SEPTEMBER/OCTOBER 2008

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

155th Annual Session One of the Best Ever

Over 350 members and guests attended one or more of the events at last month's Annual Session held at the Samoset Resort in Rockport. With the theme of "Taking the Initiative: Steps Toward Quality and Collaboration," the conference began on Thursday, Sept. 4th with a day-long educational seminar co-sponsored by the Maine Hospital Association with financial assistance provided by the Maine Quality Forum, Quality Counts and the Aligning Forces for Quality grant. Over one hundred and fifty physicians, nurses, quality improvement directors and hospital CEO's participated. Elliott Fisher, M.D., MPH, Director of the Center for Health Policy Research at Dartmouth Medical School spoke at two plenary sessions and conducted an inter-active breakout session as well. Robert Keller, M.D., gave a luncheon presentation on the future of quality improvement and variation analysis in Maine. Dr. Keller serves currently as the Chair of the Maine Quality Forum Advisory Committee and previously served as the executive director of the Maine Medical Assessment Foundation. Later in the evening (Saturday night), Dr. Keller was the recipient of the Association's Annual President's Award for Distinguished Service. The Thursday program concluded with closing remarks by Governor John Baldacci and Immediate Past Board Chair of the AMA, Edward Langston, M.D. of Evanston, Indiana.

Keynote presenter Elliott Fisher, M.D., MPH spoke to a full house on Thursday

Terry Sheehan, M.D. and Charles Danielson, M.D. review binder for General Membership meeting

Edgar Caldwell, M.D. after receiving 50-year pin

From left: Warren Muth, M.D., President, Ohio State Medical Association, Brent Mulgrew, Executive Director, OSMA, and Gordon Smith, Executive Vice President, MMA

Patricia Bergeron "pins" Charles Smith, M.D. a 50-year pin recipient

The weekend CME program focused on the topic of improving communications with patients and concluded on Sunday morning with a Public Health Leadership Forum on the topic of "Childhood Obesity – Addressing the Epidemic."

On Saturday evening, William Strassberg, M.D. out-going President turned the gavel over to Stephanie Lash, M.D., in-coming President. The remarks presented by Drs. Strassberg and Lash are included elsewhere is this issue of *Maine Medicine*. David McDermott, M.D., MPH is President-elect while Jo Linder, M.D., was elected by the 28 member Executive Committee to be its Chair for the coming year. Dr. Lash is a practicing neurologist in Bangor, Dr. McDermott is a family physician in Dover-Foxcroft and Dr. Linder is an emergency physician practicing in Portland.

Six recipients of 50-year pin awards, recognizing the 50th anniversary of their medical school graduation and honoring their medical careers attended the dinner on Saturday night and made remarks which ranged from humorous to very serious. A list of the recipient's is provided elsewhere in this issue.

Nearly one hundred persons attended the general membership meeting on Saturday morning. All nine resolutions presented were passed and can be viewed on the MMA website at www.mainemed.com.

The Session featured an exhibit hall with 42 exhibitors and several unique events including a physician art exhibit, two book signings by authors Kate Breastrup and Thomas Palmer, M.D. and a display of historic Time-Life covers featuring physicians.

Recreational opportunities included the 28th Annual Edmund Hardy, M.D. Road Race, won for the first time by the MMA President, and a nine hole gold scramble, won for the first time by a team led by an MMA Past President, Krishna Bhatta.

Incoming President Stephanie Lash, M.D. presents Past President plaque to Outgoing President William Strassberg, M.D.

Next year's Annual Session will be held at the Harborside Hotel and Marina in downtown Bar Harbor Sept. 10-13, 2009. If you missed this year's meeting, get next year's date on your long range calendar. Attendees this year will say you will not be disappointed.

Resolutions Approved at Annual Session

Resolution #1: Commitment to Promote Primary Care as the Foundation for a High Quality, Safe, Accessible and Efficient Health Care System, introduced by Edmund "Ned" Claxton, Jr., MD.

Resolution #2: Vote No on "Ballot Question One" to Protect Health Coverage, Submitted by Jo Linder, M.D.

Resolution # 3: Addressing Cost Burdens to Patients, submitted by the MMA Executive Committee.

Resolution #4: Commitment to Promote Healthy Weight by Improving the Prevention, Diagnosis, and Management of Obesity, submitted by the MMA Public Health Committee.

Resolution #5: Restructure the Current Financing System to Increase Child and Adolescent Immunization Rates, submitted by the MMA Public Health Committee.

Resolution #6: Reduction of Toxic Chemicals to Improve the Health and Well-being of Maine Citizens, submitted jointly by the MMA Public Health Committee and the Maine Chapter of the American Academy of Pediatrics.

Resolution #7: Commitment to Identify and Reduce Health Care Disparities in Maine, submitted by the Public Health Committee.

Resolution #8: Enhance Domestic Violence Screening in the Health Care Setting, submitted by the MMA Public Health Committee.

Resolution #9: Academic Detailing: Evidence-Based Prescribing Information, submitted by the Committee on Physician Quality.

The complete approved Resolutions can be found on the MMA website at www.mainemed.com.

MMA Urges No on One Vote

As the result of a Resolution passed nearly unanimously at the Annual Meeting, MMA is opposing question one on the Nov. 4 ballot which would repeal the taxes on beer, wine and soda which were proposed to be dedicated to expanding access to health care in the state. These taxes were recommended by the Blue Ribbon Commission on Dirigo on which several physicians and MMA EVP Gordon Smith served. The taxes and a 1.8% assessment on paid insurance claims would replace the controversial and unpredictable Savings Offset Payment. The beer, wine and soda tax would raise an estimated $16.8 million. MMA believes that health care coverage for Maine people is more important than a few pennies on these products which contribute significantly to ill health and high health care costs.

Health care coverage for over 68,000 Mainers is implicated by the repeal, as a portion of the funds raised from the tax was to pay for changes in the individual health insurance market that were designed to reduce the cost of health insurance for Mainers not eligible for group health insurance.

MMA is actively involved with a group of healthcare organizations and consumer groups opposing the repeal. The American Medical Association has made a generous contribution of $40,000 to Health Coverage for Maine, the organization created to manage the campaign in opposition to the repeal effort. Physicians interested in the effort to defeat the effort by the national beverage industry to repeal the tax may contribute or volunteer through the HCFM website at www.healthcoveragemaine.org or may send a check payable to Health Coverage for Maine to P.O. Box 15312, Portland, Maine 04112. Jo Linder, M.D. is the Treasurer of Health Coverage for Maine.

