President’s Message

Richard L. Alcorta, MD, FACEP, President

Maryland shares in the problems and crises facing emergency medicine nationwide. Yet Maryland has made several inroads into solving these problems through the leadership of Maryland ACEP. I am optimistic that with your help and that of new ACEP members, we will continue to improve emergency department care in the coming months.

Let us look at some common stressors facing emergency departments (ED) and recent advances to alleviate them.

Stressors Facing Emergency Departments

Stressors—some social, some economic—all contribute to the crisis facing emergency departments. These include:

- Government regulations that dictate that everyone has to have access to emergency care, but do not fund this care. The emergency department is the only health care service that is required by federal mandate to assess and treat patients. This means that every individual who needs health care can come to an emergency department for a screening examination and if medically unstable, that individual must receive care. However, although this federal mandate dictates access to care, it does not ensure funding for that care.
- Declining reimbursements for medical care by both public and private insurance. (In Maryland this is even more disproportionate for ED physicians when compared to surrounding states.)
- Increasing number of under-insured and un-insured patients, resulting in larger percentages of uncompensated patient care than in the past.
- Perceived increasing acuity of patients going to the emergency department.
- Increasing malpractice costs.
- Decreasing availability of emergency departments and of hospitals. (This, in turn, leads to a declining number of ED patient care and inpatient beds. Between 1993 and 2003, there was a nationwide loss of over 425 EDs, 703 hospital closures, and a loss of over 198,000 inpatient beds in the face of ever-increasing demand.)
- Decreasing number of specialists willing to take on-call rotations for the emergency department.

All of these stressors are inter-related. For example, we can look at the on-call specialist shortage in the emergency department.

On-Call Specialist Shortage in EDs

Nationwide, hospital EDs find it increasingly difficult to provide 24/7 availability of specialists for their patients. This is probably due to several factors, including inadequate (under-compensated and un-compensated) patient care; the rising cost of malpractice insurance premiums; the fear of malpractice claims that continue to increase; rising overhead costs for physician offices; and the growing number of ambulatory surgery/specialty centers. In addition, the recent Federal interpretation of EMTALA (Emergency Medicine Treatment & Active Labor Act) that specialists do NOT have to accept on-call rotations in the ED has probably contributed to the current specialist shortage in EDs. Obviously this shortage affects patient care—some EDs can no longer provide 24/7 specialist coverage, forcing patients to be transferred to facilities that have such specialists, and those that do must often pay substantial stipends to the specialists to recruit and retain them. From the patient’s perspective, this results in reduced access to timely essential health care.
The Maryland Board of Nursing published an updated Declaratory Ruling on 2/26/06 entitled “RN Administration of Procedural Sedation for Operative, Invasive, and Diagnostic Procedures and for Episodic Treatments or Therapies for the Adult and Pediatric Patient (e.g., Intravenous, Intramuscular, Inhalational, Oral, Rectal and Intranasal)”1 This ruling (as did the previous ruling) states that “the registered nurse may not administer procedural sedation utilizing medications classified as an anesthetic agent to include but not limited to propofol, Diprivan, ketamine, or inhalation anesthetics.” It also states that “the nurse has the right and responsibility to refuse to administer the medication for procedural sedation when the medication is one the nurse is prohibited from administering…” So if you, the physician, decide to administer the medications yourself, “the nurse has the right and responsibility to refuse to administer the patient…” The nurse “must report (to the Board of Nursing) when he or she has refused to administer or monitor the patient…”

The updated ruling now permits physician assistants (PAs) to order procedural sedation under an approved delegation agreement in which procedural sedation is specifically listed as a part of the PA's practice.

ACEP and the Emergency Nurses Association (ENA) have already addressed procedural sedation in a policy which states “ENA and ACEP support the delivery of medications used for procedural sedation and analgesia by credentialed emergency nurses working under the direct supervision of an emergency physician. These agents include but are not limited to etomidate, propofol, ketamine, fentanyl, and midazolam.”

The joint ACEP and ENA policy was created in response to a joint American Society of Anesthesiologist (ASA)/American Association of Nurse Anesthetists (ANA) policy which states propofol should be administered only by persons trained in the administration of general anesthesia, who are not simultaneously involved in these surgical or diagnostic procedures.” They also state that “failure to follow these recommendations could put patients at increased risk of significant injury or death.”

Clearly there is a lot more politics than science here—emergency physicians and nurses have been administering procedural sedation safely for years—and who is better trained to handle an airway or other complication? The literature supporting the safe and effective administration of the prohibited agents has rapidly expanded over the past decade.

A similar situation that evolved in South Dakota was reversed after a coalition with anesthesiology, nursing, and leaders of several prominent medical centers along with support from national ACEP’s EM Practice Department made a presentation of the facts to their Board of Nursing.2

Unfortunately, this Declaratory Ruling has already has put us in conflict with nurses at several facilities in Maryland—it is only a matter of time before the rest of our nurses discover their Board’s policy on procedural sedation, and refuse to carry out our orders. Maryland ACEP recognizes the importance of this issue and will continue to make it a priority on behalf of our members and our patients.

(Footnotes)

KUDOS TO:

Joseph Twanmoh, MD, FACEP, for being named Chairman of Emergency Medicine at St. Agnes Hospital.
Congratulations!

Thanks to Maryland ACEP’s membership for their efforts in helping to support this year’s membership drive. We made it to “Honorable Mention” for obtaining 10 or more new members.
Congratulations – A Report on the Outcomes Congress for the Maryland Patient Safety Center Emergency Department Collaborative

Stephen Schenkel, MD, MPP
Chair, Maryland Patient Safety Center Emergency Department Collaborative

The Maryland Patient Safety Center ED Collaborative held its Outcomes Congress on Friday morning, June 8. Approximately 60 people attended, representing over a dozen emergency departments.

As Collaborative chair, I’m a bit sad to announce that the final workshop, the Outcomes Congress, has come and gone. The Collaborative brought together a terrific group of people, all of whom care passionately about emergency medicine, and are dedicated to the care of the people of Maryland. This group proves that it is a special breed of people who find themselves in this area of medicine—a group that thrives on the unpredictable, and brings to it creativity, persistence, and wisdom.

The morning opened with a presentation by Delegate Brian McHale from District 46 in downtown Baltimore. Delegate McHale was instrumental in developing Maryland’s Patient Safety Center. He sees the wisdom of this approach to quality in healthcare and has worked at the legislative level to assist efforts in patient safety across Maryland. He spoke to the importance of our work as a medical safety net, but most impressive, he stayed through the morning to learn what the Collaborative had done. Delegate McHale thanked us for our commitment to providing care at all hours every day—and we thanked him for his efforts in helping us improve the care we provide.

