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

ADVOCACY: TO CHANGE WHAT IS INTO WHAT SHOULD BE

Larisa Traill, MD, FACEP

March 12th-16th ACEP's 2017 *Leadership & Advocacy Conference* brought more than 600 emergency physicians to Washington D.C., a record setting attendance. The annual conference offers lectures focused on healthcare reform and economics, current issues and crises, as well as media training and leadership skills. The March date posed a significant challenge to our membership as it not only conflicted with spring break, but also compounded unpredictable March weather into already hectic travel plans. Despite these factors, the MCEP membership and Chapter leaders came out in force, once again representing the largest state chapter contingent, bringing more than 37 of our members, including 18 MCEP leadership development program participants, residents, and first time attendees. Nationally, physicians from 46 states were scheduled to participate in more than 300 meetings on Capitol Hill offices with legislators and/or their health care staff. These face-to-face meetings with national leaders are a critical component of the conference. Unfortunately, a winter storm paralyzed air travel for many legislators returning to Washington and closed some Capitol Hill offices, hampering the official ACEP "Lobby Day" for many meeting registrants. A "dusting of snow", however, would not thwart the Michigan delegation. On Tuesday morning when it was readily apparent that the snowfall was negligible, with the federal government running on a three-hour delay, the opportunity to resume organized office visits that afternoon was available. Michigan members took it upon themselves to call the district offices and enlist the help of Michigan based staff to call their counterparts in Washington to confirm visit schedules. In the end we were able to meet with both Senators Stabenow and Peters and all but two representatives or their health policy staff including, to my delight, my congressman's dog; to her credit Annie was a keen listener. These visits remain a crucial element to aid in educating legislators on emergency medicine issues, to seek support for specific bills and legislative initiatives, to show appreciation for past support, and to afford legislators the opportunity to become advocates for ACEP's public policy initiatives. Key goals of these appointments were to increase congressional awareness that extending health insurance coverage does not necessarily ensure access to care and that the lack of on-call specialists as a result of EMTALA related care is a dilemma that persists.

Attendees who visited Capitol Hill focused on:

- Asking legislators to co-sponsor the "Health Care Safety Net Enhancement Act of 2017" (H.R. 548/S. 527), sponsored by Representative Charlie Dent (R-PA) and Senator Roy Blunt (R-MO). The bi-partisan legislation provides medical liability relief for physicians providing care under the EMTALA mandate. Participants also asked legislators to co-sponsor the bills and advocate for further action through Congress.
- Sharing ACEP's Health Care Reform Principles and discussing our concerns with the now defunct House ACA repeal proposal.
- Urging legislators to develop an In-District Health Care Advisory Committee with participation by an emergency physician.

Following our Capitol Hill visits MCEP members attended a "Dine Around" fundraiser, hosted by the National Emergency Medicine Political Action Committee (NEMPAC), for Sen. Debbie Stabenow (D-MI). ACEP leaders, NEMPAC Board members, and conference attendees participated in the event. Other NEMPAC "Dine Around" fundraisers included: Rep. Michael Burgess (R-TX), Senator Chris Murphy (D-CT), and Rep. Greg Walden (R-OR).

The conference also included talks on several important topics such as the opioid crisis and innovative solutions pioneered by ACEP members, quality improvement efforts and the changing Medicaid landscape. Rep. Brett Guthrie (R-KY), Chairman of the House Energy and Commerce Committee Medicaid Task Force, and former Vice President-nominee Sen. Tim Kaine (D-VA) also addressed members. And, Monday evening, attendees were entertained by no other than ZDoggMD (Dr. Zubin Damania) of YOUTube fame, whose "Health 3.0" movement to transform medicine by creating partnerships with patients and being "evidence-empowered rather than evidence enslaved" is advanced in a high energy multimedia presentation. Dr. Damania's unique perspective on healthcare and social media was inspirational; his satire, candor, and insight are unparalleled.

ACEP's Leadership and Advocacy conference continues to prove a unique event that affords emergency physicians the opportunity to demonstrate their involvement in, and commitment to, the advocacy process on the federal level. ACEP members unable to attend the conference were able to access full coverage online and via social media. In fact, ACEP President Dr. Becky Parker led a live call to action powered by Phone2Action that alerted legislators that ACEP members were in DC to advocate for the specialty and patients. Simply by using their smartphones, conference attendees sent almost 1,000 communications to legislators instantly via email, Twitter and Facebook. Registrants were also able to send messages to the new administration via Phone2Action. While there can be no guarantee that such efforts are successful, it is certain that a lack of urgency in calling for continued attention to these issues will surely fail to effect change. Indeed, in the words of that greatest of Athenians:

"Those who are politically apathetic can only survive if they are supported by people who are capable of taking action."–Pericles §

www.mcep.org

ACEP LEADERSHIP & ADVOCACY CONFERENCE

ACEP LEADERSHIP & ADVOCACY CONFERENCE

FROM THE ASSISTANT EDITOR

Nicholas Dyc, MD, FACEP

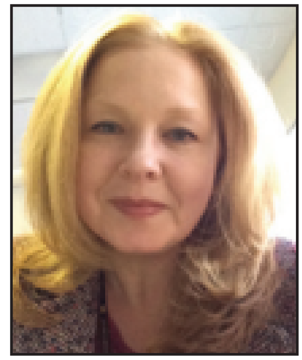
As partner in a 100% truly democratic group in southeastern Michigan, it concerns me when I think of the trend towards consolidation in our specialty and the effect it may have on our careers and our college. The day-to-day ER doctor (JAFERD as coined by the Facebook group, EM Docs) remains the foundation for MCEP success. We all share the same challenges of clinical shifts, frustrating systems, and difficult cases. In order to improve our working conditions, we must work together using our college as the common ground. If the effects of consolidation in our workplace foster an inhibition towards showing up to MCEP events, then our challenges and working conditions will get worse.

