Great Attendance at Physicians’ Day at the Legislature

Fifty-eight physicians and nine medical students, many in white coats, were in the State House for Physicians’ Day at the Legislature on Wednesday, March 13th. It was the best turnout in several years. Meetings were held with legislative leadership from both parties, and the afternoon featured a tea at the Blaine House with Governor Janet Mills.

Members were able to meet with many of their state senators and representatives as well as with Democratic and Republican leaders of the House and Senate and our five physician-legislators. Several doctors stayed around after the day was over in order to testify before the Education and Cultural Affairs Committee on a bill to repeal the philosophical and religious exemptions to school immunization requirements (L.D. 798).

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FEDERAL LEGISLATION APPROVED TO ADDRESS NATION’S OPIOID EPIDEMIC

President Donald Trump has signed a wide-reaching measure aimed at helping to stem the nation’s opioid epidemic with additional treatment options for the individuals affected and new resources to assist physicians treating patients for substance use disorders.

The legislation - “Support for Patients and Communities Act” (H.R. 6) - touches on nearly every aspect of the unrelenting opioid epidemic that is affecting communities across the nation, including numerous provisions supported by the American Medical Association (AMA) that will, among other efforts:

- Expand access to substance use disorder prevention and treatment programs, including for pregnant women and newborns with Neonatal Abstinence Syndrome (NAS);
- Fund research and development of non-opioid pain therapies;
- Crack down on international shipments of illicit drugs such as fentanyl; and
- Lift restrictions on using telemedicine for treatment of substance use disorders.

Additional provisions in H.R. 6 direct federal agencies to produce studies, reports, and guidelines related to opioid use, prescribing, and treatment.

Other AMA-backed provisions include:

- Expanding existing programs and creating new programs to prevent substance use disorders and overdoses, including reauthorization of the Office of National Drug Control Policy;
- Expand programs to treat substance use disorders, including medication-assisted treatment (MAT);
- Partially lifting (for five years) a current restriction that blocks states from spending federal Medicaid dollars on residential addiction treatment centers with more than 16 beds by allowing payments for residential substance use disorder services for up to 30 days;
- Allowing Medicare to cover MAT, including methadone, in certain settings; to treat substance use disorders;
- Require state Children’s Health Insurance Programs to cover mental health benefits, including substance use disorder services for eligible pregnant women and children;
- Increase funding for residential treatment programs for pregnant and postpartum women; require the Centers for Disease Control and Prevention (CDC) to develop educational materials for clinicians to use with pregnant women for shared decision-making regarding pain management during pregnancy; and require the Department of Health and Human Services (HHS) to implement research, prevention, and treatment recommendations related to NAS in newborns;
- Authorize an Alternative Payment Model (APM) demonstration project developed by the American Society of Addiction Medicine, with support from the AMA, to increase access to comprehensive, evidence-based outpatient treatment for Medicare beneficiaries with opioid use disorders. The APM would require demonstration participants to provide both medication as well as psychosocial support, care management, and treatment planning for opioid use disorders for eligible beneficiaries, and also includes the development of measures to evaluate the quality and outcomes of treatment, and rewards participants for performance on such quality measures;
- Authorize CDC grants for states and localities to improve their Prescription Drug Monitoring Programs (PDMPs); collect public health data, implement other evidence-based prevention strategies, encourage data sharing between states and support other prevention and research activities related to controlled substances, including education and awareness efforts;
- Expand the use of telehealth services for Medicaid and Medicare substance use disorder treatment and require the Attorney General to issue final regulations within a year to provide waivers to health care providers to allow them to prescribe controlled substances via telemedicine in emergency situations;
- Provide loan repayment for substance use disorder treatment professionals, including physicians, who agree to work in mental health professional shortage areas (HPSA) or counties that have been hardest hit by drug overdoses and clarify that behavioral health providers participating in the National Health Service Corps can provide care at a school or other community-based setting located in a HPSA as part of their obligated service requirements;
- Help stop the flow of illicit opioids into the country by mail, especially synthetic fentanyl and its analogs, which are responsible for the rise in overdose deaths;
- Provide funding to encourage research and development of new non-addictive painkillers and non-opioid drugs and treatments;
- Require HHS to study and report to Congress on the impact of federal and state laws and regulations that limit the length, quantity, or dosage of opioid prescriptions; and direct the Government Accountability Office to analyze and issue a report to Congress on the barriers to access to substance use disorder treatment medications under various drug distribution models, as well as addressing options for state Medicaid programs to reduce or remove such barriers; and direct the Medicaid and CHIP Payment and Access Commission to conduct a study on utilization management controls applied to MAT options in both fee-for-service and managed care Medicaid programs; and

