Population Health: What It Is and Why It Matters

How You Can Benefit from Maryland’s First-ever Emergency Medicine Alternative Payment Model

Highlights from the 2022 AMA Meeting
As we have seen during this pandemic, the disparities of basic health care profoundly affect our individual response to disease and overall disease outcomes.

Those with good basic health care, and good care for chronic diseases, do better than those without.

As a child I had rheumatic fever, and the sequela kept me out of school for months. If my initial strep throat had been picked up and treated, I may not have had to deal with the long-term side effects of that illness. While my experience was more likely bad luck, many children under the poverty level do not receive adequate health care and are poorly nourished, and therefore are less equipped to fight disease.

During the pandemic, the inequity of health care across the population was suddenly thrust before our eyes. The lack of access to basic health needs, such as healthy food, the internet, and community-based health care, became readily apparent when we saw these populations suffering more than affluent and non-minority populations. According to the Centers for Disease Control and Prevention (CDC), Black, Native, Latino and Pacific Islander Americans have higher rates of COVID-19 cases, hospitalization, and death compared to white Americans.

Population health is not only important for treating pandemics. A healthier population gives the possibility of a healthier populace that includes all. When the population is healthy it can strive for education, steady employment, and healthier social interactions. That healthier population has the possibility of moving our world ahead, technologically, environmentally, and humanly.

Who knows where the next Louis Pasteur will be discovered? Maybe in the slums of Brazil, maybe in the poorest neighborhoods of Baltimore. But this person may never be given the opportunity if he or she is not healthy enough to fulfill his or her potential.
Understanding Population Health

Senator Clarence K. Lam, MD, MPH

“Population health” first entered the medical lexicon nearly twenty years ago with a publication titled “What is Population Health” in the American Journal of Public Health. In that article, authors Kindig and Stoddart defined population health as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” and contend that it includes “health outcomes, patterns of health determinants, and the policies and interventions that link these two.” The differences between clinical medicine and population health are distinct and important to understand. While clinicians care for patients individually, their actions taken together can collectively affect the health and outcomes of a population. The interventions also differ, with medical treatment involving surgical procedures, pharmaceuticals, other therapies; interventions in population health often involve incentivization or payment mechanisms, the establishment of programs or services, and education and outreach. The data supporting medical decisions for individual patients in clinical care include laboratory tests, imaging, and other diagnostics, whereas the data underpinning population health include the collective health outcomes of a community as well as overall claims and payment data from providers and payers.

In fact, access to reliable and large sources of data are crucial to studying and advancing population health. Data from claims and utilization can help guide population health decisions. If a health system were seeking to reduce admissions from diabetic emergencies, it could analyze data on the prior fulfillment of diabetic prescriptions by patients to find patterns or inform interventions. Additional environmental or community-level data can be collected from government sources to inform providers and hospitals on whether factors, such as food deserts, income levels, proximity to health care, or other social determinants of health, are affecting these population health outcomes. Combining claims and utilization data from payers with environmental and community data from governmental sources can point to patterns of use and outcomes as well as identify paths to systematically address them at the population level.

It is important to recognize that population health is affected by many factors outside of the immediate clinical environments, and these social determinants of health include location of residence, employment, education level, poverty, language skills and literacy, housing, racism, transportation, and proximity to polluted air and water. Although these are considered outside of the traditional clinical environment, influencing or positively intervening in these factors can play a significant — and often necessary — role in improving population health.

In a clinical environment, population health can help address common health ailments in a systematic, evidence-driven way. Incentivizing proven interventions towards certain populations can aid in creating systems where patients receive similar levels of care for similar diagnoses in order to improve consistency in care and minimize inequities. In fact, this drive towards improved quality and health outcomes through greater standardization and uniformity in care has been facilitating a transition where value-based care as a delivery model has been gradually replacing fee-for-service or capitated approaches. Under the value-based care, payment rates to providers are tied to quality metrics, which are underpinned by population health data; this makes the accuracy and interpretation of this data to be highly important.

Maryland is unique in the resources and mechanisms in place to support population health efforts. Maryland is the only state to have been granted a waiver by the Centers for Medicare & Medicaid Services (CMS) to establish an all-payer rate-setting system where all third-party payers pay the same rate and all hospitals are compensated on a total hospital cost-of-care model in exchange for demonstrated reductions in the rate of rise in hospital care costs. The state also established the Health Services Cost Review Commission, which serves as a data clearinghouse for the collection of accurate and reliable quality measures and for analysis by policymakers as well as for overseeing various quality-based performance initiatives and measurements that tie hospital payments to specific performance benchmarks. The state’s Health Care Commission is an independent regulatory agency that aims to make quality metrics and cost information on providers, facilities, and payers available and accessible to the general public. The development of the Maryland Primary Care Program (MDPCP) creates new incentives and mechanisms for primary care providers to advance preventive and improved management of chronic diseases to avoid costly hospital admissions. Taken together, these programs and agencies put Maryland at the forefront of states with data, capabilities, and tools to improve population health.

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The Maryland Primary Care Program (MDPCP) is now more than halfway through its fourth year of operation. MDPCP has been a well received, voluntary advanced primary care program with over two thousand primary care providers in 508 practices across the state, embracing two-thirds of all eligible Maryland primary care practices and continuing to grow. The providers and practices in MDPCP have achieved notable results with expansion of access to care, reductions in unnecessary hospitalizations and emergency department visits, strong quality performance, behavioral health integration in all practices, screening and attention to the complex medical and social needs of their patients and the universal adoption of the patient-centered approach of Patient Family Advisory Councils. Using data tools developed by the Maryland Department of Health and CRISP, the MDPCP practices have been heroic leaders through the COVID-19 pandemic with fewer Covid cases, hospitalizations and deaths than non-MDPCP practices.