Sometimes it is hard to see the indirect benefits of having a strong MCEP. If profits go towards a publicly-owned and traded company, then why do I care if Medicaid reimbursement goes up? If my CME allowance goes down, why should I spend money at the Grand Hotel every summer? If our lobbyist can't win every fight in Lansing, why should I bother showing up to our Legislative meetings on my own free time? We all have such busy lives and cannot allow the trend towards consolidation to deter us from showing up and participating.

A strong MCEP provides steady long-term gains with short-term dividends. Think of it like an investor. As MCEP strengthens, so does our voice and authority. If you do not contribute your time and/or money to the college, then you should not complain when you have a lousy shift. It is not reasonable to expect others to work on your behalf. Please don't complain when the frequent flier comes in demanding unreasonable things. Please don't complain when the aggressive patient or family member threaten you. It's hard to explain how challenging our days can be, let alone expect a legislator or hospital administrator to explain it. If you can't expect a legislator or hospital admin to explain our challenges, then you cannot expect them to develop solutions. For this, I introduce MCEP.

MCEP is strong. Its strength lies in our relationships and mutual causes. We must keep it that way. The JAFERDs of Michigan make up the foundation for our college. We must continue to embrace MCEP and be aware of the risks posed by consolidation in our specialty. As life evolves and the world becomes more complex, we must remain vigilant through MCEP. If we allow stockholders, insurance companies, and government agencies to control decision making, then our patients and our specialty will suffer. Consider it an investment in the quality of your life. §

TELEMEDICINE/TELEHEALTH



Lynn Nutting

Telemedicine has been around for a while but has only come into favor recently due to more payers reimbursing the charge. Used as a way to increase access to care in underserved communities, telemedicine continues to gain in popularity. The chart below details the CPT/HCPCs specific to Emergency Medicine that may be billed by the originating site and consulting provider, the modifiers required on claim forms, the work RVUs generated and the known payers to date that reimburse for telemedicine services. §

Telemedicine Description	Synchronous real time interactive audio and video communication between provider and patient to provide a health assessment, diagnosis, treatment &/or consultation at the originating site
Originating Site/Location	Physician Office Hospital Critical Access Hospital (CAH) Rural Health Clinic Skilled Nursing Facility (SNF)
Coverage Indications	Patient at originating site is located outside of a Metropolitan Statistical Area (MSA) or a Rural Health Professional Shortage Area (HPSA) *See location link to determine eligibility* https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx
Consulting Providers	Physician Nurse Practitioner Physician Assistant Nurse Midwife Clinical Nurse Specialist Certified Registered Nurse Anesthetist Clinical Psychologist Clinical Social Worker
Consulting Provider CPT/HCPS Reporting	G0425 - ED or Initial IP - 30 minutes - 1.92 WRVU G0426 - ED or Initial IP - 50 minutes - 2.61 WRVU G0427 - ED or Initial IP - 70 minutes - 3.86 WRVU G0406 Follow up IP or SNF - 15 minutes - 0.76 WRVU G0407 Follow up IP or SNF - 25 minutes - 1.39 WRVU G0408 Follow up IP or SNF - 35 minutes - 2.00 WRVU *See CPT Appendix P for complete list of Non-Medicare billable codes*
Consulting Provider Modifier Reporting	Medicare & Government payers append GT - Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system *Alaska & Hawaii Medicare append GQ modifier w/ less restrictive rules* *CPT (Commercial payers) append modifier 95*
Originating Site CPT/HCPCS Reporting	Q3014 – Telehealth originating site facility fee - Reimbursement approximately $25
Patient Responsibility	Medicare (provider) 20% copay + deductible if applicable
Covered Payers (2016)	Medicare, Medicaid, BCBS/BCN per individual plan, Meridian Medicaid, Molina Medicaid, UHC Community Medicaid & Commercial, Paramount, HAP, Alliance Hlth Life, Priority Health Care & Caid, Health Plus Medicare
Non-Covered Payers (2016)	Aetna, Cofinity, PHP

LEGISLATIVE COLUMN

Emergency Department Assaults – MCEP is helping push SB 33, sponsored by Senator Ken Horn of Saginaw, which makes assaulting health care professionals in the emergency department a felony punishable by up to 15 years and a major fine for injuries causing severe bodily harm to those professionals trying to fulfill their duties. There are several other increased penalties in the bill but the main deterrent is the ability for prosecutors to pursue felony charges against individuals assaulting health care professionals. The bill is currently on the Senate floor and MCEP is pushing for passage this spring.

Opioid Crisis – MCEP has been monitoring and following legislative proposals pertaining to the epidemic griping our state in recent years. MCEP was invited to testify at the House Health Policy Committee on Wednesday, April 19, 2017. This day coincided with the College's Leadership Development Program Day in Lansing event. There were eight cohorts of the LDP class in attendance for the day and they got to witness first hand Dr. Rami Khoury, Dr. Jake Manteuffel, and Dr. Melissa Barton speaking before the committee.

Dr. Khoury led the discussion by introducing the College to the legislature and talking about the history of emergency medicine in the state. He spent thirty minutes walking through the College's feelings on various opioid proposals and the MAPS system. He talked about the potential unintended consequences of mandating all physicians to check MAPS and warned of the potential of driving more patients to the ED setting. A link to Dr. Khoury's presentation is on the homepage of MCEP website (www.mcep.org) and I would suggest all MCEP members use the powerpoint when talking to your state representative or state senator.

