts, long term travel planning, and advance holiday assignments.

To ensure EMAP's long term success, we look to select the highest caliber of motivated, talented and team-oriented physicians to be members of our group. Physicians applying for this position must be ABEM/AOBEM Eligible/Certified Emergency Medicine Physicians. Highly regarded graduating residents are welcome. If you think you are this candidate, please email your CV to Dr. Richard Wilson at rawilsondo@mindspring.com or Diane Wolf at dwolf@hbcmd.com.

Illinois EPIC

Illinois College of Emergency Physicians
3000 Woodcreek Drive, Suite 200
Downers Grove, IL 60515

ICEP Calendar *of* Events 2012 - 2013

October 24, 2012
Ultrasound-Guided Peripheral IVs Hands-On Workshop
ICEP Conference Center
Downers Grove

October 25-26, 2012
PACC 2012: Primary and Acute Care Collaborative
ICEP Conference Center
Downers Grove

October 25-28, 2012
Mock Oral Private Tutorials
Chicago O'Hare Marriot Suites
Rosemont

October 30, 2012
ICEP EMS Committee
11:00 AM - 1:00 PM
ICEP Board Room
Downers Grove

October 30, 2012
EMS Forum
1:00 PM - 3:00 PM
ICEP Conference Center
Downers Grove

November 2, 2012
Emergent Procedures Simulation Skills Lab
NorthShore University HealthSystem Evanston Hospital, Evanston

November 5, 2012
Emergency Medicine Board Review Intensive Faculty Meeting for 2013 Redesign
10:00 AM - 12:00 PM
ICEP Conference Center
Downers Grove

November 13, 2012
2012 EM4LIFE LLSA Article Review Course
Midwest Food Bank
Bloomington

November 15, 2012
2012 EM4LIFE LLSA Article Review Course
ICEP Conference Center
Downers Grove

November 29, 2012
Ultrasound-Guided Peripheral IVs Hands-On Workshop
ICEP Conference Center
Downers Grove

December 10, 2012
ICEP Finance Committee
9:30 AM - 10:30 AM
ICEP Board Room
Downers Grove

December 10, 2012
ICEP Board of Directors
10:30 AM - 2:30 PM
ICEP Board Room
Downers Grove

December 24-25, 2012
ICEP Office Closed
Christmas Holiday

January 1, 2013
ICEP Office Closed
New Year's Day

February 21, 2013
Emergency Medicine Conference
Par-A-Dice Hotel
Peoria

February 26, 2013
ICEP EMS Committee
11:00 AM - 1:00 PM
ICEP Board Room
Downers Grove

February 26, 2013
EMS Forum
1:00 PM - 3:00 PM
ICEP Conference Center
Downers Grove

April 9-10, 2013
Oral Board Review Courses
Chicago O'Hare Marriott
Chicago

Register for all courses online at ICEP.org!