

Maryland Medicine

The Maryland Medical Journal **Volume 13, Issue 4**

**Key Maryland
Healthcare
Stakeholders
Discuss the
Future of
Medicine**



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I N S I D E



The cover “Wordle” is a compilation of the words most often used in the answers to the eight questions by the healthcare stakeholders who contributed to this issue.

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The Last Word: The appalling events in Newtown, Connecticut, occurred as this issue of *Maryland Medicine* was being put to bed. We publish this article in the spirit of trying to respond, however inadequately, to the need for order and process to come out of chaos and death. This article is being reproduced with permission from Robert J. Ursano, MD, Professor and Chairman, Department of Psychiatry, Uniform Services (USUHS) and Director of the Center for the Study of Traumatic Stress.

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To Lead in Times of Change



PRESIDENT'S MESSAGE

Brian H. Avin, MD

The last "President's Message," printed in *Maryland Medicine*, Volume 13, Issue 3, addressed the cliff of uncertainty that physicians face, including changes in how healthcare is delivered, the various payment systems being considered, the implementation and maintenance of electronic medical records (EMRs), meaningful use, quality and value, the presidential election, the implementation of the Patient Protection and Affordable Care Act (PPACA), Sustainable Growth Rate, Medicare payment cuts, sequestration, Independent Payment Advisory Board, and the national fiscal dilemma, all of which will affect how medicine will be delivered and paid for moving forward.

The elections concluded with the reelection of President Obama. The PPACA will remain intact except for the mandatory expansion of Medicaid. This will decrease the number of Americans who would have otherwise been covered by health insurance. Access to healthcare is the critical piece of the puzzle. It will bring people into the healthcare system so that healthy lifestyles can be promoted and illnesses can be treated at an earlier stage, thus decreasing the burden of self-induced illness that leads to chronic conditions that dramatically increase healthcare expenditures. Regulations pertaining to the PPACA are being written each day and add to the uncertainty that physicians and those in the health field face. The health insurance exchange will be in place in 2014 and how the exchange will be funded and implemented is currently under discussion. The "fiscal cliff" has been avoided. The Middle East is in turmoil and the euro continues to hang on by a thread. The volatility of these issues makes it difficult to project what the new reality will look like in February and thereafter.

This issue of *Maryland Medicine* considers how medicine will be delivered and paid for in the near future. Experience has taught me that renovating a house does not ensure a new family dynamic. One

can modify the delivery of healthcare for naught if the engine driving escalating healthcare costs is not seriously addressed. Our healthcare system will remain the most costly of all developed nations as long as for-profit insurance companies provide health insurance and as long as they do not invest in keeping people healthy, perhaps through programs promoting preventive care. Insurance companies have stated that there is little incentive to invest in health promotion because the individuals they insure today will not be insured by them for the long term. Why invest in health when you cannot cash in on your investment? Medicare will end up being the beneficiary, not for-profit insurance companies. In order to significantly bend the cost curve, our nation's schizophrenic approach to healthcare will have to address how health insurance companies and corporations are incentivized to promote healthy rather than unhealthy habits. Tobacco remains the leading preventable cause of death in the United States, despite warnings from the Surgeon General 47 years ago.

So how do I see medicine evolving? I see the present system being restructured only to find ourselves in a worse hole economically because we did not aggressively address the core problems, although I hope that the healthcare system will function more efficiently and effectively. Medicine went through a similar scenario in the 1990s when we addressed costs rather than health. I envision that accountable care organizations and other cost-sharing endeavors will meet their demise when cost savings can no longer be identified. The silver lining here may be that physicians become experienced in the business of medicine and insurance and start up insurance companies that prioritize their patients and communities, rather than corporate executives and shareholders.

The Maryland General Assembly opened its 2013 session on January 9 and the major issues (from MedChi's per-

spective) that will be addressed include the Board of Physicians Sunset Review, the Health Insurance Exchange, expanding Maryland's EHR law to compensate all physicians, requiring health insurers to honor a physician's directed therapy regardless of the insurer's normal "step therapy," supporting the efforts of the Maryland Department of Health and Mental Hygiene to decrease a minor's (under the age of 18) exposure to commercial tanning beds, supporting initiatives to reduce health disparities, supporting efforts to incentivize physician participation with the Maryland Medicaid program, and continuing work to protect the integrity of the Medicaid program with respect to eligibility, benefits, and physician payment. We will continue to strive to make Maryland the first tobacco-free state in the nation by advocating for continued increases in the tobacco tax and prohibiting the sale of tobacco products by businesses that provide healthcare or dispense medications. MedChi is supporting initiatives to address childhood obesity with an emphasis on pro-active programs in the Maryland public school system. MedChi will ensure that all patients have access to physicians and that physician extenders have appropriate training and physician oversight.

As a reminder, starting in 2013, E&M Medicaid services will be paid at Medicare rates to all Maryland physicians. MedChi, along with the Attorney General's Health Education and Advocacy Unit, established a program called Insurance Watch that simplifies the process by which physicians and patients can register complaints and report health insurance company abuses by going to www.medchi.org/iwatch/medchinew.html.

Our profession is in a state of flux. Not only do we need to change with the times, we need to lead in times of change. MedChi is positioned to do just that and we are indeed leading in times of change. It is more important than ever that all

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2013 Session Shaping Up to be Challenging for Physicians



CEO'S MESSAGE

Gene Ransom, III, Esq.

Preparing for 2013, MedChi, The Maryland State Medical Society, has produced a comprehensive legislative agenda based on the resolutions passed by our members. This yearly exercise occurs at the House of Delegates meeting. Unlike other organizations, we have our policy crafted in open meetings at which we decide all major policy issues with the voice and vote of you, our members. A complete copy of the full agenda is available at www.medchi.org or <http://www.medchi.org/HOD>.

Our 2013 legislative agenda deals with various issues, including Medicaid, insurance reform, and public health, as well as the issues I briefly outline below. Significant resources are dedicated to advocacy, but we think extra focus will be needed on the following four subject areas during the 2013 Maryland General Assembly Session.

- 1. Fight New Taxes for Physicians:** MedChi will work to stop any proposed tax or fee increase directed at physicians. Additional energy will be dedicated to proposed increases that are not justified, fair, and based on good sound public policy. Currently, the State of Maryland is considering a tax on physicians to pay for the Health Insurance exchange. MedChi opposes this because there is no rational relationship between physicians and an Exchange to help insurance companies sell their products. MedChi also opposes other proposed increases that have been floated for various licensing fees related to physicians.
- 2. Improve the Disciplinary Process of the Board of Physicians:** MedChi achieved a delay in the extension of the Maryland Board of Physicians (BOP) Sunset Report last session so we would have additional time to work to enhance the legal protection for physicians to ensure that the BOP's disciplinary process is fair and transparent and results in the consistent and efficient resolution

of complaints with adequate due process protections. The complete review of the BOP will take a significant amount of time and energy during the upcoming session.

- 3. Defend the Scope of Medical Practice so Patients Are Seen by Physicians:** MedChi has long fought to ensure that all patients have access to physicians and that physician extenders have appropriate training and physician oversight. The new federal health reform law has placed unprecedented demands on the healthcare system as thousands of newly insured individuals seek physicians. It is important that these new patients find physicians and that non-physicians do not use this as an opportunity to increase their scope of practice without adequate education and training. We expect to see specific proposals to expand scope of practice for podiatrists, naturopaths, lay midwives, and pharmacists.
- 4. Strengthen Medical Liability Reform:** MedChi will continue to strongly oppose trial lawyer attempts to increase the "cap" on damages in medical malpractice cases and to abolish the defense of contributory negligence, and otherwise work to protect and strengthen the legal liability environment for physicians in Maryland. This issue is more important for this session as the result of recent judiciary advocacy. It is possible that the Court of Appeals could take judicial action that could complicate this issue during the 2013 session because it is considering a case that could repeal contributory negligence through judicial fiat.

While I focused on physician taxes, Board of Physicians reform, scope of practice issues, and tort reform, MedChi will work on numerous other items, and MedChi's Legislative Council will consider hundreds of bills. We will need your help,

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The Road More or Less Travelled:

When I travel this road, the journey is made more salient with the AMA riding with me.

EDITOR'S CORNER

Bruce M. Smoller, MD

Last November I attended the AMA Interim Meeting, held in Honolulu. Besides the obvious benefit of being in Hawaii (need I say more?), I was struck by the fact that the AMA is a very, very well organized, richly structured and accessible organization. Without seeing first-hand the workings of our professional organization, one is tempted to toss it off as having gone astray, or being unresponsive to practicing physicians. After this meeting I can tell you that nothing is further from the truth. The AMA has its problems, but being responsive to members is not one of them. Its very structure is built to receive the democratic input of its delegates, who in turn represent the various state and specialty societies, which in turn represent the wishes of its members. The representation of the practicing, front line physician is vigorous and thorough. The meetings, designed so that all, whether representing their various component societies or the individual concerns of the single delegate, are models of democratic process.

Quibble, if you will with the AMA's decision to back the Affordable Care Act—many do. The AMA's decision, however, gave it the power to retain and grow its influence at the highest councils of government, no small feat in these days of assault on the practice of medicine by all manner of politician and consultant. There seems always to be a tension, viewed from outside, between the AMA's dual (at least) mandates to represent the practicing physician and to advance and protect the public health through good medical practice. When observed from inside, however, these two seemingly polar functions seem to merge, if not into one, then into complementary spheres of action.

Perhaps I got a little too much sun in Hawaii (actually, for the duration of the meeting there wasn't much time for sun), but former distress over political ends and current management of the AMA gave way to respect for the process the more time I spent at the meeting. One thing

was certain...this organization needs the active support and investment of time and energy from practicing physicians across the country to be truly representative and most effective.

After the meeting, my family took some time in Maui for recreation. Those of you who have been to Hawaii know how beautiful it is there. We took the road to Hana while there. Hana is the end destination of a 68 mile stretch of twisting, turning, two-lane "highway," filled with waterfalls, beaches, eucalyptus trees that appear to have been painted in bright poster board colors, fern valleys and 59 one-lane bridges. It takes 2.5 hours to traverse if one does not stop, but the whole point of the road is that you must stop to take in the natural beauty of its verdant valleys. If you do it right, it takes eight hours, and then you come back the same way, as there is no road past Hana that any self respecting rental car company allows you to take without instantly voiding your warranty. The point is...it's the journey, not the destination. The road to Hana is the real life model for that old, and well worn adage; seeing really is believing here.

The road to Hana is also a metaphor for the practice of medicine these days, so fraught with slippery roads and narrow, seemingly impassable stretches, but surrounded by the richness of experience which medicine has to offer. When I travel this road, the journey is made more salient with the AMA riding with me.

At this Holiday season, and even though this journal will likely get into your mailboxes after the holidays, I would like to wish all of you a happy, peaceful and, most importantly, a healthy holiday and new year. Reprinted below is a column I wrote 5 years ago when president of MedChi. I have reprinted it several times, but its meaning never fades for me. Good Cheer!

Dear Colleagues, Staff, and Friends of MedChi:

I want to take this opportunity to wish each of you a very joyous holiday season and a peaceful, healthy and happy New Year.

