

Alabama EPIC

SPRING
2000

Interim Communique for Emergency Physicians in Alabama

In This Issue:

- EMS Week ... page 2
- Dept. Emergency Medicine at
UAB funded for study ... page 3
- Impact of 70MPH Speed Limit ... page 4
- 20 Commandments ... page 5
- Corner of Humor ... page 5
- Birmingham Member Addresses
 - Alabama Quality Assurance ... page 5
- Remarks on Current Political Issues ...
page 6
- Letter from MASA ... page 7
- Annual Conference to Include
 - ACEP Past President ... page 7
- 17th Annual Conf. Agenda ... page 8
- 17th Annual Conf. Faculty ... page 9
- Note to Members ... page 10
- Leadership and Legislative
 - Issues Conference ... page 11
- ACEP and AAP Unveil Emergency
Information Form ... page 12
- Physical Therapists Seek
 - Practice Act Expansion ... page 12
- Alabama ACEP Membership
 - Continues to Rise! ... page 12
- AMA Adopts Ultrasound Policy ... page 13
- EDS Invites Feedback ... page 13
- Advertisements ... page 14-15
- Upcoming Events ... page 16

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College of Emergency Physicians
P.O. Box 4629 • Montgomery, AL
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From The President ...

Thomas L. Arnold, M.D., FACEP

Spring is here and it is time for another Alabama ACEP annual Educational conference in Destin. This year the conference will be June 25-28, again at the SanDestin Beach Hilton. Dr. David Garvey, chair of the chapters education committee, has planned another exceptional program, which will also include ACLS and ATLS refresher courses, as well as the new ACLS-Experienced Provider course. The rogues will be out for a golf tournament at the Drs. Garvey and Heard consortium. Attendance at the educational program is good for 15 hours of ACEP Category I credit and the beach seminar is free. Ya'll come—register on the web (www.alacep.org) or call the office at 334.265.0068 and make your schedule requests now for a great time in June.

The AMA House of Delegates passed a resolution affirming that ultrasound privileges should be determined by individual medical staffs, subject to the recommended training and educational standards of each physician's specialty. This is a great victory for Emergency Medicine. Dr. Jorge Alsip, chair of the chapters practice management/reimbursement committee, was highly instrumental in getting the resolution through the House of Delegates—we all owe him our appreciation for his good and successful effort. It is now incumbent on each of us to get ourselves trained and credentialed in emergency ultrasound, bedside variety. A trauma survey of the abdomen takes about two minutes. Echocardiography for cardiac activity is quick and definitive in low flow states, and lower extremity ultrasound for DVT is so simple it's sinful. OB ultrasound is a good deal more complex but is also of great value in the ED. ACEP and other organizations sponsor frequent courses in ultrasound. Let's make sure the good effort that went into this enterprise is put to good use by increasing the quality of patient care in the ED. Do it.

Board member Dr. Janet Pribble and I attended the annual Medical Association of the State of Alabama (MASA) governmental affairs pilgrimage to Washington, DC in February. I urge anyone who might be the slightest bit interested to go—it's sort of like golf—it teaches patience. (I also had a chance to go with my family, to the Jefferson Memorial—always a humbling experience.) Several issues were roundly discussed. The so-called Patient's Bill of Rights (HR 2990) and the Campbell Bill (HR 1304) each received much attention. Other topics of

(Continued on page 2)

Opinions expressed in this newsletter do not necessarily reflect the point of view of the Alabama Chapter American College of Emergency Physicians.

Check out the
Alabama ACEP Worldwide Web Site
at: www.alacep.org

President's Message (Continued from page 1)

note were patient safety and the recent Institute of Medicine (IOM) report on Health System Failures, patient privacy and the confidentiality of individual medical records, opening the National Practitioner Database to public access, prescription drug funding for Medicare patients, and the endless machinations about 'fraud and abuse'. We heard an excellent talk by Claude Earl Fox, MD, MPH, who is the Administrator of the federal Health Resources and Services Administration. Among other accomplishments, he was Alabama State Health Officer from 1986 to 1992. He pointed out that Alabama had the first Child Health Insurance Program (CHIP) and that we were doing a good job with it. He said there was no federal funding for EMS services, and that the way to increase physician fees for Medicaid patients was to increase the state funding. Alabama has 4 to 1 federal matching funds for Medicaid. He urged us to know the Medicaid laws and regulations and said there were many viable options, but that the key to success was to know the options. Such changes, he said, could occur almost immediately since Medicaid is a state program. This information should be most valuable to the MASA Medicaid Coalition, whose next meeting is Wednesday, April 19 at 3 pm in the MASA building, 19 S. Jackson St. in Montgomery.

The Annual Educational Conference will also host the general membership annual meeting and the next Board meeting on Sunday, 25 June. At those meetings Dr. Mark Mitchell will take over as association president and we will elect the new officers and Board members for the first year of the Millennium, 2000-2001. Nominations are open for all officer positions and five (5) Board positions. Last year we had more candidates than open Board positions but that interest has translated into an additional individual effort from a lot of folks. Our membership has increased by about 25% in the last year alone and it looks like we have some good chances to make a difference in both the political climate of medicine in Alabama and in the quality of care our patients receive.

So come to Destin in June. Stay involved. Speak out and up, and do it well. Carpe Diem, conference, golf, and BEACH.

EMS

NEW CENTURY, NEW HOPE

National EMS Week 2000

May 14-20, 2000

EMS Week is observed annually during the third week of May and each year

ACEP provides a kit for planning, coordinating and promoting EMS Week activities. The tools in this kit can help you plan local activities that meet the unique needs of your own community, showcase the accomplishments of the past, and raises vital support for EMS' future. The information in the EMS Week kit is designed to be used for Public Education programs throughout the year.



**NATIONAL
EMERGENCY
MEDICAL
SERVICES
W E E K**



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Department of Emergency Medicine at UAB funded to perform study of rapid, volunteer delivered defibrillation

Sudden out-of-hospital cardiac arrest (OOH-CA) remains a significant cause of death, in spite of recent declines in overall mortality from cardiovascular disease. Existing methods of emergency resuscitation are inadequate due to time delays inherent in the transport of a trained responder with defibrillation capabilities to the side of the OOH-CA victim.

