

Maryland Medicine

VOLUME 21 ISSUE 2



**MedChi's Response to the
COVID-19 Pandemic**

**Physicians Share Their
COVID-19 Experiences**

2020 Legislative Review

MedChi's Reponse to the COVID-19 Pandemic

Since the outbreak of COVID-19, MedChi has been working around the clock as your advocate and your resource:

Economic and Business Support

- Provided guidance for state and federal assistance programs, such as PPP, state grants, loans, and EIDL to members and nonmembers alike.
- Held instructive webinars — such as the one on COVID-19 employment law hosted by Montgomery County Medical Society on March 23, with more planned.

Telemedicine and Telehealth

- Helped hundreds of practices launch and implement telehealth.
- Created a comprehensive, up-to-date summary of medical coding guidelines.
- Implemented grants programs with CareFirst and the Maryland Health Care Commission to ensure physician access to affordable HIPAA-compliant telehealth platforms.

Public Health Advocacy

- Redeployed eight MedChi CRISP employees from their contracts to schedule COVID-19 tests at MVA testing sites statewide.
- Helped Howard General, FutureCare, Johns Hopkins, and other practices with surge employment.

Education and Resources

- Secured access to and complimentary CME accreditation for informative webinars with the Maryland Department of Health, three times a week.
- Presented two clinical CMEs with a University of Maryland Medical School speaker. Also co-presented the very first Coronavirus CME webinar in the United States, on February 14.
- Developed an ongoing, comprehensive resource web page for physicians with guidelines and updates on billing, coding, telehealth, human resources, and legal issues.
- Informed physicians with regular emails sent three to five times per week, sharing up-to-date information in a user-friendly format accessible to all physicians, not just members.

Advocacy on Policy Issues

- Tort Policy: Working with Governor Hogan to expand on the public emergency immunity bill.
- Scope Policy: Collaborated with anesthesiology, ophthalmology, and orthopedic groups to protect their scope of practice against unnecessary encroachments that could adversely affect patient care.
- Telehealth Policy: MedChi was instrumental in Governor Hogan's executive order that expanded telehealth capabilities.
- Economic Policy: Working with the AMA, the State of Maryland, and federal officials to advocate for increased economic support for physicians.

Leadership

- MedChi CEO Gene Ransom has been a vocal physician advocate in the media, underscoring the needs, concerns, and sacrifices of physicians on the front lines.
- MedChi President Michele Manahan, MD, has participated in roundtable discussions, lectures, and work groups to advocate for better care and resources for Maryland's physicians.
- Shared ideas, resources, and support with our society counterparts in neighboring states.

As always MedChi remains the foremost advocate and resource for Maryland physicians, patients, and the public health.

From the President...

Michele Manahan, MD, President, MedChi



If we each had a penny for the number of times we've heard, "In these trying times..." or "In these unprecedented times..." we might not need to worry about reimbursements for the medical care we provide! Really, though, how else does one start a conversation in our current environment? These are trying times. They are unprecedented – at least in this modern era and in the experience of this country's citizenry. The human race has known death, disease, and widespread disaster countless times throughout history. It is my hope, prayer, and belief that as many of us as possible make it through to a brighter future. I hope we emerge to find we cherish each interpersonal connection with unrivaled intensity.

I'm not saying anything profound when I mention the likelihood that we will be dealing with and learning from the consequences COVID-19 for years to come. MedChi has always worked diligently for the public health and the welfare of physicians. Our organization will continue to do so. Together, we've helped secure financial protections for physicians. Together, we've worked to protect physician rights, including scope of practice, personal protective equipment access, and our freedom of speech. Together, we've worked to educate the public. Together, we've worked to support public health interventions to "blunt the curve" (another phrase we'll never forget). Together we've partnered with other health care bodies across the state and in the nation to coordinate efforts in all arenas.

There is, of course, much more to be done. We all wish for a more perfect current world. MedChi will keep working for the patients and physicians of Maryland. I am sure every one of our members will continue to do the same on a personal and professional level.

I wish for you health, well-being, peace of mind, and connectivity with loved ones. I wish you strength, perseverance, and the courage to continue to do what you have done so well: providing succor to the suffering. Please keep in touch. As President of MedChi, I stand ready to assist you and our organization. As physicians we will help our society heal as so many of our predecessors have done throughout history.

From the Editors...

Maryland Medicine Goes Digital During COVID — "Neither snow nor rain nor heat nor gloom of night," nor a pandemic can keep MedChi from its appointed rounds of keeping members informed!

As we go to press with this issue of *Maryland Medicine*, MedChi recognizes most physicians are not back in their practices fully, which is why this issue is being delivered digitally instead of arriving in mailboxes throughout Maryland. It was important to us that we continue to provide this important membership benefit that informs and educates, and is a source of collegiality and sharing. We expect this issue will be appreciated even more right now because it brings collegiality at a time of significant isolation. We know you will relate to the stories submitted by physicians about their first-hand experiences addressing the challenges and impact of COVID-19.

MedChi remains committed to keeping you informed throughout this crisis. We are here for physicians in snow, rain, heat, and, yes, in pandemics.



Archbishop William E. Lori offers a "Blessing in Time of Pandemic" outside the Baltimore Convention Center Field Hospital, while physicians look on.

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Physicians Share Their COVID-19 Experiences

Giving Care Beyond the ER

Ron Elfenbein, MD
Chesapeake ERgent Care



Chesapeake ERgent care was the first location in the state to implement drive-thru testing of COVID-19. Recently the facility started using the rapid antibody test, which yields results in ten minutes.

In addition to running the urgent care facility and working in emergency

rooms in Southern Maryland and the Eastern Shore, Ron Elfenbein, MD, collects and distributes PPE across the state and sends PPE care packages to New York and Connecticut. He is also involved in the design and distribution of intubation boxes to protect health care workers when intubating patients.

Hospitals can contact Dr. Elfenbein to obtain these boxes at no cost: elfenber@yahoo.com (video link: <https://bit.ly/3geCOu6>).

With an Impending Due Date, A Doctor Remains Cautiously Committed

Elizabeth Clayborne, MD
University of Maryland Prince George's Hospital Center



Elizabeth Clayborne, MD, is seven months pregnant, with an impending June due date. Yet this has not deterred her from being on the front lines of the COVID-19 fight.

As an Emergency Room physician at University of Maryland Prince George's Hospital Center, Dr. Clayborne works in a COVID-19 "hot spot," with Prince George's County reporting one of the highest number of infections and death rates

in the state. While she is being extra cautious to protect herself and the welfare of her unborn child, Dr. Clayborne remains

committed to seeing and administering to COVID-19 patients. She has been treating coronavirus patients amidst a staff shortage and says she will continue to work for as long as she can. As a staunch advocate for advanced care planning, she urges everyone to make a plan in case they should become critically ill. She adds that anyone — even young people, can make an advance care plan.

