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3 From the Guest Editor

Antony Hsu, MD

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"The scenario is not unfamiliar. Though the details of gender, age and medical conditions vary, the substance is the same: a patient whose cognitive capacity has been impaired by advanced age and/or disease presents to your department via EMS. This patient is acutely ill. The briefest of silences shimmers in the room as your question hangs in the air: "What's the code status?"

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



September/October 2017



Violence in the emergency department (ED) has become an all too common theme in our working environment. In the few months since becoming the president of the Michigan College of Emergency Physicians (MCEP), I have heard new stories from physicians and nursing staff about instances of ED assault. People tell me their stories because they know MCEP is trying to do something about this growing problem. Unfortunately many stories go completely untold or unreported. For many years the prevailing attitude regarding workplace violence in the ED is that it is “part of the job”. However, we need to return to the basic principles of human decency, “keep your hands to yourself”, with regard to assault of ED personnel.

The roots of that sentiment that violence in the ED is part of the job derive from the realities that we encounter when working in the ED. The baseline environment in the emergency department is one of stress and angst as patients present with life threatening conditions, whether real or perceived. Family members are present and appropriately concerned, serving as patient advocates. Our job is to diagnose and treat as well as to rule out and reassure, striving to make the patient experience excellent as we deliver care. The ED has become increasingly busy. In a recent press release from the American College of Emergency Physicians, ED visits were noted to increase by over 7% when Medicaid expansion took effect in 2014. We have personally experienced the increased volumes at Henry Ford Hospital and I know that other southeast Michigan hospitals have experienced the same. This volume increase naturally leads to increased ED boarding and waiting times for patients and families. Speaking of boarding, ED boarding of psychiatric patients has reached a boiling point in Michigan and nationally. The Michigan Department of Health and Human Services MDHHS has convened a workgroup aimed at real action, the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD). MIPAD will report its recommendations to state leaders in the fall of 2017 in an attempt to address the prolonged wait times for inpatient admissions for adult and pediatric patients. While many patients are waiting to be seen and waiting for inpatient beds, other patients are experiencing increased enforcement of opioid prescription guidelines in the midst of the opioid epidemic. Emergency physicians no longer order or prescribe opiates for chronic, non-cancer pain, increasing frustrations of patients who likely have dependence on opiate medications. Rates of people abusing these medications are increasing. All of these factors add toxicity to the emergency department environment. The vast majority of patient encounters in the ED are pleasant, and at the very least, non-violent. However, when a provider is assaulted or witnesses an assault in the ED, the stress of that event can carry on for days and weeks, if not longer.

Given all of this, it is not surprising that 75% of emergency physicians experience at least one work place violence episode each year. Even worse, more than 70% of emergency department nurses report physical or verbal assault by emergency department patients or family members in the course of a year. There is a known culture of underreporting violent incidents in the emergency department. It is widely understood that local police departments will not arrest patients for misdemeanor assault in emergency departments in southeast Michigan, and prosecuting attorneys will not bring charges against emergency department patients in the emergency department. Therefore, the prevailing attitude is, why should I waste my time making a report if nothing is going to happen? Maybe this

is “part of the job”. We have a unique profession in the United States in that with every patient encounter, we must abide by the Emergency Medical Treatment and Labor Act (EMTALA) and provide a medical screening exam. This federal law under most circumstances is an excellent patient safety provision. However, in some circumstances it can put ED personnel in harm’s way as a medical screening exam generally requires close interaction between a patient and providers to perform vital signs and a physical exam.



Jacob Manteuffel, MD, FACEP

For all of the reasons outlined above, MCEP is strongly supporting Senate Bill 33 currently in the Michigan Senate. This bill would make the assault of ED personnel a felony in the State of Michigan. This bill is crafted to add the same protection for ED personnel that emergency medical services (EMS), police and fire personnel currently have against assault under current State of Michigan law. As we are mandated to provide care under EMTALA to all patients brought by EMS, police and fire department personnel we deserve the same protections against assault. Signs warning of the penalties for assaulting a health care worker can be posted in the ED. People who commit assault in the ED will be arrested by local police and removed from the department. This bill would not subject patients with dementia or acute psychosis to arrest for assault. We must continue to proceed with extreme caution when caring for patients with dementia and acute psychosis. However a patient who is intoxicated with alcohol or other substances should be held accountable for assault of ED personnel. In no other environment in society would such behavior be acceptable, and it will not be in the emergency department either. We need to tell our stories of assault of ED personnel and we need to pass Senate Bill 33.