The National Heart Lung and Blood Institute of the National Institutes of Health awarded the coordinating trial center, the University of Washington, support for the 2.5 year study of OOH-CA. “This is a study of a comprehensive, integrated community approach in which volunteer non-medical responders (lay volunteers without a traditional responsibility to take charge) are trained to use automated external defibrillators (AEDs)”, according to Thomas Terndrup, MD, the principal investigator at the Birmingham site. The specific aim of this randomized controlled trial is to measure survival to hospital discharge following OOH-CA in community units trained and equipped to provide public access to defibrillation (PAD), compared to community units trained to provide standard care (recognition of OOH-CA, 911 access, cardiopulmonary resuscitation [CPR]). Other aims include the comparison of neurological status, quality of life, cost, and cost-effectiveness between the two groups.

“Emergency Medical Services (EMS) systems typically combine paramedic and EMT services with some level of community involvement, such as a bystander CPR training”, according to Shannon Stevens, EMT-P, Clinical Coordinator for the study. Some communities include automated external defibrillators (AEDs) at isolated sites or in mobile police or fire vehicles. Such an approach typically varies in effectiveness, with an incremental improvement in effectiveness seen in communities that organize and integrate services with the existing EMS system. “Optimal improvement in survival from sudden OOH-CA may require a program that utilizes volunteer non-medical responders (who may not have a traditional duty to respond to an emergency) who are successfully trained to use AEDs”, according to Dr. Janyce Sanford, Assistant Professor of Emergency Medicine, who will be assisting in coordinating the PAD trial in Birmingham.

Participating research sites have identified 1,000 units (e.g., public areas, gated communities, shopping malls, air-

port terminals, casinos, business parks) at 25 sites nationally, and about 40 within the Birmingham area, that contain a stable population of at least 250 people aged 50 years or greater. Following preliminary data collection, each unit will be randomized to serve as either an intervention or control group. Within each site, units will be sub-randomized to a retraining strategy. Performance at retraining will be monitored, and strategies modified if indicated.

Volunteer non-medical responders (e.g., office staff, bank tellers, merchants, and neighborhood volunteers) in both the intervention and control groups will be trained to: a) recognize OOH-CA, b) access 911 or its equivalent, and c) administer CPR. Non-medical responders in the intervention group will also be taught to use an AED promptly while awaiting arrival of the first public safety emergency medical team. The criteria for number and location of trained volunteers and devices will be a maximum 3-minute “walk through” to have the AED at the patient’s side.

A high density of AED placement and saturation of trained volunteers will be emphasized in the intervention arm to maximize our ability to see an increase in survival. Our study will provide insight into the approach that is most effective and efficient in involving a community in the effort of providing public access to defibrillation.

This study is timely and important. AEDs are proliferating rapidly in public places. Commercial and charter aircraft increasingly carry the devices and train their personnel in using them and they are deployed in public spaces such as gambling casinos. Legislation is being drafted to ease the requirements for their use. This scientific study will help to determine whether public policy and private behavior should encourage the deployment of AEDs outside of traditional settings in which users have a duty to respond. The PAD study is a randomized controlled clinical trial of a delivery system, not of a specific medical device. AEDs work well, and defibrillation is generally recognized as the most effective strategy for treating sudden cardiac arrest. But where AEDs should be deployed, how they should be deployed, how many of them should be deployed, whether the public can use them effectively, and the cost to society of broad dissemination of these devices are not sufficiently understood. Good science, ultimately, makes possible good public policy.

Impact of 70MPH Speed Limit on Alabama Interstate Fatalities

By Sam Bartle, MD, FAAP

University of Alabama at Birmingham, Pediatric Emergency Medicine

*Presented at the American Academy of Pediatrics,
Section on Injury and Poison Prevention,
Annual Meeting, Washington, DC, October 1999.*

Motor vehicle crash deaths (MVC) have contributed to over a half million hospitalizations each year in this country.¹ According to the Alabama Center for Health Statistics deaths due to MVC account for more than half of all accidental deaths in Alabama. The total number of deaths from MVC's is greater than the number of all other accidental deaths in the state combined. Alabama with 30.5 deaths per 100,000 population due to MVC is more than twice the national death rate of 15.8 deaths per 100,000 population. The younger ages are affected more by MVC deaths than any of the other causes of death. For the period of 1993 to 1997, the 25 to 44 years old age group accounted for 34.2% of all deaths due to MVC and 24.7% occurring in the 15 to 24 years old age group².

In May 1996 Alabama increased the maximum allowed speed on its rural Interstate highways from 65mph to 70mph. At that time many persons in the state worried that the faster speed would cause more MVC deaths. It was uncertain if the change in the speed limit would lead to a greater number of deaths and a higher death rate possibly due to MVC's. A study by members of the Emergency Medicine Division of Children's Hospital of Alabama was conducted to examine this question. The study examines the number and rate of fatalities on the Interstate, Federal, and State highways in Alabama before and after the speed limit change. It used the MVC fatality data and the vehicle miles traveled (VMT) reported in the annual Alabama Traffic Accident Facts Report, a joint publication of the Departments of Transportation, Public safety, Economic & Community Affairs, and Education. Fatalities occurring on Alabama's Interstate, Federal, and State roadways were examined for the years 1984 through 1998. The number of fatalities and the fatality rate for the period after the speed increase is compared to that which is predicted based on the trend of the preceding fourteen years. Trends for both rural and urban Interstates, Federal, and State highways were established and examined.

