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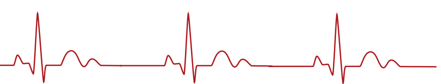

November/December 2017

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Jacob Manteuffel, MD, FACEP

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Muchmore, Harrington, Smalley & Associates

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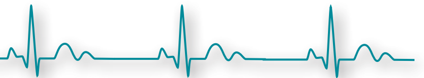
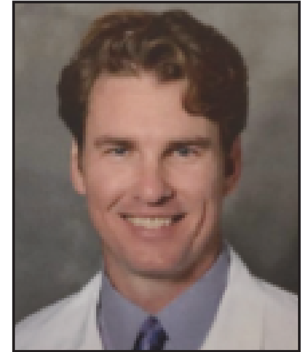
Submissions to the January/February Newsletter should be received by the Chapter office no later than January 20, 2018.

FROM THE PRESIDENT



The opioid abuse epidemic took center stage at the 2017 American College of Emergency Physicians (ACEP) Council Meeting. After some passionate testimony, the Council adopted a resolution creating ACEP policy in support of the development and study of Supervised Injection Facilities (SIFs) for people who inject drugs as a potential public health intervention. ACEP joined the American Medical Association (AMA) in adoption of similar policy in 2017. There are over 100 SIFs worldwide, while none are currently operating in the United States. The data regarding such facilities worldwide notes decreased rates of HIV, Hepatitis C as well as soft tissue infections. These facilities offer clean needles for injection and a safe, supervised setting for injection for those addicted to opiates. The cost of SIFs is mitigated by the savings from decreased disease, decreased overdose and decreased utilization of emergency medical services. Many SIFs also have counseling services and information services with access to substance abuse rehabilitation programs. President Trump's recent declaration of the opiate epidemic as a public health emergency may allow for funding for these unconventional approaches to opiate abuse that are proven to reduce harm. The ACEP Council's adoption of this resolution is an appropriate change in policy from avoiding an association with the stigma of opiate abuse to recognizing that substance abuse is a disease that requires a multi-faceted approach to treatment. Not surprisingly, on my very first shift after I returned from the council meeting I had a patient encounter with opiate abuse. The patient had crashed his car at low speed after injecting heroin in his vehicle and becoming unresponsive. The 37 year old patient claimed to have relapsed for the 4th time this year, each visit resulting in a trip to our emergency department. I listened to the police officer at bedside reprimand him for his indiscretion, followed by his mother asking him to change his code status to DNR if he continued to abuse opiates. He was not interested in substance abuse treatment as he did not feel he had a problem. I know he would benefit from access to a SIF. He would not be coming to our emergency department, and maybe he would listen to counseling or treatment options in a less confrontational environment if he were willing to use such a facility.

Also on the national scale, the American Hospital Association (AHA) developed its toolkit entitled, "Stem the Tide: Addressing the Opiate Epidemic". This was developed to provide guidance and resources to hospitals and health systems on how to work with patients, clinicians and communities to stem the opioid epidemic. The toolkit highlights successful inventions such as the Alternatives to Opiates (ALTO) program from a New Jersey emergency department, which has shown a nearly 40% reduction in cases requiring opiates. The ALTO program uses targeted non-opioid medications, trigger point injections, nitrous oxide, and ultrasound guided nerve blocks to tailor its patients' pain management needs and avoid opioids whenever possible. Examples include kidney stones, acute low back pain, broken bones, acute headache and migraine pain. The ALTO program was presented by its developers at the 2017 ACEP Leadership and Advocacy Conference earlier this year. The toolkit also highlights the need for clinical education as well as guideline implementation. The Michigan College of Emergency Physicians (MCEP) has spent more than 5 years addressing this issue and developed our own opiate prescribing guidelines, disseminating them to emergency departments in the state of Michigan in 2012. MCEP has also featured clinical education on opiate prescribing over the past several years at our educational conferences. MCEP has been and will continue to be a front runner in health care with regard to opiate abuse policy, education and legislative efforts.



Jacob Manteuffel, MD, FACEP

Leaders from MCEP have engaged state legislators on a continual basis over the years and more regularly with the multiple bills that have been introduced in the Michigan House of Representatives and Senate related to physician prescribing of opiates. Dr. Rami Khoury, MD FACEP testified in front of the House Health Policy Committee in April to inform the committee of our efforts to battle the opioid epidemic and emphasize our desire to be part of the solution. Thereafter leaders of MCEP met with key individual legislators and their staff to offer insight as to the unintended consequences some of the proposed legislation may cause as well as to answer questions about typical prescribing habits from the emergency department (ED). What duration of prescription is reasonable after an ED visit for a fracture or other painful emergency? Should a physician log into the Michigan Automated Prescription System (MAPS) before every opioid prescription is written? Should physicians be mandated to register for MAPS? Legislation has been proposed addressing each of these issues and we were able to provide information to educate legislators on the practical limitations of mandating emergency physician practice.

