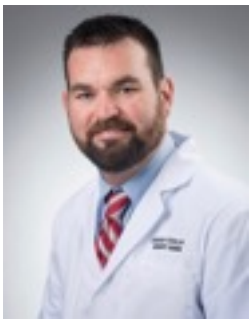
A Newsletter for the Members of the South Carolina College of Emergency Physicians

Spring 2018



Zach Kiker, MD, FACEP, President

Jackie Boylston, Executive Director
Phone: 803.315.0566

Letter From the President
Zach Kiker, MD, FACEP

What a busy and exciting year this has been. As my time as your president winds down, I am proud of the accomplishments this year. SCCEP has grown ever more interconnected with the regulatory and legislative infrastructure of this state, and we have a stronger voice than ever. We have actively participated in the SC Hospital Associations Behavioral Health Council on mental health. We are engaged with the Governor's Opioid Emergency Response Team. On the legislative front, I am proud to say we have worked closer than ever with the SC Emergency Nurses Association on the Assault on Healthcare Worker's bill. In addition, we have coordinated with multiple organizations across the state to provide input and thoughtful dialogue on solutions to the opiate crisis.

In this issue of the SCCEP newsletter, you will hear from your talented, mother of three,

USAF veteran/flight surgeon, and President-elect Dr. Christina Millhouse on her goals for the coming year. SCCEP is in great hands moving forward with her wealth of leadership experience. As you know, our organization has been on the forefront of responding to the opiate crisis for many years now. Dr. Lindsey Jennings explains how EM continues to lead the way with the state's first ED-initiated Medication Assisted Treatment program for opiate use disorder. In addition, you'll hear from this year's Leadership and Advocacy Fellow, Dr. Peyton Hassinger about his project on ED overcrowding and boarding. I want to personally thank Dr. Hassinger, Dr. Derick Wenning, and Dr. Jon Pangia for their commitment on this issue. We are in the process of engaging DHEC and the SC Hospital Association to form a work group on this topic. I am hopeful we will influence positive change on this front. Speaking of Dr. Wenning, as summer and swimming season quickly approaches, he walks you through difficult, myth-busting conversations around pediatric "dry-drowning" in this month's "PEM Corner." You'll also get an update from Dr. Lance Scott and our two Public Policy fellows around incredibly important work they are doing on the subject of Tele-Psychiatry. Dr. Page Bridges provides you with an update from our government relations committee. This year, thanks to Dr. Bridges vision and leadership, we were able to expand our legislative day in both size and format. There were dozens of practicing emergency physicians and residents (including representatives from all 4 EM programs in the state) at the Capitol advocating for you and our patients.

As you can tell, SCCEP is bigger and more active than ever, with so many talented physicians doing significant work. I want to take this opportunity to ask you to consider getting involved. We need your voice. Would you be interested in the Leadership and Advocacy Fellowship or another project? I hope you'll consider as we work together to improve emergency medicine for our patients and ourselves. I hope to see all of you at LAC and/or CEMC in just a few short weeks!

Very Respectfully,
Zach Kiker, MD, FACEP

Letter to the Membership of Upcoming SCCEP Leadership Highlights

Dr. Christina M. Millhouse, MD, FACEP
SCCEP President-Elect & Board Member
Staff Emergency Physician
Aiken Regional Medical Center
Palmetto Health Baptist

Greetings esteemed SCCEP colleagues! My name is Christina Millhouse, and I am the SCCEP President-elect who will take over as President at the end of our annual Kiawah meeting on June 7th. I would like to take this opportunity for you to get to know my background and my vision for SCCEP over the next year.

I am a mother to a 4-year-old and 8-month-old twins (all boys) and in whatever free time I have, I have a passion for dressage riding. I grew up in California, graduated from Pepperdine, and then but moved to the East Coast to go medical school at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. I completed a one-year transitional internship before becoming a Flight Surgeon for the US Air Force's High-Altitude Reconnaissance U-2 Squadron at Beale AFB in California. After seven years and thirteen overseas deployments, I completed my Air Force commitment and went to residency in EM at UC Davis in Sacramento. While I was at UC Davis, I was the California EMRA President and spent a year on the California ACEP Board of Directors. After residency, my family and I moved to Aiken, and I became involved in SCCEP and then a member of the board shortly thereafter.

My experience with such a large chapter such as California ACEP has given me a unique perspective and insight into how I hope to lead SCCEP. Our chapter has grown so much in recent years, and especially within the last year with the addition of two new residency programs in Myrtle Beach and Greenville. These have added quite a few new members, whom I hope to involve more in SCCEP.

I am passionate about SCCEP's legislative efforts. Drs. Preston Wendall and Page Bridges head up our Legislative Committee and have been doing a wonderful job at

staying on top of the ever-changing environment that is our State Legislature. From the recent litany of opioid regulation bills to our Assault Against Healthcare Workers bill, our members are an integral part of influencing South Carolina's policy. I hope to involve more members from all parts of the state in these legislative efforts. Lawmakers greatly appreciate our experience and stories from our ED's that help to personalize how important these bills are to our patients and to us.

