ADDRESSING HEALTHCARE DISPARITIES

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Addressing Health Care Disparities

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by Claudia R. Baquet, M.D., MPH and Richard Colgan, M.D.

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by Jacob Frego and Susan Stewart

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Reducing Health Care Disparities: Innovations in Annapolis
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Building a Pipeline of Future Doctors to Ease the Problem: An Update on the University of Maryland School of Medicine’s New Primary Care Track
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Educating Asians about Hepatitis B: the “HBVS”
by Amanda Wong, MPH, MS-II

June MAFP CME in Ocean City

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Editor
Addressing Health Care Disparities
by Richard Colgan, M.D.
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Addressing Health Care Disparities

Richard Colgan, M.D.

“I argue that equity is the central challenge for the future of medicine and public health”

– Paul Farmer

Caring physicians through the ages have been aware of the gap between those that have and those who have not. Moses Maimonides (1135–ACE-1204 ACE) would work by day caring for a Sultan and at night travel home by horse to care for large numbers of patients, at no charge, who awaited his return. He wrote “Patients go in and out until nightfall, and sometimes even I solemnly assure you until 2 hours and more into the night. I converse and prescribe for them while lying down from sheer fatigue, and when night falls I am so exhausted I can scarcely speak.” This publication focuses on addressing health care disparities. Although there is hope that, with the passage of recent federal legislation, we may see more Marylanders covered by health insurance, even then, many will be without equity in health care.

Dr. Claudia Baquet, Director of the University of Maryland School of Medicine’s Center for Health Disparities is the lead author on this edition’s key note article providing an overview of Health Disparities and Maryland Considerations. Dr. Baquet has been an effective champion for the underserved in our state and works tirelessly to promote health equity for all Marylanders. Jacob Frego and Susan Stewart, Executive Directors of the Western Maryland and Eastern Shore Area Health Education Centers, have co-authored an article on Maryland’s Rural Area Health Education Centers. Many readers may not know that we have these resources in our state or specifically what they do to help their communities’ health care needs. Dr. Kevin Carter, assistant professor of Family and Community Medicine at the University of Maryland School of Medicine has written a captivating story describing one patient whom he cares for that suffers from mental illness. Dr. Carter describes how he and his practice’s Patient Centered Medical Home worked together in his article, “Mental Health as a Healthcare Disparity: A PCMH Intervention.” Dr. Eva S. Hersh, Medical Director, Hospice of the Chesapeake, describes succinctly the challenges and opportunities available in caring for Lesbian, Gay, Bi-Sexual and Transsexual patients, groups who may not immediately come to your mind as suffering from inequities in health care.

One doctor can make a difference! Dr. Richard Bernstein, a pulmonologist in Annapolis, Maryland saw the need to provide free medical care to underserved members of his community. In the mid 1990’s he organized a group of doctors to volunteer and see patients in a makeshift clinic assembled in the storefront of the Lighthouse shelter. This led to an expansion of these services and the creation of the Stanton Center, an outreach medical clinic founded by the Anne Arundel Medical Center (AAMC). Dr. Scott Eden, medical director for AAMC’s Outreach Centers, describes what one community has done to address the needs of the underserved in his article, “How One Community Attends continued on page 6
Although there is hope that, with the passage of recent federal legislation, we may see more Marylanders covered by health insurance, even then, many will be without equity in health care.

to The Underserved.” In closing out this edition, Dr. Mozella Williams, Assistant Professor of Family and Community Medicine at the University of Maryland School of Medicine, offers some hope for the future in describing efforts to increase awareness amongst University of Maryland School of Medicine medical students of those who do not receive the same quality of care that I suspect each of us enjoy. Dr. Williams tells the story of the collaborative effort between the University of Maryland School of Medicine and the Maryland Area Health Education Centers in her article, “Building a Pipeline of Future Doctors: To Ease the Problem.”

It may be difficult to imagine yourself doing more than you currently do. Most family doctors working in our state today already give much of their time, energy and skills to all whom they serve. As you read the articles, consider whether or not, like Maimonides, you can do more. Albert Schweitzer (1875-1965), the Alsatian Lor- raine theologian, physician, philosopher and Nobel Prize winner exemplified a life committed to serving others. He founded the hospital Lambaréné in now present day Gabon. He cared deeply for the underserved and left his home in Europe to spend decades in Africa doing so. You might wonder do you have to travel great distances, such as Farmer and Schweitzer did to do great things? Schweitzer offers an answer to this question. “May everyone have his (or her) own Lambaréné.” I think we can do great things for those who are marginalized by society not only in Western Maryland, the Eastern Shore, Southern Maryland and Baltimore City but also in the communities in which we live.
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The term “health disparities,” which is widely used in the United States, is defined as follows: “…differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” Although the United States has increased the use of additional terminology, the terms “health inequity” and “health inequality” are more commonly used outside the United States. Health inequity (lack of fairness) and health inequality (not being equal) are “…differences in health which are not only unnecessary and avoidable, but are considered unfair and unjust.” These two terms incorporate the concept of “social justice,” whereas the term “health disparities” emphasizes differences in disease rates, health-related data and other measures.

Health disparity populations are defined as populations where there are significant differences in disease prevalence, incidence, mortality and survival when compared to the general population. This includes African Americans, American Indian and Alaska Natives, Asians, Hispanics, Native Hawaiian and other Pacific Islander, low socioeconomic groups and rural communities.

As research on the causes of health disparities and inequities has progressed, a national and global focus has defined associated factors, called “social determinants of health,” which emphasize the social, economic, and other characteristics related to health disparities. The World Health Organization Commission on Social Determinants of Health states that health inequities are “…the unfair and avoidable differences in health status….”

Socioeconomic status influences insurance status, tobacco and alcohol use, whether individuals have a usual source of care and other factors associated with health disparities. Determinants include transportation; housing or place of residence; access and availability of services; educational level; income and material goods, such as home ownership; diet; discrimination by social grouping (e.g., race, gender, and class); and social and environmental stressors. Less-educated and poorer communities are at the highest risk of being uninsured, not having a usual source of health care and delays in seeking diagnosis or treatment.

Descriptions of disparity populations have historically focused on health indicator differences between racial/ethnic groups; thus, these data are the most readily available. Disparities are also associated with geography, such as rural versus urban communities, age, gender, and a host of other factors. The changing demographics in the United States and in Maryland show an increase in racial/ethnic minority populations. The estimated population for 2009 was, over 40% of Maryland’s population was minorities. These demographics emphasize the need for clinical care delivery that incorporates cultural influences on health behaviors and compliance with treatment and cultural competence in health care delivery to meet the needs of an increasingly diverse population.

Selected Examples of Maryland’s Health Disparities

Data on health disparities in Maryland are available from state and national data collection and monitoring systems. The state Office of Minority Health and Health Disparities Chartbook contains detailed data on racial, ethnic, gender and geographic disparities for a number of diseases and disorders. Selected examples of Maryland’s disparities in diseases, disorders and related factors are listed on the next page.
Lack of Health Insurance
From 2004 to 2008, the proportions of Maryland adults in various populations who reported having no health insurance were as follows (compared with the non-Hispanic white population):
- Over 2 times higher for non-Hispanic Blacks or African Americans,
- Approximately 4.7 times higher for Hispanic/Latinos, and
- Approximately 1.7 times higher for other minorities combined (Asian and Pacific Islander, American Indian, and other).5
Source: Maryland Behavioral Risk Factor Surveillance System Data, 2004 to 2008

Late or No Prenatal Care
From 2004 to 2008, the proportions of pregnant minority women who received late or no prenatal care were as follows (compared to pregnant white females):
- Nearly 3 times higher for Black or African American women,
- Approximately 3.5 times higher for Hispanic/Latino women,
- Approximately 1.3 times higher for Asian/Pacific Islander women, and
- Approximately 1.1 times higher for American Indian women.5 Source: Maryland Vital Statistics Annual Reports 2004 to 2008

End-Stage Renal Disease
For pooled data from 1991 through 2001, compared to whites, the rates of new cases of end-stage renal disease in Maryland have been approximately
- Three times higher for Blacks or African Americans,
- Three times higher for American Indians, and
- 1.2 times higher for Asians and Pacific Islanders over 64 years of age.5

