MCEP News & Views
ADVANCING EMERGENCY CARE

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Submissions to the September/October 2023 Newsletter should be received by the Chapter office no later than September 1, 2023.

FROM THE PRESIDENT

As I'm sure many of you parents can appreciate, much of my time these days revolves around taking my kids to or picking them up from some sort of game/practice. Inevitably, practices run late, games get delayed, and I can't figure out why, but my kids are always the last ones out! Usually, I bring some work to do while I am waiting to pick them up. So, as I write this article, I am sitting in my car waiting to pick up my son from football camp. For football players, it is an exciting time of year, as this is the time of year that is filled with hope and endless possibilities for the future season. As I see the young men leaving practice, they appear tired but energetic, smiling, and excited for what this new season will bring.

My son will be a High School Freshman this year. He hasn't played much football, and he will be going to a new school and joining a new team. Although he is excited about this new experience, he is also nervous about what position he will play, learning the plays and his responsibilities, and if the rest of his teammates will accept him as one of their own. But I have seen the coaches and more seasoned players talking with him, educating him, and helping to define his role.

The football season calendar parallels nicely with our MCEP calendar. By the time you read this, we will have finished summer assembly, which will have provided us fun times, laughter, and renewed energy for the year ahead. However, just like in football, the upcoming months will be filled not only with the joy of (hopefully) wins in the legislative and reimbursement world, but also new adversities. Every football team will face adversity during their season with unanticipated losses, injuries, and even officiating calls that do not go their way. At MCEP although we certainly hope for a positive year, we need to be ready for new challenges on the horizon. I hope everything runs smoothly throughout my presidency, I know that there will likely be legislative issues that don't go our way, challenges on the reimbursement front, and some unanticipated challenges too.

Michael Fill, DO, FACEP

Just like in football, knowing that I have a strong team around me gives me faith that we will succeed in the times ahead. MCEP is strong because of a great Executive Director, support staff, and members like you! We are lucky to have a diverse board made up of physicians with a variety of insight, skill sets, and interests. We also have a good number of members that serve the college by advocating for our specialty in organizations such as ACEP, MSMS, EMSCC, and many others.

MCEP has roughly 2000 members. Each member brings a unique perspective and skill set. All of you make our organization strong. I urge you to get involved with our great organization! You all are already accepted as a member of the team, and as President, with the help of the Board of Directors and our MCEP staff, we will help you find your niche.

In the coming months, I hope that I can count on all of you to help me advocate for the specialty of Emergency Medicine and our patients. As with any team, we all have a role to play, and every role is important for success of the team! I look forward to working with all of you to have a successful year. §

FROM THE EDITOR

CHANGES

Andrew Taylor, DO, FACEP

Do you remember your first shift in emergency medicine? The first time that you stepped into the trauma bay, or the first time that you saw a resuscitation? I certainly do, and after that day I knew that I had found my specialty after only one shift. That first day was an exciting one for me, and recently I got to see another first, the first day of school. It's an exciting thing to be a part of, especially since our oldest had started kindergarten during the COVID-19 pandemic, and school was completely online during the last-first day. He never got the opportunity to pace anxiously outside of the classroom, waiting to start a new experience and meet new friends. However anxious he was, the thing that impressed me the most was that when the door opened, he walked right in excited to start the new school year. It made me think of all the changes that accompany the early stages of life, and as I write this article, it makes me think of how it compares to change and growth that is a part of emergency medicine.

Change and the chaos of emergency medicine and a busy emergency department was what made me interested in the specialty in the first place, and I expect is a reason that others are as well. No shift is ever the same, and no shift is entirely predictable. As a result of this, by necessity emergency medicine attracts those who are both able to handle the unexpected nature of the specialty, as well as adapt to chaos and change. I think it's safe to say that emergency medicine seems to have been almost constantly in a state of change. The last several years however change has seemed to be more constant than normal with the COVID-19 pandemic.

