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President's Message

Laura Pimentel, MD, MMM, FACEP, President

Health care reform, change, PPACA, bundled payments, access to care, meaningful use, electronic health records, preventing readmissions, tort reform. These terms swim



Laura Pimentel, MD,
MMM, FACEP

through my head daily as I read, think, and take care of patients. While attending ACEP's annual meeting in San Francisco, I spent much of my time attending lectures and presentations on these topics. My objective was to obtain a better sense of what our future may bring by listening to emergency medicine's thought leaders.

The opening session was fascinating. A political analyst postulated on the future of the Patient Protection and Access to Care Act. His comments suggested that the act itself may not survive the next major election cycle and/or the Supreme Court decision. It is almost assured, however, that regardless of the future of the legislation itself, several of its concepts will be implemented during the next few years. Among these are "pay for performance" and bundled payments to physicians and hospitals for defined services. Policy makers strive to reduce cost and maintain quality by paying for patient outcomes rather than volume of services; bundling payments should align the incentives of physicians and hospitals and reduce the costs of coding and billing. It is crucial that emergency physicians are at the table when the details of these strategies are defined to represent the interests of our patients and colleagues.

Another memorable talk was Dr. Brent Asplin's lecture on Health Policy. The theme of his presentation was that US medicine is on an unsustainable fiscal path. He stated that 1% of patients account for 30% of all health care spending and 5% account for 50%. Though I knew the distribution was skewed, I was shocked by those statistics. They reminded me of Atul Gawande's Hot Spotters (New Yorker, 1/24/2011). Surely, most of the top 5% are frequent ED patients; this extremely serious national problem may be an opportunity for American medicine's systems experts, the emergency physician community.

As I write this, the most immediate question I debate with colleagues is the best path forward for the specialty of emergency medicine. The broad answer is that we must add (even more) value to the system. Though one might think that providing 30% of unscheduled care including nearly all acutely ill and injured patients and serving as the safety net for the entire population 24/7 for less than 3% of the whole health care bill is reasonable value, we will be asked to do more to maintain current departmental resources and compensation.

I suggest that closer partnerships with our hospital medical staffs, nurses, and administrators are in order. Our knowledge of patients and systems are invaluable for successful initiatives to establish observation services and prevent unnecessary readmissions. Some ED physicians are already participating on disease management taskforces. Others lead or participate in patient safety initiatives such as hand washing, medication safety, and standardized

communication processes for hand-offs. Our thinking is morphing from the level of the individual doctor-patient relationship to the management of our emergency departments as a population of patients.

My theme today is change; change is difficult but also presents exciting opportunity. Maryland ACEP has been undergoing a season of change over the course of this year. This past April, we underwent the biannual change of chapter officers. We are well served by Vice President David Hexter (Med Chi past president); Secretary Steve Schenkel (Chief of Emergency Medicine at Mercy), and Treasurer Bill Jaquis (Chief of Emergency Medicine at Lifebridge Health).

Our chapter committees remain active and vibrant. The new chair of the Public Policy Committee is Orlee Panitch, a partner with MEP. Orlee has brought wonderful energy and organizational skills to public policy, and has already established relationships and communication with key legislators. The new chair of the Education Committee is Mike Winters. Mike is an Associate Professor of Emergency

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EMS Update

By David Hexter, MD, FACEP

EMS Board

Richard Alcorta, MD, FACEP

State EMS Medical Director

Helicopter Replacement: The Eurocopter Dauphin fleet utilized by the Maryland State Police is over 20 years old, and is going to be replaced. The Maryland General Assembly has approved the purchase of eleven AgustaWestland 139 aircraft. Delivery of the first two aircraft is anticipated in summer 2012.

The new aircraft are larger and carry two pilots, and will include the latest avionics and equipment to meet FAA Part 135 certification and Commission of Accreditation of Medical Transport Systems (CAMTS) standards. They will be placed in service immediately upon completion of training of aircrews, first responders, and specialty referral centers.