Infant Mortality Rate
In Maryland for the years 2004-2008, the infant mortality rates for minority populations were: (compared to the white population):
- 2.6 times higher for Blacks or African Americans,
- 1.8 times higher for American Indians,
- Similar to whites for Asians and Pacific Islanders, and
- Similar to whites for Hispanics/Latinos.5
Source: Maryland Vital Statistics Annual Reports 2004 to 2008

Mortality Disparities for Leading Causes of Death
The Chartbook also indicates that the death rates are higher among African Americans than among whites in 20 of the 23 Maryland jurisdictions where the age-adjusted rates could be calculated.
Nine of the top 14 causes of death show a mortality disparity between Blacks or African Americans and Whites.
- Black or African American age-adjusted cardiovascular disease mortality exceeds that of Whites by 52.1 deaths per 100,000 population.
- Blacks or African Americans are 16 times more likely to die from HIV/AIDS than Whites.
- Health disparities exist in Maryland’s rural regions for a number of chronic diseases, including certain cancers, cardiovascular disease, and metabolic syndrome. In addition, high rates of no health insurance, aging populations, shortages of primary and specialty health care resources and lack of public transportation contribute to rural disparities.7

Contributing Factors
The factors that contribute to health disparities are complex, may interact with each other and are multi-factorial. Some factors are modifiable, and others are not. However, it is evident that many disparities are avoidable. Risk factors and exposures, including tobacco use, alcohol intake, environmental exposures, and family history, may contribute to disparities. Lack of quality health care includes racial differences in treatment of disease; poor health-seeking behaviors, such as delays in seeking diagnosis or treatment or overuse of emergency departments; and lack of health care resources. Furthermore, social determinants of health play considerable roles in health disparities and focuses more on multidisciplinary approaches rather than a single disease focus. The failure to translate to all populations research-generated evidence and clinical best practices is referred to by Freeman and others as the “discovery-delivery disconnect” which can lead to higher mortality and poorer survival rates from diseases such as cancer.8

Another factor that is closely related to health disparities is health care access. Access is complex and extends beyond simply having health insurance. Access is critically important, especially in view of the passage of the Affordable Care Act (Health Insurance Reform 2010) and its planned implementation in 2014. Access is defined as “the ability of a person to receive health care services,” which is a function of both the availability of health care personnel and supplies and the ability to pay for those services. The following five dimensions of access are important: availability, accessibility, accommodation, affordability and acceptability.9 The concept of access and the relationship to patient satisfaction has also been recognized as important. Patient perceptions are critical for understanding barriers to health care delivery and potential modulators of treatment adherence. For example, a gay man may be reluctant to discuss certain risk factors for sexually transmitted diseases with his doctor if he does not feel comfortable disclosing his sexual orientation because of suspected prejudice. (See Dr. Hersh’s article, p. 16)

Disparities in access to care occur for many groups, including racial/ethnic mi-
continued on page 10
Overview (continued)

The Institute Of Medicine (IOM) and a number of landmark studies of African American patients and women. The IOM landmark Report brought national attention to racial/ethnic disparities in health care. Findings from this study and others showed that disparities were consistent across a wide range of disease areas and clinical services:

- Disparities are found even when clinical factors, such as the stage of disease presentation, comorbidities, age, and disease severity, are taken into account.
- Disparities are found across a range of clinical settings, including public and private hospitals and teaching and non-teaching hospitals.
- Disparities in care are associated with higher mortality among minorities.
- Prolonged lack of health insurance has significant, serious health consequences. People who are uninsured delay seeking medical care and are reported to have greater difficulty obtaining health care when they do seek it. Prolonged periods without insurance can have a serious impact on a person’s health and stability.

Whether an individual has a usual source of health care has an important influence on disparities. Patients with a usual source of care (a provider or facility where he or she regularly receives care) are reported to have better health outcomes and reduced disparities, such as smaller differences between population groups and reduced health care costs. Researchers suggest that the combination of having a usual source of care and health insurance has an additive effect on an individual’s health care quality. In addition, having a usual source of health care increases the receipt of preventive services. Patients who are uninsured, have less education and are poor are less likely to have a usual source of care.

Addressing Health Disparities and Inequities

Long-term, multilevel strategies are needed to reduce and eliminate health disparities. Patient, family, community and health care system changes are required to address differences in health and health care. Programs such as the Maryland Special Populations Network and Regional Community Network and the Maryland National Best Practice Award for rural cancer clinical trials are just some of a variety of solution-oriented programs to address disparities in health. Each incorporates bi-directional partnerships with local communities and health professionals.

Maryland has led the nation in policy solutions to identify and address health disparities. A variety of creative strategies have incorporated policy research and research-guided policy efforts. Many of these efforts have included valuable input from community-based physicians, nurses and nurse practitioners, pharmacists, social workers, oral health care professionals and others.

Maryland Health Disparities Policy and Access Initiatives

The discussion below presents several key policy and legislative activities in the state that are related to health disparities.

Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234)

The law, signed April 10, 2012, establishes a $4 million pilot project to reduce health disparities in the state; improve health care access and outcomes, such as infant mortality, obesity and cancer; and lower health care costs and hospital readmissions. The law also contains a number of permanent provisions aimed at reducing health disparities. This law creates Health Enterprise Zones (HEZs) where health outreach will be targeted, with grants for community nonprofits and government agencies and tax breaks for health care providers who locate in HEZs. The five Maryland HEZs were awarded and announced the week of January 30, 2013.

Other provisions of this law are as follows:
- It establishes a standardized method to collect data on race and ethnicity in health care (both public and private providers) and ensures that carriers are working to track and reduce disparities
- It requires hospitals to describe their efforts to track and reduce health care disparities
- It establishes a process to set criteria for health care providers on cultural competency and health literacy training and continuing education.

Maryland Office of Minority Health and Health Disparities (HB 86)

In 2004, House Bill 86 and Senate Bill 177 officially established Maryland’s Office of Minority Health and Health Disparities (MHHDD) in the state’s Department of Health and Mental Hygiene, effective Oct. 1, 2004. The Office aims to eliminate health disparities by assessing the health status of all populations, engaging local communities and partnering with the public and private sector. Health equity among African Americans, Hispanic/Latino Americans, Asian Americans, Native Americans, and all other groups experiencing health disparities is promoted. The Office reports and monitors health disparity data in the state.

Maryland State Office of Primary Care and Rural Health

This Office addresses health needs in primary health care and rural health. It provides coordination and technical assistance to stakeholders in underserved regions of the state and tracks state and federal designations for health professions shortage areas.
and medically underserved areas. http://fha.dhmh.maryland.gov/ohpp

**Maryland Health Benefit Exchange**

In preparation for the federal requirements for state implementation of the ACA, a number of activities have been completed in the state, including planning the state health exchanges discussed in the legislation. The Maryland Health Benefit Exchange (MHBE), working in partnership with the Department of Health and Mental Hygiene, the Maryland Insurance Administration, the Department of Human Resources and statewide stakeholders, is establishing Maryland’s state-based health insurance exchange, scheduled to open in October 2013.

The goal of the exchanges is to make health insurance affordable and accessible for all Maryland residents, including the approximately 730,000 (or 14 percent) of Maryland’s 5.8 million residents who are currently uninsured. To incorporate the needs of the marketplace, stakeholder insight and involvement throughout the state is necessary as the process continues to engage consumers and small employers to facilitate their understanding and use of the state-based exchange and ensure their access to health benefits. Additional information can be found at http://marylandhbe.com/.

**Health Care Reform Coordinating Council**

The Maryland Health Benefit Exchange Act of 2012 mentioned above delegated the task of selecting the state’s health benefit benchmark plan to the Health Care Reform Coordinating Council. The Council made its initial selection of the state’s benchmark on September 27, 2012, after conducting an expert analysis comparing the ten plan options and obtaining the input of an Essential Health Benefits Advisory Committee composed of a broad range of diverse stakeholders. For more information on the EHB, see http://www.governor.maryland.gov/ltgovernor/presreleases.

**What can one family doctor do?**

It would be easy to observe the perverseness of health care disparities in our state, throw up your hands and think, “I am already doing a lot.” We urge you to look critically at your own community and consider seeking additional opportunities to serve. You may save a life or change an individual’s world by doing so. As difficult as it is to run a cost-efficient family practice, we must recognize that many of our neighbors are suffering more than we are.

