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Photos throughout from our 2011 Annual Educational Conference

President's Message

Laura Pimentel, MD, MMM, FACEP, President

Congratulations to the new officers, board members, councillors and alternate councillors elected at Maryland ACEP's annual business meeting on Friday, April 15, 2011.



Laura Pimentel, MD, MMM, FACEP

This meeting was held in conjunction with our annual educational conference at the Westin BWI Hotel. Thanks to Amal Mattu, MD, FACEP and the Maryland ACEP Program Committee for planning and implementing another dynamic and successful program. The program's success was affirmed by the number of emergency medicine personnel in attendance which included emergency physicians, nurses, physician assistants, and EMTs. The speakers included Jonathan Davis, MD, FACEP; Liz Jazweic; Tina Latimer, MD, MPH; Benjamin Lawner, MD, EMT-P; Joe Lex, Jr., MD, FACEP, FAAEM; Alfred Sacchetti, MD, FACEP; Michael Silverman, MD, FACEP and Stuart Swadron, MD. Thanks, too, to the exhibitors for their support of our educational efforts. Your participation helps to make our meeting successful.

Again this year, it was an honor to be able to present awards to the following people in the following categories:

Neel Vibhakar, MD, FACEP
Maryland ACEP's
Emergency Physician of the Year

Lynn Brown, RN
Maryland ACEP's
Emergency Nurse of the Year

Wade Gaasch, MD, FACEP
Maryland ACEP's
EMS Provider of the Year

Delegate A. Wade Kach
Maryland ACEP's
Legislator of the Year

Congratulations to the awardees for their contributions to furthering the specialty of emergency medicine I would like to take this opportunity to thank Orlee Panitch, MD, FACEP for stepping up to the plate by agreeing to chair our Public Policy Committee. Orlee has been an active member of Maryland ACEP since she began her membership, and has taken an active part in our public policy, legislative and public health issues.

Editor's note – thanks to Laura Pimentel, MD, for her many years and untiring efforts as Chair of Maryland ACEP's Public Policy Committee.

I would also like to extend a huge "thank you" to Joseph Twanmoh, MD, FACEP, for his service as President of Maryland ACEP for the past two years. We have made great strides under his able and strong leadership. Thanks, Joe



Dr. Wade Gaasch accepts the EMS Provider of the Year Award from President, Dr. Joseph Twanmoh.

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 twenty 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 May 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.

Early Helicopter Activation: Early activation is the ability of 911 call centers to dispatch helicopters based on information received from the scene prior to EMS arrival. It was implemented February 2011 at many of the 911 centers. Patients will still be reassessed by EMS on arrival, and helicopters will be cancelled if transport is not needed. MIEMSS will monitor early activation for trends and appropriateness.

Helicopter Utilization: Requests for helicopters dropped substantially in 2008 after protocol changes, but since then, they have been steadily increasing. To monitor for the possibility of over- or under-triage of the lower category C and D patients, MIEMSS monitors trends in the number of patients transferred to trauma centers from community hospitals. These inter-facility upgrades have been increasing as well, but mostly in urban areas where helicopters are rarely used for scene transports. This suggests that the increase in transfers is due not to under-utilization of helicopters for trauma centers, but due to another factor such as the lack of specialists available to care for trauma patients at community hospitals.

Dynamic Helicopter Basing: We know the number of calls for helicopters rises with the increase in population at the beach in the summer. This summer, helicopters will be deployed to Cecil County (Troop 1) and Ocean City

Airport (Trooper 4) during peak days and times to achieve quicker response times in the resort areas.

New Protocols: The new protocols that took effect July 1, 2011 include many changes. Some medication changes include changing morphine to weight-based dosing at 0.1 mg/kg titrated to effect at 2 mg/min, and the addition of dexamethasone for asthma at 10 mg IV/PO for adults or 0.5 mg/kg IV/PO to a maximum of 10 mg for children. The trauma categories have been renamed as Alpha, Bravo, Charlie, and Delta to improve communication by radio. There is a new protocol for ventilator bucking, which calls for midazolam 0.05 mg/kg and/or morphine (if pain) at 0.05 mg/kg, titrated to effect. Finally, a new option for DNR has been added: DNR A (DNI), which calls for maximum effort prior to arrest, but no intubation. These new protocols are covered when you take the Maryland Base Station Annual Update Course, which can now be completed online, at your convenience.