Our keynote speaker, Dr. Bruce Siegel, Director of the Robert Wood Johnson Foundation sponsored the Urgent Matters program on improving patient flow, visited from the Department of Health Policy at George Washington. Dr. Siegel presented a brief history of emergency medicine, noting the continuing efforts in emergency medicine to maintain access to care and patient flow—and pointed out the strong connection between these two efforts. The history of emergency medicine provides a window into our medical care and our medical safety net, and, most notably, into this period of dramatic change and turmoil. Dr. Siegel predicts that out of the turmoil will come more emphasis on measurement and accountability, and that there will be opportunity for EDs already experienced in data collection and systems-based improvement.

While not all the data are in, a Collaborative summary provided a picture of the work, lessons, and successes of the Collaborative. Twenty-eight hospitals participated over the eighteen month span of the Collaborative, including two patient safety surveys, three workshops, and the development of a learning network. The fundamental place of flow in patient safety has been one of the themes of the Collaborative. At a time of increasing volumes, one-third of participating EDs have held steady or reduced yellow alert hours and one-half have held steady or reduced red alert hours. Almost one third have reduced length of stay by 20 minutes or more. Interestingly, during the course of the Collaborative, several papers emerged that directly linked waiting times with mortality, demonstrating the fundamental connection between flow and patient safety.

A second fundamental lesson of the Collaborative was the enormous amount of work going on in our EDs. Even with increasing volumes, nurse and physician shortages, ambulance diversion, and in-patient boarding, EDs in the Collaborative trialed multiple approaches to multiple patient safety challenges. With regards to patient flow alone, EDs trialed fifteen distinct approaches. In the clinical realms of pneumonia care, sepsis care, and bloodstream infection, EDs trialed a total of at least eleven different approaches. Within this variety lay another lesson of the Collaborative. Different departments met with different levels of success even with the same intervention. Like our patients, our departments are unique, and while we share innovations and ideas, one particular approach may work better within one ED culture than another.

Most valuable of all the Patient Safety Collaborative workshops were the reports by the teams and June 8th was no exception. Three teams reported on work they did, which led to valuable discussion around the room.

Michael Franklin and Andi West-McCabe from Atlantic General reported on the implementation of a thirty-minute emergency department service guarantee. They discussed the many steps necessary to bring this about—from executive involvement to generate publicity, to cross-culture bridging, and emphasis of a consistency of purpose to the development and implementation of new treatment protocols. A throughput team, including a community representative, met bi-weekly. They noted that the definition of quality

MD PATIENT COLLABORATIVE continued on page 10
During the 2007 legislative session, Maryland ACEP took active positions on numerous bills. From the healthcare perspective, the session was one of delay and deferment. While there was general agreement on the need to improve access to health care, no bill passed the legislature this session. Concerns about the significant upcoming budget deficit inhibited this initiative. Maryland ACEP strongly supported bills designed to enhance physician reimbursement. The only one that passed was SB 107 which authorized creation of a Governor’s Task Force on physician reimbursement. Our chapter has lobbied hard to place an emergency physician, Dr. Joseph Fastow, on the task force. Dr. Fastow is a board certified emergency physician and former president of Maryland ACEP. He has had a distinguished career as a clinician, teacher, administrator, and advocate for Maryland’s patients and physicians. His knowledge of the state health care system and the economics of physician practice are unparalleled. We will not know the results of our efforts until the task force membership is finalized, which should be any day.

This just in — Dr. Fastow was appointed to Governor O’Malley’s Task Force on Access and Physician Reimbursement. Congratulations, Joe.

Other items of note from the session were primarily defensive. We successfully opposed bills supported by the trial lawyers to weaken the laws currently protecting physicians sued for malpractice. HB 495 would have repealed the requirement that a plaintiff’s medical experts file a report of medical injury supporting a malpractice claim before an action is initiated. HB 110, also defeated, would have reduced the standard for recovering damages from a malpractice claim from contributory negligence to comparative negligence. This would have been devastating to physicians by substantially increasing malpractice premiums.

Emergency physician and State Delegate Dan Morhaim sponsored HB 682 “Health Care Decisions Act - EMS ‘DNR Orders - Health Care Providers.” This bill, supported by Maryland ACEP, extended legal protection for carrying out valid DNR orders beyond EMS providers to all authorized health care providers. Delegate Morhaim’s bill passed.

Since the legislative session, the Public Policy Committee had a very energetic meeting at Baltimore Washington Medical Center. Delegate Nic Kipke, representing District 31, attended. He was given a tour of BWMC’s ED followed by an hour in discussion with committee members. Our key issues and potential solutions were presented to Delegate Kipke. These included ED/hospital overcrowding, breakdown of the mental health system, low physician reimbursement and resulting exodus of physicians, crisis in subspecialty coverage, and the need for effective tort reform. Delegate Kipke pledged his ongoing interest and support. We plan to invite legislators representing members’ districts to future public policy meetings.

Senator Rob Garagiola visited the emergency department at Suburban Hospital recently at the invitation of Dr. Robert Rothstein. Dr. Rothstein and our president, Dr. Rick Alcorta, had the recent honor of attending a dinner with Governor O’Malley, Senator President Mike Miller, and other senior administrators and legislators. Our issues were personally discussed with the Governor and Senator by these able representatives.

Maryland ACEP continues to benefit from the extremely effective guidance and lobbying of Barbara Brocato and Dan Shattuck. The access to key senior governmental officials that we enjoy is largely the result of their work.

Any Maryland ACEP member interested in further information on our public policy efforts, attending a meeting, or joining the committee are invited to contact me at doctorlaura3@gmail.com.
CPOE and EMR

Joseph Twanmoh, MD, FACEP,
Secretary, Maryland ACEP and
Chair, Practice Management Committee

I remember taking a trip to Disney World for a family vacation in 1998. One afternoon, we stopped for lunch at one of the theme park restaurants. The food was fairly forgettable, but what I remember most about that meal was when we gave our order to the waiter, he was carrying a hand held device that wirelessly transmitted our order to the kitchen. The waiter did not have to walk to the kitchen to place the order. From our table, he could move directly to the next one without interruption. Wow, I thought, wouldn’t that be cool to have in the ED. Instead of writing orders on a chart, placing the chart in a rack behind several others, and waiting for the unit secretary to enter the orders, I could order tests at the bedside and move on to the next patient. Alas, such dreams only occur at Disney World.

However, this fantasy is slowing coming to reality. At a recent meeting of the Practice Management Committee, a number of medical directors met to collaborate and share information regarding computerized physician order entry (CPOE) and electronic medical records (EMR). CPOE is more common at the present time. From a flow and safety standpoint CPOE, theoretically makes sense. Why write orders on paper, only to have those orders transcribed into a computer by another person? Besides the redundancy of the system, issues of legibility and transcription error exist. If an error occurs, is it the fault of the unit secretary for misinterpreting the physician’s handwriting or for not confirming an illegible order? Since so many physicians (myself included) have such poor handwriting, do we send those physicians to penmanship classes?