COVID changed almost everything about the way that we practiced medicine in the emergency department from fluctuating volumes, the ups and downs of the PPE supply, and countless other changes to the daily life of the emergency medicine physician. It seems like much of the variability to our volumes has stabilized recently, though new challenges have emerged. Emergency department boarding has increased significantly, and with it the difficulty with being able to transfer patients to larger centers, which has especially been felt in our rural and underserved areas. Unrelated to COVID, our documentation requirements recently transitioned, with the shift to documentation and coding to a more medical decision-making-oriented model. Still, emergency medicine as always has managed to persevere and to adapt, and I am confident that it will adapt to the changes and challenges we might face in the future.

Our July/August article seems as a result expectant to discuss change as we move forward. Dr Fill writes about his transition to the presidency, and what we can expect for the year ahead. EMRAM welcomes a slate of resident leaders speaking about moving forward, and the growth of that branch of MCEP. Dr Coffey in Kids Korner speaks about adapting to the difficult pediatric psychiatry patient by using tools to assist with the challenging task of verbal de-scalation. Our resident case focuses on the difficult diagnosis of spinal epidural abscess in a pediatric patient and shows how this case unfolded and changed over the time of presentation.

Recently, one of the more significant efforts of political advocacy from ACEP and MCEP has been to focus upon violence in the emergency department. Many practicing physicians would be hard pressed to not be able to identify someone who has been impacted by violence in some way, and unfortunately many are impacted by it often. Political advocacy for violence in emergency medicine has been recently gaining some traction, and in June of this year had passed the Michigan House and moves on to the Senate, as noted in the article from Bret Marr. We elected to again present a key piece of political advocacy as it progresses in this edition of the newsletter, as this is certainly a welcome change in the safety of our specialty, and hope that we may reach as many as possible so they may be aware of this crucial legislative piece. Please consider reaching out to your local representation to help this effort!

Looking towards the future, we welcome a slate of incumbent as well as incoming Board members. The upcoming ACEP Council meeting in Philadelphia next October is also sure this year to be filled with many important pieces of advocacy and political change on a national level. I'm truly humbled at the efforts of the college and specialty to be leaders moving forward to shape the future of emergency medicine. We always welcome those to attend Board meeting and see firsthand the change is happening, as well as to express your own thoughts and hopes about the direction that you would like to see in our specialty. It was just such an experience that shaped my own interest in becoming involved with ACEP/MCEP, and it may influence our readers in the same way. After all, if my five-year-old son can move forward with such optimism and a smile on his face, it makes me hopeful that we will be able to continue our efforts to face challenges ahead to shape our specialty, just as we have always done. §

MCEP CALENDAR OF EVENTS 2023

September 6, 2023
Board of Directors
Chapter Office
Lansing, Michigan

September 15, 2023
Observation Medicine
Conference
Virtual Zoom Meeting

September 19, 2023
MCEP Councillor Meeting
Chapter Office
Lansing, Michigan

October 7-8, 2023
ACEP Council Meeting
Philadelphia, Pennsylvania

October 9-12, 2023
ACEP Scientific Assembly
Philadelphia, Pennsylvania

November 14, 2023
$traight Talk
Reimbursement Course
Somerset Inn
Troy, Michigan

December 6, 2023
Board of Directors
Chapter Office
Lansing, Michiga

KID'S KORNER

Have you ever noticed that sometimes it's tough to get a kid to talk in the Emergency Department? I'm not talking about the infants (duh) or even the young pre-K kids, who will often tell you everything about their lives as they see it from the vantage point of the height of your knees. I'm talking about the tweens and teens who answer questions with blank stares or shrugs. For me this is difficult to understand as I would talk to anyone or anything growing up. My parents would not let me kiss the Blarney Stone as they were concerned I would never stop talking!

With some of these kids, this is due to shyness. With others, its due to a lack of interest. But often, it's because they don't trust you or the situation, and thus do not want to speak to you, even if it is for their benefit. In particular, we see this in patients with mental health issues. Most of the time these kids do not understand why they are in the ED, or why they cannot have their phones, shoes, and clothes. They feel as if the world, with you at the helm of the war ship, is out to get them. It's a battle you didn't even know you were fighting until you walk in the room. You go in, ask normal questions, and do not get a response. As you ask more, they either continue to not answer, or they escalate and start yelling. You are getting words but not information. They are not talking, they are screaming. And you find yourself wishing you had picked up the pre-verbal 6-month-old instead.