Cardiac Intervention Centers: MIEMSS has designated 23 hospitals (in and out of state) that currently perform primary percutaneous cardiac intervention as Cardiac Intervention Centers. MIEMSS also entered into memoranda of understanding with three out-of-state hospitals to receive STEMI patients from Maryland. The EMS Regional Councils are meeting regularly to address STEMI plans at the regional level. Destination plans for STEMI patients will vary depending on the resources available in each region.

Stroke Centers: The EMS Board approved draft regulations for the designation of Comprehensive Stroke Centers, which will be capable of providing the full array of services expected of a tertiary care referral center, including neuro-interventional radiology. MIEMSS solicited extensive comments prior to requesting EMS Board approval



David Hexter, MD, FACEP



Richard L. Alcorta, MD, FACEP

of these regulations, with the approved version being the 14th draft. MIEMSS will publish them in the Maryland Register, to offer the opportunity for formal public comment.

EMS Electronic Patient Care Record:

The current eMAIS system will be replaced with eMEDS (ImageTrend®), an electronic patient care reporting system, which will provide improved reporting capability, faster interface, compliance with national data elements, mobile applications, billing export, and computer-aided dispatch interface. A hospital dashboard will also be available to hospitals to electronically access the final electronic patient care reports. The pilot phase was successful, and full implementation is expected by the end of 2011. eMEDS has the potential to interface with hospital-based information systems and health information exchanges, but is only in the design phase of development.

End of Life Care: The Governor signed House Bill 82, which provides for a new EMS /DNR form known as Medical Orders for Life Sustaining Treatment (MOLST) which is required to accompany patients between nursing homes and hospitals. MIEMSS, in collaboration with DHMH, has consolidated the EMS/DNR form (Option A-1, A-2 [DNI] and B) with the Life Sustaining Treatment form for nursing homes into a single MOLST form, which shall be recognized by all health care professionals. The new form is available at <http://dhmh.maryland.gov/marylandmolst/>.

"Our commitment to our patients is no longer limited to the clinical skills we demonstrate in the emergency department. Due to the changing dynamics of health care, our profession requires stellar leadership as well as political effectiveness."

-from ACEP's webpage advertising

Leadership and Advocacy Conference, 2011

The 2011 ACEP Leadership and Advocacy Conference is now complete, and I'd like to update you on new developments. The focus of the conference was to provide the tools necessary to maximize our impact as emergency medicine leaders and as advocates. Through the four days of the conference, there were sessions geared to teach policy, the art of advocacy, and to update us all on the transforming health care scene. The goal: stellar leadership and political effectiveness.

A critical component of this conference is spending time, face-to-face with our own legislators: to educate, create relationships, seek support for legislative initiatives and to show appreciation for prior support. This year, ACEP chose two specific areas to advocate for: (A) medical liability reform and (B) Medicare reforms.

Two bills are currently represented in the House--- HR 5 and HR 157. HR 5, the HEALTH Act of 2011 (Help Efficient, Accessible, Low Cost, Timely Healthcare) includes the following terms:

- Limiting non-economic damages
- Instituting of a 'fair share' rule
- Limiting attorney contingency fees to make sure the patient receives the appropriate share of the compensation
- Allowing for the introduction of collateral source benefits at trial
- Providing a reasonable statute of limitations on claims, and
- Allowing for the periodic payment of future damage awards.

The second bill, HR 157, the Health Care Safety Net Enhancement Act of 2011, provides that physicians who provide EMTALA-related services should be eligible for the liability protection that

is available to federal employees under the Public Health Safety Act. Because the nature of emergency care involves serious injury and illness, and providers have little or no relationship with the patient, the treating physicians have much higher liability exposure and subsequently higher insurance premiums. Providing this liability protection to physicians providing federally-mandated EMTALA services will ensure that emergency and on-call specialists remain available to treat patients in their own communities.