New Protocols: The EMS Board approved new protocols that will take effect July 1, 2012. One major change is that all cardiac arrest patients with return of spontaneous circulation will be transported to Cardiac Intervention Centers (by air or ground) to maintain hypothermic intervention (for adults only) initiated by EMS and for cardiac catheterization. Pediatric arrests with ROSC (no hypothermia by EMS) are encouraged to be taken to Children's National Medical Center or Johns Hopkins Children's Center by EMS. The Wilderness Protocol that permits EMS providers to provide care in remote areas where EMS care is not readily available has been updated. Finally, the MOLST form has been integrated into the protocols. These updates will be covered when you take the Maryland Base Station Annual Update Course, which can now be completed through the MIEMSS online website, at your convenience.

Ambulance Safety Task Force: Maryland averages 390 ambulance crashes per year --more than one per day. A MIEMSS-appointed Ambulance Safety Task Force made the following recommendations to reduce this unacceptable crash rate:

- Screen ambulance drivers (driving records, fitness for duty, etc.)
- Ensure initial and refresher driver training

- Increase restraint use
- Reduce excessive speed and routine use of lights and sirens
- Improve monitoring and enforcement of safety practices
- Create an ongoing statewide forum for ambulance safety issues.

EMS Electronic Patient Care Record: The current eMAIS system is being replaced with eMEDS (ImageTrend®) electronic patient care reporting system, which provides improved reporting capability, faster interface, compliance with national data elements, mobile applications, billing export, and computer-aided dispatch interface. A hospital dashboard is also available to access electronic patient care reports by the receiving hospital. eMEDS has the potential to interface with hospital-based information systems and health information exchanges. All counties except one will be using eMEDS once the rollout is completed. MIEMSS is also attempting to link the eMEDS record to the Health Information Exchange.

Transition to national EMS educational standards: As Maryland transitions to meet new national EMS educational standards by March 2016, the names of our providers will change as follows:

- First Responder becomes Emergency Medical Responder
- Emergency Medical Technician-Basic becomes Emergency Medical Technician
- Emergency Medical Technician-Paramedic becomes Paramedic.

Intermediate-99s (Cardiac Rescue Technicians) will still be recognized in Maryland, but are encouraged to become Paramedics.

End-of-Life Care: The law that creates a new EMS /DNR form known as Medical Orders for Life Sustaining Treatment (MOLST) took effect on October 1, 2011. MOLST is an easily



David Hexter, MD, FACEP



Richard L. Alcorta, MD, FACEP

recognizable DNR form that can be honored by EMS providers, all health care providers and healthcare facilities, since it consolidates all the necessary documentation into a single form. The new form is available at <http://dhmh.maryland.gov/marylandmolst/>. Final MOLST regulations are anticipated in early 2012. Until that time healthcare facilities and programs should refine policies and procedures related to end-of-life healthcare decision-making.

Practice Updates

Physician Data Restriction Program

The American Medical Association created the Physician Data Restriction Program (PDRP) in 2006 to offer physicians the option to restrict their prescribing data from pharmaceutical sales representatives.

As of June 2011, more than 28,000 physicians have registered for the PDRP since its inception in July 2006. An AMA survey found 96% of the physicians who expressed an opinion on PDRP were either satisfied or very satisfied with the program. The PDRP is offered and promoted to all physicians, both AMA members and nonmembers. Approximately 75% of the physicians enrolled in PDRP are nonmembers.

To learn more about PDRP, visit the AMA's website, ama-assn.org/go/prescribingdata.

Public Policy Update

Orlee Panitch, MD, FACEP

Chair, Maryland ACEP's Public Policy Committee

The fall season of the Public Policy Committee has been quite busy. As a committee, we created a legislative agenda that outlines the issues of concern to emergency medicine in Maryland in 2011. Collectively, we decided that we must focus on:

- the challenges of reforming our healthcare systems while being mindful of the impending influx of patients due to expanding insurance coverage.
- the need to successfully recruit and retain physicians in Maryland, particularly in the rural areas.
- the challenges we face regarding the treatment of psychiatric and substance-abuse patients.
- the challenges of implementation of electronic health records
- the issues of medical liability in the new, more cost-conscious environments that limit utilization of services.

We are united in the sentiment that emergency physicians must have a voice in the discussion of implementation of change.

