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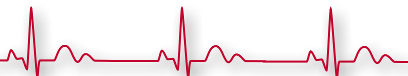
Submissions to the November/December 2023 Newsletter should be received by the Chapter office no later than December 1, 2023.

FROM THE PRESIDENT



Recently, I walked into a night shift at my ED. The waiting room was full, and there were multiple admitted patients holding in the ED for inpatient beds. I knew I was in for a difficult shift, but I did breathe a small sigh of relief when I signed into the computer and saw that many of the patients in the waiting room were low acuity. I could likely assess them quickly and "decompress" the department. I evaluated a few patients, then approached the charge nurse and asked him if he could spare a nurse to administer medications to these patients, telling him that I could likely discharge them after they received an X-ray and medications. He responded, "Sorry Dr. Fill, I'd love to help, but one of those patients was involved in a motor vehicle crash, so he needs 1:1 nursing care per State Law, and all my other nurses already have 3 patients each. I don't want the hospital to get fined, so your patients will just have to wait."

Of course, the above scenario is hypothetical, but it may soon become reality in Michigan hospitals. The Michigan Safe Patient Care Act is a package of bills, House Bill 4550 and Senate Bill 334. These bills aim to set minimum nurse to patient ratios across all hospital units. The minimum ratios outlined in these bills directly pertaining to the Emergency Department are 1 RN to 3 non-trauma/non-critical care patients, 1 RN for triage duties, and 1 RN to 1 patient for trauma/critical care patients. Further, the bill sets inpatient staffing ratios at 1 RN to 3 patients for telemetry units and 1 RN to 4 patients for med/surg units. Violations of these ratios could subject hospitals to fines of $10,000 to $25,000 per violation.[1]

Proponents of these bills say that the bills will help address burnout and stress in the nursing profession, as a number of nurses cite staffing ratios as one of the main contributors to these issues. They also cite a direct link between burnout and the exodus of nurses from the profession. The Michigan Nurses Association cites several studies showing that high staffing ratios put patients at risk for complications, such as hospital-acquired infections, medication errors, falls, preventable readmissions, and even death. Proponents of this legislation also claim that research shows that bills such as HB 4550 and SB 334 can produce cost savings for hospitals and better retention of nurses.[2]

The State of California passed similar legislation in 2004. While overall nursing job satisfaction seems to have improved, California is still reporting a shortage of 40,000 RNs statewide.[3] Also, metrics such as average length of stay, rate of decubitus ulcers, failure to rescue a patient after a post-surgical complication, development of in-hospital DVT/PE, pneumonia mortality, and postoperative sepsis have not significantly improved since implementation of the California law.[4] In the nearly 20 years since the passage of the California law, no other state has passed similar legislation.

I have empathy for our nursing colleagues who feel the pressures of understaffing and burnout. We as physicians face similar pressures. I do not disagree that these issues need to be addressed, but these bills do raise concerns in regard to unintended consequences. Arbitrary staffing ratios do not allow for adequate response to times of patient surge. These bills also do nothing to address the most significant factor leading to understaffed nursing units – nursing shortages. While hospitals may want to hire nurses, we know that many nurses have left the profession since the start of the COVID pandemic and that enrollment in nursing schools has declined.[5] Mandated staffing ratios would likely close available physical inpatient beds, as currently there are not enough nurses to staff them. As ED physicians, we know from experience that closed inpatient beds directly leads to admitted patients being held in the Emergency Department. This bottleneck of patients leads to increased ED waiting times, which means that patients presenting to the ED cannot receive a timely assessment. ED boarding and delay to assessment of new ED patients has been closely linked to worse patient outcomes.[6] The negative effect of these bills on hospital patient flow, and thus the negative impact on patient outcomes, would likely negate any positive patient care effect that the bills hope to achieve.

Michael Fill, DO, FACEP

We as medical professionals must address the workload placed on healthcare providers to improve job satisfaction, prevent burnout, and improve patient outcomes. I would suggest that we should explore strategies to increase nursing school enrollment and decrease the day-to-day tasks of our bedside nurses. Some duties that are currently assigned to RNs could likely be offloaded to nursing assistants or scribes, and this would allow nurses to focus on tasks more appropriate to their level of licensure, allow for more cost-effective care, and lead to better job satisfaction.

During one of my early experiences in advocacy, one of my colleagues told me that the vast majority of our legislators truly want to help their constituents, but they don't always know what they don't know. Most legislators have limited knowledge of our healthcare system. That is why it is important when bills such as HB 4550/SB 334 come forward, we reach out to our legislators to express our concerns. MCEP does this on your behalf, but it is also important for legislators to hear from their

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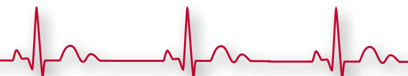
Thank you for all that you

To all of our frontline workers

From all of us at MCEP

FROM THE EDITOR



A TALE FROM THE OTHER SIDE

Last month, I found myself on the other side of the curtain in the Emergency Department. My family and I were traveling to Cedar Point for our annual weekend Halloweekends fall trip. We stayed at one of the local water park hotels so that my kids could have plenty of active fun time throughout the weekend. After the first night at the water park, we went to bed in anticipation of an early day in the morning, full of plans to get into the park as soon as it opened and to be among the first riders on the more popular roller coasters. At two in the morning, the bedroom door burst open, and my nine-year-old gasped words that made my stomach drop: "Mommy, I can't breathe!!"

