NOVEMBER/DECEMBER 2009

Maine medicine

IN THIS ISSUE

MMA Activities Focused on Health System Reform

Since the Presidential election last Fall, MMA has made comprehensive health system reform a priority. Using the 2003 MMA White Paper on Reform as the foundation for our advocacy activities (endorsing coverage for all through an individual mandate), MMA has carried out the following specific activities:

- **December 30** - Convened Public Listening Session on healthcare reform for presidential transition team.
- **April 7** - Hosted "Listening Session" with Senator Olympia Snowe, attended by over twenty-five organizations representing a variety of stakeholders.
- **June 15** - MMA's AMA delegation heard President Obama address AMA House of Delegates in Chicago.
- **July 2** - Hosted "Listening Session" at MMA with First District Congresswoman Chellie Pingree, with twenty-eight organizations participating.
- **August 28** - Participated in event with Second District Congressman Rep. Michael Michaud in Bangor.
- **September 3** - Participated in event with HHS Secretary Kathleen Sebelius at University of Maine, Orono. MMA President Stephanie Lash, MD presented.
- **September 16 -** Participated in Androscoggin County Medical Society Forum.
- **October 19** - Richard Evans, M.D., one of Maine's two AMA delegates, meets at the White House with President Obama and participates in an event with the President in the Rose Garden, promoting reform.

Richard Evans, MD greets President Obama in the Rose Garden, October 19, 2009.

During October, MMA staff was in frequent contact with staff to Senator Snowe and Senator Collins, as the Senate Finance Committee continued its work.

From June through November, MMA staff has participated in nearly weekly conference calls with the AMA Washington office. These nationwide conference calls gave all fifty state medical societies the opportunity to hear directly from AMA lobbyists on the hill. We informed MMA members and their staffs of the work going on around reform through articles in the *Weekly Update* and in *Maine Medicine*.

MMA has been successful in getting several op ed articles published, including articles by Dr. Jo Linder in the *Portland Press Herald*, Dr. David McDermott, M.D., MPH in the *Bangor Daily News* and EVP Gordon Smith, Esq., in the *Kennebec Journal*.

Our work is certainly not done. We would like to host a "listening session" with Sen. Susan Collins. And we will continue to advocate for passage of a comprehensive reform bill that covers all Americans and provides appropriate incentives to practice quality medicine.

A health reform section is currently being constructed on the MMA website. The section will provide frequent updates on the situation in Washington and will also link to several other sites that provide up-to-date information. Keep informed of developments by accessing the website at www.mainemed.com and by taking advantage of the many opportunities to learn that are available to you. And your input is always welcome. Contact president@mainemed.com or Gordon Smith, EVP at gsmith@mainemed.com.

U.S. Senator Olympia J. Snowe, April 7th, with staff William Pewen on left and MMA EVP Gordon Smith on right.

First District Congresswoman Chellie Pingree at MMA's July 2nd "Listening Session."

Members of the physician community presenting medical students with their white coats

Maine Medical Association President David McDermott, MD, MPH

Marc B. Hahn, DO, Dean UNE College of Osteopathic Medicine

White Coat Ceremony

Over 1,200 family members and friends gathered to celebrate as 124 first-year students at the University of New England College of Osteopathic Medicine participated in the College's annual White Coat Ceremony that formally recognizes the transition students make from lay persons to those assuming the responsibility of physicians. In keeping with tradition, the medical students were presented their white coats by members of the physician community.

The evening ceremony was held at the Holiday Inn by the Bay in Portland on October 8, 2009. Event highlights included welcome remarks by Marc B. Hahn, DO, the new Dean of the UNE College of Osteopathic Medicine, and Maine Medical Association President David McDermott, MD, MPH.

MAINE MEDICAL ASSOCIATION

30 Association Drive
P.O. Box 190
Manchester, ME 04351
207-622-3374
1-800-772-0815
Fax: 207-622-3332
info@mainemed.com
www.mainemed.com

NEWSLETTER EDITOR

Richard A. Evans, M.D.
207-564-0715
Fax: 207-564-0717
raevans95@earthlink.net

PRESIDENT

David B. McDermott, M.D., MPH
207-564-4464
Fax: 207-564-4461
dmcdermott@mayohospital.com

PRESIDENT-ELECT

Jo Linder, M.D.
207-662-7010
lindejo@mmc.org

EXECUTIVE VICE PRESIDENT

Gordon H. Smith, Esq.
207-622-3374 ext. 212
Fax: 207-622-3332
gsmith@mainemed.com

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Allscripts

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Contact Lisa in the MMA Membership Department at 622-3374 ext: 221 or email lmartin@mainemed.com.

David B. McDermott, M.D., President, MMA

President's Corner

What an exciting time to be an active member and engaged in the work of your Maine Medical Association! Our major committees have all held their organizational meetings for this MMA year, and are benefiting from the strength of our volunteer members and leaders as they work to address the myriad issues which affect our professional lives and those of our patients here in Maine.

Our Public Health Committee continues its work articulating for Maine citizens the strong links between global climate change and population and individual health. As our society grapples with these complex links, it is wonderful to see physicians leading the dialogue about this critical health issue. Our Committee on Physician Quality is beginning to work with the Maine Osteopathic Association and the Maine Hospital Association on the planning for next spring's third annual state-wide quality forum, to be hosted by the MOA on June 10th. The work this committee is doing to promote physician engagement in quality initiatives is critical: without the voice of the physician community at the table, efforts to improve the quality of medicine in Maine will fail to be as robust and meaningful as they can and should be. Our Committee on Physician Health has embraced the challenges of steering the Medical Professionals Health Program through its transition through staffing changes, relocation to the new John Dalco House, and the expansion of capacity as we work with the Maine State Board of Nursing to be able to offer their proven interventions and support to members of this important group of health professionals. Our Senior Section is finding great opportunities to engage and support our retired physicians and keep them involved with your MMA, engaging them in discussions and opportunity to stay involved in medicine and discussions about health system reform. Who knows more about the needs of our patients than those who have been serving them for more than fifty years? Our new Long-Term Development Committee is taking the first steps toward building support for the strength and viability of the MMA for the next fifty years, as we look to find new ways to sustain our programs and our work for Maine's physicians and their patients.