I intend to continue the growth in our Legislative Day because I believe that this is where you, as an SCCEP member, can see the value in your membership and some of the influence that you as an individual and we as a group can have to further Emergency Medicine policy.

I am greatly honored to have the privilege to represent all of you as the President of SCCEP for 2018-2019. We are always trying to monitor the current issues around the state. However, no one knows what is going on as well as those of you who work in the Emergency Departments day to day. I sincerely hope that you will reach out to me with any suggestions, concerns, or items that SCCEP should be aware of. My email is **scemdoc@gmail.com**

Sincerely,
Christina M. Millhouse, MD, FACEP
President-Elect, SCCEP

Ask the Expert

Lindsey Jennings MD, MPH serves as Assistant Professor and Assistant Program Director for the emergency medicine program at the Medical University of South Carolina in Charleston. She is also the physician champion for the first ED- based buprenorphine program in the state.

What is Medicated-Assisted Treatment (MAT)?
Medicated-Assisted Treatment (MAT) is using the combination of medication, counseling, and behavioral therapies to treat substance use disorders. MAT is the standard of care for the treatment of opioid use disorder (OUD). The most commonly used medications for treatment of OUD are buprenorphine, methadone, and naltrexone. MAT for OUD is safe, cost-effective, and efficacious. MAT for OUD has been shown to prevent relapse and death, increase retention in treatment, improve overall social functioning, and decrease infectious disease transmission and engagement in criminal behaviors.

Unfortunately, MAT is very under-utilized due to cost, access, and stigma. Estimates from the Substance Abuse and Mental Health Services Administration (SAMSHA) in 2014 indicated that as many as 2.5 million people met criteria for OUD, but only 1 million were receiving MAT. Almost all states in the US have insufficient treatment capacity to provide MAT to all OUD patients, and lack of access to MAT is the main reason for low MAT utilization rates. In the state of South Carolina we only have one public opioid treatment program (OTP) at Charleston Center. In South Carolina only approximately one-fifth of patients have access to MAT and currently approximately 25% of buprenorphine-waivered medical providers are at capacity for the number of patients that they are able to prescribe MAT per federal regulations.

How does buprenorphine work?
Buprenorphine is a partial opioid-agonist with a high-affinity for mu opioid receptors. As a partial agonist, it reduces or eliminates the symptoms of opioid withdrawal without causing a euphoric effect. Additionally, due to buprenorphine's high affinity for opioid receptors, if an additional opioid is ingested with lower binding affinity such as heroin, the opioid will have little to no effect. Buprenorphine is formulated as both monoproduct as well as in combination with naloxone. Buprenorphine is manufactured as a combination product with naloxone strictly as a safety precaution to decrease street value and prevent injection abuse. When buprenorphine/naloxone is absorbed sublingually or through the buccal mucosa, the naloxone has no effect. However, if it is injected, the naloxone minimizes the effects of mu opioid receptor activation. The monoproduct is most commonly reserved for use in pregnancy, breastfeeding, and those with a known naloxone allergy.

Why are we starting treatment from the Emergency Department?
The Emergency Department is a unique setting for starting interventions for opiate use disorder for three main reasons: 1) patients with opioid addiction interact with the emergency department disproportionately to all other parts of medicine, (2) the desire to seek treatment is often time-sensitive and it is rare to be seen the same day anywhere in

medicine outside of EDs, and (3) the patient's presenting complaint can be directly tied to OUD in many cases and patients may be more likely to engage in treatment when the deleterious effects of their substance misuse are so prominent.

What evidence is there to support the use of MAT in Emergency Departments?
The most robust study examining starting buprenorphine from the ED was published in JAMA in 2015: "Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence" by Dr. Gail D'Onofrio. In this study, patients with OUD were randomized to one of three arms: referral to treatment, brief intervention in the ED and referral, and buprenorphine induction in the ED. They found that ED-initiated buprenorphine treatment significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services.

What are the barriers to starting an ED MAT program?
The barriers to starting a program vary by site, but common barriers include lack of training in the treatment of OUD for ED providers and staff, restrictions on buprenorphine prescribing, lack of universal, evidence based screening tools in the ED, and access to and funding for next day follow up care.

Buprenorphine requires additional provider training and a DEA waiver to prescribe the medication for OUD. This training, while free, is 8-24 hours long. The DEA does grant exclusion to this mandatory training and wavier under the "72-hour rule" (Title 21, Code of Federal Regulations, Part 1306.07(b)) which allows a practitioner who is not DEA waivered to administer, but not prescribe or dispense, buprenorphine to a patient for the purpose of reliving acute withdrawal symptoms while arranging for the patient's referral for treatment. We have been able to over come the follow up barriers though a collaborative effort with our ambulatory psychiatry and DEA waivered colleagues, our local public treatment agencies, and funding from South Carolina Department of Health and Human Services, the South Carolina legislature, and South Carolina Department of Alcohol and Other Drug Abuse Services.