Not wanting to speak is the first stage of mild agitation, which will progress to speaking loudly and then yelling. It can be frustrating, especially when the department is full, and you are busy. Learning to prevent this escalation or to de-escalate quickly is not only better for the patient but for your ability to be efficient and effective.

Verbal restraint (de-escalation) is the first of 3 techniques to calm the patient and keep them safe. The others are chemical (medications) and physical restraint (isolated to a chair, bed, or room) but let's focus this article on verbal de-escalation.

In 2019 the American Association for Emergency Psychiatry developed the best practices for the evaluation of agitated children and adolescents. They outlined 10 domains of verbal de-escalation, which are based on a list of "commandments" for calming patients first developed by Dr. Avrim Fishkind in 2002. These tools are effective not only for the agitated patient, but for any patient that is not willingly open and talkative.

1) **Respect Personal Space.** We've always been taught to keep ourselves between the patient and the door, but we also need to make sure we are not blocking the patient in the room, or essentially trapping them in the room, which may be stressful to the patient. Try to keep at least two arm's length between you and the patient. Give space for issues related to prior traumas, abuse, sensory issues. If the patient feels threatened, they are less likely to open up and speak to you.

2) **Do not be provocative.** The goal with this is to avoid iatrogenic escalation. Your body language is so important to keep this from happening. Imagine a doctor who sits, hands in their laps, who makes good eye contact without staring and has a calm expression. Now imagine the same doctor standing at the door frame, arms crossed, frown on their face, typing on their computer. It's obvious which one will likely make the patient feel more comfortable and which one will just increase the patient's agitation. Be genuine, try to not multi-task or chart during the interaction. And avoid humiliating the patient.

Pamela Coffey, MD, FACEP

3) **Establish verbal contact.** Introduce yourself to the patient as soon as you meet them. Provide reassurance that they are safe, and that your role is primarily to help keep them safe. Even if you know the patients name, ask them what they would like you to call them. This simple question demonstrates to them that you value their thoughts and are interested in what they have to say. Solidify this by repeating what they say.

4) **Be concise.** Keep it simple, use short sentences and basic vocabulary. Give time for the patient to process what you say, and plan to repeat it many times. Set limits but avoid ultimatums. Instead offer choices and alternatives. "I understand this can be tough, and It's ok if you do not want to tell me your entire story, but can you please tell me what happened today?"

5) **Identify wants and feelings.** Ask them what their expectations and requests are. "Even if I cannot provide it, I need to know what you want to happen so we can work on it together." Often these kids feel like no one listens to them, so you may need to repeat this several times before they will trust that you really want to hear what they have to say. They may also not know what they want and may need to think about it for a while, and that is ok too.

6) **Listen closely to what the patient is saying.** When you ask a question, really listen to what they say. Dr George Miller, professor of psychiatry at Princeton University made a statement that became Miller's Law: ***"To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of."*** In other words, suspend judgement about what someone is saying so that we can first understand them without imbuing their message with our own personal interpretation. This is often difficult to do, but necessary for gaining their trust. Engage in conversation with the kids, they will appreciate the effort.

7) **Agree, or agree-to-disagree.** Either agree completely with them (Yes, that is true!), agree in principle (I can see how that could be true!), agree with the odds (I can see how some people might think that could be true!) or agree to disagree (Even though I do not feel that way, I understand that you feel that way). Find a common ground to help create a bond with your patient.

8) **Lay down the law and set clear limits.** This is mostly pertaining to the agitated patient as the safety of everyone is the most important aspect. Be up front about acceptable behaviors in a matter of fact but not threatening way. Not all behaviors need a

response, but if you are uncomfortable, be sure to tell the patient. Establish clear and respectable consequences for violating limits and then be prepared to carry them out if needed.

9) **Offer choices and optimism.** Provide hope and reassurance. Let them know that you have the resources to figure things out and that they will be OK. Offer food and blankets if possible. This is the part where just being kind goes a long way.

