

August 2007

PALMETTO STATE EPIC

PUBLISHED BY THE
SOUTH CAROLINA COLLEGE
OF EMERGENCY PHYSICIANS

EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE



Growth and Perseverance

"Failure is the path of least persistence"
author unknown

Randy L. Reinhardt, MD, FACEP
President

300!!! - No, not my last bowling score but a strike for our chapter...more on this later.

As we transition into the Fall, let me say what an honor and pleasure it is to serve as president for the SCCEP. My predecessors have certainly made our chapter an organization of which we can be very proud. For the last eighteen months, Dr. Steve Stanfield has done a wonderful job as president moving us in a positive direction, one I plan to continue. His efforts are to be applauded; his example to be followed.

Before I get to the goals for this year of growth, I would like to reflect on "what the college has done for you". I cannot tell you how many times I have heard emergency physicians ask, "Why should I join ACEP and SCCEP?" Well...as a member you are contributing to the "voice of emergency medicine". The chapter battles on your behalf for legislation that affects emergency medicine, not only on the local level but also the state and national level. "Failure is the path of least persistence" but this chapter has always represented persistence.

One of the most important things we do each year on the state level is to send chapter leaders to Washington DC to attend the ACEP Legislative and Leadership Conference. These leaders meet with SC Representatives and Senators to raise their awareness of, and educate them about, emergency medicine issues crucial to the health care of the citizens of South Carolina.

We were very successful, not only as a state chapter, but also as a national voice this year. The "Access to Emergency Medical Services Act 2007 (S1003/HR882)" was the main focus of our crusade. To date we have 67 co-sponsors in the House of Representatives and a total of 7 Senators sponsoring this crucial bill for us. Rep. Joe Wilson from the 2nd district of our state has signed on.

This bill, a moderate version of the 2006 bill co-sponsored by Senator DeMint, provides liability relief to physicians delivering EMTALA care, an incentive for our consultants and a tremendous help for emergency medicine. (Are any of you having a problem

retaining consultants?) The bill also provides a 10% increase in reimbursement for EMTALA care under Medicare part B and an incentive reward to hospitals for the rapid movement of admitted-ED-boarded patients to the floor.

What else has ACEP done?? **HEADLINE...** Medicare Physician Fee Schedule Draft Contains SGR Cuts for 2008. In addition to the scheduled 9.9% cut in the Medicare physician fee schedule due to take effect in January, 2008, CMS has just announced a reduction in emergency medicine practice expense for two of the 4-year phase-ins of new practice expense methodology. When combined with other adjustments necessary to achieve budget neutrality, these reductions will result in cuts close to 12% for emergency medicine.

ACEP has successfully fought similar cuts over the last nine years and is working with key policy makers on Capitol Hill to develop a legislative proposal to avert these cuts for the next several years. This would allow Congress time to develop a comprehensive SGR fix. In the coming months, as we lobby Congress to block these reimbursement cuts, all of our voices will be needed.

On the state level we are very fortunate to have a superb lobbyist, Mr. Ted Riley, who works diligently on our behalf at the state house. Ted is a wonderful advocate for our chapter, keeping us up to date on current state legislation like the absurd "informed consent" bill (SCH3532), which requires "informed consent before **any** invasive procedure is performed". (Imagine asking trauma patients to sign numerous forms just so you can try to save their lives). This and many other bills are monitored by Mr. Riley,

Continued on Page 2.....

Inside:

- 2 President's Message continued.....
- FYI - Notes of Interest
- 3 Diagnosis Present on Admission - Part II
- In Memoriam - Richard L. Alexander, MD, FACEP
- 4 Case Report - Exotic Snake Bite in SC
- 5 Case Report Continued
- Cocoa May Reduce Blood Pressure
- 6-7 SC Medical Malpractice Update & Information
- 8 JCHAO Reinstates 1st Dose Review
- 9 ACEP Report on Federal Medicare Bills
- 10 Bull Street Project Just Plodding Along (The State)
- 11 Board/Council/Liaison Roster
- Welcome New SCCEP Members!
- 12 SCCEP Calendar

President's Message continued from Page 1

who notifies us when the chapter needs to take action to affect legislation.

We are very active in EMS. Earlier this year I represented the chapter at the SC-EMS symposium in Myrtle Beach by lecturing and attending sessions of interest.

Our chapter continues its tradition of educational excellence by sponsoring a nationally-recognized Oral Board Course as well as a world-reknowned Emergency Ultrasound Course. We also sponsor an annual LLSA course, which continues to grow. Any emergency physicians needing to take the LLSA to complete their requirements for ABEM can catch up on multiple years at this friendly, fun, and informative conference. This year, as in the past, the LLSA conference was held in conjunction with the SCCEP Annual Meeting and Dinner held in Charleston.

At the Annual Meeting we elected new board members and officers from around the state. I live in Greenwood; our president elect Dr. Peter Hyman resides in Florence; our treasurer Dr. Tripp Jennings resides in Columbia; and our secretary Dr. Jorgé Infante is from Marion. So, as you can see, following Dr. Steve Stanfield's vision, we continue to grow and reach out to emergency physicians from around the state to share our ideas on emergency medicine.

At the Annual Dinner, SCCEP Awards were handed out. The *Jack Niles Leadership Award* was presented to Dr. Steve Stanfield and the *Jack Warren Emergency Physician of the Year Award* was presented to Dr. John Stewart.

