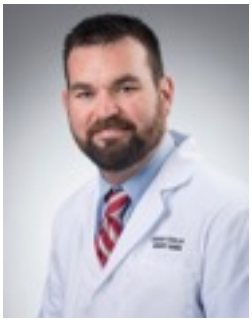
A Newsletter for the Members of the South Carolina Chapter

Summer 2017



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LETTER FROM THE PRESIDENT
Zach Kiker, MD, FACEP

As we move into the fall this year, I am confident that the South Carolina College of Emergency Physicians (SCCEP) is stronger than ever. This is due in large part to immediate past president Dr. Geoff Hayden and his tireless work over the past several years. Geoff, we all owe you a tremendous debt of gratitude.

As I have begun this year as your President, I have been awed by the depth and breadth of talent within this organization. I am honored to serve and work alongside some amazingly talented physicians. This newsletter is packed full of exciting updates about the college and several educational pieces which I hope will be value added for you.

Despite the accomplishments of the past several years, there remains much work to be done this year. The college continues to be actively engaged with the SC Behavioral Health Coalition, which is working to improve the delivery of behavioral health services across the state. We are particularly interested in the design and implementation of crisis stabilization units for acute mental health crises as well as developing programs to prevent and treat substance use disorders. In addition, we are closely monitoring issues of patient access including challenges around the country to the “Prudent Layperson” standard. Finally, two priorities this fall will be -developing an action plan for workplace safety and designing a policy statement on hospital overcrowding. Look for more to come soon on both those topics.

As a primer to this edition, you will hear an update from Dr. Lancer Scott on the accomplishments of the Public Policy Fellowship and exciting updates as we move into year two of that project. As you are well aware, SCCEP has been extremely focused the last several years on the opiate crisis. We are deeply committed to helping reduce unnecessary narcotic prescriptions while still adequately managing acute pain. In this issue, Dr. Dustin Morrow describes the technique for an US guided femoral nerve block, the benefits of having this in your clinical “toolbox”, and how you might implement a program like this at your hospital. Next, you will hear from Dr. Derick Wenning in the inaugural edition of the “Pediatric Emergency Medicine (PEM) Corner” as he outlines pearls and pitfalls in the diagnosis of Non-Accidental Trauma. One of my major goals this year –in light of the recent expansion of training programs in our state - is to develop a working relationship with all of our residencies. You’ll hear updates from all 4 programs and 2 special “Fellowship Spotlights.” Finally, you’ll get an update from our Government Affairs Committee on the ongoing debate around the ACA and much more.

In conclusion, thank you for your time and commitment to the patients of our state - you are truly the safety net. I am excited to see what this year holds and am honored to serve such an amazing group. Please contact me at anytime with ideas about how we can better serve you, our members, and our patients. Thank you!

Best,
Zach

PUBLIC POLICY FELLOWSHIP
Lancer Scott, MD, FACEP

SCCEP Announces 2nd Year of
Public Health Leadership Fellowship.

The state of South Carolina suffers from a fragmented, poorly funded and uncoordinated public health system. According to the **2014 American College of Emergency Physicians (ACEP) Report Card**, South Carolina ranks last in Public Health/Injury Prevention and 45th and 46th in the nation, respectively, for Access to Emergency Care.

Of particular concern is the status of psychiatric emergency medical care in our state. Relative to national averages, South Carolina patients have higher rates of unmet needs when it comes to mental health and substance abuse treatment. They also have higher rates of poverty and lower rates of health insurance. While the demand for mental health services is high, resources are low. SC has lower numbers of psychiatric beds (per capita) and fewer physicians accepting Medicaid than other states. Our emergency providers are finding length of service for mental health patients is increasing at alarming rates. For physicians working in large academic centers, it is not uncommon to find 30% of beds taken by psychiatrics boarders. For physicians working in rural areas, it is not uncommon to find patients waiting 5-10 days for psychiatric placement, receiving only intermittent telehealth consults simply to maintain commitment paperwork.

SCCEP is proud to announce the second year of our ACEP-sponsored Public Health Leadership Fellowship, with the primary mission of developing and advancing public health efforts for the South Carolina College of Emergency Physicians (SCCEP). The goal of the fellowship is to raise the relevance of SCCEP and Emergency Medicine in South Carolina by developing a project that focuses on emergency medicine patients and the critical role EM plays as a health care provider in our state. Secondary goals are to identify and develop young leaders and give them an opportunity to enhance their skills, and finally to be a part of transforming and advancing SouthCarolina's fragmented public health system.

Last year, two SCCEP fellows, Kristen Stoltz (MPH student, USC) and Cindy Oliva (EM Resident, Palmetto Health), worked together with a focus on psychiatric emergency care. They developed a statewide database of leaders in the field of Mental Health as it pertains to Emergency Medicine (private, public and NGO stakeholder list). They also completed an electronic survey of SC ED Medical Directors to better quantify the rate of mental health boarding in Emergency Departments and the resulting impact on ED and hospital operations. The results of their survey were presented during the Southeastern Symposium on Mental Health Annual Conference. “The Impact of Emergency Department Boarding of Psychiatric Patients: A Survey of South CarolinaHospitals,” Greenville, SC May 12th & 13th, 2017.

For additional information, please contact:

South Carolina College of Emergency Physicians (SCCEP)
Attn: **Jackie Boylston**, Executive Director, **Lancer Scott, MD, FACEP**

ASK THE EXPERT: US GUIDED FEMORAL NERVE BLOCK

Dr. Dustin Morrow is a Clinical Assistant Professor of Emergency Medicine at USC School of Medicine Greenville and Chief of the Emergency Ultrasound Division.

Case Presentation:
A 92-year old female arrives after having sustained a mechanical fall at home. She presents with an internally rotated and shortened right lower extremity. Pain is 10/10; initial blood pressure is 90/50; radiograph confirms right femoral neck fracture.

Dr. Morrow, the traditional approach to pain control for this patient would likely involve a combination of limiting mobility, Tylenol, and opiate medications. Why might we consider modifying this approach?

Opiate analgesics have well documented adverse effects, particularly in elderly populations. In addition to hypotension and hypoventilation, opiate exposure is a potent precipitating factor for delirium (Chau et al. 2008) which increases all-cause mortality for 12 months post discharge (McCusker et al. 2002).

What is the role for ultrasound in managing this patient?

The blockade of the femoral nerve and its divisions provides analgesia to most of the hip and knee joints including the skin and muscles of the anterior thigh. Neural axial blockade reduces pain without the risks imposed by opiates (Fletcher et al. 2003).