As we reflect on the hard work, the achievements and the disappointments, the gains and losses, the triumphs and tragedies of this waning year, I hope you find special joy in the warmth of family and friends (human and otherwise) and a singular pleasure in that relationship allowed us by virtue of our profession...the amity and friendship, trust and respect of our patients. I believe this is best summed up by the words uttered by Doctor Archibald "Moonlight" Graham in the movie Field of Dreams.

After being magically transformed into a young man, he is allowed to play ball again. He never was at bat during his short baseball career, and now he is at the plate ready to receive the pitch. But he spies the young daughter of Ray Kinsella choking to death and without hesitation "Moonlight" crosses that enchanted boundary between fantasy and reality, and instantly becomes an old man again...a physician, not a ball player. He saves the young girl but never gets to hit, even in fantasy.

When Ray Kinsella notes that the baseball career and lifelong dream of Moonlight Graham had lasted only five minutes and would therefore be considered a tragedy by many people, Doc Graham replied, "Son, if I'd only got to be a doctor for five minutes, now that would have been a tragedy."

It is the spirit of that thought, especially when all the legislative and regulatory chips are down, that will give perspective to our work and meaning to our days in the year ahead.

Have a safe, peaceful and healthy New Year. From the Maryland Medicine Editorial Board and myself, we wish you all the best in 2013.

Introduction: Planning for Change

Mark Jameson, MD

In the 2012 Best Picture Academy Award movie *The Artist*, George Valentin is at his prime as a silent movie star, performing hit after hit before adoring crowds. Riding the crest of fame, he refuses to adapt to the abrupt innovation of “talkie” pictures, becomes marginalized, and is finally replaced by other actors who willingly accept the new world of motion pictures.

The purpose of this issue of *Maryland Medicine*, the *Maryland State Medical Journal*, is to help prepare doctors for the changes in medical practice that are anticipated within the next three to five years. Several of those considered leaders in healthcare in Maryland present their perspectives and recommendations, including Dr. Albert Reece, Dean of the University of Maryland Medical School; Dr. Josh Sharfstein, Secretary of Maryland Department of Health and Mental Hygiene; and Ben Steffen, Executive Director of the Maryland Health Care Commission. We asked these leaders to answer eight questions. Not all felt qualified to answer all eight.

A medical career is characterized by a natural rhythm of change every three to five years. Most physicians attend a four-year college or university, followed by an additional four years in medical school, and then three to five years in residency training. Once a physician completes his or her training, the half-life of current medical knowledge is often stated to be three to five years. Physicians are well-prepared to adapt to advances in medical knowledge during the above-stated time period by reading medical journals, attending conferences, and participating in continuing medical education (CME) programs.

However, scientific advances constitute only half of the future changes in medical practice. Practicing medicine lies at the crossroads of science and society. Social forces are changing the practice of medicine as much as scientific advances are. How well prepared are physicians to adapt to the social forces shaping medical practice in the next three to five years? There are no CME classes to attend, no degrees to earn, or residency programs specializing in predicting future social changes.

Think social forces affecting medical practice are not important? Just a few years ago, who had an iPad mini, or had even heard of “insurance exchanges” or “meaningful use criteria” or the “Independent Payment Advisory Board?” Yet all have irreversibly affected the practice of medicine in a relatively short time.

Some doctors may blissfully believe that clinical skill supremacy will shield them against any external forces. After all, no one has such rigorous training as a board-certified physician, and the demand for medical care will only increase as the population ages and health insurance is expanded. For those deluded physicians who subscribe to this foolish fantasy, merely witness the simultaneous extinction of solo medical practices and the meteoric rise of mid-level practitioners. Other physicians may realize that changes are coming but simply try to “hold on” until retirement. Most physicians, though, must contend with the future changes with a realistic plan.

The locus of power in healthcare has shifted from physicians and hospitals to insurance companies and the government as the cost of healthcare has become a national imperative. Both insurance companies and government agencies possess vast patient care databases that will be used to formulate cost reduction strategies. Without proper planning, current and future practicing physicians possessing only clinical skills will be isolated and have no control over innumerable future changes. Unless physicians take basic preparatory steps, they may feel that they have become Myrmidons, and not advocates for patient care. (In Greek mythology, Myrmidons were skilled and brave warriors, but the term later denoted those who blindly follow orders.)

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What steps can we take to prepare for the future? For my own part, I offer three suggestions. The first is to embrace information technology (IT). This is a given for younger doctors, but remains a challenge for those who graduated from medical school decades ago. Tablets, smart phones, and applications (apps) are not going away. Physicians (and others in the medical field, frankly) must become proficient with a variety of IT venues, not just basic email and web surfing. Using technology to keep current on medical advances and to communicate with other healthcare professionals and patients is a critical capability. Clinical practice will become more and more IT-based.

Second, doctors must become leaders. Of all the subjects not currently offered in the medical school curriculum and residency programs, perhaps the most important is leadership training. In today's complex healthcare environment, physicians must be *leaders*, not only *healers*. In a bygone era, being a healer was synonymous with being a leader. Traditionally, the awe of clinical acumen conferred a mantle of leadership on those in the profession. No more! Now, social forces are eclipsing the leadership role of physicians. For example, physicians are increasingly team members instead of team leaders, employees rather than employers, and following guidelines instead of formulating independent clinical analyses.

Yet the necessity for physician leadership is indispensable. Cost containment will increasingly and inevitably attempt to reduce care for patients. The temptation for us is to become passive and submissive, to give up, not to challenge powerful third parties. Physicians cannot succumb to the expedient path of least resistance. We must not surrender advocacy for patients. At its core, *leadership is acting on behalf of patients and seeking solutions to improve care.*

Third, political activism is a new requirement for doctors. Traditionally, doctors shunned politics. Like it or not, now that the government funds nearly 45 percent of all healthcare, physicians are directly or indirectly working for the government. Government task forces, guidelines, regulations, licensing, and funding directly affect clinical practice. More than ever, it is critical for us to establish communication with government leaders. This can be done individually, but, more importantly, collectively through professional organizations such as MedChi, the Maryland State Medical Society, or your applicable professional specialty group. Leadership requires action.

In conclusion, superior clinical skills are no longer sufficient for physicians to practice medicine. A doctor without a plan for the next three to five years is a doctor who risks being overtaken by events and being replaced. As Benjamin Franklin wisely advised, "By failing to prepare, you are preparing to fail."

In *The Artist*, after many tribulations, George Valentin stages a successful comeback by skillfully adding dancing with a "talkie" star to his repertoire. There's a message in that for all of us.

Mark G. Jameson, MD, MPH, specializes in public health in Hagerstown, MD. The views expressed are strictly those of the author and do not represent the views of the Washington County Health Department or the Maryland Department of Health and Mental Hygiene.

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LETTERS

The Meaning of White

Dr. Gershen's "Word Rounds" feature in Volume 13 Number 3 of *Maryland Medicine*, "Black and White" was, as usual, informative and entertaining. I might add, gratuitously, a comment on the derivative meanings of "white" in another language, Hebrew. The Hebrew word for "white" is "lavan," from the root, "l-v-n" and from that is derived the verb, "to shame," "h-l-v-n," (indicating that a person who is shamed is likely to blanch or exhibit pallor) and the noun for "moon," "l-v-n-h," (a reference to the pale color of the moon). A cognate word for "lavan" in Aramaic gives rise to "Lebanon" (since the land is often identified with its snow-capped mountain peaks.

Elliot Wilner, MD
Chevy Chase, MD

68 Years After the War—a Reminder of My Service Time



I enjoyed the issue on "Medicine and the Military." During WWII I was a member of the 8th Air Patrol, 305th Bomb Group, led by General Curtis LeMay. The photo is of a rendering on my belt buckle of the plane I flew as well as a piece of shrapnel (today referred to as "flak") that hit our plane by the Germans. Luckily it didn't hit our fuel tank!

Robert Barnett, MD
Rockville, MD

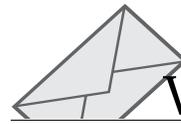
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President's Message ...

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physicians—those of us in private practice and those of us who are employed by a group, hospital, or healthcare system—work together to safeguard our profession and to best serve our patients and our communities. The mission of MedChi is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health, and we need the help and support of all physicians. There has never been a more important time for Maryland physicians to join together and support MedChi, the Maryland State Medical Society.

Brian H. Avin, MD, practices neurology in Silver Spring, MD.



WRITE TO US

The Editorial Board of *Maryland Medicine* welcomes your letters, comments, and opinions. Readers may respond to the authors or the editors by e-mail at sraskin@montgomerymedicine.org or by mail to Editor, *Maryland Medicine*, c/o Montgomery County Medical Society, 15855 Crabbs Branch Way, Rockville, MD 20855.

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MedChi
The Maryland State Medical Society

CEO's Message ...

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and your input. Please let us know how you can help us protect physicians' rights in Annapolis. Can you help out as the volunteer physician in the first aid room during session, serve on the legislative committee, or testify on a bill or issue? Can you email your legislators when we send an alert on an important issue? Can you tell your colleagues about all of the important issues MedChi is working on for them, and ask them to join? Please let me know. You can contact me at gransom@medchi.org or 1.800.492.1056 x.3305.

Gene Ransom, III, Esq., Executive Director and CEO of MedChi, The Maryland State Medical Society, may be contacted at 1.800.492.1056 or gransom@medchi.org.

8 QUESTIONS

The challenge of health care reform will require physicians to lead teams of clinicians and others to provide the best and most appropriate care for patients. But those team leadership skills are not taught in medical school. One of the most important ways that physicians can improve the delivery of care is to acquire the leadership skills necessary to direct.



Carmela Coyle became President & CEO of the Maryland Hospital Association in 2008 after 20 years with the American Hospital Association where, as a member of the executive management team, she managed analysis of legislation, regulation and trends, developed policy positions, and served as a national media spokesperson.

Key Maryland Healthcare Stakeholders Discuss the Future of Medicine

The Maryland Medicine

Editorial Board asked “leaders in healthcare in Maryland” to respond to eight questions relating to medical and related areas. Their responses are noted, by question, in the following eight articles. At the beginning of each article we have noted one of the authors. Authors did not necessarily answer all questions.

QUESTION #1

In your experience, are the current changes to medical practice benefitting patients?

Examples of current changes include EMR, prescription drug monitoring, proliferation of Urgent Care Centers, shorter hospital stays, extending medical assistance health insurance to previously uninsured patients, and increasing pervasive pre-authorization requirements.

Carmela Coyle

CEO of the Maryland Hospital Association

There is so much change afoot in health care today that you can't bundle all of the "current changes" together as either good or bad for patients. Among the recent changes that are good for patients: insurance coverage expansion that was part of health care reform. More people already have access to health care insurance, such as those up to age 26 who can remain on their parents' policies, and another 250,000 Marylanders will soon have access to health care insurance coverage who didn't before. Having more people covered means having a better chance of getting the care they need when they need it. Another recent change that is good for patients is widespread use of electronic medical records. Technology allows physicians and hospitals timely access to important clinical information needed to treat patients as effectively as possible. And Maryland is the first state to have ALL hospitals linked in our statewide health information exchange known as CRISP (Chesapeake Regional Information System for Our Patients).