I am proud to report that the state now houses two emergency medicine residencies. The Palmetto Health Richland residency under the direction of Drs. John Stewart and Thomas Cook and the brand new Medical University of South Carolina residency under the direction of Drs. Larry Raney and Sam Kini. I am confident that these outstanding facilities will continue to supply South Carolina with well trained emergency physicians further strengthening our state. I look forward to visiting both residencies this year.

Now, about the future and growth: my first goal was to reach the 300 member mark. As of this writing we have exceeded this goal. If we can maintain this number through the end of the year (# of councilors allotted is according to membership number on December 31st of each year) we will qualify for a fourth councilor at the 2008 ACEP Scientific Assembly Council Meeting. We will also be officially considered a medium size ACEP chapter. We must carry this momentum through 2007 - let us try to recruit every non-ACEP emergency physician in the state.

(Editor's note: If an emergency physician started practice prior to 2000, s/he is eligible for ACEP membership even if not boarded in emergency medicine.)

We did not win the National ACEP membership competition with its fiscal prize; however, Dr. Stanfield's membership

challenge is a great activity for the chapter to continue. Essentially under this program, if your department has 100% ACEP membership, the physicians qualify for certain SCCEP discounts.

Another goal is to memorialize Don Gregg through the chapter. Although, I did not know Dr. Gregg well, I met him at conferences and discovered a compassionate, gentle man. Dr. Gregg was awarded a SC EMS Lifetime Achievement Award for his never



Don Gregg, MD, FACEP

ending contributions to EMS, yet he was also known for simple acts of kindness, like driving ED patients home. He worked in the Greenville system for over 25 years and made emergency medicine his life. For this commitment I believe he should be memorialized by a "Don Gregg" chapter award presented annually to a resident who excels or makes a significant contribution to emergency medicine.

Next, we must continue to improve communication with each other. I support the EPIC and ask every one of you out there to contribute an article, idea, or quote at least once this year. We will consider holding quarterly regional meetings throughout the state, if you are interested; please let me know. By visiting the residencies and encouraging young physicians to get involved with the board we can continue to grow and expand the chapter's interests to better reflect evolving ideas and young physicians' needs.

ACEP members are always welcome to attend our board meetings, join a committee, or send us ideas. And we encourage you to bring a non-ACEP emergency physician with you to the courses and meetings. I look forward to this year and encourage everyone to reach out even if it's only by attending a single board meeting. We need every one of you to continue all of this work. Please check our website at www.sceep.org for upcoming events.

I am proud of my colleagues who support this chapter. With perseverance we can continue to make our chapter grow in stature and numbers! Please join if you are not a member, I promise you will be helping not only yourself but our specialty as a whole.

KUDOS to all my fellow board members and Joy Zimmer for all you do. Working together we can improve emergency medicine in South Carolina.

Finally, remember the Scientific Assembly in Seattle, Washington this year. October 8-11, 2007.

I wish you all the best in your lives and careers. Give your chapter a chance by joining, supporting and persevering with us!

Sincerely,

Randy Reinhardt MD FACEP

“Diagnosis Present on Admission”

Requirement – Part II

Pamela P. Bensen, MD, MS, FACEP

In the last EPIC, I gave you an overview of the new regulation mandating collection of present on admission (POA) information. Chances are you have now encountered the issue in your own institution and have been asked to document all conditions present on admission.

What follows is a brief discussion of examples of the types of information the hospital is looking for to support POA coding. 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.

For infection codes that include the causal organism, if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with [documented by you] pneumonia and the attending documents pseudomonas as the causal organism a few days later) the code for the organism causing the pneumonia may be used.

Any injury or poisoning documented by you to have occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission) is POA. An injury or poisoning that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission) is clearly not.

Although the above examples seem clear cut, the following will be coding nightmares for coders and physicians alike. But, your use of the correct terminology can clarify the issue.

1. The term ‘uncontrolled’ is used in coding terminology to represent diabetes ‘out of control’ or with hyperglycemia.

A diabetic patient with a blood sugar of 200 in the ED, was documented to have ‘DM’ at admission and, per the attending note, developed ‘uncontrolled’ diabetes on day 3 of the hospitalization. The coder determined the patient did not have ‘uncontrolled diabetes’ at admission. So, by implication, the physicians neglected to control the patient’s sugar.

The same diabetic patient with a blood sugar of 200 in the ED, documented by the EMP to have ‘uncontrolled DM’ at admission would have had ‘uncontrolled diabetes’ at admission.

2. A patient is admitted with high fever and pneumonia. The patient rapidly deteriorates and becomes septic. The discharge diagnosis lists sepsis and pneumonia. The documentation is unclear as to whether the sepsis was present on admission or developed shortly after admission.

Had the EMP suspected sepsis and documented ‘pneumonia, possible sepsis’, the admitting information would have supported the POA code.

3. An elderly patient clearly in pain is admitted for ‘repair of an abdominal aneurysm’. However, the aneurysm ruptures after the clerk has processed the hospital admission.

Had the EMP suspected and documented ‘abdominal aneurysm, probably dissecting (rupturing)’, again the ED admitting information would have supported the POA code.

4. An obtunded ED patient with viral hepatitis B progresses to hepatic coma after admission.

Had the EMP suspected and documented ‘viral hepatitis B, altered mental status, probable impending coma’, this would have supported the POA code.