She had been completely fine over the past few days, perhaps a little sniffly at best. Definitely no symptoms that would make one reconsider a trip, or even swab someone for Covid. If anything, she had more of a very mild seasonal allergy picture. But as I stumbled out of bed to her side, she began to have the worst sort of croupy cough interspersed by an extremely hoarse voice. Trying to keep quiet for the rest of the family, I snuggled her and took her to the balcony for some cool dry air. Unfortunately, it was unseasonably warm that night. We tried standing in front of the freezer in our room…which was also not very cold. I next attempted to steam up the shower, remembering only as I turned on the faucet that the water pressure and maximum temperature left something to be desired. As I watched, she began to have more audible stridor and developed visible and concerning retractions around her sternum. It was time to take her some place that had more resources than our hotel room. It was time for the emergency department.

At that time, I did what any parent would do. I didn't go online to look up reviews. I didn't think about driving to Rainbow Babies and Children's Hospital in Cleveland or one of the several dedicated pediatric hospitals in Toledo. I instead quickly searched "emergency department near me," set the map destination for the closest hospital to the hotel, carried my gasping daughter down what felt like miles of hallway to the car, and drove in silence on nearly empty streets through Sandusky, Ohio to the hospital. Along the way, I wondered if perhaps I was overreacting. Neither of my kids had ever been to an emergency department before for anything other than a routine Covid swab in the early days of the pandemic.

We ended up at Firelands Regional Medical Center. The triage nurses and clerks initially asked why we were there before taking a good look at my daughter, who continued her noisy and yet quiet gasping and coughing next to me. I then got the surreal experience of being the parent of a priority one patient. Any semblance of registration and triage in the waiting room stopped. The wheelchair came for my daughter, and we were taken to the pediatric code room, complete with the color-coded crash cart, the ubiquitous Broselow tape, and the airway equipment around the edges of the room. Within a minute, the attending physician, a medical student, multiple nurses, and respiratory therapy were all in the room, working as a team in a way that only a well-oiled emergency resuscitation machine can function. X-ray was only a minute or two behind. At this point, I felt relieved that I was not overreacting.

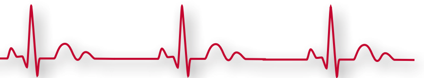
Oddly, although my daughter has no history of respiratory problems, significant allergies, or prior croup, and although she is way too old at nine years old for croup, she looked and acted like a typical toddler croup patient that night. Racemic epinephrine was given. She drank her dexamethasone. She said that the Firelands nurse was much better at viral swabs than her own mother at home. She improved back to baseline over the next 20 minutes or so. We were ultimately able to be discharged after a few hours, and she had no further issues (and fortunately, no Covid). The physician on duty noted that they sometimes treat kids who seem to react to the aerosolized humidified chlorine from the indoor water parks. I now think this and a non-Covid virus triggered her episode.

Sara Chakel, MD, FACEP

As we left, I thought about our visit. My daughter was quickly and expertly cared for in a community emergency department, similar to those that many of you work in and similar to the emergency department that I work at. An emergency physician with training to provide care across the lifespan assessed my daughter, treated her, and made her feel better, even when some aspects of her presentation were atypical. The nursing and support staff were excellent at keeping my daughter calm despite the numerous simultaneous assessments and interventions. As a parent, when my child was experiencing an emergency, I found myself incredibly grateful for our emergency care network, which is truly set up to care for anyone, anything, anytime. I'd like to extend a special thanks to Dr. Patrick Tupa for taking care of us that night.

In this month's News and Views, in light of a recent national newspaper article, Dr. Coffey revisits our 2022 article about pediatric readiness in the Kid's Korner column. In his president's column, Dr. Fill discusses the implications of House Bill 4550 / Senate Bill 334 and how MCEP advocacy is working to educate our legislators that this package is not the solution to the Michigan nursing crisis. EMRAM President Dr. Schroeder provides practical tips for both residents and attendings to combat burn-out. Dr. Powell shares useful tips to improve documentation of chest pain. Dr. Massoudi and Dr. Aydemir from Western Michigan University provide the resident case report this month. Finally, MCEP lobbyist Bret Marr celebrates our most recent legislative victory with the House and Senate passage of our MCEP-supported Violence in the ED package.

In closing, as we move into the chillier nights of late autumn, I remind you that MCEP Leadership Development Program applications are due November 15, and I would encourage any of you who are on the fence to apply. Information and the application can be found at: https://www.mcep.org/wp-content/uploads/2023/09/2024-Leadership-Program-Brochure.pdf. The program continues to be a great introduction to all of the facets of MCEP and a fantastic mentorship experience to help you find your place in the College as a future leader. §



From Dr. Coffey: Following the recent Wall Street Journal article critiquing how children are cared for in Emergency Departments, we thought it made sense to reprint this article from one year ago discussing pediatric readiness, how we are currently doing, and how we can improve. Although many children in our state are cared for in dedicated children's centers, a large percentage are also cared for in community hospitals. This article gives resources to support you in caring for our smallest patients, and as always, we greatly appreciate all of your hard work in caring for Michigan's kids. Please feel free to contact me (pamela.coffey@vituity.com) with any questions or comments.

Pamela Coffey, MD, FACEP

PEDIATRIC READINESS

Pamela Coffey, MD, FACEP

With help from:
Samantha Mishra, DO, MPH
EMS for Children Coordinator
MDHHS-BETP

Pediatric Readiness: The day-to-day ability to meet the immediate needs of an ill or injured child.

Seems simple right? Seems like exactly what we do every day in our emergency departments (EDs), without fail. But what exactly does this mean, and are we truly as prepared as we think we are? Have you ever found yourself unable to find the right-size ET tube for the infant that was rushed into your department not breathing? Have you ever had to "make do" with adult-size equipment because the peds box is not restocked? How about having to ask for the child to be weighed so you can calculate a medicine dose? Or at least try to find a Broselow tape? Being prepared for the unexpected is what we do, but we do it much less for the pediatric population.