MDPCP has a bright future. As one of the largest state-based advanced primary care programs in the nation, MDPCP has gained national attention and recognition. The hard work and good results of the providers and practices has been included in many publications, including The Milbank Memorial Fund, national newspapers like The Boston Globe, JAMA, and presentations at national health care events. The monthly MDPCP Performance Dashboard highlights the many areas in which MDPCP is excelling, including care management, reductions in unnecessary hospital utilization, and behavioral health integration.

Looking at the future of MDPCP, we expect even greater opportunities and larger impacts from this program, including:

1. **Growth** — From this year’s open enrollment we anticipate adding more primary care practices across the state, further increasing the scope and impact of the program. MDPCP is already the first Centers for Medicare and Medicaid Services (CMS) advanced primary care program to include both FQHCs and practices in the same program. We hope to add additional health centers during upcoming open enrollments.

2. **Payers** — MDPCP added CareFirst in 2020 as the initial aligned commercial payer and is actively exploring the addition of Medicaid as an aligned payer in 2023.

3. **Addressing social needs and health equity** — The MDPCP Management Office (PMO) has established a broad portfolio of active health equity projects to enhance the capacity of MDPCP practices to provide more effective care for patients of all backgrounds and will be expanding support to practices for screening and addressing the social needs of patients. Included in this work is the new Health Equity Advancement Resource and Transformation (HEART) payment that is provided to practices to address the needs of vulnerable, medically complex patients who reside in areas of highest social deprivation. Other work to date includes a visual, claims-based measures report broken down by key health equity characteristics including race, age, and sex. New projects recently started include training on cultural competency and health literacy, implementation of an automated clinical quality measures platform integrated with practice EHRs, and a partnership with MD 211 to enhance its resource directory for social needs.

4. **Addressing behavioral health needs** — The PMO will continue the work of addressing the state’s opioid crisis by expanding the evidence-based approach of Screening Brief Intervention and Referral to Treatment (SBIRT) in the community. MDPCP currently has over 340 practices that have implemented this important tool for addressing substance use disorders. The PMO will continue to support practices implementing the Collaborative Care Model to address mental health issues. We also intend to broaden primary care access to Medication for Opioid Use Disorders (MOUD) to enhance MDPCP’s role in fighting the ongoing opioid epidemic.

5. **Expanding actionable data** — The PMO continues to partner with CRISP to provide comprehensive data reports to inform better population health management. Recent additions to the MDPCP CRISP Suite include the Health Equity by Demographics report, a revised and expanded report on Specialty care, a Total Per Capita Cost measure report, and incorporating more current definitions of Chronic Condition Warehouse indicators. This fall will also see the addition of three new predictive risk models to the Likelihood of a Hospital Event report, identifying risk of severe complications from diabetes, opioids overdose, and end of life care.

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Go for Bold! One Community’s Solution to Improving Population Health

Douglas A. Spotts MD, FAAFP, FCPP

To begin to address population health challenges in our community, Meritus Health developed a Bold Goals 2030 Strategic Plan in November 2019 that followed the components of the Quadruple Aim: Health, Health Care, Joy at Work, and Affordability of Care.

Unique to the Health Bold Goals selection was consideration of the community when choosing it after studying our Community Health Needs Assessment. Upon doing so, the number one priority we identified was the epidemic of obesity and related, poorly controlled diabetes in the Washington County (Maryland) population. We studied how a similar response by Oklahoma City in 2007 transformed that community from one of the unhealthiest cities in the country to one of the healthiest in only five years.

In both cases, Oklahoma City and Washington County, the goal was to lose one million community pounds over a defined period of time to improve the health of all. This challenge was made more difficult by the arrival of COVID in March 2020 along with a decline in all county health outcomes due to inactivity, social isolation, and the now obvious health disparities and inequity. Despite the challenges of the pandemic, we launched a community-wide effort to lose one million collective pounds by 2030 beginning in the fall of 2020.

“Go for Bold: Do, Eat, and Believe in a Healthy Washington County” was conceived in partnership with the Washington County Health Department’s Healthy Washington County coalition. Through specific aims, actionable steps, and outcome measures monthly and yearly, the campaign encourages participants to increase their activity level, make healthier food choices, and mitigate stress and anxiety through mindful activities and mental health improvement “action steps”. Resources were available to all members of the community at no charge. Participants simply register for a web-based tool where they can enter their weight periodically. The tool then records cumulative weight loss without sharing personal health information. The campaign, which is based on the honor system, has become the community’s goal to move our health outcomes from the bottom quartile of all Maryland counties to being at or near the top.

To date, we have surpassed our goal to lose 35,000 pounds by June 30, 2022 (currently at 40,560) and it’s expected that we’ll more than double it by next year. Other outcomes of this campaign have included grant funding for a fresh foods grocery store with a community health hub linked to it, mobile clinic resources for vaccination and health screenings, and a care-caller program to reach out to community members who report being lonely. We have also created an Improving Health Equity Measures (IHEM) team that looks at our outcome disparities and intentionally designs improvement projects to correct them. This work has also led to an AARP-sponsored grant involving a tri-state coalition of health systems and public health agencies led by Meritus to improve health equity in actionable ways. As a family physician and as Chief Health Officer of Meritus, these achievements and outcomes remain personal and professional beacons of light and hope in an otherwise traumatic and disruptive time.