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AMA Inaugurates Woman President

Nancy H. Neilsen, M.D., Ph.D, a board certified internist from Buffalo, NY, was inaugurated as the 163rd president of the American Medical Association (AMA), the nation's largest and most influential physician organization, at the AMA Annual Meeting in June. She is the second woman to hold the AMA's highest elected office.

In her inaugural address, Dr. Nielson told physician leaders, "Physicians know the barriers to health care reform better than anyone. We must be the engineers who design a signature American solution for a better health care system."

Stephanie Lash, M.D., President, MMA

President's Corner

Remarks of in-coming President Lash at MMA Annual Session Banquet on September 6th

I would like to start my general remarks by reminding all of the physicians here and others who are interested in the work of the Maine Medical Association to read Gordon Smith's executive summary. Despite a much deserved three month sabbatical, Gordon has done a phenomenal job this past year and his summary is truly impressive and substantive. With Gordon's leadership, the membership of the MMA continues to grow and this year, for the first time, we have over 3,000 members. Financially, we continue to balance a variety of legitimate demands against our resources, and under the guidance of Dr. Brian Jumper have, I believe, done a wise and responsible job to meet our needs.

The Association continues its advocacy work, principally at the state legislature. We are very fortunate to be represented by Andy MacLean and the rest of the staff and it is clear that our voice is being heard both on health policy and budgetary issues. This is work that will need to continue and I want to thank everyone here who has taken the time to express your perspective on these issues to our policy makers. It is so important!

Looking forward over the next year, we have more to do. As a mother, and a neurologist, I would particularly like to encourage the MMA to focus on the last phrase of our mission, to "promote the health of Maine citizens." And specifically, I will work to realize Resolution #3 which we voted on this morning which states, "Therefore, be it resolved that the Maine Medical Association work with stakeholders and leaders across the state to help physicians take an active role and advocate for policy change needed to promote healthful weight."

It is not news to anyone here that in America and in Maine in particular, we have a growing public health epidemic called obesity. This is true across all demographics of our population and of most concern, is a substantial problem among children. Statistically, there are approximately twice as many obese children in America now as there were thirty years ago. And the efforts of this epidemic are being seen in virtually all areas of mental and physical health as obesity is associated with depression, anxiety, poor school and work performance, cardiovascular disease, endocrine disease, bone and joint disease, neurologic disease, certain types of cancer and the list goes on.

In trying to understand how we got to this point, and what can be done to reverse the problem, I have come away amazed by both the complexity and simplicity of the issue. It is as simple as, eat less and move more, right? The phrase, "easier said than done," comes to mind.

I hope that many of you will be able to stay and attend tomorrow's morning meeting when we have a very interesting program which has been put together by Dr. Danielson and Kellie Miller and others working with the Public Health Committee of the Maine Medical Association. We will hear about a range of programs going on here in Maine.

Finally tonight, I want to ask you to take a few minutes to imagine with me what perhaps could be done if we became very bold. I would like to share with you two ideas. This first concept was sent along to me by my mother's brother. He is an attorney who has worked as a constitutional law professor at the University of CA in Berkley. A faculty colleague of his, (ironically named Stephen Sugarman) has outlined a strategy by which the food and beverage industry is incentivised to solve the problem that, it can be argued, they have caused or at least profited from. It works something like this. Food and beverage companies are assigned childhood obesity reduction targets. When they are achieved, successful enterprises would be praised. But if the reduction goals are not met, then failing companies would face fines that would undercut their profits. The first step is to determine the extent of the industry's obligation. Suppose it were agreed that obesity rates should be reduced by 10% per year for 5 years and kept at least that low. This would return us to roughly where we were in the 1970's. The next step is to assign proportionate responsibility to individual companies (This has similarly been done with power plants and pollution). This could perhaps be done by the FDA in cooperation with the Institute of Medicine. For example, consider the Coca-Cola Company. Assume the company has been assigned a particular reduction target. To be responsible, and to avoid penalty, Coke might take direct action such as to reduce the size of its standard soda can, change its ads to attract children less or encourage the use of diet soda. Alternatively, Coke might discover that establishing more bike paths, subsidizing physical education classes, providing grants for school obesity reduction programs, or helping parents create diet plans for their children would be more effective in reducing obesity. One could even envision creating a market for obesity reduction targets entirely analogous to pollution credits which would help the moneys flow to where they can most effectively be used. An obvious problem is how to give individual companies credit for their obesity reduction success. One way is to break the problem down by geographic area.

The second "imagine if" that I would like to present to you is The Children's Fitness Tax Credit. This was passed to me by Dr. Strassberg from his work with the leadership of the American Academy of Orthopedic Surgeons. And it is an idea that has already become law in Canada. Starting with the 2007 tax year, the government of Canada allows a tax credit based on eligible fitness expenses paid by parents to register a child in a prescribed program of physical activity. Such a program must be ongoing and include a significant amount of physical activity that contributes to cardio-respiratory endurance plus either muscular strength, flexibility or balance. A total of $500 per child can be claimed as a deduction.

It seems to me that if a lawyer in California and an orthopedic surgeon in Maine can agree about the importance of an issue, and can agree that creative solutions need to be brought to bear, we have already come a long way.

I thank you for your time. I am excited about working for the Maine Medical Association on these and other issues. And don't forget to exercise off this wonderful dinner. Thank you. I can be reached at 947-0558 or stephanielash@roadrunner.com.

William Strassberg, M.D., Past President, MMA

Final Words of MMA Past President

Excerpts from President's Remarks September 6, 2008

The Role of a Professional Medical Society Today

My time tonight will focus on the role of a professional medical society in 2008. Traditionally, societies performed social and collegial functions and were forums for education and exchange of ideas. More recently, advocacy and representation of physicians and physician interests come to mind. Is it any different today?

The medical profession and the role of professional medical societies should evolve and respond to changing times… and times are difficult in healthcare today. Our profession is under siege and physicians fear loss of autonomy and the ability to best care for their patients. Coincident with this has been a resurgence and rejuvenation of the concept of medical professionalism. This response has been generated in part by a need to return to the essence of our doctoring, and our roots.

Obstacles include industry intrusion into our practice and concerns about diminished public trust in our profession. While the public questions whether medicine places their interests first, they rarely do that with their individual physician. Our patients still cherish their doctor and I do not believe that we will ever lose that individual and human connection. As control of healthcare has passed from medicine to the corporate and governmental sectors, so has the blame for defects in the healthcare system.

