05hr_SSC-HCR_Misc_pt30

Details: Medicaid and Health Care Reform. Hearing held in Madison, Wisconsin on August 28, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

Malszycki, Marcie

From: Peggy Rosenzweig [prosey5@yahoo.com]
Sent: Sunday, July 09, 2006 2:26 PM
To: Malszycki, Marcie
Subject: Fwd: [Fwd: Fwd: FW: IOM talking points]
Attachments: pat1479956107

Marcie----
As promised, this is part of the report's highlights----I'll try to retreive the body of the work under seperate cover.
I'll follow-up with you tommorow on the 19th vs the 25th.
Peggy Rosenzweig

Crisis In ER

Howard Croft <hcroft@infinityhealthcare.com> wrote:

Date: Thu, 29 Jun 2006 09:34:50 -0500
From: Howard Croft <hcroft@infinityhealthcare.com>
To: Peggy Rosenzweig <prosey5@yahoo.com>
Subject: [Fwd: Fwd: FW: IOM talking points]

Peggy,
Here are the IOM talking points.
Howie

① Dr. Howard Croft
- St. Mary's Hospital Milwaukee
- Director of Emerg. Dept

② Dr. Christine Med.
- Platteville Hospital
- Director of Em. Dept

③ Dr. Tom DiscAll
- Fox River Valley

-------- Original Message --------
Subject: Fwd: FW: IOM talking points
Date: Thu, 15 Jun 2006 16:45:28 EDT
From: WACEP@aol.com
To: gswart@wi.rr.com, rshimp@infinityhealthcare.com, tjlmdsc@execpc.com, whaselow@infinityhealthcare.com, wfalco@infinityhealthcare.com, sdriggers@hfmhealth.org, hcroft@infinityhealthcare.com, jwhit@wi.rr.com, TPAVES@aol.com, docinwis@netexpress.net, tdietrich2@wi.rr.com, tnelsonmd@pol.net, bschwein@mcw.edu, Pirrallo@mcw.edu, tmodrak@mcw.edu

FYI...
Rich

Subject: FW: Please send to chapters a little before 10:00 - YOUR TIME. Thank you.
Date: Wed, 14 Jun 2006 09:55:44 -0500
From: "Gloria Thompson" <gthompson@acep.org>
To: "Chapter Execs" <chapter-execs-reply@elist.acep.org>

Please see the e-mail below from Elaine Salter in the DC office. It includes the **embargoed** press release regarding the IOM report and the attachment with the talking points for the IOM report. If you have any questions or need other information, please contact the DC office. The IOM will release the report at 11 am EASTERN time today.

From: Elaine Salter
Sent: Wednesday, June 14, 2006 7:55 AM
To: Gloria Thompson
Subject: Please send to chapters a little before 10:00 - YOUR TIME. Thank you.

Dear Chapters
Below you'll find the embargoed press release, and talking points for the IOM report. Please keep the PR office apprised of any media activity conducted over the next couple days.
Thank you all for your help.

<<IOM Talking Points - New.doc>>

EMBARGOED FOR RELEASE AT 11:00 EST June 14, 2006.

Media Contacts:
Laura Gore: 202-728-0610, ext 3008, cell phone: 410-733-4109, lgore@acep.org
Jeff Strei: 202-728-0610, ext 3010, jstrei@acep.org
Julie Lloyd, 202-728-0610, ext 3023, acepprmedia@acep.org
Elaine Salter, 202-728-0610, ext 3007 esalter@acep.org

Nation's Emergency Care System is Fragmented and Unable to Respond to Disasters, says Institute of Medicine

Washington, DC — The Institute of Medicine (IOM) today released three groundbreaking new reports, which find the nation's emergency care system is fragmented and stretched to the breaking point, as well as severely compromised in its ability to handle disasters. As a result, the nation's emergency departments are less able to serve as the safety net for the country's troubled medical care system and to handle future natural or man-made disasters.

Dr. Rick Blum, president of the American College of Emergency Physicians (ACEP), said the reports call for an end to the gridlock in emergency departments and envision an emergency care system of the future that is more patient focused.

Nearly three years in the making, the reports confirm that only a tiny fraction of federal funding for emergency preparedness since 9/11 has been spent on medical preparedness. Although emergency service providers are a crucial part of the response to any disaster, they received only 4 percent of $3.38 billion distributed by the Homeland Security Department for emergency preparedness in 2002 and 2003 and only 5 percent of the funding from the Bioterrorism Hospital Preparedness Program.

"Congress must convene a hearing on the state of emergency medicine in this country and dedicate funding to the emergency care system to support disaster preparedness," said Dr. Blum. "Hospitals must be reimbursed for the significant amounts of uncompensated emergency and trauma care they provide. To do otherwise threatens to destroy the critical emergency care infrastructure that ALL Americans depend on. Hospitals must also be able to end the practice of boarding patients in emergency departments. When our beds are full of admitted patients waiting on inpatient hospital beds, we have only a very limited ability to see new patients, let alone have the surge capacity to deal with a disaster or epidemic."

Dr. Blum said the Access to Emergency Medical Services Act (H.R. 3875 and S. 2750) would be a first step to begin to address three of the major problems that are identified in the IOM reports

(1) the practice of "boarding" admitted patients in emergency departments until inpatient beds become available, which causes medical care gridlock (2) the liability risk of caring for emergency patients, which is deterring many medical specialists from being on-call to emergency departments, and (3) the continuing decline in payments for emergency medical care

that threatens the entire emergency care infrastructure.
The report says many of the problems in today's emergency care system are related to its fragmented nature. It calls for a seamless coordination of services from a patient's point of view, which will require continuous communication and coordination among 9-1-1 and dispatch, ambulance and EMS workers, hospital emergency departments and trauma centers, and the medical specialists that support these facilities.

The report also describes the increasing responsibilities of hospital emergency departments, which are caring for patients without medical insurance and for insured patients unable to access their physicians. Between 1993 and 2003, the number of visits to emergency departments increased from 90.3 million up to nearly 114 million. At the same time, the number of hospitals in the United States decreased by 703, and the number of hospital beds dropped by 198,000.
"The report calls on hospitals to improve efficiency and patient flow using tools developed from engineering and operations research, such as systems that track and coordinate patient flow," said Dr. Blum. "It also calls for greater accountability and public reporting of performance, as well as panels to develop evidence based protocols for EMS, emergency and trauma care of adult and pediatric patients."
The pediatric emergency care report found only 6 percent of U.S. hospital emergency departments have all the supplies necessary for handling pediatric emergencies and only half of departments had 85 percent of the essential supplies. It says the needs of pediatric patients should be taken into account in developing standards and protocols for triage and transport of younger patients.
The EMS report calls for increased funding, especially for EMS-related disaster preparedness; enhanced training for EMS workers; improved coordination among EMS agencies; and for EMS agencies and hospitals to integrate family-centered care into practice.
According to the IOM, the emergency care system of the future should be highly coordinated, regionalized, and accountable, with one lead federal agency consolidating many of the government programs that deal with emergency and trauma care.
"The nation's emergency physicians and nurses stand ready to provide the care the nation needs in any time of trouble, but they must have the basic tools, processes, and capacity to do so," said Dr. Blum.
The IOM in September 2003 convened a committee on the Future of Emergency Care in the United States Health System to identify the most important issues facing emergency patients and make recommendations on how best to deal with those issues. Charged with creating a vision for the future of emergency care, the committee looked at hospital-based emergency care, prehospital emergency medical services(EMS) and the special challenge of providing emergency care for children.
ACEP is a national medical society representing specialists in emergency medicine. With nearly 24,000 members, ACEP is committed to advancing emergency care through continuing education, research, and public education. Headquartered in Dallas, Texas, ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia. A Government Services Chapter represents emergency physicians employed by military branches and other government agencies.