Ultrasound guided femoral blocks performed in the ED has been shown to reduce opiate use over the course of the hospitalization and reduce pain at rest and during activities of daily living (Riddell et al. 2015; Morrison et al. 2016).

An educational summary of this technique is provided below, with images provided by the New York Society of Regional Anesthesia (NYSORA). We successfully trained our department with a 2-hour course of didactics and hands-on training.

Why should the emergency physician provide this service?

A hip fracture is a true, painful emergency, and we own these patients when they come through our doors. We are often better suited to perform the procedure, as we work in a department that provides cardiac monitoring and other procedure-level resources not necessarily available at the patient's next destination (most often an unmonitored floor bed). As ED lengths of stay and inpatient bed wait times are an increasing issue, we are often managing these patients (including the adverse sequelae of opiates) for longer periods of time. Sure, performing the procedure will take longer than writing an order for an opiate, but it is considerably more rewarding and less frustrating than subsequently managing opiate-induced complications, and more timely than waiting for another specialty to perform the procedure

How can I bring this technique to my department?

Start with the literature: the individual physician may feel estranged from the larger hospital system (Lathrop 2017), but we all share the common goal of improving patient outcomes and decreasing opiate use. We must improve on the current methods of pain management and have the ability to provide the same standard of care no matter what

time of day the patient presents. Get all involved parties together: I started with the support of my department and shared this identified need with hospital administration. Anesthesia shared valuable expertise and appreciated the right of first refusal for the procedure, most often performed in the middle of the night. Orthopedics developed parts of the protocol, including the preferred documentation of a standardized neurologic exam prior to blockade, and guidelines for when this procedure should be held in order to facilitate serial neuro exams (such as when there is concern for compartment syndrome). Demand for the procedure quickly grew as all the involved parties began to observe, in real time, the advantages it provided for their patients.

Ultrasound guided femoral nerve block
Primary indication: Peritrochanteric and femoral neck fractures in adult patients from a low energy mechanism, such as fall from standing.

Contraindications:

- Inability to consent or obtain consent from surrogate decision makers
- Altered mental status to point where it becomes unsafe for patient and clinician
- Rapidly expanding hematoma
- Clinical concern for compartment syndrome
- Abnormal neuro-vascular exam (absent pulses, paralysis indicating nerve damage)
- Open fractures
- Isolated greater tuberosity fracture

Anatomy
Starting with skin anatomy, we identify the anterior superior iliac spine and pubic symphysis in the inguinal crease, from which we locate the pulsatile femoral artery (Figure 1). The femoral nerve lies lateral to the femoral artery and vascular bundle, just underneath the fascia iliaca covering the psoas muscle (Figure 2). The ultrasound probe is oriented perpendicular to the vessel's long axis, pointing to the patient's right side, providing an image that slices transversely through the leg like this cadaver section (Figure 3); in this orientation, the key structures can be identified via ultrasound as in Figure 4.

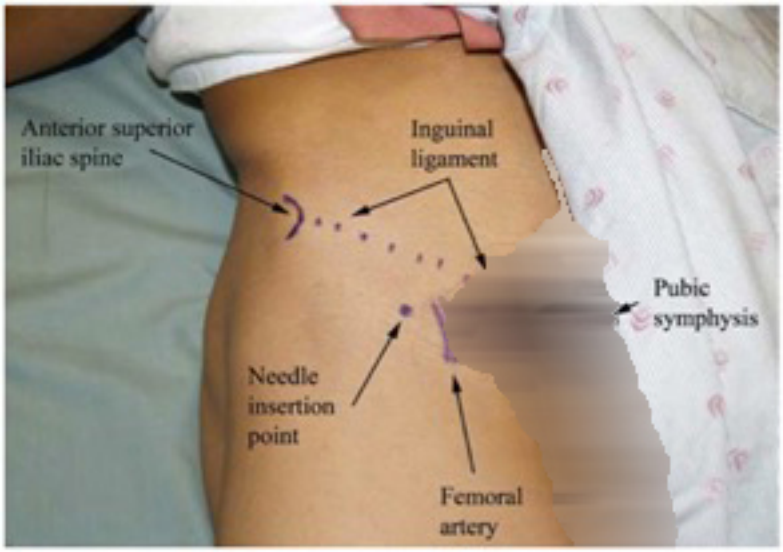

Figure 1. Identifying landmarks via inspection and palpation.

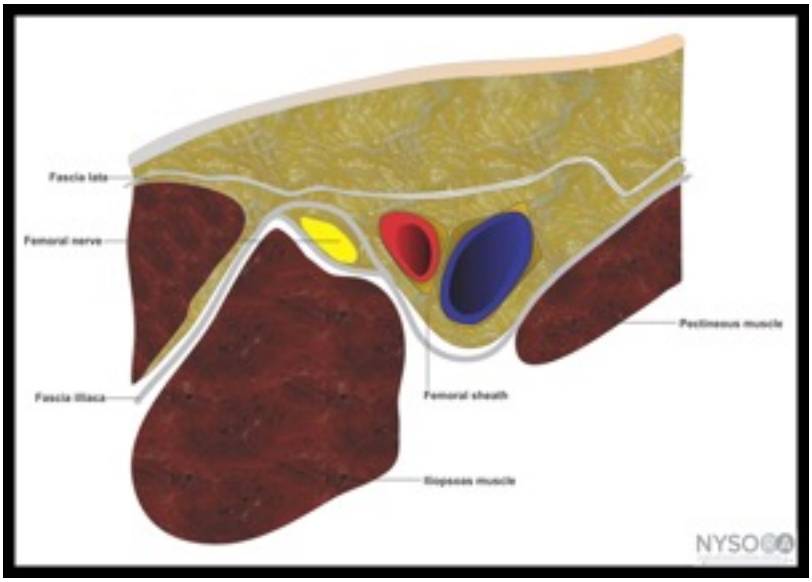

Figure 2. Orientation of the right femoral nerve and vascular bundle in the context of their fascial planes and neighboring muscles.

