

CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

FALL 2009

PRESIDENT'S MESSAGE

Dear CCEP Members,

An organization succeeds by the participation of its members, who contribute to the common good.



Members are inspired for different reasons and vary their degrees of commitment. Professional development, advancement of managerial skills, achievements through committee work, personal fulfillment, socialization, effecting change on the local or national level, advocating the protection of patients or the position of emergency medicine professionals, comprise a partial list of rewards that members receive in turn for their participation.

While some members have specific goals in mind; others serve and discover issues that become important to them. Whatever the individual reason for one's participation, it is important to be aware that the Connecticut College and the American College of Emergency Physicians have opportunities available to all emergency physicians.

This past year, through the work of the members of the college and in conjunction with ACEP, CCEP has promoted a very positive reputation and presence at both the state and national levels. CCEP provides a continued presence at the state legislature in Hartford and has cultivated relationships with our state legislators to become a consultative resource for healthcare issues that affect the practice of emergency medicine and patients seeking emergency medical care.

Nationally, CCEP members travel to Washington, DC and continue its support of national issues with ACEP, assuring a unified voice for emergency physicians. While debate rages on national healthcare reform, EM physicians express individual viewpoints reflecting the spectrum of opinion consistent with the national distribution. Although we may have differing ideas concerning healthcare reform, the most important issue is to insure the participation of emergency medicine professionals at all levels of the healthcare debate. The ability to practice EM, as we define it, should be preserved and protected. The care

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ACEP's 2010 COUNCIL MEETING

GREGORY SHANGOLD, MD, FACEP

Another ACEP Council meeting has come and gone. Connecticut's delegation participated in various discussions and voted on behalf of Connecticut's emergency physicians. The docket consisted of 27 resolutions. Included in the 27 resolutions are memoriums and commendations, however, councilors debated a variety of important issues covering a variety of aspects of emergency medicine.

For those of you who do not know, the council is comprised of representatives from the 50 states. Each state's delegation is proportional to the amount of members. Connecticut currently has five councilors (Drs. Charash, Jordan, Levine, Perez and Shangold.) In addition to our five councilors, Drs. Jacoby and Carius are non-voting members seated on the councilor floor because of the past service as national ACEP officers. In addition to state councilors, various ACEP sections have councilors. All together, there are 318 physicians composing the ACEP council. The main function of the council is to deliberate and vote on the submitted resolutions and elect ACEP's president and ACEP's Board of Directors. If members are interested in a particular issue, contact any councilor prior to the annual meeting and participate in the annual CCEP Board of Directors debate meeting as the board finalizes Connecticut's viewpoints.

Dr. Gail D'Onofrio contacted councilors because of

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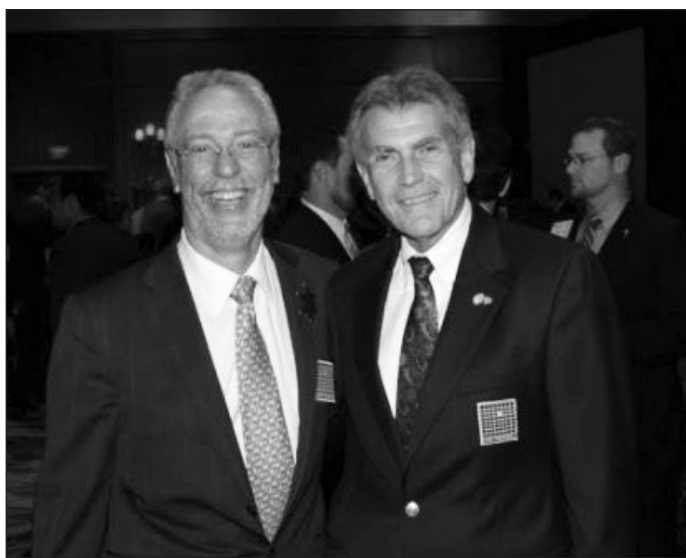
David Wilcox, Bryan Jordan, Alberto Perez, Gregory Shangold, David Charash, Peter Jacoby and Michael Carius —
Our Connecticut Delegation at the ACEP Council Meeting

COUNCIL MEETING

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resolution 8 (09) ACEM Councilor Allocation. This resolution changes ACEP's Bylaws to allow the Association of Academic Chairs in Emergency Medicine (AACEM) to have a council seat. The council passed the resolution. Although AACEM does not have 100% ACEP participation, inclusivity seemed more important than mandating membership.

Other topics at this year's meeting included directing ACEP to oppose the licensure of Doctors of Naturopathy to practice medicine independently, imposing end of life panels at institutions to better limit futile care, and mandating seat belt installation and use on school buses. Additional topics included educating hospital administrators on the limitations of patient satisfaction surveys, working



ACEP Council Meeting Day – Peter Jacoby, MD and Michael Carius, MD

with states to eliminate mandatory reporting of patients with seizure disorders and to better define and standardize definitions of inpatient-boarded patients occupying emergency department beds.