Dr. Clayborne is also an Adjunct Professor at the University of Maryland School of Medicine and a past Chair of MedChi's Ethics and Judicial Affairs Committee.

Creating Programs That Connect Community

Richard Bruno, MD
Belair Edison Family Health Clinic

As a result of the pandemic, Richard Bruno, MD, has helped to develop three programs for his local community:

Self-Quarantine Support Network helps connect volunteers in his neighborhood with vulnerable neighbors who need groceries, medication, help with dog walking or check-ins by phone (www.tiny.cc/SQSN).

Psychological First Aid Initiative trains neighbors for peer level check-ins during this pandemic, and any urgent need or mental health crisis is escalated to a network of volunteer mental healthcare providers (www.baltimoreneighborsnetwork.org).

Baltimore Health Professionals Mutual Aid Cooperative helps support frontline healthcare workers with a volunteer team that provides childcare to those who need it and runs a PPE drive to collect high-protection gear with distribution to hospitals and clinics (www.facebook.com/bmorehealthmac).



continued

A Hospitalist Reflects on a Shared Sense of Duty

Ilse R. Levin, MD

Mid Atlantic Permanente Medical Group

As a physician, I have been privileged to work in a variety of settings, from some of the best hospitals in the world such as Kaiser, and Johns Hopkins, to some of the poorest and least-equipped in Papua New Guinea and Uganda. Yet my experience these past few weeks has been something different altogether.



I thought I was always prepared, no matter where, for the conditions that lay ahead.

This last month working as a Hospitalist and primary admitter, my world of medicine was turned upside down.

Back in January, COVID-19 seemed like something in the distance: concerning but far off. We were still in the thick of dealing with the flu season, not uncommon this time of year. I am also an epidemiologist, so when the first cases of COVID-19 were reported, there was a sense of the familiar, much like the SARS and MERS outbreaks. It was neither surprising nor unexpected; we live in

a world where people travel and interact more than ever. And airborne diseases move fast, especially when the incubation period averages five to twelve days.

By the time Italy's health care system was overrun with cases, the United States was just starting to grapple with the first wave and feared we might mimic Italy's pattern. By late February our medical personnel were being advised that our supply of N95 masks was insufficient to meet the demand. (Initially, the advice was to use one N95 mask a day, but that recommendation quickly changed to one N95 mask to be used until soiled.)

By mid-March the emergency departments were distributing one gown per staffer per shift, to be carefully used, removed, and reused by the same person for every patient seen. I was fortunate enough to obtain reusable goggles from the ER, but as face shields dwindled, those without goggles were advised to take plastic sheets, punch holes in them, and use those as face shields.

The other serious issue we began to face was the fear that kept many COVID-19 patients from seeking treatment. In the span of one week, I witnessed:

- A sixty-three year-old man, who could not urinate for three days, refused to go to urgent care for foley catheter placement, and had to be admitted in septic shock;

- A twenty-two year-old man with nausea and vomiting due to a liver abscess, who stayed at home for four days until he was finally admitted in septic shock and DIC;
- A nineteen-year-old with a ring-enhancing brain mass who discharged himself from urgent care rather than be admitted to the hospital for fear of contracting COVID-19.

The hospital where I work is a vascular care center. We typically see patients with gangrene, heart failure, cellulitis, missed dialysis, Diabetic ketoacidosis, or alcohol withdrawal. I worry about these patients and how COVID-19 affects their willingness to seek help.

To limit COVID-19 exposure, our group decided that there would be one COVID-19 admitter and rounder per shift. For the day-shift hospitalists, that meant a rotation of doctors over various weeks. For the night-shift hospitalists, however, rotation was limited and therefore one physician was on call for an extended period. That position fell to me. Gradually the policy changed to all admitters having to see COVID-19 patients, in order to meet the increasing demand.

Every day I remind myself that this is my job, I signed up for this, and I knew the risks when I started. It is a simple and sobering thought. I look at my colleagues — physicians, physician assistants, nurses, respiratory therapists, paramedics, and support staff — and while all are afraid, not one of them speaks of finding ways to stay away and not come into work. We feel a sense of duty. Even with the scarce supply of PPE and the risk of exposure, we continue to put our patients first.

I come from a military family so I see the similarity between serving in military health care and serving in civilian health care during a pandemic. There is a strong sense of duty that obligates us to keep on pushing forward, because this is what we do; this is our commitment. I am extremely proud to be a part of this profession and to give back to my community.

A Doctor's Soft Touch During Hard Times

Carole Levy, MD

Mid Atlantic Permanente Medical Group

I never thought I would practice medicine during a global pandemic. COVID-19 has changed so much for so many of us in clinical practice. Visits are now done by video or phone, and prescriptions are delivered from the pharmacies to our patients. I am now triaging patients in a state-of-the-art mobile unit outside our Gaithersburg Medical Center.

To limit the spread of this illness and to reduce the number of other patients and health care workers exposed to it, our organization created a workflow to screen patients before they enter the medical center. In a matter of days, a mobile unit was erected and operationalized to allow effective and swift triage of patients seven days a week. Patients have their vital signs taken by a nurse; then a physician from our Urgent Care department performs a focused history and physical exam to determine if they are likely to have a COVID infection. We use SmartSet algorithms, which were rapidly built into our EMR and incorporate CDC testing guidelines, to help us determine who should be tested. We next determine if it is safe for the patient to go home — potentially with a portable pulse oximeter, if needed. Patients who return home are monitored by a team of physicians dedicated to home care, where they will reach out to the patient daily by video or phone to check their progress.



Occasionally a patient needs a higher level of care and is transferred inside the medical center, to our Urgent Care and Clinical Decision Unit, which is open 24-7. Patients who need COVID care, as well as those who need evaluations for other acute conditions, continue to receive care as usual.

We have revolutionized our health care delivery system in a matter of weeks, and now provide 80 percent of our patients a virtual option. We have ramped up our mail order pharmacy operations to meet demand, and now offer curbside pharmacy delivery.

As patients enter the mobile unit for triage, I show them my plastic encased ID since they can't see my face. I reassure patients who are ill that we will do everything we can to help them get better. I take extra time with patients who aren't very sick, explaining how to take care of themselves at home, how to isolate from family members, and how to monitor for signs of worsening. I

promise every patient that we are here for them. My two layers of masks, my glasses, and my face shield make it difficult to show that I am smiling, and I have to speak very loudly to be heard over the negative pressure filtration system, which makes me sound harsher than I wish. I touch their shoulders with my double gloved hands to express that I truly care. This is how I practice innovation medicine in the age of COVID.

