



COMPASSIONATE EMERGENCY CARE

A Message from:

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

ACUTE CARE, INC. is pleased to announce that as we continue to grow our specialty group practice of emergency physicians, that the quality we deliver is appreciated by the patients we serve and the strategic partners with whom we affiliate. Most recently, we are pleased to announce that we have partnered with AIG (a Standard & Poors A++ rated insurer) for our medical professional liability (malpractice) insurance. This will allow us to continue to provide the highest quality representation and professional liability insurance and allows us the ability to continue to grow in a controlled fashion in targeted areas. AIG represents the "standard" in professional liability insurance for physicians and is far superior to many of the other options that are currently available.

In addition, we are pleased to announce

our affiliation with Financial Designs to offer a full benefit package to all of our independent contractor physicians who are desirous of, or have need for such coverage. The cost of this insurance, per IRS regulations, will be payroll deducted from your compensation. The offering includes health, dental, life and disability insurance, but the menu can be modified to meet your specific family needs.

Please visit the **ACUTE CARE INC.** blog at www.acutecare.blogspot.com to keep updated on issues that have currency in our specialty. In particular we would like to begin a dialog about single payer and/or socialized medicine - as the current political environment begins to heat up in anticipation of the upcoming presidential election.

Best wishes for a healthy and prosperous remainder of 2007. If there is anything



that any of us at **ACUTE CARE, INC.** can do to improve your practice, or assist you in any way please feel free to contact us at 800.729.7813 or www.acutecare.com. Thank you very much for your vote of confidence in our specialty group practice of rural emergency physicians and our affiliated hospital clients.

Mark



National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary **By: Paul Hudson, COO**

On June 29, 2007, the Centers for Disease Control (CDC) released a report entitled, "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary". Data for the report was drawn from the 2005 National Hospital Ambulatory Medical Care Survey (NHAMCS), the longest continuously running nationally representative survey of hospital ED and outpatient department (OPD) utilization. The NHAMCS collects data on visits to emergency and outpatient departments of nonfederal, short-stay, and general hospitals in the United States.

The 38 page report, formatted as an Adobe Acrobat (PDF) document, is available on the web at: <http://0-www.cdc.gov.mill1.sjlibrary.org/nchs/data/ad/ad358.pdf>. Below, you'll find selected excerpts from the report:

- From 1995 through 2005, the number of ED visits increased from 96.5 million to 115.3 million visits annually (up by 20%) This represents an average increase of more than 1.7 million visits per year. There were, on average, about 219 visits to U.S. EDs every minute during 2005.
- From 1995 to 2005, as the number of visits to the ED increased from 96.5 million to over 115.3 million, the number of hospital EDs decreased from 4,176 to 3,795, therefore increasing the annual number of visits per ED from 23,119 in 1995 to 30,388 in 2005.
- At 1.9 percent of visits, the patient had been discharged from the hospital within the previous 7 days.
- Abdominal pain, chest pain, fever, and cough were the leading patient complaints, accounting for nearly one-fifth of all visits.

Inside this issue:

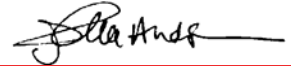
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National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary (continued)

- Diagnostic and screening services were provided at 71.1 percent of visits, and procedures were performed at 47.3 percent of visits.
- Medications were either given in the ED or prescribed at discharge at 76.7 percent of visits, resulting in 204.9 million drug mentions.
- On average, patients spent 56.3 minutes waiting to see a physician, and 3.3 hours for the full duration of their ED visit.
- About 12 percent of ED visits resulted in hospital admission. The average total length of stay for those admitted was 5.2 days, and the leading principal hospital discharge diagnosis was nonischemic heart disease.
- From 1995 through 2005, the overall ED utilization rate increased by 7%, from 36.9 to 39.6 visits per 100 persons.
- Private insurance was the most frequent expected source of payment, accounting for 39.9 percent of all ED visits.
- Other sources included Medicaid or State Children's Health Insurance Program (SCHIP) (24.9 percent) and Medicare (16.6 percent).
- No insurance (including self-pay, no charge, and charity where no other payment source was reported) represented 16.7 percent of visits.
- The visit rate for Medicaid patients (89.4 per 100 persons with Medicaid) was higher than the rate for those with Medicare (51.0 per 100 persons with Medicare), no insurance (45.9 per 100 persons with no insurance), and private insurance (23.8 per 100 persons with private insurance).