Of course, there was a resolution for ACEP to support a single-payer government health insurance system. This resolution was defeated. ACEP already has a position supporting universal coverage, but it was felt that only supporting a government run single payer system would limit its realm of influence. Interestingly, the councilors voted on their personal preference and 51% were in favor of single payer, and 49% were against single payer.

The Council listened to presentations based on last year's resolutions. ACEP released a landmark white paper on the recognition, prevalence, definition, and management of excited delirium. Other strategic topics included deeper discussions on health care reform and emergency care workforce issues. Although ACEP's goal is for an ABEM certified emergency physician to staff every emergency department, it is clear from the workforce analysis this will

not occur. Some institutions have started a dual EM/FP residency but many family physicians are currently working in emergency departments without any additional emergency training. The Council discussed how these physicians could be incorporated into the house of emergency medicine. The council seemed to agree that ACEP should work with the government to increase EM residency positions and advocate for monies to help train physicians interested in emergency medicine after completing a primary residency, but that there should be no other pathway to board certification other than EM residency completion.

Many of these issues require working with elected officials and the NEMPAC report given to the council showed that NEMPAC currently collects over \$1 million per year. This permits emergency physicians to have significant access, and therefore influence, as politicians debate our livelihood. Many of the other industries who will be affected by healthcare reform have even stronger lobbies. If you have not donated to NEMPAC, please consider donating. Donating one shift during the year can prove invaluable as ACEP continues to educate politicians on the need to fund and secure emergency care as an essential public service. The affect of EMTALA's unfunded mandate on emergency medicine is distinct from all other specialties. Now is the time for all of us to band together and have our voices and those of our patients be heard.



David Wilcox, MD, Greg Shangold, MD, Bryan Jordan, DO and Alberto Perez, MD at the Council meeting in Boston

Lastly, the council elected physicians to serve on ACEP's Board of Directors and ACEP's president-elect. Drs. Rebecca Parker and Jay Kaplan join the re-election of two incumbents Drs. Alexander Rosenau and Robert Solomon. The president-elect will be Dr. Sandra Schneider. Connecticut continues to have an excellent relationship with ACEP's board members. This affiliation allows Connecticut to approach the national board when specific local issues need to be elevated to the national level. ACEP member Michael Gerardi, M.D. from New Jersey will be speaking at CCEP's fall meeting. Please take the opportunity to join us in Rocky Hill and listen to Dr. Gerardi's impression on how the national healthcare debate will affect emergency physicians. As CCEP finalizes its 2010 legislative objectives, we will count on this relationship to ensure success..

CAREERS IN EMERGENCY MEDICINE: DAVID WILCOX

Intro: Every once in a while, EPIC interviews a Connecticut EP whose career path has taken an unusual twist or two. Dave Wilcox has had about every type of EM job known to man; he's also been a walk-in clinic entrepreneur, and he's spent years on what he terms, "the dark side", working with managed care insurance companies.

EPIC: David, you started your EM career a pretty long time ago during the frontier years of EM, which to a lot of us was a mysterious time. Where did you start out?

DW: My EM training was at Penn State, and my first attending position was at Rhode Island Hospital in Providence in 1982. We were the first residency trained, full time academic emergency physician group in New England. RIH was and still is the busiest emergency department in New England. In 8000 square feet, eight of us saw 96,000 people a year. Incredible. In 1983, we opened up a brand new department; growing from 8000 square feet to 23,000 square feet. It seemed huge; we thought we needed roller skates to get from one end of the department to the other! Of course, it's much larger now. We did 12 hour shifts and saw patients primarily and with Brown University residents and medical students. We saw an unbelievable number of patients per shift, and I loved it, despite getting to the end of a shift and realizing you hadn't eaten or used the restroom, your back hurt, your feet hurt, and you still had all those charts to review before heading home!

EPIC: Those were the good old days, I mean the bad old days, I mean the good old days. Ok, so 8 EM trained attendings parachute into RIH in the early eighties. Besides the numbers - too many patients, seen by too few docs, in too little space, can you give us a sense of what it was like to practice EM back then?

DW: In the early days of emergency medicine you had to prove your worth. You had to gain the trust of the docs in the hospital who didn't know who we were or what our training was about. How could one doc know about the emergent care of orthopedics and peds and ophthalmology and medicine and ENT? Unheard of at the time. I can still recall a second year surgery resident who was sure that they knew how to handle trauma better than us, and a Chief Surgical Resident who was surprised when he removed an appendicitis that I diagnosed and he was sure wouldn't be there. We had to diplomatically point out when they were wrong. Not easy. We had to gain people's trust, and that

took time; months and years, one specialist, one surgical resident, one primary care doc at a time.

