Maine Medicine

a quarterly publication of the Maine Medical Association

JULY AUGUST SEPTEMBER » 2014

Maine Medical Association Mission »

» **SUPPORT** Maine physicians,

» **ADVANCE** the quality of medicine in Maine,

» **PROMOTE** the health of all Maine citizens.

Visit us online: www.mainemed.com

MAINE INDEPENDENT CLINICAL INFORMATION SERVICE CELEBRATES FIVE YEARS

By Jennifer Reck, Program Manager

On August 9, 2009, the Maine Medical Association launched the Maine Independent Clinical Information Service (MICIS) and now veteran academic detailer Erika Pierce, PA-C visited a group of providers at Sunbury Primary Care in Bangor with a module on Adult Type 2 Diabetes. Five years and more than 3,300 module copies later, MICIS has reached more than 1800 providers with nine different modules. Many sites have requested multiple visits from MICIS over the years and we take our repeat customers as a sign of a job well done.

Erika Pierce, PA-C presents a MICIS module to participants at Maine Quality Counts in April of 2014.

MICIS offers free, onsite CME on the evidence-based use of prescription drugs as well as non-drug approaches when relevant. The goal is to close any gaps between the best available evidence and current medical practice. Our "academic detailers" visit practice sites throughout the state to speak with individuals, small or large groups. Evaluations have remained consistently positive with the majority of participants rating the program as "excellent" or "good" and almost 70% reporting that they plan on changing their practice in response to something they learned during a MICIS academic detailing session.

From left to right, Erika Pierce, PA-C, Noah Nesin, MD, and Elisabeth Fowlie Mock, MD, MPH, FAAFP.

The program is administered by the Maine Medical Association through a contract with the Office of MaineCare Services (OMS). The funding stream was created by a small direct assessment on pharmaceutical companies doing business with MaineCare through 2007 legislation. MICIS is further supported by a voluntary advisory committee that has been chaired by Noah Nesin, MD since the program began. MICIS is very fortunate to have benefited from Dr. Nesin's time and efforts over the years and would like to express our appreciation.

Past MICIS modules:
- Adult Type 2 Diabetes
- Anti-platelets
- Hypertension
- Atrial Fibrillation
- Chronic Pain Management
- Antipsychotics

Currently available modules:
- Obesity Management
- Antibiotic Stewardship
- COPD

If you would like further information or to schedule a visit, please contact Program Manager, Jennifer Reck at jreck@mainemed.com.

MICIS modules are developed by independent physician researchers at Brigham and Women's in Boston under the auspices of the non-profit foundation ALOSA, an organization which receives no pharmaceutical funding. The academic detailers undergo extensive training in Boston on new topics and then visit providers throughout the state acting as "ambassadors for the evidence." In addition to Erika Pierce, PA-C who has been with the program since it began, MICIS was joined in 2012 by Elisabeth Fowlie Mock, MD, MPH, FAAFP. Both bring a great deal of skill and passion for the jobs they do so well.

Recently, Dr. Mock created a FaceBook page for MICIS known as "MICIS Travels." A quick visit to this page gives you a sense of the tremendous ground covered by MICIS's academic detailers as they offer their services from York to Caribou. We would also like to congratulate Dr. Mock on compiling our first ever entirely "home grown" module on antibiotic stewardship that has received more requests for visits over the shortest period of time than any of our other modules.

If you haven't seen the antibiotic stewardship module yet, or our other current offerings - Obesity Management and COPD - please contact Program Manager Jennifer Reck at jreck@mainemed.com today.

All three modules will also be presented at the upcoming Annual Session, September 5-7, 2014. The presentations begin at 10:00am Saturday morning following the annual membership meeting. Category 1 CME is available for these sessions.

MICIS
Maine Independent Clinical Information Service

For updates from Maine Independent Clinical Information Service and to join the community,
Like "MICIS Travels" on FaceBook! »

Like

MAKE PLANS NOW TO ATTEND MMA'S 161ST ANNUAL SESSION

The Maine Medical Association has held an annual meeting every year since its founding in 1853. For 161 years, the annual meeting, which has been traditionally called the Annual Session, has provided an opportunity for MMA members and their guests to get away to a pleasant location, socialize with their colleagues around the state and learn about the trends in medical practice. This year's meeting, to be held Sept. 5-7, 2014 provides these opportunities and more, and in a location that is second to none in the opportunities for families. Bar Harbor and the surrounding communities on Mount Desert Island offer incomparable opportunities for hiking, biking, kayaking, whale-watching, golfing and many other recreational opportunities. Acadia National Park is one of the most popular national parks in the nation. So make your plans now to join us at the Harborside Hotel and Marina and the adjacent Bar Harbor Club Sept. 5-7. The meeting will begin with the opening night reception at 5:30pm on Friday, Sept. 5 at the Harborside Hotel. In addition to David Barbe, M.D., immediate past Board Chair of the AMA, several candidates for statewide and federal office will be present. Dr. Barbe is a family physician in Missouri. Several visiting State Medical Society Presidents and Executives will also be joining us.

The Annual Session Planning Committee, chaired by President-elect Lisa Ryan, has made several important changes to the meeting that members will appreciate. The meeting has been shortened by about a half day and child care options will be available. The traditional Saturday night banquet will be changed to a casual lobster bake. And perhaps most innovative of all, Dr. Ryan will be installed as the Association's first osteopathic President in the MMA's 161 year history.

On Saturday afternoon, the Maine Society of Anesthesiologists, the Maine Radiological Society, and the Maine Urological Association will hold meetings at the Bar Harbor Club.

Please come and help celebrate this milestone and enjoy the many attributes Bar Harbor has to offer.