EMTALA CONFERENCE

By: Ryan Smith, Assistant Vice President



I had the opportunity in May to attend an EMTALA conference organized by the Iowa Hospital Association, with speakers Barbara Person, from Baird Holm LLP in Omaha, Nebraska, and Nancy Ruzicka, the Director of Regulatory Compliance for Iowa Health System. I found it very interesting and insightful and wanted to share some of the highlights of the information that was presented that day.

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act. It was known as the anti-dumping statute and formed in response to the practice of some hospitals refusing to see or transferring patients based on ability to pay. The main aim of the act was to make sure that all patients receive appropriate medical screening examinations, stabilizing treatment, and an appropriate transfer if it is necessary.

It is important to note the survey process that is involved with EMTALA as well. It is a complaint-driven process and the initial allegation is the main focus, but the surveyors will also be looking for additional violations while on-site. Even if an allegation is not confirmed, the surveyors must ensure that all requirements are met at the facility.

The materials that are reviewed during the survey process are as follows:

- Dedicated ED Log for the past 6-12 months
- Policy and procedures for the ED
- EMTALA policies
- Consent Forms
- Emergency Department Committee Meeting Minutes
- Dedicated Emergency Department Staffing (physicians for 3 months, nurses for 4 weeks)

- Medical Staff bylaws
- Medical Staff minutes for the past 6-12 months
- Physician on call lists for the past 6 months
- Physician Credentials files
- 20-50 clinical records

The presenters noted that the top violation that was reported nationwide last year was the posting of signs related to the patient's right to be treated in the Emergency Department. Signs must be posted in the Emergency Department entrances, admitting area, waiting room, and treatment room. They must also be posted in the OB area if women are sent there to be screened for labor.

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MINNESOTA & WISCONSIN ATLS

The State of Minnesota and the State of Wisconsin are in the process of implementing a State Trauma System. Any hospital that will be in the Trauma System will require you to obtain ATLS or CALS in order to work in their Emergency Department. It will be important for any physician working in the Emergency Department to become certified. If you have additional questions about this requirement, please contact Kelli Olson, Senior Physician Credentialer at 1.800.729.7813 ext 121 or via e-mail at kelliol@acutecare.com.

EDUCATIONAL CLASSES

Listed below you will find websites that can help you locate an ACLS, PALS, ATLS, CALS or BLS class. If you need additional assistance or if you would like to discuss the training opportunities through **ACUTE CARE, INC.**, please contact your Credentialer.

ATLS Classes: <http://web2.facs.org/atls/ATLSSearch.cfm?Search=USA>

ACLS, PALS and BLS Classes: <http://www.americanheart.org/presenter.jhtml?identifier=3011764>

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

Online Courses: <http://www.americanheart.org/presenter.jhtml?identifier=3019205>

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The Art of Apology

By: Jennifer Richards, RN, CPHRM,
Performance Improvement Coordinator



Apologizing following an adverse event or medical mistake is becoming more prevalent among medical professionals. While disclosure can be emotionally difficult, not only for the patient but for the provider as well, experience proves that patients are grateful that the medical team has shared the facts and expressed regret. Dr. Michael Woods, in his book Healing Words: the power of apology in medicine, describes four essential components of an apology, the first of which is *recognition*. He states that the key to recognizing when to offer an apology is being aware of one's own feelings as well as those of the recipient. An apology is warranted when the patient is dealing with an adverse outcome and it is

important that, during these circumstances, the physician recognize that the patient may experience a rollercoaster of emotions. Dr. Woods states that it is imperative that the physician refrain from demonstrating negative behavior such as defensiveness or evasiveness and instead, answer all of the questions and address any concerns the patient and/or family may have.

Once the need to apologize has been recognized, Dr. Woods emphasizes the importance of expressing *regret*. An expression of regret informs your patient that you recognize his pain, anxiety, or fear, and that you feel badly about it, advises Dr. Woods. This exchange of words should be genuine and display empathy to the patient, and should take place as soon as possible following an adverse outcome as it promotes healing of the physician-patient relationship. Studies have shown that patients are less likely to contemplate litigation when a physician has

been honest with them and expressed regret about mistakes or poor outcomes.

