



# COMPASSIONATE EMERGENCY CARE

**A Message from:**

**Mark C. Menadue, DO, JD, FACEP, FCLM, President/CEO**

In a recent meeting with the Executive Director of the Iowa Medical Society, he made a convincing argument about why the rural states in which many of us practice need to stop beating our chest about low reimbursement, rural lifestyle, on-call issues, and the other negative points that sometimes are easy to fixate upon in difficult times.

In truth, we have one of the best lifestyles in the United States of America, with good schools for our children, healthy environments in which we can live and grow, very competitive compensation (which now in many cases and in many specialties leads the pack compared with the East and West coast metropolitan areas); a low frequency and severity of malpractice claims, and surprisingly competitive malpractice insurance rates - in many cases, even in the absence

of a cap on the award of tort damages.

The old adage of “when life gives you lemons, make lemonade” is certainly apropos to the circumstances in which we find ourselves. Many emergency physicians are challenged to compassionately treat a larger number of uninsured patients, who are often sicker because of deferred medical care resulting in longer lengths of stay, extended call hours, and in some cases diminution in professional fee receipts. We should be buoyed by the incredible gift we have been granted to heal and the good fortune to live in a region of the country that is somewhat immunized from the extremes that some of our colleagues are facing, to their detriment.

When I was serving in the Army Medical Corp, we used to joke with all of our colleagues who were sta-



tioned at medical centers in Hawaii that on their day off they wake up in Hawaii. Our sentiment should be similar in that while the challenges of our medical practice may be escalating, we still live in an enviable region of the country, where the patients are appreciative of our professional services, less likely to sue when there is a bad outcome, and enjoy a lifestyle and financial climate that are desirable.

*Mark*



## **RURAL PHYSICIAN RECRUITMENT CHALLENGE**

**By: Paul Hudson, FACHE, COO**

As healthcare organizations tasked with the wellness and healthcare needs of our communities, we are seemingly confronting a “perfect storm” of converging challenges. An essential component of that care is the contribution of our partner physicians. As we look ahead, we confront the difficult realities of supply and demand for the doctors we’ll need to care for our patients. Approximately 200,000 more physicians will be needed in the next decade than medical schools will turn out, leading to a nationwide physician shortage just when millions of baby boomers are entering their later years. The anticipated shortfall is already creating stiff

competition among healthcare providers across the country to recruit doctors. **ACUTE CARE, INC.** is in the process of confronting that challenge and devising effective strategies to ensure that our partner facilities will continue to have access to physician services in their Emergency Departments, the communities’ healthcare “safety net”.

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## CONTINUED—RURAL PHYSICIAN RECRUITMENT CHALLENGE

From 1980 until 2003, the number of new physicians graduating from U.S. medical schools remained stable at 15,000-16,000. During those years, the U.S. population increased by 24 percent. Also, of 836,000 U.S. physicians, 33 percent are over age 55. The demographic issues are further complicated as baby boomers have reached their 50s and many are approaching their 60s, when they are likely to need more medical care.

Experts project the growing U.S. doctor shortage will become even more acute in rural America. Just as baby boomer physicians begin retiring, younger physicians are seeking greater work-life balance than their predecessors did. Younger physicians are increasingly unwilling to tolerate the excessive workload and on-call responsibilities that have often led to burnout of their established physician colleagues, particularly given the increasing number of physicians - both male and female - committed to balancing work with family and personal commitments.

Still, there's hope.

In a 2007 physician survey on rural health care, the majority of physicians surveyed indicated that they would be open to practicing rural medicine. Among more than 600 physicians who said they had no rural healthcare experience, 29% indicated they never had been offered a position in a rural area, 25% said they just never considered it, and 32% said they'd never found the right rural medicine opportunity. Because of long-held myths and misperceptions about rural medicine, young physicians might not pick a rural health setting unless they are sought out, educated about the tangible benefits of practicing in a smaller community, and offered the opportunity.

Meanwhile, our plight has gained national attention and support of the broader healthcare industry.

"The decrease in practicing primary care physicians and the alarming dearth of medical students planning to pursue primary care is a problem that cannot be ignored," said American Medical Association (AMA) Board Member William Hazel, MD. "The AMA is working to reverse this trend and to ensure adequate access to care for patients."