Be sure to check out the inserts on MMA’s Benefit Golf Tournament and Annual Session in this issue.

Continued on page 2
Ron Harwood has always been a problem solver. But when he was diagnosed as legally blind in 2012 as a result of glaucoma, he knew this was a problem he’d need help solving.

He absolutely loves gardening and manages a unique garden and farm where he grows produce in recycled five-gallon buckets. Finding new ways to improve techniques and equipment has always been challenging but rewarding.

When he lost his vision, what were once simple daily activities—navigating around the farm, identifying crops, harvesting produce—were now entirely new challenges.

The Iris Network was the next step for him—as it is for many others—after vision loss. With their certified and expert staff, they provide educational, rehabilitative, vocational, social, and supportive housing services for the visually impaired.

The specialists who assist him know that his situation is unique from others with vision loss or blindness. When he tells them about a challenging task he’s encountered, they listen and come up with a personalized solution.

Through a combination of these programs, he learned about the equipment and technology available to help him. Now he knows he can continue to work, read, enjoy his hobby, and most importantly, adapt his life to remain independent.

He’s learning how to use technology on his iPad and talking watch. He can use it around the farm. Thanks to a connection from The Iris Network, he’ll be receiving a braille label machine and will make plastic braille markers to identify which plants are in each bucket in his garden.

Ron needed to be able to walk around his land and gardens, and The Iris Network partnered with Maine’s Division for the Blind & Visually Impaired which connected him to a certified orientation & mobility specialist. They customized cane training on the rough terrain and began using a GPS-based mobility assistant to map the farm so he could navigate more easily.

Without the support and resources from The Iris Network, he wouldn’t be able to do what he loves. Through flexible training options, the opportunity to adapt and function independently is available to others like him. Specialists go to home, school, work, and community settings—or consumers are invited to the center. The Initiative for Low-Vision Clinic in Maine in Portland—where they can have their remaining vision assessed and learn to live independently using compensatory techniques, adaptive devices, and access technology.

Referring patients to The Iris Network at (207) 774-6273 gives people like Ron the ability to conquer their personal challenges and thrive.

In the afternoon the participants took the lead by breaking into groups for roundtable discussions including current resources in Maine and how we can share them.

One of the most important items to emerge from the Summit was the enthusiasm and energy of the participants. There was a contagious “air” in the room and excitement at future possibilities. Everyone attending the summit contributed, and there was a sense that instead of being a one-time event, this might indeed be the first annual meeting of healthcare leaders throughout the State of Maine. The original concept of this Summit was to convene leaders in the State to share many different perspectives of the problem and more importantly potential solutions that are available in Maine and how to share, and establish collaborative relationships. We have reached all these goals.

The group clearly expressed an interest in meeting again within a year and connecting throughout the year to establish and share ways of reducing current burnout and actively promoting wellness. I have confidence that the healthcare leaders in Maine will continue to move forward to tackle burnout and allow our physicians to concentrate and do what they do best—care for patients and improve the health of all citizens of Maine. I challenge the Maine Medical Association and its membership to continue to lead the way in this very important initiative.