Dr. Woods lists *responsibility* as the third component of an apology. He defines responsibility as accurately disclosing everything you know about the situation in question. In addition to informing patients of the facts, physicians need to assume responsibility for coordinating the care for the patient and alleviating their fear of being neglected and abandoned. Taking responsibility for their



actions does not necessarily mean that the physician made a mistake, but rather that an error occurred as a result of outside factors or situations beyond the physician's control.

Remedy, or an offer of restitution, is the final component

of an apology. Remedy corrects the error and develops a mechanism to prevent it from recurring. While the term 'remedy' may invoke fears of settlements or judgments, Dr. Woods advises that confronting unfortunate outcomes directly and handling them with sensitivity can defuse the outrage that fuels these outlandish rewards.

While providing an apology following an unexpected outcome is a rather new concept, many hospitals and insurance companies are acknowledging its potential benefit. **ACUTE CARE, INC.** will continue to monitor these developments as this important aspect of patient care evolves. In the meantime, if you are interested in learning of additional resources pertaining to apology and disclosure of adverse events, feel free to contact me by phone at 1.800.729.7813 or via email at jenniferferr@acutecare.com.

Jennifer Richards

Kenneth P. Schultheis, DO, FACEP, Chief Medical Officer

By: Joshua Porter, Vice President

**"I eat, sleep, drink, live and love
Emergency Medicine."**

If Kenneth Schultheis, DO, was a politician, this would be the opening line to his standard stump speech on the campaign trail. But Dr. Schultheis isn't a politician and thousands of patients over the years can be thankful that he chose medicine instead of law or politics.

Those who know Dr. Schultheis undoubtedly would agree he would have been successful in any career, but medicine suited his easy demeanor and uncompromised compassion for people. His life's work has been about helping those in need. Dr. Schultheis not only believes the opening line of his speech – he lived it.

After five years as the Chief Medical Officer at **ACUTE CARE, INC.**, Dr. Schultheis is stepping down September 1st for his second chance at retirement. Barb Moats, DO, will assume the role of Chief Medical Officer and Dr. Schultheis will continue to consult and do peer review with the organization.

"Ken Schultheis has been a tremendous asset to our organization and all of our affiliated hospitals," says Mark C. Menadue, DO, JD, FACEP, FCLM, President/CEO of **ACUTE CARE, INC.** "His commitment to Emergency Medicine is unmatched. It has been our fortune to have Dr. Schultheis mentor and guide our group practice the last five years during a tremendously exciting period of growth."

After serving as the Medical Director and staff physician in the Emergency Department at Mercy Medical Center-Des Moines for 28 years, Dr. Schultheis took a couple of years off before coming to work with **ACI** in 2002. He once described his retirement in typical Ken Schultheis-style, "you can only eat at fine restaurants, read the *Wall Street Journal* from cover-to-cover and play golf for so long."

Dr. Schultheis began his career at Mercy in 1972 after graduating from

medical school at the College of Osteopathic Medicine (now Des Moines University). True to his straightforward ways, Dr. Schultheis stayed until his retirement in 2000, serving as the Medical Director the last 20 years. He still lives in the only house he's ever owned, just a solid four-iron from his beloved Wakonda Country Club in Des Moines.



Originally from Detroit, MI, Dr. Schultheis almost wound up behind the counter at a pharmacy instead of treating those in more critical need. He earned his degree from Wayne State University, but his career as a pharmacist didn't last long. It was a stroke of luck for the patients of Mercy Medical Center and all of his friends and colleagues at **ACI**, that the soon-to-be Dr. Schultheis didn't feel challenged enough in pharmacy and applied to medical school.

During his career, Dr. Schultheis served on numerous boards and worked with organizations ranging from the Des Moines Police Department to local EMS providers. He served as the President of the Iowa Chapter and maintained his Fellow status with the American College of Emergency Physicians, along with serving as the President of the Medical Staff at Mercy.

His expertise and clinical acumen made him the perfect fit for a growing organization in need of a leader for its affiliated physicians. Over the past

five years at **ACI**, Dr. Schultheis has mentored and projected his unique approach to Emergency Medicine on hundreds of colleagues. His service to this organization, our affiliated hospitals and physicians is unparalleled.

"Dr. Schultheis has transformed **ACUTE CARE, INC.** by serving as a consistently accessible, clinically experienced and collaborative physician resource and practice leader," says Paul Hudson, Chief Operating Officer. "His dedication to the role of Chief Medical Officer, and to his colleagues – caregivers and administrative staff – working in **ACUTE CARE, INC.**'s affiliated healthcare facilities provides our partners in Emergency Medicine an extraordinary opportunity for collaboration, consultation and counseling."