One thing that appears to be clear at this time is that there will likely be a mandate regarding registration for MAPS. Mandate for use may be mitigated by the incorporation of the MAPS system to existing electronic medical records (EMRs) allowing for real-time information of patient controlled substance prescriptions with an abuse risk calculator available without logging into a separate system or account. The State of Michigan has agreed to cover costs of integration of MAPS into EMR until August 1st, 2019. The MAPS system migrated to a new platform in the spring of 2017 allowing for real-time prescription monitoring without the approximate 2 week lag time of the old system. In addition, running a report now takes seconds as opposed to the 5-10 minute search of the old system. The new MAPS platform will notify you when you search for a patient if a patient is a "Suspected Pharmacy/Prescriber Shopper" given the number of prescriptions they have from different prescribers filled at different pharmacies. Registering for MAPS now however is slightly more complicated than previously with multiple physician identifiers required. To register for MAPS you will need your: 1) Drug Enforcement Agency (DEA) number, 2) physician license number, 3) controlled substance license number, 4) NPI number, and 5) primary employer address. Residents will enter the DEA number of the facility in which they are training. Professional license numbers and controlled substance license numbers can be located at: www.michigan.gov/verifylicense. NPI numbers can be located at: www.npinumberlookup.org. Register for MAPS at: https://michigan.pmpaware.net/login.

Another useful feature of the new MAPS system is the ability to review your prescription history over the past 2 years. When logged into MAPS, click on "RxSearch" and then "MyRx". A MCEP member contacted our

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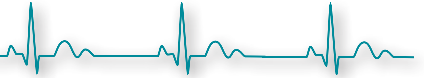
FROM EDITOR



ARE WE ENTITLED TO PAID PARENTAL LEAVE?

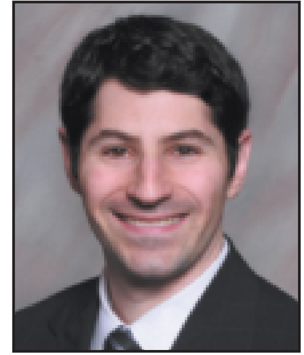
I am impressed as always with the thought-provoking discussions and innovative resolutions presented and voted on at the ACEP Council Meeting. This year the meeting was in Washington D.C., our nation's capital, and the current political climate and legislative agenda were certainly hot topics. I felt that one of the subjects discussed at the Council Meeting in particular was quite important and shows the progressive nature of our specialty, paid parental leave.

The resolution asked ACEP to develop best practices regarding paid parental leave. Parental leave includes both mothers and fathers. This topic was not only discussed for an extended period of time on the Council floor, but has become a central focus in our government as well. The issue debated was not so much the idea of parental leave. This view seemed to be universally accepted. However, "paid" parental leave seemed a bit more controversial, though the overwhelming atmosphere was one of acceptance.

Paid parental leave is not a new subject matter. There are 40 countries across the world that mandate paid parental leave. In 2016, Estonia was the leader giving 87 weeks of paid leave. Other countries on this list include a significant number of European countries, Canada, Iceland, Japan, Israel, and Australia. The United States does not mandate any paid parental leave though it has been a big topic of conversation.

Two initiatives have been proposed recently, one through the Trump administration, which asks for 6 weeks of paid leave for mothers and fathers, and one by the democrats, which adjusts FMLA to allow 60 individual days of paid parental leave, leave to take care of sick family members or to take care of one's own illness. Both of these plans have a significant price tag but are believed to be an important ideal that our country should espouse.

Why is paid parental leave so important? Studies show that paid parental leave can decrease infant mortality by 10%, increase vaccinations, and increase breast feeding, which has been found to be beneficial for infants in many regards. There are also benefits for the mother including mental health (decreasing depression) and wellness lasting for years. Studies in the UK have also found that fathers having paid parental leave of 10 days or more increased their involvement with their children.



Gregory Gafni-Pappas, DO, FACEP

So how does this apply to emergency medicine? Physicians in general tend to have large debts on top of bills to pay. Plus, there is already a significant amount of time spent away from family. All of these financial constraints add up to significant stress when choosing to have children. Sure, physicians can try to work extra hours before the delivery date and after parental leave, but this adds time, stress, and physical exhaustion to an already demanding job.

There are some companies within emergency medicine that now offer paid parental leave. Some programs are more robust than others, but still a step in the right direction. For our specialty, there is an argument that smaller companies will have a more difficult time absorbing the costs of paid parental leave, considering shifts still need to be filled while paying someone on leave. Thus, the physicians working in the group pay for the physician who is on parental leave and there is slightly less money to go around to the other physicians in the group. However, in the long run, changing the culture and financial model to accept paid parental leave could have far more benefits in regards to health and wellness than the current model. Plus, after a number of years, most physicians will benefit from the change as older physicians retire and new physicians enter the workforce, taking their allowed paid parental leave.