The AMA's new policy includes a multi-pronged action plan that gets to the heart of the decline in the number of primary care physicians by addressing medical student debt, recruitment and training, and increased payments by insurers for primary care services. One challenge facing medical students considering primary care is their substantial medical school debt. On average, a medical student graduates owing \$140,000, which can lead students to consider pursuing a career in higher-paying specialties. The AMA pledged to support programs to decrease the debt load of physicians who choose to practice primary care, including scholarships and loan repayment plans.

**ACUTE CARE, INC.** is uniquely well suited to serve as your partner in confronting this challenge. As an Emergency Medicine group practice with 20 years of experience in providing practice management solutions for small rural and non-urban healthcare facilities, our specialized knowledge of and experience in the market, and regionalized structure (recruitment, credentialing and scheduling) provides a distinctive advantage that allows us to successfully meet our commitments under the most difficult of circumstances. Along with our locum tenens and permanent placement service lines (detailed elsewhere in this newsletter), we are proud to offer a comprehensive suite of offerings to assist you in meeting your commitments.

Together, we can weather this storm.



### Question of the Quarter:

#### What's the difference between credentialing and credentials verification?

The following is adapted from resources provided by HCPro ([www.hcpro.com](http://www.hcpro.com))

One point of confusion for many people is the difference between the terms credentialing and credentials verification. Credentials verification—determining whether a practitioner's credentials are authentic and valid—is only one aspect of the credentialing process. With credentials verification, there is nothing to decide and the results speak for themselves; an applicant has or has not graduated from medical school, has or has not completed a residency, and does or does not have a valid license to practice medicine in a particular state.

The term credentialing, however, refers to the overall process of gathering and verifying credentials information, reviewing that information, and making a decision to grant or deny membership and the request for privileges.

**MOVING? CHANGING ADDRESSES?**

Please remember to keep your Credentialer updated on any address changes. Even if you are moving out of state and you are archiving your file with **ACUTE CARE, INC.**, we need your new address. This assists us in forwarding any correspondence that may come to our office. If you are an active physician planning a move, you are required to fill out a new W-9 form before we are able to change your address, please contact your Physician Credentialer at 1.800.729.7813.

**CREDENTIALING CORNER****Handy Physician Websites**

If you are looking for an ACLS, ATLS, BLS, CALS, or NRP class the Physician Credentialers at **ACUTE CARE, INC.** can help.

We have listed below the websites that can help you find a certain course.

To lookup ACLS & BLS courses go to:

<http://www.americanheart.org>

To lookup ATLS courses go to:

<http://www.web2.facs.org/atls/existing.htm>

To lookup CALS courses go to:

<http://www.calsprogram.org/>

To lookup NRP courses go to:

<http://www.aap.org/nrp/nrpmain.html>

This website is here to assist you in printing a duplicate DEA certificate

<https://www.deadiversion.usdoj.gov/webforms/dupeCertLogin.jsp>

If you would like assistance finding a course, or have any other credentialing questions or concerns, please feel free to contact the Physician Credentialer for your region.

KY, VA, WI, OH, WY  
Lisa Coulter  
Physician Credentialer  
Ext. 140

Western IA, KS, NE  
Gina Ryan  
Physician Credentialer  
Ext. 139

Eastern IA, MO  
Rachel Wiezorek  
Physician Credentialer  
Ext. 144

MN  
Lindsay Oltrogge  
Physician Credentialer  
Ext. 131

Locum Tenens  
Christina Boat  
Locum Tenens Credentialer  
Ext. 171

IL, IN  
Emily Piper  
Physician Credentialer  
Ext. 112

**LOCUM TENENS & ACUTE CARE, INC.**

Joy White, Assistant Vice President, Development, oversees the Locum Tenens Department, which consists of Joe Evans, Locum Tenens Specialist; Kelli Olson, Locum Tenens Specialist; and Christina Boat, Locum Tenens Credentialer. Both Joe and Kelli perform scheduling, recruitment, and sales duties for the Locum Tenens Department. They assist our partner facilities with coverage for Emergency Departments, Family Practice Clinics, Urgent Care Clinics, and a host of other specialties. Christina is responsible for physician credentialing. We team with physicians and allied health providers to assist our partner facilities in providing needed coverage.

For physicians and allied health providers **ACI** can offer a range of medical specialties for their area of interest. We currently have locums opportunities in the following states: Minnesota, Iowa, Wisconsin, Illinois, Nebraska, Kansas, Kentucky, and Missouri.