We are seeing continued growth in MMA's online communities. Take a few minutes online to join our discussion groups on LinkedIn ® and Twitter ®. There are links on our home page, www.mainemed.com, that take you through the steps to sign up with these services. We are using them to keep our members updated on a timely basis on important developments in health system reform activities. As this article goes to press, there will be increasing activity in Washington that will affect our practice of medicine for an entire generation of physicians. Stay aware! Stay involved! Let our leaders in Washington know what is important to you and to your patients. Our online communities can be a tool to help us communicate with one another and build dialogue across the state. But they will only work if we use them!

MMA's strength comes from our membership. If you have colleagues who are not members of MMA, please encourage them to join with us. We can do much more for you and your patients when we have the strength of every physician in Maine joining together to help us in our work. Let me know what's on your mind using the tools above!

David B. McDermott, MD, MPH, CPE is practicing emergency medicine at Mayo Regional Hospital in Dover-Foxcroft. He became President of MMA in September of 2009. You can reach him by email at president@mainemed.com, connect with him on LinkedIn ®, and follow his tweets @mmapresident.

Chronic Narcotic Use Guideline Education in MaineCare

By MaineCare staff

Due to increasing concerns regarding the appropriate, safe use of long-term narcotics, the Pharmacy Unit of the Office of MaineCare Services will expand the scope of its *chronic* narcotic prescription monitoring efforts starting January 1, 2010. The specific goal is to promote the widespread adoption of key elements of the existing standards of care (most notably the joint Rule 11 of the Boards of Licensure in Medicine and Osteopathy) as they pertain to "new" chronic narcotic patients. This effort will require a prior authorization (PA) for any member who has had 90 days of narcotics in the past 100 days (and no chronic, sustained narcotic prescriptions in the previous nine months; i.e. **new chronic starters**). A PA will not be required for hospice patients or for those members being actively treated for a life threatening illness such as AIDS or cancer. It is expected that 100 to 130 MaineCare members per month would meet the criteria requiring such a PA. Providers will be given thirty days to complete the Prior Authorization. Pharmacies will be granted overrides to continue dispensing narcotics during this time period for all affected patients.

The PA will concentrate on determining how thoroughly the following principles of pain management have been addressed:

- Confirming an appropriate indication for chronic narcotics
- Reviewing non-pharmacologic and non-opioid drug treatments considered and/or tried
- Verification that a narcotic/controlled substance contract exists
- Reviewing the intended monitoring plan (such as whether Urine Screens and Random Pill Counts may be appropriate).
- Verification that Prescription Monitoring Program reports are used routinely and not misinterpreted

It is anticipated that only a handful (minimum of 1 to maximum of 5) of Chronic Narcotic Use Prior Authorizations will be required of each provider. Some patients will require a follow-up PA 3 to 12 months later to see how well actual monitoring results and contract violations are handled. Exemptions will be granted quickly once it is clear that appropriate selection and re-evaluation/monitoring of chronic narcotic patients is occurring.

Providers may wish to take advantage of a consultation program for chronic pain jointly sponsored and supported by the Maine Medical Association and the Maine Board of Licensure in Medicine. This program provides free, professional consultations. To schedule a visit to your practice contact Noel Genova directly at noelpac@aol.com or 207-671-9076, or Kellie Miller at kmiller@mainemed.com or 622-3374 ext. 229.

We will soon publish a list of Narcotics that will be included in the monitoring program. Please bring your questions, concerns or comments to the Drug Utilization Review Committee on November 10. The meeting begins at 6pm with the open session closing at 7:30 and is located at the Office of MaineCare Services, 442 Civic Center Dr. Augusta. Or you can email Jennifer.Palow@maine.gov pharmacy Unit Manager, Office of MaineCare Services.

Thank you for serving MaineCare members.

Updated Sentinel Event Statistics

The Joint Commnission's sentinel event statistics have been updated at www.jointcommission.org. Since the sentinel event database was implemented in January 1995 through March 31, 2009, The Joint Commission has reviewed 5,901 sentinel events. A total of 6,036 patients were affected by these events, with 4,132, or 68 percent, resulting in patient death. The 10 most frequently reported sentinel events are:

Type	Total	2008	First Quarter 2009
Wrong-site surgery	784	116	43
Suicide	715	102	17
Operative/post-operative complication	659	63	28
Medication error	503	46	11
Delay in treatment	472	82	30
Patient fall	367	60	26
Unintended retention of foreign body*	252	71	40
Assault, rape or homicide	224	41	6
Patient death or injury in restraints	192	13	3
Perinatal death or loss of function	181	32	6

* Added to reviewable events in June 2005; data represents events reviewed since that time. Contact: Anita Giuntoli, agiuntoli@jointcommission.org

Upcoming at MMA

DECEMBER 1	6:00pm	MMA Legislative Committee
DECEMBER 2	1:00pm	Aligning Forces for Quality, Executive Leadership Team
	2:00pm	Quality Counts Board Meeting
DECEMBER 4	11:00am – 3:00pm	Medical Professional Health Program Open House
DECEMBER 7	4:00pm	Academic Detailing Work Group
DECEMBER 9	Noon	MMA, MDA, MOA Staff Holiday Luncheon
	4:00pm	Committee on Public Health
DECEMBER 10	8:30am	Pathways to Excellence (Maine Health Management Coalition)
DECEMBER 15	8:30am	Infection Control (APIC, Pine Tree Chapter)
DECEMBER 16	2:00pm	MMA Executive Committee
	5:00pm	MMA Committee on Budget and Investment
DECEMBER 17	5:30pm	Maine Association of Psychiatric Physicians
DECEMBER 25		Office Closed for Christmas Holiday
JANUARY 1		Office Closed for New Years Day
JANUARY 6	1:00pm	Aligning Forces for Quality, Executive Leadership Team
	2:00pm	Quality Counts Board
JANUARY 21	5:30pm	Maine Association of Psychiatric Physicians
FEBRUARY 3	1:00pm	Aligning Forces for Quality, Executive Leadership Team
	2:00pm	Quality Counts Board Meeting
FEBRUARY 10	4:00pm	Committee on Public Health
FEBRUARY 24	2:00pm	MMA Executive Committee

Upcoming Specialty Society Meetings

DECEMBER 2, 2009 — Dry Dock Restaurant and Tavern – Portland, ME
Maine Chapter, American College of Emergency Physicians
6:00pm – 9:00pm
Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

JANUARY 27-30, 2010 — Grant Summit Resort Hotel & Conference Center – Sunday River, Newry, ME
20th Annual Downeast Association of Physician Assistants Winter CME Conference
Contact: Kellie Miller 207-620-7577 or kmiller@deapa.com