What more can you do? Consider pursuing evidence-based advocacy with your local or state elected officials. Legislators are receptive to hearing from doctors who are on the front lines of providing care to underserved members of the community. Ask your county health officer or Area Health Education Center director how you may partner together to improve your community’s health. Keep abreast of the medical issues that are presented before the General Assembly each year. Look for calls for action by Med-Chi’s leadership on health care disparity issues. You may find that serving others outside of the traditional office visit provides you with a great sense of fulfillment and personal satisfaction. Whatever level of involvement you choose, we hope this article and MFD edition has encouraged you to reflect on the health care disparities that exist not only in our state, but also in our neighborhoods. Each of us can do more to brighten the life of someone who is less fortunate.

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**Note:** CME questions for this article are posted at www.mdafp.org: CME Quiz tab, Spring, 2013.

**REFERENCES**

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16. US HHS National Best Practice Award for increasing cancer clinical trial participation and availability on the rural Eastern Shore: Award recipients: CBaquet, MD, MPH and MDeShields, MD.

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Maryland’s Rural Area Health Education Centers

Two of three Maryland Area Health Education Centers (AHECs) serve rural populations in the state’s nine counties on the Eastern Shore and the four Western Maryland counties, three of which are Appalachian. Maryland has three AHEC’s. The Baltimore City Area Health Education Center (BAHEC), established in late 2003, serves Baltimore City and Baltimore County. BAHEC builds and strengthens inner-city capacity to serve low income and under-served populations via its clinical education program. Maryland’s bustling Washington, DC-Baltimore corridor is better known to most Americans than are the state’s two “wings” to the west and east. The state’s mostly prosperous central core is flanked by rural regions that continue to face long-term hardships in economics and health disparities.

Established in 1997, the Eastern Shore Area Health Education Center (ESHAEC) serves the entirety of the Eastern Shore and offers programs that bring about improvement in health and health disparities. Maryland’s Eastern Shore consists of nine counties with a land mass of 3,324 square miles. These counties join a peninsula pointing into the Atlantic Ocean and are bordered to the west by the Chesapeake Bay, to the east by Delaware and the Atlantic, and to the south by Virginia’s Atlantic coast.

The new millennium promises continuing changes to the economy of Maryland’s Eastern Shore. The once-strong combination of land and water farming still remains significant but is being challenged by tourism and diversified business enterprises. Estimated total population in 2010 of 449,226 reveals a growing elderly (over 65) population, mirroring national trends and also the Shore’s growing attraction as a retirement destination. The African American population of 73,181 is not distributed equally by county, as African Americans range from a total of 6 percent in Cecil County to 42 percent in Somerset County. A growing Hispanic population is emerging, with a growth rate up to 270 percent in Queen Anne’s County.

According to the Maryland Behavioral Risk Factor Surveillance Survey 2000-2010, the Eastern Shore’s hypertension rate for white citizens was 32 percent and, for black residents, even higher at 49 percent. Further, Eastern Shore’s death rate for diabetes for ages 45-74 and Mid-Eastern Shore rates for white residents was 26.7 percent and for black residents, 88.2%, according to Maryland Vital Statistics 2001-2010. These statistics demonstrate racial disparities within a rural region already facing geographical disparities.

The AHECs work to address these health disparities through recruiting primary care practitioners and other health care professionals, offering health careers programs for secondary school and college students, working with health professionals to bring to the area continuing medical and other education programs addressing local health concerns, providing medical literature and librarian services, and initiating other programs, often for low-income and uninsured residents, through coalitions and task forces with community partners in education, health care, government, and other sectors. Recent programs from both Centers include the following:

• Both AHECs participate in the State Health Improvement Planning Process (SHIP). WMAHEC serves in three local health improvement coalitions and net-
The state’s mostly prosperous central core is flanked by rural regions that continue to face long-term hardships in economics and health disparities.

works. ESAHEC serves on both the Tri-County Health Planning Committee serving the Lower Shore and the Mid-Shore Health Improvement Coalition serving the Mid and Upper Shores. Specific issues addressed are obesity, diabetes and tobacco use. Also, and increasingly, behavioral health is being addressed, particularly as it relates to total body wellness.

• The Maryland AHEC Program, under the direction of Dr. Claudia Baquet of the University of Maryland School of Medicine, is a key partner in both AHECs’ health disparity programs. Recently, community educational sessions held in both regions focused on low clinical trial participation by minorities in rural counties and rural people in general. A combination of well-attended events included a Mini-Med School for the public on Bioethics and specific health issues, continuing medical education programs on research priorities, and focus groups and community education programs on cancer, clinical trials, and tissue donation. Both AHECs are known for having many well-established partnerships in their regions. Dr. Mary DeShields of the Eastern Shore Cancer Research is of particular note in her efforts with the ESAHEC.

• ESAHEC worked with Associated Black Charities and the Dorchester County Health Department to participate in the Dorchester’s Health Disparities Conference held in April 2012.

• Through two U.S. Health Resources and Services Administration grants, ESAHEC served as the lead agency in developing a partnership addressing children’s oral health disparities on the Eastern Shore. Through this effort, minority children now have increased access to oral health care and all children have, as needed, expanded access to hospital sedation care. This oral health outreach effort continues as ESAHEC is working with its partners to implement fluoride sealant and educational programs revolving around Women, Infants and Children (WIC) centers.

• WMAHEC currently serves as the lead agency for two U.S. Health Resources and Services Administration (HRSA) Office of Rural Health Policy network initiatives. The Garrett-Allegany Health Workforce Development Network, with partner University of Maryland School of Medicine, developed a three-week curriculum in Western Maryland required of third-year medical residents in the Department of Family and Community Medicine, along with other initiatives to improve the number of primary care and mental health practitioners in these counties. Other partners include health departments, Federally Qualified Health Centers, and private practitioners.

• The second HRSA-funded network in Western Maryland is the Mountain Health Alliance (MHA), a collaborative effort among stakeholders in three Maryland counties and contiguous counties in Pennsylvania and West Virginia. The first issue tackled by MHA has been increasing access to oral health care in Allegany County and the Hancock area of Washington County in Maryland and in Mineral County, West Virginia. Once oral health disparities are significantly addressed, MHA’s focus will change to other priorities if funding allows.

• Both AHECs work with their regions’ health professionals to develop continuing education and training programs, sometimes open to the community. The issue of health disparities is incorporated into many of these programs, and a number of the offerings are interprofessional in nature. Also, both AHECs are Primary Access Libraries for the National Network of Libraries of Medicine, providing full-text articles for professionals and students, and other medical library-related services. Both AHECs also run well-established programs that get young people interested in becoming health professionals, engaging a “grow your own” philosophy. Furthermore, the AHECs offer interprofessional geriatric educational programs for health professions students; geriatric educational opportunities for professionals and caregivers; and clinical education opportunities via rural healthcare practitioners and facilitation of student housing.

For years, rural AHECs in Maryland have been proactively working to address health disparities, but much remains to be accomplished. Working with local partners, assisted by University partners led by Dr. Claudia Baquet, Western Maryland and Eastern Shore Area Health Education Centers will continue involvement in the State Health Improvement Planning process, the Health Enterprise Zone effort, and potentially the Maryland Health Benefit Exchange under the Federal Affordable Health Care legislation. Both Centers will continue to seek opportunities for mission-specific programs and funding to improve the health and wellbeing of their regions’ rural residents through increased access to and improved quality in health care.

Mr. Frego is Executive Director of the Eastern Shore AHEC in Easton. Ms. Stewart is Executive Director of the Western Maryland AHEC in Cumberland.
The Maryland

Kevin P. Carter, M.D.

“Who are you? What are you going to do to me? What’s wrong with me?” And so began my now 2 year relationship with Sue as a patient.

Mental Health as a Healthcare Disparity: A PCMH Intervention

As the years progressed she also developed numerous medical conditions including type 2 diabetes, hypertension, asthma, and symptomatic bradycardia requiring a pacemaker. The schizophrenia symptoms worsened causing verbal outbursts, homicidal threats, and suicidal ideation. She developed symptoms of depression and anxiety. As she reached her 50s, Sue could no longer live independently. She was requiring frequent ER visits and hospitalizations and her mental illness had become difficult to control. Sue was placed in an assisted living facility... and now entered our team.