If you have an interest in Locums coverage for your facility or if you are interested in Locums opportunities, please contact one of the Locums team members.



Joy White  
[joyw@acutecare.com](mailto:joyw@acutecare.com)



Joe Evans  
[joee@acutecare.com](mailto:joee@acutecare.com)



Kelli Olson  
[kelliol@acutecare.com](mailto:kelliol@acutecare.com)

## **CODING AND DOCUMENTATION CONCEPTS: CRITICAL CARE, REDUX** (CONTINUED FROM PRIOR NEWSLETTER)

The following is based on resources provided by EPBS-Intermedix (www.epbs.com)  
and the American Academy of Professional Coders (www.aapc.com)

### **1 - What was the severity of the illness or injury? Did the patient meet the "Criticality" guideline?**

The following list of conditions/presenting problems **MAY** indicate the patient meets criticality guidelines:

#### **VITAL ORGAN SYSTEM FAILURE EXAMPLES**

##### **Shock**

Cardiogenic, Hypovolaemic, Anaphylactic, Septic, Neurogenic, Spinal

##### **Circulatory failure**

- ACS / Acute MI / Unstable Angina
- Dissecting aortic aneurysm
- GI Bleed with hemodynamic instability
- Multiple system trauma
- Cardiac dysrhythmias requiring intervention
- Drug ingestion with hemodynamic instability
- Critical Burns
- Clinically acute/requiring urgent intervention:
  - o Hypo/hypertension
  - o Brady/tachy-arrhythmias

##### **Central nervous system failure**

- Unstable cervical fracture
- Intracranial hemorrhage
- Status Epilepticus
- Coma; metabolic, toxic, anoxic, traumatic
- Acute Stroke with altered mental status

##### **Respiratory failure.**

- Acute CHF with respiratory failure
- Asthma with respiratory failure
- PE with hemodynamic instability
- Respiratory failure with immanent intubation

##### **Renal, hepatic, metabolic failure**

DKA with hemodynamic instability

### **2 - Were there life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician?**

Withdrawal of or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition. Examples may include:

- Epinephrine
- Atropine
- Bicarb
- Anti-arrhythmics
- Vasopressors
- Nitroglycerine Drip
- Fluid/Blood Resuscitation for frank shock/burns
- Chest tubes for hemo/tension/pneumothorax
- Bi-PAP (bilevel positive airway pressure)
- C-PAP (continuous positive airway pressure)
- Intubation
- Defibrillation
- Transcutaneous Pacemaker
- Cardioversion
- Thrombolytics
- Magnesium Sulfate
- Dobutamine
- Mannitol
- Narcan
- Initiate ventilator in the ED

### **3. How much time did I spend in the care of this critically ill/injured patient? 30-74 minutes exclusive of procedures?**

Should explicitly state; "Critical Care time was XX minutes exclusive of procedures".

##### **INCLUDED TIME (add to CC time)**

- Time spent with the patient
- Time spent engaged in work directly related to the patient's care whether at bedside or elsewhere in the ED
- Reviewing test results or image studies
- Discussing the patient's care with other medical staff (within your hospital or at the receiving hospital of a transfer)
- Documenting the medical record
- When the patient is unable or clinically incompetent to participate in discussions, time spent with family members or surrogate decision makers. (obtaining hx, reviewing dx/prognosis, discussing tx; must bear on patient management)

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### Promotions



Jennifer Richards RN, BS, CPHRM, AVP PI/Risk Management	Amanda Jenkins Regional Coordinator
Joy White Assistant Vice President, Development	Morgan Hammer Director of Operations
Kathy Storm Assistant Vice President, Operations	Angie Wood Regional Coordinator
Susan Core Director Legal/Human Resources	Jared Randles, Director of Information Technology

### New Hires

Cheryl Overdyk Administrative Assistant	Christina Boat Locums Tenens Credentialer
Katy Niehus Physician Scheduler	Tiffany Dalrymple Physician Scheduler
Katie Brown Physician Scheduler	Christina Flores Recruitment Specialist

## PRACTICE OPPORTUNITIES

**Carlinville, IL**  
**Carlinville Area Hospital**  
 Annual OPV: 5,485  
 Coverage: 24 hours a day,  
 7 days a week

**Pinckneyville, IL**  
**Pinckneyville  
 Community Hospital**  
 Annual OPV: 3,739  
 Coverage: 24 hours a day,  
 7 days a week

