



VOLUME 9 / MAY 2009



MEP's New Look

ANGELO FALCONE, MD



MEP has rolled out a new "look and feel" to our promotional materials. As part of this process we engaged HZDG, a design and marketing firm based in Rockville, to review all of MEP's collateral material including our current website. First I would like to thank Amy-Catherine McEwan and Mike Cetta for spending many hours researching firms, determining the one who would offer the "best fit" for MEP and making sure the material reflects the core values and principles we hold so dear. The intent of this overhaul was to sharpen the MEP image and help us to stand out in the marketplace. Our focus was concentrated on two distinct groups; potential providers who would be interested in joining MEP and hospital clients that would be interested in obtaining more information about MEP.

One of the changes you will notice is our tagline. The "Excellence in Emergency Medicine" has been changed to "Your Partner in Emergency Care". Partnership is a key part of MEP's culture and history, both with our client hospitals and our providers. In addition we have sought to maintain the historical reference of "MEP". Initially founded as "Montgomery Emergency Physicians" we have grown far beyond our Montgomery County roots. In order to be inclusive we have changed MEP to stand for Medical Emergency Professionals. While it doesn't exactly roll off the tongue it does incorporate the professional emergency medical and business expertise which defines MEP as a company.

As mentioned, part of this work involved updating the MEP website. To date the website has been admirably managed and maintained by PSR. As we reviewed the website we sought to reach new potential employees and have the MEP name more easily remembered. With the rollout of this new website we will be changing the URL for MEP to "EmergencyDocs.com". We thought it easier to remember than MEPED.net and would show up more frequently when internet searches are done by potential applicants. The old URL will continue to remain active and will be forwarded to EmergencyDocs.com. With the release of this new website there will be a location for our current providers to "land" and be linked to the data on their individual dashboards, similar to the previous website. These data will continue to be managed and updated by the folks at PSR.

Take some time to browse the website and provide feedback. We are very excited about the new look and believe it will help to continue to set MEP apart.

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New Year, New Challenges

ANGELO FALCONE, MD

As we continue in 2009, challenges appear at every turn. Our country finds itself in the worst economic crisis since the great depression. We witness this in the patients for whom we care at all our facilities. I have been surprised by the response to the question "What do you do for a living?" as I find significantly more people state, "I've been laid off recently"!

Perhaps the end result of that is the increasing volume (and acuity) of patients we are treating in the EDs which MEP serves. Capacity and throughput have become critical rate limiting steps in the care we provide. With the move to EMR at many hospitals, these challenges have only been compounded.

In challenge, there is opportunity. Over the last 6 months, the leadership of MEP has explored ways to improve the efficiency of the process of how patients are treated. We have also explored improving the working environment for each provider.

Two major efforts are underway; a process commonly called Rapid Medical Evaluation (RME) and scribe programs. RMEs use process redesign to compress the time a patient sees a provider. Typically it involves subdividing types of patients by acuity and focusing provider-RN resources to a particular location of the ER to improve overall flow. While all patients benefit, those who benefit the most are the mid-range acuity (triage category 3 such as patients with abdominal pain, vaginal bleeding, headaches, gastroenteritis and low risk chest pain). These are patients who typically wait the longest to be treated.

The second major initiative is a scribe program for MEP. Scribes have been implemented in many higher volume EDs across the country. Scribes act as your personal assistant and help with charting, gathering data and completing discharge instructions you prescribe for a patient. They have been especially effective in hospitals with EMRs and free the physician from being a "slave" to the computer.

The end result is faster care for the patients we treat and a reduction in the non-essential secretarial work in which you are currently engaged. Stay tuned for more information as these programs are rolled out in an ER near you.



Dr. Aaron Snyder Congratulates Jerry Wilhelm
for 40 years service

Western Maryland Health System Welcomes MEP

AARON SNYDER, MD FACEP

January 1, 2009, MEP partnered with Western Maryland Health System (WMHS) to oversee ED operations at their two facilities in Cumberland Maryland; Memorial and Braddock Emergency Departments.