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A Cardiologist's Point of View

Lisa Williams

Baltimore City Medical Society

Camellus Ezeugwu, MD, of the Just Heart Cardiovascular Group has always maintained a busy cardiology practice in Baltimore. But since the pandemic started, in-office patient visits have fallen by more than 80 percent. In response, the practice has escalated its use of telemedicine tremendously. Staff engagement with patients using programs such as chronic care management and remote patient monitoring has also been enhanced and expanded. Many high-risk elderly patients who do not have smart phones have been encouraged to use any type of phone at their disposal to call the office for help.

Dr. Ezeugwu notes that the practice has recently implemented a new answering service (integrated with their electronic health record system) to ensure that all patient-care calls are captured and addressed. Calls can be directed to the provider

for immediate response at the patient's discretion. If the issue is not urgent, the patient can choose to leave a message in a general mail box. For patients who require in-office visits, Dr. Ezeugwu says his staff wear masks and gloves. In addition, staff wipe down all common areas and limit seating in the waiting room so that proper social distance is maintained.

"COVID-19 has certainly shown us the value of technology," Dr. Ezeugwu admitted. "There are some patients who are afraid and reluctant to use technology — particularly the elderly and non-English speaking patients. Some are also concerned with whether or not technology-based care will be covered by their insurance. Or patients are reluctant to go to the ED or their doctor's office to be evaluated for cardiac symptoms for fear of being exposed," he said. "Obviously, we need a patient care re-education process during this difficult time."



An Ophthalmologist Finds Gratitude Amidst Chaos

Shruti Aggarwal, MD

Katzen Eye Group

Health care workers in all fields have put their lives on the front lines to help treat others. Ophthalmologists are no exception. As patient care is at the core of our practice, the current pandemic has brought us a degree of chaos and uncertainty. With routine clinical visits now cancelled, we wonder how to best provide proper care to our patients, many of whom are elderly and vulnerable. In addition, many of these patients suffer from chronic vision issues such as glaucoma, corneal transplantation, and retina neovascularization, and are therefore in urgent need of evaluation and treatment. While telemedicine can aptly serve other specialties, it is not a viable option for ophthalmology. There is no way to check vision, intraocular pressure, or to perform a bio-microscopic exam by virtual means.

The deferment of routine care and elective surgeries may potentially have negative consequences that last well beyond the current pandemic. In some cases, the pathology may progress and worsen. In others, the necessary interventions will be further postponed, creating a backlog of patients that will need to be treated after the pandemic bans have been lifted. Likewise, elective surgeries — which are typically the mainstay of revenue, have been deferred. When the ban is lifted and surgeons are able to perform elective surgeries, they will have to take on a larger volume than usual to meet the high demand.

There may be a push for bilateral same-day surgeries, and this, too, involves its own type of risk.

Equally significant is the financial impact of the pandemic on physician practices. Many have been forced to lay off, furlough, or reduce pay for staff and providers. For "newly minted" ophthalmologists who are frequently burdened with student loans and providing for their young families, this adds another layer of stress. Some physicians who joined productivity-based private practices are no longer eligible to transition from associate to partner. Others who joined private equity are being furloughed. Recent grads face bleak employment prospects. Every ophthalmologist is feeling the pinch. It is not certain if our practice will ever revert to normal.

In spite of the stress and uncertainty, I am filled with gratitude. First and foremost, I am grateful to the selfless: those who have put their lives on the line to serve. Next, I am grateful for family and friends and the long overdue opportunity for quality time with them. And, finally, I am grateful for our profession. As physicians we will emerge from this experience more humble, more thoughtful, and with empathy.



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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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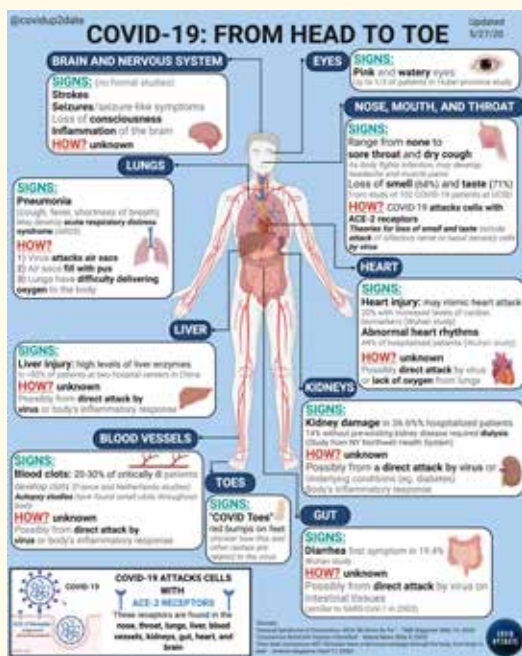
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Separating Fact From Fiction, Johns Hopkins Medical Students Get Creative

Victoria Hecht
MedChi

When Johns Hopkins University School of Medicine first announced that medical student clerkships would be cancelled due to the escalating COVID-19 pandemic, Lucy Nam was devastated. Medical rotations provided hands-on learning and made her feel useful and relevant. To make matters worse, the announcement came during spring break, while students were scattered across the country and well beyond the Baltimore campus.



Feeling the need to stay involved and craving connection, Lucy set up a Facetime call with classmates Neha Anand and Alexandra Berges. How could they stay involved? How could they be of use during this global pandemic? If necessity is the mother of invention, then crisis is its co-parent. By midnight that night, the three students had hatched an idea. @covidup2date would be a social media forum for up-to-date information about the pandemic, reporting fact-based findings and relying strictly on reputable sources.

The idea for this platform was borne out of the constant barrage of rapidly evolving information being circulated about COVID-19, much of it based on rumor and false information. The platform's first priority, therefore, was to separate fact from fiction. Early on, the students dedicated themselves to presenting a COVID-19 myth that they could attempt to debunk — a new one each day — and illustrating their findings with infographics to better engage their audience.

On March 18, the first post was created and released with bated breath to the Internet community. Positive feedback soon followed so the students kept going.

By the following month, @covidup2date had expanded to almost 3,000 followers. The original med student team behind it grew as well, pulling contributions from the University of Maryland, UCSF, Yale, and their own Johns Hopkins School of Medicine.