On the other hand, does it make sense to pay a physician to spend his or her time entering orders when a $10/hr unit secretary can do the same? The answer is, it depends. It depends on whether you build the system correctly and efficiently. And build is the key word. Those who have experienced the journey of CPOE will tell you that hospital information systems do not come with a simple “plug and play” version of CPOE. You must build the order sets for the system to function. They way you want it to. For instance, if you want an abdominal CT to rule out appendicitis, you really need to order an abdominal and pelvic CT. If you want oral and IV contrast, you must order that as well. What you want to avoid is a system where you have to place four separate orders, one for the abdominal CT, one for the pelvic CT, one for oral contrast, and one for IV contrast. This may seem ridiculously simple, but at this time, computers still don’t think. You have to tell it exactly what you want it to do. Thus, the take home message was not to underestimate the time involved with developing and implementing CPOE in your institution. Time spent up front planning will save you headaches later on.

If CPOE is still in its infancy, then EMR can be considered prenatal. The Institute of Medicine (IOM) issued a report concluding that “computer-based patient records are an essential technology for health care electronic records should be the standard for medical and all other records related to health care.” Sadly, that statement was made in 1991. In 2007 the majority of us are still recording with paper and pen. Perhaps more tragically is the huge push by hospitals to implement EMR. It is tragic because the method is to take a user-unfriendly system and force it onto physicians. These systems, marketed by the large information system vendors, are all based on computers, with the smallest versions at least as large as a tablet PC, with many requiring keyboard entry. I find it hard enough to jot notes at the patient’s bedside holding a clipboard, never mind typing one handed while standing and holding a laptop or tablet PC with the other hand. One creative work-around solution is to put the laptop on a cart so that you can wheel the cart/laptop contraption into the patient’s room and enter information. That dovetails nicely with functionality. Sometimes I find it hard just to walk through the crowded hallways of the ED. Now I get to try to wheel this thing with me as well. If that wasn’t enough, one of the members told of a comparative demonstration where salesmen from various EMR vendors were requested to complete an ED chart in real time. These were individuals who were supposedly familiar with their systems and touting the wonders of their EMR. Each vendor was required to complete a chart in 30 minutes. One of the largest vendors was unable to complete a chart in the time required. Can you imagine spending 30 minutes to complete a chart?

The point is that the creators of this new technology are always trying to get the user to conform to their system, instead of creating technology that conforms to the user. Bob Rothstein, who is the ED Chairman at Suburban...
ANNAPOLIS – Now that the session has ended, the real work begins. During the next few months there will be a number of studies, task forces and work groups coming together to examine access to care, health insurance coverage, health care workforce shortages, physician reimbursement, and mental health issues to name just a few. Some of these activities are already underway. For example:

* Delegate Dan Morhaim is chairing the Joint Committee on Health Care Delivery and Financing, which is helping to bring focus to the provider shortage issues. This group has met twice already this summer, with members of Maryland ACEP testifying about recruitment and retention and access issues.

* The Governor’s Task Force on Health Care Access and Reimbursement (SB107) was signed into law and took effect on July 1, 2007. Maryland ACEP submitted a letter to the Governor and the Secretary of Health and Mental Hygiene recommending that Joseph Fastow M.D., M.P.H be appointed to this Task Force.

* The Maryland Hospital Association (MHA) and MedChi (in cooperation with the specialty societies) are conducting a workforce shortage survey and the Medical Group Management Association (MGMA) is collecting data on physician reimbursement in Maryland. The data collected by these studies and surveys will be invaluable to the advocacy efforts to access, reimbursement and tort reform.

* The Maryland Health Care Commission (MHCC) will be putting together a task force to develop a plan to guide the future mental health service continuum. The plan will include a statewide mental health needs assessment of the demand for inpatient hospital psychiatric services and community-based services and programs. Maryland ACEP will have a seat on this task force.

* Maryland ACEP will also have a seat on a work group established by Senate Bill 938 – “Public Health - Injury

Reports – Workgroup”. The workgroup will develop recommendations on whether the reporting requirement should be extended statewide; health care providers or other individuals who should be subject to the requirement; the types of injuries that should be reported; and the penalties for failing to file a report.

*House Bill 949 – “Military Health Care Personnel - Staffing Initiative” requires the Secretary of Health and Mental Hygiene, with the Governor’s Workforce Investment Board (GWIB) and appropriate health care provider regulatory boards, to make findings regarding barriers under the Health Occupations Article to licensing or certifying individuals with training and experience in providing health care through military service that is equivalent to training and experience required for licensure or certification. The findings and recommendations for licensure and certification must focus on meeting employment needs in acute hospital emergency rooms and other units and community-based healthcare settings. They must be determined in consultation with specified organizations and any other interest groups determined appropriate by the Secretary. Maryland ACEP is named in this legislation and will be included in the determination of the recommendations.

We must capitalize on these and other opportunities to lend our expertise and help craft solutions that will address the current health care crisis in Maryland.
Charles Emergency Physicians at Greater Baltimore Medical Center

Charles Emergency Physicians (CEP) at the Greater Baltimore Medical Center (GBMC) is recruiting additional BC/BP EM physicians to join our democratic, single-hospital EM group. We are a stable, growing practice, staffing the GBMC ED for over twenty-nine years, in the fastest growing ED in Central Maryland for fiscal year 2006, caring for nearly 60,000 patients this year.

GBMC completed construction of a new, state-of-the-art ED in May 2004, including:
1. Expanded computer resources throughout the department (all patient examination rooms, hallways and caregiver stations; registration, order-entry, results reporting, PACS image display, and optical medical records review).
2. Expedited imaging with embedded radiology suites and adjacent, 24/7 CT and US facilities.
3. Successful Urgent Care and Pediatrics centers.
4. A waiting room with free internet stations, specially designed children’s waiting area, handsome rosewood furniture/cabinetry, and free local telephone access.
5. Improved clinical operations designed to reduce unnecessary delays (quick look nurse, standing orders, clinical unit coordinator, facilitated X-ray).
6. Outstanding decontamination/Hazmat/Disaster facilities.
7. Valet parking.

GBMC, an independent, community hospital in Towson, Maryland, is routinely a highly-rated hospital, for example:

Despite the fact that we are centrally located in Towson, Maryland, the campus has a restful, bucolic ambience. Visit our web site (www.gbmc.org) for pictures and more information.

The hospital has joint residency programs with The Johns Hopkins Hospital in Obstetrics & Gynecology, Ophthalmology and Otolaryngology, as well as excellent, GBMC-based Internal Medicine and Podiatry programs.

Full-time and part-time positions considered.

For more information contact: John M. Wogan, M.D., FACEP, Chair, Department of Emergency Medicine, GBMC at 410-828-2528 (O); 410-828-2526 (Fax) or jwogan@gbmc.org

I spoke to Maryland’s reimbursement issues in the context of what is happening in other states. It was an opportunity to share what Maryland has gone through over the last 15 years with the balance-billing prohibition and the resulting struggles to ensure fair reimbursement. This meeting reinforced that there is a lot to be learned from other states and their experiences. As the task forces and work groups in Maryland progress, they will undoubtedly look to the surrounding states to see what models do and do not work.