JANUARY 23 - 24, 2010 — Sugarloaf/USA
Maine Section, American College of OB/GYN
Contact: Cindy Croteau 207-662-2749 or crotec@mmc.org

FEBRUARY 4 - 6, 2010 — Grant Summit Hotel – Sugarloaf/USA
20th Annual Winter Conference Contemporary Topics in Orthopedics
Contact: Donna Rogers 207-947-8381 ext: 212 or drogers@downeastortho.com or Janet Stevens 207-469-6471 or j5stevens@roadrunner.com

FEBRUARY 12 - 14, 2010 — Sugarloaf/USA
Maine Urological Society
MMA Contact: Kellie Miller 207-622-3374 ext: 229 or kmiller@mainemed.com

FEBRUARY 13 - 14, 2010 — Sugarloaf/USA
Maine Society of Anesthesiologists
Contact: Anna Bragdon 207-441-5989 or msainfo@roadrunner.com

MARCH 5-7, 2010 — Rangeley Inn – Rangeley, ME
Maine Gastroenterology Society Meeting
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

MARCH 10, 2010 — MMA Headquarters – Manchester, ME
Maine Chapter, American College of Emergency Physicians
6:00pm – 9:00pm
Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

APRIL 24, 2010 — Hilton Garden Inn – Freeport, ME
Topics in Gastroenterology 2010 Update
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

APRIL 29, 2010 — Holiday Inn by the Bay – Portland, ME
Maine Association of Psychiatric Physicians General Membership Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

APRIL 30, 2010 — Holiday Inn by the Bay – Portland, ME
Maine Association of Psychiatric Physicians 2010 Psychiatry Update Educational Sessions
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

MAY 1-2, 2010 — Sunday River – Bethel, ME
American Academy of Pediatrics, Maine Chapter Spring Conference: Newborn Management
Contact: Aubrie Entwood 207-782-0856 or agridleyentwood@aap.net

Maine Critical Access Hospital Collaborative Wins President's Award from New England Rural Health Roundtable

By Kim Crichton, Program Officer, Maine Health Access Foundation

The New England Rural Health Roundtable has awarded its annual President's Award to a collaborative of Maine Critical Access Hospitals focused on improving medication practices and safety. The collaborative received the award at the 12th NERHR annual symposium October 30th at the Portland, ME Marriott.

For nearly 18 months, fourteen of Maine's smallest, most rural hospitals have been meeting in monthly sessions facilitated by Judy Tupper of the Muskie School of Public Service. These hospitals face the same challenges to medication safety as all hospitals nationwide, including implementing new technology and other tools that assure the best possible care, and systematically and accurately communicating with patients and community health care providers about an individual's medications and health.

Providing technical assistance, Ms. Tupper has guided participants to assess organizational practices, learn from national best practices, candidly share experiences, and plan and implement specific solutions to address the needs of small, rural hospitals. "What made this collaborative work," said Ms. Tupper, "is the trust built among members and the information sharing and learning throughout. The work and approach has had a great, positive impact on these rural hospitals and the communities they serve. With the national attention they are already receiving for their work together, they will have the opportunity to expand their impact outside the state."

The Maine Health Access Foundation (MeHAF) provided funding for project planning, the technical assistance Judy Tupper has provided to the Collaborative, as well as the specific implementation projects at each of the fourteen hospitals. The Foundation intends to help the collaboration disseminate solutions generated by the project including medication reconciliation, interventions related to high-alert medications, enhanced patient and staff education and tele-pharmacy plans that more closely involve pharmacist in remote regions.

Gordon Smith, MMA EVP

Notes from the EVP

In lieu of an EVP article, following is an Op Ed Exclusive to the Kennebec Journal prepared by Gordon H. Smith, Esq.

The Case for Reform

As a national health reform proposal continues to take shape in Washington, it is important not to lose sight of the proverbial forest for the trees. In this case, the trees are the many details that any comprehensive bill necessarily would have to include. And no one is going to like all of the details. As lobbyists, we know all too well that it is far easier to defeat a bill than to pass one. And the more complex a bill, the more controversial it is likely to be and the easier to defeat. To draft a bill that meets defined objectives and to pass it in an area as complicated as health care requires patience, diplomacy, compromise, and real legislative skill. The formula for defeating a bill is much simpler. Focus on a limited number of controversial points, take them out of context, and speak loudly. In every possible way, try to drown out your opponents, thus causing the public to forget the overall objectives.

The primary objectives of health care reform should be the following:

- Provide appropriate public or private insurance coverage to all Americans; and
- Reduce the exorbitant cost of health care by slowing the growth trend.

If our leaders will focus on these objectives, measuring each legislative provision against these two benchmarks, the overall objectives are likely to be met. But, if supporters of the status quo are allowed to drown out the voices of the uninsured, the underinsured, employers, and employees who cannot afford annual double-digit increases in health insurance, reform is likely to fail and another opportunity will be lost.

One example of these tactics is the latest complaint of reform opponents that the Senate Finance Committee proposal is fundamentally flawed because it leaves 17 million people without coverage. The bill expands coverage by 29 million, ensuring that 94% of U.S. residents are covered. These skeptics are the same people who object to most of the measures that get the bill to cover 94% - that is, mandates to purchase insurance with subsidies for those who cannot afford coverage.

While physicians are concerned with many of the provisions in the Senate Finance Committee bill, particularly its failure to fix the flawed Medicare payment schedule for physicians, its promise of coverage for 29 million Americans currently without coverage is a positive attribute too large to be ignored. And while many of its provisions will cause financial pain, through increased fees and other revenue enhancements, all of these have to be weighed against the fact that many more patients in need of treatment will access that treatment earlier instead of seeking care in the highest cost settings when the problems have become acute. Coverage and cost must be the priority.

One example of the cost issue: Physicians participating in the Maine Medical Association's group health plan face a 29% increase in their health insurance premiums, effective February 1, 2010. Some options for families will now approach $30,000 per year in this small group plan offered by Anthem Blue Cross Blue Shield of Maine. Imagine this in a state where the average wage earner makes about $35,000 per year. As anyone responsible for purchasing coverage for their employees knows all too well, if your loss experience is good in a given year, the health insurance company takes the difference. But if you have a bad year, your health insurance company wants its perceived or real loss back in the next year. The employer and its employees don't win in this cruelest of lotteries.

I cringe when I hear those opposing reforms say that Congress must avoid destroying the private, employer-based insurance system that is working so well. Working well for whom, I would ask.