In addition to the daily myth-debunking, posts now include reports on scientific developments, the economic impact of COVID-19, tips and ideas on how to get involved, and human interest stories about people whose actions have stood out during the crisis. Based on the abundant thread of comments from @covidup2date followers, the social media accounts are a much-needed resource and outlet for sharing factual information. @covidup2date can be found on Facebook, Instagram, and Twitter.

@covidup2date Creators: Alexandra Berges, Lucy Nam, Neha Anand and Team. Editorial: Alyssa Kretz, Alyssa Schledwitz, Ashley Zhou, Ashling Zhang, Brittany Tsou, Christine Gao, Christopher Leland, CJ Reuland, Clarissa Ren, Eilarayna Gelyana, Elisabeth Abeles, Evelyn Leland, Galen Shi, Grant Wilson, Inghu Siddarthan, Jennifer Chen, John Morkos, Minnie Jang, Rohan Panaparambil, Sahba Seddighi, Sara Wallam, Sarah Frey, Sarah Rapaport, Shannon Wongvibulsin, Tangkwa Sakulsaengprapha, Thomas Le, Ved Tanavde. Graphics: Amy Xu, Felicia Chang, Jenny Wang, Jonlin Chen, Oscar Covarrubias, Sabrina Wang, Sophie Gu, Terrence Tsou, Zoe Cosner. Translation: Dr. Irene Corso, Raphael Ospino, Jose Munoz. Website: Nabila Ali.

Adaptability in the Time of COVID-19

The Staff

Stone Run Family Medicine



Stone Run Family Medicine, a team with four providers and fourteen staff in Rising Sun, Maryland, quickly realized they needed to start preparations to protect their patients and have the ability to test for COVID-19 infection. Led by Joseph Weidner, MD, the practice began to perform testing for SARS-COV-2 NAA shortly after March 6. The group had sufficient supplies to obtain

specimens by nasopharyngeal (NP) swabs in the office. As they started seeing patients with symptoms for COVID-19, they initiated sampling inside the examination rooms. This proved cumbersome for the provider, having to remain in Personal Protective Equipment (PPE) while waiting for influenza test results. If the influenza test proved negative, the practitioner would procure the NP sample to send for SARS-COV-2 testing. At the same time, they ramped up telemedicine visits to assess patients for upper respiratory illness and COVID-19. Staff concerns with the aggressive nature of COVID-19 grew. Concerns about keeping exam rooms hygienic led to the desire to evaluate symptoms of acute infectious illnesses via telemedicine. In mid-March, the decision was made to see patients presenting symptoms in an outside setting. This outdoor setting came to be called the “Alfresco Clinic.”

As Stone Run Family Medicine is independent, its decision-making process can be nimble. On March 13, two evaluation teams were established — each made up of a provider (MD, PA-C, or CRNP), a clinical assistant, a scribe, and a runner. Runners were responsible for trips to the office grabbing orders, notes, and supplies. Providers and clinical assistants donned PPE and continually disinfected reusable supplies. Patients pulled up in their cars to the evaluation team, while scribes in masks stood a safe distance away. Seven patients were seen in that initial open-air clinic.

With unpredictable weather being a threat to the outdoor clinic, two 10-foot by 20-foot canopies were donated by the Rising Sun American Legion. Unfortunately, a severe wind storm damaged the tents two weeks into the operation. Swift action on the part of staff resulted in relocating the clinic to the back parking lot, where a storage pod was cleared



for the clinic teams. Each day a single team staffed the clinic. By keeping providers and staff on a rotation schedule, the use of limited PPE and supplies became more efficient.

Patients who did not present with respiratory symptoms were followed up using telemedicine. To date the Stone Run Family Medicine Team has performed a variety of procedures in the “Alfresco Clinic,” including suture removal, EKGs, PFTs, phlebotomy, and injections. The creation of the “Alfresco Clinic” enabled Stone Run to evaluate more than 250 patients with symptoms and test more than 100 for COVID-19, while providing point-of-care testing to diagnose influenza and Group-A streptococcus. While this has been a challenging time, the staff has been able to meet the need and serve their community.

A Physician's Memorable Spring

Tyler Cymet, DO

American Association of Colleges of Osteopathic Medicine



For Tyler Cymet, DO, Chief of Clinical Education with the American Association of Colleges of Osteopathic Medicine, the Spring of 2020 will remain indelibly etched in his memory. Below, he shares several “stand out” moments:

March 16, 2020: 16,000 students were taken off rotations for two weeks due to safety issues.

March 30, 2020: Extended “the pause” for three more weeks.

April 2020: Assessed revising clinical experiences tied to a medical school and not a health care facility. Conducted a webinar on putting together online courses in clinical medical sciences.

March–April: Completed shifts caring for COVID-19 patients at University of Maryland Capital Regional.

March: Shaved off my beard so that my mask would fit. First time I have seen my face since 1983!

April: Worked at the Baltimore Convention Center Field Hospital; a 250-bed COVID care facility.

A Walk-In Clinic Pivots to Telemedicine

Irfana Ali, MD

Fast Track Urgent Care



Our practice quickly changed from being a walk-in clinic without the need for online scheduling to a 95 percent “scheduled visit” practice. Almost all of these scheduled visits are COVID-related. Our doors are now closed to in-person patient visits in case they are COVID-19 infected; now we see them as telemedicine cases only. We have very few walk-in visits at this time.

Our staff positions have had to adapt too. We now have a

“Telemedicine Coordinator” as we needed someone to support the video platform, to troubleshoot connection issues, to obtain triage information, and to enter registration data into our

EMR. The vast majority of our procedures have turned into nasal swabs for COVID testing, while using our limited PPE appropriately and carefully.

For me, the most important adjustment has been the change in patient flow now that we are using telemedicine. It's much slower now since we cannot see multiple patients at once. I'm used to having rooms full of patients and floating back and forth between them. Now almost all rooms are empty as we see individual patients on a monitor and in sequence.

Fast-tracking My Practice to Telemedicine

Carolyn O'Connor, MD

Spectrum Family Medicine

Experiencing a pandemic in real time has been overwhelming. While it sounds like a cliché, the sheer amount of information we are trying to absorb truly feels like a fire hose. We are inundated with scientific information as well as media coverage. Never in our lifetime has one phenomenon dominated the world's attention. Added to that is the personal fear for one's safety and one's loved ones' well-being.



One noteworthy aspect of this ordeal for me as a physician is the astonishingly short amount of time it took for me to adopt telemedicine. Previously, I had balked at becoming a telemedicine doctor. I remember thinking: “my practice is busy enough; I don't need this work.” I thrive on personal interaction with my patients, as I think they benefit from a kind touch on the arm when discussing distressing news or emotions. As I am not particularly good with technology, I thought it would be difficult to get started and become an efficient telemedicine user. Wasn't I surprised!

