

**MARCH 2015**



## **PRESIDENTIAL REPORT**

**STEPHEN SCHENKEL, MD, FACEP**

Over the last few months, three recent topics of have held sway at a variety of state level meetings that are worth keeping in mind as we navigate the changing environment of our new Maryland Medicare waiver, the global budget, and population health. I offer each of these three as topics worth keeping in mind as they evolve over the next year.

### Defensive Medicine

In January, Professors Dianne Hoffman (Director, Law and Health Care Program, University of Maryland School of Law) and Bradley Herring (Associate Professor of Health Economics, Johns Hopkins Bloomberg School of Public Health) presented their findings on the cost of defensive medicine to a joint work group gathered on the same topic. (Slides of the report can be found at <http://hscrc.maryland.gov/documents/md-maphs/wg-meet/dm/Agenda-Defensive-Med-presentation-Panel-Discussion.pdf>.) The report consisted of a summary of the literature and a number of uncertain conclusions.

The presentation revealed a number of interesting elements. First was the potentially very broad definition of defensive medicine and the degree to which we may all have differing definitions in mind when we use these two words. While often considered as actions taken to avoid malpractice litigation, the broader definition also includes greater attention to record keeping, focus on communication with patients and other providers, and working to minimize the risk of a bad outcome. In other words, the common interpretation of defensive medicine as something to be avoided may readily be turned upside down to reveal the many good elements inherent in a careful approach to diagnosis and treatment. This sort of defensive medicine may also be called good medicine. This point was made by one of several Emergency Physicians present at the meeting. This was a second interesting element – Emergency Physicians present outnumbered all other physicians combined. We are clearly involved.

What about cost? The panel concluded that there are no reliable estimates of what defensive medicine costs. They did, note, though that two tort reforms already in place in Maryland – our cap on noneconomic damages and the lack of joint-and-several liability (by which liability may be divided among multiple parties) – likely decrease the cost of defensive medicine in Maryland. In other words, among the panels' strongest statements was a defense of tort reforms that we have in place, reforms which are threatened annually.

### Opioid overdose and death

Over the past several years we have spent quite a bit of time discussing opioid overuse, chronic pain, and the appropriate role of the Emergency Department in chronic pain management. Along with a number of other state organization, a Maryland ACEP task force suggested guidelines and released a pamphlet regarding pain treatment.

This year the topic has morphed a bit so that locally, regionally, and

nationally we are seeing increased attention to opioid associated mortality. Increased prescription of more powerful narcotic analgesics, readier access to heroin outside of city centers, and lacing of heroin with fentanyl have all been blamed. Governor Hogan has announced plans for a task force to tackle opioid associated mortality.

Individually and as Maryland ACEP we have been asked to help by providing ideas and implementing programs. Some potential approaches have included prescription or distribution of naloxone to users of heroin (and, through state training programs, their friends and families) and efforts to expand the role of the Chesapeake Region Information System for Patients (CRISP) and its associated Prescription Drug Monitoring Program. Other ideas include enhanced access to treatment programs, implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs, and better alignment of our regulatory structure which has long focused on insufficient pain control with little or less attention paid to the corollary challenges of narcotic addiction and overuse.

If you have not yet heard about efforts to reduce opioid associated mortality from your local department of health, you can likely anticipate hearing before long. One role MD ACEP can play in this is the sharing of ideas and experience as we are all brought into a state-wide effort.

### Care Coordination

Care coordination has become the mantra for a health system to simultaneously decrease costs and improve outcomes. There are several presumptions behind this (some with better evidence than others): that our provision of health care is dreadfully fragmented, that this fragmentation increases costs and obstructs better outcomes, that we have at least some of the tools to improve communication and coordination, and that the payment structure can be designed to better convince physicians and other clinicians to overcome barriers with a view toward better alignment. To this end, Medicare has started to pay primary care physicians a fixed monthly fee for care coordination and our Maryland HSCRC has formed a workgroup to recommend mechanisms toward improving care coordination and population health (I have the pleasure of serving on this workgroup; <http://www.hscrc.state.md.us/hscrc-workgroup-care-coordination.cfm>). Topics of discussion have included primary care medical homes, the use of the CRISP database to align care, identification of high utilizing patients, and the development and sharing of patient specific care plans.

The emphasis on care coordination challenges and opportunities to Emergency Medicine. One large challenge is that we have somehow become the symbol of fragmented and non-coordinated care. Thus repeat emergency visits are viewed as a systemic failure rather than the success of patients choosing where to seek care. As hospitals seek to align themselves with the goals of Maryland's new waiver, our value within our institutions will likewise be associated with our ability to align emergency medicine with the goals of care coordination, "appropriate" utilization, and enhanced coordination. Ironically, we have the background for this; while little recognized, coordinating care

## -PRESIDENTS REPORT CONT. FROM PAGE 1

across all hours of the day and days of the week, and communicating consistently with both patients and other providers, is essential to the practice of emergency medicine.

The recommendations of the HSCRC care coordination workgroup are under way and will likely be released over the next several months. This represents one middle step in a process of aligning clinical care in Maryland with the goals of our new waiver.