Let us hope that our elected representatives remain focused on the primary objectives and are not distracted by the politics of distortion, distraction, and destruction.

Gordon H. Smith, Esq., of East Winthrop is Executive Vice President of the Maine Medical Association.

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The MMA Welcomes Dee Kerry deHaas into newly created Development Director Position

As part of the Maine Medical Association's strategic plan to begin a more formal approach to development, Dee was hired in September into a two day per week position and will be working with Dr. Brian Jumper, Chair of the newly formed Development Committee, to provide leadership and management of fundraising activities. She will focus her attention on individual donors and events but will also reinforce MMA's relationships with community organizations, hospitals, and other health care provider agencies and investigate potential grant opportunities. She will also be working under Lisa Letourneau, MD, MPH, for the Quality Counts program three days a week.

In collaboration with the Development Committee, Dee will be implementing MMA's comprehensive development plan which includes an annual campaign, several targeted fundraising events, soliciting gifts-in-kind, donations to the Maine Medical Education Fund (MMEF), major and planned gifts and bequests to the MMA trust (MMET).

Dee relocated from Rhode Island to Winthrop this past winter with her husband Tony, a chemical engineer with Invensys Corporation, and their two children Amy (11) and Charlie (10). Prior to moving to Maine, Dee spent seven years serving as the Assistant Director for the John Chafee Center for International Business at Bryant University. In that role, Dee was responsible for corporate partnerships and fundraising, event management and directed the international business continuing education program. Prior to working at Bryant, Dee spent many years working at Harvard Medical & Dental Schools in Boston running their Student Enrichment Program where she coordinated programs in student research, international programs and community service for first and second year students.

She spends her leisure time with her family kayaking, hiking, snowshoeing, skiing and enjoying the beauty of Maine!

Committee on Loan and Trust Administration Approves Loans to Maine Medical Students

The Maine Medical Education Foundation is a 501(c)3 entity established to loan funds to Maine residents enrolled in or accepted by approved medical schools. The MMEF Committee on Loan and Trust Administration, chaired by Dr. Mark Bolduc, met on Wednesday, June 18, 2009 to review 56 loan applications. Listed below are students who will be receiving loans totaling $384,000 from the MMEF this year.

MMEF Loan Recipient	School Attending
Laura Amar-Dolan	Dartmouth Medical School
Elisabeth Anson	University of Vermont College of Medicine
Jonathan Ashcroft	St. George University School of Medicine
Kathryn Barus	University of New England
Christopher Bloombert	University of New England
Tiffany Bombard	Albany Medical College
Aaron Bos	University of Vermont College of Medicine
Nicole Boutaugh	University of New England
Jodi Brown	Midwestern Univ-Azcom
Jacob Crothers	Tufts
Alison Daigle	LECOM
Rosamund Davis	University of Vermont College of Medicine
Jessica Deane	University of Vermont College of Medicine
Sarah Decker	Dartmouth Medical School
William Demmons	Sabo University
Adam Duquette	University of New England
Theodore Elsaesser	University of Vermont College of Medicine
Michael Erkkinen	Dartmouth Medical School
Emily Estell	University of New England
Erik Fisher	Weill Cornell Medical College
Mellory Giberson	University of Vermont College of Medicine
Judith Griffin	Columbia University College
Ryan Guay	University of New England
Elizabeth Hewett	Dartmouth Medical School
Edward Hunt	St. Matthews University School of Medicine
Zahraa Ibrahem	Windsor University School of Medicine
Geoffrey Kendall	Tufts

MMEF Loan Recipient	School Attending
Jennifer Kendall	Albany Medical College
Danae Kershner	University of New England
Matthieu Larochelle	University of Vermont College of Medicine
Michael Larochelle	University of Vermont College of Medicine
Nicholas Larochelle	University of Vermont College of Medicine
Brandon Libby	Dartmouth Medical School
Anna Liberatore	University of Vermont College of Medicine
Matthew Lunser	Midwestern Univ-Azcom
Samuel Madore	University of New England
Matthew Malek	University of Rochester School of Medicine
Andrew Marubu	Emory University
Leah Morey	Tufts Medical School
Matthew Morgan	University of New England
Lindsay Nadeau	University of Vermont College of Medicine
Kathryn Ndzana	University of Connecticut
Michelle-Lynn Ouellette	Dartmouth Medical School
Emily Parent	University of New England
Abigail Sanders	Dartmouth Medical School
Jeremy Silver	University of Vermont College of Medicine
Jennifer Steinkeler	Tufts
Alexandra Swartz	University of Vermont College of Medicine
Craig Szela	Harvard Medical School
Holly Thro	Tufts
Kristen Wagner	University of New England
Maria Weinstein	University of New England
Lauren Wendell	University of Vermont College of Medicine
Eric Worthing	University of Vermont College of Medicine

MaineCare Out-of-State Care

By Judith Chamberlain, MD, Medical Director for Maine, Schaller Anderson

Did you know that MaineCare has spent up to 30 million dollars a year on medical care provided outside of Maine? Most of that care is in Boston, and in some cases it is care that we cannot provide in Maine. However, as we have reviewed requests for care out of state over the past year, at least 10% of that care could have been provided in Maine.

Recently representatives of MaineCare, Schaller Anderson, the Maine Medical Association and the medical leaders of Maine's largest hospitals met specifically to discuss how to improve coordination of in-state care for children, especially those with multiple medical needs. It is clear that at least some care is requested out-of-state because of the availability of multi-specialty clinics with "one-stop-shopping" for specialty care. We hope to provide a way to make it easy for families to access several specialists in Maine in one place and on the same day, as multi-specialist clinics in Boston have done.

In the meantime, the staff at Schaller Anderson has been working to find in-state specialty care for MaineCare members when it is available. There are a number of ways Maine physicians can help both to facilitate out-of-state care when needed and to keep care in Maine when possible. Here are a few:

1) MaineCare requires a letter from a Maine provider to authorize out-of-state care. For non-emergent care, this is supposed to be sent 30 days before the planned visit.
2) When you write a letter of medical necessity, you are saying that in your professional opinion this is care that ***can not*** be done in Maine (not the same as saying that the MaineCare member wants to go to a particular doctor in Boston or elsewhere). It helps if you provide some detail about previous care such as in-state consultations or procedures.
3) Follow-up care should be done in Maine when possible after a consultation or procedure out-of-state. We sometimes need to remind our colleagues to the south that all medical care does not stop when you drive north across the bridge at Kittery. It is important for our patients to have physicians close to where they live who understand the care they have gotten out-of-state. It also will save our patients time and money if we can provide their care closer to home.
4) Many visits out-of-state include tests that could be done here. A member may need to see a subspecialist for evaluation, but the CT, MRI, EEG, blood test requested could be done in Maine. In almost every instance where we have asked the out-of-state subspecialist, they have been happy to have a test done in Maine and results or images sent to them. Schaller staff members are working on coordinating this care and will continue to work with physicians in Maine to smooth this process.