It takes a village to move a mountain. And I believe our village of emergency medicine is one of the strongest in the house of medicine. I applaud the ACEP councilors for choosing the righteous path and supporting paid parental leave to benefit our physician parents and their children. I hope that we all strive to make the right decisions in our local companies and at the highest level of government. §

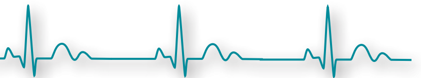
FROM THE PRESIDENT

(Continued from Page 2)

leadership a few weeks ago to notify MCEP membership that he received a home visit from the DEA regarding prescriptions written fraudulently in his name. This has prompted other MCEP members to review their prescription history and other possible fraudulent activity has been noted. With this new functionality of MAPS, MCEP will address how to report fraud with the State of Michigan and have fraudulent prescriptions removed from profiles. I encourage the members of your practice to also review their history to help prevent diversion of prescription medications. It is also interesting to note that the State of Michigan does not quantify the number of pills written but the "Days Supply" instead. For example, if one were to prescribe 10 diazepam tabs with a prescription stating: 1 PO Qhs PRN, the "Days Supply" is 10. However if one were to prescribe 15 diazepam tabs with a prescription stating: 1 PO Q8hr PRN, the "Days Supply is 5". This is the information the State of Michigan is tracking.

I do believe we can be part of the solution to the opioid epidemic as emergency physicians. One of the first steps is to register for MAPS sooner than later as it will likely be a requirement in the near future. We can use the MAPS system and become familiar with it and look forward to the integration with our institution's EMRs. We should review our prescription histories for possible fraudulent activity and prevent diversion. With these small steps we can begin to do our part in the complicated battle with opiate abuse we encounter on a daily basis.

**Editor's Note: Due to MCEP's recent web-site upgrades and the importance of the topic, we decided to incorporate some of the content from a recently published electronic President's Report into this article.* §



MCEP DECEMBER 2017 LEGISLATIVE REPORT

Bret Marr, MHSA

The Michigan Legislature has been in session since after Labor Day. Much of the session has been spent on smaller legislative issues but a major focus was on moving bills in the Senate and House focusing on the opioid epidemic. MCEP has been highly involved in those bills from their beginning so EDs throughout the state have had their voices and concerns incorporated into those bills. The Legislature will be in session until mid-December dealing with local government finance issues. We don't expect any of those issues to impact emergency physicians but we'll monitor them closely to be safe. Below is an update on a couple of issues specific to healthcare professionals.

Auto No-Fault Update

In late September, House Speaker Tom Leonard and Detroit Mayor Mike Duggan announced a bi-partisan plan to dramatically reform Michigan's auto no-fault insurance system. This plan would have provided temporary relief for auto insurance subscribers but would have required long-term financial constraints for healthcare providers. The bills were opposed by almost all healthcare providers in the state, including MCEP. Testimony took place over several public hearings and the House Insurance Committee ultimately reported the bills favorably out of committee and to the House floor for consideration. After much debate within the House Republican caucus, the bills were finally put up for a full vote of the House. The proposal failed on a 45-63 vote with most Democrats being joined by over a dozen GOP members in opposition. While the defeat of the proposal was a victory for supporters of the current system, we all know that this proposal can be brought forward again. We don't expect the proposal to surface again any time soon but the bill is still "alive" until December 31, 2018 so lame duck of next year is the most likely time for this to come up again.

ED Assaults

MCEP supported the reporting of a bill by Senator Ken Horn last spring to increase fines and penalties for assaults on healthcare professionals in an emergency department setting. Our proposal has stalled in the Senate due to concerns that there are several bills seeking increased penalties for certain professions (some included sports officials, court personnel and electrical workers). MCEP is increasing its focus on telling the story locally to state and local officials. MCEP is working to craft letters to local prosecutors and sheriffs to prosecute these persons assaulting healthcare professionals. If local law enforcement doesn't want to take the time to enforce these current laws, we can show state officials that they need to step in to make these assaults a priority. What we need from MCEP members: Tell us about the frequency of assaults and severity of those assaults to help us document the situation in our emergency departments.