# # #

Thank you,

Elaine

****

Elaine Salter

Public Relations Coordinator
American College of Emergency Physicians
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(202) 728-0610 x3007/(800) 320-0610 x3007 - phone
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esalter@acep.org

Advancing Emergency Care

More Than Ever Come Together in New Orleans! –
Please Join For *Scientific Assembly*, Oct. 15-18, 2006

Preliminary Talking Points
Institute of Medicine Report on
Hospital-Based Emergency Care

(also Overall Talking Points)

Main Point 1: The IOM Reports are landmark studies that confirm our nation's emergency departments are fragmented and stretched to the breaking point, unable to respond to disasters.

- — Underneath the surface, a national crisis in emergency care has been brewing and is now beginning to come into full view.
- — Hospitals must end the practice of boarding patients in emergency departments and ambulance diversion, except in the most extreme cases, such as mass casualty events.
- — An ambulance is diverted every minute in America, threatening the lives of sick and injured patients by delaying medical treatment.
- — Emergency departments provide a health care safety net for everyone — the insured as well as the uninsured. The problem affects every single American.
- — Emergency physicians treat 5 million more patients every year — more than 300,000 a day. 113 million came in 2003. U.S. hospitals have lost more than 198,000 beds since 1993.
- — The nation's emergency physicians provide the most charity care of any medical provider — 95 percent in 2003, compared with 31 percent of all other physicians

Main Point 2: Congress must convene a hearing to address the problems facing emergency patients.

- — Congress must dedicate funding to the emergency system for disaster preparedness and to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care.
- — It's not enough to address the problem by asking people not to get sick.
- — These results are a wakeup call to the nation to recognize emergency care as an essential community service that must be funded.
- — The IOM reports confirm the results of ACEP's 2006 National Report Card on the State of Emergency Medicine — that 80 percent of states earned near-failing grades for their lack of support for emergency care systems., and the nation overall received a C-

Main Point 3: Congress must ensure that America is ready to respond to medical emergencies during a disaster and every day.

- — The reports confirm that only a tiny fraction of federal funding for emergency preparedness has been spent on medical preparedness. Although emergency service providers are a crucial part of the response to any disaster, they received only 4 percent of $3.38 billion distributed by the Homeland Security Department for emergency preparedness in 2002 and 2003.
- — Emergency departments are completely unsupported and unprepared for disasters, such as terrorist events, pandemic flu and hurricanes.
- — Congress must recognize the role of emergency physicians and nurses in responding to disasters, and allocate funds accordingly.
- — Emergency physicians are like the levies in the nation's health care system. They have a crucial role to play in disaster planning at the local, state and federal levels.

- **Main Point 4: Emergency physicians are asking the public to visit www.acep.org and send a message to Congress to convene a hearing and support of the Access to Emergency Medical Services Act** (H.R. 3875 and S. 2750).
  - — This issue affects everyone. It is a national problem that requires a federal solution:
  - — The nation's emergency physicians are advocating for passage of the Access to Emergency Medical Services Act, which if passed, would:
    - o Address the growing lack of resources in emergency care by recognizing emergency medicine as an essential community service that must be funded.
    - o Address the growing physician shortage by extending limited liability protection to physicians who care for patients in emergency departments
    - o Provide financial incentives to hospitals to end the practice of "boarding" patients in the

Who is the IOM: **The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public.**

Preliminary Talking Points
Institute of Medicine Report on
Emergency Medical Services

- **Main Point 1: The Institute of Medicine report about Emergency Medical Services confirms the need to strengthen, improve and integrate EMS systems.**

  — The EMS report calls for increased funding, especially for EMS-related disaster preparedness; enhanced training for EMS workers; improved coordination among EMS agencies; and for EMS agencies and hospitals to integrate family-centered care into practice.
  —Consistent funding is essential to ensure the viability and effectiveness of these systems. EMS resources are limited, affecting the ability of EMS to respond.
  —EMS should be actively supported by communities, citizens and politicians.
  —An effective EMS system is essential to any emergency response to disasters and other public health crises.
  —A national EMS research agenda is needed to improve patient safety.
  — Emergency professionals have one goal in mind: to save lives.

- **Main Point 2: All EMS systems need physician oversight to ensure quality care and patient safety, ideally a board certified emergency physician.**

  —Medical directors should have authority over all clinical and patient care aspects of the EMS system or service, with the specific job description dictated by local needs.
  —ACEP leaders are promoting the integration of emergency medical systems to improve patient care and patient safety.
  —EMS decision-making by EMS leaders and policymakers must be based on scientifically based methodology.
  —All EMS systems must broaden their focus to include all patient issues, not only the transport of patients.

- **Main Point 3: When ambulance patients are diverted to other hospitals because of overcrowding, it delays care for patients, which can be life-threatening when minutes count.**
  — Boarding ties up staff and resources that could be used to care for additional patients.
  — Physician medical directors stand ready to improve the systems, and have long focused on the primary objective: paient Care. We welcome anyone who wants to join in this effort.

Who is the IOM: The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public.

Preliminary Talking Points
Institute of Medicine Report on
Pediatric Emergency Care

- **Main Point 1: The Institute of Medicine report on pediatric emergency care calls for all hospitals to be prepared to care for children.**

  — The pediatric emergency care report found only 6 percent of U.S. hospital emergency departments to have the supplies necessary for handling pediatric emergencies and only half of departments had 85 percent of the essential supplies. —The needs of pediatric patients should be taken into account in developing standards and protocols for triage and transport of patients. —Every hospital should be equipped to care for children during a national emergency.

- **Main Point 2: Physicians who provide emergency care to children have training to care for kids, such as board certified emergency physicians.**

  —Emergency physicians are experts in managing childhood emergencies. They are trained to provide the highest levels of care to all patients and receive comprehensive training in caring for childhood emergencies.

  —Emergency physicians and nurses care for more than 20 million sick and injured children every year.

  —The American Board of Emergency Medicine and the American Board of Pediatrics in 1992 developed the subspecialty of pediatric emergency care. More than 1,000 doctors are board certified in this subspecialty. The majority are pediatricians who sought training in emergency procedures, and the others are emergency physicians who work in children's hospitals.

  —Parents of children who are experiencing a medical emergency should take them to the nearest hospital emergency department. If additional equipment and skills are needed, they will be transported to another facility.

  —Nobody is more involved in preventing injuries than emergency physicians- public education/lobbying efforts on behalf of car seats/ helmet laws/gun safety.

- **Main Point 3: Emergency physicians have promoted consistent standards and quality of care for children around the world and continue to work to improve the standards of care.**

Who is the IOM: The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public.