It is with this mandate that we set out to discuss our issues this fall with key legislators. In September, the Public

Policy Committee met with Senator Rob Garagiola at Shady Grove Adventist Hospital in Rockville. As the Majority Leader of the Senate, Senator Garagiola was instrumental in the passage of the Assignment of Benefits Legislation, passed in 2011. We discussed insurance issues as well as staffing concerns, and the senator provided us with insight into the operations of the senate and guidance in how to effectively advocate. A brief discussion of medical liability reform followed, and we were encouraged to delve more deeply into this area as reforms are rolled out.

In October 2011 the Public Policy Committee convened at Calvert Memorial Hospital where we were joined by Senate President Mike Miller. President Miller was very generous with his time and guidance. We discussed the issues of retention of physicians and the critical shortages in the rural areas of Maryland. President Miller himself brought up the subject of liability reform, including a discussion of the reliability of expert witnesses. President Miller was supportive of further exploration into reform.

In November 2011, the Public Policy Committee convened at Civista Hospital in La Plata, Maryland. The meeting was

well attended with a long roundtable discussion covering issues concerning liability reform, representation and the SGR.

In December, the Public Policy Committee held a teleconference to discuss the proposed changes in the Maryland Medicaid system. We will be watching closely as Medicaid both expands (in enrollees) and contracts (in budget) in the coming months.

There have been many opportunities to advocate this fall. Members have attended a number of functions for legislators, to continue to improve and grow relationships. This fall Maryland ACEP has reached out to the following legislators:

Senators Frosh, Garagiola, Kasemeyer, King, Klausmeier, Middleton, Montgomery and Shank. Delegates Barkley, Brochin, Bromwell, Cullison, Frick, George, Glass, Jones, Kaiser, Ariana Kelly, Kevin Kelly, Mizour, Morhaim, Norman, Pugh, Reznik, Szeliga, Tarrant, Valentino-Smith, and Wood.

Many thanks go out to the Maryland ACEP members who have given of their time to participate in these efforts.

Emergency Medicine Opportunity

Osler Drive Emergency Physician Associates (ODEPA), a well-recognized Emergency Medicine group in Towson, MD at St. Joseph Medical Center (SJMC) has opportunities for full-time and part-time BC/BP Emergency Medicine physicians. Physicians at ODEPA are rewarded with a productivity-based compensation model.

St. Joseph's is a 364-bed, acute care regional medical center, recognized numerous times as one of the nation's top heart hospitals. This Level II facility has a 28-bed ED, a 10-bed fast track, and an annual ED volume of 50,000. Ample and equitable coverage is provided by both physicians and mid-levels.

Towson inhabits charm, beauty and the sensible lifestyle you're looking for. With Baltimore in close proximity, the leisure options are endless: from the National Aquarium and the Museums, to the Symphony and several major professional sports franchises, this is your home. If you're looking to get away, the Baltimore/Washington International Airport is only minutes away, making the area easily accessible and an attractive destination for all.

Qualified candidates please contact Sharon Doggett, CPC, PRC at (800) 346-0747, Ext. 6008 or e-mail CVs to sdoggett@psrinc.net.

Legislative Update

Barbara Brocato and Dan Shattuck
Maryland ACEP Government Relations Consultants

Ready, Set, Go...

It has been a busy time since we last wrote, and the 2012 Legislative Session is fast approaching. This past summer brought a special session on congressional redistricting, a new round of deliberations on tax increases and budget cuts; and all the while the work on health care reform has continued to move forward.

The last few months have also seen two members of Maryland ACEP appointed to key committees and boards:

Orlee Panitch M.D. was appointed by the Secretary of Health and Mental Hygiene to serve on the newly formed Prescription Drug Monitoring Advisory Board (she is the only emergency physician) which will be working towards developing regulations and implementing the monitoring program passed into law during the 2011 Session. This is a very important initiative and one of the Governor's key priorities. As the only emergency physician on the Board, she will provide an important perspective as regulations are developed to balance patient protections, safety and access to care.