WMHS has a long tradition of excellence and MEP is proud to join their clinical operations. The Memorial ED is the regional trauma center for Western Maryland and parts of southern Pennsylvania and eastern West Virginia. The Braddock Hospital and ED is home to the region's only comprehensive cardiac program with a full range of cardiothoracic surgical services and interventional cardiology services.

In November 2009, the two current hospitals will be merging into one brand new state of the art hospital. The new ED will have 48 beds with a 16-bed fast track area. There will be specialty areas in the ED with 4 specialized trauma bays, psychiatric treatment areas, and even 3 waiting room areas (adult, pediatric, and behavioral health).

MEP is proud to join the Western Maryland Health System! We look forward to the new hospital and continued care of our patients with excellence, compassion, integrity and trust.

MEP is the recognized leader in providing exceptional emergency medical care. We improve the health and promote the well being of the individuals and communities we serve.

Body Language

DAVID KLEIN, MD

The next patient was a 25 year old female in room 2. The nurse's note read "severe abdominal pain - rates it a 10 out of 10". Like any good emergency medicine physician, I was already considering the differential diagnosis prior to entering the room.

Severe pain in a young female. Could be an ectopic, an appendicitis or a torsed ovary. I was prepared to perform a quick history and physical, order pain medications for the severe pain and hopefully not miss a catastrophic illness. I was surprised upon entering the room to find a patient sitting upright in the stretcher eating a bag of Fritos and laughing with her boyfriend.

Should my differential change? Why? The nurse's note is still correct. The patient did state that she has severe pain and it is probably still rated a 10 out of 10 on her scale. (I didn't ask). My impression of the patient's level of illness and the patient's credibility changed in an instant just by observing her actions. It would be very hard for her to get that credibility back, wouldn't it? What changed? Why did she lose her credibility? Body language. I was always taught that a good ED clinician should be able to determine a patient's acuity of illness by observing the patient from across the room. How? Body language.

Words have indisputable definitions but they still can mean different things to different people. Conditions and emotions that cause us to move or act in a certain way is more universal and unaffected by personal definitions. An astute clinician can usually tell if the patient has a torsed ovary or a severe case of appendicitis by their body language. The "severe pain" that is rated as a 10 is important but not as much as the body language.

If we can draw conclusions about patients from their body language, is the opposite also true? What can patients tell from our mannerisms and actions? I know that I should walk into a room and show empathy and have good listening skills. I know that this patient is not worried about the patient in room 6 with chest pain, nor should they be. They are only concerned with their abdominal pain and desire our undivided attention. Furthermore, I don't want a patient to complain and I want to do well on the MEP patient satisfaction survey. Does my body language make a difference? You bet it does. I can ask each patient if they are feeling better. I can ask them if they have any questions. Does it matter if I appear rushed or tired?

Case in point. I read a book recently called "My Stroke of Insight" by Jill Bolte Taylor, a neuroanatomist at Harvard, who had spent years studying the brain. She unfortunately had a brain hemorrhage. The book is about her thoughts during the time of the hemorrhage and how she noticed her brain recovering on the cellular level. I want to focus on how she describes her time immediately post stroke when she was still aphasic and in the hospital.

"Because I could not speak or understand language, I sat silently on the sideline of life.....Although I could not understand the words they spoke; I could read volumes from their facial expressions and body language. Dr. David Greer was a kind and gentle young man. He was genuinely sympathetic to my situation and took the time to pause during his busy routine to lean down near my face and speak softly to me. He touched my arm to reassure me that I would be okay. Although I could not understand his words, it was clear to me that Dr. Greer was watching over me. He understood that I was not stupid but that I was impaired. He treated me with respect. I'll always be grateful for his kindness."

No words were spoken but she was comforted and gained confidence in the doctor and in her recovery. His body language alone comforted her.

