

# Maryland Medicine

VOLUME 21 ISSUE 1



**Artificial Intelligence:  
Opportunities &  
Challenges**

**Perspectives  
on Patient Portals**

**Data Exchange  
in the Digital Age**

## MedChi Leadership Participates in AMA State Advocacy Conference



MedChi CEO Gene Ransom was joined in January by several MedChi physician leaders for the American Medical Association's 2020 State Advocacy Conference in Bonita Springs, Florida (L to r: Michele Manahan, MD, MedChi President; Ilse Levin, DO, MedChi Delegate; Willarda Edwards, MD, AMA Board of Trustees and MedChi Past President; and Gene Ransom, MedChi CEO).

Mr. Ransom participated in a drug pricing transparency panel discussion with Mary Mayhew, Secretary of Florida's Health Care Administration, and Jennifer Reck, Project Director for the National Academy for State Health Policy Panelists. The panel discussed the unproductive blame games that slow efforts to enact meaningful legislative solutions. Mr. Ransom shared the progress that's been made in Maryland to address drug pricing transparency and future efforts.

Maryland Delegate Terri Hill, MD, was also in attendance at the conference and served on a panel discussing prior authorization reform from her unique perspective as a physician and lawmaker.

## MedChi is Your Advocate in Annapolis

MedChi's **Legislative Council** and its three subcommittees meet weekly to review and take action on many bills related to scope of practice, insurance, boards and commissions, and health care access and delivery. Contact Chip O'Neil if you're interested in participating: [coneil@medchi.org](mailto:coneil@medchi.org).



Twenty physicians and practices managers participated in **Legislative Skills Training Workshops**, which were presented by Steven Wise, Esq., of MedChi's Lobbying Firm.

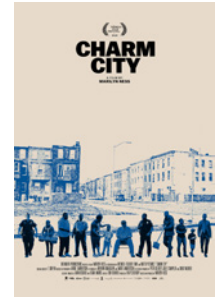
Renee Bovelle, MD, an ophthalmologist practicing in Bowie, Maryland, spent the evening of Martin Luther King, Jr. Day serving as **Physician of the Day** in MedChi's State House First Aid Room. Dr. Bovelle met with the new Speaker of the House, Adrienne A.

Jones (D-10, Baltimore County), pictured left.

## April CME Activities

MedChi and the Maryland Psychiatric Society (MPS) will present **The Impact of Gun Violence on Patients & Communities: What Can We Do About It?** on Wednesday, April 15 (5:30–9:30 p.m.), at MedChi's Osler Hall, in Baltimore. Join us for a viewing of the film "Charm City," a candid portrait of citizens, police,

community advocates, and government officials on the frontlines during three years of unparalleled, escalating violence in Baltimore. A lecture by Carol Vidal, MD, MPH, Assistant Professor of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine, will follow the film. The program will conclude with a panel discussion featuring the film's director Marilyn Ness, Damion Cooper, Th.M., Nathan Irvin, MD, MSHPR, and Paul Nestadt, MD. This activity will offer 3.25 CME credits for attendees.



On Friday, April 17 (7:30 a.m.–4 p.m.), MedChi and Chesapeake Employers Insurance will present **Delivering Quality Healthcare to Patients with Workers' Compensation Insurance** at the Maritime Conference Center in Linthicum Heights, Maryland. The purpose of the meeting is to discuss problems (e.g., causation, overtreatment, and inaccurate diagnoses) in delivering care to the injured worker that affect the quality of outcomes as measured by the standard of being able to return to work. Presenters will review problems and offer potential therapeutic options to allow the injured worker to return to the job. This activity will offer 7 CME credits for attendees.

For information and registration: [MedChiCME@medchi.org](mailto:MedChiCME@medchi.org); Frank C. Berry, 410.539.0872, ext. 3307.

## What You Need to Know

1. The MIPS Submission window is open through March 31, 2020.
2. Medicare Part D ePrescribing Rule takes effect on January 1, 2021.
3. CRISP has added many tools to the Unified Landing Page (ULP) to assist practices in managing their own accounts for accuracy.
4. Maryland Department of Health has transitioned from Beacon to Optum for Medicaid Behavioral Health Services.
5. The Maryland Health Care Commission (MHCC) seeks physicians' (MD or DO) and nurse practitioners' responses to a health information technology (health IT) survey. **The survey inquires about electronic health records, health information exchange, telehealth, and social determinants of health. The survey should take about five minutes and can be accessed at the following link: [www.surveymonkey.com/r/MHCCproviderHIT](http://www.surveymonkey.com/r/MHCCproviderHIT).** Responses will help MHCC in assessing health IT trends and inform policy and future planning in Maryland.

## From the President...

*Michele Manahan, MD, President, MedChi*

Greetings, all. I hope the New Year has gotten off to a healthy, happy start for everyone in the MedChi family. We are entering a busy season with legislative agendas on top of the usual business of keeping our practices thriving.



On the legislative front, we are facing new challenges this year. We predicted some, and we have been surprised by others. Having recently attended the AMA's State Advocacy Summit, I think we can be proud of our society's past efforts and successes. We have a strong history of meeting challenges head on and moving our profession in the right

direction. It may be an election year, but our patients still need the same forward-thinking, proactive work from their physicians, and I know we'll deliver. Please stay in touch through the many avenues available to share the opinions of yourselves and your colleagues. Visit [www.medchi.org/YourAdvocate](http://www.medchi.org/YourAdvocate) to get involved and ensure your voice is heard.

For those interested, please consider joining the new IDEA (Inclusivity, Diversity, Empowerment, and Advocacy) Task Force that will soon be forming. We hope to shape a future in which each individual's unique summation of characteristics is valued and lauded. I am sure we can all think of instances in which we have heard of the medical profession falling a little short of where we would like to see it when we consider these issues. We hope to shake the dust of past experiences from our shoes and walk together toward a brighter tomorrow. Please contact Catherine Johannesen, MedChi Chief of Staff, at [cjohannesen@medchi.org](mailto:cjohannesen@medchi.org), or 800.492.1056, ext. 3308, if you are interested in this task force.

