Maryland ACEP
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EPIC

Emergency Physician Interim Communique

In this issue - January 2016

Letter from the President

William P. Jaquis, MD, FACEP

The last year seemed to pass quickly, and we have been in a management transition through the last several months. I am happy to introduce and reintroduce you to a new management team. After several years of working with AMG, we have moved into a relationship with AMR to perform our executive management services. Many thanks go to the MD ACEP executive team, Board, and Committee Chairs in particular for their patience and diligent review to make this transition.

The issue of opioid use and abuse has continued to be in the forefront in the state and in the county throughout this year. The Lieutenant Governor's Task Force has completed its initial report (*click here to read*) which is fairly comprehensive, and the city of Baltimore led by Dr. Wen as Commissioner has this as a high priority as well. I know that all of our Departments continue to refine our efforts toward appropriate prescribing, naloxone use, and will continue to look at possible opportunities to assist with this health care emergency. Once again, we have established our profession as providers who are willing to find solutions where we can, though we know the problems exist far beyond our walls. I anticipate additional approaches in the upcoming year, including the continued development of a stabilization center in South Baltimore.

Our value is also being expressed in our approach to the health of our communities. In the era of payment reform, the appropriate treatment and disposition of patients in the hub of care, the ED, continues to be highly visible. Our continued ability to work with expanding teams in the ED on patients who use our services frequently will expand our value. Many of us have adopted focused approaches to "frequent utilizers," and Dr. Schabelman shares with us in this EPIC the successful program he has developed at Bon Secours. In December several of our Directors met to share notes on these programs as part of the MD ACEP Practice Management Committee. If you are a Director who is not on that list serve, please let me know.

In the next year, I believe we will continue to see more discussion on physician payment models. As the national movement toward increasing pay for value and alternative payment models expands, Maryland is likely to lead some of that discussion. Our involvement is highly important, especially given the national approach to out-of-network and balanced billing. The insurance industry has portrayed us unfavorably with the "surprise bill" tag even though the surprise to most consumers is the shift in cost from the insurers to the patients.

It is difficult to believe that my year as President is two-thirds through. I look forward to working with all of you in 2016 which will bring again much opportunity for us to show our value.

MD ACEP Partners with AMR Management Services

MD ACEP is pleased to announce our partnership with AMR Management Services. With more than 18 years of experience, AMR Management Services provides professional services to a variety of local, regional, national and international nonprofit trade associations, professional societies and foundations.

AMR Management Services has retained Lauren Myers to serve as Executive Director for MD ACEP. Lauren has over 8 years of experience in various roles working with state medical specialty societies. Within that time, she has spent 4 years working directly with MD ACEP. She brings her knowledge and energy to MD ACEP, continuing her role as Executive Director.

Lauren works directly with the AMR Management Services team, which includes Parker Allen - Member Services Director, Jenny Pasley - Accountant, Will Engle - Director of Conference and Events, Sam Hearn -

Graphic Designer, and Mike Cooke - Web Designer. This team effort will provide continuity and enhanced personalized service to the Chapter.

SAVE THE DATE
APRIL 8, 2016
7:30 am- 5:00 pm

MD ACEP 2016 ANNUAL EDUCATIONAL CONFERENCE and ANNUAL MEETING

BWI MARRIOTT
1743 West Nursery Rd
Linthicum Heights, MD 21090

Lectures and Speakers include:

The Last Lecture: What I Have Learned over 49+ Years in the Pit
Joe Lex, M.D.

Busted! Myths in EM
Anand Swaminathan, M.D.

Critical Care Pearls for the Busy Emergency Physician
Peter DeBlieux, M.D.

Updates in Trauma Resuscitation
Deborah Stein, M.D.

The Pressure is On! Pregnancy Disasters
Priya Kuppusamy, M.D.

Emergency Medicine in a Confined Space
Leah Bright, M.D.

When Seconds Count...The Crashing Aortic Dissection
George Willis, M.D.

Bucking the Trend: A Negligence Defense Survives!
Hugh Hill, M.D.