It's easy to assume that all kids will be brought to a major children's center. Yet a national survey from 2013 showed us that 69% of children seeking emergency care are seen in EDs that treat less than 15 kids per day. It also demonstrated that on a scale of 100, EDs scored an average of 70 in pediatric preparedness. Those are humbling statistics. But we know we can do better, and so does the Emergency Medical Services for Children National Pediatric Readiness Project.

The Emergency Medical Services for Children (EMSC) is a US federal government health initiative that aims to reduce child and youth disability and death due to severe illness or injury. It is the only federal program focused specifically on improving the quality of emergency care for children. It partners with state-led programs to expand and improve emergency medical services and treatment for children. In Michigan, the EMSC works with the Bureau of EMS Trauma and Preparedness (BETP), the Division of Emergency Preparedness and Response (DEPR) arm of the Michigan Department of Health and Human Services (MDHHS), and the state EMS/Trauma system.

The core principle of the EMSC program is pediatric readiness. It encompasses all aspects of pediatric care including pre-hospital providers, transport, EDs, and trauma programs. It involves every location that cares for the acutely ill or injured child including critical access hospitals, rural, suburban, and urban EDs, trauma centers, and primary children's hospitals. Every person involved in the acute care of a child is included. The EMSC is a central home for promoting collaborative and integrated efforts to improve readiness to care for pediatric patients across the entire spectrum of emergency care.

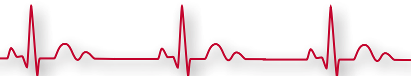
Nationally, the concept of pediatric readiness started in 1993 when the Institute of Medicine (IOM) examined the challenges of emergency services and recommended "that EMS agencies and emergency departments (EDs) appoint a pediatric emergency care coordinator (PECC) to provide pediatric leadership for the organization." In 2001, ACEP released the Guidelines for Care of Children in the Emergency Department as a policy statement. But, in 2006, the IOM described the current state of pediatric emergency care as "uneven." So, in 2009, the AAP, ACEP, ENA, and EMSC released a joint policy statement. This was the first cross-specialty collaborative effort in aligning care for children. From this, the 2013 National Pediatric Readiness Project (NPRP) was started and launched the first quality improvement initiatives. With this, they conducted the first national pediatric readiness assessment with an 83% response rate that represented more than 4000 EDs in the country. We learned:

- 69% of children seeking emergency care are seen in EDs that treat less than 15 children per day.
- The overall median score for the nation was 70 (out of 100). Michigan scored a 68.
- The median pediatric readiness score was higher for EDs with high volumes of pediatric patients.
- Trauma center status was not predictive of higher pediatric readiness scores.
- Over half of the EDs lacked a physician and/or nurse PECC.
- Having a PECC strongly correlates with improved pediatric readiness.
- Presence of a QI plan that includes pediatric-specific indicators is associated with improved pediatric readiness.

From this data, the 2009 policy statement was revised to create the current 2018 joint policy statement:

Pediatric Readiness in the Emergency Department. A Joint Policy Statement of the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association. https://www.acep.org/globalassets/new-pdfs/policy-statements/pediatric-readiness-in-the-emergency-department.pdf

As per this statement, "These recommendations provide current information on equipment, medications, supplies, and personnel considered critical for managing pediatric emergencies in EDs. This statement also offers recommendations for the administration and coordination of pediatric care in the ED; pediatric emergency care QI, performance improvement (PI), and patient safety activities; policies,



procedures, and protocols for pediatric care; and key ED support services. It is believed that all EDs in the United States can meet or exceed these recommendations and that some hospitals, such as those with pediatric critical care capabilities or children's hospitals with greater resources, will develop and implement even more comprehensive recommendations and share their expertise with their local and regional communities. These updated recommendations are intended to serve as a resource for clinical and administrative leadership of EDs as they strive to improve their readiness for children of all ages."

The complete statement with details can be found at the link above. But in summary, the recommendations include the following:

1. Administer and coordinate the care of children in the ED by appointing a PECC made up of both a physician and a registered nurse coordinator.
2. Maintain adequate competencies for physicians, advanced practice providers, nurses, and other ED health care providers.
3. Establish and maintain a quality improvement / performance improvement process in the ED.
4. Establish specific policies, procedures, and protocols for the emergency care of children in the ED such as sedation protocols, restraints, etc.
5. Medication safety for pediatric patients: Obtain weights in kilograms for calculations, monitor small dose error risks (a simple misplaced decimal point can be catastrophic), and use an ED pharmacist to assist with dosing.
6. Utilize support services designated for pediatrics, including imaging that reduces radiation doses based on weight or age.
7. Equipment, supplies, and medications: As many are weight-based and age-based, ensure you have the right supplies available for all ages and sizes.

These guidelines were well received, and there was energy to adopt them across the country. The NPRP created a website www.pedsready.org with links for updated toolkits and checklists to help with establishing these guidelines in emergency departments. And, in 2021, they embarked on the second National Pediatric Readiness Assessment to see just how well it worked. In Michigan, our assessment was championed by Dr Samantha Mishra, MDHHS-BETP EMSC Coordinator. Under her leadership, we had a 100% response rate from all Emergency Departments in the state.

- Michigan scored a 71/100. The average range for EDs that see up to 10,000 pediatric patients per year was 69.6 (total range was 40-100). Those that see greater than 10,000 pediatric patients per year scored an average of 90 (total range was 68-100).
- *In comparison, in 2013, Michigan had 99.3% response rate and scored a 68/100. Volume less than 10,000 pediatric patients scored a 66 with a range of 35-98. Volume greater than 10,000 scored an 85 with a range of 62-100.*

Additional Michigan data showed that:

- 47% of EDs have a pediatric nurse coordinator, and 32% have a pediatric physician coordinator.
- 65% of physicians and 90% of nurses complete pediatric competency evaluations.
- Between 30-40% of EDs have QI/PI initiatives.
- Between 90-100% of EDs have safety guidelines in place.
- Policies and procedures are mixed. About 40% have a disaster plan in place, while 90% have a child maltreatment policy in place.
- The ED checklist for supplies was successful. Most EDs had 90-100% success in this domain!

