

The President's Column : Collaboration, Structure, and Recognition

By LTC J. Dave Barry, MC, USA



Our Board of Directors had an especially productive spring and early summer. I'd like to take this opportunity to update you on the projects we're working on for you. Under the direction of our immediate past president, Col. Lee Payne, we revised the chapter's strategic plan, focusing and honing the chapter's goals and measures of effectiveness. This year I hope to build on those objectives by concentrating on a couple noteworthy themes: collaboration, structure and recognition.

Collaboration with other like-minded organizations builds ties within the EM community and expands Government Services scope of influence, allowing us to act as better proponents of issues important to our members and, in turn, more effectively serve them. Government Services has a strong tradition of leadership in the EM community both within national ACEP and in various other EM-focused organizations. The initiative, drive, and leadership of our members is a key resource that we look to utilize not just outside the chapter but also internally. Building leaders prepared for their various leadership roles in terms of knowledge and experience is a major objective outlined by our Board of Directors. Collaboration and mentorship within our chapter is a key component to this objective. Although our annual conference, Government Services Symposium, and the 'collective wisdom' section of our website (including pre-deployment and operational medicine resources, past EPICs and the Annals of Navy EM) serve to promote internal collaboration, I urge you to voice additional ideas you may have.

A strong foundation is essential for GSACEP to best serve the interests of its membership. This was the impetus for Col. Payne's initiative to solidify the chapter's strategic plan, the development of well-defined objectives by the Board of Directors, and an expansion of our committee structure. But the real challenge is building on this foundation by promoting member participation. Involvement in the organization not only serves to improve EM for future members, but also helps to sharpen your own leadership skills, share and discuss contrasting

ideas and viewpoints, foster long-lasting friendships and realize the wide-ranging opportunities available in an EM career both in and out of national service. So, I ask you to participate by sharing your needs and ideas with the Board.

In the near future, we plan to send you a survey to query your opinions on what topics and services are most important to you. After completing the survey (or right now), expand your involvement by joining one of our committees (listed in our Board of Directors section of gsacep.org), and listed here on page 2 of The EPIC), running for GSACEP office, or contributing to an initiative important to you. As an example of a noteworthy initiative, GSACEP recently submitted a resolution to the national ACEP council to educate all EM physicians on the wide-ranging problems of TBI (traumatic brain injury) and PTSD (post-traumatic stress disorder) in the millions of post-war veterans now entering the civilian ranks. Your ideas and passion could be the start of our next resolution.

Finally, it never ceases to amaze me how productive, selfless and accomplished our various members have been. Our Board recognizes this and has expanded the chapter awards and sponsorship opportunities. We profile our Excellence Award winner, COL Dave Della-Giustina, and new award recipients, COL Frank Christopher, and LCDR David Bruner, in this issue of the EPIC. The various award and scholarship opportunities are outlined on the GSACEP website under "What's New at GSACEP." Please take the time to nominate all of your deserving colleagues and acknowledge their widely diverse achievements.

The common theme here is inclusiveness: Inclusiveness by collaborating with our EM brethren in other organizations; inclusiveness in our membership by supporting the priorities of our deployed providers, residents, medical students, VA and active duty members; inclusiveness in participation by serving on GSACEP committees, contributing to initiatives, and/ or nominating your colleagues for awards. I hope you will join me and the Board of Directors in these aspirations.

I look forward to hearing from you, working with you, and serving your interests.

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GSACEP AT SCIENTIFIC ASSEMBLY 2012

Tuesday, October 9, 0900-1100

Location: Embassy Suites, Creston Salon A, 3rd Floor
GSACEP Board of Directors Meeting
All members invited.

Tuesday, October 9, 2000-2200

GSACEP 35th Anniversary Celebration & Honoring
ACEP Council Speaker COL Marco Coppola DO, FACEP
Denver Museum of Art
RSVP required. Look for formal notice in the mail in August

FROM THE EDITOR'S DESK

MAJ Rachel Villacorta-Lyew, MC, USA

Happy Summer to you and welcome to another edition of the GSACEP EPIC! A tremendous amount has happened since our last edition. In this issue are highlights from two outstanding organizational events- The Government Services Symposium, April, 2012, and the ACEP Leadership and Advocacy Conference, May, 2012. GSS 2012, at beautiful Squaw Valley, had excellent educational lectures, networking opportunities, and occasions for recognizing members within our organization for advancing emergency medicine.