10) **Debrief patient and staff.** Once the acute interaction has passed, go back, and talk to the patient, especially if they were agitated or withdrawn. Once the patient is feeling better, they may want to talk more. If the interaction was aggressive, be sure to talk to the staff who may not have dealt with a violent child before. Give opportunity for feedback, and let the patient recap the event for you. This is an opportunity to identify any other areas that need addressed, as well as reassure the patient that things are going to be ok.

These tools can be used in any order, and you may find some are more relevant than others. You may need to focus on #5 (wants and feeling) for the nervous patient and #8 (lay down the law with clear limits) for the agitated one. Establish Verbal contact (#3) might be most important in a child who is trying to identify their gender and #6 (Listen closely to what the patient is saying) might be more important for a child who is feeling misunderstood. With the agitated patient, using these tools might help prevent needing to use medication or physical restraints. As you practice them you will find that some work better than others. But hopefully in using these tools, you will have a more effective and efficient patient encounter. §

REIMBURSEMENT COLUMN

THE PSYCHIATRIC PATIENT

Psychiatric patients represent a particularly difficult subset in the coding realm. It's often unclear to our coding teams the complexity of the providers decision making process and treatment algorithms. Here are a few recommendations to help capture an E&M level 5 (99285).

COMPLEXITY OF PROBLEMS ADDRESSED:

It's helpful to clearly state if the psychiatric patient is suicidal or homicidal. If so, was there a plan, a gesture or attempt, an ingestion of any substance, or a past history of attempt? This type of clarity allows insight to the coding teams to justify a presenting complaint as "acute injury or illness that poses a threat to life or bodily function."

DATA:

Include any medical clearance screening labs or independent interpretation of EKG or rhythm strips. Document usage of any cognitive screening measures such as the Hack's Impairment Index or Mi-SMART forms. The MI-SMART form often saves the provider from ordering a battery of unnecessary screening labs. It's important to document any other sources of information received about the patient. Sources can include family, EMS, police or patients previous psychiatric professionals and review of past medical records or outpatient notes. Finally, document any discussions with QHP's regarding patient care and disposition, such as social work, care coordinators, and psychiatric teams/institutions.

Don Powell, DO, FACEP

RISK:

Document discussion/decision making process regarding discharge if not admitted. Was inpatient psychiatric hospitalization considered? List any psychoactive medications given with route administered and their potential toxic side effects.

By adding this clarity to provider documentation our coding teams can capture appropriate level of care for the psychiatric patient. §

Don H Powell, DO, FACEP
President- Medical Management Specialists, PC

HOUSE VOTES TO INCREASE PENALTIES FOR VIOLENCE IN MICHIGAN'S EMERGENCY DEPARTMENTS!

On Tuesday, June 27, 2023, the Michigan House voted 97-11 on House Bill 4520 and 99-9 on House Bill 4521 to increase penalties on assaults on health professionals and volunteers in emergency departments. MCEP has long advocated for these increased penalties and worked to pass legislation last session in the House that died in the 2022 Lame Duck session. MCEP Executive Director Christy Snitgen and Board President-Elect Dr. Michael Fill testified with several ED nurses from around the state in early June at the House Criminal Justice Committee hearing on the legislation.

The bills now go to the Senate for consideration. The Senate will refer the bill to the Senate Civil Rights, Judiciary and Public Safety Committee. The Committee consists of the following members:

Senator Stephanie Chang, Chair, D-Detroit
Senator Sue Shink, Vice Chair, D-Ann Arbor
Senator Paul Wojno, D-Warren
Senator Jeff Irwin, D-Ann Arbor
Senator Sylvia Santana, D-Detroit
Senator Jim Runestad, Minority Vice Chair, R-White Lake
Senator Ruth Johnson, R-Groveland Township

We expect a hearing on the bill in September after the Legislature returns from its summer recess. MCEP will call on all members to contact their state senator toward the end of the summer to encourage them to support the legislation and adopt this legislation. We appreciate all the calls and emails that members sent to House leaders the past several months. Also, many thanks to MCEP's Leadership Development Team that spent a day in April lobbying legislators in Lansing!