Of concern for our patients is the trend toward insurance coverage placing a greater and greater financial burden on patients themselves. The proliferation of high deductible insurance coverage means patients have "coverage" but it can be so skimpy as to provide little security for them and their families. When is insurance really not insurance at all?

Senator Rob Garagiola

Maryland Senate Chair of the Health Subcommittee in the Finance Committee

It is my hope that the recent changes in medical practice are benefitting patients. First and foremost, it is the physicians who are in the trenches, providing care day-in and day-out, who are making the biggest difference in improving patient care. At the same time, I recognize that there are a lot of pressures being imposed on physicians, including additional administrative responsibilities, without commensurate increases in reimbursement. However, I am hopeful that the recent changes, particularly in health information technology (IT), will further benefit patients and reduce some of those administrative burdens on physicians.

There is great promise that health IT, including electronic health records (EHRs) and health information exchange, will improve health outcomes, streamline medical practice processes, reduce redundant tests and generate savings, enable reliable connections among care delivery sites, and improve the referral process for patients. Unfortunately, in 2011, Maryland (at 29.2 percent) was slightly below the nation as a whole (at 33.8 percent) in the ambulatory physician EHR adoption rate, according to the Board of Physicians and National Center for Health Statistics. Maryland is the first state to require that health insurance carriers provide incentives to promote adoption of EHRs. Under the Medicare EHR incentive program, providers may receive up to \$44,000 over five years, and under the Medicaid

EHR incentive program, providers may receive more than \$63,000 for adoption and meaningful use of EHR.

The goal of the prescription drug monitoring program (PDMP), enacted in 2011, is to slow the rapidly rising rate of prescription drug abuse, while preserving legitimate patient access to optimal pharmaceutical-assisted care. For the first time, comprehensive information on controlled substances prescribed and dispensed will be made available to doctors, pharmacists, and other healthcare providers. The PDMP will provide a powerful clinical tool for the prevention, early identification, and treatment of prescription drug abuse and addiction. The current estimated timeframe for full program implementation is the summer of 2013.

Preauthorization requirements imposed by payers have become increasingly burdensome on healthcare providers, compelling the General Assembly to act in the 2012 session. SB 540/HB 470 established a phased approach for implementation of electronic prior authorization requests, requiring reporting, and requiring providers to use an online prior authorization process by July 1, 2015.

The Affordable Care Act expands coverage to both parents and childless adults up to 138 percent of the federal poverty level, beginning in January 2014. It is estimated that 154,000 additional individuals will be enrolled in Medicaid in the first full year of implementation (2015). These efforts to extend medical assistance to additional low-income uninsured individuals will likely encourage individuals to obtain preventive care and discourage them from waiting to seek care until an illness becomes advanced. In addition, this medical assistance will provide a source of reimbursement for healthcare providers, who may now be providing free or discounted care to these uninsured individuals.

David Horrocks

President of the Chesapeake Regional Information System for Patients (CRISP)

I believe that EMR and electronic communication will be enormously beneficial to patients over time. It isn't so much the individual interaction between a physician and patient during an office visit—or a physician's use of a keyboard instead of a pen—that will make the difference. Rather, physicians today are receiving, assessing and digesting enormous amounts of information, much of which comes from outside the practice. Doing that on paper is not efficient.

An electronic infrastructure is the foundation for many other things, including public health initiatives, computer-assisted decision support, and a foundation for new types of patient/clinician and clinician/clinician interaction, such as real-time alerts and the provision of patient-collected information for use during medical care. Undoubtedly, in this early period when the foundation is still being built, many of the benefits are not yet fully realized. In fact, some interventions will require the majority of practices to be electronic before they can be widely implemented. But all are impossible if we stay stuck with paper.

Gene Ransom, III, Esquire

Executive Director of MedChi

The changes in healthcare has positive and negative aspects. New technology has increased life expectancy, and access to care has increased dramatically. However, while technology and physician skills have never been better, we face growing barriers in the physician-patient relationship. Government regulation, new requirements, defensive medicine and bureaucratic complexities from payers and policy makers make it harder for the physician-patient relationship to develop. As we move to a new outcome-driven healthcare world, physicians will have to work to protect and nurture the physician patient relationship.

Patrick Redmon, PhD

Executive Director of Maryland's Health Services
Cost Review Commission

Generally, changes in medical practice are improving patient care, but not all changes do so. New technologies, techniques, and treatments offer life saving capabilities that have not been possible before, and advances in information technology offer the promise of better care coordination and evaluation in various populations.

New technology is often expensive. However, our medical system has a bias toward early adoption and diffusion of technologies whose marginal benefit may be low. This result is inefficient.

E. Albert Reece, MD

Vice President for Medical Affairs for the University System
of Maryland

Many of the current changes in medical practice have the potential to significantly benefit patient care. For example, the ongoing transition by many hospitals and medical practices from paper-based records to electronic medical records (EMRs) brings the risk of these computer-based systems failing or their information being used inappropriately. However, EMRs also can be used to monitor and improve patient care and safety. Studies have shown that electronic drug monitoring systems allow care providers to spend less time documenting medications and more time on direct patient care, and they reduce charting errors. EMRs also have the potential to save our healthcare system billions of dollars. Recently, it was estimated that the widespread adoption of interoperable EMR systems could save \$142 billion to \$371 billion annually in healthcare expenditures.

Healthcare reform also has the potential to significantly benefit patients, especially for those who previously lacked access to healthcare. The Affordable Care Act for the first time makes

evidence-based preventive services available nationwide through individual and group health plans, Medicare, and Medicaid. As a result, the majority of Americans will now have access to evidence-based preventive measures that have the potential to greatly improve their health and reduce their healthcare costs. However, such efforts will only bring incremental improvements unless we "re-engineer" prevention into healthcare teaching, management, and delivery by reconnecting medicine to public health services.

Joshua Sharfstein, MD

Pediatrician and Secretary of the Maryland Department of
Health and Mental Hygiene

Changes in medicine offer both benefits and challenges for patients. Certainly, better access to health insurance saves lives and improves health. In addition, many physicians using the Maryland Health Information Exchange have told me that electronic access to key clinical data has improved care and reduced the numbers of unnecessary invasive procedures. Better integration of clinical and community health efforts can bring major improvements in the health of patients.

At the same time, there are new challenges. For example, I have heard from other physicians struggling to implement an effective electronic health record. Struggles with implementation may reduce the amount of time physicians have to spend listening to their patients.

Ben Steffen

Executive Director of the Maryland Health Care Commission

I'll emphasize two of the initiatives noted in the question.

1. Expansion of private insurance coverage and Medicaid through federal health care reform will have the most direct benefit to patients. On health care reform, Maryland is already recognized as a leader. Under the Governor Martin O'Malley/Lieutenant Governor Anthony Brown administration, Maryland will expand coverage to more than 190,000 patients by 2020. While Maryland residents who are uninsured will benefit the most, those that are already insured in the non-group and small group markets will have access to more comprehensive insurance benefits. Individuals and families who purchase in the non-group market will be eligible for subsidies if their family income falls below 400 percent of the federal poverty level (FPL) with the most substantial subsidies available to those with incomes below 300 percent of the FPL. (In 2012, 400 percent of the FPL means about \$92,000 for a family of four.) The bottom line on healthcare reform is that more patients will have access to the care they need and physicians will be assured that those services will be reimbursed.

2. The efforts to jump start the adoption of electronic medical records (EMR) by both Maryland and the federal government is an initiative that has significant potential to reshape the delivery of care. More extensive and timely clinical information is essential to improving the quality and efficiency of care and virtually all of the delivery system reforms contemplated under health care reform assume that EMRs will be widely adopted by physician practices. Maryland is the only state that requires private carriers to provide financial assistance to physicians adopting EMRs. Maryland has some challenges for EMR adoption because many practices are small, but we have an important advantage in that our political leadership is highly engaged.

“Maryland physicians have always demonstrated the willingness and ability to improve health care delivery. While physicians represent only one part of the health care delivery system, they are the captains of the ship. Maryland physicians can continue to provide excellent care to their patients by counseling on wellness and prevention.”

QUESTION #2

How can medical practices be changed to improve patient care?



Majority Leader Rob Garagiola is the Maryland Senate Chair of the Health Subcommittee in the Finance Committee.

Senator Rob Garagiola

I feel that the medical community should take the lead on this issue and is able to identify those important practices. I am hopeful that some of the new changes and programs will assist the medical community in this endeavor, for example utilization of the health information exchange.

David Horrocks

The nature of interactions patients have with their physicians will continue to change. This is not to say that face-to-face interactions will be replaced entirely, but I believe they will be augmented by other means of communicating. For instance, patients will embrace new ways of sending important information to their physicians, and in turn the physicians will use new methods to automatically remind patients of their own responsibilities for their care, like taking medications or having a blood-pressure reading.

Reimbursement is the key to accelerating this change. In my judgment, today's reimbursement system doesn't support new, richer models of interaction very well, though there are signs that this is about to change. A call to my physician is often more convenient, more timely, and potentially more effective than scheduling a face-to-face chat, but my doctor is only paid for the second option.

Gene Ransom, III

Medical practice needs to focus on the patient, and move its focus away from outside issues. We need to end defensive medicine. Promote systems that allow for a physician-patient relationship to develop, and remove barriers that interfere with that relationship.

Patrick Redmon, PhD

The system for delivering care needs to be changed. The American system is fragmented, and because payment systems

are structured around the separate delivery systems, the problems stemming from the fragmentation are difficult to solve. From a system perspective, better care coordination is essential, beginning with prevention. A rational system would focus on improved health outcomes instead of treating illness after it occurs. Further, that system would coordinate care instead of bouncing patients from one setting to another.

E. Albert Reece, MD

Medical practice can be changed to improve patient care by continuing to focus on safety and quality. The 1999 Institute of Medicine (IOM) report, *To Err is Human: Building a Safer Healthcare System*, estimated that preventable medical errors result in between \$17 billion and \$29 billion per year in additional healthcare costs as well as loss of patients' trust in the healthcare system. It also found that such preventable medical errors diminished satisfaction among both patients and health professionals.

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One of the report's main conclusions was that "the majority of medical errors do not result from individual recklessness or the actions of a particular group, but by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them." Thus, according to the report, mistakes can best be prevented by designing the health system at all levels to make it harder for people to do something wrong, and easier for them to do it right. Therefore, making processes and conditions more conducive to the use of checklists and quality control procedures, information sharing, and collaborative care will continue to improve patient care. EMRs are an important part of that process.

Furthermore, the 2001 IOM report, "Crossing the Quality Chasm: A New Health System for the 21st Century," called for improving patient care by improving six dimensions of healthcare performance: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Thus, we should judge the quality of our professional work, delivery systems, organizations, and policies first and only by their ultimate ability to improve conditions for the individual patient and to relieve suffering, reduce disability, and maintain good health.