Emergency physicians can make a major difference and provide a value added service to their hospitals by remembering to document all conditions present in the ED (POA), to use the correct coding terminology (uncontrolled), and to apply adjectives and phrases (probable, possible, suspected...) to indicate the seriousness of the condition.....(Continued in next issue)

In Memoriam

Richard L. Alexander, MD, FACEP
Emergency Physician, Colleague, Friend
1954 - 2007



Richard Lynn Alexander, MD, FACEP, age 52, died Sunday, April 22, 2007, at Tuomey Regional Medical Center from complications of multiple myeloma.

He is survived by his wife Jackie, daughter Michelle and her husband Jimmy, and granddaughter Amber.

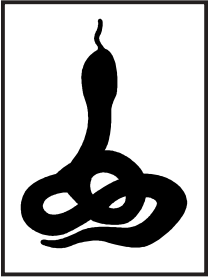
A SCCEP member since 1999, Dr. Alexander served as an attending physician at Tuomey Regional Medical Center. According to partner Dr. Scott Dilts, "Richard was a rather gregarious individual who had a knack for being able to quickly connect with his patients. He was a strong patient advocate and was well liked by both patients and colleagues. He loved to practice medicine, and when forced to retire from clinical practice because of his illness he continued to work as a medical consultant for the local newspaper and did some research for brokerage firms reviewing biotech stocks. His passionate past-times were traveling and ball-room dancing with his wife."

Case Report of an Exotic Snake Envenomation in South Carolina

by William H. Richardson, MD , Medical Director, Palmetto Poison Center

Attending Physician, Palmetto Health Richland Department of Emergency Medicine

Eric T. Elliott, MD, Resident Physician, Palmetto Health Richland Department of Emergency Medicine



A 21-year-old Caucasian male was bitten on the volar surface of his right mid-forearm by an African Puff Adder (*Bitis arietans*) at approximately 8:00am. The patient stated the snake was a pet that he had obtained from another amateur herpetologist when he traded his nonvenomous python for the poisonous puff adder. After arriving at a rural South Carolina emergency department, the treating emergency physician contacted the Palmetto Poison Center.

The patient initially presented to the emergency department with a phone cord wrapped around his proximal right arm resulting in a significant cyanotic appearance to his distal arm. There was moderate pain at the bite site with two visible fang puncture marks and swelling in the forearm. Vital signs included blood pressure 136/88, pulse 104, and oxygen saturation 99% on room air with a respiratory rate of 20. The phone cord was removed, the extremity was elevated, and morphine was administered for pain control. Initial pertinent available laboratory results included: WBC 13.5, Hgb 17, Hct 48.8, platelets 230, and fibrinogen 320.

Following consultation with the Palmetto Poison Center, arrangements were coordinated for transportation of the patient to Palmetto Health Richland medical intensive care unit (MICU), and species-specific antivenom for this exotic snake envenomation was available at Riverbanks Zoo in Columbia, South Carolina. A Riverbanks Zoo herpetologist was contacted regarding the case and had 30 vials of South African Institute for Medical Research polyvalent antivenom (SAIMR) available. The antivenom was delivered to the receiving hospital, and the patient was transferred by ambulance to the intensive care unit.

On arrival to the MICU, the patient had edema proximally to the right shoulder and distally beyond the bite site to the wrist. Pain extended to the axilla with some soreness described in the right upper chest wall. There was erythema surrounding the bite site with a small amount of dried serosanguineous fluid. Ecchymosis was present in the mid-forearm. The patient was pretreated with diphenhydramine 50 mg and methylprednisolone 125 mg intravenously as a precaution prior to antivenom administration. The patient reported receiving crotaline Fab antivenom (CroFab) one year ago for a canebrake rattlesnake envenomation to his left hand but did not experience adverse effects or any anaphylactic symptoms at that time. Labs drawn immediately prior to SAIMR antivenom administration included platelet count 233K, INR 1.3, and fibrinogen 226. Five vials of SAIMR antivenom were administered over sixty minutes without signs of allergic reaction, and this initial dose was begun approximately four hours from the time of the initial bite. Following antivenom administration, a repeat INR was 1.3, fibrinogen 205, and platelet count was 202K. More swelling and fullness in the forearm and proximal arm were noted so five additional vials of antivenom were administered. This seemed to slow the progression of swelling, fibrinogen increased to 252, INR decreased to 1.2, and the platelet count increased to 210K. Approximately six hours following the second dose of antivenom, more swelling seemed to develop in the right shoulder and more ecchymosis was noted in the arm. Subsequently, 5 more vials of SAIMR antivenom were administered. This stopped the progression of swelling, and pain was well controlled. Repeat laboratory results were platelet count 212K, INR 1.2, and fibrinogen 248. Creatinine phosphokinase (CPK) peaked at 161. The patient was transferred to a regular floor hospital bed the following day and eventually left the hospital against medical advice at 10:30pm on hospital day #2.

For exotic snakebites, persuading the patient to stay in the hospital long enough to be treated is often a practical problem.¹ This patient was ultimately contacted by telephone by the Palmetto Poison Center seven days from the date he left the hospital at which time he stated the swelling and pain were mostly resolved and all that remained were two visible healing fang marks surrounded by a small area of bruising. Telephone follow-up two days later suggested continued improvement.