Contact:  
 Kara Langenberg  
 1.800.729.7813, ext. 133

**Platteville, WI**  
**Southwest Health Center**  
 Annual OPV: 9,507  
 Coverage: 24 hours a day,  
 7 days a week

**Pineville, KY**  
**Pineville Community  
 Hospital Association,  
 Inc.**  
 Annual OPV: 14,636  
 Coverage: 24 hours a day,  
 7 days a week

Contact:  
 Whitney Jacobson  
 1.800.729.7813 ext. 166

**Fairfield, IA**  
**Jefferson County Hospital**  
 Annual OPV: 7,244  
 Coverage: 24 hours a day,  
 7 days a week

**Knoxville, IA**  
**Knoxville Hospital and  
 Clinics**  
 Annual OPV: 6,916  
 Coverage: 24 hours a day,  
 7 days a week

Contact:  
 Jason Taylor  
 1.800.729.7813 ext. 155

**Albany, MN**  
**Albany Area Hospital &  
 Medical Center**  
 Annual OPV: 1,965  
 Coverage: 6 p.m. Friday to  
 6 a.m. Monday

**Long Prairie, MN**  
**Long Prairie Memorial  
 Hospital and Home**  
 Annual OPV: 2,734  
 Coverage: 7 p.m. Friday to  
 7 a.m. Monday

Contact:  
 Christina Flores  
 1.800.729.7813 ext. 171

**Creston, IA**  
**Greater Regional  
 Medical Center**  
 Annual OPV: 6,009  
 Coverage: 6 p.m. to 6 a.m.  
 Monday through Friday, and  
 6 a.m. Saturday to 6 a.m. Monday

**Independence, KS**  
**Mercy Hospital**  
 Annual OPV: 6,500  
 Coverage: 24 hours a day,  
 7 days a week

Contact: AJ Cauterucci  
 1.800.729.7813 ext. 136

## How To Make A Referral!

The process starts with contacting one of our Recruitment Specialists by phone (1.800.729.7813) or e-mail with the name of a potential physician candidate for one of our 70+ practices. That Specialist will log your referral, contact the physician, describe our organization's practice opportunities, and – if the physician agrees – send an application.

1. After **ACI** receives a complete application from a referred physician and that physician's credentials have been approved at one of our affiliated facilities, the person who refers the candidate to **ACI** will immediately receive a **\$500 bonus**. Referral Bonus checks will be mailed weekly.
2. The person who refers a physician candidate will receive an **additional \$1,000 bonus** if the referred physician works a total of 150 hours over the next three months.
3. The person who refers a physician candidate will receive an **additional \$1,500 bonus** if the referred physician signs a full-time contract with **ACI** within nine months of referral.

## CODING AND DOCUMENTATION CONCEPTS (Continued from Page 4)

### Procedures and services included in CC and not separately reportable (add to CC time)

#### *Interpretation of the following:*

- Cardiac output measurements
- Chest x-rays
- Pulse oximetry
- Blood gases
- Information in computers

#### *Perform the following:*

- Gastric intubation
- Temporary pacing
- Ventilator management
- Vascular access procedure
- Blood draw for specimen
  - o Arterial or venous

- Family medical psychotherapy
- Any service not listed here should be reported separately.

### EXCLUDED TIME (deduct from CC time)

- Time spent in activities that occur outside the ED since the physician is not immediately available to the patient
- Time spent in activities that do not directly contribute to the treatment of the patient
- Time spent performing separately reportable procedures or services, since time performing procedures is paid separately in the procedure payment, e.g., CPR, intubation, chest tubes, laceration repairs, etc.

Again, these are indicators of criticality. This does not mean all of these patients will meet the criteria for critical care coding. Many of these patients may have significant workups requiring a lengthy commitment of time by the physician and ultimately may not receive treatment/interventions that were life-and-organ supporting.

Documentation requirements are less stringent for critical care coding, as there is no specific requirement regarding the history (HPI, ROS, PFSH) or examination. The record still needs to accurately and clearly reflect the patient's condition with adequate documentation to support the patient's criticality. For example, we would not generally expect to see the listed conditions/presenting complaints and find in the same documentation the patients were alert, oriented, in no distress/mild distress and have the physician request Critical Care time, unless the patient's condition clearly deteriorated during their course in the ED. So it is very important to accurately report the patient's condition, the interventions, and the amount of time in minutes of critical care time rendered in order to ensure Critical Care coding is done correctly.