I wish to thank the following people without whom the Summit would not have been successful:

Michael Turtlet, President, The AMA; Martha Sorell and Nora Lacey from the New Brunswick Medical Society; Gordon Smith, Director of Opioid Response in Maine; Andrew MacLean and Susan Kring from the AMA; Paul Arsenault from Northern Light Sebasticook Valley; Barnhart MD from the Board of Licensure in Maine; Jenna Mehrert from the National Alliance on Mental Illness; facilitators Judann Smith and Derek Ah from the Daniel Hanley Center for Health Leadership; and special thanks to Cathryn Stratton from the MMA who put many contributions and hours into making this an excellent program; and all the engaged participants!
I was honored to be appointed Interim CEO by the Executive Committee effective February 1st and appreciate the Committee’s confidence in me to guide the MMA, through the CEO Search and transition period. I am very excited about the work before us and am ready to meet the challenges because of 20 years of mentorship by Gordon Smith and many volunteer physician leaders. While I am in my 21st year of service to MMA, I do not assume that all readers of Maine Medicine know much about me. Born at the Maine Medical Center, I grew up in Bridgton and graduated from Lake Region High School. I attended Duke University on a ROTC scholarship, received an undergraduate degree in Political Science, and accepted a commission as an officer in the U.S. Marine Corps. I served four years on active duty as a Communications-Electronics Officer assigned to units based in Hawaii before returning to attend the University of Maine School of Law. I have very much enjoyed my legal, public policy, and political work on behalf of the physicians of Maine. I am fortunate to serve with a dedicated and experienced professional staff at MMA and we currently are busy preparing for the CEO transition, completing extensive renovations to the Frank O. Stred Building, representing physician and patient interests at the State House, planning for the Annual Session in Bar Harbor in September, supporting medical specialty societies and other physician organizations, and responding to legal and practice management needs of individual members. Please touch base with me any time by email at amaclean@mainemed.com or by phone, 207-622-3374, ext. 214 (D) or 207-215-7462 (C) if you have suggestions about how MMA can better serve the physicians of Maine.

FISCAL FITNESS FOR LIFE: FINANCIAL PLANNING - MAKING INFORMED DECISIONS
By Larry Perry, ChFC, CLTC, Baystate Financial

Helping individuals think accurately about how financial decisions made today impact being able to enjoy the tomorrows that they hope for, is a significant challenge, one few financial advisors are able to overcome. The result is often poor decision-making on the part of individuals, not the least of which is a decision to ignore the subject altogether.

Informed decision-making is the foundation of good financial planning. Building a perspective from which you can make informed decisions regarding your finances is imperative to understanding how those decisions are made. While one may believe that this is a rather simple and straightforward statement, the groundbreaking research done by two Israeli psychologists, Amos Tversky and Daniel Kahneman, from the late 1960s into the 1980s, on human error in decision making, was worthy of a 2002 Nobel Prize in Economics! (Their work and their lives are the subject of Michael Lewis’s 2013 book, The Undoing Project.)

Their 1981 paper Evidential Impact of Base Rates and their development of the heuristic concepts Availability, Representativeness, and Anchoring in decision-making not only served as a catalyst for the movement toward Evidence-Based Medicine, but also stood long-held theories on rational decision making in economics on their head and served as the foundation of Behavioral Economics.

By first positioning yourself to make an informed decision prior to making that decision, you can have confidence that you are putting forth a best effort in addressing your most important financial priorities. Experience over the years has shown that individuals often confuse Financial Planning with Investment Advice. Taking a truly comprehensive view of your financial circumstances to ensure that the right things get done, the right way, at the right time, increases the likelihood that the future you hope for is the future you may actually get to enjoy.

With the increasing demands (both professional and personal), on a physician’s time and energy (both physical and emotional) it is no wonder that important personal financial planning concerns are placed on the “I’ll get to it someday” list. In their Alpert School of Medicine at Brown University mindfulness workshop, Optimizing Your Inner Operating System in a Technological World, Drs. Ronald Epstein and Michael Krasner from The Rochester Medical Center, addressed how stress leads one’s mind to engage in one of two behaviors. It seeks to either “block out” or to “simplify.” While “blocking out” certainly takes less energy, it often leaves one vulnerable to bad timing. On the other hand, while “simplifying” does take a bit of forethought, it does provide an avenue for moving forward and gaining control.