Our practice manager and licensed social worker, Harriet Mandell, has served as Sue’s overall case manager for 5 years. She is the primary contact between our practice and Sue’s brother who serves as her power of attorney. Sue’s previous primary care provider was a physician in our office who had left the practice around the time that I met Sue in the hospital. Around the same time as this hospital admission, we had recently hired a nurse care manager, Karen Deheer, and clinical pharmacist, Katy Pincus, to join our practice as part of our patient centered medical home transition. Ms. Deheer has been instrumental in preventing our patients from becoming “lost” in the medical system. She helps with care transitions, coordinating and attending specialist visits, making home visits, addressing medication compliance concerns, and serving as a wonderful patient advocate. Dr. Pincus has been extremely helpful performing detailed medication reconciliations, advising on optimizing medication regimens, and helping to improve our evidence-based treatment plans.

Sue was one of the first patients to have the full support of our multidisciplinary care team. She had recently been to multiple hospitals with shortness of breath and signs of fluid overload, but had short stays and was discharged only to have the symptoms occur again. Ms. Mandell went to see Sue and after speaking to Ms. Deheer, determined that she likely was in congestive heart failure. They coordinated transportation to bring Sue to our hospital so that our team could work together to treat her and hopefully prevent another short hospital stay and quick readmission.

We were able to determine that her pacemaker battery had stopped working, and the subsequent bradycardia was causing her recurrent fluid overload. She also had a medication list that exceeded 15 medications and had been refusing her lasix at the assisted living facility because they were trying to give it at times she didn’t like. We diuresed her for a few days and the cardiology team placed a new battery for her pacemaker. After speaking with Ms. Mandell to learn Sue’s back story, Sue and I had some very interesting conversations. We made a deal that I would do my best to avoid any “surprise” medical treatments or procedures without her being completely informed beforehand. It was a new experience for me to have a patient convinced that a pill with a new color amounted to poison being added to her medication. We worked to create a medication schedule that fit within her schedule. Sue agreed to have me serve as her new primary care physician and Ms. Deheer helped to set up a follow up appointment for the next week that could include our whole team.

Kevin P. Carter, M.D.

“They have put poisons in my insulin.” “My nurse beat me up.” “They’re trying to kill me!” These are just a few of the statements I’ve heard from my patient “Sue.” I first met Sue when she was an inpatient on my medical service. My first experience with Sue was seeing a nurse walking out of her room, shaking her head, and saying “Good luck” to me as I walked in. As I entered, there was the distinctive smell of yeast present and a severely edematous, disheveled-appearing woman looking at me, quickly snapping, “Who are you? What are you going to do to me? What’s wrong with me?” And so began my now 2 year relationship with Sue as a patient.

Mental illness has been identified as major cause of health care inequality. In 2008, a group of 37 experts in psychiatry from around the world came together to discuss this important issue and were able to show that compared to the general public, those with severe mental illness suffered from serious inequalities in physical health and had shorter life expectancies.1

Sue is definitely one of my most interesting and complicated patients. She is a highly educated woman who worked as a school teacher and has interests in music, linguistics, and reading. She was initially diagnosed with paranoid schizophrenia during her college years and began multiple rounds of inpatient and outpatient treatments resulting in complicated medication regimens.
Fast-forward 2 years. Sue has not required any ER visits or hospitalizations since our first meeting. Our pharmacist, Dr. Pincus, has performed multiple medication reconciliations, especially each time Sue’s psychiatrist has modified her psychiatric medications, and found ways to decrease the number of pills and avoid potential drug interactions. She even helped find pill colors that Sue was not scared of. We worked to transfer all of her specialty care, including psychiatric care, to our hospital system to allow for easier communication between all her health care providers. Ms. Mandell works to facilitate required paperwork for all visits and Ms. Deheer attends Sue’s visits to see me and her specialty providers to make sure everyone is always receiving the same information. Sue’s brother and power of attorney, who lives out of town, has arranged to come for visits in the office a few times per year to help with the care coordination. Ms. Mandell speaks with him to discuss all issues and successes we encounter in the care of his sister.

Sue is now 70 pounds of fluid lighter, enjoys reading sci-fi novels, hasn’t threatened to kill anyone in a few months, and is generally pleasant and cooperative in her visits with me. She has been one of the greatest success stories from our PCMH multidisciplinary care team. There is no way that I could have come close to achieving this current level of clinical success without the help of everyone involved. From my experience with Sue, it has also become clear to me that while all patients can benefit from a multidisciplinary care model, those with mental illness are especially in need of these efforts. To continue working towards relieving healthcare disparities, we must recognize that it is the combined efforts of all providers in the health care system that will lead us to advancements and solutions.

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Note: References for this article are posted at www.mdafp.org; Publications tab. CME questions for this article are posted at www.mdafp.org; CME Quiz tab, Spring, 2013.
Health Disparities Affecting Sexual and Gender Minorities

When we consider health disparities of LGBT (Lesbian, Gay, Bisexual and Transgender) people, it’s important to keep in mind that the LGBT umbrella covers six distinct groups: gay men, lesbians, bisexual women, bisexual men, transwomen (male to female) and transmen (female to male.) Each group has distinct health concerns that do not affect the others. There are also issues that are common to all six groups. Let’s consider the shared issues first.

Access to Care and Communication with Healthcare Professionals

People’s health risks can be profoundly affected by their sexual behavior. Having a minority gender identity or sexual orientation profoundly affects one’s social development, sense of belonging, and personal safety. To provide a patient with the best possible care, the clinician benefits from knowing who the patient is as a person. Sexuality and gender are key aspects of every person’s identity. Unfortunately, sexual histories are rarely taken at a patient’s first visit to a new primary care provider, and even less often taken at subsequent visits.

How to ask about sexual behavior? Be polite but clear and direct. Ask this question of each patient: “Do you have sex with women, men, or both?” If your office uses a medical history questionnaire for new patients, consider including this question. Many patients, especially new patients, may not be willing to answer this question in writing at the first visit. Even if they don’t answer, including this question makes patients aware that your practice understands and welcomes sexual and gender diversity. Some GLBT patients who don’t initially answer the question will “come out” to the physician after a few visits, because this question encouraged them to do so.

How to ask about gender identity?

In the section of your new patient questionnaire that asks about gender (or sex), add more options. In addition to M and F, add Transfemale, Transmale, and Other:________________ . Again, even if the transgender person is not comfortable stating their unusual gender identity in writing, seeing the full spectrum of gender identities listed lets them know that this practice is aware of transgender people and willing to care for them.

Won’t these questions alienate my heterosexual patients?

You may be surprised to hear this: Not very often. Typically there may be one objection every 2-3 months, generally from a heterosexual man who feels that being asked these questions is tantamount to questioning his sexuality or his masculinity. What helps you out in this situation is that you can honestly say, “I ask everyone these questions,” making it clear that no one is raising questions specifically about him.

Tobacco

LGBT people use tobacco at much higher rates than the population as a whole. LGBT-focused tobacco cessation literature is available.

Fitness (Diet and Exercise)

LGBT people, like all Americans, are prone to obesity. This is particularly true of lesbians, perhaps because they are not subject to as much social pressure to be thin as heterosexual women are.

Substance Use/Alcohol

As a group, with many individual exceptions, LGBT people use illegal drugs and alcohol more frequently than the general population. Many LGBT people’s social lives are limited to a small, tightly knit group of friends. If everyone in the group is drinking or drugging (or smoking), the behavior is normalized. This peer group effect can serve as an excuse not to change. In the gay male population, use of amphetamines and cocaine is greater than in the general population. There are specific LGBT groups in both Alcoholics Anonymous and Narcotics Anonymous. Twelve-step programs are free and have been effective for many.

Depression/Anxiety

Depression and anxiety affect LGBT people at a higher rate than the general population. This is due, at least in part, to effects of homophobia and transphobia, and the rejections many LGBT people have experienced from their families and religions. LGBT people in their teens and twenties have a much higher risk of attempting suicide than heterosexuals of the same age and sex. Young LGBT people with signs of depression need close monitoring; suicide threats should be taken very seriously in this group. When referring for mental health care, it’s important to make sure that the counselor or therapist is affirming (not just neutral) towards LGBT people.