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

MCEP PURSUES MICHIGAN MEDICAID REIMBURSEMENT INCREASE

MCEP Leadership, led by Health Finance Committee Chair Dr. Michael Gratson, have begun the process of pushing for an increase in Medicaid reimbursement for visits to emergency departments. Some in the college may recall that MCEP pursued a similar effort in the mid-2000s. This is a multi-year process, but it starts with conversations with the state's Medical Services Administration (MSA), which is part of the Department of Health and Human Services. MCEP will keep members posted as these discussion progress over the coming months.

STATE BUDGET FINALIZED AND SUMMER LEGISLATIVE RECESS

The last week of June traditionally signifies the final process of the state budget being passed. The state's fiscal year doesn't start until October 1st of each year, but it has been a tradition to get the budget done several months prior to the start so local units of government and other state stakeholders can prepare for the coming year. The FY 2023-24 budget has significant focus on health issues, mainly on the behavioral health crisis in our state. With final passage of the budget, the legislature will be at recess for the month of July and limited days in August. As mentioned earlier, the fall session starts after Labor Day and traditionally runs into the holiday season. §

MCEP President Michael Fill, DO, FACEP and Christy Snitgen, MCEP Executive Director, testified at the House Criminal Justice Committee.

SPINAL EPIDURAL ABSCESS IN AN IMMUNOCOMPETENT PEDIATRIC PATIENT WITHOUT NEUROLOGICAL INVOLVEMENT: CASE PRESENTATION AND EMPHASIS OF IMPORTANCE OF HIGH INDEX OF SUSPICION

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INTRODUCTION:

Spinal epidural abscess (SEA) is a rare bacterial infection that may lead to devastating neurological sequelae and, therefore, requires prompt diagnosis and treatment. Although a triad of symptoms have been described, early symptoms are usually nonspecific leading to a broad list of differential diagnosis and often delayed diagnosis[3,6]. Delayed treatment is associated with life altering neurological deficits[2].

The clinical triad that has been described includes back pain, fever, and neurological deficits and is only present in an estimated 8% of patients diagnosed with SEA[1,5]. The most common clinical presentation includes fever and back pain[2]. SEA should be included in the differential diagnosis for any patient with back pain, fever and/or spinal tenderness[4]. As illustrated by the case presented, this rare and possibly devastating diagnosis often presents with nonspecific symptoms. Hence an awareness of the possibility of this diagnosis will reduce the likelihood of delayed diagnosis.

CASE PRESENTATION:

A 14 year old male with a history of patent foramen ovale (PFO) initially presented to the emergency department (ED) with complaints of fever, chills, fatigue, neck pain and headache. The patient had no history of trauma, no prior surgical history, no sick contacts, and no recent travel. Social history is benign, patient attends school, denies sexual activity, denies alcohol, tobacco, and other substance use. Physical exam, CBC, CMP, and ferritin were initially unremarkable. Rapid test for COVID-19 was negative. There was mild elevation of D-dimer to 510ngFEU/mL and the CRP was 30.9mg/L. Patient was discharged home from the ED with presumed diagnosis of viral infection and instructions to continue symptomatic management at home. He reported having worsening symptoms for the two days following the ED visit with subsequent improvement of symptoms. He had a three-day period of no fever and mild, intermittent neck and back pain. The patient returned to the ED five days after his initial presentation with recurrence of symptoms including fever, worsening fatigue, headache, back and neck pain. Parents reported that the patient was sleeping up to 20 hours per day. Physical exam revealed tachycardia but no focal findings, no neurological deficits or nuchal rigidity. Patient had no tenderness to palpation along his spine, sensation and strength were intact in all extremities, gait was normal, and Romberg sign was negative. CRP had decreased to 14.4mg/L while ESR had gone up to 28mm/hr from 17 mm/hr five days earlier. Infectious mononucleosis screen was negative. Rapid test for influenza was negative. Lumbosacral and thoracic x-rays were within normal limits. Patient was admitted to the pediatric floor for further work up.