Joshua Sharfstein, MD

A more relevant question today may be: how can medical practices be changed to improve patient outcomes? As physicians, we care not only about providing excellent care, but also about preventing illness. New payment structures will increasingly

reward practices that help keep patients healthy (whether primary, secondary, or tertiary prevention), even if that means a lower rate of acute hospitalizations or surgeries.

Ben Steffen

Many physicians, payers, patients, and employers are frustrated with the current system that yields high costs and uneven results. Three essentials are needed to improve care, include becoming better integrated with other providers of care, adopting more comprehensive and better integrated information systems, and recognizing that purchasers (employers and patients) of health care are demanding value for the dollars they invest in care. A point on integrating with other providers warrants clarification, it does not always mean practice consolidation. Maryland physicians do not necessarily need to become employees of large systems. While large integrated multi-specialty organizations such as the Mayo Clinic and Geisinger, among others, do a great job of providing care, I think it is possible that virtual organizations of providers may be able to achieve similar results.

Carmela Coyle

Widespread use in physician offices of electronic medical records is one sure way to improve patient care. Think of it: America's banking system is so coordinated that you can be almost anywhere in the world and still access all the details of your bank account via an ATM or even your iPhone. Yet in health care, a patient moving from a doctor's office to a specialist to a hospital must take charge of making sure their records are brought to each place of care, because they often still don't talk to each other!

And medical practices can continue to implement changes to make it easier for patients to be involved in their care. Offer open scheduling and more flexible hours so patients with pain don't have to wait months for the next available appointment, and likely wind up in the more costly emergency department setting in the interim. Send care reminders to help make sure patients get the follow up and routine checks they need for a particular condition. Provide email opportunities to connect directly with physicians. Make follow-up phone calls to patients after appointments to see if their condition has improved. All of these consumer-friendly practices are being employed by some of the leading physician practices today, regardless of reimbursement. Steps like these can help to make sure we truly engage patients and their families in the care delivery process, and that means better care.

“THE NATURE OF INTERACTIONS PATIENTS HAVE WITH THEIR PHYSICIANS WILL CONTINUE TO CHANGE. THIS IS NOT TO SAY THAT FACE-TO-FACE INTERACTIONS WILL BE REPLACED ENTIRELY, BUT I BELIEVE THEY WILL BE AUGMENTED BY OTHER MEANS OF COMMUNICATING. FOR INSTANCE, PATIENTS WILL EMBRACE NEW WAYS OF SENDING IMPORTANT INFORMATION TO THEIR PHYSICIANS, AND IN TURN THE PHYSICIANS WILL USE NEW METHODS TO AUTOMATICALLY REMIND PATIENTS OF THEIR OWN RESPONSIBILITIES FOR THEIR CARE, LIKE TAKING MEDICATIONS OR A BLOOD-PRESSURE READING.”

QUESTION #3

What can physicians do to improve health care delivery?



David Horrocks is the president of the Chesapeake Regional Information System for Patients (CRISP), Maryland's statewide health information exchange.

David Horrocks

As physicians look to Electronic Medical Records (EMR) and the future of medical care, I believe an important component is clinician-to-clinician communication. This is an element of health IT that is sometimes overlooked. The tools to do this, such as direct secure messaging and real-time encounter alerts, are now available but they only work if groups or communities of clinicians are all willing to use them. Some degree of cooperation and coordination could go a long way to improvement in this area.

In the not too distant future, The Centers for Medicare and Medicaid (CMS) will require electronic summaries of care when sending referrals as a requirement of Meaningful Use. There is no reason that this couldn't be done today for physicians who are frequently sharing the same patients: the benefits for patient care could be great.

Gene Ransom, III

Physicians are amazingly busy just trying to manage their practices. The key to improving health care delivery is being active in policy discussions. Many of the people making policy decisions do not understand the practice of medicine. For example, the Maryland General Assembly has only one physician member of its 181 Delegates and Senators. While not every physician needs to run for office, they need to be active in policy discussions, informed and engaged.

E. Albert Reece, MD

Individual physicians can do their part to improve patient care by embracing their role within the context of a highly functioning healthcare team. Medicine is increasingly becoming more collaborative, interdisciplinary, and patient-centered. Thus, physicians need to be ready to adapt to new models of care.

Physicians also can take an active role in healthcare reform rather than wait-

ing for all aspects of this program to be introduced. This includes becoming informed about the implications of reform on practice so that they can both explain it to their patients and become an advocate for their patients when reforms negatively affect their care. Indeed, when patients need their physicians to write letters or complete forms in order for them to qualify for a particular health benefit, it is another opportunity for physicians to strengthen the therapeutic relationship with patients. Staying proactively informed, thus, is beneficial to the physician and the patient.

Joshua Sharfstein, MD

Physicians focused on preventing illness and achieving better outcomes will increasingly find reasons to partner with others in the healthcare system. Pharmacists can help educate their patients about appropriate medication use; nurses can assess the chronically ill between visits; home care may help keep people out of hospitals. Expanding

these connections between levels of care and treatment may provide a path for greater health—and greater rewards under new reimbursement systems.

Ben Steffen

This is a time of great experimentation and great collaboration. We are seeing experimentation in the types of healthcare delivery models, such as patient centered medical homes and accountable care organizations. Participants in these programs see more benefit working collaboratively than by engaging in conflict. This change is, in part, the result of federal health care reform, which provides a framework for delivery system reform, but has also encouraged a change in perspective—particularly on the part of clinicians and payers. While each practice must carefully assess which of these types of changes to adopt, a practice cannot be afraid to innovate.

Carmela Coyle

Become an active participant in the full continuum of your patients' care. The future of care delivery and of keeping the cost of health care affordable for all Marylanders centers on the ability of different providers – physicians, hospitals, nursing homes, home health agencies – to work together, to coordinate care for a patient, to manage that patient's health and illness, and to do so as a team. That requires seamless patient transitions from one provider to another. And the journey often starts in the physician's office. Take time with your patients. Ask them not only about the concern with

which they are presenting today, but about other issues or concerns that they may have. Don't simply hand "off" a patient to another provider (goodbye!). Instead, hand 'over' the patient to the next appropriate caregiver and stay informed and involved.

Take advantage of leadership education opportunities. The challenge of health care reform will require physicians to lead teams of clinicians and others to provide the best and most appropriate care for patients. But those team leadership skills are not taught in medical school. One of the most important ways that physicians can improve the delivery of care is to acquire the leadership skills necessary to direct the care teams of the future.

Senator Rob Garagiola

Maryland physicians have always demonstrated the willingness and ability to improve healthcare delivery. While physicians represent only one part of the healthcare delivery system, they are the captains of the ship. Maryland physicians can continue to provide excellent care to their patients by counseling on wellness and prevention.

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QUESTION #4

Is the “patient-centered medical home” (PCMH) a valid concept?

While technology and physician skills have never been better, we face growing barriers in the physician-patient relationship. Government regulation, new requirements, defensive medicine and bureaucratic complexities from payers and policy makers make it harder for the physician-patient relationship to develop.



Gene Ransom, III, Esq. is CEO and the Executive Director of MedChi, The Maryland State Medical Society.

Gene Ransom, III

Yes, if that concept is taken to mean physician-coordinated care organized around the patient using a team delivery model.

Patrick Redmon, PhD

The medical home model shows promise for providing better patient outcomes. Conceptually, this model provides a method for coordinating patient-centered care and improving outcomes, potentially at lower costs. The difficulties with the model are twofold. First, the concept has not been fully embraced in this country. The current payment structures have to be adapted to make the concept workable on a broader basis. Second, patients have to be engaged to yield the full potential of this model. The sociological component of improved care is as important as the medical practice component.

E. Albert Reece, MD

The medical home is a valid concept, especially in this era of skyrocketing healthcare costs. Research already is bearing this out. According to The Centers for Medicare and Medicaid, healthcare costs in the United States account for approximately 16 percent of the nation's gross domestic product (GDP) and are projected to be almost 20 percent by 2020. Thus, patient-centered medical homes (PCMHs) are increasingly being seen as a way to keep costs down while still delivering quality care. Indeed, managed care companies, hospitals, and clinics have begun pilot programs around the United States to test their efficacy. CareFirst BlueCross BlueShield, for example, started a PCMH program in Maryland in 2011. This program offers participating primary care physicians higher reimbursement rates for developing and following through on care programs for patients with chronic diseases. In the program's first year, 23 of the 52 groups in the program received a total of about \$815,700 in incentive payments, according to a state report, even though the program was not expected to achieve any measurable cost savings in its first year.

Joshua Sharfstein, MD

The medical home in the United States and elsewhere is a proven concept to deliver better outcomes at lower cost and with higher patient satisfaction. The challenge for us is how best to implement this approach in Maryland. There are

effective models and ineffective models. Effective medical home models provide extra resources to the practice and the opportunity for substantial gain-sharing as health outcomes improve and costs come down. A rewarding part of my job is meeting enthusiastic physicians who report satisfaction and rejuvenation upon switching to a successful medical home model.

Ben Steffen

The "medical home" is a valid but evolving concept. Federal healthcare reforms are premised on primary care physicians playing a key role in improving quality, reducing costs, and increasing patient satisfaction. Key elements of a medical home are practice transformation to more patient-centered care, increased patient engagement, stronger care management, and greater access to patient-specific clinical information through an electronic health record. Enhanced reimbursements are built on a traditional fee-for-service and a shared savings formula to sustain the new delivery model. Successful physician leadership and commitment are thought to be keys to success. Over the next several years we will begin to refine the appropriate implementation of each of these elements. How should care transformation occur, is recognition by an accreditation organization important, and who should finance care management, are several of the questions that we hope to answer. Lieutenant Governor Brown has been a staunch advocate of primary care and Maryland continues to experiment with several approaches to medical home implementation under his leadership.