STDs

All sexually active people are at risk for sexually transmitted diseases, however STD’s occur at a very high rate in gay and bisexual men and in transwomen. A person can be infected with any STD without any symp-
toms. The more partners a person has had in the past year, the more often they should be tested for STD’s. The Centers for Disease Control (CDC) recommends that all MSM (men who have sex with men) get a blood test for syphilis every 6 months, and more often for men who have had more than two sexual partners in the last year. This is recommended even for gay men who are in a relationship they believe to be monogamous. There is no specific CDC recommendation for how often to check for HIV. Local STD specialists recommend doing an HIV test with every RPR. Hepatitis C infection also is more common among MSM, particularly among those who have been the receptive sexual partner in anal sex with multiple partners.

MSM have high rates of Hepatitis A and Hepatitis B. Immunization for Hepatitis A virus and Hepatitis B virus is recommended for all men who have sex with men (MSM) and are not already immune or (in the case of Hep B) in a carrier state. By the CDC definition, the group MSM includes transwomen as well as gay and bisexual men. Screen for these infections by checking for Hepatitis A immunity (total Hep A Ab), Hepatitis B immunity (Hep B sAb) and current Hepatitis B infection (Hep B sAg). If Hep A Ab is present the patient is immune to Hep A. If the antibody is not present, the patient should be vaccinated for Hep A. The Hepatitis B sAb, if present, indicates the patient is immune to Hep B. If the patient tests positive for HepBsAg, they are a carrier, meaning that they are infected with Hepatitis B. Those who do not test positive to either HepB sAb or Hep B sAg should be vaccinated against Hepatitis B.

It has repeatedly been shown that the use of condoms (either male or female type) and dental dams greatly reduces the risk of sexually transmitted diseases.

Safe sex is effective at reducing the risk of viral hepatitis, and is currently the only means of prevention for the very serious Hepatitis C virus. HPV vaccine, which is effective for preventing genital warts, cervical cancer, anal cancer is covered by insurance up to age mid-20’s, depending on the insurance plan.

People are much more likely to become infected with STD’s when they are intoxicated with alcohol or drugs, when they do not know their partner, and when they meet a partner through the internet. All of these situations occur frequently for gay, male bisexual, and transfemale patients.

**Intimate Partner Violence**

LGBT people suffer from violence in intimate relationships at least as often as the general population. Medical providers, emergency room staff and police are less likely to suspect or ask about intimate partner violence when the partners are the same sex. It is especially difficult for LGBT people to get help if they are not able to acknowledge being in a relationship.

**Issues Specific to Transpeople**

**Access to Healthcare**

Currently, only a few healthcare providers in Maryland have the knowledge and experience necessary to independently treat transgender people. Transgender health care is not taught in medical schools, and there are few experienced providers available to mentor providers who want to learn these skills. For a transperson early in transition (just starting hormones), it is essential to get care from an experienced provider, although many must travel to another state to do so. Transpeople who are well into transition (on hormones for over a year) and knowledgeable about their treatment regimens can be successful working with (and teaching) a willing but inexperienced provider.

**Health Care Coverage**

Unfortunately, many medical insurance companies do not cover transgender health care. Make sure the patient finds out his or her insurance company’s policy. If you see your trans patient for medical problems in addition to transgender care, consider billing for the other issues rather than for transgender care. Female hormones (pills) are often covered for transwomen. Testosterone (injectable) is almost never covered for transmen.

**Health History**

Ask your transgender patient about his or her entire trans health history, including any hormones or other trans-specific medical treatments.

**Injections**

Many African-American transwomen purchase injections of loose silicon or oil to change the contours of the face, breasts, or buttocks. These injections are done by non-licensed individuals. The silicone or oil can later shift position, causing a deformed appearance and ugly scars. Plastic surgery to correct this is at best partially successful. The silicones and oils used in these injections are not medical grade, may be contaminated and are often injected using a shared needle. Hepatitis and HIV can be spread through shared needles. Cosmetic injections are dangerous and patients should be advised not to have them.

**Hormones: Major side effects**

**Major side effects of estrogen:** blood clots in the legs and lungs (usually in smokers or patients over 40), elevated blood pressure and rising glucose.

**Major side effects of testosterone:** weight gain, rising blood pressure and glucose, rising LDL, falling HDL

**Hormones Causing Cancer?**

Although it is much feared, there is no evidence that cross-gender hormone treatment causes cancer. Transpeople should continued on page 18
Minorities (continued)

have cancer screening based on the body organs that are present. For example, transmen who still have a uterus should continue to have cervical Pap smears on the schedule for women of the same age.

Issues Specific to Lesbians

Breast Cancer

Lesbians are more likely to have risk factors for breast cancer, yet they are also less likely to get mammograms and clinical breast exams by medical professionals. As a result of this combination of higher risk and less screening, lesbians who develop breast cancer may be diagnosed later in the disease, when it is less curable. Risk factors for breast cancer that are more common among lesbians than non-lesbian women include smoking, alcohol use, obesity, less use of hormonal contraceptives, and fewer full-term pregnancies.

Heart Health

Heart disease is the leading cause of death for women in this country. Lesbians’ higher rates of smoking and obesity result in an increased risk for heart disease.

Gynecological Cancer

Lesbians have higher risk for ovarian and endometrial cancers. The risk factors for these cancers are similar to those for breast cancer: smoking, obesity, few or no full-term pregnancies, little or no use of hormonal contraception.

Alcohol and Illegal Drugs

Heavy drinking and binge drinking are more common among lesbians compared to heterosexual women.

Issues Specific to Gay Men and Other Men who Have Sex with Men.

Fitness/Eating Disorders

Problems with body image are much more common among gay and bisexual men than heterosexual men. Gay men are more likely to develop an eating disorder such as bulimia or anorexia nervosa. Some MSM become “addicted” to exercise to the point that it becomes a danger to their health. Some who are trying to develop larger muscles take anabolic steroids, which can cause health problems from mental instability and rage to impotence. Some supplements used for body-building, such as creatine, can damage the kidneys.

Depression

Likely due to homophobia, rejection, and discrimination, MSM are more likely to be depressed or anxious. These problems are more severe for MSM who remain secretive about their sexuality and those who lack adequate social support.

HIV/AIDS, Safe Sex

Even though increases in safer sex practices have been effective in reducing the rate of HIV infection among MSM, the idea of safer sex has not been embraced by all parts of the community. Younger MSM (under 26) of all ethnic groups continue to become infected at high rates. So do African-American MSM, especially younger men. In the Baltimore area and other large cities, there are now dual epidemics of HIV and syphilis among African-American MSM under age 30.

Unprotected anal intercourse, especially for the receptive (“bottom”) partner, is the riskiest kind of sex in terms of becoming infected with HIV and other STD’s. Use of both a condom and a lubricant can greatly decrease that risk. Either a “male” or a “female” condom may be used, but never both at the same time – the two condoms stick together, causing microscopic tears. (For the same reason, it is not a good idea for a man to wear two condoms at once.)

Another aspect of HIV prevention is treating all HIV infected people with anti-retroviral medications to decrease the amount of HIV virus in their ejaculate, blood and vaginal secretions. If an HIV positive person has no detectable HIV virus in their blood, it is extremely unlikely (although NOT impossible) for that person to infect their partner(s).

HPV (virus that causes warts and cervical and anal cancer)

Of the many sexually transmitted infections for which gay men are at risk, Human Papilloma Virus (HPV) is the most common. HPV causes anal and genital warts and anal and cervical cancer. Some health professionals now recommend routine screening with anal Pap smears, similar to the test done for women to detect early cervical cancer. Condom use is essential to prevent transmission of HPV as well as the hepatitis viruses. There are no effective treatments for HPV. Recurrence of the warts is very common. The rate at which the infection can be spread between partners is very high.

Some health professionals now recommend routine screening with anal Pap smears, similar to the Pap test done for women to detect early cancers. Safe sex should be emphasized. Treatments for warts caused by HPV do exist, but recurrences of the warts are very common, and the rate at which the infection is spread between partners is very high.

For additional information about GLBT health and more tips on making your office welcoming, visit the website of GLMA, the Gay and Lesbian Medical Association: glma.org.

Dr. Hersh, MAFP Secretary, is Medical Director, Hospice of the Chesapeake, Annapolis. She invites your comments and questions to her by email at evastephanie@gmail.com

Note: CME questions for this article are posted at www.mdafp.org: CME Quiz tab, Spring, 2013.
Reducing Health Care Disparities: Innovations in Annapolis

Scott Eden, M.D.