FORWARD
E PLURIBUS UNUM

Malszycki, Marcie

From: Peggy Rosenzweig [prosey5@yahoo.com]
Sent: Wednesday, July 12, 2006 8:06 PM
To: Malszycki, Marcie
Subject: Fwd: ACS report
Attachments: pat209809426

marcie----this is another part of the "crisis" picture. hope this helps to shed light on the total problem at hand. let me know if you need more info. I'll be in the Capitol next week ----i'll stop by to say hi! peggy rosenzweig

Rich Paul <richardpaul@dls.net> wrote:

> From: "Rich Paul" <richardpaul@dls.net>
> To: "'Peggy Rosenzweig'" <prosey5@yahoo.com>
> Subject: ACS report
> Date: Wed, 12 Jul 2006 16:36:07 -0500
>
> Here you go. It's a PDF file.

A Growing Crisis in Patient Access to Emergency Surgical Care

Introduction

Many changes have occurred in the surgical practice environment in the past two decades, but policy experts have given little scrutiny to the potential for unintended and undesirable effects. Even the rare policy research paper that notes how stresses in the system affect surgical patients tends to gloss over the implications of the situation. Surgeons in practice, however, have begun to take notice. While intermittent access and availability issues are becoming evident in many service areas and settings, one area raising deep concern universally is emergency care.

In March 2005 and March 2006, the American College of Surgeons hosted meetings with leaders of the surgical specialty societies to examine reports of a growing shortage of surgeons available to cover emergency departments (EDs) and trauma centers. In some specialties, the insufficient number of participants in emergency call panels has reached crisis proportions, and patients throughout the nation are feeling the impact. Furthermore, surgeons who remain in the emergency care system are experiencing professional and personal burdens that are simply unsustainable. The American Medical Association reached the same conclusions at meetings last fall and again in March of this year.

The situation is of such concern that several specialty organizations[1] independently surveyed their members on this issue. Despite the different survey populations, the findings were remarkably similar:

- A majority of surgeons take ED call five to 10 days a month; some surgical specialists take call far more often.
- Many surgeons provide on-call services simultaneously at two or more hospitals, and a significant number say they have difficulty negotiating their on-call schedules.
- Hospital bylaws typically require surgeons to participate in on-call panels, although older individuals are often allowed to "opt out," and they are more frequently taking advantage of this option.
- A significant number of surgeons have been sued by patients first seen in the ED, and some physicians are offered discounts on their liability coverage if they limit or eliminate ED call.

Despite earlier predictions, the number of surgeons trained through the nation's graduate medical education system has not expanded for more than two decades. A growing patient population and a stable supply of practicing surgeons are combining with other forces to produce surgical workforce shortages, particularly in specialties with total workforce numbers in the hundreds or low thousands. Our nation's trauma centers and EDs are feeling the most pervasive effects right now, although spot shortages are occurring in other settings and specialties as well.

The reasons for concern are clear. Patients need prompt access to definitive care when confronting a surgical emergency. But even more is at stake. Our nation's EDs provide the one point of universal access to our health care system. They are the nation's final safety net. Indeed, the public fully expects such access, and it is doubtful that patients realize it is eroding. Yet, policy experts and decision makers seem to be unaware of the trend, and certainly no focused efforts are under way to resolve the problem.

Equally important, our emergency care system (including the EDs, hospitals, trauma centers, and the health care professionals who comprise it) forms the foundation of our nation's response to future terrorist attacks and natural disasters. Emergency care capability has never been more important than it is in the post-9/11 world, and the need to strengthen it has never been more urgent.

The following information is an effort to document, based on the limited sources available, some of the underlying causes of this imminent crisis. Also included are proposed actions that should be explored immediately to begin addressing them. Clearly, much work remains to be done.

Overview of Surgical Care in the Emergency Department

According to the National Center for Health Statistics,[2] approximately 114 million ED visits (39 per 100 people) took place in 2003, representing a 26-percent increase since 1993. In addition, nearly half of all hospital EDs reported that they were at or beyond capacity in 2005 and, as a result, were forced to divert ambulances to other facilities. The problem is particularly acute for teaching hospitals, which reported that 79 percent of their EDs were at or over capacity. Overcrowding is attributed to many factors—inpatient capacity and patient flow management among them—but frequently cited issues are the federal mandate to screen and stabilize all patients and a scarcity of on-call physicians and surgeons to provide specialty care.[3]

A variety of patient emergencies may require surgical care. Common reasons for surgical admissions involve gallbladder disease, gastrointestinal bleeding, appendicitis, heart disease, aneurysm, stroke, and complications associated with procedures, devices, implants, or grafts. Patients suffering injuries from external forces, or trauma, most often require emergency surgical intervention. Trauma accounts for approximately 11.4 percent of nonpediatric and nonmaternity hospital admissions originating in the ED, according to the Agency for Healthcare Research and Quality.[4]

Formally designated trauma centers that function as part of a state or regional trauma care system are known to provide the highest quality care to severely injured patients.[5] Perhaps contrary to general assumptions, relatively few trauma center patients are victims of violence. According to the College's own National Trauma Data Bank® (NTDB),[6] victims of motor vehicle traffic accidents represent the largest segment of patients treated in our nation's trauma centers. Falls are the second most common cause of severe injury and are the most prevalent source of trauma in the elderly.

A March 2005 Harris interactive public opinion poll commissioned by the College's Committee on Trauma and the Coalition for American Trauma Care revealed that Americans appreciate the importance of prompt access to specialized trauma care services. Nearly all respondents recognized that it is extremely (63 percent) or very (31 percent) important to receive treatment at a trauma center in the event of a life-threatening injury. In fact, most respondents (eight out of 10) believed that having a trauma center nearby is of equal or greater value than a fire or police department.[7] Additionally, a significant majority indicated they would be extremely or very concerned to discover that their state's trauma system fell short of recognized standards of care. Unfortunately, a survey conducted by the Health Resources and Services Administration in 2002 found that only eight states met all the recognized criteria for a fully developed trauma care system, although 26 states met most criteria.[8]

Trauma systems provide an important means of ensuring access to emergency surgical care for the most severely injured patients. The trauma system model of regionalized care also holds promise for ensuring that patients receive treatment for other surgical emergencies, including those resulting from disasters. State or regional trauma systems are the bedrock for responding to disasters, whether natural or man-made, and policymakers have failed to support them with the vigor they show for other disaster preparedness and response programs.

The Underlying Problem: An Emerging Workforce Crisis

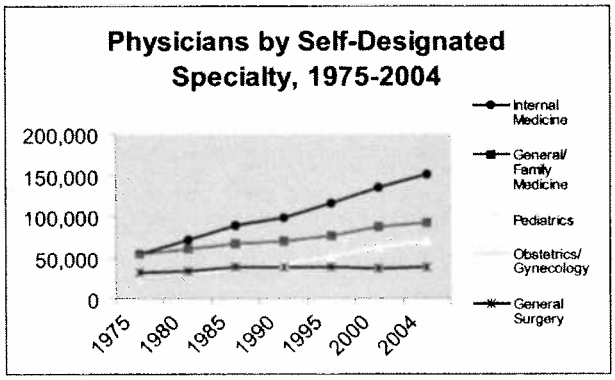
A growing shortage of surgical specialists available to cover our nation's EDs is threatening access to prompt acute care services. While the science of forecasting physician supply and demand continues to evolve, it is apparent that previous predictions of an oversupply of specialists missed the mark. Conventional wisdom has shifted with the introduction of new peer-reviewed studies, and physician workforce analysts now project potential shortfalls in specialties that are crucial to community-based emergency care response.