In this issue, *Maryland Medicine* focuses on emerging technologies that impact you, your patients and your practice. From telemedicine to patient portals, being aware of the challenges and opportunities of adoption is important. We hope this issue is helpful and informative.

Finally, please know that I am happy to address anything you wish over the coming months. As we work this year to redefine our physician identity and reaffirm the patient-physician relationship, we need feedback from the frontlines. How can we help you execute your calling? We are ready and waiting to lend a hand.

## Artificial Intelligence: The Dangers of Coming to Clinical Decisions Without Physician Input

*Renee Bovelle, MD, and Rob Campbell, MSCS*

A recent survey hosted by The HealthCare Executive Group (HCEG) of more than 100 health care, C-suite, and director level executives ranked their most critical challenges, issues, and opportunities for 2020.<sup>1</sup> Not surprisingly, the list includes health care policy, privacy, and security. These topics are at the forefront of health care organizations, large and small. While the list is demanding and challenging, rapid technological advances in Artificial Intelligence (AI), offer an entirely new set of opportunities and challenges, and health care, privacy, and data security and cybersecurity policies must keep pace. This article explores a small set of opportunities and challenges of AI in health care.

### Artificial Intelligence


Artificial Intelligence (AI) uses algorithms, heuristics, pattern matching, rules, deep learning, and cognitive computing to approximate conclusions without direct human input. AI, or augmented intelligence, is a branch of computer science concerned with simulating "intelligent" behavior in computers. In clinical medicine, AI teaches a computer to recognize specific patterns. Machine learning refers to a branch of AI in which computer systems input large amounts of data, which they then use to learn how to carry out a specific task. Researchers can solve complex problems that would be difficult or near impossible for humans to solve. AI's strengths are in identifying relationships in raw data that can be used to support diagnosing, treating, and predicting medical outcomes. AI has broad applications in almost every field of medicine, including drug development, patient monitoring, and patient treatment plans. The health care industry is rapidly adopting AI, but health care providers must remain vigilant about patient privacy and the security of data. Artificial Intelligence (the output is decision making) and Machine Learning (the output is new knowledge gained) can be integrated when needed into one system.

### Opportunities

AI can identify patterns based on collected and labeled data—the model stores knowledge and is continuously developed until it "proposes accurate outputs" on a training set. Medical specialties, such as radiology, ophthalmology, and dermatology, which rely heavily on imaging, are especially well-suited to use artificial intelligence.

*continued on page 5*





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*Artificial Intelligence, continued from pg. 3*

**Imaging.** The FDA has approved an artificial intelligence mechanism that alerts physicians to possible stroke signs on heat CT angiography scans. This innovation may allow for faster diagnosis and treatment of hemorrhagic and ischemic stroke.<sup>2</sup> Computers can scan retinal images using AI algorithms to determine if the patient has diabetic retinopathy and, if so, the stage. Patients requiring treatment can be screened and referred more quickly.<sup>3</sup>

**Clinical Decisions.** Researchers at Cleveland Clinic are investigating AI analysis of patient data to help predict outcomes in spine surgery.<sup>4</sup> Machine learning and AI can take into account imaging, surgical factors, mortality prediction, and other factors to help physicians determine surgical candidacy. Lead author Michelle S. Lee, BA, of Cleveland Clinic, states, “With advances in computer processing capability, data storage, and networking, these computer-based algorithms can perform the intricate and extremely complex mathematical operations of classification or regression (specifically nonlinear regression) on immense amounts of data to detect intricate and potentially previously unknown patterns in that data. Machine learning algorithms have been able to analyze complex and large volumes of electronic medical record data to produce predictions for a wide range of clinical problems.”<sup>4</sup>



**EHR.** AI can be applied in voice-to-text transfer for data input into EHRs. It reduces administrative inefficiencies in EHR use.<sup>5</sup> In some cases, AI can automatically extract risk factors or other data from unstructured notes in clinical records, thus enhancing clinical research. A recent article in JAMIA points out that AI enabled algorithms can accurately evaluate enormous amounts of unstructured data and notes.<sup>6</sup>

**Challenges.** Physicians must collaborate with AI developers to avoid repeating the problems we currently have with EHRs. The software engineers generally do not have a medical background. They must have input from physicians to account for workflow and other issues. There are several potential pitfalls that must be avoided when implementing AI in health care. Poorly designed algorithms, inadequate data sets, and unconscious and implicit bias are just some of the difficult issues that can lead to a misdiagnosis or put patient safety at risk.

**Storage and Data Security Practices.** Current laws and policies are not enough to protect an individual’s PHI. Today’s practices of notifying patients and obtaining consent for data use are not adequate; the strategies for de-identifying data useful in

the context of AI without revealing PII or PHI require close attention. An example is when Google was to post more than 100,000 images of human chest X-rays publicly, the National Institutes of Health (NIH), which had provided the images, indicated that the images contained PII details, which would be potential privacy and legal violation if posted.<sup>7</sup>

**Cybersecurity Policy.** According to the *AMA Journal of Ethics*, in June 2018, the AMA adopted a new policy to provide a framework for AI.<sup>8</sup> However, much more needs to be done. Addressing concerns about privacy and security remain challenging. Policy and procedures should be implemented to ensure that data are properly de-identified. Data sold or stolen in a breach can be reconstructed and interfere with patient privacy. Patients should be made aware of when they are receiving a prognosis based on AI prognostication. Physicians or other professionals may need to provide AI counseling in a similar manner to our current genetic counseling. Policy should be developed to prevent discrimination based on possible future disease states.

It is apparent that AI is an excellent tool to be added to our medical armamentarium. We physicians must work with policymakers, industry, and other stakeholders to safeguard patient privacy and welfare. Security policy development must be a collective operation of all entities and stakeholders.