We encourage you to participate in the meetings and work of the Public Policy Committee. We look forward to a busy and productive summer as we work towards the 2008 Session. For a full report on the 2007 Session go to: http://www.bmbassoc.com/mdacep07.html.
Many Thanks.....

To those listed below for their contributions to Maryland ACEP’s PAC (EMPACt) since the last edition of the EPIC. PAC monies enable us to create good will, contribute to important political events, and to express thanks to elected officials who stand up for us in Annapolis. We are a relatively small organization, but we have been able to score some big victories in Annapolis with our “white hat” reputation and a distinct character separate from the medical establishment. Your contributions help significantly to continue our legislator rapport, to educate, and support legislative issues that favor our patients and improve the delivery of quality emergency care in Maryland.

Cory Carpenter, MD
Michael Cetta, MD, FACEP
Robert Corder, MD
David Denekas, MD, FACEP
Dina Esterowitz, MD, FACEP
Kerry Foley, MD, FACEP
Johnnie Ford, MD, FACEP
Neal Frankel, DO, FACEP
Michael Granofsky, MD, FACEP
Sam Hsu, MD
Michael Kent, MD
Daniel Kohn, MD, FACEP
Brian LaRocco, MD

Scott McPherson, MD
David Michaels, MD
Andrew Milsten, MD, MS, FACEP
John Moghtader, MD, FACEP
Steven Remsen, MD, FACEP
Larry Romane, MD, FACEP
Stephen Schenkel, MD, MPP
David Scherage, DO
John Skiendzielewski, DO
Jeffrey Sternlicht, MD, FACEP
Philip Lee Strauss, MD
Douglas Sward, MD

For those members who have not contributed to our PAC, please consider doing so. Our chapter’s legislative efforts can only continue with your support, through your dues and through a PAC contribution.

When your ACEP dues notice arrives in the mail, check off the “PAC contribution” line item for $100 to continue providing the financial infrastructure that allows Maryland emergency physicians to have a voice in Annapolis. If you wish to contribute more than $100, the law requires that you do so by check sent directly to EMPACt at the address on the back cover. We welcome any size contribution and look forward to your support of this important endeavor. Contributions are totally voluntary and there is no penalty for failure to contribute.
Hospital, and his group came up with an ingenious solution. Instead of waiting for the hospital to force a user unfriendly EMR system on them, they developed an EMR of their own. Functionality was a high priority for them. The system could not slow them down when seeing patients. What they came up with was a computer pen and template system. The computer is a device about the size of a medium-sized magic marker. One writes on templated charts made of special grid lined paper that the computer recognizes. Like any templated charting system, documentation is a combination of check boxes and free text handwriting. Periodically during a shift, the physician will dock the pen to a PC and the information from the pen is downloaded. From the PC, the physician will eventually print an H&P that is placed on the chart. Later the H&P is scanned into the hospital information system where it can be retrieved by anyone authorized to access the system. The three PCs are backed up by a single server. Should the server go down, each PC still has copies of the charts in its hard drive.

There are obvious limitations with this system. For one, it is not the fully integrated EMR that hospitals dream of. Handwritten information cannot be abstracted and used for tracking or reporting. It does not interface with order entry or other on-line documentation such as nurses’ notes. However, it does offer a number of advantages over paper. Information in check boxes can be captured and used for data analysis. Charts are never lost anymore. If the medical records department says that the physicians H&P is lost or missing, it can easily be retrieved. Real time feedback on documentation for coding exists, which has improved revenue to the group. Compared to other systems which cost hundreds of thousands of dollars, this one is downright cheap, roughly $10,000 to install; but arguably the biggest achievement is that it moves us closer to an EMR without sacrificing the functionality of paper and pen. It actually makes it easier instead of harder to take care of patients. Rather than reacting to a situation put upon them to change, the emergency physicians at Suburban took the initiative to come up with a creative solution to a difficult problem.

While we are still far from wireless transmission of orders, a la Disney, we are slowly entering the 21st century. The key will be to have systems that are functional and built around the way we take care of patients as opposed to the data.
included not only clinical activity, but speed of coming back to the clinical area and the sense of how much people cared. The new process was tested when volumes almost doubled for a three day holiday weekend—volumes that increased staffing and a robust system handled in stride.

Bonnie Forsh from Washington County discussed the impact of an admissions unit on rates of patients leaving without being seen—a single, significant number to target for change. Increasing ED waiting times and the availability of a physical space nearby helped advance the idea. The plan combines a solid goal, an understanding of ED limitations, and economic efficiency. We wish there were another Collaborative workshop to hear how it all comes together.

Mimi Novello from Franklin Square discussed a number of processes put in place to improve ED flow including the development of ED teams of one physician, three nurses, and a tech. This created a “pull-effect” in the department, drawing patients back to treatment rooms, and simultaneously encouraging people to work together more effectively, especially as they came to know each others’ methods and strengths. Trouble spots in the team approach, especially on days of high volume, led to the development of advanced triage and flex-care areas. All was implemented through iterations of research, process design, trialing, data collection, and evaluation.

The presentations included impressive highlights. A “brag-book” developed by Collaborative participants detailed further strategies developed by seven hospitals to improve event reporting, decrease time to pneumonia care, research the patient experience, solve problems as they come up, implement holding orders, decrease central line infections, and implement a sepsis protocol. All of these are examples of the effort required to improve patient safety. Simply listing them underestimates the creativity, dedication and hard work that has gone into making them a reality—and to the resulting improvements.

As Collaborative chair, it is difficult to write about the final workshop without a tremendous sense of pride. Maryland’s emergency medicine community includes a highly talented and versatile population of nurses, physicians, techs, administrators, and other staff who want to see that patients receive the best care possible. The Collaborative brought together a group of people who proved that despite the daily challenges, we continue to meet the demands placed on our specialty, continue to excel, and continue to improve. In his keynote address, Dr. Siegel noted that we continue to be the safety net in a turbulent medical world. I can imagine no better group to weather the turbulence and see the safety net through intact while pushing for improvement.

Everyone involved in the Collaborative deserves thanks and congratulations. I’d like to thank everyone individually here, but will limit myself to a few. Our core faculty has been superb. Many have been available at a moment’s notice for question or task: Jan Bahner, Tom Falvo, Joe Twanmoh, Bill Frohna, and Shawna Perry. My special thanks to all. The Maryland Patient Safety Center supported the Collaborative from inception through conclusion. Special thanks go to Bill Minogue and Margaret Toth for their continued encouragement. Thanks certainly go to all of our participants, guests, speakers, and assistants who, over the course of two years in planning and collaboration, have made this exciting and creative—and helped patients all along the way. Finally, special thanks to ZeAmma Walker whose dedication and organizational ingenuity has helped improve emergency care for all the people of Maryland. It is truly a privilege to work with so talented a group.