What outcomes have ED buprenorphine projects in South Carolina had so far?
There are three sites that have started ED buprenorphine projects in South Carolina: MUSC started in December, and programs have more recently started at Waccamaw Tidelands and Grand Strand. Between all three programs we have screened over 750 ED patients for substance abuse with approximately 400 positive screens for any type of substance abuse and 150 positive screens for OUD. Approximately half of those patients were eligible for ED-initiated buprenorphine, and of those 50% were started on treatment.

Over 70% of patients arrived for next day treatment and 80% were still in treatment at 30 days.

How do these programs work operationally?
The logistics of each program are site-specific, but they tend to have many of the same components. At all of the sites in South Carolina staff have been hired to screen patients for substance abuse and identify patients that would be candidates for ED buprenorphine programs. These individuals meet with potential candidates in the ED, perform a brief motivational interview to assess their commitment to treatment, and facilitate the referral process.

At our site if a patient is identified as a candidate, both our nurses and physicians are notified. Our nurses complete a Clinical Opioid Withdrawal Scale (COWS), a tool similar to the CIWA for alcohol abuse. It is important to start buprenorphine when the patient is in withdrawal. If the patient is not withdrawing, buprenorphine has the potential to precipitate acute withdrawal. For our program patients cannot be started on buprenorphine unless their COWS is 8 or greater. If the COWS is appropriate and the physician agrees that the patient is a good candidate, then 8mg of buprenorphine is ordered and the patient is sent for a next day appointment to receive further doses of buprenorphine. Currently there are no national guidelines on the COWS cutoff or the specific buprenorphine dose to start in the ED, and many programs differ in these areas. However, a suggested workflow is currently being developed by national experts.

How do you see the initiation of MAT from the Emergency Department developing over time?
It is difficult to predict how ED buprenorphine programs will fare in the future. As a specialty we are currently grappling with what our role will be in addressing the opioid epidemic. As one of the youngest specialties in medicine we tend to be open to new ideas, and I've been amazed by how emergency physicians have embraced the idea of addressing and treating opiate use disorder from the ED. We all deal with the effects of the opioid epidemic on a daily basis. The implementation of these programs allows us to start patients on definitive treatment when they need it which fills a void in care for this patient population.

Screening for substance use disorders and beginning treatment from the ED seems to be part of an overall trend to better address the needs of our patient population. Over the past several years there is recognition that the ED is a main entry point for many patients to the health-care system, and for many of our patients, it is the only way they interact with healthcare. As a result, many public health screening interventions have been rolled

out in EDs- from universal screening for HIV and hepatitis C to domestic violence screening. As a specialty it is important to continue to advocate for these services for our patients. The sustainability of ED-initiated buprenorphine will depend on many factors, but the importance of expanding EM education about OUD treatment, ensuring future funding, and expanding referral sites to send our ED patients to post buprenorphine induction, cannot be stressed enough.

Leadership and Advocacy Fellowship

Peyton Hassinger, MD, FACEP

Dear SCCEP Members,
I am honored to be working with and for you this year through the South Carolina Leadership and Advocacy Fellowship (SC-LAF). My name is Peyton Hassinger.

I completed residency at Palmetto Health Richland in 2014 and have been working in Columbia at Palmetto Health Baptist and Parkridge since then. As a fellow, my task will be to develop and implement a project that will benefit our state and my hospital. I am excited to introduce project idea. My interest in the SC-LAF centers around my desire to improve the practice of emergency medicine for patients, physicians, and hospitals. During my relatively short time as an emergency physician, I have seen hospital overcrowding dramatically worsen: long ED wait times and ED boarding have become the new norm. I believe that hospital overcrowding significantly limits our ability to safely and effectively practice emergency medicine. I also believe that as emergency physicians, we have the responsibility to advocate for our patients and work towards a solution to the problem.

To that end, I have spearheaded a new “Surge Plan” committee at Palmetto Health Baptist whose goal is to develop protocols to prevent ED boarding and EMS diversion. As

a fellow, I hope to translate what we learn from this “Surge Plan” committee into an SCCEP policy statement. This policy statement will address how best to manage and prevent hospital overcrowding and emergency department boarding. This policy statement would build on ACEP’s existing policy statement(s) on hospital overcrowding as well as the “Full Capacity Protocol” developed by Dr. Peter Viccellio at New York’s Stonybrook Hospital. My goal would be to develop an SCCEP-endorsed “rubric” that could be used at any hospital to implement meaningful and immediate change that would help solve the problem of overcrowding.

SCCEP is beginning the process of engaging with our state legislature and regulatory bodies to pass resolutions similar to ones passed in states such as Texas, New Mexico, Pennsylvania, New York, and Virginia. These resolutions include, for example, statements from Governors and Departments of Health encouraging hospital CEO’s to take immediate action to address the problem of overcrowding by using inpatient hallways to board patients and smoothing of elective procedures throughout the week.