In May of 2012, Michael T. realized he needed to go to the ER. Suffering from abdominal pain for several weeks, and now in exacerbating pain, he could not ignore the pain any longer. Upon his arrival, the ER physicians discovered an 8 centimeter abdominal aortic aneurysm that threatened Michael’s life. Acting quickly, they repaired his aneurysm and released him with blood pressure medication for his hypertension.

Michael lost his job and his health insurance in 2007. He had no primary care provider, and, like countless others, found himself in the ER with a preventable condition that threatened his life and cost exponentially more to repair than it would have cost to treat the underlying condition.

Michael’s story is alarming, but not an anomaly. When we talk about health care disparities, access to care is the most basic disparity. For thousands of Anne Arundel County residents who have Medical Assistance (which is not broadly accepted), no insurance, or insufficient cash to go to a private practice or an urgent care center (where the size of the bill is uncertain), the emergency room is their only primary care access point. All the health care disparities – infant mortality, rates of diabetes and cancer, longevity, the secondary problem of overuse of the ER for non-emergencies, and the hypertension that spawned the aneurysm that nearly killed Michael - none of these can be addressed until we solve the access issue.

The Reach program connected Michael to Anne Arundel Medical Center’s Community Health Center. There he found a medical home that monitored and controlled his blood pressure. However, he started having mild shortness of breath in November. Although not something he would have normally found worthy of an ER bill, he found the Health Center affordable enough to make a visit, which he did in early December.

In 1994, recognizing the need for more accessible health care, the Anne Arundel Medical Center created the Outreach Center, where volunteer physicians saw patients at the Lighthouse homeless shelter pro bono. Since its conception, the Outreach Center has moved to the city of Annapolis’ Stanton Center, expanded to medical specialties and dental services, and provided 7,000 visits in 2011.

The Outreach Center helps to meet a desperate need in the community, but the volume of need remains staggering. As of 2010, Anne Arundel county (population 544,400) had 57,000 uninsured residents, 38,000 medical assistance recipients, and 25,000 Hispanic residents (many with a language barrier to care). This led me to advocate for a community health center, built as a social business, which would work to meet two bottom lines. The first, to fulfill a social mission: providing access to care. The second: to become financially self-sustaining. Social businesses strive to bring in enough revenue to employ a full time staff, to whom they pay a competitive wage, so they are not dependent on volunteers. While I believe in charity and volunteerism, the supply of both is limited. I believed dependence on these alone would not allow us to expand our services enough to meet the community’s need.

In Tori Bayless, who became the president of the medical center in 2009, I was fortunate enough to find an enthusiastic supporter. She, along with the Anne Arundel Medical Center Board, agreed that that the community health center needed to be a full service primary care practice, with consistent staff, translation services, night call, and acute, chronic, and preventive health services.

To be financially self-sustaining, our business plan pointed to 30 patient interactions per day per provider. This is a number significantly higher than the federal government’s goal of 22 patient interactions per provider per day for its federally qualified health centers, a goal that itself is hard to meet. Aiming to achieve 30 patient visits a day, I searched for ways to improve primary care efficiency and capacity, and found Dr. Peter Anderson’s concept of increasing examination rooms to three per provider and clinical support staff to two per provider to increase efficiency and capacity. Adapting Dr. Anderson’s concept, we trained our medical assistants to handle new tasks: performing medication reconciliation, recording social history items, taking an initial history of present illness and reviewing of systems using templates I created in our EMR system, setting up refills for review, writing referrals, updating preventive service items, and reviewing and triaging messages and refill requests. This frees providers from doing clerical work and allows them to focus their skills on the issues that only they can address. We’ve not reached 30 patient interactions per provider per day, but regularly see 20 to 25 patients per provider per day. Although we made the staffing and rooming changes to help raise our volume capacity, it also allowed us to do all of the increased documentation that is demanded of us by the government and private insurers. The Community Health Center recently achieved Level 3 NCQA recognition.

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As for our Community Health Center’s goal of achieving financial self-sufficiency: we’re not there yet. We have had great success with evening hours on Mondays and plan to extend other days and possibly have Saturday hours as well, which will help our finances. However, the Community Health Center’s financial impact - a study by Johns Hopkins MBA students documented a 9.75% decrease in hospital discharges from the ER and inpatient services for our patients - on the overall finances of the Anne Arundel Medical Center demonstrates our ability to reduce unnecessary health care costs.

When considering the impact of our services, I always return to stories like Michael’s. In December, our nurse practitioner saw Michael for his shortness of breath, and initially believed he might have chronic obstructive pulmonary disease. But closer questioning revealed some chest discomfort as well as shortness of breath on exertion, so she appropriately contacted the Reach Program for a cardiology consultation. Within a few days, Michael saw a cardiologist, was catheterized, and found to have multiple critical coronary artery stenoses. Nine days after his appointment for shortness of breath he underwent a quadruple coronary artery bypass procedure. Thanks to a generous sliding scale and a payment plan, the cost to Michael is bearable.

The system worked well for Michael. Today, he is still with us, feels well, and is not disabled by his vascular disease. His case gives me hope and shows the potential of an effective care network, but I remain mindful of the many cases in our community, like Michael’s, that we must continue to scale up to meet.

Through our services and others’ the Anne Arundel Medical Center has begun to meet the challenge of creating a primary care network that can meet the needs of our entire community. Through our collective efforts, our patients’ health and lives have improved, meaning a healthier work force, fewer medical bankruptcies, and a fairer chance for success for all our citizens.

Dr. Eden is Medical Director, Anne Arundel Medical Centers Outreach Clinics, Annapolis.

Innovations (continued)

Obviously, primary care is not the whole story. We knew we needed access to specialists to meet our patients’ needs. The hospital’s physician liaison, Heidi Katz, and I met with numerous specialists to request that they see our uninsured patients on a sliding scale basis, and to clarify which specialists participated in the medical assistance program. Over 75 specialists agreed to participate and see our patients at reduced rates.

On January 19th, 2011, we opened the Community Health Center. After 2 years of operation, we have 4,500 active patients. With a full time family physician and a full time family nurse practitioner, we provided 8,000 visits in 2012. We are reaching our target groups, with 40% of patients under Medicaid, 50% uninsured, 10% under the Reach Program, and 50% of our patients are Hispanic. We continue to receive patient referrals from our advisory board of community partners, and to refer our patients to services those community partners provide.

The Outreach Center remains a great partner, providing free care to the community, and is expanding its primary care hours.
Building a Pipeline of Future Doctors to Ease the Problem
The University of Maryland School of Medicine’s New Primary Care Track

Mozella Williams, M.D.

Here’s a little trivia for you. Which physician scientist once said in 1954, “I feel that the greatest reward for doing is the opportunity to do more.”?

I will credit the author of this quote in a few moments, but as I contemplate and look forward to what the summer of 2013 holds, these words ring true. It does seem that the satisfaction of finally opening the door of success typically leads to another corridor, full of opportunity and potential for growth and development.

This has certainly been the case over the past five years for the University of Maryland School of Medicine’s Family Care Track (FCT), a two-year longitudinal program within the Department of Family and Community Medicine. The FCT, re-vamped by Dr. Richard Colgan in 2006, matched entering medical students interested in Family Medicine with family physician mentors. Thanks to dedicated faculty and residents, accommodating community preceptors who welcomed these students into their private offices during the students’ requisite 80-hour summer experience, and the organization and support of the Maryland Area Health Education Centers (BAHEC, ESAHEC, WMAHEC), as well as with funding support from the MAFP and MAFP Foundation, the FCT was a wonderful success story for our institution and the future of the primary care workforce.

The numbers speak for themselves. Of the FCT graduates, 67% have gone into a primary care medicine field, 33% into Family Medicine specifically. Compare that to approximately 35% and 9% respectively when looking at the entire graduating class. You will no doubt be curious to know that 31% of FCT students stayed in Maryland for their residency training.

Opportunity

Last fall Dr. Colgan and I were delighted to collaborate with our faculty colleagues Drs. Linda Lewin (general pediatrics) and Nikkita Southall (general internal medicine) to launch the Primary Care Track (PCT) in October, 2012. Over the year prior we enjoyed traveling throughout Maryland to the Area Health Education Council (AHEC) offices, various community health centers and private continued on page 22
Innovations (continued)

offices to understand your motivations and challenges when helping to strengthen the pipeline for our future primary care doctors.