CT scan of the head and cervical spine were normal. Echocardiogram revealed a small PFO with left to right shunt but no vegetation or acute changes. Respiratory viral panel was negative, urine and blood cultures were also obtained. Additional lab work obtained included Troponin-T quantification, total creatine kinase (CK), Antistreptolysin O (ASO) titers, Cytomegalovirus (CMV) titers by PCR, *Bartonella* DNA detection by PCR, and Herpes Simplex Virus 1 and 2 (HSV) DNA detection by PCR, Cryptococcal antigen testing, and Quantiferon Gold-TB testing - all of which were negative or within normal limits. On day two of hospitalization, the patient's headache, neck pain and back pain worsened, with intermittent episodes of emesis. He was afebrile but was taking acetaminophen and NSAIDs for pain. Blood culture was positive for methicillin-sensitive *Staphylococcus aureus* (MSSA) and the patient was started on ceftriaxone, doxycycline and vancomycin. The following day, a lumbar puncture was performed and revealed pleocytosis with a white blood cell count of 2,041mm^3, and 28mm^3 RBCs. CSF glucose was 34mg/dL and protein was elevated at 81mg/dL. Additional CSF

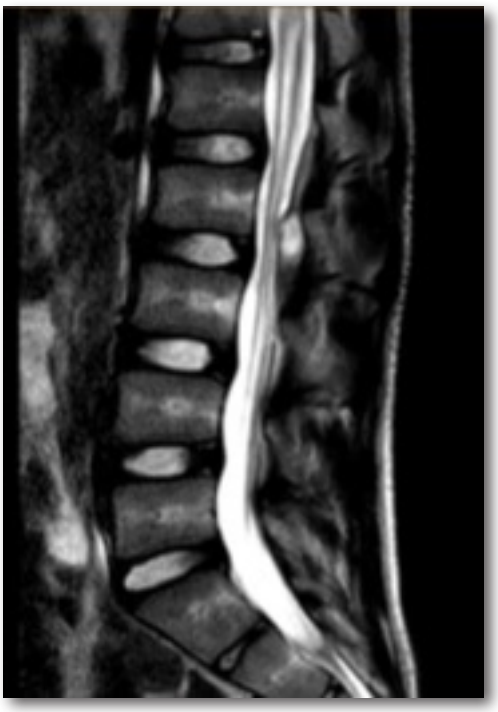

Figure 1. Sagittal MRI demonstrating epidural abscess present at L3-L4

studies obtained included HSV-1 and 2 by PCR, Enterovirus by PCR, and Cryptococcal antigen. CSF culture revealed MSSA, ceftriaxone and doxycycline were discontinued, and the patient was started on nafcillin and rifampin. MRI of the spine was obtained which revealed an epidural abscess measuring 3.04 cm x 1.34 cm x 5.46 cm, involving the posterior aspect of the spinal canal at the L2-L3 level. Neurosurgery was consulted and advised against surgical intervention due to benign neurologic exam indicating the lack of neurological involvement. A PICC line was inserted, and the patient was discharged home. He received a total of 6 weeks of IV nafcillin. Repeat MRI 4 weeks after the start of IV antibiotics revealed complete resolution of the epidural abscess.

DISCUSSION:

As represented by the case summarized here, the most common causative organism of SEA is *Staphylococcus aureus* (MSSA and MRSA)[6]. Staphylococcus aureus accounts for an estimated 63% of spinal epidural abscesses, followed by gram-negative bacilli (~16%), streptococcal (~9%), and other organisms (~10%). The bacteria usually enters the epidural space through the hematogenous route. However, an estimated one-third of patients with SEA do not have an identifiable source[1].

Known risk factors for SEA include immunocompromised status, IV drug use, direct instrumentation to the area such as recent epidural injection, lumbar puncture, CNS surgery and acupuncture[4]. Spinal epidural abscess in an immunocompetent pediatric patient is extremely rare. A case report and review of the English literature published in 2019 only found 31 published cases[4]. Since delayed treatment is associated with life threatening neurological deficit, a high index of suspicion is advised. Studies suggest that neurological deficits are frequently a late manifestation of illness, and hence should not be relied on for the diagnosis[3]. We recommend early imaging in patients with unexplained fever and history of back pain, even if neurological deficits are absent.