There were 174 MVC deaths on Alabama Interstate highways for 1997, the first full year after the speed limit increase. Of these 174 deaths 99 occurred on rural Interstates and 75 on urban Interstates. These results are all significantly higher than that which would have been predicted by the trend established by the years prior to the speed limit increase. The

1997 fatality rate on Alabama Interstate highways is 3.259 deaths/VMT, which was also significantly higher than the trend of the previous fourteen years would suggest. In 1998 the number of MVC deaths on Alabama Interstate highways dropped to 114 crash deaths statewide, with 80 deaths occurring on rural Interstates and 34 deaths on urban Interstates. The 1998 Interstate deaths all fall into the trend predicted from the prior year results. Alabama Federal and State highways MVC deaths on both rural and urban roads continued to follow the expected trend based on the preceding years results. (See graph)

The idea that higher driving speeds cause more MVC deaths is based on the amount of kinetic energy in a vehicle that is released at the time of impact during a crash. This energy or force increases exponentially, proportionally to the square of the speed at which the car is traveling. The greater the vehicle is traveling, greater the amount of energy is released at the time of impact. This results in a more severe crash, which in turn increases the likelihood of a fatality. But since the number of MVC deaths did not stay consistently higher after the speed limit increase, and in fact fell in 1998, it could be possible to surmise that higher speeds may not be a unique factor in determining MVC fatalities. One may have to consider speed as a cofactor when considering its effects on Interstate crash deaths.

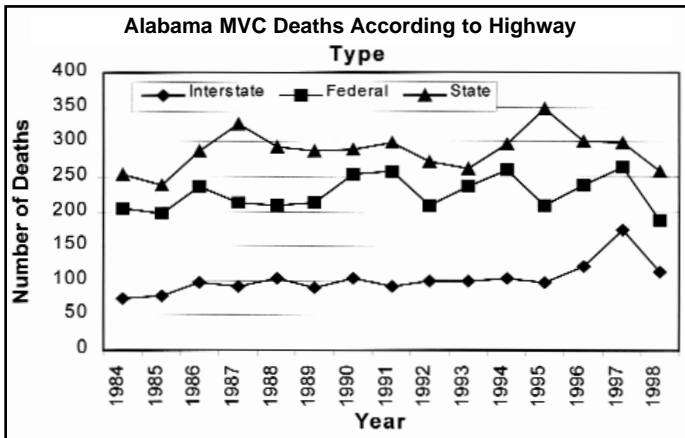
To conclude, the overall number of MVC deaths on Alabama Interstate highways are increasing. The number of deaths and the death rates due to crash deaths remain higher in Alabama than that compared to the national level. There are many variables that have to be considered affecting the number of MVC deaths and the fatality rate on Alabama highways. Before it can be determined if legislating a change of the speed limit can decrease the number of MVC deaths these factors need to be considered. Further evaluation of the annual MVC deaths need to determine if the 1997 results was either a spurious or truly a significant finding. Additional study is also required to determine what impact these other factors such as vehicle safety and impact design, road construction design, seat belt usage or driving habits have on MVC deaths.

¹Baker et al. The Injury Fact Book. Second Edition. Oxford University Press. 1992.

²Alabama Center for Health Statistics. Health Statistics and Surveillance. Vol7, No3. February 1999.

(SEE CHART ON PAGE 5)

Impact (continued from page 4)



THE CORNER ON HUMOR

The Bear in Billings

This one's a real groaner:



A bear walks into a bar in Billings, Montana, and sits down. He bangs on the bar with his paw and demands a beer. The bartender approaches and says, "We don't serve beer to bears in bars in Billings".

The bear, becoming angry, demands again that he be served a beer. The bartender again tells him "We don't serve beer to bears in bars in Billings".

The bear, very angry now, "if you don't serve me a beer, I'm going to eat that lady sitting at the end of the bar".

The bartender, once again says "Sorry, we don't serve beer to bears in bars in Billings".

The bear goes to the end of the bar, and as promised eats the woman. He comes back to his seat and again demands a beer.

The bartender says "Sorry, but we especially don't serve beer to bears in bars in Billings that are on drugs".

The bear says "I'm not on drugs".

The bartender says, "Yes, you are, that was a barbitchyouate".

Birmingham Member Addresses Alabama Quality Assurance Foundation

Alabama ACEP Past President Christopher J. Rosko, MD, FACEP, Birmingham, gave two lectures in late February during the recent 16th Annual Robert Sherrill, MD Conference, "Quest for Quality", sponsored by the Alabama Quality Assurance Foundation (AQAF), the University of Alabama Birmingham School of Medicine, the Medical Association of the State of Alabama (MASA), and the Alabama Hospital Association. Dr. Rosko's first lecture on "Chest Pain" was delivered during the educational session on cardiovascular disease quality improvement, and the second lecture and session covered "Pneumonia Treatment and Prevention". For more information about these lectures or the next AQAF annual conference, contact Dr. Rosko or the Alabama ACEP office.