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# Patient Portals

## Efficiency vs. Effectiveness in Maintaining Human Touch

### A Patient's Perspective

Susan D'Antoni, FAAMSE

I pride myself in being technologically adept in most situations. However, given that my only computer course in college was FORTRAN complete with those never-ending “do loops,” I’m always pleased when I can find what I want on the internet, use graphic design and other software proficiently, post on a regular basis to various social media sites, download the latest version of software, and learn my around a new iPhone, or iPad. In other words, technology doesn’t scare me. I tend to jump right in and look for ways it can make my personal and professional life easier and more enjoyable, and I can be most informed.

**This lack of fear includes use of patient portals. I have accessed four patient portals in the last year frequently — each with a varying degree of satisfaction.**

Before last fall, I signed up and used patient portals offered by my primary care physician and gynecologist. My usage was typical and routine — I’m part of the 85 percent who used the portal to try to access lab results, or request a prescription refill. I would receive an email notice generated via the EMR that there was a new report in my medical record, fail two or three times to get into the portal, be required to change my passwords, and then look and look for the new report until I’d either find it or abort the process due to user fatigue. After all, if it wasn’t a normal result, I would get a phone call from my physician. At least that was my expectation.

### A Physician's Perspective

Carolyn B. O’Conor, MD

New communication tools appear frequently these days. As with every innovation, there are benefits and drawbacks. Patient portals are no exception.

**Benefits can include clear, written communication, which can be reviewed more than once, making portals superior to phone communication.**

**The potential drawbacks are numerous, and some may have yet to be realized.** My patients report “password” fatigue as they tire of trying to keep up with portals and attendant passwords for multiple physicians.

Our patients sometimes report that email alerts from the portal land in “spam,” and therefore they are unaware we have communicated something. Some patients ignore the email because they think it is routine communication like a reminder to schedule an appointment or get a flu shot.

When I ask patients if they have seen their lab results in the portal, they often report they have not. Sometimes they forget their password or they see the email but don’t follow through. The system does not flag lab results that have not been viewed by a patient.

**When I have important or abnormal results to communicate, I take a “belt and suspenders” approach and ask my medical assistant to call the patient.** I also send a letter if we haven’t reached the patient by phone.

### Patient Portal Use in America, 2018

- Only 28 percent of the estimated half of patients offered access to their medical record by a provider or insurer viewed their record in the past year.
- 24 percent of patients offered access to their medical record did not look at it in the past year.
- Patients who didn’t look at their medical record online said they preferred to talk to their doctor (76 percent), did not see the use for it (59 percent), or were concerned about privacy (25 percent).
- Among the top reasons for using the portal were to get lab results (85 percent), refill a prescription or make an appointment (62 percent) and message with their provider (48 percent).
- Just 17 percent used the portal to download a copy of their medical record.
- Even so, 82 percent said the health information provided online was easy to understand and helpful.

*Study published by the Office of the National Coordinator for Health Information Technology*



## *A Patient's Perspective continued*

When I found myself needing to see four additional specialists for a newly-discovered medical condition, I expected to be encouraged to use four additional portals. It turned out that this was not the case, since two of the four physicians don't have patient portals even though they use EMRs.

Communication and coordination with my care team has become really important. Call me "old school," but I prefer actually talking to my physician or clinicians especially if the discussion includes more than a report of normal lab results. In one situation, I contacted a medical practice and requested my physician to call me. My call was directed to a voicemail message noting that it could take up to 72 hours to get a call back, and that my physician could respond much faster if I would send a message via the portal. I did send a message which she replied to promptly but it turned into a series of messages and replies which was probably just as frustrating for her as it was for me. Time could have been saved and satisfaction increased if we could've had a five minute phone call instead.

**With all the technology in medicine today, we have to strive even harder to retain the human touch. A patient portal is just one tool to improve patient communication and engagement.**

It should never be a substitute, or relied upon heavily for the patient-physician relationship that I and other patients value so much.

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## *A Physician's Perspective continued*

Apart from lab results, our patient portal has several other capabilities. Patients can request refills, new referrals, or ask general questions. Often, the portal makes patient care more efficient. On the other hand, we do not diagnose and treat new problems through the portal.

**Some patients ask too many questions through the portal, and communication bogs down. If I am worried about the risk of unclear communication or even liability issues, I ask patients to schedule an appointment to delve deeper into their concerns.**

In our practice, about 75 percent of patients are web enabled, but only half of those actively use it. When I ask patients if they are web enabled, they don't know. Frequently, we have to provide patients with a temporary password. I believe education and repetition are key to making the portal more useful.

**Patient portals offer benefits, but are not risk free. It is important to have clear written policies, signed by patients, with information regarding appropriate use of the portal and communications.**

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# MedChi and Maryland Primary Care Program Connect Physicians to Health Care Technology Resources

Colleen George and Andrea Mullin

Since January of 2019, MedChi has been exploring ways to connect physicians to technology-based health care resources. This led to MedChi's collaboration with four technology-driven companies that have a specific focus on health care:

- DrFirst's Backline App
- Caring One's Telephonic Outreach Program
- Care Innovations' mySugr App
- Lyft's Concierge Dashboard

**Backline:** Dr First's Backline is a secure messaging system that allows physicians to connect and chat with patients while keeping protected health information (PHI) secure. For convenient access, Backline can be downloaded on to any phone, allowing the provider to reach beyond the walls of the hospital and have 24-hour access to patients. This technology is compatible with IOS, Android, and web browsers.

**Telephonic Outreach Program:** This Caring One program aims to reduce hospital readmission by connecting a recently discharged patient back to his or her Primary Care Physician (PCP). A call coordinator from Caring One receives an electronic notification of a patient discharge. They then conduct telephonic outreach to the patient and will assist in scheduling a post-discharge appointment with the patient's PCP.

**mySugr App:** Care Innovations designed an app called mySugr, which assists in simplifying diabetes management. The goal of the program is to help patients get to self-management while offering continuous virtual support through the app. The app includes instant and exclusive access to a mySugr Coach who is a trained and certified diabetes specialist.

