

I Don't Feel "Unnecessary"

By Nicholas F. Vasquez, MD, FACEP

Each day we go to work in this state's emergency departments, we see patients that are either in need or patients that are in need of a doctor. These of course are two very different populations. The first is what we trained for. Our departments are set up to meet their needs quickly and powerfully. The second group is everyone else. I don't know about you, but most of my day is made up of "everyone else."

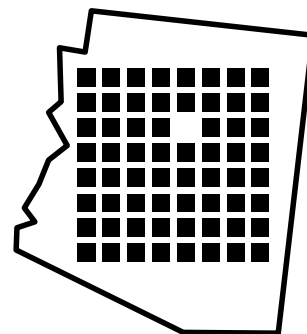
I've often heard the accusation that these patients are just here for primary care. My experience tells me otherwise. Most of these patients present to the ED after having tried to get care elsewhere first. In fact numerous surveys (including some done by ACEP) show that many patients in the ED are citizens with doctors and insurance but they couldn't get in when they had a need. Where there is a will, there is a way. Over time, those patients who need a doctor have sought out ways to find them. Urgent cares, walk in clinics, minute clinics, and ED's have all made a business from this need. In my ED, we've adapted the way we triage to improve patient flow primarily because of all these "non-urgent" patients. We're not the only one; other prominent ED's now employ multiple strategies from advertising how long their wait times are to pre-registration by telephone prior to coming in. Everyone it seems is focusing on meeting this "unnecessary" need.

That term "unnecessary" comes up a lot these days. Ever since the nation heard of accountable care organizations and their focus on primary care, ED visits have often been described as being both unnecessary and expensive. Personally, I don't feel my vocation is unnecessary and I don't believe my patients think it is either. On a recent shift I saw a cancer patient with pneumonia, an ex-prisoner who needed his catheter taken out, two old women who fell and broke bones, and much more.

I'm not arguing that these patients couldn't be seen elsewhere. What I'm arguing is that they won't be seen elsewhere. Where would they go? One patient with recurrent shingles called her PCP and was told she'd be seen in 4 weeks. Another patient tried and failed to find a specialist near him who would take new Medicare patients. The list goes on, and I know all of you have stories similar to mine.

I think we would all like primary care to be more accountable to their patients. Currently a new accountable care organization is forming in Tucson with the hope of improving the care for their citizens. Here in Phoenix, there are a number of medical home projects are underway. AzACEP will be interested to see how the ED fits into their model.

One day this nation may have accountable primary and specialty care with enough capacity to see all of the patients. Then maybe we can go back to "routine" emergency medicine. Until then, we must strongly advocate for our role in health care. We must help to define our role in accountable care. I hope we will see improved coordination between the existing ED's and these new organizations. I for one feel we have a lot to offer.





News and Notes

2% Campaign

ACEP has launched a campaign to educate policymakers, the news media and the public about the value of emergency medicine and that emergency care constitutes less than 2% of all health care spending. Because of the cost-cutting environment in Washington and in state legislatures, this campaign is also designed to promote the high value of emergency care, using positive patient stories.

The campaign launched April 27 in New York with a Health Writers' Conference, featuring ACEP's president Dr. Sandy Schneider and ACEP's past president Dr. Angela Gardner, our own **AzCEP board member Dr. Kathy Hiller**, plus members from Connecticut, Oregon and Washington, DC, highlighting different aspects of emergency care.

In addition, the results of a new poll of ACEP members were released showing increased stress on emergency departments, despite health care reform. ACEP spokespersons in 10 top media markets are conducting media interviews to promote the poll results and reinforce the "**Just 2%**" messages. The campaign will continue with print and radio ads through ACEP's Leadership & Advocacy Conference in Washington.

Campaign materials, including video and a "Just 2%" booklet, explaining (using government statistics) how emergency care is less than 2 percent of the nation's health care dollar are available at this link: <http://www.acep.org/Content.aspx?id=78701>

Are you Prescribing Controlled Substances? Sign-up to request access to the CSPMP database today!

Arizona's Controlled Substances Prescription Monitoring Program (CSPMP) is a valuable tool for physician use. The program is maintained by the Arizona State Board of Pharmacy (ASBP) and requires pharmacies and medical practitioners who dispense controlled substances listed in Schedule II, III, and IV to a patient to report prescription information to the Board of Pharmacy on a weekly basis. As required by A.R.S. § 36-2602, this program improves the State's ability to identify controlled substance abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription controlled substance drugs in an efficient and cost effective manner that will not impede the appropriate medical utilization of licit controlled substances. As of April 21, 2011, there are 2,658 medical practitioners and 639 pharmacists with authorized access to the database. Medical Practitioners who wish to access the database may request a user name and password to gain access. Go to this link, www.azpharmacy.gov/CS-Rx_Monitoring/practioner_procedures.asp, to request access to the database. Further questions are directed to Dean Wright,

Prescription Monitoring Program Director at (602) 771-2744 or by email at dwright@azpharmacy.gov.