Regarding Medicare reforms, ACEP is backing a repeal of the SGR. This year and next, we are scheduled to have a nearly 30% cut in physician reimbursement rates under the current SGR. With the instability and unreliability of the Medicare reimbursement system due to the implausibility of the SGR, Medicare beneficiaries have had limited access to all aspects of care as outpatient physicians opt out of Medicare. ACEP advocates the creation of a stable, reliable Medicare reimbursement system that affords seniors the opportunity to have consistent access to primary care.

Finally, ACEP supports the repeal of IPAB, the Independent Payment Advisory Board. IPAB is concerning to physicians. IPAB will be an independent agency without accountability to Congress, health care providers, or to the public. The implementation of the cost-cutting measures generated by IPAB are then considered to be obligatory. With both the SGR and IPAB in play, physician reimbursement rates within the Medicare reimbursement systems are subject to two independent measures charged to cut costs primarily from physician reimbursement. There is great concern that this may cause a cataclysmic departure of physicians from the Medicare Program. Access to physician care would ultimately suffer.

The Maryland ACEP Delegation met with our Senators' staffs collectively. We spent significant time with Priscilla Ross, Senator Cardin's Senior Policy Aide. Priscilla won an award at this ACEP Conference for excellence in Congressional Leadership. Her interest and dedication to health care was immediately evident. We also met with staff in Senator Mikulski's office. While we were very well-received in both offices, there was no palpable enthusiasm from any staff to support HR 5. At the root of that particular bill lies the conflict of the definition of state's rights. HR 157 seemed to garner more traction--- the argument to be under Federal liability protection is clear and, albeit expensive, nonpartisan. I am hoping that we will be able to continue momentum on this front. Regarding the SGR, there is clearly momentum to create a sustainable formula. The actual 'fix' is quite controversial. However, there is agreement that a final, permanent solution must be found. Finally, in regard to the IPAB, most offices agreed that it is far from a perfect system, and would happily repeal it if there were other cost cutting measures to replace it. We were invited, in earnest, to help problem-solve and create solutions to the cost crisis.

There remains plenty of work for us to do on the National level. Clearly we must continue to foster the relationships we are developing with our legislators and continue to serve as an educational resource to them. And, the lessons learned on the national stage are very applicable to the local scene--- we must continue to be deeply involved. We must be a part of the solution to our national healthcare crisis. It is only through continued advocacy and involvement that we can hope to reform healthcare to be sustainable for our patients, the Nation, and for ourselves--- the providers.

Thanks- and please--- stay tuned!

Summer 2011 Update

Barbara Brocato and Dan Shattuck
Maryland ACEP Government Relations Consultants

This time last year legislators were primarily focused on their campaigns and the 2010 elections. With the elections over and the next round not until 2014, there will be a lot more meetings, briefings, hearings and work groups in the coming weeks and months. In fact there will be a special session held this October, primarily to approve a legislative redistricting plan, but that does not mean there won't be other issues raised. The State's operating budget will be a major topic, as well as proposals to increase revenue to the transportation trust fund.

The State's budget is always on the front burner, given that it is only in effect for one year. While the legislature must pass a balanced budget for the current fiscal year, that does not mean that the budget projections for future fiscal years are in balance. The current state of the economy almost guarantees there will be gaps in revenue vs. expenditures, even before structural imbalances in the budget are taken into account.

In Maryland, a significant portion (28%) of the State's operating budget is allocated to health-related spending. This includes the State Medicaid program, which in Fiscal Year 2012 represents 70% of the health care dollars spent in Maryland.