MCEP has joined the efforts of the Michigan Emergency Nurses Association to make assaulting ED personnel a felony in Michigan. This is the top legislative priority for MCEP. Please email me (jmanteu1@hfhs.org) your stories and ask your nursing colleagues to do the same. In addition, please include your State of Michigan Senator and Representative on the email, which can be found here: <http://www.michiganvotes.org/MyLegislatorsKeyVotes.aspx>. Please also include MCEP’s President Elect and Legislative Chair, Dr. Rami Khoury, MD FACEP (rami.khoury@allegiance.org) on your email. While passing Senate Bill 33 won’t end all violence against ED personnel, it will be a significant first step in a needed change of culture of the working environment in the emergency department. So I implore you to please tell your stories! If you need assistance, please contact the MCEP office (mcep.org). §



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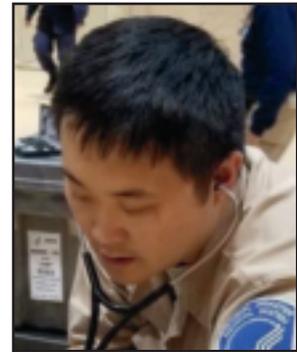
“We’re demobilizing at 11pm, Good job everyone.” The Georgia-3 Disaster Medical Assistance Team commander set into motion the closing time for the clinical care we had been providing to the town of Silsbee, a small town just north of Beaumont, Texas that had been nearly cut off by rapidly rising floodwaters. After temporarily relieving the exhausted local medical providers, the town was now coming back online with roads and local clinical facilities re-opening after being damaged and overwhelmed by the worst flooding in United States’ history brought on by Hurricane Harvey in August 2017. We had arrived at the town’s high school gym in the dark of the night after traveling in a chartered bus accompanied by dozens of armed US Border Patrol agents. Previous teams that deployed to downtown Houston had been shot at when traveling from Dallas and armed escorts were now a required precaution when deploying to the front line. Inappropriate responses by a couple bad apples would not deter our mission, to provide medical care in austere environments when states ask for federal help.

Although this was my first deployment to a natural disaster, other DMAT members have responded to a variety of natural disasters, world conferences and sporting events within the US, terrorist attacks in DC and NYC and even Haiti’s devastating earthquake. As of this writing, Irma has just hit and Maria will have hurt Puerto Rico this season. The initially deployed team consisted of 2 ED physicians, a critical care NP, multiple RNs, EMT-P’s and specialized personnel with training in logistics, security, communications and administrative staff. Our team commander, a professor in emergency management, led our impressive group of 39 intrepid souls for 10 days. We have been trained and prepared to deploy in a field with independently powered tents but had the fortunate opportunity on this trip to set up our clinical zones in the well-lit high school gym. As the chief medical officer for the clinical staff, I took care of our team members’ health during the trip as well as setting up the schedules for the providers to meet the local demand and work clinically daily. Another ED physician and a pediatrician joined us a day later and we incorporated VA internists

from Dallas and San Antonio during the deployment, sharing supplies and dividing duties.

Over the course of 5 days, our field tent encountered patients less than 1 month old and older than 90; patients who just wanted their tetanus shot updated since they had been walking in putrid flooded valleys and one who needed to be intubated due to a drug overdose. We even had a patient with hypertensive crisis who lost pulses on the way to the local hospital but eventually survived to the ICU. Our pharmacy cache and 2 pharmacists helped provide 5 days of medicine while the local pharmacies were understaffed or otherwise completely closed. Pure clinical acumen was practiced since we lacked imaging and lab testing beyond the basic iStat for the first couple of days and only the glucometer and urine dipsticks for the remaining deployment. Despite our limitations, word rapidly spread via Facebook and the local television channel so successfully that we ended up seeing 485 patients, the vast majority in the last 3 days. The local citizenry and county leadership were extremely grateful and every DMAT team member coalesced with one another by the end despite coming from 4 different states.