Care Coordination

Esti Schabelman, MD, MBA
Assistant Professor of Emergency Medicine
University of Maryland School of Medicine
Chief of Emergency Medicine, Bon Secours Hospital Baltimore

The Maryland Medicare Waiver commits hospitals to reduce the 30-day hospital readmission rate, and limit the growth in per-capita healthcare spending to 3.58%. One important step towards meeting these metrics is addressing the problem of ED "high utilizers", who are disproportionately responsible for readmissions (and re-visits) and the rise in per-capita healthcare spending. Several hospitals around the state have chosen to address high utilizing patients with management plans. These plans typical "pop-up" in the medical record when a patient is registered in the ED and provide recommend courses of action to physicians and care managers, or simply highlight a patient's past studies and workups, in order to minimize readmissions and complex workups on patients presenting with chronic complaints.

I have seen multiple methods for management plan creation, usually supervised by a committee of various physicians, social workers, and case managers. Some hospitals choose to make generic management plans which they then place on patients that meet the criteria for those plans (chronic pain, COPD, radiation reduction, etc.). Others have entire workgroups dedicated to discussing individual patients and creating individualized plans for each patient's needs. Other EDs, such as my own, have a mix of both methods of plan creation.

In the nine months that we have had management plans at my hospital, we have placed over 300 management plans on our highest utilizers. 207 patients have had plans for greater than six months. Comparing an equal amount of time pre and post plan, our management plans on those 207 patients have decreased their ED visits by 61% (2702 to 1065), admissions by 64% (287 to 104), observations by 76% (214 to 51), x-rays by 70% (538 to 162), CTs by 70% (444 to 135), MRIs by 74% (27 to 7), ultrasounds by 70% (67 to 20), and narcotic pain medication use by 69% (67,359 morphine equivalents prior to the plans and 20,760 morphine equivalents post-plans). From the data that I have seen from other hospitals, both individualized and generic plan creation have about the same success rate as this, though hospitals that employ generic plan creation generally have more patients on management plans.

What remains to be seen is whether or not the management plans are simply redirecting patients to other EDs, or whether they are accomplishing true population management and helping direct and focus resources towards the highest utilizers, helping them address the problems that bring them to the ED so frequently. CRISP has recently begun to index these management plans, and has the intent to create an entire management plan section within the CRISP portal so that we can share data between hospitals and attempt to minimize treatment variation between EDs. Future directions for these plans include the ability to create inter-hospital alerts when a patient has a management plan from another hospital and creating alerts when a patient has had a previous ED visit or admission within the past 30 days (so you can check CRISP for the workup and not repeat unnecessary tests).

The final hurdle toward universal adoption of these plans is a fair method for ED physician reimbursement; many EDs still pay ED physicians based off of their professional billings - while decreasing this high utilizer volume and expense is clearly good for hospitals under the Medicare Waiver, it remains to be seen what benefit Emergency Medicine physicians will receive for decreasing their own volumes (and thus professional fees) and for helping to manage their patients better. Only when hospitals and physicians are able to benefit from the appropriately reduced utilization will adoption of these plans increase and lead to a robust, state-wide, population management system.

Lobbyist Report

Pam Metz Kasemeyer, Esq.
Schwartz, Metz & Wise, P.A.

It was a busy legislative interim for issues relevant to Emergency Medicine. Most of the interim issues summarized below are under active consideration during the 2016 Legislative Session which convened January 13th. Further, the 2nd year of a four year term tends to be the most active and 2016 should be no exception given the tremendous increase in bill requests which have already been placed with the Department of Legislative Services. Stay tuned - active membership participation will be critical.

Discussions on Opioid Prescribing and Related Issues: Issues surrounding heroin and opioid abuse continued to dominate this interim. The Lieutenant Governor issued his Final Report from Heroin and Opioid Emergency Task Force. Approximately 35 recommendations were contained in the Task Force's Final Report. Included in the report is reference to the voluntary

prescribing guidelines drafted by the MD ACEP in conjunction with the Maryland Hospital Association that expand upon the work previously done by MDACEP. MD ACEP and MHA will be convening emergency medicine leaders, poison control centers and other experts, in the Spring, to discuss implementation, barriers, and the potential need for revisions to those guidelines.