The "20 Commandments" of COBRA

by Stephen Frew, JD

- 1. THOU SHALT:** Log in every patient who presents, together with complaint/diagnosis and disposition.
- 2. THOU SHALT:** Provide a medical screening examination [by physician, preferably], beyond triage, in the hospital to every person presenting to the hospital (including hospital-owned ambulances).
- 3. THOU SHALT NOT:** Delay the Medical Screening Examination to secure verification or authorization from third party payor, nor attempt to influence the patient by drawing payor status issues to the patient's attention prior to completion of Medical Screening Exam and initiation of stabilizing care.
- 4. THOU SHALT:** Provide necessary testing, including on-call services, to exclude the presence of a life threatening emergency condition.
- 5. THOU SHALT:** To the extent of the capabilities of the hospital, provide stabilization, such that the patient is not likely to deteriorate from or during transport or discharge – in the case of OB patients with contractions present, until stabilized by delivery of baby and placenta – and make a medically appropriate transfer if the patient exceeds hospital capabilities.
- 6. THOU SHALT:** Provide on-call coverage schedule listing on-call physicians by individual name for all medical specialties represented on the medical staff, and maintain the list of the individuals on-call for five years.
- 7. THOU SHALT:** Require on-call specialists respond to the hospital to attend the patient in timely manner and provide stabilizing care and/or definitive treatment in the hospital.
- 8. THOU SHALT:** Transfer COBRA patients only for services or care not available at your facility.
- 9. THOU SHALT:** Treat OB patients with contractions as unstable patients under the law.
- 10. THOU SHALT:** Obtain and document advance acceptance from the receiving hospital.
- 11. THOU SHALT:** Provide medically appropriate vehicles, personnel, and life support equipment for all COBRA transfers.
- 12. THOU SHALT:** Provide a physician certification with clearly stated risks and benefits of transfer for all COBRA transfers.
- 13. THOU SHALT:** Provide medical records, labs, reports and consultation records to accompany the patient on all COBRA transfers.
- 14. THOU SHALT:** Include the name of any on-call physician who refused to respond or failed to make a timely response in the transfer records of any COBRA patient transferred as a result of that refusal or lack of timely response.
- 15. THOU SHALT:** Obtain written refusal of services by a patient or responsible party that refuses exam, treatment, or transfer that documents the specific risks of refusal associated with the individual case, or document the reasonable efforts by the hospital to obtain written refusal.
- 16. THOU SHALT:** Obtain written consent to transfer from the patient or responsible party, or document the reasonable justification for not obtaining the written consent.
- 17. THOU SHALT:** Document in the medical record sufficient specific data and information to substantiate the appropriate nature of the actions taken in the individual case.
- 18. THOU SHALT:** Obtain full vitals on all presenting patients and maintain documented vitals at appropriate frequency during the stay, and in ALL CASES obtain discharge vitals or vitals at the time of discharge or transfer, and document such in the record.
- 19. THOU SHALT:** Post COBRA signs in all entries, waiting areas, registration and care areas, and signs that conflict with the intent and purpose of COBRA shall not be posted.
- 20. THOU SHALT:** Report any possible violations of COBRA by another facility within 72 hours of receipt of the patient.

Stephen A. Frew is a nationally known expert on EMTALA compliance and risk management issues. He is a health care attorney based in Rockford, Illinois. Questions on EMTALA can be directed to his website forum <http://www.med-law.com/wwwboard/index.html>.

Remarks on Current Political Issues

By Tom Arnold, MD, FACEP

Alabama Chapter ACEP President

The Managed Care Reform movement is gaining momentum, but the fight will be long and contentious. Most of these proposals are under the term of 'Patient Protections' in one guise or another. The House passed a measure (HR 2990) which is quite good; the Senate version (S. 1344) is woefully inadequate. The measure is in conference committee now. The core provisions of HR 2990 are coverage for emergency services based on the "prudent layperson" standard, without prior authorization, and the provision of guidelines for authorization and coverage for post-stabilization care. ACEP's position is that the conference committee should preserve the language of the House version and include the prudent layperson standard as well as other provisions which provide for access and coverage for emergency medical services. MASA and the AMA urge the inclusion of language which includes:

- Ensuring that the 'medical necessity' of patient care is based on 'generally accepted standards of medical practice' rather than health plan definitions based solely on cost.
- Establishing medically based grievance and independent third-party external appeals procedures for physicians and patients.
- Disclosure of comparative information for patients and prospective enrollees on covered benefits, cost-sharing, service areas, physician and provider access (including access to specialists), and physician composition, as well as, non-discrimination based on health status.
- A ban on gag clauses and gag practices in all plans.
- Ensuring use of the "prudent layperson" standard for emergency services.
- Establishing procedures to assure continuity of care for patients and access to specialty care.
- A prohibition on incentive arrangements to limit medically necessary care to patients.
- Health plan accountability so that health plans would be liable for negligent medical decision making regarding denial of covered services.
- Establishes a floor, not a ceiling, in regard to patient protections, and that does not preempt stronger state patient protection statutes.

Most citizens of the US place HMO reform high on the political agenda and believe that it is an issue whose time has come. The arguments are simple: Physicians should determine patient care, health care, health plans should be liable for medical decisions, if they insist on making them, and all patient protections should apply to all patients (there should be no ERISA preemption). Physicians are unlikely to accept a watered-down version of a patient protection bill; whether

the Congress can mount the political will to pass meaningful legislation before an election, in which each party campaigns the issues being debated, is uncertain.

Anti-trust relief for physicians is long overdue. The initial intent of the Sherman Anti-Trust Act was to protect individuals and small companies from the largest companies. Today, we are backwards in this regard: physicians are guilty, per se, if they discuss costs and prices among themselves, but the health plans (there are six which now control the health care market) can discuss all they want. Therefore, they are in a position to fix prices and to unfairly control the health care market. Such practices force patients to accept the cheapest care, prevent patients from learning about a broader range of treatment options, allow for the non-consensual release of confidential patient information to third party payers, and forces unreasonable rules and restrictions on physicians. The solution is the Campbell Bill (HR 1304) which would allow self-employed physicians a limited ability to negotiate with health plans over contract terms and fair fees. It would not place physicians or health plans at risk under the National Labor Relations Act, and specifically bars physicians from any "collective cessation of patient care". It restores balance to the healthcare market and is an idea whose time is now.

In regard to the recent Institute of Medicine (IOM) report on Health System Failures, the existing culture of blame and punishment suppresses information about errors and must be changed into a culture for safety which encourages information sharing and promotes a systems-wide approach to what are, systems errors. Mandatory reporting further reinforces the culture of blame and punishment. We need research to analyze the existing data, private sector grants for well-designed targeted research to identify the root causes of bad outcomes, the extension of peer review liability protections, and the broad dissemination of best practice strategies. We do not need another system of 'get the doctors' sponsored by HCFA or any other group.

Patient privacy protections are another big issue this year. Certainly this issue should be a part of a true patient protection act, but politicians think differently than scientists. The problem arises when third party payers request information contained in a medical record, in order to see if the service billed for was actually necessary. Thus more information than is necessary is released to health plans and other insurance and regulatory bodies, most often to non-physicians. Non-physicians are not bound by our professional ethics, either voluntarily or by culture or tradition. The perceived need for information does not confer a right to it. The possession of the information does not insure its proper use.

