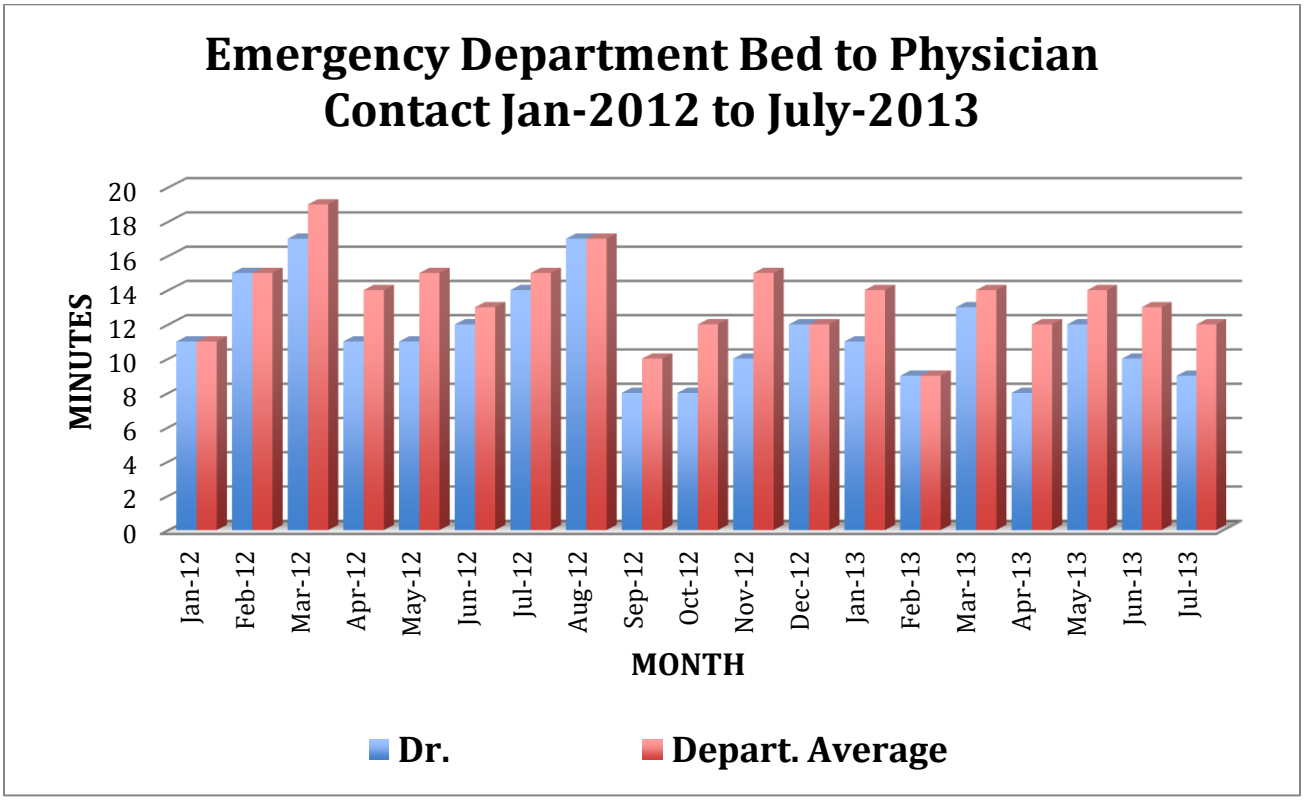
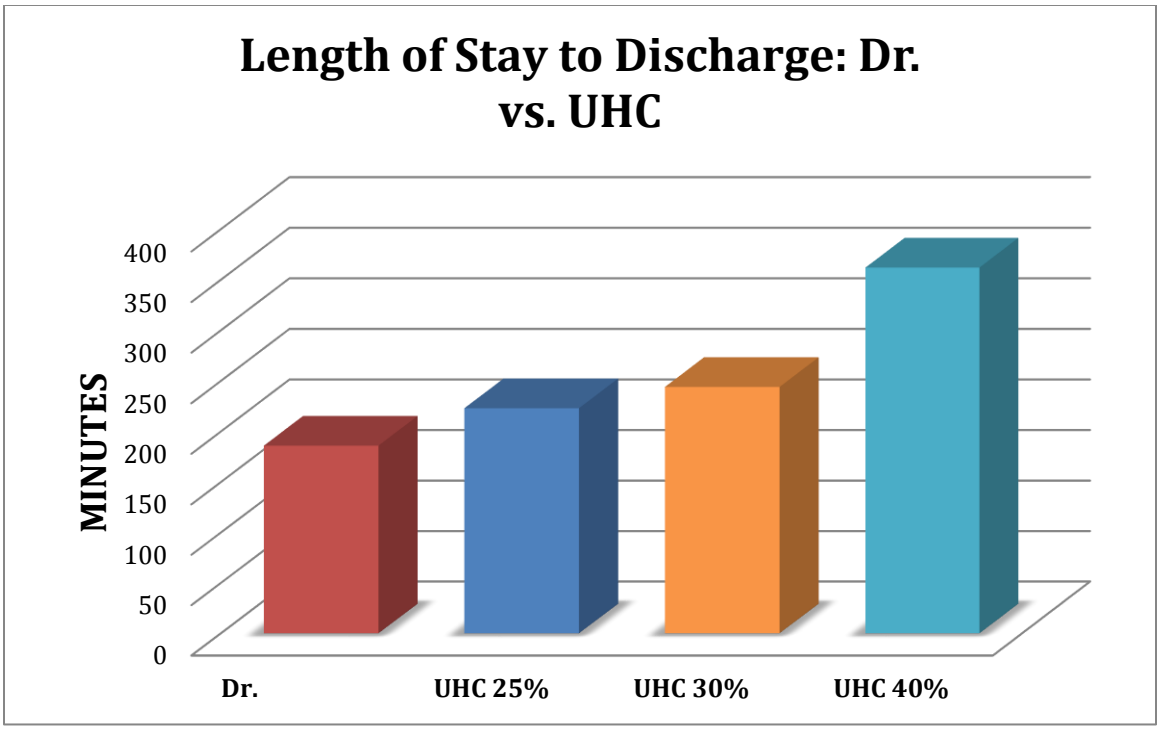
Clinical Service:

I was hired by Dr. Marvin Leibovich 6 years ago as a Clinical Assistant Professor of Emergency Medicine. I am boarded in emergency medicine by the American Board of Emergency with recertification in 2007. I have averaged approximately 170 hours a month on duty in the department for that period of time. This averages out to about 15-16 shifts a month. The shifts are on a rotational basis. I work mostly 12 hour shifts that cover nights, weekends, holidays, and mid day shifts. I have a monthly schedule as a part of this packet. I have diagramed my clinical hours worked for the years listed below. I have maintained one of the highest RVWs and total number of treated patients for any physician working in our department. When I first started working at UAMS we were averaging approximately 32,000 ED visits a year. We are now approaching 60,000 visits per year. We have maintained the same number of staff and residents despite this increase. The total number of hours I have worked is a reflection of the loss or lack of full-time staff in our department. We hope with the recent hiring of full-time staff we will be able to cut back hours in the department.





Dr. Clinical Hours Worked

FISCAL YEAR	HOURS
2013	2,143
2012	2,056
2011	2,084
2010	2,100
2009	2.056
2008	1,936

Number of RVWs

FISCAL YEAR	RVWs	RVW/HR	Dept. Average RVW/HR
2013	16,063	7.49	6.43
2012	17,141	8.33	6.79
2011	17,856	8.57	6.68
2010	18,202	8.67	7.09
2009	16,181	7.87	6.22
2008	14,281	7.38	6.00

Charges and Collections

Fiscal Year	Charges	Collections	Percent Collected	Total Charges	Total Collections	Percent Collected
2013						
2012	1,435,209	431,417	30%	11,090,930	2.877.8887	25.95%
2011	1,848,827	456,877	24.7%	12,945,963	3,048,380	23.50%
2010	1,882,824	440,599	23.4%	11,683,026	2,679,406	22.90%
2009	1,678,793	386,383	23%	9,856,963	2,179,703	22.10%
2008	1,489,836	320,998	21.54%	8,802,987	1,910,261	21.70%

Fiscal Year	Collections as Per Cent of Total Collections
2013	
2012	13.35%
2011	14.98%
2010	16.4
2009	17.7%
2008	16.97%

I have maintained above departmental average on our Press Ganey Evaluations. I have also been selected for the Dean's Circle of Excellence.

