



Vol. XXXVI No. 8



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Submissions to the January/February Newsletter should be received by the Chapter office no later than January 20, 2017.



Amid the frigid slings and arrows of a Michigan winter I write to our dedicated membership with not only an update on what the College's recent activities have been and what our efforts will be going forward, but also a reminder that despite the gloomy skies and quite frankly depressing weather, we must take care of our own health. We give *of* ourselves in our clinical and administrative responsibilities, now is the time to give *to* ourselves.

As I am sure many of you are aware, September and October were occupied with preparation for and attendance at ACEP's Council meeting where MCEP's 18 Councilors and 15 Alternate Councilors spent two days passing, defeating, and deliberating resolutions pertinent to our practice. Many resolutions passed each year at ACEP's annual Council meeting help shape our day-to-day clinical practice. I encourage each of you to review the full list of resolutions discussed, available on ACEP's member website.

In November, Diane Bollman, the College's powerhouse and indefatigable Executive Director was diagnosed with Acute Lymphoblastic Leukemia. Members rallied around her and are grateful for all the wonderful staff at Sparrow Hospital who were able to have her healthy for discharge in time for the holidays. Much appreciation is conveyed to all those members who sent flowers, photos, and heartfelt wishes for a swift recovery. Our thoughts and prayers are with Diane and her family going forward into the next phase of her treatment.

On December 7th, MCEP's board of directors held its annual holiday lunch and board meeting. It was the first meeting Diane had missed in more than 25 years and her exuberant presence was sorely missed indeed. Kudos was given to Dr. Brad Uren for his recent appointment to Governor Rick Snyder's Michigan Pharmacy and Therapeutics Committee. Dr. Uren will join the 11-member committee that advises the Michigan Department of Health and Human Services on issues affecting prescription drug coverage and Michigan Medicaid Programs. The board also discussed various issues regarding 2016 CME and educational programming as well as plans going forward in 2017, which include an MCEP collaboration with Ohio ACEP to provide an expanded Midwest medical student symposium next spring.

In state legislative updates, the College now officially supports Michigan POLST legislation, HB 5482 (Physician Orders for Scope of Treatment), a bill that was reviewed by the House Committee on the Judiciary and referred to the order of Second Reading of Bills on November 29th. MCEP again has also signed the Healthcare Leadership Council's petition to repeal the IPAB (Independent Payment Advisory Board), a piece of the ACA legislation with significant bipartisan opposition. The College is also following IMLC (Interstate Medical Licensing Compact) Legislation, HB 4582, which passed in the House in February and has been referred to the Senate Committee on Health Policy for fiscal analysis: 17 states have signed similar legislation and 9 states have legislation introduced and pending.

Senate bill 1019, a bill that would have expanded the scope of practice for nurse anesthetists to work autonomously, died during the lame duck session after successful campaigning by physician groups, including those by MCEP and MSMS. The bill is expected to be re-introduced in the 2017-2018 legislative session.

The board also discussed an upcoming AM radio segment being arranged with the assistance of ACEP to correct misinformation on the opioid epidemic egregiously espoused by misinformed Warren mayor, Jim Fouts

on WJR in September. The mayor's comments suggested that emergency physicians are largely culpable for the problem, comments which give a misleading impression to the public.

This year's Leadership Development Program class graduated at our December board meeting. This year's graduates include: Dr. Jim Berry, Dr. Sara Chakel, Dr. Pamela Coffey, Dr. Michael Gratson, Dr. Dominique Hill, Dr. Jennifer Jaquint, Dr. Robert Klever, Dr. Joel Krauss, Dr. Daniel LaLonde, Dr. Joel Michaelson, Dr. Marcus Moore, and Dr. Kathryn Redinger. Congratulations to an outstanding class! The College is accepting applications for next year's class. Please don't hesitate to contact the office to express your interest or to nominate a colleague.

New business discussed included Michigan's recent pediatric readiness score and the development of a pediatric facility recognition program through EMSC (Emergency Medical Services for Children) and the AAP. The board was delighted and honored to have Dr. Lee Benjamin, Director of Pediatric Emergency Center Clinical Operations at Saint Joseph Mercy Hospital, Ann Arbor, address the board and membership with a brief and succinct presentation on the state of pediatric readiness in Michigan.

Going forward our priorities will be continued legislative support for POLST, CPR in schools, the IPAB repeal, and our continuing work on ED/Hospital boarding and violence against healthcare workers, continuing to follow IMLC legislation, and work on a statewide push system for MAPS data. The College's various other committees also have their own ongoing objectives, including research collaborations, formation of a statewide volunteer member research registry, and a statewide choosing wisely campaign, among many others.

Our upcoming Winter Symposium at Boyne Mountain will once again coincide with ACEP's Wellness Week. I hope many of you will be able to join us at the conference not only for our educational programming, but also for some winter camaraderie and wellness activities, not the least of which include Solace Spa discounts—for those of you who, like myself, recognize their own limits on the slopes and prefer to deflect winter's blow in a warm tub with a hot toddy. In a follow up article I will write a more expansive focus on the current, and rather dismaying, state of physician wellness. But, for now, although it is not incidental to medicine, at the core of the deepest values of our profession is the axiom: "First do no harm". Harmlessness must begin with oneself. If we hope to encourage our patients to enjoy healthy, sustainable lives, we must lead by example. The importance of adopting healthy eating, exercising, and sleeping habits cannot be overemphasized. The need to set boundaries, take a break from technology, manage stress, and nourish creativity, a natural antidote to burnout, must be balanced with the desire to be involved with and engaged in the profession. Indeed perhaps the best advice may be that of two millennia old inscriptions from the temple of Apollo in Delphi: *'Nothing in excess'* and *'Know thyself'*. §



Larisa Trill, MD, FACEP



## TO REDUCE EMERGENCY DEPARTMENT BOARDING AND HOSPITAL CROWDING, LOOK BEYOND THE ED

Many hospitals in the country operate at capacity, and many patients are boarded in the emergency department. Although there are many ED-based flow initiatives, virtually none of these address the most significant impediment to flow: boarding of admitted patients in the emergency department due to lack of inpatient beds. Only a few interventions really have any lasting and significant impact on boarding and capacity.

This is one of a series of interviews that highlight dramatically effective interventions to reduce boarding and crowding. Eugene Litvak, PhD, is a world-renowned expert in hospital flow who made the remarkable discovery that our problem with capacity is driven in large part by elective scheduling, not by ED admissions. We sat down to discuss his experiences tackling the issue of hospital crowding.

### Participants



**Peter Viccellio, MD, FACEP**, is vice chairman of the department of emergency medicine and associate chief medical officer for the Health Sciences Center at Stony Brook University in New York.



**Eugene Litvak, PhD**, is president and CEO of the Institute for Healthcare Optimization and an adjunct professor in operations management at the Harvard School of Public Health in Boston.