This campaign has taught me some invaluable lessons, from which I have developed three motivating factors that were necessary to transform our community’s health from one of sickness and chronic disease to one of wellness and prevention: we cannot settle for the status quo; we must be agile innovators; and we must act quickly and boldly.

Physicians are uniquely positioned to lead their teams in these areas to improve self, system, and community and to build resilience. Imagine if MedChi convened a statewide and physician-led effort to tackle obesity and diabetes with equity for all patients in Maryland! We can no longer wait for someone else to do this; it’s time to go for bold!

Douglas A. Spotts, MD, is a family physician and Chief Health Officer at Meritus Health.
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How Physicians Will Benefit from Participation in Maryland’s First-ever Emergency Medicine Alternative Payment Model in 2023

Angela G. Cai, MD; Jonathan J. Oskvarek, MD, MBA; and Jesse M. Pines, MD, MBA, MSCE

In 2023, Maryland emergency physicians will be able to participate in the first-ever government-based alternative payment model (APM) in emergency medicine. An APM is a way to pay for care that rewards value and is not purely fee-for-service. The new APM was designed by emergency physicians for emergency physicians with support from state regulators and the broader medical and hospital community as a collaboration between the Maryland Chapter of the American College of Emergency Physicians (ACEP), the Health Services Cost Review Commission (HSCRC), MedChi, the Maryland State Medical Society, and the Maryland Hospital Association (MHA). The APM falls under HSCRC’s Episode Quality Improvement Program (EQIP) model. EQIP is a physician-centric APM and aligns with the goals of Maryland’s Global Budget Revenue (GBR) program, which aims to control costs and improve quality of care.

The focus of the APM is to reduce fourteen-day total cost of care for a subset of emergency department (ED) visits where variation exists in the decision to admit. Included diagnoses are chest pain, syncope, pneumonia, atrial fibrillation, and others, and are carefully chosen by leaders in emergency care. Model architects identified diagnoses where there was variation in admission practices between emergency physicians and across emergency departments and engaged an expert panel of Maryland ACEP emergency physicians to achieve consensus. The vast majority of diagnoses in the model have evidence-based rules around hospital admission, and all are amenable to the creation of clinical protocols. With chest pain, for example, the HEART score has been shown to identify patients who are at low risk for major adverse cardiovascular events (MACE). The idea is that emergency physicians would implement standardized protocols like the HEART score for the program’s diagnoses, ensuring patients receive evidence-based care and ideally close follow-up. The final list includes 535 ICD-10 diagnoses representing about one in four ED visits.

The way the program works is that when a patient with Medicare insurance is seen by a participating ED physician, this triggers an ED episode. The total cost of care is then calculated up to fourteen days. Costs include the ED visit, a hospital admission if it occurs, and any other services. Importantly, it excludes downstream visits with specific unrelated diagnoses like COVID-19, trauma, pregnancy, psychiatric care, and others. The goal is to focus physician efforts on safely reducing hospital admissions where clinically appropriate and providing linkages to outpatient care, ultimately lowering the fourteen-day maximum total cost of care by avoiding expensive inpatient care. This would be completely achievable by implementing protocols, providing feedback to physicians around their admission practices, and developing pathways for rapid follow-up. Importantly, the model is at the physician site-level where episodes are attributed to a physician within an ED. This is because site-level case mix and other local practice differences often determine whether patients get admitted.

Beginning this summer, emergency physician groups will be able to submit their physician national physician identifiers (NPIs) for program participation. Participating physicians within a hospital will then receive a historical target price as baseline. Target prices are calculated based on 2019 patients with the same diagnoses at the same site, to reduce the influence of care disruptions caused by the COVID-19 pandemic. As 2023 unfolds, HSCRC will then calculate the actual costs for eligible patients within ED episodes. This information will be fed back to the physicians on a regular basis by HSCRC.

At the end of 2023, the differences between the target price in the baseline and performance period will be compared by HSCRC. Participating physicians able to lower their costs will receive a bonus payment up to 50–80 percent of the savings associated with cost reductions. In the first year of the program, bonuses will be one-sided, meaning that there is no downside risk of participation. Future versions of the program may have two-sided risk (e.g., an upside and a downside) which physician groups will have to decide if they want to take on. Importantly, EQIP is designed as a voluntary program. Therefore, there is no plan for requiring participation.

What could this mean in terms of actual dollars? In a simple example, imagine 5,000 patients from a given ED qualify for the program and have a target price of $2,500. If costs drop during the performance period by $200 on average (8%) that would equate to $1,000,000 in total savings. From that, the physician group could receive a payment bonus of $500,000 or more. Importantly, this payment would be made directly to the physician group and not the participating hospital. MD ACEP and others are working to secure the participation of other insurers — including CareFirst — to maximize the potential returns to physician groups who participate in the program.

Along with potential shared savings from the model, participation has other financial and non-financial benefits.

