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Submissions to the May Newsletter should be received by the Chapter office no later than May 9, 2016.

FROM THE PRESIDENT

James Ziadeh, MD, FACEP

"Help! Someone call security now!" Unfortunately, these are words I've heard all too often while working in the Emergency Department over the last twenty years. Workplace violence is something we have all become accustomed to but we shouldn't have to tolerate it.

Workplace violence is defined as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors."

We have all seen every permutation of this definition. Each day we witness our colleagues on the receiving end of some terrible things. I've seen broken jaws, broken hands, and broken spirits over the years. While some might initially think it is just the belligerent intoxicated patients dishing this out, that's not the case. Patients present with a whole host of medical conditions that predispose them to violent acts. Whether it is the mental health patient in acute psychiatric crisis or the elderly patient with acute delirium, or simply the patient with poor impulse control that is tired of waiting for their test results or irritated that they haven't gotten their pain medication of choice, we need to recognize that there are a number of situations that put us at risk.

Some sobering statistics reveal the magnitude of the problem. According to the Bureau of Labor Statistics, the health care and social assistance industries accounted for the majority, nearly 60%, of all nonfatal assaults and violent acts by persons in 2007.[1] In the Emergency Department specifically, a 2013 study found that violent events against health care workers occurred over four times in a nine month period.[2] This study also found that nurses felt significantly less safe and suffered more stress than their physician counterparts.

One study focusing on violence against nurses in Emergency Departments found that 25% of emergency nurses surveyed reported experiencing physical violence more than 20 times in the past 3 years.[3] What is most concerning is that violence in the Emergency Department is grossly underreported. There is no reason to believe that the true numbers are not significantly higher. There are a number of contributing factors for why providers may choose to not report. For example, there is a long held, but erroneous belief, that violence in the ED is "just part of the job." In addition, there may be a feeling that reporting simply doesn't translate into change and is therefore of no value. This would clearly be the case if there is no institutional policy to address reports of violent acts against care providers.

There are a number of risk factors that contribute to violence in the ED as well. These are often categorized as either patient factors or environmental factors. Some of the more obvious patient risk factors include intoxication, mental health conditions, previous history of violence in the ED setting and access to firearms. Environmental factors include working understaffed, working alone, and working in direct contact with potentially violent patients. In addition, long wait times can often trigger a violent event. Also, overcrowding, poorly lit corridors and rooms, unrestricted movement of patients and visitors, and a lack of security presence are well known contributors.

A lack of staff training and departmental policies to deal with violence in the ED also puts our providers at risk. Hospitals are currently held to very high standards for patient safety and these initiatives are the cornerstone of hospital accreditation. We need the same level of scrutiny placed on provider safety in the workplace, especially in the Emergency Department. Fortunately, more attention is being placed on workplace violence. In 2010, the Joint Commission issued hospital accreditation standards related to violence prevention. In August 2015, the Occupational Safety and Health Administration cited a New Jersey hospital for failing to protect its employees from violent patients. Following a patient complaint, federal officials found that at least 8 employees were the victims of violent patients. Some of the findings included employees' sufferings lacerations, bruises, exposure to blood borne pathogens, and being bitten and barricaded in rooms. The hospital also faced thousands of dollars in penalties for failing to report these incidents correctly on a federal form. I would imagine that hospitals all across our country could have been on the receiving end of this level of scrutiny.

Every provider in the emergency department has an obligation to keep our patients safe. We need to commit to expecting no less for ourselves. There are a number of interventions that can be adopted to keep your Emergency Department as safe as possible. The National Institute for Occupational Safety and Health has outlined several things that can be instituted to decrease the risk of violent acts. Examples include having an alarm or signaling system to immediately alert security of a violent act in progress. My particular department uses an Ekahau RTLS (Real Time Location System). Employees wearing the badge simply pull their cord if they feel threatened and security is immediately alerted to the employee's exact location within the Emergency Department. This system is also being utilized hospital wide.

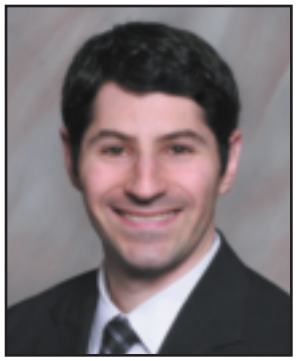
Also, having enclosed nursing stations, adequate waiting rooms for families, and well-lit corridors and rooms can provide for a safer environment. The value of staff training cannot be emphasized enough and it is critical to provide all employees with training in recognizing and managing assaults, resolving conflicts, and maintaining hazard awareness. If your electronic health record is capable, instituting a potential for violence flag for patients who previously committed a violent act in the ED is an additional safeguard.