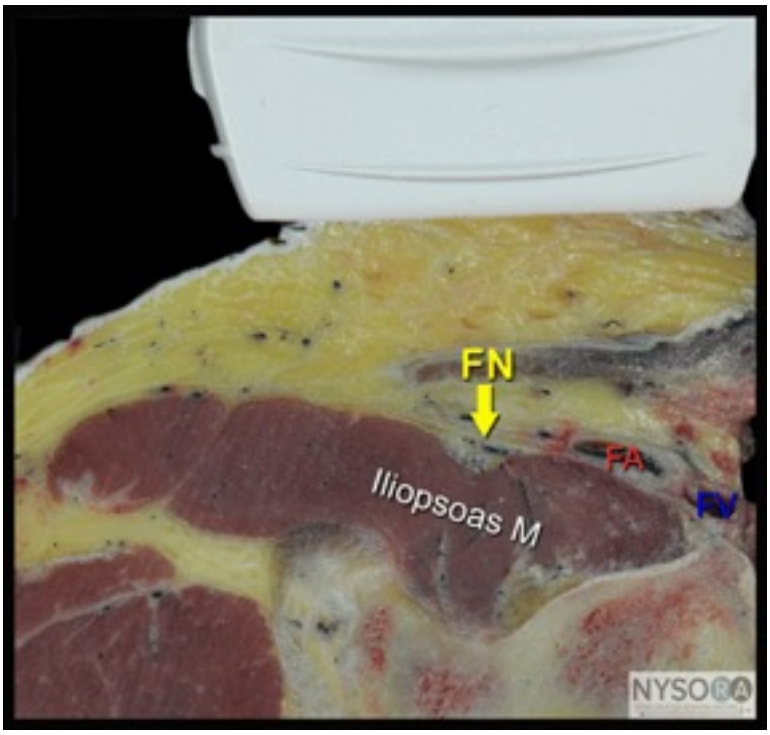

Figure 3. The femoral nerve in the context of its surrounding structures, identified in a cadaver.

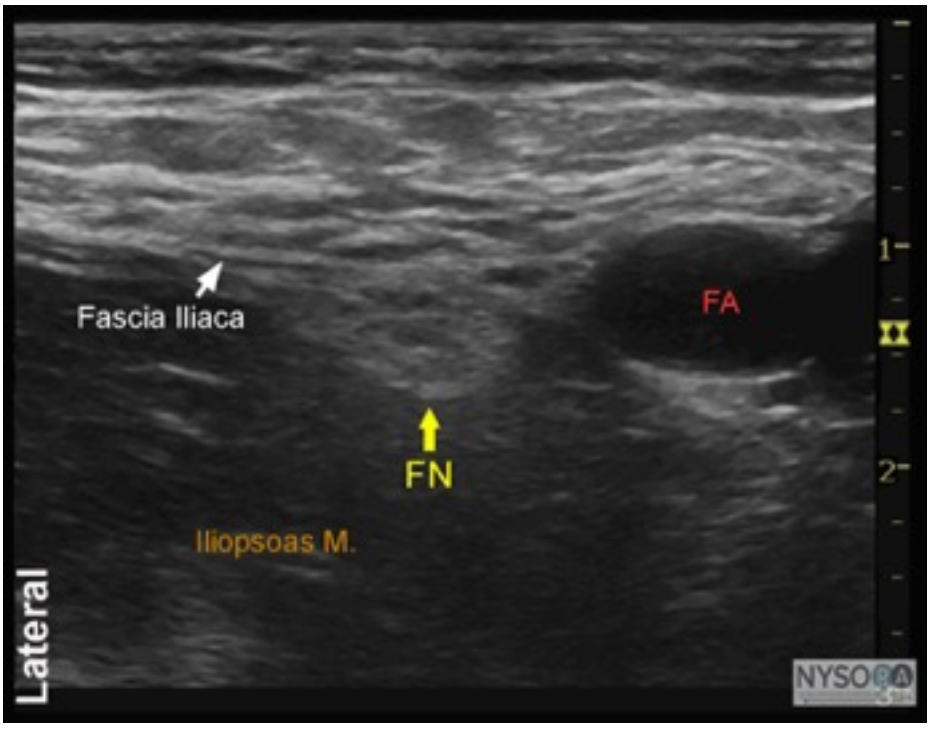

Figure 4. The corresponding ultrasound image to Figure 3, showing the structures which should be identified in order to perform the femoral nerve block successfully.

Anesthetic Safety

Institutionally, we use Ropivicaine due to the higher safety profile (Scott et al. 1989; Neal 2012) than bupivacaine. Both are long acting (12+ hours of analgesia). Lidocaine is shorter-acting and depends on a shorter estimated time to definitive therapy. Possible Agents are described in Table 1.

All staff involved with the procedure and monitoring the patient should be trained in recognition of Local Anesthetic Systemic Toxicity (LAST). LAST most commonly manifests within the first 30 minutes after administration via direct vascular injection (note we are not using a continuous infusion catheter). LAST is usually limited to perioral numbness and tinnitus. The most important intervention is to prevent LAST by using ultrasound guidance; nonetheless, it is essential to continue to monitor for potential LAST by asking your patients about symptoms, having trained staff monitoring them for these symptoms, and having intralipid agents prepared. Reassuringly, no reports in the literature from single injection blocks under ultrasound guidance have been found to date. Additionally, know your agent's limitations and maximum dose. See Lipidrescue.org for details on administration and for provider checklists on safe use and educational resources.

Agent	Without Epinephrine	With Epinephrine	Duration	Notes
Lidocaine	5 mg/kg (max 300mg)	7 mg/kg (max 500mg)	30-90 min	• 1% soln contains 10 mg/ml • 2% soln contains 20 mg/ml
Mepivicaine	7 mg/kg	8 mg/kg		
Bupivicaine	2.5 mg/kg (max 175mg)	3 mg/kg (max 225mg)	6-8 hr	• 0.5% soln contains 5 mg/ml • May cause cardiac arrest if injected intravascularly • Do not buffer with bicarbonate
Ropivacaine	3 mg/kg			

Table 1. Local anesthetic agents. Copied from: (Michael Holtz, Kevin Lu, Ross Donaldson, Daniel Eggeman, Daniel Ostermayer n.d.)

Equipment requirements

- Ultrasound machine with a linear high-frequency vascular probe
- 20-30mL of Ropivicaine 0.2% / Bupivicaine 0.25-0.5% / Lidocaine 1-2% preservative free
- 3-6 inch 22 gauge spinal needles

- 30mL syringes
- 1mL insulin syringes for skin analgesia with lidocaine.
- Skin cleansing agent (chlorhexidine / alcohol / betadine).
- Intralipid on call

First we identify the appropriate patient, as per the indications/contraindications: the patient is usually elderly, s/p a fall from standing, with a radiographically confirmed fracture of the hip. The patient should be consented for this procedure and an assessment of this patient's ability to remain still and be comfortable during the procedure should be made at your best judgment; attempting a deep fascial plane injection near a large artery on a confused or combative patient is often not possible. We want to ensure we perform a thorough neurologic and vascular examination: confirm the presence of pulses, intact sensation, and that the compartment overlying the fracture is not rapidly expanding or tight on palpation to suggest impending compartment syndrome. If there is concern for compartment syndrome or if there is absence of pulses, the procedure should be abandoned and appropriate definitive therapy discussed with the consultant or transferring facility. We make sure to talk with our patient about symptoms of LAST prior to, during, and after the procedure.