The national Leadership and Advocacy Conference is always an energizing event where the movers and shakers of emergency medicine and anyone with a story to share about something they'd like to change about our healthcare system interact with the policy makers of our government. Check out a couple of new perspectives by our scholarship winners.

On the horizon in October 2012, is the ACEP's national Council meeting and their academic Scientific Assembly in Denver. Our chapter will be sponsoring and presenting a resolution to the

national assembly called the Joining Forces Roundtable to promote the recognition and treatment of the increasing population of veterans. Any ACEP member is welcome to take part in the council proceedings up to the voting process. It is an impressive process that takes place prior to the Scientific Assembly. As always, the lectures at Scientific Assembly are fantastic. Also of note, the GSACEP chapter is celebrating its 35th anniversary. Be on the lookout for an invitation to our reception and network with your fellow GSACEP members!

Lastly, I'd like to encourage fellow members to get more involved in the committees of our chapter which include membership, communications and education. This organization exists for its members and it's the members who drive the activities of the organization. The time commitment is variable, but your involvement is vital to have an effective Government Services Chapter. Contact a committee chair for more information!

Enjoy this edition of EPIC!

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THE 2012 GSACEP AWARD WINNERS



COL David Della-Giustina, MD, FACEP, is the 2012 recipient of the Excellence in Military Emergency Medicine Award for lifetime contributions to Military Emergency Medicine. COL Della-Giustina has been Chief of the emergency department at Madigan Army Medical Center (WA) for the past 10 years. COL Della-Giustina has also served as the program director for the Madigan- University of Washington Emergency Medicine Residency from 1998- 2003 and as the Emergency Medicine Consultant to the Army Surgeon General from 2002-2007. He was President of GSACEP from 1999-2000, and a Councillor for GSACEP from 2001 to 2004.

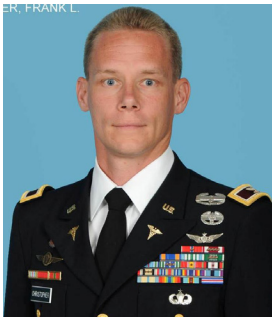
A graduate of the United States Military Academy, COL Della-Giustina received his MD education from the Uniformed Services University of the Health Sciences, and completed his emergency medicine residency training at Madigan. He served as the Associate Program Director of the Emergency Medicine Residency and the Hospital and Departmental Research Director at Darnall Army Community Hospital, Ft. Hood, TX, from 1995 to 1998 before heading to Madigan.

In his distinguished career, COL Della-Giustina has deployed four times, with U.S. Special Operations Command, from 2004 to 2007, in Operation Iraqi Freedom and Operation Enduring Freedom. He received the Combat Medical Badge for providing patient care while under direct fire from the enemy in Iraq.

At Madigan, COL Della-Giustina not only developed the residency program into one of the best and well-respected medical training programs in the Army and the military, but has promoted the evolution of the subspecialty fellowship programs within emergency medicine at Madigan and beyond. He played a major role in establishing the ultrasound fellowship at Madigan, and in solidifying it as a program of excellence. Furthermore, he utilized and applied military experience to advance wilderness medicine and has been integral in developing the wilderness medicine fellowship at Madigan.

COL Della-Giustina holds several university faculty appointments and is often an invited lecturer at GSACEP and at ACEP's Scientific Assembly on numerous occasions. COL Della-Giustina has published many peer-reviewed articles, and is a regular contributor to emergency medicine textbooks. He is a recipient of the 2004 Surgeon General's Physician Recognition Award for Lieutenant Colonel given annually to the most outstanding Lieutenant Colonel physician in the Army based on multiple areas (leadership, teaching, research, clinical, military) and of the 2002 American College of Emergency Physicians National Faculty Teaching Award given annually to 10 physicians for outstanding teaching in emergency medicine.

After 25 years of military service and a medical career demonstrating contributions in the multiple facets of emergency medicine spanning clinical, academic, and leadership excellence, it is an honor to present COL Della-Giustina with the Excellence in Military Emergency Medicine Award.



