

A Newsletter for the Members of the Louisiana Chapter

Winter 2017



Mark Rice, MD, FACEP, President

[Nancy Bourgeois](#), Executive Director

Phone: 985.507.1797

From the President Mark Rice, MD, FACEP

Wow, so much has happened since our last newsletter. Our country has elected a new president and the Congress is poised to actually do something instead of sitting in grid lock. Fortunately, our organization, with resources from NEMPAC, will be present and play a role in the shaping of future health policy. Unfortunately I will not be able to attend ACEP's Leadership and Advocacy this year because it falls at the same time as my youngest daughter's first birthday. Several of our members will be attending and I encourage anyone who is free March 12-15 to attend. No the March date is not a typo. This year the date of LAC has changed to March, but next year the tentative plan is to return to the traditional meeting schedule in May. I also encourage our members to sign up for the 911 Legislative Network. This ACEP group does a fantastic job of keeping our members up to date on both local and national healthcare policies effecting emergency medicine. The 911 Legislative Network is currently in need of any emergency physicians in the 5th Congressional District of Louisiana. Rep. Ralph Abraham, MD (R) is the representative from this district and has been extremely hospitable to our delegates in

Washington, D.C. and emergency medicine would benefit greatly from a continued relationship. If you are interested in being more active in emergency medicine policy, then please join.

I would like to thank Dr. Jim Aiken, Dr. Luke LeBas, Dr. Mike Cuba, Dr. Michael Smith, Dr. Dave Coffin, Dr. Owen Grossman, and Dr. Bear Caffery for attending the annual ACEP Council meeting. Our delegation did a great job at representing Louisiana in Las Vegas, NV. All of our Councilors and Alternate Councilors spent time on the council floor representing Louisiana. You may even find some pictures of our councilors performing pushups on the council floor as a way to build awareness of the 22 United States veterans who commit suicide daily. A special thank you to Dr. Jay Kaplan who has served ACEP so well as our president and now will continue service as a Louisiana ACEP member and Immediate Past President of ACEP.

The ACEP Council reviewed many issues and the discussions and debates were often enlightening. Some resolutions that might interest our members include the following:

Resolution 9 Accreditation Standards for Freestanding Emergency Centers

RESOLVED, That ACEP explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers; and be it further

RESOLVED, That ACEP explore the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where they are allowed by state law.

Action: The Board of Directors is currently evaluating the concept. A workgroup will be assigned with representation from the Freestanding Emergency Centers Section.

Resolution 11 CMS Recognition of Independently Licensed Freestanding Emergency Centers

RESOLVED, That ACEP lobby to MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided; and be it further

RESOLVED, That ACEP suggest the AMA lobby MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided.

Resolution 18 Opposition to CMS Mandating Treatment Expectations (as amended)

RESOLVED, That ACEP work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence based care of individual patients; and be it further

RESOLVED, That ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

Resolution 28 Reimbursement for Opioid Counseling

RESOLVED, That ACEP develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for our patients; and be it further

RESOLVED, ACEP develop a toolkit and education for implementing safe opioid use, reversal agent instruction, and drug abuse counseling in our Emergency Departments.

A total of thirty-one resolutions were discussed during the Council meeting. For a more comprehensive review of the resolutions and the dispositions check out ACEP's website.

Finally, my term as your president is coming to a close. I hope you have found favor in my service and I look forward to continuing to be involved in ACEP and our state chapter. We all know that our emergency departments are well oiled machines, but a machine cannot run without the smallest components doing their jobs. All of our board members have done a fantastic job of advocating for emergency medicine over the past two years. The efforts of previous boards as well as this one have brought you increased protection with our battery against a healthcare worker legislation. Our board members have forged relationships on Capitol Hill and here at home with local legislators to better serve you and our patients. Most of all I would like to thank Nancy Bourgeois for her continued dedication and service to Louisiana ACEP. The future of emergency medicine in Louisiana is certain, we will continue to take on a more prominent role within the healthcare industry. I look forward to the future and hope you will join me on our next adventure.

La-ACEP Annual Meeting and Elections

The 2017 annual meeting will be a joint meeting between the Emergency Residency Programs and La-ACEP. The meeting will be held on April 5th in Shreveport, La. The Shreveport Residency program at LSUHSC will be our host. Details regarding the meeting times and location will be sent via separate e-mail in the near future.