Hospital overcrowding is a growing problem that we all have to face. Let’s use our collective voice to speak confidently and clearly to our hospital administrators and state legislators, sharing with them our vision for a solution.

Sincerely,
Peyton Hassinger, MD, FACEP

Pediatric Emergency Medicine Corner

An Approach to the ‘Dry Drowning’ Discussion with an Anxious Parent

Derick Wenning, MD, FACEP
Medical Director
Pediatric Emergency Department
Palmetto Health Richland
SCCEP Secretary & Board Member

Unfortunately in our line of work, the media can misconstrue a medical diagnosis leading to pandemonium and headaches for all of us as the health care professionals manning the safety net. This is exactly the case with 'Dry Drowning' and the publicity this phenomenon received over the past year. With summer months ahead, many physicians have spoken out against this diagnosis and have attempted to offer education to the public regarding the correct terminology surrounding drowning and the injuries that may occur. That's all fantastic work, but how do you relay that to the parent of a two year old who is currently in your emergency department? What do you say to calm their fears? I hope to offer some tips that may make the experience more pleasant for you and informative for the patient and family.

1. **Step 1 – Swallow your pride.**

This may be the most difficult step, but it is the most important. I know it can be frustrating during a busy shift, but if someone poses a question related to dry drowning to you – be calm, don't lash out and immediately begin berating the patient's family for the lack of correct information the media has provided. This is your chance – make the best of it.

2. **Step 2 – Validate concerns and the reason for the ED visit.**

Let the family know you understand and address their concerns. They are worried about their child; so let them know you are on their team. Ask specifically what concerns they have, and say something like, "I'm glad you brought little (Insert name here) to the Emergency department so we can make sure nothing serious is going on." Then let them know what your plan of action is – something a simple as observation for change in respiratory status, or obtaining a CXR, etc.

3. **Step 3 – Drowning education**

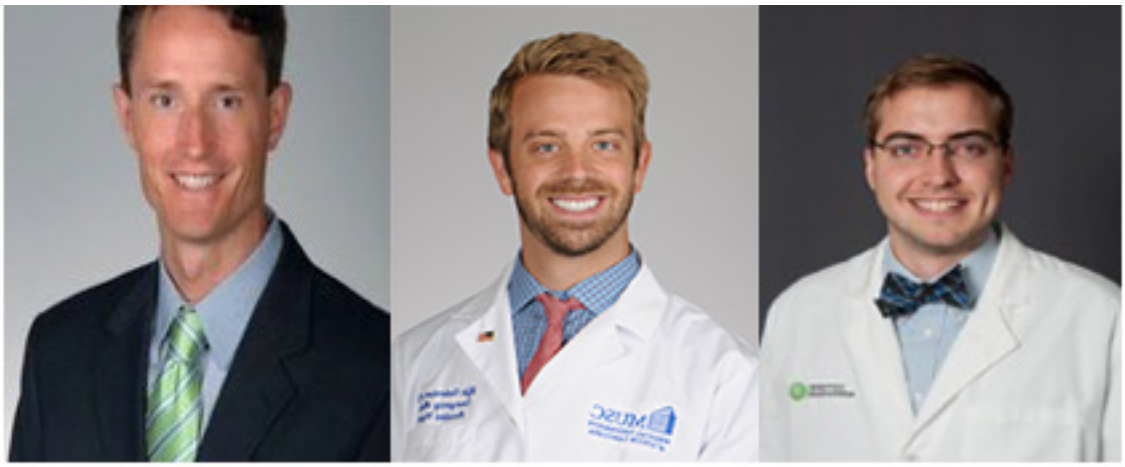
Now that you've established rapport, this is your opportunity to educate and inform about what drowning is and how 'dry drowning' is nothing more than a hot topic misnomer that is confusing for everyone. When seeing a patient for a drowning concern, you have essentially three choices for diagnosis (a) Fatal drowning, (b) Non-fatal drowning with injury, and (c) Non-fatal drowning without injury. In 2002, there was a worldwide consensus definition for drowning. Taken directly from this document is the following: "Thus, we believe the terms "wet", "dry", "active", "passive", "silent" and "secondary" should no longer be applied to describe a drowning victim." The parents may care, or may not about specifics regarding diagnosis. What will concern them the most though, is if you send their child home will they suffer the same fate of the children publicized on the news? Put their minds at ease with step 4, which will continue your education piece.