Carmela Coyle

The "medical home" is a critically important concept, but remains largely untested. If we are going to successfully reduce the cost of care in Maryland, it will require us to focus on keeping people well, preventing illness and treating people in the community, not in the emergency department. It will require us to make sure that every patient has a "quarterback" to coordinate and manage their care. That "quarterback," in most cases, will be the primary care physician. That's what the medical home concept is all about – to create a single point of contact for

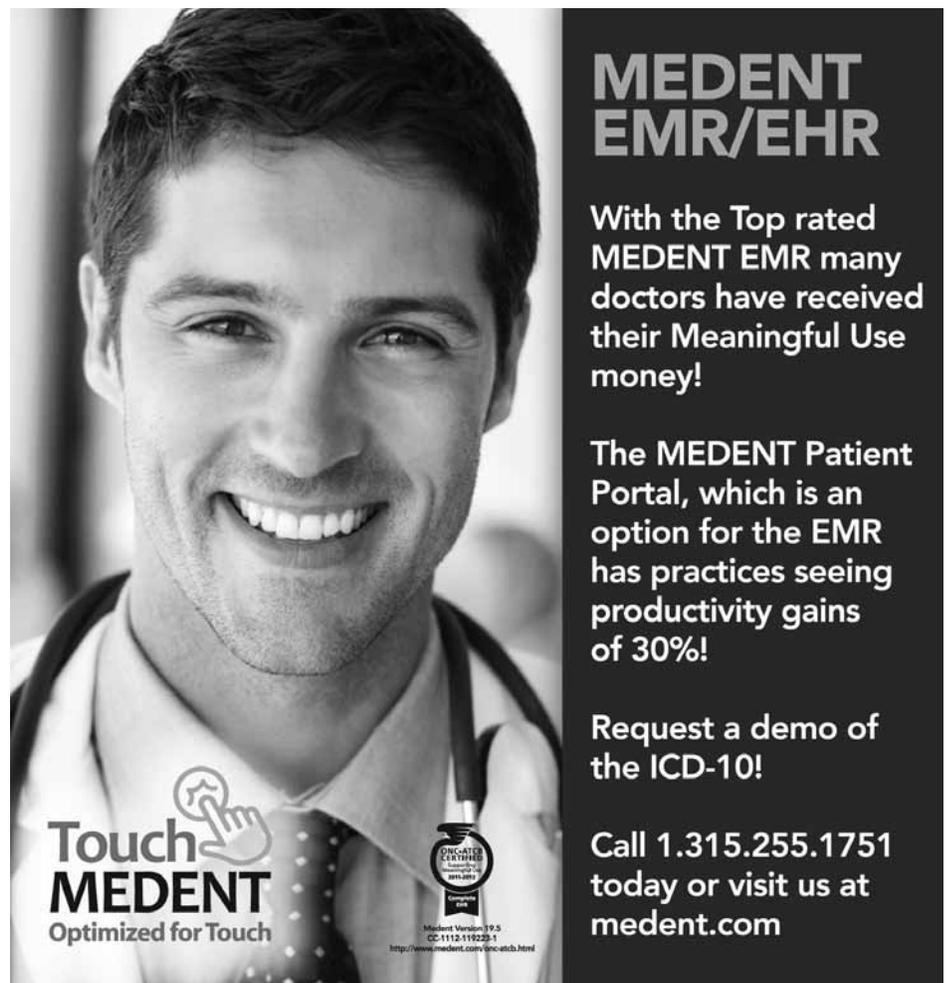
the coordination of a person's care. We anxiously await deeper evaluation of the model's effectiveness.

Senator Rob Garagiola

The patient-centered medical home seeks to improve quality, lower costs, and increase clinician and patient satisfaction. I am hopeful that these goals will continue to be met. The Maryland Multi-Payer Patient Centered Medical Home Pilot Program, authorized by 2010 legislation, is underway. The program includes five large commercial carriers, Medicaid, and some self-funded employers; 339 clinicians in 52 medical practices around the state; and approximately 250,000 patients. All of the 52 practices have achieved National Committee on Quality Assurance recognition—two-thirds of them at Level II or Level III. In the first six months of the pilot program, practices had to submit data on quality and cost; about half of the practices showed savings over and above expectations, primarily through reduced hospitalizations.

David Horrocks

Whether the patient-centered medical home model is appropriate clinically is for others to decide. But I like that reimbursement models are being considered and adjusted in ways that recognize that we do need new ways of interacting with patients and coordinating care. As Maryland's statewide health information exchange, CRISP is working to deploy tools that are useful to doctors in PCMH programs.



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“A rational system would focus on improved health outcomes instead of treating illness after it occurs. Further, that system would coordinate care instead of bouncing patients from one setting to another.”

QUESTION #5

What do you think healthcare in this country will look like in 2020?



Patrick Redmon, PhD, is the Executive Director of Maryland's Health Services Cost Review Commission, the agency responsible for the regulation of hospital rates in the state.

Patrick Redmon, PhD

The system is likely to evolve in ways that we do not anticipate today. With insurance expansions, efforts to control healthcare costs (both public and private), technological innovations, and governmental budget uncertainties, both financing and delivery systems face challenges:

- Will there be enough providers to deliver to an expanded insured population?
- Will the skill mix for physicians and other healthcare professionals match the demand for services?
- How will we pay for healthcare services in an era of tight budgets?

We are likely to see changes and innovations in response to these challenges that few would predict from our vantage point today. Based on our current situation, budgetary pressures are likely to drive system changes to slow spending growth

in state and federal budgets. That can only be accomplished by reducing payments to providers, reducing utilization of services, or covering fewer services. Each option has consequences for the delivery system in the future. Ideally, we could improve efficiency and make the most of every dollar we spend for healthcare services.

E. Albert Reece, MD

Due to advances in research, trends in health literacy, and recent healthcare reforms, healthcare in this county in 2020 is likely to be much more personalized, patient-centered, and value-based. For example, naturally occurring variants in genes have been linked to a high risk of adverse reactions to commonly prescribed drugs. Thus, the accumulation of genomic information will continue to put pressure on the practice of medicine to become more personalized so the incidence of such adverse reactions is minimized. The arrival of the \$1,000 genome, where the cost of sequencing a patient's

entire genome soon will roughly equal the cost of an MRI, will greatly increase this pressure.

In addition, only 12 percent of American adults are proficiently literate about health information, and poor health literacy is a stronger predictor of a person's health than age, income, employment status, education level, or race. More than a third of American adults—77 million people—have difficulty with common health tasks, such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart. Thus, there is increasing pressure for individual patients and providers to work together to ensure effective communication. Finally, bringing down the overall cost of healthcare, while improving its quality for all Americans, represents one of the central goals of health reform. By 2020, healthcare will have begun to move dramatically away from a volume-based approach, where profits are maximized by seeing as large a volume of patients as possible, to a value-based approach, where the measurement

and dissemination of health outcomes become mandatory for every provider and every medical condition. Outcome results data not only will drive providers and health plans to improve outcomes and efficiency, but also will help patients and health plans choose the best provider teams for their medical care.

Joshua Sharfstein, MD

I hope that healthcare is more oriented toward prevention, outcomes, and value in 2020. From a patient's perspective, this means better health at a lower cost.

Ben Steffen

As healthcare accounts for about 17 percent of spending in the economy, even with the dramatic changes that are now underway, we must remain hopeful that we can make changes while pragmatically recognizing that changes are going to occur slowly. Here is my Christmas 2020 wish list:

1. We will have cut in half the percent of Maryland residents who are uninsured from about 14 percent today to 7 percent, and along with that progress,
2. I'm hopeful that we will have seen significant success in reducing disparities between white and minority populations.
3. If we are to succeed in meeting those goals, I expect that we will have had significant success in developing more integrated systems that deliver high quality, cost effective care to residents across all Maryland communities.

Carmela Coyle

I think health care will be more coordinated, with physicians, hospitals and other providers more connected than we've seen before and payment incentives in place that begin to align the financial interests of each so that we are all pulling on the same rope in the same direction together as we care for patients. I think care will be delivered by larger and more consolidated organizations. And I think health care will be leaner, with even greater pressure on providers for efficiency. At the same time, I believe health care in 2020 will be able to demonstrate better quality and safety.

Senator Rob Garagiola

I envision healthcare being delivered through large, integrated systems, including accountable care organizations. I can also see the internet, electronic communication, and social media playing a greater role in physician/patient relationships, with patients taking on greater responsibility in their wellness and preventive care.

David Horrocks

This is a really important question. Our policymakers certainly have a vision. I'm not sure all the changes we've begun have shown the initial, rapid effects that many hoped for. But over the course of ten years, perhaps they will. I would hope that in 2020 access

to care—and primary care in particular—is more broadly available and the lack of health insurance is no longer a hindrance to Americans who have a need for care.

I suspect that many forms of routine care that have cost little to patients will begin to have more of a direct fee. For example, if I have a cold and go to the doctor, I used to pay a \$10 co-pay. Today the co-pay is \$20. Under many health plans this is now an out-of-pocket expense. I suspect the patient's role as a paying consumer will grow and change some aspects of care delivery.

Gene Ransom, III

By 2020 America will have gone thru a major change in its healthcare delivery system. We will shift to value based purchasing. Healthcare workers will be rewarded less on utilization and more on outcomes. It will result in a change in who profits in healthcare, and there will be winners and losers.



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More than a third of American adults—77 million people—have difficulty with common health tasks, such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart. Thus, there is increasing pressure for individual patients and providers to work together to ensure effective communication.



E. Albert Reece, MD, is Vice President for Medical Affairs for the University System of Maryland, Dean of the University of Maryland School of Medicine in Baltimore, and a member of the Institute of Medicine of the National Academy of Sciences.

QUESTION #6

From your perspective, what are the three most important factors driving this transition?

E. Albert Reece, MD

The three most important factors driving this initiative are:

- Research and technological advances;
- The increasing prevalence of chronic disease; and
- The spiraling cost of healthcare. Technological advances not only are saving lives, but also are driving up the cost of care, by almost two-thirds by some estimates. Indeed, the primary reason for the increase in the health sector's share of GDP over the past 30 years is due to technological advances in medicine. Likewise, the increasing incidence of chronic disease is changing the face of medicine. Chronic diseases such as obesity and diabetes are at epidemic proportions in many regions of the country, and the care of individuals with these conditions is often more complicated and expensive than that of patients with acute conditions. As the incidence of people with chronic illnesses increases, there will be significant changes in the division of care provided by specialists, general practitioners, and paramedics.

Closely related to the first two factors, the spiraling costs of healthcare in the United States will continue to alter the practice of medicine for the foreseeable future. Healthcare spending in the United States dwarfs that in any other industrialized country. The rate of growth in recent years has slowed relative to the late 1990s and early 2000s, but is still expected to grow faster than national income for some time to come. Thus, there are likely to be increasing efforts to control costs by controlling the unnecessary use of technology and preventing chronic illnesses before they occur.

Joshua Sharfstein, MD

First, the unacceptably high and growing cost of healthcare. Second, a recognition that our overall health outcomes must be improved. Third, an understanding that changes in healthcare delivery can achieve better value.

Ben Steffen

First, political leadership is essential. We are fortunate to have strong Maryland leaders in the O'Malley Administration and in the General Assembly that are fully committed to healthcare reform. Second, Maryland's providers and carriers are committed to the reforms. Although representatives of these groups do not often agree, we have been able to achieve remarkable consensus. Lastly, I think that Maryland residents, whether if they personally benefit or not, seem largely committed to healthcare reforms.

Carmela Coyle

The three most important factors driving this transition are new health care system objectives focused on best value for the health care dollar; the widespread use of electronic health records that will allow for greater care coordination and sharing of clinical information; and the trend toward greater patient and family engagement in health and health care, without which we will be unsuccessful in improving outcomes and lowering costs.

Senator Rob Garagiola

To me, the three most important factors are:

- Engaging consumers to take charge of their health, to increase wellness and prevention;
- Expanding healthcare coverage to a large percentage of the uninsured will encourage preventive care and better ensure compensation for our physicians; and
- Aligning provider and payor incentives to improve health-care quality while reining in costs.

David Horrocks

I would include the following:

1. Reimbursement models;
2. The success of health reform in driving down the number of uninsured; and
3. Interoperability of health information technology (IT) tools

Gene Ransom, III

There is one major factor...COST! According to various respected sources, National health spending will account for nearly one-fifth of the U.S. economy in 2021. That is not sustainable, and will drive change.

