Dear Mr. Kennedy,

My name is Dr. Stephen Anderson and I am a practicing emergency physician in the state of Washington and a member of the American College of Emergency Physicians (ACEP) Board of Directors. I was also one of the physicians who worked closely with our state representatives to come up with cost saving solutions that you highlight in your editorial and wanted to add some context to your comments.

The price of always being prepared in emergency medicine is not cheap. Orlando proved to us this week the price of not being prepared could have been deadly. That said, emergency medicine is proud to be responsible stewards of the health care dollar, while being there as society's safety net 24/7/365. So we in Washington State were particularly pleased to have been called out for an innovative approach to getting the right person, to the right place, at the right time. Thank you.

Your reference to the "ER is for Emergencies" program in Washington State began as a solution to an initial flawed policy proposal aimed at blocking access to care for our most vulnerable population. The landmark solution was a collaborative effort by the State Dept. of Health, the Washington State Hospital Association, and the American College of Emergency Physicians. It was titled the Washington State 7 Best Practices, and I was honored to have been a Co-author. Please allow me to state upfront:

This was not about blocking access; this was all about coordinating care.

The 7 Best Practices only succeeded because all parties, including patient advocates, agreed to it. All the aspects of the seven initiatives played into the success. Briefly those included:
1) An Emergency Department Information Exchange to alert providers of high risk/ high utilizers upon entry to the system.
2) An education effort for patients, providers, legislators & administrators.
3) Establishment of a robust Prescription Monitoring Program that was pushed to providers (instead of time intensive pull systems).
4) Identification of a subset of utilizers at highest risk/ greatest need, with a program to coordinate their care (ensure primary care and social service access).
5) Creation of care management plans for our super utilizers.
6) Adoption of guidelines for the treatment of chronic non-cancer pain in the emergency department.
7) Feedback systems to hospitals and emergency department directors around care metrics to stimulate and track success.

Please notice there is nothing mentioned about blocking access, or cutting costs. Everything was about increasing resources to control and coordinate care. As you

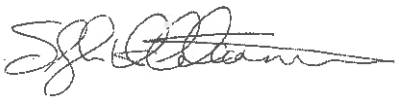
pointed out, it not only showed powerful success in many metrics, it saved the state of Washington $33 million the first year in the Medicaid population alone.

We have subsequently held several "boot camp training sessions" for states through the National Governor's Associations on how to reproduce this elsewhere. ACEP has also entered into an agreement this year to expand the Emergency Department Information Exchange system nationally.

We would be pleased to work with Louisiana to find successes that can benefit Hospitals, Legislatures, Providers & Patients. But we would ask you to remember:

Our patients don't need a moat in front of our emergency department, they need a back door at discharge that isn't revolving, and actually leads somewhere.

Sincerely interested in working with you,



Stephen H. Anderson MD, FACEP