4. Step 4 – Disposition Plans

Now to the last step. What are you going to do? First the obvious answers -Any child who received resuscitation efforts immediately after the drowning event such as rescue breathing or CPR warrants inpatient observation regardless of symptoms on presentation. Any patient that is symptomatic with respiratory abnormalities should also be hospitalized. The child who received no intervention and is completely normal for a several hour (4-6) observation period who also has a normal CXR near the end (not arrival) of the observation period has a very low chance of deterioration and can be safely discharged home. Of course, good return precautions for respiratory symptoms are a must. A patient who returns for re-evaluation is not a failure. It is the result of good discharge education and presents a chance to find something potentially missed on the initial encounter. Lastly, the patient who presents over 24 hours or even longer after an event warrant evaluation based upon presenting symptoms. If the child has a normal exam and vitals there will be little to do medically. Then conversations to tackle 'dry drowning' starting with step one is important for both parental concerns and your personal sanity.

Remember, you are the expert. This is your time to take care of business and provide the best care and education for your patients as EM docs do everyday. I hope this provides helpful information for your next drowning patient. And always, thank you for all that you do.

Public Policy Leadership Fellowship



Lancer Scott, MD, FACEP | Kyle Embertson, MD | Timothy Depp, MD

This year SCCEP's public policy fellowship is again focusing on mental health care and it's impact on Emergency Departments around the state. Last year helped to shed some light on the challenges that are faced by hospitals and ED physicians caring for mental health patients. Specifically this year we are in the process of studying the impact tele-psych has made. We are currently in the process of analyzing data collected from ED medical directors around the state with regards to psychiatric boarding in the ED, access to tele-psych, and what has and has not worked to help implement the most efficient care for these patients. We are presenting this data at the upcoming Southeastern Symposium on Mental Health in May.

For additional information, please contact:

South Carolina College of Emergency Physicians (SCCEP)
Attn: Jackie Boylston, Executive Director, Lancer Scott, MD, FACEP
E-Mail Address: **sccep.exec@gmail.com** or **scottlan@musc.edu**

Coastal Emergency Medicine Conference
June 8-10, 2018
Kiawah Island, SC

Who has taken their family to a CME event only to have your significant other say "never again"? I have dragged my family to CME events coast to coast, and my spouse, usually

toting 3 small children while I am at the meeting all day, self-describes them as ‘h-e-double hockey sticks’, then came Coastal Emergency Medicine Conference (CEMC).

In its 6th year we have established a solid reputation for great speakers, a balanced curriculum, and a whole lot of fun. It is the only conference that my spouse actually requests that we go to as a family, every year!

With a planning committee comprised of practicing emergency physicians from all three sponsor states, you can combine cutting edge Emergency Medical Education with a family friendly event that your spouse and/or family will actually enjoy!

From trauma and stroke to pediatrics and cardiology, we have all the bases covered for your hospital based CME requirements. Couple that the breadth of additional sessions on leadership, toxicology, the LLSA and the infamous tristate residency jeopardy tournament and CEMC is not to be beat. This year will also host the American College of Emergency Physicians President-elect, Dr. John Rogers!

If that wasn’t enough we are also hosting a new feature this year, the Junior Physician Workshop on Saturday morning, a chance for your school aged children to see what ‘mommy and daddy do at work’ with sessions on hand hygiene, ultrasound, and hands only CPR! This year’s meeting has something for everyone.

Finally, back again is the annual Oyster roast at Mingo Point, a great event with sunset over the marsh, food, music, and a chance to network with colleagues. We hope you will consider joining us this year the Kiawah Island Gold Resort, from June 8th-10th. For more information check out our **conference web page**, you won’t be disappointed.

Residency Updates

Greenville Health System
Camiron Pfennig-Bass, MD, MHPE
Department of Emergency Medicine, Greenville Health System
Emergency Medicine Residency Director
Clinical Associate Professor
University of South Carolina School of Medicine Greenville

The Greenville Health System EM Residency has had a busy and exciting Spring. In March, we celebrated a great match and are looking forward to welcoming our newest class in just a few short months. We are honored to announce the GHS EM Class of 2021.

- Selom Avotri- Morehouse School of Medicine
- Ethan Brown- University of South Carolina School of Medicine Greenville
- Erich Burton- Edward Via College of Osteopathic Medicine
- Conner Graham- University of North Carolina at Chapel Hill School of Medicine
- Ashlee Davis- Mercer University School of Medicine
- Graham Roberts- Wright State Boonshoft School of Medicine
- Fredrick “T.J.” Lynch Jr.- The Brody School of Medicine at ECU
- Thomas “T.J.” Davis- Chicago College of Osteopathic Medicine of Midwestern University
- Hannah Shull- University of South Carolina School of Medicine Greenville
- Cody Meyers- University of Alabama School of Medicine

Our current PGY-1 residents have been working very hard clinically inside the hospital on their rotations, but continue to find time to serve the community in Greenville in a variety of ways. Most recently, our residents taught hands-only CPR at Safe Kids’ Day and Health Careers Night at the Greenville Drive. In addition, the intern class embraced the opportunity to travel to Columbia to participate in Legislative Day last month. They are now eagerly preparing to lead the Young Physicians’ Workshop that will be held at the Coastal Emergency Medicine Conference in June. Finally, we are proud of our residents, Bijal Shah, Ben Theobald, and David Wong, who were chosen to present their research abstracts at the Health Science Center Research Showcase in April. We are excited to

wrap up this charter year of our residency program and look forward to all the opportunities in the future.