Patrick Redmon, PhD

First, the aging of the population is a long-term issue that will demand more resources as the baby boom generation moves into retirement. This aging, combined with the expansion of insurance coverage through the Medicaid program, leads to the second factor: the increased role of governmental financing in healthcare delivery. Expanding financing provides improved opportunities for those who were not insured to seek care—a desirable policy goal. The consequence of the expansion is the fiscal pressures that result, particularly if healthcare costs continue to grow faster than the broader economy.

The third factor is technological innovation. While technology has been a substantial driver of healthcare costs, innovation has generated vast benefits to our society. However, these benefits are not the same for every new technology. There are many innovations that may not be worth the additional costs. The policy question will be whether we can develop market incentives or regulatory processes to encourage adoption of efficacious technologies and discourage the diffusion of marginal innovations.



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How can medical practices be changed to improve patient outcomes? As physicians, we care not only about providing excellent care, but also about preventing illness. New payment structures will increasingly reward practices that help keep patients healthy (whether primary, secondary, or tertiary prevention), even if that means a lower rate of acute hospitalizations or surgeries.

QUESTION #7

What non-clinical skills do physicians need to remain viable in the next 3-5 years?



Joshua Sharfstein, MD, is a pediatrician and Secretary of the Maryland Department of Health and Mental Hygiene.

Joshua Sharfstein, MD

I am not sure I accept the premise of this question. Many physicians will thrive based on clinical skills. There will also be new opportunities for physicians to lead integrated teams, in some cases across settings of care that keep patients healthier at a lower cost. Physicians interested in this kind of opportunity should start by understanding quality improvement and the three-part aim and develop a familiarity with successful models of care.

2. As the delivery system reforms contemplate significant organizational changes, practice transformations will not occur unless and until physicians embrace and lead that change.
3. Collaboration, not only across specialties and with other healthcare providers (and yes, we need more of that to occur) but even more broadly, with carriers and with local community organizations, must increase.

Ben Steffen

Physicians will need to become technology innovators, organizational leaders, and effective collaborators.

1. In terms of technology, Maryland practices lag in the adoption of EHR. We need to speed adoption if we are to succeed with broader reforms.

Carmela Coyle

Leadership, to engage in and lead the transformation of care; collaboration, to successfully work in teams with others to better coordinate care; and compassion for the patients they touch.

Senator Rob Garagiola

I would list the following:

- Flexibility, as the healthcare system evolves;
- Continued skill development in patient relationships and communicating with patients and families; and
- Expanding business acumen.

David Horrocks

Physicians will need to be open-minded to new clinical and operational approaches while at the same time be careful not to “risk everything” on things that are unproven. Refusing to adapt over the next five years will be very dangerous to a small practice. But so might be putting too much faith in any one unproven model.

There is also no escaping the need to use technology, and I’d suggest small practices work to become expert *users* of technology but resist becoming *operators* of technology. What I mean by that is

I'd form good partnerships with advisors such as a state-certified managed services organization (MSO) that can help navigate the changing technology landscape and provide reliable support. I would also lean towards proven technologies, especially with EMR selection—products that are certified, are market leaders, and have received positive reviews from your peers.

Gene Ransom, III

Physicians will need leadership skills, an understanding of public policy/advocacy and management skills.

E. Albert Reece, MD

Physicians need to prepare themselves for potentially altered roles brought on by changes in the marketplace or by healthcare reform initiatives. In Massachusetts, for example, a new law

expands the role of physician assistants by requiring health plans to list them as primary care providers in directories. It also allows patients to choose a physician assistant as their primary care provider. They still will work on teams with doctors, but they will have their own group of patients for whom they are primarily responsible. Thus, as healthcare reforms are instituted in various degrees, physicians will need to pay attention to those reforms and be prepared to adapt to their new roles.

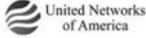
Physicians should also embrace becoming lifelong learners. Physicians are not always prepared by the medical educational system to develop and carry out their own lifelong learning curriculum, including identifying their own learning needs and establishing learning goals to meet these needs. Thus, they must commit to learning those skills on their own. There is evidence that lifelong learning among physicians leads both to better patient satisfaction with care and to higher job satisfaction among physicians.

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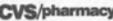
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“This is a time of great experimentation and great collaboration. We are seeing experimentation in the types of healthcare delivery models, such as patient centered medical homes and accountable care organizations. Participants in these programs see more benefit working collaboratively than by engaging in conflict.”



Ben Steffen is the Executive Director of the Maryland Health Care Commission. The views expressed are those of Ben Steffen, Executive Director at MHCC. They do not represent positions of the Maryland Health Care Commission.

QUESTION #8

How can physicians effectively advocate for their patients, with payors, legislators and regulators in this post-reform era?

Ben Steffen

Physicians have always been effective advocates for their patients with policymakers, regulators, and payers. When physicians speak for their patients, our policymakers and regulators listen. Let's not forget that physicians play important advocacy roles for patients when they serve in policymaking positions. Today in Maryland we have a unique situation in that energetic, public-minded physicians serve in four major policymaking positions in the State – Dan Morhaim, MD holds a leadership position in the Maryland House of Delegates; Joshua Sharfstein, MD, Maryland's Secretary of Health and Chair of the Maryland Health Benefit Exchange, in collaboration with the Lt. Governor leads state health reform activities; and Laura Herrera, MD has been recently named Deputy Secretary for Public Health Services. In addition to heading public health programs, Dr. Herrera will continue to develop Maryland's State Innovation Model, a new initiative that we hope The Centers for Medicare and Medicaid will fund. Craig Tanio, MD serves as chair of the Maryland Health Care Commission (MHCC), and has actively involved the MHCC in a host of important new initiatives. I am confident that physicians are, and will continue to be, effective advocates and establish policies that serve the best interest of patients.

Carmela Coyle

MedChi is a respected organization with respected leadership. As a physician, know the impact of policy issues and changes on your patients – how do they affect your patients, your relationship with your patients, and, especially, your ability to take care of your patients. If there is an issue that threatens to put a wall between the care your patients need and your ability to provide that care, speak up and let your elected officials know.

Senator Rob Garagiola

Physicians can advocate in the following ways:

- Be active in their medical society and specialty organizations;
- Participate in workgroups and advisory committees established by the Maryland General Assembly and executive branch agencies;

- Testify in Annapolis and Washington, DC on issues of importance to their medical community; and
- Take the time to reach out to legislators representing them.

David Horrocks

Physicians certainly need to stay informed while ensuring that health policy doesn't become an overly time-consuming part of the job. Technology users have user groups and similar forums to understand how technology is changing. MedChi, The Maryland State Medical Society, is set up to serve this function both by keeping members aware of policy issues and providing them with a forum for peer discussion.

Gene Ransom, III

The best way for physicians to advocate is through their active participation and membership with MedChi, The Maryland State Medical Society and their local county component.

E. Albert Reece, MD

Physicians need to be attentive to the effects of the new health reform program to see where it falls short in providing needed care. In those instances, physicians must advocate for change with all relevant groups to address such gaps in care. Indeed, one of a physician's primary goals should be to help patients obtain the services they need to lead healthy, independent lives. This is particularly true for patients, such as the very young or elderly, who cannot advocate for themselves.

According to the American Medical Association, physicians can best serve as their patients' advocates by helping them defend their right to:

- Receive accurate healthcare information and discuss the benefits, risks, and costs of appropriate treatment alternatives;
- Make their own decisions regarding the healthcare that is recommended by their physician;
- Courtesy, respect, dignity, responsiveness, and timely attention to their needs;
- Confidentiality of their health information;
- Continuity of healthcare between their primary care provider and any specialist care they may receive; and
- Have access to adequate healthcare personnel, procedures, and technologies.

Joshua Sharfstein, MD

Physicians can most effectively advocate by understanding the direction of change within healthcare and developing and leading new models of care. Seeking to "turn back the clock" by demanding higher reimbursement within a fee-for-service structure will not be a successful strategy.

Bookends

Mark Jameson, MD, MPH

We thank all of our contributors for offering their unique insights and perspectives on the future of healthcare in Maryland. Each contributor is a dedicated leader striving to improve healthcare. Several themes repeatedly emerge in the contributors' discussions:

- Electronic medical records are as basic as vital signs;
- Collaborative and interdisciplinary healthcare is replacing physician-directed care;
- Healthcare will be delivered by large integrated healthcare systems, not individual physician practices; and
- Cost containment is a primary driving factor in decision making.

Given this reality, physicians may feel they are practicing medicine between two bookends. One bookend is the patient. The other represents the imposing forces of administrative, pre-authorization, and regulatory requirements. On a bookshelf, the most valuable items are individual books, or, in this case, patient care. No two books are the same and no two patients are the same. Physicians are concerned that the bookends of patient care are being compressed more tightly together to meet the demands of other parties—not patients. New rule books are being written by those who finance healthcare, not those providing patient care.

Books require time to read, study, and treasure. Time is irreplaceable and time spent with patients is the most prized and privileged period for physicians. Physicians' angst today is largely due to constraints imposed on time spent on direct patient care. Thus, we can all hope that Dr. Albert Reece correctly presages the future when he writes that, by 2020, healthcare will have moved away from a volume-based approach to a value-based approach. Ideally, the number of books on book shelves should grow with time. Perhaps it is time for physicians to expand the bookshelf by writing a new book for patients.

Mark G. Jameson, MD, MPH, specializes in public health in Hagerstown, Maryland. The views expressed are strictly those of the author and do not represent the views of the Washington County Health Department or the Maryland Department of Health and Mental Hygiene.



Energy Drinks and the Unwanted Buzz: A Case Report

Tom Noff, MD, and Jerald Insel, MD

Introduction

Energy drinks are popular and widely available. People are increasing their energy drink consumption, unaware of the adverse effects the ingredients may cause. Niacin is an ingredient added to energy drinks to provide a sense of flushing known as a “buzz.” The following discusses the case of a patient who presented with chest pain and an incidental finding of abnormal liver function tests.

Case Presentation

A 46-year-old Caucasian woman presented to the emergency department of the hospital with complaints of chest pain. The patient had a history of severe coronary artery disease that was managed medically. The medications included venlafaxine 150mg QD, aspirin 81mg QD, nebivolol 10mg BID, ranolazine 500 mg BID, losartan 100mg QD, acetaminophen 325mg QD, and tramadol 37.5mg QD.

Physical examination revealed hypertension of 140/70 mmHg and pulse of 62 bpm with normal heart sounds. Laboratory studies revealed a low potassium level of 3.4 mmol/L with elevated alanine aminotransferase (ALT) and aspartate aminotransferase (AST) of 325 units/L and 437 units/L, respectively. Total bilirubin and BUN levels were normal. The patient denied fever or alcohol and illicit drug use. Six months prior to presentation, she began drinking three to five energy drinks daily, each containing 30 mg niacin, as well as two liters of highly caffeinated soda.

Discussion

Numerous studies have documented the serious health impacts of energy drink overconsumption and their role in provoking seizures¹ and even cardiac arrest.² The majority of energy drink studies have described the adverse health effects of caffeine, with few studies focusing on the adverse effects of niacin.