Please feel free to contact MCEP or myself with any legislative or state issues. As always, thanks for taking the time to read this and thank you for your involvement in MCEP's government affairs activities. §

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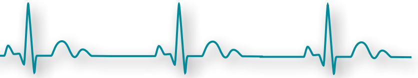
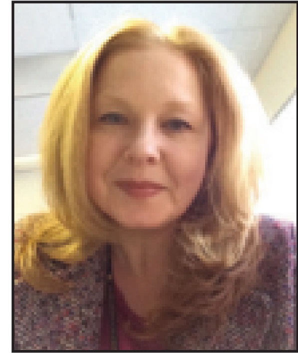


MICHIGAN MEDICAID UA/UD PAYMENT STRUCTURE



Lynn Nutting

Since the introduction of the Michigan Medicaid two tiered payment system in January of 2004, providers have seen slight increases in Emergency Medicine reimbursement. Current payment methodology is based on whether the patient was released from the Emergency Department (ED) or admitted, and indicated on the claim form by appending one of the two modifiers listed below to Emergency Medicine Evaluation & Management codes, CPT 99281-99285.

- UD - Beneficiary was released (discharged) from the ED = $50.44
- UA - Beneficiary was admitted to the hospital or transferred to another hospital from the ED = $97.06

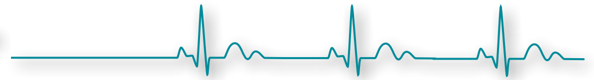
Per Michigan Medicaid regulations, the above modifiers are not to be added to Critical Care, Observation or procedural CPT codes, as payment for those services are rendered according to designated Michigan Medicaid fee schedule amounts. Note that procedural CPT codes may be paid in addition to Emergency Medicine visit codes.

General Coding/Billing Considerations

- UA/UD modifiers are placed in the first position on the claim line to ensure correct carrier processing. All other modifiers should follow.
- Per Michigan Medicaid conversation with MCEP representation, the UA modifier may be added when patients are dispositioned to outpatient areas within the hospital outside of the ED (i.e. cath lab, outpatient surgery, etc.).
- Providers other than Emergency Medicine physicians may not report UA/UD modifiers.
- UA/UD is appended whether the Michigan Medicaid insurance is primary or secondary.
- Children's Special Health, Adult Benefit Waiver and Blue Caid require UA/UD.
- Out of state Medicaid carriers do not accept UA/UD.
- Please find the most common Michigan Medicaid HMO plans requiring UA/UD listed below:

BCN Medicaid HMO	**Family Health HMO**
Botsford Health Plan	**Kid's Care of Michigan**
Cape Health Plan	**Master Care HMO**
Care Choices Medicaid	**MI Child In Network**
Children's Choice	**MI Child Out of Network**
Community Choice Medicaid	**Midwest Health Plan**
Comprehensive Health Services Medicaid	**Molina Health Plan**
County Health Plans HPMS or County Health Plans Not HPMS	**Omnicare Medicaid HMO**
Good Health Plan	**Paramount Medicaid**
Great Lakes Health Plan	**PHP Medicaid**
Health Alliance Plan (HAP) Medicaid HMO	**PHP of Southwest Michigan Medicaid**
Health Plan of Michigan	**Priority Health Medicaid**
Health Plus Medicaid	**Total Health HMO**
Health source HMO	**Upper Peninsula HMO**
McLauren Health Plan	**Wellness Plan Medicaid**

MCEP RESIDENT CASE REPORT



AN UNUSUAL CAUSE OF JAUNDICE AFTER AN ACETAMINOPHEN OVERDOSE

Rebecca A. Hess, MD and Robert W Shaffer, MD
University of Michigan Department of Emergency Medicine, Ann Arbor, MI

INTRODUCTION

In this case report, we describe a previously healthy male who was initially evaluated in our emergency department for a suspected unintentional acetaminophen overdose. He was admitted to the hospital on IV N-acetylcysteine and was released prior to completion of the protocol when his acetaminophen level fell below the detectable threshold. Despite treatment, he returned the day after discharge with new onset jaundice and hyperbilirubinemia.

NARRATIVE

A 21-year-old African American male with no significant past medical history initially presented due to concerns for an inadvertent overdose of acetaminophen that he had been using for dental pain. He reported taking approximately 5000 mg in divided doses during the 18 hours prior to initial presentation. He became concerned for a potential overdose when he developed nausea and a burning epigastric discomfort, prompting him to seek emergency medical evaluation. He reported no additional medication ingestions, and denied any recent alcohol consumption. His initial pulse was 115, and the remainder of his vital signs were normal. His physical exam demonstrated no jaundice, scleral icterus, or significant reproducible abdominal pain. Laboratory studies were obtained and were significant only for an ALT of 50 IU/L, total bilirubin of 1.7 mg/dL, and an acetaminophen level of 94 mcg/ml that was measured approximately 5.5 hours after his most recent ingestion. Given the fact that his ingestion spanned 18 hours and his presentation was delayed, we could not be fully reassured he had not suffered a potentially toxic exposure. Therefore, we initiated N-Acetylcysteine per intravenous protocol and he was admitted to the hospital. He completed half of the IV protocol and was discharged the following morning when his acetaminophen level fell to <10 mcg/ml.

