MAY/JUNE 2009

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

MMA and MHA Co-host Health Care Reform "Listening Session" with Senator Snowe

The Maine Medical Association was pleased to co-host a successful "Listening Session" on health care reform with Maine's Senior Senator Olympia J. Snowe at Portland City Hall on April 7, 2009. Twenty-seven organizations representing health care professionals, consumers, hospitals, employers, health plans, and government presented their respective ideas on health care reform. Senator Snowe is a member of the Senate Finance Committee, a Committee that will have an influential role in the health care reform debate in the nation's capital.

Jo Linder, M.D., Chair of MMA's Executive Committee, presented the Association's testimony which is available on the MMA website at www.mainemed.com. The MMA's statement noted the need for better support for primary care, coverage for the uninsured, and support for an individual health insurance mandate. MMA first proposed a mandate for individuals to purchase coverage, with appropriate subsidies for low-income individuals, in its *White Paper on Health Care Reform in Maine*, drafted in 2003 during the development of Governor Baldacci's Dirigo Health Program.

Martin's Point President and CEO David Howes, M.D. chats with Noel Genova, PA-C (L) and Maine Children's Alliance President/CEO Elinor Goldberg

MMA EVP Gordon Smith with Senator Olympia J. Snowe and MHA VP Mary Mayhew

Listening session participants

The one point that I believe all organizations represented around this table agree on is that, with respect to America's health care, the status quo is unacceptable. Continuing on the present course is not an option. The Maine Medical Association recognizes this, as does the American Medical Association.

MMA Executive Committee Chair Jo Linder, M.D.

MMA President Stephanie Lash, M.D. presented the MMA's testimony at a second "Listening Session" with Senator Snowe at Husson University in Bangor on Wednesday, April 8, 2009.

The local media provided extensive coverage of both events.

As a moderate Republican on the Senate Finance Committee, Senator Snowe is expected to be a major player in the Congressional debate about health care reform. Accompanying her at the sessions was her principal legislative assistant for health care, William Pewen, Ph.D., M.P.H. *Roll Call* magazine recently named Dr. Pewen one of the ten most influential health staffers on Capitol Hill. He has advised Senator Snowe on health care matters for the past six years.

The health care reform debate in Washington is heating up. On Monday, May 11, 2009, AMA President-elect J. James Rohack, M.D. and Chair-elect Rebecca J. Patchin, M.D. joined representatives of the American Hospital Association (AHA), the Pharmaceutical Research & Manufacturers of American (PhRMA), medical device manufacturers, and the Service Employees International Union (SEIU) in a meeting at the White House with President Obama in which they discussed efforts to slow the growth of health care costs and health care reform generally. You can find more information about the AMA's principles for health care reform on the web at: http://www.ama-assn.org/ama/pub/legislation-advocacy/current-topics-advocacy/health-system-reform.shtml. You can find more information about the President's views on health care reform on the web at: http://www.whitehouse.gov/omb/fy2010_key_healthcare/.

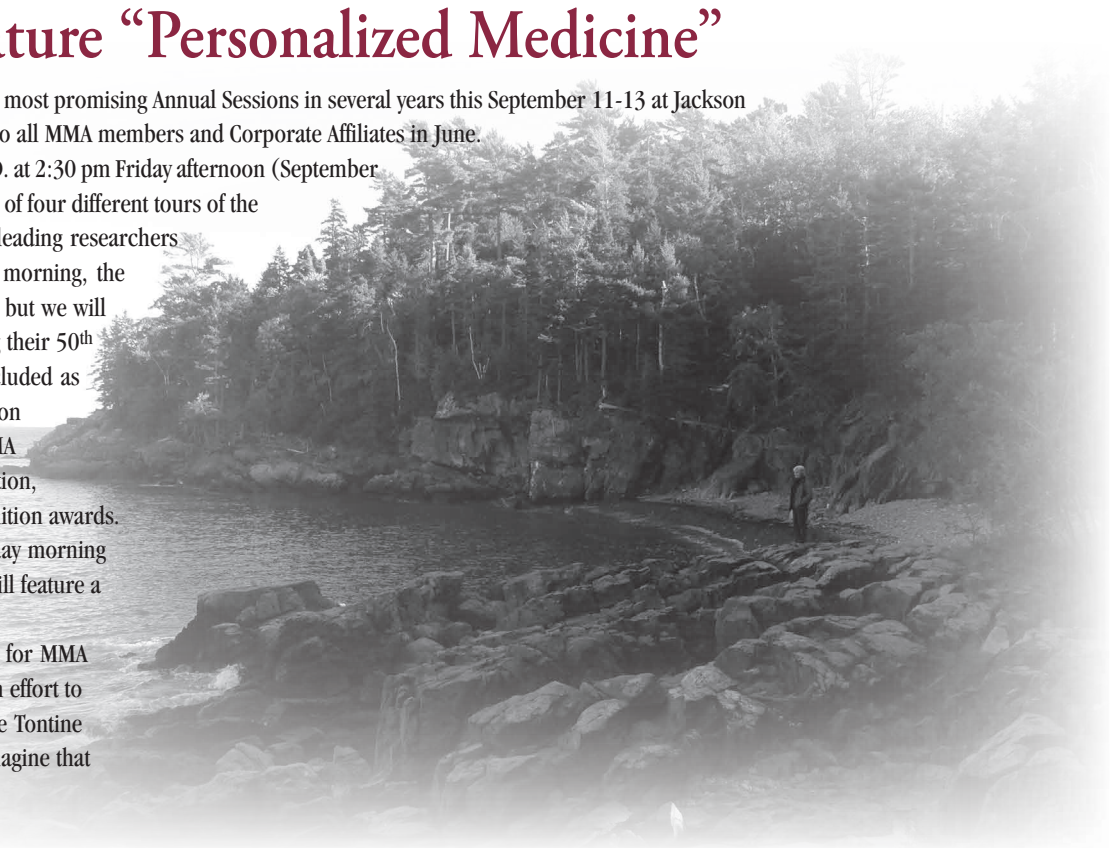
156th MMA Annual Session to Feature "Personalized Medicine"

A collaborative effort between MMA and Jackson Lab will result in one of the Association's most promising Annual Sessions in several years this September 11-13 at Jackson Lab and the Harborside Hotel and Marina in Bar Harbor. Registration materials will be sent to all MMA members and Corporate Affiliates in June.

The meeting will begin with a keynote talk by Jackson Lab President Richard Woychik, Ph.D. at 2:30 pm Friday afternoon (September 11th) in the lecture auditorium at the Lab. Following the presentation, attendees will pick one of four different tours of the lab featuring topics such as cryogenics, diabetes, and cancer. Following the tours with the leading researchers in each subject area, the opening night reception will be at the Laboratory. On Saturday morning, the traditional business meeting will be held at the Bar Harbor Club adjacent to the Harborside, but we will include during the meeting, the annual recognition of members who this year are celebrating their 50th anniversary of their medical school graduation. Traditionally, this recognition has been included as part of the Saturday evening banquet. Saturday afternoon will feature CME sessions by Jackson Lab researchers matched with state leaders in a given specialty area. On Saturday evening, MMA President Stephanie Lash, M.D. will pass the gavel to David McDermott, M.D., M.P.H. In addition, the Mary Cushman Award for Humanitarian Service will be presented along with other recognition awards.