HealthGrades Names Tops Cities for ED Care

John Commins, for HealthLeaders Media, April 14, 2011

Heart attack victims and other people in need of emergency care have a better chance of surviving in Cincinnati hospitals, where risk-adjusted mortality rates for patients admitted through the emergency department are the lowest in the nation, according to a study from HealthGrades.

HealthGrades Emergency Medicine in American Hospitals found large differences in mortality rates for patients admitted through the ED, both by hospital and by market area, based on an analysis of more than seven million Medicare patient records from 2007 to 2009.

The study focused on 12 of the most common medical emergencies, including heart attack, stroke, pneumonia, and chronic obstructive pulmonary disease, and included only cases admitted to the hospital from the emergency room, representing the continuum of a care. Hospitals performing in the top 5% in the nation were designated by Denver-based HealthGrades as Emergency Medicine Excellence Award hospitals.

"In the case of a medical emergency, patients need to get to the closest emergency room as fast as possible. No exceptions," Rick May, MD, the study co-author and HealthGrades vice president of clinical quality services said in a media release. "That said, we encourage patients to prepare in advance by identifying top-performing hospitals close to home. Our research shows that it's not just the care you receive the moment you arrive that makes the difference between life and death, but the hospital's ability to continue to provide you with the right care at the right time if you need to be admitted."

The top 10 cities for emergency medicine identified by the study are:

1. Cincinnati
2. **Phoenix**
3. Milwaukee
4. Dayton, OH
5. Cleveland
6. West Palm Beach, FL
7. **Tucson**
8. Baltimore
9. Houston
10. Detroit

The study also found that:

On average, for the 12 conditions studied, the percentage of cases admitted through the ED increased 2.64% from 2007 to 2009.

Emergency Medicine Action Fund Announced

New grassroots effort aims to influence health care reform’s regulatory implementation.

By Nancy Calaway, ACEP Communications Manager

With changes in the health care system already underway, a new initiative is looking to positively impact the regulations that will be written and implemented under this sweeping reform. The Emergency Medicine Action Fund, launched by ACEP in February, will pool contributions from individual emergency physicians and groups, chapters, and anyone else interested in advancing emergency care to provide financial support for advocacy activities in the regulatory arena. “This is probably the most important, defining moment for emergency medicine in our lifetime,” said ACEP President Dr. Sandra Schneider. “The decisions that are made now will set the course for us for years to come and we must positively influence the regulatory agenda. This Action Fund will help us do that and create a practice environment we can thrive in.”

The Emergency Medicine Action Fund will pursue a regulatory agenda that supports emergency physicians and quality emergency care. For example, evolving practice models and demonstration projects, such as accountable care organizations and bundled payments, are two areas of the Patient Protection and Affordable Care Act where the Action Fund might be able to wield some influence. “We need to be out there with the rule writers, working to ensure that emergency medicine’s perspective is valued,” said Dr. Angela Gardner, ACEP Past President who first proposed a national grassroots initiative focused on federal regulatory affairs. “It is critical that we be involved in these decisions regarding the formation of the future of health care delivery. This is our opportunity to be part of it.”

The following organizations have been invited to designate representatives to the initial Board of Governors – American Academy of Emergency Medicine (AAEM), Association of Academic Chairs of Emergency Medicine (AACEM), American College of Osteopathic Emergency Physicians (ACOEP), Emergency Department Practice Management Association (EDPMA), Emergency Medicine Residents’ Association (EMRA), and Society for Academic Emergency Medicine (SAEM).

One of the unique features of the Emergency Medicine Action Fund is that chapters can band together to form coalitions that would be eligible to have a seat on the Board of Governors. Or chapters can organize individuals and groups in their states for collective representation. The first 10 groups of contributors at \$100,000 will be granted seats on the Action Fund’s Board of Governors. “We are encouraging chapters and small to mid-sized groups to combine their resources,” Dr. Schneider said. “This is intended to be an inclusive effort, and everyone’s contributions are needed.”

The Emergency Medicine Action Fund is modeled on a successful initiative sponsored by CAL/ACEP, CAL/AAEM, EDPMA, and rural emergency physicians in California that has raised several million dollars for state advocacy since 2004. Wes Fields, chair of the California Emergency Medicine Advocacy Fund, said their program doubled the size of the CAL/ACEP advocacy staff, increased the number of lobbyists and consultants, and engaged in legal activities related to physician payment practices. He has been appointed by Dr. Schneider as the founding chair of the new national Action Fund. “I view this as the best form of free speech on behalf of emergency physicians and our patients,” Dr. Fields said. “It is not partisan. It is not political. “The rule writers and the policy makers will hear emergency medicine speaking with one voice, with one set of goals, one approach,” he added. “We need wide and deep support, even from those who are not members of the College.” CEP America, the nation’s largest emergency medical partnership, will be the inaugural donor, pledging \$100,000.