**PV: This is one of a series discussing hospital and ED crowding and its impact on patient safety finance, and staffing. How did you get into the whole arena of hospital capacity and flow?**

EL: I came to this country in 1988 from the former Soviet Union. I already had dozens of publications in the United States, and many of my colleagues recommended that I should go anywhere but health care because in this industry, efficiency is not a goal; there is no interest to increase efficiency. That was a red flag for me. I started doing some limited consulting at hospitals and started trying to learn the environment at the hospital, working with the frontline people, ie, nurses, physicians, etc. At that point, I met Dr. Michael Long, an anesthesiologist. At that point, the

question that we were trying to address was, what happens with hospitals overcrowding? We found that at the same time hospitals are getting more and more overcrowded, the hospitals' census and bed occupancy experienced large fluctuations. My initial belief was that everything stemmed from the emergency department. There are two main portals to any hospital. Emergency departments are responsible for over 50 percent of all admissions, and there are elective admissions, mostly surgical, typically responsible for up to 30–35 percent of admissions, the remaining admissions being medical referrals, transfers, etc.

**PV: So your first assumption was that this was due to influx of emergency patients?**

EL: Absolutely. It was based on the common sense for two reasons: First, the volume is the highest among all admits, and second, it's unpredictable by its nature. Elective admissions are smaller in terms of the volume, and their schedule is up to us. Unfortunately, our health care delivery is not always based on common sense.

**PV: What did you find?**

EL: It was impossible for Dr. Long and me to get the data from emergency departments. Nobody wanted to share the data with us. However, we were able to get the data from one operating room. Two transparencies were on the desk in front of us. One of them was bed occupancy, and the other was surgical volume. We found they were overlapping. They had about the same shape. So if you put it up to the window glass and overlap one over another to compare, we found that they practically coincided. That was for me a real aha moment: Emergency department admissions had very little to do with variability. Since then, for years I have talked to many hospital emergency department leaders asking, "Five Tuesdays from now, short of a bus crash or flu epidemic, could you predict approximately how many patients are going to be admitted to your emergency department?" The answer was always yes. Then I asked many operating room managers the same question: "Five weeks from now on Tuesday, how many surgeries are you going to perform?" Given that typically over 70 percent of all surgeries performed are elective, I was very surprised to find out that people cannot answer this question. That, to me, was clear evidence regarding the source of this variability. Of course, this was not just the surgical admissions. This is true for the other elective admissions, eg, cath lab.

**PV: Do you find this to be true at most institutions?**

EL: Practically everywhere. In dozens of hospitals where I asked this question, the answer was the same. It's not just in the United States. It's true in Europe, Canada, you name it. It looks like an international plot against health care cost and quality and the main driver of capacity problems.

**PV: In response to this, there were three things that were implemented that we refer to as smoothing: separating out the emergency surgical flow from the elective surgical flow, smoothing the number of surgeries over the week, and also smoothing them to predict the number of ICU beds needed.**

*(Continued on Page 4)*



## GUEST EDITORIAL

(Continued from Page 3)

EL: That is absolutely correct. Moreover, I would say that's not *an* intervention. That is *the* intervention. We have only two options. The first option is to provide excessive resources to staff at the peak level, which no hospital in the world has resources to do. The other choice is to staff below the peak level, a pivotal way of staffing hospital wards today. Typically, we staff them at the average level that has been documented historically from the last year. About 10 years ago, we received a grant from the Robert Wood Johnson Foundation to study two community and two academic hospitals, and we found that ward bed occupancies changed every hour, if not every half hour. There is absolutely no way that one may have a pool of nurses dynamic enough to address heavy peak volumes because nurses do not live in the hallway to address every hour or half-hour change in the census.

**PV: In the places where you helped to implement smoothing of the elective schedule, what was the end result?**

EL: The end result was huge, both financial and quality wise at every hospital. Cincinnati Children's is probably one of the most impressive examples. When we started working with them on smoothing, their census was at the 76 percent level. In order to address peaks, they planned to build a new tower for \$100 million in capital costs. Each bed in the United States, in terms of the capital cost, varies from \$1.5 million to \$3 million in capital cost alone. Plus, the annual operational cost *per bed* is at least half a million dollars. At the end of our smoothing project, they abandoned their plan to build the new tower. The average census reached 91 percent, a 15 percent increase. Their surgical volume increased dramatically without capacity issues because when we cut off the peak, we filled up the valley. It's not just the peaks that create quality consequences; when we have those valleys, that's a waste of our resources. Their surgical volume dramatically increased, and according to their report, their margin improved by over \$100 million a year. It's not just \$100 million in avoided capital cost; it's an additional over \$100 million a year margin improvement and quality improvement.

**PV: I understand that hospitals had had significant problems with boarding in the emergency department that also disappeared as soon as they smoothed their capacity.**

EL: Boston Medical Center is a Level I trauma center. Their emergency department was constantly overloaded. After surgical smoothing, their ambulance diversion decreased by 20 percent. Their waiting time dropped to 2.8 hours compared to five plus hours at other academic hospitals in Boston. Improvement in the emergency department overcrowding was not at the expense of the surgeon. Due to their nature of being a Level I trauma center, their cases were frequently bumped by the emergent surgeries with gunshot, etc. The number of cancelled or rescheduled cases dropped by 99.5 percent, from the average of 700 a year to about six a year.

**PV: What are the upsides and the downsides?**

EL: Ottawa Hospital is a large academic hospital. They reported a \$9 million margin improvement, and they reported 40 lives were saved in the first year. Why? Because they documented that when the hospital is overcrowded and the operating rooms are overcrowded, the waiting time to get emergent or urgent surgery could become prohibitive, resulting in an increased mortality rate.

**PV: Hospitals are doing so many different things to address crowding. Few**

**have been effective or sustained. Would you consider this intervention just one of many on the list of things that hospitals can do?**

EL: As long as we have those peaks, we are going nowhere. Let me give you another example from 2009 publication in *Critical Care Medicine*. At the Johns Hopkins neurological ICU, authors found that during peaks in admissions, the hospital readmission rate increased by 500 percent. What does that mean? I believe that [the Centers for Medicare & Medicaid Services] suggest that there should be a 20 percent reduction in the hospital readmission. If you do not smooth, you could report a success, with 400 percent instead of 500 readmission rate during those peak days. When I say that Cincinnati Children's was able to improve their margin by \$100 million a year, hospitals of similar size that do not do that will waste \$100 million a year. In terms of safety, cost, readmission rates, and mortality rates, it's dangerous to the patient and the financial well-being of the hospital to ignore these peaks and troughs. I consider this an absolutely essential part of any effort to address crowding. Without it, you will not solve your problem.

**PV: In summary, you have found that smoothing improves the hospital's available capacity to decrease emergency department boarding of admitted patients, and you're going to have steadier nurse-patient ratios without peaks and valleys. It's going to be safer for the patients, it's going to be better for the hospital's financial line, and it's going to actually be better for the doctors, particularly those that are doing elective surgery, because they don't get their cases bumped, their patients are placed in the preferred rooms, and one can run the elective operating room with a higher capacity because it's much more predictable.**

EL: That is absolutely correct. So what is the alternative today? Let's build more beds. The average hospital bed occupancy in the United States is much lower than in any industrialized countries. In the US, it's about 66 percent on average. One-third of our hospitals are empty, and yet we are overcrowded. That's everyday life compared to Canada, for example, when their average bed occupancy is 90 percent. We have this luxury of having a lot of beds, and yet we are overcrowded. Building more beds would not solve the problem.

