

**MAY 2016**

## **PRESIDENTIAL REPORT**

### **DREW WHITE, MD, MBA, FACEP**

Spring is in the air, and with similarly renewed excitement, your group of newly elected and re-elected leaders at Maryland ACEP are preparing themselves for a productive year ahead!



Congratulations to the new officers, board members, councillors and alternate councillors elected at Maryland ACEP's Annual Educational Conference and Meeting held on Friday, April 8, 2016 at the BWI Marriott. Dr. Jaquis and his predecessors have left our Chapter in excellent financial, political and general overall shape. I want to thank Dr. Jaquis for his outstanding representation at both our state level as well as nationally in his position on the National ACEP Board.

Thanks, as well, to all of you who attended our annual meeting. Our attendance by emergency physicians, advanced practice providers, nurses, residents, and others was very strong this year. This was in no doubt due to the hard work of Dr. Michael Winters and the Education Committee putting together yet another panel of outstanding speakers. Dr. Joe Lex, slated to retire this year, gave an inspiring farewell speech to our attendees- humbly imparting the ups and downs of his career as well as anecdotes and pearls that make us proud to do what we do. The day followed with high-yield and lively lectures from Drs. Swaminathan, DeBlieux, Stein, Kuppusamy, Bright, Willis, and Hill. All registrants also received a complimentary copy of Dr. Michael Silverman's book, "Director's Corner: Lessons in Emergency Medicine Leadership and Management." Thanks also to the exhibitors for their support of our meeting and educational efforts.

As many of you will recall, starting with the 2014 election, Maryland ACEP moved to an electronic voting system to allow members that cannot attend the meeting to still participate in the election process of their leadership. I am happy to report that we have seen a continued increase in the voting percentage of our membership, with an additional 25 % increase in voting this year compared to 2015, yet another indicator of our engaged membership.

I also want to remind everyone that National EMS Week is coming up May 15-21. Emergency departments and hospitals throughout our state and around the country are busy planning activities to honor our pre-hospital providers. Please take an extra few minutes to thank our colleagues during this week. If you would like any suggestions for activities, ACEP has a good list of resources at <http://www.acep.org/emsweek>.

Also coming soon on May 15-18, 2016 is ACEP's [Leadership and Advocacy Conference](#). If you have not yet had a chance to attend this unique conference, this will be an ideal year given the upcoming elections. Fellow ACEP members from all over the country come to the Grand Hyatt Hotel in Washington, DC to "celebrate emergency medicine's accomplishments and continue to work for a better political

environment for our specialty and our patients." On Sunday evening, Maryland ACEP will be hosting a desert reception to help kick off the conference, and everyone is welcome to attend. If you are unable to make it for the entire conference, Tuesday, May 17<sup>th</sup> is ACEP's Lobby Day and provides a unique opportunity to travel to Capitol Hill to visit with your Members of Congress and staff.

Finally, I want to thank you for your support. I am proud to serve as your elected President during these challenging and exciting times in Maryland and nationally. I encourage you to attend one of our Board Meetings, join a committee, submit suggestions and/or concerns to us, and participate in whatever way will deliver you the most value from your MD ACEP Chapter.

## **WELCOME TO THE MD ACEP 2016-2017 LEADERSHIP**

<b>PRESIDENT</b>	Drew White, MD, MBA, FACEP
<b>VICE PRESIDENT</b>	Neel Vibhakar, MD, FACEP
<b>SECRETARY</b>	Orlee Panitch, MD, FACEP
<b>TREASURER</b>	Bob Linton II, MD, MBA, FACEP
<b>IMMEDIATE PAST PRESIDENT</b>	William Jaquis, MD, FACEP

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## **RESIDENT REPRESENTATIVES**

**Johns Hopkins University**  
Nicholas Rademacher, MD  
**University of Maryland**  
Maite Huis i' nt Veld, MD



## LOBBYIST REPORT

PAM METZ KASEMEYER, ESQ.  
SCHWARTZ, METZ & WISE, P.A.