He subsequently returned three days post-ingestion with complaints of headache, vomiting, dark urine, scleral icterus and jaundice. He denied fevers, respiratory complaints, abnormal bleeding, abdominal pain or neurologic symptoms. His vital signs were normal, and his physical exam was notable only for scleral icterus and jaundice. Laboratory studies included the following: WBC 9.3, Hgb 12.2 (previously 15.5), plt 230, AST 29, ALT 36, Alk Phos 84, Lipase 27, TBili 6.7, indirect bili 6.1, acetaminophen <10, INR 1.0, LDH 214, and haptoglobin <10. An abdominal ultrasound demonstrated only trace perihepatic ascites. The marked reduction in haptoglobin, predominance of indirect hyperbilirubinemia, and lack of transaminitis were most consistent with an acute hemolytic anemia, rather than a direct hepatotoxic insult from his acetaminophen ingestion. He was re-admitted and hematology was consulted. He was ultimately found to have qualitative Glucose-6-Phosphate Dehydrogenase (G6PD) enzymatic deficiency, and his acute hemolysis was felt most likely to have occurred as a result of the oxidative stress related to his acetaminophen ingestion. He was discharged the following day on folic acid. On follow-up one week later, his bilirubin had normalized to 0.9.

DISCUSSION:

G6PD deficiency is the most common human enzyme defect and affects an estimated 400 million individuals worldwide.[1] It is an X-linked genetic disorder, and therefore homozygous males tend to be affected more than heterozygous females.[1] It's incidence is highest in malaria-endemic regions of the world such as Africa, Mediterranean Europe, the Middle East, and South Asia where it confers a selective advantage in protecting against plasmodium infection.[2] Prevalence may be as high as 50% among Kurdish Jews.[3] In North America, the disorder is far less common and is typically found in immigrants from these aforementioned regions.[3]

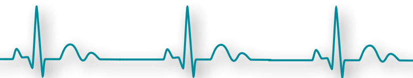
The G6PD enzyme is present in all cells and serves to provide reduced NAPDH that in turn maintains reduced glutathione that can counteract oxidative stressors that would otherwise lead to cellular damage and destruction. Because erythrocytes lack mitochondria, they rely exclusively on this pathway for NADPH production and are most prone to oxidative damage and hemolysis when G6PD deficiency exists.

Over 400 abnormal mutations in the G6PD gene have been described which account for the profound variability in how individuals with the disorder are affected[4]. Complete absence of the enzyme is incompatible with life, but in the normal circulating erythrocyte, only 2% of normal G6PD function is required to combat ordinary oxidative stress.[5] Therefore, even individuals with severe enzymatic deficiency may not develop clinical symptoms unless a significant oxidative stress is present. For simplicity, the clinically significant genetic variations are grouped into one of three classifications (Table 1). [5]

In these individuals, acute hemolysis may occur during an exposure to a number of oxidative triggers including many infections (i.e. hepatitis A, hepatitis B, CMV, salmonella), drug exposures, chemical exposures (i.e. aniline dyes, naphthalene and henna), and the ingestion of fava beans ("favism"). [1,5,6] Clinical effects are generally apparent 1-2 days following the exposure.

While numerous drugs including acetaminophen have been implicated in case reports as triggers for acute hemolytic crises, evidence is largely anecdotal and a causal relationship for many of these lack clear evidence when used at therapeutic doses.[7-11] A recent literature review found seven medications for which solid evidence supports their use and should be routinely avoided in individuals with G6PD deficiency (Table 2). [3]

Clinically, patients with acute hemolysis may endorse abdominal pain, back pain, dark colored urine, fatigue, scleral icterus and jaundice. Splenomegaly may be present. Laboratory abnormalities may include a decline in serum hemoglobin, indirect hyperbilirubinemia, elevated LDH, decreased haptoglobin, and presence of hemoglobin pigment casts on urinalysis. A direct antiglobulin test (DAT or Coomb's test) should be negative since the hemolysis is not immune-mediated. Heinz bodies may be present on a peripheral smear. Rarely, hemoglobinuria may lead to acute tubular necrosis and acute renal failure. 1 Neonates with G6PD deficiency



are especially prone to neonatal jaundice, bilirubin-induced neurologic dysfunction, and kernicterus, and should be managed with phototherapy and exchange transfusions (with non-G6PD deficient blood) according to guidelines established by the American Academy of Pediatrics.[12]

Most instances of acute hemolysis are self-limited. Management should focus on discontinuation of any offending drug, food, or chemical and the treatment of any underlying infection. In rare instances, profound hemolysis may require transfusions using blood donors who are not G6PD deficient.[1]

TABLE 1: CLASSIFICATION OF G6PD DEFICIENCY VARIANTS [5]