Several prominent communication specialists have demonstrated that 7% of the impact of our communication comes from the words that we choose while 38% comes from the tone of voice and 55% is achieved with our body language. So what can we do to improve the way we use our body language in speaking with patients? Eye contact; both with the patients and with every family member in the room. As mentioned by Jill Taylor, human touch sends a message in itself, shake everyone's hand, sitting down next to the patient when speaking rather than standing near the doorway or curtain, these are just some ideas. I would welcome others.

I want to close with a quote from Randy Pausch, author of "The Last Lecture" just months prior to his death.

"The display of sincere emotion is not terribly complicated and it is always moving to human beings. It is surprisingly easy to recognize. This can be learned by watching people tell you a story in a language that you do not understand. You realize before you get the translation whether you believe what they are saying and whether you care. Sincerity translates on a far more primal level than language."



Benefits Corner

FAMILY MEDICAL LEAVE

As MEP continues to expand its roster of active FT employees, MEP is no longer a "small business" in terms of benefits administration. While MEP has always provided up to 60 days unpaid leave to their providers; since MEP has met the 50 FT employee threshold, the Federal Government has a requirement that MEP offer Family Medical Leave to its employees. Briefly:

The Family Medical Leave Act became effective on August 5, 1993 and entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. Recent amendments expanded the FMLA to provide additional leave benefit arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, or to care for a covered service-member with a serious injury or illness.

FMLA applies to all public agencies, including state, local and federal employers, local education agencies (schools), and private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar year (MEP).

To be eligible for FMLA benefits, an employee must 1) work for a covered employer (MEP is); 2) have worked for the MEP for a total of 12 months; and 3) have worked at least 1,250 hours over the previous 12 months.

MEP will grant an eligible employee unpaid leave during any 12-month period for one or more of the following reasons: a) for the birth and care of a newborn child of the employee, b) for placement with the employee of a son or daughter for adoption or foster care, c) to care for a spouse, son, daughter, or parent with a serious health condition, d) to take medical leave when the

employee is unable to work because of a serious health condition; or e) for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

MEP will grant an eligible employee who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness, unpaid leave to care for the service member.

MEP has the option to allow an eligible employee to "substitute" (run concurrently) accrued paid leave (such as sick or vacation leave) to cover some or all of the FMLA leave.

MEP will maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. Arrangements will be made for employees to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, an employee will be restored to his original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment.

This is a truncated explanation of the FMLA. MEP will be distributing their FMLA policy shortly. Each employee will receive a copy of the policy via email and copies will be available at each campus' MEP administrative office. If you have any questions once the policy is distributed, please contact Susan Damron, the MEP benefits manager at sdamron@med-edge.com or 972-739-3709.

MEP IS LOOKING FOR EXCELLENT PROVIDERS

LIKE YOU

MEP is always looking for talented Physicians and MLPs. We know the best place to find these people is to ask you. Therefore, we offer a bonus if you refer a colleague who is hired.

Please think about people you have worked with, trained with or know, who you think would be a good clinical and cultural fit with us.

Referral Bonuses:

Full time Physician candidate is hired:
\$10,000

Full time Extender candidate is hired:
\$5,000

Please contact Aaron Snyder, Director of Recruiting at
ASnyder@EmergencyDocs.com

or

MEP Recruiter,
Amy-Catherine McEwan at
ACMcEwan@EmergencyDocs.com

if you have any questions, and thank you for helping us grow the MEP family.

MEP is the recognized leader in providing exceptional emergency medical care. We improve the health and promote the well being of the individuals and communities we serve.

Have Scalpel; Will Travel

MARK HAYWARD, PA-C St. Mary's Hospital



I got an interesting email in December of last year. A friend of a friend was looking for a PA to work on a joint United Nations/State Department project in Haiti. I had just finished a year-long stint of ER contract work, and I was looking for something out of the ordinary, so I sent him my resume. Two weeks later I flew out of Reagan National on my way to Port-au-Prince, Haiti.