The pipeline

This popular imagery, the pipeline, is bantered about in almost every conversation about our current healthcare workforce shortage. Whether at our national conferences, local meetings, or simply chatting casually among our colleagues, the question remains the same: Where are we going to find a workforce to meet the important, ever-increasing, healthcare needs of our society? Successful solutions to solving Maryland’s healthcare shortage are certainly elusive, having complicating influence from political, economic, and demographic factors. As you’ve read in other articles of this publication, the statistics are staggering and the levels of complexity seemingly unending, eg. the Baquet/Colgan article on p. 8.

However, I can’t help but agree with Dr. Jonas Salk (had you already guessed he was the author of our quote?) when he says that we must embrace the next task, challenge, endeavor with the understanding that these new challenges are what mark our successes. Dr. Salk spoke these words while accepting the Congressional Medal for Distinguished Civilian Achievement in April, 1956 for his extraordinary work on the polio vaccine, a condition which, in its time, affected virtually all segments of society and was certainly deemed a “healthcare crisis.”

Our physician healthcare shortage creates a similar profile to the challenge of 100 years ago. Clearly our solutions will not come from the laboratory workbench. It will come through innovative, dedicated, and hard-working physicians, educators, and students who believe there are solutions to be found.

So where are the successes so far in the PCT? A hefty number of 39 students applied to the program, and mentors were found for all. Students were allowed to choose an area of interest (FM, IM, Peds, or undecided). With the support of the SOM faculty we were able to accommodate all requests: 19 students with family physicians, 11 with general internists, and nine with general pediatricians. The students shadow their mentors for approximately 5 hours every month. Each session they are journaling brief descriptions about their patient encounters and reflections.

Additionally, we’ve had two outstanding lectures from distinguished family physician guest speakers: Dr. Kevin Ferentz discussing the importance and basics of smoking cessation counseling in primary care, and Dr. Kisha Davis describing her unique path in primary care and healthcare policy-making during her year as a White House Fellow.

Another important success is the connection we’ve made outside the University of Maryland School of Medicine. In partnering with the Maryland AHECs, their staffs have coordinated numerous physician meetings throughout the state. Thanks to the leadership of Western Maryland AHEC Executive Director Susan Stewart and Eastern Shore AHEC Executive Director Jacob Frego we now have Physician Advisory Boards in place in both areas, to more accurately understand and respond to the concerns and needs of physicians willing to support early medical students.

Given these successes, one wonders what new opportunities await. As you know, summer is right around the corner. Once they’ve completed their first year of medical school, each PCT student will travel near and far within Maryland, to complete an 80-hour experience in an underserved practice. Assigning and organizing these experiences is already well underway due to the extraordinary efforts of our program coordinator, Ms. Niashia Jones and the AHEC executive directors.

Also, September 2013 brings with it a new incoming class of medical students, with bright minds, enthusiasm, and innovation – many of whom will have an interest in our cherished role as primary care physicians. I smile just thinking about it.

Dr. Williams, a MAFP and MAFP Foundation Board member, is an Assistant Professor at the University of Maryland School of Medicine in the Department of Family and Community Medicine. She is Associate Director of Medical Student Education and Director of Community Health Relations for the PCT.

If you practice in an underserved area of the state and would be interested in mentoring a PCT student please contact Dr. Williams at: mowilliams@som.umaryland.edu

Note: CME questions for this article are posted at www.mdafp.org: CME Quiz tab, Spring, 2013.
Being aware of ethnic health disparities is an important part of patient care. Yet with Maryland boasting a higher than average proportion of Asian and Pacific Islanders – most of whom live in Montgomery and Howard Counties – it bears mentioning that a leading racial/ethnic health disparity in the US is chronic hepatitis B (CHB). The leading risk factor for CHB is being foreign-born in an endemic country. Despite making up less than 5% of the US population, Asians and Asian Americans make up more than half of the chronic hepatitis B burden. The CDC estimates that 1 in 12 Asians and Pacific Islanders are living with CHB and two thirds are not aware of their disease because they have not been tested. Without appropriate monitoring or treatment, 1 in 4 of those with CHB will die of liver cancer or liver failure.

What can we as healthcare professionals do about this? Education, education, education. Multiple studies, including the most recent Institute of Medicine report on Prevention and Control of Hepatitis B and C, have found that not only is prevention and disease awareness dismal among at-risk populations, but physician/provider knowledge is lacking as well.²

So here’re some hepatitis B education highlights for our Asian and Pacific Islander patients and colleagues, using the mnemonic HBVS:

**H: Healthy but at risk**
Most people who are infected at birth become asymptomatic chronic carriers. You can feel perfectly healthy while still being at risk for liver cancer (about 80% of hepatocellular carcinoma in Asians is due to hepatitis B infection), so it’s important to get screened for HBV if you are at risk of chronic infection. Furthermore, if you are diagnosed with CHB, you can still live a healthy and productive life. See Screening on how to manage these patients.

**B: Birth, Blood and Sex are the major forms of transmission.**
Hepatitis B is highly infectious. Most Asians with CHB were infected at birth before newborn hepatitis B vaccination was introduced, and so are more likely to be asymptomatic and to develop liver cancer or damage in their 30’s and 40’s. Household contacts are also at high risk. Do not share razors, toothbrushes, needles or other sharp objects. Hepatitis B is NOT transmitted through food, water, eating utensils, casual contact (shaking hands or sneezing) or breastfeeding. Emphasizing that it cannot be transmitted through casual contact can help alleviate the cultural stigma attached to this diagnosis.

**V: Vaccination**
The vaccine is a 3-shot series given at 0, 1, and 6 months, which takes some effort on the part of both provider and patient to complete. The series does not need to be restarted if there is a less than 10 year gap between shots. Booster shots are not recommended for those with normal immune status. Babies born to HBV positive mothers need HBIG and the first shot of the vaccine within 12 hours. Otherwise, it is included in the normal pediatric series. An easy thing to tell your patients is “3 shots for life.”

**S: Screening**
- **Screening for infection:** The CDC and IOM recommend routine hepatitis B screening for high-risk populations. A comprehensive list can be found at http://www.cdc.gov/hepatitis/HBV/TestingChronic.htm, but here’s the gist: you should screen those from regions with high endemcity (Asia, Africa, Eastern Europe, the Middle East, and Pacific Islands) or those unvaccinated who have parents from these regions; household contacts of those with CHB; MSM; injection-drug users; HIV-positive persons; immunosuppressed patients; and pregnant women. The HBsAg and anti-HBs tests alone are recommended for patients born in areas of high endemcity (no need for HBcAb at the screening stage).
- **Screening for liver cancer/damage:** Those who are chronically infected with hepatitis B should get:
  - Every 6 months: ALT and AFP tests to look for liver damage and liver cancer.
  - Every 1 year: abdominal ultrasound to look for liver cancer.

**REFERENCES**


Ms. Wong is a 2nd year medical student at the University of Maryland School of Medicine.

Note: CME questions for this article are posted at www.mdadfp.org; CME Quiz tab, Spring, 2013.
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President

Richard Colgan, M.D.
Associate Professor and Vice Chair of Medical Student Education, University of Maryland Department of Family & Community Medicine
Keynote Address: A Quest to Learn the Art of Medicine

Wanda Filer, M.D.
Director, American Academy of Family Physicians
Greetings from AAFP and Installation of MAFP Officers

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Suzanne Doyon, M.D., FACMT

What's New in Addiction?
Bath Salts and Beyond
Christopher J. Welsh, M.D.

PCMH and Practice Transformation
Niharika Khanna, M.D.

Chronic Kidney Disease for Primary Care
Michael J. Choi, M.D.

The Well Woman Exam: Providing Appropriate Age-Based Care
Nancy Beth Barr, M.D.

In the Room Nutrition Counseling
Ramona G. Seidel, M.D.

Disability Determination
William D. Hakkarinen, M.D.

Exercise for the Patient Who Never Exercises
John L. Ferrell, III, M.D.

DERMATOLOGY DAY AT THE BEACH
SATURDAY JUNE 29TH

Comprehensive presentations by Faculty from the Department of Dermatology, University of Maryland School of Medicine
Moderator: Department Chairman Anthony A. Gaspari, M.D.