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

19 South Jackson Street • Post Office Box 1900 • Montgomery, Alabama 36102-1900
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Dear Alabama ACEP Members:

The Medical Association of the State of Alabama (MASA) is continuing its reduced dues program in 2000 and joins with the Alabama Chapter, American College of Emergency Physicians (Alabama ACEP) to extend a special invitation to you to join MASA. New members may join in 2000 for \$100, followed by \$200 in the year 2001. (Dues are normally \$400 annually.)

Why join MASA? You gain benefits that could influence your practice for a lifetime, plus you gain the opportunity to have a voice and to make a difference.

Emergency physicians will continue to face many challenges to their practice of medicine and method of reimbursement. Just as AMA was instrumental in helping ACEP fight implementation of the 1997 HCFA documentation guidelines, MASA has been a strong supporter of our efforts to include the "prudent layperson" standard in Alabama patients' rights legislation, and in the recently modified rules governing Medicaid patients and HMO's in Alabama. The Medical Association's AMA delegation played a key role in gaining passage of the ACEP-sponsored ultrasound imaging policy at the December 1999 AMA meeting. Through the AMA and MASA, the concerns of emergency physicians will be heard more clearly in Montgomery and Washington than if we work through ACEP alone.

A recent example: the initial proposal to resolve the franchise tax crisis in Alabama included a gross receipts tax on physicians' and other professional practices. Had this been approved, it would have cost approximately \$2000 per physician. Working with other professional associations, Medical Association lobbyists were instrumental in changing this direction to one of a modified net worth tax with graduated tax rates. Additional efforts raised the threshold level for the minimum tax base from \$100,000 per owner/shareholder to \$500,000. The result of this effort is that approximately 90% of the physicians in Alabama will pay the \$100 minimum tax.

These are just a few examples of how the Medical Association is working day-to-day on behalf of the physicians of Alabama. We should make an effort to increase our membership in MASA and play a more active role. Please take a moment to call the MASA Membership Dept. in Montgomery at 1-800-239-6272 and request membership application materials. We need more members who want to make a difference.

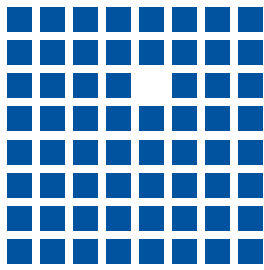
Sincerely,

Jorge A. Alsip, MD, MBA, FACEP
Board of Censors, District 1

Annual Conference to Include ACEP Past President

Alabama ACEP is pleased to announce that the annual educational conference June 26-28, in Destin, Florida, will feature ACEP Immediate Past President Dr. John Moorehead of Oregon. Dr. Moorehead will address the conference attendee's on "The Future of Emergency Medicine" and "Wellness for the Emergency Physician".

All members should plan to attend this great annual event on the gulf coast. Contact Dr. David Garvey, education committee chair, or the Alabama ACEP office to register or for more information.



ALABAMA ACEP

17th Annual Educational Conference

“Emergency Medicine: Into The New Millennium”

June 26-28, 2000 – Destin, Florida

A G E N D A

Sunday, June 25

- 2 - 5:00 pm Registration
 5 - 7:00 pm Board of Directors meeting
 7 - 9:00 pm Welcome Reception (Courtyard)

Monday, June 26

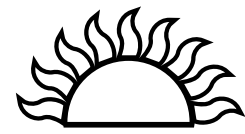
- 6:45 am Continental Breakfast
 6:55 am Welcoming Remarks by
 Tom Arnold, MD, FACEP
 Legislative Remarks by the Medical Association
 of the State of Alabama (MASA)
 7:00 am John Moorehead, MD, FACEP -
 “The Future of Emergency Medicine”
 8:00 am Richard Aghababian, MD, FACEP -
 “Rapid Identification of Acute Coronary Syndrome”
 9:00 am Cory Slovis, MD, FACEP -
 “Treatment of Acute Coronary Syndromes”
 10:00 am Break
 10:30 am Robert Zalenski, MD, FACEP - “Case Studies”
 11:30 am Roundtable Discussion - Emergency Cardiac
 Care: Recent Innovations

Tuesday, June 27

- 6:45 am Continental Breakfast
 7:00 am Loring Rue, MD, FACS - “Trauma Systems”
 8:00 am Mary Fallat, MD, FACS -
 “Pediatric Trauma Assessment”
 9:00 am Kevin Olson, MD - “Pediatric Controversies”
 10:00 am Break
 10:30 am Larry Stack, MD, FACEP - “Visual Diagnoses”
 11:30 am Rick Belcher, MD, FACEP - “Toxicology Cases”

Wednesday, June 28

- 6:45 am Continental Breakfast
 7:00 am William Smock, MD -
 “Clinical Forensic Medicine”
 8:00 am Diane Fite, MD - “Domestic Violence”
 9:00 am John Moorehead, MD, FACEP - “Wellness”
 10:00 am Break
 10:30 am George Knox, JD - “Being a Good Witness”,
 Sponsored by Medical Assurance
 12:30 pm Adjournment



ANCILLARY ACTIVITIES

Monday, June 26 – 2-7:00 pm

- ACLS Refresher Course, Fee \$150

Tuesday, June 27

1:30 pm

- 2nd Annual Alabama ACEP Golf Tournament, Fee \$80

2-7:00 pm

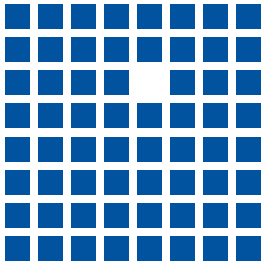
- ATLS Refresher Course, Fee \$350

Wednesday, June 28 and Thursday, June 29

1-7:00 pm Wednesday and 7:00 am - 7:00 pm Thursday

- ACLS-EP (Experienced Providers)
 Provider & Instructor Course,
 Fee \$250

Something special is happening at this year's Alabama ACEP annual meeting and conference. On Monday night, June 26, Genetech, Inc. will be hosting a reception. The reception will be held from 6:00 to 8:00 pm in the Sandpiper A-D room of the Sandestin Beach Hilton. Hors d'oeuvres and refreshments will be served. William Rodgers, MD, Professor of Cardiology at UAB, will be present to discuss new advances in thrombolytic therapy. The atmosphere will be relaxed and informal. The reception will be a great way to unwind at the end of the day. Bring a guest and plan attending this fun and informative reception. Genetech looks forward to seeing you there!