Meeting registration materials can be found as an insert with this issue of *Maine Medicine*.

PRESIDENT'S CORNER »

Guy G. Raymond, M.D., President, Maine Medical Association

Greetings from your President.

What a whirlwind of a year! It is hard to believe that we are well into the summer. I hope that you have all been enjoying the wonderful weather and taking advantage of it.

In early June, I was in Chicago for the AMA Annual Meeting. I am in awe of the preparation and work that goes into AMA activities and the depth of study and analysis that generates the advocacy themes and AMA policy. The installation of the new AMA president was indeed an impressive event. I was also struck by the caliber of the individuals that comprise the leadership of our national organization.

Dr. Robert Wah, our new AMA president, brings a vibrant personality and engagement to the organization, invoking the concept of team-based care and improving access to high quality care with the advance of telemedicine. Dr. Steven Stack who attended our MMA Annual Meeting last fall, is the new president-elect.

The AMA addressed key medical issues seeking to study the impact of maintenance of certification on the quality of medical practice, the formulation of evidence-based changes to resident duty hours rather than an arbitrary limit, the implementation of federal and state initiatives to improve access to medical care, increased financial support to increase the number of graduate medical positions, and finally, a shift to competency-base education to streamline the transition between undergrad medical education and graduate residency programs. The House of Delegates assures through its policy making process that all physicians can have a representative voice in formulating policy.

On the home front, your association continues with its educational initiatives, with HIPAA training programs, the First Friday programs, and the Annual Practice Education Seminar. Contract reviews and other legal services are keeping pace with our projections. Preparations for the MMA Annual Meeting in Bar Harbor on September 5 to 7 are progressing well. There will be minor changes in the format of our Annual Meeting which hopefully will be more appealing to our younger members.

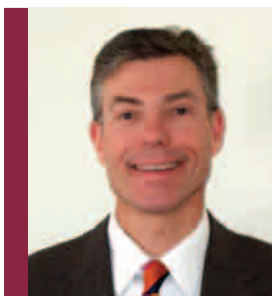
Finally, I had the honor of hosting the MMA Board of Directors at my home in Wallagrass (near Fort Kent, the best kept secret in Maine) in July. It was a productive meeting and we showed our leadership good northern Maine hospitality, making the trip up north a worthwhile venture for the many members who attended, several making their first journey to the County.

I wish you all a fun and healthy summer.

Present your ideas or concerns to Gordon (gsmith@mainemed.com or 207-622-3374 ext: 212) or myself (president@mainemed.com or 207-834-3155) as we "move" ourselves to better serve you to advance the care of your patients.

LEGISLATIVE UPDATE »

Andrew MacLean, Esq., Deputy Executive Vice President, Maine Medical Association



Election Day Looms for Maine Political Candidates; Compliance Resources Now Available on www.mainemed.com

The 126th Maine Legislature adjourned in May and political campaigns for all 186 legislative seats, the Blaine House, both seats in the U.S. House, and the seat of Maine's senior U.S. Senator are heating up with the approach of Labor Day. The 127th Maine Legislature will be seated in December and will begin work in early January 2015. The MMA staff welcomes input from individual members, practices, or specialty societies on the MMA's legislative agenda for the next legislature. MMA Legislative Committee Chair Amy Madden, M.D. will convene an organizational meeting of the committee to review election results, finalize MMA's legislative agenda, and prepare for the next legislative session in early December – meeting details will be published in *Maine Medicine Weekly Update*, our electronic newsletter in November.

The MMA offers four tools to assist you and your staff with your efforts to comply with the new laws enacted by the 126th Legislature and signed into law by the Governor.

1. The first tool is a two-sided, color advocacy wrap-up included as an insert in this *Maine Medicine*. You also can find it on the web at: http://www.mainemed.com/sites/default/files/content/mma%202014%20advocacy%20wrapup%20IV.pdf.

2. The second tool is a Powerpoint presentation of the highlights of the previous legislature's work with an emphasis on day-to-day practice management issues. You can find this presentation on the web at: http://www.mainemed.com/sites/default/files/content/testimony/126th%20Legislative%20Update_May%202014_for%20Website.pdf.

3. The third tool is a legislative summary of every bill tracked by the MMA advocacy team during the previous legislature. This document is a report from StateTrack, a product of CQ Roll Call that is divided by broad subject matter category and allows you to see the full final text of any enacted bill as well as the legislative history of any bill tracked by MMA. You can find this report on the web at: http://www.cqstatetrack.com/texis/statetrack/insession/viewrpt?report=53aad6b21db5&sid=&Report.workflow=.

4. The final tool is a sample document to help you comply with the price transparency requirements enacted in L.D. 1642. You can find this sample document on the web at: http://www.mainemed.com/sites/default/files/content/testimony/ld1642%20Sample%20Documents.pdf. Most bills become effective 90 days after adjournment of the legislature and that date is August 1, 2014. Emergency legislation becomes effective immediately upon the Governor's signature and some bills include a specific effective date.

If you have not done so already, now is a great time to get to know the candidates for the General Election to be held on November 4, 2014. You can find the General Election information on the web here: http://www.maine.gov/sos/cec/elec/upcoming.html.

During the legislative session, the MMA staff provides links to bills for review and comment, updates on the legislature's work, and calls-to-action through our weekly electronic newsletter, *Maine Medicine Weekly Update*. The Legislative Committee conducts conference calls to review new bills and to provide updates on legislative activity every Tuesday evening at 8:00 p.m. during the session. Any interested member or staff person is welcome to participate. Please see each week's *Maine Medicine Weekly Update* for conference call information.