**Concierge Dashboard:** A common obstacle in health care is transportation. Many patients lack the necessary resources to get to and from a doctor's appointment, which leads to missed appointments and inconsistent care. The Lyft Concierge Dashboard allows a physician's office to send a patient a ride right away, and allows patients to request a ride within a 24-hour window or schedule a ride up to seven days in advance. The dashboard displays the current status of all rides, scheduled rides, and ride history.

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## Data Exchange in the Digital Age

Craig Behm

When CRISP became Maryland's Health Information Exchange (HIE) ten years ago, we had the luxury of starting from scratch. Practically no patient information was being shared, so anything we exchanged was better than the status quo. The industry has come a long way since then, resulting in vast quantities of health records moving across the continuum of care. Although these records may technically be available to physicians, actual insights to improve care are largely inconvenient, at best. The HIE has a new challenge: to provide meaningful information to physicians conveniently to enhance their patient interactions.

**CRISP, along with partners at MedChi, Maryland Medicaid, and the Health Services Cost Review Commission, is tackling this challenge head-on.**

**First, we are continuing to clean-up the data shared through the HIE.** The integrations with hospitals, ambulatory practices, skilled nursing facilities, and other clinical settings are critical to a functioning HIE. Our technical operations team monitors these connections to reduce downtime. We are also reviewing the specific documents to normalize names and codes. The result should enable you to quickly find Discharge Summaries, for example, because they will be consistently submitted and named.

**Second, we are developing new tools to better use electronic health record (EHR) functionality.** None of the fantastic data available in the HIE is useful if you are unable to access it quickly. We invested in building an application, or app, very similar to those available on your smartphone. This app follows national standards so it can be deployed in multiple EHRs without customization. It is available in Epic, Cerner, and Athena; we are testing in eClinical Works. Users on these systems can view CRISP information directly within their systems with no additional clicks or logins. We hope other EHR vendors will allow us to deploy this tool in the near future.

**Finally, we are exploring new types of data and organizations that can contribute to the shared understanding regarding the care of your patients.** The Total Cost of Care Model, and specifically the Maryland Primary Care Program, are causing physicians to consider social determinants during patient encounters and even outside of face-to-face treatment. CRISP is taking incremental steps to expand the HIE to better align with these efforts. We already share Care Alerts and Care Teams so you can understand the full range of individuals and services engaged in the treatment of your patient. Ambulatory physicians or their staff can submit this information to enable smooth transfers from hospital discharge planners, highlight critical details about a patient, and increase transparency across any health care setting the patient may visit.

**The next step in building care team information is to include referrals to community organizations and knowing when the patient is successfully enrolled.** We have a pilot to allow physicians, care managers, or other staff to submit a referral through CRISP to a non-health care entity such as Meals on Wheels of Central Maryland. Our intention is to make it easier to connect patients with the services that will support wellness between physician visits.

**Maryland has a solid foundation to build on as we collectively leverage data to support physicians and their patients.** While we have a lot more work to do to meet the challenge of conveniently sharing meaningful information, I am confident we will continue to make progress over the coming weeks and months. None of this is possible without input and engagement from our users.

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## Telehealth and the U.S. Department of Veterans Affairs: A Growing Success Story

Victoria Hecht

**In March of 2019, VA Secretary Robert Wilkie announced that the agency will seek more than \$1 billion in federal funding to expand its telehealth network for veterans.** In his Capitol Hill testimony, Wilkie noted that the agency topped one million virtual visits in 2017, a 19percent increase over the prior year, and wants to increase the number of veterans using connected care from the current rate of 13 percent to 20 percent.

**The VA has quickly become a leader in large scale deployment of telemedicine.** In 2014, the VA's national telehealth programs served more than 690,000 veterans, which accounted for more than two million telehealth visits. Approximately 55 percent of telehealth visits were veterans living in rural areas with limited access to VA health care.

As clinicians continue to try and find ways to reduce costs and improve efficiency, the VA model has proven that telehealth programs can be effective in achieving these goals. According to VA officials, telehealth programs have contributed to a 34 percent reduction in readmissions and a 42 percent drop in bed days in 2014. The VA managed to deliver cost savings while also keeping patient satisfaction scores high. In a 2014 survey of about 10,000 participating veterans, VA officials report that clinical video telehealth received a 94 percent satisfaction rate.

Wilkie's budget request is part of a campaign aimed at helping

the nation's estimated 18.2 million veterans access healthcare when and where they most need it, while also taking the strain off of the VA's network of 170 hospitals and 1,063 outpatient care sites.

**In 2018, the agency launched its "Anywhere to Anywhere VA Health Care Initiative", a program that allows VA-sanctioned clinicians to treat veterans via telemedicine no matter where the physician or patient are located, thereby circumventing state laws that might hinder connected care.**

More recently, the VA has forged partnerships with Walmart, T-Mobile, Philips and Verizon to expand access to care for veterans through telehealth and mHealth platforms. This past December, the VA and Walmart jointly opened its first telehealth center in Asheboro, North Carolina, as part of a pilot program to bring VA telehealth to veterans in their local communities through public/private partnerships. Soon Walmart will be expanding its telehealth sites to Wisconsin, Michigan and Iowa.

"These types of events will help accelerate our shared journey to full-integrated, seamless access to healthcare, no matter where a veteran resides," Wilkie said in a press release issued in March of last year. "Indeed, from anywhere to anywhere."

*Victoria Hecht is MedChi's Development Coordinator. She can be reached at [vhecht@medchi.org](mailto:vhecht@medchi.org).*



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## Is It Time to Take On Telemedicine?

Allie Clark

Telehealth integration into care delivery continues to trend upward. What was a \$38 billion industry in 2019 is set to rise to \$130 billion in just five years. Direct-to-Consumer telemedicine vendors are rapidly partnering with payers across the country to capitalize on this growth. A recent study found that 94 percent of private insurers offer telehealth services. Private practices have responded by incorporating their own telemedicine programs.

While outsourcing telemedicine can be tempting, your practice may lose the benefits of patient retention and continuity of care. Taking on telemedicine yourself will improve your bottom line and the quality of your patients' care. You are in the position to provide the most consistent care based on an existing knowledge and relationship with the patient.