The Puff Adder (*Bitis arietans*) is considered by many to be Africa's most dangerous snake because of its large size, potent venom injected deeply by long fangs, striking speed, and willingness to bite.² With a thick body and an average length of one meter, this species is found in most of sub-Saharan Africa and is responsible for more fatalities than any other African snake.³ Data on the actual number of snakebites in Africa is difficult to collect, but fragmentary evidence suggests that over a million envenomations occur each year, with thousands of deaths.⁴ The American Association of Poison Control Centers' National Poisoning and Exposure Database reported 98 cases of exotic poisonous snake envenomations in the United States in 2005. Forty-five of these cases were described as moderate to major outcomes, but no deaths were reported.⁵ It is also suspected that significant under-reporting may occur in these cases.

African puff adder envenomations can cause severe local and systemic symptoms. Local effects may include severe pain, ecchymosis, edema, hemorrhagic bullae, and necrosis. Hemolysis and coagulopathy also commonly occur. Systemic effects include

continued on Page 5.....

nausea, generalized weakness, hypotension, and rarely shock. Neurological effects are not seen with African puff adder envenomations. Treatment options include opioid analgesics, anxiolytics, slight elevation and immobilization of the affected extremity, tetanus immunization, routine supportive care, and antivenom administration. Frequent laboratory data should be obtained to monitor for development of thrombocytopenia or coagulopathy. Antivenom should be administered if there is rapidly expanding swelling, worsening coagulopathy or thrombocytopenia, or any signs of swelling that could cause airway compromise. Fasciotomy should not be considered unless there are obvious signs of compartment syndrome with significantly elevated compartment pressures despite aggressive antivenom treatment, pain control, and extremity elevation. Other historically relevant treatments may be contraindicated. A tourniquet should never be applied as it may worsen edema. Prophylactic fasciotomies are inappropriate, and antibiotics are not indicated unless there is extensive bite site necrosis or evidence of infection.^{6,7,8} Surgical debridement of bullae or necrotic tissue may be required, most commonly a few days following the envenomation.

The South African Institute for Medical Research polyvalent antivenom, manufactured using the venom of eleven venomous snake species, can be effective against the venoms of the puff adder, the Gaboon viper, the green and black mamba, and several cobras in Southern and Central Africa. Reported adverse reactions include serum sickness, usually 10 to 14 days following antivenom administration, and acute anaphylaxis, which is rare. Patients receiving antivenom should be admitted to a monitored bed and observed closely.⁹

The most effective approach for obtaining exotic antivenoms is via zoos or antivenom banks as most hospitals are unlikely to stock these products. An on-line Antivenom Index has been established by a joint project of the American Association of Poison Control Centers (AAPCC) and the American Zoo and Aquarium Association (AZA). Your regional poison control center has access to this index and can help determine the appropriate antivenom treatment for any exotic envenomation, identify zoos with up-to-date available supplies of the antivenom, and provide instructions for timely procurement of the product.

1. Warrell DA. Treatment of bites by adders and exotic venomous snakes. *BMJ* 2005;331:1244-7.
2. Mallow D, Ludwig D, Nilson G. True Vipers. In: *Natural History and Toxinology of Old World Vipers*. Malabar, Florida: Krieger Publishing Company;2003:359.
3. Spawls S, Howell K, Drewes R, Ashe J. *A Field Guide To The Reptiles Of East Africa*. London: A & C Black Publishers Ltd.;2004:543.
4. Chippaux JP. Snake-bites: Appraisal of the global situation. *Bulletin of the World Health Organization* 1998;76:515-524.
5. Lai MW, Klein-Schwartz W, Rodgers GC, et al. 2005 Annual Report of the American Association of Poison Control Centers' National Poisoning and Exposure Database. *Clin Toxicol* 2006;44:803-933.
6. Blaylock RS. The identification and syndromic management of snakebite in South Africa. *SA Fam Pract* 2005;47:48-53.
7. Blaylock RS. Antibiotic use and infection in snakebite victims. *S Afr Med J* 1999;89:874-6.
8. Nordt SP, Clark RF. Rattlesnakes and other crotalids. In: Ford MD, ed. *Clinical Toxicology*. 1st ed. W.B. Saunders Co.; 2001:Chapter 109. Available from MDCConsult. Accessed May 7, 2007.
9. The South African Institute for Medical Research. South African Electronic Package Inserts. Available at: <http://home.intekom.com/pharm/saimr/snake.html>. Accessed May 7, 2007.

Cocoa May Reduce Blood Pressure

Four out of five "trials involving cocoa drinkers revealed a reduction in blood pressure by an average 4.7 mm mercury for systolic and 2.8 mm for diastolic, compared with those who didn't drink cocoa," according to a study published in the American Medical Association's Archives of Internal Medicine. The research "covered 10 studies on cocoa (N=173) and 5 tea studies (N=343). Neither green nor black tea was associated with a significant reduction in blood pressure.

The benefits are believed to come from polyphenols (or flavonoids). Current guidelines call for people with high blood pressure to eat a diet rich in fruits and vegetables, also high in polyphenols. These compounds are thought to protect against heart disease and high blood pressure, but there are no current recommendations for people at risk for high blood pressure or heart disease to include polyphenol-rich cocoa in their diet. Polyphenols "are similar to using one-drug therapy with common blood pressure-lowering medications such as beta-blockers and ACE inhibitors."