To find more information about the MMA's advocacy activities, visit the Legislative & Regulatory Advocacy section of the MMA web site, www.mainemed.com/legislation/index.php. You will find more information about the Maine Legislature, including schedules, committee assignments, legislator contact information, audio coverage of legislative work, and newly enacted laws on the web at: http://www.maine.gov/legis/.

The MMA welcomes your participation in our legislative advocacy activities. For more information, please contact Andrew MacLean, Deputy Executive Vice President, at amaclean@mainemed.com.

23RD ANNUAL PRACTICE EDUCATION SEMINAR

MMA's 23rd Annual Practice Education Seminar was held at the Augusta Civic Center on Wednesday, June 18th.

Two keynote presentations anchored the annual program which attracted physicians and practice managers around the state. The morning Keynote talk was by Carol Vargo, Director of Care Delivery and Payment Collaborations in the AMA Physician Satisfaction and Practice Sustainability Strategic Initiative Group. Carol presented findings from the Rand/AMA survey conducted last year which determined the various factors that affect physician professional satisfaction and their implications for Patient Care, Health Systems and Health Policy. The noontime Keynote presenter was MMA Past President and MaineCare Medical Director Kevin Flanigan, M.D. who spoke on the activities and first year results of the State Innovation Model (SIM) grant. Nine breakout sessions were offered in the afternoon.

Dr. Kevin Flanigan

Sam Surprise

One of the more popular talks was entitled, *Best Practices, Reinventing Yourself for the Future of Healthcare* presented by Barbara Slager, M.D. and Beverly Neugebauer of Coastal Women's Healthcare in South Portland.

A few binders with the presentations are available from MMA at a cost of $30. Call the office at 622-3374 to order a copy.

Next year's Practice Education Seminar will be held in May with the specific date to be announced soon. The Augusta Civic Center will again be the location.

SAVE THE DATE

September 26th-27th
Maine Medical Association
Manchester, ME

DIRECT PRIMARY CARE (DPC) WORKSHOP FOR MAINE PHYSICIANS

Friday 9/26:
1:00 pm – 5:00 pm
Saturday 9/27:
8:30 am – 12:30 pm

Dr. Brian Forrest, *(founder of Access Healthcare Direct & AAFP DPC Workgroup Leader)* and Maine physicians developing an integrated Maine Direct Care network for existing practices to improve affordability, increase patient centered access, and reduce practice overhead.

Come explore the options!
All are welcome.
CME credits will be available.

For more information and to register, email:
MaineDPCProject@yahoo.com

NOTES FROM THE EVP »

Gordon H. Smith, Esq., Executive Vice President, Maine Medical Association

I hope you all are enjoying the summer and taking the time to kick back a bit and enjoy a good book and some family time.

One of my summer reads is *Five Days at Memorial*, a non-fictional account of the aftermath of Hurricane Katrina at Memorial Hospital in New Orleans. It is a very sobering story. The author, Sheri Fink, M.D., was the guest speaker at the Annual Medical Staff dinner at Mercy Hospital which is how I became acquainted with the book and the story. I need to finish it up and get it back to Scott Rusk, M.D. who was good enough to loan it to me. He must expect it back as he took the time to place an impressive seal on it indicating that it came from his "library." I was impressed.

In this issue, I have chosen to share with readers a summary of the talk I recently gave to the Portland Rotary Club. I was asked to provide some comments on the current healthcare landscape in Maine in about twenty-five minutes. I did the best I could in the time allotted and highlighted the following points:

1. The current landscape is very rocky, full of bumps in the road and I analogized to the uneven road surfaces throughout our state as a result of all the re-paving projects going on. I stated that I thought that many physicians were suffering from *change fatigue* and that primary care physicians, particularly, were challenged by the many administrative tasks being assigned, misaligned incentives, electronic medical records and loss of control.

2. The Affordable Care Act (ACA) is accelerating transformational change throughout both the delivery system and the payment system, but fee for service is still dominant and alternatives to it are still in their infancy and largely untested. Therefore, there is a lot of misalignment in terms of incentives and quality metrics.

3. The nation and our state are deeply divided in its opinion on the ACA and its reliance upon the existing pluralistic system of private and public payers. I discussed the prospects of a single payer system, or a Medicare for All approach and the political realities involved in getting there even if a clear majority of voters favored that approach.

4. I discussed the importance of achieving universal access to care, through either the present system of public and private payers or through a single public payer, or a hybrid approach. I also discussed the importance to low-income Mainers of the state expanding MaineCare with federal funds as provided for in the ACA but vetoed by Governor LePage.

5. I concluded with comments that I borrowed from Dr. Robert McAfee regarding the importance to one's health of genetics (we can't choose our parents), social circumstances, the environment, and most of all, personal behavior. That as important as our health care system is to people, it pales in comparison to the impact of poverty, personal behavior and these other factors.

I believe my remarks were well received and I appreciated the Portland Rotary providing me with the opportunity to share these thoughts. And I thank you as well for taking the time to read these short highlights.

I hope to see many of you at the MMA's 161st Annual Meeting, Sept. 5-7, 2014 in Bar Harbor. Incoming President Lisa Ryan, D.O has chaired the committee planning the meeting and attendees will find some significant changes from past annual meetings. We hope you will enjoy these departures from tradition.