We gather our supplies and nursing staff to assist with patient monitoring. We then use the ultrasound to scout the inguinal crease where the fascia iliaca, femoral nerve, and artery are clearly visualized. We use a lateral approach to avoid puncturing and injecting into the nerve bundle, which can cause long standing neuropathy after the procedure. We mark the site of insertion, clean the skin, and place 1mL of lidocaine in the superficial skin as most of the discomfort from the procedure is due to skin puncture. We perform the procedure with the needle parallel with the probe to ensure complete needle visualization throughout the procedure. Once we have penetrated the fascia iliaca lateral to the nerve and artery, we aspirate: aspiration should produce an empty vacuum in the syringe, and no blood, ensuring that we are not in a vessel. We then inject under ultrasound guidance: look at the ultrasound screen while injecting; look for black fluid to spread under the fascia plane of the fascia iliaca and start to dissect medially toward the femoral nerve. Unlike other nerve blocks, the fascia iliaca is a hard stop to anesthetic diffusion, so if we are not below this fascial plane, no amount of agent will penetrate it and no analgesic effect will be obtained. Ultrasound guidance is critical to directly visualize the anesthetic heading toward the target nerve, as in the image series below. Once the procedure is complete we question the patient regarding their pain, perioral numbness, palpitations, confusion, or additional complaints. These questions get repeated at 15 and 30 minutes while the patient remains on cardiac monitor.

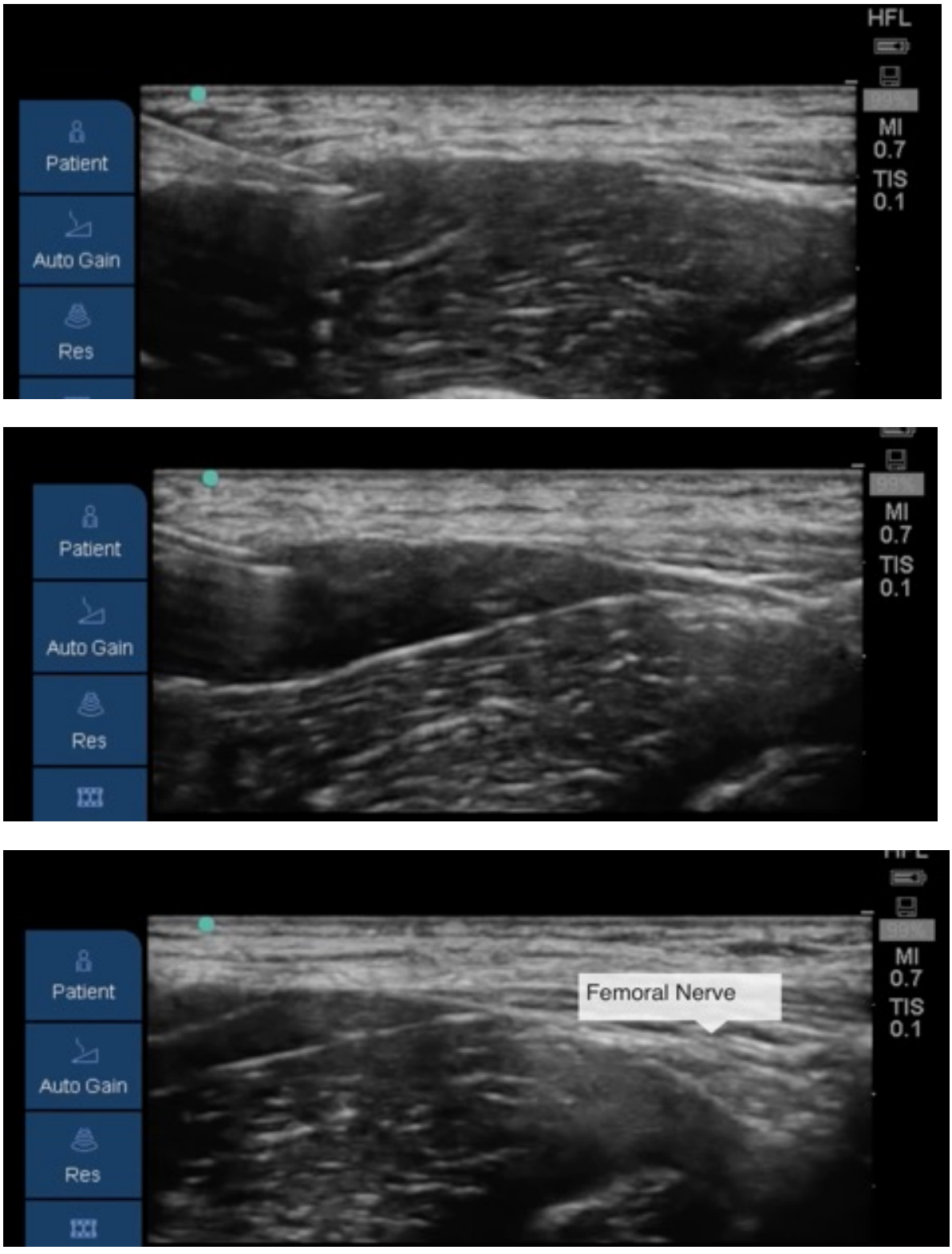
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Figure 5. Beginning, middle, and end images during an ultrasound-guided femoral nerve block. Taken from youtube: **Access full video**.

Image credit: New York Regional Society of Anesthesia nysora.org

Chau, D.L. et al., 2008. Opiates and elderly: Use and side effects. *Clinical Interventions in Aging*, 3(2), pp.273–278.

Fletcher, A.K., Rigby, A.S. & Heyes, F.L.P., 2003. Three-in-one femoral nerve block as analgesia for fractured neck of femur in the emergency department: A randomized, controlled trial. *Annals of Emergency Medicine*, 41(2), pp.227–233.

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Riddell, M., Ospina, M. & Holroyd-Leduc, J.M., 2015. **Use of Femoral Nerve Blocks to Manage Hip Fracture Pain among Older Adults in the Emergency Department: A Systematic Review**. *Cjem*, 18(4), pp.1–8.

