



Quarterly Meeting: Special Session
Date: April 19, 2006
6pm to 8:30 pm

1 **Present:** Gail Katz (Chair-Emeritus/Public Awareness Chair), Karen Kaiser (Chair), , Kathryn Hebert (Chair-
2 Elect), Mary Vargas (Treasurer), Carol Billett (Secretary), Lynn McPherson (Director), Stacy Ramga (Visiting
3 Pharmacist/Student), Laura Scarpaci (Palliative Care Pharmacy Resident), Helen Hatchett, Micke Brown
4 (Director/Professional Education Chair), Brian Rosen (State Government Affairs: Purdue Pharma), Jack
5 Schwartz Esq (Assistant State Attorney), Don Yee (Maryland Board of Pharmacy).

6 **Participants by Conference Call:** Michael Gloth MD (Board of Physicians)
7

8 **Absent Board Members:** Will Rowe (Director/Policy Committee Chair: excused), Tim Keay MD (Director:
9 excused), Joe Berman MD (Director: excused), Shannon Leidig (Coordinator: excused)
10

11 Meeting called to order by Karen Kaiser @ 6:15 pm.

12 Welcome and introductions were made.
13

14 **Special Session Topic: Access to Pain Care When Provider Suddenly Removed From Practice**
15 **(Unplanned Abandonment)**
16

17 **Issue 1 Discussion:** Legislative response: The beginning of meeting was spent discussing how to get Maryland
18 legislators to the table and responsive to pain issues in the state. Key members were invited: Paula Hollinger (RN),
19 Morhaim & Harris (both MD's and recommended by Dr. Gloth) and Bobo (past activist on health related issues). Each of
20 the four state legislators declined the invitation to attend and failed to send a staff representative after letters were sent
21 electronically on March 23, 2006, additional hand delivered hard copies were taken by Karen Kaiser and follow up
22 telephone contacts from MPI leaders within their voting districts were made by Helen Hatchett, Gail Katz, Will Rowe and
23 Karen Kaiser. Delegate Bobo expressed interest and invited Karen Kaiser to plan a visit with her at a later date.
24

25 Suggestions offered were:

- 26 • Have someone who knows legislator personally or at least have constituents make direct contacts-- some of this
27 was done without success.
- 28 • Meeting scheduled too close to the end of the legislative session (which was particularly brutal this year)
- 29 • Campaign fundraising for this election year required immediate attention due to late start because of legislative
30 session.
- 31 • Arrange individual meetings at the district office rather than in Annapolis may be successful.
- 32 • Have person living with pain in attendance during the face to face meetings
- 33 • Extend invitation to Joan Stern, who attended Women In Government session about pain management in 2005;
34 Mary Vargas presented and might have significant impact as first contact.
35

36 **Action:** Micke will investigate use of APF database for Maryland: send out survey question asking who has personal
37 contacts with Maryland legislators. Mary Vargas will contact Delegate Stern to discuss access problem and inquire about
38 her interest in participating.
39
40

41 **Issue 2 Discussion:** Development of a statewide plan re: access for patients to pain specialists during period of
42 interruption in service whether from a natural disaster or loss of physician.
43

44 For example, Case manager in the emergency department in Harford Co reported on the incident where a physician who
45 treated chronic pain patients had an MI and there was no one to write orders for these patients. A temporary plan was
46 made in this small community to have the patient's primary care physician take over the pain patients over a short term.
47 The ED physicians helped with the creation of a system of acute intervention and rapid referral for these chronic pain
48 patients, when they were seen in that setting.

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2 Another example was cited where a pain physician practice secondary was abruptly restricted in opioid prescribing, and
3 then closed due to disciplinary action from the Maryland Board of Physicians (MBOP) and the DEA. A question was
4 raised whether there is a precedent with other physician specialties, such as nephrology or oncology, when they are
5 removed from practice? Is there a similar problem with access to care for renal or cancer patients who abruptly lose a
6 provider? The difference is that there is stigma, an unfair prejudice against pain patients. They are often labeled as
7 difficult patients to manage. More and more physicians are unwilling to treat, much less pick up more patients, who
8 require opioid management due to opioidophobia.