National data is still being compiled so it is uncertain how we are doing in comparison to the rest of the country, but this information shows that Michigan still has room for improvement. Our scores did not change much since 2013, and there is still a discrepancy between large-volume and small-volume pediatric EDs. The largest gap in our state seems to be in designating a coordinator and developing polices and QI initiatives, which are key steps to integrating any of these guidelines into practice. Your individual department data can be obtained from your coordinator (or the person who filled out the survey). If your department has not already adopted these guidelines, I strongly encourage you to step up and take the lead, perhaps even take on the role of the pediatric coordinator. If your department does not have a pediatric champion, perhaps this is your calling.

Following these guidelines may seem overwhelming. It may seem like extra work and cost when you don't see that many acutely ill or injured children. But part of being an Emergency Department is not knowing what will pass through our doors next. We know that the more ready we are, the better we are at taking care of any patient, especially kids. §

https://www.pedsready.org/

https://publications.aap.org/pediatrics/article/142/5/e20182459/38608/Pediatric-Readiness-in-the-Emergency-Department?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000

https://emscimprovement.center/domains/pediatric-readiness-project/readiness-toolkit/

MCEP CALENDAR OF EVENTS

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

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

January 25-28, 2024
Midwest Winter Symposium
Mountain Grand Lodge
Boyne Mountain, Michigan

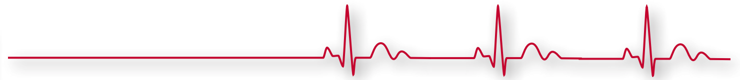
January 27, 2024
Board of Directors
Mountain Grand Lodge
Boyne Mountain, Michigan

February 9, 2024
EMRAM ITE Review
Virtual Zoom Meeting

March 6, 2024
Board of Directors
Chapter Office
Lansing, Michigan

March 21, 2024
Critical Care in the ED Conference
Virtual Zoom Meeting

REIMBURSEMENT COLUMN



THE CHEST PAIN PATIENT

Don Powell, DO, FACEP

Last month, we discussed the intricacies of the psychiatric patient and capturing proper documentation. This month, we will follow that theme and discuss another cohort of patients that is classically an E&M level 5 (99285) but that under the new coding guidelines can often slip to an E&M level 4 (99284) if not carefully documented. The chest pain patient is a subset of our patient population that often uses a high level of cognitive decision-making that can, if captured, result in level 5 or even critical care reimbursement.

COMPLEXITY OF PROBLEMS ADDRESSED:

The addition of a differential diagnosis in the Medical Decision Making (MDM) can be critical for our coders to understand the physician's mindset and decision-making process. Recall that in order to achieve high level Complexity of Problems Addressed (COPA), the physician needs to indicate:

- 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment, or
- 1 acute or chronic illness or injury that poses a threat to life or bodily function.

Here is a sample statement: "This 60-year-old with a history of hypertension, diabetes, and hyperlipidemia presents with acute severe chest pain. My differential diagnosis includes pneumonia, pneumothorax, ACS, PE, aortic dissection, and GERD." This gives our coding team a very clear idea of our thought process.

DATA:

In this patient cohort, the physician often refers to previous office notes, cardiology consults, previous echocardiograms, EKGs, stress testing, and imaging. All these are important to document for complexity. This is also a patient population where certain assessment tools are often used to effectively rule out the need for further testing. If one uses these rules, it is important to document as we can get "credit" for these tests by documenting our cognitive decision-making. Examples include the PERC rule, the Well's score, and the HEART score.

One of the biggest lost opportunities in documentation is also found in this category. It is critical to document an independent interpretation of any EKG, rhythm strips, or imaging.

Lastly, if any discussions about patient management or test interpretation with other external physicians or qualified health professionals occurred, then document. Consultants such as cardiology are often involved in reviewing EKGs, in discussions regarding inpatient versus outpatient management, and in determining further testing.

RISK:

There are several areas in the risk category that often play out in this patient population. Often, drug therapy requiring intensive monitoring for toxicity is involved. Were IV controlled substances like morphine used? Were aggressive rate control or blood pressure medications such as IV diltiazem or beta-blockers used? Was nitroglycerin used? Were thrombolytics or heparin used?

The decision to admit or discharge these patients is often complex and requires shared decision-making. Document if the HEART score was used. Document reasons you considered admission versus discharge. Document any review of the patient's medications and/or changes. Document if any social determinants of health played a role in your decision-making process.

RECAP:

The chest pain patient requires a high level of cognitive involvement. With proper documentation, one can achieve proper reimbursement for this work. §

Don H Powell, DO, FACEP
President- Medical Management Specialists
Director of Reimbursement and Advocacy- Emergency Care Specialists

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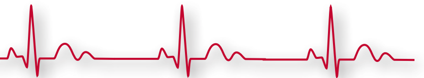


VIOLENCE IN MICHIGAN'S EMERGENCY DEPARTMENTS PASSES STATE SENATE

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

On Thursday, October 15, 2023, the Michigan Senate passed House Bill 4520 and House Bill 4521, increasing penalties for 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 Senate in the 2022 lame duck session. MCEP Executive Director Christy Snitgen and Board Member Dr. Pamela Coffey testified in the Senate Civil Rights, Judiciary, and Public Safety Committee in early October. The bills were reported from that committee without opposition the following week.