Financial Planning is complex. Accessing professional expertise and technical support to help “simplify” the process will make it easier to take it off the “I’ll get to it someday” list and can help to ensure that time spent addressing important personal financial issues will be time well spent.

Lawrence J. Perry, ChFC, CLTC is a registered representative of and offers securities, investment advisory and financial planning services through MML Investors Services, LLC. Member SIPC. OSJ: 200 Clarendon Street, 19th & 25th Floors, Boston, MA 02116. 617-585-4500. CRN2002104-246213

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Wealth Management
LambertCoffin.com
Portland & Blue Hill

30 Association Drive, PO. Box 190
Manchester, Maine 04351
(1) 207-622-3374
(1) 207-622-3332
info@mainemed.com
www.mainemed.com

NEWSLETTER EDITOR
Richard A. Evans, M.D.
(1) 207-564-0715 (F) 207-564-0717
raevans95@earthlink.net

PRESIDENT
Robert Schlaier, M.D.
(1) 207-487-6453 (F) 207-487-3790
president@mainemed.com

PRESIDENT-ELECT
Amy Madden, M.D.
(1) 207-495-3323
amy.madden@healthreach.org

INTERIM CEO
Andrew Maclean, J.D.
(1) 207-480-4187 (F) 207-622-3332
amaclean@mainemed.com

Information in this newsletter is intended to provide information and guidance, not legal advice. Since exact language and definitions of key terms are critical to understanding the requirements of legislation, rules or laws, we encourage you to review each carefully. Articles submitted to Maine Medicine represent the views of the author only and do not necessarily represent MMA policy.

THANKS TO 2019 SUSTAINING MEMBERS
Thank you to the following practice who has shown support for the MMA’s long-term growth by renewing at an additional sustaining membership level.
Dahle Chase Pathology

www.mainemed.com
Mindfulness

In the recovery, health, and wellness fields we often hear people talk about being present and being mindful as they attempt to manage the stress and the challenges they experience in life. While it all sounds well and good to some, it gets interpreted by others as fluffy and a little “out there”. This often times occurs because the person discussing it doesn’t bring the concept into daily life. We came across the following quote at a conference recently attended.

“The average human looks without seeing, listens without hearing, eats without tasting, moves without physical awareness, inhales without awareness of odor or fragrance, and talks without thinking.”

So many people tell us that they can relate to this statement because their lives are so busy and hectic, juggling many different things in their lives (work, partner, kids/family education, improving the house, fun). Many people speak to the fact that this is what life is about these days with different priorities. What if we told you the quote above was from Leonardo DaVinci, (1452-1519) and that this has been part of our “human condition” longer than we realize (500+ years).

This whole idea of stress and burn-out are not new, it just looks a bit different throughout the years/decades/centuries.

The quote states clearly that we are not paying attention to the things that we are experiencing. Our minds and attention are elsewhere.

Mindfulness is the ability to be fully present, aware of where we are and what we’re doing, and not overly reactive or overwhelmed by what’s going on around us. It is an awareness that arises by intentionally paying attention to what is happening at the present moment. Dr. Jon Kabat-Zinn, author of Mindfulness-Based Stress Reduction, adds a third component “without judgement”.

We have worked in a profession for many years that requires simultaneously juggling multiple priorities, high volume, at breakneck speed, while at the same time teaching wellness & mindfulness to others because “they need it”. It is an interesting paradox.

What do we need to shift in order to help us all be mindful? What would need to occur in the health & wellness fields for us all to learn how to pay attention (fully and on purpose), in the present moment, with no judgements?