COL Frank Christopher, MD, is the first recipient of the GSACEP Medical Director Leadership Award for his contributions to the emergency department. COL Christopher has been Chief of the Department of Emergency Medicine and recently transitioned to Deputy Commander for Clinical Services at Womack Army Medical Center, Ft Bragg, NC. Prior to taking this position, COL Christopher was the first physician to command a battalion in combat since Vietnam.

Through his leadership, WAMC's emergency department has accomplished much. It has increased its critical care capacity while reducing the time to provider and overall length of stay for all patients. He was involved in expanding the WAMC ambulance services to meet the needs of a growing military installation. Under his leadership, the department pioneered the model Sexual Assault Nurse Examiner (SANE) program in the Army for their capability to perform forensic exams, having been profiled in the AMEDD Mercury newsletter and The Paraglide. COL Christopher also established the presence of a licensed clinical social worker and the DEM after-hours pharmacy to enhance quality of care for their patients.

COL Christopher established a committee overseeing medical, nursing, and EMT training at all levels which includes a monthly interdepartmental Grand Rounds program attracting speakers of national recognition and averaging over 100 attendees per month. COL Christopher facilitated WAMC joining the Mid Carolina Trauma Regional Advisory Committee, improving cross-jurisdiction and interfacility treatment (and protocols) for trauma patients across the spectrum of injuries. As part of this consortium, WAMC is setting conditions for future establishment as a Level 3 regional trauma center. COL Christopher established the WAMC Department of Emergency Medicine as an educational experience for community emergency medicine at a high volume military treatment facility with a large troop and family population for PGY-3 EM residents at other military programs.

COL Christopher's extraordinary leadership manifests itself in other ways through operational medicine. He is the creator of the in-theater (Iraq) military premedical training centers (winning the Surgeon General's Excalibur Award) and co-creator of the Army Medical Simulation Training Center concept; providing sustainment training for pre-hospital care personnel across the Army.



LCDR David Bruner, MD, is the first recipient of the GSACEP Rising Star Award presented to a young physician who displays exceptional service to GSACEP and leadership to the field of Emergency Medicine.

LCDR Bruner merited this award for many reasons. Recognized as a leader by his peers, he was Chief Resident at Naval Medical Center- Portsmouth in 2008-09 and recipient of the Resident's Attending choice for Junior in both 2010 and 2011.

In addition to his role as Assistant Program Director for Curriculum Development at NMC, Portsmouth's Emergency Medicine Residency Program, he has strong research and writing experience. He has been published in a number of emergency medicine journals and served as a reviewer for several journals. LCDR Bruner is Editor-in-Chief of the Annals of Navy Emergency Medicine and has held that position since 2009.

For the last several years, he has participated as faculty at GSACEP's annual conference, and served this year on the Planning Committee. At national ACEP, Dr. Bruner served on the ACEP Education Committee from 2010-11. He was named Distinguished Fellow in the ACEP Teaching Fellowship program in 2010.

HONORARY MEMBERSHIP



Please congratulate our Government Services Chapter's very own executive director, Ms. Bernadette Carr, for her recognition and award as an Honorary Member of the American College of Emergency Physicians.

Ms. Carr single-handedly leads the most geographically diverse chapter within ACEP with remarkable passion, dedication, and humble selfless service. During her 15 year tenure, the chapter has more than doubled its membership from 447 to over 914 members across the globe in varied government services. In addition to the geographical diversity of the chapter membership, there remains the constant challenge of member turnover and the repeating challenge of developing future leaders from an often junior pool of emergency physicians as members transition out of the military. Bernie is the glue and corporate

knowledge that not just holds the chapter together but has propelled the chapter into being a leader within ACEP. Under her guidance, more chapter members have risen to the highest levels of ACEP leadership as well as expanded their involvement in ACEP committees and Council activities. In addition, the chapter is financially solvent and secure which has been tested to extremes during the past decade of war during which many of the members have prominently served and continue to serve. Under Ms. Carr's leadership, the role of emergency medicine within the military and VA has strengthened due to activities and partnerships within GSACEP and ACEP. In addition she has selflessly served on ACEP Committees and Task Forces, namely National Chapter Relations, Membership, Public Relations, and the Chapter Executives Task Force .

Thank you Bernie for all that you have done on behalf of GSACEP and its members.