**PV: Some hospitals reading this will say, though, that they run at an average occupancy of 85-90 percent. Would this apply to them?**

EL: Cincinnati Children's census is about 90 percent. That's the same as in Canada. In Canada, when we started working with the Ottawa Hospital on these issues, they reported their census in excess of 100 percent. If your average bed occupancy is 85 or 90 percent, then every peak in census hits the ceiling. Every peak means that emergency patients are going to be boarded, quality of care is diminished, and yet the next day's valley will result in waste. In short, hospitals lack capacity because of the way they choose to do business.

**PV: What does it take to make this happen? Why isn't every place adopting this?**

EL: That's a key question. The answer is multifactorial. First and foremost, if the hospital does not have an inspired and committed leadership, it's not going to happen. If the hospital CEO, personally, is not supportive of this intervention, it's not going to work. Second, surgeons do not realize that if they agree to smoothing, they would increase their volume, reduce



their overtime, and improve their and patient satisfaction. At Cincinnati Children’s, despite a one-third reduction in waiting time for emergent and urgent surgery, they increased the number of cases and yet the overtime dropped by 57 percent.

“When I say that Cincinnati Children’s was able to improve their margin by \$100 million a year, hospitals of similar size that do not do that will waste \$100 million a year. In terms of safety, cost, readmission rates, and mortality rates, it’s dangerous to the patient and the financial wellbeing of the hospital to ignore these peaks and troughs. I consider this an absolutely essential part of any effort to address crowding. Without it, you will not solve your problem.” —Eugene Litvak, PhD

**PV: I think the principle could be said, by a surgeon, that you don’t cure constipation by adding more colon.**

EL: Absolutely. Leadership and education are critical. Surgeons should be educated to appreciate the benefits of this intervention. The third reason is that in order to accomplish smoothing, hospitals should do pretty intense data analysis. Not all hospitals have these resources, and the government should do its job to invest in hospitals getting the necessary

technical support. Last but not least, I think emergency physicians must do a better job of explaining to the public the real cause of overcrowding and boarding. No matter what you do in your emergency department—and I am not suggesting that emergency departments are flawless—you alone cannot resolve overcrowding. That message should be known by the public.

**PV: What would happen nationwide from implementing this intervention?**

EL: The return on investment would be huge. In 2012, two leading US health policy experts, Dr. Arnold Milstein and Dr. Stephen Shortell, in their piece “Innovations in Care Delivery to Slow Growth of US Health Spending” in the *Journal of the American Medical Association*, estimated that national diffusion of patient-flow optimization—optimally managing patient demand and health care capacity—has the potential to reduce total US per capita spending by 4 percent to 5 percent, which is \$120–\$150 billion a year. This intervention does not require capital investments. Quite the contrary, hospitals that implemented this approach saved millions of dollars and many human lives. §

*This article first appeared in the November 2016 issue of ACEP news. It is reprinted with permission.*

## MCEP Calendar of Events

**January 7-8, 2017**  
EMRAM In-Service  
The Johnson Center  
Howell, Michigan

**January 26-29, 2017**  
Winter Symposium  
Mountain Grand Lodge  
Boyer Falls, Michigan

**January 27, 2017**  
Board of Directors  
Mountain Grand Lodge  
Boyer Falls, Michigan

**March 1, 2017**  
Board of Directors  
Chapter Office  
Lansing, Michigan

**March 9, 2017**  
Critical Care Practice in the ED  
Somerset Inn  
Troy, Michigan

**March 12-15, 2017**  
ACEP Leadership Conference  
Washington, DC

**April 18, 2017**  
SIMWARS/Annual Meeting/  
Research Forum  
CMU Education Building  
Saginaw, MI

**April 27-28, 2017**  
APLS  
Spectrum Health  
Grand Rapids, Michigan

**May 3, 2017**  
Board of Directors  
Chapter Office  
Lansing, Michigan

**May 6, 2017**  
Mock Oral Boards  
Sinai-Grace Hospital  
Detroit, Michigan

**May 12, 2017**  
SaveMIHeart Conference  
Livingston Co. EMS Complex  
Howell, Michigan

**July 30 – August 2, 2017**  
Michigan EM Assembly  
Grand Hotel  
Mackinac Island, Michigan

**July 31, 2017**  
Board of Directors  
Grand Hotel  
Mackinac Island, Michigan

**August 15, 2017**  
Residents’ Assembly  
The Johnson Center  
Howell, Michigan

**September 6, 2017**  
Board of Directors  
Chapter Office  
Lansing, Michigan

**September 11-12, 2017**  
EM Ultrasound Course  
Chapter Office  
Lansing, Michigan

**October 10, 2017**  
MCEP Councillor &  
Board of Directors Meetings  
Chapter Office  
Lansing, Michigan

**October 28-29, 2017**  
ACEP Council Meeting  
Washington, DC

**October 30 – November 2, 2017**  
ACEP Scientific Assembly  
Washington, DC

**November 13, 2017**  
LLSA Review Course  
Chapter Office  
Lansing, MI

**December 6, 2017**  
Board of Directors  
Chapter Office  
Lansing, Michigan

# REIMBURSEMENT CORNER



## Effective 2017, Six New CPT Codes Created for Moderate Sedation

CPT 2017 brings with it 6 new Moderate Sedation codes to replace former Moderate (Conscious) Sedation CPT codes, 99143-99145 & 99148-99150.

**Same Provider Performing Procedure and Sedation** (sedation billed in addition to procedure)

1. 99151 - Initial 15 minutes; patient under 5  
(first 10-22 minutes of intra-service time)
2. 99152 - Initial 15 minutes; patient 5 yrs and over  
(first 10-22 minutes of intra-service time)
3. 99153 - Each additional 15 minutes intra-service time
  - 23-37 minutes = 1 unit
  - 38-52 minutes = 2 units
  - 53-67 minutes = 3 units
  - 68-82 minutes = 4 units

## Other Provider Performing Procedure, Sedation Delivered by Different Provider

1. 99155 - Initial 15 minutes; patient under 5  
(first 10-22 minutes of intra-service time)
2. 99156 - Initial 15 minutes; patient 5 yrs and over  
(first 10-22 minutes of intra-service time)
3. 99157 - Each additional 15 minutes intra-service time
  - 23-37 minutes = 1 unit
  - 38-52 minutes = 2 units
  - 53-67 minutes = 3 units
  - 68-82 minutes = 4 units

## Moderate Sedation Facts:

- Pre-service and post-service activities are included in sedation work, but the time used to calculate moderate sedation includes intra-service time only
- Intra-service time less than 10 minutes is not reportable. Report initial sedation code at 10 minutes
- Intra-service time:
  - \* Begins with the administration of the sedation agent
  - \* Ends when the procedure is completed and patient is stable for recovery
  - \* Ends when continuous face to face time with the patient ceases
- Intra-service time includes:
  - \* Order and administration of initial and subsequent doses of sedating agent(s)
  - \* Continuous face to face attendance of qualified health professional
  - \* Monitoring of patient response to sedating agents (O2 sat, heart rate, BP)
- Moderate sedation is not used to report pain control, minimal sedation, deep sedation or monitored anesthesia care



Lynn Nutting,  
Revenue Cycle Coding Director,  
University of Michigan Health



James Blakeman,  
Senior Vice President, EGO, Inc.