Sunday morning will begin with the annual road race which is being moved from Saturday morning to Sunday morning as a part of our public health program. The public health CME session will feature a panel of presentations on environmental toxins.

This year's Annual Session has been designed to be more convenient and less expensive for MMA and attendees alike. It is a difficult year for everyone, but we sincerely hope you will make an effort to join us. Maine's physicians have held a similar event every year since the first meeting at the Tontine Hotel in Brunswick on April 28, 1853. Could those physicians attending that first meeting imagine that their efforts would be sustained for one hundred fifty-six years!



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Looking for E-Prescribing Info?

These online publications from the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) are a good place to start.

1. A Clinician's Guide to Electronic Prescribing (AMA) www.ama-assn.org/ama1/pub/upload/mm/472/electronic-e-prescribing.pdf
2. Medicare's Practical Guide to the E-Prescribing Incentive Program (CMS) www.cms.hhs.gov/partnerships/downloads/11399.pdf

Physicians may earn a 2-percent bonus on all 2009 Part B charges if they successfully meet Medicare's electronic prescribing reporting requirements.

Stephanie Lash, M.D., President, MMA

President's Corner

There is probably no more important time, than now, to participate with organized medicine in the health care delivery debate. So very much is presently being debated and decided. Whether or not you agree with all of the positions of the Maine Medical Association, your state and national specialty organizations, or the American Medical Association, it is time to join in this public effort.

President Obama has a mandate and commitment to work towards substantial health care reform. The economic forces facing medicine are much more acute than even one year ago. Here in Maine, we are fortunate to have representation in the Congress that has been keenly aware of the critical importance of health care to the people of Maine. And Senator Snowe, one of the senior members of the Finance Committee, is in a position to directly help craft these reforms.

Within the past year, we at the MMA conducted a survey of Maine physicians. We were surprised to read, in several of the responses, frustration and unhappiness from doctors concerning specific positions the organization had taken. It is not surprising that physicians have differing opinions about some issues. What was surprising is that the positions that these doctors were angry about are not positions that the MMA has ever supported. So I encourage you to check on the web site, www.mainemed.com. If you don't find the information you need there, call or e-mail me directly, (207) 947-0558; stephanielash@roadrunner.com, or call the MMA office at (207) 622-3374. I hope, as you get more information, you will be pleased with what you hear about what the MMA has and is doing. And if not, we especially want to hear from you. We need to do our very best to represent the full range of opinions.

So get involved. Learn what is going on in Augusta. Learn what is going on in Washington. And learn how this will affect you and your patients. Participating in this process is truly all of our responsibility as members of the guild of medicine. And in a larger sense, is part of our responsibility to our patients. I can be reached at 947-0558 or stephanielash@roadrunner.com.

E-Mail Use by Health Care Providers: Good, Bad or Inevitable?

By Beth Dobson, Esq., Verrill Dana, LLP, Health Care Industry Group (bdobson@verrilldana.com)

Long holds on the telephone and "telephone tag" between and among patients, providers, and others are frustrating, inefficient and can contribute to poor physician/patient communication. When used appropriately, e-mail can facilitate physician/patient communications that are prompt, efficient, effective, and provide a lasting record.

While there are privacy laws and other standards that generally govern all physician/patient communications, the preeminent guidelines for electronic communications are the AMA Guidelines, available at http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/young-physicians-section/advocacy-resources/guidelines-physician-patient-electronic-communications.shtml.

Important components of prompt, efficient and effective e-mail communications include the following:

1. Policies and practices should be tailored to the specific nature of the facility or practice. For example, a pediatrician's office will require different guidance for appropriate e-mail use than an obstetrician's office.
2. Appropriate and inappropriate subject matter should be identified. Appropriate communications are generally understood to include such things as appointment scheduling, prescription refills, billing questions, and referrals. Inappropriate communications include urgent requests for medical advice, detailed descriptions of medical problems or recommendations, and communications with heightened privacy considerations such as HIV, STD, mental health, and substance abuse.
3. Practices or providers should develop guidelines or policies concerning appropriate email use and security measures. Policies for internal staff should be followed by appropriate acknowledgements and training. Patient agreements should authorize and disclose the risks of e-mail use.
4. All users of e-mail -- staff, patients, providers, and others -- should be counseled about the appropriate form and content of communications such as "write concisely," "retain copies," "patients should use full name and birth date."
5. As with other patient records, provisions should be made for retaining either electronic or paper copies of electronic communications to ensure that these communications are accessible parts of the record.

While the initial transition to e-mail use may be challenging, studies show that e-mail can lead to increased patient and physician satisfaction because of increased efficiency and the prompt responses associated with e-mail.

So, if email use can be managed effectively, what is holding it back?

1. Technology resistance.
2. Liability concerns associated with untimely or incomplete responses to e-mail.
3. Privacy concerns.
4. Volume - concerns about floods of e-mail.

Each of these concerns, however, can be addressed or mitigated with appropriate guidelines, policies, agreements, security measures, monitoring, and corrective actions.

With respect to malpractice-type liability for being unresponsive or non-responsive, or for giving incomplete advice in response to e-mail inquiries, insufficient precedent exists to say for sure what risks e-mail use creates, but it seems likely that traditional standards of negligence would apply. Thus, if a health care provider responds with due care — that is, with an accurate response, recommendation to follow-up, reminders that patients should call in urgent or emergent situations — the liability risk would be appropriately managed. For example, an automated reply to all patient e-mails would help meet the appropriate standard of care if it (1) confirms receipt, (2) advises about a potential delay in response, (3) indicates that a call or other means of communication should be used if the patient's inquiry is urgent or emergent, and (4) indicates that an appointment should be scheduled if there is any change or worsening of a condition.

Resistance to change or technology should not, alone, be reasons to avoid the use of e-mail as another means of physician/patient communications.