Steven Schenkel M.D. was chosen by the Secretary of Health and Mental Hygiene to serve on the Health Care Reform Coordinating Council's Subcommittee on Health Care Delivery and Payment Reform. This subcommittee is composed of stakeholders from across the spectrum (insurers, hospitals, health systems, physicians, mental health, etc.); and has an important role in the health care reform discussions (see below).

Health Care Reform:

At the most recent meeting of the Governor's Health Care Reform Coordinating Council (HCRCC), updates were provided on the work being done in Maryland on health care reform. Specifically the HCRCC meeting focused on two areas:

1. The Health Insurance Benefit Exchange – The legislature charged the Exchange, in consultation with advisory committees and other stakeholders, to study and make recommendations to the Governor and General Assembly regarding six domains relating to the Exchange's design, operations, and sustainability by December 23, 2011. The six domains are:

1. Small Business Health Options Program (SHOP)
2. Navigator
3. Marketing/Advertising
4. Operating Rules
5. Market Rules and Risk Selection
6. Financing the Exchange

Once the final recommendations are released, legislation will be introduced during the 2012 session to enact some of the recommendations. We will continue to follow and report as the recommendations continue to develop. Full presentation can be found at: http://dhmh.maryland.gov/healthreform/pdf/2011/HCRCC.Exchange_Update.11.14.11_2.pdf

2. Health Reform Timeline – A broad summary was provided detailing the work completed so far in 2011 and what is planned for 2012. The work has been categorized into the following five areas:

- ❖ Health Benefit Exchange, Eligibility and Enrollment, and Insurance Market Reform
- ❖ Health Care Delivery and Payment Reform
- ❖ Public Health, Safety Net Providers, and Special Populations
- ❖ Workforce Development
- ❖ Communications and Outreach

Full presentation can be found at: http://dhmh.maryland.gov/healthreform/pdf/2011/HCRCC_meeting_presentation.11.14.11_1.pdf

As mentioned above Dr. Schenkel is serving on the newly formed Health Care Delivery and Payment Reform

Subcommittee. The subcommittee will meet quarterly in 2012. The goals of the Subcommittee are to:

1. Achieve cost savings/quality improvements through payment reform and innovation in health care delivery models,
2. Promote improved access to primary care, and
3. Achieve reduction and elimination of health disparities through exploration of financial, performance-based incentives and incorporation of other strategies

The next meeting of the HCRCC is scheduled for Thursday, January 5th.

For more information and to access additional information about the HCRCC, membership, reports, papers and handouts from its meetings, etc.: <http://dhmh.maryland.gov/healthreform/>

The Budget:

The State's operating budget continues to project a significant shortfall between revenue and expenditures of almost a billion dollars. To bridge the gap many program cuts will be examined and implemented, and there will be discussions to increase revenues through possible increases in taxes or an expansion of services that can be taxed.

Of primary concern are health budget cuts. The Department of Health and Mental Hygiene was charged by the Legislature last session to identify at least \$40 million in savings in the Medicaid program. Discussions throughout the summer and fall have explored limiting outpatient hospital visits and establishing copays on ED visits. We have been working closely with the Maryland Hospital Association and other providers



Barbara Marx Brocato

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to ensure that cuts which are unfavorable to patients or physician services are not enacted. During the 2012 Session we will continue to participate and work with the regulators and policy makers to preserve such funding.

On the Federal level the Supercommittee has failed to agree on a package of \$1.2 trillion in budget savings, putting into motion significant across-the-board cuts over the next ten years. This potentially will have a major impact on the state and the millions of dollars in federal funds received making an already precarious state budget more uncertain.

Redistricting:

Over a week in October the General Assembly convened a Special Session to approve legislation to establish the State's Congressional districts. The final legislation and maps can be seen at: Senate Bill 1/House Bill 1 – Congressional Districting Plan: <http://mlis.state.md.us/2011s1/bills/sb/sb0001e.pdf>

During the first month and a half of the 2012 Session the legislature must approve new state legislative districts. The Governor has to unveil his plan on the first day of the session (January 11th), and the legislature has until February 24th to enact its own plan or the Governor's will become final. This will be a hot-button issue as legislators

work to retain the shape and character of their current district boundaries as best they can. For all the latest data, maps and details go to: Maryland Redistricting and Reapportionment Web Site: <http://mlis.state.md.us/Other/Redistricting/redistricting.htm>

Issues and Bills to watch:

While we don't anticipate legislation at this time directly related to health care reform, we do expect to see legislation introduced to implement the yet to be released recommendations concerning Maryland's Health Benefit Exchange, and expect legislation to be introduced addressing health care disparities.