The signature tribute to Dr. Schultheis' legacy at **ACI** was no matter how bad the day or situation, his ever present smile never faded. New employees at **ACI** often wondered why the distinguished man with silver hair always greeted them with such gusto. If you'd pass Dr. Schultheis in the hall on a rainy beginning to the work week, he'd belt out his typical, "Welcome to Monday!"

While all of us will miss Dr. Schultheis' easy persona, none will miss him more than his colleagues in the Performance Improvement Department, Karen Weltha, RN, and Jennifer Richards, RN.

"He is always dedicated to providing quality patient care," says Jennifer Richards. "His wealth of knowledge and easy-going style allows him to have a unique relationship with our physicians, our clients and the team here at **ACI**. We will certainly miss his skills, but more so we will also miss his charm and positive attitude."

When he arrived five years ago, he walked into a role as the lead clinician for a group that worked in six states with roughly 35 facilities. As Dr. Schultheis passes the torch to Dr. Moats, **ACI** provides service to 70 community hospitals in 12 states. This incredible growth has been a tribute in no small part to the leadership and guidance of Dr. Schultheis.

CONTINUED

Over the years, Dr. Schultheis was a valued member of the development team, often flying his own plane for onsite presentations. Armed with the standard stump speech, Dr. Schultheis had a way of making everyone in the room comfortable with the level of care and compassion he expected out of our physicians. Several nursing managers would walk out of our presentation and wish Dr. Ken Schultheis was working in their Emergency Department. He left an indelible impression on everyone, from hospital CEOs to physicians.

"We're going to miss Dr. Schultheis because he knew the rural market," says Ryan Smith, Assistant Vice President. "He understood the level of compassion and commitment our clients were searching for in an ED group. That especially showed when he was

sitting across the table from fellow physician leaders."

Dr. Schultheis will probably go back to playing more golf and enjoying the good life with his wife of 41 years, Linda. He might sneak a few more trips to see his children and grandchildren in Dubuque or West Des Moines.

Whatever his plans for his second run at retirement are, we hope Dr. Schultheis doesn't spend too much time eating, sleeping, drinking and living Emergency Medicine.

Given what we've seen the last five years, we already know he loves it.



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 and need to fill out a W-9 form, please contact your Physician Credentialer at 1.800.729.7813.

EMTALA CONFERENCE (CONTINUED)

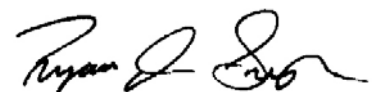
Another main area of focus was the requirements as they pertain to on-call physicians. The Emergency Department must, at all times, maintain a list of on-call physicians who are on-call for duty after the initial exam. This list is to ensure that the ED staff is aware of which physicians, specialists, and sub-specialists are available. It is important to note that the individual physician must be listed, not the group. This call list must be conspicuously listed and retained for five years. The physician must respond to the hospital if it is requested by the person who is performing the medical screening. To maintain compliance, there is to be no transfer for physician convenience and no "send them to the office" if an emergency medical condition has not been ruled out. One of the new on-call requirements from CMS is that the facility must also have written policies and procedures in place if a physician is allowed to conduct elective surgery while on call or serve call at more than one hospital simultaneously.

The question of, "Where in the Hospital does EMTALA apply?" was also discussed at length. It will apply if a patient presents him/herself to the Dedicated Emergency Department for treatment or examination of a medical condition. Also, if a patient presents on hospital property (including off-site premises) and requests examination or treatment for what may be an Emergency Medical Condition.

There was also an interesting discussion of the case where a patient presents on campus outside of the Emergency Department. Ms. Ruzicka and Ms. Person discussed the fact that CMS presumes individuals needing emergency care will present to the ED. Generally EMTALA will NOT apply to individuals presenting outside the ED, with the exception whereas EMTALA can be triggered outside the ED if a "prudent layperson" (i.e. Registration Clerk) would believe that the individual needs treatment for an emergency medical condition. They talked about the importance of setting up "scripts" for registration personnel and anyone who might come into contact with a patient presenting to any area of the hospital, with the example being the hospital employee simply asking "Are you asking to be seen in the emergency room or do you need directions to the doctors' office?"