Finally, I want to take the time to thank our current President Guy Raymond, M.D. for an outstanding year. As medicine is in the midst of transformational change, so it is that the Maine Medical Association also must change or risk irrelevancy, bankruptcy or both. Dr. Raymond has been an exceptional leader in preparing MMA for that change and in supporting the staff and Board as we move ahead. I have enjoyed working with him, and playing with him as we both enjoy running and golfing. He maintains a definite edge in the golf, but I have at least a slight advantage in the running! You can enjoy the competition yourself if you attend the Annual Meeting and participate in (or observe) the 34th Annual Road Race at 7:00am Sunday morning, September 7. The President may be secretly in training for this race and hoping to eek out a final victory before passing the gavel to Dr. Ryan.

Please feel free to communicate with me at any time about anything. Best means to do that is through e-mail to gsmith@mainemed.com or by calling me at the office at 622-3374 ext. 212 or on my cell phone at 215-7461.

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SUBSCRIBE TO MMA'S MAINE MEDICINE WEEKLY UPDATE

Each Monday, *Maine Medicine Weekly Update* keeps physicians and practice managers in the loop with breaking news by email only. It's a free member benefit – call 622-3374 to subscribe.

INVITE A PHYSICIAN TO JOIN MMA

Encourage your colleagues to become an MMA member and take advantage of the benefits of membership. Contact Lisa in the MMA Membership Department at 622-3374 ext 221 or email lmartin@mainemed.com.

Thanks to 2014 Sustaining Members

Thank you to the following who have shown their support for the MMA's long-term growth by renewing at an additional sustaining membership level.

Pen Bay Medical Center

UPCOMING AT MMA »

AUGUST 12
4:00pm - 6:00pm
MMA Committee on Physician Quality

AUGUST 13
4:00pm - 6:00pm
MMA Public Health Committee

AUGUST 20
11:30am - 2:00pm
Senior Section
Topic: Single Payor: Its time has come?

SEPTEMBER 8
4:00pm - 8:00pm
Maine Professional Health Program (MPHP)

SEPTEMBER 25
8:00am - 3:30pm
Pathways to Excellence

OCTOBER 3
9:00am - 12:00pm
First Fridays Educational Program:
Risk Management Seminar
Presented by Medical Mutual Insurance

OCTOBER 8
4:00pm - 6:00pm
MMA Public Health Committee

OCTOBER 14
4:00pm - 6:00pm
MMA Committee on Physician Quality

OCTOBER 15
11:30am - 2:00pm
Senior Section
Topic: The Aging "Loco" Motion: You can't be Idle on a Moving Train!

4:00pm - 6:00pm
MMA Board of Directors

OCTOBER 28
5:00pm - 9:00pm
Maine Chapter, American Academy of Pediatrics

NOVEMBER 10
4:00pm - 8:00pm
Maine Professional Health Program (MPHP)

NOVEMBER 20
8:00am - 3:30pm
Pathways to Excellence

AMA DELEGATE REPORT »

By Maroulla Gleaton, MD & Richard A. Evans, MD

Dr. Gleaton and Dr. Evans at the AMA Annual Meeting

Maine AMA delegates Richard A. Evans, MD and Maroulla Gleaton, MD recently attended the 2014 Annual Meeting of the American Medical Association in Chicago. Also attending was Maine Medical Association President Guy Raymond, MD who participated in the Inauguration Ceremony of Robert Wah, MD as Dr. Wah was installed as the 169th President of The American Medical Association. Dr. Wah is an endocrinologist and obstetrician–gynecologist who had a distinguished military career in the U. S. Navy. Among his many accomplishments, Dr. Wah served as chief medical officer for the Computer Science Corporation and as the first national deputy coordinator for the Office of the National Coordinator for Health Information Technology.

In focusing on its Strategic Goals and as the nation's health care system continues to evolve, the AMA's strategic plan is dedicated to sustainable physician practices that result in better health outcomes for patients by ensuring that enhancements to health care in the United States are physician-led, advance the physician-patient relationship, and ensure that health care costs can be prudently managed.

The AMA's plan emphasizes three core areas of focus: improving health outcomes with concentration on Type 2 Diabetes and cardiovascular disease in particular; accelerating change in medical education (in conjunction with 82% of the nation's medical schools), working to improve physician training and rapid dissemination of best practices to other health professionals; and professional satisfaction and practice sustainability. The AMA conducted a national study with RAND Health to identify drivers and detractors of physician professional satisfaction and is in the process of developing useful resources and solutions to address these issues.

The 2014 Annual Meeting was both collegial and very expansive, covering a diverse array of topics that affect all physicians. Numerous resolutions and reports were discussed in eight reference committees before being brought to the members of the House of Delegates, comprised of over 500 delegates and 500 alternate delegates, for final deliberation and vote.

Of particular interest was a report by The Council on Medical Education regarding the Maintenance of Certification (MOC), Osteopathic Continuous Certification and Maintenance of Licensure. Significant concerns were raised regarding the time, administrative burden and costs, monetary and others, associated with participation, and the need to lessen the burden for physicians with multiple board certifications. The AMA will work with the ABMS to resolve this ongoing problem. Additionally, the House amended this report to ensure that the AMA oppose mandatory MOC as a condition of medical licensure and encourage physicians to strive constantly to improve their care of patients by the means they find most effective.

Another topic of particular interest involved the 90 day grace period in physician payments by some insurers for patients receiving care under the Health Exchanges of The Affordable Care Act. The House adopted policy that these health plans should pay providers for all covered services during a grace period and that the AMA will seek appropriate changes to federal law and regulations to protect state prompt payment laws.

A Board of Trustees (BOT) Report regarding whether or not cheerleading should be considered as a sport brought spirited discussion both in the reference committee and on the House floor. A very effective case was made regarding the mounting inherent dangers of this activity, including concussions and catastrophic injury related to participation in this event. The BOT report was amended by the House to designate cheerleading as a sport and supports the implementation of recommendations designed to improve its safety, equivalent to those that apply to other athletic activities formally recognized as "sports" by appropriate accrediting bodies.