The 436<sup>th</sup> Session of the Maryland General Assembly concluded at midnight on Monday, April 11<sup>th</sup>, when it adjourned “Sine Die” with the traditional confetti release in both the Senate and House chambers. In this Session, the General Assembly considered 2,832 legislative bills – 584 more than last Session – and resolutions as well as the proposed Fiscal Year 2017 budget. MDACEP followed more than 40 bills as well as the FY2017 Budget, and several of the bills of particular interest to MDACEP were enacted. A summary of the bills of particular interest follows. The full list of bills monitored by MDACEP accompanies this report.

**Medicaid:** Medicaid E&M codes were increased from 92% of Medicare to 96% of Medicare for all physician specialties. Please note that this increase will only occur if Governor Hogan agrees to fund the increase through the State’s Revenue Stabilization Fund. Similar to last Session, the General Assembly “fenced off” almost \$80 million to be used to fund eleven General Assembly priorities, including E&M codes for primary and specialty physicians and psychiatry. Governor Hogan has the right (or not) to fund these priorities. To the extent that these programs are not funded by the Governor, the monies will remain unspent.

**Medical Malpractice:** Several bills were introduced this Session by both the trial lawyers and provider groups on medical liability. Senate Bill 450/House Bill 1487 (*Health Care Provider Malpractice Insurance – Scope of Coverage*) is the only bill that passed this Session and finally allows physicians to purchase one policy for both medical liability and coverage for the defense of a health care provider in a disciplinary hearing arising out of the practice of the health care provider’s profession. While no other bills passed, through concerted advocacy the physician and business community did ward off an effort to move Senate Bill 574/House Bill 869 (*Civil Actions – Noneconomic Damages – Catastrophic Injury*), which would have eviscerated the current cap by tripling the maximum amount of noneconomic damages that may be recovered in a health care malpractice case.

Other bills introduced but not passed include, House Bill 606 (*Patient Safety Early Intervention Programs*) (the apology bill) which passed the House but did not receive a vote in the Senate; Senate Bill 849/House Bill 814 (*Task Force to Study the Establishment of Health Courts*); House Bill 992 (*Health Care Malpractice Claims – Health Care Alternative Dispute Resolution Office – Repeal*); and Senate Bill 513/House Bill 377 (*Maryland No-Fault Birth Injury Fund*).

**Prescription Drug Monitoring Program (PDMP) and Other Substance Abuse Related Legislation:** Addressing Maryland’s heroin and opioid overdose epidemic has remained a priority for this Administration as well as key legislative leaders. As a result, the Administration, as well as Senator Kathy Klausmeier and Delegate Erin Barron, introduced Senate Bill 537/House Bill 437 (*Department of Health and Mental Hygiene – Prescription Drug Monitoring Program – Modifications*) and Senate Bill 382/House Bill 456 (*Prescription Drug Monitoring Program – Revisions*) that proposed mandatory PDMP registration by all controlled dangerous substance (CDS) prescribers as well as broad mandatory PDMP query requirements for prescribers and pharmacists prior to prescribing or dispensing a CDS. The bills as introduced also included authority for the PDMP to directly refer cases to law enforcement and the licensing boards. The bills quickly became one of the most hotly debated health issues of the Session.

After many weeks of workgroup meetings, the bills were amended to address many of the physician community’s concerns. As amended, the bills now require:

Mandatory registration of all CDS registrants by 2017. The registration process remains linked to the CDS license registration process, however, the Secretary of Health and Mental Hygiene has authority to delink it if issues arise with timely issuance of CDS licenses.

Mandatory query but only under very limited circumstances with a number of exceptions, which may be expanded by the Secretary by regulation. The mandated query provisions become effective on July 1, 2018. Again, the Secretary has the authority to delay the mandate’s implementation if the PDMP technical capacity and “ease of access” will not support the increased system demand of the mandate.

With regard to the use of the data by law enforcement, the physician community opined that direct referral authority to law enforcement completely undermines the current construct of the PDMP which was purposefully structured to be a health care “tool” for providers and not a “tool” for law enforcement. Fortunately, after significant debate amongst the stakeholders and aggressive advocacy by the physician community, all provisions related to direct referral to law enforcement or licensure boards were deleted from the legislation.