As mentioned before, this was a very informative meeting where they went on to talk about several case studies and allowed the participants to talk about their own experiences with EMTALA at their facilities. One of the main themes throughout the day that I took from this very beneficial conference was the importance of documentation in all aspects of patient care, especially in the emergency room. It seems that many of the facilities have gotten themselves into trouble in violation of EMTALA simply by not thoroughly documenting each patient visit and adding them to the ED log. If you don't document it, it didn't happen.

If you would be interested in a copy of the presentation from this conference, which includes the case studies and much more in depth information about the EMTALA law and requirements, please feel free to contact me at 1.800.729.7813.

Barbara Moats, DO

By: Joshua Porter, Vice President

Barb Moats, DO, has been a part of the medical community her whole life – and her work address has rarely changed.

Her career in medicine has spanned four decades. She worked as a critical care nurse. She returned to medical school and worked her way through residency. She spent countless nights in the Emergency Department of a metro hospital.

She retired earlier this year to a peaceful life on the farm. She traded her scrubs for riding boots. She traded a love of treating sick patients, for a love of equine friends.

Surrounded by 30 horses on an acreage in Dallas County seems like a tranquil retirement, but Barb Moats, DO, couldn't help but keep an interest in her life's work – medicine.

With the retirement of Ken Schultheis, DO, September 1, Dr. Moats will become the Chief Medical Officer at **ACUTE CARE, INC.** Dr. Schultheis is leaving the organization after serving as the CMO for the past five years. He will continue with **ACI** in a consulting capacity, helping ease the transition for Dr. Moats and continuing to do outside peer review.

"We are extremely honored and privileged to have Dr. Barb Moats join our healthcare team," says Mark C. Menadue, DO, JD, FACEP, FCLM, President/CEO of **ACUTE CARE, INC.** "Dr. Moats brings over 20 years of experience in one of Iowa's busiest Emergency Medicine settings and will be an asset to our organization, affiliated hospitals and group practice physicians."

Just like her predecessor Dr. Schultheis, Dr. Moats was drawn back to medicine and the specialty she loved. Dr. Schultheis came to **ACI** after a two-year retirement from a 28-year practice as an Emergency Medicine physician at Mercy Medical Center-Des Moines. It took Dr. Moats

just eight months to get back into the game.

"I stayed my whole career in Emergency Medicine because it was fun and exciting," says Moats. "It's a very challenging specialty. I was fortunate to work with a good team of physicians. We had a team approach that was realistic for treating our patients."

Dr. Moats began her career as a critical care nurse at Iowa Methodist Medical Center in Des Moines. She spent the better part of her nursing career on the Intensive Care Unit floor at Methodist and serving as an Acute Care Specialist, training and educating other nurses. Along the way, she returned to school at Drake University to obtain her Bachelor's Degree. While at Drake, a professor and mentor suggested that she should continue her education in medical school.



She received her medical degree in 1981 from the College of Osteopathic Medicine (now Des Moines University) and was accepted in the Internal Medicine residency at Iowa Methodist. Internal Medicine seemed like a perfect fit for a career healthcare professional who was already familiar with intensive care.

When she completed her internship and residency in 1984, an opening as a staff Emergency physician was available. The position allowed Dr. Moats to maintain a stable schedule and care for her daughter. She spent the next 23 years in the Methodist ED before retiring this past January. Dr. Moats be-

came Board Certified in Emergency Medicine in 1991 through the American Board of Emergency Medicine.

"Emergency Medicine residency-trained physicians are obviously the best fit for an ER doc, but family practice and internal medicine-trained physicians are ideal because they see a smattering of everything in their training," says Moats. "I learned something new every day I was in the ED because we were surrounded by great physicians."

Dr. Moats served under Larry Baker, DO, while at Methodist. Dr. Baker is one of the pre-eminent Emergency Medicine physicians in the state and the Medical Director for both Iowa Methodist and Iowa Lutheran hospitals in Des Moines. While at Methodist, Dr. Moats served as the Medical Director for Life Flight, the helicopter air-medical service based at the hospital.

"I came to know Dr. Moats as Life Flight's Medical Director and a practicing Emergency Medicine physician when she and I worked together at Iowa Methodist Medical Center in Des Moines," says Paul Hudson, Chief Operating Officer. "I believe that Dr. Moats' style of confident, collaborative leadership in a high performing team environment is an ideal match for **ACUTE CARE, INC.** and that her extensive clinical experience and rapport with her peers makes her uniquely well suited for the Chief Medical Officer role."