These are only a few of the interventions available to help improve safety. However, despite our best efforts, violent acts will occur and it is imperative that your institution has procedures to assure that these events are not only reported but also investigated for opportunities to improve workplace safety.

On the legislative front, two bills were introduced by the Emergency Nurses Association in 2013 which made an assault against a Health Professional performing in their duties a felony and also updated the Code of Criminal Procedure to include sentencing guidelines for these felonies.

Continued on Page 3

CMS QUALITY MEASURES AND THE JOINT COMMISSION — ARE YOU FRUSTRATED TOO?



Gregory Gafni-Pappas, DO, FACEP

Has anyone had a recent joint commission visit or struggled with implementing new quality measures imposed by CMS? I for one am a bit tired of black and white impositions that don't directly benefit our patients, have no evidence based support, and only create a more complicated system for providers who are trying each day to give the best care they can to their patients.

While the joint commission and CMS have the admirable goal of creating standards to improve patient care, many of their measures fall short of this objective. Take for instance the new CMS PQRS measure #317, a blood pressure measure aimed to make sure that those with hypertension get follow up care and treatment for blood pressure. While I believe it is important to control blood pressure, this measure states that any systolic BP 120 or greater or diastolic 80 or greater is considered above normal and that patients be given instructions to follow up with their primary doctor for a recheck. The work around for many departments has been to embed this in the patient's discharge instructions so that the department complies with the quality measure. This is certainly not going to benefit our patients as we know that a majority of patients never read their discharge instructions. On top of this, the blood pressure values seem quite low for an emergency department. I can't remember the last time I saw a middle-aged patient with a systolic below 120 unless they were dehydrated or septic. The white coat phenomenon is generally at work when patients present to the ED. This measure continues to force hospitals and providers to play a game that ends in stalemate where the benefit of the measure becomes uncertain.

Another example is the joint commission's constant bombardment of our procedural sedation care. During the last visit to our hospital, the reviewers decided that an exam needed to be documented and timed just prior to the sedation. This came out to about 15 minutes from our estimation but it was never explicitly stated. Any emergency physician knows that the Mallampati score is unlikely to change if we do the exam 1 hour or 15 minutes prior to sedation. Furthermore, there is always a general inspection of the patient prior to sedation. If the exam an hour before was normal, but the patient becomes short of breath or tachycardic in the interim, we most certainly are aware of this to decide whether proceeding with sedation is appropriate. The most recent nitpicking is regarding discharge instructions for patients receiving sedation. Again, the work around is to put these in the paper discharge instructions that the patients generally do not read. Does this actually benefit our patients? Please show me the evidence of benefit and I'd be happy to comply. For the amount of work we do and the risk we take with conscious sedation, it amazes me that CMS still will not pay for the procedure unless we are in constant attendance for more than 16 minutes. This is yet another example of non-evidence based impediments that do not benefit the patient directly.

Appropriate quality measures in my opinion are those that directly improve patient care. As emergency physicians, we need to take it upon ourselves to create our own measures that will decrease patient mortality, morbidity, and avoidable complications, as well as improve patient experience. ACEP has taken a strong stand on developing home grown quality measures based on data and evidence. In creating CEDR (Clinical Emergency Department Registry), ACEP plans to collect data from multiple emergency departments across the country to investigate how we can best impact our patients on an individual basis. ACEP also took a stand recently against patient satisfaction surveys asking questions about pain control, stating "questions about pain have resulted in unintended consequences and the pursuit of high patient-satisfaction scores may actually lead health professionals and institutions to practice bad medicine by honoring patient requests for unnecessary and even harmful treatments." They have asked the government to remove these questions until adequate research has been completed. In a country where each individual matters, we need to ask ourselves whether we want the opinions of large organizations telling us what to do when evidence is lacking, or whether we need to stand up and do the right thing for our patients, and create quality measures, based on evidence, that are proven and meaningful. If you are interested in being a part of this discussion, please visit https://www.acep.org/cedr/ to learn more about CEDR, or become more involved on the MCEP or ACEP quality committees. §

FROM THE PRESIDENT *(Continued from Page 2*

Both bills passed the Senate but unfortunately failed to pass in the House. Currently, MCEP is working on a draft bill related to violence against health care providers with the help of the House Health Policy Committee, which will be introduced in an upcoming session in Lansing. With hard work, determination, and a strong voice, I am confident we can get the legislative recognition this issue deserves. Until then, stay safe and keep providing the fantastic care you do, 24/7/365. §