We are now looking for new members with all backgrounds to join us, especially physicians, nurse practitioners and physician assistants. Anticipate a lengthy credentialing and selection process followed by online and locally-administered hands-on training. Once the process is complete, all deployments are covered by the USERRA Act to provide job and benefit continuation protections. §



*Antony Hsu, MD
Emergency Physician
St. Joseph Mercy Hospital
Ann Arbor, MI*

MCEP Calendar of Events

October 27-28, 2017
[ACEP Council Meeting](#)
Washington, DC

October 29 - November 1, 2017
[ACEP Scientific Assembly](#)
Washington, DC

November 13, 2017
[LLSA Review Course](#)
Chapter Office
Lansing, MI

November 16, 2017
[Straight Talk](#)
The Johnson Center
Howell, Michigan

December 6, 2017
[Board of Directors](#)
Chapter Office
Lansing, Michigan

January 25-28, 2018
[Winter Symposium](#)
Mountain Grand Lodge
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January 26, 2018
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I'm going to use this month's column to discuss the problem of denial of payment for emergency visits. The issue recurs regularly as third party payers seek to minimize the cost of care delivered in an emergency department. Just when we think we have met that threat to reimbursement for mandated care, it rears up with new policies from insurers seeking to dissuade member usage of the ED.

The Prudent Layperson standard is the foundation of our defense against efforts to deny payment for emergency visits. This standard defines a PLP as one who possesses an average knowledge of health and medicine. The standard establishes criteria that insurance coverage is not based on the final diagnosis but rather on whether the prudent layperson might anticipate serious impairment to his or her health in an emergency situation. I think even we forget this standard occasionally when we don't recognize that the patient's concern for their well-being has led them to seek our help.

The hallowed Prudent Layperson (PLP) standard was first put into federal law in 1997 for all Medicare and Medicaid patients. This was extended to all federal employees in 1999. The Affordable Care Act codified the PLP standard into federal law for all carriers in 2010 along with laws in over 30 states.

This year Maine revisited the policy by proposing to allow higher copayments for an ED visit that did not lead to an admission. When this was challenged, Maine changed the wording to allow higher copays if the final diagnosis was on a non-emergent list. These changes put the onus on the patient to determine the legitimacy or severity of their symptoms before evaluation. We know chest pain can be caused by GERD but may feel like an MI. How does a patient figure that out? Copays are a big deal

to patients. So our specialty organizations are meeting the challenge in Maine.

Anthem and Blue Cross announced to members this year in states such as Missouri, Kentucky, Virginia, Georgia, and Indiana that they would not reimburse ER visits for non-emergencies. So again patients will be asked to sort out febrile illness in an infant. Is it a viral URI or meningitis? Is persistent vomiting a bowel obstruction or a viral gastritis? Is this headache a migraine or tension or is it a cerebral hemorrhage? You can see where financial disincentives to avoid an ER visit can be potentially dangerous.

We are aware that a hospital system in the Detroit area has announced to their covered employees that inappropriate ED use would not be covered. Ouch, right in our backyard.

My take home message is that this threat to our reimbursement is also a threat to our patients' healthcare. We need to support the work being done by professional organizations like MCEP, ACEP, and EDPMA to challenge these proposals. Meanwhile document well the patient's concerns and what you considered in your medical decision making. Your MCEP Board is asking you to let us know about your experiences with denial of payment by payers for your emergency care. You can send that information to me, Dr. Manteuffel, Dr. Monfette, or any board member you know. §



Warren Lanphear, MD, FACEP

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MCEP OCTOBER 2017 LEGISLATIVE UPDATE

After returning from a two month in-district period, the Michigan Legislature returned to session after Labor Day. There are several issues that MHSA and MCEP are following on behalf of emergency physicians throughout the state. We'll start with what the college is pushing legislatively and finish with where we are threatened.