Good News

Maryland ACEP membership has reached 527 members. By passing the 500 mark and gaining another councillor, this gives us more of a voice at the national level. Maryland ACEP now has 6 councillors. Thanks, members, for your support.
On Wednesday evening, August 1, MedChi held a meeting in Osler Hall to discuss the possibility of creating a physician/government-developed fee schedule as an alternative to the current insurance carrier determined reimbursement system. The evening’s event was in response to a resolution that was passed at the April House of Delegates meeting and mandated the Forum. It was conceived by Dr. Sharon Pusin, Chair of our Medical Economics Council, who has represented us in support of physician activities before the Maryland Insurance Administration and the Department of Health and Mental Hygiene.

The evening’s Forum consisted of an introductory presentation by Dr. Pusin describing the current status of physician reimbursement, providing a set of general options we might take, and concluding with a framework and set of parameters for a potential fee schedule. It was followed by two panels:

A Current Physician Panel
- Mary Newman MD — Internal Medicine-large group
- Mel Stern MD — Solo-based Pediatrician
- David Hexter MD — Hospital-based Emergency

A Legislator’s Response Panel
- Senator Mac Middleton — Chairman: Senate Finance
- Delegate Michael Busch — Speaker: House of Delegates

Our MedChi lobbyists spoke to help summarize each of the two panels. Pam Metz-Kasemeyer for the former and Jay Schwartz for the latter. The evening concluded with a Q and A discussion session.

The Forum hosted nearly 100 persons for the dinner/discussion event and even brought in new membership! From the beginning we sought to establish the context of desperation and concern on the part of all physicians regarding the current payment situation (we are in the lowest reimbursement quartile in a very wealthy state with one of the highest costs of living and business expenses in the country). I mentioned that this situation could impact on patient access to care and reduce physician availability to Maryland citizens in the future. We acknowledged the Governor’s Task Force on Patient Access and Reimbursement and the Physician Workforce Study, both of which will quantify and describe this situation in detail.

To further set the tone for the evening, I noted that most physicians would ordinarily be strongly in opposition to a government-operated fee system. The mere fact that this discussion was occurring reflected our extreme desperation at this point. To alleviate the concerns of those physician adamantly opposed to this notion, I mentioned that the evening’s approach was exploratory and open-minded and did not indicate MedChi’s current or future approach but rather reflected our deep concerns with the current payment system controlled by the insurance carriers in the state.

Sharon described the plight of a physician who was recently forced to reach into his personal savings to pay for his rapidly increasing practice expenses while at the same time he was receiving diminishing insurance payments for patient services. She noted that there are antitrust prohibitions which prevent a balanced negotiating process for the physicians. She offered several options we might take which included becoming salaried by a hospital or merging into a large group, or lobbying either for collective bargaining or regulating the medical loss ratios of the insurers. She concluded her remarks by presenting a model for a government operated fee schedule. The new payment system would be based on payments that would be higher than our current prevailing rates. These rates would be created by modifying the Medicare RVST system so they would be fair and reasonable to all specialties. The rates would be increased annually based on a predetermined economic indicator.

Mary noted the value of work performed by primary care physicians on behalf of the patients following surgical procedures or Minute Clinic visits for which they might not receive payment. With overhead rising at 3-8% annually and payments sometimes increasing less than 1%, she asked “How long can we continue” and “must we become a boutique practice?” These low rates of reimbursement contribute to the fact that only 14% of internal medicine residents decide to practice general medicine.

Mel asked the simple question, “Are you better off today than you were in 1993?” Only one person raised her hand in the affirmative. He described the concept of a Physician Reimbursement Board, which would serve as a “state-protected” mediator in negotiations between the insurance carriers and the physicians. This would protect against potential anti-trust arguments raised by the insurers whose fiduciary responsibilities lie not to the patient but rather to their shareholders.

Dave described EMTALA (Emergency Medical Treatment and Active Labor Act), which mandates the provision of medical care without regard to payment received. The fact that insurers can take advantage of this situation and pay fees that may be below costs is one reason that hospitals have difficulty recruiting sufficient numbers of emergency physicians and anesthesiologists, to identify two specific hospital-based specialties. He also reminded the group that physician reimbursement is not included in the Maryland All-Payer system for hospital costs. Therefore, when hospitals supplement the fees paid to a physician they must take resources that would otherwise be used to improve the overall system. He expressed concern that a state-determined fee schedule would probably require...
PRESIDENT’S MESSAGE continued from page 1

Making Changes Within the Maryland ACEP Framework

None of the above challenges are unique to emergency departments of any particular state; they occur across the nation. Maryland ACEP, however, has been a leader in making inroads into ensuring better emergency medical patient care and promoting emergency medicine advocacy within the Maryland Legislature. Examples include the following:

- **Enactment in 1993 of the “Prudent Layperson Standard” which has been adopted by 36 other states (in 1997, it was adopted for Medicare and Medicaid patients).**
- **Removal of the HMO “gatekeeper authorization-to-admit requirement” for the first 24 hours (and later extended to 72 hours) regarding the psychiatric patient who is a threat to him/herself or others and, who, therefore, needs hospitalization. (This reduced one of the barriers to hospital admission for the psychiatric patient.)**
- **Required HMO compliance with Maryland law governing care delivered by hospital-based emergency physicians.**
- **Required HMO reimbursement for medical screening services.**
- **Required HMO “Reimbursement of Non-Contracting Providers.” (HMOs are required to pay providers the greater of 125% of the contractual rate or the UCR as of January 1, 2000.)**
- **Required HMO reimbursement of non-contracting providers for services to trauma patients at designated trauma centers.**

Many of the above have become model initiatives for other states, and Maryland ACEP has offered consultation and advice to some of them.

Where do we go from here?

Even with these advances, Maryland ACEP still has to clarify the 125% non-participating reimbursement methodology to prevent insurance carriers from basing their rate on a single discounted contracted provider and require that insurance companies honor the assignment of benefits.

Your individual involvement can make the difference on many of these issues. You may ask how. The legislative process is truly open, and legislators welcome public and expert input. This allows each of us to provide important messages in a concise and friendly way. Legislators are particularly responsive to their individual constituents, especially those with whom they have had personal contact. You can develop shared interests with your legislators.

It is imperative that we create a competitive and favorable practice environment for health care providers, to strengthen recruitment and retention of specialists and of emergency medicine physicians. By doing this, Maryland will move toward ensuring and maintaining quality patient access to specialty medical care.

The following memo was sent to Maryland Hospital Risk Management Directors, Hospital and Emergency Department Staff and Hospital Executives from Dr. Robert R. Bass, Executive Director of the Maryland Institute of Emergency Medical Services Systems (MIEMSS) regarding “Helicopter shopping” for Interfacility Transports during Marginal Weather Conditions.

The Maryland Institute for Emergency Medical Services Systems (MIEMSS) is the State agency responsible for coordinating emergency medical services in Maryland. MIEMSS also licenses commercial helicopter and ambulance services. Hospitals call commercial ambulance and helicopter services to transfer patients to other facilities when definitive care is emergently required that can not be provided by the transferring facility.

The Federal Aviation Administration has recently identified “helicopter shopping” as a contributing factor in fatal medical helicopter crashes. Helicopter shopping refers to the practice of calling one or more additional medical helicopter services after an initial request for service has been declined. Not infrequently, refusals are due to bad weather or other adverse conditions.