1. Janocha JA, Smith RT. Workplace safety and health in the health care and social assistance industry, 2003-2007. Bureau of Labor Statistics. 2010
2. T Kowalenko, D Gates, GL Gillespie, P Succop, T Mentzel. "Prospective Study of Violence Against ED Workers". American Journal of Emergency Medicine, 2013, Volume 31 (1): 197-205.
3. Gacki-Smith J, Juarez AM, Boyett L, Homeyer C, Robinson L, MacLean SL. Violence against nurses working in US emergency departments. J Nurs Adm 2009; 39:340–9.

THE HONEYMOON IS OVER!

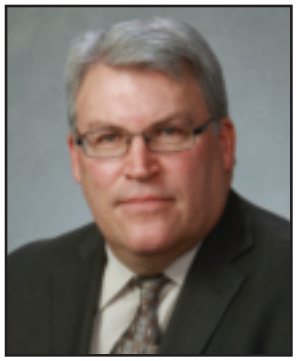
I remember thinking about the transition to ICD-10 coding scheduled for October 1st of 2015 like we thought about New Year's 2000. Remember Y2K and all the apprehension that hospitals would be unable to function because of mass failure of technology to handle the simple date change? Those of us working that night got to experience the non-event.

We woke up on October 1 last year with business as usual knowing the expected hit on our revenue wouldn't really be evident for 90 days. That period passed and we learned that our charts were being accepted by payers without many rejections. What happened? Did we really get that good at the new codes?

Yes and no. Training sessions for providers and coders helped introduce the new system. The expected increased time for coding per chart did happen because of the new numbers and unfamiliarity. So the cost of coding increased as well but it has come down some with gained experience. The key to ICD-10 success was coding for increased specificity which meant providers needed to document more for the diagnosis, e.g. right/left, proximal/distal, exact bone fractured (not just ankle), type of asthma, type of anemia, etc. Providers have struggled with some of the nomenclature additions.

Medicare instructed the MACs (Medicare Administrative Coordinators) last year not to deny for lack of specificity in ICD-10 within certain parameters. We've been warned that the past six months were just a "honeymoon" and the payers are now going to look for the specificity that ICD-10 was built upon. This grace period is surely to expire this fall. The nonspecific codes will be rejected. Some payers have been still accepting ICD-9 codes and that is surely coming to an end.

The CDC announced 2670 ICD-10 proposed code changes on March 22, 2016 including 1943 new ones, 422 revisions, and 305 deletions. There are 260 diabetes combination codes for reporting manifestations, 152 new codes in the already dense musculoskeletal chapter, and 885 new codes in chapter 19 which deals with external causation including many fracture codes for the skull, face, and neck. This all means greater detail must be documented by providers.



Warren Lanphear, MD, FACEP

Since CMS co-manages Medicaid with the states, denials could occur there as well. Some commercial payers are already demanding greater specificity for claims filed now and are denying nonspecific codes altogether. So here it comes.

Dr. William Rogers, MD, FACEP, the CMS ICD-10 Ombudsman, spoke at a recent EDPMA billing and coding conference and addressed emergency medicine's concern with the need for diagnosis specificity. He acknowledged the concern of the amount of resources it would take if these claims are denied and require an appeal, but said at this point that there is not a plan in place to exclude certain specialties from using specified codes. EDPMA and ACEP are lobbying to exclude Emergency Medicine from being required to use specified codes.

So the message here is to take heed of the direction given to you from your coding and billing people and provide the specific information needed to submit claims with the best possible specificity. It's always better to do this the first time around and avoid responding to their requests for more information. Every delay leads to revenue cycle interruptions which you will surely feel as they add up.

My thanks to Michelle Renis from Medical Management Specialists and John Holstein from Zotec for their help with this column. §

MCEP RECOGNITION OF GROUPS/EMERGENCY DEPARTMENTS WITH 100% MCEP MEMBERSHIP

The Michigan College of Emergency Physicians is again proud to recognize emergency groups and departments that have 100% MCEP membership.

MCEP will reward physician groups/hospitals with 100% participation in MCEP with the following considerations: publication of the name of your group/hospital in News & Views and a membership plaque suitable for display, along with a framed certificate for each ED staffed by the group. Those continuing their 100% MCEP membership will receive a brass plate with the current year to be added to the original display plaque. All awards will be presented at the Presidents' Banquet taking place during MCEP's Annual Michigan Emergency Medicine Assembly. This year's Assembly is scheduled for July 31 - August 3, 2016 at the beautiful Grand Hotel on Mackinac Island.