EPIC: So you were involved with the cultural change at a dyed in the wool New England city hospital that had been doing business in the same way for years.

DW: Yes, in New England we are very traditional; we tend to change gradually over time. Emergency Medicine came much more slowly to New England than it did in other parts of the country.

EPIC: When did you start training your own residents?

DW: The Brown University EM program started in the late 1980's. However, I had moved to UMASS Medial Center in Worcester, and their EM residency started in the mid 1980's. UMASS was a relatively new hospital medical center at that time, and Richard Aghababian, MD enticed me with the directorship for the first emergency medical helicopter service in New England (Lifelight).

EPIC: So tell us what we all want to know - what were the salaries back then?

DW: I can remember standard salaries of \$60-70,000 a year in New England. RIH was different; we were fee for service, and despite a lousy collection rate similar to many inner city tertiary hospital EDs, because we had a very high census, we did very well. My first year at Rhode Island Hospital I made \$125,000, which in 1982 was big money.

EPIC: And you simultaneously went into the walk-in business, is that right?

DW: Not quite simultaneously, but close. I went to UMASS in '83, and started walk-in centers in '84, early during the walk-in center trend. I was interested in doing something in Connecticut, where my wife and I are from. In 1984 we opened an office on the East Hartford-Glastonbury line, and a second office in Wallingford in 1985. I was full time at UMASS, so work weeks were 100 hours plus.

EPIC: So you're a young guy, with a young family, a full time emergency physician working all shifts, only a few years past residency, the director of the helicopter program - that would keep a lot of us busy. But you were also out

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DAVID WILCOX

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there creating a business, researching real estate and hiring staff, equipping an office. Sounds like a busy time! How did you make out?

DW: Very well; we were very successful. We learned that there is a large segment of young to middle age healthy working people who do not have family doctors, or do not really want to make appointments to see doctors. They want service now and they want to move on with their life. If you provide that service, and if you do it well, they will keep coming back. And then they bring their kids, or they bring their parents. Within a year we had to develop a primary care business in addition to urgent care. That's what the need was, that's what the market demanded. For 15 years, I was the family doctor for a whole array of patients from kids to grandparents. It was a pleasant counter balance to my academic emergency medicine at UMASS. Our Worker's Comp business also expanded at that time, starting with urgent minor injury

treatment, then pre-employment physicals and drug screening. Nobody else was doing it in the area; we became the de-facto experts and developed our occupational medicine business.

EPIC: Did you get any resistance from the primary care community?

DW: I met with the family docs, internists, and pediatricians in the area to let them know that we weren't there to steal patients, and that we'd always refer their patients back to them for follow-up, which we did every time. We generated new business; we saw people who wouldn't be inclined to go to an ED to wait for hours, or they couldn't get an acute appointment with their family doc, or they couldn't take time off work. We were open evenings and weekends, something private offices didn't do.

EPIC: And you were still full time in

Worcester?

DW: I was full time at UMASS from 1983 to 1986. As the CT offices grew, I went to half time at UMASS, maintaining my clinical teaching position, which I loved, but reluctantly giving up the medical directorship for the helicopter service. We had grown Lifelight incredibly, but time constraints demanded that I give it up. The CT offices continued to grow through the 1990's, and I gradually reduced my UMASS hours, finally leaving the world of teaching residents and medical students in 1999. I also taught at Northeastern University in their Paramedic program from 1982 until 2003.

EPIC: It's an interesting topic, the academia in-or-out decision. At least for a while you were in a position as one of the early emergency medicine educational leaders. Do you remember what you were thinking in this regard back then in the 1980s?

DW: The walk-in centers were important to me, because I didn't want to be financially dependent on Brown, UMASS or any hospital for my entire livelihood. That did not make me comfortable. The walk-ins were a business decision - a way that I could make a good living without being dependant on something I couldn't directly control, like a specific hospital or ED. As our kids grew, I wanted more time with them, so I sold the Wallingford office to a group of local doctors in 1991, and sold the East Hartford office to ECHN in 1998.

EPIC: What then?

DW: I took a position with EMCARE as the Chairman of Emergency Medicine and Ambulatory Services at Landmark Medical Center, a two hospital system in Woonsocket, RI. I was commuting from CT to RI to MA. I would leave home in CT early Monday morning for Landmark, head to UMASS for my standard Tuesday overnight shift because I always wanted to be there for Wednesday morning Grand Rounds, then head back to Woonsocket for the rest of the week, and try to be back in CT for some portion of the weekend.

EPIC: And then?

DW: Since our kids were established in their CT schools, we didn't move to RI, and I researched CT alternatives. A managed care opportunity arose with ConnectiCare.

EPIC: You gave up clinical work?