The reports of Haiti's death have not been exaggerated. The principal industry is foreign aid. A wealthy and corrupt elite at the top of the Haitian food chain have a strong vested interest in perpetuating the misery and despair that keep the money flowing in, from Canada, the US, Cuba, Venezuela and other big contributors. For the most part, the roads, public buildings, and most infrastructure elements look as though somebody stopped paying the rent about twenty years ago. With the exception of some truly impressive highways being built by foreign donors, the country hasn't had

basic maintenance or even a tune-up since "Baby Doc" Duvalier got voted off the island in 1986. With garbage-nibbling goats and pigs on most street corners, and tin-roofed shanties built side-by-side with simply opulent multistory villas, the city of Port-au-Prince is without a doubt the most squalid yet luxurious place I have ever lived. It truly has to be seen to be believed.

Furthermore, outside the capital city, and disregarding the ever-present poverty, corruption, and crumbling infrastructure, Haiti is an interesting and even beautiful place. Located on the western half of the island of Hispaniola in the Caribbean, it's a tropical island only two hours away from Miami. Moreover, I was there from January into early April. So, while my family shivered and froze in ice storms, sleet, and all the charm of a DC winter, I was enjoying 84-degree weather and chasing a wide variety of local lizards, geckoes, and tree-frogs. Haiti has beautiful beaches, world-class snorkeling and scuba diving, and even the comfortably crumbling remains of a former Club Med, now renamed Club Indigo and available with all the amenities for a third of the price. Tourism is not as successful as it could be due to a chronic national image problem worsened by the occasional kidnapping-for-profit that supplements narcotics income for local drug gangs. However, these risks are substantially lower, and vastly more interesting, than the comparable problems of death by road rage, MVC, or brain aneurysm while commuting on the Beltway. So Haiti has a lot to recommend it, although I recommend packing some Cipro and loperamide along with your swimsuit and sunscreen.

As far as the actual work I was doing, the details are still a little fuzzy. The UN has an unofficial slogan: "There are no failures, only limited successes." In other words, even if you never do anything, you can always claim that it was what you meant to do in the first place. Less cynically, my work was primarily preventive in nature, ensuring that a group of US law enforcement officers had appropriate medical support during their work in Haiti. This program was conducted under the auspices of the UN, funded by the US State Department, and served to enhance the capabilities of the Haitian National Police forces. I did a lot of contingency planning and was quite happy that most of my preparations proved to be entirely unnecessary. In between times, I provided routine primary care to the officers, and raised tree-frog tadpoles in a juice pitcher. Everyone seemed reasonably content with the arrangement, including the frogs.

I will make one serious note about medical work in Haiti. The people who impressed me the most were and are the medical volunteers, primarily from the US but also from the Philippines, Cuba, Argentina, and many other countries. Expatriate Haitians, off-duty UN medical providers, an alphabet soup of non-governmental organizations, and a scripture concordance's worth of church groups are meeting the medical needs of many Haitians on a day to day and year to year basis. If you get the chance to participate in one of these projects, do so. This volunteer work fills a critical need in a country that is truly extraordinary in most respects. Spending time in Haiti is a little bit like running a marathon: you may throw up occasionally, and you'll definitely need a shower afterwards, but you'll never forget the experience. Let me know if you're interested.





It Really ALL is in the Detail

SCOTT FREEDMAN, MD



Officials from MEP and SGAH celebrate the opening of the new facility

When we start seeing patients at the beginning of our shift, we take for granted there will be working computers, a cart filled with T sheets, and a full compliment of supplies and functioning equipment. We give little consideration to what may be on (or missing) from the supply or med cart. We likely give even less thought to how accessible the supplies, tools, and outlets are. Though we know, none of this just happens, I have been privileged to be integrally involved in the design and layout for our new Pediatric ED and therefore have gleaned a great appreciation for all the behind the scenes production work that goes in to making a unit functionally successful.

A number of years ago, the primary issues that went into proposing a new Pediatric ED were location, available space and evaluating anticipated needs for overall number and type of ED patient rooms. We then went through many versions of blueprints balancing budget constraints with space and flipping back and forth between a birds eye view with how things might practically look and feel while working.