- Beginning in 2017, the procedures below may be billed with sedation. Prior to 2016, procedures contained sedation, but now sedation is separately billed/reimbursed

- 31622- Diagnostic Bronchoscopy
- 32551- Tube Thoracostomy / Insertion Chest Tube
- 33010- Pericardiocentesis
- 36555- Insertion CVP, Under 5 yrs
- 36568- Insertion PICC Line, Under 5 yrs
- 92953- Transcutaneous Pacing
- 92960- Elective Cardioversion

- Payment -Medicare (WPS-Michigan), Performed in Facility Setting, Locality 01 (Macomb, Oakland, Washtenaw & Wayne counties) §

CPT	Work RVU	Total RVU	WPS Pmt
99151	.50	.67	\$24.93
99152	.25	.35	\$12.90
99153	0	0	\$11.22
99155	1.90	2.63	\$97.34
99156	1.65	2.15	\$79.81
99157	1.25	1.63	\$60.43



[www.mcep.org](http://www.mcep.org)



## 2016 YEAR END WRAP-UP

The Michigan Legislature is in session until Thursday, December 15th. They will adjourn until mid-January when the 99th State Legislature is seated. Governor Snyder has set his State of the State for Tuesday, January 17, 2017 at 7p. Lots to cover in this edition so we'll keep it brief and hit the high points.

**Election Results** - Obviously, major changes on the horizon in D.C., especially for healthcare. MCEP will keep in constant contact with ACEP as those changes begin to unfold in the nation's capital. Undoubtedly, any change in D.C. will have an impact on Michigan. One thing that didn't change was the Michigan House of Representatives. The GOP had a 63 seat majority in 2015-16 and will continue to have 63 seats in the next session. The Michigan Supreme Court also stayed at a 5-2 GOP majority. The State Senate is not up until 2018 which will be a huge election year.

**Assaults in the E.D.** - This was MCEP's priority for this year. Unfortunately, it was introduced late in the cycle and the clock ran out on us. However, we have sponsors in the House and Senate lined up for next year. Sen. Ken Horn (R-Frankenmuth) sponsored SB 1082 after discussions with MCEP members in Saginaw this past summer. He plans on reintroducing the bill again next year. Rep. Mike Callton (R-Nashville) and Rep./Dr. Ed Canfield (R-Sebewaing) sponsored HBs 5592 & 93, respectively, to provide for enhanced penalties for assaulting health care professionals in the emergency department. Dr. Canfield plans on reintroducing those bills again next session.

**Opioid use in the state** - We joke sometimes that with 148 legislators in the House and Senate, we have to watch for 148 bills on opiates. It's not quite that bad but there's not a month that goes by without some type of hearing on opioid use and proposals to decrease usage among Michigan's citizens. One of the most dangerous issues to MCEP members is the thought of a small group of legislators to mandate usage of the MAPS system by all physicians.

Dr. Rami Khoury, MCEP's Legislative Chair, spent several hours with Senate Health Policy Chairman Mike Shirkey (R-Jackson) touring Henry Ford Allegiance Emergency Department and discussing the issue. After the meeting, Sen. Shirkey was comfortable with the effort of MCEP members' usage of MAPS and not supportive of the mandating requirement. MCEP testified in the spring on the need for a MAPS upgrade and is assisting the department in testing new system updates.

## NEW LICENSING REQUIREMENTS

"There will be new licensing requirements that emergency physicians need to be aware of including education on identifying victims of human trafficking.

- Training standards for identifying victims of human trafficking - Rule R 338.2413 - **Please note:** This is a one-time training that is separate from continuing education. Licensees renewing for 2017 must complete training by renewal in 2020; renewals for 2018 by 2021, and renewals for 2019 by 2022. Beginning in 2021, completion of the training is a requirement for initial licensure.

For more information please visit [http://w3.lara.state.mi.us/orr/Files/AdminCode/1313\\_2013-114LR\\_AdminCode.pdf](http://w3.lara.state.mi.us/orr/Files/AdminCode/1313_2013-114LR_AdminCode.pdf) for the revised rules».



*Bret Marr, Lobbyist  
Muchmore, Harrington,  
Smalley & Associates*

**A.P.R.N. Legislation** - HB 5400 is sponsored by Rep. Ken Yonker (R-Walker) and sat in the House Health Policy committee for seven months until a deal was cut between the Michigan Nurses Assn and MSMS. The bill has since moved quickly through the process and should be finished by the end of the year.

**C.R.N.A.: SB 1019** - SB 1019, sponsored by Sen. Mike Kowall (R-White Lake), provides an expanded scope of practice for nurse anesthetists. The bill moved through the Senate in September of this year and has had hearings in the House Health Policy Committee. While it doesn't appear to have support of the committee, there's always a chance of the bill being discharged to the floor and voted on by the House. MCEP is opposed to this legislation and will ask members to reach out to their legislator if needed.

**Auto No Fault Reform** - MCEP has watched this issue since early 2015 when the Senate passed a proposal that would have hurt all health care providers. A deal is being negotiated between the health care community and auto insurance representatives to address fraud and attendant care issues. If this issue gets resolved this session, there will be limited talk about auto no fault reform next year. §

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# DR. SELDINGER AND HIS WIRE

By Jamal Adas, MD\*

Frank Borschke, MD, FACEP\*\*

Bradford L. Walters, MD, FACEP\*\*\*

It is quite likely that during your recent ED shift you have used the wire through the needle technique commonly known as the Seldinger wire technique for some procedure. Most likely it was to place a central line. This advancement in intravenous catheterization has not just become ubiquitous, but it has revolutionized the placement of such lines and increased the safety of the procedure. Additionally, it supported the placement of larger lines to facilitate rapid fluid resuscitation and the placement of such things as transvenous pacemakers or Swan-Ganz catheters. The older and more ancient emergency physicians who trained in the era preceding the Seldinger technique can appreciate what a major advancement in emergency medicine and critical care this was.

In that early era central lines were often placed using a device called an Intracath (see picture). The Intracath involved using a large bore needle to access the vein through which one then passed a smaller gauge, single lumen catheter through the needle into the vein. The needle and catheter were then backed out of the vein and skin so that a plastic cover could be clamped over the cutting bevel of the needle. This prevented the cutting bevel of the needle from sheering the catheter. Finally, the line was secured to the skin.

There were many glaring disadvantages of using something like the Intracath. One was the substantial damage that could occur from using such a large bore needle in order to establish a central line. Imagine a 10 to 14 gauge needle inserted into an area where major arteries and the lung are close by. Pneumothorax was a more common complication of central line insertion using the Intracath compared to the use of Seldinger's technique, especially when, in those ancient days, lines were inserted without the use of ultrasound. The needle used to puncture the blood vessel was also larger than the catheter, so leakage around the catheter was common. Another complication was that the sharp bevel of the heavy needle could (and did) cut through the catheter, that fragment could embolize to the heart requiring cardiac catheterization or even surgery to remove.

Needless to say, the Seldinger process of intravenous cannulation was a major advance in safety, reliability, reduction of complications, and the ability to place multi-lumen and specialty devices. One major difference from previous techniques was that the Seldinger technique utilizes a much smaller needle to access the vessel, making it less prone to injure adjacent structures. It also resulted in a smaller puncture hole in the cannulated vessel and a tighter fit around the catheter resulting in less leakage. The end result was that the Seldinger technique took the worry out of being "close" to other important structures; and central lines became a safer and more common procedure, particularly in the ED.