CLASS	G6PD Activity	Clinical Manifestation
I (rare)	severely deficient	Chronic non-spherocytic hemolytic anemia
II	<10%	Transient acute hemolysis
III	10-60%	Transient acute hemolysis

TABLE II: Medications that may precipitate hemolysis in patients with G6PD deficiency [3]

Dapsone	Methylene blue (treats methemoglobinemia)
Nitrofurantoin	Rasburicase (treats malignancy-related hyperuricemia)
Primiquine (anti-malarial)	Tolonium chloride/ toluidine blue (dye used to identify mucosal dysplasia)
Phenazopyridine/Pyridium (anesthetic for dysuria)	

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RECENT GRADS BEGIN CAREERS ACROSS COUNTRY

With a total of 26 (allopathic and osteopathic) emergency medicine residencies, Michigan sends many of its newly trained emergency medicine physicians all over the United States and the globe. In this issue, we list where the 2017 graduates will be practicing.

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

Corey Alvarez, MD	Brevard Physician Associates, Melbourne, FL
Jesse Ellsworth, MD	FESPA, Novant Health, Winston Salem, NC
Kamara Graham, MD	CEP America, Mercy San Juan Medical Center, Carmichael, CA
Christopher Heberer, DO	Covenant HealthCare, Emergency Care Center, Saginaw, MI
Sara Jacob, MD	US Acute Care Solutions, Carolinas Medical Center-Northeast, Concord, NC
Heather Sherwin, MD	San Juan Regional Medical Center, Farmington, NM
Tyler Weese, MD	Team Health Locums

From Genesys Regional Medical Center, Grand Blanc, MI:

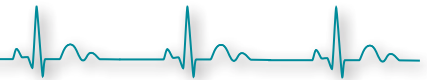
Jamie Barach, DO	Covenant Medical Center, Saginaw, MI
Erika Bramlett, MD	USACS, Genesys Regional Medical Center, Grand Blanc, MI
Dane Caputo, DO	North Valley Emergency Specialists, Banner Thunderbird, Glendale, AZ
Emily Hammer, DO	USACS, Genesys Regional Medical Center, Grand Blanc, MI
Kaitlyn Martz, DO	Covenant Medical Center, Saginaw, MI
Kevin Truong, MD	CEP America, Garden Grove Hospital and Medical Center, Garden Grove, CA

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

Tyler Brian Andre, MD	Kadlec Medical Center, Tri-Cities, WA
Elizabeth Jean Arnall, DO	Kaiser Permanente Southern California, Downey, CA
Brett Lee Baumgartner, DO	Intermountain Health Care, Cedar City and St. George, UT
Nicholas Robert Bope, MD	Infinity Healthcare, Appleton, WI
John Walter Brainard, MD	Kaiser Permanente, Walnut Creek, CA
Christopher Adam Chesnut, MD	Elkhart Emergency Physicians Inc., Elkhart, IN
Maxwell Jason Geers, MD	Infinity Healthcare, Milwaukee, WI
Nicholas Jay Gould, DO	Professional Emergency Physicians, Fort Wayne, IN
Paul Michael Guernsey, DO	PeaceHealth St. John Medical Center, Longview, WA
Charles Everett Mansell, MD	Mercy Medical Center, CEP America, Redding, CA
Daniel Stuart Mortensen, MD	Emergency Physicians, Inc. Holland, MI
Matt John Perala, MD	St. Lukes Hospital, Duluth, MN
Mary Kathleen Russo, DO	Southern Colorado Emergency Medical Associates, Pueblo, CO
Timothy Sean Ryan, DO	Palmetto Emergency Services, Murrells Inlet, SC
Paul Michael Shotkin, MD	Beaumont Hospital, Royal Oak, MI
Anton (Tony) Lee Temple, MD	Emergency Service Partners, Harker Heights, TX
Aaron Forrest Triplett, DO	Mayo Health Systems, Eau Claire, WI
Christina Marie Weaver, DO	University of Arizona in Tucson, AZ
Daniel George Zindrick, MD	CEP American, St Joseph's Mercy Hospital, Aurora, IL
Kevin Praful Patel, DO	Baylor Scott & White, Dallas, TX

From University of Michigan, Ann Arbor, MI:

Moneer Abdo, MD, MBS	Detroit Receiving Hospital and Harper Hospital, Detroit, MI
Michael Cover, MD	University of Michigan, Ann Arbor, MI
Thomas Cunningham, MD	Kaiser Permanente Panorama City, Los Angeles, CA
Mary Eddy, MD	ApolloMED, James River Group, Richmond, VA
Rebecca Hess, MD	EPMG, Saint Joseph Mercy Hospital, Ann Arbor and Chelsea, MI
Drew Jones, MD, MS	Stanford University, Stanford, CA
Matthew Malone, MD	The Ohio State University, Columbus, OH
Daniel Micheller, MD	633rd Medical Operations, Langley Air Force Base, VA
Patrick Minges, MD	University of Michigan, Ann Arbor, MI