Energy drinks are caffeine-based beverages that usually contain sugar, stimulants (caffeine), and supplements. Vitamin B complexes, which include niacin, are a supplement added to many energy drinks. A complete list of ingredients for the energy drink consumed by the patient can be found in Table 1.

Consumers often experience a rush or “buzz,” an adverse effect of niacin, shortly after their first sip. Consumers, who mistakenly associate this feeling with increased energy, are in fact experiencing vasodilatation of blood vessels known as “niacin flush.”

Overconsumption of energy drinks increases niacin blood levels—a single energy drink can contain 30mg of niacin. Niacin is known to be hepatotoxic at levels of 2–3 grams per day and has been of concern with patients receiving slow-release niacin for dyslipidemia.³ To date, there is only one other report of hepatotoxicity caused by niacin in energy drinks.⁴ That patient presented with complaints related to hepatitis. Our case report is the first to describe asymptomatic liver damage caused by excessive energy drink consumption.

The patient’s medications—nebivolol, venlafaxine, losartan, acetaminophen, and ranolazine—are metabolized by the liver and were suspected as a cause of abnormal liver function tests (LFT). However, those medications had been taken regularly for more than 12 months and continued throughout the hospitalization. During the hospitalization, no energy drink consumption occurred and LFTs began to normalize, making medications an unlikely cause of increased liver enzymes. However, there is still a suspicion that the interaction of medications with niacin and other ingredients contained in the energy drink may affect liver function, causing elevated enzyme levels.

Conclusion

After ruling out other etiologies, it was concluded that the patient’s elevated ALT and AST levels were likely caused by the overconsumption of energy drinks. The hepatotoxic effects of niacin were suspected to be responsible for those findings.

Table 1: Ingredients of the Energy Drink (as listed on the product label) (a)

Ingredients (serving size: 2 fluid ounces)	Amount per Serving	Daily Value, %
Niacin	30mg	150%
Vitamin B6	40mg	2000%
Folic Acid	400mcg	100%
Vitamin B12	500mcg	8333%
Sodium	18mg	<1%
Energy blend	1870mg	Not known (b)

(a) Other ingredients: purified water, sucralose, natural and artificial flavors, EDTA calcium disodium, sodium benzoate, potassium sorbate, foam Control Agent.

(b) No set United States Recommended Daily Allowances (USRDA) value.

Tom Noff, MD, and Jerald Insel, MD, are cardiologists at Good Samaritan Hospital, Baltimore, Maryland. For a complete list of references, contact Susan Raskin at 301.921.4300 or sraskin@montgomerymedicine.org.

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Planning For Change: The Implementation of the Patient Protection and Affordable Care Act 2013

January 1

Averted 26.5 percent Medicare rate reduction due to Sustainable Growth Rate.

Increased Medicaid payments for primary care services provided by primary care physicians to 100 percent of the Medicare payment rate for 2013 and 2014.

January 31

Deadline to file for a hardship exemption for ePrescribing to prevent a 1.5 percent Medicare payment penalty.

March 1

Estimated start of FDA's first continuing education requirement for physicians prescribing long acting opioids as part of Risk Evaluation and Mitigation Strategy (REMS).

April 1

Affordable Care Act requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Summer (estimated)

Data collection to start for Maryland Prescription Drug Monitoring Program.

October 1

Individuals and groups begin enrolling in Maryland's Health Benefit Exchange.

2013, Date Unknown

Maryland Health Enterprise Zones to be announced and program implemented.

Four Maryland Accountable Care Organizations to start enrolling patients.

2014

January 1

Maryland Health Benefit Exchange becomes operational. Stage 2 Meaningful Use Criteria reporting period takes effect requiring 17 core objectives and 3-6 menu objectives.

October 1

ICD-10 coding required (more than 68,000 codes, compared to 13,000 codes in ICD-9)

2014, Date Unknown

Maryland pilot Multipayer Patient Centered Medical Home to end and State of Maryland to decide to extend statewide.



WORD ROUNDS

The Odyssey of Words

Barton J. Gershen, MD,
Editor Emeritus

Thirty years after the death of Muhammad, the first great Muslim empire arose. It was named after Umayya ibn Abd Shams, the patriarch of that family, and is known as the **Umayyad Dynasty** (631-750 CE). Umayya's great great grandson was named **Prince Attab**, and in his honor a suburb of Baghdad was named **al Attabiya**. A beautiful silk cloth was made there and is called *attabi* after its place of origin. Latin preserved this name intact, but the French shortened it to *tabis*. The cloth is a watered silk fabric characterized by colored stripes, which course through the fabric.

Some years later, it was observed that the coats of certain cats resembled striped tabis cloth. They became known as tabis-colored cats. Eventually the expression became tabby-colored, and ultimately those cats became known simply as **"tabby cats."** Finally, all cats became known as **tabbies**.

From a great Muslim dynasty, through a prince, a suburb of Baghdad and a silk cloth, such was the journey of our word for a cat – and such has been the odyssey of many terms.

Harald Blatand Gormsen was King of Denmark from 958 to 985 CE, and is most famous for temporarily uniting contentious Danish tribes and merging them with Norway. In 1994, Ericsson – the largest manufacturer of telecommunications equipment in Sweden – developed a small, wireless transmitter for use in exchanging data over short distances. Currently this popular device enables hands-free communication between a headset and PDAs, mobile telephones, PCs, car stereo systems, etc.

A consortium of over 17,000 telecommunication companies – known as the Special Interest Group – now controls the standards, licensing, and trademark for this device. In labeling the product, Ericsson developers decided to name it after the Danish King who had so

successfully merged an organization of many tribes into one kingdom. Harald Gormsen's middle name **Blatand** was an epithet (nickname) engendered by the peculiar color of his teeth. It meant **"Blue**

 (H) and  (B) =

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tooth" – and thus the new invention received its unusual name. The company logo is composed of the Runic letters "H" (Harold) and "B" (Blatand):¹

Early Germanic languages were written in the Runic alphabet, before the Latin alphabet became fashionable. No one knows why King Harald's teeth were blue, but some have suggested it was due to his fondness for eating blueberries.

In the 10th and 11th centuries an **acre** of land was loosely defined as the amount of arable earth that a farmer could plow with a yoke of oxen in a single day. The narrow trenches created by the plow were known as **furrows** and the length of a furrow was usually defined as the longest side of that acre. (Acre derives from Greek *agros*, meaning a "field," which may be seen in words such as **agriculture** and **agrarian**.) Most cultivated acres were rectangular in shape rather than square, so that the plow would not have to be turned as often. The standard length of a "furrow" was therefore the long side of that rectangle. Eventually, as more precise standards were required, the length of a furrow was set at 220 yards. The area of an acre was then set at 220 yards by 22 yards (660 feet by 66 feet) – or 43,560 square feet.

The expression **"a furrow long"** as a means of describing distance, eventually was shortened. Through colloquial usage it became a **furlong**, and is used today mainly to describe the length of a race track for horses. The Preakness, for example, is a track that is 9.5 furlongs (1 and 3/16th miles) long, and the Belmont is 12 furlongs (1 and 1/2 miles) long.

In the late 18th century, Dominican friars established a monastery located in *Rue St. Jacques* in Paris. During the French Revolution a group of dissidents, comprised of disgruntled members of the *Estates General*, formed a club which met at the monastery. These were the men who ultimately created the "Reign of Terror," marked by mass exterminations of their enemies. From September 1793 through July 1794 more than 30,000 people were executed, over half of them by the **guillotine**.

Since the Dominican monastery was located on St. Jacques Street, and since Jacques translated into Latin is *Jacobus*, the terrorists who met there became known as **Jacobins**. Among those whom they annihilated were King Louis XVI, Marie Antoinette and the **Girondins**. The Girondins were a more moderate group of rebels, opposed to the brutality of the Jacobins. These men were from the province of *Gironde* in southwestern France, which explains their name. The **guillotine** had been invented by a surgeon named Antoine Louis in 1792, but it was heavily promoted as a more humane method of execution by **Joseph Guillotine**, a physician serving in the *Estates General*. Because of his enthusiastic endorsement, the deadly instrument was named after him. Although he was imprisoned, Guillotine escaped death and was released after Robespierre was executed. Because of the disrepute and embarrassment associating his name with that gruesome instrument of death, and to preserve his anonymity, Guillotine

changed the family name and returned to medical practice. Dr. Louis was not as fortunate, dying “under the knife” during the reign of terror.

A choreographic maneuver that originated from ballet is known in French as a *chassé*. It consists of a gliding triple step movement that may be sideways or diagonal. It has been adapted for many other varieties of dance such as ballroom, line, and square dancing. Americans, unfamiliar and distrustful of French words, gradually changed the spelling and pronunciation of the word. It became **sashay** and has assumed a slightly different connotation: to walk with a strut or a proud swagger. The word is often heard in grade B western movies, for example “let’s sashay down to the bar.”

Another French dance term is *dos à dos*, meaning “back to back” (from Latin *dorsum*). This type of movement has been incorporated into our traditional American square dance. One of the many maneuvers cued by the square dance caller results in partners circling each other back to back. In this case the French expression has again been altered to a more American sounding phrase: **do-si-do**.

The Latin word for a pointed stick or a stake was *palus*. A stake driven into the ground was known as a *pale*, and by extension, a fence built with such pointed stakes was also called a *pale*. (We might term it a picket fence.) Fences such as these were constructed to protect a village or an encampment. They were also used to confine and restrict prisoners or other disagreeable populations – to “fence them in.” If any member of that community strayed outside the enclosure, he was said to be “**beyond the pale**.” Several such barricaded settlements have been established throughout history. The English established an **Irish Pale** in 1446 and the **Russian Pale**, was sustained between 1791 and 1917, restricting Jews to specified villages. Punishment was severe for anyone who wandered beyond the pale. In current usage, the expression has come to mean someone behaving in a manner unacceptable to society – beyond the limits of good taste.

The term pale is little used today other than in that expression. It may be found, however, hidden in the term **impale**, to strike a stake through someone’s heart – as was done to Dracula and his disciples. It is also buried in the term **palisades**, a line of cliffs that resembles a fence, such as the Hudson Palisades located along the western bank of the lower Hudson River. (The word pale, meaning an ashen or washed-out color, originates from a different Latin word – *pallere*: “to be pallid.”)

In Judaism, the holiest day of the year is *Yom Kippur*, which is celebrated annually in September or October (the Hebrew calendar is based on the lunar cycle, thus falling out of phase with the Gregorian calendar based on a solar year; every 2-3 years the Hebrew calendar adds an extra month in order to amend this disparity). In Hebrew *Yom* means “day” and *kippur* means “atonement”, thus this day of worship is the “day of atonement” – a time during which each congregant confesses his sins and requests forgiveness of God. The word **atonement** was originally **at one-ment**, that is, to be “at one” with their deity, to be reconciled. Over the centuries, the two words “at” and “one” were combined, resulting in atone and atonement. (In ancient Israel, the high priest would remove the sins of his entire congregation and figuratively place them on the head of a goat. The goat was then sent into the wilderness, a symbolic way of collectively divesting the sins of his congregation. The goat was allowed to escape – thus the expression “a **scape goat**.”)