And I thought chocolate was just a good antidepressant! Bring on the cocoa, lets skip the sledding.

South Carolina Medical Malpractice Update

by Greg Jones, CIC, CPCU - Wachovia Insurance Services

The SC Medical Malpractice JUA announced on May 30 that their annual rate increase would average 9.5% and be effective July 1, 2007. Unfortunately, Emergency Medicine was one of the exceptions to the 9.5% average with the largest rate increase of all classes- a +15.1% increase. Other specialties with above average increases were General Surgery (+10.2%), and Neurology (+12.1%); Anesthesiology had no increase, and all other physician classes had a +9.1% increase. This is the fifth consecutive year the JUA's medical malpractice rates have increased for Emergency Medicine Physicians (28.7%, 32.2%, 12.7%, 7.2%, and now 15.1%) bringing the annual premium for an emergency physician with \$1MM/\$3MM limits to \$21,263. According to Marsh, the program manager for the JUA, the 15.1% rate increase for Emergency Medicine was directly attributable to higher claims activity and payment for the overall class of Emergency Medicine.

On a positive note, the JUA/PCF announced the availability of a "claims-made" coverage form and a "shared limit" endorsement. The "shared limit" endorsement is particularly important to the emergency medicine community because this means that a group can consider eliminating the separate "entity" policy which cost an additional 20% (\$4,253 per physician) in order to provide defense of claims made against the practice's legal entity (e.g. P.A.) The "shared limit" endorsement provides defense of the entity (if named) under the physician's individual policy and is available for 1% of the premium (usually \$213). The downside of the "shared limit" endorsement is this "sharing of limits" whereas the separate entity policy provides a separate \$1MM/\$3MM limit in addition to the physician's individual limits. The "available limits" can be a factor in any medical malpractice mediation or settlement conference, so groups should consult an attorney or knowledgeable broker when considering the "shared limits" approach.

The Patients' Compensation Fund increased their rates effective June 1, 2007 an average of 8.6% across the board for all specialties and all limits (except anesthesiology), while the "unlimited" coverage rates increased 15%. The PCF continues to have fiscal challenges, trying to increase rates enough to help reduce their \$200MM + deficit, yet not so much as to drive away good groups into the private marketplace, thus necessitating an assessment on the remaining groups. Only time will tell if they are able to continue to walk this "fiscal tightrope" successfully.

Overall, the private market for medical malpractice is growing more competitive, with both MAG Mutual and Medical Protective competing rather aggressively for business. Neither insurance carrier raised rates in 2006, and early indications are that both companies may be filing for slight rate decreases in 2008. The Doctors Company (the largest physician owned company in the US) has effectively left South Carolina because they could not gain any significant market share, although they remain filed and approved in our state.

Both MAG Mutual and MedPro can write emergency physician groups on "slot-rated" policies and MedPro still offers an occurrence policy. However, ED groups are not in either company's "preferred group", and emergency groups will face rigorous underwriting from either company.

South Carolina remains a "good" state for medical malpractice insurers, and recent experience shows that. According to data taken from the National Practitioner Data Bank through 2006, the average indemnity paid in South Carolina has fallen every year since 2001, and actual claims count has fallen in every year since 2001 except one. That, coupled with the Tort Reform passed last year has made South Carolina a "desirable" state. Consequently, there are a number of insurance carriers who can provide very competitive quotes to groups on a "surplus lines" (i.e. non-admitted) basis. However, a thorough investigation of these carriers is essential, because their coverage forms may be more restrictive (e.g. claims-made) and they may exit the market just as quickly as they entered. Consequently, a hasty change for short-term savings can end up costing physicians much more in premiums over the long term. Because emergency medicine is such a difficult class of medical malpractice to underwrite, it is crucial that your malpractice insurance be placed with a stable carrier who is committed to the malpractice marketplace and who understands emergency medicine.

Note: If you would like a "checklist" for evaluating malpractice carriers, have your medical malpractice insurance alternatives reviewed, or have any questions about your medical malpractice insurance, you can contact Greg Jones at:

Wachovia Insurance Services
843-573-3560 (phone)
843-556-6777 (fax)
843-729-7661 (cell)
Greg.A.Jones@wachovia.com



BETTER THAN BOTOX.

**GET RID OF MALPRACTICE INSURANCE WORRIES
ONCE AND FOR ALL.**

+EPIC

EMERGENCY PHYSICIANS INSURANCE COMPANY
Risk Retention Group

A partnership of the best EDs in America.SM

866.374.2467
www.epicrrg.com



UNDER THE DOME

A Report From The Capital

*by Ted Riley, Esq - Lobbyist
Tara Boone - Paralegal*

New State Treasurer

On July 24th the General Assembly convened for a Joint Session to elect a new state Treasurer. Representative Harry Cato nominated Representative Converse Chellis for the position with Cato noting Chellis' service in the House on the Labor, Commerce and Industry Committee and as Chairman of the House Rules Committee. Cato went on to stress the military experience held by Chellis, a Citadel graduate and former Captain in the Air Force. Senator Harvey Peeler nominated Senator Greg Ryberg for the position with Peeler noting that Ryberg has a long history of success in business and is fiscally conservative and holds sound management skills.

The members of the Joint Assembly voted Converse A. Chellis, III as the new state Treasurer, with Chellis receiving 122 votes and Ryberg receiving 34. The Reading Clerk read Representative Chellis' letter of resignation from the House, and Chellis was immediately sworn in as the new State Treasurer.