Brett Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

Please feel free to reach out to Dr. Rami Khoury, Chair of MCEP's Legislative Committee, or Bret Marr with any questions you may have on state legislative or regulatory issues. §

PHYSICIANS/POSITIONS AVAILABLE

KALAMAZOO, MI: We are hiring NOW. Growing-yet established-democratic group offering competitive benefit and preeminent shareholder package and sign-on bonus. Offering self-regulated schedule, APP coverage, specialty back up coverage. Foster your academic interests with teaching and research opportunities through Western Michigan University Homer Stryker M.D. School of Medicine. Looking for Board Certified/Board Eligible Emergency Medicine Physicians/Residents interested in partnership opportunity where you will share in ownership and our vision for continued growth in our region. Full time, permanent positions for hospitals from rural single coverage to Southwest Michigan's only Level 1 Trauma Center. Kalamazoo is a vibrant, cultural community with excellent school districts and professional opportunities for partners/spouses. Settled among inland lakes and only two hours from Detroit and Chicago. Email CV to corporate@swmes.com attention President. [6-6]

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 [5-5]

Want ads, and/or placement ad rates for MCEP News & Views issues are available on our website at www.mcep.org or you can contact the Chapter office at (517) 327-5700 for further information.

MCEP BOARD VACANCY

Recently, the MCEP Board of Directors regretfully accepted the resignation of Michael Nauss, MD, FACEP. The Board announces that this position will be filled at the July 31, 2017 Board of Directors meeting to be held during the Michigan Emergency Medicine Assembly at the Grand Hotel on Mackinac Island, Michigan. Dr. Nauss has two years remaining in his term.

Members interested in being nominated for election for this two-year term position on the Board of Directors should contact the Chapter office and attend the July 31st Board meeting.

MICHIGAN TELEMEDICINE UPDATE

Telemedicine is coming to an emergency center near you. As the US healthcare system struggles to switch from fee for service to pay for performance, many health systems are looking at telemedicine as a way to increase resources, lower costs, and improve patient care. In a report to the state legislature entitled *Recommendations for Addressing the Needs of High Utilizer/Super Utilizer Patients in Michigan*, which MCEP helped to create, telemedicine was listed as one of several ways to improve access and provide timely, appropriate care for patients. Emergency centers share common challenges including door to provider times, access to specialty care, patient surges, provider coverage, and 30-day re-admission rates. Over the next few years, emergency centers are likely to see an increased adoption of service in the emergency center such as tele-psychiatry, tele-neurology, or tele-ICU to meet such challenges. Anyone offering telemedicine services in Michigan should be aware of key legal statutes and bills governing telemedicine and licensing requirements.

Michigan's newest telemedicine law was signed by Governor Rick Snyder and will take effect on March 21, 2017. This new law imposes new standards and restrictions for telehealth. It broadly defines telehealth as the use of electronic technologies to provide remote clinical care, education, public health services, or administration and includes telemedicine services. Meanwhile, telemedicine is defined more narrowly as the use of electronic communication to connect patients and health care providers. Such provider-patient interactions must occur using two-way audio/video technology to allow the provider to examine the patient and the patient to interact with the provider in real time. The new law also requires a provider to obtain consent for treatment before providing such services, although inmates at correctional facilities are exempted from the consent requirement. It also allows remote prescriptions through telehealth except for controlled substances. Unfortunately, this does make Michigan one of a few states that specifically prohibit prescribing controlled substances through telehealth. The new law remains silent on the need for an in-person exam before providing telehealth services. Overall, this new law is fairly permissive for offering telemedicine services in Michigan.

Michigan's telemedicine parity law was established in 2012 via MI Compiled Law Services Sec. 500.3476. It is generally a weak law, but it does contain the prohibition that "contracts shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine." This prohibition opens the door to including telemedicine services within insurance contracts. The law also recognizes that "Telemedicine services are subject to all terms and conditions of the health insurance policy agreed upon between the policy holder and the insurer, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts." Essentially, this law is permissive to allow insurers to pay for telehealth services, but it does not require insurers to pay for services not defined in the policy holder's agreement. The Center for Connected Health Policy website contains additional details on telehealth related laws in Michigan and all other states.

In order to provide telemedicine services, a provider must be licensed in the state where the patient is physically located. This means that a physician licensed only in Michigan cannot provide telehealth services for a patient located in a neighboring state. When working with patients living near bordering states, this can complicate the delivery of telehealth and require telemedicine providers to seek licensing in multiple states. The Interstate Medical Licensure Compact was created to help physicians easily obtain a license in multiple states. It allows providers to apply for a license in a participating state and become licensed in all states participating in the compact. Currently, 18 states have enacted legislation to be part of the compact. Nearby states already participating include Wisconsin and Illinois. Michigan HB 4282 was introduced in 2015 to allow Michigan to join with the Physician License Compact. Although the bill successfully passed through the Michigan House of Representatives, it was referred to the Committee on Health Policy in February 2016 and was not voted on in the Senate before the end of 2016. At this time, it appears that the bill will need to be re-introduced in the Michigan Legislature before it can be voted on.

Michael Baker, MD
Past-President, MCEP
Director of Telehealth, EPMG

Telemedicine is rapidly becoming a recognized part of the medical experience in Michigan. Michigan's telehealth related laws, while not the strongest in the nation, are certainly sufficient to provide a framework for developing telemedicine programs, working with payers, and licensing telehealth providers. §

Links:

http://www.michigan.gov/documents/mdch/High-Super_Utilizer_Report_Healthy_MI_Act_12-2014_487676_7.pdf
http://www.cchpca.org/jurisdiction/michigan
http://licenseportability.org

MCEP PEDIATRIC COMMITTEE ESTABLISHED

Michigan College of Emergency Physicians is proud to announce the formation of the first Pediatric Committee, approved by the Board of Directors at the March meeting. The goal of this committee is to identify pediatric issues pertinent to the members of MCEP, and provide resources and solutions to improve pediatric emergency care in Michigan. Objectives include working with members of MCEP, other MCEP committees and outside organizations to achieve this goal. If you are interested in joining this committee, please contact the Chapter Office at (517) 327-5700 or mcep@mcep.org.