Developing mindfulness is a skill and we know and understand that skills need to be learned and practiced (it doesn’t happen through osmosis). William James (1842–1910) stated:

“The faculty of voluntarily bringing back a wandering attention, over and over again, is the very root of judgement, character, and will. An education to improve the faculty would be the education, par excellence. But it is easier to define this idea, than it is to teach it.”

Learning and developing mindfulness is simple, but not easy. Dr. Jon Kabat-Zinn is an excellent resource should you want to explore the skill more thoroughly. You can find more at https://www.mindfulnesscds.com/.

IMPROVING MENTAL HEALTH AND WELLNESS

Improving Mental Health and Wellness is a critical issue that needs to be addressed on an ongoing basis. Maternal-child health provides the foundation for a healthy start in life and ensures that kids are ready to learn in school. Quality Counts (QC), a Qualidigm Company, has worked tirelessly during the past nine years to identify, analyze, and implement ways to positively impact the health of Maine’s youth.

We are proud to report that our programs have already produced significant results; however, challenges remain, that require a response both at the practice and state level.

Maine Child Health Improvement Partnership (MECHIP)

QC has a long-standing commitment to improving child health through partnerships and collaboration with public and private sectors. QC worked with MaineCare in support of the “Improving Health Outcomes for Children” (iHOC) program to establish MECHIP, which is a part of the National Improvement Partnership Network (NIPN). MECHIP brings together partners to serve as an advisory group on QC child health initiatives, as well as developing strategic priorities for future child health work.

QC has worked with partners to significantly improve the rates of childhood immunizations, developmental screening, autism screening, lead screening, and interventions on weighty health and oral health.

Perinatal Quality Collaborative for Maine (PQC4ME)

QC is working to develop a Perinatal Quality Collaborative for Maine (PQC4ME) with statewide partners to improve maternal and newborn health in Maine. The intent of the PQC4ME is to strengthen existing health systems to improve maternal, fetal, and neonatal outcomes through interprofessional educational programs and quality improvement projects. Currently the PQC4ME has two initial priority areas: improving care for moms with perinatal substance use and substance exposed infants, and evaluating infant mortality rates in Maine.

MAINENCE

Maine Children’s Hospital along with the Quality Counts team are working with the Maine Hospital Association to improve outcomes for mothers and newborns. Maine is working on maternal newborn quality systems and is part of the National Perinatal Quality Collaborative (NPNPCQI). Our goal is to improve hospital care of substance exposed infants and improve maternal/family involvement.

Maine Infant Mortality Research Project

According to the Centers for Disease Control and Prevention, in 2016 Maine had a higher infant mortality rate than all other New England states. The PQC4ME recently started the Maine Infant Mortality Research Project, a one-year initiative designed to identify the drivers of infant mortality (IM) in Maine. The project is a fact-based assessment of the primary drivers of IM and will explore implementation strategies to reduce Maine’s infant mortality rate (IMR). QC is currently working to develop an Advisory Group to oversee the project, identify and review data, and explore successful strategies to lower the IMR.

If you are interested in participating in this work, or learning more about other strategies to help improve child health in Maine, please contact: Amy Beisiele, MD, MBA at abeisiele@mainenqualitycounts.org.
The Health & Human Services Committee held a public hearing on L.D. 1313, An Act To Enact the Maine Death with Dignity Act on Wednesday, April 10th. An ad hoc committee established by the MMA board and chaired by Past President Charles Pattavina, M.D. prepared a Statement on the topic scheduled to be on the board agenda on April 24th. https://www.mainemed.com/sites/default/files/content/Physician_Assisted_Suicide_Statement.pdf.

Finally, the Appropriations & Financial Services Committee continues its work on Governor Mills’ State FY 2020-2021 biennial budget. L.D. 1001. Governor Mills presented a relatively non-controversial budget that maintains current services (other than implementing MaineCare expansion) in most health and social service program areas. You can find biennial budget materials on the Committee web site: http://legislature.maine.gov/office/129th-afa-committee-information/9599.

