Maryland ACEP
www.mdacep.org
EPIC
Emergency Physician Interim Communique

AUGUST 2015

PRESIDENTIAL REPORT

WILLIAM JAQUIS, MD, FACEP

In my prior column, one of the items I highlighted was the ongoing local and national dialogue regarding the inappropriate use of opioids. As most of you know, the Governor as well as our local health departments has continued to move this issue forward. As also noted in Pam Metz's article, the Governor will soon announce his approach to this health concern.

Thankfully, we were well prepared for this collaboration. Many of you have already been following many of the principles that are outlined in the plan that the Governor's office and Maryland Hospital Association (MHA) will announce. Thanks to being forward-looking, Maryland ACEP had used the thoughts of many of our emergency physicians to develop best practices a couple of years ago. When it came time for our state leadership and the MHA to work on their objectives, our work product provided a blueprint for the ED-based approach to appropriate use of pain medications. I also believe that this process will continue to ask health systems to enhance their approach to opioid use, screening for abuse, and addiction treatment.

The collaboration with the many stakeholders that we have had in emergency medicine is a great illustration of where our organization provides value. We have seen in many other states a more Draconian approach, with little input from EDs on a best practice. Our ability to reach out to our membership to both give and receive information, our advocacy that establishes us as good partners with other stakeholders, and our internal leadership and action have led to a better outcome. Those factors also allowed us to have input into a final product. As an example, we were able to share information with the architects of this policy more recent information on how EDs use and prescribe opioids. From FDA data, we prescribe about 4% of the immediate release opioids. While we have been and will continue to be part of the solution to a national health issue, the strategy and policy must go way deeper in solving this issue.

In closing, I would like to express my appreciation to all of our leadership – past, present, and future – that provide their time and effort to improve the experience of our ED providers and patients related to these kinds of issues. I also am grateful for the opportunity to work with the exceptional emergency providers throughout Maryland who allow us to accomplish the outcomes we do. There will certainly continue to be challenges, but we are well prepared to face them.

SAVE THE DATE: APRIL 8, 2016
Maryland ACEP 2016 ANNUAL EDUCATIONAL CONFERENCE & ANNUAL MEETING
BWI MARRIOTT

LOBBYIST REPORT

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

It has been a relatively quiet interim as the new Administration settles in, establishes its leadership team, and identifies its priorities. Nonetheless, there are a number of interim activities that are of direct or peripheral interest to MDACEP members that are summarized in this article. It is likely that the activity level will increase in the fall and MDACEP will keep you apprised of those activities.

Hospital All-Payor Waiver Implementation: Waiver implementation activities under the purview of the HSCRC continue to be a State priority and have not changed with the change in Administration. The focus of the HSCRC has shifted to the second year of implementation of the revised Waiver, whereas the first year focused on placing hospitals on global budgets. Currently, 95% of hospital revenues are under global budgets. Medicare completed its audit the first year of the Waiver and found that the State met its benchmark savings requirements and quality improvement requirements, but fell short on meeting readmission targets. The next year will focus on clinical improvement (better chronic care, more coordinated care and better episodes) and payment alignment. HSCRC has awarded eight regional planning grants to address care coordination and has projected a .4% increase in rates to support these activities, which is in addition to the .25% granted for projects that can be shovel ready by January 1st.

Heroin Overdose and Opioid Addiction Issues: The Governor's Heroin and Opioid Emergency Task Force was convened shortly after the Governor took office. The Task Force has held "town meetings" around the State and is expected to issue an interim report on its findings and recommendations in late August with a final report due in December. To that end, MDACEP was contacted by the Maryland Hospital Association (MHA) in regard to their effort to develop opioid prescribing guidelines for their institutions. This effort was initiated in response to the Governor's call for a comprehensive response to heroin and opioid addiction issues. MHA utilized MDACEP guidelines developed in 2014 that were reflected in a patient education brochure and endorsed by MHA. Those guidelines, which are voluntary, have been expanded upon and will be released as a component of the interim report of the Governor's Task Force. The guidelines have been reviewed by MDACEP leadership and members involved with the original policy development. The interim report of the Governor's Task Force will include the release of the guidelines and MDACEP will join MHA at that event. The guidelines will continue to be evaluated and refined as voluntary implementation progresses. MDACEP will remain at the forefront of the discussion to ensure policies and implementation issues reflect the perspective of MDACEP members.

CDS Licensure Issues: The State's process for issuing a controlled dangerous substance license to providers has become extraordinarily problematic.

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Various stakeholders have been working to identify solutions to resolve the delays and bureaucratic roadblocks to both initial licensure and renewals. Additional discussions will take place with DHMH and the Board of Physicians, as well as the other provider and institutional stakeholders. While it remains a work in progress, virtually all stakeholders including DHMH recognize that the "system" is broken and changes are required.

Medicaid: There are a number of issues of relevance to MDACEP members with respect to Medicaid that warrant comment. The first involves the redetermination process that now is required to be done through the Exchange. Medicaid has been working through a number of implementation challenges, not the least of which is educating Medicaid recipients on the new requirements for redeterminations. It remains a work in progress with the real test to come this fall when a significant percentage of the enrollees will be required to utilize the Exchange to retain their benefits. The success of this process will impact the continuity of coverage of those individuals accessing services in the emergency department. Also of relevance is the implementation of the new ASO model for the integration of behavioral health. Effective January 1, ValueOptions, as the contracted ASO, has responsibility for managing the administration of both mental health and substance abuse services for the Medicaid program. While the transition has gone relatively well, there remain a number of unanticipated challenges that will need to be addressed. Again - a work in progress. Finally, MDACEP will be meeting with Medicaid leadership to discuss the IRO program that was the subject of budget language in 2014. MDACEP is hoping to renew the effort to establish a market conduct/claims review program for low cost high volume services that cannot be fairly addressed by the current appeals process under Medicaid.