House Bill 6 (*Criminal Law – Improper Prescription of Controlled Dangerous Substance Resulting in Death*) would have increased criminal penalties on a provider if the provider prescribed, administered, distributed, or dispensed a controlled dangerous substance (CDS) to a person in nonconformity with State law and the use or ingestion of the CDS was a contributing cause of the person’s death. The bill failed in the House Committee.

House Bill 838 (*Civil Immunity – Emergency Care for Drug Overdose – Protocols*) proposed to limit current immunity protections for public safety personnel who are authorized to administer medication for a drug overdose by providing immunity only if the public safety personnel acted in accordance with the protocols established for the individual’s license or certification. Linking immunity from liability with protocols would have created a significant disincentive for public safety personnel to administer Naloxone. The bill failed in the House Committee.

**Assignment of Benefits:** For the second year, legislation that would have changed the State’s assignment of benefits law was defeated. Senate Bill 335/House Bill 1505 (*Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers – Modifications*) would have removed the ability of non-preferred hospital-based and on-call physicians to accept an assignment of benefits, and instead, mandate the rate in law (AOB formula) and forbid balance billing.

**Behavioral Health and Crisis Management Services:** With regard to the need for more crisis management services, Senate Bill 551/House Bill 682 (*Behavioral Health Advisory Council – Clinical Crisis Walk-In Services and Mobile Crisis Teams – Strategic Plan*) requires the Behavioral Health Advisory Council, in consultation with local core service agencies, community behavioral health providers, and interested stakeholders, to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide and operating 24 hours a day, 7 days a week.

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An interim report is due December 1, 2016 that reflects the progress made on the development of the strategic plan. A final report is due December 1, 2017.

Child Abuse and Neglect Reporting: Senate Bill 310/House Bill 245 (*Child Abuse and Neglect – Failure to Report*) requires an agency that is participating in a child abuse or neglect investigation, and that has substantial grounds to believe that a person has knowingly failed to report suspected abuse or neglect, to file a complaint with the appropriate licensing board (if the person is a health practitioner), law enforcement agency (if the person is a police officer), or the appropriate agency, institution, or licensed facility at which the person is employed (if the person is an educator or human service worker). Legislation that sought to criminalize “failure to report” has been proposed and defeated for multiple years. Passage of this bill will end the debate on criminalization and minimizes the potential for inappropriate referral of a physician for “failure to report” abuse and neglect due to the requirement that the failure must be “knowingly” based on “substantial evidence”. Passage of this legislation should hopefully end the legislative debate of “failure to report”.

## PEDIATRIC EM UPDATE

SCOTT FREEDMAN, MD, FACEP

In emergency medicine, we are trained to practice to evaluate patients by considering the top life-threatening conditions which may be the cause of the patient’s underlying complaint. It is incumbent upon us to, at the very least, document through our medical decision making the rationale for why (and why not) these diagnoses are able to be ruled in or out. Performing laboratory tests and radiographs are often an integral part of the practice in these evaluations.

In pediatrics, we are trained to a different mindset. Certainly, we need to consider serious, potentially lethal causes of acute illnesses. However, we are also taught we need to be highly judicious in ordering tests on children. Much of our training centers around topics such as the importance of developmental milestones, family centered care, family presence, the medical home, and anticipatory guidance.

Where the two fields come together is in pediatric emergency medicine. In community hospitals, where we treat many children in our EDs, those children with complex, “tertiary care” medical histories are not commonly seen. Our duty of course remains to be vigilant, but this does not equate to overzealous testing or a need to always treat.

We often use the term, supportive care in our practice. What does this really mean? In bronchiolitis we now are taught, supportive care should be the mainstay of treatment especially for mild cases. Many providers recognize this means, nasal suction, oxygen, and hydration. Though this isn’t wrong, I would make the case supportive care really means *support in care*.

Change the paradigm and consider supportive care really means pausing to listen, comfort, empathize, and reassure. Often less is more. Let us all agree less testing and treatment for bronchiolitis, upper respiratory infections, bronchitis, and self-limited crying in infants should be an essential part of our practice with nearly every child. There are many other instances where this hold true as well. It isn’t enough to say “it’s just a virus”. State we understand what it means to have a child with fever, be congested, restless, and eat poorly while ill. Commiserate with the worries of these parents. Simply put, more care does really mean *MORE CARE*.