The Seldinger technique is used today for procedures beyond just placement of an intravenous catheter. This includes arterial line placement for monitoring or arterial catheterization. Additionally, variations of the technique have been used for intubation and cricothyroidotomy, where either a wire or stylet/boogie is inserted into the trachea and an endotracheal or cricothyroidotomy tube is passed over it thus guiding the tube into place. Other applications of the Seldinger technique



include the placement of suprapubic catheters, ultrasound or CT guided drainage of abscesses or other fluid collections, and the placement of PEG tubes. Throughout the hospital the process of inserting a needle into an anatomical space, passing a wire through that needle, and then inserting a catheter over the wire occurs on a daily basis.

Dr. Sven-Ivar Seldinger was the man behind this advancement in medicine. But, who exactly was he and how did he come to develop his eponymous technique of catheter insertion? Somewhat surprisingly, Sven-Ivar Seldinger, MD (1921-1998) was a radiologist. He was born in the small town of Mora, Sweden, where his parents ran the Mora Technical Institute. In that environment young Sven became quite accomplished when it came to practical engineering that would serve him well in later life. He trained in medicine at the famed Karolinska Institute just north of Stockholm from 1940-1948, and later went on to train in radiology at the Karolinska Hospital. He remained there for his entire career.

In 1952 as a radiology resident one of his duties would be to cannulate various arteries for arteriography. Devices and techniques in those days were crude, difficult to use, and often the cannula was so narrow it was difficult to inject the necessary volume of contrast rapidly. Seldinger's first attempt in creating a better device used a flexible catheter with a side hole. Through the side hole, he inserted a long needle so that the point came out beyond the end of the catheter by a couple of millimeters. The needle was then inserted through the skin into the targeted artery and withdrawn. A wire was subsequently advanced down the catheter to facilitate further progression into the artery. It sounded functional, but it did not work well in practice.

Seldinger continued to ponder some way to improve the process of cannulating arteries. Looking at the needle, wire, and catheter, he "...had an acute attack of common sense," in the words of Phokion the Greek. He realized he was using the wrong sequence. He found that placing the



needle in the vessel, advancing the wire down the needle, and then passing the catheter over the wire was far more effective. It allowed the large bore catheters necessary for arteriography to be placed successfully and easily. In his first case he successfully cannulated the brachial artery, advanced the catheter up the arm, and after injection of contrast found a mediastinal adenoma that had not been seen during surgery.

One would think that the chief of radiology at the Karolinska would have been thrilled by young Dr. Seldinger's new technique that promised cannulation of almost any artery in the body. However, that was not the case. He demanded that Seldinger do a second project for the thesis necessary to graduate from a radiology residency. In time Seldinger was eventually able to defend his technique successfully by using it to perform percutaneous cholangiograms. He went on to become a respected member of the Karolinska Hospital radiology department. His revolutionary catheter placement technique morphed into the many variations on its theme that we use so often today. While his original intent was to facilitate arterial catheterization, the most common use of the Seldinger wire technique in today's era is to establish a central venous line. Sven-Ivar Seldinger went on to win numerous awards and gain widespread recognition before his death at the age of 67 in 1998.

So, when you do your next central line, take a moment to thank the innovative and brilliant radiologist who first developed the technique that made the procedure more effective and safer.

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**The Intracath –**



The Intracath was commonly used before the various Seldinger-based kits became available. To use it one would remove the needle, catheter, and guard from the sterile bag. Then they would gently place a Tb syringe on the needle (not pictured) so as not to jam the syringe too tightly onto the needle. One then inserted the needle into the desired vessel. Once assuring one had good blood return the Tb syringe was removed and without losing position in the vein the catheter was inserted through needle. One would then back out the needle, with the catheter inside, to a point where it was just outside the skin. They would then clip the green guard over the bevel, careful so as not to crimp the catheter, and suture the guard to the patient's skin. If the catheter did not thread easily into the vein then you could not pull it back, as it could catch on the cutting bevel of the needle and shear off. That sometimes required operative removal of the catheter fragment. The entire process was difficult and fraught with complications. §

\*Dr. Adas is a resident in the Beaumont Health Emergency Medicine Residency.

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\*\*\*Dr. Walters is the assistant emergency medicine residency director and attending physician at William Beaumont Hospital, Royal Oak, MI

## MEMBERS IN THE NEWS

**Gov. Rick Snyder Appoints Dr. Brad Uren to the Michigan Pharmacy and Therapeutics Committee**

Brad Uren, MD, FACEP, Past President of the Michigan College of Emergency Physicians, assistant professor of emergency medicine at the University of Michigan, and WCMS president, has been appointed by Gov. Rick Snyder to the Michigan Pharmacy and Therapeutics Committee.

Uren will join the 11-member board, which advises the Michigan Department of Health and Human Services on issues affecting prescription drug coverage and Michigan Medicaid Programs.

“Dr. Uren has extensive knowledge in this field and I am confident he will make positive contributions to this committee,” Snyder says.

Uren will represent physicians on the committee and will serve the remainder of a two-year term expiring Oct. 1, 2017. §



# PHYSICIANS/POSITIONS AVAILABLE

**BEAUMONT HEALTH:** Beaumont Health Department of Emergency Medicine is seeking candidates for full time employment for the Beaumont Troy Campus. The successful applicant will be board certified/eligible in emergency medicine. Applicants must have M.D. or equivalent. Accredited by the Joint Commission as a Stroke Center of Excellence as well as being an accredited Chest Pain Center and has level 2 trauma designation with a volume approaching 100,000 visits a year. Physician is expected to work 14 shifts/month. Salary and benefits package are competitive. If interested in this opportunity, please forward CV to: Roberta Simone, MSA, BSMT, at [Roberta.Simone@Beaumont.org](mailto:Roberta.Simone@Beaumont.org) [3-3]

**CASS CITY, MI:** Seeking a BC/BE Emergency Medicine Physician for a full-time position in our 5,500 visits/year, low volume Emergency Department. This is an opportunity to practice Emergency Medicine in a spacious new Emergency Department with supportive administration and outstanding ancillary staff. We work 24 hour shifts and have an on-call suite for resting at night. The hospital offers competitive compensation which includes comprehensive benefits, CME and PTO. If interested please send CV to Scott Greib, MD, FACEP at [sgreib@hillsanddales.org](mailto:sgreib@hillsanddales.org) or call 989-912-6296 for more information. [ufn]

**KALAMAZOO, MI:** Growing yet established democratic, group offering competitive benefit and preeminent shareholder package and sign-on bonus. Self-regulated schedule, midlevel coverage, scribe assistance, specialty back-up coverage, teaching opportunities. Looking for Board Certified/Board Eligible Emergency Medicine Physicians/Residents. Full-time, permanent for various level hospitals (from rural to level 1 trauma). Cultural community with easy 2 hour access to either Chicago or Detroit. **Email CV to [corporate@swmes.com](mailto:corporate@swmes.com) Attention President, Jim De Moss, DO, FACEP or [asmith@swmes.com](mailto:asmith@swmes.com) Group info: [www.swmes.com](http://www.swmes.com) [6-4]**

**MEDICAL DIRECTOR, SOUTHWESTERN, MI:** Kalamazoo Emergency Associates, PLC, an established democratic group providing Emergency Care in Kalamazoo, MI, Plainwell, MI, Marshall, MI and Portage, MI is seeking Board Certified or Board Prepared Emergency Physicians. Experience in Emergency Medicine Leadership/Directorship a plus.