The MMA encourages you to introduce yourself to your two members of the legislature, if you do not know them already. You can find your legislator using the Maine Voter Information Lookup Tool on the www.mainegov. website: https://www.maine.gov/portal/government/e-democracy/voter_lookup.php. If you have any questions about your legislators, please contact the MMA staff.

During the legislative session, the MMA staff provides links to bills for review and comment, updates on the legislative work, and calls-to-action through our weekly electronic newsletter, Maine Medicine Weekly Update. Finally, we are always recruiting volunteers for MMA’s Doctor of the Day Program at the State House. This is an excellent opportunity to participate in Maine’s state legislative advocacy. Find out more about the program on the MMA web site: https://www.mainemed.com/advocacy-policy/doctor-day-program-maine-legislature.

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

The MMA welcomes your participation in our legislative advocacy activities. For more information, please contact Andrew MacLean, Interim CEO, at amaclean@mainemed.com.
Vaccine Hesitancy Endangers Public Health

Medical professionals have recognized the value of vaccines in preventing contagious disease since the introduction of the smallpox vaccine by Edward Jenner in 1796. Maine law first required immunizations within a year after statehood, in 1821. Louis Pasteur refined the technique and developed vaccines for rabies and anthrax, and he used the technique of treating the infectious agents so that they lost their ability to infect but still stimulated the development of immunity. Maurice Hilleman, a 20th century American microbiologist working at Walter Reed Army Medical Center, developed vaccines for measles, mumps, chicken pox, meningitis, hepatitis A and B, pneumonia, and Haemophilus influenzae. He is widely considered to have saved more lives than any other medical scientist of his time.

Now, in the 21st century, we are seeing a growing and vocal movement against vaccines. Through the use of social media, and emboldened by “research” on the internet, a small group of people is campaigning to eliminate legal requirements for immunization of school children and refusing to immunize their own.

The issue has come to the fore in the current session of the Maine Legislature, through the pendency of a bill (LD 798) that seeks to eliminate non-medical exemptions from the legal requirement that children starting school must be immunized for a number of contagious diseases, including measles, mumps, rubella, chicken pox, polio, diphtheria, tetanus, and pertussis. Recently a requirement was added for vaccination against meningococcal disease in the seventh and twelfth grades.

While vaccine “hesitancy,” as it is sometimes called, has been around almost as long as vaccines themselves, it contradicts broad scientific agreement and increasing human knowledge about how to prevent the spread of disease. In recent years, proponents of this view have embraced a now-discredited (and withdrawn) paper by British physician Andrew Wakefield that purported to show a connection between the MMR (measles, mumps, rubella) vaccine and the development of autism in children.

Several large-scale studies, published in such publications as the Journal of the American Medical Association, have established that there is no such causal connection, and Wakefield’s paper has been criticized as fraudulent. As a result, he has been barred from practicing medicine in his home country, the United Kingdom.

Opponents of immunization, who are opposing LD 798, have sought and pressed a variety of other bases for their opposition to school immunization requirements. Some claim that such requirements are an unconstitutional infringement of their individual rights, a claim that has been rejected by courts, including the U.S. Supreme Court, for more than a century. It is clearly established that the interests of public health outweigh the individual’s interest in making their own decisions about what is injected into the bodies of their children.

Conspiracy theory plays a significant part in the opposition to immunization requirements. Adherents to those theories see a conspiracy among the U.S. CDC, “Big Pharma,” and the “medical establishment” (and sometimes “the government”) to profit from the sale of vaccines.

Perhaps most common among those opposing mandatory immunization is the experience of having a child who had a significant medical event around the time of a vaccination. In most of these cases, temporal correlation is seen as establishing a causal relationship. The argument is made on both an individual and a population basis. The proponents argue that as immunizations have increased, so have a variety of developmental disabilities…so there must be a connection.