GHS Residents and Faculty at SCCEP Legislative Day

Medical University of South Carolina
Jeffrey S. Bush, MD, FACEP
Program Director
Emergency Medicine
Medical University of South Carolina

Exciting times are happening in the low country as we approach the new academic year here at MUSC. Our next class of interns are eager to join us and we look forward to their arrival in July. Of the 6 new interns, we are proud to keep two of our own from MUSC. Two more are coming from Virginia and the remaining two are from West Virginia and Florida. Of the six graduating residents we have one going into a critical care fellowship at LSU and one resident staying on at our pediatric emergency medicine fellowship. The remaining four residents plan on working in the community in New Orleans, Orangeburg, Atlanta, and Charleston. Additionally we are actively looking for our first official chair for fairly new Department of Emergency Medicine, and we have enjoyed meeting the

candidates. While we are sad to see our graduating residents and Dr. Ed Jauch go, we are excited for them as they embark on the next stages of their careers and we are looking forward to the start of the next academic year.

Palmetto Health
Thomas Cook, MD
Program Director
Dept of Emergency Medicine
Palmetto Health Richland
Columbia, SC

The Palmetto Health EM residency had another successful match this spring matching 13 residents from 9 different states including three from SC. In addition, we have three new incoming fellows - two in Ultrasound and one in EMS. Our Global Health program continues to thrive with several trips to Uganda and Haiti over the past academic year. The graduating class of 2018 will be taking excellent community EM opportunities across the country from California to the Carolinas.

Grand Strand Medical Center
Dietrich Jehle, MD, FACEP, RDMS
Emergency Medicine Residency Program Director
Academic Chair, Emergency Medicine
Grand Strand Medical Center

We are looking forward to working with our next class of 12 residents that will be starting in the end of June. Casey Wilson, MD, from Johns Hopkins, will be joining us as our new ultrasound director in the middle of June 2018. The “Radical Ropes” course along with several beach wellness activities have been well received by the residents.

The EM program will be incorporating transesophageal echo into our second-year anesthesia rotation and hope to bring this expertise to the emergency department.

We are working to finalize electives for the 2nd and 3rd year. In addition to the traditional emergency medicine electives, we are excited about the possibility of having a short International Health experience elective in Honduras at a hospital that sees 292,000 patients year (the busiest hospital in the United States sees 217,000 year) with a heavy exposure to penetrating trauma (19-20 homicides a day). The sponsoring program will

provide armed guards for our residents. Students that have travel to this Honduras site thus far have felt safe.

SCCEP Government Affairs Update

Page Bridges, MD

Preston Wendell, MD, FACEP

On April 10, SCCEP held our annual Legislative Day. As always, this provided a great opportunity for us to connect with our legislators and advocate for bills that will impact us as emergency physicians. This year, we had an exciting addition to our usual schedule – the first Annual Legislative Day Symposium. During this half day session, we had the opportunity to hear from several speakers on the importance of advocacy and how to become involved. Ted Riley discussed his role as a lobbyist for SCCEP and monitoring bills as the come through committees. Dr. Preston Wendell and Dr. Lancer Scott (both previous SCCEP presidents) discussed their experiences in advocacy and encouraged all participants to become involved in advocacy at the local, state, and even national level. Residents from across the state were present for this symposium, and for many, this was their first exposure to advocacy and the important role emergency physicians can play in health policy. We look forward to continuing and expanding the symposium next year – if you have any feedback or suggestions, please fill out **the survey**.

Following the symposium, we went to the State House to meet with our State Senators and Representatives. Specific topics this year included assault on healthcare workers and the opiate crisis. We advocated for legislation to increase penalties for anyone who assaults a healthcare worker, and we plan to continue working with the Emergency

Nurses Association to support this legislation. With regard to the opiate crisis, multiple bills targeted at decreasing prescriptions for opiates and increasing access to treatment were under consideration. We shared stories from the emergency department and the impact of this crisis on our patients. Legislators were moved by these stories, and we will continue to work to support efforts to address the impact of opiates in South Carolina.

SCCEP Election Results

A special thank you to all of our board of directors and councilor candidates this year. Congratulations to new board members Dr. Kat Moore and Dr. Peyton Hassinger! In addition, congratulations to Dr. Ken Perrry, Dr. Christina Millhouse, and Dr. Garrett Clanton on their re-election to the board. On the councilor slate, Dr. Matthew Bitner and Dr. Christina Millhouse are our newly elected councilors and Dr. Stephen Grant was re-elected.

Congratulations again and thank you all for your service to the college!

SCCEP Calendar of Events 2018

Leadership & Advocacy Conference
May 20-23, 2018
Washington, DC

SCCEP Board Meeting
Thursday June 7, 2018
Kiawah Island, SC

Coastal Emergency Medicine Conference
June 8-10, 2018
Kiawah Island, SC

ACEP18 Scientific Assembly
October 1-4, 2018
San Diego, CA

Don’t Miss the Premiere Event for Emergency Medicine Advocates and Leaders!