Specifically as it regards the Medicaid program, the Department of Health and Mental Hygiene (DHMH) will be convening a workgroup of interested parties to:

- (1) Examine the sustainability of special fund revenues supporting the Medicaid program;
- (2) Examine the significant drivers of costs in the Medicaid program; and
- (3) Make recommendations to reduce expenditures and growth in the Medicaid program through program restructuring or any other means. In developing these recommendations, the workgroup shall incorporate recommendations being developed by other existing groups working on Medicaid-related reforms.

DHMH shall submit a report based on the workgroup's findings and recommendations to the budget committee by December 15, 2011, and the budget committee shall have 45 days to review and comment." We are working to make sure emergency physicians have a seat at the table for these discussions.

Discussions continue on federal health care reform and its implementation, paving the way for major changes to health care delivery in Maryland. The Maryland Health Services Cost Review Commission (HSCRC) continues to develop and implement new capitated and fixed cost payment methodologies for hospital services in Maryland, and continues to explore how these methodologies could be extended to include physician services.

The Maryland Health Care Commission (MHCC) is developing regulations concerning the implementation and utilization of electronic medical records,

and at the same time, continues to develop and grow the patient-centered medical home model.



Barbara Marx Brocato

By executive order, the Governor has created the Office of Health Care Reform, to oversee and staff the operations of the Coordinating Council on Health Care Reform established last year. This body is made up of cabinet-level officials, state policy makers and regulators, with the mission to ensure Maryland is meeting the federal health care reform implementation requirements and timelines. Over the summer, a major focus of the council will be the development of the health insurance exchange.

On your behalf, we will work to ensure that the changes proposed and ultimately implemented do not upend or undermine the care you provide to the patients you see every day.

Other issues in the coming months include:

- The July 1, 2011 implementation of the assignment of benefits law that was passed during the 2010 Session. We will work with our bill sponsors and be watchful of how compliance unfolds, with an eye towards how the law impacts the ability to negotiate fairer rates with the insurers;

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Practice Management Holds Successful Meeting

On June 2nd, our Practice Management Committee Meeting met at Baltimore Washington Medical Center with 14 members of the committee. Special thanks to John Wogan, MD, FACEP who discussed "Peer Review, FPPE, and OPPE: Strategies and Solutions." This talk was followed by a roundtable discussion on scribes. Thanks to all who attended. We appreciate your participation, and hope the information presented was useful.

- Working with the Maryland Hospital Association (MHA) on the feasibility of developing a registry of in-patient psychiatric beds;
- Working with DHMH and other stakeholders in the establishment of Maryland's prescription drug monitoring program; and
- Continuing discussions with legislators on medical malpractice liability insurance legislation introduced last session.

The summer months are often a time of transition in state agencies, and most notable is the appointment of Therese Goldsmith, as the new Commissioner of the Maryland Insurance Administration, who will begin her tenure on June 13th. For the last year and a half we had the pleasure of working closely with Beth Sammis, who ably served as Acting Commissioner.

We welcome your new Public Policy Chair Orlee Panitch M.D. She is coming on board at an exciting time in healthcare, and we look forward to working with her and the committee. We especially want to thank Dr. Laura Pimentel, MD ACEP's new President and former Public Policy Chair. During Laura's tenure as Chair, she was always ready and willing to tackle the many issues that MD ACEP faced with great tact and thoughtfulness. We greatly enjoyed working with her as Chair, and look forward to working with her in her new capacity as President.

Stay tuned for an interesting summer, and as always feel free to contact us with any questions or find out how to get more involved!

EMPC Update

*William Jaquis, MD, FACEP
Maryland ACEP Treasurer*

Much like the United States government, the American College of Emergency Physicians (ACEP) has a governance structure that allows for checks and balances within the system. The business of the College tends to be much more effective, however. Many of the resources you see that come out of the College have come through that structure to be vetted.

Two days prior to the annual Scientific Assembly, the ACEP Council has its meetings. The Council is composed of representatives from the state chapters that are allocated based on the number of members in that state. In addition, there are representatives from other interested parties such as ACEP sections. The Council is charged with reviewing the proposed legislation that comes before it in the form of resolutions. Each resolution that comes through the Council is referred to Reference Committees. Those committees hold hearings during the initial phases of Council that are open for comment by the members of Council and the Board. From that debate, the Reference Committee makes recommendations on each resolution. Those recommendations then come back to the Council for the Council as a whole to debate, if necessary, and then to vote.