SB 33 was introduced in the spring by Sen Ken Horn of Saginaw. The bill is a priority for the college and seeks to enhance penalties for assaults in the emergency department. The bill was reported out of committee in late spring and is sitting on the Senate floor waiting for action. MCEP is working with members of the Senate to explain the need for the bill but there are multiple bills seeking to increase penalties for assaults on various professionals. Please take the time to talk to your state Senator and Representative and explain the importance of providing a deterrent for the increasing number of assaults in your workplace. If you are having trouble locating your state officials, please contact the MCEP office for assistance.

MCEP continues to be active in the ongoing opioids debate. The House Health Policy committee and the Senate Health Policy committee are both working on packages that MCEP has had input on pertaining to the availability of opiates and prescribing patterns. We will continue to monitor these bills and participate where necessary to ensure no unintended consequences are placed on emergency physicians in the state.

Auto no-fault reform continues to be a topic of heated debate in Lansing. Over the years, multiple proposals to gut the state's no fault system have been debated and defeated. MCEP has been an active part of coalitions looking to maintain the current patient protections in place for our citizens. Last week, House Speaker Tom Leonard and Detroit Mayor Mike Duggan introduced a bill overhauling the no fault options motorists are given in the state. Motorists will be allowed to pick lower cost insurance packages that also come with dramatically reduced benefits. Many in the health care industry are arguing that the lower cost packages are balanced on the back of provider payment reductions. Several provisions in the bill require reimbursements to be pegged at Medicare rates. Hearings in the House start this week before a vote is taken in House Insurance.

As always, please feel free to reach out to MCEP or MHSA with any questions you may have on any topics being debated in Lansing. §



Bret Marr

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THE ATTENTION GETTING CARDIAC ARREST

Habib Mohammad Bilfaqi MD; Anthony T Lagina III, MD, FACEP, Detroit Receiving Hospital-Wayne State University

Introduction

A 45-year-old caucasian male was brought in by EMS pulseless and intubated with a supraglottic airway. Per EMS, the downtime was unknown. EMS did initiate CPR, though as a BLS unit they were not able to obtain an EKG or IV access. There was no response to 2 mg of intranasal Narcan. The patient was found with an empty bottle of Vyvanse next to him.

ER/Hospital Course

Vital signs were absent as the patient presented to our resuscitation bay in CPR. The patient was placed on a cardiac monitor that showed ventricular fibrillation. The patient was intubated, given one amp of epinephrine via IO line and given two rounds of electrical defibrillation. Initial EKG showed evidence of atrial fibrillation (figure 1). Repeat EKG showed evidence of an inferior and posterior ST elevation MI (figure 2), and we then had subsequent loss of pulses. CPR was restarted and the patient was given another amp of epinephrine. He then went back into ventricular fibrillation and was given another dose of electrical defibrillation. We did regain pulses and the patient was then started on a norepinephrine drip and sent to the catheterization lab. His catheterization showed evidence of vasospasm but no occlusive disease and a reduced ejection fraction of 5-10%. He subsequently had an Impella device placement for hemodynamic support. He was admitted to the intensive care unit where he underwent hypothermia protocol and was placed on amiodarone and levophed drips. On hospital day two, he was placed on CRRT for worsening acidosis secondary to cardiogenic shock. The patient died later that day due to complications of cardiogenic shock and multiorgan failure. He went into PEA, and the patient did have five cycles of CPR performed prior to declaring the patient dead.

Discussion

Our patient initially presented to the hospital in ventricular fibrillation after ingesting an unknown amount of Vyvanse, isdexamfetamine dimesylate, a prescribed medication for ADHD.

