JANUARY/FEBRUARY/MARCH 2013

Maine medicine

IN THIS ISSUE

MMA Board Considers Future Services, Direction of Association

The MMA Board of Directors held its annual President's Retreat in January at the Chateau Frontenac in Quebec City. Board members conducted a regular business meeting, engaged in strategic discussions about the future of the association, and heard an update on the Canadian health care system from Canadian Medical Association representative Daniel Tardif, M.D. The weekend also provided an opportunity for board members to get to know each other, their families, and MMA staff better.

Janis Petzel, M.D. and other Board members

Top: Daniel Tardif, M.D., M.B.A
Bottom: Brent Mulgrew, JD, Ken Christian, M.D., and Michael Parker, M.D.

The following items are highlights of the business meeting on the afternoon of Friday, January 18th:

- Review and approval of proposed amendments to the 2013 MMA budget;
- Review and approval of an amended Resolution from the Public Health Committee entitled, Limits on the Possession of Dangerous Weapons (following several spirited Board discussions about the role of the physician community, and MMA specifically, a majority of the Board voted in favor of the amended Resolution);
- Review of the 12 bills on the MMA's legislative agenda for the 126th Maine Legislature;
- Discussion of the move of the Quality Counts staff from the Stred Building to the Hanley Building and potential new tenant for the former QC space in the Stred Building;
- Discussion of participation with Maine Health Management Coalition and Quality Counts on the "Choosing Wisely" Campaign.

The following two presentations constituted the Board's agenda for Saturday morning, January 19th:

- Ohio State Medical Association Executive Director Brent Mulgrew presented OSMA Membership & Affiliations: 2013 Pricing and Sales Strategy in which he discussed the OSMA's response to the changing physician marketplace;
- Daniel Tardif, M.D., M.B.A., a primary care physician who is a hospital Chief Medical Officer and health care consultant in Quebec, presented an overview of the Canadian health care system and some of its current challenges.

On Sunday morning, January 20th, the Board participated in the following discussions:

- A conversation facilitated by MMA President Dieter Kreckel, M.D. about physician professionalism, professional satisfaction, and leadership roles in society and how the MMA could enhance these;
- An initial conversation to review and evaluate the various MMA programs and services according to an evaluation matrix containing 4 factors: 1) relatedness to mission, 2) percentage of use by members, 3) financial results or potential, and 4) staff time.

OSMA Executive Director Brent Mulgrew facilitated the review and discussion of twenty-five MMA programs and services.

Andrew MacLean, Esq.

Legislative Update

126th Maine Legislature Begins Work of First Regular Session

The 126th Maine Legislature began the work of its First Regular Session on January 8, 2013 and is expected to be in session at the State House in Augusta until its statutory adjournment deadline of June 16, 2013. The four physicians in the 126th Legislature received key health policy committee assignments to the Appropriations, Health, and Insurance Committees. The MMA Legislative Committee, chaired by Amy Madden, M.D., has begun its weekly conference calls – all members and/or their staffs are welcome!

The first several weeks of the session have been devoted to committee orientation and drafting of bill proposals to meet the January 18, 2013 cloture deadline. Governor LePage released both his SFY 2013 supplemental and SFY 2014-2015 biennial budgets on Friday, January 11th. The Appropriations Committee held public hearings on the supplemental budget during the week of January 21st and likely will be considering the biennial budget through March at least. You can find materials related to the Governor's budget proposals on the Bureau of the Budget web site: http://www.maine.gov/budget/.

The four physicians in the new legislature sit on committees with major roles in the development of health policy in Maine. The senior member of the physician delegation, Rep. Linda Sanborn, M.D. (D-Gorham), received a coveted seat on the Appropriations & Financial Affairs Committee. Sen. Geoffrey Gratwick, M.D. (D-Penobscot) is the Senate Chair of the Insurance & Financial Services Committee and Rep. Jane Pringle, M.D. (D-Windham) also sits on the IFS Committee. Finally, Rep. Ann Dorney, M.D. (D-Norridgewock) is a member of the Health & Human Services Committee.