Time and technology are two common reasons why physicians choose not to take on telemedicine. Physicians often feel that they don't have time in their schedule to "add" video visits or assume they cannot operate nor afford new technology. These are reasonable concerns for over-burdened clinicians, yet both can be easily addressed. You can do telemedicine yourself, and your practice will be better for it.

### Why It's Worth It

**Payer Coverage:** Maryland's private payer parity law requires that insurance companies cover services delivered through telemedicine that they would cover in a face-to-face setting.

**Reach More Patients:** Licensing law allows Maryland-licensed physicians to see patients via telemedicine in neighboring states as long as they have no physical office. Maryland is also a member of four interstate licensing compacts that allow a variety of health care physicians to see patients virtually in other member states.

**Add More Visits:** Our research has shown that many telemedicine appointments are made for health concerns that patients would not otherwise seek care for in-office. Instead of replacing office visits with virtual ones, you could be seeing revenue added from virtual visits in addition to those that are regularly scheduled.

**Reduce No-Shows:** Studies have shown that integrating telemedicine into care plans reduces appointment no-shows by as much as 50 percent.

**Increase Billable Events:** By using telemedicine as an alternative to site visits or phone calls, you are able to qualify typical patient encounters into billable events, including a variety of follow-up and consultative services. With the new

telehealth codes for Medicare that were implemented in 2019, most if not all of these services are now fully covered.

**Time:** Many telemedicine appointments can be integrated seamlessly into a daily schedule without adding time to the day. Simply changing the delivery of care from a phone call or another appointment slot to a video visit adds convenience and the option for reimbursement. Using telemedicine for the things you already do when following up with your patients will not use up any additional time in your day.

Video visits also open the opportunity for you, as the physician, to participate in appointments remotely. Consider how you might adjust the days or times you are in-office or working from home, and you might find that you end up with more time.

**Technology:** Specialized equipment is not required to effectively implement a telemedicine program. We use the same technologies in virtual care that are used in our personal lives. 89 percent of Americans own a smartphone or device that has embedded video-calling apps. Using technology that promotes ease-of-use might also cut down on the time it takes to execute your telemedicine appointments, effectively putting to rest the two most common reasons why physicians don't choose to do telemedicine themselves.

**You Can Do It:** As physicians, the core of what you do centers on "hope." Telemedicine is another vehicle with which you can continue to provide hope and health to the people who need you. So let this be a message of hope to you. Your concerns are legitimate, but the solutions are real and the benefits indisputable. Telemedicine is worth it, and you can do it yourself!

For more resources on how to start a telemedicine program, visit [www.simplevisit.com](http://www.simplevisit.com). SimpleVisit is a telemedicine service supporting medical groups with user-friendly video visit solutions. There are HIPAA and ethical considerations that must be considered before initiating telemedicine. Please consult appropriate resources.

*Allie Clark is an Industry Analyst for SimpleVisit, a Maryland-based tech company. She may be reached at [allie@simplevisit.com](mailto:allie@simplevisit.com).*



## AMA Provides Ethical Guidelines When Using Health Information Technology to Care for Your Patients

Do you have questions associated with the ethics of using telemedicine to treat your patients? Do you question the ethics of using patient portals to communicate with your patients? What is a physicians' ethical responsibility when using Artificial Intelligence, or AI, to treat patients?

The American Medical Association's (AMA) Council on Ethical and Judicial Affairs (CEJA) has considered these important questions and has developed guidelines for physicians to use. The Council on Ethical and Judicial Affairs (CEJA) has two

primary responsibilities. Through its policy development function, it maintains and updates the 169-year-old AMA Code of Medical Ethics. In its judicial function, it promotes adherence to the Code's professional ethical standards.

To find the policies of the AMA, go to <https://www.ama-assn.org/form/policy-finder>.

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## Member Profile: George Bone, MD—Early Adopter of Health Information Technology

Colleen George

George Bone, MD, was born in Guyana and moved to the United States to enter Gustavus Adolphus College in Florida at the age of sixteen, having completed high school at this young age. He graduated with a degree in Chemical Engineering and then decided to go to medical school. During his first two years of medical school at St. Louis University School of Medicine he worked as a research chemist. After medical school he completed a residency in Internal Medicine at St. John's Mercy Medical Center, also in St. Louis.

From there, Dr. Bone's path to owning a private practice in Prince George's County took many turns. He did a six-month cardiology fellowship, conducted research at the National Institute of Health, and worked as an Emergency Room physician. He finally settled in Maryland, opening his practice in Prince George's County in 1996.

Dr. Bone is an active MedChi member and has served as president of the organization and as president of the Prince George's County component medical society. I met Dr. Bone when he became the first chairperson of MedChi's Information Technology (IT) Committee. Dr. Bone was an early adopter

of Electronic Health Records(EHR), and has always seen the need for improvement in the efficiency in medical record documentation.

As he puts it: Paper records are bad for recall, and good for documentation; and electronic records are good for recall and bad for documentation. As such, both methods have a negative impact on accurate record keeping, the physician's time and the practice bottom line.

Dr. Bone recognizes that most EHR systems are a problem for physicians and believes the key is a restructured EHR system that is less a tool for billing and more a tool for medical record data capture.

Dr. Bone continues to work with an iCloud data company to alleviate some of these issues and ensure the voice of the physician is heard. We thank him for his efforts on behalf of all physicians in Maryland.

*Colleen George is Executive Director of the Center for the Private Practice of Medicine. She can be reached at [cgeorge@medchi.org](mailto:cgeorge@medchi.org).*



## CRISP FREE Services for Ambulatory Practices

Connect. Share. Improve Patient Care

CRISP is a regional health information exchange (HIE) serving Maryland and the District of Columbia. CRISP is a non-profit organization advised by a wide range of healthcare industry stakeholders. All of the following services are available for FREE to ambulatory practices. For more information, visit the CRISP website at [www.crisphealth.org](http://www.crisphealth.org).

### Health Records

Health Records is available to clinical staff. As clinical information is created and shared with CRISP, it is made accessible in real time to participating health care providers right within their workflow.