The Secretary of Health and Mental Hygiene has announced that he will be seeking legislation this session to "develop a mechanism to resolve scope of practice disputes between professional occupation boards to facilitate providers practicing to the full extent of licenses". No further specifics were released at the meeting, but we will follow this closely and report back as it continues to develop.

The Maryland Board of Physicians has undergone a sunset review and legislation will be introduced focusing on the function and duties of the Board. The sunset review process occurs at regular intervals, and is a top-to-bottom look at the Board's operations, and is conducted

by the nonpartisan Department of Legislative Services. In particular the review has raised concerns with the Board's responsiveness to complaints, the time it takes to resolve them, and the transparency and openness of meetings.

The sunset legislation coupled with the Secretary's scope of practice initiative will lead to extensive discussion and debate this Session about the regulation and oversight of physicians and how scope of practice issues may be resolved in the future. There could be fundamental changes made to the Board, and we will be engaged in these discussions from the outset.

There may be opportunities to discuss and advocate for liability reform. There is recognition by some policy makers and legislators that with the changes underway and under discussion concerning health care reform, some relief in the tort arena may be worthwhile to explore. Stay tuned for more information as this issue continues to develop.

We and members of the Public Policy Committee will continue to be front and center on these and other issues over the coming weeks and months. We encourage your participation and involvement and invite you to contact us with any questions at 410-269-1503 or Barbara@bmbassoc.com

Medicine and Director of the Emergency Department at University of Maryland Medical Center. He is planning the annual education meeting scheduled for April 2012. Mike already has several wonderful speakers lined up for the meeting. Drew White, chief of Emergency Medicine at Washington Adventist, chairs the Membership Committee. Our membership has grown by nearly 15% as the result of Drew's efforts. Neel Vibhakar, chief of Emergency Medicine at BWMC, chairs the Practice Management Committee. Neel maintains a very active

virtual group of ED directors and leaders who share questions and collaborate on the numerous challenges of management and administration. He conducts biannual emergency department medical directors' meetings and has grown the committee to include representatives from nearly every ED in the state.

The next major change on the near horizon is the selection of a new Executive Director. Our beloved Claire Jefferson has announced her retirement after nearly 17 years of leadership and direction of

the chapter. We are very indebted to her for her years of work and dedication on our behalf. Immediate Past President, Joe Twanmoh, Chief of the Emergency Department at St. Agnes, is guiding the Search Committee toward a decision on this very important position.

As we move toward the holiday season and the turn of another year, I am pleased to be part of a wonderfully engaged community of emergency physicians positioned to mold and guide the future of our specialty.

Practice Management Committee Review

Neel Vibbakar MD, FACEP

Chair, Maryland ACEP Practice Management Committee

The past six months have been an active time for the Practice Management Committee. Below are some of the topics that have been discussed among the various emergency medicine directors, assistant directors, and administrators.

Boarding Observation Patients

Does your hospital require that the attending physician see their observation status patients in the ED prior to transfer upstairs?

There were a total of 10 responses. No one who responded has a requirement at their hospital that the admitting attending physically see the patient in the ED prior to sending them upstairs.

As far as the use of ED space for observation patients, 3 hospitals use ED space for observation patients (with one of those mentioning only very specific types observation patients). The other 7 hospitals who responded do not use ED space as an observation unit, although a couple mentioned that they do board them from time to time in the ED anyway due to a lack of inpatient beds.

Head CT Utilization

Have you been asked to reduce CT utilization based on the proposed CMS measure OP-15 (Use of Brain Computed Tomography in the ED for Atraumatic Headache)?

There was a general concern regarding this measure across the 12 responses and no ED reported a request by the hospital to reduce CT utilization at this time.