Key note speaker will be Dr. Gillian Schmitz, ACEP board member. Dr. Schmitz will speak on Freestanding Emergency Departments, A Growing Trend. Dr. Rice will present an update on the state of the state for La-ACEP. We will also invite members of our state legislature and congressional delegation to discuss the proposed health care legislation and Senator Bill Cassidy's bill, the Patient Freedom Act of 2017.

Election of Officers

The positions of President-elect, Secretary/Treasurer and three board positions are to be filled. Dr. Roland Waguespack has graciously agreed to be on the slate for President-elect. Other nominations will be accepted from the floor. There are three board positions to be filled to replace the positions held by Dr. Luke Le Bas, Dr. David Coffin and Dr. Tracy Legros.

If you have an active interest in your profession and feel that you have the time and talents to offer your organization please consider a position on the board. Our meetings are held by teleconference once a quarter and one annual meeting per year. The time commitment is nominal, most of the correspondence is by e-mail. The office, located in Ponchatoula, is available to assist you in any way possible to help orient you to the work of the state chapter and national organization.

Committee Updates

La-ACEP has representation on a number of statewide commissions and task force groups related to health care and emergency medicine:

LERN- Louisiana Emergency response Network- Dr. Will Freeman, former president of La-ACEP serves as the state chair and there are 9 regional commissions that according to present legislation require an emergency physician to be a member. If any of you are interested in helping to develop and refine the state Trauma and Time Sensitive Illness Program you may contact our headquarters for further information. LERN is also involved with the maintenance and extension of the state STEMI and Stroke prevention and treatment programs.

Psychiatric Admittal Legislative Update- La-ACEP is included in the membership of the committee that is reviewing and updating the current legislation and policies related to psychiatric evaluations, admissions, transfers and treatment alternatives. Dr. Mark Rice and Dr. Jon Cuba represent La-ACEP and Dr. Dan Godbee is an emergency physician member serving as Medical Director for EBR EMS on the committee.

Louisiana Commission on the Prevention of Opioid Abuse - focuses on the epidemic of opioid abuse in our state. Dr. Luke LeBas is our La-ACEP representative and his father, State

Representative LeBas is on the commission. The Governor is sponsoring a series of GovTalks at the state capitol on the subject. The meeting report will highlight the comments, concerns and recommendations on the state's response, treatment and overdose prevention. For more information on the talks or the proceeding from the commission meetings you may contact Jolan.Jolivette@la.gov or (225) 219-7553. Proposed Recommendations from Teams:

Team 1 Identify and evaluate the causes of opioid abuse in Louisiana

1-1. {The team is compiling the information for the commission's report.}

Team 2 Evaluate responsible use of opioid medications, including adoption of "Guidelines for Prescribing Opioids for Chronic Pain (March 2016 from CDC).

2-1. Practitioner licensing boards should adopt the CDC guidelines, which focus on the first twelve weeks of therapy.

2-2. Practitioner licensing boards should adopt the rule Medications Used in the Treatment of Non-Cancer Related Chronic or Intractable Pain, promulgated by the La. State Board of Medical Examiners in April 2000 [LAC 46:XLV.§6915 – 6923]

2-3. Develop roster of addiction medicine specialists and pain management specialist whose consultation should be required for long term therapy; advertise this roster to the prescriber community.

2-4. Educational programming is required in multiple groups, to educate everyone about addiction, alternatives to opioids, and risks v benefits of opioids:

- Professional medical programs need to educate their students;
- Practitioner membership organizations and their licensing boards need to educate their licensees; and
- Practitioners and educators need to teach younger and older adults.

Team 3 Evaluate and recommend reasonable alternatives of medical treatment to mitigate the overutilization of opioid medications, including integrated mental and physical therapy health services.

3-1. Non-opioid therapies should be tried and optimized before considering an opioid prescription, and further, this approach should also be considered in the reassessment of a patient who has received opioid prescriptions.

3-2. There should be an early referral to a psychotherapist when the prescriber lacks sufficient training to apply good evidence-based cognitive behavioral psychology.

3-3. Recognize physical therapy health services as one of the primary treatment paths for managing chronic pain issues.

3-4. Encourage training and utilization of Medication Assisted Treatment (MAT) with methadone, Buprenorphine, and naltrexone.

3-5. Ensure providers are educated regarding utilization of the Prescription Monitoring Program (PMP) data and how to recognize and report potential and actual misuse, abuse, and addiction.

3-6. Adopt a pharmacy formulary by legislation in the Louisiana Workers' Compensation system.