RESEARCH FORUM AT THE GOVERNMENT SERVICES SYMPOSIUM 2012

Here are the results of the Research Forum at The Government Services Symposium 2012:

Best Resident Poster: LCDR Elliott Ross - NMCS D

Title: Portable Pulse Oximetry vs. Arterial Blood Gas Analysis in a Field Environment at Altitude

Best Staff Poster: CPT Jason Heiner - SAMMC

Title: Clinical effects and antivenom use for snakebite victims treated at 3 U.S. hospitals in Afghanistan

Best Resident Oral Presentation: LCDR Joe Katora - NMCP

Title: Comparison of 3 commercially available vented chest seals for prevention of tension pneumothorax in a communicating pneumothorax porcine model

Best Staff Oral Presentation: Gillian Schmitz - UCSD

Title: Primary vs. secondary closure of cutaneous abscesses in the ED: a RCT

WINNER OF THE NEW SPEAKERS FORUM

LT Luke Day, MC, USN: Medical Decision-Making and Error in Medicine

PRESIDENT ELECT'S COLUMN

By Col Christopher Scharenbrock, USAF, MC



What a great honor to be selected as the President-elect for Government Services Chapter of the American College of Emergency Physicians. So many outstanding individuals who have been a part of this organization and I believe that we have a truly noble purpose as physicians who take care of our nation's treasures -- the men and woman who have signed on the

dotted line to defend our great country.

I was working a recent shift in the Emergency Department here at Travis Air Force Base in sunny northern California. I was covering the urgent care shift seeing countless kids with colds, minor injuries, retirees who couldn't get appointments. There was the occasional immediate gratification case that attracted me to the specialty -- like the two year old girl with a Nursemaid's whose eyes lit up the moment she realized her radial head was reduced. The next patient though wasn't promising to be as easy: a 45 year old Veteran Affairs patient with hip pain who the triage nurse was saying was demanding an MRI.

In my opinion he didn't need an MRI -- but he needed a doctor. A quick review of his chart revealed that he had been medically retired from the Army as a corporal, most likely because of his diagnosis of bipolar disorder. Further review of pharmacy records showed he was supposed to be on a multitude of medications including Lithium which he was clearly not taking.

As I stepped into the room, I encountered a mountain of a man (at least fifty pounds bigger than me) in relatively good shape who was none too happy. He had managed to go to three other civilian hospitals that day for his hip pain that had been worsening over several weeks and received what sounded like cursory evaluations, one plain film, and a recommendation to see an Orthopedics doctor and get an MRI.

He'd called to set those appointments up and lacking insurance was at least per his recollection told "No". His prescriptions for pain medications were unfilled as he said he didn't have the money to fill them, though he also mentioned later in the interview that he smoked two grams of marijuana per day (No doubt home-grown; this is California, after all).

He had taken the names of all the providers he had seen and mentioned his plans to report them to the state medical board.

So, in summary; a non-compliant veteran bounced from hospital to hospital, claiming he couldn't get into the VA, imposing and unhappy.

Well...what a great case! I think he was surprised when I listened to his story, put him in a gown and actually examined his hip. He was point tender on the posterior margin of the greater trochanter, exacerbated by internal and external rotation. His hip otherwise ranged well, and was afebrile. Plain films looked fine, and I told him he had greater trochanteric bursitis and that we could try injecting it.

I did wimp out and order CBC, CRP, and ESR which, of course, were normal. I talked with the Ortho PA on-call about the case to make sure they had no problem with me doing the case. After a sterile prep, I put 10mg Decadron with 2.5 cc of one percent Lidocaine into the bursa with complete relief of his pain within about 30 seconds.

He left the department practically skipping (a scary thought -- of course I recommended that he should still see his PCM since a little Lithium in his diet might be for the greater good).

As I reflect on the case, I was wondering what other stories this gentleman might have. Was he like the reserve Army sergeant who was generally considered a screw-up, but was the gunner for my HMMVV that put a 50 caliber round directly in the center of the engine of a vehicle careening toward our convoy stopping a potential suicide bomber?

The past decade of war has produced millions of veterans who will need our care. TBI, PTSD, Wounded Warriors have become the new lexicon. I wonder what we as federal emergency physicians can do to better take care of veterans like this one.