*Lori Hart*

## New, Improved Website

By: Paul Hudson, Chief Operating Officer



On April 1<sup>st</sup> the newest version of the **ACUTE CARE, INC.** website went live on the web ([www.acutecare.com](http://www.acutecare.com)). The most obvious new feature is a complete revision of the appearance and navigation aspects of the site. However, there's much more to the new site than the elegant new look. Jared Randles, Director of Information Technology, provided technical expertise on the project and served as our liaison to the site's designer. Lisa Coulter, Physician Credentialer; Kelli Olson, Locum Tenens Specialist; and Clarissa Lehman, Client Services Director; served as our project team and approached the assignment with a "clean sheet of paper" attitude. Their hard work is evident in impressive new features like an online application; quick web-based educational resources and new CME activities; links to our weblog ('blog'), online calendars (for facilities and physicians), "submit availability" features; and the "featured physician" / "featured hospital" banner on the home page. While we are proud of our new site and excited about its role in connecting to both current and potential partners, we are already at work at the next phase and additional functional improvements. Please visit the site and tell us what you think!



**PRN, PART-TIME, FULL-TIME,  
and Medical Director  
opportunities available  
at our Hillsboro, IL location:**

**\*\*\* HILLSBORO, IL \*\*\***

Hillsboro Area Hospital  
Annual Outpatient Volume: 4,464  
Shifts: 12-, 24-, 36-, 48-hour shifts available  
Coverage: 6:00 p.m. Monday to 7:00 a.m. Thursday; and  
6:00 p.m. Thursday to 7:00 a.m. Monday



**PRN, PART-TIME, and FULL-TIME  
opportunities available  
at our Oelwein, IA location:**

**\*\*\* OELWEIN, IA \*\*\***

Mercy Hospital of Franciscan Sisters, Inc.  
Annual Outpatient Volume: 5,715  
Shifts: 12-, 24-, 36-, 48-hour shifts available  
Coverage: 7:00 a.m. Saturday to 7:00 a.m. Monday

**PRN, PART-TIME, and FULL-TIME  
opportunities available  
at our Windom, MN location:**

**\*\*\* WINDOM, MN \*\*\***

Windom Area Hospital  
Annual Outpatient Volume: 3,273  
Shifts: 12-, 24-, 36-, 48-, 60-, 72-hour shifts available  
Coverage: 24 hours a day, 7 days a week

**PRN, PART-TIME, and FULL-TIME  
opportunities available  
at our Pineville, KY location:**

**\*\*\* PINEVILLE, KY \*\*\***

Pineville Community Hospital Association, Inc.  
Annual Outpatient Volume: 14,636  
Shifts: 12- and 24-hour shifts available  
Coverage: 24 hours a day, 7 days a week



**PRN, PART-TIME, and FULL-TIME  
opportunities available  
at our Eldorado, KS location:**

**\*\*\* ELDORADO, KS \*\*\***

Susan B. Allen Memorial Hospital  
Annual Outpatient Volume: 13,980  
Shifts: 12-hour shifts available  
Coverage: 24 hours a day, 7 days a week



**ATTENTION PHYSICIANS & FACILITIES!**

**YOU CAN ACCESS YOUR  
MONTHLY  
CALENDARS VIA THE  
ACUTE CARE, INC.  
WEBSITE!**



[www.acutecare.com](http://www.acutecare.com)

**CONTACT YOUR PHYSICIAN  
CREDENTIALER FOR YOUR  
USERNAME OR PASSWORD.**

**C** OLLABORATING TO REACH GOALS

**A** DVANCING A FAMILY-CENTERED APPROACH  
TO TREATMENT

**R** ESPECTING OUR PATIENTS, THEIR FAMILIES  
AND OUR CO-WORKERS

**E** DUCATING, INNOVATING AND TRANSLATING  
DISCOVERIES IN EMERGENCY MEDICINE



***ACUTE CARE, INC.***

P.O. Box 4130 • Des Moines, Iowa 50333

**Please check out the audio version of the  
*ACUTE CARE, INC.* Newsletter on the web!!!  
[www.acutecare.com](http://www.acutecare.com)**