

April 2007

PALMETTO STATE EPIC

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OF EMERGENCY PHYSICIANS

EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE



Emergency Medicine and Mental Health

*Stephen C. Stanfield, MD, FACEP
President*

When I was a medical student many years ago and dreamed of someday becoming a practicing emergency physician, I experienced what I now realize was tunnel vision. My vision was that I would be performing life saving procedures at the bedside of patients who were battling disease. I thought most of my time would be spent in the trauma bay performing resuscitations or in the cardiac room, snatching patients from the jaws of death with a Hollywood cardioversion.

Never in my wildest dreams did I imagine that, in 2007, the South Carolina College of Emergency Physicians would convene a meeting to discuss one of the biggest problems facing our specialty today - mental health!

The significant changes experienced by the mental health system in South Carolina over the past decade have affected emergency departments throughout the state. The Department of Mental Health, facing consecutive budget cuts in the 1990's followed the trend of many states and de-institutionalized the mental health care system. In theory this was a wonderful concept allowing for patients that otherwise would have spent most of their lives in a psychiatric hospital to live in a community where their mental health care needs would be addressed by a community mental health care worker. This system also made fiscal sense, since it would shift some financial burden from the state to the respective county budgets. This great plan was going to be the savior of mental health in South Carolina.

Undoubtedly some patients flourished in the community setting and contributed to society as a result of de-institutionalization. The reality of the situation, however, is that there are other patients who still need institutionalization on a short or longer-term basis to overcome the challenges of psychiatric illness.

After de-institutionalization, budget cuts continued to the point where our mental health care system has deteriorated and is barely recognizable. Long-term and even short-term beds have been shut down causing a backlog of patients waiting for

treatment. (Editorial note: In the 1970s and 1990s, this same process was tried in other states. All were dismal failures.)

As is common with most problems facing our society, the plight of the mentally ill has now manifested itself in the emergency department. Physicians from across the state contacted the chapter with stories of mental health patients held for days and even weeks in their emergency departments, while awaiting beds at a psychiatric facility. This boarding is so common at my institution that we have converted a waiting room into a holding area for mental health commitments. Boarding is not healthy for patients suffering from mental illness or patients with other pathologies who wait longer for ED beds to become available.

What is the solution?

On February 21, SCCEP members met with Dr. Ron Prier from the Department of Mental Health and David Almeida from the National Alliance on Mental Illness (NAMI) for an answer to this question. Emergency physicians from major teaching hospitals and small rural community hospitals, hospital administrators, state legislators, and social workers made up the remainder of the panel to contribute to the discussion.

Although many potential improvements were discussed, nobody ventured to pose a single solution to the problem. With an issue as complex as mental illness, which affects as much as 50% of the population at some point in life, there is never a simple solution.

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Our problems began with de-institutionalization; however, going back to the old system is clearly not in the best interest of patients. So, the answer is a multifaceted approach, which includes education of elected officials, physicians and the general public; improved communication and cooperation among community mental health centers and EDs; and increased funding to open more psychiatric beds and provide subsidies for hospitals that house a disproportionate number of mental health patients. Psychiatric disease is often exacerbated by substance abuse, so it is clear that the Department of Alcohol and Other Drug Abuse Services' (DAODAS) efforts to decrease alcohol and other substance abuse must continue.

Novel approaches such as having psychiatrists "round" on the mental health patients housed in the ED were also discussed. This approach, though it appears costly, allows for treatment to begin while patients are still in the ED and in some cases results in discharge or decertification of committed patients. Dr. Prier reported that there are also projects underway to provide "tele-psychiatry" to underserved areas of SC to potentially provide "psych rounds" in the ED.

Individual emergency departments must work in a constructive manner with their local community mental health agency to optimize care of this shared population of patients. As your representative organization, SCCEP can work with the Department of Mental Health and NAMI to increase education and awareness of the problem and support legislative efforts which favorably impact the care of the mentally ill in our state. In addition SCCEP has appointed a liaison to serve on "SC Partners in Crisis", an organization that advocates for responsible mental health and substance abuse services in South Carolina.