I can guarantee that he will be a customer for life in our department -- he'll someday have an even greater malady, no doubt an EP down the road will gain a currency case. Not all military hospitals have memorandums of understanding to take care of veterans. The arrangement here at DGMC allows the VA to reimburse DGMC for the care provided (75 percent CMAC), allowing the hospital to hire additional VA staff to help us take care of their patients. Other regions of the country may have ample VA hospitals to take care of their patients, but I have to wonder why so few board certified Emergency Medicine physicians are employed in the VA healthcare system? And what a great transition for the military EM physician who has either served a career in the military or for various reasons will separate when their commitment is up to be able to find a great job in a VA facility.

I think that's where we need to go: our nation's veterans as well as our retirees, soldiers, sailors, and airmen and their families have sacrificed and they deserve the very best.

RESIDENT SCHOLARSHIP WINNER REPORTS ON ACEP'S LAC

By Capt Katherine Racicot, USAF, MC

This past May, I attended the ACEP Annual Leadership and Advocacy Conference in Washington, DC as one of the GSACEP resident scholarship recipients. First, I would like to thank the leadership of GSACEP for your help in providing me with this wonderful opportunity. The Leadership and Advocacy conference is one of ACEP's most popular events, second only to the yearly Scientific Assembly. The goal of the conference is two-fold, with a focus on creating effective leaders as well as teaching participants how to advocate for our specialty at the local, state, and national level. Although there were many "veteran" attendees, 25% of the attendees were residents, and there were many other first-timers who, like me, were totally new to the policy side of emergency medicine.

The first day of the conference was devoted specifically to first-timers like myself and involved several lectures on introduction to advocacy and current issues in healthcare, as well as group sessions on how to deliver powerful presentations. The second day was devoted to issues facing the specialty, such as liability reform, changes in Medicaid reimbursement, and consequences of the Affordable Care Act. One of the highlights of this day was a presentation from an alumnus of my residency at Wright State, Dr. Nathaniel Schlicher, who was instrumental in successfully advocating for a halt to the Washington State zero-tolerance Medicaid emergency payment policy. Had this law gone into effect, it would have denied Medicaid payment for ED care given to patients diagnosed with one of about 500 conditions deemed by the state to be "non-urgent." Dr. Schlicher and the Washington state chapter of ACEP were able to advocate for their patients and make policymakers recognize that this law violated the "prudent layperson" standard, i.e. the public should not be expected to be able to recognize what is and what is not an emergency. This presentation inspired me by showing how someone who seemed not all that different from me, someone new to advocacy and policy-making, was able to make a difference on a state level, simply by standing up for what he knew was the right thing for his patients.

Feeling ready to tackle the issues, we set off to a day of meetings on Capitol Hill with various legislative representatives. Along with a group from Ohio ACEP, I met with the Legislative Directors for Senator Rob Portman and for Congressman Mike Turner,

from my district in Dayton, Ohio. I was nervous going into these meetings, but I quickly learned that just like anyone else who I talk to about my job, these legislators responded to my stories about my patients. One of the issues we discussed was the abundance of new synthetic drugs, such as "bath salts." The house has already approved H.R 1254 (Synthetic Drug Control Act of 2011), and three similar bills have been proposed in the senate (S. 409, S. 605, and S. 839). I believe that talking about patients I have seen who have suffered serious morbidity and even mortality from these drugs helped the issue stick in the policy-makers' minds and helped show a more human side to a potentially dry piece of legislation. In a similar vein, we discussed the growing shortages of critical emergency department drugs. As emergency medicine physicians, we witness firsthand the consequences that can result for our patients when we are faced with drug shortages. Again, I felt that telling stories of the patient I needed to intubate with no etomidate or succinylcholine or the patient with a hypertensive emergency who I couldn't treat with labetalol secondary to a drug shortage helped drive the issue home. Congress is currently considering a House and Senate version of drug/device user fee legislation that includes measures which would require drug manufacturers to report any potential shortage to the FDA. If the FDA has this information in a timely manner, it will hopefully be able to work with other manufacturers to produce the drug or to reallocate resources to ensure the right drugs are in the ER when we need them.