The House also supported a resolution that encourages medical staffs to develop medical staff membership categories for primary care physicians who provide low volume or no volume of clinical services in the hospital (community physicians), and to engage these community physicians, as appropriate, in medical staff and hospital activities.

The AMA has long supported the concept of physician-led teams within the patient-centered medical home (PCMH). A recent JCAHO memo raised significant concerns with its interpretation that included non-physician led PCMH's. The House adopted policy that directs the AMA to develop a report back at the 2015 Annual Meeting comparing physician-led PCMH's and non-physician lead PCMH's in terms of quality of patient care, per patient total medical expenditures, total health care costs, access and patient outcomes. Additionally, the AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home's or patient centered medical home's as being anything other than MD/DO physician led.

The above only affords a snapshot of the numerous concerns physicians face in the day to day practice of medicine. For more details of all resolutions and reports presented at Annual 2014, we encourage you to visit the AMA website at www.ama-assn.org. You may also feel free to contact either of your AMA delegates at any time for additional assistance.

By Richard Dillihunt, MD

A Visit with a Neighbor

For decades, I have admired the Canadian health care system, first while at a remote Northern Quebec fishing camp. There, impromptu sick call was held for the Cree, local aboriginal people with rights to this remote land. Members of this tribe had various complaints that we treated with our medical chest. Despite the difference in language in the elderly, the shyness barriers were easily overcome. They seemed completely confident in our medical abilities.

We felt privileged as caregivers to be given such confidence and warm doctor-patient relationships came forth. Over the years we saw burns from campfire mishaps, an acute gallbladder, and a mangled hand injured beyond our medical capabilities. We made radio calls to regional flying services, and patients were fetched and flown to various medical centers. There were no lawyers or insurance companies involved. The only physical evidence of health care coverage was a small card that each patient guarded carefully. This card admitted them to their national health care system. It provided quality medical care covering all 35 million Canadians scattered across the second largest nation on earth.

The patient with the injured hand was emblematic of this system. A radio call summoned a floatplane, and the patient was loaded and lugged across and down the 150 km of the Peribonka River to the medical center in Chicoutimi. After treatment, he was returned by air. That little card had covered all medical care and transportation. Imagine what such a journey would cost us!

This system of universal health care came into being in 1946. It is attributed to a Canadian native son, Tommy Douglas. As premier of Saskatchewan, he established a universal single payer health care for all of Canada. After his death he was voted "Greatest Canadian" by the Canadian Broadcast Corporation viewers.

Although medical service for the Cree and Inuit have been difficult for the Canadian government to perfect, they have enjoyed great success. Given the vast territory, the nation does well to spread its resources over ten million square km, much of it being a harsh environment.

The Canadian system deserves careful scrutiny by every American who has concerns regarding our badly broken health care system. Inspection of how the Canadians have successfully developed their universal single payer form of health care uncovers features that the US needs to seriously consider. Just recently Danielle Martin, a brilliant young Canadian physician, called attention to the superior provisions of Canada's public system in her testimony before Sen. Bernie Sanders' committee in Washington. She showed that the Canadian system is based on need, not on the ability to pay. Her interaction with Sen. Burr (R-NC) went viral, generating over 700,000 views on YouTube across North America. Many major media outlets focused on her evidence-based, intelligent, and energetic defense of Canadian Medicare.

Canadians take great pride in their medicare-for-all system. They know that Canada's life expectancy rates and maternal and infant mortality figures are superior to America's, and their quality of care is equal to ours. They are aware that, traditionally, wait times have been a source of intense criticism of their system. They understand that this is largely overblown by stateside special interest groups whose propaganda has brainwashed America about horrendous waiting times for referrals and elective surgery. The facts show differently. Canada has addressed wait time issues with a Wait Time Alliance. Through this alliance there has been much improvement, and changes have been uncovered to correct this problem.

Two nations have developed, through different pathways, health care systems which are clinically similar and among the world's best. When compared, Canada has taken the high ground, selecting a route featuring social justice and equality with a strong nationalism. Canadians are caring for one another. America's profit- driven hard-nosed traditions and business practices have permeated the ways and means of the USA's health care.

Lacking checks and balances, our system costs nearly twice that of Canada's per capita, $8233 vs $4445 yearly. This accounts for 17.6% of America's GDP while Canada's health care expenditure is 11.4% of her GDP according to 2012 statistics. The most stunning statistic of all is this. Even with the ACA finally deployed, there are over 30 million uninsured American citizens, approximately equal to the entire population of Canada where everyone is covered by Medicare, and a simple little card replaces by comparison a vast array of paperwork that chokes our system.

The Canadian system is remarkably popular in America. Maine must pay attention to this surge. Because of our unique geographical location, we are surrounded by Canadian relatives, friends, and neighbors. Canada can provide us with more than frigid winds. We need to lead the way in acknowledging a very attractive Canadian healthcare system.

Editor's Note: The opinions expressed above are the opinion of MMA member and retired surgeon Dr. Dillihunt. MMA members with concurring or opposing opinions are welcome to share them with MMA for possible publication in future issues of Maine Medicine. Comments and articles (please keep your articles under 600 words) may be shared with Shirley Goggin at sgoggin@mainemed.com.

So What is Financial Planning?

By Larry Perry, Baystate Financial,
lperry@baystatefinancial.com

Have you ever asked yourself what successful physicians and financial planners have in common? Three things come to mind. Both occupations attract individuals that are process oriented. They both rely on a philosophy for intentional living, a framework for creating happiness in the face of life's natural tendencies toward chaos and entropy. The work that they both do frees people to focus all of their mental, physical, and spiritual energy toward their highest goals and survive life's toughest challenges.