Our IT employee installed Microsoft Teams, our primary telemedicine platform, on Thursday, March 12. We also use Doxy.me. On Monday, March 16, I tried using Microsoft Teams to see two patients, but was not successful. I ended up calling them on the phone to work through their medical issues. On Tuesday, March 17, I saw at least ten patients via telemedicine. Within a week, 95 percent of my practice visits had become virtual. Telemedicine was a hurdle that I thought I could not overcome. Never say never.



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Ali Hendi, MD

Mohs and Dermatologic Surgery

Our practice remains open to care for patients whose skin cancer is aggressive, and for whom delayed treatment would cause harm. Over the past several weeks we have seen patients who have had more anxiety over their skin cancer being left untreated than the pandemic. These patients are grateful to us for keeping our doors open and providing services, even if on a limited basis.

When referring physicians' offices are closed, we see patients for an in-office evaluation for lesions that require immediate attention. Oftentimes we perform same-day biopsy and surgery to minimize the number of visits. Additionally, we use absorbable sutures post-surgery to minimize visits.

We have put a number of practices in place, including limiting the number of daily surgeries so that patients remain in the procedure rooms for the duration of Mohs and closure. We have removed magazines and newspapers from the waiting room and separated used pens from clean ones. We are committed to patient and staff safety.

A few years ago my wife, Azi, and I started a company — Luminora, which manufactures sun protective clothing. Through Luminora we brainstormed on how we can help others during this pandemic and potentially flatten the curve. We decided to use the resources in our existing business to make protective face masks. Using our proprietary Luminology Technology® fabric, we are creating masks that are moisture impermeable, which shield against respiratory droplets, while still being comfortable and breathable enough to wear for extended periods. They are also machine washable and reusable.

We started this initiative several weeks ago, and the response so far has been tremendous. We have donated masks to many health care professionals and are happy to help any industry in need. We offer custom logo printing on the masks, and our turnaround time is quick. More information can be found at: www.luminora.com.



An ICU Unit Learns to Adapt

Sarah Nelson, MD

Johns Hopkins University School of Medicine

When asked what changes her practice had undergone since COVID-19, Sarah Nelson, MD, a neurologist, is quick to commend her Intensive Care Unit (ICU) staff, comprised of doctors, nurses, and support staff, for their ability to quickly adjust and adapt. "All of our staff have adapted to the changes and continue to espouse caring for our patients as the number one priority," admits Dr. Nelson, "while knowing the risks of being exposed to COVID-19 each and every day."

Adaptation includes physical change, such as expanding to a three-service ICU from a two-service one, and administering to the needs of a newly transformed COVID unit and an additional ICU unit. In addition, there have been numerous schedule changes and additional meetings held virtually. Staff has had to re-educate themselves with the new protocols for COVID-19 care and assessment. All of which has been fast-paced and challenging.



University of Maryland Medical students teamed up with community partner Hungry Harvest to distribute box lunches and fresh fruit to families in west Baltimore.

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Nature Welcomes Walk-ins

Brooke M. Buckley, MD
CoreLife

“The opposite of play is not work, it’s depression” — Stewart Brown

In March of 2020, my busy world came to a screeching halt. Conferences, speaking engagements, meetings, school, gatherings, and games... cancelled. Like the magical snow-day dream of middle school, instantaneously my calendar was wiped clean. Unlike vacation, this break came with no known end. Unlike snow days, this break carried a crushing weight of uncertainty.

For the first time in my adult life, I had nowhere I was required to be outside of my own home and my six-foot socially distant bubble. More significantly, every activity in which someone could demand of my time (my most precious resource) was stricken from my calendar. Every moment that was typically given away for goal-seeking or to serve others now lay in my hands. The virus — this microscopic force — redefined space and time without instructions.

I lived the requisite stages of grief. I yelled to make the quietness go away, needing my busy calendar to direct my every waking moment. I cried, begging to bring back that which I am “supposed to” do. I mourned the comfort of small talk with clerks and acquaintances I barely knew but were part of my daily pattern. I spent time with my spouse and children whose daily rhythm had fallen out of step to me. I stared in my cupboard at ingredients that stumped me. I paced my yard without flowers to plant or mulch to lay. I surfed and surfed and surfed, hoping social media would rescue me. I sat in silence, listening to my racing thoughts, trying to understand why I so badly needed things, appointments, and random people. I considered why my own home and family had become so foreign. The best I could come up with was the warm embrace of habit. I am a doer. I do my life and that has been enough.

Finally, having exhausted all other options to distract my discomfort, I went outside.

I had no plan, goal or purpose. It was sunny, I was home, and normal life was on pause. So I went outside. Initially I was anxious. What was I supposed to do? Where what I supposed to go? After the self-conscious questioning subsided I lost track of time and function. My activity resembled childhood days outside in complete absorption — moving, noticing, enjoying, wandering.



Positive psychologists might say I fell into flow. Flow is a state of complete absorption into an activity (<https://bit.ly/3gdTNNb>). It is commonly described as being ‘in the zone’: a place between anxiety and boredom where we lose space and time and simply do. The health benefits of flow are well established. Notably, flow is associated with decreased stress, enhanced problem-solving, and improved self-esteem (<https://bit.ly/2LPMUnt>).

Flow has the same benefits as play. Interestingly, when flow happens outside, we often label it as play. In his book, *Play*, Dr. Stewart Brown defines play as “purposeless, all-consuming, and fun” (<https://bit.ly/3e6HSPO>). The act of doing something enjoyable and losing yourself in that activity fits both definitions. The benefits of play include all those of flow including enhanced cooperation, creativity, and intimacy creation (<https://bit.ly/36nU63H>). This state helps us to become better, healthier, and happier. Although often associated with outdoors, play is available to us anywhere once we identify our play personality: jokester, storyteller, kinesthete, creator, explorer, conductor, artist, collector (<https://bit.ly/36oHHwl>). Connecting the mode that brings us to this state of flow allows us to choose that mode as a catalyst to enter the state of play. This can be done in any setting. If managed appropriately we can play all day, even once the busy world resumes. Infusing

continued on page 19



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Nature Welcomes Walk-Ins, continued from pg. 17

the purpose of improving health through purposeless activity greatly appeals to the comfort zone of my overbooked brain.

The imperative of social distance has placed a hard stop on the habit of being busy. A complete rebooting of ‘why’ we do what we do. This affords us the time to sit with our choices, both good and bad. I am filled with thoughtful reflection on how I have chosen to live my life.