Team 4 Recommend policies and procedures for more effective interagency, intergovernmental, and medical provider communication, cooperation, data sharing, and collaboration with other states, federal government, and local partners (non-profit agencies, hospitals, health care and medical service providers, and academia) to reduce opioid use.

4-1. Prescriber licensing boards should require continuing education regarding the CDC Guidelines; collaborate with academia for curriculum and professional associations for learning opportunities.

4-2. Prescriber licensing boards should encourage use of the PMP and should consider mandatory registration of their licensees to access the program data.

4-3. Establish an Opioid Collaborative group similar to the PMP Advisory Council, for ongoing efforts on this topic.

4-4. Conduct a census of treatment facilities, and then advertise their availability to primary care providers for referrals for MAT.

4-5. Conduct census of secure prescription drop boxes in every parish, and then advertise their availability to increase community awareness and utilization.

Team 5 Evaluate and recommend policies and procedures for improved access and more effective opioid abuse treatment and prenatal care for pregnant women with substance abuse problems, including but not limited to clarifying current services available for those women, increasing the number of providers properly trained to provide care to this group, and effective ways to achieve treatment over incarceration.

5-1. All health care providers to women of reproductive age should utilize the National Quality Family Planning Guidelines.

5-2. Verbal screening for substance abuse should be conducted in the primary care and obstetric settings.

5-3. Universal screening for substance use should be conducted for reproductive age individuals, using validated screening tools such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

5-4. Care providers should use the substance disorder toolkit, forthcoming from the Medicaid Innovator Accelerator Program.

5-5. Universal screening for pregnancy should be conducted in the prescribing provider's office.

5-6. Public and private managed care organizations should develop a preferred network of

physicians or other advanced care providers who are experienced not only in obstetrical care but also the management of opioid maintenance.

5-7. State birthing facilities should obtain authorization from the federal Drug Enforcement Administration (DEA) to allow birthing hospitals at least 72 hours or longer to transition pregnant women to MAT.

5-8. A roster of care providers experienced in the care of women whose babies are at risk of Neonatal Abstinence Syndrome (NAS) should be posted in conspicuous areas in prenatal care and opioid maintenance clinics.

5-9. Providers and clinics that participate in the care of women of reproductive age who are prescribed opiates during the course of treatment, or that are using MAT for addiction, should encourage and offer pregnancy testing during all visits.

5-10. Birthing facilities should define protocols to identify and treat NAS.

5-11. Develop a comprehensive guide of best practices for opiate abuse prevention for prescribers.

5-12. Conduct a study to determine if the 2014 changes to Louisiana's PMP (requirement for prescribers issuing opiate prescriptions for non-cancer related chronic pain to review patient's PMP record prior to issuing the initial prescription) have had any effect.

5-13. Additional research is needed to identify the personal, social, and structural influences that increase the risk of NAS.

5-14. Information about NAS should be incorporated into academic curricula for medical students and residents, as well as continuing education for licensed practitioners.

5-15. The public should be made aware of the effects of substance use prior to and during pregnancy.

5-16. Voluntary evidence-based home visitation programs should be supported as they provide comprehensive management for families struggling with NAS and/or substance abuse issues.

5-17. Training programs for providers who care for NAS-affected families should be improved.

5-18. There is a need for further review and research of referral pathways within and across state and local systems to ensure access to follow-up care for families.

5-19. Healthcare payors, both government and private, should consider adequate reimbursement for care and care coordination services associated with high-risk pregnancies.

5-20. A coordinated care model should be implemented at substance abuse treatment centers.

5-21. A medical home model should be implemented for infants with NAS.

5-22. There is a need to support and expand evidence-based home visitation programs and home-based mental health services.

5-23. Perform systematic environmental scan to identify existing local level practices and innovative models that are effectively coordinating care and supports throughout pregnancy and early childhood.

5-24. Conduct further study to develop more extensive workforce that is well trained to identify

and provide culturally competent interventions for prenatal substance exposure and resultant conditions.

Team 6 Evaluate medical professional training needs and the efficacy of educational materials and public education as an outreach strategy to raise public awareness about the dangers of misuse and abuse of opioid drugs.

6-1. Both student and licensed medical practitioners need education on the following topics:

- Best practices in prescribing opioids for chronic non-cancer related pain;
- The use of opioids after acute injury or surgery;
- The use of opioids in special patient populations, e.g., pregnant women, pediatrics, elderly.
- Alternatives to opioids;
- When to initiate treatment for addiction; and
- Proper prescribing of Buprenorphine.