Activities planned by the Emergency Medicine Action Fund are intended to enable participants to make contributions that would be tax-deductible business expenses (tax deductibility can be determined only by participants’ tax advisors). NEMPAC, the National Emergency Medicine Political Action Committee of the ACEP, gives contributions to candidates who have listened to the needs of emergency medicine and made a positive change. However, NEMPAC may be used only to support candidates. The Action Fund can enhance regulatory advocacy with policy makers to ensure emergency physicians receive fair payment for their services. It can also fund numerous meetings with regulators to help guarantee that patients receive the best care, and provide funding for studies to demonstrate the value of emergency medicine. “With the new Congressional session upon us, it is as important as ever to be active on both the legislative and regulatory fronts,” Dr. Schneider said. “We will depend on all of these funds to make our case. This will be the year we ask everyone to dig a little deeper. In these challenging times, we need contributions to both the Action Fund and NEMPAC.” Find out more about the Emergency Medicine Action Fund at www.acep.org/EMActionFund.

How is the Emergency Medicine Action Fund Different from NEMPAC?

Both are valuable tools that need our continued support, but the Emergency Medicine Action Fund serves a different purpose than NEMPAC.

	NEMPAC	EM Action Fund
Gives campaign contributions to Congressional candidates	YES	
Funds meetings with regulators and policy makers		YES
Enhances emergency medicine advocacy efforts	YES	YES

*Maricopa Medical Center
Resident's Column
By Jacob Erickson, MD*

The Mayan calendar will soon end in 2012, and if what is depicted in a recent, but may I say very poor, Hollywood movie, the world is to come to an end. This means that I will only have one year to practice medicine as an attending. This would mean that all I have done to get this point will be nearly in vain. This of course means that all of the underclassman behind me will not get a chance to practice. So, I say to my fellow graduates from emergency medicine this year, do all you can to make a difference in the lives of your patients, do all you can to better medicine, do all you can to promote the specialty of emergency medicine. I for one will strive to make the changes I hope to see for the specialty of emergency medicine.

On a lighter note, Maricopa Emergency Medicine residency just returned from our retreat at Mormon Lake. We discussed the impact of recent changes to the curriculum, changes to shift work, the impact the triage doc has had on the flow of the department, and many other large endeavors taken this year. The input received will hopefully continue to improve the efficiency of the department and the educational experience the residency can offer. Drs. Eric Katz and Shaun Adnand have gone to great lengths improving the Maricopa residency program, and they have continuously adapted the curriculum to ensure that our residents are confident facing the growing responsibilities of emergency medicine physicians. Of course other activities completed at retreat were better complimented with a beer or shot of whiskey.

We had an incredible match this year. We continue to receive students from across the US and from different backgrounds. I will have to say that this is the most promising match yet, just a slight step behind the caliber of residents from my class (ha, ha). I am sure the interns are glad to see this year end and I have full confidence in their abilities. The second years are ready to take the helm as seniors and lead the residency.

I will miss residency, I will miss practicing in this southwest corner of the US. I mean really, where else can you train and see such a diverse population and such a breadth of pathology? Our trauma experience has included unique cases such as sky divers from Luke AirForce Base, explosions from refineries, traumatic gunshot wounds in a State that is probably the most lenient on gun control, motor vehicle ejections from the back of pickups and rollover ATV accidents. We get to work with Native Americans and see pathology that is unique to this population. I have seen tropical diseases from Central America, other unique infectious diseases seen in this region such as coccidioides, hanta virus, etc. I have cared for rattlesnake bites, black widow spider bites, scorpion stings and have even administered rabies vaccine and immunoglobulin to a woman who was bit by a dog in Mexico during vacation.

This will be my last contribution to the EPIC. I want to thank you for giving me the opportunity to share my thoughts and experiences at Maricopa Medical Center. I wish all fellow emergency physicians the best of luck in your careers. I hope you all will have enjoyment with what you do. Seriously, what the hell did the Mayans know?

Beating the Odds: Emergency Care in the 21st Century

Option 1; ITLS Provider Course - Oct. 3-4

Arizona's premier scenario based trauma course, ITLS! Students wanting Adult ITLS will receive the same excellent instruction from our volunteer support team of instructors, faculty, models and moulage artists to obtain ITLS certification.

Option 2; Pediatric ITLS Provider Course - Oct. 5

Your one-day Pediatric ITLS course option.