Once we pass through the stages of grief and detox ourselves from being busy, can we reintroduce ourselves to play and nature. Through this, we heal in multiple ways. First, we develop the skills to play and have fun. Second, we gain the benefits of play. Third, we redefine our relationship to nature. We remember how to go outside for the pure enjoyment of nature. Once we strip away goal-oriented behavior, we are more apt to receive nature’s many benefits.

Contrary to my long-held belief, the outdoors does not require a competition, a chore, a date, a rare phase of the moon or a newly arrived package to accept our admittance. Nature takes walk-ins, today and every day. A month ago, I would never have gifted myself unscripted time outdoors. It sounded too childish, too selfish, too anxiety-provoking. My tight brain required

scripted purpose. For decades, I had required an appointment to enjoy nature. As such, I had avoided the health benefits of the outdoors and play. Unscripted free time needed a worthy excuse and a sufficient time slot. This practice denied me the very simplicity of play and flow, both key requisites to a healthy life. I searched gyms and happy hours looking for this peace, not knowing it was right outside my door.

They say it takes three weeks to form a habit (<https://bit.ly/2TwOLSI>). There is evidence that habit formation is not that simple. I am not proposing a magic switch to frolic to health. What I am suggesting is to allow this social-distancing disruption to change your relationship with nature. Allow increased unscripted time to take you where your brain and body feel engaged and free. Learn from that freedom and reframe play as an essential tool. Take yourself on a date with the great outdoors — no expectations and no plans. Reintroduce yourself to nature and learn the rhythm of your own dance.

It took a pandemic to slow me down enough to realize that nature takes walk-ins. Maybe playing outside will be a valued habit that will remain. See you outside.

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Preventing and Addressing Physician Burnout

Michele Manahan, MD, Johns Hopkins Plastic & Reconstructive Surgery, and Loralie Ma, MD, Greater Baltimore Medical Center Baltimore

For many physicians, the COVID-19 crisis means increased difficulty, isolation, and anxiety, which exposes them to greater risk with personal vulnerabilities, maladaptive coping patterns and diminished self-care. Even before the COVID-19 pandemic there was well-published evidence of physician burnout, and while recent data suggest a promising trend toward improvement in this area, there is concern that this trying time may cause us to lose the momentum gained.

The triad of physician burnout involves emotional exhaustion, a sense of depersonalization, and feelings of ineffectiveness — each of which is associated with increased medical error, decreased patient satisfaction, and potentially adverse outcomes. Left untreated, burnout can lead to depression, substance use and suicidality. With all that we have learned anecdotally and through evidenced-based interventions about the importance of our shared responsibility in addressing professional burnout, we want to intensify our own internal efforts when they are most needed.

The Maryland Physician Health Program (MPHP) — a charitable affiliate of MedChi, maintains complete readiness with a trained clinical staff to assist physicians and healthcare professionals with any issues and symptoms they may be experiencing due to the COVID-19 crisis, through a safe and confidential process. MPHP clinicians work closely with a vetted network of community providers and have access to local and national resources.

At this unprecedented time when every physician and health care professional is so critical, we feel obligated to safeguard their sense of well-being and bolster their reserves. For this reason, we encourage you to reach out to MPHP staff with any individual or broader concerns, or that you refer colleagues who you feel may benefit from seeking out help and support. MPHP can be reached at: 410.962.5580 or 800.992.7010; or by email: phpinfo@medchi.org. MPHP Staff is also available through a HIPAA-compliant videoconference platform.

We are deeply grateful for the courage, dedication, and sacrifice of all those on the front lines. We value and appreciate the mutual partnership and know you are committed to preserving and protecting the wellness and health of physicians throughout Maryland.

CRISP and Maryland Department of Health Collaborate for COVID Reporting and Tracking

To support Maryland's ongoing response efforts to the COVID-19 outbreak, CRISP has partnered with the Maryland Department of Health (MDH) to provide resources for reporting and tracking COVID-19, as well as clinical data to the health care community. Some of the ways in which CRISP collects and reports this data are:

- 1. Test Ordering and Scheduling:** CRISP has developed a centralized physician ordering system and a patient self-scheduling tool to support drive-through testing sites.
- 2. Information at the Point-of-Care:** CRISP now provides alerts when a patient tests positive or negative for COVID-19, as well as confirmed cases as reported to DC Health and the MD Department of Health. These alerts are made available to a patient's care team based upon:
 - A list of positive cases sent to CRISP from DC Health and MDH.
 - Positive and negative lab results from LabCorp and Quest Lab feeds. These results are limited to ordering physicians that are CRISP participants with executed lab request forms within our system.
 - Positive and negative results from hospitals performing COVID-19 tests in the District, which are then reported to CRISP.
- 3. Reporting:** CRISP is streamlining COVID-19 related data collection and serving as a single source of information to hospitals, policymakers, and other health care stakeholders
- 4. Contact Tracing and Response:** CRISP is supporting surveillance, testing, and response efforts necessary for the state to resume normal operations over time.

For more information on the tools we provide in response to COVID-19, contact CRISP Customer Care at 1.877.952.7477 or email support@crisphealth.org.



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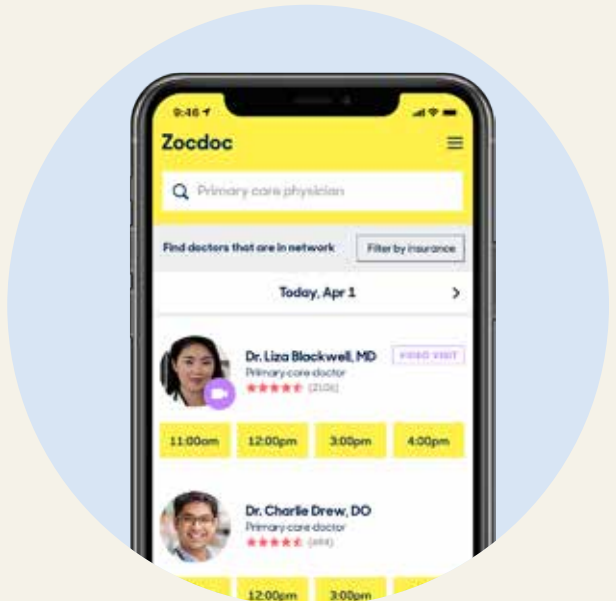


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MedChi's Newest Physician Members

MedChi welcomes the following new members, who joined between January 20, 2020, and April 29, 2020.