Scott, D.B. et al., 1989. Acute toxicity of ropivacaine compared with that of bupivacaine.*Anesthesia and analgesia*, 69(5), pp.563–9.

PEDIATRIC EMERGENCY MEDICINE CORNER

Dr. Derick Wenning is the medical director of the Pediatric Emergency Department at Palmetto Health Children's Hospital in Columbia.

Child Abuse: You are the Frontline of Detection

For my first PEM topic in this year's SCCEP Newsletter, I wanted to shine a light on an unfortunate diagnosis that we all will most likely encounter at one point or another: non-accidental trauma. Approximately, 680,000 infants were determined to be maltreated according to Child Protective Services in 2015 – a number that is likely underreported. Unfortunately, up to 30% of children who die as a result of child abuse have been seen at least once by a healthcare provider for injuries that were unrecognized as an abusive injury. I recognize that there are many barriers in the way of detection and reporting of potential child abuse cases in emergency departments nationwide, and a simple educational newsletter cannot solve this. My hope is to discuss 'red-flag' presentations and injuries that may help you answer the question the next time you are taking care of an injured child: Is this abuse?

First, here are some historical pearls when evaluating an injured child to give you clues to the possibility of NAT (Non-accidental trauma):

- Are there other recent injuries or past fractures?
- Social history – Who lives at home? (e.g. an unrelated adult male)
- History of open DSS/CPS case?
- Family history of substance abuse, mental health diagnoses, or domestic violence?

Another tool that has been recently published as an effective screening tool for child abuse is the ESCAPE questionnaire:

- Is the history consistent?
- Was seeking medical help unnecessarily delayed?
- Does the onset of the injury fit with the developmental level of the child?
- Is the behavior of the child, his or her caregivers, and their interactions appropriate?
- Are the findings of the head-to-toe examination in accordance with the history?
- Are there signals that make you doubt the safety of the child or other family members?

Next, a head-to-toe physical examination can provide clues to non-accidental injuries. The skin is the most commonly injured organ in abuse cases, and bruising to specific areas such as the ear, neck, torso, buttocks, and thighs should raise suspicion of abuse. In addition, other injuries such frenulum tears, mouth, and lip injuries on pre-mobile infants are also concerning injuries requiring further evaluation. Patterned bruising, 'dip' type burn injuries or stocking-type burns are also red-flag findings for abuse.

There are several fractures that have high specificity for non-accidental trauma, and any of the following injuries need to be reported as suspected abuse:

- Posterior rib fractures
- Metaphyseal 'bucket handle' fractures of the extremity
- Scapula fracture
- Sternal fracture
- Spinous process fracture
- Any fracture in a non-ambulatory infant.

Any of these prior listed fractures in a child needs further evaluation with a complete skeletal survey to look for other acute or healing injuries.

So, what do I do if I suspect child abuse?

- Talk to the family and let them know your suspicions. Tell them what is taking place is for the safety of the child and nothing else.
- Notify the police in the county/city where the injury took place.
- Notify DSS/CPS to open a case for possible abuse.
- If the child is less than 2 – order a CT Head and skeletal survey. ***

- Blood work – CBC, PT-PTT-INR, AST/ALT, Amylase/Lipase to assess for blunt abdominal injury. If abdominal labs are abnormal, CT imaging of the abdomen and pelvis is indicated. ***
- If the current injury requires hospitalization, then admit or transfer to an admitting facility.
- Do not discharge a patient home until it has been determined that a home disposition is safe for the child.

***Understandably, if a patient is to be transferred to a pediatric tertiary-care center and the patient is stable, these examinations can be deferred. ***

Thank you for all that you do, and I hope this review has been helpful. Please stay tuned to the next PEM corner, discussing the vital Pediatric specific equipment needed in every community emergency department.

SCCEP EDUCATIONAL UPDATES

Residency Updates

Greenville Health Systems
After years of planning, our first class of emergency medicine residents has arrived in Greenville! The ten residents that comprise our first class (picture attached) have finished their first month of orientation and have started to settle into their intern year. We are so excited to have these young physicians as part of GHS, and they have already made an impact on our department with their enthusiasm, compassion, and incisive questions. Although the charter class has just arrived, we are already preparing for application and interviews for our second class. We have already interviewed several students that have completed an away rotation with us, and will begin accepting applications in ERAS soon. This year has been brought many exciting changes to GHS, and we are looking forward to continuing to grow during our second recruitment season.

Medical University of South Carolina
We are happy to welcome our new first-year class: Dr. Andrew Weber (University of Wisconsin), Dr. Tessa Warner (University of Wisconsin), Dr. Adrienne Soo (UNC), Dr. Jordan McCarhty (MUSC), and Dr. Marykate Kalotschke (SUNY). This is our first new class since becoming a department as of July 1st. We hope to expand the residency for the upcoming year and we will be applying for an additional 4 residents per year. We are excited for a great year!

Palmetto Health
The emergency medicine program at Palmetto Health awarded diplomas to ten wonderful physicians this past June. Five of these graduates began fellowship training in a variety of sub-specialties including emergency ultrasound, EMS, simulation medicine, global health, and resuscitation. This is the highest percentage of graduates going into fellowship training in the program's history. We also welcomed thirteen new interns from nine different medical schools and nine different states. Five of the new interns graduated from medical schools in South Carolina. Finally, all four of the emergency department's fellowships filled with outstanding candidates, and this brings the total number of residents and fellows in training for this academic year to forty-six.

Grand Strand
Emergency Medicine Residency at Grand Strand Medical Center started July 2017 with 12 residents per year. We had an active orientation month that included:

1. ACLS, PALS and ATLS
2. Toxicology day at “Alligator Adventure”
3. EMS day with Myrtle Beach Fire Company including use of the “Jaws of Life” to cut apart vehicles

4. Ultrasound training day at the Horry/Georgetown Ultrasound Training Center
5. Simulation skills day with difficult airway procedures, central lines and suturing techniques
6. All of the residents were trained in ultrasound-guided midline catheter placement
7. Shadowing nurse program was well received by nursing and resident staff

Junior chief residents were selected for the coming year. Our weekly didactic program is up and running including the use of a flipped classroom methodology using Emergency Medicine Fundamentals and Foundations. One of our new residents was honored for swimming out into the ocean on his day off; saving a drowning victim and pulling him back to safety.