Option 3; Lecture Track - Oct. 3-4 *Check out our speakers!!*

Our popular new track will offer each registrant choices of timely and interesting EMS topics, which will be presented by nationally recognized speakers in the EMS field. Just look at our line-up... EMS providers, physicians & a nurse!

Dr. Dan Spaite; Saving Brains in Arizona: The Excellence in Prehospital Injury Care (EPIC) Project

Dr. Ben Bobrow; Evolving AHA Guidelines & Arizona's VERY COOL System of Post-Cardiac Care

Dr. Sydney Vail; Less than Lethal Munitions & Tactical Medicine: Back to Basics for EMS

Dr. John Gallagher; EMS Medical/Legal Liability Case Reviews

John Valenzuela, CEP; Violent Patient Management & Predictable is Preventable

Suzanne Buchanan, RN, BSN, CCRN; Emergency Burn Management

Lane Spalla, CEP; Boots on the Ground: On-scene command MCI perspective from the Tucson Shooting

Dr. Jason Roosa; Mission Lifeline: The AZ State STEMI System of Care

Dr. David Slattery; The Clock Starts Now! Optimizing the AHA's Chain of Survival for Sudden Cardiac Arrest Before EMS Arrives-Lessons From the Casino AED Program

Registration open NOW; www.itlsaz.org/itlsriver

**Kingman Regional Medical Center/
Midwestern University
Emergency Medicine Residency
Update**

By Tim Sichi, DO, MPH

Although one would not imagine a rural emergency department would see a many GSW victims, we have our share. To better understand the patterns of GSW from different calibers of weapons at different ranges we completed an off site ballistics lab during our regular scheduled lectures. The target was a semi transparent ballistic gel which is designed to roughly mimic the density and viscosity of the human body. We utilized firearms provided by the ED staff including AK47, AR15, 9MM Glock, 12 and 20gauge shotguns, 45 caliber handgun, 7mm rifle, 300 Winchester Mag rifle, .17, .22 and .223 caliber rifles. It is conservative to say we used a broad variety of firearms. We also used a broad variety of ammunition and bullets. It was interesting to see the various types of wound patterns based on the amount of grain and the shape of the bullet/shot. The gel retained most of the trajectories which were not fully jacketed or of the hollow point design. We were able to retrieve these remnants and see how various fragments were distributed in the gel. On of the most illuminating displays was the high powered high grain hunting rifles which transmitted so much force into the ballistics gel that even when they failed to make contact with the wooden table below the gel the wooden table was broken due to the shock wave. We were also able to see the powder burn distribution when a firearm is discharged at close range. Another revelation for many of the residents was the wide distribution of the shock wave near the entry point aside from the direct bullet trajectory.

While most EM physicians all know the ATLS protocol, we at KRMC will have a new set of knowledge questions and understanding of the wound patterns created by various weapons and may be able to better predict the extend of injury based the appearance of the presumed entry wound, the presence or lack there of an exit wound.

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Thank you for your service to AZ and our patients!

UNIVERSITY OF ARIZONA RESIDENT'S COLUMN

By Jen Luman, MD

There comes a time in the natural cycle of life and emergency departments where all good things must change, and that time has come to the University of Arizona. In July, Dr. Harvey Meislin will be stepping down after a long and successful tenure as the chair of emergency medicine. In his place, current residency program director Dr. Sam Keim will take over the helm as the interim chair. Dr. Keim's change in title will create an opening in the residency program, and our own Dr. Al Fiorello will be stepping up as the new program director.

This has the department buzzing with ideas for change while attempting to maintain the stability and foundation that has made the University of Arizona excellent for 30 years under Dr. Meislin. Change always fosters new innovations, and we look forward to some bright ideas that will come with the new leadership while maintaining the continuity of an excellent residency and research program. In addition to the leadership changes, additional faculty changes are underway as well. Dr. Dan Spaite will be the Distinguished Chair in Emergency Medicine at the COM-Phoenix, Dr. Sam Keim has been named the Distinguished Professor of Academic Emergency Medicine and Dr. Kurt Denninghoff has been named the Distinguished Professor of Research in Emergency Medicine.

New faces joining the intern class from around the country next year include Jessica Anderson from the Medical College of Wisconsin, Marcus Boin from OHSU, Julie Carland from the U of A, Christopher Davis from UW, Benjamin De Witt from the University of Pittsburgh, Daniel Falvey from the University of Minnesota, Steven Groke from the University of Utah, Nicolaus Hawbaker from Loyola, Nicholas Hurst from the U of A/COM Tucson, Raj Joshi from Ross University, Michael Mitchell from UW, Jennifer Smith from the Chicago Medical School at Rosalind, Casey Solem from the U of A/COM Phoenix, Nicholas Stea from the U of A/COM Tucson, Matthew Thompson from the University of Kansas, and Corrine Walker from the U of A/COM Tucson. The combined emergency medicine-pediatrics residency has expanded to three residents next year, and these spots will be filled by Whitney Kiebel from Michigan State, Erin Tromble from the University of Wisconsin, and Garret Pacheco from the University of Arizona/COM Tucson.