Partnership opportunities available. For qualified applicants please forward CV to [kea@borgess.com](mailto:kea@borgess.com) attention Sara Buchanan. [3-2]

**PETOSKEY, MI:** Northern Michigan Emergency Physicians, PC, a well-established democratic group providing the Emergency Services in Petoskey for 17+ years, is seeking a Full-Time BC/BE Emergency Physician. Stable contract with competitive compensation and benefit package. Excellent reputation and relationship with Administration and Medical Staff. Regional Referral Hospital with comprehensive subspecialty coverage and annual ED volume of 25,000 visits. 4 Physician shifts and 1 APC shift/day. For details contact Kal A. Attie, MD, FACEP at 231-838-2655 / [kalattie@mac.com](mailto:kalattie@mac.com). [3-3]

**PHYSICIAN HEALTHCARE NETWORK/MCLAREN PORT HURON:** Physician HealthCare Network's Emergency Medicine Department is offering a career opportunity that provides the option to work in a diverse practice environment, seeing a higher level of acuity and treating a more rural patient population at McLaren Port Huron Emergency Center. Physician HealthCare Network, PC, is a Multi-Specialty Group based in Port Huron, MI that is physician owned, offering a wide variety of services to the community. McLaren Port Huron Hospital is a 186 bed not-for-profit facility treating nearly 42,000 emergency room patient visits a year. You will have the opportunity of a partnership track position with excellent compensation and bonus potential, a robust profit sharing/401k participation, comprehensive benefits, pleasing work environment with outstanding staff and physician assistant support, a variety of shift options and strong collaboration with your partners. With its location on Lake Huron and the St. Clair River, Port Huron offers sandy beaches, friendly parks, convenient marinas along with beautiful scenery. Port Huron provides easy access to major airports and the metro Detroit area: including the arts, fine dining and many major sports teams. Interested candidates please contact: Todd Dillon 314-236-4496 [tdillon@cejkasearch.com](mailto:tdillon@cejkasearch.com) [5-3]

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## FREE DENTAL CARE FOR LOW INCOME ELDERLY AND DISABLED PATIENTS

The Michigan Donated Dental Services (DDS) program is accepting applications from Michigan residents who are elderly, permanently disabled, or medically compromised. Applicants must be in need of extensive dental treatment, have no dental insurance, and have income below 200% of the federal poverty level. The program does provide dentures and partials but does not do orthodontics or emergency treatment. Some areas of the state may experience a wait time but applications are being sought in the following areas: Ingham County, Washtenaw County, Northern Oakland County, Hillsdale/Lenawee Counties, and Emmet County. All care is donated and provided by volunteer dentists and dental labs. Applicants must be able to arrange reliable transportation. Applications can be found online at <http://www.smilemichigan.com/DDS> or by calling 517-346-9455 (Southeast Michigan) or 517-346-9454 (rest of the state).



By: May T. Tun, MD and Anne Messman, MD of the Emergency Medicine Residency Program at Wayne State University/Detroit Medical Center/Sinai Grace Hospital, Detroit, MI.

## PAINFUL WRIST IN A 25 YEAR OLD MALE

**Introduction:** A 25-year-old previously healthy African American male presented to the emergency department with a complaint of left arm pain for the past one day. He awoke with the pain and it worsened throughout the day. The pain was diffuse throughout his left upper extremity but worst at his wrist and exacerbated by movement. He denied any trauma to the area, fever, chills, numbness or tingling in the left arm, or any rashes or penile discharge. He denied any past medical or surgical history. He had no drug allergies and was not taking any medications. He had occasional marijuana, alcohol and tobacco usage. His vital signs were within normal limits and he was afebrile. On examination, the patient was alert and oriented, and in moderate distress secondary to pain. Cardiac, pulmonary, and abdominal examinations were benign. The left upper extremity was diffusely tender to palpation throughout, worst at the left wrist. Any passive or active range of motion of the left upper extremity caused extreme pain. There were no signs of trauma, focal swelling, warmth or erythema in the left upper extremity. Sensation was intact and pulses were equal in all extremities. Initial laboratory tests were notable for a WBC count of 13.5, increased bands of 0.9 K/CUMM and 85% neutrophils. BMP was normal. ESR was normal at 10. X-ray with four views of the left wrist showed no abnormalities.

**ED/hospital course:** The patient received morphine 6 mg IV to control his pain, which had to be re-dosed several times secondary to severe pain. Repeat vital signs showed an increase in temperature from 36.3 C to 37.8 C. The patient was then admitted for further work-up.

During his inpatient course, C-reactive protein (CRP) was obtained which was elevated at 22.7 mg/L. Blood cultures and urinalysis were negative. The patient was empirically started on IV ceftriaxone and vancomycin. Orthopedic surgery was consulted and the patient underwent arthrocentesis of the left wrist; 2 mL of yellow turbid fluid was removed. This grew rare coagulase-negative *Staphylococcus* and rare beta lactamase-positive *Moraxella catarrhalis*. He subsequently received left wrist arthrotomy for irrigation and drainage of the infection and partial synovectomy. He was discharged 2 days later on oral antibiotics for 2 weeks.

**Discussion:** Septic arthritis is caused by microbial infiltration of the joint space. The prevalence of septic arthritis in ED patients presenting with monoarticular arthritis is as high as 27%.<sup>1</sup> Risk factors include IV drug usage, low socioeconomic status, alcoholism, diabetes, skin infections, immunosuppression, chronic arthritis, recent joint surgery and prosthetic joints.<sup>2</sup> Wrist septic arthritis is less common than other joints, and the most common causative organism is *Staphylococcus aureus*.<sup>3</sup> The classic presentation includes fever, painful active and passive range of motion, warmth, and effusion; pain is the most common finding with the highest sensitivity.<sup>4</sup> Given the non-distensible nature of the wrist, effusion can be minimal.<sup>3</sup> X-ray of the affected joint may show soft-tissue swelling, cartilage and joint space destruction, or can be normal.<sup>5</sup>

Typical laboratory abnormalities include an elevated WBC, ESR and CRP. A study of ED patients with septic arthritis showed ESR and CRP to have sensitivities of 90%. However, a meta-analysis study showed ESR

to have poor specificity.<sup>4,6</sup> There is no reliable laboratory marker to rule-out septic arthritis. The definitive diagnosis is arthrocentesis with synovial fluid analysis showing a WBC count of >50,000/mm<sup>3</sup> with >90% PMNs. Gram stain of the synovial fluid may have bacteria but a negative gram stain does not exclude the diagnosis. Synovial cultures should be obtained for definite diagnosis. Early diagnosis and treatment is the key to avoid any disabling complications. The patient should be admitted for IV antibiotics and orthopedic consultation. Antibiotic choice includes cefazolin for gram positive organisms with vancomycin if MRSA is suspected, or ceftriaxone for gram-negative bacilli.<sup>2</sup> A short course of IV antibiotics with an additional 2-3 weeks of oral therapy is sufficient.<sup>7</sup> Septic arthritis can cause high morbidity and mortality with a delay in treatment. There is no set diagnostic criteria for septic arthritis in adults. Practitioners should maintain a high index of suspicion for septic arthritis in patients with severe joint tenderness even in the absence of risk factors and unclear laboratory testing. §

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## RECENT GRADS BEGIN CAREERS ACROSS COUNTRY

With a total of 26 (allopathic and osteopathic) emergency medicine residencies, Michigan sends many of its newly trained emergency medicine physicians all over the United States and the globe. In this issue, we list where the 2016 graduates will be practicing.