Contrary to earlier assumptions, the number of surgeons trained in our nation's graduate medical education system has remained stable for more than 20 years *(Figure 1)*. As a result, U.S. population growth has outpaced the supply of surgeons. Furthermore, because the elderly comprise a disproportionate share of the surgical patient population, the "graying of America" is placing even greater demand on the supply of specialists.

An analysis conducted by the Lewin Group of the American Hospital Association's "ED and Hospital Capacity Survey of 2002" showed that neurosurgeons, orthopaedic surgeons, general surgeons, and plastic surgeons were among the specialists in short supply for ED on-call panels.[9] A similar survey conducted by the American College of Emergency Physicians in 2005 showed that nearly three-quarters of ED medical directors believe they have inadequate on-call specialist coverage, compared with two-thirds in 2004. In that survey, orthopaedic, plastic, and neurological surgeons, as well as otolaryngologists and hand surgeons, were reported as most often being in short supply.[10] Using conservative estimates of U.S. population growth, it is apparent that the ratio of surgeons in these specialties available to provide emergency services that Americans will need is on the decline *(Figure 2)*.

The problem is compounded by an aging surgical workforce, which makes fewer surgeons available for ED coverage due to decreased workload capacity and retirements. In many

Figure 1



Source: American Medical Association (AMA): Physician Characteristics and Distribution in the US, 2006 edition

specialties that are key to ensuring adequate emergency call coverage, approximately one-third of the practicing surgeons are age 55 or older *(Figure 3)*. Contributing to this shortage are provisions in many hospital bylaws that allow older physicians to opt out of ED on-call responsibilities.

Workforce shortages exist across a range of medical disciplines, but generally are far more significant for surgery. The workforce in nonsurgical specialties has grown steadily over time, while the number of individuals entering surgery each year has been relatively stable for more than two decades. In general surgery, for example, the rate of growth is not only slower than the growth in the general population, but it is significantly below the rate for nonsurgical specialties, including primary care specialties. (This statement is not intended to deny the genuine issues in other areas, but to clarify that the problem in general surgery is far more acute and generally overlooked.)

Other professional trends add to the problem, including the growing movement toward specialization. Program directors, professors of surgery, and other individuals who are familiar with residency matches report that about half of all general surgery residents go on to pursue fellowships and subspecialization. As their scope of service becomes narrower, a new and alarming trend has emerged—many surgeons no longer feel qualified to manage the broad range of problems they are likely to encounter in an ED.[12] We can anticipate that, as hospital credentialing policies and state

licensing requirements become more restrictive in coming years, this issue will be of increasing concern. Furthermore, if additional research confirms suspicions that younger surgeons are inclined to narrow the focus of their practice, the implications are even more troubling as older surgeons begin to retire.

Another important but overlooked factor is the small number of specialists produced by training programs each year. As an example, approximately 130 neurosurgery residency training positions are offered each year, far fewer than the largest medical specialty, internal medicine, which offers more than 4,700 positions.[13] In addition, recent studies have found that the number of operative cases has generally and significantly decreased for all neurosurgery residents because of compliance with the 80-hour workweek restrictions.[14] Considering the small number of neurosurgeons practicing in the U.S. today (approximately 3,200), the large portion of whom are older than age 55 (34 percent), and the time it takes to train a neurosurgeon (about seven years), it will be difficult to safely and adequately replace a shrinking pool of neurosurgeons participating in on-call panels.

The inadequate number of specialists providing emergency call services is taking its toll on quality of care. In a recent survey of ED administrators, 42 percent said that lack of specialty coverage in the ED poses a significant risk to patients. And, of those who indicated they would not choose their own ED as a source of care if they were seriously hurt (12 percent), an overwhelming majority (74 percent) listed the lack of specialty reinforcement as the reason.[15]

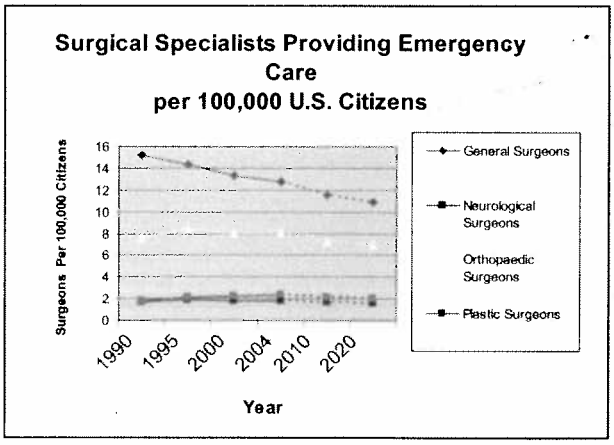
These workforce trends must be viewed within the context of rising demand for emergency services. Sharply accelerating need is chasing declining capacity, and the result is an emerging crisis in prompt access to emergency surgical care. In the short term, we need to develop new ways to manage our surgical resources in order to meet current needs. In the long term, we need to better understand and address the underlying causes of these problems.

Short-Term Solutions

We must develop the means to make our current emergency care system work well, despite the pressing workforce shortage. The American College of Surgeons has a long history of originating programs to improve emergency care, and we are now applying these models to new efforts to make effective use of scarce health care system resources.

- For example, the College's publication ***Resources for Optimal Care of the Injured Patient*** outlines the resources hospitals must have in order to fulfill their commitment to trauma patient care at various levels. State and local authorities throughout the U.S. have used this guidebook as the foundation for trauma center designation. In addition, the College's Committee on Trauma provides hospital consultation visits at the request of hospitals, communities, or state authorities to assess trauma care and to verify trauma center compliance with these criteria. Similar programs are conducted in collaboration with the American Burn Association to define and assess the resources required for burn treatment centers.

Figure 2

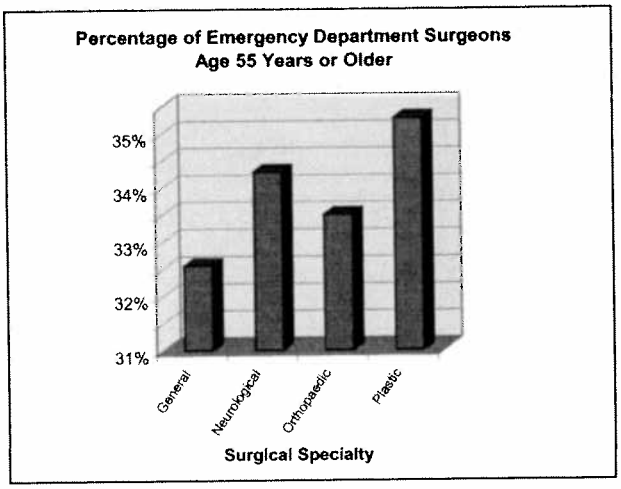


These data are for active surgeons, and the historical data were derived using figures from the AMA report titled, "Physician Characteristics and Distribution in the US," 2006 edition, Tables 5.2 and 5.16. The projected data beyond 2004 assume a flat supply of surgeons from 2004 through 2020 and steady increases in the U.S. population to 325 million by 2010 and 345 million by 2020. These projected population figures are similar to those used by the Centers for Medicare & Medicaid Services, according to Richard A. Cooper, et al.[11]