Advocacy and representation remain cornerstones of our role. These functions are rather self explanatory, especially as one extends the definition of advocacy and physician interest beyond self interest to also encompass best patient care and an improved healthcare system. These concepts of physician advocacy and patient primacy are seen in the MMA mission statement:

To support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens

The continued growth of our vigorous profession, strengthened by increased autonomy and accountability, is compatible with one that helps lead improvements in public health and provides leadership in healthcare reform.

A third and important contemporary role today is one of visibility as the voice of medicine. Your medical society, be it county, state, or national, specialty or primary care, is our representative and is the public's window into the house of medicine. Physicians will intermittently disagree with one platform or another, but like it or not, member or not, professional associations represent us at the table.

On the state level, I am proud of our Maine Medical Association, our vitality, and I am never one to miss pointing out that we are one of the few medical societies nationally with an increasing membership and are a strong voice of medicine in Maine.

Every physician carries that burden to speak and that privilege. When we speak, when we act - our interactions with patients, people, colleagues, coworkers, and industry, define and shape the profession. The sum of these individual encounters becomes the face the public sees, and a virtuous circle develops. Collectively we are indelibly linked to our professional association as we individually create the personae it represents. Our aggregate actions are the profession of medicine.

Medicine faces many challenges today - our profession under siege, our autonomy at risk, and our professional standing and respect are threatened. This morning when I spoke to our general assembly, I spoke about the state of medicine in Maine and my concerns about scope of practice, healthcare reform, Dirigo, sugar, and the corporate veto. Physicians today are overwhelmed by these concerns and about diminishing reimbursement, pre-authorization, suffocating paperwork, and industry and government rules we must practice by.

There was not time enough to talk about the place of our profession in 2008. Today the public is bombarded by information disseminated by insurance companies, product manufacturers, and drug companies. Society is offered information that may or may not be true about conditions they may or may not have. Patients will come into my office requesting a specific brand of joint replacement just as if they were buying a car! Pharmaceutical company info-mercials have created info-disease and epidemic illness becomes rampant when a new drug is found to treat a commonplace symptom.

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Upcoming at MMA

OCTOBER 8	6:00pm	Maine Health Management Coalition, Orthopedic Metrics Group
OCTOBER 9	11:00am 1:00pm	Aligning Forces 4 Quality Quality Counts! Board
OCTOBER 14	6:00pm	American Academy of Pediatrics, Maine Chapter Board Meeting
OCTOBER 15	Noon 2:00pm 5:00pm	MMA Operations Committee MMA Executive Committee MMA Budget and Investments Committee
OCTOBER 18	8:00am	Downeast Association of Physician Assistants
OCTOBER 22	11:00am 1:00pm 4:00pm	PCMH Working Group Physician Payment Reform Working Group MMA Public Health Committee
OCTOBER 23	6:00pm	Maine Association of Psychiatric Physicians, Executive Council
OCTOBER 29	11:30am	MMA Senior Section
NOVEMBER 5	12:30pm 2:00pm	Aligning Forces 4 Quality Quality Counts! Board
NOVEMBER 6	3:00pm	Quality Counts Integration Advisory Committee
NOVEMBER 7	9:00am	First Fridays CME
NOVEMBER 10	5:30pm	Medical Professionals Health Program Committee
NOVEMBER 12	6:00pm	Payor Liaison Committee
NOVEMBER 13	4:30pm	Committee on Physician Quality
NOVEMBER 19	9:00am 11:00am 1:00pm	PCMH Planning Group PCMH Working Group Physician Payment Reform Committee
NOVEMBER 25	8:00am	Aligning Forces 4 Quality
NOVEMBER 26	9:00am	PCMH Planning Group
DECEMBER 3	Noon 2:00pm	MMA Operations Committee MMA Executive Committee
DECEMBER 4	3:00pm	Quality Counts, Behavioral Advisory Committee
DECEMBER 5	9:00am	First Fridays CME
DECEMBER 10	6:00pm	Maine Health Management Coalition, Orthopedic Metrics Workgroup
DECEMBER 17	11:00am 1:00pm 4:00pm	PCMH Working Group Physician Payment Reform Group MMA Public Health Committee

Upcoming Specialty Society Meetings

OCTOBER 17-19, 2008 — Harborside Hotel & Marina – Bar Harbor, ME
Maine Chapter of the American College of Physicians 2008 Annual Scientific Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

OCTOBER 18, 2008 — Maine Medical Association – Manchester, ME
Downeast Association of Physician Assistants (DEAPA)
MMA Contact: Kellie Miller 207-622-3374 ext: 229 or kmiller@mainemed.com

NOVEMBER 14, 2008 — Hilton Garden Inn – Freeport, ME
Maine Association of Psychiatric Physicians General Membership Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

NOVEMBER 15, 2008 — Eastern Maine Medical Center – Bangor, ME
American Academy of Pediatrics, Maine Chapter Fall Conference Cutting Edge Pediatrics: Practical Hardcore Medicine for the Maine Pediatrician
8:00am – 3:00pm
MMA Contact: Aubrie Entwood 207-782-0856 or agridleyentwood@aap.net

DECEMBER 3, 2008 — Portland Location TBD
Maine Chapter, American College of Emergency Physicians
6:00pm – 9:00pm
MMA Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

FEBRUARY 14-15, 2009 — Sugarloaf/USA
Maine Society of Anesthesiologists Meeting
MMA Contact: Anna Bragdon 207-441-5989 or msainfo@roadrunner.com

MAY 1, 2009 — Harraseeket Inn – Freeport, ME
Maine Society of Eye Physicians and Surgeons Spring Meeting
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

Classified Ads

Medical Director Sought:

Mercy Hospital in Portland is seeking a **Medical Director** for Mercy Primary Care. At Mercy Hospital and at our locations throughout greater Portland, you'll find more than the latest technology and highly skilled doctors, nurses, physician assistants, therapists and support staff. You'll also experience the special approach we take to healthcare, recognizing each patient as a whole person-body, mind and spirit.

FMI please contact
Ed de Oliveira @
207-553-6092 or via email
deoliveirae@mercyme.com.
www.mercyhospital.org

If you would like to know how your classified ad can appear in the next issue of *Maine Medicine*, contact Shirley Goggin at 445-2260 or sgoggin@mainemed.com.