### Stay involved

MD ACEP has been involved in the statewide efforts on all three of these topics. One of our goals, stated casually, has been to be sure we have a seat at the table. We are sitting at all of these tables (and more) and rely on our board and membership to keep ourselves aligned, understand the challenges in daily clinical practice, and communicate the importance of high-level decision making to clinical practice as represented by an emergency physician treating an individual patient. Please get involved and stay involved – attend a meeting, join a committee, talk with our board members, or run for the board.

And please come to the Annual Educational Conference coming up on March 20<sup>th</sup>. It promises to be an excellent day of learning and camaraderie. (<http://www.mdacepmeeting.com/>)



### **EMS UPDATE**

**TIMOTHY CHIZMAR, MD, FACEP  
& RICK ALCORTA, MD, FACEP**

Effective July 1, 2015 with the annual Maryland EMS Protocol changes, there will be a new Spinal Protection Protocol for patients delivered to our emergency departments by EMS. The protocol is based on a newly published joint position on the EMS management of spinal cord emergencies from the National Association of EMS Physicians and the American College of Surgeons Committee on Trauma. Drs. Elliot Haut and Michael Millin, both of Johns Hopkins Medicine and who have contributed to the national literature on this topic, were primary authors of this new Maryland EMS Protocol.

Contrary to the theoretical teaching that spinal backboards prevent spinal cord movement and thus further injury, there is recent and evolving literature demonstrating patient harm including: severe pain, decubitus ulcer formation, delays in patient transport, and unnecessary radiological testing. New research further demonstrates that there is likely *less* movement of the spinal column when the patient, with a cervical collar placed prior to movement, is assisted by providers from a seated car to a soft EMS mattress *without* the use of a backboard.

With new and emerging research in mind, Maryland EMS (MIEMSS) has developed a new Spinal Protection Protocol as outlined below. An educational update on this topic will also be provided to all hospital-based EMS Base Station hospital personnel in the Spring of 2015 through the required annual online learning management program.

#### **Inclusion criteria for Spinal Protection Protocol**

Patients with a blunt traumatic, high-energy mechanism of injury that has potential to cause spinal cord injury or vertebral instability **and** one or more of the following:

Midline spinal pain, tenderness, or deformity  
Signs and symptoms of new paraplegia or quadriplegia

Focal neurological deficit

Altered mental status or disorientation

Distracting injury: Any injury (e.g., fracture, chest or abdominal trauma) associated with significant discomfort that could potentially distract from a patient's ability to accurately discern or define spinal column pain or tenderness

**Spinal Immobilization Treatment** is the application of a correctly-sized cervical collar, backboard device and securing straps with padding. This has been our historical standard EMS practice. The indications for Spinal Immobilization Treatment are very limited and they include:

Patients meeting the spinal protection protocol that are with neurological deficit, or not able to ambulate on their own accord (with the addition for pediatric patients "who are unable to respond during assessment"), **shall** be immobilized with a cervical collar **and** a backboard.

**Spinal Protection Treatment** applies to all patients with a mechanism of injury concerning for a possible spinal cord injury. These patients should be placed in a cervical collar if they meet the inclusion criteria above.

The following patients only need application of a cervical collar and do not need to be placed in full immobilization with a backboard:

- (1) Patients that are found by EMS providers to be standing or ambulatory,
- (2) Patients that have a GCS of 15 and are able to safely extricate them-selves from the environment (e.g., vehicle seat) without gross movement (flexion, extension, or rotation) of the spinal column, and
- (3) Patients that do not have evidence of a neurological deficit

# MD ACEP 2015 Annual Educational Conference & Annual Meeting

[www.mdacepmeeting.com](http://www.mdacepmeeting.com)

Time is Running Out to Pre-Register

**Pre-registration closes March 18 at 3 pm**





## LOBBYIST REPORT

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

The 433<sup>rd</sup> session of the Maryland General Assembly began its 90 day Session on January 14<sup>th</sup>. Legislative sessions always begin slow in the first year of a new four year term, however, this session is particularly slow given that more than 30% of the legislators are newly elected, having never served in office before. Several legislators this year have also made a move from the House of Delegates to the Senate. In addition, the new Governor, Larry Hogan is a Republican and thus has commenced a four year term with Democrats securely in control of the legislature and Republican Governor Larry Hogan in charge of the Executive Branch. The current tone reflects "bipartisanship" from both the Executive and the Legislature and there is cautious optimism that tenor will remain a work in progress.

With respect to issues of interest to ACEP, there has been only one bill introduced of significant interest - House Bill 3 (*Prescription Drug Monitoring Program - Prescribers and Dispensers - Required Query*) which will require all doctors to query the Prescription Drug Monitoring Program (PDMP) before writing a prescription for a controlled substance. At this point the PDMP is a "voluntary" program that allows doctors to check up on patient prescription habits. Aside from the historic policy of the physician community opposing mandates that dictate actions when treating a patient, the technical capacity of the PDMP makes mandatory query an unworkable proposal and it is unlikely to move forward. That being said, there is significant discussion about opioid abuse, heroin overdose and related issues that will be the subject of various initiatives and the PDMP interface on those issues will undoubtedly be raised as both leadership in the General Assembly and the new Administration have committed to addressing overdose prevention and opioid abuse issues.