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Ten Things You Need to Know About Value-Based Care in Maryland

Gene M. Ransom III

Maryland and MedChi are both leaders on value-based care initiatives. Maryland has several state-specific advanced payment models, and MedChi worked hard last session to get comprehensive value-based care legislation passed. While this is a complicated topic — to say the least, we have boiled it down to the ten things you need to know about value-based care in Maryland:

1. Maryland was instrumental in developing physician-friendly value-based care legislation this session — This legislation contains the strongest protections for the physician community for those physicians that chose to enter these arrangements and for those that want to remain fee-for-service, including a provision that states that a carrier may not reduce the fee schedule of a physician who remains fee-for-service and does not participate in a two-sided incentive arrangement.

2. MedChi is helping other states as they develop legislation — Recently MedChi gave a presentation to the AMA advocacy resource center on the Maryland legislation, and the society fielded questions for two other State societies who are dealing with similar bills.

3. MedChi can help practitioners who are considering value-based contracts — MedChi is happy to answer questions for those practices who are considering these models. MedChi can also be a resource for physicians in an employed setting to better understand what these models mean to them from a bonus or payment perspective.

4. Maryland has several state-specific federally-approved advanced payment models — The State of Maryland has the Maryland Primary Care program, and four tracks under the Episode Quality Improvement Program (EQIP) for physicians to be in a federally CMMI Approved Advanced Payment Model (AAPM).

5. The Maryland Primary Care Program (MDPCP) is widely successful — This program, now in its fourth year, is one of the largest and most successful advanced payment models in the United States. You can learn more about this adult primary care advance payment model on the Maryland Department of Health’s website.

6. MDPCP open enrollment has resumed this summer — Enrollment in the MDPP was temporarily closed by CMS in 2020 due to COVID and reopened this summer. If you would like to be added reach out to MedChi and we can help you get signed up.

7. The Maryland Primary Care program is considering expanding to Medicaid — MedChi has been working with State and Federal officials to create an MDPC-like program in Medicaid. Nothing formal has been offered to date by Medicaid.

8. The Episode Quality Improvement program (EQIP) was launched in 2022 for specialists — The Episode Quality Improvement program (EQIP) is a voluntary program that will engage specialist physicians who treat Maryland Medicare beneficiaries in care transformation and value-based payment through an episode-based approach. The first “performance year” of EQIP will cover a range of initial Clinical Episodes in the specialty areas of cardiology, gastrointestinal, and orthopedics.

9. EQIP is currently considering expanding to other specialties in 2023 — Discussions with HSCRC, CMS and MedChi are currently underway to add “bundles” around additional specialties including Urology, ER, and Ophthalmology in 2023.

10. If you have an idea for a new advanced payment model, please reach out to MedChi — MedChi has been at the forefront for these types of programs, and we’re on a roll. But there’s always room for expansion. If you have an idea or an opportunity, please reach out so we can help develop payment models that benefit physicians and patients.

Value-based care has been a buzz word in health care for years. MedChi and the state of Maryland are on the cutting edge of this issue. The key is making sure physicians and patients aren’t forced to take undue risk and ensuring that programs are voluntary and physician-driven. We need your help to stay in front of, and focused on, this important issue.

Gene M. Ransom III is the CEO of MedChi.
Understanding Population Health, continued from pg. 3

With health care costs continuing to rise unsustainably, it is unsurprising that both payers and patients are expecting higher quality and better value from the care being provided and received. Population health is being used to understand and improve these health outcomes for groups of individuals through policy interventions that are increasingly linked to provider reimbursements. For providers, this means that an understanding of population health not only becomes more and more important, but it is necessary to provide high quality care that is often mandated by a growing number of payers. This movement of provider compensation being tied to quality indicators will likely continue unabated in the near term, and so it becomes incumbent on providers to understand the drivers of health outcomes, recognize the implications of greater reliance on population health data, and prepare their practices for a future where population health interventions are integral to their delivery of care.

Clarence Lam, MD, MPH, is a board-certified physician in preventive medicine. He serves as director of the preventive medicine residency program at the Johns Hopkins Bloomberg School of Public Health and as medical director for occupational health at the Johns Hopkins Applied Physics Laboratory. He is a State Senator representing District 12 in the Maryland General Assembly.

The Future of MDPCP, continued from pg. 4

6. Adding support and reducing administrative burden
— The PMO continues to augment the financial support from CMS with on-the-ground technical assistance from coaches and a robust education system of remote learning and practical guidance on key topics such as addressing unnecessary hospital utilization and a series on diabetes and hypertension best practices.

7. Exploring new payment strategies — In partnership with the CMS, MDPCP is continuing to develop payment strategies that move primary care payments toward non-visit based payments to support team-based advanced primary care delivery with the launching of a novel Track 3 in 2023.

As Maryland continues to transform the delivery of health care for the better and more equitable health of all Marylanders, MDPCP will continue to listen to stakeholders to ensure that we are doing our part to meet the needs of providers and patients alike.

Howard M. Haft, MD, MMM, CPE, FACPE, is Senior Medical Advisor; Alice Sowinski-Rice, MPH, is Operations Manager; and Chad Perman, MPP, is Executive Director for the MDPCP Management Office, Maryland Department of Health.