MIEMSS has recently been made aware of several interfacility medical helicopter flights that had to be aborted after picking up patients because of bad weather in the area. In all these cases:

- The medical helicopter services that ultimately provided the transports were unaware that other services had already declined requests for transport because of bad weather in the area.
- The need to abort the flight resulted in significant delays in getting patients to definitive care and posed a significant safety risk to patients and crews.
- Patients would have arrived at the referral center more quickly and more safely by ground ambulance.

Recommendations:

Each hospital should develop policies and procedures to address the use of use medical helicopters for interfacility transfers that address the following:

1) Early consideration of transfer by ground ambulance when a medical helicopter service refuses a flight request due to bad weather or other adverse conditions

2) When there is a compelling medical indication for transfer by air and a potential that bad weather or adverse conditions are localized, any additional medical helicopter services called must be made aware of the circumstances surrounding previous refusals

If you have any questions, please contact Dr. Doug Floccare at (410)-706-0880 or Rene Fechter (410)-706-8511 at MIEMSS
funding by physicians and would necessitate that we provide extensive financial information from our practices to the commission. He concluded by suggesting that the legislature repeal the ban on balance billing and more stringently mandate reassignment of benefits by the carriers.

Pam discussed the implications of the discussion to this point and raised the question of payment for increased technology that will be required to improve patient quality. Should not the physician be able to recoup the cost of additional electronic and computerized systems in the same way that other business are able to increase costs to cover overhead expenses?

The second panel was convened and included two of the most knowledgeable and powerful legislators in Maryland. Senator Mac Middleton has represented Charles County since 1995 and serves as Chairman of the Senate Finance Committee, which has jurisdiction over all Health Policy matters. He acknowledged that most legislators have too much on their plates to fully understand the complexities of physician issues but nevertheless they do recognize the current reimbursement crisis, particularly as it relates to the primary care physician. He advised us that it is most important to come to Annapolis with a unified position when we seek legislation. He thought we were together and clear during our discussions regarding the medical malpractice crisis in 2004 and suggested that we use this approach as a model for our future presentations.

Speaker of the House, Mike Busch, was first elected from Anne Arundel County in 1987. He was Chairman of the Economic Matters Committee from 1993-2003 before being elected Speaker in 2003 and reelected in 2007. He described his longstanding support of physicians and discussed a number of specific actions he has taken on our behalf and in support of our patients, including the Patient Access Bill, Appeals and Grievances, and the override of the Governor’s Vetoes of HB 2 on malpractice premium subsidies. He commented that he became acutely aware of the reimbursement problems when an obstetrician informed him that he had received $3200/delivery in 1990 and only $1800 in 2005. During this same period his malpractice insurance rates had doubled. Speaker Busch warned us that we need to work together or we would find insurance companies reducing payments to the lowest schedules of Medicaid reimbursement. That remains his worst fear, I believe, and why he wants to be helpful to us.

Jay discussed the All-payer System as a current government rate-setting system and mentioned that hospitals benefit from the system and fully support it. He further noted that at its origin (in 1976) physicians were given the option of either remaining in or leaving the system. While the overwhelming majority left, he stated that seven groups still remain, “and they are doing quite well today.”

A lively Q & A session followed with discussants at both the “Pro” and “Con” microphones. A question regarding removal of the balance billing restriction was raised but Senator Middleton doubted that it could be passed this year. Several physicians asked that Maryland repeal its high number of mandated benefits, but Speaker Busch said they were created because insurers were unwilling to pay for reasonable medical expenses. He did not, however, defend the mandate for in vitro fertilization.

Some physicians suggested that Maryland go to a totally free market system, but the Speaker reminded them that several years ago physicians sought legislation that would allow them to participate in some of the existing HMO networks. He also noted that, since the Medicare rates are published, the insurance companies already have a basis upon which to determine their position. Additional requests included being paid for certain administrative requirements and for responding to patient phone calls similar to the billing practices of lawyers and accountants.

The discussion continued for over an hour and the total meeting lasted for two and one-half hours. The two legislative leaders demonstrated their depth of knowledge of this field and their willingness to be supportive of physicians. They said they would best be able to help us when our interests were consistent with the needs of their constituents and the community they were elected to serve. They expressed their concerns over teacher and nursing shortages and certainly did not want to have to deal with a physician shortage as well. They also supported the patient’s ability to see the physician of his or her choice.

At the conclusion of the discussion, MedChi members appreciated the efforts of our physicians in preparing their presentations and the willingness of our legislative leaders to spend their evening with us, coming to Baltimore from Anne Arundel and Charles County respectively. We are quite fortunate to have these particular elected officials in Annapolis who have spent so much of their political careers learning about the complex field of medicine and health care. I want to thank our lobbying team for their continuing efforts to serve and advocate for the House of Medicine.

I am certain that our elected leadership has heard and is sympathetic to our problems, and understand our current desperation regarding current reimbursement. Through this latest MedChi Forum on physician payment we have taken another step toward increasing awareness and addressing the problems with the payment system in Maryland and its attendant impact on restricting patient care and reducing our ability to provide the highest quality of care for our patients.

As a final note, we recently learned that three physicians have been appointed by the Governor to serve on his Task Force: our own members George Bone and Joe Fastow, and Ivan Walks, former Washington, DC, Health Commissioner. We look forward to the first meeting of this most important body.

Reprinted with permission, August 6, 2007 MedChi News
Management Advisory: Ramping Up For PQRI

By Ronald W. Stunz, MD, FACEP
Medical Director, Vice President, Healthcare Business Resources

The Physicians Quality Reporting Initiative officially begins on July 1, 2007 and HBR will begin coding and reporting on selected measures effective this date of service.

As a reminder, the program is voluntary, no enrollment is necessary, and successful participation will be rewarded by a bonus payment of 1.5% of 2007 Medicare covered charges payable in a lump sum in July 2008.

In the final CMS publication of the 2007 quality measures, twelve measures are associated with the E/M codes for Emergency Medicine. Successful participation in the program requires 80% reporting compliance on only three measures.

Here are the important points to keep in mind:

SELECT: the measures that your practice will be reporting. The 12 measures that Emergency Physicians may report are listed in the table, along with our recommendations. You need to report on only three measures to qualify for the bonus however, it is probably prudent to select more than three measures, since you are required to achieve 80% reporting compliance on at least three measures. As an example, reporting on the two EKG measures (for chest pain and syncope) and three pneumonia measures, vital signs, oxygenation, and mental status, would provide sufficient quality reporting to qualify for compensation under the program without being unduly burdensome in terms of documentation requirements. It is critical to select the measures you will report, begin reporting on July 1, and avoid any changes in your selection through the remainder of 2007. HBR will require e-mail confirmation of the measures your practice has elected to report no later than May 31, 2007.

DOCUMENT: the requisite information for each measure in your clinical record. Electronic records and templated charting systems may require some customization to capture certain necessary elements. Please make HBR aware of any substantive changes in chart structure engendered by the PQRI documentation requirements.