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS 2017 BOARD OF DIRECTORS CANDIDATES

SARA CHAKEL, MD, FACEP

- Graduate, University of Michigan Medical School, Ann Arbor, MI, 2003
- Emergency Medicine Residency, University of Michigan / St. Joseph Mercy Hospital Emergency Medicine Residency Program, Ann Arbor, MI, 2007
- Clinical Instructor in Emergency Medicine, Foote Health System / Allegiance Health, employed through the University of Michigan, Jackson, MI, 2007-2008
- Senior Medical Officer, Emergency Department, The Townsville Hospital, Townsville, Queensland, Australia, 2008-2010
- Locum tenens physician, Emergency Department, Schneider Regional Medical Center, St. Thomas, United States Virgin Islands, 2010-2011
- Locum tenens physician, Emergency Departments, West Medical Center, Willoughby, OH and Tripoint Medical Center, Concord, OH, both part of the Lake Health Medical System, 2011-2013
- Attending physician and core faculty member, Emergency Medicine Residency Program, St. Mary Mercy Hospital, Livonia, MI, 2013-present
- Clinical Assistant Professor, Michigan State University College of Osteopathic Medicine, 2015-present
- Chair, Clinical Competency Committee, Emergency Medicine Residency Program, St. Mary Mercy Hospital, 2015-present
- Graduate, MCEP Leadership Development Program, 2016
- Alternate Councillor, ACEP Council Meeting, 2016
- Diplomate, American Board of Emergency Medicine
- Fellow, American College of Emergency Physicians

Born and educated in Michigan, Dr. Chakel left Michigan one year after residency to work for five years as a travelling physician in Australia, the U.S. Virgin Islands, and Ohio in a mix of settings that involved academics, teaching, and community practice as well as many more snakes, stingers, and mosquitos than will ever be seen in a standard Michigan summer. She returned home to Michigan in 2013.

An MCEP member since 2003, Dr. Chakel has been active in the college as a member of the Education committee since 2015, a participant in the Leadership Development Program in 2016, and a member of the Legislative and Pediatrics committees starting in 2017. She is also a member of the ACEP Wellness Section and the American Association of Women Emergency Physicians (AAWEP). Dr. Chakel will bring both the perspective of a community teaching hospital and the personal experience of working in different care environments to the board of directors. She is especially interested in physician wellness initiatives.

NICHOLAS DYC, MD, FACEP

- Graduate Wayne State University School of Medicine, Detroit, MI, 2008
- Emergency Medicine Residency, St. John Hospital and Medical Center, 2008-2011
- Attending Physician, St. John Providence Hospital (Southfield) and Providence Park Hospital (Novi), 2011-current
- Attending Physician, Allegiance Hospital (Jackson), 2011-current
- Emergency Medicine Ultrasound Director, Allegiance Hospital, 2013-current
- Emergency Medicine Core Faculty, Allegiance Hospital, 2013-current
- MCEP Leadership Development Program Class of 2012
- MCEP PR Committee Chair, 2013-current
- MCEP News and Views Assistant Editor, 2013-current
- ACEP Councillor, 2015-current
- ACEP Alternate Councillor, 2012, 2014

Dr. Dyc graduated from residency in 2011 and immediately became an active member of MCEP. Graduating with the 2012 Leadership Development Class, he joined the Public Relations Committee and immediately made an impact. Taking classes in web-design at Schoolcraft College has given him the ability to create posters, logos, and other media content for MCEP. Dr. Dyc then turned his focus onto Twitter, creating an MCEP Twitter account, linking this social media to the MCEP Facebook page, and assisting members in receiving tweets from MCEP. Dr. Dyc worked with Diane and a MSU IT team to develop and utilize the technology for our electronic newsletter and social media posts. He has helped grow our likes on Facebook to over 1,000, an almost 10-fold growth in 4 years. Dr. Dyc works closely with the directors of several conferences like Observation Medicine in order to promote their success. He has also led other campaigns like the Bone Marrow Registry Drive at the Winter Symposium this year. A second term on the Board would consist of more work towards advancing our social media presence, use of technology, promoting our conferences, and encouraging younger students and doctors to become engaged as our specialty continues to evolve and grow.

(Continued on Page 10)

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS 2017 BOARD OF DIRECTORS CANDIDATES

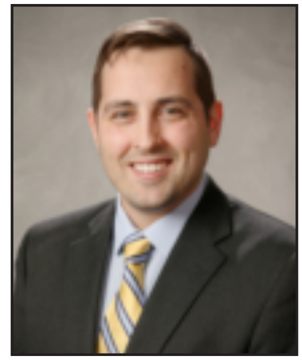
(Continued from Page 9)

MICHAEL FILL, DO, FACEP

- Graduate, Lake Erie College of Osteopathic Medicine, Erie, PA, 2005
- Osteopathic Intern, Emergency Medicine Emphasis – Botsford Hospital. Farmington Hills, Michigan. 2005 - 2006
- Emergency Medicine Residency, Botsford Hospital, Farmington Hills, MI 2006 - 2009
- Chief Resident, Emergency Medicine Residency, Botsford Hospital, Farmington Hills, MI 2008 - 2009
- Attending Physician, Henry Ford Allegiance Health 2009-present
- Attending Physician, Garden City Hospital, Garden City, MI 2009-2012
- Attending Physician, Providence Park Hospital, Novi, MI 2016 - present
- Assistant Medical Director, Jackson County Medical Control Authority 2012 - present
- Stockbridge Area Emergency Services Authority Educational Medical Director 2013 - present
- Clinical Faculty - Jackson College Emergency Medical Technician and Paramedic Programs
- Jackson Community Ambulance Mobile Intensive Care Unit Director, 2011 - present
- Huron Valley Ambulance Board Quality Committee Member, 2010 - present
- MCEP Emergency Medical Services Committee Member
- Michigan Emergency Medical Services Coordination Committee member, 2017
- MCEP Public Relations Committee Member
- Graduate, MCEP Leadership Develop Program, 2013
- MCEP Alternate Councilor, 2013 - 2015
- Associate Clinical Professor MSU College of Osteopathic Medicine
- Core Faculty, Henry Ford Allegiance Health Emergency Medicine Residency