As the department grows with new people we are simultaneously expanding facilities and programs. The University Physicians Hospital-Kino will open the doors to a new 55 bed ED in August, which represents a major expansion of emergency department services on the medically underserved south side of Tucson. In addition, efforts are underway to seek trauma center certification for UPH-Kino to continue expand the medical services at the hospital. Finally, the department will be starting both a medical toxicology and ultrasound fellowships within the next year.

Our research success continues to grow with a major presence through our resident Scholar Quest program. Several residents have had research accepted for national SAEM in Boston and will be travelling east in June to share their results. Oral presentations include Drs. Nikki Vasconcellos, Erik Schenk, Lisa Chan, Kevin Reilly on "The Impact Of Implementing In-room Triage To Improve Emergency Department Throughput," Drs. Melissa Zukowski, Jenny Mendelson, Sid Patanwalla, Dale Woolridge with "Pediatric Prescribing Errors: The Effect of an Educational Based Intervention on Prescription Errors Amongst Emergency Medicine Residents," and Drs. Targhee Orr, Leah Bennett, Mazda Shirazi presenting "Can tile prevent scorpions from crossing a barrier: an experimental controlled trial," Drs. Carrie Adrion, Charlene Shaughnessy, Angela McKellar on "Diagnosis of long bone fractures by ultrasound in the Emergency Department," and Drs. Joy Hardison, Alex St. John, Larry DeLuca, Kurt Denninghoff with "Using The H-index As A Method For Rating Productivity And Impact Of Academic Departments Of Emergency Medicine." Finally, Drs. Austin Gross, Ryan Earp, Justin Mitchelson, and Dan Beskind will present a poster on "Motor component of the Glasgow Coma Scale (mGCS) as a prehospital risk adjustment measure for trauma patients."



Dr. Dan Spaite getting the Endowment for Chair in Emergency Medicine at Phoenix-COM

CAPITOL HAPPENINGS

By Richard E. Bitner, Legislative Counsel

Distractions Fail to De-Rail Session Completion in 100 Days

Despite a host of distractions, some of which continue to be-devil numerous legislators, the 50th Arizona Legislature managed to sustain its focus and complete the state budget and other legislative business within 100 days, adjourning the first regular session *sine die* at 5:45 am April 20th. Shortly thereafter, House Speaker Kirk Adams announced his resignation to pursue the 6th District Congressional seat long held by Congressman Jeff Flake, who has declared he will seek the US Senate Seat opening created by Senator Kyl's decision to retire at the end of this term. The House Republicans quickly caucused and agreed to elect Representative Andy Tobin, formerly House Majority Leader, as the new House Speaker, and Representative Steve Court was also selected to replace Tobin as Majority Leader. Proceedings are on-going to appoint Kirk Adam's successor from House District 19.

Of the 1350 bills introduced, 386 were passed and sent to the Governor, who doubled last year's veto performance, rejecting 29 of those measures. The 357 bills signed into law by Governor Brewer have a general effective date of July 20th, unless enacted with an emergency clause or a delayed effective date specified.

On-going "distractions" that continue to dog legislators into the interim include:

- Whether criminal charges will be brought by the Maricopa County Attorney against Senator Scott Bundgaard for a domestic dispute involving his former girlfriend in the right-of-way on SR 51 last February 25, and whether legislative ethics proceedings will follow thereafter.

- Re-call proceedings brought against Senate President Russell Pearce appear close to submitting sufficient valid signatures, setting the stage for a re-call election, most likely in March of 2012.

- The Fiesta Bowl scandal continues to shake out, with the possibility of not only of civil or criminal charges being brought against Fiesta Bowl officials, and staff, but also potentially involving some legislators, depending on whether authorities conclude they took tickets to football events in a manner prohibited by law or otherwise improperly failed to disclose gifts. Senate Ethics Chairman Ron Gould has already opined there may be legislative ethics violations to be pursued, but has indicated he will take no official action on any legislative ethics complaint that could be filed until the conclusion of the county prosecutor's criminal investigation.

Adoption of "Balanced Budget" Leaves Large Questions on Future of AHCCCS Funding

Governor Brewer's initial budget proposal in January contemplated the outright elimination of coverage under AHCCCS for some 280,000 "childless adults". Pegged to save \$541 million in state costs, it would, as estimated by the Siedman Institute at ASU, involve the loss of \$2 in federal matching funds for every state dollar "saved", and some 30,000 job losses to the state economy. The proposal was thought to require a federal waiver of "maintenance of effort" (MOE) requirements in order to be pursued by the state, but Secretary of Health & Human Services Kathleen Sibelius instead concluded no MOE waiver is needed. In a somewhat surprising move, Secretary Sibelius promptly issued a ruling that Arizona can indeed proceed with its plan, as to 250,000 of the "childless adult" AHCCCS population, since the waiver currently in effect for this childless adult group is scheduled to expire September 30th of this year. Because it is an "optional" coverage under Medicaid, Arizona is free to "non-renew" this element in its request for a new waiver, and there is no violation of the "maintenance of effort" provisions in last year's federal healthcare reform act.