Post Script: *While patient issues are the paramount concern with physician e-mail use, financial security is also a major concern. Care should be taken to ensure that computers with e-mail, internet and other external access are segregated from computers used in sensitive accounting and banking functions to avoid the risk of infection by malicious software or viruses, which could lead to unauthorized access or use of personal or financial data.*

Thanks to 2009 Sustaining Members

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

John Arness, MD ~ Robert McAfee, MD ~ Edward Morse, MD ~ Michael Parker, MD ~ Hugh Robinson, MD
Elihu York, MD ~ Cardiovascular Consultants of Maine

Upcoming at MMA

JUNE 3	2:00pm	MMA Executive Committee
	5:00pm	MMA Budget and Investments Committee
JUNE 4	4:00pm	MMA Committee on Physician Quality
JUNE 10	6:00pm	MMA Payor Liaison Committee
JUNE 11	8:00am	HRSA Grantees Strategic Partnerships
JUNE 16	8:30am	APIC (Infection Control): Pine Tree Chapter
JUNE 17	9:00am	Patient Centered Medical Home
JUNE 18	8:30am	Pathways to Excellence (Maine Health Management Coalition)
	6:00pm	Maine Association of Psychiatric Physicians, Executive Committee and Committee Chairs Meeting
JUNE 23	1:00pm	Aligning Forces for Quality, Steering Committee
JULY 1	Noon	Aligning Forces for Quality, Executive Leadership Team
JULY 13	5:30pm	Medical Professionals Health Committee
JULY 21	5:00pm	American Academy of Pediatrics, Maine Chapter Board Meeting
AUGUST 5	Noon	Aligning Forces for Quality; Executive Leadership Team
AUGUST 12	11:30am	MMA Senior Section
AUGUST 19	4:00pm	MMA Public Health Committee

2nd Annual Quality Symposium

Hospital-Physician Relations: Building a Foundation of Trust and a Shared Vision of Excellence

Wednesday, June 24, 2009

8:00 a.m. - 2:30 p.m.

The Samoset Resort, Rockport, ME

Baypoint Ballroom

Presented by:

Maine Hospital Association, Maine Medical Association, Maine Osteopathic Association

With sponsorship from the **Maine Quality Forum**

For more information, visit www.themha.org or www.mainemed.com

Upcoming Specialty Society Meetings

JUNE 6, 2009 — Hilton Garden Inn – Freeport, ME

Maine Gastroenterology Society – Gastroenterology Update

MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

JUNE 18, 2009 — Maine Medical Association – Manchester, ME

Maine Association of Psychiatric Physicians Executive Committee & Committee Chairs Meeting

6:00 - 9:00 pm

MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

JUNE 25, 2009 — Lobster Bake on Cabbage Island

Maine Chapter, American College of Emergency Physicians

Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

SEPTEMBER 9, 2009 — Maine Medical Association – Manchester, ME

Maine Chapter, American College of Emergency Physicians

Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

SEPTEMBER 11 - 13, 2009 — Harborside Hotel & Marina – Bar Harbor, ME

The following Specialty Societies will be holding meetings in conjunction with MMA's Annual Session taking place at the Harborside Hotel & Marina in Bar Harbor, Maine:

Maine Society of Orthopedic Surgeons (Sept. 11-12)

MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

Maine Association of Psychiatric Physicians (Sept. 12)

MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

Maine Society of Anesthesiologists (Sept. 12 – 2:00 pm - 5:00 pm)

Contact: Anna Bragdon 207-441-5989 or msainfo@roadrunner.com

Maine Urological Association (Sept. 12 - 2:30 pm - 4:30 pm)

MMA Contact: Kellie Miller 207-622-3374 ext: 229 or kmiller@mainemed.com

OCTOBER 2, 2009 — Harraseeket Inn – Freeport, ME

Maine Association of Psychiatric Physicians General Membership Meeting

5:00 pm - 9:00 pm

MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

OCTOBER 2, 2009 — Harborside Hotel & Marina – Bar Harbor, ME

Maine Society of Eye Physicians and Surgeons Fall Business Meeting

(To be held in conjunction with the 8th Annual Downeast Ophthalmology Symposium)

10:30am – 12:00pm

MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 2-4, 2009 — Harborside Hotel & Marina – Bar Harbor, ME

8th Annual Downeast Ophthalmology Symposium

(Presented by the Maine Society of Eye Physicians and Surgeons)

MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 16-18, 2009 — Jordan Grand Hotel at Sunday River – Bethel, ME

Maine Chapter of the American College of Physicians Annual Scientific Meeting

MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

Visit the MMA website at
www.mainemed.com

Gordon Smith, MMA EVP

Notes from the EVP

While it may seem from our communications to members that all we do the first six months of the year is legislative advocacy, in fact, there are quite a few other projects in which we are engaged along with our consistent presence at the State House in Augusta.

On the education side, we are gearing up for our 18th Annual Practice Education Seminar being held on June 3rd at the Augusta Civic Center. Last year, more than 100 members and practice managers attended to receive the latest information on practice trends and compliance. This year we are pleased to have our new Attorney General Janet Mills provide the keynote presentation, with a second featured talk by Mila Kofman, J.D., the state Superintendent of Insurance. Both of these departments are of increasing importance to Maine physicians. We also have held two successful First Friday presentations this year and will continue this popular series of educational presentations in the Fall.

We are also excited about presenting the second joint conference on Quality Improvement with the Maine Hospital Association on June 24 at the Samoset Resort in Rockport. There has never been a more important time to discuss opportunities for physicians and hospitals to work together to improve the quality of medical care provided to patients. I hope many of you will be able to attend.

The Coding Center, with our new Director Gina Hobert, C.P.C., M.B.A, is off to a successful start this year with two AAPC classes going presently and a third scheduled to begin in August in Lewiston. It does not appear that coding, reimbursement, and documentation issues will become any less important in the health system of the future currently being designed in Washington. That being the case, I suspect that The Coding Center will have a bright future.

Our state contracts including practice assessments, chronic pain prescribing, and academic detailing are also keeping us busy. I want to acknowledge the terrific work of our consultants on these projects, including Nancy Morris, Noel Genova, PA-C, and Erika Pierce, PA-C.

Our April 15th Corporate Affiliate Breakfast featuring WGME News Anchor Kim Block attracted nearly 100 guests and was a great opportunity to promote support from our corporate partners for the June 3rd Seminar, the June 22nd Annual Golf Tournament, and our 156th Annual Session in September in Bar Harbor.

This year's Annual Session will offer education from Jackson Lab on "personalized medicine." I call your attention to the "Save the Date" insert in this issue of *Maine Medicine*. If you have never been to an Annual Session, this is a great year to give it a try!

While these events and activities take up a lot of time, we always have time to answer questions, to send you to appropriate resources, and to continue to advocate on your behalf in Augusta and Washington.

Thanks for your continued support of MMA and I hope each and every one of you enjoy our Maine summer. You deserve it!

An MMA event to really get your engines going! Cool Cars... Great Food & Drinks... and Good Company

Thursday, June 18th from 5:30 to 7:30 at Portland Motor Club

Maine Medical Association presents a very special early evening out at Portland Motor Club, a unique facility to Maine providing secure, climate-controlled garaging and care of vehicles with year-round access and a club lounge for members. Guests will visit with colleagues and friends in the midst of some great classic and muscle cars while enjoying fine catered fare and drinks courtesy of Portland Motor Club by way of introducing this specialized service to Maine's medical community.

Plan to stop by on **Thursday, June 18** from **5:30 to 7:30** to see something special and to experience this handsome, full-service facility for car lovers. And you are welcome to bring your spouse and/or a friend or two, especially if you know that they're automobile enthusiasts.

The evening will feature...

- a unique venue for socializing with colleagues and friends
- an introduction to the Portland Motor Club car marina concept
- a conversation with the owner about collecting cars
- catered hors d'oeuvres & drinks

Stop by on the way home or make a special trip and plan on having dinner out with friends afterwards. But it's worth your time to stop by for this special event. And don't miss a great surprise at 7:15!