While she has spent her entire career at one of Iowa's busiest hospitals, Dr. Moats understands the inherent obstacles providers in rural America face. She is both excited about and accepting of the challenges that come from leading a specialty group practice located in predominantly rural communities spread across 12 states.

"There is a different approach to rural medicine," says Dr. Moats. "I was blessed working in an Emergency Department where we had access to almost every specialist and subspecialist. When you're working in a community hospital without access to specialists, you have to be able to treat and evaluate quickly."

As the Chief Medical Officer, Dr. Moats will join the Performance Improvement Department at **ACI**, which includes two Registered Nurses, Jennifer Richards and Karen Weltha, Performance Improvement Coordinators; as well as, Performance Improvement Specialist, Ricki Marsh. Dr. Moats will also act as the liaison for our extensive network of physicians performing outside peer review. Dr. Moats will serve on the Executive Leadership team and will be involved in medical director guidance, physician mentoring and quality assurance. Dr. Moats will be a key contact for not only our affiliated physicians, but our client hospitals.

For the best physicians, they never really leave medicine when retirement calls. Barb Moats doesn't see patients anymore, but she is still contributing to the pursuit of quality emergency medical care. It didn't take her long to figure out she wanted to stay close to her life's work.

She hopped right back on the horse.




“YOU NEED TO TAKE ONE OF THESE EVERY SIX MONTHS, BUT YOU CAN BREAK IT IN HALF...”

Cartoon created by: Salvador Chavez, MD

The Countdown is Over – PQRI Begins

By: Lori Frost, Assistant Vice President/Comptroller



Starting with dates of service on and after Sunday, July 1, the Physician Quality Reporting Initiative (PQRI) kicked off for 2007. Mandated by Congress for the latter half of 2007, PQRI has come up to speed astonishingly quickly. The Centers for Medicare and Medicaid Services (CMS), charged with implementing Congress' desires for the program, had only the first six months of 2007 to interpret, design and implement PQRI for 2007.

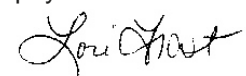
The measures that apply to Emergency Medicine are straightforward and commonly-performed in the appropriate patient cases, such as ordering an EKG for a chest pain patient. The fact that the EKG was ordered, performed, and/or interpreted is usually easily gleaned from the patient chart, and will be coded for the PQRI measure as needed. The difference in this quality measure documenting and normal coding is that if such a measure is not performed (e.g., the EKG is not done), then the provider must document why not. The coder must be able to find such information, and append a modifier to the PQRI code to signify the reason

why the quality measure was not performed.

This “negative” reporting is the real challenge for successful PQRI reporting. For most practices, the decision of how and where to put the information in the cases where the measure is not performed is the only real issue. Depending on the measure itself, the “why not” information may be placed in a standardized quality measure component, such as an additional sheet of a template, or a separate heading in dictation, or may be found in the body of the chart itself. Being clear and consistent in this placement will go a long way to ensuring that the coders can find and apply the information via the correct modifier.

On July 2, 2007, CMS issued a press release announcing a proposed rule that was published in the July 12, 2007, Federal Register. This rule describes proposed changes to the Medicare Physician Fee Schedule for 2008. While the entire proposed rule has not yet been analyzed, it appears that PQRI will be funded through 2008, with additional measures to be added, including possible structural measures such as use of EHRs and e-prescribing. The proposed rule lists several new measures from the AMA Physicians Consortium for Performance Improvement and Quality Insights of Pennsylvania as possible additions for PQRI 2008, providing they achieve endorsement or adoption by the quality organizations charged with measure development by Congress.

Facilities participating in PQRI 2007 should begin receiving reporting information feedback on physician documentation and measure reporting by the July month-end reporting cycle.