DW: No, I continued to work per diem in various Connecticut EDs. When you're working on the insurance side, you're at risk for losing credibility with your colleagues if you don't work clinically. It's important to keep your hand in so you continue to understand their issues. Being an insurance company Medical Director is all about finding a middle ground between the payer and the doc, the patient, or the hospital.

EPIC: Wasn't that quite a leap going into the insurance business?

DW: Just like most other doctors, my opinion of managed care was not the best in the late 1990's. However, everything in life is an educational opportunity; if I

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just set my prejudices aside and took an objective look, I might find something interesting and worthwhile. I had been in both emergency medicine and primary care administration, running emergency departments and medical offices, and I understood documentation, coding, billing and the frustration docs have with the insurance industry. ConnectiCare was, and still is, rated one of the top 10 HMOs in the country, and actually had very good CT physician satisfaction. They were fair with providers; docs could actually call and talk to them. I felt good about working there; I went in thinking maybe I can make a difference, finding the middle ground between my colleagues and the insurance world. It was very satisfying; I was given latitude to not only make the rules, but also to bend the rules if necessary to develop a future working relationship with docs or hospitals. It was a wonderful experience from 1998 to 2002, but ConnectiCare was modest in size, without upward mobility at the time.

EPIC: And after Connecticare?

DW: I moved to Anthem Blue Cross/Blue Shield figuring that there might be greater upward mobility in a large national company. However, I was frustrated by not having any flexibility; I could no longer bend the rules when necessary to work with providers. I need to be able to look my colleagues in the eye and feel that I'm being fair with them. Being forced to issue denials routinely, as a matter of course, was what I hated most about insurance companies when I was a provider myself. I did not renew my contract after the first year. I took a year out, doing consulting work in managed care, as medical legal expert witness, in pharmaceuticals, and practicing about half time per diem EM.

EPIC: Where were you picking up shifts?

DW: While I was at ConnectiCare I worked at least a shift a week at St. Francis. Over the past dozen years, I also worked at Day Kimball, Johnson Memorial, Windham, New Britain, Bridgeport, and Middlesex Hospitals.

EPIC: So what did you like more, larger tertiary or smaller community EDs?

DW: I worked in some of the largest and some of the smallest hospitals in the state. I learned that, surprisingly, at small hospitals the solo emergency doc can be busier than at big hospitals with high volume, but additional attending and training staff available. At the smaller facilities it's just you; when you do an overnight shift you're it for the whole hospital. In addition to the ED, if somebody crashes on the floor or goes sour in the unit, you're the one that responds until the community doc comes in, and I can tell you, they're not always so quick about coming in!

EPIC: So, small or big?

DW: In general, I think that the smaller hospitals are where you have the best opportunity to bond with the nursing and tech staff. They make all the difference in

your practice experience.

EPIC: OK let's have it – what's the best ED in Connecticut to work per diem shifts?

DW: Absolutely the best staff was at Johnson Memorial. It comes from the top down. Charlie Bizilj is just a wonderful guy.

EPIC: Yes, the best.

DW: My next opportunity was with Wellcare in 2004, which combined the best of ConnectiCare and Anthem. I was Medical Director with the large national company, and Chief Medical Officer for Wellcare of CT. They provide government programs, Medicare and Medicaid. It was a challenging yet interesting position. Unfortunately, the upheaval in CT Medicaid forced Wellcare to not continue in CT after 2008.

EPIC: You mean the money that the state had allocated to CT Medicaid was just not enough to make a go of it?

DW: Yes, and as everybody knows, state and federal government bureaucrats can present problematic relationships. They have all the power, and as a Medicaid or Medicare insurer, the state or federal government is your customer. One of the most awkward parts of my position was getting my physician colleagues to take care of their Medicaid and Medicare patients, who were our members, for charity level reimbursement. You can't run an office on Medicaid, or Medicare. However, even in the problematic transient Medicaid population, we had our success stories. Yearly well child screening exams for HUSKY kids improved from less than 50% to 84%. Our young pregnant moms received almost 80% of their prenatal visits. With good managed care, our asthmatics reduced ED visits by over 60%, and hospital admissions by over 50%. It just shows that, despite our misgivings about managed care, with concerted effort and good care management, you really can improve health status while appropriately decreasing health care resource utilization and costs.

EPIC: David, you've been involved with ACEP for years, especially with the Council. You've really become the face of the Emergency Medicine Foundation with the Council Challenge. For the uninitiated out there, what is EMF?

DW: Our ACEP Emergency Medicine Foundation funds research in emergency medicine. I've always recognized the importance of research to emergency medicine, helping to define and refine our specialty. I thought I could leverage my contribution dollars to further support our research. I had been Councilor or Alternate Councilor from three different state Chapters for 15 years when I initiated the Council Challenge in 1997. I matched the first \$5 of each Councilor's contribution to encourage participation. We started off well with the 250 Councilors in 1997, and it grew from there. The 2009 Council meeting netted \$87,195 from 318 Councilors. The ACEP Council has contributed over a half million dollars since the inception of the Challenge, with 100% of those donations going directly to research, and it is fully

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tax deductible.