YOU MUST RSVP with the number in your party by June 11 to: info@portlandmotorclub or call 207-775-1770.

And, if you have a special car of your own and want to drive it to this special event, you can park your car in the "car corral" that we'll have set up for the evening!

For directions and a map, please visit **www.PortlandMotorClub.com**. Portland Motor Club is located at 275 Presumpscot Street in Portland, about 1/2 mile from Washington Avenue. For more information, call Kal Rogers at Portland Motor Club at 207-233-9970 or e-mail him at: info@portlandmotorclub.com

Join us!

Independent Medical Examiners Wanted

The Maine Workers' Compensation Board is searching for physicians to perform independent medical exams under Section 312 of the Workers' Compensation Act. An independent medical examiner shall render medical findings on the medical condition of an employee, which may be binding if adopted by the Board. Applicants must be licensed by the State of Maine, have an active, treating practice, be Board-certified and demonstrate experience in the treatment of work-related injuries. Various specialties are needed, including orthopedics, physiatry, neurology and general medicine. This is an opportunity to receive reasonable compensation for issuing fair and objective opinions while providing a public service to the workers' compensation community. For additional information, please contact Betty Inman at (207) 941-4557 or e-mail your CV to betty.inman@maine.gov.

Annual MMA Golf Tournament

June 22, 2009

11:00 a.m. – 5:00 p.m.

Augusta Country Club

Manchester, Maine

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.

Gina Hobert, Director

Coding Updates *by Gina Hobert, BS,CPC, CPC-H, CMOM, Director, The Coding Center*

Maine Medical Association Tel: 888-889-6597 Fax: 207-512-1043 ghobert@thecodingcenter.org

Why do Providers Need to Know Coding Basics?

A comment I often hear from many physicians is "all I want to do is treat my patients." The truth is, despite their tendency to avoid the topic, providers must take the responsibility for coding seriously. With the constant changes of our medical system, who other than the person treating the patient is best qualified to determine the correct code to use when submitting claims for reimbursement?

Documentation requirements themselves have changed dramatically over the last several years for a number of reasons. Whatever the reason for the changes, the important thing to remember is that the content of the medical record is essential for patient care and serves as evidence in defense of insurance fraud and malpractice. In addition, it provides supporting documentation for insurance carriers requiring documentation to support the level of service billed to them.

Coding responsibilities should not be the sole responsibility of a coder. There are several different codes that can be used to describe the same procedure. Only the provider knows how to fully and accurately describe what service has been performed and the level of medical decision-making involved. Ultimately, it is the provider who will take final responsibility for the level of payment that service generates, regardless of how the code was selected for coding. If your office staff does the coding and billing for you, and is doing it wrong, you still are the responsibility party.

If we over code, we are guilty of defrauding the insurance companies and in the case of Medicare, the government. Doctors, NP's, and PA's are all targets of audits with criminal as well as civil penalties. Unfortunately, many providers are not aware of, or opt not to learn about, proper coding. Not only do we need to look at over coding, we need to be aware of down coding. This happens when providers or their staff submits a claim for a lower level of service than the level actually performed. Although down-coding may sound like a great idea, it isn't. The impact of under-coding is that many providers cheat themselves out of payments deserved. The second issue is fraud. Whether you under code or over code you are miscoding, and it's against the law.

This article was not meant to scare you, but to help inform you of the importance of knowing the basic coding rules. There are provisions out there to help protect you. A practice Compliance Program is one way to provide protection. These are programs that outline how you handle internal quality improvement. They can include provisions for internal audits or external audits, training, or other components that will assist your practice in improving its compliance and accuracy in billing and coding. With a compliance program in place, the office of the inspector general (OIG) would look upon your errors as mistakes rather than fraud. As a result you would be financially responsible for overpayment but usually not found criminally liable.

The Office of the Inspector General (OIG) is responsible each year for catching providers who commit Medicare fraud. They profile the providers and decide on a particular area to focus on. Level 4 (99214) and Level 5 (99215) visits are common ones, and when they do an analysis of percent of visits listed as level 4 or 5, they typically target the providers on the outer end of the curve, not the lower end outliers. Coding your super bill before giving it to your office staff eliminates any uncertainty. All you need to do is learn to code and document properly and it really isn't that difficult.

Some coding basics to get you started:

ICD-9 Codes (International Classification of Diseases, 9th Revision)

- ICD-9 codes describe the reason for the medical services to commercial and government payers in alpha/numeric codes. Carelessness in linking the diagnosis to the proper code can lead to a denied claim. The diagnosis or clinical suspicion must be present for the procedures to be considered medically necessary.
- Make every effort to code to the highest level of specificity. Many office staff check the alphabetical index (Volume 2) of the ICD-9 book for the patient's condition but do not cross-reference to the list of diseases (Volume 1) for the most specific code.
- Use signs and symptoms to describe medical necessity for a procedure or service when a more specific diagnosis doesn't exist, such as when a patient's symptoms await confirmation from a lab test. Section 16 of the ICD-9 manual lists signs and symptoms codes (780-799.9) to be used if a diagnosis is not available or until a diagnosis can be proven or if a pathology report returns negative. Since terms such as "suspected" or "rule-out" are not acceptable as a diagnosis, doctors must code the signs and symptoms that brought the patient to the office and that prompted certain tests.

CPT Codes (Current Procedural Terminology)

- The CPT book is updated annually by the American Medical Association. In addition to keeping the most current edition on hand, doctors and their staff should review the introductory section on the CPT process and on coding for evaluation and management (E&M) services.
- Physicians can use any code, but most use the same 20 to 30 codes specific to their area of expertise. These are the codes that should be listed on your superbill, which should be reviewed regularly (at least once a year) and updated as needed. Also take time to review other sections of the CPT book. Organized into six major sections, each offers definitions, explanations of terms, and factors relevant to each section.
- E&M codes (99201 - 99499), used by all medical specialties, can be considered the "overview" codes that all physicians must use in submitting claims. The E&M codes are more subjective than procedure codes, and, therefore, are the most difficult to understand. Many Medicare guidelines have been written to interpret these codes. Codes in the remaining sections of the handbook deal with specialty-specific procedures.

Chief Complaint

- A patient's chief complaint gives evidence to the insurance company why the patient sought your services. Since insurers typically are paying 70% to 80% of the bill, they are entitled to know the reason the patient came to your office and whether the services you rendered are considered appropriate.

Billing for E/M Services

Keep in mind that

- A new patient is one who has not received any professional services from the physician within the previous 3 years.
- Two office or hospital visits are not payable for the same patient on the same day by the same physician.
- Administration of a drug on the same day as an office visit is not separately payable (only bill for the office visit and the drug.)
- Medicare patients may not be charged for the completion of paperwork.
- When a hospital admission following a nursing home visit occurs on the same day, only the hospital admission is covered.