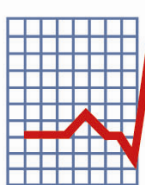


C OLLABORATING TO REACH GOALS

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



Promotions

Hayley Schuster
Regional Coordinator

Ricki Marsh
Performance Improvement
Specialist

Jennifer Reynolds
Regional Coordinator

New Hires

Kara DeKoter
Physician Scheduler

Emily Voeller
Administrative Assistant

Kelli Jackson
Administrative Assistant

Matt Prignitz
Recruitment Specialist

Rachel Wiezorek
Physician Credentialer



Erin Smith
Physician Credentialer

Mark Edwards
Paralegal

Karey Brandon
Physician Scheduler

PRACTICE OPPORTUNITIES

Creston, IA
Greater Regional Medical Center
Annual OPV: 5,195
Coverage: 6:00 p.m. to 6:00 a.m. Mon.-Fri.

Hawarden, IA
Hawarden Community Hospital
Annual OPV: 1,000 ED
Coverage: 24 hours a day, 7 days a week

Contact: Jessie Lyman
1.800.729.7813 ext. 136

Centerville, IA
Mercy Medical Center
Annual OPV: 6,000
Coverage: 24 hours a day, 7 days a week

DeWitt, IA
Genesis Medical Center
Annual OPV: 3,481 ER
872 UC
Coverage: 24 hours a day, 7 days a week

Contact: Matt Prignitz
1.800.729.7813 ext. 131

Canton, IL
Graham Hospital
Annual OPV: 13,500
Coverage: 24 hours a day, 7 days a week

Vandalia, IL
Fayette County Hospital
Annual OPV: 8,204
Coverage: 24 hours a day, 7 days a week

Contact: Jennifer Reynolds
1.800.729.7813 ext. 129

Worthington, MN
Worthington Regional Hospital
Annual OPV: 5,789
Coverage: 24 hours a day, 7 days a week

Redwood Falls, MN
Redwood Area Hospital
Annual OPV: 3,350
Coverage: 24 hours a day, 7 days a week

Contact: Jennifer Reynolds
1.800.729.7813 ext. 129

ATTENTION PHYSICIANS & FACILITIES!

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www.acutecare.com

CONTACT YOUR PHYSICIAN CREDENTIALER IF YOU NEED YOUR USERNAME OR PASSWORD.

FRIENDLY REMINDER

PHYSICIANS: PLEASE BE CERTAIN THAT YOU ARE ON TIME FOR YOUR SCHEDULED SHIFTS. A LOT OF TIMES THERE IS A PHYSICIAN AND/OR PATIENTS WAITING FOR YOU TO ARRIVE. ALSO, BE SURE YOU ARE SIGNING IN AND OUT ON THE SIGN-IN SHEET POSTED IN EACH EMERGENCY DEPARTMENT. THIS ALLOWS US TO PAY OUR PHYSICIAN ACCURATELY WITHOUT HAVING TO CONTINUOUSLY DO PAYROLL ADJUSTMENTS. IF YOU ARRIVE EARLY OR STAY LATE FOR ANY REASON, PLEASE BE SURE TO MAKE NOTE OF THAT REASON IN THE COMMENT SECTION. OUR POLICY IS THAT WE WILL NOT PAY FOR EXTRA HOURS UNLESS A REASON IS INDICATED ON THE SIGN-IN SHEET. THANK YOU FOR YOUR ATTENTION.

**PRN, PART-TIME, and FULL-TIME opportunities
available for our Robinson, IL location:**

***** ROBINSON, IL *****

Crawford Memorial Hospital
Annual Outpatient Volume: 8,816
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 Maquoketa, IA location:**

**MEDICAL
DIRECTOR
OPPORTUNITY**

***** MAQUOKETA, IA *****

Jackson County Regional Health Center
Annual Outpatient Volume: 4,800
Shifts: 12 and 24 hour shifts available
Coverage: 24 hours a day, 7 days a week

**PRN, PART-TIME, and FULL-TIME opportunities
available for our Marshall, MN location:**

***** MARSHALL, MN *****

Avera Marshall Regional Medical Center
Annual Outpatient Volume: 6,647
Shifts: 12, 24, 36, and 48 hour shifts available
Coverage: 24 hours a day, 7 days a week

**MEDICAL
DIRECTOR
OPPORTUNITY**



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

***** BOONE, IA *****

Boone County Hospital
Annual Outpatient Volume: 9,700
Shifts: 12 and 24 hour shifts available
Coverage: 24 hours a day, 7 days a week

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 60+ 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 **\$250 bonus**. Referral Bonus checks will be mailed weekly.
2. The person who refers a physician candidate will receive an **additional \$250 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 \$500 bonus** if the referred physician signs a full-time contract with **ACI** within nine months of referral.