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Final Words of MMA Past President

Excerpts from President's Remarks September 6, 2008

This has got to stop…and physicians and the house of medicine are the ones best suited to initiate change. The challenging medical environment noted above however, has found physicians drawn into the mix. Reasserting our place in medicine will not be easy, but our leverage is the trust that the public places in us, and trust will be strengthened as we demonstrate to the public that we serve without self interest and with the true essence of our profession. Altruism, morality, integrity - these basic characteristics define a physician, but also our profession. Not only are individual physicians expected to demonstrate morality and virtue, but so are the institutions and organizations representing them.

Professionalism can be taught explicitly. I submit that leadership societies and those serving as leaders should view education about professionalism as a central function. Furthermore, I am proud to say that the MMA has taken that first step. The MMA Professionalism Program, adopted this past year, encompasses patient safety, relationships with industry, and the twin concepts of autonomy and self-regulation. These three initiatives are currently underway within MMA committees and I look forward to their growth and development. We must recognize that this is not a simple task. All of these initiatives require introspection, and self-assessment can be uncomfortable. It is healthy to review our actions and behaviors but it is important for this to be a positive process. Easy? No. Necessary in today's times? Certainly.

Our challenge as an organization today is to continue to educate ourselves and our members, advocate for ourselves and our patients, and help foster and nurture the willingness and desire to be introspective. It is in this way we serve our patients best.

Thank you for being there when your patients, and the world around us, needs you.

Postscript:

My personal highlight of the entire annual session occurred shortly after the Saturday evening banquet, where I gave the speech above. Several physicians came up and thanked me for an educational weekend. They noted that they enjoyed my speech immensely, and that it made them proud to be a physician.

Well, this is what it is all about, and I am pleased that the thoughts touched them in that way. Let us keep moving ahead.

I have enjoyed interacting with all of you these past two years. As always, I can be found at baybones@midcoast.com.

CMS Pays $36 Million in Bonus Money Under the PQRI Program

The Centers for Medicare & Medicaid Services (CMS) announced it has paid $36 million in bonus money to 2007 participants in the voluntary Physician Quality Reporting Initiative (PQRI). More than 56,700 health professionals took a share of the funds with the average incentive payment being $600 and the average payment for a physician group being over $4,700. The largest payment to a physician group was $205,700.

CMS noted that 52 percent of 109,000 participants from last year were awarded payments. The program allowed eligible physicians to earn a 1.5 percent bonus on their Medicare charges by satisfactorily submitting quality data for services they delivered between July and December.

To access feedback reports, participants must register in the Individuals Authorized Access to CMS Computer Services (IACS) system. Individuals and organizations are encouraged to register as soon as possible at www.cms.hhs.gov/MMAHelp/07_IACS.asp.

The 2008 PQRI program has grown to include 119 quality measures, which were published in the Physician Fee Schedule for 2008.

Find more information about PQRI, including how you can participate, at www.cms.hhs.gov/PQRI.

The Joint Commission Urges Development of a National Performance Measurement Data Strategy

Health care organizations, practitioners, purchasers, oversight bodies and the public all rely on performance data to determine priority areas for quality improvement, evaluate performance, and make informed health care decisions. Yet, most performance measurement efforts operate in isolation from one another, rarely provide a consistent picture of overall quality, and represent a significant cost to the health care industry, according to a call for action released by The Joint Commission. The Joint Commission's newest public policy white paper, "Development of a National Performance Measurement Data Strategy," proposes a framework for creating a data infrastructure to support performance measurement activities that improve the quality of American health care. The detailed solutions, proposed by a special Joint Commission expert Roundtable, focus on creating a data infrastructure that addresses consumer expectations for data privacy, supporting a data highway that allows for data sharing and linkages, and operating under an agreed-upon set of rules and governance structure. A complete copy of the Joint Commission white paper, "Health Care at the Crossroads: Development of a National Performance Measurement Data Strategy," is available at **www.jointcommission.org.**

The report is part of a continuing series of white papers on key public policy issues that impact patient safety and health care quality.

For the entire news release, go to **http://www.jointcommission.org/NewsRoom/NewsReleases/nr_03_06_08.htm.**

Questions or comments can be addressed to Terri Tye at ttye@jointcommission.org.

Notes from the E VP

has been included as an insert in this issue.

Other inserts include:

- ***First Friday's Programs***
- ***Doctor of the Day***
- ***Ballot Initiative***
- ***Top Ten Legislative Accomplishments***
- ***Medical Protective***

Jana Purrell, CPC

Coding Updates *by Jana Purrell, CPC, Coding/Reimbursement Specialist*

Maine Medical Association Tel: 888-889-6597 Fax: 207-787-2377 jpurrell@thecodingcenter.org

Effective October 1, the ICD-9-CM changes for the upcoming year go into effect.

There are a large number of changes this year and they affect almost every specialty. There are more than 450 new codes, more than 60 revised codes, and 25 deletions.

Areas to take note of include a new section of codes related to secondary diabetes, numerous codes for headaches, revised codes for leukemias in relapse, new fever codes, many new codes for eosinophiliac disease, pox infections and methicillin-resistant Staphylococcus aureus (MRSA) conditions. There are new codes for decubitus ulcers, and pap tests of both vulvar and anal tissue conditions. New codes have been established for benign and malignant cancerous tumors. Finally there are new codes this year to report family and personal conditions related to military deployment.

Because of the large number of changes this year, we are unable to list them all here but the entire list can be found at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.

Some things you can do to prepare for the changes include:

- Assign a person to be responsible for implementing the new codes
- Review not only the new codes but also any revisions or deletions as these may also change how you code certain diagnoses
- Be sure that all necessary documents are updated – electronic and/or paper. This may include getting Information Technology (IT) staff involved
- Educate all appropriate staff – not just billing/coding but clinical staff and providers – documentation may need to change
- Provide up-to-date coding resources – new ICD9 books and updated software
- Keep at least one old coding resource available for outstanding claims, appeals, or for legal issues

On another note, The Department of Health and Human Services (HHS) announced a proposed regulation that would replace the ICD-9-CM diagnosis coding system with the greatly expanded ICD-10-CM (diagnosis) code sets, effective Oct. 1, 2011. Up until now, we have not had a specific date for implementation. While it has not been finalized, it is one step closer and it is time to start preparing for the huge transition.

The current ICD-9 system contains approximately 17,000 codes and is expected to start running out of available codes next year. In comparison, the ICD-10 code sets contain more than 155,000 codes and accommodate many new diagnoses and procedures. The thought is that the additional detailed codes will assist in the implementation of electronic health records because they will provide more detail in the electronic transactions.