Budget and Control Board – New Executive Director

Henry White, Executive Director of the Budget and Control Board, resigned his position on July 24th. On August 14th, Frank Fusco was appointed the new Executive Director, a position he previously held before Mr. White.

New Director of the Department of Health and Human Services

The Senate Medical Affairs Committee also met on July 24 and approved the appointment of Mary Emma Forkner as the new Director of the South Carolina Department of Health and Human Services. The Senate accepted the recommendation of the Committee, and Ms. Forkner is officially the new Director.

When asked about her priorities for the agency, Ms. Forkner said she will first deal with the non-emergency transportation issues, then health of convenient choices and maintenance of effort of other programs.

Secretary of Transportation

And, the Senate Transportation Committee confirmed the appointment of Buck Limehouse as the new Secretary of Transportation, a position put in place by the recently enacted DOT reform bill. The Senate accepted the recommendation of the Transportation Committee, and Mr. Limehouse is officially the new Secretary of Transportation.

In light of the recent tragedy in Minnesota, the reliability and safety of South Carolina's bridges are of immediate concern for the DOT. Mr. Limehouse said it would cost \$2.9 billion dollars and 20 years to repair the bridges that have substandard ratings (about 1,800 bridges in South Carolina). The DOT currently plans to spend \$105 million on bridges in 2007 and \$125 million in 2008.

Please contact our office if you would like more information.

Riley Pope & Laney, LLC

P.O. Box 11412, Columbia, SC 29211

803-799-9993

Ted Riley (lobbyist) - triley@rplfirm.com

Tara Boone (Paralegal) - tboone@rplfirm.com

JCHAO Reinstates 1st Dose Review

Emergency department medications must be reviewed prospectively by a pharmacist, according to JCHAO. This reverses an interim action that allowed medications to be retrospectively reviewed by a pharmacist within 48 hours.

The Joint Commission's stated reason for the standard: to prevent ED medication errors. ACEP Board members stated the delay in patient care caused by a pharmacist review could be far more harmful.

The reversal may not be permanent; according to ACEP President Brian Keaton, MD, who says JCAHO president Dennis O'Leary, MD plans to convene an internal task force to address concerns presented to JCAHO.

ACEP, the American Academy of Emergency Medicine (AAEM) and the Emergency Nurses Association (ENA) are working on a united opposition to this potentially detrimental accreditation standard.

In May 2006 and January 2007, ACEP, AAEM and ENA jointly expressed their concerns about the standard and the AMA opposed the requirement of first dose review by a pharmacist.

ACEP will keep us updated.

FYI - Notes of Interest

A no-fault injury compensation system has worked in New Zealand for over 30 years, so all physicians pay \$700 a year for indemnity insurance and it is almost impossible to sue a physician.

Maine is considering funding Medicaid programs through a 50¢ increase on tobacco products (including smokeless tobacco), a snack tax, a tax on bottled soft drinks & syrups, and a beer & wine tax.

Federal Medicare Bills

by *Jeanne L. Slade, ACEP Political Action Director*

The Senate approved legislation (S. 1893) to expand the State Children's Health Insurance Program (SCHIP) and the House passed the CHAMP Act (H.R. 3162), a broader SCHIP reauthorization bill. Provisions included in H.R. 3162 would:

Provide Medicare physician payment updates of 0.5 percent in 2008 and 2009. Physicians face cuts of approximately 11 or 12 percent in 2010 and 2011.

Prospectively remove drugs from the physician payment formula beginning in 2010.

Replace the SGR with a system that breaks payment calculations into six different categories of physicians services within the Medicare fee schedule based on Gross Domestic Product (GDP), with a preference given to primary, preventive and emergency department care;

Gradually equalize cost sharing for mental health services.

Create a "medical home" demonstration program that would provide additional incentives to physicians who actively manage and coordinate patient care.

Establish a panel (outside of RUC) to identify physicians' services for which the relative value is potentially mis-valued.

Require GAO to analyze the Medicare physician fee schedule to identify opportunities for increased use of "bundled" payment methodologies.

Institute a certification process for diagnostic imaging devices. Physicians will still be allowed to bill for the technical and professional components if the equipment has been certified, which would begin on January 1, 2012 for ultrasound services.

Ban physicians from self referring patients to any hospital, not just specialty hospitals, in which they have ownership; provide an exception for hospitals that were in operation with Medicare provider agreements as of July 24, 2007; and require "grandfathered" hospitals to meet financial and quality standards going forward.

H.R. 3162 includes \$86 billion in new spending (\$47 billion for SCHIP) over five years primarily paid for by increasing the tobacco tax by 45 cents per pack and eliminating overpayments to Medicare Advantage. The projected cost over 10 years is \$251 billion.

The Senate version of the bill, S. 1893 also reauthorizes SCHIP for five years but does not include any Medicare provisions. The Senate measure would cost \$35 billion, paid for by increasing tobacco taxes by 61 cents. The principal difference in cost between the House and Senate SCHIP provisions is due to different eligibility criteria.

The House and Senate must now reconcile differences between the two bills in conference before a compromise version can be presented to the House and Senate for final approval. ACEP anticipates preliminary talks to begin between House and Senate staff during the congressional recess with more substantive negotiations taking place in September when Members of Congress return to Washington, DC.

