MCEP
ADVANCING EMERGENCY CARE

News & Views

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Submissions to the July/August Newsletter should be received by the Chapter office no later than July 15, 2016.

FROM THE PRESIDENT

"The future ain't what it used to be" – Yogi Berra

Many of us remember the not so distant past when score cards, quality metrics, patient satisfaction and discussions of population health just didn't carry quite the same punch that they do today. The thought of these things being part of our everyday life seemed so far away. Well, the future finally made it here. The pressures being placed on health care systems and providers to drive quality and value over volume are significant and the financial impact of failing to drive this change is growing each year. The endless array of quality measures and documentation requirements may very well improve patient outcomes but there are unintended consequences, such as time away from our patients and decreased job satisfaction for providers.

In many ways, our life as Emergency Medicine physicians has become easier but in other ways not so much. We have access to a wide array of new technologies and advances in healthcare that have lessened the diagnostic dilemmas of years past. If you have been practicing long enough, you'll remember the days of trying to diagnose a pulmonary embolism with a VQ scan or waiting hours for delayed films on your IVP study for a kidney stone. Clearly things have come a long way.

However, in other ways, our lives have become much more difficult. One of the greatest frustrations among physicians is the EMR. For so many of us, the EMR was a shock to the system and our workflow. I was used to filling out a T-Sheet in the blink of an eye and moving on to the next patient. Our efficiency as providers has clearly been impacted by the need to navigate endless screens with multiple clicks in addition to dealing with pop-ups, hard stops, and an array of in-your face warnings. So much of technology has made our lives easier but in the realm of the EMR, the opposite appears to be the case. Ultimately, we need to find better ways to streamline our workflows, jettison non-patient care related tasks, and get back to the bedside so we have the time to connect with our patients in a meaningful and personal way.

With Emergency physicians being pulled in so many directions, keeping sane and preventing burnout is getting that much harder. It's fitting that this year marked ACEP's first year to introduce a wellness week in January. I wrote about this in an earlier newsletter article and I hope all of you had a chance to reflect on your own personal wellness and create a plan to stay on top of it.

As I start to wind down my term as President and reflect on all of our accomplishments, I cannot help but think of how proud I am of our Chapter. Over the years, we have seen continued growth in membership, an active board of directors, action oriented committees, and multiple educational offerings that rival any national conference. Our first ever ED Directors course was a huge success and we saw our Observation Course move to a national venue in Nashville, a first for our Chapter. In this past year, the Chapter launched a new quality committee with the goal of partnering with other organizations on quality initiatives to improve patient care. We are also pursuing strategies to tackle overcrowding in our emergency departments and have developed a task force to begin this work.

This year also marked our largest class of the leadership development program with a class of twelve. Dr. Robert Malinowski has done an outstanding job growing this program into one that is nationally recognized as a model for other chapters. Many of the graduates of this program have gone on to leadership roles within the College including many of our past presidents. Continuing the LDP will assure a steady stream of talented individuals to lead our organization forward.

James Ziadeh, MD, FACEP

Along those same lines, Dr. Jake Manteuffel has been successful in engaging medical students from across the state with a unique outreach program designed to develop future leaders in Emergency Medicine at the earliest stages.

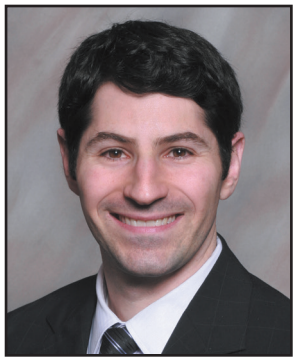
MCEP has also seen incredible growth in our social media presence allowing us to reach out in unique and novel ways to our membership and others. On the payment front, we scored a huge victory this year on Medicaid reimbursement. Over the last two years, the College has been involved in multiple meetings in Lansing which have finally paid off with an impressive twenty percent increase in treat and release payment. This is all due to the hard work of several members including Drs. Antonio Bonfiglio, Brad Uren, Rami Khoury, and Kevin Monfette along with Diane Bollman, our executive director, and Bret Marr, our lobbyist.