6-2. Education planners should take note of the Providers' Clinical Support System (PCSS-O) initiative, funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by the American Academy of Addiction Psychiatry. The PCSS-O project maintains an inventory of more than 100 online modules and webinars on topics related to pain, opioids, and addiction, as well as a support network.

6-3. Establish evidence-based treatment requirement for residential treatment programs to embrace the use of maintenance medications.

6-4. Implement public education and awareness programs on availability of naloxone in the state.

6-5. Consider a petition to the federal Food and Drug Administration (FDA) to change the classification of naloxone nasal spray from prescription-only to over-the-counter.

6-6. Develop a commitment to prevention and treatment.

Team 7 Assess alternatives to incarceration and medical treatment of opioid addicted individuals suffering from severe substance abuse disorders.

7-1. Further develop the Louisiana Drug Court Program administered by the Louisiana Supreme Court.

7-2. In lieu of the \$26,000 annual cost for the incarceration of an offender, consider funding the \$5,000 cost of a participant in the drug court program.

7-3. Explore other funding options which may be available through Medicaid expansion.

7-4. Facilitate the access of drug court program personnel to the state PMP database.

Team 8 Recommend any appropriate changes to relevant legislation, administrative rules, or pharmaceutical use to mitigate opioid abuse.

Laws & Rules

2-1.

2-2.

3.6

4.1

4.2

4.3

7-4.

Budget

7-2.

7-3.

Medicare/Medicaid Enhancement Program- DHH has appointed a new Medical Director to replace Dr. Gee, Secretary of DHH, on the Medicare/Medicaid Task Force. Their intention is to create a subcommittee for emergency medicine and EMS that addresses access to care, treatment facilities and reimbursement issues. Dr. Laura Richey sits on the committee along with Dr. Randy Pilgrim and Dr. Jim Aiken.

Alternative Transportation Locations- this work group is reviewing the recommendations regarding alternative destinations outside of the hospital emergency department such as freestanding EDs and Urgent Care Centers. Dr. Chuck Burnell and Dr. Jeff Elder represent La-ACEP on the work group. The group is exploring issues such as medical direction, admitting orders, transfers and pre-hospital liability.

Leadership and Advocacy - The Leadership and Advocacy Conference will be held earlier than usual to accommodate the meeting site in Washington, DC. The meeting will be held on **March 12-15, 2017**. We will be sending three emergency residents, one from each program and they will be accompanied by Dr. Cuba and Dr. LeBas. Anyone interested in attending as a part of the Louisiana delegation should contact headquarters for details. This is clearly an important year for us to meet and network with our new and returning congressional members in this critical period for health care. If any of you have personal contacts with the Louisiana members please let us know so we can make prior contacts with them and their staff before the meeting. Prime scheduling of appointments is essential for maximum success with our visits to the Hill. As you can imagine most of them will be pretty busy during that time and personal visits are challenging.

Patient Freedom Act- Senator Bill Cassidy, sponsor. Senator (doctor) Cassidy has introduced an alternative plan to the Affordable Care Act (Obama Care). Included below is a one page summary of the legislation which has many other sponsors signed on in support. If you have any comments or concerns you may contact Senator Cassidy directly at (202) 224-5824 or send us an e-mail at laacep@bellsouth.net for more information: Repeals: This proposal

repeals burdensome federal mandates imposed by the Affordable Care Act, such as the individual mandate, the employer mandate, the actuarial value requirements that force plans to fit into one of four categories, the age band requirements that drive up costs for young people, and the benefit mandates that often force Americans to pay for coverage they don't need and can't afford.

Keeps: This proposal keeps essential consumer protections, including prohibitions on annual and lifetime limits, prohibition of pre-existing condition exclusions, and prohibitions on discrimination. It also preserves guaranteed issue and guaranteed renewability and allows young adults to stay on their parents' plan until age 26, as well as preserving coverage for mental health and substance use disorders.