Recall that the House voted in late June in an overwhelming fashion to send the bills to the Senate. The Senate made one minor change, expanding the bills to mental health facilities as well as hospitals. The House is expected to concur in the changes the last week of October and send the bills to the Governor for her signature. This is a great moment for physicians and staff in Michigan's emergency department settings and the culmination of lots of work from MCEP members over the past several years!

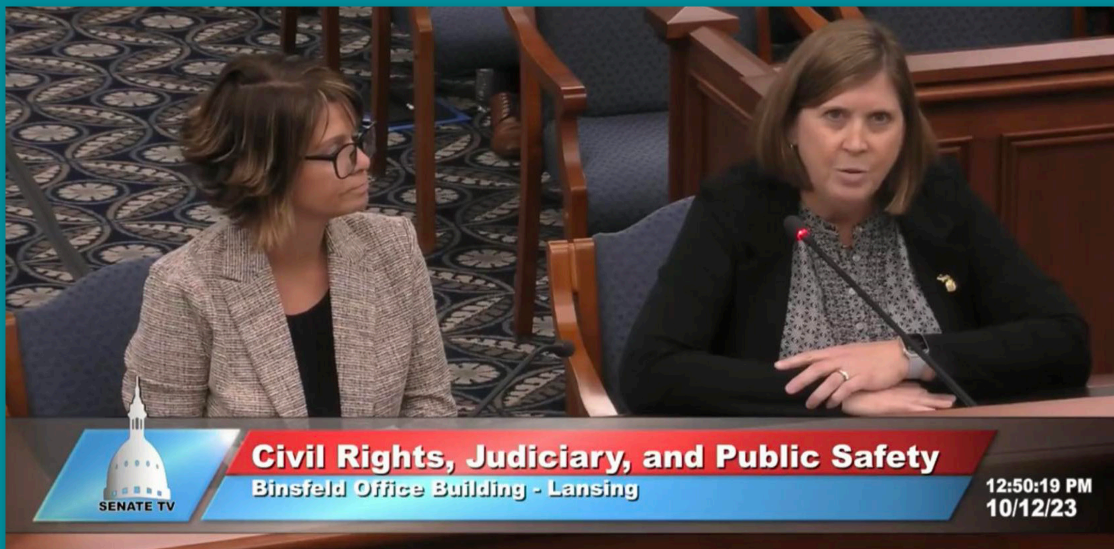
LEGISLATURE PREPARES FOR EARLY ADJOURNMENT

As a quick refresher, the Michigan legislature runs on a two-year cycle that starts at the beginning of an odd-numbered year and ends 24 months later after an even-year election cycle. Traditionally, the fall of the odd year is heavily focused on policy issues and wraps up in mid-December. Earlier this year, while enjoying their first complete majority in forty years, legislative Democrats passed a number of policy proposals that did not receive immediate effect, meaning those bills will not take effect until the end of March 2024 if the legislative session ends in December.

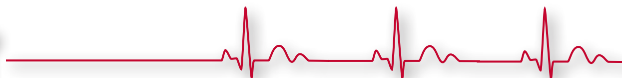
One option to allow those bills to take effect earlier is for the legislature to adjourn earlier and let the 90-day effective date clock begin ticking earlier. If the legislature leaves by mid-November, one of the bills Democrats would like to take effect earlier, the moving of the 2024 presidential primary to February 27, 2024, could take effect. This has shortened the fall session and made it function more like a lame duck session.

MCEP PURSUES MICHIGAN MEDICAID REIMBURSEMENT INCREASE

MCEP leadership, led by Health Finance Committee Chair Dr. Michael Gratson, has 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 discussions progress over the coming months. §



EXECUTIVE DIRECTOR CHRISTY SNITGEN AND DR. PAMELA COFFEY, MD, FACEP TESTIFYING AT THE SENATE CIVIL RIGHTS, JUDICIARY AND PUBLIC SAFETY COMMITTEE HEARING.



OVARIAN TORSION AFTER HYSTERECTOMY: A CASE REPORT

Nahal Massoudi, DO and Baturay Aydemir, MD of Western Michigan University Homer Stryker MD School of Medicine, Kalamazoo, MI

INTRODUCTION

Ovarian torsion is defined as a partial or complete twisting of the ovary and/or fallopian tube around its vasculature, causing ischemia. It can affect females of any age and can even occur after hysterectomy.[1] Ovarian torsion is a true medical emergency with an associated severe mortality.[2] Delayed diagnosis and management can result in hemoperitoneum, peritonitis, and infertility. The classic patient presentation is sudden onset of abdominal pain followed by nausea and vomiting. There can also be multiple episodes of self-resolving abdominal pain preceding the presentation.[3] Here, we present an uncommon case of ovarian torsion one year after a hysterectomy procedure.

CASE

A 39-year-old G5P3 woman with a history of obesity presented to an outside emergency department for sharp worsening intermittent right lower quadrant abdominal pain radiating to the flank. She had three episodes of emesis at the peak of her pain. She reported running on the treadmill one hour prior to the onset of her pain. About one year prior to presentation, the patient had a hysterectomy with bilateral salpingectomy due to uterine fibroids and abnormal uterine bleeding.

On examination, the patient had right lower quadrant abdominal tenderness without rebound as well as tenderness of the right adnexa on pelvic exam. Her laboratory workup was unremarkable. After receiving hydromorphone and ondansetron, the patient's pain and nausea improved. A CT scan without contrast revealed possible ovarian cysts. The patient was then transferred to our emergency department for a pelvic ultrasound, which revealed an enlarged right ovary measuring 6.9 x 3.7 x 4.6 cm, with an included 3 cm cyst. Doppler scan demonstrated a normal flow pattern. The obstetrics and gynecology (ob/gyn) service evaluated the patient and discussed with her that ovarian torsion is rare after a hysterectomy and bilateral salpingectomy. Since the patient's pain had improved and ultrasound revealed normal Doppler flow, they recommended discharge with a follow-up appointment the following morning.