Attendees at the annual **Leadership & Advocacy Conference** will advocate for improvements in the practice environment for our specialty and access for our patients. First-timers will receive special training on how to meet and educate your Members of Congress while seasoned participants will build upon valuable Congressional connections. A new “**Solutions Summit**” has been added on May 23 where attendees will discover innovative solutions on key topics such as opioids and end-of-life issues that demonstrate emergency medicine's value and leadership. CME credit will be given for the Summit.

Confirmed Speakers Include:

- U.S. Surgeon General Vice Admiral (VADM) Jerome M. Adams, M.D., M.P.H.
- HHS Assistant Secretary for Preparedness and Response Bill Kadlec, MD will be presenting during the Public Policy Town Hall on Emergency Preparedness.
- Amy Walter, National Editor for The Cook Political Report, will offer her predictions for the mid-term elections.
- Senator Bill Cassidy, MD (R-LA)
- Representative Kyrsten Sinema (D-AZ)

REGISTER TODAY!

Not able to attend the LAC18? Now is not the time to sit on the sidelines.

Join the **ACEP 911 Grassroots Legislative Network** today to help emergency medicine convey our principles and priorities to legislators in Washington DC and their home districts. With the mid-term elections coming up in November and party control of the House and Senate hanging in the balance, now is the perfect time to reach out on the local level to educate your legislators about the specialty and offer to serve as a local resource on issues relating to the delivery of health care.

Already a member of the Network? Take your advocacy to the next level. Host an emergency department visit for your legislator or invite them to meet with a group of local emergency physicians from your chapter. Visit the **ACEP Grassroots Advocacy Center** for detailed information on how to join the program and start engaging with legislators today!

Preparing to Give Testimony before State Legislators
Harry J. Monroe, Jr.
Director, Chapter and State Relations, ACEP

Over the years, I have worked with many lobbyists preparing for upcoming meetings. In some of those instances, the lobbyist would be gathering information to represent us himself in meetings of stakeholders or legislators or staff. In other instances, the legislator was preparing the client to give testimony at a legislative hearing.

In all of these circumstances, every good lobbyist I have worked with has required an answer to this question: what is the argument of the other side? What will our opponent say?

If you do not have a fair answer to that question, then you are not yet prepared to provide your testimony.

Because we tend to live in an environment in which we share our views with people who agree with them, too often we fail to think through the alternative point of view. Thus, insurers are against us, we often state, for example, because they are only in this for the money. They don't care about their "customers," our patients. The bottom line for their

shareholders is their only concern.

My point is not that there is not a point to this. However, no insurer is going to arrive at a hearing to explain that, you know, we caught him. He doesn't care about anything but making a buck.

There are no Perry Mason endings at legislative hearings. Insurers don't confess.

The truth is that insurers, wrongly I think most of the time, have their own story, their own rationale, for their policy. We have to understand that story so that we are sure to be able to counter it – and to avoid walking into traps as we tell our own story.

None of this to say that we should have a need to fully explain or defend the insurer's point of view. Quite the contrary, a more typical approach, as appropriate, would be to briefly summarize the opposition's position before pivoting to an explanation as to why it is wrong and how we have a better solution to the problem that the policy maker wants to solve.

That sort of response is a way of showing ourselves to be fair minded and solutions oriented. It is a crucial part of effective state advocacy.

Articles of Interest in *Annals of Emergency Medicine*

Sam Shahid, MBBS, MPH
Practice Management Manager, ACEP

ACEP would like to provide you with very brief synopses of the latest articles in ***Annals of Emergency Medicine***. Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Kellogg K, Fairbanks RJ.
Approaching Fatigue and Error in Emergency Medicine: Narrowing the Gap Between Work as Imagined and Work as Really Done.
Annals of Emergency Medicine – April 2018 (**Epub ahead of print**)

This is an editorial commenting on an article by Nicolas Perisco and colleagues, “Influence of Shift Duration on Cognitive Performances of Emergency Physicians: A Prospective Cross-Sectional Study.” The article reports that there was significant cognitive decline after a 24 hour emergency shift, though not one after a 14 hour shift. The editorial goes on to describe some of the consequences of their finding, for example the fact that any cognitive decline likely also occurs in all emergency workers. They suggest we repeat the study using 8 and 12 hours shifts which are more common in the US.

Hall MK, Burns K, Carius M, Erickson M, Hall J, Venkatesh A.
State of the National Emergency Department Workforce: Who Provides Care Where?

This is a cross-sectional study that analyzed the Centers for Medicare and Medicaid Services’ (CMS) 2014 Provider Utilization and Payment Data Physician and Other Supplier Public Use Files and found that of 58,641 unique EM clinicians, 61.1% were classified as EM physicians, 14.3% as non-EM physicians, and 24.5% as advanced practice providers. Among non-EM physicians categorized as EM clinicians, Family Practice and Internal Medicine predominated. They also found that urban counties had a higher portion of EM physicians compared to rural counties.