Our case demonstrates some of the more important complications from an amphetamine overdose and further broadens the scope beyond drugs of abuse. The most common side effects are hypertension and tachycardia.¹ On a presynaptic level, they inhibit reuptake of catecholamines, causing an adrenergic surge that causes a rise in blood pressure and heart rate. Some of the other common side effects include serious cardiovascular complications, such as cardiomyopathy, dysrhythmia, and myocardial infarction.²

The role of amphetamine in vasospasm and vasoconstriction is not completely explained due to adrenergic surge. The exact pathophysiological mechanism of myocardial infarction is not well known. Some proposed mechanisms include coronary spasm with intracoronary thrombus,³ prothrombic activation, increased myocardial oxygen demand, and catecholamine-caused platelet aggregation with subsequent thrombus development.⁴

In regards to management, calcium channel blockers may be effective in treatment of suspected coronary vasospasm. Beta blockers should not be used as they may worsen coronary vasospasm, though the exact pathophysiological mechanism is unknown. Thrombolytics or intravenous anticoagulation may also help if there is presence of a thrombus.² §

Figures

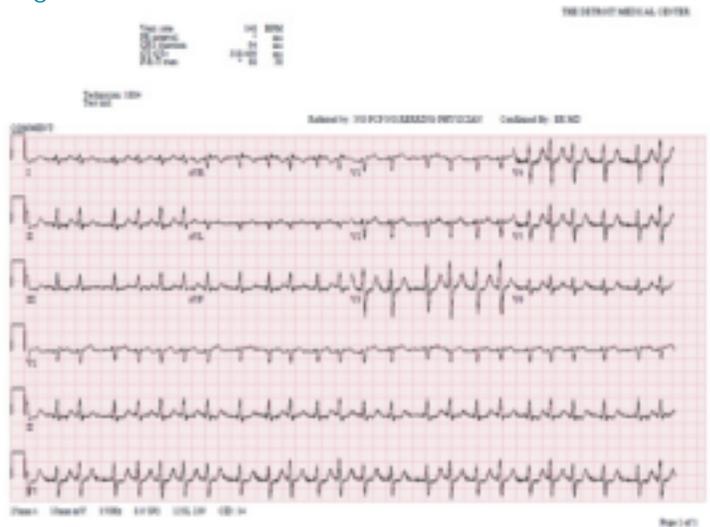


Figure 1: Atrial Fibrillation

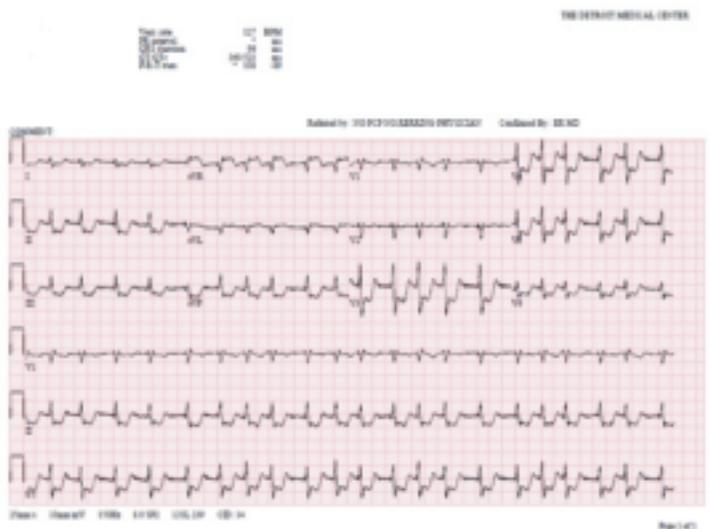


Figure 2: Inferior and Posterior Elevation MI

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ON THE RADAR: MI-POST LEGISLATION

Diana Nordlund, DO, JD, FACEP

The scenario is not unfamiliar. Though the details of gender, age and medical conditions vary, the substance is the same: a patient whose cognitive capacity has been impaired by advanced age and/or disease presents to your department via EMS. This patient is acutely ill. The briefest of silences shimmers in the room as your question hangs in the air: "What's the code status?"

Our system is imperfect. Many individuals are unwilling to discuss end-of-life care while they are still able to do so. Even if a decision is made and documented, it very likely will not transfer readily between medical care settings. In some cases, patients leave the hospital with a DNR status, but full code status is automatically re-instated upon arrival to a nursing home. Thus, a patient who recently requested DNR care may be subject to aggressive resuscitative measures upon re-presentation to the emergency department a only few days later.