CMS is accepting comments until October 21, 2008 related to the proposal.

We will continue to watch the progress of ICD-10-CM and bring you more information as things progress.

You can also find information at:
http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

Medical Mutual Insurance Company of Maine Risk Management Practice Tip: Adult Emergency Care in the Office Setting

Patients and visitors commonly assume that if an unexpected medical event occurs while at a physician's office, the physician and staff members will respond with expertise and appropriate equipment to take immediate action. Being prepared to manage a medical emergency in the office setting involves evaluation, preparation and planning.

Evaluation

Adequate preparation begins with a thorough office system evaluation to determine the unique characteristics of the office setting and the patients served. Based on this evaluation, a focused plan can be developed that uses strategies designed to meet the specific needs of your patient population based on your resources.

A retrospective look at emergencies that have presented or developed will assist in formulating a profile of trends for which the office can prepare. Determine the average response time for EMS. Once you have completed your evaluation, preparation and planning can begin.

Office Preparation

Based on the evaluation of the office setting, patient population and available resources, determination of appropriate equipment can be made. If definitive advanced life support is readily available (such as the practice is located in an urban area), then a minimal amount of equipment and supplies may be necessary. In more rural areas where transport times can be delayed, it may be necessary to insure the availability of adequate supplies to support the patient.

Providers and staff must maintain competency in the equipment that is available in the office. At a minimum, all practices should have staff trained in basic life support (BLS) present when patients are at the office.

Planning

Key to an emergency response is a coordinated plan. A written protocol insures that staff members have an understanding of their respective roles during an emergency event. Ideally, the plan should delineate specific responsibilities of each staff member. Once the plan has been developed, conduct drills to practice the office's response to a medical emergency. These drills provide staff the opportunity to learn their roles, evaluate the plan, implement changes and develop the confidence and skill needed to respond effectively when an emergency does occur.

Ongoing monitoring of supplies is important to insure that they are not outdated and are in proper working order. On a monthly basis, the emergency equipment and medication should be evaluated. A log of this review should be maintained.

Lack of appropriate training and equipment may result in an adverse outcome. Do not wait for an emergency event to discover that you are ill-prepared.

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.

Kellie Miller, Director of Public Health Policy, MMA

Public Health Spotlight

MMA Public Health Forum on Childhood Obesity Creates Insights & Discussion

Childhood Obesity - What's a clinician to do?, was the central theme of MMA's First Annual Public Health Forum, held in conjunction with the 155th Annual Session of the Maine Medical Association. Dr. Victoria Rogers, Dr. Robert Holmberg, Dr. David McDermott, Dr. Charles Danielson, and Dr. Stephanie Lash, MMA President encouraged MMA members to use the strategies they presented to become more engaged with their patients to provide consistent evidence-based prevention messages to all families, and to become more involved in school and community advocacy activities. The "Let's Go" kit was highlighted for office-based use and is available at no cost to physicians at www.letsgo.org. **Single copies of the Toolkit can be ordered FREE of charge** by physician practices, hospitals, health centers, and other healthcare organizations in Maine. Simply log on to www.jsmccarthy.com/mainehealth and place your order on MaineHealth's online catalogue. If you are a first-time user of the catalogue, please send an email to lambee@mmc.org to request a user name.

If you have questions or need additional information, don't hesitate to contact Kellie Miller, Director of Public Health Policy at 207-622-3374, ext 229 or kmiller@mainemed.com. Visit the MMA website @ www.mainemed.com for more information on the public health resolutions (promote healthy weight, restructure the current financing system for immunizations, enhance domestic violence screening, reduction of toxic chemicals and reduction of health care disparities) approved at the 155th Annual Session of the Maine Medical Association.

The resolution, Enhance Domestic Violence Screening in the Health Care Setting submitted by the MMA Public Health Committee was approved at MMA's most recent Annual Session. The MMA Public Health Committee will step up its efforts to work collaboratively with the Maine Chapter of Physicians for Social Responsibility (PSR) through their project, "Domestic Violence Response Initiative" to increase educational opportunities that provide medical personnel with the knowledge and tools they need to safely and effectively address domestic violence in their patient populations.

Domestic violence is a public health problem that can significantly and negatively impact our patients' health outcomes. Domestic violence can manifest itself in many ways. Depression, PTSD, chronic pain, anxiety, migraines, sleep disorders, substance abuse, unwanted or multiple pregnancies, poor nutrition, unexplained or inconsistent symptoms, repeated doctor visits, STI's and HIV are all health problems associated with domestic abuse. Pre-existing health conditions can also be exacerbated by chronic abuse.

Robert McAfee, M.D., speaks in support of enhancing domestic violence screening in the health care setting

Charles Danielson, M.D., Chair of MMA's Public Health Committee, speaking in support of restructuring the current financing system to increase child immunization rates

In the medical field, we have a unique opportunity for early identification and intervention of abuse through screening and referral. Identification of domestic abuse through routine screening of all female patients is a Standard of Care recommended by;

- The American Medical Association (AMA)
- Joint Commission in Accreditation of Healthcare Organizations (JCAHO)
- The American College of Obstetricians and Gynecologists (ACOG)
- The Centers for Disease Control (CDC)
- The Nursing Network

Routine screening, as opposed to indicator based screening, can increase the identification of domestic abuse, provide opportunities for patient disclosure, lead to a reduction in mortality, save the healthcare system million of dollars, and help physicians provide vital options to patients. Face-to-face screening by skilled healthcare workers has been shown to significantly increase the identification of domestic violence (McFarlane et al, 1991). This important physician-patient interaction validates the patient's situation, communicates that the healthcare provider is willing to listen, that abuse is an issue to be taken seriously, and that help can be provided in a safe way.

Since 1996, the Domestic Violence Response Initiative (DVRI) has been providing medical personnel in Maine with quick interactive trainings that prepare them to integrate routine domestic violence screenings into their practices. During the one-hour training session a volunteer physician, teamed with a local domestic violence prevention advocate, reviews the basics of domestic violence, the health risks associated with abuse, clinical "red flags," and introduces a proven screening rubric. Trainings can be accomplished in any office setting and can be tailored to fit specific patient populations. CME credits are available.

According to researchers at the University of Maine's Muskie School, 2004 marked a ten-year high for domestic violence assaults. In 2006, domestic violence represented 47.5% of all reported assaults. In May, Maine's Department of Public Safety noted that of the homicides reported this year so far, 76% were classified as "domestic homicides." Between 1976 and 2005, only 11% of all homicides were related to domestic violence.