Stiell IG, Clement C M, Lowe M, Sheehan C, Miller J, Armstrong S, Bailey B, Posselwhite K, Langlais J, Ruddy K, Thorne S, Armstrong A, Dain C, Perry JJ, Vaillancourt C.
Multicentre Program to Implement the Canadian C-Spine Rule by Emergency Department Triage Nurses.

This multicentre two-phase study demonstrated that with training and certification, ED triage nurses can successfully implement the Canadian C-Spine Rule, as reflected by more rapid management of patients, and no missed clinically important spinal injuries.

Lumba-Brown A, Wright DW, Sarmiento K, Houry D.
Emergency Department Implementation of the Centers for Disease Control and Prevention Pediatric Mild Traumatic Brain Injury Guideline Recommendations.

These are the Centers for Disease Control and Prevention’s (CDC) 2018 “Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children,” published in JAMA Pediatrics. As the Emergency Department clinicians may be the first

healthcare provider to evaluate an injured child they play an important role in the recognition and management of mild traumatic brain injury. The key practice-changing takeaways in these new guidelines include: using validated and age-appropriate post-concussion symptom rating scales to aid in diagnosis and prognosis; and incorporating specific recommendations for counseling at the time of ED discharge.

New Resources from ACEP

The following **policy statements** were recently revised and approved by the ACEP Board of Directors:

- Alcohol Advertising
- Trauma Care Systems

Four **information papers and one resource** were recently created by several ACEP committees:

- Disparities in Emergency Care – Public Health and Injury Prevention Committee
- Empiric and Descriptive Analysis of ACEP Charges of Ethical Violations and Other Misconduct – Ethics Committee
- Fostering Diversity in Emergency Medicine through Mentorship, Sponsorship, and Coaching – Academic Affairs Committee
- The Single Accreditation System – Academic Affairs Committee
- Resources: Opioid Counseling in the Emergency Department – Emergency Medicine Practice Committee

These resources will be available on the new ACEP website when it launches later this month. In the meantime, for a copy of any of the above, please contact **Julie Wassom**, ACEP's Policy and Practice Coordinator.

Help Fight to Protect Our Patients Against Anthem's Unlawful Practices

ACEP continues to keep the pressure on Anthem Blue Cross Blue Shield for denying coverage to emergency patients in six states with a **new video campaign**. More will follow if this effort isn't stopped. Anthem's policy violates the prudent layperson standard, as well as 47 state laws.**Spread the word!** #FairCoverage #StopAnthemBCBS

Graduating Residents: Renew your Membership Today!

Take advantage of huge discounts and freebies!

ACEP is offering $20 off national dues, PEER for $50 and a free 2018 Graduating Resident Education Collection of 25 courses specifically for emergency physicians in their first year out.**Click here** to take advantage. Those who renew also get a cool ER/DR T-Shirt and Critical Decisions in Emergency Medicine online free for one year. **Renew now** using Promo Code FOCUS2018. Check it off the list!

Free Training on Medication-Assisted Treatment

Eight hours of training on medication-assisted treatment (MAT) is required to obtain a waiver from the Drug Enforcement Agency to prescribe buprenorphine, one of three medications approved by the FDA for the treatment of opioid use disorder. **Providers Clinical Support System (PCSS)offers free waiver training for physicians to prescribe medication for the treatment of opioid use disorder.**

PCSS uses three formats in training on MAT:

- Live eight-hour training
- "Half and Half" format, which involves 3.75 hours of online training and 4.25 hours of face-to-face training.
- Live training (provided in a webinar format) and an online portion that must be completed after participating in the full live training webinar (Provided twice a month by PCSS partner organization American Osteopathic Academy of Addiction Medicine)

Trainings are open to all practicing physicians. Residents may take the course and apply for their waiver when they receive their DEA license. For upcoming trainings consult the **MAT Waiver Training Calendar**. For more More information on PCSS, **click here**.

Become an Accredited Geriatric Emergency Department Today

Recognizing that one size ED care does not fit all, **The Geriatric Emergency Department Accreditation Program** (GEDA), was developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter. Become accredited and show the public that your institution is focused on the highest standards of care for your community's older citizens.

Make Change Happen in ACEP

The Council meeting is YOUR opportunity to influence the ACEP agenda. If you have a hot topic that you believe ACEP should address, write that resolution! It only takes two members to submit a resolution. **Click here** to learn the ins-and-outs of Council Resolutions, and **click here** to see submission guidelines. **Deadline is July 1, 2018.** Be the change - submit your resolution today.

Welcome New Members

Megan L Hilbert, MD
Matthew Neal, MD

South Carolina College of Emergency Physicians, 2107 Bayberry Court, Columbia, SC 29206