While this is by no means an answer to a very complex problem, I was pleased to witness the participation of emergency physicians and those involved in the care of mental health patients. It is obvious by the number of people in attendance that the care of mental health patients has become a significant challenge for hospitals and emergency departments alike. I encourage each of you to share your ideas about potential solutions and the ways that your department has overcome some of the problems faced by less than adequate mental health facilities.

ANNUAL MEETING - DINNER

Make your reservation now to attend the SCCEP Annual Meeting and/or Dinner. Monday, April 16th.

***Meeting - 2-5 pm at Historic Embassy Suites,
Meeting Street, Charleston SC***

***Dinner - 7 pm, McCrady's Restaurant, Charleston
SCCEP Members and 1 guest - Free
Contact Joy Zimmer - 800/241-2237
scccep@sc.rr.com***

Mental Health Department to Keep Money From Sale of State Hospital Campus

The SC Supreme Court ruled the state can sell the 178-acre State Hospital campus on Bull Street in Columbia, valued at \$12 - \$30 million and the Department of Mental Health will keep the money.

Mental health advocates see this as a major victory. "When SC started closing long-term hospital care for patients, we were promised the (savings) would be reinvested in mental health services," said Dave Almeida, executive director of the SC Chapter of the National Alliance on Mental Illness. "This is the last chance for the state to make good on that promise."

Two years ago, the governor wanted the proceeds of the land's sale to go to the state's general fund. The issue ended up before the Supreme Court when SC Attorney General Henry McMaster argued a "charitable trust" existed because the General Assembly in the 1800s dedicated the land to the treatment of the mentally ill and left the hospital's board of regents to manage it. The decision is at loggerheads with a 2005 directive by the General Assembly that 50% of the sale of surplus state property goes to the general fund for maintenance of other state property.

Developers can now build thousands of homes, offices and stores reshaping the city's core and transforming the economy. But it could take three years and tens of millions of dollars to move the remnants of the Mental Health Department's operation to other locations. Currently there are 60 children and 140 patients temporarily housed there.

ABEM Reassesses Link between LLSA and ConCert Examination

The ABEM Board of Directors recently decided to remove the link between previous Lifelong Learning Self-Assessment (LLSA) readings and the development of ConCert examinations as part of its Emergency Medicine Continuous Certification program.

When the EMCC program was first developed, ABEM created a strong link between the LLSA component and the ConCert examination. However, concerns developed that diplomates would be responsible for knowing the content of up to 400 specific articles when taking the ConCert examination.

In an effort to meet ABEM's goals and the needs of its diplomates more effectively, each of the ConCert examinations (beginning with the 2007 exam) will be developed without a necessary reliance on the identified readings, according to ABEM officials. However, information in the readings that is important to the practice of emergency medicine remains viable for testing, they added.

Government Affairs Report

Allison Harvey, MD, FACEP

On the National front, the ACEP sponsored “big kahuna” is the Access to Emergency Services Act (H.R. 882). The act would:

1. provide liability relief to physicians delivering EMTALA or post-stabilization care to the uninsured,
2. provide additional Medicare physician payments for patients treated in the ED,
3. collect data on boarded patients, and
4. establish a bi-partisan committee to examine barriers to emergency care, including liability, overcrowding, boarding, and lack of on-call specialists.

It was introduced last year with many co-sponsors, and has recently been re-introduced to the House, and soon to the Senate. Last year Sen DeMint sponsored the bill in the Senate. Please call him and encourage him to do the same this year! (202) 224-6121 in Washington, DC.

On the state level, all the talk is about a cigarette tax. Initially the outlook was rosy, with everyone predicting passage. Now there are almost 10 different bills floating around, each sending the money to a different place. We need someone to take the lead and push a bill through the house, but no legislators have stepped up. If you know one personally, please call them! SCCEP’s stand is **a cigarette tax will reduce smoking and improve health, we don’t care where the money goes!**

The SCMA has been working with Judge Toal to come up with suitable language to regulate out-of-state expert witnesses. Last year she struck down, as unconstitutional, a regulation by the Board of Medical Examiners which would have required experts to get SC licenses. When the language is available, a bill will be introduced to codify the new regulation. In the meantime, Rep Murrell Smith (attorney) from Sumter has introduced a bill (H. 3378) that would undermine these efforts by specifically stating that expert witness testimony is not the practice of medicine. We have asked our lobbyist (Ted Riley) and the SCMA to strongly oppose this effort.