REPORT: by submitting the appropriate CPT II codes along with the appropriate Evaluation and Management and ICD-9 codes for the clinical encounter. For our clients for whom we provide coding services only, it is critical that your billing office understand the requirement of reporting these additional codes on the Medicare billing form. There is no formal enrollment for the PQRI program; you will be enrolled automatically by submitting the PQRI’s CPT II codes on your Medicare billing form.

COORDINATE: with your hospital regarding submission of your report. Hospitals will have an interest in knowing which measures their ED groups are reporting. Hospital quality indicators (“Hospital Compare Measures”) may overlap with physician measures, and CMS is calling for “harmonization”, i.e., congruency of these two reports. Because of this overlap, there may be some pressure on ED groups to report on physician quality measures they may not have otherwise chosen. Additionally, the Hospital Compare measures themselves may place additional documentation obligations on your charting, beyond the scope of PQRI.

MONITOR: your progress through your coding and billing departments, since CMS will not be issuing any interim reports. Remember, you must be reporting 80% of the time on at least three measures; the numerator of this fraction is how many times you report, even if the report is a negative, e.g.; “Aspirin not received for acute myocardial infarction”; the denominator is the number of cases of myocardial infarction presenting to the ED between July 1 and December 31, 2007. The clock on the denominator begins ticking July 1, regardless of when you submit your first report. This underscores the need to begin reporting on July 1 and to make no changes in the measures you have selected.

While data will be collected from CMS billing forms based on the NPI number of the individual physician submitting the bill, the bonus payment will be paid in one lump sum in July 2008, payable to the Tax ID of the group practice.

Emergency Physicians are encouraged to participate in the PQRI program, representing as it does CMS’ attempt to begin to compensate physicians based on their performance in selected clinical scenarios. While the 2007 data will not be published by CMS, it is to be anticipated that future data gathered from quality reporting initiatives will become part of the public record, available online to patients and insurers as soon as 2009.

HBR has consistently had a voice in the discussions leading to the promulgation of the measures for the 2007 program, and we will remain proactive with CMS through EDMPA and ACEP as the 2008 program evolves.

We will be scheduling meetings and/or conference calls to discuss the specifics of the PQRI program with your practice in the weeks ahead, and with your assistance and input we anticipate a smooth transition into the July 1 start date.

Further resources from CMS are available online at: http://www.cms.hhs.gov/pqri

Please call me at any time with specific questions related to the program.

Ronald W. Stunz, MD, FACEP
610-668-6476
Rstunz@HBR-Inc.com
2007 Physician Quality Reporting Measures for Emergency Medicine

Aspirin administration within 24 hours for acute myocardial infarction
EKG performed for nontraumatic chest pain in patients over 40
EKG performed for patients with syncope
Documentation of Advance Care Plan or surrogate decision maker for patients >65
Consideration of thrombolytic therapy for acute ischemic stroke
Evaluation for dysphagia in patients with acute ischemic stroke or intracerebral hemorrhage.
Anticoagulation at discharge for atrial fibrillation with acute ischemic stroke or TIA
Antiplatelet therapy at discharge for acute ischemic stroke or TIA
Documentation of oxygenation in community acquired pneumonia (CAP)
Documentation of vital signs in CAP
Documentation of mental status in CAP
Administration of appropriate antibiotic for CAP

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Hydroxocobalamin (Cyanokit®) For Acute Cyanide Poisoning

Bryan D. Hayes, PharmD
Clinical Toxicology Fellow, Maryland Poison Center

Suzanne Doyon, MD, ACMT
Medical Director, Maryland Poison Center

Cyanide is a potent and ubiquitous toxin that can cause rapid clinical deterioration and death if not recognized quickly by the healthcare team. The most common etiology of cyanide exposure in the United States is through smoke inhalation from house or structural fires. Poisoning by cyanide is under-recognized and is thought to be as common as carbon monoxide poisoning from smoke inhalation. Cyanide poisoning should be suspected in all fire victims, especially those exposed to closed-space fires (high heat and low oxygen conditions), and in patients with altered mental status, hypotension, or metabolic acidosis with elevated lactate and excessive venous oxygen saturation. Cyanide causes its toxicity by binding to the ferric ion in cytochrome oxidase and inhibiting oxidative phosphorylation, thereby halting cellular respiration and energy production.

For many years the only antidotal therapy available in the U.S. was the Cyanide Antidote Kit. This three-component kit contains amyl nitrite, sodium nitrite, and sodium thiocyanate. While effective, the Cyanide Antidote Kit also has many drawbacks. The nitrites induce methemoglobinemia which can be potentially deadly in patients with already reduced oxygen carrying capacity, such as those with concurrent carbon monoxide poisoning. Additionally, the nitrites are potent vasodilators which cause hypotension and reflex tachycardia. For patients in shock from cyanide poisoning, this effect can be fatal. There are case reports of pediatric fatalities from dosing errors which resulted in profound methemoglobinemia and hypotension. This has led some healthcare providers to disregard the nitrites altogether and use only sodium thiocyanate. Although the sodium thiocyanate element of the antidote kit is relatively free of adverse effects, it has a slow onset of action rendering it suboptimal for use by itself. One Cyanide Antidote Kit is designed to treat two patients simultaneously. Hospital cost for one kit is approximately $325.

The FDA approved hydroxocobalamin for use as a cyanide antidote in December 2006 and it has recently become available for widespread distribution. It is marketed by Dey, L.P. as Cyanokit®. Hydroxocobalamin chelates cyanide and forms cyanocobalamin (a form of vitamin B₁₂) which is excreted in the urine. The kit contains two 2.5 g vials of hydroxocobalamin as a lyophilized powder. Each vial should be reconstituted with 100 mL of normal saline (not included in the kit). Dosing for adults is 5 g administered as an IV infusion over 15 minutes. A second 5 g dose can be given if an incomplete clinical response is observed. Pediatric patients should receive 70 mg/kg as an initial dose. Due to its red color, hydroxocobalamin causes self-limiting skin reddening and chromaturia in most patients that may last up to a week. Hydroxocobalamin also causes a transient, relative hypertension which resolves within 4 hours. Allergic reactions are possible, including pustular rash and facial swelling. These effects can effectively be treated with antihistamines and steroids. Each kit is intended to treat one victim at a cost of $650. There have been reports of hydroxocobalamin causing laboratory interference with certain colorimetric assays (aspartate aminotransferase, bilirubin, creatinine, and magnesium) due to the molecule’s red color. Although interference with those labs is not of clinical significance in an acute cyanide poisoning victim, a recent study demonstrated the potential for hydroxocobalamin to interfere with cooximetry measurements. An increase in measured carboxyhemoglobin fraction with increasing concentrations of hydroxocobalamin was most notable. These effects need to be considered particularly in smoke inhalation victims with potential for concurrent carbon monoxide exposure, because it may lead to potentially erroneously reported carboxyhemoglobin levels.