### Encounter Notification Service (ENS)

ENS allows primary care physicians, care coordinators, and others responsible for patient care to receive real-time alerts when patients are admitted/discharged at hospitals. Proactively coordinate your patients' care and schedule any necessary follow-up treatment or visits.

### Prescription Drug Monitoring Program (PDMP)

The Maryland Prescription Drug Monitoring Program gives prescribers, dispensers and other licensed staff access to prescription information for all Schedule II-V drugs filled in Maryland, Virginia and some neighboring states.

For more information and to sign up for any of the **CRISP User Services** contact MedChi at **410.878.9898** or email [cgeorge@medchi.org](mailto:cgeorge@medchi.org).

## MedChi's Newest Physician Members

MedChi welcomes the following new members, who joined between November 20, 2019, and January 19, 2020.

- Akbar Abyaneh, MD — MAPMG\*
- Stephanie Addison Holt, MD — MAPMG
- Rita Aidoo, DO — Patient First
- Danso Ako-Adjei, MD — MAPMG
- Deborah Alema-Mensah, MD — MAPMG
- Mir Ali, MD — MAPMG
- Cynthia C. Amitin, MD — Cross Keys Pediatrics
- Sarah Arnold, MD — Patient First
- Pankaj Arora, MD — MAPMG
- Juliana Aruna, MD — MAPMG
- Ari Avram, MD — MAPMG
- Abimbola Ayoola, MD — Advanced Radiology
- Anil Bajnath, MD — Patient First
- Darrell Baranko, MD — MAPMG
- Neha Bhatia, MD — MAPMG
- Ruchika Bhatt, MD — MAPMG
- Bernhard Birnbaum, MD — Patient First
- Sean Bourne, MD — MAPMG
- Cary Brown, MD — Center for Advanced Wound Healing and Hyperbaric Medicine
- Shereene Brown, MD — MAPMG
- Ann Burke, MD — Holy Cross Health
- Alejandra Bustillo, MD — MAPMG
- Justin Capasso, MD — MAPMG
- Elizabeth Carter, MD — MAPMG
- Maria Lourdes Castineira Garcia, MD — MAPMG
- Jamie Chaffo, MD — MAPMG
- Helen Chen, MD — MAPMG
- Kai Chen, MD — MAPMG
- Pamela Coffey, MD — MAPMG
- Tomika Coleman, MD — MAPMG
- Angelita Coleman, MD — Capital Women's Care
- Dimitri Coupet, MD — MAPMG
- Naznin Daginawala, MD — MAPMG
- Kassandra Dassoulas, MD — MAPMG
- Andrew Davis, MD — MAPMG
- RaShonda Dennis, MD — MAPMG
- Anish S. Desai, MD — Pulmonologists, PC
- Pardeep Dhanoa, MD — MAPMG
- Oluchi Dike, MD — MAPMG
- Raymond Dormevil, MD — MAPMG
- Brian Dummett, MD — MAPMG
- Brandon Eilertson, MD — MAPMG
- Laura Emmanuel-Allen, MD — MAPMG
- Firoozeh Etaati, MD — MAPMG
- Binetou S. Fall, MD — MAPMG
- Oluwafunmilayo Fatuyi, MD — MAPMG
- James Fitzpatrick, MD — MAPMG
- Molly Fitzpatrick, MD — MAPMG
- Natelaine E. Fripp, MD — Patient First
- Megan Gaddis, MD — MAPMG
- Adey Gebru, MD — MAPMG
- Tanya Ghatan, MD — Capital Women's Care
- Laura Gifford, MD — MAPMG
- Tedra Gilmore, MD — MAPMG
- Andrew Golden, MD — MAPMG
- Kristy Golden, MD — MAPMG
- Kavya Gorukanti, MD — MAPMG
- Weyinshet Gossa, MD — Patient First
- James E. Gray, III MD — Patient First
- Yeneisha Greene, MD — MAPMG
- Mary Beth Grotz, DO — Patient First
- Deme Gurmu, MD — MAPMG
- Mark C. Hartley, MD — OrthoVirginia
- Jennifer Huckabee, MD — MAPMG
- David Jang, MD — MAPMG
- Konrad W. Jarrett, MD — Patient First
- Wilnise Jasmin, MD — Patient First
- Joi A Johnson-Weaver, MD — Patient First
- David Juan, MD — MAPMG
- Anitha Kandaswamy, MD — Patient First
- Jun Kang, MD — MAPMG
- Nandita Kapa-Kalahasty, MD — MAPMG
- Laura Kaplan-Weisman, MD
- Riny A. Karras, MD — MAPMG
- Elisabeth Allison Kerness, MD — Patient First
- Harold P. Kramer, MD — Patient First
- Thania LaMirand, MD — Patient First
- Michael Landau, MD — Patient First
- Rodney Laster, MD — MAPMG
- Mark J. Lester, MD — Annapolis Pediatrics
- Ann Liechtenstein, DO — Montgomery Hospice
- Dionne Lynch, MD — Patient First
- Jack Manns, MD — MAPMG
- Michele Martin-Jones, MD — Patient First
- Surendra Marur, MD — Patient First
- Joseph McClain, MD — MAPMG
- Kelly McCune, MD — Capital Women's Care
- Christopher McGinn, MD — MAPMG
- Yared Medhane, MD — MAPMG
- Leopoldine M. Kenmogne, MD — MAPMG
- Sagal Mohamud, MD — MAPMG
- Anne Kress Monroe, MD — Patient First
- Heather Murphy, MD — MAPMG
- Faryal Nadeem, MD — MAPMG
- Chuck Ng, MD — MAPMG
- Khanh Nguyen, MD — Patient First
- Hong-Hanh Nguyen, MD — MAPMG
- Christelle Judith Nong Libend, MD — MAPMG
- Ibironke Oduyebo, MD — MAPMG
- Ekenesenarienrien Omokaro, MD — MAPMG
- Joy Onaghise, MD — MAPMG
- Ogechi Opara, MD — MAPMG
- Folasade Osagie, MD — MAPMG
- Osasee Osagie, MD — Patient First
- Enrique I. Oviedo, MD
- Prathyusha Pagadala, MD — MAPMG
- Cheryl L. Parks Thunell, MD — MAPMG
- Arpan Patel, MD — MAPMG
- Shreyas Patel, MD — MAPMG
- Marie Pereira, MD — MAPMG
- Marilyn D. Perry, DO — Patient First
- Sujina Pradhan, MD — MAPMG
- Jennifer Prendez, MD — MAPMG
- Allison Rague, MD — MAPMG
- Marla Rejbi, DO — MAPMG
- Kathy Ruxton, MD — Premier Allergist
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- Richard Sisson, MD — MAPMG
- Alyssa Small Layne, MD — MAPMG
- Matthew S. Smith, MD — Patient First
- Vitaly Stepensky, MD — Patient First
- Melinda Sutton, MD — Patient First
- Jordan Tacktil, MD — MAPMG
- Christopher Tebrock, MD — MAPMG
- Kasahun D. Temesgen, MD — Patient First
- Teemu Tha, MD — MAPMG
- Melik Tiba, MD — MAPMG
- Kama K. Tillman, MD — MAPMG
- Tochi Umunakwe, MD — MAPMG
- Jamie VanArtsdalen, MD — MAPMG
- Tania Vora, MD — MAPMG
- LaTashia D. Walker, MD — MAPMG
- Charlotte Watts, MD — MAPMG
- Dinesha Weerasinghe, MD — MAPMG
- Taylor J. Wiley, MD — Peninsula Orthopaedic Assoc., PA
- Marc E. Wilson, MD — MAPMG
- Szuhuei Wilson, DO — MAPMG
- Shirley Xing, MD — MAPMG
- Jia Xu, MD — MAPMG
- Kara Yakish, MD — MAPMG
- Eric Yakish, MD — MAPMG
- Darren Young, MD — MAPMG
- Omayya Youssef, MD — MAPMG
- Christopher Zarraga, MD — MAPMG
- Dou Zhang, MD — MAPMG