ALABAMA ACEP
17th Annual Educational Conference
“Emergency Medicine: Into The New Millennium”
June 26-28, 2000 – Destin, Florida
Faculty

Richard V. Aghababian, MD, FACEP

Assistant Dean, Continuing Medical Education
 Chairman, Department of Emergency Medicine
 University of Massachusetts Medical School
 Worcester, Massachusetts

Rick Belcher, MD, FACEP

Assistant Professor, Emergency Medicine
 Assistant Residency Director
 Vanderbilt University Medical Center
 Nashville, Tennessee

Mary E. Fallat, MD, FACS

Chair, Committee on Trauma,
 Kentucky Chapter American College of Surgeons
 Associate Professor of Surgery, Division of Pediatric Surgery
 Kosair Children's Hospital
 Louisville, Kentucky

Diana Fite, MD, FACEP

Past President, Texas College of Emergency Physicians
 Clinical Assistant Professor,
 Emergency Medicine Residency Program
 University of Texas Medical School
 Houston, Texas

Ken King

Director of Chapter and State Relations
 American College of Emergency Physicians
 Dallas, Texas

George Knox, Jr., JD

Attorney-at-Law
 Partner in Lanier, Ford, Shaver and Payne
 Huntsville, Alabama

John Moorehead, MD, FACEP

Immediate Past President,
 American College of Emergency Physicians
 Professor of Emergency Medicine
 Public Health and Preventative Medicine,
 Oregon Health Sciences University
 Portland, Oregon

Kevin Olson, MD, FAAP

Clinical Assistant Professor, Emergency Medicine
 University of Alabama School of Medicine, Huntsville
 Director, Pediatric Emergency Department,
 Huntsville Hospital
 Huntsville, Alabama

Christopher J. Rosko, MD, FACEP

Assistant Medical Director, Department of
 Emergency Medicine, University of Alabama
 at Birmingham
 Assistant Clinical Coordinator,
 Alabama Quality Assurance Foundation
 Past President, Alabama Chapter American College
 of Emergency Physicians, Birmingham, Alabama

Loring W. Rue, III, MD, FACS

Professor and Chief, Section of Trauma,
 Burns and Surgical Critical Care
 Director, Injury Sciences Center
 University of Alabama at Birmingham School of Medicine
 Birmingham, Alabama

Corey M. Slovis, MD, FACEP

Professor, Emergency Medicine
 Chairman, Department of Emergency Medicine
 Vanderbilt University Medical Center
 Nashville, Tennessee

William Smock, MD, FACEP

Assistant Professor, Emergency Medicine Medical Director,
 Clinical Forensic Medicine, Fellowship Program
 University of Louisville
 Louisville, Kentucky

Lawrence Stack, MD, FACEP

Assistant Professor, Emergency Medicine
 Assistant Residency Director
 Vanderbilt University Medical Center
 Nashville, Tennessee

Robert J. Zalenski, MD, FACEP

Director of Clinical Research
 Associate Professor, Department of Emergency Medicine
 and Internal Medicine
 Wayne State University Health Center
 Detroit, Michigan

Remarks on Current Political Issues (Continued from page 6)

(Continued on page 10)

The AMA and MASA do not support the over 600 pages of proposed new regulations since they do not inadequately protect patient confidentiality and privacy. The substantial increase in administrative burdens for physicians is unacceptable—the regulations would require that physicians ensure that their business partners (here read as health plans and third party payers—see above) act in compliance with these regulations. How can an individual physician force large (there are about six) health plans to comply with over 600 pages of regulations? In addition, the physician would be liable for the actions of his/her business partners. The proposed regulations would be liable for the actions and burdensome and do not strike the proper balance between patient confidentiality and the need for information sharing. Hippocrates said,

“Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.”

It is still good advice. Perhaps we can spread around this 3000 year old message. Maybe it will be seen as new. Or perhaps you would be pleased to receive targeted mail from drug companies (or email which your children might read) concerning new treatments available for a disorder which someone with your same name had 20 years ago, all because

of a database error which sent the wrong information automatically to a mailing list or automatic email generator. Maybe you could even convince a large health plan to sell your health insurance despite the computer error. Who knows?

Other issues of note are:

- Coverage for the uninsured and insurance market reform
- Due process for physicians in regard to fraud and abuse allegations with a shift in emphasis to education and correct coding rather than punitive actions for inadvertent billing errors or omissions
- Regulatory relief from the counter-productive burden in Medicare and other federal health programs
- Medicare reform which will insure its long-term solvency and also preserve the right to choose your own physician
- Expansion of the State Child Health Insurance Program
- A viable coherent long-term funding mechanism for Graduate Medical Education
- Inclusion of uncompensated care and stand-by costs in RBRVU calculations
- Trauma and EMS funding

We are all involved in these political processes, whether we are active or passive about it. We all think about most if not all of these issues, and many others as well. The more we can speak in reasonable and coherent voices about the issues, the more likely we will have success. Personally I doubt that the votes of physicians can do much to change these types of policies, nevertheless, it is our duty as citizens to participate in our demographic processes. Over and above that basic right and obligation, we, as physicians, have the obligation to do what is right for our patients and the public health as well. Speak to the issues and join the debate, we too will someday get old, or

Note to Members PLAN TO ATTEND

the following NEW Sessions Added to the 17th Annual Conference

- Monday, June 26, 12:30 - 1:00 pm:
Lunch Meeting on the National ACEP “Vehicle Injury Prevention” (VIP) Program
By Mr. Ken King, Director of State & Chapter Relations American College of Emergency Physicians
Sponsored by the American College of Emergency Physicians
- Wednesday, June 28, 12:30 - 1:30 pm:
“Quality Improvement in the ED - Oil and Water or Oil and Vinegar?”
By Christopher J. Rosko, MD, FACEP, Assistant Medical Director, Department of Emergency Medicine
University of Alabama at Birmingham (UAB)
Assistant Clinical Coordinator, Alabama Quality Assurance Foundation
Past President, Alabama Chapter American College of Emergency Physicians
Sponsored by the Alabama Quality Assurance Foundation

disabled, or unable to afford private health insurance.