PEDIATRIC EMERGENCY MEDICINE COMMITTEE

SCOTT FREEDMAN, MD, FACEP

The judicious and appropriate use of antibiotics in acute care medicine continues to be a front and center topic for which each of us has a vital role. Whereby fever as a presenting complaint is the most common medical reason a child is brought to the ED for evaluation, we all need to do our part to have the integrity and confidence in ensuring when treating with antibiotics is justified and when more so, it is not.. It is not enough for a young child to have a red or dull (or worse, a cerumen-obstructing) TM to call it acute otitis media,, or a red throat with a negative rapid strep screen to diagnosis "(bacterial) tonsillitis", or purulent nasal congestion for a few days duration to diagnose bacterial sinusitis and prescribe a course of antibiotics to a febrile child. Unless, you have been living and practicing in a cave (which none of us has), you have both heard and read about the growing antibiotic resistance and why over-prescribing of antibiotics is a predominant factor contributing to this. We each need to be comfortable with caring for the febrile young child with these respiratory findings or no identifiable source at all by history or exam. The overwhelming majority of these pediatric patients will have a self-limited viral illness and we need to we need to take a moment of time to explain to parents that fever and the height of fever are neither diagnostic, dangerous, nor predictive of the type of infection with which it is associated. Be comfortable with the diagnosis of "acute febrile (viral) illness".

Having practiced this specialty of pediatric emergency medicine for greater than 20 years, there have truly been only a handful of dissatisfied customers who leave without a prescription who feel their child was wrongly diagnosed and "undertreated". Our duty in regards to what we ought to do for most children we see with febrile illness is providing reassurance, vigilance, and ensuring these patients do understand the recommendation to follow up with their pediatrician in short order for reevaluation especially should their condition persist or deteriorate.

In future EPIC editions, we will look to provide a brief focus on which specific antibiotics to prescribe when warranted for specific illness complexes and why Ceftriaxone ("Cef-ur-wonderful") should only occasionally be the ED treatment answer for febrile children.

EMS UPDATE

TIMOTHY CHIZMAR, MD, FACEP

Maryland CARES™ Update

In an effort to increase survival from out of hospital cardiac arrest (OHCA), Maryland EMS (MIEMSS) continues to work toward full statewide participation in the Cardiac Arrest Registry to Enhance Survival (CARES™). CARES (https://mycares.net) is a secure web-based data management system in which EMS agencies and receiving hospitals can enter local data and analyze their progress compared to regional and national trends. The Centers for Disease Control and Prevention (CDC) in cooperation with Emory University and American Heart Association (AHA) launched this secure, HIPAA-compliant, database to allow for a uniform and reliable method of data collection on OHCA.

One goal of the large registry is to reduce the regional disparity in survival from cardiac arrest. The median national survival rate to hospital discharge from OHCA is 7.8%, with wide variation across the country from near 0% to close to 50% survival in locations such as Seattle.

Maryland EMS data is submitted automatically from the statewide eMEDS® electronic pre-hospital record to the national database. In the near future, hospitals will receive an electronic request to complete the data collection on six data points regarding discharge outcomes on all OHCA patients. Please encourage your hospital to participate in this effort. One data point collected will be Cerebral Performance Category (CPC) data on survivors to hospital discharge. Through collection and analysis of the data, Maryland EMS strives to help increase statewide survival from cardiac arrest.

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Magnesium Added to EMS Formulary

As of July 1, 2015, all Maryland ALS ambulances will carry magnesium sulfate. Magnesium was added to the EMS formulary with the following indications:

- Torsades de Pointes and refractory VF/VT (1-2 gm IV/IO over 2 min)
- Moderate to Severe Asthma or bronchospasm (1-2 gm IV/IO over 10-20 min), with medical consultation
- Pregnant Patients with seizure (after midazolam given, 4 gm IV/IO over 10 min)

REGISTER NOW for the 9th Annual
Wilderness Medicine &
Survival Skills Conference

September 18-20, 2015

Theme: Travel, Tropical, and Urban Survival

This 2.5 day conference attracts national speakers and is accredited through the
Wilderness Medical Society for credits for the FAWM (Fellow in the Academy of Wilderness medicine) track .

Click here for more information and registration

The Maryland EMS for Children Department at MIEMSS is offering an **APLS: The Pediatric Emergency Medicine Resource** hybrid course featuring:

- Simulation of Pediatric Critical Care Scenarios
- Hands-On Practice of Procedures
- Small Group Discussions
- Pediatric Faculty from Children's National Health System, Johns Hopkins Children's Center, and University of Maryland

AAP and ACEP designed the APLS course to highlight the critical information physicians need to rapidly assess and care for critically ill and injured children in the emergency department or office-based setting. This course is jointly provided by MedChi.

To register, please visit http://marylandemsc-apls.eventbrite.com or complete the form below.

Course Dates and Locations: 8:00 am – 5:30 pm

Date	Location	Register By
August 26, 2015	WMHS in Cumberland, MD	August 12 , 2015
October 6 , 2015	MIEMSS in Baltimore, MD	September 22, 2015
December 10, 2015	MSMH in Leonardtown, MD	November 23, 2015
February 12, 2016	UM UCH in Bel Air, MD	January 29, 2016

we're in this together

AS AN MEP PROVIDER, you are never alone. From one on one mentorship that begins even before your first shift, to our leadership academy and model of local ownership, to our culture of shared success and teamwork, your career at MEP will be about working and succeeding together.

- Ongoing Career Mentoring
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