Rep. Fletcher Smith (attorney) from Greenville has introduced a bill (H. 3532) that would require informed written consent before any invasive procedure is informed. Apparently, this lawyer doesn’t make it to the ED very often, because many of our patients would die waiting on written consent. What exactly does he consider invasive anyway? Are IV’s, rectal exams and pelvic exams invasive? Needless to say, we have asked Mr. Riley to work against this one as well!

There are many more interesting bills floating around, but these are the highlights. If you have a keen interest in these matters, feel free to join the SCCEP Government Affairs Committee. Please stay involved, call your legislator, donate money to good legislators (pay for performance), and keep up the good work.

HHS OIG Work Plans Include EMPs

Annually the Office of the Inspector General (OIG) investigates to see if Medicare funds are used appropriately. In 2002, EDs and EMPs were under scrutiny for procedure coding of services billed by both the hospital and physician; payment for physician services in teaching hospitals; physician evaluation and management service codes (E&M); and the use of staffing companies and EMPs in relation to reassignment rules. Each year the OIG has added new reviews to their previous ones.

In 2004, they focused on identifying physicians with aberrant coding patterns, high volumes of high-level E&M codes; accuracy of place of service codes; and prescribing patterns for drugs, including OxyContin, Oxycodone, Hydrocodone, Xanax, Diazepam, and Soma.

In 2005, the OIG added reviews of the use of modifier –25 and of physician relations with billing companies to determine the impact on physician billings; and they continued to review, negotiate, settle, and litigate EMTALA violations.

In 2006, the OIG again focused on billing company – physician relations and expanded their interest into emergency health services furnished to undocumented aliens.

Additional areas of interest in 2007 include payments made under Medicaid waivers for Hurricane Katrina evacuees and payments for interpretation of ED x-rays to determine whether the services were medically necessary and if the tests were interpreted contemporaneously with treatment.

Although most OIG Work Plans and Reports do not apply to us, it is important to be aware that big brother is watching. OIG Work Plans and Reports can be found at: <http://oig.hhs.gov>

SCCEP LLSA REVIEW COURSE

Now Covering 2006 and 2007

April 16-17, 2007

*Historic Embassy Suites
Meeting Street, Charleston, SC*

2007 Review

April 16 - 0800 to 1400

April 17 - 0800 to 1245

2006 Review

April 17 - 1330 - 1830

For more information go to:

www.sceep.org/llsa

“Diagnosis Present on Admission”

Requirement – Part I

By *Pamela P. Bensen, MD, MS, FACEP*

Have you heard of POA? Do you know what POA is? Do you care what POA is? Should you care what POA is?

All claims involving inpatient admissions to hospitals subject to a new regulation mandating collection of present on admission (POA) information MUST indicate what conditions were present on admission. When does this affect you and your hospital?

According to Medicare, “A joint effort between the physician and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. Documentation from any physician involved in the care and treatment of the patient supports the determination of whether a condition was present on admission or not.” Nurses notes and lab results cannot be used as evidence in the absence of physician documentation.

Present on admission is defined as present at the time the order for inpatient admission occurs, so conditions developing during an emergency department visit or observation (both classified as outpatient visits) are considered present on admission.

Based upon your documentation, a coder, a non-physician, in your hospital is going to report:

1. Conditions you explicitly document as being present on admission,
2. Conditions diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma),
3. Conditions diagnosed during the admission clearly present but not diagnosed until after admission,
4. Diagnoses confirmed after admission, if at admission they are documented as ‘suspected’, ‘possible’, ‘rule out’, ‘differential diagnosis’, or constitute an underlying cause of a symptom present at the time of admission,
5. Conditions that develop during an outpatient encounter prior to a written order for admission,

When documentation is unclear, coders are encouraged to query physicians whether the condition was present on admission.

Although there is a list of conditions exempt from the POA rule (e.g., late effects of infectious diseases, normal delivery, personal or family history of malignant neoplasm, psychosocial circumstances), it is not practical to memorize the list. It is easier to document all medical conditions present in the ED (e.g., possible MI, atrial fib-flutter [list both if you think both are present], tachycardia, COPD, ‘uncontrolled’ DM, hyperglycemia, hypokalemia, anemia).