\*MAPMG (MAP-MG): Mid-Atlantic Permanent Medical Group

## MCMS Takes Deep Dive Into What Women, Employed, and Early Career Physicians Need and Value

In January, Montgomery County Medical Society (MCMS) conducted three focus groups of women, employed and early career physicians—members and potential members—to engage them in a conversation about what keeps them up at night and their challenges as physicians. The Executive Board of MCMS recognized the need for a deep dive with these physician segments because they are critical to the growth of the Society. As with most counties, Montgomery County medicine has changed a great deal in the last five to ten years, and our medical societies must keep up with the trends and needs of all physicians.

There were a lot of lessons learned from these engaging discussions. Smaller groups of physicians are now being convened to prioritize the needs and wants of each physician group, and to develop an action plan and allocate resources for events, programs, and new initiatives. This research will be shared with MedChi and other components. If you have questions, please contact Susan D'Antoni, CEO, or Marissa Valerie, Physician Outreach Specialist, at 301.921.4300.

## New MCMS Officers Elected for 2020–21

Montgomery County Medical Society (MCMS) recently elected leadership for the coming year. The following physicians will serve with Annette Pham, MD, President, Otolaryngology & Facial Plastic Surgery; President-Elect: Irfana Ali, MD, Emergency Medicine; Vice President: Tuesday Cook, MD, Bariatric Surgery; Secretary: Bailey Cannon, MD, Obstetrics and Gynecology and Treasurer: Angela Marshall, MD, Internal Medicine. An installation of MCMS officers and fundraising event for the National Capital Physicians Foundation, a 501c3, is being planned for Sunday, June 14. This event is open to all physicians, friends, and the community.

For more information or to sponsor this event, contact Susan D'Antoni, CEO, at 301.921.4300, or at [sdantoni@montgomerymedicine.org](mailto:sdantoni@montgomerymedicine.org).

## Update on PANCREATICOBILIARY DISEASES

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**Reena C. Jha, MD**  
MedStar Georgetown University Hospital  
Georgetown University Medical Center  
Washington, D.C.

**Emily R. Winslow, MD**  
MedStar Georgetown University Hospital  
Washington, D.C.

### FACULTY

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MedStar Southern Maryland Hospital Center  
MedStar Georgetown University Hospital  
Georgetown University Medical Center  
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**Jason S. Hawksworth, MD**  
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## Q & A with BCMS President, Dr. Kalra

Lisa B. Williams

Kavita B. Kalra, MD, is the 117th President of Baltimore City Medical Society (BCMS). She joined BCMS in 2014 and quickly engaged with committees and the Board. She co-chaired the Women in Medicine Committee for a number of years and served in officer positions leading up to president.

### **What motivated you to become a physician?**

I had a lot of early encounters with physicians due to illness in the family, and it was during one of these visits that I decided that medicine is the right career for me. I was moved by the compassion and empathy of the profession.

**With what you know now about the practice of medicine, what would you tell your first-year medical student self and your first-year medical resident self?**

For the medical student, I would say, yes, Anatomy matters! Those foundation blocks of didactic medicine do matter and will help you in later life.

For the resident, I would say, there is

light at the end of the tunnel! One day, you will look back at this time and indeed say it was necessary and definitely worth it! The 2 a.m. hypoglycemia call from a nurse does have a role to play in your professional development as an internist.

### **What prompted you to join MedChi-BCMS?**

A colleague, Dr. Lowentritt, introduced me to MedChi-BCMS, and I never left. I have enjoyed being a part of the BCMS board and the interaction in various committees with like-minded and sometimes opinionated individuals. As you can imagine, this leads to stimulating and informative discussions.

### **Can you comment on medicine in this digital age?**

I think this is an exciting time for medicine. We are in the infancy stage for medicine's interaction with the digital age, and this is a time in which a lot more is possible. We have already seen advances in patient safety with the addition of technology, and I am sure more advances are coming in other areas of medicine. The capability of artificial intelligence (AI) is being actively researched for applications in medicine. These include applications in using AI as a cognitive assistant in analyzing protocols, data mining, and in recognizing patterns to assist in fields like radiology and pathology. Additionally, the use of Blockchain technology is also being explored for securely sharing large amounts of data.