### From Beaumont Health System, Royal Oak, MI:

Alexander Brown, MD	Ultrasound Fellowship, MSU/GRMEP, Grand Rapids, MI
Swati Dhanireddy, MD	Carney Hospital, Dorchester, MA
Michael Fleming, MD	Christus St. Elizabeth Hospital, Beaumont, TX
Fadi Kasyouhanan, MD	Beaumont Health System, Royal Oak, MI
Stephen Knight, MD	Beaumont Hospital, Grosse Pointe, MI
Vinny Kumar, MD	Doctor's Hospital, Columbus, OH
Emily Nguyen, MD	Moses Cone Health System – Wake Forest Baptist Med. Ctr., Greensboro, NC
Ahamefula Nnodim	Emerginet, Atlanta, GA
Michael Oleksiak, MD	Advocate Sherman Hospital, Elgin, IL
Andrew Pressman, MD	Beaumont Hospital, Troy, MI
Christopher Seitz, MD	St. John Macomb Oakland, Warren, MI
Faizan Shakeel, MD	OSF St. Anthony Hospital, Rockford, IL
Sajid Shakhan, MD	St. Mary's Hospital, St. Louis, MO
Sukhvir Singh, MD	Advocate Sherman Hospital, Elgin, IL
Daniel Wells, MD	Henry Ford Medical Center – Fairlane, Dearborn, MI
Jennifer Rosario, MD	St. Johns Hospital – Southern Illinois University, Springfield, IL
Vishnu Pandurangadu, MD	Rush University, Chicago, IL
Jehnan Liu, MD	Grossmont, La Mesa, CA

### From Central Michigan University, College of Medicine, Saginaw, MI:

Layla Abubshait, MD	Faculty Development and Medical Education Fellowship, Beth Israel Deaconess Medical Center/ Harvard University, Boston, MA
Ali Ahmed, MD	St. Luke's Hospital, Maumee, OH
Laith Alreshaid, MD	Resuscitation and Ultrasound Fellowship, University of Southern California, Los Angeles, CA
Stephen Gau, MD	Corona Regional Medical Center, Corona, CA
Summer Grace, DO	Davis Hospital, Layton, UT; Ogden Regional Medical Center, Ogden, UT
Robyn Lorenzo, DO	Covenant HealthCare Emergency Care Center, Saginaw, MI
Dylan Mezey, MD	Advocate Trinity Hospital, Chicago, IL
Michael Owen, MD	Locums Tenens
Warren Singleton, MD	Carolinas Healthcare System – Monroe, Charlotte, NC
Aaron Wasserman, MD	Reid Hospital, Richmond, IN

### From Detroit Receiving Hospital, Detroit, MI:

Kevin Belen, MD	Emergency Medicine Physicians
Nile Chang, MD	Emergency Medicine Physicians
Hannah Ferencick, MD	Critical Care Fellowship, Albert Einstein college of Medicine, Montefiore Medical Center
Lauren Holmquist, MD	MCES
Lyudmila Khait, MD	Ultrasound Fellowship, WSU, DMC & MCES
Sean McCormick, MD	Emergency Medicine Physicians
Justin Stimac, MD	Kaiser Permanente, South Sacramento Medical Center
Jessie Swan, MD	Care Point PC, Denver CO
David Viau, MD	Emergency Medicine Physicians
Henry White, MD	Alleghany Health Network, Emergency Medicine Physicians
Megan Wolf, MD	Kaiser Permanente, South Sacramento Medical Center
Joseph Wollman, MD	MCES & WSU SOM EM

### From Genesys Regional Medical Center, Grand Blanc, MI:

Barbie Fernelius, DO	Covenant Hospital, Saginaw, MI
Andrew Franklin, DO	Covenant Hospital, Saginaw, MI
Michael Khalil, MD	Detroit Medical Center Sinai-Grace, Detroit, MI
Benjamin Peek, DO	Emergency Medicine Physicians, Pittsburgh, PA
Benjamin Schoener, MD	McLeod regional Medical Center, Florence, SC

### From Henry Ford Allegiance Health, Jackson, MI:

Heath Brown, DO	St. Vincent's, Indianapolis, IN
Jonathan Grima, DO	Broward Health Medical Center, Fort Lauderdale, FL
Andrew Ohar, Do	Wake Forest Baptist Health, Watauga Medical Center, Cannon Memorial Hospital, Boone NC

### From Henry Ford Health System, Detroit, MI:

Riham Alwan, MD	University of Cincinnati Children's Pediatric EM, Cincinnati, OH
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Nicholas Busch, MD	North Memorial Medical Center, Robbinsdale, MN
Christopher Clark, MD	Ultrasound Fellowship, Henry Ford Health System, Detroit, MI
Caroline Dowers, MD	Ultrasound Fellowship, Henry Ford Health System, Detroit, MI
Katherine Flannery, MD	Henry Ford Medical Center – Fairlane, Dearborn, MI
Patrick Fleming, MD	Hurley Medical Center, Flint, MI
Carynne Fox, MD	Mt Caramel Hospital, Columbus, OH
Brad Johnson, MD	Providence Centralia, Centralia, WA
Meghan Liroff, MD	Henry Ford Medical Center – Fairlane, Dearborn, MI
Sarah Lucey, MD	Sports Medicine Fellowship, Henry Ford Health System, Detroit, MI
Sam Langberg, MD	Ultrasound Fellowship, Detroit Receiving Hospital, Detroit, MI
Jessie Tan, MD	Kaiser Permanent, Sacramento, CA
Kevin Wickenheiser, MD	TeamHealth, St. Charles, Toledo, OH
Jayna Gardner-Gray, MD	Henry Ford Health System, Detroit, MI
Gina Hurst, MD	Henry Ford Health System, Detroit, MI
Jacqueline Pflaum-Carlson, MD	Henry Ford Health System, Detroit, MI
Lauren Rodriguez, MD	Unknown at this time
McKenna Knych, MD	Beaumont Hospital, Royal Oak, MI

#### **From Henry Ford Macomb Hospital, Clinton Township, MI:**

James Bruce, MD	St. John's, Longview, WA
Megan Cahill, DO	Henry Ford Macomb Hospital, Clinton Township, MI
Michael Cotarla, DO	Henry Ford Medical Center – Fairlane, Dearborn, MI
Paul Garret, DO	US Air Force
Jason Muir, DO	Henry Ford Macomb Hospital, Clinton Township, MI
Jennifer Wong, DO	Sports Medicine Fellowship, JPS Health Network, Fort Worth, TX