The common thread that can be found in the testimony against LD 798 is the stress upon the interests of the individual, with almost no mention of the interests of the community. The Vaccine Health and Safety Trust has identified vaccine hesitancy as one of the ten greatest threats to global health in 2019. The Maine Medical Association asks its members to speak up on behalf of public health.
Health Literacy: Delivering the Message Right Improves Patient Safety and Reduces Liability

Patient safety cannot be assured without addressing the negative effects of low health literacy and ineffective communications on patient care. Improving health literacy is an important factor in engaging patients in preventive care, improving adherence to medication regimens and treatment plan instructions, improving the patient’s ability to self-manage their healthcare and reducing the incidence of communication related errors and poor outcomes. Patient may mask their health literacy level from their care providers.

Risk Management Recommendations for Effective Patient Communications:

• Assess the literacy levels and language needs represented by the patients/community served;
• Train staff to recognize and respond appropriately to patients with literacy and language needs;
• Use well-trained medical interpreters for patients with low English proficiency;
• Adopt the universal precautions approach to health literacy: make clear communications and plain language the standard for all patient communication;
• Provide a comfortable atmosphere/environment; do not appear hurried or distracted;
• Speak clearly and loudly if indicated: make good eye contact;
• Assess the patient’s ability to self-manage their own health care: Assure the patient understands when to seek health care and recognizes the need to pursue preventive health strategies.

Criteria are specified in the CSS policy Manual for patients with opioid and benzodiazepine prescription of the foregoing drugs is appropriate.

Clear, practical and clinically functional policies that assure evidence-based prescribing and management of opioids (including tramadol), benzodiazepines, hypnotics, and stimulants (including hallmarks of an untreated use disorder) is integral to the program’s success, consistent with the concepts and practice of whole-person care.

As part of this expansion, the Schmidt Institute is offering providers/practices, licensing boards, and medical societies a step-wise program implementation package supported by expert consultants; monitoring and advisory services for individual providers, panels or groups who wish to engage in the CSS process (whether the monitoring/reporting is compulsory, or not); and identified, objective monitoring of specified controlled substance prescribing.

The Schmidt Institute was created to inspire the development and spread of innovative, research-based models of care that support rural populations across the healthcare continuum, with a focus on meaningful collaboration between healthcare providers and community partners; the rigorous evaluation of new ideas; and the publication of best practices. They are partnering with a wide range of funders, academic institutions, research centers, provider groups, community-based organizations, and ACOs.

For additional information about CSS or the Schmidt Institute, please contact: Larry Clifford, Director of Planning & Development at lclifford@pchc.com or 507-301-2778.

Schmidt Institute to Expand Controlled Substances Stewardship Model
By Larry Clifford, Director, Planning & Development, The Schmidt Institute

Maine’s Schmidt Institute – the research and innovation arm of St. Joseph Hospital/Covenant Health and Penobscot Community Health – is in the process of expanding their Controlled Substances Stewardship (CSS) program – an internal, high quality improvement program managed by an inter-professional committee that meets weekly to review patient care that entails the prescription of opioids, benzodiazepines, hypnotics, and/or stimulants (including hallmarks of an untreated use disorder).

During the past three decades, aggressive and misleading marketing by pharmaceutical companies promoted chronic opioid analgesic prescribing in the United States. During the past three decades, aggressive and misleading marketing by pharmaceutical companies promoted chronic opioid analgesic prescribing in the United States. Aggressive and misleading marketing by pharmaceutical companies promoted chronic opioid analgesic prescribing in the United States.

Key features of the program include:

• Compassionate, integrated care for patients whose prescriptions are tapered;
• Prompt referral and access to expertise in alternative pain management and other relevant services, such as medication assisted treatment (if opioid use disorder is diagnosed);
• Inter-professional advisory support for frontline providers that are caring for patients with chronic pain, substance use disorders, or other complex conditions/circumstances;
• Clear, practical and clinically functional policies that assure evidence-based prescribing and management of opioids (including tramadol), benzodiazepines, hypnotics, and stimulants; and
• Informed consent and patient-provider agreements that provide unambiguous description of risks and expectations of compliance with safeguards when a prescription of the foregoing drugs is appropriate.