Complete documentation of every condition present when you see the patient will help the hospital code correctly with a minimum of effort and prevent ‘dinging’ of the hospital for supposed development of the condition after admission. The higher the proportion of conditions listed on the discharge

summary which are supported by a POA code, the better the hospital looks to the agencies analyzing the POA data.

Help your hospital by making a complete diagnosis list, including differential diagnoses. This comprehensive list also supports a higher level of medical decision making for the EMPE&M code, which could improve emergency physician reimbursement.

Continued next issue

Palmetto Poison Center Receives AAPCC Certification

The Palmetto Poison Center (PPC) at the Univ. of South Carolina’s College of Pharmacy has received national certification from the American Association of Poison Control Centers.

The certification, which has been awarded to 58 poison control centers throughout the nation, recognizes centers that provide poison control services 24 hrs-a-day, 7 days-a-week by healthcare professionals, including pharmacists and nurses, who are formally trained in toxicology as certified specialists in poison information. Centers must provide education to the public and healthcare professionals in the states they serve. Certification also requires centers to have a medical director who is a board-certified physician in medical toxicology and a managing director board certified in applied toxicology.

Dr. William Richardson is the medical director for the Palmetto Poison Center, and Dr. Jill Michels is the managing director. Only certified centers are eligible for federal Health and Human Services HRSA Poison Control Program grants.

The Palmetto Poison Center provides information on exposure to poisonous materials for the general public and healthcare professionals. Calls range from accidental and intentional ingestion of poisonous substances or medications to adverse drug effects, occupational exposures, envenomations, and biochemical disasters. Over 50% of calls involve exposures in pediatric patients below 6 years of age.

In 2005, the PPC received approximately 38,000 calls from around the state. 77% of these poison-exposure calls handled by the center were able to be treated with first aid at home, work, or school without having to refer patients to a healthcare facility.

A recent USC study found that for every dollar spent on the Poison Center, more than \$7 were saved in unnecessary healthcare costs, including emergency room and physician visits, ambulance services, and unnecessary medical treatments. Additional savings occur when indirect costs are taken into account. These include assisting health professionals in optimally managing poisoned patients, decreasing hospital stays, poison prevention education, real-time data analysis to identify poisoning clusters, and providing the general public free, around-the-clock access to certified poison information specialists.

The Palmetto Poison Center is proud to serve the entire state of South Carolina. Call 1-800-222-1222 for information regarding poison prevention and treatment of exposures.

Musings During A Night Shift

by N. John Stewart, MD

Deep in thought during a brief moment of solitude, I could not help but wonder how my career had taken such a tumultuous turn. I, like everyone, had ideas of how my life would or should progress. Now, here I sit watching what we used to call a “drunk” meander through the ED shouting obscenities at the staff. Naturally, in these modern times, we refer to such unfortunate individuals as those who have succumbed to an addiction and as such are psychiatrically impaired.

“What has happened to medicine?” I thought. During my formative years I like most had a hero. Many would speculate that being a doctor, I would have chosen Marcus Welby, Doctor Kildare, Doctor Zorba or Dr. Ben Casey. Well actually, I did choose a doctor hero because as long as I can remember I wanted to practice medicine. But MY hero was Doc Adams - no, not Patch Adams, but Doc Galen Adams on Gunsmoke.

As I sat there sometime around 2:30 a.m. I asked myself how Doc Adams would handle such a situation. You see, Doc Adams was the perfect physician for his time. Practicing medicine in the old west without the use of technology, he helped everyone. Just think, Matt Dillon must have been shot at least fifty times and I watched Doc patch him up every time. I also learned how to treat scurvy on one episode. What a great guy!

No one knows how Doc ended up in Dodge, but there he was with his shingle hanging in front of his upstairs office. I could only speculate that this was also his apartment because he always seemed to be there.

Riding his horse and buggy, Doc could cover what appeared to be most of the West. And, one thing always fascinated me — regardless of his practice he always had time to eat and drink with his close friends, Matt, Chester, Festus, Newly and Ms. Kitty. This is intriguing because he never seemed to charge for his services. Just how was he able to survive without Medicare and Medicaid?