Maryland's First-Ever Emergency APM, continued from pg. 7

Because the APM qualifies as an advanced alternative payment model (AAPM) with the federal government, it would allow emergency physicians to avoid participating in and incurring potential reimbursement penalties from the Merit-based Incentive Payment System (MIPS) program, which are up to 9 percent in 2023. Avoiding MIPS also saves the costs of program participation and eliminates the time, effort, and costs of MIPS quality improvement efforts, many of which are not centrally relevant to emergency medicine practice. Second, with participation in an AAPM, participating physicians will receive a 0.75 percent payment bonus on all Medicare fee-for-service encounters. Take an ED with a Medicare population of 20,000 and an average payment of $165 per patient. This would result in a guaranteed bonus of about $25,000 for participation and would avoid a potential MIPS penalty of up to $300,000.

The final benefit of participation is that it will move emergency physicians squarely in the direction of evidence-based, value-based care. This will undoubtedly become more important in the future as similar models replace fee-for-service payments. Ultimately, we highly encourage all emergency physicians and groups to participate in the Maryland EQIP APM in 2023. We believe that it presents an attractive opportunity to emergency physicians to improve care and potentially achieve significant financial rewards.


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Maryland Medicine
Highlights from the 2022 AMA Annual Meeting

Catherine Johannesen, CAE

After two and a half long years apart, the American Medical Association was finally able to convene in person this June for the 2022 Annual Meeting in Chicago, Illinois. Along with the delights of connecting with old friends and making new connections, the Maryland delegation to the AMA was able to successfully advocate on a national level on behalf of the physicians and patients of Maryland. Here are some highlights:

Padmini Ranasinghe, MD, was re-elected to a second term on the AMA Council on Science and Public Health (CSAPH). Dr. Ranasinghe is a Johns Hopkins internist and assistant professor who specializes in preventive medicine, post-disaster mental health, and physician and medical student wellness. She currently serves on MedChi’s Board of Trustees as Vice Speaker of the House and Treasurer.

MedChi successfully advocated for the AMA to add to its environmental health policy that physicians should be encouraged to include assessments for environmental determinants of health in patient medical history-taking. This effort was initiated by medical students from Johns Hopkins University School of Medicine, supported by MedChi’s House of Delegates, championed by the Maryland delegation to the AMA, and ultimately adopted by the AMA House of Delegates.

This policy will lead to support for physician training for assessment of environmental health determinants such as proximity to air pollutants, an important tool in addressing both health inequities and environmental health justice.

The AMA made headlines by pushing back on the criminalization of abortion care, declaring climate change a public health crisis, and detailing plans to address the “infodemic” of medical disinformation. Education sessions at the meeting address health equity among other key topics, and Jack Resneck Jr., MD, was installed as AMA president. Visit www.ama-assn.org for more details on the meeting.

Pictured left to right: Willarda Edwards, MD, AMA Board of Trustees Member and MedChi Past President; Brooke Buckley, MD, AMA Political Action Committee Board Member and MedChi Past President; Loralie Ma, MD, MedChi President and Maryland Delegation Vice Chair; Padmini Ranasinghe, MD, Maryland Delegate, AMA Council on Science and Public Health Member, and MedChi Board Member.

Catherine Johannesen, CAE, is MedChi Chief of Staff and can be reached at CJohannesen@medchi.org.
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MedChi, The Maryland State Medical Society, established the Maryland Physician Health Program (MPHP) in 1978 by physicians, for physicians.

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MedChi Welcomes Flavio Kruter, MD, President, Carroll County Medical Society

Flavio Kruter, MD, is a specialist in Medical Oncology and Hematology. After graduating medical school in Brazil, he completed his fellowship in Hematology and Oncology at the George Washington University and the University of Maryland. Dr. Kruter is Board Certified in Internal Medicine and Medical Oncology.

In 1993 Dr. Kruter opened his private practice in Carroll County, Maryland. He has a reputation of caring for patients with cancers and blood disorders. His involvement in active clinical research has allowed him to provide the most up to date treatment modalities for the community he serves. Dr. Kruter is the Medical Director of the William E. Kahler Regional Medical Center in Westminster, MD. He has been a MedChi member for over twenty years.

Inaugural Class of Baltimore City Community Health Advocates

The first graduates of the Community Health Advocates Training (CHAT) program took time for a group photo (see below), following completion of the two-day course, “With Every Heartbeat is Life.” Offered by the Association of Black Cardiologists (ABC), in collaboration with Baltimore City Medical Society Foundation (BCMSF), the course, developed by the National Heart, Lung, and Blood Institute at the National Institutes of Health, covers twelve sessions.

Session topics include risks for heart disease; healthy meal preparations; heart attack signs; taking your blood pressure; cholesterol check; and diabetes. During the coming year, Advocates will give presentations to Baltimore City civic and community, business, and faith-based groups. They will also participate in group activities, such as health fairs, cooking demonstrations, and town hall sessions.

For more information on the CHAT program, contact Lisa Williams.

Kaiser Permanente Announces Center for Gun Violence Research and Education

Teresa Healey-Conway

Kaiser Permanente is working to prevent and to provide care to those at risk of committing or being harmed by gun violence.

The new Center will focus on:

- Creating screening tools identify individuals at risk committing acts of gun violence
- Identifying adequate intervention models to prevent gun violence
- Addressing the long-term psychological consequences on those who experience gun violence
- Educating the public, health care stakeholders, businesses, policymakers, and community-based organizations about the role they can play in reducing gun violence

In 2020, more than 45,000 people in the United States died from firearms injuries. Kathleen Keeffe, MD, an Advanced Urgent Care physician with Kaiser Permanente and the Mid-Atlantic Permanente Medical Group, who also chairs MedChi’s Public Health & Disaster Preparedness Committee emphasized that research and education will focus on a wide range of gun violence situations, including accidental shootings, suicide, and intimate partner violence. Furthermore, intervention efforts will be comprehensive and go beyond looking at gun violence as something to be solely addressed through legislation. “Health care workers, teachers, families, and community members are going to need to be part of the solution and they need concrete guidance on how they can be effective.”