While there is often latitude on how the Board may choose to proceed with the Resolutions, the Council can certainly drive some of that agenda. As the resolutions that pass come to the Board, the Board then assigns the work of achieving the outcome of the resolutions that made it through the Council floor. Much of that work goes to the ACEP committee structure to develop and then send a product to the Board for their consideration.

It is my privilege this year to Chair the Emergency Medicine Practice Committee (EMPC). You may see an entire list of committees and members, as well as the general scope of each of the committees, on the ACEP website acep.org. In general, the work of the EMPC is on matters that affect your working environment on a day-to-day basis. We start the initial committee year with a set of objectives that have come from the previous year from Council resolutions, that are standard components of our Committee, or that may have come from the Board directly. During the year, there are often additional objectives assigned from the current Council proceedings. Following is the discussion of the objectives for this year.

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Dr. Neel Vibhakar accepting Emergency Physician of the Year Award from President, Dr. Joseph Twanmoh.

Practice Management Committee Review

Neel Vibbakar MD, FACEP
Chair, Maryland ACEP Practice Management Committee

Since the last EPIC Newsletter, the Practice Management Committee has been very active, with noteworthy discussions on a variety of topics that many have, hopefully, been able to utilize to improve the clinical care and patient flow in their emergency departments.

Over the past 9 months, there have been over 12 topics and over 130 emails exchanged among various emergency medicine directors, assistant directors, and administrators. Here is a summary of just some of those topics.

Airway

Who manages inpatient airways?

Interestingly, the responses varied, and demonstrated the different environments we must practice in as emergency medicine physicians. Six stated that their department is not involved in inpatient airways, four stated they respond to ground floor and radiology only, and another four said they will respond only if anesthesia, respiratory, and/or the intensivist is unavailable or needs help. And, this is only at the discretion of the ED physician as long as it will not compromise patient care in the ED. Four respondents stated their ED responds to all inpatient airway emergencies.

Business Cards

Does your group hand business cards to patients, and if so, what is the process for patient call-backs?

As everyone knows, being asked for a business card is the ultimate compliment in the care you have provided with the patient hoping you have an office “on the outside.” Similarly, many have expressed increased patient satisfaction when they do provide business cards and typically the callbacks are compliments about the care they received.

A little more than half stated that their group does have business cards. For those that do, the general hospital/ED number is on the card. In addition, a couple of hospitals have an email address available to patients, while some other hospitals

stated that the physician provides their own phone number or spectralink number with a time that they could be reached if necessary.

Pain Protocols

Has anyone developed a procedure/protocol for dealing with patients coming to the ER frequently for pain-related complaints?

Patients who present frequently for pain-related issues can be challenging, and require the emergency physician to evaluate and balance the current presentation with the previous history that is available to them.

Two EDs have taken on a formal process for the issue. In one ED, staff created a pain policy for chronic pain patients that was approved by their Medical Executive Committee. This policy is posted, and states that chronic pain patients may not receive pain medications. They have strong support from social work as well as support from surrounding pain management clinics. The second ED created pain contracts for those patients who have visited the ED 10 or more times for controlled substances, or who have altered prescriptions in the past. The contract states that they will not receive narcotic pain medications unless they have objective findings. Those charts are flagged at registration, and patients are offered referrals to pain centers.

For other EDs, staff reviewed individual cases and created personalized plans for these patients resulting in a reduction in ED visits.

Some responded that no protocols are used at their institution, with one expressing concern for possibly undertreating patients with occult causes of their pain, as well as having a potentially negative effect on satisfaction scores.

PMD Communication

Does anyone have a good system for communicating with private attendings regarding patients being admitted to the hospitalist service or being discharged home?