- The College's ***Trauma System Verification Program*** provides a comprehensive, on-site trauma system review to help states and regions assess their organizational strengths and weaknesses in providing optimal care for injured patients beyond the walls of individual trauma centers. Following the "Model Trauma Care System Plan" that the Health Resources and Services Administration introduced in 1992, these reviews may be conducted at a multistate, single-state, regional, county, or local level, depending on a particular system's scope and needs.
- The ***Advanced Trauma Life Support® Program*** (ATLS) is a series of courses offered throughout the U.S. and abroad to provide an organized approach for the evaluation and management of seriously injured patients. Now in its 25th year, this program exposes both physicians and physician extenders to proven methods of appropriately assessing and initially managing severely injured patients. ATLS is the widely accepted "gold standard" educational program for inculcating all members of the trauma team in the common principles of emergency care and is applicable in both large urban centers and small rural EDs.
- More recently, the College initiated the ***Rural Trauma Team Development Course*** to help all members of the health care team provide the initial assessment and stabilization of severely injured patients. It is designed to integrate the trauma care team of a small rural hospital or clinic into a larger state or regional trauma care system, both to improve the efficiency of resource use and to ensure that injured patients receive the appropriate level of care.

The American College of Surgeons and other surgical specialty societies remain committed to developing new strategies for expanding access to urgent services. For example, we are achieving some consensus on how to apply the trauma system model so that a blueprint can be developed for better regionalizing specialty care services that may be required in an emergency situation. We believe this new structure would relieve EDs of the burden of being expected to cope with the broad range of potential surgical problems at all hours of the day and night. This strategy would be particularly appropriate for

Figure 3



These data are derived from the AMA report titled, "Physician Characteristics and Distribution in the US," 2006 edition, Table 1.2.

services provided by specialties with workforce numbers in the few hundreds or thousands, such as neurological and hand surgery.

In addition, the ATLS and Rural Trauma Team Development Course models could be applied to develop and implement protocols that allow physicians and surgeons in the ED to better assess whether conditions and injuries would best benefit from immediate, definitive specialty care or stabilization and treatment the following day, thereby lessening the demands on specialists on call.

Of course, the profession cannot address all of the contributing causes on its own; the federal government will need to intervene as well. Together, we can strengthen our nation's emergency care system. In the short term, we will work with Congress to reauthorize and appropriate funds for the Trauma Care Systems Planning and Development Act, a program administered by the Health Resources and Services Administration that aims to ensure that state and regional systems of care are operating throughout the nation to provide prompt access to surgical care that severely injured patients need. We also will work with policymakers to help ensure that an emergency surgical workforce is identified and prepared to assist in the event of a national terrorist attack or natural disaster.

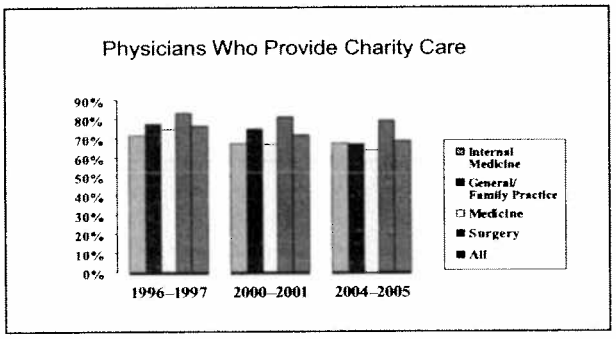
Forces Shaping the Workforce Crisis

The single most important factor shaping the surgical workforce issue today is declining reimbursement. Physician concerns center not only on reimbursement for the emergency services themselves, which frequently are uncompensated, but also on insurance payments for procedures that comprise a major component of elective practice. These payments have been declining steadily over the past two decades. Related issues, such as the disruption that late-night emergency care causes to a surgeon's routine practice schedule and the lifestyle impact of frequent on-call service, undermine surgeons' willingness to take call.

As a recent report from the Center for Studying Health System Change noted, surgical specialists are more likely than other specialists or primary care physicians to provide charity care, probably because of their emergency on-call responsibilities *(Figure 4)*.[16] Yet, the number of both surgeons and other physicians who are providing charity care is decreasing, a trend the center attributes to declining practice incomes, which make it more difficult for physicians to subsidize unpaid care.

NTDB data confirm that surgeons bear the significant brunt of providing uncompensated care provided to severely injured patients.[6] According to data compiled from more than 1.5 million patient records at 565 U.S. trauma centers, "self-pay" is the largest single payment category for trauma center patients (21%), followed by Medicare (17%), with Medicaid not far behind (11%) *(Figure 5)*. And, while hospitals may draw upon special federal and state financing streams to offset the costs of providing care to patients with little or no health insurance coverage, physicians and surgeons may not.

Figure 4



Source: Center for Studying Health System Change

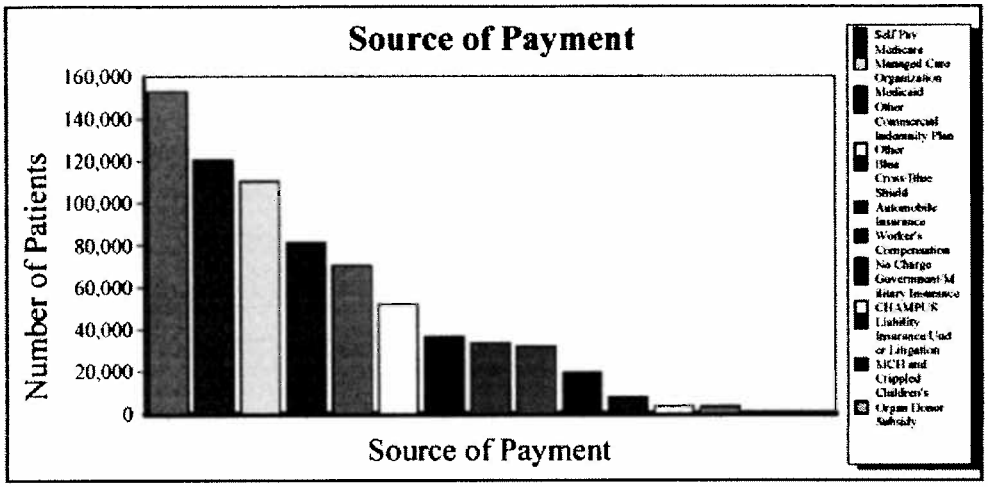
Further, as Table 1 illustrates, Medicare payments for many operations that elderly patients most often require are considerably lower than they were in the 1980s. These are actual, national average payment amounts, with no adjustment for inflation between 1989 and 2006. Payment levels for services frequently provided to injured patients in the ED have not fared much better, as shown in Table 2. Because many private insurance plans and Medicaid programs use the Medicare physician fee schedule as the basis for their own payment arrangements, these trends are reflected throughout the health care system. Again, the overall decline in practice income makes it difficult for surgeons, most of whom are in solo and small group practices, to shoulder the burden of caring for patients who are unable to pay. According to information that the Centers for Medicare & Medicaid Services recently released, the Medicare reimbursement situation will only worsen as the sustainable growth rate system produces further across-the-board payment reductions, amounting to an additional 39 percent in the next nine years.[17]

All specialties have concerns about the Medicare payment system, but its flaws are especially problematic for surgical specialists. As Medicare data show, medical services generally are growing at a rate that allows many specialists to offset per-service payment reductions by increasing service volume. However, the volume rates for surgical procedures are not growing—in fact, for many surgical services, volume is actually shrinking. So, not only are the overall payment cuts not offset, but, under the sustainable growth rate system, the increasing number of services provided by other physicians is actually *causing* the reductions.