MOLST Form

What impact does the MOLST form have on ED physicians?

In a response by Laura Pimentel, President of Maryland ACEP, in collaboration with Dan Morhaim, Maryland State Delegate and Rick Alcorta, Maryland EMS Medical Director regarding support for the MOLST; MD ACEP's support for the bill was contingent on specific language designating accountability for the form's completion. That language was

to make it clear that ED physicians would not be expected to fill out. Emergency physicians are only accountable to respect the patient's wishes as stipulated on the MOLST. The responsibility for the MOLST rests with the healthcare facility's, not the physician. It is to be completed upon discharge from an inpatient admission, not an ED visit. Otherwise it is to be completed upon admission to skilled nursing facilities, assisted living, hospice, etc.

Oral Contrast

Have EDs abandoned the routine use of PO contrast for nontraumatic abdominal pain? If so, how long has this practice been in place? Have you had an increase in the number of repeat CT scans needed? How have your radiologists responded? And do you have any rules around who it applies to?

There were a total of 16 hospitals that responded. The overwhelming majority agreed that the literature shows PO contrast is not necessary in the majority of patients who present with abdominal pain, and many have had discussions with their radiology peers to eliminate PO contrast for certain patient populations.

Of the 16 that replied, 3 have eliminated the routine use of PO contrast, 2 were in the process of eliminating it with new protocols/guidelines, and 1 does not use it for appendicitis cases. None reported an increase in repeat scans.

The other 10, despite discussions with radiology, continue to use oral contrast. Surgery sided with the ED at some hospitals and with radiology at others.

Radiology Discrepancies

With regard to the reconciliation of radiology discrepancies, does anyone using a PACs system feel that they have a foolproof way of "catching" all discrepancies?

There were a total of 9 responses. Seven of those responses were uniform in that there was "no magic bullet," as much of the process has the "human factor" issue. However the PACs system does allow for an electronic tracking mechanism rather than a paper log that makes the process a little easier. To expand on two explanations, one ED in a university setting has a dedicated senior resident review all positive reads for the previous 24 hours and performs a chart review to see whether it was picked up prior to discharge. In another ED, staff has found that a written policy has helped solidify the process. In that process, a recall is generated if the ED neglects to place a preliminary read. While that causes increased work for the ED physician the following day (to ensure the patient was treated appropriately), it works well as a feedback loop from the physician performing the unnecessary recall to the physician who failed to enter the preliminary reading.

Maryland ACEP Reaches Membership Milestone

Maryland ACEP has crossed the 600 mark for enrolled members. This means that Maryland ACEP has gained another councillor to vote on your behalf at national ACEP's Annual Council Meeting, bringing our total number of councillors to seven. Thanks to all who have participated in making Maryland ACEP a growing and viable organization.

Kudos also go to membership chair, Drew White, MD, who is to be commended on his efforts to promote and expand membership. His energy and innovative ideas are welcome and appreciated in helping Maryland ACEP to be an evermore effective advocate for you the emergency physicians, in Maryland.

Maryland ACEP Welcomes New Executive Director

The American College of Emergency Physicians, Maryland Chapter (MDACEP) is pleased to announce it has retained Beverly Lynch, a principal of the Advocacy & Management Group (AMG), as our executive director. Bev has considerable expertise in association management of state medical specialty societies. She has served as the Executive Director and Lobbyist for the New Jersey Chapter of ACEP for the past fifteen years. She brings that knowledge and energy to MDACEP, as its new executive director.

In recognition of her efforts managing the New Jersey Chapter, Bev was named an honorary member of the American College of Emergency Physicians.

Bev will be working closely with Lauren Myers, who has five years of experience working with New Jersey ACEP, and will provide event planning, association management, and administrative support. This team effort provides continuity and personalized service to the members.

Bev and her AMG team plan to assume the responsibilities on January 1, 2012. The MD ACEP offices will remain at the MedChi building on Cathedral Street in Baltimore, and the contact information will remain the same.

AMG has a team in place to advance the already excellent foundation at MD ACEP—and take it to new heights—with increased membership, timely communications, new benefits designed to grow the membership. We anticipate a seamless transition as Bev and her team continue the excellent work already in progress for the annual meeting in April.