Our state has a hodgepodge of methods to deal with this challenge. For instance, the Michigan Do-Not-Resuscitate Procedure Act (1996) legislates that pre-hospital providers must honor a facially valid DNR that is present on scene for a patient presenting in cardiopulmonary arrest. The Michigan Patient Self-Determination Act (1990) recognizes the validity of the Health Care Durable Power of Attorney (HCDPOA), a form of advance directive in which an individual can pre-select a patient advocate to make medical decisions on his or her behalf in the event of incapacitation. Michigan law does not, however, specifically acknowledge living wills, in which a patient can make specific selections regarding what measures may or not be taken on their behalf in acute care situations.

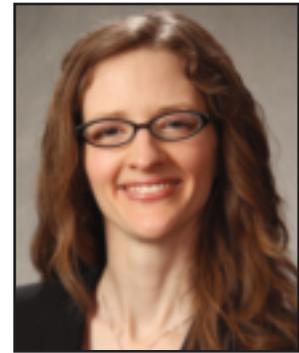
Pragmatic concerns remain, in part because the DNR act applies only to out-of-hospital care, and the power-of-attorney model is often impractical when making real-time decisions in the ED. Thus enters the Physician Orders for Life-Sustaining Treatment, or POLST program; a model that has been successful in a number of states and is being developed in several more. Specific to Michigan, House Bill 4170 is presently working its way through our legislature and attempts to resolve some of these issues.

POLST programs (in Michigan, called POST, or Physician Orders for Scope of Treatment) encompass a specific patient population: adults of sound mind (or who have a guardian or HCDPOA) who are suffering from an advanced illness that is foreseeably expected to cause death within the next year. Unlike a DNR, a POST form includes instructions regarding what measures may be taken in a non-cardiopulmonary arrest situation. Furthermore, a POST form typically addresses other specific measures such as tube feeding, IV fluids, and antibiotics.

The POST bill, if passed, would establish a committee to direct a developing POST program in our state. It would include representatives from the EMS community, medical control authority, and palliative care community, though notably, does not specifically require input from an emergency physician. The bill describes the expected contents of the form and under what circumstances the form could be revoked or changed. It further specifies that a copy of the form shall be made part of the patient's permanent medical record by the attending provider while the patient keeps the original.

Of note, the bill specifies that the POST form shall be used to delineate care *outside* of a hospital, in which setting emergency medical services providers shall adhere to its provisions unless exceptions exist. Exceptions include that

the medical condition prompting care is unrelated to the condition upon which the POST form was premised. Legal immunity is provided to providers who follow a facially valid POST; to those who disregard one reasonably thought to be invalid/revoked; and to those who provide care that meets the generally accepted standard in spite of a known facially valid POST.



Diana Nordlund, DO, JD, FACEP

In stark contrast, a POST form does not have the same gravity in the acute care setting. The bill specifically provides that providers *may* use it as a "communication tool." Not only does it expire after one year, but it must be specifically renewed, updated, and initialed by both the attending health professional and the patient (or the patient's advocate or guardian) after a patient has been transferred from one care setting/level to another or when there has been an unexpected change in the patient's medical condition. Though the original POLST program paradigm espouses a form that readily transfers between care settings, this bill specifically contravenes that intention.

Thus, if passed as written, this bill is likely to have little practical effect on the challenges that face emergency department providers when making critical decisions for this subset of patients. As of this writing, it has been passed by the House of Representatives and been referred to the Committee on Health Policy. §

A poster for a course titled "Straight Talk XXVI: Emergency Medicine Reimbursement Issues...". The poster features a background of US dollar bills. At the top left is the Michigan College of Emergency Physicians logo. The title "Straight Talk XXVI" is in large green letters. Below the title is a large graphic of a key with a dollar sign on its head. At the bottom, it says "November 16, 2017" and "Johnson Center, Cleary University-Livingston Campus Howell, MI". A red banner at the bottom states: "This course presents valuable information and updates for emergency physicians, billing and coding professionals, and group managers."



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