Some surgeons are exhibiting market responses to these pressures, some of which affect access to emergency services. Certain surgeons have been forced to minimize financial disruptions to their practices by subspecializing in narrow fields dominated by elective services. In some cases, those surgeons who narrow their scope of services are able to omit hospital-based care

from their practices, making them unavailable for emergency on-call panels. According to a survey conducted by the American College of Emergency Physicians, 51 percent of ED directors in 2005 reported deficiencies in on-call coverage because specialists left their hospitals to practice elsewhere.[10] Hospital ED administrators report these specialists frequently relocate to ambulatory surgery centers (31 percent).[15]

Figure 5



In other cases, surgeons may eliminate risky or less profitable services from their practices. For example, a recent survey of neurosurgeons revealed that 38 percent now limit the types of procedures they perform. Of those, 57 percent have eliminated pediatrics, 13 percent no longer provide services related to trauma, and 11 percent no longer perform cranial procedures.[18] For other surgical specialties with elective patients requiring hospital resources, one option has been to form their own specialty facilities equipped to provide only a limited range of nonemergency procedures.

Table 1. Medicare Payments for Key Operations (1989–2006)

Procedure	1989 Average	2006 Average	% Change
Remove cataract	$1,573	$684	-57%
Total knee replacement	$2,301	$1,511	-34%
Carotid endarterectomy	$1,677	$1,129	-33%
Prostatectomy (TURP)	$1,139	$695	-39%
Partial colectomy	$1,256	$1,226	-2%
Laminectomy	$2,078	$1,051	-49%
Hernia repair	$560	$469	-16%
Coronary arteries bypass	$3,957	$2,049	-48%
Mastectomy	$1,051	$997	-5%

Also affecting the availability of surgical care in EDs are liability issues unique to emergency care. Part of the growing reluctance to take call is because of a genuine concern that ED patients will sue. Surveys by the American College of Surgeons and the American Association of Neurological Surgeons/Congress of Neurological Surgeons revealed that more than one-third of respondents had been sued by a patient who was first seen in the hospital ED.[19] A 2005 hospital ED administration survey also lists "malpractice concerns" as the principal factor discouraging specialists from providing ED coverage.[15] Furthermore, because liability premiums have outpaced payments for their services, some surgeons have concluded that they simply cannot afford the added liability risk for a largely uninsured patient population.

In addition, younger surgeons, who often take the on-call shifts at trauma centers, are leaving states with the most severe liability problems. For example, according to the Project on Medical Liability in Pennsylvania, funded by the Pew Charitable Trust, "Resident physicians in high-risk fields such as general surgery and emergency medicine named malpractice costs as the reason for leaving the state three times more often than any other factor."[20] Further, an American Hospital Association study found that more than 50 percent of hospitals in medical liability crisis states now have trouble recruiting physicians, and 40 percent say the liability situation has resulted in less physician coverage for their EDs.[21] The crisis has even forced the

Table 2. Medicare Payments for Key Emergency Procedures (1990–2006)

Procedure	1990 Average	2006 Average	% Change
Open treatment nose fracture	$1,044	$720	-31%
Open treatment eye socket fracture	$888	$714	-20%
Open treatment humerus fracture	$833	$751	-10%
Repair heart wound	$1,203	$1,129	-6%
Repair ruptured abdominal aneurysm	$2,535	$2,243	-12%
Burr hole for hematoma	$1,526	$1,087	-29%
Craniotomy for hematoma	$2,245	$1,749	-22%
Repair retinal detachment	$2,760	$1,375	-50%

closure of trauma centers in Florida, Mississippi, Nevada, Pennsylvania, and West Virginia at various times in recent years.[22]

Specialties that have experienced particularly high premium increases—including neurosurgery, orthopaedics, and general surgery—are also among those that provide services emergency patients most frequently require. According to a report from the General Accounting Office, soaring medical liability premiums have led specialists to reduce or stop on-call services to hospital EDs, seriously inhibiting patient access to emergency surgical services.[22]

Declining payments from all sources, a large burden of uncompensated care being provided in EDs, escalating practice overhead and medical liability premium costs, and new practice patterns that are causing some surgeons to narrow their breadth and limit in-hospital care are combining to produce an unfortunate result: the pool of surgical specialists from which to draft an emergency call schedule is being drained.

Long-Term Solutions

Many of the solutions the surgical profession has identified for these problems are enormous in scope and envelop the structure of our health care system and the interests of many stakeholders. Certainly, it is time for policy researchers and policymakers to begin addressing these difficult issues, bearing in mind that no stakeholder has more to lose than the surgical patient. Hence, it is time that surgeons and policymakers initiate changes that are currently feasible to address the underlying causes.

Federal and state laws do little to encourage surgical specialist participation in emergency on-call panels. The Emergency Medical Treatment and Labor Act (EMTALA), for example, was signed into law in 1986 as an effort to address the problem of patient-dumping by hospital EDs. The law grew both in scope and complexity for a number of years and was often interpreted in such a restrictive sense that it imposed untenable burdens on specialists providing emergency coverage. Although the federal government has taken steps to address some of the law's most serious weaknesses, specialists tend to view EMTALA as a mandate to provide uncompensated care around-the-clock, and the law is widely believed to be a primary factor behind practice behavior changes that are taking surgeons away from hospitals and EDs. In addition, the American College of Emergency Physicians noted in a recent report that EMTALA may actually encourage uninsured patients to seek ED care in increasing numbers because they are aware of the federal mandate to provide screening and stabilizing care.[23]

> *The College pledges to work with regulators to continue refining laws such as EMTALA to remove disincentives for specialists to provide emergency care.*

State insurance laws also unintentionally contribute to the problem of uncompensated trauma and emergency care. One such statute, known as the Uniform Accident and Sickness Policy Provision Law (UPPL), permits health insurers to deny coverage for trauma care for alcohol- or drug-related injury. The original intent of UPPL was to free sober drivers from paying the medical bills of those who drive while intoxicated. However, the result is that surgeons receive no compensation for services provided to insured patients, who often require care in the middle of the night. Although a few states have repealed their UPPL laws in recent years, most still have them on the books.

Indeed, it is important to remember that there are few mechanisms that can be used to provide compensation to surgeons and other specialists who care for the uninsured or patients who are covered by programs like Medicaid, which traditionally provide low reimbursements. Unlike hospitals, surgeons do not have access to Medicare's "disproportionate share" payment program, and most states that collect funds for trauma and ED care through special driver's license fees, traffic violation fines, and so forth, funnel the money to institutions rather than to physicians.