Fellowship Spotlights

Palmetto Health Global Health

In August, Palmetto Health Emergency Department welcomed our first Global Health fellow, Carly Brady, a 2017 graduate of the Palmetto Health EM residency program. The Palmetto EM residency has maintained a robust global health program for several years with ongoing programs in Tanzania, Uganda, and India. The majority of our residents participate in some type of global health initiative during their residency training. The fellowship is an exciting addition and will focus on acute care development and research capacity building in resource-poor settings.

The PH Global Health Fellowship is partnering closely with OneWorld Health, a Charleston based nonprofit committed to empowering communities to achieve long-term improvements in health and quality of life. This past March, we marked the initiation of this partnership with a multidisciplinary trauma training session in Masindi, Uganda. The training took place at Masindi Kitara Medical Center in Masindi, Uganda. A total of forty-two healthcare providers including physicians, clinical officers, nurses and midwives traveled from eleven different facilities in Uganda to participate in the session. The conference consisted of lectures derived from the American College of Surgeons' Trauma Evaluation and Management (TEAM) curriculum and covered topics such as rapid assessment of the injured patient, burn management and pediatric trauma.

The most unique aspect of this conference was provided by the Palmetto Health-USCSOM Simulation Center. The didactic lectures were coupled with hands-on experience as the providers were introduced to the concept of simulation medicine as a

training tool. The participants were divided into teams who went through nine separate stations with simulated trauma patients. At each station, the group completed the full ATLS primary and secondary survey and discussed appropriate interventions as pertained to their facility's level of care. One of the most innovative aspects of the conference was a unique, low-cost simulation station in which providers were taught the proper insertion and management of a thoracostomy tube in the setting of acute trauma.

Feedback from the providers was extremely encouraging and as a result the decision was made to make this an annual event. In March of 2018 multiple providers from the PHR EM department including the current Global Health Fellow will return to continue these exciting educational opportunities and lead the 2nd Annual Acute Care Conference in the same location.

Dr. Spenser White teaching the orthopedics session in which providers learned stabilizing measures for femur fractures and pelvic fractures.

The same course was performed twice which allowed the local medical facilities to continue functioning while sending as many providers as possible.

GREENVILLE HEALTH SYSTEM

Primary Care Sports Medicine Fellowship

The Greenville Health System/University of South Carolina School of Medicine Greenville fellowship is a one (or optional two-year) ACGME accredited program sponsored by the Department of Family Medicine. The fellowship is designed to provide comprehensive sports medicine training in musculoskeletal and non-musculoskeletal disease in athletes and active individuals. We provide coverage for professional, collegiate, and high school athletes, as well as, the typical “weekend warrior.”

Our fellows have ample opportunity to work with athletes through prevention, diagnosis, treatment, and rehabilitation of a variety of injuries. Our program is part of an academic health center and as such our physicians provide not only patient care, but also contribute to education, scholarly activity, and service.

Our fellows have extensive exposure to primary care sports medicine faculty, orthopedic surgery faculty, and allied health professionals (athletic trainers, clinical athletic trainers, physical therapists, physiotherapists). There is also extensive team coverage including high school, collegiate, professional (USA Karate and single A baseball).

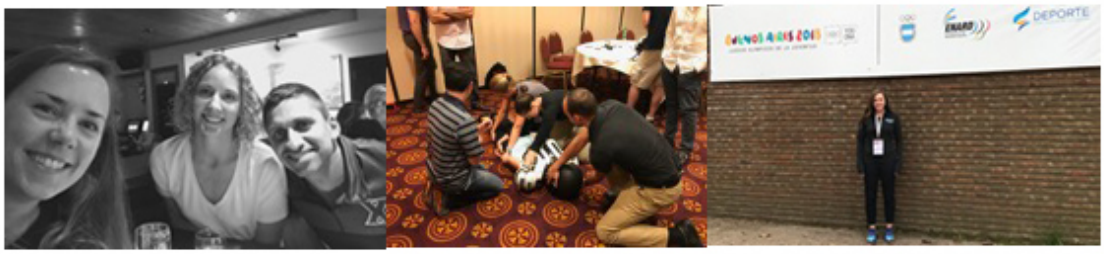
As an Emergency Medicine grad, you are scheduled one shift a week in the GHS emergency department (for which there are multiple locations including the University ED as well as smaller community EDs). There are several EM-boarded sports medicine faculty with whom you work.

You are also given at least half a day per week for dedicated and protected research time.

There are two fellowship positions each year for any field of primary care (EM, IM, Peds, Med-Peds, Family, PM&R). Emergency Medicine applicants are always viewed as exceptional candidates.

Some highlights from the current fellowship year include our attendance at the Fellows Research &

Leadership Conference held in Boulder, Colorado, endless time for learning from our faculty in clinic, as well as Libby's role as the team doctor for the USA Karate Junior National Team as they competed in the PanAmerican Karate Foundation Junior Championships in Buenos Aires, Argentina.


Libby, Jenna and Irf in Boulder, CO

For more information, please visit our **website**.

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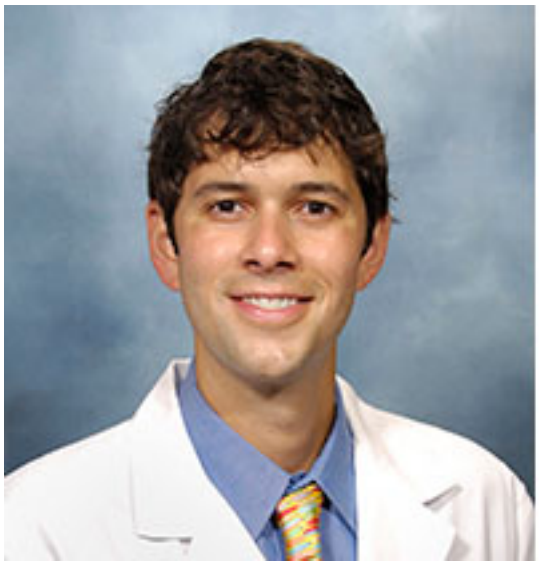
SCCEP GOVERNMENT AFFAIRS UPDATE



Preston Wendell, MD FACEP
Page Bridges, MD
Co-Chairs, SCCEP Government Affairs Committee

Seven years after its passage, the Patient Protection and Affordable Care Act (ACA) continues to be a focus of federal health policy efforts. As in prior years, many Republicans in 2016 campaigned on the promise to repeal and replace this law; after winning the House, Senate, and the Presidency, these efforts began in earnest. After a tumultuous spring and summer, the Senate rejected all proposed bills to repeal this law, and the ACA remains in place. For a timeline with explanation of many of the proposed bills, please **click here**.