State Option: The bill repeals Title I of the ACA (while retaining important consumer protections), and allows states to choose one of three options:

- 1. Reimplementation of the ACA: Option 1 allows the State to reinstate Title I of the ACA, including its mandates and other requirements. The State can continue to receive federal premium tax credits, costsharing subsidies, and Medicaid dollars, to the extent that such subsidies do not exceed the contributions that would have been made under Option 2.
- 2. Choose a New State Alternative: Option 2 allows the State to enact a new market-based system that empowers patients while still ensuring those with pre-existing conditions are protected. The State could continue to receive funding equal to 95% of federal premium tax credits and cost-sharing subsidies, as well as the federal match for Medicaid expansion. States can choose to receive funds in the form of per beneficiary grants or advanceable, refundable tax credits, but in both cases, funds will be deposited in a Roth Health Savings Account (HSA), meaning the money will go directly to the patient.
- 3. Design an Alternative Solution without Federal Assistance: Option 3 would return power to the States to design and regulate insurance markets that work for their specific populations, without any federal assistance.

Option 2: A New State Alternative with Federal Assistance

Who is helped? This proposal provides financial assistance to legal residents of the United States not receiving health insurance through their employer or public programs like Medicare and Medicaid. The goal is to provide roughly the same federal benefit available to those who get insurance through their employer. To ensure that everyone is covered, States will be able to auto-enroll uninsured individuals in basic health care coverage unless that individual opts out.

What are the benefits? The basic health plan would provide all eligible individuals with a Roth Health Savings Account, a high deductible health plan, and a basic pharmacy plan. Americans

could purchase more robust coverage if they chose, and without the ACA's restrictive mandates, the options available would not only likely be more affordable, but individuals could pick among plans to find one that best suits their specific needs. The Patient Freedom Act would also establish new protections for those who need emergency care, by placing limits on out-of-network surcharges for emergency medical services paid for with an HSA. The proposal also requires providers to publish "cash prices" for services paid for with an HSA or with cash.

How is it funded? Each State will receive the same level of funding it would have received under the ACA if 95% of those eligible for subsidies enrolled. In addition, the State will receive the money that would have been paid for a Medicaid expansion. If states have already expanded Medicaid, the State can choose to keep the Medicaid expansion or convert that funding into subsidies to help individuals purchase private insurance. To help Americans access health insurance, States will establish a method for depositing funds for each person directly into that individual's Roth HSA, meaning health care dollars will go directly to the patient.

Executive Director Update Nancy Bourgeois

Happy New Year! We all begin our year with resolutions to make the world a better place. My resolution for La-ACEP is to make our office more accessible and responsible to your needs. We want to help you make decisions about your destination in your professional specialty. If you have questions you can contact us about your membership or we can direct you to the appropriate department and national leaders at ACEP. Having said that, I hope you will contact our headquarters with your request, it is important to us to hear from you. I will get back to you as soon as possible. Unfortunately, we do not have a sizeable staff of full time employees like some states. I can probably handle the "sizeable staff" description but I am the only employee. Don't be discouraged though we do our best between myself and the valuable board members to stay in contact with you and up to date on the needs of our members. Let us know what your issues are-thanks!

While you are contemplating the future and direction of emergency medicine I hope you make the time to read through the great materials at your disposal. The ACEP Journal and monthly ACEP Highlights newsletter are full of valuable information of clinical treatment and professional development. The on-line materials are super, especially ACEPNOW- for example, the recent article entitled ACEP Outlines Flaws, Biases in New England Journal of Medicine Story on Balance Billing. Worthy of your attention and contemplation considering how much

interest our Insurance Commissioner has in the subject.

January 22-28 was the second annual Wellness Week sponsored by ACEP. Many of you are very young and fit, but if there are any of you out there who have had one too many king cakes how about joining me for a challenge to lose 5 pounds this quarter? Remember you are healers, but you are not impervious to health conditions and particularly heart disease. In memory of one of our own, Dr. Jay Smith, medical director of North Oaks Medical Center in Hammond who died tragically in 2016 while on a fishing trip with his colleagues. Rest in Peace Dr. Smith. We celebrate your life and your dedication to your profession.

Clinical News

CT Can Indicate Mortality Risk in Elderly with Trauma

NEW YORK (Reuters Health) – Opportunistic CT screening for osteopenia and sarcopenia in older adults with traumatic injury can provide insight into frailty and one-year mortality, according to Seattle-based researchers.

[Read More](#)

HCV Infections Less Prevalent than Previously Estimated

NEW YORK (Reuters Health) – The global estimate of hepatitis C virus infection (HCV) is lower than previously thought, making World Health Organization targets for reducing infections and HCV-related deaths more attainable, researchers suggest.

[Read More](#)

Free CME for Reading Annals of Emergency Medicine's Practice and Clinical Updates

Earn CME credit while reading the number-one journal in our specialty. Each month, a new Annals of...