Maine physicians should be proud of the quality of primary and subspecialty care we provide to all of our patients. We should encourage our patients to seek care close to home unless that care is truly not available in Maine. If you have questions about out-of-state prior authorizations for MaineCare, please contact Dr. Judy Chamberlain, Medical Director for Schaller Anderson at (207) 228-8894 or chamberlainj2@aetna.com.

Gordon Smith joins James Harrison Onpoint Health Data President and CEO

The Maine Health Information Center (MHIC) Announces Name Change to Onpoint Health Data

On October 1, 2009, the Maine Health Information Center (MHIC) changed its name to Onpoint Health Data. This change is the result of a careful brand assessment process under way since early 2009. For over 15 years, the non-profit data organization has been the primary tenant in the Daniel F. Hanley Building located on MMA campus in Manchester.

"We felt it was time to update our brand to better reflect who we are and how we've grown," says Onpoint Health Data President and CEO James Harrison. "Our new name brings more clarity to our mission and strategic direction and reflects our recent, significant growth outside the state."

"Northern New England has been our home for more than 30 years and continues to be our base of operations. It's where we got our start and where we continue to do much of our most innovative work," Harrison adds. "It's a past the organization is proud to celebrate—and take forward. Onpoint Health Data remains committed to meeting this region's research and data needs as it takes on new opportunities and challenges in other parts of the country."

Rising interest from states across the nation has fueled recent growth at Onpoint Health Data. To keep pace, the organization has been investing heavily in its people, infrastructure, and analytic services. The new brand, reflecting this growth, is a natural next step.

In concert with its name change, Onpoint Health Data also is updating the name of its ground-breaking claims database product, known by clients as NCDMS or the National Claims Data Management System. This comprehensive data solution, the first in the nation to integrate claims from all payers in all settings, is now Onpoint CDM (Claims Data Manager).

While the name is changing, some important things remain the same. First and foremost, the organization remains committed to providing the responsive solutions and service its clients need and expect. Onpoint Health Data remains an independent, nonprofit organization dedicated to delivering reliable data management and thoughtful analytic services. And it continues to be staffed by an expert and diverse group of health data professionals.

The Maine Health Information Center has been a front-runner in health data services since its founding in 1976 by the Maine Medical Association, the Maine Hospital Association, Blue Cross Blue Shield and other organizations. It's a tradition the organization looks forward to continuing under the banner of Onpoint Health Data.

About Onpoint Health Data

Founded in 1976, Onpoint Health Data is an independent, nonprofit, health data organization focused on providing healthcare data management, analysis, and reporting services to a wide range of clients. Onpoint Health Data is recognized for supporting and promoting the use of high-quality healthcare data as the basis for decisions in healthcare policy and management while ensuring the privacy and security of patient-specific data.

Public Health Spotlight

Kellie Miller, Director of Public Health Policy, MMA

MMA's Public Health Committee's 2010 Activities and Priorities

The Maine Medical Association's Public Health Committee met October 21, 2009, under the direction of the newly elected Chair, Dr. Norma Dreyfus. Dr. Hugh Tilson presented his role in organizing the Sagadahoc County Board of Health, which has been exemplary in meeting the demands of our current PH emergency. (H1N1) His work is an example of what physician involvement can do in each of our sixteen counties within the state's eight Public Health Districts. Dr. Tilson presented, "Launching the SHIP" (The Sagadahoc Health Improvement Project), which began in December 2004, along with an overview of the Sagadahoc County Board of Health's strategies to strengthen their county's public health infrastructure using the Essential Services of Public Health as their Guide. His slides are available for download on the MMA website under the Public Health Committee meeting information at www.mainemed.com. Dr. Tilson, Doctor of Public Health, has expressed his willingness to give a course on Public Health Leadership to MMA physicians. A questionnaire will be sent out to the membership inquiring about interest in participating.

Dr. Dreyfus presented the Public Health Committee's 2010 Public Health priorities for discussion by the members and all members in attendance agreed enthusiastically on the following priorities:

1. Environmental Toxins
2. Immunization Financing
3. Strengthening Maine's Public Health Infrastructure
4. Global Climate Change and Adaptation

Dr. Dreyfus stated, "these are exciting times for public health both from a state and national perspective. We are looking forward to bringing the committee up to date on the priority issues so that we can move forward with like-minded groups in making a difference."

The next meeting of the Public Health Committee is scheduled:

December 9, 2009, 4:00 – 6:00 pm, Maine Medical Association (also available via video-conferencing through the MMC's Dana Center) There will be presentations by guest speakers on 2 of the very important Public Health issues that the Committee has chosen as priorities with a panel presentation titled**: "Our Public's Health – Climate Change, Energy Efficient Hospitals/MESHnet and Environmental Toxins."** Paul Santomenna, Executive Director of Physicians for Social Responsibility, will talk about hospitals contribution to greenhouse gas emission and the work of the Hospital Network. Lani Graham, MD, will provide an overview of health care and environmental toxins, which will include findings from the "Hazardous Chemicals in HealthCare" report, (*detailing the first investigation ever of chemicals found in the bodies of health care professionals. including MMA Past President Stephanie Lash, MD.)*, Matt Prindiville of the National Resources Council of Maine, will provide an update on federal and state legislation including TSCA reform; and Syd Sewall, M.D. will discuss the use of the *Pediatric Environmental Toolkit* in clinicians offices.

Two hours of educational credits have been applied for. For more information and to register for this free educational offering, contact MMA at 207-622-3374, ext. 219 or via email to Maureen Elwell at melwell@mainemed.com. Registration deadline is December 4, 2009.

Visit the MMA website at www.mainemed.com

Medical Mutual Insurance Company of Maine Risk Management Practice Tip:

Medication Reconciliation in the Physician Practice

The Institute of Medicine has reported that there are 7000 patient deaths each year due to medication errors. Chart review data indicates over 50% of medication errors occur at the interfaces of care. The transfer of care is recognized as a potential critical failure point for patient safety.