AMG currently provides executive direction to two Maryland medical specialty organizations (ophthalmology and sleep), and as both executive director and lobbyist for several New Jersey physician specialty organizations. As state lobbyists, they are also uniquely qualified to oversee and manage contract lobbyists

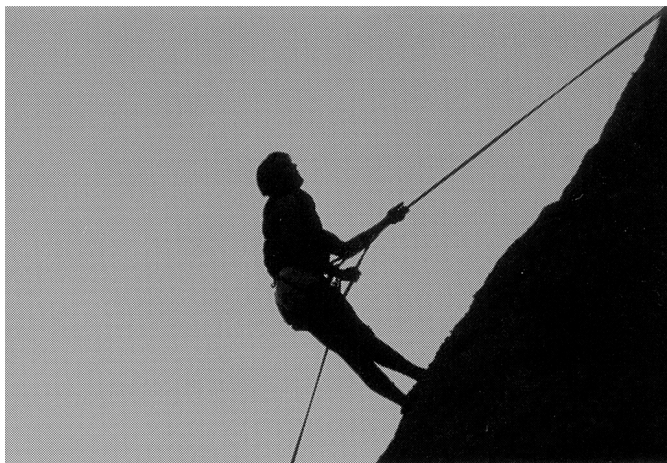
to ensure top performance and proactive efforts. The Search Committee and MD ACEP Board of Directors are pleased with this unanimous decision, and look forward to new programs and initiatives under Bev's management.

Bev's background is "all Maryland" -- she hails from Bel Air, Maryland, and holds degrees from two Baltimore-based colleges. AMG colleague, Patricia White, works remotely out of her Monkton home.

MD ACEP's Executive Director, Claire Jefferson, retires at the end of this year, having served the Chapter for almost 17 years. She has provided MD ACEP with outstanding service, enthusiasm and support and we will miss her. We wish her well in her "retirement," and her future endeavors.

On behalf of the MD ACEP Board of Directors, we extend our warmest wishes for a joyous holiday season.

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Baltimore City Medical Society 2011 Pre-Med Intern Program

Maryland ACEP will again work with Baltimore City Medical Society and their Mini Internship program. As she is interested in emergency medicine as well as other fields in pathology, she will be shadowing Steve Schenkel, MD, in the emergency department at Mercy Medical Center. Laura Minang has been chosen. Please read her bio below.

I come from a family of five, born and raised in Cameroon, West Africa. I love reading, sports (basketball) and music – singing, dancing and playing the organ. Having grown up in a developing country like Cameroon, with a great need for academic institutions, medical personnel and health facilities, I became very interested in pursuing a career in medicine. Personal encounters with nurses and doctors, as they went about attending to patients and how the patients revered them, left an indelible impression on my young mind, and steadily pulled me towards the medical profession. The death of family members and friends without knowledge of the cause of death has intensified my desire of becoming a physician and established in me an interest in research as well.

When I graduated from high school, I sought college education in the United States, and I am currently a biology/

premed student at Johns Hopkins University. Prior to Hopkins, I studied for an associate's degree at Hagerstown Community College where I worked as an office assistant at the Children's Learning Center, and as Home Health Aide and Human Resource Manager at Optimal Healthcare in Hagerstown. Over the summer, I explored my interest in science through a research internship at the National Institutes of Health.

The Baltimore City Medical Society pre-med internship is a stepping-stone toward achieving my goal of becoming a physician because it offers training on the ethical practice of medicine and provides valuable first-hand information from the medical personnel and students already in the field through visits to hospitals and other health institutions. It is an honor to be this year's intern, and I look forward to the wonderful learning experience. Thank you Baltimore City Medical Society!

Thanks to those MD ACEP members who have contributed to EMPACT, our state PAC during the month of November. These contributions help support our legislative efforts in the health care arena, ever watchful of your interests as emergency physicians.