AzCEP reacted with other AHCCCS providers to oppose this approach, including participating in a AHCCCS Provider Day at the Legislature in February. While seemingly meeting little initial success in these efforts the coalition persists. And, at our first ever ED DOC Day at the Legislature on March 24th, AzCEP continued to emphasize with our legislators the heavy costs of this approach to the state economy, impacts on providers left to deal with even more uninsured patients, and the patient hardships individually to be faced by those losing AHCCCS coverage.

Following Secretary Sebelius's ruling, Governor Brewer did re-think and reformulate her budget cutting approach and what was ultimately enacted by the Legislature abandoned the idea of eliminating eligibility for "childless adults" in its entirety, in favor of a "freeze" on enrollment of this category effective July 1st, coupled with new 5% provider reimbursement cuts effective October 1st and a number of new co-pays and individual accountability measures for enrollees. The overall impact of the total package is expected to reduce AHCCCS expenditures by more than \$500 million. The key elements of the budget cuts enacted for the AHCCS program by the program are summarized below, and can also be reviewed at the AHCCCS website "updates" page: www.azahcccs.gov/shared/news.aspx#OptionsreMedicaidEnrollment.

- Eliminate enrollment of childless adults for an estimated savings of \$190 million. An estimated 150,000 enrollees could lose coverage in the first year. Enrollment in this category is to be frozen on July 1, subject to federal approval, meaning no new adults may enroll and those with existing coverage retain it as long as they maintain their eligibility continuously on and after June 30th. After October 1st, subject to approval of a new waiver for all of Arizona's AHCCCS program, this program will be eliminated except for those continuing prior coverage under the freeze. Those who lose coverage for any reason may not re-enroll. While the Governor and Legislature have chosen to refer to this as a "freeze" it is, in fact, a phaseout of the entire program through attrition. *The Arizona Center for Law in the Public*

(Continued on page 9)

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Interest has said it will file a special action with the Arizona Supreme Court by the end of May challenging the freeze of coverage for this population as an unconstitutional violation of the “Medicaid expansion” provisions of Prop 204, which guarantees AHCCCS coverage for all individuals at or below 100% the federal poverty level. Lead counsel Tim Hogan has said they will immediately move for a stay of the July 1st implementation date on the freeze and ask for speedy Supreme Court action on direct review. Should the petitioners prevail in this action, it would appear the Legislature would need to take speedy action to either enact additional revenue sources to support AHCCCS eligibility for this population, or enact further draconian cuts to other state supported institutions to shift appropriations over to AHCCCS.

Eliminate “spend down” program. Effective May 1, this program is frozen and beginning October 1 all those already eligible will be phased out. This program currently covering some 5000 individuals exists to allow individuals who would not ordinarily qualify for AHCCCS but who have sustained extensive medical expenses to qualify for AHCCCS after “spending down” their assets to below 40% of the federal poverty level. This is a state program not required by Medicaid and CMS has already approved its elimination.

Eliminate enrollment of parents earning 75-100% of FPL for estimated general fund savings of \$17M. This contemplates no new enrollment for parents earning between 75-100% FPL. Coverage would continue for those already enrolled as of September 30, 2011, but only so long as they retain continuous eligibility. ***This provision requires CMS approval and will also fall under the state constitutional challenge being mounted by the Arizona Center for Law in the Public Interest (see above).***

Eliminate Federal Emergency Services Program participation. This would end Medicaid reimbursement for emergency care given to non-qualified aliens for an estimated savings of state general funds of \$20M. Obviously, federal matching dollars supporting the program would be lost to the state. This requires approval under the new waiver effective October 1st. CMS approval is deemed unlikely, and it would appear to require a change in federal law.

Require 6-month redetermination of eligibility for potential savings of \$15M. Federal approval again seems unlikely, based on prior rejections, but changing federal fiscal circumstances could produce a different result.

Expand mandatory co-payments for parents and children, including a new co-pay for “non-emergency use of an emergency department”. CMS approval required prior to planned October 1 implementation; CMS has rejected many of these in the past.

Institute a no-show penalty for missed appointments, to be paid to provider. *SB 1357: AHCCCS; Missed appointments; Provider Remedy* implementing this with a \$25 missed appointment fee was signed by the Governor, but remains subject to federal approval.