Many hospitals instituted combination of actions depending on whether the patient is being admitted or discharged from the ED. The majority of EDs stated that they have the ability to auto-fax the chart and/or summary to the PMD. Some place a call to the PMD even if they use the hospitalist service, and others stated they let hospitalists communicate with PMDs for those patients who are admitted.

PE in Pregnancy

What is your primary imaging modality to assess for PE in pregnant patients: CT angio or VQ scan?

The overwhelming majority of hospitals use CT angio.

Patient Flow

Patient flow, both in the emergency department and as an inpatient, continues to be challenging for every emergency department. There were numerous ideas implemented to help address these challenges, with all recognizing that the crowding issue does not stop in the ED, but continues all the way through the inpatient stay and discharge.

These ideas included:

- 1) Capacity Alerts: triggers for number of patients in waiting room, pages to all directors and admitting office, call for help from floors to take patients to floor and calling in additional personnel
- 2) One call attempt for report, if not successful, automatic call to charge nurse and then send patient
- 3) Monitoring of boarding minutes, priority is placed and measured for review by administration
- 4) Yellow Alert triggers notification of physicians, nursing and administration
- 5) Pre-diversion process: when boarders begin to accumulate, unit directors get paged.

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- 6) LEAN event, general hospital involvement, and setting up time expectations and improving communications with spectralink phones.
- 7) Resource hospitalist who has no clinical responsibility other than to move patients from critical beds (IMC, PCU).
- 8) Hospitalist and resident teams that will accept an admission out of the ED without orders written before the patient goes to the floor.
- 9) Bed Czar who manages house flow and regularly communicates with all areas including the ED.

Bar Coding/Medication/Validation (BMV)

Are you doing CPOE in the ED? Is nursing doing Bar Coding/Medication/Verification (BMV)? Is BMV an initiative in the near future for you?

There were a total of 17 responses. Of those 17 hospitals, 13 currently do CPOE. 3 currently have BMV (with one of those 3 doing it only for boarders). Another 6 hospitals have future plans to initiate BMV.

Radiology Services

Who reads plain films at night at your institution (ED vs radiology vs night hawk)? If ED provides wet-reads, is there any stipend for this service? Does anyone bill for plain film interpretations?

There were a total of 13 responses with a near uniform response. All departments read their own plain films at night, with

some reading them both during the day and night. No ED receives a stipend or directly bills for their interpretations.

Thanks to all who have actively participated in the Practice Management Committee discussions. Your input is the



Drs. Drew White and Arjun Channugam

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Drs. Andrew Stolbach and Jonathan Davis

Public Health Briefs

The Future of Health in Baltimore City

The Report Card

In May of last year, the Baltimore City Health Department issued its “2010 Baltimore City Health Disparities Report Card”, the first comprehensive review and examination of health disparities in Baltimore. Having completed its examination, covering 30 health indicators by demographic and socioeconomic stratifiers, the department issued its final grade --- a “D” --- and is moving forward with initiatives for major improvement.

Commissioner’s Plans

Four months following the release of the Report Card, Oxiris Barbot, M.D., former Medical Director of New York City’s Office of School Health, was appointed to lead Baltimore City’s 1,200 employee health department. In accepting the position, Dr. Barbot noted her training as a pediatrician, as well as her background in

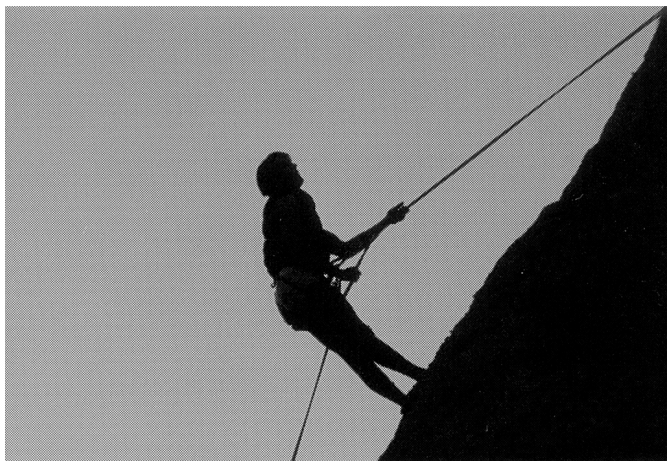
underserved communities and developing policies and programs in primary care and public health.