The MMA has submitted a legislative agenda of 12 bills on topics ranging from physician licensing and discipline, prescription drug diversion and abuse, restoration of MaineCare coverage for ambulatory surgical facility services, use of tanning beds by minors, and clear identification of health care practitioners of different licensing levels. The bills are titled as follows:

- An Act to Amend the Health Care Practitioner Licensing, Disciplinary, and Reporting Statutes Regarding Alcohol and Drug Abuse
- An Act to Amend the Laws Governing Prosecution of Individuals Possessing a Controlled Substance under Certain Circumstances
- An Act to Restore MaineCare Coverage for Ambulatory Surgical Center Services
- An Act to Provide Immunity for Prescribing and Dispensing Intranasal Naloxone Kits
- An Act to Amend the Postgraduate Education Requirements for Physicians Who Have Completed an Accredited Residency Program in Oral and Maxillofacial Surgery
- An Act to Clarify Physician Delegation
- An Act to Amend the Prescription Monitoring Program Participation Requirements
- An Act to Amend the Maine Medical Radiation Health and Safety Act
- An Act to Amend the Health Plan Improvement Act Regarding Prescription Drug Step Therapy and Prior Authorization
- An Act to Reduce Youth Cancer Risk
- An Act Establishing the "Health Care Professional Transparency Act of 2013

Dieter Kreckel, MD, MMA President, Jack Forbush, DO, MOA President-elect and Senator Andre Cushing on opening day of the Legislature

During the legislative session, the MMA staff provides links to bills for review and comment, updates on the legislature's work, and calls-to-action through our weekly electronic newsletter, *Maine Medicine Weekly Update*. Also, the MMA Legislative Committee holds a weekly conference call to review bills and brief members on legislative action every Tuesday night at 8:00 p.m. for any interested physician or physician staff member. The conference call information is published each week in the *Maine Medicine Weekly Update*.

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

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

MMA 2013 FIRST FRIDAYS EDUCATIONAL PROGRAMS

8:30am – Registrations and Breakfast

All programs – 9:00am – Noon @ Maine Medical Association

$70 per program, per attendee ($60 if attending three or more in one calendar year)

April 5
Annual Coding Seminar
presented by the Learning Center at Baker Newman & Noyes

May 3
Update on the Affordable Care Act

June 7
Annual HIPAA Update

September 6
Risk Management Seminar
presented by Medical Mutual Insurance Company of Maine

November 1
Annual Compliance Seminar: Preventing Allegations of Fraud and Abuse

December 6
Accountability, Transparency & Public Reporting: The Importance of Your Data

Register today at: https://www.mainemed.com/events/first-fridays

Subscribe to MMA's *Maine Medicine Weekly Update*

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

Dieter Kreckel, M.D.
President, MMA

President's Corner

Hello to all my friends and fellow physicians here in Maine. I trust that your Holiday season was spent with Family and Friends and wish everyone a Happy New Year. My time as president is nearing the half way point already. I feel like I just started.

Earlier this month I joined Dr. Jack Forbush, President Elect of the Maine Osteopathic Association, on opening day at the Legislature as Doctors of the Day. It was a great opportunity to meet many of our legislators. I encourage everyone to serve as Doctor of the Day at least once. The legislators really enjoy seeing you and hearing from you. It lets them know that you care enough to take time and be with them. I cannot stress enough how important it is to make that connection if we are to be taken seriously. Gordon, Andy and Jessa are well known to them and do a great job. I would say, however, that having one of you standing next to them will not only be appreciated but your presence will be noted!

The weekend of January 18-20th found your board spending time together to consider the direction and priorities of the Association. The staff of the association is involved with numerous projects and activities on a daily basis that are aimed at making your lives as physicians more fulfilling. To be more effective, we need to scale back activities that do not bring you the 'bang for the buck' and instead concentrate more time and energy on those that do. Brent Mulgrew, JD, Executive Director of the Ohio State Medical Association, was asked to help us move forward on this project. He had been working with his physicians and society to make their efforts more up to date and meaningful in Ohio. His expertise, presentation of what is going on in Ohio and his facilitation of our meeting were greatly appreciated. We expect to continue our work and will let you know the outcome of our efforts. As that happens, we will, of course, continue to get feedback from all of you to help in the process.

We were also joined by Dr. Daniel Tardif from Quebec, Canada. He gave an enlightening presentation on the health system in Canada. A number of myths were dispelled. It was very interesting to see how the system works in Canada and the provinces compared to what we deal with here in the States. I wish to thank Dr. Tardif once again for taking time to talk with us and hope we can continue to exchange ideas in the future.