Medication reconciliation is a formal process of obtaining a complete and accurate list of each patient's current medications including name, dosage, frequency, and route, and using this list to guide drug choice usage anywhere within the health care system. Medication reconciliation involves comparing a patient's current list of medications with the physician's new medication orders at any subsequent interface of care, e.g., admission, unit transfer, step-down care transfer, discharge to home and after the patient/physician office encounter.

Implementation Steps for the Medication Reconciliation Process

1. Develop guidelines that address the following:
   - a. Generation of a patient home medication list
   - b. Identification and resolution of high-risk situations
     - Patients on high-risk medications
     - Patients on greater than five medications
     - Specific interventions for elderly or compromised patients
2. Adopt a standardized form for reconciling medications.
   - a. Patient Identification
   - b. Allergy Verification
   - c. Preparer Signature
   - d. Physician Signature
   - e. List each medication
     - Dosage
     - Frequency
     - Date/Time of last dose
   - f. Other data
     - Person providing information
     - Patient weight
     - Over-the-counter medications and herbals
     - Pregnancy/Breast feeding
3. Assign responsibility for reconciling medications to a healthcare professional with sufficient expertise.
4. Place the medication reconciliation form in a highly visible location in the patient's medical record.
5. Assure reconciliation occurs.
   - a. Identify who is responsible for reconciling the medication list.
   - b. Compare each medication to the previous medication list and resolve discrepancies.
   - c. Review and update the medication list when the patient encounter is a telephone call and there is a medication change.
6. Documentation expectations.
   - a. Document review, revision of the medication list at each patient encounter.
7. Develop guidelines for clinical staff and providers.
   - a. Specify conditions that require a consultation; e.g., greater than five medications, high risk medications.
8. Provide orientation and ongoing education on the established expectations to all healthcare providers.
9. Develop strategies to educate patients/families in monitoring medications and maintaining accurate medication lists. Engage other healthcare facilities in the process when appropriate.
10. Establish a process for quality improvement.
    - a. Review a random sample of medical records each month to determine compliance with the guidelines.
    - b. Encourage reporting of errors identified through the reconciliation process.
    - c. Develop a strategy to share the results of the review process with staff/providers.

Other considerations for successful implementation:

1. After obtaining the patient's consent, involve the patient's family members.
2. Involve the facility where the patient resides, e.g., LTC, SNF, assisted living, independent living.
3. Thoroughly test the process before automation.

Resources:
Excellent resources are available by accessing this practice tip at www.medicalmutual.com

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.

Maine's Patient Centered Medical Home Pilot Launches with First Learning Session

By Lisa M. Letourneau, MD, MPH

Physician practice teams from around Maine who were selected to participate in Maine's Patient Centered Medical Home (PCMH) Pilot launched the initiative by holding their first learning session at the Maple Hill Farm Bed & Breakfast in Hallowell, Maine on Friday, October 30th. There will be three sessions per year over the course of the three year pilot. Christine Sinsky, MD and Tom Sinsky, MD practicing physicians from Iowa and expert presenters on the topic of Medical Homes, worked with the over 125 people in attendance to support their work and share best practices on transforming to this new model of care.

The Maine Patient Centered Medical Home Pilot includes 22 adult and 4 pediatric practices from communities across the state who will be working together over a 3-year period. The Patient Centered Medical Home is a new model for delivering primary care services to consumers. Participating practices commit to achieving national recognition standards and work to meet established core expectations. The Patient Centered Medical Home offers an exciting and promising approach to transforming healthcare as it supports both the practice transformation and the payment reform required to improve primary care.

The Dirigo Health Agency's Maine Quality Forum, *Quality Counts*, and the Maine Health Management Coalition are the conveners of this multi-stakeholder effort. The ultimate goal of this effort is to sustain and revitalize primary care both to improve health outcomes for all Maine people and to reduce overall healthcare costs.

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2009 MPAF Honor

The **M**aine **P**hysicians **A**ction **F**und (***MPAF)*** and its counterpart the American Medical Association Political Action Committee (*AMPAC*) help ensure that the voice of medicine is heard and effectively represented in the State Legislature and in Congress. MPAF would like to thank these Maine physicians who supported our political action committee in 2009 and understand its importance to both their *patients* and their *practice.*

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Thank You

Andrew MacLean, Esq.

Legislative Update

ELECTION DAY RECAP & PREVIEW OF COMING LEGISLATIVE SESSION

Although Maine had no significant statewide or legislative races this fall, the seven ballot questions prompted a greater voter turnout than expected on Election Day. The 186 members of Maine's 124th Legislature will return to Augusta for the beginning of their Second Regular Session on Wednesday, January 6, 2010. They will face a supplemental state budget to address a budget gap estimated to be more than $200 million, 88 bills carried over from the first session, and new bills approved by majority vote of the Legislative Council, the 10 members of the legislature's leadership. The MMA's Legislative Committee, under the leadership of Chair Lisa D. Ryan, D.O., has scheduled an organizational meeting to prepare for the second session for Tuesday, December 1, 2009 at 6:00 p.m. at the MMA office in Manchester. Any interested member is welcome to attend.

The MMA did not participate in any of the referenda campaigns, but two questions did have implications for the practice of medicine in Maine. Passage of Question 5 (medical marijuana) has generated more inquiries from the press and from members about medical marijuana and the defeat of Question 4 (TABOR) means that the difficult state budget situation will not be more so by adding another layer of governmental process.

Governor Baldacci begins his final year in office in January and the Democrats will begin 2010 with control of both the Maine Senate (20 D, 15 R) and Maine House of Representatives (95 D, 55 R, 1U). The national health system reform debate in Washington likely will continue to provide context for state legislative action. The 124th Legislature's Second Regular Session is scheduled to last until mid-April.

As is common between legislative sessions, the legislature has carried over a number of bills and these bills often are complex and/or controversial.

The carry-over list includes the following bills of interest to the MMA:

- L.D. 701, *An Act to Fund the Screening and Early Detection Elements of the Statewide Cancer Plan*;
- L.D. 257, *An Act to Establish the Health Technology Clinical Committee*;
- L.D. 1365, *An Act to Establish a Single-Payer Health Care System*;
- L.D. 20, *An Act to Require Insurance Companies to Cover the Cost of Prosthetics*;
- L.D. 425, *An Act to Require Private Insurance Coverage for Certain Services for Children with Disabilities*;
- L.D. 1198, *An Act to Reform Insurance Coverage to Include Diagnosis for Autism Spectrum Disorders*;
- L.D. 821, *An Act to Support Collection and Proper Disposal of Unwanted Drugs*;
- L.D. 1262, *An Act to Restrict Gifts to Health Care Practitioners from Pharmaceutical and Medical Device Manufacturers*; and
- L.D. 1408, *An Act to Establish the Universal Childhood Immunization Program*.