EPIC: So why is research important in emergency medicine?

DW: Two reasons. First, there are clinical issues that need to be studied. Second, and very importantly, from the early days of our EM, research has helped to define our specialty, and it continues to refine our specialty today.

EPIC: Who at EMF makes the decisions about which issues are worth studying?

DW: There is a review committee that looks at all research proposals. Proposals may involve bench research, clinical research, or practice management research in community or academic settings by medical students, residents or attendings. Perhaps our most important publication so far is the ACEP Work Force Study, documenting US EM practice patterns. Initiated in the early 2000's, we're currently working on the third iteration. Other examples of practice research that have been funded are studies in ED operations and hospital induced ED crowding.

EPIC: If a CCEP member had an idea for a project, say some new ED operational idea, which I guess you'd call

practice research, what would he or she do?

DW: You can check out EMF on the ACEP website, or call or email the EMF at ACEP headquarters and they can assist you through the application process. There are plenty of applicants who have received grants who had never done research before. The requests for funding come from all over; if it's a good idea, and well thought out, there's a good chance you'll get funded.

EPIC: Any words of wisdom for your fellow emergency docs in Connecticut?

DW: All CCEP members should seriously consider some financial "give back" to support our patients and our specialty. Please contribute to our EMF for EM research and contribute to our National Emergency Medicine Political Action Committee (NEMPAC) to improve our political access to enhance EM influence in health care reform. We're talking about the good of our patients, and the future of our specialty. Despite the current economy, the vast majority of us continue to make a good income. There should be some "give back" for our patients and our specialty. You can contribute on your annual dues statement, online, or by phone, and payments can be scheduled monthly or quarterly to ease the giving. Your EMF donations are 100% deductible, reducing your state and federal tax burden. Do it today!

JOBS IN CONNECTICUT NOW

HARTFORD HOSPITAL

Full time and part time opportunities for EM residency trained or EM board certified physicians in our 95,000 visit, 60 bed, ED. Our Fast-Track, run by PA/NP's, sees 23,000 visits per year. We are the main clinical site for the UConn EM Residency, a three year program with 12 great residents per year. We are a Level I trauma center and the major toxicology program for CT with a fellowship. We have experienced PA/NP's, nurses, RT's, and ancillary help. Our call list includes most specialties. Competitive salary and benefits. Contact AJ Smally, MD FACEP at asmally@harthosp.org or 860-545-3536.

MIDSTATE MEDICAL CENTER

A new part time position is now available for an EM boarded/prepared emergency physician. Midstate is a busy community hospital seeing 50,000 patients/yr. An entirely new 52 bed ED (and 30 bed inpatient pavilion) is currently under construction with finish date one year from now. We expect to install a state-of-the-art ED information system (Allscripts) in 6 months. We offer a competitive compensation package and a very pleasant working environment. Our staff is extremely stable – current position is in addition to our 11 physician, 5 PA group. Special consideration will be given to someone seeking night or weekend hours. Please call Fred Tilden MD, FACEP, 203 694-8278. ftilden@midstatemedical.org.

NORWALK HOSPITAL

We have per diem positions available for EM residency trained, ABEM/AOBEM certified/prepared EP's with EM experience to work in a modern 50,000 visit ED. Norwalk Hospital is a progressive, teaching, 270-bed Level II Trauma Community Hospital located in Fairfield County on Long Island Sound, not far from New York City. All shifts are 8 hours or less, with 55 hours of coverage per

day. PLEASE CONTACT: Michael Carius, MD, FACEP, Chairman, Department of Emergency Medicine, Norwalk Hospital, at mcarius@acep.org or 203-852-2281.

WATERBURY HOSPITAL

Full Time and Per Diem positions available for ABEM Board Certified/Board Eligible emergency physicians to work in a Level 2 Trauma Center with 58,000 visits per year. Double and triple coverage with in-house medical and surgical house staff. Hospitalist service and pediatric and orthopedic physician assistants in-house. Prompt Care area staffed by experienced Physician Assistants 16 hours daily. Cardiac care center with 24/7 cath capability.