A variety of mechanisms for improving the reimbursement issues that underlie the problem must be pursued. Of course, the federal government needs to take on the formidable task of comprehensively addressing the ever-growing number of Americans without health insurance. Moreover, the current Medicare payment system that is producing negative annual updates for all physician services, regardless of their unique value or spending trends, must be reformed.

The College will continue to work at the state level to eliminate UPPL laws that deny reimbursement for care provided to insured patients, as well as develop new strategies to provide physicians with access to the financing mechanisms available to facilities that provide uncompensated care.

At the federal level, we believe the government should support EMTALA's mandate that physicians provide care for the uninsured of emergency department patients by providing some tax relief for these services. Such a tax credit or deduction could be based on overhead costs as determined in the Medicare physician fee schedule. Alternatively, the government could adjust the practice expense "pools" it develops for each specialty in determining overhead costs in the Medicare fee schedule by taking into account the impact of uncompensated care on those costs, as it has for emergency medicine. Finally, we believe Medicare should support those hospitals that have resorted to paying stipends to ensure on-call coverage by recognizing these costs when determining changes in hospital market basket or updates under the prospective payment system, as it does for critical access hospitals.

To improve access in rural areas, where the surgical workforce problem is most acute, Medicare provides 5-percent bonus payments to physicians who practice in physician scarcity areas. Unfortunately, the program appears to work better for primary care physicians than for specialists, largely because bonus payments are based on the location where services are rendered. Surgeons who care for sparse populations tend to provide their services either in regional hospitals or office buildings near those institutions. As a result, the actual site of service may be outside a physician scarcity area, even though the vast majority of the population being served resides in such an area. Another program provides 10-percent bonuses to physicians who render services in health professional shortage areas, but that program applies only to primary care and mental health providers.

Similarly, federal programs geared toward recruiting more physicians to provide care in underserved areas tend to favor primary care and certain nonphysician providers. The National Health Service Corps, for example, provides scholarships and medical school loan repayments to health professions students in return for a period of service in an urban or rural health professional shortage area. Again, no such program is available to surgeons and other specialists.

We will work with Congress to create a health professions support program to cover medical school debt for young surgeons providing surgical care in community or rural hospitals/trauma centers. We also will work with policymakers to refine current laws pertaining to physician scarcity areas so they may more effectively encourage surgical specialists to provide care in areas where demand is greatest.

Even federal programs providing limited medical liability protections for volunteer physicians tend to favor office-based care rather than treatment for the uninsured in the nation's EDs. The Volunteer Protection Act, for example, applies only to individuals serving in not-for-

profit organizations. In addition, Public Health Service Act section 224 provides Federal Tort Claims Act protection for services provided to patients of community health centers. However, because the focus is on community health centers, these protections only apply to primary care and office-based services. Surgeons who provide care to patients referred by community health centers receive no protections under the statute.

All medical and surgical specialty organizations support enactment of comprehensive, common sense, medical liability reforms. Until a comprehensive and nationwide solution emerges, however, interim steps addressing the most immediate concerns should be considered. For example, policymakers can limit exposure to medical litigation and provide qualified immunity for EMTALA care by bringing these mandated services under the Federal Tort Claims Act. Similar strategies may be pursued on the state level.

One federal program intended to ensure prompt access to surgical care for severely injured patients was established in the Trauma Care Systems Planning and Development Act of 1990 mentioned previously. Administered through the Health Resources and Services Administration, in the past several years this program has distributed $31.4 million in funds to all 50 states and five territories for the purpose of developing state and regional trauma care systems. But today, even with this influx of federal funds, the nation's trauma systems remain incomplete, and, unfortunately, only one-fourth of the U.S. population lives in an area served by a trauma care system.[24] Furthermore, efforts to reauthorize the program failed in 2005, no funds were appropriated for 2006, and the President's fiscal year 2007 budget proposes its elimination—all despite the fact that in 1999 the Institute of Medicine called on Congress to "support a greater national commitment to, and support of, trauma care systems at the federal, state, and local levels."[25]

In addition to advocating the reauthorization of the Trauma Care Systems Planning and Development Act, we will work with policymakers in the future to expand this concept to other surgical emergencies, including those resulting from natural or man-made disasters. We also will explore improvements in telemedicine to facilitate specialist consultations across state lines.

Finally, it is vitally important that policy researchers and policymakers gain a greater understanding of the forces that are undermining our nation's emergency care system. Studies of the growing uninsured population, for example, must expand their focus beyond the important but narrow issue of chronic disease management and begin considering the implications for access to high-quality acute care services for all Americans. The American College of Surgeons is committed to initiating this dialogue and will continue its collaboration with representatives of all surgical specialties to improve our understanding of the problems confronting surgical practice today and to develop innovative solutions to resolve them.

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For more information, contact the
Division of Advocacy and Health Policy
American College of Surgeons
202/337-2701 ahp@facs.org

June 2006


FORWARD

Malszycki, Marcie

From: Malszycki, Marcie
Sent: Friday, August 04, 2006 9:46 AM
To: Volz, David
Subject: August 28th Hearing

Here is the line up of speakers that I have so far. I have not called any of them cause I still need to talk to Carol and make sure she is okay with these. Please let me know if your boss is okay with these speakers and if she has anyone else she wants to speak.

1. Marshfield Clinic Director, speaking on Chronic Disease Management 715-221-8692
2. Hoven Consulting, Speakers from the WI Academy of Family Physicians speaking on the Medicaid Reform Task Force
3. Bryodrick and Associates, Speakers from LogistiCare speaking on Specialized Medical Transportation/ brokering system not pursuing. -DHFS proposed
4. Peggi Rosenzweig, Speakers coming to present on Crisis in ER's
5. Lisa Maroney, Dr. Jeff Grothman speaking on health care reform. He is a part of the National American Hospital Association Task Force (I have not gotten any information from them yet so this is tentative).

Please let me know if you have any changes, additions, or comments. I will be discussing further with Carol on Tuesday next week when she returns to the office. I will then begin putting the notice together and inviting speakers.

Thanks!!

Marcie Malszycki
Office of Senator Carol Roessler
608-266-5300

- discussions - cost control
② HSA's

40 min total

(4) (6) 8/10 HIRSP update 441-5777 Amie Goldman

(5) (7) 8/10 Badger Care Plus

Jason Helgerson, Executive Assistant

(7) (8) Olsen's Speaker yes


FORWARD

Malszycki, Marcie

From: Hermes, Ron
Sent: Monday, August 07, 2006 9:40 AM
To: Malszycki, Marcie
Subject: Fwd: New Contact Info for HIRSP

Here you go.

>>> Ron Hermes 07/20/06 8:56 PM >>>
Hi Sandy and Marcie-
I am sending you this email in hopes that you would be willing to do me a favor. Below is an email regarding the changes to the HIRSP program that went into effect on July 1. I, unfortunately, do not have access to the "all legislative" email list. I was hoping, that as clerks for your respective Health committees, that you would be willing to send this email to your colleagues so that they know the Department is no longer responsible for the HIRSP program.