Next month I will be at the National Advocacy Forum in Washington, D.C. There, with other representatives, we will be discussing the ACA, SGR and other issues related to our daily lives as physicians caring for our patients and will visit with our congressional delegation. Though it is easy for us to say that it does not make a difference, I would say that if we do not continue to present our issues and keep the faith with the physician-patient relationship we all cherish, we will never succeed. We need to maintain our ability to advocate for our patients and quality medical care.

I hope all is well with all of you. Please do not hesitate to let us know how we can help. Please contact me at any time at 369-0146 or president@mainemed.com.

Gordon H. Smith, Esq.

Notes from the EVP

It is my pleasure to communicate with you for the first time in 2013 using the vehicle of our quarterly publication. I hope you also are aware of our weekly update which is sent out electronically to over 4,000 physicians, office staff, residents and medical students in the state every Monday. I also hope you will review our new website at www.mainemed.com. After two years of re-design work on the project, the site went live on January 18. The site has lots of new features (and no password protected portions). I encourage you to check it out!

As you will know from reading President Dr. Kreckel's article, the 25-member MMA Board held a strategic planning session at its annual retreat in January. The Board is engaged in a very important exercise ranking the value of twenty-five service/program/products offered by MMA to its members. We hope to finish that exercise at the March 5th Board Meeting.

MMA's officers and board members work hard for you. A third of the Board turned over last September and were replaced by the following new Board members:

Laura Jett Anderson, M.D.	**Norway**
Paul Cain, M.D.	**Auburn**
Steve Feder, M.D.	**Damariscotta**
Thomas Marshall, M.D.	**Farmington**
Mark McAllister, M.D.	**Waterville**
Kristen Mitchell, D.O.	**Monmouth**
Janis Petzel, M.D.	**Hallowell**
Benjamin Young, M.D.	**Portland**

If you know any of our new board members, please share with them any thoughts you have regarding MMA and its activities.

It will be a busy year at MMA and I look forward to working on your behalf. Contact me at anytime with your thoughts and concerns.

State Representative Linda Sanborn, M.D. received the Legislator of the Year Award from the Maine Chapter, American Academy of Pediatrics. This annual award recognized her work as an ongoing advocate for children's health in the Maine Legislature. From left, Rep. Sanborn, Chapter President Steve Feder, D.O., and Chapter Vice President Janice Pelletier, M.D.

Save the Date: MMA's 160th Annual Session
October 4-6, 2013 at the Holiday Inn by the Bay

Medical Mutual Insurance Company of Maine Risk Management Practice Tip:
Violence Management in a Physician Practice

Violent behavior is escalating in health care. Clear objectives and practice goals, in tandem with employee involvement and employee training, are essential ingredients to achieve a comprehensive plan for maintaining a violence-free workplace. A zero-tolerance policy must address intimidation, verbal and nonverbal threats, physical assaults, stalking and harassment.

Motivating Factors

Employee dissatisfaction and increased anxiety may occur as a result of mergers and downsizing. Employees may experience reduced benefits, loss of seniority, layoffs and a lost promotion opportunity. Violence is also likely to occur when employees are treated poorly or favoritism prevails.

Patients become sensitive and vulnerable when they are ill and when they are dealing with job changes and downsizing. Medical reasons may cause their anxiety to escalate into agitation, anger and violence. Unmet patient expectations, feeling ignored, long waits and frustration with payers may provoke violent behavior.

Strangers, visitors, vendors and individuals associated with employees may perpetrate workplace violence. Violence may be random, and the office may become victim of an intruder. Any cause of mental turmoil, criminal intent or domestic unrest may be a motivating factor.