Your life's goals and dreams are your own, but the path to achieving them may need clarity, individual attention, and personalized guidance that you may not feel comfortable with alone. Just as your patients rely on your knowledge, credentials, and experience to help them recover and move forward, you need professionals to help you develop and implement a financial plan that will serve as a well-organized road map. As your life changes, so will your plan.

The core belief of Baystate Financial is that each individual's tailored plan should begin with the following basic elements:

1. An understanding of where you are when it comes to cash reserves, debt management, income, expenses and savings.
2. A balance between your current lifestyle and future expectations.
3. An understanding of the tax implications of your investment portfolio.
4. A thorough documented investment strategy based on your goals, expectations, and tolerance for risk.
5. Appropriate solutions that help protect you and your family from the unexpected events that are probable during your life.
6. The legal documents to facilitate objectives in the event of a serious disability or unexpected death.

Transforming a life of work into a lifetime of financial well-being is no easy task, and while having a plan to assist you in doing the RIGHT THINGS the RIGHT WAY at the RIGHT TIME with the RIGHT PEOPLE and for the RIGHT REASONS does not guarantee success, it certainly does increase the probability that the future you hope for is the one you will get to enjoy!

A fully implemented, complete financial plan helps people to:

1. Make promises to the ones they love.
2. Prepare for Life's tragedies that befall all of us.
3. Honor and fulfill the important promises we make to ourselves and others in a chaotic world.

WHAT'S YOUR PLAN???
http://financialpicture2.com/view/1864/90

Securities and financial planning services are offered through New England Securities Corp., (NES) (member FINRA/SIPC), a Registered Investment Adviser. Baystate Financial and NES are not affiliated entities. Neither Baystate Financial nor NES provides tax or legal advice. Please consult your tax advisor or attorney for such guidance. L0913342500[exp1014] [AllStates] [DC,GU,MP,PR,VI]

By James H. Maier, MD

Phthalate Regulation

A class of chemicals collectively known as phthalates in widespread use as plastic softeners in home and child products, have names so complex and difficult to remember that they are known by the initials signifying their composition: DEHP, DBP, and BBP. Enough scientifically valid evidence has accumulated that these and other phthalates are banned in toys and child care products by the Consumer Product Safety improvement Act of 2008, although this ban is being contested. Trace amounts above one tenth of 1% are considered unsafe in products like vinyl child raincoats or backpacks, toys or teething rings. However because these chemicals are also added to many other common household and even hospital products such as shower curtains, IV bags and tubing, and are used in vinyl siding and flooring, they pose a particular risk to pregnant women. Exposure of a developing male fetus may set the stage for later abnormalities in development of reproductive organs, lower sperm counts as an adult, or damage to heart, liver and kidneys. Safety testing looking only at outcomes over limited time periods, typically months instead of years, would likely not detect longer term adverse health consequences.

Phthalates certainly deserve to be on anyone's list of dangerous "chemicals of high concern" because of their widespread presence all around us. It is therefore regrettable to learn (PPH 12/2/13 Alfond denies trading chemical vote for Medicaid bill) that possible political trade-offs apparently may have been a factor in the demise of a bill sponsored by Rep. Gay Grant which would have added phthalates to a priority list for urgent legislative action to ban or remove them. Even more distasteful is the suggestion that campaign contributions by the chemical industry may have played a part in allowing insidious poisoning of Maine citizens by phthalates to continue unchecked.

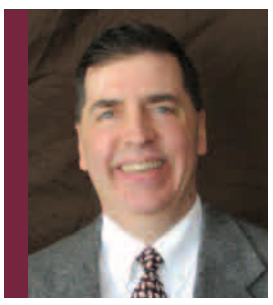
In contrast to the above concern of true public health significance, the LePage administration's decision to list known poisonous substances such as mercury and arsenic as "priority chemicals" has been rightly criticized by environmental groups as meaningless action only masquerading as concern for public safety. These "devils we have long known" are already being phased out, by contrast with the more sinister devils such as phthalates lurking all around us whose long term toxicity thus far goes largely unrecognized and unregulated.

Despite the cynical foot-dragging in the Blaine House, Maine's legislature has been a national leader in taking action to phase out some of the most notoriously toxic chemicals in child toys and sippy cups (most notably BPA) with the passage of the "Kid Safe Products Act." But the Governor's veto of a bill that would have extended the ban to protect older children and pregnant mothers from these toxins predictably demonstrates that his loyalties are to the corporations who produce them, rather than to current and future generations of Maine citizens whose health is at risk.

A far broader and potentially historic version of the struggles here in Maine to protect people and the environment is being played out currently in Washington. Despite gridlock on most any other constructive action, a bipartisan effort to replace the long outdated and toothless "Toxic Substances Control Act" (TSCA) with a new "Chemical Safety Improvement Act" (CSIA, Senate bill S. 1009)) has already gained 22 sponsors. This bill needs strengthening in many areas before it can expect endorsement by environmental and other groups concerned with public safety, but it is an attempt to address the frightening reality that of the 80,000 chemicals surrounding us, only a small handful have been tested for safety, fewer yet banned outright. For example the bill will need changes in language that specifically designate timetables for EPA testing and taking action based on the "reasonable certainty of no harm," rather than waiting for clear evidence of adverse health outcomes to only then determine "unreasonable risk." Moreover, the final form of the bill should not preempt states' own chemical policies and restrictions which may already be protecting citizens to a greater extent than any Federal legislation. Adequate funding is not yet addressed in S.1009.