9
10 What happens in other medical systems of care does not work well with pain patients? Pain services are limited in number
11 and over burdened in patient load; many times a waiting list of 3-6 months for a first appointment is required. Patients
12 taking opioids without a new provider are then forced into unsupervised withdrawal or faced with finding access to
13 medications elsewhere.

14
15 Dr. Gloth advised that these patients have struggled hard to find a provider in the first place. The MBOP was designed
16 with the primary responsibility to protect the public from “bad” physician practice. Protecting the public by addressing
17 access to care issues when someone is suspended or has become ill has not been on their radar screen in the past. What is
18 their responsibility to provide care for these patients?

19
20 A discussion is in process with MBOP to have a letter from the Medical Board for the patient that explains the situation
21 that their routine provider is unable to prescribe their opioid analgesics, and make a statement about who is going to
22 become their provider. This may help ease the transition to new providers. Commonly, pain patients are tainted, when
23 referred to a new provider due to loss of provider from disciplinary action. This creates an atmosphere of fear for some
24 physicians. There is a perception that regulatory attention will be focused on those who accept these patients into the
25 practice. This means that the patient with pain experiences unintentional abandonment; an under-realized casualty of
26 disciplinary action from medical boards and/or law enforcement.

27
28 Because this is unintentional patient abandonment, is there a role for local medical societies and health departments? Who
29 else is ethically responsible to address this issue? Community Health Centers exist – there are about 20 in Baltimore City.
30 There is thought to be a rural counterpart. These centers get federal funding based on their numbers of patients and
31 catchment area. Perhaps in advance the county board or societies could help to identify “back up” practitioners, this will
32 help decrease the stigma/fear for physicians taking on unknown patients.

33
34 An additional suggestion was made to convene a meeting of the licensing boards for medicine, nursing and pharmacy.
35 Other healthcare professional boards should be invited as well. The goal would be the development of a collaborative
36 statement of Maryland licensing boards that supports and adopts the provisions of the Model Policy. This would send a
37 powerful message to the healthcare community and a positive step in improving Maryland’s pain policy grade as
38 evaluated by the Pain and Policy Studies Group (PPSG).

39
40 Another suggestion was made about the creation of a partnership pain treatment program between pharmacy and
41 physicians. There is strong interest in the development of a pilot collaborative practice program; legislative support has
42 been created and not yet tested in this venue.

43
44 Insurance access is a huge issue whenever a change in providers occurs. Available referral sources may not accept or
45 participate in insurance plans of patients now abandoned. The Kaiser plan provides referral to their patients automatically
46 when there is a loss of provider, no matter the cause. It might be helpful to assess the Kaiser Permanente model as well as
47 the ACS model that was used in responding quickly during the Katrina disaster. It was suggested that the state emergency

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1 plan most likely failed to address the needs of pain patients during the most recent revision. The pharmacy board has
2 relaxed rules in cases of disasters that scripts may be filled.

3 Could a patient's pharmacist have letter for patient who frequents /contracts with the same pharmacy the letter to include
4 their current meds, doses, and allergies, as another form of verification when there is a sudden loss of provider?
5

6 **ACTION ITEMS:** Create a focus group to continue to look at this problem; assess the access to provider barrier in
7 Maryland; survey the public experience as well as apply for project funding. One possible survey that could be easily
8 done through APF is to query consumers who have lost physicians, temporarily or permanently and to ask what did under
9 these circumstances.
10

11 Karen charged the formation of this task force. Members suggestion were: Will Rowe (Chair??), Gail Katz, Mary Vargas,
12 Michael Gloth, Helen Hatchett, Kat Hebert, Micke Brown and Jack Schwartz (ad hoc advisor). Micke will recruit
13 additional nurses from the Maryland Chapter of ASPMN.
14

15 Karen will contact MBON for representative.
16

17 Don Yee expressed interest in supporting this activity and reporting to the pharmacy board. He will investigate if Kaiser
18 will share their model with the task force.

19 **Adjournment @ 8:15pm**
20

21 Recorded by: Carol Billet & Micke A. Brown on April 19, 27 2006.

22 Reviewed by: Executive Committee: _____, 2006

23 Approved by MPI Board: _____

24 Supporting documents: Hurricane Katrina Emergency Opioid Mgt Plan; Letters of Invitation; Restaurant
25 Directions