Provider reimbursement reduction of 5% effective October 1st. The budget authorizes the AHCCCS Administration to make further provider payments as it may deem necessary to balance the budget. This move comes on top of the five percent cut that already took effect April 1.

As an alternative to these cuts to healthcare coverage and provider payments, AzHHA and other healthcare organizations have proposed reforming AHCCCS and provide funding through a special healthcare assessment. This plan would save the state several hundred million dollars and leverage billions of federal dollars Arizona taxpayers are already paying that will otherwise be used to support healthcare in other states. This plan remains on the table and AzCEP will continue to encourage Governor Brewer and lawmakers to support this viable alternative to eliminating healthcare coverage and instituting these provider payment cuts.

Aggressive reductions in provider reimbursement only serve to further restrict healthcare access as fewer physicians elect to serve AHCCCS patients, leaving many of the newly uninsured the only viable option of seeking care in the emergency department. Further information and updates on the AHCCCS funding crisis and alternatives are available on the Arizona Hospital & Healthcare Associations website: http://www.azhha.org/member_and_media_resources/reports_data_and_tools.aspx

Final Action on Other Key Bills of Interest to AzCEP

Enacted:

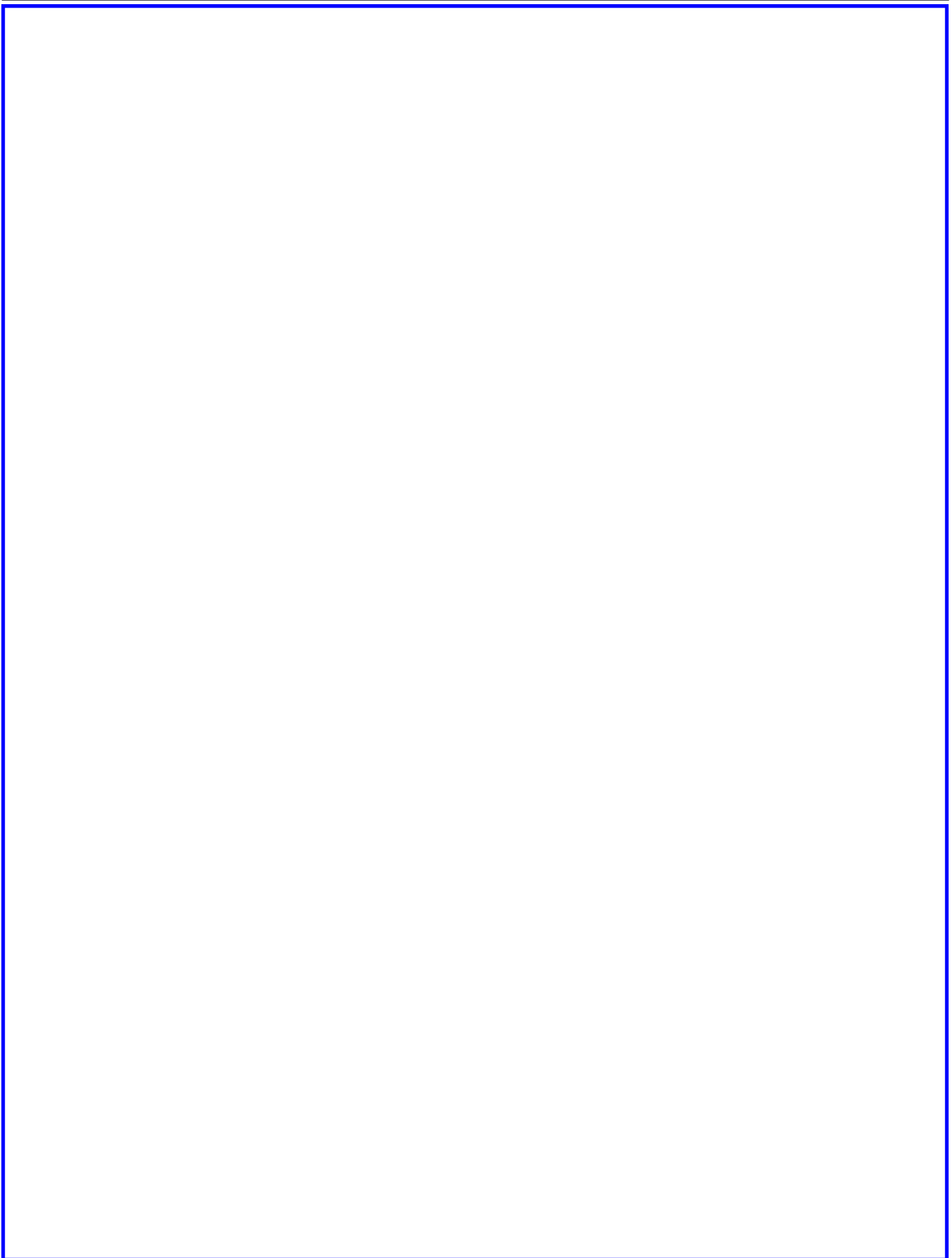
HB 2157: DHS; Stroke Care Protocols - The Department of Health Services is required to adopt rules by January 1, 2014 to establish standards for hospital-based and rehabilitation stroke care, and to compile statewide stroke quality improvement databases.