In a recent keynote address, sponsored by Johns Hopkins Urban Health Institute, Dr. Barbot shared key findings of the 2010 report card and outlined her vision for “Healthy Baltimore 2015.” Her vision is to have a health policy agenda that articulates priorities for action. Toward that vision, she plans to work to create an organizational framework for partners to support and build on improvements in the city’s health and to provide clear and transparent measures of success. A key component of Dr. Barbot’s approach to improving disparities is community engagement. Beginning this year, neighborhoods and communities will engage with the department to identify

one or two key disparities and develop innovative and grassroots initiatives to improve those disparities.

The 2010 Health Disparities Report Card and implementation reports for “Healthy Baltimore 2015” are accessible at www.baltimorecityhealth.org. Comments are encouraged via the department’s Facebook and Twitter pages or you may contact the department on 410-396-4398. (Re-printed from BCMS Messenger, Baltimore City Medical Society newsletter, March/April 2011)

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ACEP's Position on Impaired Drivers

Craig Price

National ACEP Director, Chapter and State Relations

Laws addressing physician reporting of drivers who may be impaired due to seizures or other medical conditions vary widely among the states. While every state allows physicians to report impaired drivers, some mandate that physicians report these drivers to the state or potentially face penalties that could include criminal charges. And, only about half of all states provide physicians with immunity from liability for reporting drivers who may be impaired.

ACEP's position on this issue is contained in the "Physician Reporting of Potentially Impaired Drivers" policy statement, which was approved in April. Check ACEP's website for details.

Chapters with state laws that are inconsistent with the principles in the policy statement may want to consider future advocacy efforts to change their state law. If you are interested in finding out more about the reporting laws in your state, here are a couple of resources that might help.

Summaries of specific state laws on physician requirements to report drivers who suffer seizures or similar disorders are available on the Epilepsy

Foundation web site at: <http://www.epilepsyfoundation.org/living/wellness/transportation/drivinglaws.cfm>

Also, a 2010 report from the AMA entitled "Physician's Guide to Assessing and Counseling Older Drivers" includes a chapter on state licensing and reporting laws, also addressing state laws pertaining

to immunity for physicians who report impaired drivers. For information on your state laws, go to Chapter 8 of the guide, available on the AMA web site at: <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/older-driver-safety/assessing-counseling-older-drivers.page>



Speaker Dr. Stuart Sawdron and Executive Director Claire Jefferson



Dr. Joseph Twanmob, President and Dr. Richard Alcorta, Past President

Objective 1 is to review and provide input to outside organizations on issues that affect emergency medicine practice. The organizations could be the Joint Commission, the AMA or the American Hospital Association. The recommendations from EMPC then go to ACEP leadership to draft responses to the requesting organization. In the past, EMPC has been part of the review process for medication reconciliation for the ED. This year, we have reviewed and commented on the National Patient Safety Goals for the Joint Commission on ventilator-associated pneumonia and catheter-associated urinary tract infections.

Objective 2 is to monitor the environment and make recommendations to the Board on practice management issues including the development of information papers, PREPs, and policy statements. Currently there is no specific activity in this area.

Objective 3 is twofold. ACEP retains a list of policy statements that are generally fairly precise comments that establish an ACEP position on a topic. You can see a list of these on the ACEP website. They are often useful at the hospital level to succinctly state ACEP's view on an issue with which you might need assistance. The policy statements do need to be reviewed periodically. Some no longer are needed, while some need to be restated for the current practice climate. The policy statements this year are Caring for Borders, and Specialty Hospitals. You can see the current statements now on the website, and will then be able to see the changes as they go through the process.