Consultation vs. Referral

- One of the most troublesome coding decisions is whether a visit is a consultation or a referral. A *consultation* is a rendering of advice or your professional opinion, followed by a report of your findings to the referring physician. A consultation visit results in the patient returning to the primary care physician who initiated the care. Diagnostic testing can be provided and billed in a consultation.
- If the consultation results in the physician assuming care of that patient, the visit is a *referral* and should be billed as a new patient.

Unbundling Services

- Unbundling refers to the duplicative coding of services or procedures that a provider submits as being performed on the same day. Whether intentional or not, unbundling is considered by payers to be a form of fraudulent or reckless billing. To avoid this error, review the global package concept in the surgical guidelines of the CPT book. Detailed discussion of the CPT global package rules are outlined here.

If you have questions about the information in this article or other coding questions, feel free to contact me at 888-889-6597.

H1N1 Novel Influenza in Maine

Basic Resources *Strategies on the same subject can be found on page 5*

Because recommendations from U.S. CDC are being updated very frequently, we (the Maine CDC) strongly urge clinicians, school officials, and others to review the most updated guidance before making clinical or other decisions. We will not be issuing a health advisory for every update. There are several resources for information:

- The U.S. CDC's website can be found at: http://www.cdc.gov/h1n1/.
- Maine CDC's website has Maine-specific information, including daily updates and press updates as well as links to federal information. It is located at: http://www.maine.gov/dhhs/boh/swine-flu-2009.shtml and is found on the Maine CDC's homepage: http://www.mainepublichealth.gov/.
- Maine Department of Education's website has resources and information for schools. It can be found at: http://www.maine.gov/education/h1n1/index.html.
- Health care providers or school officials needing updated clinical guidance should call Maine CDC's 24-hour clinical consultation line (1-800-821-5821). This is also the resource to report a suspected case and obtain testing information including expediting the transportation of samples for testing. Maine CDC's Health and Environmental Testing Laboratory (HETL) will perform influenza RT-PCR tests and subtyping for influenza A positive specimens. Instructions on collecting and submitting laboratory diagnostic specimens for H1N1 influenza testing are available at http://www.maine.gov/dhhs/etl/micro/submitting_samples.htm.*.
- The public information line with questions about H1N1 may also call our information support line at 1-888-257-0990 weekdays from 9am to 5pm.

Public Health Spotlight

Kellie Miller, Director of Public Health Policy, MMA

Because of the circumstances surrounding the novel H1N1 influenza outbreak, this issue of the Public Health Spotlight has been reserved for the Chair of the MMA's Public Health Committee, Charles Danielson, M.D. We encourage our physician members to ask questions and refer them to the MMA's Public Health Committee for further discussion and clarification. If you would like to respond to Dr. Danielson, please email Kellie Miller, staff to the Public Health Committee at kmiller@mainemed.com. We look forward to your involvement and participation during this time of an emerging novel influenza strain to provide guidance and strength to the Maine CDC.

Novel H1N1 Influenza Strain and the Maine Medical Association's Role

By Charles Danielson, MD, Chair, MMA Public Health Committee, practicing pediatrician in Waterville, Maine

With the recent appearance of this novel H1N1 influenza strain, many have asked what should the MMA do, how can we help? As professionals we want to support the greater good while providing for the individual in front of us. Supporting community or population health and providing individual clinical services are complementary and interactive functions. For the MMA, a useful distinction is between preparation and response. Clearly, the preparation determines your response options in the face of an outbreak. Unfortunately planning matters (and that means meetings, ugh!).

What should the MMA do?

1. *Promote Maine CDC as our primary and definitive source:* To accomplish its mission the agency needs: a. information about the incidence spread and morbidity, b. expertise and resources to assess and respond, c. authority not only to investigate and quarantine but to align other resources from EMS and public safety to nursing home emergency rules and regulations, and perhaps most important d. the independence to respond based on good science.
2. *Monitor the response, effectiveness, advise, and at times amplify available information.* Information is critical, email and the web are the lifeblood. The resources on the Maine CDC website are detailed and quite good including useful links. The challenge to Maine CDC is to inhale useful data and express valuable information. Maine CDC must receive the usual information about the outbreak and provide clear and timely information to practitioners and the public about infected, exposed, and worried individuals. There are multiple special populations that may need specific messages including health facilities, schools, and businesses. Physician offices with recurring and often intense exposures over long periods of time may pose a special challenge.

   We should encourage our members who are concerned about or confused by the government response to include an email to MMA PHC staff. We will examine these for common concerns and decide how to respond or get a response from Maine CDC. As an organization with many clinicians, we have a greater understanding of what we need to respond to our patients than does the Maine CDC. If recommendations are confusing we can work to clarify them or at least prepare scenarios that lay out reasonable responses such as specifically who to test or treat. This can be very helpful with such nonspecific symptoms as nasal congestion, sore throat, and cough.
3. *Be prepared to respond to the media:* If the MMA is well organized and thoughtful we can provide valuable information to the public not only about the outbreak, treatment, and exposure but also about the response if the outbreak becomes more severe and rationing or greater restrictions are demanded. There will be questions around "how well is government doing its job?" Our monitoring of the issue and feedback from members will allow us to offer credible and important information.
4. *Review the effectiveness of the response*: With an eye to improved future preparedness, MMA should review the response to the outbreak from scientific perspective, the public and professional information perspective, and operational perspective. Our goal is to identify what worked and what did not. A portion of the August 2009 PHC meeting will address this issue. E-mail Kellie Miller (kmiller@mainemed.com) with your thoughts and concerns. We should remember that while the swine flu of the 1970s was a bust the next year, the 1918 great flu came back with a vengeance.

You might look at these and say, the MMA does most of that already. And that is good, you do not want to change routines in a crisis. We will be best served by working with a strong Maine CDC.

Sign Up to Be a Doctor of the Day at the Maine State Legislature

Call Maureen Elwell at 622-3374, ext. 219 for details

Managing Transitions: The Anticipated and the Unforeseen

By Barbara A. Appleby, JD, MA, AIF® and Barry L. Kohler, JD, CFP®, CLU, BDMP Wealth Management

Transitions occur whether or not we desire them and whether or not we have prepared for them. After more than a quarter century in working with professionals, their practices, and their families, we have discovered that **every transition works better if some planning has occurred**.

Planning decisions occur in relation to what we call "The Planning Horizon." When we are working "below the horizon," we are considering Tools, Tactics, Techniques, and Strategies. In other words, issues that address **who** is going to help (lawyer, accountant, etc.) and **how** is he or she going to help. By contrast, "above the horizon" issues relate to **what** do we want to do and **why** is that important to us. In our experience, when planning fails to result in action, in most cases it is due to a lack of clarity; in other words, insufficient time has been devoted to "above the horizon" considerations.