Dr. Fill became a member of ACEP and MCEP during his residency. After graduation from residency in 2009, he began participating in various EMS Committees, and was named the Assistant Medical Director for the Jackson County Medical Control Authority in 2012. He began serving as a member of the MCEP EMS Committee in 2012, which led him to participate in and graduate from the MCEP Leadership Development Program in 2013. Since that time, he has become more active in the State of Michigan EMS system, participating in local EMS education in the communities of Jackson and Stockbridge, as well as participating in the research presentation portion of the Statewide Medical Control Seminar in 2015. Dr. Fill was also named as an MCEP representative to the Emergency Medical Services Coordination Committee (EMSCC) in January of 2017. Dr. Fill primarily practices Emergency Medicine at Henry Ford Allegiance Health in Jackson, MI where he serves as a member of the Core Faculty for the Emergency Medicine Residency. He is also on staff at the Providence Health System in Southeast Michigan.

MICHAEL GRATSON, MD



- Graduate, Wayne State University School of Medicine, Detroit, Michigan, 2010
- Residency in Emergency Medicine, Beaumont Health System, Royal Oak, Michigan, 2015
- Chief Resident, Beaumont Health System, Royal Oak, Michigan, 2014-2015
- Attending Physician, Beaumont Health System, Royal Oak and Troy, Michigan, 2015-present
- Associate Clinical Professor, Oakland University William Beaumont School of Medicine, Royal Oak, Michigan, 2015-present
- Diplomate, American Board of Emergency Medicine
- MCEP, Alternate Councilor, 2016
- MCEP, Health Finance Committee, 2012-present
- MCEP, Legislative Committee, 2012-present
- MCEP, Leadership Development Program Graduate, 2016
- MCEP, Faculty Student Advisor, 2016-present

Dr. Gratson first became involved in MCEP while during his residency in 2012. He first became members of the Health Finance and Legislative Committees and continues to serve to this day. Recently, Dr. Gratson has completed the Leadership Development Program and has become a Faculty Advisor to the MCEP Medical Student Council. He has been active legislatively both on the local and national level to improve the conditions for both those who work and those who receive care in an emergency medical setting. Dr. Gratson aims to continue this work and to serve the members of MCEP in a larger role.

WARREN LANPHEAR, MD, FACEP

- Graduate Michigan State University College of Medicine, East Lansing, MI, 1983
- Emergency Medicine Residency, Butterworth Hospital, Grand Rapids, MI, 1983-1986
- Staff physician, War Memorial Hospital, Berkeley Springs, WV, 1986-1989; Chief of Staff 1988-1989
- Attending Physician for ECS at SH Gerber, Zeeland, United Memorial, Reed City, and Kelsey Hospitals and West Shore Medical Center/ Manistee part-time
- Core Faculty, EM Residency Program, GRMEP/Spectrum Health Butterworth (Grand Rapids), 1990-2004
- Clinical Assistant Professor, Department of EM, MSU/CHM, 1989-present
- President, Emergency Care Specialists, PC, 2009-present
- MCEP Board member 2014-present

Dr. Lanphear has practiced emergency medicine for 31 years. He served in the National Health Service in rural West Virginia. Upon returning to West Michigan in 1989, he has spent his career with ECS. He has been a residency faculty member, a flight physician, and a rural ED physician at several western Michigan sites. Dr. Lanphear now divides his clinical time between pediatric EM, rural EM, and observation medicine. He continues to teach preclinical students at MSU/CHM. His current interests are pediatric EM, legislative action, teaching, and independent group management. He regularly contributes a column on billing and reimbursement for the MCEP newsletter.

EMILY MILLS, MD

- Bachelor of Science, Michigan State University, 2006
- Doctor of Medicine, Wayne State University School of Medicine, 2010
- Emergency Medicine Residency, University of Michigan/St. Joseph Mercy Hospital, 2014
- Attending Physician, St. Joseph Mercy Hospital, Ann Arbor, MI, 2014 – present
- Attending Physician, St. Joseph Mercy Livingston, Howell, MI, 2014 – present
- Attending Physician, St. Joseph Mercy Brighton, Brighton, MI 2014 – present
- MCEP Leadership and Development Program graduate, 2015
- MCEP Alternate Councilor, 2016
- Assistant Residency Program Director, University of Michigan/St. Joseph Mercy Hospital Emergency Medicine Residency program, 2016 – present
- Core Faculty, University of Michigan/St. Joseph Mercy Hospital Emergency Medicine Residency program, 2016 – present
- MCEP Quality Committee, Co-Chair and member, 2016 – present
- Diplomate, American Board of Emergency Physicians

Dr. Mills has been a member of MCEP and ACEP since beginning her post-graduate training in 2010. Following completion of her residency, she began clinical work with EPMG at St. Joseph Mercy Hospital in Ann Arbor. She continues to develop her leadership skills with ongoing participation in EPMG's quarterly leadership and management forums. She participated in the MCEP Leadership Development Program in 2015. After LDP completion, she remained involved in MCEP chapter activities by assisting with the development of the Quality Committee and currently serves as Co-Chair. She also served as an Alternate Councilor for the chapter at the 2016 ACEP National Council Meeting in Las Vegas. She has strong interests in patient safety and quality, medical education, mentorship, physician wellness, and clinical operations. She would be honored and delighted to serve as a member of the MCEP Board of Directors.