The Governor's budget has been introduced and while detailed analysis is still underway, it appears that Governor Hogan has not made further reductions in the E & M code reimbursement rates from those made by Governor O'Malley in the final days of his Administration. At this juncture reimbursement will be 87% of Medicare effective April 2015 and will be maintained at that rate through FY 2016 if the General Assembly does not make further reductions through its deliberations. MDACEP will stay actively engaged throughout the budget process.

Finally, the Medicaid Advisory Committee met Monday January 26<sup>th</sup> and the Independent Review Organization (IRO) initiative that ACEP spearheaded with the adoption of budget language in the 2014 Session was the subject of discussion. The IRO report submitted to the General Assembly outlined the differences in approach and capability of the Medicaid program and the Maryland Insurance Administration in addressing claims denials and disputes. The primary shortfall of the Medicaid program is the inability to fairly and effectively address systemic patterns of claims adjudication denials/disputes. Under MIA, these disputes are often handled through targeted "market conduct" studies, capability not currently present under Medicaid. While no definitive action to establish such capability has been initiated, Medicaid is interested in continuing the dialogue with relevant stakeholders with the end goal the establishment of such capability. It remains a work in progress.

MARYLAND >> VIRGINIA >> WASHINGTON, D.C. >> WEST VIRGINIA

EMA, an established fourteen-hospital, regional, democratic, physician-managed group seeks full and part-time BC or BP Emergency physicians to practice in Maryland, Northern Virginia, Washington, D.C. and West Virginia. Since 1971, EMA has offered our physicians an unmatched quality-of-life with the security of our 100% contract stability!



- Physician-owned/managed group
- Democratic partnership structure
- Quality-of-life centered practice
- Administrative & clinical opportunities
- Initially five weeks of paid time off per year
- Full benefits package for physicians and family

**ACEP Booth #631**

Send CV: Emergency Medicine Associates, P.A., P.C.  
Phone: 1-800-942-3363  
Fax: 240-686-2334  
Email: Recruitment@EMAonline.com  
[www.EMAonline.com](http://www.EMAonline.com)

**LIVE, WORK & PLAY WITH US!**



**we're in this  
together**

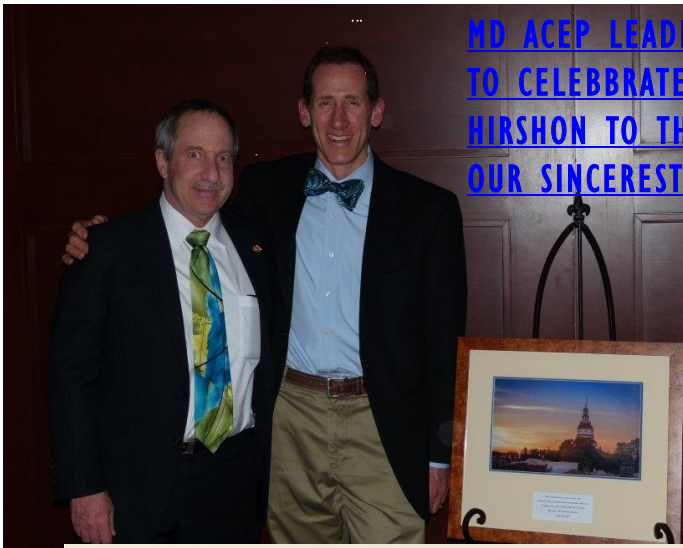
AS AN MEP PROVIDER, you are never alone. From one on one mentorship that begins even before your first shift, to our leadership academy and model of local ownership, to our culture of shared success and teamwork, your career at MEP will be about working and succeeding together.

- Ongoing Career Mentoring • MEP Leadership Academy
- Meaningful Partnership Opportunities
- Full- & Part-Time Travel Positions Available



Contact: Sandra Lee  
(301) 944-0049  
[slee@mephealth.com](mailto:slee@mephealth.com)  
[MEPHealth.com](http://MEPHealth.com)





MD ACEP LEADERSHIP HELD A DINNER IN JANUARY  
TO CELEBRATE THE ELECTION OF DR. JON MARK  
HIRSHON TO THE ACEP BOARD OF DIRECTORS—  
OUR SINCEREST CONGRATULATIONS!



Maryland Chapter  
AMERICAN COLLEGE OF  
EMERGENCY PHYSICIANS  
ADVANCING EMERGENCY CARE

## Maryland ACEP 2015 Annual Educational Conference

Register Online Now at: [MDACEPmeeting.com](http://MDACEPmeeting.com)



**EMERGENCY MEDICINE:  
CURRENT TOPICS**

**Friday, March 20, 2015**



# DC / ACEP

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

**SAVE THE DATE**

**8th Annual Joint MedStar - GW LLSA Conference**

**Presented by: DC ACEP Chapter**

Review the 2015 LLSA Articles/Patient Safety LLSA Module

**Tuesday, May 26<sup>th</sup>**

**7:30 am - 12:00 pm**

Free for DC ACEP Chapter members  
\$125 for non-members