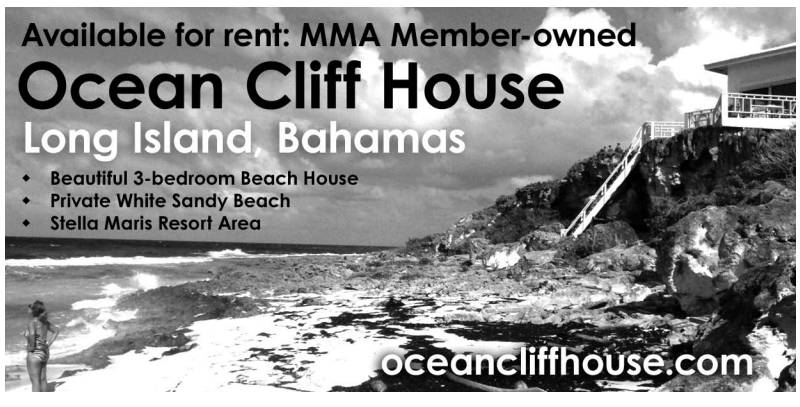
Most busy professionals spend so much time taking care of their patients and clients that they do not spend enough time attending to their own affairs. As a result, when an unanticipated event occurs, the result is a "fire drill" which all too often brings about undesirable consequences that could have been avoided with a little planning. The two most common unintended negative consequences are that (a) *the family* is not adequately protected, and (b) in the case of a business owner or professional, *the business or practice* is not transitioned in an optimal way or in a way that meets the owner's multiple objectives.

All planning (both strategic and tactical) should begin with an exploration as to what the client is trying to accomplish. It is important to define the objectives as clearly (and concretely) as possible. This clarity helps assure that accomplishing one objective will not inadvertently adversely impact another important goal or value. And as we all know, often the presenting problem (what at first one *thinks* is the problem) may not be the *real* problem. The diagnostic tools available to planners can be very helpful in attaining the needed clarity to enable planner *and* client to proceed to the next phase of the planning process; namely, considering creative solutions that accomplish and optimize multiple goals.

While there are often pressures to move too quickly from diagnosis to treatment, it is almost always a mistake to do so. Sometimes these pressures come from the client (who can often be bottom-line driven and results-oriented). Sometimes the pressures come from the advisor who may have a particular bias or even agenda. Most charitably, a technical advisor may see only the issues that his or her array of tools can help fix. Less charitably—but all too frequently—the "problem solver" has only a limited set of solutions and is in search of problems to fix. ["To a man with a hammer, everything looks like a nail."]

In our view, the most successful planning for complex situations occurs when there is a Team Leader—a professional whose fiduciary obligation and duty of loyalty is to the client. The Team Leader leads the planning process, and oversees the work and coordinates the recommendations of the other technical experts whose contributions are required to obtain the best result for the client. Engaging a team of professionals with a Team Leader is obviously not the least expensive way to proceed. However, as in any professional endeavor, the least expensive approach is rarely the most appropriate, advisable, or best solution—and as we all know, many times even "free" can be just way too expensive.

But whether you choose to DIY ("do it yourself") or avail yourself of the professional services of an experienced Team Leader, for the sake of your family, your patients, your partners, your practices, and your own peace of mind, make some planning a priority—even if you know that accidents only happen to other folks and that your own mortality is only a purely theoretical possibility.



H1N1 Novel Influenza in Maine
Overall Strategies

Resources on the same subject can be found on page 4

The overall goal of Maine's efforts to address H1N1 is to minimize its impact in our state.

Strategies to slow the spread of this infection include:

- Having easily available tools (soap/water, hand sanitizer, tissues, reminder posters, etc) for maintaining respiratory etiquette in workplaces, schools, daycares, and wherever people are gathered;
- Isolating people with symptoms such as a fever and respiratory symptoms (whether they have had a test for influenza or not);
- Isolating appropriate household contacts;
- Encouraging people at high-risk for complications to take precautions;
- Implementing other community mitigation strategies such as closures and cancellations when appropriate.

These strategies can: delay the peak of the disease in order to "buy time" for the production and distribution of a vaccine against this new virus; decrease the number of people who get sick from this virus in a given community, thus reducing the "surge" on healthcare systems; and reduce the total number of people who get sick or die. Because H1N1 is now found to be circulating in various parts of the globe, including places in the southern hemisphere where the time for seasonal influenza is beginning, we also need to prepare for what could be a more severe fall and winter with seasonal influenza since both H1N1 and seasonal influenza viruses could be circulating simultaneously. Such preparations include:

- Reviewing successes and lessons learned from the last two weeks and adjusting one's pandemic influenza plans appropriately;
- Reviewing and adjusting one's pandemic plans for a higher severity index; and
- If applicable, preparing for mass vaccinations.

The most important strategies to minimize H1N1's impact in Maine continue to be:

- Maintain vigilant respiratory etiquette: covering coughs and sneezes with sleeves or a tissue; washing hands frequently; and staying home if ill, especially with a fever.
- Stay informed since this event is changing and so is the resulting guidance.
- Make preparations. If one does not have a pandemic influenza plan, then preparation check lists for a variety of settings can be found at: **http://www.pandemicflu.gov/plan/checklists.html**. These plans generally call for such measures as ensuring adequate critical supplies are on hand and preparing for higher than normal absenteeism.

Kim Block Wow's Attendees at Annual Corporate Affiliate Breakfast

Long-time WGME News anchor Kim Block addressed nearly one hundred guests at the Annual MMA Coporate Affiliate breakfast on Wednesday, April 15th at the Portland Country Club. Kim talked about her team's travel to China last fall to document the work of Portland surgeon Reed Quinn, M.D. and his team of medical professionals. Dr. Quinn's team travels to China periodically to treat Chinese children and teach Chinese physicians under the auspices of the *Maine Foundation for Cardiac Surgery*.

The WGME story, *The China Journey*, recently won an Edward R. Murrow Award from the Radio-Television News Directors Association.

Kim Block is the most recognized news anchor in Southern Maine and has been at the station for twenty-seven years. Her late father practiced surgery in Virginia and was active in the AMA, a connection she noted during her talk. Retired Portland surgeon and former AMA President Robert McAfee attended the breakfast and presented Kim with some photos of her father at AMA functions.

MMA's Corporate Affiliate Program provides an opportunity for businesses, professional firms, and other vendors interested in Maine's medical community to network with MMA members and to support MMA activities through joint marketing. The program is operated under the auspices of MMA's Committee on Membership and Member Benefits. The Committee is currently chaired by Kevin Flanigan, M.D. of Pittsfield, a former MMA President.

MMA will make a contribution in Kim's name to the Foundation.

Andrew MacLean, Esq.

Legislative Update

124th Maine Legislature Faces Continued Budget Challenges As It Approaches June 17, 2009 Adjournment

Governor presents legislature with plan to cover new $569 million budget gap; legislature enacts and Governor signs same sex marriage bill (L.D. 1020); committees rush to complete public hearings and work sessions on their bills in order to get bills out into floor debate in the House and Senate; MMA is tracking more than 250 bills of interest to Maine physicians.

The 186 members of Maine's 124th Legislature now are two-thirds of the way through their First Regular Session. The Appropriations Committee continues its work on the State FY 2010-2011 biennial budget (L.D. 353) and Committee chairs are under great pressure from legislative leaders to complete their work.