Mohammed M. Chaudry, MD — Nova Vascular
Laura L. Giusto, MD — Chesapeake Urology, A United Urology Group Member
Wendy Hookman, MD — Washington Center for Women's & Children's Wellness
Alan L. Kaplan, MD — Chesapeake Urology, A United Urology Group Member
Adam J. M. Kern, MD — Chesapeake Urology, A United Urology Group Member
Andrew C. Kramer, MD — Chesapeake Urology, A United Urology Group Member
Nitasha Kumar, MD — Arthritis & Rheumatism Associates, P.C.
Karen Laugel, MD — Righttime Medical Care
Ann Lichtenstein, DO — Montgomery Hospice

Victoria Lilling, MD — Capitol Orthopaedics and Rehabilitation
T. Brian Marcoux, Jr., DO — The Johns Hopkins Hospital
Melissa Mendez, MD — Chesapeake Urology, A United Urology Group Member
Sriparna Mitra, MD — Shady Grove Pediatric Associates, PC
Matthew J. Rabinowitz — Johns Hopkins University School of Medicine MD Candidate
Leanna-Marie Robertson, MD — Ear, Nose & Throat Associates
Charles L. Schnee, MD — MedStar Franklin Square Medical Center
Nishant Shah, MD
Richard G Silver, MD — THRIVE
Eleonor F Yabut, MD — Saint Agnes Hospital



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TELEHEALTH LEGISLATION

Pamela Metz Kasemeyer, Schwartz, Metz & Wise, P.A.

The passage of two bills that dramatically altered the statutory framework for telehealth services is an example of how changing circumstances can rapidly impact the path of legislation. When first introduced, **HB 448/SB 402: Health Care Practitioners – Telehealth and Shortage** (passed) was opposed by MedChi and other stakeholders who were concerned that an in-person visit would no longer be required to allow asynchronous interaction. MedChi expressed caution about moving too quickly in allowing medicine to be practiced solely using apps and other electronic means. However, with the onset of COVID-19, the use of telehealth became more urgent and the concerns regarding asynchronous communications were diminished as a result. As enacted, the bill authorizes a health care practitioner to establish a practitioner-patient relationship through either a synchronous or asynchronous interaction. A health care practitioner must perform a clinical evaluation before providing treatment or issuing a prescription. A health care practitioner who prescribes a controlled dangerous substance (CDS) through telehealth is subject to all federal and state law relating to the prescription of CDS.

The bill was amended, however, to prohibit the use of telehealth in prescribing a Schedule II opiate unless there is a declared catastrophic emergency or the individual who is prescribed the opiate is a patient in a certain health care facility. The legislation prohibits a health occupations board from establishing a separate standard of care for telehealth. The General Assembly not only passed the bill but made it an emergency bill, which is now in effect having been signed by the Governor.

Also enacted as emergency legislation and signed into law by the Governor was **SB 502/HB 1208: Telehealth – Mental Health and Chronic Condition Management Services – Coverage and Pilot Program** (passed), which requires Medicaid, subject to the limitations of the state budget, to provide mental health services appropriately delivered through telehealth to a patient in the patient's home setting. The bill also expands the definition of "telehealth" for purposes of private insurance coverage to include the delivery of mental health care services to a patient in the patient's home. By December 1, 2020, MDH must apply for a §1115 waiver to implement a telehealth pilot program for the provision of services in the home setting. MDH must also study and report by December 1, 2021, on whether substance use disorder services may be appropriately provided through telehealth to a patient in the patient's home setting. The pilot program and study provisions of the bill terminate June 30, 2025.



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MEDICAID INCREASE AND FY 2021 BUDGET

Danna L. Kauffman, Schwartz, Metz & Wise, P.A.

Despite extreme pressure from other budgetary demands, such as education (Kirwan) funding, the projected structural deficit and preliminary expenses allocated for the COVID-19 pandemic, MedChi successfully secured an additional \$4 million in funding to maintain E&M Codes at the current level of 93 percent of Medicare. This success is particularly notable given that the General Assembly eliminated any further reductions to the hospital Medicaid Deficit Assessment after Fiscal Year 2021, setting it at \$294,825,000 for this fiscal year and each year moving forward. Previously, the agreement was to phase-out the Assessment by \$25 million each fiscal year. Other notable funding was the restoration of the Community Health Resources Commission (CHRC) budget. The CHRC currently is funded at \$8 million. The Administration proposed to reduce that amount to \$4 million

in HB 152/SB 192: The Budget Reconciliation and Financing Act (passed). The General Assembly rejected the reduction and restored the amount to the original \$8 million but requires that \$1 million be used to support Local Health Improvement Coalitions.

Several reporting requirements were included in the FY2021 budget, including requiring the Health Services Cost Review Commission to report on the following: (1) the effectiveness of the Maryland Primary Care Program; (2) how it intends to manage hospitals that are generating excessive operating profits under regulated rates under the Total Cost of Care Model; and (3) the State's hospital medical liability market through the funding of an independent actuarial analysis. The General Assembly is also requiring the University of Maryland Medical System to submit a report detailing specific responses to findings and recommendations contained in the March 2020 Office of Legislative Audits Special Review of Board of Directors Activities and the December 2019 Special Committee of the Board of the University of Maryland Medical System internal forensic audit report undertaken with advice by Latham and Watkins, LLP.

Given the additional expenses incurred by the State as a result of the COVID-19 pandemic and the loss of State revenues, it can be expected that reductions will need to be made to the State budget for both Fiscal Year 2020 and the upcoming Fiscal Year 2021. As always, MedChi will stay vigilant to continue to protect physician funding.

TORT ISSUES STILL A HOT TOPIC IN ANNAPOLIS

Steve Wise, Schwartz, Metz & Wise, P.A.

While there were many unusual things about the 2020 Session, one thing remained constant: physicians and hospitals battling the trial lawyers on tort matters. This year, three main bills occupied the field. First, **HB 1037: Civil Actions – Noneconomic Damages – Personal Injury or Wrongful Death** would have lifted the limit on non-economic damages if the plaintiff proved that damages resulted from “willful, wanton, malicious, reckless or grossly negligent acts or omissions.” MedChi, MHA, and other groups opposed the bill, which died in committee, because these standards would be unclear to juries and result in “limitless” avoidance of the cap. The cap was put in place to ensure liability insurance remains affordable and that patients have access to care, and the bill undermined those goals.

Second, **SB 879/HB1563: Maryland Infant Lifetime Care Trust** was an initiative by Maryland hospitals to address the \$200 million plus malpractice award against Johns Hopkins. It was a variation of the birth injury fund bills that had been introduced in prior sessions. The bill provided for attorney’s fees and addressed other issues raised by the trial bar with respect to prior birth injury fund legislation. Despite these new provisions, the trial bar vigorously opposed the legislation and it failed.