While we have seen progress and success on a number of fronts, there are still issues which significantly impact our Emergency Departments and the care we provide. Opioid abuse and addiction has become a national hot button issue. Each and every one of us is impacted by this crisis on a daily basis but we should be proud to know that as a specialty, we were among the first to sound the alarm on this epidemic. Here in our own state we have developed useful prescribing guidelines that I would encourage you to review if your department doesn't already have guidelines in place. I would like to also recognize Dr. Rami Khoury for his unwavering commitment on behalf of the College to helping solve the opioid abuse epidemic through his work with the state and his ongoing education efforts that have now reached the national stage.

Two other important issues that deserve our full attention are the mental health crisis and violence in the workplace. MCEP is committed to improving the safety of our work environment and we are actively working to reintroduce legislation to address assaults against healthcare providers. As a College, we are fortunate to have such dedicated individuals who care deeply about our specialty and who are committed to advancing the interests of both our patients and specialty.

I would like to take a moment to thank Dr. Kevin Monfette, our immediate past president, for his guidance and input over the past year. Also, the success of MCEP would not be possible without Diane Bollman, our executive director, and all of the office staff who do an outstanding job keeping this Chapter humming along so effortlessly. Lastly, I want to thank every member of this Chapter. Representing you over the past year has been a true honor and a humbling experience. I will forever be grateful for being given this opportunity to serve all of you. §

EVIDENCE BASED MEDICINE IS BASED ON THE POPULATION, NOT THE INDIVIDUAL



Gregory Gafni-Pappas, DO

Recently I had a conversation with my mother involving the use of zinc to prevent a URI from developing. She exclaimed that zinc lozenges were her savior and that I should really start using them when I am sick, or when my children are sick so that I don't get sick myself. I went on to teach her that "the evidence shows" that zinc lozenges do not prevent colds, nor do they shorten their course. I was proud of my evidence based medicine teachings and confidently smirked at this lesson to my mother. However, my air of confidence quickly faded when my mother quashed my comment and stated, "I know you believe in the evidence, but I don't care, they work for me!" Initially I was shocked. Why wouldn't she believe the evidence? It was plain to see that they just don't work. After some deep thought, I learned some very important lessons from this experience.

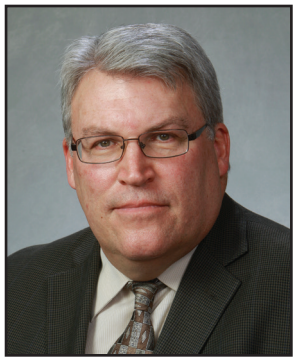
First, one experience for a patient can profoundly change their beliefs regarding a treatment or medication. The experience can be positive or negative. Antibiotics are a great example of this phenomenon. We've all certainly had multiple patients with symptoms of a viral URI who feel strongly that an antibiotic will cure their illness. Many of these patients come in towards the peak of their illness, so it makes sense that when they are prescribed antibiotics, their symptoms begin to improve over the next 24-48 hours. You can be assured that the next time they are sick, they will want another antibiotic. Tamiflu is another great example of a medication proven to decrease length of illness by at most 16 hours, if that, yet when patients are confronted with the possibility of a medication that will help cure their illness sooner, they jump to take this medication, even if side effects of nausea and vomiting are possible.

Second, physician's anecdotal experiences can have a profound effect on the way they practice, even ignoring the evidence and allowing their experience to affect their practice. Take for example epidural steroid injections for low back pain. Much evidence has come out in recent years attesting to the fact that they do not improve patient's symptoms. Yet they continue to be a mainstay of treatment for low back pain patients, likely because the injection is less invasive than surgery, and because anecdotal experience by patients and their physicians continue to drive practice. And have you ever tried to enact change in a department or hospital by taking multiple strong evidence-based articles to a meeting just to have the meeting participants ignore the evidence right in front of them? I have learned a lot in my career thus far, sometimes the hard way, understanding that evidence is not always enough to establish change.