Brendan Munzer, MD	University of Michigan, Ann Arbor, MI
Graham Smith, MD	University of New Mexico, Albuquerque, NM
Sarah Tehranisa, MD	Case Western Reserve School of Medicine & University Hospital, Cleveland, OH
Ryan Tillman, MD	Methodist Charlton Medical Center, Dallas, TX
Jeffrey Vlasic, MD, MS	University of Michigan, Hurley Medical Center, Flint, MI

From Sparrow Hospital/MSU Lansing, MI:

Alison Marciniak, MD	Ascension/Ministry Medical Group, North-Central, WI
Eyad Khattab, MD	Brigham and Women's Hospital, EM Fellowship, Boston, MA
Matthew Jolly, MD	Columbia St. Mary's, Milwaukee, WI
Sascha DeAngelo, MD	The Permenente Medical Group, Sacramento, CA
Michelle Hackner, MD	DeGarA, McLaren, Lansing, MI
Jamila Power, MD	Sparrow Health System, Lansing, MI
Kate Hughes, DO	University of Arizona Medical Simulation Fellowship, Tucson, AZ
Brett Gerstner, DO	Michigan State University, College of Osteopathic Medicine, East Lansing, MI
Phillip Singer, DO	EmCare-University of Texas Medical Branch, Galveston, TX
Colin Seguin, DO	Munson Medical Center, Traverse City, MI

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

Nancy Anaya, MD	University of California San Francisco, San Francisco, CA
Harrison Chine, MD	North Shore Medical Center, Miami, FL
Carly Darr, MD	St. Joseph Mercy Oakland, Pontiac, MI
Olga Dewald, MD	Sparrow Health System, Lansing, MI
Ryan Duhé, MD	Greenville Health System, Greenville, South Carolin
Corey Fellows, DO	Spectrum Health, Butterworth Hospital, Grand Rapids, MI
Conrad Hilton, DO	Hendrick Medical Center, Abilene, TX
Emily Johnson, MD	UP Health System Portage Hospital, Hancock, MI
Zeid Kalarikkal, MD	Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, NY
Christopher Sponaugle, MD	Chandler Regional /Mercy Gilbert Medical Center, Phoenix/Chandler, AZ
Stephanie Thom, MD	University of Kansas Medical Center, Kansas City, KS
Christina Thomas, DO	Washington University, Barnes Jewish Hospital, St. Louis, Missouri

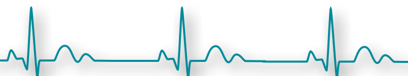
From Henry Ford Wyandotte Hospital, Wyandotte, MI:

Alyssa Gappy, DO	EPMG, Wyandotte, MI
Alex Grimaldi, DO	Providence Medical Group, Medford, OR
Edwin Lui, DO	Baptist Health System, San Antonio, TX
Russell Piper, DO	Team Health Parkwest Medical Center, Knoxville, TN
Jason Sesuda, DO	EPMG, Ann Arbor, MI

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

Thaer R. Ahmad, MD	Advocate Christ Medical Center, Chicago, Illinois
Kevin Richard Binsell, MD	War Memorial Hospital, Sault Ste Marie, MI
Michael Nathan Helmreich, MD	Physician Healthcare Network at McLaren Hospital, Port Huron, MI
Eric James Kalivoda, MD	St. John Hospital & Medical Center, Detroit, MI
Mitchell Louis Judge Li, MD	Mercy MD-1 in Southern WI and northern IL
Charles Shin Lin, MD	TeamHealth at Sunrise/Mountainview Hospitals, Las Vegas, NV
Hanyann Yang Ng, MD	USACS, Denver, Colorado
Michael Ryan Patch, MD	USACS, Tampa, Florida
Richard Haven Paul, MD	IEP at Providence Hospital, Southfield, MI and St. Joseph Mercy, Pontiac, MI
Nathan Paul Roelant, MD	TeamHealth at Beaumont Hospital – Wayne, Wayne, MI
Truc Cong Tran, MD	Grand River Emergency Medical Group, Grand Rapids, MI
Joseph Sehwa Tsao, MD	TeamHealth Special Ops in various locations nationwide

(Continued on Page 10)



2017 — WHERE ARE THEY GOING?