**21ST CENTURY CHALLENGES
21ST CENTURY SOLUTIONS**



**LEADERSHIP AND
LEGISLATIVE ISSUES
CONFERENCE**

**May 15 – 18, 2000
Loews L'Enfant Plaza Hotel
Washington, D.C.**



American College of
Emergency Physicians®

ACEP and AAP Unveil the Emergency Information Form

ACEP and the American Academy of Pediatrics have developed the Emergency Information Form (EIF) for Children with Special Needs. This document represents the culmination of years of work on the part of both organizations to create a tool that will assure prompt and appropriate care for children with special health care needs. Emergency personnel will be able to use the EIF as a tool to transfer critical information for these patients presenting to emergency departments. The EIF will ensure that a child's complicated medical history is concisely summarized and available when needed.

MedicAlert Foundation, a nonprofit 501c(3) organization, has agreed to serve as the central repository for any child who registers with this program. MedicAlert has a 24-hour emergency call center from which information can be faxed anywhere in the world at any time.

ACEP and AAP recognize the vital role MedicAlert has played in this project.

The forms are available from ACEP (800-798-1822), from CAL/ACEP (800-735-2237), or from the AAP and ACEP web pages: www.aap.org and www.acep.org, respectively.

Physical Therapists Seek Practice Act Expansion

*Reprinted with permission
from the MASA "Leadership Letter", March 2000*

Physical therapists are petitioning the Alabama Legislature to enact broad revisions to their current practice act, including the legal authority to "diagnose and treat" without a referral from a physician. A bill has been prepared (but not yet introduced) which would accomplish several expansions of their power. Representatives of MASA have met with the physical therapists organizations and identified the following issues MASA opposes.

Eliminate the requirement for a mandatory referral from a licensed physician or dentist for treatment.

Permits the physical therapist to perform testing, make a diagnosis and initiate a treatment plan without an examination by a physician.

The definition of physical therapy practice has been expanded to include treating "other health conditions."

The definition of physical therapy practice includes the following undefined terms:

- Airway clearance techniques
- Debridement and wound care
- Physical agents or modalities
- Electrotherapeutic modalities

The definition of testing includes electrodiagnostic and

electrophysiological testing, an EMG testing issue.

Other licensed healthcare professionals, including physicians, would be prohibited from representing, implying or claiming that he or she is a provider of physical therapy.

The proposed bill permits physical therapists to make referrals to "appropriate healthcare practitioners."

The Board of Physical Therapy has its power expanded to adopt rules regarding ethical standards of the Physical Therapy Association.

The bill could expose physicians and other healthcare providers to criminal prosecution if they advertise the availability of physical therapy services.

The Alabama Legislature could consider their proposal during this season. MASA members should contact their state senator and representative encouraging opposition to the "proposed physical therapy practice act expansion." You may contact your legislators by writing:

HOUSE - Alabama State House
11 South Union Street
Montgomery, AL 36130

SENATE - Alabama State House
11 South Union Street
Montgomery, AL 36130

Alabama ACEP Membership Continues to Rise!

For the past two years, in each quarterly newsletter we have reported an increase in the membership of the Alabama Chapter ACEP. We have done it again. The current Alabama Chapter ACEP membership is 295, another all-

time high! This helps the association apply what is known as the "strength in numbers" concept. Now let's shoot for over 300. Special thanks to Dr. Neil Christen, membership committee chair, the board of directors, and other mem-

bers across the state who have persisted in encouraging emergency physicians to join the College. Keep up the good work!

AMA Adopts Ultrasound Policy

By Jorge A. Alsip, MD, MBA, FACEP

At its December 1999 Interim Meeting, the American Medical Association House of Delegates approved an ultrasound imaging resolution submitted by ACEP and co-sponsored by the American College of Obstetrics and Gynecology. In approving the resolution, the AMA acknowledges that specialty-specific ultrasound imaging is within the scope of practice of physicians with training in the technology and that physicians should qualify for privileging if they possess appropriate training as specified by their respective specialty association.

The ACEP/ACOG resolution was widely supported by other specialties, and was opposed only by radiologists and cardiologists. The AMA reference committee heard from several physicians who testified that they were being prevented by hospital credentialing committees from performing focused ultrasound examinations, and many felt that AMA policy would facilitate the use of ultrasound by properly trained non-radiologists.

Ultrasound has been an emerging technology among emergency physicians; however, it has been viewed as being within the realm of radiology practice. ACEP has two policies addressing ultrasound. "Use of Ultrasound for Emergency Department Patients" states in part, "ACEP supports and encourages the immediate availability of ultrasound technol-

ogy for emergency department patients by appropriately trained and credentialed physicians, including emergency physicians."

"Use of Ultrasound Imaging by Emergency Physicians" states in part, "Ultrasound imaging enhances the physician's ability to evaluate, diagnose, and treat emergency patients. As these are often time-dependent studies in acutely ill or injured patients, the emergency physician is in an ideal position to use this technology. Focused ultrasound examinations provide immediate information and can answer specific questions about the patient's physical condition. Such bedside ultrasound imaging is within the scope of practice of emergency physicians."

Along with these ACEP policies, the newly adopted AMA policy on ultrasound should support emergency physicians who have obtained the appropriate training and wish to introduce ultrasound technology to their emergency departments. Emergency physician AMA delegates and alternate delegates from Alabama and several other states were instrumental in gaining the adoption of this policy, underscoring ACEP's ability to work within the AMA to establish policies that advance the quality of emergency medical care.