MARCUS MOORE, DO, FACEP

- Graduate, Michigan State University Lyman Briggs School 2000
- Graduate, Michigan State University College of Osteopathic Medicine 2004
- Emergency Medicine Residency Genesys Regional Medical Center 2008
- Emergency Medicine Physician Statcare PC (Genesys) 2008-2012
- Board Certified Emergency Medicine 2009-present
- Medical Director Swartz Ambulance Company 2009-2012
- Emergency Medicine Physician Medical Center Emergency Services DMC Sinai Grace and Harper University Hospitals 2012-present
- Medical Director DMC Sinai Grace Hospital 2015
- Vice Chief Emergency Medicine DMC Sinai Grace Hospital 2015-present
- Utilization Review Committee Member Sinai Grace Hospital
- Process Improvement/Peer Review Committee member Sinai Grace Hospital
- Emergency Medicine CMS Metric Management Sinai Grace Hospital
- Member ACEP, MCEP, AOA
- FACEP since 2015
- Specialist Educator of the year 2010 Genesys Regional Medical Center
- Emergency Medicine Educator of the year 2010 Genesys Regional Medical Center
- Assistant Clinical Professor Michigan State University – COM 2008-present
- Assistant Clinical Professor Michigan State University – CHM 2008-2012
- Assistant Clinical Professor Wayne State University – SOM 2012-present
- Therapeutic Hypothermia Protocol Developer Genesys Regional Medical Center
- Trauma Board Member at Genesys Regional Medical Center
- Anticoagulant Reversal Protocol in Trauma Co-developer Genesys Regional Medical Center
- Statcare Public Relations Ambassador
- Pre-hospital C-PAP program developer Swartz Ambulance Service
- King Airway program developer Swartz Ambulance Service
- MCEP Leadership Development Program Graduate – 2016
- MCEP Legislative Committee member - currently

Dr. Moore is highly interested in legislative policy and advocacy for our specialty via the conduit of our government. He has a broad practice exposure including the workings of a small private practice group to a large group practice. Dr. Moore has experience in the suburban medical environment as well as his current practice in the urban, primarily underserved, hospital environment of northwest Detroit. Dr. Moore has been highly involved in clinical medical education his entire career and has a deep understanding of the needs of that sector. Finally, Dr. Moore has been most naturally involved in a multitude of leadership roles at the hospital level, which has led to his interest in the greater picture of our practice environment. Dr. Moore completed the MCEP Leadership Development Program over the 2016 calendar year. This gave a fantastic understanding of the political environment we are required to maintain influence on. Dr. Moore looks ahead to being able to use these experiences to leading our specialty from the MCEP forum.

MCEP RESIDENT CASE REPORT

By: Ali Ahmed, MD and Mark Dalton, MD of the Central Michigan University College of Medicine, Saginaw, MI.

HPI

A 42 year old male was brought in via EMS for palpitations for 2 days. The patient denied any active or prior chest pain but reported lightheadedness, nausea, vomiting, fatigue and shortness of breath. He was noted to be diaphoretic and EMS reported him to be in atrial fibrillation. He reported no significant medical history and stated he had not seen a physician in years. Over the last few days he reported weight loss, fevers and excessive sweating. He did note that he had been living in an apartment without air conditioning. The patient denied any prescription or over the counter medications, as well as recreational drug use with the exception of heavy marijuana use in the prior few days.

Review of Systems: As above
Past Medical History: None
Past Surgical History: None
Family History: None
Medications: None
Allergies: None known

Physical Exam:

Vitals: 108/78; 189; 20; 36.5; 95% on room air
Constitutional: Cachectic appearing male, no respiratory distress.
Head: Normocephalic and atraumatic.
Mouth/Throat: Oropharynx dry.
Eyes: EOM intact. Pupils are equal, round, and reactive. Bulging eyes, non-icteric sclera.
Neck: Normal range of motion. No JVD.
Cardiovascular: Normal heart sounds. No murmur. Irregularly irregular tachycardia.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress or wheezing.
Abdominal: Soft. Bowel sounds are normal. No masses, tenderness, rebound or guarding.
Genitourinary: Penis normal.
Musculoskeletal: Normal range of motion. No edema or tenderness.
Lymphadenopathy: No cervical adenopathy.
Neurological: Alert and oriented to person, place, and time. He displays normal reflexes. Coordination normal. No facial asymmetry. No dysarthria. Symmetric biceps and patellar reflexes. Symmetric intact strength of bilateral upper and lower extremities. No pronator drift. No asterixis or ankle clonus.
Skin: Skin is warm and diaphoretic.

Laboratory Data:

Hemoglobin 12.9; WBC 40.0; Platelets 143; Sodium 132; Potassium 5.2; Chloride 98; CO2 17; BUN 52; Creatinine 1.0; Glucose 48; ALT 1565; AST 2089; TBili 3.6; DBili 0.7; Lactate 5.8; TSH <0.01; FT4 8.3; T3 Total >800; INR 3.58; Ammonia 132; Hepatitis Panel Negative; Acetaminophen < 10; UDS Positive for Cannabinoids

Radiology:

CT Chest/Abdomen/Pelvis:
1. Enlarged mediastinal and hilar lymph nodes.
2. Heterogenous enhancement of the liver can be seen with hepatitis.
3. Pericholecystic fluid is seen, findings can be seen with acute hepatitis.
4. Mild pancreatic fat standing in the region of the pancreatic tail. Additionally there is mesenteric fat stranding with prominent mesenteric lymph nodes and findings can be seen with pancreatitis and mesenteric panniculitis.