In late April, the Appropriations Committee reached agreement on complex and contentious hospital and physician reimbursement issues raised by the Governor in both his supplemental (L.D. 45) and biennial budget proposals, including efforts to reach parity between MaineCare's reimbursement of hospital-based physicians and those paid according to the MaineCare fee schedule. The agreement included four parts:

- Reductions in hospital reimbursement. The plan included a $9.1 million cut in hospital reimbursement in FY 2010, the General Fund amount representing the Governor's original proposal for cuts in reimbursement for critical access hospitals and hospital-based physicians. Reimbursement for critical access hospitals is reduced from 117% to 109% of costs. Outpatient services are reduced from 89.7% of costs to 83.6% of costs. Inpatient and ER services are reduced from 100% of costs to 92.8% of costs. The TEFRA rate is reduced 7.2% overall and affects each hospital differently.
- Reimbursement for physicians paid according to the MaineCare fee schedule. The plan maintains a 3% increase in hospital periodic interim payments (PIP) ($2.2 million) in FY 2010, but uses a projected PIP increase in FY 2011 to move the fee schedule to 70% of Medicare rates effective February 1, 2010.
- Implementation of an APC/DRG payment system for hospitals. The plan directs DHHS to begin implementation of an APC/DRG payment system for hospitals beginning April 1, 2010. The conversion of the payment system is intended to be budget neutral. Each hospital will move to the new payment system at the beginning of its first fiscal year after April 1, 2010. DHHS will re-weight the APC/DRG system to increase reimbursement for preventive services and chronic disease management. The Department will report back to the HHS Committee on the conversion in January 2011.
- Report on hospital efforts to reduce ER use and to manage chronic conditions. The plan also would require the Governor's Office of Health Policy & Finance to report to the HHS Committee in January 2010 on hospitals' efforts to reduce ER use and to manage chronic conditions.

On Friday, May 1, 2009, Governor Baldacci released an overview of his proposal to address a new $569 million budget gap that has arisen because of continued poor economic conditions. His proposal closes a $129 million budget gap for the current fiscal year ending June 30, 2009 and a $440 million gap in fiscal years 2010-2011. The Governor uses federal stimulus funds to address about $100 million of the $440 million gap. The remainder of the gap is addressed as follows:

- Cuts to education, including higher education ($84 million);
- Adjustments/increases to state income taxes/enhanced collections ($77 million);
- Unidentified cuts or "efficiencies" to be developed by a special streamlining commission ($37.5 million);
- Cuts to human services programs ($36 million);
- Cuts to property tax relief programs ($28 million);
- Cuts to state employees ($27 million);
- Hospital reimbursement delays ($15 million); and
- Capping state support for the milk price stabilization program ($14 million).

The Governor's proposal includes no further cuts in DHHS programs in the current fiscal year (FY 2009). The additional DHHS cuts in the next biennium include:

- Eliminate targeted case management (TCM) for MaineCare members receiving care management from Schaller Anderson ($1.37 million in each year of the biennium);
- Increase the eligibility requirement for TCM for children from a CAFAS score of 50 to 70 ($3.8 million in each year of the biennium);
- Increase MR waiver residential reductions in rates from 5% to 7% ($1.7 million in each year of the biennium);
- Move children's PNMI reimbursement rates to the New England average ($8.9 million in each year of the biennium);
- Pharmacy savings ($1.7 million in FY 2010 and $2.6 million in FY 2011);
- Pay a portion of hospital payments by cascade ($15 million in FY 2010); and
- Antivirals for influenza pandemic – paid for from ARRA funds ($2.2 million in FY 2010).

As this issue of *Maine Medicine* goes to press, the Appropriations Committee is working on these most recent budget issues with an expectation that the legislature will have the budget enacted by mid-May.

While the state budget issues have dominated the health policy debate at the State House this session, the MMA has worked with medical specialty organizations, the Maine Hospital Association, and other health care organizations on a wide variety of health care legislation, including bills on sentinel event reporting, certificate-of-need (CON), due process rights in health insurer profiling and tiering programs, minors' rights to health care services, and immunizations.

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 MMA also holds weekly conference calls of the Legislative Committee on Thursdays at 8:30 p.m. To find more information about the MMA's advocacy activities, visit the Legislative & Regulatory Advocacy section of the MMA web site, www.mainemed.com. You will find more information about the Maine Legislature, including bill text and status, session and committee schedules, committee assignments, legislator contact information, audio coverage of legislative work, and newly enacted laws on the web at: http://janus.state.me.us/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.

Medical Mutual Insurance Company of Maine Risk Management Practice Tip: Chaperone Presence in the Physician Office Practice

The presence of a chaperone is appropriate when performing "intimate" examinations to avoid provider exposure to accusations of unprofessional conduct or sexual assault. Chaperone use is recognized as minimizing this risk.

The American Medical Association Ethics Policy on the "Use of Chaperones during Physical Exams" speaks to preventing potential issues that may be encountered during examinations. In consideration of the risks, clinical guidelines in addition to physician discretion, must dictate practice.

Chaperone Etiquette and Recommendations:

- Arrange for a chaperone when conducting an "intimate examination" regardless of the patient's sex. Exempt restrictive age limits from consideration.
- Engage a member of the clinical staff when possible. Avoid requesting friends and relatives to chaperone due to potential embarrassment and inadvertent breach of confidentiality. Consider alternatives although at times no other option is available.
- Introduce the chaperone to the patient. Record the name and qualifications of the chaperone in the encounter note.
- Limit discussion of confidential and sensitive patient information when a chaperone is present.
- Provide the patient an opportunity to engage in a confidential discussion regarding their medical care.
- Provide patients with a private area in which to undress and dress.
- Supply proper attire for an examination. Minimize exposing more of the patient's body than necessary.
- Confirm that the door to any public access area is closed.
- Request the presence of a familiar individual or family member for patients with learning difficulties or who lack mental capacity. Resistance to an intimate examination or procedure must be interpreted as refusal of consent and the procedure must be abandoned. In life-saving situations the healthcare provider should use professional judgment.
- Refrain from insisting the presence of a chaperone on an unwilling patient who may be uncomfortable with an observer. Express unwillingness to proceed without a chaperone. Ask the patient to re-consider or accept a referral to another physician. Document the declination of a chaperone in the patient's medical record.
- Avoid the patient who demands excessive physician attention or causes apprehension.
- Trust your instincts and comfort level when faced with a patient who seems reluctant to be examined.

Reference:
The American Medical Association: Use of Chaperones During Physical Exams

Medical Mutual'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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Hospice Volunteers Celebrates 30 Years

By Betsy Elder, Executive Director, Hospice Volunteers in Mid Coast Maine

For the past thirty years **Hospice Volunteers: Center for Grief and Loss in Mid Coast Maine** has provided free and unique end-of-life direct care assistance and grief support services to the Mid Coast community at large. Hospice Volunteers (HV) is a free-standing, independent, non-profit charitable organization which advocates practical choices for the dying and their families with an emphasis on comfort when curative measures are no longer productive. Just as choice is important in the way that we live, Hospice believes that it is also important to die on our own terms. Focused on family care, HV is a spiritual and philosophical resource to grieving families when a life threatening diagnosis has been made, during the illness, by providing direct care assistance to the patient and respite to the family of caregivers, and after death through continued support of grieving children, families, and adults with volunteer peer facilitated bereavement support groups. Their mission is; *Hospice Volunteers is a volunteer organization that provides caring, supportive, non-medical services to individuals and families coping with dying and grief and promotes education and dialogue within the community about end-of-life issues.* For more information call 207-729-3602 or visit their website at www.hospicevolunteers.org.