### **Where do you envision organized medicine within the next 5 to ten years?**

This is a tough question, as we clearly have a need for organized medicine, but there are real challenges involved in engaging physicians, especially younger physicians, and encouraging them to appreciate the benefits of organizing for common goals. This is where, hopefully, virtual technology and social media may help us reach more physicians. I am confident that once my non-member colleagues see the benefits of joining professional societies to help us move forward with common goals, they will want to be a part of this movement. Especially now as we are facing nationwide challenges such as opioid abuse, mental health and firearms, it is important for all of us to have a voice in the national discussion that relates to medical topics, and organizing is the best way to do so.

*Lisa B. Williams is CEO/Executive Director, Baltimore City Medical Society and Baltimore City Medical Society Foundation. She can be reached at [info@bcmsdocs.org](mailto:info@bcmsdocs.org).*

## Update on MSS Activities

The MedChi Medical Student Section kicked off its first meeting of the year by holding executive board elections. Congratulations to the new MSS generation! During their Legislative Advocacy Day in Annapolis on February 4, they spoke to a diverse group of legislators regarding bills that would tackle opioid addiction, vaccines, and e-cigarettes. On January 11, 2020, MSS members participated in the AMA Medical Student Section Region 6 Conference, which featured discussions on the intersection of medicine and policy and a keynote address by Maryland lawmaker Mary Washington.





## Have You Ever...

- Noticed while at work that a physician colleague smelled of alcohol?
- Been concerned by a physician who was so upset and angry with colleagues that it interfered with patient care?
- Been plagued with worry or concern because a colleague "just doesn't seem right?"

## Do You Know Where To Turn If...

- You think a physician friend might have a drinking problem?
- A colleague is self-prescribing pain-killers or other controlled medications?
- A colleague seems depressed, is experiencing mood instability, or is overly anxious to the point that their performance is being affected?

# MPHP

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For more information and/or a confidential consultation for you or a colleague who may benefit from our help, please call **800-992-7010** or **410-962-5580**.

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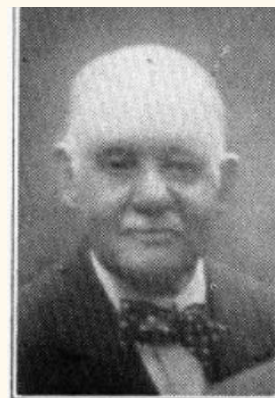
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## MedChi's First African-American Member: Whitfield Winsey, MD

On April 12, 1882, Whitfield Winsey, MD, was elected the first African-American member of the Medical & Chirurgical Faculty of Maryland. The by-laws had recently been changed from only accepting "gentlemen" as members, because of the number of women and African-Americans who were becoming physicians.



Dr. Winsey had previously been rejected by a local medical society in East Baltimore, where he resided. He was elected to the Faculty by unanimous vote and as was noted in the Medical Annals of Maryland, "there should be no membership requirements other than those of character and attainment."

Dr. Winsey was a student of Dr. John Richard Woodcock Dunbar, who began tutoring him in 1867. Dr. Dunbar had important connections in the medical community, and because of those, Dr. Winsey was able to attend Harvard Medical School.

In 1872, Dr. Winsey became the first black, college-trained physician to come to Baltimore and be admitted to practice. Dr. Winsey set up his medical practice at 1220 E. Fayette St. During the 1870s and 1880s, his name appears in the pension files of several black Civil War veterans as their physician.

In 1889, Dr. Winsey served as a delegate to the AMA meeting in Columbus, Ohio. In 1894, Dr. Winsey and a group of prominent black physicians founded Provident Hospital on Orchard St., which was the first private teaching hospital for blacks in Baltimore. According to his biography in the Medical Annals of Maryland, Dr. Winsey was also a delegate to the International Medical Congress in Washington, DC. In addition, he was author of several papers read before the Faculty, the Clinical Society of Maryland, and the Medical Congress.

Dr. Winsey died on June 6, 1919, and his funeral was held at St. Catherine's Church is what is now the Sandtown-Winchester section of Baltimore.



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## Events

For a complete list of MedChi and component events, visit <http://www.medchi.org/Events>.

### March 4

Montgomery County Medical Society Physicians' House Call on Annapolis. MedChi Office, 224 Main St., Annapolis, MD. Chip O'Neil, 410.539.0872, ext. 6001

### March 11

Baltimore City Medical Society Board Meeting. 6 p.m. MedChi Bldg., Malouf Board Rm., 1211 Cathedral St., Baltimore, MD. Lisa Williams, 410.625.0022.

### March 11

Baltimore County Medical Association Board of Governors' Meeting. 6:15 p.m. Patricia Keiser, 410.296.1232.

### March 19

MedChi Board of Trustees Meeting. 6 p.m. MedChi Building, Osler Hall, 1211 Cathedral St., Baltimore, MD. Barbara Fitzgerald, 410.539.0872, ext. 3304.

### March 28

Baltimore County Medical Association Annual Dinner and Installation of Officers. 7 p.m. Patricia Keiser, 410.296.1232.

### April 2

Maryland Psychiatric Society Annual Dinner. 6–9:30 p.m. Martin's West, 6817 Dogwood Rd., Baltimore, MD. Meagan Floyd, 410.625.0232.

### April 15

The Maryland Psychiatric Society & The Maryland State Medical Society presents, "The Impact of Gun Violence on Patients & Communities: What Can We Do About It?" CME meeting. 5:45–9:30 p.m. MedChi Building, Osler Hall, 1211 Cathedral St., Baltimore, MD.

### April 15

Baltimore County Medical Association Board of Governors' Meeting. 6:15 p.m. GBMC, Rooms D & E, 6701 N. Charles St., Baltimore, MD. Patricia Keiser, 410.296.1232.

### April 25

Baltimore City Medical Society President's Gala. Lisa Williams, 410.625.0022.