Radiology available 24/7. Ultrasound available in the E.D. Dedicated nursing and helpful technician staff. Attractive clinical requirement with templated schedule and overnight shifts virtually eliminated with 2 dedicated overnight physicians. Competitive salary, full benefit package offered. Generous moonlighting rate offered. Contact Chris Michos, MD @ (203) 573-6215 or CMichos@wtbyhosp.org

WEST HAVEN VA MEDICAL CENTER

Per Diem positions available for nights at the VA in West Haven, a major teaching institution for Yale University. We are a 10,000 volume level III ED. Seeking BE/BC ER or IM/FP Physicians with ER experience. The ED is supported 24 hrs by all subspecialties. Patients are admitted to Yale House staff and Attendings. There is no major trauma, pediatrics, or obstetrics. We rely on a renowned electronic medical record (CPRS), so typing skills and basic computer knowledge is a must. Feel good about practicing pure medicine again while giving back to our country by treating our nations Veterans!

Contact: Craig Zalis, MD craig.zalis@va.gov or (203) 932-5711 x 2991

MEETING WITH CONGRESSMAN ON MEDICAL LIABILITY REFORM

In September, Dr Jorge Otero and Dr. Greg Shangold organized a meeting at Norwalk Hospital with Congressman Himes to discuss medical liability and suggestions for reforming the system. CCEP invited the CT State Medical Society and the CT Emergency Nurses Association to participate in the meeting, along with defense and plaintiff attorneys.

The meeting went extremely well with emergency medicine physicians and surgeons educating Congressman Himes of serious problems associated with the current medical malpractice system and how it affects the access and quality of health care provided in the emergency departments across the state. Dr. Shangold discussed the practice of “defensive medicine” and

the lack of “On Call Specialists” as reasons the medical liability reform is needed. Attorney Madonna Sacco of Danaher, Lagnese and Sacco attended the meeting and explained her frustration with the system. Attorney Sacco represents physicians and

hospitals in Connecticut malpractice cases. For the defense attorneys, Stewart Casper of Casper & de Toledo discussed how the system is fair from his standpoint.

The two hour meeting went by too quickly and Congressman Himes has asked CCEP to reconvene the group to focus on possible solutions and improvements to the malpractice liability systems. CCEP will send a notice out on the listerv inviting all interested members to attend the meeting.



CCEP Board Members and Councillors with Congressman Himes: Mark Friedman, Larry Levine, Bryan Jordan and Mort Salomon



Helen Kenny, CTENA and Bill Kohlhepp, PA



Greg Shangold, David Wilcox, and Mark Friedman



Margarita Garces-Shapiro (Congressman Hime's Constituent Service Representative) and Jorge Otero, MD

MIDDLESEX UNVEILS WAITING TIME WEBSITE

BY MIKE SAXE, M.D., CHAIR, DEPARTMENT OF EMERGENCY MEDICINE, MIDDLESEX HOSPITAL

On September 8th, Middlesex Hospital unveiled an innovative website that lists the “Door to Provider” times at each of its three ED sites.

The website (www.MiddlesexERtime.com) is connected to the ED's Cerner tracking system, and updates every five minutes, 24/7. It shows the real-time “Door to Provider” times at each of Middlesex's ED sites—Middlesex Hospital in Middletown, Shoreline Medical Center in Essex, and Marlborough Medical Center in Marlborough. The time posted for each site is the longest time of any patient in that ED site who has not yet been seen by a physician or PA. For instance, if there are five patients who have not yet been seen by a provider and the longest time is 58 minutes, it will say 58 minutes. It resets every five minutes.

Middlesex established the website to provide an accurate answer to the most common phone question our ED's receive: “How long is the wait?” Only a handful of ED's in the country—and no others in the Northeast—have such a website. Many of our patients live

within driving distance of more than one of our ED sites. Our hope is that some of these patients will access the website (when they don't have a “911” emergency) and choose to go to the ED site that has the shortest waiting time. This, in effect, will help to direct patients to the site whose staff is most able to meet their needs in a timely manner. Our three ED's all share the same clinical information system, specialty coverage, staff skill sets, and technology, meaning that patients receive nearly identical care at each of our ED sites.

The Middlesex goal for “Door to Provider” time is an average of 30 minutes or less at each of our three ED sites. We either beat that goal or come within minutes of it in each of our sites.

The new website has received lots of coverage from print, radio, and TV media. We expect that our patients will find it useful, and that it will actually help our ED system to better match patient demand to readily available services. At the time of this writing (one week after unveiling the website), it is too early to tell. Check it out at www.MiddlesexERtime.com.

BOOK BOYCOTT

As all of you know, our friend and Council member, Dr. William Petit, lost his family in a horrific manner in 2007 due to a home invasion. As has also been reported extensively, one of the perpetrators met with and assisted writer Brian McDonald in the publication of a sensationalized book about this tragedy, apparently in hopes of shifting blame from himself and casting it on the second perpetrator. The published book, which includes graphic details, has been recently offered for sale by Amazon and Barnes & Noble, as well as other booksellers, and has been

Institutions to contact:

Barnes & Noble, Inc.

P.O. Box 111

Lyndhurst, NJ 07071,

tel: (800) 962-6177

e-mail: customerservice@bn.com

fax: (201) 559-6910

Amazon

Jeff@amazon.com

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in the headlines frequently these past few weeks.