Conversations with Senator Angus King's office have reassured environmental groups that he clearly "gets it" with respect to the need for a powerful new version of legislation to protect all citizens from chemical hazards. Representative Chellie Pingree has also been an activist on this issue. Call or write to thank them for their support and let the rest of Maine's delegation know you support a strong version of the CSIA which will help America catch up with protections already present in many other developed countries.

Editor's Note: The opinions expressed are the opinions of Dr. Maier and do not necessarily represent the views of the Maine Medical Association. Dr. Maier is a member of Physicians for Social Responsibility, and serves on the Maine Medical Association's Public Health Committee.



Off-cycle Enrollments in Marketplace Plans

By Mitchell Stein
Independent Health Policy Consultant

August 1 marks the midpoint between the end of the first open-enrollment period (April 15) and the beginning of the next one (November 15). But that doesn't mean no one can enroll in a health care plan now. The ACA recognizes that an individual's circumstances can change and allows for special enrollment periods. Below we'll review the ways people can enroll in health coverage outside of open-enrollment. In your role as either a provider, an employer or an individual, familiarity with these rules may prove useful.

The concept of having an open-enrollment period is not new. That's how Medicare works and that's how employer plans work - with the important exception that new employees can enroll when they first become eligible, even outside the open-enrollment period. Similar to employer plans, the Marketplace also has exceptions to the open-enrollment period. These special enrollment periods fall into two general categories. The first one, which will impact the most people, is when there is a qualifying life event such as:

- Marriage, divorce, birth, adoption or taking in a foster child
- Losing other health coverage (for example, if you lose your health coverage because you turned 26 and were no longer eligible to be covered on your parent's plan, lost your job, stopped being eligible for MaineCare, or your COBRA ended). Note: voluntarily cancelling an individual health plan or being terminated for not paying your premiums does not give you a special enrollment period
- Permanently moving to an area with different health plan options
- Gaining eligible immigration status (i.e. get a Green Card or Work Permit/Social Security Number)
- Certain changes to your income if you are enrolled already in a Marketplace plan

The second category is for complex cases. Most of them are the result of something going wrong with the process but the list also includes an exception for survivors of domestic abuse.

In addition to those two categories, members of federally recognized tribes and Alaska Native shareholders can enroll in Marketplace coverage any time of year.

Above we've discussed how some people can use the Marketplace outside of the open-enrollment period, but remember, the Marketplace will always only represent a small portion of those enrolled in health coverage, what about everyone else?

Most people in this country have in the past and for the foreseeable future will continue to get their coverage at work - and for the most part the rules about how that works have not changed. If you are a new employee and your employer offers health coverage, sometime within your first 90 days on the job your employer will allow you to enroll in that coverage. If you already work at a job where coverage is available but in the past have not enrolled, your employer will have their own annual open-enrollment period. (Note that your employer's annual open-enrollment does not necessarily coincide with the Marketplace open-enrollment period.)

With respect to Government plans such as MaineCare (Medicaid) and CHIP, the program rules specify that enrollment cannot be limited to a specific period of time. Individuals can join the program at any point as long as they meet the appropriate eligibility requirements. Note that because for the most part there is no premium paid by the individual there is no harm to the program from keeping the doors open all year long. In fact hospitals can use "presumptive eligibility" to see if an individual qualifies for MaineCare when they need treatment - if they do qualify they can be enrolled in the program immediately.

It is important to be aware of all the different possibilities outlined above because of a concept know as churn. Churn refers to the fact that during the year, an individual's circumstances may change thereby qualifying them/disqualifying them from different programs.

"Approximately half of all low-income, non-elderly Americans experience a change of income or family circumstance in a given year, which may result in an involuntary shift in how they are covered from health insurance purchased through an exchange (Marketplace) to Medicaid — or vice versa. This process, called "churning," could lead to both gaps in coverage and disruptions in the continuity of care." Source: http://healthaffairs.org/blog/2014/03/12/ha-web-first-medicaid-marketplace-churning-state-by-state/

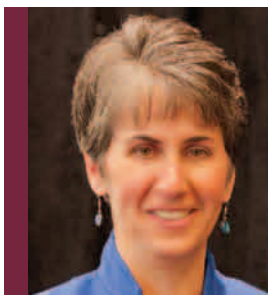
In order to prevent these gaps in coverage, it should prove helpful to be aware of the programs available and their specific enrollment periods.

For additional information about the Marketplace and enrollment, resources for patients or providers, or to schedule a presentation or meeting, contact Susan Kring, ACA Outreach Coordinator at 662-2364 skring@mainemed.com. Additional information is also available on our Health System Reform webpage: https://www.mainemed.com/education-info-cme/health-system-reform.

Mitchell Stein is an independent health policy consultant. He was formerly the Policy Director for Consumers for Affordable Health Care and before that worked for Health Dialog in Portland and Mercer Consulting in New York. Mitchell has spent over 25 years working in the area of health benefits and health policy and is considered one of Maine's foremost experts on the Affordable Care Act.

MAINE QUALITY COUNTS »

By Lisa Letourneau, M.D., M.P.H., Executive Director, Maine Quality Counts



The Maine Chronic Pain Collaborative: Maine Physicians on the Front Lines of Change

The headlines are sobering: "Maine 'Leads' the Nation in Rate of Long-Term Opiate Prescriptions"; "Maine Has Highest Rate of Prescription Opiate Addiction in Country." And the statistics are challenging: according to 2010 CDC data, prescription drugs accounted for 95% of all drug overdose deaths in Maine; there were 85 painkiller prescriptions written for every 100 people in Maine; and rates of drug overdoses, overdose deaths, and addiction have risen along with the prescription rates of opioid medications. While these numbers clearly reflect a multi-factorial and complex set of issues, the urgency of identifying more effective methods to manage chronic pain and tackle the thorny issues of over-prescribing of opioid medications cannot be overstated for Maine providers.