The Domestic Violence Response Initiative was created by the Maine Chapter of Physicians for Social Responsibility (PSR/Maine). DVRI receives support from the Bingham Program, The Paul Newman Foundation, the Maine Community Foundation and the members of PSR/Maine. To hold a DVRI training at your medical facility, please call PSR/Maine at (207) 772-6714.

Victoria Rogers, M.D., Public Health Forum panelist discusses the "Let's Go" initiative for health care providers

Hospital May Provide Software Interfaces to Physicians

By Kate Healy, Partner, Verrill Dana, LLP, Health Law Group and Health Technology Group

The Centers for Medicare and Medicaid Services ("CMS") recently issued an advisory opinion (CMS-AO-2008-01) that considered whether a hospital's license of proprietary software interfaces to physician group practices constitutes a compensation arrangement under the Stark Law, 42 U.S.C. § 1395nn (2003). The Stark Law prohibits a physician from making referrals of certain designated health services ("DHS") to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. The Stark Law also prohibits the entity furnishing the DHS from submitting claims to Medicare that are the result of a prohibited referral.

The hospital requesting the advisory opinion wanted to permit physicians to use a custom software interface to facilitate access to the hospital's electronic health record system by physicians on its medical staff in order to allow the secure transfer of patient information between the parties. Integrating the two systems required the development of an interface to extract data from the hospital's health information system and transfer it to the physicians' individual electronic medical record systems. The hospital proposed developing several versions of a physician practice interface to allow the physician practices to electronically order or communicate the results of laboratory tests or procedures. Under the proposed arrangement, the interface (1) would be used only to order or communicate the results of tests and procedures furnished by the hospital, (2) could not be modified to perform some other function, and (3) could not be resold, transferred or assigned by a physician practice. Significantly, the hospital proposed to pay the entire cost of the interface.

CMS analyzed the proposed arrangement under the definition of a compensation arrangement under the Stark Law. 42 U.S.C. § 1395nn(h)(1)(C)(ii); see also 42 C.F.R. § 411.351. CMS concluded that the proposed arrangement fell within the statutory exception to the definition of a compensation arrangement because the interface would be used solely to order or communicate test results furnished by the hospital and was not for the benefit of the physicians' private practices. CMS cautioned that its conclusion does not extend to an interface that could be used for purposes other than those proposed by this hospital.

This advisory opinion is helpful for hospitals and physician group practices that want to establish software interfaces for the sole purpose of allowing the parties to order or communicate the results of tests and procedures furnished by a hospital. Unfortunately, the limited application of the advisory opinion also indicates that hospitals and physician group practices cannot rely on it to support arrangements that involve more versatile software and need to consider structuring such other arrangements to fit within a Stark exception. The electronic health records exception and the fair market value exception are both good candidates for these types of arrangements.

It is important to note that both the electronic health record exception and the fair market value exception require, among other things, a signed written agreement between the parties. Because the Stark Law is a strict liability statute, hospitals and physician group practices should consult with their legal counsel to ensure that any arrangement they negotiate is structured to meet all applicable regulatory requirements.

In Memory of Thomas E. McDermott, M.D., 1949-2008

The Association was shocked and deeply saddened to learn of the death of Dr. Thomas McDermott of Waterville who died unexpectedly as the result of a whitewater rafting accident on the Kennebec River in late August.

Dr. McDermott, 58, was a family physician at Kennebec Medical Associates in Waterville and also was certified in chemical dependency treatment by the American Society of Addiction Medicine.

Dr. McDermott was a former chair of the Association's Committee on Physician Health and was an active member of the committee to the present time. He provided important leadership to the committee at an important time in its transition.

"As stated well in his obituary, Tom helped countless people through the years, and he always put the needs of others before himself," noted Gordon Smith, EVP of MMA.

Our thoughts go out to Tom's wife, Dayle McDermott and his son and two daughters.

Committee on Physician Health meets in Bar Harbor, September 2005, with Dr. McDermott chairing

Thomas McDermott, M.D., receives MMA Special Recognition Award in 2006, recognizing his years of service as chair of the Committee on Physician Health

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Certification Commission Helps Physicians Choose Electronic Health Records

The decision to move from paper to electronic health records (EHRs) can be a daunting task. With more than 200 software products to choose from, it's hard to know which is best for your practice. And if you do find a product that you are considering purchasing, how can you be guaranteed that it meets certain standards?

The Certification Commission for Healthcare Information Technology (CCHIT®) was founded with the goal of helping physicians choose an EHR product that's not only right for their practice, but that also fulfills expectations.

Since 2006, CCHIT, an independent, non-profit organization and a federally recognized certification body, has been inspecting and certifying EHR products.

All of the products that are CCHIT Certified are rigorously tested in the following areas:

- ***Functionality*** – the ability to create and manage electronic records for your patients, as well as automate the workflow in your office
- ***Interoperability*** – the ability to receive and send electronic data to others such as laboratories and pharmacies
- ***Security and reliability*** – the ability to keep your patients' data private and secure

With these basic questions covered, your practice can spend less time "screening" a myriad of vendors, and more time comparing a smaller number of candidate products in depth.

CCHIT certification helps physicians make informed purchasing decisions for EHR products, ensuring that these systems can enhance the quality and efficiency of health care. Ultimately, all stakeholders – and especially patients – will benefit greatly from the widespread adoption of health information technology.

A list of certified products, more information about CCHIT and a *Physician's Guide to CCHIT Certification* is available at **www.cchit.org.** For information about evaluating, selecting and implementing EHRs in your practice, go to **www.ehrdecisions.com.**

Andrew MacLean, Esq.

Legislative Update

MMA'S 2008 ADVOCACY EFFORTS HIGHLIGHTED AT ANNUAL SESSION

The Vice Chair of the MMA's Committee on Legislation, Samuel P. Solish, M.D., presented the following report at the General Membership meeting at the Samoset Resort in Rockport, Maine on Saturday, September 6, 2008. Dr. Solish is an ophthalmologist with Eyecare Medical Group in Portland. The MMA's summary of health care legislation from the 2 years of the 123rd Maine Legislature mentioned in the last paragraph of the report below is available from the MMA office and will be distributed at medical staff and specialty society meetings this fall. The MMA Legislative Committee will hold its organizational meeting for the 124th Maine Legislature following Election Day on Tuesday, November 4, 2008. Look for a notice of the meeting in the Maine Medicine Weekly Update.