Criteria are specified in the CSS Policy Manual for patients identified with: >50 morphine milligram equivalents dose of an opioid; a chronic prescription (as specified in the policy manual); any chronic combination of an opioid with a benzodiazepine; more than one drug from the same class; an emergency department report that associates the patient’s care with the drugs specified; a hypnotic drug, inappropriate use of a stimulant; or any combination of the foregoing.

Through a review of electronic health records and care coordination with prescribers, the committee advises (or detects and corrects), any drift from evidence-based practice. It also assures compliance with the policies and procedures specified in the CSS Policy Manual. The inter-professional composition of the committee (a physician, a pharmacist, a mental health provider, an RN, and a FNP) is integral to the program’s success, consistent with the concepts and practice of whole-person care.

Following the review, the committee communicates its findings to the patient’s provider, including any recommendations for change in treatment, alternative approaches to the underlying problems/symptoms, and tapering schedules (if indicated). Although the recommendations of the committee are advisory and not binding, deviation from the prescribing requirements of the CSS Policy Manual may result in a provider performance review and, if deviation is intentional and persistent, dismissal from the organization.

o Visuals: Draw pictures, use three dimensional aids, media;
• Use accepted methods to probe for patient understanding:
  • Ask open-ended questions about their health history and clinical symptoms;
  • Encourage patient to ask questions;
  • Provide patient discharge and other instructions in written and verbal language the patient understands; provide the patient with a medication list, information about medications, diagnosis, results of procedures and laboratory tests and plans for follow-up care; verify patient understanding;
  • Use adopted principles to test for patient understanding:
    • Auscultation.
    • Visuals: Draw pictures, use three dimensional aids, media;
    • Print materials: Large print, fifth or lower grade level, key points;
    • Teach back: Ask the patient to repeat back or teach back to the clinician the clinical information or instructions discussed;
    • Show back: Ask the patient to show back to the clinician the patient care process reviewed;
    • Telephone: Have patient repeat back their understanding of telephone instructions, test results or patient follow-up appointments/studies;
    • Ask me three questions: Ask the patient to answer three key questions from the patient encounter;
• Note: All levels of patients have difficulty with multi-step instructions;
• Design the informed consent process to include forms written in simple sentences and in the language of the patient; use teach back during the informed consent discussion; and engage the patient in a dialogue about the nature and scope of the procedure;
• Reduce the barriers for low health literacy patients entering the health care system;
• Place patient follow-up calls.

In summary:

The reading and arithmetic skills required to understand and successfully participate in today's healthcare systems far exceed the abilities of today’s average adult. Clinical professionals and staff members can reduce untoward events and poor outcomes related to communication breakdowns because of low health literacy through a comprehensive patient assessment and adoption of the universal precautions approach to health literacy.

References may be found by accessing the complete practice tip at www.medicallmutual.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.
Northern Light Health

For more information, please contact our Provider Recruitment team at:
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In 2019, MICIS is offering presentations on:
• Clinical Opioid Update 2019
• Legal Opioid Update 2019
• Co-prescribing Benzodiazepines and Opioids: The Black Box of Increased Overdose Risk
• Opioid Use Disorder and Medication-Assisted Recovery: Caring For Our Communities
• Treating Complex Patients with Chronic Pain who are Prescribed Opioids (Note: this is not an opioid topic.)
• Managing Depression in Older Patients (Note: this is not an opioid topic.)

A 3-hour presentation is also available (includes Clinical Opioid Update 2019, Legal Opioid Update 2019, Co-prescribing Benzodiazepines and Opioids, and Co-prescribing Benzodiazepines and Opioids).

Individual academic detailing sessions are available in February of 2019 on these topics:
• Opioid Use Disorder and Medication-Assisted Recovery: Caring For Our Communities
• Co-prescribing Benzodiazepines and Opioids: The Black Box of Increased Overdose Risk
• Treating Complex Patients with Chronic Pain who are Prescribed Opioids
• Managing Depression in Older Patients

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2019 Education Topics