I was heartened, therefore, to attend the recent launch of the Maine Chronic Pain Collaborative, a pilot program that includes eight innovative primary care practices in Maine committed to improving care for patients with chronic pain and addressing the tough issues surrounding opioid prescriptions. Maine Quality Counts, in partnership with the Maine Primary Care Association, the Maine Medical Association, and Penobscot Community Health Center, launched the pilot program in May with the goal of improving the quality, management, and safety of care for patients with chronic pain.

The eight practices participating in this effort have committed to developing action plans to improve chronic pain management and safe opioid prescribing, attending learning sessions, and participating in "Project ECHO," a new method for clinical case review that uses video conferencing technology to connect local providers with national chronic pain experts. With two in-person learning sessions and one webinar under their belts, practices are working to implement a set of key changes for improving chronic pain management, developing practice policies and standardized approaches to treating their patients.

With the help of their fellow participants and peer consultant physicians Noah Nesin, Rich Entel, and Elisabeth Fowlie Mock, practices are working to optimize the roles of team members, improve workflow and apply technology to improve patient outcomes. The peer consultants serve as a primary resource for the practices and provide the support and collegiality that comes from talking to someone who has "been there." In addition to reviewing their existing tools, such as chronic pain medication agreements, practices are developing new tools to identify community resources to assist their patients. Practices are also working to integrate behavioral health into their chronic pain patients' care. Participating practices are also in direct and frequent contact with each other about the tools and policies they are implementing and revising.

With the help of Maine physicians leading the way, the Maine Chronic Pain Collaborative represents commendable commitment and leadership in action on the part of the participating practices, their physician leaders, and their practice teams. The current pilot program runs through January 2015 and will be followed by an evaluation phase. I look forward to sharing with you the best practices that emerge and encourage you to apply them to your own work with chronic pain patients moving forward. For more information, visit the Maine Quality Counts website, http://www.mainequalitycounts.org/page/2-1007/chronic-pain-collaborative, or the Maine Primary Care Association site: http://mepca.org/chronicpaincollaborative/. You may also contact the Collaborative's manager, Eric Buch, at the Maine Primary Care Association: ebuch@mpca.org or (207) 621-0677 x218.

Please join me in thanking the eight primary care practices participating in the Maine Chronic Pain Collaborative. They are: Bucksport Regional Health Center, CMMC Family Medicine Residency, DFD Russell Medical Center, EMMC Center for Family Medicine, Harrington Family Health Center, Sacopee Valley Health Center, Scarborough Family Medicine and St. Joseph Internal Medicine.

AMA CME WEBCASTS AVAILABLE

Free webcasts are now available to members through the American Medical Association Organized Medical Staff Section. **Access webcasts 24 hours a day, seven days a week**, and earn valuable AMA PRA Category 1 Credit™.
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These activities are designed for medical staff leaders (e.g., chiefs of staffs, medical staff presidents, medical directors and medical staff members), physicians interested in leadership issues, medical staff service professionals and medical staff legal counsel.

MEDICAL MUTUAL INSURANCE COMPANY OF MAINE RISK MANAGEMENT PRACTICE TIP:

Minors and the Right to Consent to Health Care Treatment

States have historically recognized the right of parents to make health care decisions on their children's behalf. There are situations, however, where parental consent is not reasonable or appropriate. The understanding that some minors have the capacity and perhaps the right to make important decisions about their health care treatment has been established in federal and state policy.

Apart from statutes that address minors and the right to consent to specific types of health care treatment, the usual requirement of parental consent may be trumped either by the unique circumstances giving rise to the need for treatment or by the fact that the minor is entitled to be treated as an adult. For example, in the event of a medical emergency, it is not necessary to wait and obtain parental consent to treat a child; a minor who is "emancipated" or who lives as an adult does not require parental consent for health care treatment.

When Minors Consent to Health Care Treatment
As provided by law, a minor who may consent to healthcare services is entitled to the same confidentiality afforded to adults. Minors should always be informed that if their chart records their parents' insurance and the insurance is billed for the visit, their parents will receive notification from the insurer that the visit occurred. Offer the minor the option to make other payment arrangements to maintain the confidentiality of their treatment. (If a minor comes to an Emergency Department for care, assure no payment questions are asked until the minor has received a Medical Screening Exam (MSE) to avoid an EMTALA violation.)

Information recorded in a minor's record that is protected by statute should only be released on consent of the minor.

A minor may consent to the following care by Maine law:

- Blood donation at age 17
- When the minor meets the definition of Emancipated Minor
- Sexual assault forensic exam
- Treatment for sexually transmitted diseases
- Treatment for abuse of drugs or alcohol
- Psychological services associated with the abuse of drugs or alcohol
- Contraceptive services

Lawmakers have generally not imposed a parental consent or notification requirement on minors' access to reproductive health care and other sensitive services. Abortion is an exception. Maine has a law that allows a minor to have an abortion without parental consent; however, the minor's ability to consent to an abortion is subject to the satisfaction of specific conditions. Consult with an attorney before performing an abortion on a minor in the absence of parental consent.

Imminent Harm
In instances of imminent harm (for example, suicidal ideation, sexual abuse), confidentiality may be forsaken. Inform the patient of what information needs to be disclosed and to whom. Offer the patient the opportunity to disclose information to parents or others in advance of your disclosure.

Medical Mutual Insurance Company of Maine's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

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