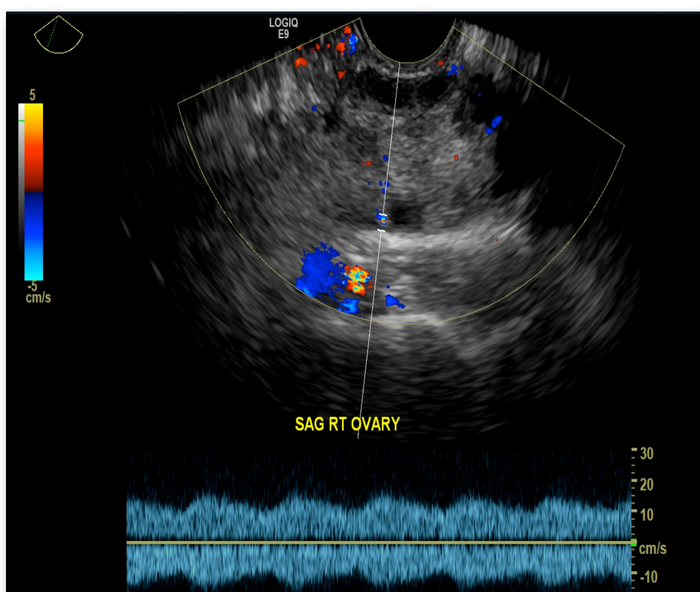


Figure 1. Transvaginal ultrasound still image showing an enlarged right ovary with a preserved doppler arterial flow.

The patient presented to the ob/gyn office with worsening pain and nausea, and she was sent back to the emergency department. A repeat pelvic ultrasound again showed an enlarged right ovary with bilateral normal Doppler flow. Given the persistence of symptoms, the ob/gyn service took the patient for a diagnostic laparoscopy, where the patient was found to have a hemorrhagic torsion of the right ovary which could not be salvaged and that required right-sided oophorectomy. After the operation, the patient reported improvement of her pain.

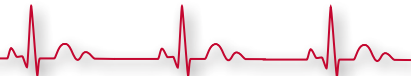
DISCUSSION

Ovarian torsion after a hysterectomy is not a common occurrence, comprising about 8% of total torsions.[1] However, complications related to torsion can be life-threatening, including ischemia and infection. Ovarian torsion can be a challenging diagnosis due to its nonspecific signs and symptoms. Currently, there is no test that is both highly specific and highly sensitive for diagnosis of ovarian torsion.

Most patients with ovarian torsion present with nausea and vomiting (70%), and approximately 70% of patients also present with a sharp abdominal pain.[3] The ultrasound result in our patient was significant for an enlarged right ovary and the presence of a cyst; however, the Doppler scan demonstrated a normal flow pattern. In one study, the specificity of pelvic ultrasound to rule in ovarian torsion was 99.6% but the sensitivity of ultrasound in ruling out ovarian torsion was found to be only 72%.[4] This means that around 28% of ovarian torsions were missed by ultrasound due to absence of abnormal flow patterns. In our case, the patient did have a normal Doppler flow pattern causing delay in the diagnosis and appropriate management. Unilateral ovarian enlargement of the affected ovary was discovered to be one of the most common findings in ovarian torsion, which was present in our patient. Additionally, our patient had an ovarian cyst which further increased her chance of having a torsion.

In our case, in which the patient had a prior hysterectomy, the ob/gyn team discharged the patient home. However, the patient's pain worsened on follow-up appointment, and she ultimately returned to the hospital and underwent emergency laparoscopy with findings of an unsalvageable torsed right ovary. This case shows that ovarian torsion needs to be considered even in patients with a prior history of hysterectomy.

Clinicians should have a high degree of suspicion for ovarian torsion



in any aged woman with acute abdominal pain, nausea, and vomiting regardless of their gynecological surgery history. Patients with previous hysterectomy and infertility are still at risk for other complications related to ovarian torsion, and failure to recognize this diagnosis can cause increased morbidity in patients. It is important to inform the patient about the risks and benefits of diagnostic laparotomy and complications related to missed ovarian torsion. If the patient is discharged, detailed return precautions should be discussed with patient as well as plans for close outpatient ob/gyn follow up. §

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Michigan Emergency Doctors Political Action Committee
6647 West St. Joseph Highway
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(517) 327-5700

Dear Doctor:

As members of MCEP, ACEP, and the health care community, we dedicate ourselves to advancing quality emergency care. Increasingly, key decisions affecting our ability to fulfill this mission are made by elected officials—few of whom are medically trained and even fewer of whom are emergency physicians—in Lansing and in Washington, DC.

Emergency physicians face myriad challenges in emergency departments, not the least of which is violence in the workplace. A long-existing barrier to delivery of quality care, ED violence has steadily increased at a rate greater than four times the rate for workers in the private sector overall. MCEP is coordinating efforts to introduce a group of bills in Michigan legislature to address these concerns, and the momentum is promising.

I strongly encourage you to contact your legislator, so they understand the fundamental role that emergency physicians play in safeguarding and advancing the health of our communities as well as how violence in the ED affects quality patient care. Supporting MEDPAC this year is one of the most important ways you can become involved in transforming these bills into laws. A contribution of any amount will make it more likely that ED physicians and the rest of the ED team can benefit from heightened protections against violence in the ED.

You have an opportunity to strengthen our voice in Congress. Supporting MEDPAC allows our message to reach our legislators: A safe environment for both patients and health care providers in the ED is imperative to quality care. It strengthens our voice on this issue and future issues that impact our care, our patients, and our profession.