Prevention, Education and Preparedness

1. Conduct a safety assessment and analyze the physical workplace. Improve security measures by addressing high-risk factors in the practice, e.g., the door to the clinical suite and access and egress doors must be lockable.
   - Consider a keypunch lock system.
   - Illuminate walkways and parking areas. Inspect a vehicle, hallway or elevator before entering.
   - Restrict movement of the public within the facility. Escort patients to and from examination rooms.
2. Communicate to staff that vulnerable times of risk occur during mealtimes when available staffing is low, at the opening and closing of the facility, and at night. Do not leave the office unmanned or leave an employee alone.
3. Solicit and promptly address employee grievances. Train supervisors to assist employees experiencing stress.
4. Educate staff in managing antagonistic behavior. Train staff to be attentive, project calmness and avoid acting defensively. Set clear limits regarding the actions of an angry person, understanding that a frightened patient may use anger to control a situation. Create an atmosphere of support by encouraging an angry person to talk. Listen, maintain eye contact and empathize. Stand at an angle and not directly in front of the person. Use delaying techniques such as asking a question to instill a calming effect.
5. In some situations there will be time to create a care plan. Discuss with the patient the behavior(s) the patient needs to change. Educate staff to the plan and the approach that has been agreed upon.
6. Train staff to recognize early warning signs of anxiety and escalating agitation:
   - distinct facial expressions such as glaring, facial flushing.
   - body language that includes finger drumming, pacing, sitting rigidly at a distance with arms crossed tightly.
7. When a potentially violent situation is recognized, request assistance from other employees. When behavior becomes threatening or personally insulting, establish a "time out." If a threat is reiterated, consider it a danger signal and call the police.
8. Identify escape routes. Establish a back-up means of obtaining assistance with communication devices, codes or silent alarms that alert employees to an unsafe condition. Arrange seating so that an exit is available to you.
9. Instruct and encourage employees to report occurrences of violent behavior. Specify that no reprisals will be taken against an employee who reports or experiences workplace violence.
10. Contact law enforcement authorities to form a liaison and receive help in identifying ways to obtain support and prevent workplace violence.

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

Visit the MMA's Newly Redesigned Website at: www.mainemed.com

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PATIENT CENTER

CONTACT US

www.mainemed.com

The Maine Medical Association's website has been redesigned to provide convenient access to relevant information to assist you in your practice of medicine.

MMA is happy to announce that no area of the site is password protected, allowing everyone easy access to all information. In addition, the site allows for easy navigation through user friendly menus. We would also like to remind you that our site is secured, so you do not need to worry about registering for educational programs, making donations, or paying your dues online.

We are very pleased to now have information on our site regarding our Peer Review Program, our Office-based QI Program and Continuing Medical Education, to name a few. You will also find many helpful downloadable documents, including the updated Physician's Guide to Maine Law and sample HIPAA forms. In addition, we now offer a search feature on the home page.

We continue to refine areas of the site and also plan to continue to improve and add information that will be helpful to our membership and the public. Please check out the site today and let us know what you think. We encourage suggestions on what other information you would like to see.

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POISON Help
1-800-222-1222

Northern New England Poison Center

In Maine, New Hampshire & Vermont, the Northern New England Poison Center provides immediate treatment advice for poison emergencies.

They also provide information about poisons and poison prevention, twenty-four hours a day, seven days a week.

HHS re-launch of HealthCare.gov to include new information about the Health Insurance Marketplace

HHS recently launched the newly rebuilt www.HealthCare.gov website, where Americans will be able to get the information they need for open enrollment in October. Consumers now have the opportunity to sign up for emails and text messages, which will provide them with more information to help them make well-informed decisions when the time to enroll for coverage begins. And come October, individuals and small businesses will be able to buy insurance from qualified private health plans and check if they are eligible for financial assistance — all in one place. The website will help you prepare for the coming new Health Insurance Marketplace (also known as Health Insurance Exchange), learn about the law, and more.

Read the Secretary's Blog: http://www.healthcare.gov/blog/2013/01/affordable-insurance-countdown.html.

Follow @MarketplaceGov on Twitter.

Like Health Insurance Marketplace on Facebook.

Please direct questions to HHSIEA@hhs.gov.

Thanks to 2013 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.

Melanie Cutler, MD
Russell DeJong, MD
Maroulla Gleaton, MD
Dana Graichen, MD
David Jones, MD
Charles McHugh, MD
Roger Renfrew, MD
Michael Szela, MD
Mid Coast Hospital
Orthopaedic Associates of Portland

Lisa M. Letourneau, M.D., MPH

Quality Counts

By Lisa M. Letourneau, M.D., MPH, Executive Director, Quality Counts

QC 2013: Aligning Maine's Forces to Become the First State to Reach the Triple Aim

The United States has the most costly health care system in the world. Health care expenditures account for a staggering 17% of gross domestic product and by 2020 it is estimated that this figure will increase to 20%.[1] Unfortunately, even though we spend twice as much on health care as the next most costly nation, this does not translate into better health outcomes; compared to other countries, the U.S. ranks 31st on life expectancy and 36th on infant mortality.[2]

How can we achieve high quality care and contain costs? In their 2008 *Health Affairs* article, Berwick et al. introduced the "Triple Aim" framework and proposed that improving our health care system requires the simultaneous pursuit of three aims: improving patient experience of care, improving the health of populations, and reducing the per capita cost of health care. In Maine's newly forming Accountable Care Organizations (ACOs), many provider groups are using the Triple Aim model as the framework for achieving better coordinated care while controlling costs.