The Cyanokit® is a safe and effective alternative to the Cyanide Antidote Kit and has the potential to become the mainstay of therapy for cyanide poisoning victims in the U.S. France has used hydroxocobalamin since 1996 with concurrent thiocyanate administration to suspected cyanide poisoning victims. This option is a suitable alternative given that they have distinct mechanisms of action.

The Maryland Poison Center is available 24-7 to answer all questions and assist in the management of all poisoned patients. Please call 1-800-222-1222 to reach one of our certified specialists in poison information.
Comparison of Cyanide Antidote Kit and Cyanokit®

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<th>Cyanide Antidote Kit (Amyl nitrite, sodium nitrite, sodium thiosulfate)</th>
<th>Cyanokit® (Hydroxocobalamin)</th>
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<tr>
<td><strong>Initial Dose</strong></td>
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<td>Adults: Sodium nitrite 300 mg IV</td>
<td>Adults: 5 g IV</td>
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<tr>
<td>Pediatrics: Sodium thiosulfate 12.5 g IV</td>
<td>Pediatrics: 70 mg/kg IV</td>
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<td>Adults: Sodium nitrite 0.15-0.33 mL/kg IV</td>
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<tr>
<td>Pediatrics: Sodium thiosulfate 1.65 mL/kg IV</td>
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<tr>
<td><strong>Adverse Effects</strong></td>
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<tr>
<td>Methemoglobinemia, vasodilation, hypotension, tachycardia</td>
<td>Skin reddening, chromaturia, hypertension</td>
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<tr>
<td><strong>Cost</strong></td>
<td>~$325/kit (treats two patients)</td>
<td>~$650/kit (treats one patient)</td>
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Another Dynamic Annual Educational Conference

Over 150 people attended Maryland ACEP’s Annual Educational Conference and Awards Luncheon on Friday, April 20 at the BWI Marriott Hotel. An outstanding program was presented. Congratulations to Maryland ACEP’s Education Committee for their planning and support. Kudos to Chair, Larry Linder, MD, FACEP and members Arjun Chanmugam, MD, FACEP; Jon Mark Hirshon, MD; and Amal Mattu, MD, FACEP.

Thanks also go to our supporters for their sponsorship of this event.

Silver Sponsors - Jansen Ortho-McNeil; Med Chi Agency; Montgomery Emergency Physicians.

Exhibitors - Astra Zeneca, Biomerioux, EmCare, Healthcare Business Resources, Med Surge Advances, Sanofi-Aventis and Team Health

Amal Mattu, MD, FACEP received the “Emergency Medicine Award” from Richard Alcorta, MD, FACEP and Jon Mark Hirshon, MD, FACEP

Deanna Lyston, RN, accepted the “Nursing Recognition Award” for Thomas Crusse, RN. With her are Drs. Alcorta and Hirshon.

Pat Gainer, JD, recipient of Maryland ACEP’s “EMS Award” flanked by Drs. Alcorta and Hirshon.

Sheila De Riso, RN, recipient of Maryland ACEP’s “Nurse of the Year” Award with Richard Alcorta, MD, FACEP; Sheila’s supervisor at Montgomery Hospital, Carol Mays, RN; and Jon Mark Hirshon, MD, MPH, FACEP

Richard Alcorta, MD, FACEP, Stephen Schenkel, MD, MPP and Jon Mark Hirshon, MD, MPH, FACEP. Steve was recognized for his exhaustive efforts in making our Town Hall event such a success.

Jon Mark Hirshon, MD, MPH, FACEP received his outgoing president’s awards flanked by Claire Jefferson, Chapter Executive; and Richard Alcorta, MD, FACEP, Incoming President.

Senator John Astle received Maryland ACEP’s “Legislator of the Year Award” with Jon Mark Hirshon, MD, MPH, FACEP, Outgoing President and Richard Alcorta, MD, FACEP, incoming president.
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Emergency-care System Stress Threatens All

Even with a temporary reprieve, the potential closure of Prince George’s Hospital Center due to lack of financial support is yet another symptom of the crisis brewing across the country that is threatening people’s access to lifesaving emergency care.

The residents of Maryland need to take notice.

The Prince George’s Hospital Center’s three trauma centers treat 120,000 patients annually — closure of this facility means an additional 328 trauma patients going to other facilities each day. And be very clear that access to emergency care and trauma care for everyone in the area is threatened when an emergency department closes — it doesn’t matter whether a person is insured or uninsured.

The number of emergency visits continues to increase — one in three Americans will visit an emergency room this year — while hundreds of emergency departments have closed. This means fewer emergency departments serving more patients. In the United States, most emergency care systems are not supported well enough to handle day-to-day emergencies, let alone a disaster or act of terrorism. The nation’s emergency departments are fragmented and stretched to the breaking point, and may soon fail as a critical component of the health-care safety net.

Jon Mark Hirshon, Annapolis

The writer is immediate past president of the Maryland Chapter of the American College of Emergency Physicians.

Commentary

On April 24th, the Maryland Board of Nursing disappointedly failed to do the right thing for patients in Maryland. In what I believe is their myopic wisdom, the Members of the Board did not revise their policy concerning procedural sedation as it impacts patients in emergency departments and intensive care units.

Emergency physicians and intensivists are trained to take care of critical ill patients. We use many medications for this, including anesthetic agents. Our medical licenses and training give us the ability to use these agents. However, the Maryland Board of Nursing restricts the ability of nurses to monitor and recover these patients in certain circumstances. Why is this? There are legitimate reasons for this, because these medications in inexperienced hands can be life threatening. However, as Board Certified Emergency Physicians, we are trained and certified in the use of the agents. Additionally, the current scientific literature shows that these agents can be safely given for procedures in emergency departments.

Why did the Board of Nursing do this? I believe there are two main reasons. First, there is a strong, politically astute nursing constituency, Certified Nurse Anesthetists (CNAs), who view this issue as affecting their income. Whether this is true is open for debate; how many emergency departments have anesthesia (either physicians or CNAs) on call 24 hours a day to help emergently reduce dislocated limbs? As with other time dependent procedures, time delays can adverse impact recovery for many of these injuries. Second, I believe that the Board of Nursing is anxious about being viewed as leaders. While greater than 20 states do not have rules on the use of these agents, and thus allows the use of these medications, only a small number of states have explicitly stated that these agents can be used in this setting.

Why does this decision make a difference? First, it means that when an emergency physician or orthopedist in an emergency department (ED) in Maryland needs to reduce a dislocated shoulder, unless a CNA or an anesthesiologist is available, the patient will be given older medications which are less effective and have greater risk. Second, if the newer medications are used, then ED patient flow will suffer since the emergency physician will need to stop everything else to monitor the patient after the procedure is completed. This is what the experienced ED and ICU nurses are trained to do!

We in Maryland ACEP need your support as we take this battle to all levels of government. Please contribute to our political action committee. It is only through access that we can get our voices heard for this and other critical issues designed to allow us to help our patients.

Jon Mark Hirshon, MD, MPH, FACEP
Immediate Past President, Maryland ACEP