Press Ganey Scores

Fiscal Year	Dr. Average	Department Average
2013	83.1	82.4
2012	83.8	83.6
2011	81.6	82.5
2010	84.9	83.7
2009	83.4	81.2
2008	83.1	80.50

I have taken on additional projects as my administrative duties have increased. Most of those projects involve Billing and Coding issues. Steve Michener and myself, along with the IT department, have developed and implemented an Emergency Image Repository for our department. We are able to upload images "real time" from our ultrasound machine and store them in that repository. We have the ability to look up any images obtained from this site from any computer. We are able to review those images during our monthly Trauma M & M. Some of the images have been used for publications and for Dr. Ashley Bean's Ultrasound instruction manual. We are now able to bill for those services that require image capture. Before this was available we were not able to capture those lost revenue. This revenue amount was estimated at $75,000-$100,000/yr. I have also given lectures with regards to billing issues. As a result of that information, I was able to develop forms that make it easier to document essential items to be able to charge for Trauma Ultrasound Images (FAST), Critical Care, Moderate Sedation, and Smoking Cessation. None of these items were billed with any consistency in the past. We have gone from 0%

Critical Care billing to over 10%. This also represents a significant revenue capture. We continue to explore other areas of lost revenue, cost containment, and savings for our department. Each of these areas are periodically monitored and reviewed with administration.

There are additional areas that I have been actively involved in. I have been involved in the development and certification of our Level 1 trauma system. As a part of the team I attend meetings that involve our current system. This is a joint venture that requires both emergency medicine and the trauma surgery service. In order for us to continue this Level I status, we need to be involved with research and statewide education with trauma. I have given lectures to our surrounding communities as part of this out reach program. I am also actively involved in research in this area. Part of this process is to ensure that all ED attendings maintain their certification and continuing medical education requirements to keep our Level I status. As an attending I often discuss trauma transfers from other hospitals. I ensure that this remains an easy process and encourage the use of our Trauma X-ray Repository. Upon trauma arrival I supervise our surgical and emergency medicine residents during all parts of the evaluation. I also assist in any procedures that need to be performed.

I have been active in the American College of Emergency Physicians. I have been on the Board of Directors for a long time. Last year I was elected the president of the Arkansas Chapter of the American College of Emergency Physicians. I was also able to represent our state in the nation's capital to discuss current topics of interest to our organization and our state. I met with our state Senators and a select group of our Representatives to discuss topics that included: Banning Bath Salts and Synthetic Marijuana, Mcaid and Mcare payments to physicians (independent payment advisory board under the affordable healthcare act), Potential increases in emergency department census due to the affordable health care act, and prescription drug monitoring program for our state. I met locally with Senator Percy Malone along with Dr. Gene Shelby and Dr. Leibovich in response to the statewide prescription drug monitoring law that was passed last year. We were advisors to the committee that evaluated this program extensively. Out of a growing national concern for the abuse and overuse of narcotic pain medications, I was involved as a committee member for the development of a statewide guideline for the prescribing of opiates in the emergency department. Our committee met and provided state and national data to ACEP, the Arkansas State Medical Board, Arkansas Hospital Association, Arkansas State Health Department, Arkansas State Medical Society, and UAMS. The guidelines are to be published and placed in every emergency department throughout the state with these institutions listed as sponsors.

Arkansas Emergency Department Opioid Prescribing Guidelines

1. One medical provider should provide all opioids to treat a patient's chronic pain.

2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.

3. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.

4. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.

5. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.

6. EDs are encouraged to use the Arkansas Prescription Drug Monitoring Program.

7. Physicians should send patient pain agreements to local EDs and work to include a plan for pain treatment in the ED.

8. Prescriptions for controlled substances from the ED should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription.

9. EDs are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.

10. EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program.

11. EDs should maintain a list of clinics that provide primary care for patients of all payer types.

12. EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.

13. The administration of Demerol® (Meperidine) in the ED is discouraged.

14. For exacerbations of chronic pain, the emergency medical provider should contact the patient's primary or prescribed prescriber or pharmacy. The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.

15. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.

16. ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

17. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.

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