Dr. Petit has asked that we, as his friends and colleagues, boycott this book and neither buy nor read it. In fact, if you are inclined, he asks that you send an email, make a phone call, or send a letter to any or all of the following entities involved in the publication and sale of this book to let them know your opinion regarding the dissemination of this book.

Thank you, Barbara Levine, Vice President of Operations, Connecticut State Medical Society, Tel. 203-865-0587, email: blevine@csms.org

PRESIDENT'S MESSAGE

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and unique concerns of our patients must not be neglected or forgotten in any nationally adopted healthcare reform.

To assure the support of our participation and to take a proactive role to protect the interests of emergency medicine, ACEP leadership has encouraged the, "Give A Shift" program. In order to support the National Emergency Medicine Political Action Committee (NEMPAC), emergency physicians are asked to give the equivalent amount received of working one shift, roughly about one thousand dollars for one year. NEMPAC supports the development of legislation that advocates the interests of emergency physicians and their patients.

2009 has seen unprecedented participation from ACEP members. This involvement is in response to the largest historical opportunity for change in our healthcare system, as well as, the expected direct impact reform will have on every practicing emergency physician. For physicians that do not have the ability to donate a full shift, there is the, "Starbucks Alternative." If each ACEP member donated the cost of one cup of coffee each week, the impact to NEMPAC would be tremendous. $\$5.00 \times 52 \text{ weeks} = \$260.00/\text{year}$. $25,000 \text{ members} \times \$260.00 = \$6.5 \text{ million}$. At this time the NEMPAC stands a little over \$1 million. It is the fourth largest medical PAC in the United States! There are many flexible programs available, which enable contributions to be made, including credit card payments spread over a year. Please follow the NEMPAC link on the ACEP or CCEP website.

As we go to print with this issue of EPIC, the U.S.

Senate is considering a bill to repeal the Sustained Growth Rate (SGR) formula that has prevented meaningful or appropriate reimbursement for physicians. ACEP, in conjunction with national medical societies has worked to repeal or fix the SGR and until now has met with little success. The ACEP 911 Network has 1350 ACEP and EMRA members that maintain contact with Congressional legislators and ACEP's political advocacy group. Support for legislation like this and other important issues is gathered at the grassroots level and with simple phone calls, letters and e-mails we can educate our representatives when they need the information to vote appropriately. Please consider joining this network and advocate by communicating with your senators and representatives. Join by following the ACEP Advocacy link on the ACEP website.

As we move into a new year under the leadership of Dr. Gregory Shangold, I challenge the altruistic spirit common to all emergency medicine physicians. Make a commitment to participate and support the organizations that champion emergency medicine every day. Support at any level strengthens the voice of all physicians practicing emergency medicine. We have the ability to effect change on behalf of our patients and ourselves. The chance to succeed is maximized by your participation.

Thank you for a fulfilling and rewarding year serving the college as president.

Sincerely yours,

B. Bryan Jordan, DO, FACOEP

SUCCESSFUL CONCLUSION TO LEGISLATIVE SESSION FOR EMERGENCY PHYSICIANS

State Approves Funding SAFE/SANE Program and Life Star

By MICHAEL S. DUGAN, SENIOR VICE PRESIDENT/LOBBYIST, OCTOBER 5, 2009

The longest running budget battle in the state's history concluded last week but not before the Legislature approved two of the Connecticut College of Emergency Physicians' top legislative priorities. In a difficult budget climate, where the state was running an \$8.6 billion deficit on a \$37 billion biennial budget funding for any new program like the Sexual Assault Forensic Examiners (SAFE) program was in serious jeopardy. On behalf of CCEP we put together a lobbying strategy with our coalition partners which included bi-partisan legislative support for the SAFE program. As a result of these efforts, we were able to provide funding for this critical program for victims of sexual assault. In addition, we worked closely with the Democratic leaders of the General Assembly to preserve funding for the Life Star helicopter that nearly fell victim to budget cuts.

On behalf of CCEP, at the start of the legislative session we sought the introduction of legislation in the Public Health Committee that would establish a sexual assault forensic examiner program. Both the co-chairs of the Public Health Committee, Senator Jonathan Harris (D-West Hartford) and Representative Betsy Ritter (D-Waterford) were instrumental in drafting legislation that would provide the necessary resources to victims of sexual assault. The legislation would authorize the Office of Victim Services (OVS) to establish a program to train SAFE personnel and make them available to victims of sexual assault at participating hospitals. The legislation creates a 12-member committee to advise OVS on the establishment and implementation of the program. The president of CCEP will serve as one of the members of this panel along with representatives of; the chief court administrator, chief state's attorney, victim advocate, the commissioner of the Department of Public Health (DPH), the Department of Public Safety's Division of Scientific Services, the State Police, president of the Connecticut Hospital Association, Connecticut Sexual Assault Crisis Services, Forensic Nurses Association, the Police Chief Association and the Emergency Nurses Association.