Of note in the recommendations of the Task Force is the requirement for mandatory registration and mandatory use (phased-in) of the Prescription Drug Monitoring Program (PDMP). The Health and Government Operations Committee held a briefing on the Task Force report and the staff from the Prescription Drug Monitoring Program gave an overview of the activities of the Program, including coordinating information with other states, and the issues that would currently need to be resolved on the IT side prior to mandatory registration and use. At this time, the Administration has not indicated that it will be introducing legislation on the recommendations; however, various legislators have stated that they are drafting legislation to regulate "pain management clinics" and to implement the recommendations of the Task Force on the PDMP. It is anticipated that other legislators may introduce legislation as well. It will be an active issue throughout the Session.

Medicaid Issues: MD ACEP has been actively engaged with the Medicaid program on a number of issues critical to emergency medicine. Most notably is Medicaid's response to the end of the federal government's pilot program that allowed IMD's (Maryland's 3 independent psychiatric hospitals) to get matching federal funds for Medicaid psychiatric admissions has now ended. The end of the program means that all Medicaid psychiatric admissions to the IMDs (not general hospitals) are now paid for soley with state general revenue, which is fiscally devastating. The State has applied for a waiver to continue the program and is also seeking federal legislation. However, until federal funding is restored, the State has sought to limit its fiscal exposure by requiring emergency departments to call 4 acute care hospitals to determine bed availability before contacting an IMD. This policy has created operational challenges and EMTALA compliance concerns. MD ACEP continues to work with the Department and the Hospital Association to find a permanent funding solution and restoration of federal participation.

MD ACEP has also continued to engage the Medicaid program in discussions related to the development of a mechanism for the Department to address claims adjudication issues that involve high frequency, low cost claims disputes that cannot reasonably addressed through the existing independent review process that is essentially a "loser pays" program. The concept would be the development of a program that mirrors the targeted "market conduct" study approach utilized by the MIA with respect to private

carrier claims practices. The discussions with DHMH are ongoing with MD ACEP currently charged with compiling data on claims adjudication problems with the various MCOs.

Finally, MD ACEP will again advocate for reinstatement of full Medicaid/Medicare parity for E & M Code reimbursement. During the 2015 Session, reimbursement was successfully restored to 92% of Medicare. In 2016, efforts will be undertaken to restore it to 100% of Medicare for all physicians specialties.

New Leadership, High Attendance Highlight ACEP15

Near-record attendance at ACEP15 in Boston brought new leadership, new faces, and healthy contributions to ACEP's advocacy program and the Emergency Medicine Foundation (EMF).

Attendance at the conference matched the record attendance at ACEP14 in Chicago, although final numbers are still being determined.

A new President-Elect and four members of the Board of Directors were elected by the ACEP Council, which also elected its new leadership. Contributions to the National Emergency Medicine Political Action Committee(NEMPAC) and the EMF also pushed closer to the goals set for the year.

Leadership

Incoming President Jay Kaplan, MD, FACEP, took the reins of ACEP in Boston as Rebecca Parker, MD, FACEP, was elected President-Elect.Dr. Kaplan is director of the patient experience for CEP America in Emeryville, California, and a practicing clinician in the emergency department at Marin General Hospital in Greenbrae, California.

Dr. Parker, who had served as Board Chair, is an attending emergency physician with Vista Health in Waukegan, Illinois. She is senior vice president of Envision Healthcare and president of Team Parker LLC, a consulting group. She is also a clinical assistant professor at the Texas Tech University Health Sciences Center at El Paso department of emergency medicine.

The Council reelected two Board members and voted in two new members. Vidor Friedman, MD, FACEP, and William Jaquis, MD, FACEP, were reelected. Christopher S. Kang, MD, FACEP, FAWM, and Mark Rosenberg, DO, MBA, FACEP, were also elected to the Board.

James M. Cusick, MD, FACEP, was elected Council Speaker, and Col. (ret.) John McManus, MD, MBA, MCR, FACEP, was elected Vice Speaker.

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