The research will go beyond addressing deaths from firearms to injuries and wounds. According to the Centers for Disease Control, more than 70 percent of those who are medically treated for gunshot wounds survive “While there is an urgency among the public regarding preventing gun deaths, we can’t forget about the many people who survive gun violence. The long-term physical and psychological trauma that survivors experience must be addressed as well.”

The full statement from Kaiser Permanente can be found at https://k-p.li/3BnelzI.

Teresa Healey-Conway is Executive Director of Anne Arundel, Howard County, and Prince George’s County Medical Societies and can be reached at THealey-Conway@medchi.org.
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This drug savings program will grant funds to local CMN Hospitals to help kids within the communities they do business.
I was convinced that I would hate *The Emergency* when I chose to review it. Another screed, I anticipated, about the lack of medical care or the quality of medical care or the uncaring of medical care. I reasoned, though, that a reviewer need not love the book. A good review can help readers avoid books that are a waste of time or fundamentally flawed. It can provide a guide to what is, in a nonfiction book such as this, true and what is fevered conjecture. So I set about reading it. I thought I would hate this book. Turns out, I didn't.

*The Emergency*, by Thomas Fisher, MD, centers on the experiences of an emergency medicine physician at a university-affiliated hospital in Chicago's South Side. With poverty of money, time, and resources as the constant companion of both patient and caregiver, the author explores his theory that systemic inequities ultimately contribute to poor patient outcomes. Fisher, out of Pritzker medical school and a Harvard post graduate, also spent time in the boardrooms of Health Care Corporations, adding to his jaundiced take on American health care.

*The Emergency* is written for the layperson, but is an entertaining memory read for any doctor who has spent time in the emergency room. The stories, clearly chosen to inform and teach the reader about the frustrations of the big city hospital emergency room, detail the frustrations and occasional tragedies caused by an integral part of “the system,” which from Dr. Fisher’s viewpoint is racially biased in ways that negatively impact his patients.

Sprinkled amongst the stories of good intentions, treatment insufficiencies, and depredations of Big Medicine, there are unsent letters written by Dr. Fisher to his patients and colleagues, explaining how the system cheats them or at the very least, is stacked against them. This is a conceit that most reviewers of this book clearly think does not work. I think it does. The patients, whether compositely or individually, were made more alive when they became intimate recipients — albeit unknowing, of Dr. Fisher’s letters. I thought it a touching way to document Dr. Fisher’s analysis of their troubles while emphasizing the human connection.

I am not, for the moment, commenting on how accurately or to what degree that represents reality; but this format allows Dr Fisher (who comes across as a very compassionate and knowledgeable doctor) to personally explain his feelings about societal neglect and medical and social malfeasance. By the third such letter, it becomes apparent that he feels he is fighting a never-ending worsening battle with “the system.” The structure works because these interludes come directly after each treatment narrative, punctuating the frustrations of treatment in the face of societal roadblocks and conveying Dr. Fisher’s fatigue, compassion, and sense of futility in very human proportions.

Dr Fisher ascribes these very real problems, in the main, to the “system,” which he feels makes hospitals such as his a necessary but unsatisfactory waystation along his community’s path to declining health. He decries the long waits, the inadequate funding, the social inadequacies, the racial disparities and the very real frustrations of poverty. What he does not do very well is to place these in the perspective of medical care in general. Thus he seems to give short shrift to the fact that some of these problems are ubiquitous and exist in every medical setting. Personally, I’ve worked in many emergency rooms — from Bellevue and Charity to hospitals in the South Bronx that make the Chicago hospital in which he works look like the Mayo Clinic on a Sunday. Yes, community poverty plays a huge part: the waits can be interminable and the patients seem to come through revolving doors all too

*continued on page 20*
frequently. But these problems exist in private hospital settings as well. Poverty is a force multiplier that makes other problems that much worse: systems are inefficient, human beings will not always maintain their own good health, and waits are interminable everywhere (despite the best insurance). And yet we all try to deliver quality health care despite these roadblocks. Is it worse in places like his Chicago? Of course. But other endemic factors which have nothing to do with race are given little currency, including a general lack of investment in one's own recovery that is seen all too often in patients. This lack of investment is universal, and not limited to the South side of Chicago, the Hasidic neighborhoods of Brooklyn, or the tree-lined avenues of Beverly Hills.

Two other minor problems with the book: Dr Fisher shows us he's caring and compassionate but comes across as unflappable, without rancor, and a bit too saintly for credibility. To be human is to be irritable under the pressure of the ER, especially in the time of COVID-19. It is a little too much to believe that Dr Fisher never deviated from his calm professorial demeanor. ERs can be emotional cauldrons, a fact alluded to in the interstices of this book, but this is not evident in his descriptions of patient encounters.

Lastly, a forward by Ta Nehisi Coates is bit too “stuck on for commercial endorsement” for my taste and added nothing to the book but a recognizable name and a structural racism thrust in the health care arena, of which he is not an expert.