(Continued from Page 9)

From Henry Ford Health System, Detroit, MI:

Brandon Busuito, MD	AppolloMD, Denver, CO
Lauren Cameron Comasco, MD	Beaumont Health System, Royal Oak, MI
Christopher Clark, MD	Henry Ford Health System, Detroit, MI
Caroline Dowers, MD	Henry Ford Health System, Detroit, MI
Laura Chess, MD	Henry Ford Health System, Detroit, MI
Michael Dreis, MD	ERMED SC, Milwaukee, WI
Jessica Everett, MD	Ohio State University, OH
Brian Harber, MD	Spectrum Health, Grand Rapids, MI
Elie Harmouche, MD	Bellevue Hospital, New York, NY
Justin Hourmozdi, MD	Emergency Medicine, Indianapolis, IN
Irandokht Jooniani, MD	Kaiser Permanente, Riverside Medical Center, Riverside, CA
Deanna Minisee-Ryce, MD	Bellevue Hospital, New York, NY
Eric Okelberry, MD	Utah Emergency Physician, Salt Lake City, UT
Ashley Pinawin, MD	Alexian Brothers Medical Group, Elk Grove Village, IL
Kevin Rooney, MD	Sinai Grace, Detroit, MI
Nicholas Satterfield, MD	University of Michigan Physician Group, Hurley Medical Center, Flint, MI
Timothy Stevens, MD	EPMG, Henry Ford, Wyandotte, MI

From St. Mary Mercy Hospital, Livonia, MI:

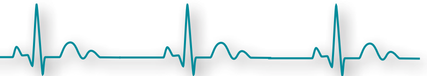
Christopher Brock, DO	St. Mary Mercy Hospital, Livonia, MI
Iman Elgammal, DO	Centinela Regional Medical Center, Inglewood, CA
Christopher Gore, DO	St. Vincent's Hospital, Birmingham, AL
Heather Jones, DO	Emergency Service Partners, Austin, TX
Elizabeth Madore, DO	St. Mary Regional Medical Center, Lewiston, ME
Michael Monticciolo, DO	St. Mary Mercy Hospital, Livonia, MI
Torey Murray, DO	St. Francis Hospital, Memphis, TN

From Beaumont – Botsford Hospital, Farmington Hills, MI:

Eric Beal, DO	Private Practice, College Station, TX
Rachael Caster, DO	Locum Tenums, US Acute Care Solutions, Royal Oak, MI
Richard Delgado, DO	Locum Tenums, US Acute Care Solutions, Miami, FL
Benjamin Kirk, DO	CEP, San Luis Obispo, CA
Derrick Morford, DO	Private Practice, US Acute Care Solutions, Denver, CO
Patrick Rodriguez, DO	CEP, Evanston, IL

From Henry Ford Macomb Hospitals – Clinton Township, MI

Nicole H. Adams, DO	Henry Ford Wyandotte Hospital, Wyandotte, MI
Jennifer J. Cinto, DO	Plans to practice Emergency Medicine on the west coast
Steven R. Denhof, DO	Spectrum Health, Grand Rapids, MI
James B. Lee, DO	Peace Health St. John Medical Center, Longview, WA
Kyle D. Martin, DO, MPH	Global Emergency Medicine, Brown University, Providence, RI
Melissa L. Shear, DO	Emergency Medicine Physician Stamford, Connecticut



MCEP WORKPLACE VIOLENCE SURVEY

As an emergency physician I do not need to tell you that workplace violence in the emergency department is a major problem that affects most emergency physicians. Back in 2005 a survey of the MCEP membership was undertaken as an ACEP chapter grant and results were published in *The Annals of Emergency Medicine.*[1] The issue continues to resonate as noted in a recent editorial by the MCEP president, Dr. Jacob Manteuffel. We plan to undertake a follow-up survey using electronic survey means not available back in the early 2000's. One additional issue to explore will be the impact on social media and workplace violence and threat. In the near future you will receive an email with a link to the survey developed by my Oakland University William Beaumont School of Medicine student research group. The survey has no personal identifiers and responses will be completely anonymous. **Please** take the few minutes it will take you to complete the survey. We believe it is important and will give meaningful information about a critical issue in emergency medicine. We thank you in advance. If you have any questions or concerns, please email me (blwalters@beaumont.edu).

Bradford L. Walters, MD, FACEP

Amanda Amen, MS-2, OUWB
Hamzeh Omar, MS-2, OUWB
Rebecca Yue, MS-2, OUWB

1 - *Kowalenko T, Walters BL, Khare RK ,Compton S. Workplace violence: a survey of emergency physicians in the state of Michigan. Ann Emerg Med 2005;46:142-147.*

MCEP Calendar of Events

January 25-28, 2018
Winter Symposium
Mountain Grand Lodge
Boyne Falls, Michigan

February 3-4, 2018
EMRAM In-Service
The Johnson Center
Howell, Michigan

January 26, 2018
Board of Directors
Mountain Grand Lodge
Boyne Falls, Michigan

March 7, 2017
Board of Directors
Chapter Office
Lansing, Michigan

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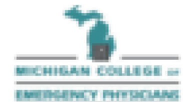

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