#### **From Lakeland HealthCare, St. Joseph, MI:**

Erik Achramowicz, DO	Lakeland Health, St. Joseph and Niles, MI
Jonathan Krauss, DO	Lakeland Health, St. Joseph and Niles, MI
Joseph McCarthy, DO	Lakeland Health, St. Joseph and Niles, MI
Christopher Milligan, DO	Lakeland Health, St. Joseph and Niles, MI; Sturgis Hospital, Sturgis, MI
Robert Nydza, DO	Lakeland Health, Bemidji, MN
Brian Spinks, DO	Mosaic Life Care, St. Joseph, MO

#### **From McLaren Macomb Medical Center, Mount Clemens, MI:**

Jaret Copeman, DO	Avera McKennan Hospital & University Center, Sioux Falls, SD
Andrea Gerber, DO	Avera McKennan Hospital & University Center, Sioux Falls, SD
Crystal Pulice, DO	Henry Ford Medical Center – Sterling Heights, Sterling Heights, MI
Shaun Ramsey, DO	Munson Healthcare Hospitals, Cadillac and Grayling, MI
Christopher Shamass, DO	McLaren Macomb, Mt. Clemens, MI

#### **From McLaren Oakland, Pontiac, MI:**

Adam Hunt, DO	Covenant Medical Center, Saginaw, MI
Mary Ellen Kenworthy, DO	Johnston Memorial Hospital, Abingdon, VA
Neeraja Murali, DO	Novert Health UVA Prince William Medical Center, Manassas, VA
James Sutton, DO	Huron Medical Center, Bad Axe, MI

#### **From Metro Health Hospital, Wyoming, MI:**

David Haller, DO	Metro Health Hospital, Wyoming, MI
Matthew Tanis, DO	Metro Health Hospital, Wyoming, MI

#### **From MSU/Lansing EM Residency Program & MSU/College of Osteopathic, Lansing, MI:**

Michelle Carson, MD	Memphis, TN
Ihsan Djomehri, MD	Sparrow, Lansing, MI
Jason Epstein, MD	Kaiser, Sacramento, CA
Melissa Jarboe, DO	Columbia-St. Mary, Milwaukee, WI
Jeffrey Kenyon, MD	Kaiser, Sacramento, CA
Jeffrey McGowan, DO	Sparrow, Lansing, MI
Minh-Thu Nguyen, MD	South Georgia Medical Center, Valdosta, GA
Keith Rosenberg, MD	Southern Maine Healthcare, Biddeford, ME
Rachel White, DO	Chowan Hospital, Denton, NC

#### **From Sinai-Grace Hospital/Wayne State University, Detroit, MI:**

Abdallah Ajani, MD	DMC Sinai-Grace Hospital, Detroit, MI
Tamara Augustine, MD	Global Health Fellowship, Chinle Comprehensive Healthcare Facility, Chinle, AZ; Zanmi Lasante, Mirebalais, Haiti
Andrew Berwick, MD	Sports Medicine Fellowship, DMC Sinai-Grace Hospital, Detroit, MI
Luke Bisoski, MD	Toxicology Fellowship, DMC Sinai-Grace Hospital, Detroit, MI
Ryan Ernst, MD	Emergency Medicine Physicians, Nationwide
Natalie Hrabec, MD	DMC Sinai-Grace Hospital, Detroit, MI

*(Continued on Page 14)*



## 2016 — WHERE ARE THEY GOING? *(Continued from Page 13)*

Steven Irving, MD	Emergency Ultrasound Fellowship, Banner Health, Tucson, AZ
Sharmin Kalam, MD	Emergency Ultrasound Fellowship, Yale-New Haven Hospital, New Haven, CT
Usama Khalid, MD	Emergency Ultrasound Fellowship, Emory University; Atlanta VA Medical Center, Atlanta, GA
Nicholas Morelli, MI	DMC Sinai-Grace Hospital, Detroit, MI
Sameed Shaikh, DO	UC Health: Memorial Hospital, Colorado Spring, CO
Lindsay Taylor, MD	Emergency Ultrasound Fellowship, Virginia Commonwealth University Health System, Richmond, VA

### From St. John Hospital & Medical Center, Detroit, MI:

Parag Amin, MD	EMP, Columbus, OH
Ashley Bowerman Nosek, MD	TeamHealth, St. John Providence Hospitals
Michael Jakob, MD	Critical Care Fellowship, University of Western Ontario, Canada
Trevor Kuston, MD	Swedish Covenant Hospital, Chicago, IL
Marson Ma, III, MD	Unknown at this time
Veronica Miles, MD	Providence Hospital, Southfield, MI; St. Joseph Mercy, Pontiac, MI
Mohamed Moussa, MD	Beaumont Hospital – Dearborn, Dearborn, MI
Grant Nelson, MD	Ultrasound Fellowship, WSU School of Medicine; St. John Hospital & Medical Center, Detroit, MI
Andrea Patineau, MD	TeamHealth, St. John Providence Hospitals
Lindsay Richmond-Pruneau, MD	Providence Hospital, Southfield, MI; St. Joseph Mercy, Pontiac, MI
Ashwin Sabbani, MD	Memorial Regional Hospital, Hollywood, FL
Fei Lu Ye, MD	Riverside Medical Center, Chicago, IL

### From St. Mary Mercy Hospital, Livonia, MI:

Colin Kenny, MD	Christus Spohn Hospital, Corpus Christi, TX
Terrence Liang, DO	Grand Strand Medical Center, Myrtle Beach, SC
Alex Moore	St. Mary Mercy Hospital, Livonia, MI
Pamela Polynice, DO	Baylor Medical Center, Dallas, TX
Nicole Shattuck, DO	Medical Center of Trinity, Trinity, FL
Tiffany Yost	St. Joseph Medical Center, Kansas City, MO

### From University of Michigan, Ann Arbor, MI:

Kara Baker, MD	North Shore Medical Center, Salem, MA
Joseph Betcher, MD	Clinical Ultrasound Fellowship, University of Michigan, Ann Arbor, MI
Michael Boyd, MD	Heritage Valley Health System, Sewickley, PA
Christine Brent, MD	The Jewish Hospital Mercy Health, Cincinnati, OH
Jennifer Cheung, MD	Mercy Health-Fairfield Hospital Cincinnati, OH; Cincinnati Children's Hospital Medical Center
Heather Gregory-Martin, MD	Eastern Maine Medical Center, Bangor, ME
Christopher Fung, MD	Critical Care Fellowship, University of Michigan, Ann Arbor, MI
Dana Liu, MD	Wake Forest Baptist Health, Greensboro, NC
Allen Majkrzak, MD	Clinical Ultrasound Fellowship, University of Michigan, Ann Arbor, MI
Ashley Pavlic, MD, MA	EPMG, Ann Arbor, MI
Zachary Sawaya, MD	MidMichigan Community Hospital, Midland, MI
Alan Sielaff, MD	EPMG, Ann Arbor, MI
Cody Soyk, MD	North Memorial Medical Center, Robbinsdale, MN
Elaine Todd, MD	Genesis Healthcare System, Zanesville, OH
Matthew Watson, MD	Mercy Hospital, Washington, MO

### From Western Michigan University School of Medicine, Kalamazoo, MI:

Justine Abel, DO	Mayo Clinic, Eau Claire, WI
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