I was suddenly startled back to reality when my intoxicated patient fell to the floor. Interrupting my pensive reminisces, I felt obligated to help him back to his bed. Fortunately or maybe naturally, he was not injured. Later that night, after receiving several additional patients, many with two-carbon altered mental status, I returned to my thoughts. You see, most of these intoxicated patients are sent to the ED by the police and this really began to trouble me. Doc Adams could offer me no help with this situation for he never faced this quagmire. His friend Matt Dillon, US Marshall, always put “drunks” in jail and never involved Doc. Why had medicine changed so drastically? Why don’t the police arrest these people for being drunk and disorderly? Then it hit me! Of course! Doc Adams chose to practice in Dodge City because the whole town seemed devoid of attorneys — Matt Dillon could arrest a person without fear of legal reprisal.

It’s 7 a.m. now and time to leave. My intoxicated patient is sober enough to discharge. No, no psychiatrist will see him or get him over his addiction. There is no place at the State Hospital to help him. Detox says he has exhausted his welcome. He will return to the street only to be seen again. What a night! Is medicine as much fun as it used to be? Is it me? Or do all physicians feel the same stress?

Oh well, I sure hope a Gunsmoke rerun comes on today!

American College of Emergency Physicians Section of Careers in Emergency Medicine

Call for Essays for Longevity and Tenure Awards

We want to recognize longevity in the practice of emergency medicine!

The ACEP Section of Careers in Emergency Medicine is soliciting nominations for an award for emergency physicians in the following two categories:

- A Longevity Award for the physician with the longest active career in emergency medicine.
- A Tenure Award for the physician with the longest active career in the same emergency department.

Recognition is also given to those physicians who are still actively practicing emergency medicine after 20, 25, 30, and 35 years.

Eligibility Criteria

To be eligible, you must have worked an average of 1,000 or more hours per year in emergency medicine practice or teaching; hours for residency training and administration are not included. You must be a current ACEP member. Previous recipients are eligible again after five years.

Nomination Information

Please submit a full historical sketch (eg, Attending Emergency Physician, June 1974 to December 1979) accounting for your career, and a brief essay (300 words or less) about why you have made emergency medicine your career.

Award recipients will be recognized during the Section meeting at the 2007 ACEP Scientific Assembly in Seattle, Washington (October 8–11). Additional recognition will be given in the Section newsletter.

To be considered for the awards, nominations must be received by Monday, July 9, 2007. Submit your application for nomination to Tracy Napper, Section of Careers in Emergency Medicine, ACEP, PO Box 619911, Dallas, TX 75261-9911; fax 972-580-2816; e-mail to careers.section@acep.org.

ER HAIKU

by K. Edwin Leap, II, MD, FACEP

I am a long-time poetry lover. I first loved poetry when my grandmother taught me to read it years ago. I am also an amateur student of Asian culture and martial arts. I have read a bit about haiku, and you'll recall from elementary school (where teaching haiku is standard) that it is based on a pattern in which the first line has five syllables, the second seven and the third five. Historically, not all conformed to that. However, most had some rich allusion to nature, especially things like the moon or the cherry blossoms in spring. Haiku writers often seemed to allude to the transitory nature of life. If only the great masters had worked in a modern emergency department. Ah, what rich poems we would have! These are my homage to life in the ER, and to the poets I poorly honor with my own haiku.

Lortab is for pain
It is not a vitamin
You need every day!

My ears are bleeding
Your ceaseless talk like a pin
In my tympana.

I'll stitch the drunk's eye.
You stay home and rest on call;
Why should you come in?

Some words are scary;
Joint Commission and lawyer.
Black magic for sure!

The pear trees' white bloom
Will not enlighten my soul.
Nor will drunks tonight.

The night falls around;
The stars are bright gems above.
Where is the coffee?

It is not a ten;
It is not even a one.
Let me show you ten!

Is it hard to breath?
Long-haired cats and cigarettes
Do not replace air!

Schizophrenic folks
Live here for days or for months.
(I see monsters too!)

Disability!
Like reaching enlightenment!
With a check thrown in...

One day I'll retire
And be a snow-plow driver.
I'm tired of thinking!

Customer service;
We will be just like Wal Mart!
But people pay there!