Please **click here** for ACEP's statement on future legislation.

At this point, the ACA is in effect, and insurers and patients are continuing into the next enrollment period with the expectation that the law will remain largely unchanged. Over the summer, there were significant concerns over the possibility of numerous counties without any insurers selling on the marketplace. As of late August, however, all counties have at least one insurance provider, indicating increased stability of the markets. For more information about this, please **click here**.

In addition to the ACA, policymakers continued to work on steps to combat the opiate crisis. On July 31, the President's Commission on Combating Drug Addiction and the Opioid Crisis published an interim report that recommended that the President declare a

state of emergency to help address the crisis. The commission made numerous additional recommendations, including increased support for addiction recovery and physician training. A final report is expected later this year with further recommendations and additional details regarding proposals. For more information about the commission and its recommendations, please **click here**.

SCCEP Calendar of Events 2017-2018

ACEP17 October 29-Nov 1, 2017
Washington, DC

SCCEP Fall Board Meeting November 16, 2017

LLSA 3 Year Course Saturday, March 24, 2018
DoubleTree by Hilton Hotel & Suites Charleston, Historic District
181 Church Street, Charleston, SC

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

SCCEP Legislative Day and Annual Meeting, April 2018, Date TBD
Columbia, SC

SCCEP Board Meeting, Thursday June 7, 2018
Kiawah Island, SC *Install new leaders.

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

ACEP assists DMAT teams as they prepare to respond to Hurricane Harvey

Rick Murray, EMT-P
Director, Dept of EMS and Disaster Preparedness

ACEP was pleased to furnish classroom space over the weekend of August 26 to DMAT teams from several states that were staged before they deployed. MN Chapter Executive Shari Augustine, who is a member of the MN DMAT, contacted ACEP staff to inquire of the possibility of using the ACEP Board Room for training for the various teams. Space was provided for training for over 240 members for DMAT teams and U. S. Public Health Service personnel. This provided them the opportunity to receive some last-minute training and briefings before they deployed to various areas of the Texas coast that were impacted by Hurricane Harvey.

ACEP has a lot of **resources for the public** about preparing for and surviving disasters and they are being promoted to general public audiences.

Also, here are some **general talking points** about responding to disasters. They can helpful in talking with the news media.

National Disaster and Life Support Foundation

The National Disaster Life Support Foundation is very pleased to have partnered with the American College of Emergency Physicians (ACEP) to provide disaster medicine training and to further develop the NDLS education materials.

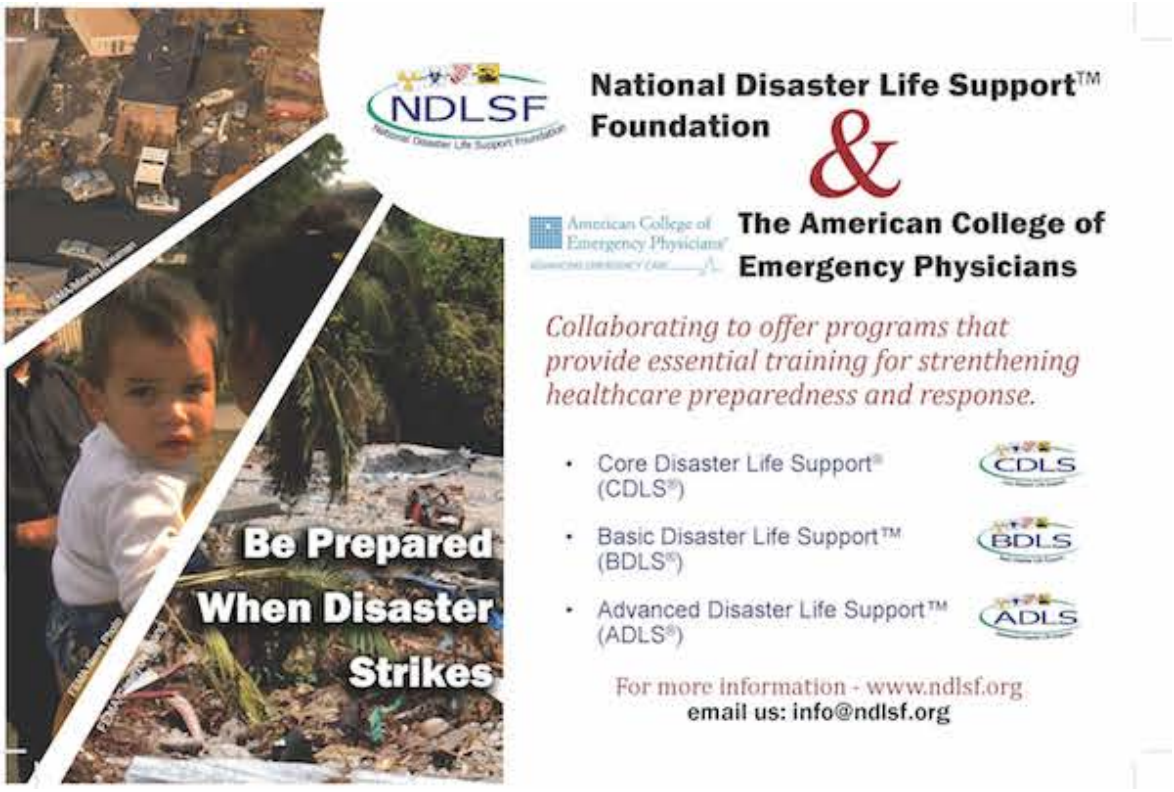
The NDLS program began in the late 1990's with a realization that there was a lack of standardized training for medical and nursing providers who may be responding to disasters. Individuals were medically trained within their specialty to the same National Standard, however disaster specific education was not included in the majority of medical and nursing curricula. Examples of the missing material included:

- Scene safety
- Standardized triage methodology
- Incident Management

- Identifying and requesting needed resources
- What constitutes a disaster
- Public Health impact of disasters

The NDLSF established an affiliated membership-based organization for the purpose of overseeing the development and revision of the curriculum. This organization is the National Disaster Life Support Education Consortium (NDLSEC).

The NDLSEC Annual Meeting will be held in conjunction with ACEP's 2017 Annual Scientific Assembly in Washington, D.C., October 29 – November 1, 2017.