Us abdomen:
Mild gallbladder wall thickening without calculi. The gallbladder wall thickening may be related to hepatitis or and/or ascites.

ED Management and Discussion:

Patient was in atrial fibrillation with RVR on initial assessment with heart rate as high as 215. He was given sequential doses of Adenosine for 30 mg total with no change of heart rate. The patient was then given Cardizem 20 mg bolus and started on 5 mg/hr drip. This was rapidly increased to 15 mg/hr with a second 20 mg bolus given as well. Rate continued to be greater than 150 beats per minute. He was also hypoglycemic and given 25 g of D50.

Lab work initially demonstrated hyperthyroidism with concerns for thyroid storm, while additional blood work also demonstrated findings consistent with hepatic failure. At the direction of both cardiology as well as endocrinology the patient was then medicated with 40 mg Methimazole, 100 mg Hydrocortisone, 5 mg Metoprolol and 500 mg SSKI. Empiric broad spectrum antibiotics, lactulose and FFP were also given. The patient was eventually transferred to a regional transplant center.

The patient demonstrated lab work consistent with thyrotoxicosis as well as hepatic failure. At the time of transfer, the exact etiology was unknown. While many etiologies can be considered, there is also the possibility that these two pathologies were in fact related. Thyroid and GI functions are closely related and thyroid dysfunction can cause various GI symptoms. Conversely gastric disease can mimic some thyroid pathology[1]. There are few case reports of patient's presenting with hyperthyroidism as well as liver failure.[2] One theory as to the etiology of this association include ischemia due to the increased catabolism, as evidenced by panlobular necrosis of the liver on autopsy in a similar case.[3,4]

Treatment of hyperthyroidism is multifaceted, with the goal of inhibiting thyroid hormone release, synthesis and peripheral conversion.[5] In regards to release inhibition, one may use either Propylthiouracil or Methimazole. PTU is generally preferred because it also helps prevent T4 to T3 conversion. We elected to use Methimazole at the discretion of the consulting endocrinologist, partially due to the rare side effect of acute hepatitis that can occur in the use of PTU.[6] Both beta-blockers and glucocorticoids assist with inhibition of peripheral conversion, which we elected to use. Lastly potassium-containing solution is given 1 hour after initial therapy to prevent further hormone production. §

AMERICAN HEALTHCARE'S ONE CONSTANT IN A SEA OF CHANGE: EMERGENCY MEDICINE

Written by John G. Holstein, James Augustine, MD, FACEP, Jay Kaplan, MD, FACEP, Rebecca Parker, MD, FACEP, Alex M. Rosenau, DO, FACEP

In these post-election days of uncertainty, when the words "repeal and/or replace" are echoed in many circles, there are a few issues meriting clarification and particular emphasis.

First, emergency physicians have championed the issue of patient access for decades. The American College of Emergency Physicians (ACEP), emergency medicine's largest professional association began in 1968, with patient access as a primary mission to American society. This issue is of central importance, as our population continues to age, coincidental with the increasing age of emergency department patients, however there are substantial risks in this environment for adults as well for children. A just released Children's Health Fund report[1] noted that "approximately 28% of children in the U.S. still do not have full access to essential health services."

Second, emergency physicians' commitment to their patients is no more clearly evident than in the prudent layperson definition of an emergency, established in Sally Richardson's letter[2] in 1998 and in the Affordable Care Act. Today it is especially important and significant to review this definition here:

"The Balance Budget Act defines emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part. While this standard encompasses clinical emergencies, it also clearly requires managed care organizations to base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and to cover examinations where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson."

This definition is a central issue in every emergency medicine physician contract with insurance companies. Prior to the standard being formally promulgated in the Federal Balance Budget Act of 1997, insurance companies were denying patient claims for a variety of reasons, but it was clear the Federal government had confirmed the central importance of recognizing and respecting the patient's perception of their illnesses upon coming to the emergency department regardless of the final diagnostic outcome. It is the patient's presenting symptoms that carry the day, not the final diagnosis. This nuance heightens the significance of the experience, skill-set and knowledge of emergency physicians who must engage their patients frequently without any prior history, faced solely with the presenting picture of illness and/or accident as presented by the patient. This allows the emergency physician to make the diagnosis of an emergency, not the patient or an insurance representative over the phone. Experience showed that to do otherwise unacceptably put patient lives at risk, a fact emergency physicians testified to during the creation of the law.

The issue being challenged again by the insurance industry is their desire to refuse payment, and shift costs on to the back of their patients through high deductibles and co-pays, with only the health of their bottom line as a beneficial outcome. This exponential increase in patient responsibility harkens back to the HMO insurance era when the prudent layperson definition of an emergency was created. An October 2015 survey by ACEP[3] showed the following results:

1. Seven in 10 emergency physicians responding to a new poll are seeing patients with health insurance who have delayed seeking medical care because of high out-of-pocket expenses, high deductibles or high co-insurance.

2. Nearly three-quarters (73 percent) reported seeing increased numbers of Medicaid patients who have delayed medical care, because health plans are failing to provide adequate numbers of primary care physicians ("narrow networks").

3. A recent survey of registered voters conducted by Morning Call Consult for the American College of Emergency Physicians found[4] that 30 % of respondents said they delayed or avoided emergency medical care out of fear of costs.

Emergency physicians have coupled the prudent layperson concept with championing patient access to secure fair insurance company payment for emergency services. It has by no means an easy path to secure these hallmark principles.