**MedChi’s Speaker of the House
announces that the
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To herald the commencement of *Yom Kippur* a ram’s horn – known as the *Shofar* – is blown by the rabbi. But this is not the only occasion on which that occurs. Every 50 years, the ancient Hebrews were commanded to absolve all their debtors, release all their slaves and celebrate the occasion with song and dance. (“*This fiftieth year is sacred—it is a time of freedom and of celebration when everyone will receive back their original property, and slaves will return home to their families.*” *Leviticus 25:10*)

On this occasion a ram’s horn was also to be blown. In Hebrew a ram was known as a *yohbel* and in street vernacular the horn itself also came to be called a *yohbel*. The bible was initially translated into Greek, and this 50-year celebration came to be known as a *yobelos* or *iobelos*. As this word entered the English language it has morphed into the word **jubilee** – a time for celebration – but essentially the horn of a ram.

In Homer’s *Odyssey* the resourceful hero **Odysseus** (for whom that book is named), undertakes a harrowing and lengthy journey. Following defeat of the **Trojans** (as recounted in *The Iliad*) Odysseus and his men set out for home, but they encounter numerous terrifying adventures, which delay their return. That protracted and frightening voyage has led to the term **odyssey**, named for our protagonist. (The term **Iliad** derives from the Greek name for Troy: *Ilium*. Citizens of Troy were known as **Trojans**.)

From the moment a word is created and enters the public domain, it begins a transformative evolution in its journey through time and human discourse. That journey is often quite prolonged, and convoluted, and it frequently results in a surprising finish.

Words, too, appear to have an odyssey.

Barton J. Gershen, MD, Editor Emeritus of Maryland Medicine, retired from medical practice in December 2003. He specialized in cardiology and internal medicine in Rockville, Maryland. If you are interested in purchasing a copy of Word Rounds: A History of Words (Both Medical and non-Medical) and Their Relationship to One Another by Dr. Gershen, please contact Flower Valley Press, P.O. Box 83925, Gaithersburg, MD 20883, or www.amazon.com.

Reference:

1. Bluetooth logo: <http://www.logoeeps.com/bluetooth-logo-vector/3848/>

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The Last Word

“Restoring a Sense of Safety in the Aftermath of a Mass Shooting: Tips for Parents and Professionals” on pages 33-34 may be torn out and reproduced for your patients, physicians and staff as a guide for future use.



Center for the Study of Traumatic Stress

The Center for the Study of Traumatic Stress (CSTS) is part of the Uniformed Services University's Department of Psychiatry, located in Bethesda, Maryland, and a partnering center of the Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury.

Restoring a Sense of Safety in the Aftermath of a Mass Shooting: Tips for Parents and Professionals

Too often our children are exposed to violence that is both senseless and harmful. Many children, those living in close proximity to a tragic event, and those who will learn about the event through television, social media, or newspaper coverage, will be affected and upset. The timing of this tragedy — the holiday season — makes this Connecticut school shooting even more upsetting. Many children will soon be on school holidays putting additional responsibility on parents and caregivers to reassure children who may know about or ask questions around this event.

Communicate effectively with your children

A high profile event of this magnitude can result in confusion and distress among communities across the country. Distress can result in distortion about the facts of the event. Therefore, special attention should be given when communicating with children and adolescents.

- When speaking with your children, it is best to use communication that is factual, simple, clear and sensitively worded.
- Don't overwhelm young children with too much information. They might want to talk intermittently or might need concrete information to be repeated.
- Use language that is appropriate to your child's age.
- Young children sometimes exhibit "magical thinking" which might lead them to believe they are responsible for what happened.
- Children may have ideas or beliefs that are difficult to know unless you *ask them*.
- Adults can encourage children to talk, but should respect their wishes when they may not want to.
- Ensure that your children are not exposed to media reports about the event that are repetitive, confusing, or frightening.

Physical safety and security always take priority

It is difficult to predict children's reactions to learning about these types of events and whether children's immediate reactions will lead to sustained psychological problems.

- Common posttraumatic responses in children include:

nightmares or fears related to the trauma, avoidance of reminders of the trauma, and repetitive play that mimics the trauma.

- While symptoms are often transient, they should be clinically treated if they persist. If you have questions contact your child's health care or behavioral health care provider to seek advice or guidance.
- Some children may act out as a reaction. Talk to your child about what is troubling them and do not punish or reprimand them.

Answers to some common questions

Below are some common questions and answers to help guide caregivers addressing a confusing or senseless act of mass violence with children and adolescents:

Why do these things happen?

Children, like adults, often want to know the motives of people responsible for these horrible events. Past events have resulted from many causes including mental illness, rage, extreme political or religious beliefs, and frank hatred. Unfortunately, we usually can't be sure what led a specific individual acting in such a way. It does not help children to have them fear groups of people who fall into any specific demographic categories. Doing so only leads to discrimination, stigma, and victimization of people who also are struggling to cope with these events. More importantly, help your children understand that adults, including government authorities work hard to identify and stop dangerous events before they even happen.

Will this happen again and how do I keep my children safe?

Unfortunately, violent events are likely to occur in the future. It is important to remember that despite our awareness, random violence occurs rarely and does not occur in most neighborhoods. Remember that parents and professionals strive to keep our children safe yet allow them the space they need to grow and develop. Use the following guidelines:

- know your children's whereabouts, who they are with and when they are to return home

- set clear and consistent curfews
- have a clear method of communication in normal and emergency situations (e.g. cell phone)
- educate them about places or situations that are more likely to put them in danger and teach them to avoid high-risk exposures
- monitor federal and local advise about risks that might surface
- be vigilant about safety in your community
- strive to keep open communication with children and adolescents

How does one plan for this type of emergency?

Discuss hypothetical emergency situations with your children and calmly talk with them about what they can do to keep themselves safe when danger presents itself. Instruct them to trust and seek help from police and other authorities who are likely to be on the scene quickly. Always encourage your children to say something when they see something suspicious. Establishing a communication plan for locating family members can help to reduce anxiety. Parents should know where their children are and children should tell parents when they have changed their location.

Is my child okay?

Children will show a wide variety of reactions. There is no “normal” reaction to stressful events. Some reactions include tearfulness, separation or bedtime anxiety, or regression in behaviors. More severe reactions may include reliving the trauma through dreams, emotional numbness, increased startle responses, withdrawal or physical symptoms like racing heartbeat, nausea or change in appetite.

These types of events, while tragic, can sometimes lead to positive opportunities. They become opportunities to open, or reopen, channels of communication among family members. They may provide us opportunities to appreciate each other more and to express our love for one another. They may provide opportunities for families to better plan how they will cope with future difficult times or topics. It is important to focus on what might positively emerge from these tragic events while we also acknowledge tragic losses.

Online Resources

If you have any questions about your child’s health or response to a traumatic event you can seek professional advice from a community primary care or behavioral care provider or review additional resources at the following sites:

Center for the Study of Traumatic Stress
 National Child Traumatic Stress Network
 American Academy of Child and Adolescent Psychiatry
 American Academy of Pediatrics
 American Psychiatric Association
 American Psychological Association
 American Red Cross

www.cstsonline.org
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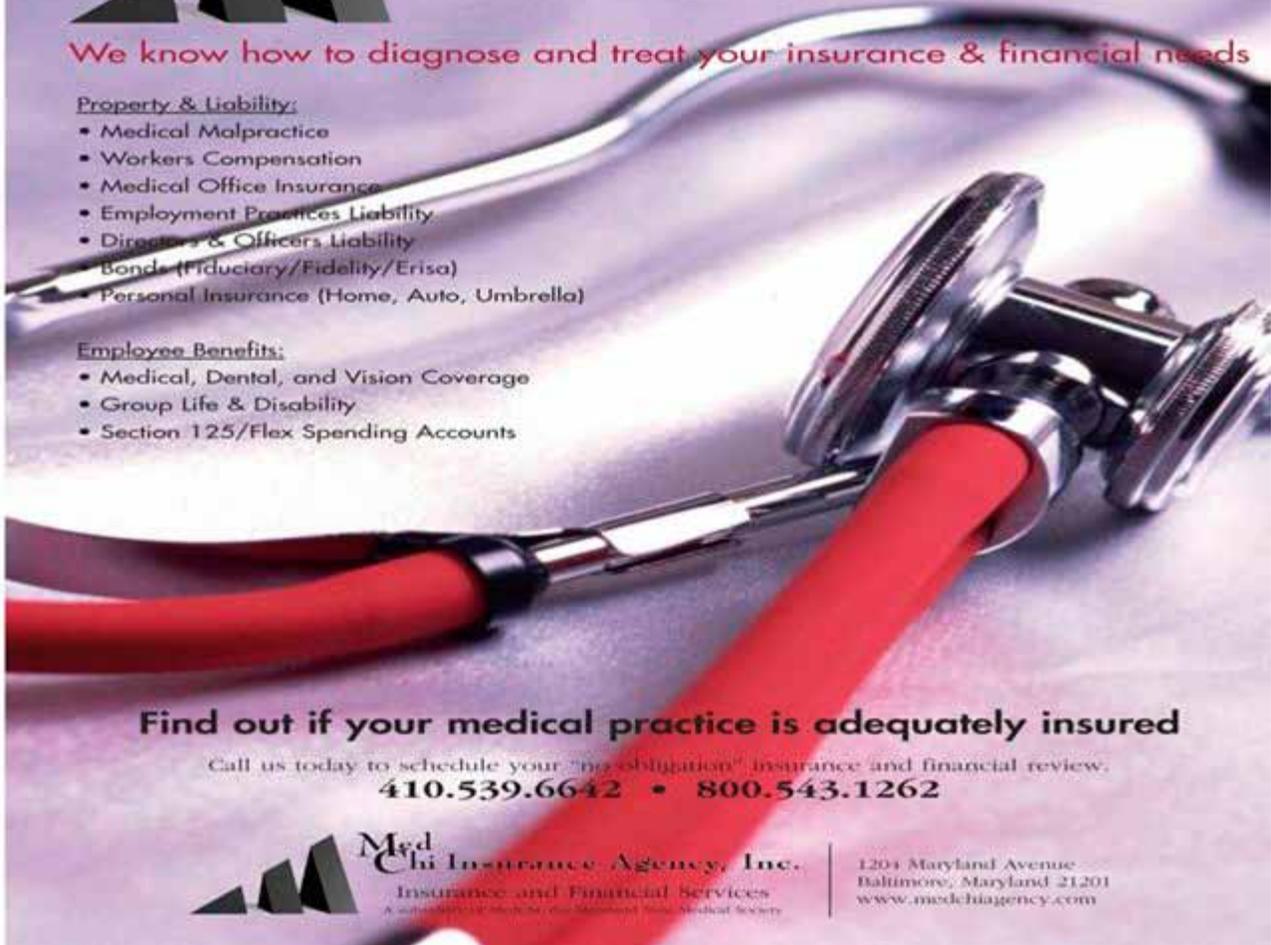
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