HB 2548: Medical Helicopters; Non-Trauma Patients; Guidelines - The Department of Health Services is to develop guidelines on the use of medical helicopters for non-trauma patients, which shall be distributed to all emergency receiving facilities in the state.

HB 2620: Medical Records; Disclosure; Release - Comprehensive re-write of Arizona’s medical records statutes designed to establish all requirements necessary to comply with federal healthcare reform initiatives for implementing electronic medical records, including the ability to secure federal implementation grants.

SB 1030: Physician Assistants; Prescribing Authority - Effective July 20th Physician Assistants already authorized to prescribe Schedule II and III controlled substances for 14 days will have their authority automatically increased to 30

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days, unless withdrawn by their supervising physician. All other current requirements concerning delegation of prescribing privileges by a supervising physician to a physician assistant remain in effect, except that a physician assistant is now prohibited from prescribing medication intended to perform or induce an abortion.

Defeated:

SB 1405: Immigration Status; Hospital Admissions – This proposed requirement for hospital staff to collect evidence of citizenship on patients presenting for care and notify federal immigration authorities of those unable to document their citizenship was actively opposed by AzCEP and other health care organizations. It was one of a half dozen anti-immigration measures narrowly defeated on the Senate floor this year.

Vetoed:

SB 1593: Health Insurance; Interstate Purchase - Governor Brewer vetoed this legislation after receiving unprecedented levels of comment in support of and opposed to the legislation. AzCEP joined with other health care providers in a joint letter with 32 organizations signing on to oppose the manner in which floor amendments were adopted without ever receiving a public hearing, and the substantive policy changes that would have allowed out of state health insurers to enter the Arizona market and ignore a host of “insurance mandates” in Arizona’s insurance code, so long as they complied with legal requirements in their home state. Going even further, the law would have allowed Arizona based insurers to ignore the mandates, if a health insurer in another state with looser laws sold one policy in Arizona that did not honor them. More than 30 categorical “mandates” could have been set aside under this scheme, including all of AzCEP’s hard won elements of our “imprudent layperson” statute, which we focused on in a separate letter to Governor Brewer limited to AzCEP’s concerns on the very negative impacts on this proposal for emergency medicine.

Many thanks to all of you who participated in the first ever ED DOC Day at the Legislature. We hope you will continue to build on the relationships you formed with your legislators that day, and will encourage other AzCEP members you know to join in for the next Day at the Legislature in 2012. Those desiring more information about legislative developments or AzCEP Public Affairs involvement than provided here may wish to check the AzCEP website for updates, consult the Arizona Legislative Information System (ALIS) at “www.azleg.gov”, or contact me or members of the Public Affairs Committee or Executive Team for assistance.

CLASS/COURSE OFFERINGS

This is a partial listing of classes that are often needed by emergency physicians.

ACLS/PALS

*Contact www.wizardeducation.com for a listing of ACLS, PALS, plus many more offerings.

*For a state-wide listing, call the American Heart Assoc. at 602-414-5345 or visit www.americanheart.org/az-co-nm-wy/

*Or try taking ACLS online!
Go to; { www.ncs.org/eacls } for more info.

Calendar of Events

Mark your Calendar and Get Active in AzCEP!

- June 1-2 Summer Retreat/Membership Meeting, The Ritz-Dove Mtn.
- July 6 Exec. Committee, Chapter Office
- Aug. 3 Board of Directors, Chapter Office
- Sept. 7 Exec. Committee, Chapter Office
- Sept. 28 Board of Directors, Chapter Office
- Nov. 2 Exec. Committee, Chapter Office
- Dec. 7 Board of Directors, Chapter Office

***All AzCEP members are welcome and encouraged to attend the Board Meetings. Contact the Chapter office at 602-336-4599 for additional information.**

Board Meetings, unless otherwise noted, are held at 12:00 noon at our Chapter office in the Arizona Medical Association building, 810 W. Bethany Home Road, #110, Phoenix, AZ 85013.

Changed Your Address?

If you change your business or home address please notify the National ACEP Office or AzCEP & the correction will be forwarded.

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AzCEP Mission Statement

The Arizona College of Emergency Physicians (AzCEP) exists to support the highest quality emergency medical care and to serve as advocates for our patients, our members and our specialty. {adopted by the AzCEP board, 10/2001}

Summer Issue of the Arizona EPIC

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