Janos Bacsanyi, MD
Susan Owens, MD
William White, MD

CMS 2012 Medicare Shared Savings/ACO Program

CMS has posted the application for the 2012 Medicare Shared Savings/ACO program. The 21 page application can be submitted between December 1 and January 20 for participation beginning April 1, 2012 and between March 1 through March 30 for participation beginning July 1, 2012. For more information visit www.CMS.gov

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“ABCs” of HIT (Health Information Technology)

The following glossary of frequently used technical terms is provided by MedChi Network Services.

ASP – Application Service Provider

– A vendor that deploys, hosts, and manages from a centrally managed host facility away from the physician practice. Applications are delivered over networks on a subscription fee/rental basis. Also referred to as the Software as a Service (SaaS) Model.

Authentication – The verification of the identity of a person or process through a unique user ID and secure password.

CCHIT – Certification Commission for Healthcare Information Technology

– A recognized certification authority for electronic health records and their networks offering ONC-Authorized and Testing Certification Body (ONC-ATCB) certification for systems to become eligible for the American Recovery and Reinvestment Act (ARRA) Medicare and Medicaid Incentives.

Client/Server – An information-transmission arrangement in which a client program sends a request to a server which then separately processes and fulfills the request. This usually implies that the server is located on site as opposed to the Application Server Provider arrangement.

CDSS - Clinical Decision Support System – Software designed to aid clinicians in decision making by matching individual patient characteristics to

computerized knowledge bases for the purpose of generating patient-specific assessments or recommendations.

CPOE - Computerized Provider Order Entry – The act of a clinician entering treatment instructions and orders for patient services directly into an EHR system.

EHR – Electronic Health Record – A patient health record including treatment history, medical test reports, and images stored in an electronic format that can be accessed, managed, and consulted by authorized clinicians and staff electronically across more than one health care organization.

HIE – Health Information Exchange – An electronic system providing instant and secure sharing of EHRs among approved doctors’ offices, hospitals, labs, radiology centers, and other health organizations.

HL7 – Health Level 7 – The interface standards for electronic interchange of clinical, financial, and administrative information among healthcare oriented computer systems that enable disparate health care applications to exchange key stats of clinical and administrative data.

ISP – Internet Service Provider – An entity that provides a connection to the internet. Connection will be at a bandwidth or data transmission rate which

is the maximum amount of information (Measured in bits/second) that can be transmitted along a channel.

Patient Portal – A secure web-based system that allows a patient to register for an appointment, schedule an appointment, request prescription refills, send and receive secure patient-physician messages, view lab results, pay bills electronically, and access physician directories.

Doc for the Day

It’s time to begin signing up to serve as Doctor of the Day in Annapolis. You and a nurse will be in the first aid room for the day. Feel free to sign up for multiple days! If you would like to participate, please contact:

Stephanie Wisniewski
Legislative Coordinator
MedChi
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Phone: (410) 539-0872, ex 6001
Fax: (410) 263-4207

AMA Secures Redaction of Physicians' NPIs on Revalidation List

CMS recently published a list of providers who have been contacted to revalidate their Medicare enrollment. In response to AMA advocacy, CMS has now revised the list to redact providers’ National Provider Identifier numbers (NPIs)—with only the last four digits displayed—in an effort to guard against provider identity theft. Physicians should periodically check the list of providers who have been contacted for revalidation to ensure that they have not missed their revalidation notice mailing from their Medicare Administrative Contractor (MAC). While CMS has extended the revalidation effort through 2015, physicians who are contacted to revalidate must do so within 60 days or may have their Medicare enrollment deactivated. CMS has indicated

that the first set of providers contacted for revalidation were those who are enrolled but are not yet in CMS’ Medicare Provider Enrollment, Chain, and Ownership System (PECOS). CMS also recently updated a MLN Matters article on revalidation that provides additional information.

List of providers contacted to revalidate (click on “Revalidation Phase I Listing”):
https://www.cms.gov/medicareprovidersupenroll/11_revalidations.asp

MLN Matters article on revalidation:
<https://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf>

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SAVE THE DATE!

Annual Educational Conference and Business Meeting

Thursday, April 26, 2012 Weston BWI Hotel

Many dynamic speakers have been lined up for another spectacular conference!

Be sure to attend!

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