What it all comes down to is that evidence is based on a population while beliefs are individual, drawing from both acquired knowledge and experience. A personal experience can be much stronger than the evidence itself. Take for example the HEART score. It is a fantastic new risk assessment tool for chest pain patients. If a patient is determined to be low risk, there is a less than 1% chance for a major adverse cardiac event within 30 days. For physicians, this is an excellent new tool since most of us are willing to accept a less than 1% risk even if the risk is not zero. And even though most patients are also willing to accept this risk and go home, there are certain individuals that would rather be admitted for observation and a stress test because their risk tolerance is less. This likely owes to the patient's own life experiences, whether personal or family history, though it could also be cultural or value-based. Either way, their individual beliefs can ultimately change disposition in the world of shared-decision making.

What does this mean for our own emergency medicine practices? I think our conversations with patients need not only revolve around the evidence, but also take into account the patient's beliefs and our own values. And while evidence needs to be an important part of our medical practice, tolerance of other's viewpoints, while educating on the risks and benefits, needs to be forefront in our patient discussions. Evidence is certainly important and I love being able to quote this or that article, but there is still an art of medicine that drives our actions. So the next time my mom tells me about her newest remedy, I may think twice before arguing the evidence. §

SEDATION DOCUMENTATION AND CODING



Warren Lanphear, MD, FACEP

This month I am focusing on a review of emergency department sedation documentation and coding. There are reimbursement differences depending on the payer but a standardized approach to documentation is beneficial. We provide great care and we should be reimbursed appropriately.

Moderate sedation is drug-induced depression of consciousness that preserves a patient's ability to respond purposefully and airway interventions are not expected. Examples of this are low dose fentanyl and midazolam. Deep sedation involves patients that cannot be easily aroused but respond purposefully following repeated or painful stimulation. Airway interventions may be necessary. This review is not addressing minimal sedation (anxiolysis) or general anesthesia.

There are three codes for moderate sedation provided by the same physician performing the procedure. They cover the first 30 minutes of service under age 5 and over age 5 and each additional 15 minutes of service. There are three additional codes for this service when provided by a physician other than the provider doing the procedure. Documentation of START and STOP times are obviously very important.

Deep sedation in the ED is usually done with propofol, etomidate, or a benzodiazepine. Dissociative sedation (i.e. ketamine) is often grouped with deep sedation agents requiring the same degree of monitoring. CPT codes for deep sedation are based on the body area for the procedure, the ASA level, and units of time. Deep sedation best practice is to have different providers for the sedation and the procedure. Most payers allow billing for the E&M level and the sedation or the E&M level and the procedure but not all three and never the procedure with sedation. These bills often require extra work defending your care and the assigned codes. There are variations in what different payers accept and reimburse but a standardized approach is helpful.

Enough with the coding lesson; below is best practice documentation for ED sedation.

1) Brief HPI (why sedation is needed)
2) Indication/procedure
3) Diagnosis - specific
4) Location of sedation (ED, MRI, observation unit,etc.)
5) ASA status
6) NPO status
7) Exam – airway, neck, heart, lungs, neuro
8) Mallampati score
9) Discussion of risks, benefits, complications
10) Consent
11) Monitoring – BP, EKG, continuous pulse ox, EtCO2
12) Time out
13) START and END times
14) Post sedation exam
15) Post sedation instructions

My thanks to Michelle Renis of Medical Management Specialists for her help with this article. The ACEP website was another valuable resource. §

MCEP RESIDENT CASE REPORT

By: Veronica Miles, MD; Hafez M. Bazzi, MD, FACEP and Dilnaz Panjwani, MD, FACEP of the St. John Hospital and Medical Center, Emergency Medicine Residency Program, Detroit, MI.

Introduction: An 85 year old female presented via EMS from home for altered mental status. EMS was initially called by family for a leg wound evaluation. When EMS arrived they found the patient had altered mental status and was in poor living conditions. EMS reported family had attempted to shower the patient and the patient was found on the ground, cold, with a wet towel around her. The patient was noted to have multiple abrasions and petechiae by EMS. There was no family at the bedside. Upon arrival the patient was noted to be hypothermic, bradycardic and altered with a GCS of 10. No further information could be obtained from the patient or EMS regarding past medical, surgical or family history. The only known history was an allergy to ciprofloxacin.