Please forward the name of your emergency physicians, the name of your group, and name of your hospital emergency department(s) to the Chapter office by fax, (517) 327-7530 or by e-mail to mcep@mcep.org by **June 1, 2016**. §

PHYSICIANS/POSITIONS AVAILABLE

BAY CITY, MICHIGAN: MCLAREN BAY REGION, EMERGENCY MEDICINE OPPORTUNITY. Explore an excellent opportunity for a BC/BE Emergency Physician or board certified FP, IM, GS with at least 5 years contiguous Emergency Department experience, to join our group in either a full or part-time capacity at a growing, profitable hospital in Bay City. Since opening a new ED in 2007, patient volume growth has been steady with an expected 45,000+ patient visits this year. McLaren Bay Region has a supportive administration team and progressive medical staff that provides coverage for all of the major specialties. Our group offers a stable contract and sign on bonus with productivity compensation package opportunity in excess of $200/hour. Current staffing reflects 40 hours physician coverage with mid-level assistance in main ED and Fast Track. Bay City and surrounding communities offer affordable housing and a short commute to major cities and Northern Michigan. If you are interested in this opportunity, please send CV to Kenneth Parsons, M.D., M.P.H., FACEP, at kpmdmph@comcast.net or call 989-894-3145 for more information. [ufn]

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 or call 989-912-6296 for more information. [ufn]

DEARBORN, MICHIGAN/DETROIT METROPOLITAN AREA: Excellent compensation available for a clinically superior Emergency Physician to practice at BEAUMONT HOSPITAL – DEARBORN. The ED at this highly regarded facility experiences 80k patient visits annually and is a Level II trauma center. Newly remodeled for the efficient care of a higher acuity patient population, the ED provides an excellent work environment. Work with EM residents during 76 hours of daily physician coverage. Multiple shifts, staffed with capable APCs, also help manage patient flow. Considerate scheduling and EPIC EMR await EM boarded candidate. To confidentially discuss, please contact Sandy George, recruiter, at TeamHealth: 248.224.5842 or send your CV to sandy_george@teamhealth.com. [2-1]

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. [3-2]

OWOSSO, MICHIGAN/ LANSING, FLINT AREAS: Rewarding opportunity for a highly-qualified Emergency Physician at MEMORIAL HEALTHCARE; easy commute from Lansing and Flint. Top compensation available to a physician who is BC/BE in Emergency Medicine or Primary Care w/ ED experience. Full-time preferred but part-time will be considered at this 29k patient volume ED serving the Shiawassee County region. Friendly environment with 26 hours of EP coverage daily plus 12 hours of additional APC ED assistance. Scribe assistance during peak hours. Additional Pediatric NP shift in the works to add to ED efficiency. To confidentially discuss, please contact Sandy George, recruiter, at TeamHealth: 248.224.5842 or send your CV to sandy_george@teamhealth.com. [2-1]

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MCEP Calendar of Events

May 15-18, 2016
ACEP Leadership Conference
Washington, DC

July 31 – August 3, 2016
Michigan EM Assembly
Grand Hotel
Mackinac Island, Michigan

August 1, 2016
Board of Directors
Grand Hotel
Mackinac Island, Michigan

August 16, 2016
Residents' Assembly
The Johnson Center
Howell, Michigan

August 18, 2016
ED Leadership & Management Course
The Johnson Center
Howell, Michigan

September 7, 2016
Board of Directors
Chapter Office
Lansing, Michigan

September 12-13, 2016
EM Ultrasound Course
Chapter Office
Lansing, Michigan

September 15-16, 2016
Observation Medicine Course
DoubleTree Hilton Hotel
Charleston, South Carolina

September 27, 2016
MCEP Councillor & Board of Directors Meetings
Chapter Office
Lansing, Michigan

October 3, 2016
MCA Conference
Grand Traverse Resort
Traverse City, Michigan

October 4, 2016
Michigan Trauma Conference
Grand Traverse Resort
Traverse City, Michigan

October 14-15, 2016
ACEP Council Meeting
Las Vegas, Nevada

October 16-19, 2016
ACEP Scientific Assembly
Las Vegas, Nevada

November 14, 2016
LLSA Review Course
Chapter Office
Lansing, Michigan

MCEP RESIDENT CASE REPORT

By: Fei Lu Ye, MD and Dilnaz Panjwani, MD, FACEP of the St. John Hospital and Medical Center, Emergency Medicine Residency Program, Detroit, MI.