Your tooth hurts badly.
You have no money for care!
Your camera phone is nice...

You could be pregnant?
Goodness, did you take a test?
Let's do one for free!

DOCUMENTATION PEARLS (From ACEP)

Physical Exam (PE) Requirements

Examine the Exam! All ED patients must be examined to be coded and billed. According to Medicare Documentation Guidelines a minimum of one body part is required for even the lowest ED E/M code 99281. A 99284 PE typically *requires five to seven body areas or organ systems, while a 99285 requires eight organ systems to be examined. Only organ systems may be used to satisfy the requirements for 99285.

*see ACEP FAQ on Evaluation and Management (E/M) Documentation Requirements

The Level 5 Caveat

The definition of 99285 includes the concept that the History, Physical Exam, and Medical Decision Making requirements must be met "within the constraints imposed by the urgency of the patient's clinical condition and/or mental status". Most Medicare carriers require a description of the patient's urgent condition and the physician's thought process. So make sure to document why the severity of your patient's illness precludes performing a full History or Exam.

Laceration Repair

These high RVU procedures are categorized as Simple, Intermediate, or Complex. Remember that not all single layer repairs are automatically considered simple. If the wound is heavily contaminated and requires "extensive cleaning or removal of particulate matter" a one layer repair may be reported as Intermediate.

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newsletter of the South Carolina College of
Emergency Physicians

Editor: Joy Zimmer

Medical Editor: Pamela Bensen, MD,MS, FACEP

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WELCOME NEW MEMBERS AND TRANSFERS

Following is a list of new members and transfers who have
joined the chapter since the last EPIC was published. We
welcome them to South Carolina and SCCEP.

Anthony L. Bostick, MD - Tega Cay

Jarod Fox - Student, MUSC

Milli Gist - Student, MUSC

Ashley L. Kuklantz - Student, MUSC

Anna S. Shalkham, MD - Lexington

Boris Shkylar, DO - Murrells Inlet

Mary O. Titus-Dalu, MD - Charleston

Heather L. Wilkinson, DO - Hilton Head

On Your Mark. Get Set. Go!

Last year South Carolina College of Emergency Physicians
tied for second place in the ACEP Membership Challenge,
small chapter division. Let's be first this year!

It's time to start working toward this year's ACEP Chapter
Membership Challenge - 207 in 2007! The Challenge started
March 1, and runs through June 30, 2007.

Our chapter has a chance to win a \$5,000 prize in the small
chapter category, based on the number of new active or
cancelled (for 12 months) members we sign up.

This year, every chapter that recruits at least 5 new members
will be entered into a drawing for one of three 2007 Scientific
Assembly full conference registrations. We can use the
prize to reward our top recruiter. We will have specially
designed t-shirts to recognize our top volunteers. All volunteers
will receive Certificates of Appreciation.

More importantly, we will swell the ranks of our members so
we can accomplish more.

Please send me the name, email, and phone number of every
emergency physician in your department who is not an
ACEP member, even if you or they think they cannot become
a member. I will contact the physicians to verify their
eligibility, based on the 2005 ACEP Council membership
criteria. pamben@alum.dartmouth.org

*Thanks for your help,
Pam Bensen, Membership Chair*

SCCEP CALENDAR OF EVENTS

SCCEP ANNUAL MEETING

Monday, April 16, 2007 - 2pm - 5pm
Historic Embassy Suites, Meeting Street, Charleston, SC

SCCEP ANNUAL DINNER

7 pm - Monday, April 16, 2007
McCrary's Restaurant, Charleston, SC
(To make a reservation for Annual Dinner contact Joy Zimmer - 800/241-2237)

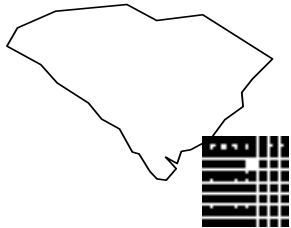


LLSA COURSE

April 16-17, 2007
Historic Embassy Suites, Meeting Street, Charleston, SC
Register online at: www.sccep.org/llsa
or call Joy Zimmer at 800/241-2237

SCCEP EMERGENCY ULTRASOUND COURSES

For dates and locations - www.emergencyultrasound.com



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