*The Emergency* is a fast read. And for non-ER physicians, it will bring back memories of teaching hospitals and long nights tending to elderly ladies who ate too much salt on a Saturday night. Finally, it teaches some of us — me included, about forces I never gave too much thought to when I was fortunate enough to be able to treat people in the ER and could then go home.

Bruce Smoller, MD, a former MedChi president, is a psychiatrist in Montgomery County who consults for the Federal Government. He can be reached at Bruce.Smoller7@gmail.com.
In Memoriam

Gene M. Ransom III

George Malouf Sr., MD, a giant in Maryland medicine, passed away last week at the age of ninety-eight. Dr. Malouf was a leader in many ways: as a public servant, in organized medicine, in the Maryland and Prince Georges County community and to his family and friends.

I first met Dr. Malouf in the mid-1990s. At that time I was a newly minted attorney for the society while he worked as treasurer for MMPAC (MedChi’s political action committee) — a post he held for nearly thirty years. Back then I made regular visits to his office in Hyattsville where we made fundraising calls, managed the PAC, and discussed politics, advocacy, and MedChi. It was there that he taught me invaluable lessons about the importance of honor, loyalty, and hard work. Dr. Malouf held various political appointments for the state of Maryland including Chair of the Health Resources Planning Commission and a position on the Health Care Access and Cost Commission. His skills with people and deep understanding of the political landscape was unparalleled.

Born in Zahle, Lebanon in 1924, Dr. Malouf graduated from the Université Saint-Joseph Faculty of Medicine in Beirut, Lebanon in 1948. He went on to complete his residency in Otolaryngology and Ophthalmology at Boston University in 1953. Later, he served as Captain in the U.S. Army with an honorable discharge in 1957. Dr. Malouf held many positions in the Maryland medical community. He served as President of the Maryland State Medical Society (MedChi) in 1984 and he was a charter member of the Maryland Society of Eye Physicians. Dr. Malouf was also active in the American Medical Association (AMA) as an elected delegate and longtime chairman representing Maryland. In 1992, the AMA awarded him the prestigious Benjamin Rush Award for citizenship and community service. Dr. Malouf was a lifelong member of the Antiochian Orthodox Church.

Dr. Malouf’s impressive legacy and appointments oftentimes overshadow the remarkable strides he made in equality of opportunity for everyone. His election as MedChi’s President in 1984 as a foreign-born medical graduate from Lebanon was considered groundbreaking at the time. Throughout his career, Dr. Malouf fought for access to opportunity for all citizens. He was a staunch supporter of, and campaigned alongside, the first black President of MedChi, the first woman President of MedChi, and the first black woman President of MedChi. Dr. Malouf believed that people should be judged by the content of their character and the work that they produced; not where they were originally born, their gender, or the color of their skin. Dr. Malouf’s openness to diversity remains a huge part of his legacy and is largely the reason behind MedChi’s longstanding commitment to diversity and inclusion.

MedChi mourns the loss of a truly great leader and friend.

Gene M. Ransom III is the CEO of MedChi, The Maryland State Medical Society.

To read Dr. Malouf’s obituary, visit https://www.dignitymemorial.com/obituaries/washington-dc/george-malouf-10770946.
MedChi’s Newest Physician Members

MedChi welcomes the following new members, who joined between April 25, 2022, and June 30, 2022.

Yemul Quran E. Shirin Almecci, MD — Endocrine and Diabetes Associates, LLC
Bryan T Ambro, MD, MS — The Centers for Advanced ENT Care, LLC
Peter L. Beilenson, MD, MPH
Beatriz H. Chanduvi, MD — Endocrine and Diabetes Associates, LLC
Monique Kamaria Chheda, MD — Shady Grove Dermatology, Laser & Vein Institute
Cynthia G. Chrosniak, MD — The Centers for Advanced ENT Care, LLC
Katherine V Day, MD — The Centers for Advanced ENT Care, LLC
Mark A. Dettelbach, MD — The Centers for Advanced ENT Care, LLC
Natalie Ann-Marie Earl, MD, FACS — The Centers for Advanced ENT Care, LLC
James L. Frazier, MD — LifeBridge Neurosurgical Associates
Michael R Freedman, MD — Evolve Medical Clinics
Reena Garg, MD
Anurag Gupta, MD — Endocrine and Diabetes Associates, LLC
John Hakim, MD
Gregory L. Heacock, MD — The Centers for Advanced ENT Care, LLC
Matthew A Hilburn, MD — The Centers for Advanced ENT Care, LLC
J. Gregory Hobelmann, MD — Ashley Addiction Treatment
Linda Hollifield-Kennedy, MD, MPH — Department of Homeland Security
Andrew Kessler Johnson, MD — The Centers for Advanced ENT Care, LLC
Jana L. Kaplan-Fastow, MD — Anne Arundel Medical Center
Natasha Kasid, MD — Endocrine and Diabetes Associates, LLC
Peter J. King, MD — The Centers for Advanced ENT Care, LLC
Carla M. Lawson, MD — The Centers for Advanced ENT Care, LLC
Joshua Lim, MD
Johnna Mahoney, MD, FAAP
Nora Malaisrie, MD — The Centers for Advanced ENT Care, LLC
Jasmine E. Malcolm, MD
Jared Mathews, MD — Jared Mathews, MD
Christopher P. Mesick, MD — The Centers for Advanced ENT Care, LLC
Saverio Mirarchi, MD, MBA — University of Maryland Medical Center
Mohit Narang, MD — Maryland Oncology Hematology, PA-Columbia
Alireza Sadegh Nejad, MD, PhD — The Centers for Advanced ENT Care, LLC
Jaime P. Olenec, MD — The Centers for Advanced ENT Care, LLC
Raena Olsen, DO — MedStar Health: Gastroenterology at Silver Spring
Olubayo O. Oludara-Fadare, MD — Ace Urgent Care and Primary Care Center
Seth Oringher, MD — The Centers for Advanced ENT Care, LLC
Annalisa Overstreet, MD — The Centers for Advanced ENT Care, LLC
J. Michael Pardo, MD — The Centers for Advanced ENT Care, LLC
Katherine Perry, MD — The Centers for Advanced ENT Care, LLC
Sanjay Prasad, MD — The Centers for Advanced ENT Care, LLC
William Regine, MD — University of Maryland Proton Treatment Center
Howard N Robinson, MD
Michael P Rodrigues, MD — The Centers for Advanced ENT Care, LLC
Amy Startt Rogstad, MD — Endocrine and Diabetes Associates, LLC
Barbara Ross-Lee, DO
Naheed F. Saif, MD
Philip S. Schoenfeld, MD — The Centers for Advanced ENT Care, LLC
John Sealey, DO
Vibhav Kumar Sekhsaria, MD — Family ENT Allergy and Asthma Care
Kevin Shaigany, MD — The Centers for Advanced ENT Care, LLC
Jessica C Shen, MD — The Centers for Advanced ENT Care, LLC
Archana R. Shetty, MD — Endocrine and Diabetes Associates, LLC
Stephanie Solazzo, MD
Joydeep Som, MD — The Centers for Advanced ENT Care, LLC
Martin Peter Sorensen, MD — The Centers for Advanced ENT Care, LLC
Duane J. Taylor, MD — The Centers for Advanced ENT Care, LLC
Christopher Wagner, MD — Spring Grove Hospital Center
Jack B. Williams, MD — The Centers for Advanced ENT Care, LLC
The Mystery of John Whitridge, MD