ED/Hospital Course:
Vital Signs: 132/103 P 48 RR 16 T 85.4 Rectal 94% RA,
Repeat VS 93/65, P 35 RR 22 100% on 9L
Exam revealed an elderly female in distress, disheveled and unkempt. The patient had ecchymosis and petechiae over the entire body and abrasions over the coccyx. There was a large shallow wound on the anterior left leg, with drainage and erythema at the edges. The skin was cool and dry. There was swelling to the bilateral lower extremities. Pupils were 4 mm and minimally reactive. The patient was bradycardic, with an irregular rhythm. Lung and abdominal exam were benign. Neurological exam showed that the patient was opening her eyes spontaneously, withdrawing from pain, and moaning unintelligibly, unable to follow commands. She did have a gag reflex. Initial labs were remarkable for WBC count of 16.9, platelets of 67, BUN of 50, creatinine of 1.23, troponin of 0.05, CPK of 490, lactic acid of 9.2, ammonia of 45, and a cortisol of 35. An ABG was performed and was 7.26/41/103/18. An EKG revealed atrial fibrillation with slow ventricular rate. Chest x-ray showed mild cardiomegaly with no infiltrates. The patient was started on broad-spectrum antibiotics for possible sepsis. Re-warming techniques were initiated. The patient's family then arrived with her home medications, including levothyroxine. They revealed that the patient had not taken her medications in over a month. At that time thyroid function labs were sent which revealed a TSH of 50.65, T4 of 3, and T3 total of 30. The patient received synthroid as well as hydrocortisone in the ER. Given her persistent hypotension, she required vasopressors. The patient was admitted to the ICU and received thyroid hormone replacement as well as IV antibiotics. She did require intubation and was extubated on day 11. The patient had improvement of her mental status. However she then required re-intubation on hospital day 14 and was terminally extubated on hospital day 15. Her final diagnosis was myxedema coma and possible aspiration.

Discussion: Myxedema coma is a metabolic emergency and has a high mortality of 30-60% if not recognized. Even with early recognition it still carries a 25% mortality rate. It is rare in the United States due to early recognition and treatment of hypothyroidism. Factors that carry a poorer prognosis include temperature less than 93 degrees, advanced age, bradycardia, sepsis, myocardial infarction, and hypotension. Myxedema coma occurs in patients with long-standing untreated hypothyroidism and is often precipitated by an acute event or secondary insult. This can include infection, hypothermia, myocardial infarction, drugs (amiodarone), stroke, burns, GI bleed, or trauma. It affects multiple organ systems since thyroid hormone is vital for many functions. Neurologically patients have lethargy and stupor, which rarely progresses to coma. Cardiovascular depression occurs causing decreased contractility and bradycardia resulting in low stroke volume and diminished cardiac output. Decreased renal function occurs as well as decreased GI motility. Patients can present with megacolon, ileus or obstipation. Hypothermia results from decreased metabolism and decreased thermogenesis. If diagnosis is suspected labs should be obtained prior to initiating treatment and should include TSH, Free T4, T3 and cortisol. Differential diagnosis includes sepsis, depression, adrenal crisis, congestive heart failure, hypoglycemia, drug overdose and meningitis. Treatment includes airway management, thyroid hormone replacement, treatment of co-infections with broad-spectrum antibiotics, and supportive measures. Stress dose steroids are started until adrenal insufficiency is ruled out. Hormone replacement should be started prior to lab results if suspicion exists. Due to decreased GI motility, replacement must be given intravenously. The optimal mode of hormone replacement is controversial. Due to its rarity, no large trial exists to compare replacement strategies. Replacement may include T4 alone, T4 and T3 or T3 alone. Rapidly increasing levels carry the risk of precipitating an MI or arrhythmias. This is accepted because of the mortality rate if untreated. Hydrocortisone should be given before thyroid hormone to improve peripheral conversion of T4 to T3. Patients should be treated and monitored in an ICU.

Conclusion:
Myxedema coma is infrequently encountered given the prevalence of treatment of hypothyroidism. However given its high degree of mortality, prompt diagnosis and a high index of suspicion are important for early diagnosis and treatment. §

MCEP Calendar of Events

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

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]

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 **Attention President, Jim De Moss, DO, FACEP or** asmith@swmes.com *Group info:* www.swmes.com [6-2]

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