Actually going to Capitol Hill and meeting with people from the legislature solidified many of the lessons of the conference. I learned how important it is to clearly communicate my message and to make information both easily understandable and memorable when interacting with staffers who meet with hundreds of constituents per day. One of the biggest things I took away from this conference is both how easy and how rewarding it is to become involved in emergency medicine advocacy. I would encourage both residents and attending physicians to not only stay active in GSACEP but to also make contact with their state ACEP chapter. There are many resources on the ACEP website, such as the 911 Network and NEMPAC, ACEP's political action committee. There is truly no better advocate for the specialty of emergency medicine than an emergency medicine physician, and I thank GSACEP again for giving me this opportunity.

“ALL POLITICS IS LOCAL”

By MAJ Christopher Weissman, MD, MHA

I had the incredible opportunity to attend the 2012 ACEP Leadership and Advocacy Conference. The phrase that continued to come to my mind throughout the conference was “all politics is local”. The structure of the conference was to empower members with healthcare policy information and facilitate relationships with their local representatives. The ultimate goal was to position members to effectively advocate for patients and the specialty at the local level. For those, like me, with an interest in healthcare policy, this conference was nirvana. There were two big issues on the minds of many of the conference attendees. One was the Supreme Court’s pending decision on the constitutionality of the health insurance mandate of the Affordable Care Act. A second issue related to how individual state budgetary crises would impact Medicaid reimbursements. The example case for the second issue was the 12-month odyssey Washington ACEP experienced.

The Washington state Healthcare Authority (HCA) manages the state’s Medicaid system. The HCA planned to implement a policy for retrospective reimbursement denials for over 500 diagnoses deemed “unnecessary” and limit patients to 3 ED visits per year. This plan was in response to the perception that overutilization of the Emergency Department is a primary driver of “wasteful” Medicaid spending. In actuality, ED visits are only 2% of all healthcare expenditures. Washington ACEP, the Washington State Medical Association (WSMA) and Washington State Hospital Association (WSHA) participated in a workgroup with the HCA and corroboratively created an alternative plan. The HCA later rejected the plan. Washington ACEP took legal action and won a stay against implementation of the original policy. The workgroup met again and arrived at another compromise which the HCA later rejected...again. The workgroup then took a multi-facet approach by appealing to every “friend” who would listen: the state legislature, CMS, patient advocacy groups, a media campaign... anything to stop the HCA from enacting this policy. Eventually, the Governor suspended the policy in favor of allowing the workgroup to create an alternative plan. The plan addresses some of the drivers of ED overutilization: access to primary care and inappropriate opioid use by patients. Implementation begins July 1, 2012 and success will be based on the level of Medicaid savings. Washington ACEP leveraged every relationship, from local representatives to other specialty organizations and even the Emergency Medicine Action Fund; this led to a patient-centered policy authored by the primary stakeholders to solve a state legislative issue.

My personal highlight of the conference came on the 3rd day when all the members went on scheduled visits with congressional representatives from their area. I went with the lone representative from Hawaii ACEP, Dr. Elizabeth (Libby) Char, on her scheduled



Left to Right: MAJ Christopher Weissman, MD, MHA, Senator Inouye (D-HI), and Dr. Libby Char

visits. Dr. Char is a former EMS director in Honolulu and was born and raised in Hawaii. We were able to meet with staffers from the offices of each House member and a staffer from Senator Akaka’s office. But, the highlight was meeting Senator Daniel Inouye. He is 87 years old and serving his 10th term. He is the longest current serving senator. He is the President Pro Tempore of the United States Senate and Chairman of the Senate Appropriations Committee. More importantly, he is a World War II veteran and Medal of Honor winner from one of the most decorated units of the war. He recounted that he had aspirations of being an orthopedic surgeon prior to losing his right hand in the war. He personally meets with any constituent from HI who makes an appointment to see him in Washington. He knows the island and his constituents well. He knew about the hospital closures in and around Honolulu. He knew about the paucity of specialty care in surrounding islands and challenges of transporting those patients to Honolulu for care. His only concern related to healthcare is how he can leverage his position to help his constituents.

The conference was an incredible experience. I appreciated the importance of establishing relationships with my local representatives. We have the same interest...they want to represent their constituents to the best of their abilities (and be re-elected), while we want to advocate for our patients and specialty in a way that ensures quality, evidence-based medical care. Aiding in finding solutions to problems at the local level is a way of ensuring both agendas are met. The Leadership and Advocacy conference positions members to use relationships with local lawmakers to help them cultivate patient-centered healthcare policies for their constituents. Again, all politics is local.