Introduction: A 72 year old male presented to the ED with bilateral suprapubic pain radiating to his back for 3 hours. The patient awoke at approximately 5am with bilateral suprapubic pain. He described the pain as sharp, 10/10, constant, and gradually getting worse over time. The patient was diaphoretic, screaming out in pain and nauseous. He denied vomiting, diarrhea, hematuria, dysuria or chest pain. He admitted to a history of hypertension, hypothyroidism, CAD with stents and a prior smoking history. He denied any alcohol or drug use. He had no allergies.

ED/Hospital Course: Vital signs were as followed: Temperature was 97.4°F, HR 81 bpm, BP 146/91, and O2 saturation 96% on room air. On physical exam, the patient was in severe distress, was diaphoretic, fully alert and morbidly obese. Breath sounds were equal bilaterally, bilateral pulses were palpated distally, and the patient had a regular heart rate and rhythm. The abdomen was soft and non-distended.

The patient was transported for CTA of the abdomen/chest/pelvis which showed a 10.6 cm abdominal aortic aneurysm with signs of leaking with bilateral common iliac artery aneurysms. Vascular surgery was immediately placed on consult and the patient was moved to a resuscitation bay and given 1L of fluids wide open. 2 units of blood were given and an H & H was repeated. Labetalol 10mg boluses were given to the keep the blood pressure < 140mmHg. After evaluation by vascular surgery, the patient was immediately taken to the OR for endovascular repair of a leaking AAA. The patient was transferred to the SICU with adequate blood pressure and no vasopressor requirement. The patient went back in for AAA coiling embolization 7 days later. After 11 days in the hospital, the patient was discharged with home agency referral.

Discussion: In the United States, about 200,000 new cases of AAA are diagnosed each year and approximately 50,000 to 60,000 surgical AAA repairs are performed (1). Ruptured AAAs are responsible for about 15,000 deaths in the United States annually (1, 2). One in 10 men older than 80 years has some aneurysmal change in his aorta. Screening studies have shown that AAA's occur in 2 to 13% of men and 6 percent of women over the age of 65 (1). Aneurysms identified by screening that are less than 3.5cm in diameter are unlikely to rupture (2).

Most AAA's do not cause symptoms (2,3), and the patient may not be aware that they have an aneurysm. Those larger than 5cm in diameter are at greater risk for rupture and a vascular surgeon should be consulted (4,5). Providers should have suspicion for AAA in patients with history of hypertension and smoking, and those with pain in the chest, abdomen, lower back, flank, and radiation of pain to the groin or legs. The pain may last for hours or days and it's generally not affected by movement (5). Acute rupturing AAA is a true emergency that, if not rapidly identified and repaired, will lead to death. The classic presentation is of an older (>60 years) male smoker with atherosclerosis who presents with sudden onset severe back or abdominal pain, hypotension and a pulsatile abdominal mass, with variation of flank pain, groin pain, hip pain or pain localizing to one quadrant of the abdomen (5).

If the diagnosis of rupturing AAA is clear clinically, vascular surgery should immediately evaluate the patient (5). In the unstable patient, abdominal ultrasound has a 90% sensitivity for identifying AAA (5). In the stable patient, CT can also identify the AAA (5).

The patient is stabilized with large-bore IV access, fluids for hypotension, treatment of hypertension and cross-matching of several units of PRBCs with transfusion as needed (3,4,5). Patients should also be moved to an area in the ED where there is increased supervision (3,4,5). §

References

1) Hallett, JW. Management of abdominal aortic aneurysms. *Mayo Clin Proc* 2000;75(4): 395-399.

2) Jim J, Sanchez L. Abdominal Aortic Aneurysms: Endovascular Repair. Mount Sinai Journal of Medicine 2010; 77(3): 238-249.

3) Newman AB, Arnold AM, Burke GL, et al. Cardiovascular disease and mortality in older adults with small abdominal aortic aneurysms detected by ultrasonography: the cardiovascular health study. Ann Intern Med 2001; 134:182.

4) Tintinalli JE, Stapczynzki JS. Tintinalli's Emergency Medicine A Comprehensive Study Guide 7th edition; 451-458.

5) Melnick VM, Heiken JP. The Acute Abdominal Aorta. Radiology Clinics 2015; 1209-1224.

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