The case presented here also highlights the potential for nonsurgical treatment in cases that do not involve the nervous system. A recent paper published in 2020 summarized how emergent drainage of the abscess is the treatment of choice even for patients with no neurological symptoms (due to risk of deterioration with conservative management alone)[5] but our case highlights that not all cases require surgical intervention. In the absence of significant neural involvement, prolonged IV antibiotics with follow up MRI might be sufficient. §

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Emergency Medicine Reimbursement Issues...

$traight Talk XXXII

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November 14, 2023

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This course presents valuable information and updates for emergency physicians, billing and coding professionals, and group managers.

EMRAM: REVIEW OF THE PAST AND FUTURE DIRECTIONS

The Emergency Medicine Residency Association of Michigan (EMRAM) helps to provide a platform of communication and interchange of ideas amongst Michigan EM residents. EMRAM participated in numerous events last year. Firstly, EMRAM was involved with the Michigan Emergency Medicine Assembly at the Grand Hotel. At this event, there are several educational sessions which provide medical and legal updates in addition to stimulating EM topics. During the conference there was time to explore Mackinac Island, play golf, horseback ride and sample fudge. EMRAM also sponsored the EMRAM Teacher of the Year Award which was presented at the Michigan Emergency Medicine Assembly. Congratulations to the 2023 award recipient was Dr. Benjamin Schoener from Central Michigan University.

Additionally, EMRAM sponsored the Emergency Medicine Career Planning: Life After Residency event in Troy. This event educated residents on financial planning, litigation, work-life balance, and offered job networking. Furthermore, EMRAM offered two scholarships to the ACEP Leadership & Advocacy Conference in Washington D.C. From this opportunity residents learned to better advocate for emergency medicine, learned about current medical policies, and developed relationships with policymakers EMRAM also sponsored a Mock Oral Board Review Course which took place in May. Michigan residents were able to refine their oral board cases skills before they participated in their official oral board examination.

EMRAM participated in the MCEP Midwest Winter Symposium, which took place at the snowy wonderland of Boyne Mountain. At this conference they discussed practice changing EM hot topics. There was also the ability to network with physicians from around the state. Additionally, residents led medical student procedural skills stations and simulations to further spark medical student's interest in emergency medicine. There was also plenty of free time in the afternoons for participants to snow ski, snowboard, and enjoy the indoor waterpark.

EMRAM also sponsored SIMWARs, which took place in Kalamazoo this previous year. This crowd favorite event allowed for residents to compete against other residency programs on different medically simulated cases. EMRAM also became a new sponsor in the 2023 SonoW.A.R. (Ultrasound Wilderness Adventure Race) events this year. This fun filled event allowed EM residency programs across Michigan to travel to Belle Isle. Teams hiked approximately 4 miles around the island to find hidden stations, which challenged their ultrasound and wilderness medicine skills. We hope to continue sponsoring this event in the future to allow for even more Michigan EM residency engagement. The EMRAM board is also happy to announce the return of the In-Training Exam Review course this year in February.

I am honored by the ability to transition from the EMRAM Treasurer last year to President this year. Thank you to the previous 2022- 2023 board members: Krishna Patel (President), Michael Muradian (Vice President) and Ghufraan Akram (Secretary). I am happy to welcome the new EMRAM board, which consists of Lindsay Davis (Vice President), Brittany Ladson (Secretary) and Daniel Dunaske (Treasurer).

Laura Schroeder, MD, MS

Laura Schroeder (President):
"I was born and raised in Michigan; therefore, I am very passionate about promoting quality medical training within the state. My initial exposure to EMRAM was as a medical student during a MCEP Winter Symposium. Thanks to the well-organized and interactive event, my interest in emergency medicine began to bloom. My goal is to help advocate for beneficial learning environments for both my fellow residents and medical students interested in emergency medicine. As the EMRAM president, I will continue to create more career enhancing education, networking, and wellness events throughout Michigan. Furthermore, in efforts to unify EM programs from around the state, I hope to continue recruiting numerous EM resident program representatives to become involved with EMRAM."