- Non-Melanoma Skin Cancer
- Eczema and Dermatitis
- Viral Infections of the Skin
- Melanoma Update
- How to Optimally Use Dermatopathology
- Birthmarks, Lumps and Bumps in Children: When to Worry
- Faculty Q&A

EXTRA CREDIT SESSIONS

- ABFM Self Assessment Module (SAM) Study Hall – Preventive Health
- Primary Care Network Presents: Chronic Migraine in Primary Care
- Annenberg Center Presents: Getting to Goal with Patient-Centered Diabetes Care

INFORMATIONAL WEBSITES

- Maryland Academy of Family Physicians - www.mdafp.org
- Ocean City, MD – www.ocoocean.com
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Nominations Slate

The MAFP Nominations Committee recommends the following slate. Nominations from the floor will be accepted. Elections will take place at the Annual Business Meeting Luncheon on Friday, June 28, 2013 at the Clarion Resort Fontainebleau Hotel in Ocean City, MD. Newly elected officers will be installed later that day by AAFP Director Wanda Filer, M.D. at the Installation Luncheon.

Eugene J. Newmier, D.O., Chair – Immediate Past President and Acting Eastern District VP
Joyce Evans, M.D. – Committee Chair, Editor-in-Chief
Yvette Oquendo-Berruz, M.D. – President
Kisha N. Davis, M.D. – President Elect

TREASURER
2013-15; two year
Ramona G. Seidel, M.D.

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Patricia A. Czapp, M.D.
2012-14; two year (completing term)
Eastern District
vacant
2013-15; two year
Western District
Matthew Hahn
2013-15; two year

DIRECTORS
2013-14; one year
Central District
Mozella Williams, M.D.
Eastern District
Kim R. Herman, M.D.
Southern District
Trang M. Pham, M.D.
Western District
Kevin P. Carter, M.D.
At Large
1. Nancy B. Barr, M.D.
2. Kristin M. Clark, M.D.
3. Shana O. Ntiri, M.D.
4. Mark Wilson, M.D.

DELEGATE TO AAFP
Adebawale G. Prest, M.D.
2/2 year term limits
2013-15 (1st term)

ALTERNATE DELEGATE TO AAFP
Eugene J. Newmier, D.O.
2/2 year term limits
2013-15 (1st term)

IN MID-TERM PRESIDENT
Yvette Oquendo-Berruz, M.D.
2012-2014

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Kisha N. Davis, M.D.
2012-2014

VICE PRESIDENT
Central District
Jocelyn Hines, M.D.
2012-14

SECRETARY
Eva S. Hersh, M.D.
2012-14

DELEGATE TO AAFP
Howard E. Wilson, M.D.
2/2 year term limits
2012-14 (2nd term)

ALTERNATE DELEGATE TO AAFP
Yvette L. Rooks, M.D.
2/2 year term limits
2012-14 (2nd term)

2013 AAFP Family Medicine Global Health Workshop in Baltimore

The 2013 Family Medicine Global Health Workshop is scheduled for October 10-12 in Baltimore. The deadline for abstract submissions is June 15, 2013. The 2013 conference theme is “Global Health through Family Medicine: Reflecting on the Past, Preparing for the Future.” Practicing physicians, faculty, residents and students with an interest or experience in international activities/global health are encouraged to submit abstracts for poster and peer sessions at the 2013 AAFP Family Medicine Global Health Workshop. The theme of this year’s workshop is “Global Health through Family Medicine: Reflecting on the Past, Preparing for the Future.” The workshop is a great opportunity to network with global health experts and peers with similar interests. Submit your abstract by June 15, 2013.

Register before July 31 to receive the early bird registration fee. Direct questions to Rebecca Janssen, AAFP Program Coordinator, at rjanssen@aafp.org.
David L. Stewart, M.D., Associate Professor and Chair of the Department of Family & Community Medicine, has been awarded the inaugural Dean’s Faculty Award for Diversity and Inclusion in recognition of his work in the area of health disparities. The award was given during the University of Maryland School of Medicine’s (SOM) 6th annual Celebrating Diversity Reception last month in Baltimore. “The purpose of this award is to recognize a SOM faculty member for extraordinary work advancing diversity and inclusion throughout the field of medical education, both here at the School of Medicine and throughout the United States,” said Dean E. Albert Reece. “There is no one more deserving of this honor than David. He has proven his dedication and commitment to improvement of health care disparities throughout his more than 25 years at the University of Maryland School of Medicine.”

F. Veronica Deza, M.D. of Columbia has been appointed to the Cultural Competency Working Group in the DHMH Office of Minority Health and Health Disparities.

Kim R. Herman, M.D. of Denton has been appointed to The Maryland Council on Cancer Control.

The following have been appointed to AAFP Committees with terms of varying length beginning on December 15, 2012:

Kisha N. Davis, M.D. (President-Elect) to the Commission on Governmental Affairs (4 year term);

Joseph W. Zebley, III, M.D. (Past President) reappointed to the AMA Delegation (2 year term)

Joseph Nichols, M.D. (Resident, FSHC) and Max Romano (student, JHUSM) to the Commission on Health of the Public and Science (1-year terms) joining Patricia A. Czapp, M.D. (Director) and Yvette L. Rooks, M.D. (Past President), each in mid-term on that Commission.

Dr. Stewart surrounded by faculty and staff from UM DFCM at the Award Ceremony.

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Residency Corner
University of Maryland FM Residency
by Ryane A. Edmonds, M.D., PGY-3

In this edition of the Residents Corner I would like to highlight some of the accomplishments of the residents, as well as our program’s involvement in community service. Our diverse group of residents continue to exceed academically, professionally and personally.

Dr. Ariana Martin (PGY-2) made quite an impression while doing her Adult ER rotation. She singlehandedly delivered a newborn and the placenta in just fifteen minutes while on one of her recent ER shifts!

Our Practice has an ongoing “Biggest Loser” competition, where participants can compete to achieve their weight loss goals. This is an amazing office rivalry which also promotes living a healthy lifestyle to our office staff. Recently two of our interns, Dr. Felicia Washington and Dr. Janna Becker, won the Biggest Loser competition in weeks 2 and 3. Now, when they advise their patients to eat healthy, exercise, and lose weight, they can use themselves as shining examples!

Also, I would like to wish intern Dr. Jason Singh special congratulations. He is a new dad to a healthy and beautiful son. He and his wife are smiling from ear to ear!

Outside of all the great things that residents have been doing, the University of Maryland Family Medicine program manages to work hard in the community. A few of the service activities we have and will fulfill at various area programs were/are: From the Heart sponsored by UMMC—Reginald F. Lewis Museum (2/10/13), Baltimore Healthy Expo at Baltimore Convention Center (2/23/13), Spring into Good Health at Mondawmin Mall (4/5/13), and The Smoking Cessation program for Furman Templeton Teachers (4/11/13).

The Maryland Academy of Family Physicians is saddened by the passing of its members

Ernesto M. Ablang, M.D., Elkton (recently of Wilmington, NC)
Hugh W. Irey, M.D., Annapolis

Memorial contributions have been made to the MAFP Foundation in their honor.
members (continued)

Welcome New and Transferred Members  November 1, 2012 - January 31, 2013

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Zoovia Aman, M.D.
Ivan J. Briones
Rafai a. Bukhari, M.D.
Anatoli But-Husaim, M.D.
Shabir Dard, M.D.
Stephanie L. Davis, M.D.
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Opeyemi A. Falebita, M.D.
John Ferrell, M.D.
Victor Gong, M.D.
Tracy L. Gutierrez, M.D.
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Jessica Jacobs, M.D.
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Faiza Mahmud, MBBS
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Christine S. Tu, M.D.
Shalini K. Vaid, M.D.
Alba M. Wayal, M.D.

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Erin A. Corriveau, M.D.

Student
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Crystal S. Bae
Elaine Bigelow
Ann M. Decker
Norma E. Farrow
Alicia Gaidry
Danielle R. Glick
Eric Gottlieb
James D. Hamm
Brian L. Heiss
Michelle D. Ho
Jennifer S. Hong
Anja Jones
Xiaohong Liu
Nicholas W. Masters

Michelle P. McCrone
Lina Mezci
Ashley C. Miller
Melanie Muszelik
Andrew Peacock
Adi Rattner
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