EDS Invites Feedback from Medicaid-Enrolled Emergency Physicians

EDS would like to thank emergency physicians enrolled in the Alabama Medicaid Program for providing high-quality care to Medicaid recipients in need. As you know, recent months have brought many changes in the Alabama Medicaid information system, and the first months of operation under the new system may have been stressful for enrolled emergency physicians. EDS wants to reaffirm its commitment to ensuring Medicaid providers receive correct payment of claims in a timely manner. If you are still experiencing problems with the new Medicaid system, EDS wants to hear from you so we can identify opportunities for improvement and resolve any issues affecting your claims payment.

The customer relations unit at EDS is staffed with professionals trained to respond to your claims submission and enrollment questions. EDS would like to introduce the teams that make up the customer relations unit who are dedicated to helping you receive the assistance you need.

The Provider Assistance Center (PAC) answers approximately 1,300 provider phone calls daily regarding billing requirements, claim payment, and eligibility status. PAC staff

may be reached by calling 1 (800) 688-7989 or by sending an e-mail to provrelations@eds.com. In addition, an Automated Voice Response System (AVRS) allows providers to access information including check amount, claim status, recipient eligibility, drug and procedure code pricing, and prior authorization requirements. Providers can access AVRS by calling 1 (800) 727-7848.

For providers who submit claims electronically, the Electronic Media Claims (EMC) team is committed to responding to provider inquiries regarding technical issues with electronic billing and questions regarding EDS *Provider Electronic Solutions* software (provided free upon request). Contact the EMC team by sending an e-mail to emchelp@eds.com, faxing your name, provider number, phone number, and problem to the EMC Help Desk at (334) 215-4298, or calling 1 (800) 456-1242.

Provider representatives are able to perform in-office visits to assist providers with claims submission. If you would like to schedule a visit with your provider representative, please send an e-mail message to provrelations@eds.com or fax your request to (334) 215-4298.

NEW HORIZONS

Computer Learning Centers, Inc.

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- We have the largest range of PC and networking classes available.
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- Cost-effective six-month and one-year club memberships are available.
- On-site training can be conducted at your location with everything provided, including computers.
- Free 60-day help desk support service with each class.

New Horizons would like to extend the courtesy of a **FREE** single day of training to the membership of the **Alabama Chapter American College of Emergency Physicians (Alabama ACEP)**. **Would that be of benefit to you?** Please contact Jim Lay in Montgomery at 334-323-5200, ext. 306 or (800) 610-2522 for a class schedule or to enroll in a class. I look forward to providing computer-training solutions for your company.

P P E **Physician's Practice Enhancement, Inc.**

PPE is offering great Emergency Medicine opportunities in the Birmingham area. We have **IMMEDIATE** openings for full and part-time physicians with the progressive three-hospital Eastern Health System, Inc.

Medical Center East - Birmingham, Alabama

35,000 visits/yr.; double/triple and Fast Track ED physician coverage.
Great RN/PMD backup! Family Medicine Residents rotate through ED.
Great teaching opportunities and administrative opportunities!

Successful applicants should possess Emergency Medicine Board Certification/Board Eligibility or Primary Care Board Certification with EM experience; ACLS, ATLS and PALS/APLS. We offer a highly competitive employee compensation with Medical/Dental/Prescription Coverage, 401K, flexible scheduling and CME reimbursement for full-time physicians and **INCENTIVE BONUS FOR ALL PHYSICIANS**.

Medical Center Blount - Oneonta, Alabama

13,000 visits/yr.; 12 hour shifts. New facility! State of the Art ED! Great RN/PMD backup!

Successful applicants should possess BE/BC in Emergency Medicine or Primary Care, ACLS, ATLS and PALS/APLS. We offer a highly competitive employee compensation with Medical/Dental/Prescription Coverage, 401K, flexible scheduling and CME reimbursement for full-time physicians and **INCENTIVE BONUS FOR ALL PHYSICIANS**.

St. Clair Regional Hospital - Pell City, Alabama

16,000 visits/yr.; 12 hour shifts. Great RN/PMD backup!

Successful applicant should possess BE/BC in Emergency Medicine or Primary Care, ACLS, ATLS and PALS/APLS. We offer a highly competitive employee compensation with Medical/Dental/Prescription Coverage, 401K, flexible scheduling and CME reimbursement for full-time physicians and **INCENTIVE BONUS FOR ALL PHYSICIANS**.

Fax your C.V. to (732) 212-0061 or call Marisa Brennan or Chris Garriel toll free 1-877-377-6884.

Work hard but enjoy the rewards!

ALABAMA: Come join us!

We are a small but well established physician group searching for Emergency Medicine Physicians that are **BC/BE** EM and/or Primary Care Specialist with ER experience interested in being a part of a thriving, highly skilled physician team of 20+ years. We staff 5 busy facilities requiring proficiency and speed. Census ranges from 20K to 65K with NP/PA and residents at certain facilities. Work part-time or full-time with 14-16 twelve-hour shifts per month and enjoy flexible scheduling. Compensation for full-time is **200K to 300K** per year. Career opportunities located in Anniston, Montgomery & Prattville. For more information, contact Jeanie Shaw at 334-272-1050, 800-824-7421 or email: jshaw@aeras.com

Have you ever looked for a special way to express appreciation to someone who has made a significant contribution to your life or career?

By making an honorary donation to the Emergency Medicine Foundation you can express your appreciation to someone for any reason or special occasion. You may wish to congratulate someone on his or her graduation or promotion or thank someone for their support. You may also donate a speaker's fee to EMF.

A donation made to EMF in memory of a friend or colleague will pay lasting tribute to their memory.

At the same time your donation will support research and education in emergency medicine.

Upon receipt of your donation EMF will send a card to the person or family of your choice acknowledging your gift. The amount of the gift will be kept confidential.

To make a gift to EMF send your check, type of gift, the name of the person you are recognizing and the name of the person or family to receive the acknowledgement to:

Emergency Medicine Foundation
PO Box 619911
Dallas, Texas 75261-9911



Emergency Medicine Foundation

Making a difference
in emergency medicine

For additional information contact Janet McEwen at 800-798-1822, ext. 3215