Please contact me if you have any questions or concerns.

Many thanks,
Ron

Hello-
As you know, the 2005 Wisconsin Act 74 transferred the administration of HIRSP from DHFS to the HIRSP Authority effective July 1st. I want to make sure you have updated contact info so that any calls or inquiries regarding HIRSP can be directed appropriately.

Effective immediately, calls and inquiries from HIRSP members, providers and from legislative offices concerning a specific HIRSP member should be directed to the numbers below.

The main HIRSP Customer Service phone numbers remain the same: toll free 1-800-828-4777 and local 608-221-4551. Contact info for the HIRSP Authority is:

HIRSP Authority
Amie Goldman, Chief Executive Officer
10 E. Doty Street, Suite 800
Madison, WI 53703
phone: 608.441.5777
fax: 608.441.5776

Please let me know if you have any questions.

Ron Hermes
DHFS Legislative Liaison

→ Any Specifics?
→ update
A Goldman@HIRSP.org


FORWARD
E PLURIBUS UNUM

1

Malszycki, Marcie

From: Maroney Lisa A. [LMaroney@uwhealth.org]
Sent: Wednesday, August 09, 2006 9:33 AM
To: Malszycki, Marcie
Subject: Aug. 28 Hearing

Marcie,

Again, thanks to you and Carol for allowing us the opportunity to testify. The title of the UW Health presentation will be: **The Role of an Academic Health Center in Health Care Reform.**

The UW Health 3 speakers are as follows:

1 Dr. Robert Golden, Dean

UW School of Medicine and Public Health

2 Dr. Jeff Grossman,

Senior Associate Dean for

Clinical Affairs and

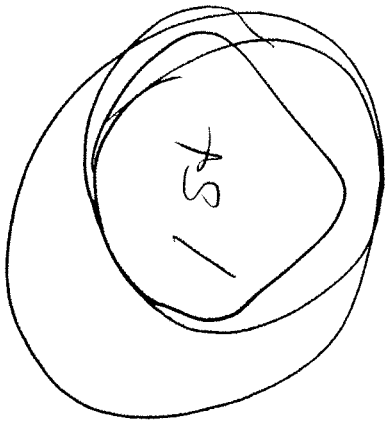
President and CEO

UW Medical Foundation

3 Donna Sollenberger,

President and CEO

UW Hospital and Clinics



Thanks also for allowing us to be the first group to testify when the hearing starts at 10:00 a.m. As we discussed, our power point presentation will be 20 minutes. Let me know if there is anything else I can provide.

Lisa Maroney

UW-Madison, Health Sciences

State Relations

635 Science Drive, Suite 150

Madison, WI 53711

(608)265-1653

(608)263-6394 fax


FORWARD
PLURIBUS UNUM

Malszycki, Marcie

From: Michael Welsh [mike.hovenconsulting@tds.net]
Sent: Thursday, August 10, 2006 4:23 PM
To: Malszycki, Marcie
Subject: WAFP - Senate Health Care Reform Committee

Marcie:

The Wisconsin Academy of Family Physicians greatly appreciates the invitation to speak before the Senate Health Care Reform Committee -- and we will take you up on the offer.

The following WAFP members will be there to present our MA Reform Task Force Report:

- **Glenn Loomis, MD**
- **Alan David, MD**
- **Steve Wilhide (representative from American Academy of Family Physicians)**

Please let me know if you have any questions. Thanks again.

Michael Welsh
Government Affairs Specialist
Hoven Consulting, Inc.
44 E. Mifflin St, Suite 600
Madison, WI 53703

Office: (608) 310-8833
Fax: (608) 310-8834
mike.hovenconsulting@tds.net


WISCONSIN STATE LEGISLATURE


FORWARD

Malszycki, Marcie

From: WACEP@aol.com
Sent: Friday, August 11, 2006 1:39 PM
To: Malszycki, Marcie
Cc: prosey5@yahoo.com
Subject: Emergency Physicians - 8/28 hearing

3

Marcie,
Peggy Rosenzweig asked that I forward to you the names of the two physicians who will be representing the Wisconsin Chapter of the American College of Emergency Physicians at the hearing on August 28. Here they are:

1

Christine Duranceau, MD - President
She's a board certified emergency physician practicing at the Southwest Health Center in Platteville. I believe she's also the medical director for the EMS system there. I will verify that information as soon as she returns from a trip (probably Monday). I am not able to reach her until then.

2

Howard J. Croft, MD - Governmental Affairs Chair
Board certified in emergency medicine and the emergency department director at Columbia St. Mary's Hospital in Milwaukee.

We very likely will have a PowerPoint to go with the testimony. I will make sure we have a copy of the printout of the slides. I'm certainly glad to send you an advance copy if you want it... probably would be a day or two before the hearing.

Let me know if you need anything else.

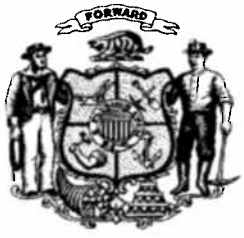
Rich Paul
Wisconsin ACEP
800/798-4911
WACEP@aol.com

Malszycki, Marcie

From: Brett, Allison
Sent: Friday, August 11, 2006 11:58 AM
To: Malszycki, Marcie
Subject: RE: Phone call

Peggy Rosenzweig called, representing emergency room physician. She did not have one of the names for the presenters of the meeting, and the woman from Platteville is Dr Christine Duranceau. She thought there may be a 3rd physician but he wont be there. There will only be 2 presenters you have the name of the other one. A man will email you materials you need prior to the meeting as well as the specific roles the physicians play. Her # is 414-975-8825 if you have further questions!

WISCONSIN STATE LEGISLATURE



Malszycki, Marcie

From: WACEP@aol.com
Sent: Monday, August 14, 2006 8:18 AM
To: Malszycki, Marcie
Cc: prosey5@yahoo.com
Subject: Fwd: Emergency Physicians - 8/28 hearing
Attachments: Emergency Physicians - 8/28 hearing

Marcie,
Here's a little update from Dr. Duranceau regarding her local affiliations . . .

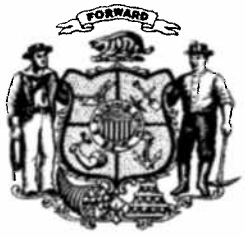
Rich,
I was the emergency medical director and the EMS Director for Platteville EMS for the last 6 years until this last August 1.
Christine

Rich Paul
Wisconsin ACEP

In a message dated 8/11/2006 1:39:07 PM Central Standard Time, WACEP writes:

> Marcie,
> Peggy Rosenzweig asked that I forward to you the names of the two physicians who will be representing the Wisconsin Chapter of the American College of Emergency Physicians at the hearing on August 28. Here they are:
>
> Christine Duranceau, MD - President
> She's a board certified emergency physician practicing at the Southwest Health Center in Platteville. I believe she's also the medical director for the EMS system there. I will verify that information as soon as she returns from a trip (probably Monday). I am not able to reach her until then.

WISCONSIN STATE LEGISLATURE



Hogan, Rebecca

From: Lipp, Elizabeth
Sent: Monday, August 14, 2006 10:08 AM
To: Hogan, Rebecca
Subject: Mike Shattucks info

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