Third, The Emergency Medical Treatment and Labor Act (EMTALA) formally established by Congress in 1986 is a hallmark of emergency medicine, establishing the unfunded mandate requiring everyone presenting to an emergency department receive a medical screening examination, regardless of their ability to pay for the services provided to them. This federal law set the standard for emergency medicine care being available to all patients 24/7/365. Emergency medicine today provides the highest incidence of EMTALA mandated care among all medical specialties.[5]

Now let's establish a few related and very significant facts about emergency medicine.

1. As specified in Federal law, emergency physicians do not bill insurance companies and patients at different rates, nor at different charge levels. This is an erroneous perception commonly promulgated in lay articles.

2. Emergency physician, professional-fee bills only on unusual and very rare occasions reach into the thousands of dollars. If any emergency physician, professional-fee bill reaches into 4 figures at all it would necessarily mean the service provided by the emergency physician was at the ceiling of his/her skill-set and with the patient's life at stake.

3. Expanding the scope of emergency care to include EMS to the patient's final disposition, including laboratory and radiology, emergency medicine accounts for just 2% of our nation's health care expenditures.[6]

4. The Federal government and insurance companies pay far less than the billed charges. In point of fact the average emergency physician reimbursement across the nation is in the hundreds of dollars. EM experts believe the average professional fee payment per emergency department

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AMERICAN HEALTHCARE'S ONE CONSTANT IN A SEA OF CHANGE: EMERGENCY MEDICINE

(Continued from Page 13)

visit is approximately $160 per visit with geography, payer mix, Medicaid expansion or not and extent of out-of-network billing restrictions potentially influencing the number. This is certainly far below the thousands of dollars commonly portrayed today in many industry articles. This is coupled with the reality that many patients cared for in emergency departments actually pay the physician nothing for their care. This is referred to as charity care. We make the distinction between charity care, that for which no payment is expected and uncompensated care, which you expected to be paid, but received nothing.

Putting this issue of cost in a broader, societal perspective Jones[7] notes Americans were projected to spend $82.83 this year on Halloween. Lake[8] notes Americans today spend $100/month solely on fast food, or $1,200 annually. Pressman[9] reports the average monthly American cable television bill is $103. Lazar[10] notes the average monthly American auto payment for a new car is $493.

5. The current and increasingly pervasive issue of out-of-network balance billing issue as it applies to emergency medicine is simply one of emergency physicians rightfully insisting on fair reimbursement for their services. Unlike other physician specialists, emergency physicians may not turn patients away if they have no insurance, cannot pay for their care, or cannot afford their co-pay or deductible. In other words no patient, regardless of their ability to pay, may be turned away from the emergency department for any reason. This is US federal regulatory law, the aforementioned EMTALA Act.

6. No one has ever considered Medicare, and definitely not Medicaid, as a system of fair reimbursement. Medicare reimbursement amounts have been based on federal budgetary considerations rather than on what physicians have been customarily paid. To consider either or both of these rate structures, or even a system based on a modicum reimbursement factor above Medicare reimbursement rates, would bankrupt many emergency practices and departments across the country. It would also harken our healthcare system back to the days when emergency departments were routinely staffed by non-certified physicians.

7. The exploding system of retail healthcare and urgent care center development has had virtually no impact on emergency department visits in the country. Pines[11] reports that retail clinics have done nothing to reduce the lower acuity patient visits to emergency departments. These visits occur due to the lack of patient access to primary care and/or the lack of an ability to secure an appointment. Clearly Americans trust emergency physicians to deliver high quality, expert and efficient care when they are concerned they have an emergency condition.

8. Emergency department visits continue to rise in both volume and also acuity. This year emergency departments are tracking at 150,000,000 patients. To put this in perspective this translates to 5 patients per second; 18,000 patients per hour; or 411,000 patients per day treated in our emergency departments. This daily number of patients treated in our emergency departments equates to approximately the population of Oakland, CA.

As the baby boomer population ages, Americans are surviving longer with more chronic conditions, making the patient population and management of them by emergency physicians more complex. This coupled with the fact people are delaying care due to concern about insurance coverage and/or cost (i.e. high deductibles) heightens the significance of the importance of emergency physicians and the central place and function they hold and serve in our healthcare system.

9. The current insurance company mega-mergers being considered involving Aetna-Cigna and Anthem-Humana reportedly involve a price tag of $90 billion.[12] In today's healthcare marketplace it is a frequent call-to-action that physicians and insurance payers move toward a more amicable and conciliatory working relationship. Insurers commonly refer to "surprise bills" while emergency physicians refer to "surprise coverage."[13] In this context it is critically important to distinguish the emergency physician, professional-fee payment as contrasted with hospital, facility-fee payments, with the former being dramatically less than the latter, as explained above. A reimbursement increase of as little as 1% of the $90 billion insurance industry mega-mergers to emergency physicians could potentially move this needle, in the sense of both advancing better relationships between insurers and emergency physicians, as well as easing strained relationships between patients and emergency physicians.

10. The bottom line is emergency medicine is a central and stable rock, in a healthcare system that continues to change and evolve. Emergency physicians continue as the safety net of the system; in many ways and for many patients they are the only net. Regarding healthcare costs, the above note of emergency physician, professional-fee payments, on average, being $160 per patient visit certainly puts the issue in perspective, demonstrating emergency physicians are not a central problem today in American healthcare. Their proposed solution is to utilize an independent, transparent charge database, such as Fair Health, coupled with fair coverage for our patients. Model legislation will potentially also include a minimum benefit standard as well. In the meantime, amid all of the evolving changes in our healthcare system, emergency medicine remains a rock solid, stable constant, always there for Americans, always reliable, 24/7/365. §

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MCEP Calendar of Events

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 14-15, 2017
Observation Medicine
Double Tree Downtown
Nashville, Tennessee

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