The Legislative Council has approved the following "legislative requests" or "LRs" of interest to the MMA for consideration during the second session:

- L.R. 2092, *An Act to Protect Minors from Unscrupulous Marketing Practices*;
- L.R. 2172, *An Act to Allow the Board of Dental Examiners to Grant Permits to Qualified Individuals to Practice as Dental Residents*;
- L.R. 2306, *An Act to Amend the Laws Governing Advanced Practice Registered Nurses*;
- L.R. 2457, *An Act to Establish an Office of Administrative Law Judges for Licensing Boards*;
- L.R. 2417, *An Act to Amend the Law Pertaining to Smoke Detectors and Carbon Monoxide Detectors*;
- L.R. 2329, *An Act to Ensure the Continuation of the Maternal and Infant Death Review Panel*;
- L.R. 2301, *An Act to Prevent the Spread of Eastern Equine Encephalitis*;
- L.R. 2212, *An Act to Create the Children's Wireless Protection Act*;
- L.R. 2038, *Resolve, to Allow for the Proper Disposal of Medical Supplies*;
- L.R. 2437, *An Act Enabling Expedited Partner Therapy*;
- L.R. 2480, *An Act to Repeal the Fee Increase for Copies of Vital Records*;
- L.R. 2094, *An Act to Expand the Opportunity for Persons to Acquire Health Care Coverage under the State's "Mini-COBRA" Program*;
- L.R. 2125, *An Act Concerning the Use of Long-term Antibiotics for the Treatment of Lyme Disease*;
- L.R. 2237, *An Act to Protect Individuals with Health Insurance from Catastrophic Risk*;
- L.R. 2430, *An Act to Improve Health Insurance Security*;
- L.R. 2492, *An Act to Adopt a Drug Benefit Equity Law*;
- L.R. 2199, *An Act to Maintain Compliance of Maine's Insurance Laws with National Standards*;
- L.R. 2134, *An Act to Aid in the Prevention of the Spread of HIN1 Influenza by Ensuring the Provision of Earned Paid Sick Time*;
- L.R. 2240, *An Act to Improve Maine's Air Quality and Reduce Regional Haze at Acadia National Park and Other Federally Designated Class I Areas*;
- L.R. 2182, *An Act to Clarify Maine's Phaseout of Polybrominated Diphenyl Flame Retardants*; and
- L.R.. 2183, *An Act to Amend the Laws Governing Noise Limitations on Wind Turbines*.

The legislature also will consider the following state agency bill requests:

- L.R. 2406 (FAME), *An Act To Amend the Health Professions Loan Program*;
- L.R. 2233 (DPFR), *An Act To Correct Errors in the Laws Relating to Unlicensed Practice and Other Provisions of the Professional and Occupational Licensing Laws*;
- L.R. 2317 (DHHS), *An Act To Enhance Newborn Bloodspot Screening To Conform to Federal Newborn Screening Standards*;
- L.R. 2321 (DHHS), *An Act To Clarify the Child Abuse or Neglect Substantiation Process*;
- L.R. 2318 (DHHS), *An Act To Update the Laws Affecting the Maine Center for Disease Control and Prevention*;
- L.R. 2322 (DHHS), *An Act To Update the Laws Affecting the Department of Health and Human Services, Division of Licensing and Regulatory Services*;
- L.R. 2316 (DHHS), *An Act To Amend the Maine Certificate of Need Act of 2002 Concerning Right of Entry and Investigation*;
- L.R. 2402 (DHHS), *An Act To Amend the Laws Regarding Authority and Oversight of Certified Nursing Assistant Educational Programs*;
- L.R. 2399 (MHDO), *An Act To Amend the Maine Health Data Processing Center*;
- L.R. 2379 (DHHS/AG), *An Act To Make Maine's Laws Consistent with the Federal Family SmokingPrevention and Tobacco Control Act*;
- L.R. 2230 (DVA), *An Act To Amend the Rights and Liabilities of the Supervisory Physician of a Physician Assistant*.

As mentioned above, the MMA's Legislative Committee will hold its organizational meeting for the upcoming session on Tuesday, December 1, 2009 from 6:00 p.m. to 8:30 p.m. at the MMA offices in Manchester. If you would like to attend, please R.S.V.P. to Maureen Elwell, Legislative Assistant by email at melwell@mainemed.com or by phone at 622-3374, ext. 219.

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.

Seat Belt Use in Maine

By Robert Flint, Police Officer, Biddeford, Maine Police Department

Seat belt use in Maine has become more frequent in the past few years, primarily due to the enactment of the seat belt law and its subsequent enforcement. Use levels currently are near 80%, up from the 50th percentile just a few years ago. It is great that so many people are buckling up, but what about the 20% or so who refuse to do so?

One might ask, "Who in their right mind would get into a vehicle and ride at any speed without wearing a seat belt?" You can be assured that most of us wouldn't run straight into a brick wall with our arms at our sides, but hitting the wall wouldn't inflict nearly as much force as a 30 mph crash does on the unrestrained human body. Yet here we are, living in a country that tests most things to see that they are safe, where people demand safety of the products they use, and we still have people who think "accidents" won't happen to them.

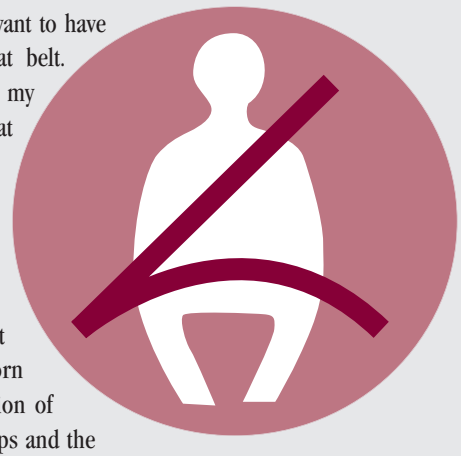
In 2008, there were 38,805 reportable motor vehicle crashes in Maine and of those crashes, 155 involved a fatality (this includes all vehicle types and pedestrians). There were 108 fatality crashes that involved passenger vehicles and of those killed, 51 were wearing their seat belt, 45 were not belted, and it is unknown if the other 12 were or were not belted. Twenty seven (27) percent of the fatal crashes were alcohol related and 34 percent were speed-related.[1] This certainly leaves many other causation factors, other than the ones we normally associate with death and destruction on our highways—alcohol and speed.