## EMS UPDATE

TIMOTHY CHIZMAR, MD, FACEP

### Mobile Integrated Health

The Mobile Integrated Health Working Group (MIHWG), a subcommittee of the State EMS Advisory Council (SEMSAC), started meeting in July, 2015 at the request of Dr. Kevin Seaman, Executive Director of MIEMSS. In many communities throughout the nation, emergency medical services (EMS) has expanded its role to include community paramedicine (CP) or mobile integrated health (MIH) programs. The overarching goal of such programs is to engage EMS as a partner with hospitals to meet the “Triple Aim,” namely, lowered costs, improved patient experience, and improved outcomes.

These programs (CP and MIH) have been able to link patients to preventative health services, reduce 911 call volumes, and improve the continuity of care from the hospital to the patient’s home, with a goal to reduce complications and hospital readmissions for patients.

The MIHWG made **four recommendations** in its Phase I document:

The Protocol Review Committee, EMS Board and SEMSAC should continue develop an **Optional Supplemental EMS Protocol for Mobile Integrated Health**. As part of this protocol, a Mobile Integrated Health Advisory Council (MIHAC) would also be established. Protocol development allows EMS providers to carry out additional or modified functions.

MIEMSS should establish a dedicated working group to address the role of **alternative destinations** for EMS patients in Maryland (i.e. urgent care destinations for lower acuity patients).

The State ALS Education Committee **develop additional MIH/CP educational modules for paramedics**. In the future, this may lead to specialized or advanced-practice paramedics in Maryland.

The MIHAC should establish an interagency subcommittee to **evaluate reimbursement models for EMS agencies conducting MIH services**. This subcommittee would consist of: EMS agencies, hospitals, insurers, and relevant state regulatory agencies.

The MIHWG of the SEMSAC will continue its work to develop an efficient and professional Mobile Integrated Health Program in Maryland. As a member of Maryland ACEP, I welcome your comments and suggestions on this important task ahead of us. I can be reached by email at [тчizmar@umem.org](mailto:тчizmar@umem.org).

## ACEP Committees Accepting Applications for Volunteer Members Until May 16

Members interested in serving on a national committee are asked to submit an interest form and curriculum vitae by May 16, 2016. Please include specific information explaining qualifications and experiences relevant to the particular committee.

Most committee work will be accomplished through email and conference calls, but committee members are expected to attend the organizational meetings at the annual meeting Oct. 16–19 in Las Vegas. The appointment is contingent upon completion of a conflict-of-interest form.

Members interested in serving on a committee are asked to contact Mary Ellen Fletcher at 800-798-1822, ext. 3145, or [mfletcher@acep.org](mailto:mfletcher@acep.org). Committee interest forms are available [online](#).



## Congratulations to the MD ACEP 2016 Award Recipients! Presented by Dr. Bill Jaquis

Legislator of the Year was awarded to Delegate Geraldine Valentino-Smith, who was unable to attend. Her legislative director graciously accepted the award on her behalf.



Emergency Nurse of the Year was awarded to Cathy Weber, BSN, RN, CEN of Shore Regional Health at Dorchester.



Physician of the Year was awarded to Dr. Michael Silverman, MD, FACEP. Dr. Silverman has been a MD ACEP Board member for over eight years and a member of ACEP for 25 years.



EMS Physician of the Year was awarded to Benjamin Lawner, DO, EMT-P, FACEP who was unable to attend. Dr. Tim Chizmar accepted the award on his behalf.

## *Maryland Chapter of ACEP is hosting a Dessert Reception*

*Sunday, May 15, 2016  
9:30-11:00 pm at the  
Grand Hyatt Washington,  
Penn Quarter A  
(just below the lobby level)*

*Join us after your dinner plans on  
Sunday for dessert, coffee, and cordials.*



**Do you want to get more involved with MD ACEP?? Board Meetings are open to all members...join us!**

The next meeting will be held on June 17 from 11:30 am– 2:00 pm at the MedChi Offices:  
1211 Cathedral Street, Baltimore, MD 21201

*If you plan to attend, please email Lauren Myers at [lmyers@amrms.com](mailto:lmyers@amrms.com) so we can plan accordingly for lunch.*