If you are interested in hosting an emergency department visit for your U.S. Representative or would like to set up a meeting with your legislator during the August recess, please contact Jeanne Slade in the ACEP Washington D.C. office for assistance.

Jeanne L. Slade

Director, Political Action

American College of Emergency Physicians

2121 K Street, NW, Suite 325

Washington, D.C. 20037

202-728-0610, ext. 3013

202-728-0617 (fax)

email: jslade@acep.org

Note: The Senate and House will be in recess from August 6 to August 31 for the summer work period.

Pertussis

by *Sandra Counts, PharmD*

*AnMed Health Family Medicine Residency Program
Associate Professor of Family Medicine*

If you suspect pertussis, call the Health Dept to see if lab testing is indicated. The health dept tests high risk contacts, per director Leigh Beasley MD., including:

- a. people with babies in the home who haven't been immunized
- b. pregnant women who will deliver soon
- c. kids in a classroom where none of the pertussis PCRs have come back positive.

The 2 equally acceptable Zithromax treatments for adult pertussis are (SC DHEC recommended) 500 mg daily for 6 days and (Up-to-date and Sanford's) a 'Z-pack' regimen...500 mg on day 1, 250 mg days 2-5. ID specialist Dr. Potts says either is acceptable, and the generic Z-pack is the least \$.

Dr Beasley asks that you treat all close contacts, not just symptomatic ones. Waiting for symptoms means that that person is a real case and the contact circle grows. Please treat close contacts as soon as they are identified, even if they're asymptomatic

There are 2 phone numbers for questions about pertussis:

- a. The Health Dept...260-4358
- b. The "Epi-Pager" (medical consults/after hours questions):1-866-298-4442. At the tone, dial in your phone number, and they will call you right back.

**RELIEF FOR EDS FORCED TO HOLD PSYCH
PATIENTS FOR EXTENDED PERIODS NOT
EXPECTED FOR SOME TIME**

According to the following article by Jeff Wilkinson in The State newspaper, relief is approximately two years away.

**Bull Street Project Just Plodding Along
Old hospital campus could be ready
for transfer by 2009**

by *JEFF WILKINSON - jwilkinson@thestate.com*

It could be 2009 or later before the old State Hospital campus on Bull Street in Columbia is turned over to developers.

State Mental Health officials say it will take at least two years to prepare facilities to house the 250 patients still at Bull Street.

A new psychiatric hospital is planned for Faison Drive, near Farrow Road, for children and juveniles, including 80 at Bull Street. The agency has about \$20 million of the \$43 million needed for that project. In January, it will ask the General Assembly for the balance.

The agency also is replacing roofs at the G. Werber Bryan Psychiatric Hospital, also on Faison Drive, so 140 adult patients can be moved there from Bull Street. Lawmakers have appropriated nearly all the \$7.8 million needed for that work.

“It benefits the agency not to move too hastily because we’ve got patients on the grounds,” said Mark Binkley, general counsel for the S.C. Department of Mental Health.

“I understand the sense of excitement, particularly in the city, but our No. 1 job is taking care of the patients,” he said. “We don’t want to shutter our facilities too quickly without a backup.”

The timeline for Bull Street’s sale could be moved up, Binkley said, if Mental Health commissioners decide to sell the land in phases, rather than as a single tract. “That’s the \$64,000 question,” Binkley said. “Or rather, the \$30 million question.”

The 178-acre campus is the largest tract to become available in downtown Columbia in decades. Estimates of its value have ranged from \$10 million to \$30 million.

Columbia developer and financier Don Tomlin, who is helping guide the project and has vowed not to make money on it, said he is advising the state to sell the land to one “master developer” rather than in sections.

“One company as a buyer can be a better pilot to move this property from a zero tax base to more than a billion dollars in economic impact,” he said. “Its redevelopment would be more logical, deliberate and better-executed.”

Tomlin said it’s not necessary to delay until all patients have left the Bull Street property to start development. Instead, a sales agreement could require a developer to build first in areas not

being used by patients, he said. “An intelligent buyer can work out a deferral.”

Selling the Bull Street property has been proposed — on-again, off-again — for years. However, Gov. Mark Sanford revived the idea in late 2003.

A 2005 plan for the campus developed by New Urbanism guru Andres Duany and his Miami-based firm, Duany Plater-Zyberk & Co., calls for 1,257 residential units — from apartments and lofts to single-family homes — 179,000 square feet of retail and 638,000 square feet of office space.

The plan also calls for the renovation and reuse of about a dozen historic buildings, including the iconic Babcock Building, with its signature red cupola. A central park around a lake eventually would connect with the Three Rivers Greenway.

No deadline exists for the sale of the property. However, both Sanford and Columbia Mayor Bob Coble are urging a speedy resolution.

“We obviously want this taken care of as quickly as possible,” Sanford spokesman Joel Sawyer said. “It’s incredibly important in terms of economic development for the region, and we want to bring those surplus dollars into the state.”

Coble said city staffers already are studying the zoning needed. He, too, is seeking urgency. “But the issues that face the commission about relocation are serious,” the mayor said.

Mental Health officials might hire a marketing consultant, Binkley said. “We might need to be advised on which way to go.”

The wheels of state government have been turning slowly on the project.

The process was bogged down for months as the S.C. Supreme Court decided who would get the money from the property’s sale — the Mental Health Department or the State Budget and Control Board. The court ruled the land is owned by a public trust controlled by the Mental Health Commission.