Objective 4 is to continue to develop information to educate members about patient satisfaction surveys including how emergency physicians can assist hospital leaders with appropriate interpretation of the scores and gain leverage in having the hospital partner with the emergency physicians to create an environment conducive to patient satisfaction. This has been a very interesting objective. As you might expect, there is a lot of discussion in the College about how surveys are used. Realizing that surveys of some type are a part of life for all of us, the intent of this

objective is to help our members understand the scope of the surveys and how they can and should be interpreted. There may also be opportunity within this objective to develop a better model.

Objective 5 is to develop a minimal skill set for practitioners in the ED who are not board-certified or residency-trained in emergency medicine. Again, there is a lot of discussion regarding who can, should, and does staff emergency departments throughout the country. ACEP, through this objective, hopes to provide guidance to hospitals where there may not yet be the possibility of staffing the ED entirely with residency-trained and/or board-certified emergency physicians.

Objective 6 is to explore the need for a policy statement regarding alternative methods to intravascular access in the emergency department. Within this discussion might be topics such as use of ultrasound, intraosseus use, and PICC lines.

Objective 7 is to develop an information paper on Federally Qualified Health Centers in clinical practice. For those of you who are not aware of these entities, stay tuned. This subcommittee is producing a paper that is very understandable. Basically, FQHCs may provide some opportunity where they are available to deliver care to those patients who are uninsured or underinsured instead of coming to the ED.

Objective 8 is to work with the Quality & Performance Committee as needed to assess and develop a strategy to repeal the CMS quality measure on pneumonia. DONE!

Objective 9 is to develop an information paper on the use of scribes in the ED. There is a great product coming out of this committee that will discuss the considerations of using scribes. Scribes and scribe companies are increasingly being suggested as adjuncts to the practice of emergency medicine to assist physicians by decreasing the time spent on charting.

Objective 10 is in collaboration with the Academic Affairs Committee and the Rural Emergency Medicine Section, to develop practice and training models for physicians

in rural areas. There is a lot of symmetry with Objective 5 in this, but this considers all physicians both EM-trained and non-EM-trained in using College resources to optimize the knowledge required to practice in a rural setting.

Objective 11 is in collaboration with the Academic Affairs Committee, to develop strategies and resources to teach residents about the cost of care. This objective is just getting off the ground, but represents an opportunity to provide our training program with more knowledge about the practice of emergency medicine in the current environment.

Objective 12 relates to electronic prescription monitoring. The resolution suggests that ACEP support a web-based monitoring program in every state, and look to ways the system can be an asset to the ED without becoming onerous.

Objective 13 came out of Maryland. The objective is to help understand how widespread the practice is of independently staffing the ED with nurse practitioners. In this case, there would be no physician involvement in the care of patients in the ED.

As you can see, there is a great deal of interesting and practical work that comes out of EMPC. All of the work is done by members who volunteer their time and efforts to help each of us who practice emergency medicine have the most efficient and effective practices we can. It is another example of the value the College provides. Thanks to all those dedicated physicians who are involved.

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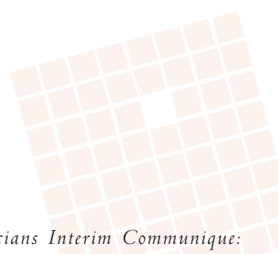
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9/15 Lt. Governor Anthony Brown

LG Brown leads O'Malley administration activities in health care

9/22 Jeff Singer

Executive Director, Health Care for the Homeless

9/29 Jeffrey Levi, Ph.D.

Executive Director, Trust for America's Health

(and Professor of Health Policy, George Washington University
School of Public Health and Health Services)

10/6 Liz Fowler

The White House Health Care Reform Director

10/13 New Maryland Health Care Commission (MHCC) Director

The new director has not been named, but engagement is confirmed
with acting director.

10/27 Lobbyist Panel: Vinny DeMarco and Bob Douglas

Discussing and dissecting Maryland's new alcohol tax legislative
history, process, and politics

11/3 James Corless

Director, Transportation for America: connecting transportation
and health care