[Read More](#)

Diversity and Inclusion: Our Chapters, Our Duty

Ryan P. Adame, MPA, CAE

Deputy Executive Director, California ACEP

Chair, ACEP Chapter Executives Forum Member, ACEP Diversity & Inclusion Task Force

Diversity. Inclusion. Worthy goals or buzzwords? What do they mean to you? What is your reaction when you hear them being discussed? How much have you reflected on the diversity of your leadership, or the opportunities for inclusion in your organization? I hope you will take a moment to consider your answers to these questions, as well as to whatever feelings or emotions you experienced when you read “diversity” and “inclusion” because acknowledging our successes and shortcomings is, I believe, the first step to building organizations that better serve our physicians and, in turn, their patients.

Here are some statistics to consider about ACEP membership: women comprise 26% of total membership, 28% of committee membership, are 26% of committee chairs, and 27% of the Council. In senior leadership, women represent just 12.5% of the ACEP Board of Directors, and just 19% of Chapter presidents are female. Approximately 1% of ACEP members are African-American and another 1.5% are Hispanic. While this is just a sample of membership attributes, there are many, many other aspects of diversity to consider: other ethnic groups to be sure, but also LGBT members, religious cross-sections, as well as generational considerations.

Why does this matter? To me, this matters because we have the opportunity and the duty to help build more diverse organizations that are reflective of the memberships we serve. Beyond diversity, inclusion matters because without meaningful participation by a diverse group of people, diversity can be reduced to a demographic check-box exercise. Our task, in my view, is to assist and, when necessary, lead our physician members in meaningfully integrating voices and perspectives that are as different as the millions of patients they treat every year.

As the staff leaders within our family of organizations, we have unique access to and influence over our programs, our communications, and, most importantly, our leadership. I urge you to examine what your Chapter currently does to ensure better diversity and inclusion in leadership. Maybe right now the answer to that is “nothing.” We all have to start somewhere. Perhaps that means making inroads in your educational conference faculty’s diversity. Perhaps it means that you have to cultivate younger leaders differently, or help connect members from underrepresented groups with current leadership. Many Chapters already have resident members of their Boards of Directors but if you do not, there is another opportunity. Check that your meetings and conferences do not conflict with major religious holidays. Consider programming aimed at unconscious bias and/or health care disparity.

There are many avenues by which our family of organizations – ACEP, Chapters, and EMRA – can build better, more diverse, more inclusive organizations for our members. But first, like our

members do each and every day, we have to triage. We have to look honestly and soberly at our organizations as they are today and ask ourselves how we can make them more diverse, more inclusive for the members of today and tomorrow.

New Congress, New Administration, New Challenges

Now is not the time to sit on the sidelines. Wondering how can you influence health care policy on the national level?

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.

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.

Newly elected and veteran legislators are hiring key staff, getting up to speed on important issues, and setting priorities for the new Congress. Now is the perfect time to reach out on the local level to educate the member about the specialty and offer to serve as a local resource on issues relating to the delivery of health care.

ACEP 911 Legislative Network

Host a Member of Congress in your Emergency Department



59
NEW MEMBERS OF
CONGRESS

Congress is shaping the nation's delivery of health care

CONTACT JEANNE SLADE IN THE
DC OFFICE: JSLADE@ACEP.ORG

ACEP will work with your schedule & provide visit materials.

www.ACEPAdvocacy.org

Go to the [ACEP Grassroots Advocacy Center](#) for detailed information on how to join the program and start engaging with legislators today!

Emergency Department to Hospital Admission and Discharge, Developed and Provided by ACEP, SHM and Our Educational Partner

EARN FREE CME - Heart Failure Management: From the Emergency Department to Hospital Admission and Discharge

Emergency medicine clinicians and hospitalists have a unique, collaborative relationship in the

continuum of care of acute heart failure (AHF) treatment- providing optimal patient care from first point of access through hospitalization to discharge.

Click [here](#) to take this free CME course and get up-to-date, evidence-based information on the clinical presentation of AHF, the importance of an accurate and timely diagnosis, and more! This program developed and presented by ACEP in collaboration with Haymarket and is made possible through an educational grant from Novartis.

Welcome New Members

Matthew T. Burger
Frederic C. McCall, III
Patrick L. McGaully, MD
Christopher Trosclair

**Louisiana Chapter ACEP, P.O. Box 1324,
Ponchatoula, LA 70454**

Copyright © 2016 Louisiana Chapter ACEP. All rights reserved.