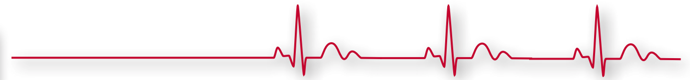
Your donation can be a one-time only donation or broken into quarterly or monthly payments. A link to MEDPAC can be found here: **https://themedpac.org/**.

If you would like to donate quarterly or monthly, please contact our office at 517-327-5700 or email madeyv@mcep.org.

Please join me in supporting the Michigan Emergency Doctor Political Action Committee!

Sincerely,

Diana Nordlund, DO, JD, FACEP
Immediate Past President, Michigan College of Emergency Physicians Chair, Michigan Emergency Doctors' PAC Board of Trustees



A RESIDENT'S GUIDE TO COMBATING BURNOUT

Laura Schroeder, MD, MS

I hope all the new interns are enjoying the transition from medical student to physician. Reflecting back on my intern year, I remember how stressful residency felt at that time. I was faced with many new responsibilities, had to learn the flow of the hospital, and worked long hours in addition to studying. Life as a resident can be very overwhelming at times. Unfortunately, this can lead to resident fatigue, exhaustion, and burnout. Here are some strategies I have utilized to help improve my wellness during residency:

1. **When in Doubt, Vent it Out:** We all have those physically, emotionally, and mentally exhausting shifts sometimes. Make sure you find someone who you can talk to about these rough cases. Find your person to vent to, whether it be a co-resident, attending, mentor, friend, or spouse. It will help you clear your mind and de-stress.
2. **Stop, Breathe, and Let it Go:** Do not hold onto the stress of work. Take a few minutes every day to clear your mind using mindful meditation techniques. You can also use breathing techniques such as 4-8-7 breathing. This method involves taking 4 seconds for inspiration, holding your breath for 7 seconds, and taking 8 seconds for expiration. Additionally, there are numerous other techniques online that you can try out to help reduce stress.
3. **Work-Life Balance:** Create a list of your priorities. Schedule time for important things outside of work, whether that be family, friends, or hobbies. This helps give you things to look forward to and can make your work week feel shorter. Respect the time you have scheduled for these things. Do not feel guilty about enjoying your free time; it is okay to take a break from work or studying.
4. **Relax and Rest:** It is crucial that you take enough time to sleep. Your body needs sleep to recharge and stay healthy. Being an emergency medicine resident, it can be difficult to have healthy sleep habits when your schedule constantly flips from days to nights. One useful tip while on nights is scheduling your sleep time and keeping that time protected. In order to get the amount of sleep I require, I set an alarm to remind me when I need to go to bed.
5. **Connect with Your Patients:** It can be challenging in the fast-pace setting of the emergency department to connect with patients. To be efficient at our jobs, we need to be in and out of rooms very quickly. This often does not leave time to connect with our patients like other specialties. I challenge you, for just one patient per shift, to take an extra two minutes in the room talking with a patient and making a connection with them. This is more likely to create a meaningful patient experience, help strengthen the physician-patient relationship, increase your patient satisfaction, and help combat burnout.
6. **Stay Active and Exercise:** After a long shift it can be challenging to find the time or motivation to exercise. However, I have found exercising for at least 30 minutes a day helps me burn off stress and sleep better. If you are not keen on hitting the gym, that is okay. There are numerous other ways to stay active including walking, hiking, biking, running, or even creating co-resident sporting events.
7. **Discover New Passions:** With our chaotic schedule it can be challenging to plan "fun" time for ourselves. I would challenge each of you to find an exciting new passion or hobby outside of medicine. There are endless possibilities from salsa dancing to rock climbing. This helps offload work stress and gives you something to look forward to in your free time.
8. **Teamwork Makes the Dreamwork:** For things to go smoothly in the emergency department, the entire interdisciplinary team needs to work together. Make sure during your long stressful shifts that you do not take your crew for granted. Let your work colleagues know they are appreciated and that they are doing an awesome job. Feeling appreciated can help prevent their burnout as well.
9. **Become Engaged:** If you are frustrated by something, get involved to make changes for the better. This can include running for chief at your residency, joining a hospital committee, or even becoming a representative at a statewide or national level. Do not be content, strive for excellence, and push yourself out of your comfort zone. §

UPCOMING MCEP/EMRAM EVENTS:

- January 25-28, 2024: MCEP Winter Symposium at Mountain Grand Lodge, Boyne Mountain, Michigan
- February 1, 2024: EMRAM scholarship nominations open for sponsorship to attend the ACEP Leadership & Advocacy Conference from April 14-16, 2024 in Washington, D.C.
- February 9, 2024: EMRAM Online In-Training Exam Review Course

www.mcep.org

MCEP AWARDS PROGRAM

The Michigan College of Emergency Physicians is now accepting nominations for the following awards:

JOHN A. RUPKE, MD LIFETIME ACHIEVEMENT AWARD
The purpose of this award is to recognize a member who exemplifies the specialty of Emergency Medicine in the State of Michigan and who through a distinguished career has had a major impact on the practice of Emergency Medicine. The recipient will have demonstrated a lifetime of contributions to the practice of emergency medicine by an unparalleled commitment to professionalism, leadership, and service which has established the recipient as an inspiration and role model throughout the specialty. The recipient must be an active, life or active honorary member of the College.