Of particular concern are the people whom I stop that hold notes or letters from a physician that legally allow them to be excused from wearing a seat belt. In my dealings with these people there are some constants; their dislike of wearing a seat belt, and many of them are unpleasant and difficult individuals to deal with. The excuses listed on the doctor notes range from the frequent "back problem" and "claustrophobia", to the best one yet, "PTSD due to service in Vietnam that included the extrication of many bodies that were trapped in burning vehicles". I highly doubt there were many seat belts in use in Vietnam between 1964 and 1974.

I would encourage each one of you to take a few moments some time, and after securing yourself in your seat belt, to see just what kind of mobility you do have. You can reach anywhere in the vehicle you need to reach while driving—remember, when you're behind the wheel, driving is the number one priority. You can move in your seat, bend forward and to either side, and reach the floor, etc. When I talk to the people who dislike wearing a seat belt and I listen to their comments, they talk like they need to be doing Richard Simmons-like exercises while in the car, because their back bothers them so much.

I suspect that many physicians issue these notes to people only because they seem to be a reasonable request or because these people are "problem" patients and it is better to just give them what they want and let them go on their way. Don't get me wrong—there are probably people who have a valid reason for not wearing a seat belt, but I believe they are few and far between.

I have spoken to a doctor I know and asked him if he has ever given such a note to a patient. He told me he hadn't and he seemed genuinely surprised by my question, and even said he had never heard of such a thing. I explained the *medical exception* to the Maine seat belt law and his response was that he couldn't see why a doctor would want to have his patient(s) not wear their seat belt. His comments seemed to reflect my thoughts, as he went on to say that injuries suffered as a result of not being belted would make anything else being already suffered by the patient, even worse.



Another problem area, are those who wear the seat belt, but do so improperly. A properly worn seat belt is one with the lap portion of the belt secured firmly over the hips and the shoulder portion worn over the shoulder, and across the chest. There are documented case and crash studies where persons who were wearing their seat belt improperly, actually suffered worse, or even fatal injuries, because of the manner in which the belt was being worn. If the lap belt is worn too high, significant damage can be done to the internal organs. If the shoulder belt is worn under the arm, instead of over the shoulder, the belt, when pulled taught, can actually slide low enough to go below the rib cage and cause crushing injuries to internal organs. I worked through a similar case study in training, where a young woman was killed when her shoulder strap, which was being worn under her arm, was pulled so tight while restraining her during a head-on crash into a tree, her liver was ruptured. Incidentally, the driver in that same crash, who was wearing a seat belt properly, did survive.

In closing, I would ask that the next time a patient comes to you and asks for a seat belt excusal note, please give it some thought. It is important for all of us to do our own little part, even if that means keeping ourselves out of harm's way so that someone else can get the emergency treatment they desperately need. I can only guess how difficult and insistent some of your patients must be—I'm sure you've seen more than your fair share of rolled eyes when you discuss things like trans fats, alcohol intake, tobacco use, and exercise, just to name a few—but please, ask yourself, what is really best for the patient. I know, I'm only a cop and you're the doctor, but sometimes and more often than we should admit, we really do know better than a lot of people, what is really the best for them.

[1] Maine Bureau of Highway Safety.

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Robert Flint is a Police Officer with Biddeford, Maine Police Department and is assigned to the traffic unit. He retired from the Maine State Police in 2005 after 23 years of service. He has been a police officer since 1978 and a member of a crash reconstruction unit since 1986. He has investigated hundreds of crashes, with several of those being fatal, and most of the people he has seen who died while secured in their seat belt, likely would have died even if they were not secured—the crash was so catastrophic. However, it is likely that many of those who died while not secured would have lived had they stayed inside the vehicle. Your chance of surviving a car crash is greatly improved if you remain secured inside the vehicle.

Thank You

Thanks to 2010 Sustaining Members

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

Rebecca Brackett, MD ~ CMMC- Anesthesia ~ Dahl-Chase Pathology Associates ~ Midcoast Hospital ~ Sunbury Primary Care

New Biomonitoring Study Detects Four Chemicals on EPA's Recently Announced Top Priority List

Physicians for Social Responsibility (PSR) in partnership with American Nurses Association (ANA) and Health Care Without Harm (HCWH) recently released the *"Hazardous Chemical In Health Care"* report, detailing the first investigation ever of chemicals found in the bodies of health care professionals. The inquiry found that all of the 20 participants (MMA Past President Stephanie Lash, MD participated from Maine) had toxic chemicals associated with health care in their bodies. Each participant had at least 24 individual chemicals present, four of which are on the recently released Environmental Protection Agency list of priority of chemicals for regulation. These chemicals are all associated with chronic illness and physical disorders.

The medical profession is asking whether we can reduce prevalence of disease by changing the way we manage chemicals. Nurses and doctors volunteered for this study because they believe it is their responsibility to better understand how chemicals impact human health, explained Kristen Welker-Hood, ScD, MSN, RN, Director of Environment and Health Programs, Physicians for Social Responsibility, co-principal investigator and a co-author of the report.

Other findings include:

- Eighteen of the same chemicals were detected in every single participant;
- All twenty participants had at least five of the six major types of chemicals tested;
- Thirteen participants tested positive for all six of these major chemical types;
- All participants had bisphenol A, phthalates, PBDEs and PFCs, priority chemicals for regulation by the EPA and associated with chronic illness such as cancer and endocrine malfunction.

"The Hazardous Chemicals in Health Care" report offers preliminary indicators of what the broader health care community may be experiencing. The project tested for 62 distinct chemicals in six categories: bisphenol A, mercury, perflourinated compounds, phthalates, polybrominated diphenyl ethers, and triclosan. The chemicals tested in the investigation are used in products common to the health care setting, from baby bottles, hand sanitizer, and medical gauges, to industrial paints, IV bags, and tubes and stain-resistant clothing.

In addition to data on testing, the report includes recommendations on how health care professionals can protect their patients and themselves by avoiding the use of toxic chemicals. For a copy of the full report, request a copy by contacting MMA staff, Kellie Miller at 207-622-3374, ext. 229 or via email at kmiller@mainemed.com.

Maine Medicine

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