2008 ANNUAL REPORT OF THE COMMITTEE ON LEGISLATION
by Katherine S. Pope, M.D., Chair and
Samuel P. Solish, M.D., Vice Chair

Following a final flourish of activity on the Dirigo Health Program, school and jail consolidation, bridge repair and maintenance, and driver's license security, the 123rd Maine Legislature adjourned its second session late in the evening of Friday, April 18, 2008. The 2008 session included definitive action on Dirigo Health Program funding legislation and successful efforts to close a substantial gap in the biennial budget while maintaining a MaineCare physician fee increase.

During the 2-year cycle of each legislature, the MMA Legislative Committee tracks more than 350 bills of interest to Maine physicians and their patients. As you will see from the MMA's "Top Ten" list of accomplishments in the 123rd Legislature in your meeting binder, the Committee participated in the development of significant state health policy ranging from the widely publicized budget and Dirigo Health debates to the prohibition of smoking in cars when children are present, primary seat belt enforcement, healthy weight initiatives, and updating our HIV testing laws, among others.

We believe it was a successful session with the MaineCare fee increase from approximately 53% to 57% of Medicare rates effective July 1, 2008 plus a dollar increase, per member per month, in the Primary Care Case Management (PCCM) fee, defeat of lay midwifery licensing, and enactment of an alternative funding method for the Dirigo Health Program among the highlights. During the summer, the MMA has been actively engaged in the defense of the "health access surcharge" and the beer, wine, and soft drink tax increases in the Dirigo legislation (L.D. 2247) in the face of a "People's Veto" initiative. On November 4, 2008, this issue will appear as Ballot Question 1.

The Legislative Committee met 3 times since the last annual session, once in late 2007 to assess the coming session and then twice in 2008. The Committee held conference calls to brief members on legislative action each week it did not meet in person. Building upon successful legislative forums with physicians and key policy makers in the legislative and executive branches in 2007, the Committee held two legislative forums in 2008 – one on the supplemental budget situation and the MaineCare physician fee increase and another to feature the 8 candidates (6 Democrats, including Stephen Meister, M.D., an Augusta pediatrician, and 2 Republicans) competing to fill Maine's First Congressional District seat vacated by Congressman Tom Allen who is running against Maine's junior Senator Susan Collins.

Katherine S. Pope, M.D., Outgoing Chair

Samuel P. Solish, M.D., Incoming Chair

We would like to thank all the MMA members who contributed to our advocacy activities this year - - Legislative Committee members, participants in our weekly conference calls, those who served as "Doctor of the Day" at the State House, witnesses at legislative public hearings, and contributors to the *Maine Physicians Action Fund*, the MMA's affiliated political action committee. All of you made substantial contributions to a successful year of advocacy for physicians and patients in the Maine legislature and executive branch agencies. "As I step down after serving 5 years as Chair of the Committee, I would like to say thanks to the MMA advocacy staff and to Vice Chair Samuel Solish, M.D., who has agreed to become the new Chair of the Committee," said Dr. Pope. She added, "I have very much enjoyed my role in the MMA's advocacy work and I wish the Committee the best of luck in the 124th Maine Legislature."

For more information about the MMA's advocacy work during the two years of the 123rd Maine Legislature, please see the "Top Ten" accomplishments and the comprehensive summary of health care legislation in your meeting binder.

You can find joint standing committee assignments on the web at: http://janus.state.me.us/house/jtcomlst.htm.

You can find your Senator and Representative on the web at: http://janus.state.me.us/house/townlist.htm.

To find more information about the MMA's advocacy activities, go to www.mainemed.com and visit the Legislative & Regulatory Advocacy section of the site. 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://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.

Updated Sentinel Event Statistics

The Joint Commission's sentinel event statistics have been updated on the website, www.jointcommission.org. Since the sentinel event database was implemented in January 1995 through June 30, 2008, The Joint Commission has received 5,208 reports of sentinel events. A total of 5,336 patients were affected by these events, with 3,713, or 70 percent, resulting in patient death.

The 10 most frequently reported sentinel events are:

Wrong-site surgery	691
Suicide	641
Operative/post-operative complication	598
Medication Error	470
Delay in Treatment	390
Patient fall	307
Assault, rape or homicide	198
Patient death or injury in restraints	183
Unintended retention of foreign body*	175
Perinatal death or loss of function	159

* = Added to reviewable events in June 2005; data represents events reviewed since that time.

Questions regarding this information should be directed to Anita Giuntoli at agiuntoli@jointcommission.org.

Initiative Will Reduce Paper, Possibly Liability Risk

A new effort to improve patient safety offers benefits for physicians. You can cut down on the paper that fills your desk and potentially cut your liability risk by agreeing to receive product-related safety notices electronically. This is a project that has been in the making for three years; you can participate *for free* by taking two minutes to enroll.

The initiative is called the Health Care Notification Network (HCNN). The Food and Drug Administration (FDA), the AMA, liability carriers and others created HCNN to send you information about FDA-mandated product recalls and warnings in a more timely, efficient and effective manner – before you read about them in the newspapers.

Some Key Facts

Once you understand the benefits of HCNN, you can enroll by providing your e-mail address. It will not be sold or disclosed to any third parties. Others on your staff, such as your practice manager or head nurse, may also enroll to receive the FDA-mandated alerts.

Then you and your staff will begin receiving medication recalls, warnings and national public health emergency notifications via your email inboxes. This process will allow for the organization and storage of notices for future reference. You can also forward messages to patients affected by any recall. Of course, HCNN alerts also can be received via mobile devices that access the Internet, such as a Blackberry.

"Relying on paper-based U.S. mail and weeks of delay to deliver time-urgent patient safety alerts to doctors in 2008 is indefensible and unsafe," explained Nancy Dickey, M.D., former AMA president and chair of HCNN's governing board.

"After a few years of work with the FDA and many other partners, we are finally moving from the Paper Age into the Internet Age in terms of patient safety alerts. We encourage all U.S. physicians to take two minutes and enroll today. Physicians and their patients will realize immediate benefit," Dr. Dickey added.

If you choose not to participate, you'll continue receiving paper notices, often referred to as "Dear Doctor letters." However, recent surveys of practicing physicians revealed more than 90 percent of respondents prefer patient safety alerts sent immediately online rather than through the mail. Also, more than 50 percent were pleased to have other office staff receive alerts.