Founded in 1979, HV was one of the first volunteer hospices established in the country. Struggling against conventional medical thought of the time and working from borrowed spaces, a few dedicated and visionary Brunswick/Bath volunteers created the second organized hospice in Maine and found themselves among the leaders of the American hospice movement. HV partners with CHANS Home Healthcare Agency to offer a well integrated, interdisciplinary medical team to actively dying patients with a Hospice insurance benefit. HV's service territory includes over 28 towns and while 90% of its clients are CHANS referrals, HV does not constrain its service strictly to patients covered by Medicare. No one who requests HV free services is ever denied. Leadership for HV is provided by a board of directors and four staff. More than 120 active, caring and capable volunteers are the backbone of the organization. Because HV is a non-profit whose services are free, it relies on charitable donations to operate. None of their good work would be possible without financial support from institutions, towns, individuals, United Way, annual appeal, grants, special event fund-raisers and other donor-funded activities.

Hospice Volunteers Grief and Bereavement Programs

In addition to providing Hospice direct patient care assistance to CHANS referrals and anyone with a terminal illness, HV hosts several bereavement support groups. HV services have expanded over the years to meet the needs of children and families coping with illness and death. Hospice Volunteers provides on-going *drop-in* and *structured* adult grief support groups, *Transitions: Mid Coast Grieving Children's Program, the Grieving Parent's Program* and the *Living Loss, Living Hope Program.* These facilitated peer support groups provide a safe place for children and families to process their experiences of loss. Short-term outcomes include relief from grief and long-term outcomes involve a *normalizing* of the dying process and possibly more deaths occurring at home with family and caregivers involved, present and participating. The director of these on-going programs works closely with school faculty and mental health professionals to support their work with children in crisis or who are suffering from a loss within their family circle, student body or school staff. Bereavement activities are not funded by clients and no reliable revenue stream exists to support this important work. Because HV is the only entity offering free peer supported grief groups along eighty miles of coastline (south of Rockland and north of Portland) it serves bereavement clients from all around Maine's Mid Coast. HV will be launching a Survivor of Suicide Grief Group in fall 2009.

David Howes, M.D. Elected Chair of HealthInfonet Board

David Howes, M.D.

The Board of Directors for HealthInfoNet, a Maine nonprofit corporation working to build a statewide health information exchange, has elected David H. Howes, M.D., president and CEO of Martin's Point Health Care, as its new chairman. HealthInfoNet was founded to construct, test and implement a new statewide system that will provide patients with better coordinated, and more efficient health care through the sharing of vital health information.

Widely recognized for his leadership role in the adoption and use of health information technology systems to improve health care delivery, Dr. Howes has served as a board member of HealthInfoNet since the organization's inception in January of 2006. He will serve as chairman during 2009.

Dr. Howes succeeds Chuck Hewett, Ph.D., who has served as HealthInfoNet's board chair for the past three years. Hewett is Chief Operating Officer of the Jackson Laboratory in Bar Harbor. Hewett will remain on the board of directors as immediate past chair. Other officers elected to new terms on the board include Dan Coffey, Executive Vice President, Eastern Maine Healthcare Systems in Brewer (Vice Chair); Nona Boyink, President of HealthReach Network and MaineGeneral Rehab and Nursing Care in Waterville (Secretary); and Richard "Skip" White, Market Service Leader, Cigna Healthcare of Maine in Falmouth (Treasurer).

Also elected to the HealthInfoNet Board of Directors was Barry Blumenfeld, M.D., Chief Information Officer at MaineHealth in Portland and attorney and state legislator Peter Mills of Somerset County.

During Dr. Howes' tenure as chairman, health care providers participating in HealthInfoNet are expected to begin using the statewide health information exchange to support patient care. This is part of a two-year demonstration phase that will involve sharing of patient medical information across six Maine health care provider organizations which together care for half of those seeking medical care in Maine each year. The project is supported by patients, physicians, state government, businesses and insurers. Supporters believe a health information exchange will improve patient safety, improve health outcomes and decrease growth in health care costs.

Dr. Howes received his medical degree from Dartmouth Medical School in Hanover, NH, and began his medical career as a family physician serving the residents of a fishing community along the Maine coast. He joined Martin's Point in 1989 as Unit Medical Director in Bath and became President and CEO in 1996. He is Board Certified in Family Practice.

HealthInfoNet Background

HealthInfoNet is an independent, nonprofit Maine organization working collaboratively with a coalition of stakeholders to build a statewide electronic health information exchange. HealthInfoNet began as a project called the Maine Health Information Network Technology in 2004.

After an extensive planning and development process involving a broad range of stakeholders, including the Maine Medical Association, it was reorganized as an independent nonprofit organization in early 2006. Working with its seven pilot phase participants; Central Maine Healthcare, Eastern Maine Health Systems, Maine General Medical Centers, MaineHealth, Martin's Point Health Care, Franklin Memorial Hospital and the Maine Centers for Disease Control, it will help Maine become one of the first states in the nation to operate a statewide health care information exchange. Visit www.hinfonet.org for more information.

MMA wants to hear from you!

Issues or concerns you would like to see addressed by the MMA:

Comments / feedback on what MMA is doing:

Please provide your name and telephone number or e-mail address so that we may contact you if clarification or further information is needed.

Telephone:_____

E mail:_____

Return to MMA via fax at 207-622-3332.

Thank You

Note from a Physician Hospice Volunteer

By Linda Hopkins, M.D., Bereavement Coordinator, VNA Home Health & Hospice, South Portland, ME

As a retired physician, I took the hospice volunteer training in 1999. I came to the training looking forward to spending my time helping people facing a difficult time of life and feeling this is a type of volunteering I might be more comfortable with than many other members of our community. The class turned out to be an enriching personal growth experience and the volunteering was a liberating care giving experience. I visited homes not to "fix things" but to listen and to be a supportive presence. As a volunteer, there is time to pay attention to this human experience in a way that the time constraints of medical practice rarely allow. There are an estimated 400,000 hospice volunteers in the USA providing more than 16 million hours of service every year. The Medicare Hospice Benefit actually requires that at least 5% of patient care hours are delivered by volunteers. For myself, my hospice volunteer experience has turned into a second career providing bereavement support to hospice families and training to hospice volunteers. For more information about training in your area, I encourage you to contact a local hospice. Linda Hopkins, M.D., Bereavement Coordinator, VNA Home Health & Hospice, South Portland, ME, 207-780-8624; 1-800-757-3326.

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