Meg Fairfax Fielding

If you’ve been to the MedChi offices in Baltimore, then you know there are a lot of nooks and crannies. In one of my searches of the buildings, I opened a door and was quite startled to see someone looking back at me. On second glance, I realized it was a marble bust.

After a bit of work, we managed to get the eighty pound bust up to my office where I examined it. The bust was sculpted by Baltimorean William Rinehart in Rome in 1874. Fortunately, this information was chiseled into the side of the bust, which gave me a starting place for my research.

I found a copy the 1948 catalogue raisonné of Rinehart’s works and searched through the images in the catalogue. I discovered a match to a bust in the catalogue of John Whitridge, MD (1793–1878). Dr. Whitridge was born in Rhode Island and was a graduate of Union College and later Harvard in 1819. He became a member of the Faculty in 1821 and practiced medicine in Baltimore for fifty-three years. He died in the place where he was born, in Tiverton, Rhode Island on July 23, 1878. Sadly, there is not much more information about Dr. Whitridge.

The bust had been exhibited in Baltimore in 1874, and it was noted that Rinehart’s skill in sculpture was exemplary: “The pose is splendid and the lines of the face are delineated with consummate skill. The hair is one of the most noticeable features of the work and exhibits the skill of a master.”

After consulting with various conservators, I spent a few days cleaning the bust, making a concerted effort on the eyes, on which someone had drawn eyeballs. The marble was transformed from a dingy gray to a gleaming white, which now glows in the late afternoon sunlight. The Whitridge bust is one of several marble busts in our collection that you can see when you visit MedChi’s Baltimore headquarters. And if you’re on a Zoom call with me, you can see him lurking in the background.

Meg Fairfax Fielding is the Director of Development and The History of Maryland Medicine at the Center for a Healthy Maryland and can be reached at MFielding@medchi.org.

MedChi Events

A complete list of MedChi and component events can be found at: http://www.medchi.org/Calendar-of-Events.

SEPTEMBER
13: Gender Pay Equity Subcommittee Meeting
14: Baltimore City Medical Society Board of Directors’ Meeting
15: MedChi Board of Trustees Meeting
21: Baltimore County Medical Association Board of Governor’s Meeting
28: Baltimore County Medical Association CME Program

OCTOBER
8: Baltimore City Medical Society Foundation’s 50th Anniversary Gala
11: Gender Pay Equity Subcommittee Meeting
12: Baltimore City Medical Society Board of Directors’ Meeting

NOVEMBER
2: Baltimore County Medical Association Board of Governor’s Meeting
9: Baltimore City Medical Society Board of Directors’ Meeting
16: 15th Anniversary Furlong Memorial Lecture, Joint meeting with Baltimore City Medical Society and Baltimore County Medical Association
ANNUAL MEMBERSHIP SOCIAL
SATURDAY, AUGUST 27TH
12:00 PM ~ 3:00 PM
JOIN US FOR A NETWORKING LUNCHEON AT THE GUINNESS BREWERY!

Tickets ~ $50 per person
(LUNCHEON ONLY; BREWERY TOUR TICKETS SOLD SEPARATELY)
Residents/Fellows ~ $30
Students ~ FREE

*Brewhery tours can be purchased separately by contacting Guinness directly.

REGISTER TODAY!
Visit: www.medchi.org/social

For more information, contact Jenine, jfeaster@medchi.org.