Finally, **HB 684 and SB187: Civil Actions – Health Care Malpractice Claims** was introduced by the MHA and supported by MedChi. This legislation would have adopted the Daubert standard for expert witness testimony, which is followed by federal courts and is generally regarded as providing a sounder and more reliable basis for expert testimony than the current Frye/Reed standard used in Maryland. The Daubert standard requires that parties and experts work harder to ensure that expert opinions are grounded in reliable science or demonstrable relevant experience. Both bills failed.

BOARD OF PHYSICIANS TASK FORCE MAKES PROGRESS

Steve Wise, Schwartz, Metz & Wise, P.A.

In 2018 MedChi established a Board of Physicians Task Force to address issues that members had raised with the Board’s disciplinary processes. Working through the Board of Trustees and the Legislative Council, MedChi was able to use legislation introduced earlier this year to address two of the issues identified by the Task Force.

HB 560/SB 395: State Board of Physicians and Allied Health Advisory Committees – Sunset Extension and Program Evaluation, which passed, were the culmination of a legislative review and re-authorization of the Board. This process was used to reach agreement with Board leadership to evaluate

an expungement program in coordination with MedChi for physicians with minor infractions. This will take place over the 2020 interim. Second, the Board is required to evaluate and report back to the General Assembly on the use of a third peer reviewer in instances when the initial two reviewers do not agree. The Task Force had concerns about how disagreements are resolved in this scenario.

Working with the Board, MedChi was also able to resolve a longstanding issue involving the discipline of integrative medicine physicians. This group had complained of disparate treatment by the Board in its handling of standard of care cases involving Lyme Disease. **HB 259/SB 103** originally established a separate disciplinary process for integrative medicine, but that process was full of holes through which potentially bad actors could escape. Amendments were agreed to that simplified the bill, so that now a professional board cannot act against a practitioner “solely” because he or she uses integrative methods, and that the standard of care must still be observed.

HB 937 - Naturopathic Doctors – Formulary Content, and Scope of Practice died in the HGO Committee. MedChi opposed this legislation and argued that naturopaths with no residency and limited pharmacology background should not be prescribing drugs, and that prescription drugs would be a “loose cannon” for their scope of practice.

PODIATRISTS ARGUE FOR EQUAL FOOTING

Steve Wise, Schwartz, Metz & Wise, P.A.

The Maryland Podiatric Medical Society had legislation introduced, **HB 428 - Health Occupations – Podiatric Physicians**, that would have allowed podiatrists to use the term “podiatric physician,” which they argue is already permitted in thirty-six other states. The podiatrists maintain that their academic training is on par with MDs and DOs, in that they are now required to complete a residency, and that this new title would not be misleading as the term “physician” is modified by “podiatric.”

MedChi opposed this bill and argued that the term “physician” should be reserved for MDs and DOs, as it has been under Maryland law. In a similar vein, naturopathic doctors also sought to be called “physicians” when they were first licensed years ago, but this was not authorized by the General Assembly. HB 428 was not voted on by the Health & Government Operations Committee during the shortened Session, but MedChi did receive a letter from Chairman Shane Pendergrass, who made it clear that the bill would likely pass the House in 2021 barring new or additional information that would weigh against its passing. If the legislation is defeated it will require a concerted, well-planned, and meritorious effort leading into the next session.

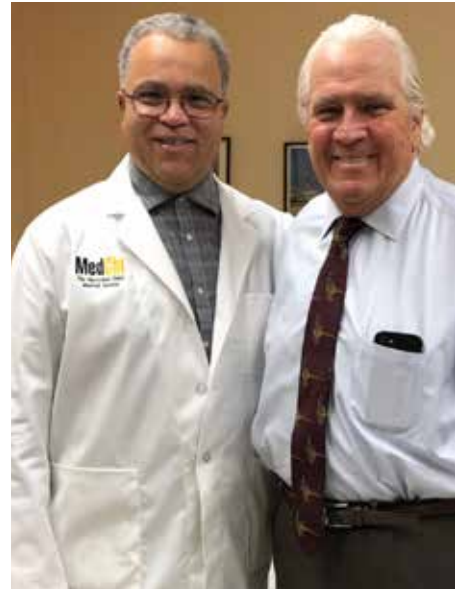


MedChi works with the Maryland General Assembly each legislative session to provide volunteer physicians who serve the medical needs of lawmakers and their staff. Volunteer physicians spend the day in Annapolis and have the unique opportunity to interact with legislators on the House and Senate floors, attend committee meetings, and get a firsthand look at the legislative process, while giving back to the public servants who support physicians' issues.

Pictured, this page, left to right: Mozella Williams, MD; Gary Sprouse, MD; J. Ramsey Farah, MD; Walter Giblin, MD; George Malouf, MD; Gene Ransom and Loralie Ma, MD; Laura Kaplan-Weisman, MD; Padmini Ranasinghe, MD. Pictured, facing page, left to right: Carolyn O'Connor, MD, Steve Rockower, MD, and Larry Green, MD; Francisco Ward, MD, and Sen. Mike Miller; Tyler Cymet, DO; James Williams, MD, and Sen. Chris West; Ben Lowentritt, MD, and Gene Ransom; Renee Bovelle, MD; Paul Quesenberry, MD (left), Algernon Prioleau, MD (center), and Delegate Paul Corderman (right); Russell Wright, MD, and John Gordon, MD.

Volunteers must have an active, unrestricted medical license and be a current MedChi member to participate. If you are interested in serving as MedChi's Physician of the Day in the Maryland State House's First Aid Room for the 2021 legislative session in Annapolis, contact Chip O'Neil at coneil@medchi.org or 410.539.0872, ext. 6001.





Isn't It Time You Joined MedChi?



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Not only that, but MedChi membership can also help you directly in various ways:

- Get paid for your hard work
- Be a human resources expert
- Get answers to all your practice questions
- Take your business skills to the next level
- Expand your leadership skills and network
- Participate in local community health events
- Connect with your peers
- Advocate for the future of medicine
- Receive discounts and subscription benefits with our preferred vendors

MedChi is the only society representing all physicians in Maryland. Maryland's medical association is comprised of health practitioners from more than fifty medical specialties and continues to grow with more than 8,000 members, including private practitioners, academic physicians, retired physicians, residents, and medical students. Sixty percent of your dues are tax deductible and include membership in your local society.

**Click here to join MedChi or renew your membership online: <https://www.medchi.org/Get-Involved>.
Current members may contact members@medchi.org or 410.539.0872, ext. 3301 for questions about your membership.**