Under this legislation, a SAFE must be a physician or a registered or advanced practice registered nurse. A SAFE may provide immediate care and treatment to adolescent and adult victims of sexual assaults in a hospital setting. The SAFE must follow existing state sexual assault evidence collection protocols, the hospital's policies and accreditation standards. The legislation provides for written agreements between hospitals and OVS concerning their participation in the SAFE program.

At the February 11th public hearing before the Public Health Committee, Dr. Greg Shangold presented testimony on behalf of CCEP. Dr. Shangold stated, "the consistent and efficient collection of evidence that ensues after the creation of a rapid response SAFE program will benefit the victims, emergency departments and prosecutors as we all strive to provide timely

and compassionate emergency care to victims of sexual assault." Following the hearing this legislation enjoyed the unanimous support of the Public Health Committee on a 30 to 0 vote.

Our legislation was referred to the Appropriations Committee where we were able to gain an overwhelming vote of 50 to 1 despite the difficult budget climate. Appropriations Committee co-chair Sen. Toni Harp (D-New Haven) and ranking member Sen. Dan Debicella (R-Shelton) were instrumental in moving this legislation out of this committee.

In late March following a meeting where CCEP presented Governor M. Jodi Rell (R) with a Leadership Award for her support of the SAFE program, the Governor announced that she would utilize \$350,000 of federal stimulus money to fund the SAFE program. With Governor Rell's financial commitment of federal stimulus money, we proceeded to work closely with the Democratic leadership and the chairs of the Public Health Committee to ensure that every budget draft considered during the summer and early fall continued to include the SAFE program.

Following the conclusion of a seven month long budget stalemate, together with our coalition partners we successfully lobbied for the inclusion of the SAFE language in the Public Health budget implementer (SB 2051 section 47 to 49). The General Assembly finally approved this proposal on September 24th and it was signed by the Governor October 6th. The passage of this legislation is a credit to the commitment of CCEP, our coalition partners, an active lobbying campaign and the support of many legislators.

In another budget battle, CCEP worked closely with Senate Democrat leader and President Pro Tempore, Senator Donald Williams (D-Brooklyn) to preserve funding for the Life Star helicopter. From early February and into the summer months there were repeated calls by the Governor to ground the Life Star program to save \$1.4 million annually. We were contacted by the chief of staff to Sen. Williams asking if CCEP would be interested in attending a press conference to highlight the importance of Life Star. Drs. Shangold and Kenneth Robinson attended a press conference on behalf of CCEP giving firsthand accounts of how Life Star is critical in saving lives. As a result of these efforts, the final budget document was approved on August 31st providing full funding of the Life Star program.

As the new lobbyist for CCEP one of our charges was to raise the profile for emergency physicians within the halls of the State Capitol. This session CCEP worked closely with numerous legislative leaders including the President Pro Tempore of the State Senate, chairs of the Public Health and Appropriations Committees as well as Governor Rell. Together we raised CCEP's profile, while accomplishing our legislative goals of providing the best possible care for the patients you serve. We look forward to our continued success on our mutual endeavors at the State Capitol.

CCEP MEMBERS HONORED FOR THEIR ACHIEVEMENTS

David Wilcox, M.D., FACEP received ACEP's 911 Award for Outstanding Legislative Achievement award last spring. This is the second time he received this Award, the first time being in 1997.

Peter Jacoby, M.D., FACEP was selected this year as one of the Connecticut Hospital Association's Healthcare Heroes. The Healthcare Hero Awards are given to healthcare professionals for their commitment in leading, representing and serving hospitals and other health-related organizations.

Congratulations!



William Sanders, MD, FACEP accepts the ACEP section of careers in Emergency Medicine's Tenure Award at the recent Boston meeting

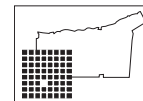
SAVE THE DATE DECEMBER 3RD AND 4TH 15TH ANNUAL MANAGEMENT OF THE DIFFICULT AIRWAY COURSE

This newly expanded 2-day program is designed for practicing emergency physicians and those involved in emergency airway management. The course offers lecture-based material, hands-on skill stations, case based sessions on high-fidelity human patient simulators and a large animal lab. Participants can choose to enroll in either the one-day session (Lecture and skills stations) or the full 2-day course (Simulation cases and animal lab). Participants will be instructed on a variety of state of the art airway techniques and equipment.

Hartford Hospital — *Course Director:* Thomas Nowicki, MD

For more information please contact: Crestina Walker (860) 545-0001 — cbwalke@harthosp.org

www.ctacep.org
CCEP'S WEB SITE



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