Now, the Mental Health Department, at the request of the attorney general’s office, will have to sue the state to modify the trust to sell the land. The step is considered necessary housekeeping but is time-consuming.

Reach Wilkinson at (803) 771-8495.

Printed with permission of The State newspaper.

Do you have any news, views, funny stories, interesting cases, praise, recognition or comments you would like to share with your colleagues. If so, we are always looking for articles of interest for the EPIC. Please e-mail your submission to scep@sc.rr.com

PALMETTO STATE EPIC

newsletter of the South Carolina College of
Emergency Physicians

Editor: Joy Zimmer

Medical Editor: Pamela Bensen, MD, MS,
FACEP

EPIC is sent to emergency physicians in South
Carolina. The opinions expressed in this newsletter
are not necessarily those of the Chapter or the
American College of Emergency Physicians.

2006-2007 CHAPTER OFFICERS

Randy L. Reinhardt, MD, FACEP
President

Peter D. Hyman, Jr., MD, FACEP
President-Elect
Jorge Infante, MD
Secretary

Tripp Jennings, MD
Treasurer

Stephen C. Stanfield, MD, FACEP
Immediate Past President

2007- 2008 BOARD MEMBERS

Pamela P. Bensen, MD, MS, FACEP

Stephen A.D. Grant, MD, FACEP

Patrick S. Hunt, MD, FACEP

Sarvotham Kini, MD, FACEP

Troy Privette, MD, FACEP

Laurence H. Raney, MD, FACEP

D. Gabe Simpson, MD, DABEM

COUNCILORS

Stephen A.D. Grant, MD, FACEP

Allison L. Harvey, MD, FACEP

Stephen C. Stanfield, MD, FACEP

RESIDENT LIAISONS

Dusty Moses, MD (PGY-III) - PHR
Jennifer Laughlin, MD (PGY-I) - MUSC

MEDICAL STUDENT LIAISONS

MUSC–Sherief Khalil

EXECUTIVE DIRECTOR

Ms. Joy Zimmer

CHAPTER OFFICE

1007 Fairwood Drive

Columbia, SC 29209

803/783-1616

803/319-0598 (Cell)

E-Mail: sccep@sc.rr.com **Website:** www.sccep.org

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.

Abigail L. Adams, MD - Resident, PHR

Matthew Ahern, DO - Resident, PHR

Neil Andrews, MD - Resident, PHR

Gary J. Baggett, DO, FACEP - Spartanburg

Robert W. Bankov, MD, FACEP - Varnville

Matthew D. Barker, MD - Beaufort

Eric S. Brittain, MD - Mt. Pleasant

Heather A. Brown - Student, USC

Amanda Cain, MD - Resident, PHR

Virginia Daugherty - Student, MUSC

Joshua C. Davis, MD - Resident, PHR

Bonnie B. Dellinger, MD - Resident, MUSC

Tara J. Drew - Student, MUSC

Jennifer Fernandez - Student, MUSC

Aaron Garrett, DO - Sumter

James S. Goudie, MD - Myrtle Beach

Lindsay Gould, MD - Resident, PHR

Erin C. Heritage, MD - Resident, PHR

Bogdan M. Irimies, DO - Rock Hill

Brianne Klimovich, MD - Resident, PHR

Robert D. Kosciusko, MD - Resident, PHR

Jamie Do Kuo, MD - Resident, MUSC

Jason M. Landry, MD - Resident, PHR

Jennifer Laughlin, MD - Resident, MUSC

Joseph Mahoney, MD - Resident, MUSC

Patrick M. O'Malley, MD - Columbia

Pauline Meekins, MD - Charleston

Adner Pazo, MD - Resident, MUSC

Wendy Regal, MD - Greenville

Richard B. Rody, MD - Spartanburg

Andrew Ross, MD - Resident, MUSC

Scott T. Rouse, MD - Florence

John Shea - Student, MUSC

Jenna L. Telmont, MD - Resident, PHR

SCCEP MEMBER REMINDER UPDATE YOUR CONTACT INFORMATION

Please remember to notify ACEP and SCCEP when you
have a change in your contact information (address, hospital,
phone number, e-mail address). We want to keep you
informed in a timely manner - and we can only accomplish this
if we have your up-to-date information (particularly your e-
mail). I am constantly getting e-mails returned because the
address is changed. So PLEASE, include the chapter on your
"people to let know of an e-mail change" list.

Thank you, Joy Zimmer

SCCEP CALENDAR OF EVENTS

SCCEP ORAL BOARD COURSE

September 30-October 1, 2007

Las Vegas Embassy Suites, Las Vegas, Nevada

SCCEP Board Meeting

To be announced - information will be mailed out

ACEP Scientific Assembly

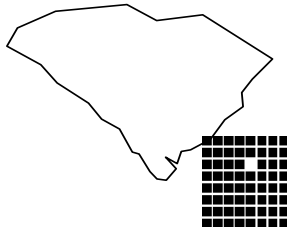
Seattle, Washington

October 8-11, 2007



SCCEP EMERGENCY ULTRASOUND COURSES

For dates and locations - www.emergencyultrasound.com



**PALMETTO
STATE
EPIC**

CHAPTER OFFICE
1007 Fairwood Drive
Columbia, SC 29209
1-803-319-0598 (phone)
scecp@sc.rr.com