RONALD L. KROME, MD MERITORIOUS SERVICE AWARD
The Meritorious Service Award was created in 1983 and named after Dr. Krome, its first recipient. To be eligible for this award the recipient must be an active, life or active honorary member of the Michigan College of Emergency Physicians and a present or past MCEP leader (Board Member, Committee Chairperson). Under criteria, the member will have had to make an outstanding contribution to the College by significantly helping to achieve one or more of its purposes and/or objectives. The recipient's personal leadership attributes will include one, but not limited to one of the following examples: Inspirational, Innovative, Diplomatic, Planner, Organizer, Manager/Administrator, Arbitrator, Consensus Maker, and Decision Maker.

THE LEGACY AWARD
The purpose of this award is to recognize a member who has served as an active leader of the College for at least ten years and who, in that capacity has made sustained contributions to the growth and maturation of the College through an exceptional commitment of time and expertise. The recipient will have been actively involved in College activities for a period of ten or more years, demonstrating ongoing service to the College. To be eligible for this award the recipient must be an active, life or active honorary member of the Michigan College of Emergency Physicians; present or past MCEP leader (Board Member, Committee Chairperson).

EMERGENCY PHYSICIAN OF THE YEAR AWARD
The purpose of this award is to recognize Clinicians of unusual merit, to espouse and encourage members to pursue the ideals of emergency medicine and to convey these same ideals to the public through the news media. To be eligible for this award the recipient must be: a current member of MCEP, an outstanding emergency physician role model, maintain high professional standards and clinical orientation, provide quality health care, and be active in community service and education. Current and past members of the MCEP Board of Directors and Officers are not eligible for this award.

SIGNIFICANT CONTRIBUTION AWARD
The purpose of this award is to recognize an individual who has demonstrated a superior contribution to the College. Recipients of this award can be a member or non-member of the Michigan College of Emergency Physicians. The recipient will have created, implemented, executed, or performed an assignment, task, or function of significant benefit to the College.

The deadline for receipt of nominations for these awards is February 15, 2024. Nominees for all awards will be reviewed and selected by the MCEP Nominating Committee with approval of the Board of Directors. Awards will be presented at the Michigan Emergency Medicine Assembly during the Presidents' Banquet at Boyne Highlands on July 30, 2024.

MCEP AWARDS PROGRAM NOMINATION FORM

AWARD:____

NOMINEE FOR AWARD:

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Name

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Address City State Zip

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Telephone E-mail

NOMINATION SUBMITTED BY:

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Name

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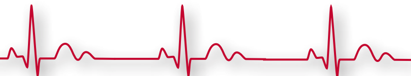
PLEASE ATTACH A BRIEF BIOGRAPHICAL STATEMENT ABOUT NOMINEE AS WELL AS A CURRENT CURRICULUM VITAE, LETTERS OF SUPPORT ARE OPTIONAL. RETURN TO: MCEP, 6647 WEST ST. JOSEPH HWY., LANSING, MI 48917, PHONE (517) 327-5700, FAX (517) 337-7530, E-MAIL MCEP@MCEP.ORG. THIS FORM IS ALSO AVAILABLE FOR DOWNLOAD ON OUR WEBSITE, WWW.MCEP.ORG.



Representative Rashida Tlaib visited the Emergency Department at Trinity Livonia in late August to learn more about issues facing emergency physicians and our patients, including violence against healthcare workers, emergency department boarding, and reimbursement challenges. She noted that her office arranged this visit after MCEP members visited her office and spoke with her staff in Washington, D.C. at this year's ACEP Leadership and Advocacy Conference. Pictured from left to right are Rob McCurdy, MD; Nick Nickolopoulos, RN; Sara Chakel, MD; Congresswoman Rashida Tlaib; Matthew Griffin, MD; Jodi Galdes, MD; Patricia Paz-Arabo, MD; Patrick Milostan, RN; and Alecia Ngo, RN.

MCEP had one of the largest delegations at the ACEP Council meeting in Philadelphia in early October. This year, our delegation submitted two memorial resolutions in memory of Gloria J Kuhn, DO, PhD and Richard M. Nowak, MD, MBA, FACEP. We also submitted Resolution 54: Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions, which was adopted by the Council.

FROM THE PRESIDENT *(Continued from Page 2)*

individual constituents. I encourage you to reach out to your legislators and to attend one of our MCEP Legislative Committee meetings (there is a virtual option!). We as physicians don't always like to hear it, but lobbying our legislators also takes money, and your MCEP membership dues help. I would also encourage you to donate to the Michigan Emergency Doctors Political Action Committee (MEDPAC) as this will help the College promote legislation that is beneficial to not only Emergency Medicine, but the healthcare profession in general.

MCEP is always advocating for you and our mutual patients. We all must continue to be engaged with our hospital systems and legislators to ensure safety for ourselves, our colleagues, and our patients. §

1. http://www.legislature.mi.gov/documents/2023-2024/billintroduced/House/pdf/2023-HIB-4550.pdf
2. Resources - SAFE PATIENT CARE ACT | Save Lives | Support Nurses (misaferhospitals.org) https://www.misaferhospitals.org/resources.html#research
3. California's mandatory nurse staffing ratios: Key lessons 2 decades in (beckershospitalreview.com) https://www.beckershospitalreview.com/nursing/californias-mandatory-nurse-staffing-ratios-key-lessons-2-decades-in.html
4. Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care (chcf.org) https://www.chcf.org/wp-content/uploads/2017/12/PDF-AssessingCANurseStaffingRatios.pdf
5. New Data Show Enrollment Declines in Schools of Nursing, Raising Concerns About the Nation's Nursing Workforce (aacnnursing.org) https://www.aacnnursing.org/news-data/all-news/new-data-show-enrollment-declines-in-schools-of-nursing-raising-concerns-about-the-nations-nursing-workforce#:~:text=Data%20from%20AACN%27s%20Fall%202022,(see%20trend%20chart%20below).
6. Association between boarding in the emergency department and in-hospital mortality: A systematic review | PLOS ONE https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0231253