Next we participated in more specific needs to the unit. Where would the rooms be located relative to the nursing stations, supply and med rooms and bathrooms. We had to work around unanticipated building support columns, ventilation issues, and plumbing problems. At the same time, we provided significant input to the aesthetic design of the unit. With every step and choice, costs were scrutinized and more options considered. Throughout all of this, we worked closely with administration, the architects and design team as well as the construction team and their subcontractors.

We have witnessed (and heard) phases of demolition of existing building space, to the commencement of the bare bones brick and mortar construction, to framing and build out. We have had to modify our desires on many occasions due to unexpected issues involving gas, power, and water lines among other things.

So this week we plan our final construction walk-through. We will need to consider things such as light switch locations, placement of electrical outlets for safety and accessibility. Are the pipes under the sinks potentially inviting to a toddler who may view them no different than his Little Tikes backyard play-set. Are the telephone jacks located where patients and parents can get to them easily or are they too close to the curtain tracks?

So with great anticipation, pride, and excitement we will be opening our new Pediatric ED on May 20, 2009. For our patients and families, I believe they will be truly wowed by its aesthetic design and layout. I believe our staff will be exceptionally pleased with its size and space. All the details that will allow it to function smoothly, safely, practically, and efficiently did not happen magically. We owe much gratitude to many, many people for all the details large and small.



Pediatric ED
(Before)

Mridula Naik, Pediatric ED Specialty Nurse Coordinator and Valerie Ulrick, Shady Grove ED Business Coordinator applying finishing touches to the trauma bay on the morning of the opening.



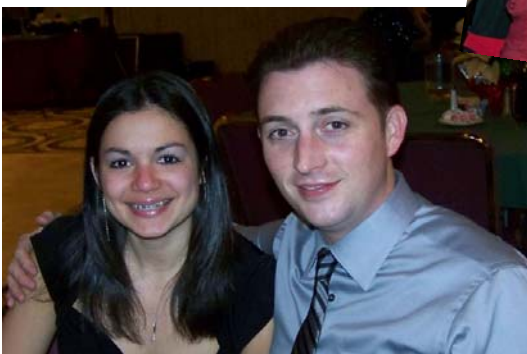
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MEP
Shady Grove
Adventist
Hospital
and
MEP St. Mary's
Hospital



Annual Holiday
Celebrations
January
2009



We want your news! Please submit your articles, photos and new baby information for the next issue to ACMcEwan@EmergencyDocs.com



Near Hits and Misses

ANGELO FALCONE, MD

“May you live in interesting times” is one of my favorite quotes. As many of you know, I was involved in a 40 car pile up on I-70, in January, as I drove to work at WCH with my daughter Katelyn.

I have pondered many things since the crash. The fact that a half mile more or less and I would have missed it. The tragedy of the two women killed traveling in separate SUVs on their way to the same meeting in Hagerstown. The father of the family traveling to Ohio who sustained an amputation at the scene and lost his other leg after surgery trying to save both. The surreal experience of treating patients at the scene of the accident, and then taking care of them in the ER an hour later.

Finally the scariest moment was when I thought the worst of the crash was over, only to see a tractor trailer coming off the road at our car. As I struggled to get out of my vehicle (my door was pinned against another car), I thought this may be it for me. Thankfully it missed us by 15 feet.

Moments like these, I would prefer not be repeated. They must, however, be appreciated. I think of the times I have delivered news to a patient or family that has changed the trajectory of their lives. It is often too easy to rush past these moments and not realize the gravity of the words we are speaking. It is in those times when we show our humanity.

These are “pivot points” in a life. Because of events such as above, few things are the same. The routine challenges become unimportant and less stressful, as they should. The hope and opportunity these events provide are the chance to re-examine and redefine who we are, what is important and how we spend our time.

My hope is we all take the chance to recognize these events for what they are – precious gifts. May we see them as such, whether we are the messenger or the person to whom the message is being delivered.

Be well.



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