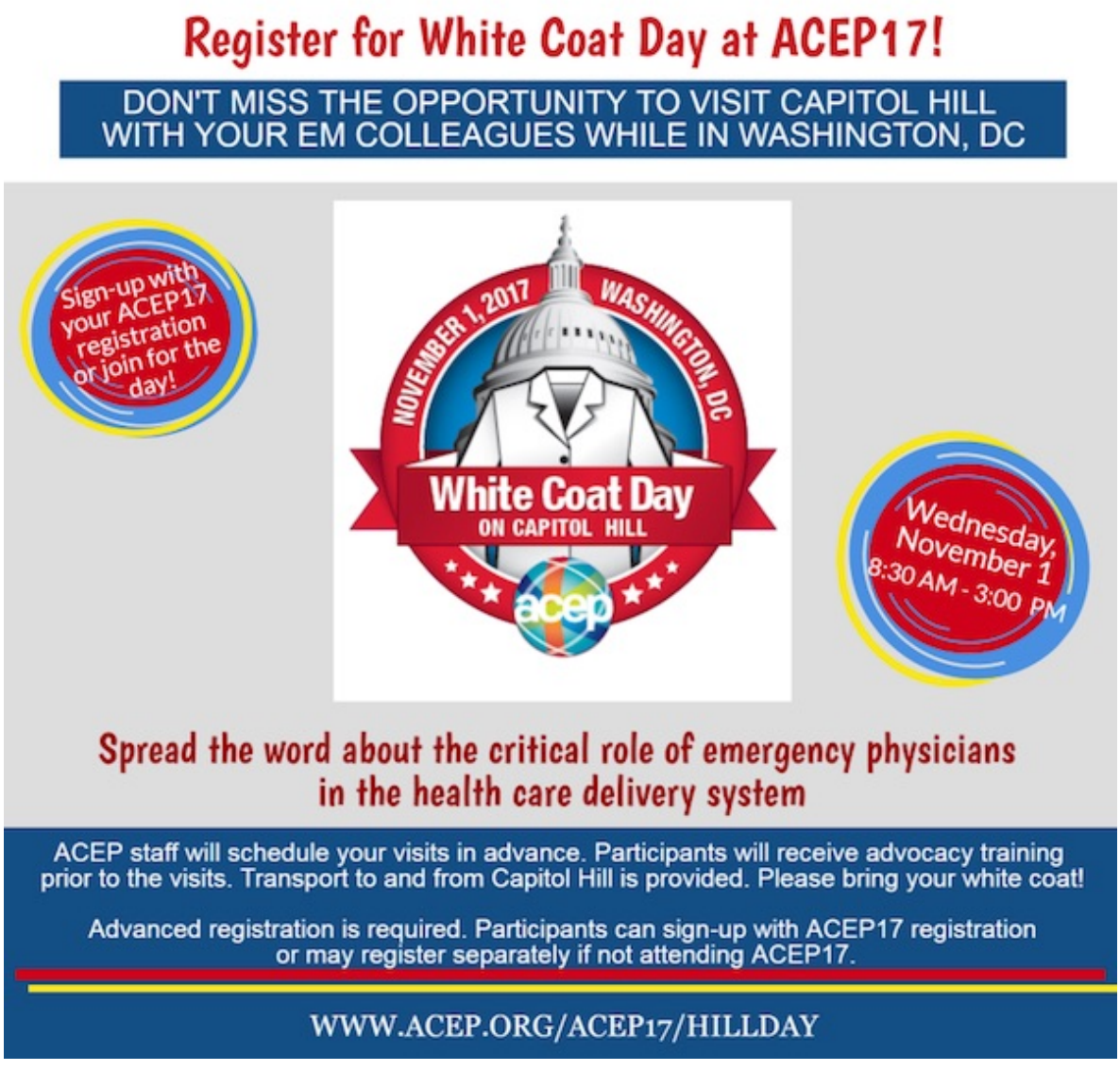


White Coat Day on Capitol Hill at ACEP17

Decisions made by Congress influence the practice and the future of emergency medicine on a daily basis. Join your emergency physician colleagues in Washington, DC on November 1 and spread the word to legislators and their staff about the critical role of

emergency physicians in our nation's health care delivery system. White Coat Day participants will be asked to attend a special advocacy training session prior to heading to Capitol Hill. Transportation will be provided and all participants will receive a customized schedule and materials to share in the meetings.

There is no fee to participate but advanced registration is required. Participants can sign-up as with their ACEP17 registration or may sign-up separately if not registered for ACEP17. Go to**White Coat Day** for more information or contact **Jeanne Slade** in the ACEP DC Office.



ACEP17 Wellness Activities and Resource Center Giveaways

Wellness & ACEP Resource Center
Sunday, October 29 - Tuesday, October 31
Location: Exhibit Hall

Stop by the wellness center in the ACEP Resource Center of the exhibit hall and discover tips from the experts to improve your well being daily. **View full list of activities and schedule.**

Product Giveaways
Held daily in the Resource Center

Sunday –PEER

- PEER one-year membership
- PEER Print Companion

Monday – CDEM

- Trauma special edition
- 2- year print
- One-year Residency Education Portal

Tuesday – ACEP eCME

- My Residency Learning Portal
- Trauma, Stroke, Cardiovascular bundle
- Procedures and skills course
- Featured guest on ACEP Frontline

Articles of Interest in *Annals of Emergency Medicine*

Sandy Schneider, MD, FACEP
ACEP Associate Executive Director, Practice, Policy and Academic Affairs

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. **Read More**

No Emergency Department is Immune from Violence

But you can be better prepared and reduce the risk of harm to your patients, your staff, and yourself. You can implement security measures, changes in your processes and policies, education and training, and attention to design details. Learn how with these new free resources from ACEP, all in one place, easy to find -- **Violence in the Emergency Department: Resources for a Safer Workplace**

Welcome New Members

Josh Bailey, MD
Gregory P Bookout, DO
Brooks M Briel
Ian Broussard, DO
Andrew P Connor, DO
Nicolas E Ellis
Samuel Fleming, MD
Steven Graves, MD
Warren C Harvey, Jr
Aaron M Hittson, MD
Lauren Kinley, DO
Jonathan Leggett, DO
William Alexander Manning, MD
Meridith Marlow
Jacob Pope, DO
James P Pursglove

Robert Razick, MD
Anthony W Rekito, MD
S Russ Richardson, MD
Eric Ritchardson
Matthew Scalise
Bijal Shah, MD
Joshua Shinoff
Patrick Spotts, MD
Robert C Taylor
Caitlin Tidwell, MD
Jimmy L Turner, II
Jacob Wayland, MD
James A Wilkins

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