Lindsay Davis (Vice President):
" I grew up in North Carolina and went to medical school at Lincoln Memorial University in Tennessee. I am passionate about emergency medicine, training and education for residents and medical students. This year I hope to get the residents across the state more involved in EMRAM events. In my free time I love any chance to get outside and have fun with friends, whether it's a day on the slopes or a hike in the mountains. Getting to see new places or to go for a run are some of my favorite things as well.

I am looking forward to the year!"

Brittany Ladson (Secretary):
"I am a graduate of Michigan State University College of Osteopathic Medicine and a current PGY-2 resident at Central Michigan University Emergency Medicine Program. This year, I am hoping to have more resident engagement in EMRAM by offering new activities for everyone to get involved in. My goal is to have more opportunities for professional development and research. I am looking forward to serving Michigan emergency medicine residents this year!"

Daniel Dunaske (Treasurer):
"I'm a Michigan native, being born and raised in Traverse City. I attended Lake Erie College of Osteopathic Medicine where I obtained both my doctorate and masters in medical education. Currently, I'm a PGY-2 at Central Michigan University and loving every second of it! I hope to not only build upon previous initiatives this year, but also help forge ties amongst Michigan's amazing residency programs through fiscally responsible networking initiatives and educational opportunities to collaborate." §

2023-2024 MCEP EXECUTIVE COMMITTEE

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MICHAEL FILL, DO, FACEP

PRESIDENT-ELECT
THERESE MEAD, DO, FACEP

TREASURER
MICHAEL GRATSON, MD, MHSA,FACEP

SECRETARY
LUKE SASKI, MD, FACEP

IMMEDIATE PAST PRESIDENT
DIANA NORDLUND, DO, JD, FACEP

2023-2024 NEW BOARD OF DIRECTOR'S MEMBERS

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JEFFERY MCGOWAN, DO, FACEP

DIANE PARATORE
DO, MBA, MEd, FACEP

LUKE SASKI, MD, FACEP

LAURA SCHROEDER, MD, MS

Opening Reception

Annual Meeting

Outgoing President, Dr. Diana Nordlund, giving her final address as President of the Chapter.

Dr. Diana Nordlund receives the Gavel Award from Incoming president, Dr. Michael Fill.

Dr. Diana Nordlund presents incoming president, Dr. Michael Fill, with the gavel as he transitions to the President of the Chapter.

ACEP President-Elect, Dr. Aisha Terry, speaking to the MCEP Membership.

ACEP President-Elect Candidate, Dr. Ryan Stanton, speaking to the MCEP Membership.

President, Dr. Michael Fill, presenting his Inaugural address.

ACEP President-Elect Candidate, Dr. Jeffery Goodloe, speaking to the MCEP Membership.

MCEP Fundraising & Add-On Events

MEMF Annual Golf Tournament Women's Longest Driver Winner; Nicole Klee with Dr. Jake Manteuffel.

MEMF Annual Golf Tournament Men's Longest Driver Winner; Dr. Nick Dyc with Dr. Jake Manteuffel.

MEMF Golf Tournament 1st Place Winners: Dr. Kevin Monfette, Kevin Meyer, Dr. Caleb Davis, and Dr. Jacob Sinkoff.

MEMF Annual Golf Tournament Women's Closets to the Pin Winner; Dr. Andrea Brault with Dr. Jake Manteuffel.

MEMF Annual Golf Tournament Men's Closets to the Pin Winner; Clay Funnel with Dr. Jake Manteuffel.

Whiskey Tasting

President's Banquet

MCEP was honored by the presences of 15 Past MCEP Presidents

Dr. Kathleen Cowling receives this year's John A. Rupke, MD Lifetime Achievement Award from Dr. Robert Malinowski.

Dr. David Betten receives this year's Emergency Physician of the Year Award from Dr. Jeff McGowan.

Dr. Melissa Barton receives this year's Legacy Award from Dr. Earl Reisdorff.

Dr. Benjamin Schoener receives this year's EMRAM Teacher of the Year Award from Dr. Rebecca Dimanche.

Dr. Nicholas Dyc receives this year's Ronald L. Krome, MD Meritorious Services Award from Dr. Michael Fill.