You may have already received a letter from your liability carrier about HCNN; tens of thousands were mailed to physicians, explaining details of the project. These letters spelled out key aspects of HCNN including:

- Enrollment is free.
- Notices will arrive days or weeks ahead of paper alerts.
- No spam messages or advertising will appear.
- Opting out can happen any time you desire.

In the future, officials may utilize HCNN to communicate highly important emergency public health warnings or bioterror alerts, since it offers the advantage of speedy transmittal. But the network will not increase or decrease the total number of alerts you receive. The HCNN will simply replace paper alerts with electronic ones.

If you fail to open e-mail from HCNN, you will receive a paper notice. Therefore, enrolling with an e-mail address you check regularly is key to maximizing the benefit of your involvement and limiting medical liability.

About HCNN's Governance

HCNN is governed by a not-for-profit organization called iHealth Alliance. This entity ensures physician privacy and data security, and guarantees that the network is used ONLY for patient-safety-related alerts.

The iHealth Alliance Board is composed of leaders from medical liability carriers, medical societies, patient advocacy groups, practicing physicians and an FDA representative.

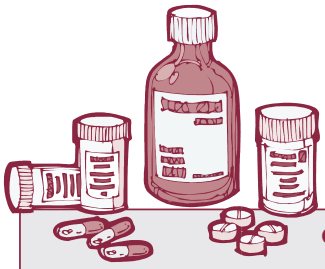
Funding for HCNN comes from the same health care manufacturers who currently pay for paper FDA alerts. That's why you'll find no advertising on the HCNN Web site; it is sustained by health product manufacturers.

Don't put off enrollment. Visit www.hcnn.net and read the FAQ (frequently asked questions) section at the bottom of the page. Then take two minutes to enter your information, reduce your paperwork – and maybe your liability risk.

Benefits of the Health Care Notification Network – www.hcnn.net

- Improved patient safety
- Reduced professional liability
- Immediate receipt of important clinical information
- Increased convenience for practices
- Ability to have patient safety alerts sent to other staff members
- Reduction in office paperwork and mail
- Ability to get more information about a specific patient safety alert

The Health Care Notification Network was designed to improve patient safety and public health, and to protect the interests of patients and health care providers.



Center on Aging Wins EPA Grant for Pilot Drug-Return Program

The UMaine Center on Aging has received a $150,000 grant from the U.S. Environmental Protection Agency to launch a first-in-the-nation pharmaceuticals-return program to help keep tons of medications out of rivers, streams and groundwater.

According to the EPA, the UMaine pilot will start, implement and evaluate a mail-back plan to remove unused over-the-counter and prescription medications from homes. Typically, unused, unneeded or expired medications are flushed down toilets or thrown in the trash, and ultimately can make their way into the environment. Since compounds in many medications can be destroyed only through incineration, they often pass through landfill and wastewater treatment plants and end up in rivers, lakes and streams.

In the United States and in England, studies have shown that pharmaceuticals and common personal health care products in the environment can cause genetic changes in fish and wildlife.

Unused, unneeded or unwanted drugs stored in homes also can wind up in the hands of children exploring medicine cabinets, or thieves who steal and sell pain medications, muscle relaxants and other drugs, says Len Kaye, director of the Center on Aging, which serves as administrator for the Maine Benzodiazepine Study Group (MBSG). The study group is a consortium of lawmakers, policy makers, and professionals in health care, geriatric care, law enforcement, social work, private industry and other disciplines pressing for new ways to curtail the storage or casual disposal of potentially dangerous medications. The group has been awaiting the EPA funding, which will enable the implementation of the Maine Unused Pharmaceutical Disposal Project adopted by the legislature in 2004.

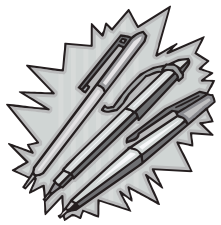
"We're extremely pleased to receive word that our grant application has been approved by the EPA," says Kaye, who also is the principal investigator for the EPA grant. "Now we can take steps to eliminate some of these medications from the waste stream and keep them out of the hands of people who should not have them. It's been a very serious problem with established detrimental effects on the environment and wildlife."

The Maine project also will include an inventory of the types and quantities of drugs being returned. Inventory data could prove useful to the medical community in changing its prescribing practices to reduce the incidence of unused medications.

EPA Project Officer Kathy Sykes says that while some states have held one-day drug-return programs, the Maine initiative and a St. Louis program both are the first pharmaceutical return programs of such proportion. The Maine mail-back and inventory aspects of the program are firsts in the country, she adds.

Kaye estimates that, in Maine, the pilot project will remove 1.5 tons of unwanted medications from homes or the waste stream.

More information about the project can be found on the Center on Aging Web site at www.umaine.edu/mainecenteronaging or by going directly to www.mainebenzo.org. In addition to the Center on Aging, the EPA and the MBSG, other project partners include the Community Medical Foundation for Patient Safety, Maine departments of Environmental Protection and Health, Maine Drug Enforcement Agency, Maine offices of Elder Services, Substance Abuse and Attorney General, the Maine Pharmacy Association, Maine RSVP Programs, Margaret Chase Smith Policy Center at UMaine, National Council on Patient Information and Education, Northern New England Poison Center, Northeast Occupational Exchange and the Villanova University Center for the Environment.



New Rules to Stop the Flow of Free Pens and Lunches Out

The Pharmaceutical Research and Manufacturers of America (PhRMA) Board of Directors voted to adopt new measures that they hope will demonstrate that pharmaceutical marketing practices "comply with the highest ethical standards."

In a press statement, PhRMA said its new voluntary Code on Interactions with Healthcare Professionals will take effect in January 2009. It reaffirms that interactions between company representatives and health care professionals "should be focused on informing the healthcare professionals about products, providing scientific and educational information, and supporting medical research and education."

Among other changes, the revised code prohibits:

- Distribution of non-educational items such as pens, mugs, and other logo products.
- Company sales representatives from providing restaurant meals to health care professionals but allows occasional meals in the health care professionals' offices in conjunction with informational presentations.

Other sections of the new code have more detailed standards regarding the independence of continuing medical education.

See the 7/10/08 press release with a link to the new code at www.phrma.org/news_room.

Northern New England Poison Center

In Maine, New Hampshire and Vermont, the Northern New England Poison Center provides immediate treatment advice for poison emergencies. They also provide information about poisons and poison prevention, twenty-four hours a day, seven days a week.

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