Maine Quality Counts (QC) is committed to transforming health and health care in Maine by leading, collaborating and aligning improvement efforts. In pursuit of this mission, QC is leading several efforts to spark statewide conversations about the Triple Aim and how it can provide a model for transforming care. Recognizing that health care providers play an integral role in meeting the goals of the Triple Aim, QC encourages all to participate in the following upcoming events:

- **Quality Counts 2013 Annual Conference: Aligning Maine's Forces to Become the First State to Reach the Triple Aim**

  Each year, Maine Quality Counts (QC) hosts a statewide conference highlighting efforts to improve health care quality. This year's conference will be held on Wed, April 3, 2013 at the Augusta Civic Center, and will feature keynote speaker **Dr. Donald Berwick**, leading a discussion on how Maine health care providers, patients, and communities can work together to achieve the Triple Aim. Presented in partnership with the Maine Primary Care Association, Maine Health Access Foundation and the Maine Public Health Association, QC 2013 will also feature nationally renowned speaker **Rosemary Gibson** addressing the role of patients in improving care, as well as a wide variety of breakout sessions offering attendees specific models and tools for working collaboratively to care and control costs.

Dr. Donald Berwick

- **Triple Aim - Special Webinar Series**

  In concert with the theme of QC 2013, QC will also be offering a new noontime webinar series designed to introduce to the Triple Aim, facilitate discussion, and share learnings and best practices. This year-long series will be held on the 3rd Thursday of each month and will feature presentations by national and local speakers who are actively engaged in achieving the goals of the Triple Aim. This webinar series kicks off on February 21, 2013 (12N – 1PM) with an overview of the three dimensions of the Triple Aim.

For more information and to register for these exciting events, please visit the Maine Quality Counts website at www.mainequalitycounts.org.

[1]Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2010-2020. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf

[2]Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health and Cost. *Health Affairs* 27(3), 759-769. doi:10.1377/hlthaff.27.3.759

Save the Date: MMA's 160th Annual Session October 4-6, 2013 at the Holiday Inn by the Bay

Common Sense Compliance

Alphabet Soup, Accountability and You

By Stacey Mondschein Katz, Esq.

Stacey Mondschein Katz, Esq.

Healthcare laws, rules, regulations and agencies can be a regular "alphabet soup" of acronyms. We use many of them daily. But have you heard of "HONI"? On January 2, 2013, Hospice of North Idaho or "HONI" became known not for its compassionate end-of-life care, but as the first organization to settle a HIPAA Security Rule violation impacting less than 500 individuals. Under HITECH, these "smaller" breaches must be reported to Federal DHHS within 60 days following the year of the breach, and do not appear on the "Wall of Shame" (the DHHS internet listing.)

HONI reported to DHHS that an unencrypted laptop computer containing the electronic protected health information (ePHI) of 441 patients had been stolen in June 2010. The Office of Civil Rights (OCR) investigated and discovered that HONI had not conducted a risk analysis to find and fix the gaps in its PHI safeguards, and failed to have policies or procedures in place to address mobile device protection as required by the HIPAA Security Rule.

OCR Director Leon Rodriguez said: "This action [against HONI] sends a strong message to the health care industry that, regardless of size, covered entities must take action and will be held accountable for safeguarding their patients' health information." He also stated that "[e]ncryption is an easy method for making lost information unusable, unreadable and undecipherable" (creating a "safe harbor" under the breach notification rule. The provider would not need to report the potential loss or exposure of properly encrypted ePHI as a breach).

Small practices are on the radar now. The OCR recently penalized a two physician cardiology practice in Arizona $100,000 for its security failures and lack of risk analysis, policies and procedures.

Get ahead of the regulators. Look at your PHI and your safeguards, which need not be complicated. Consider locked doors and drawers for paper files and portable devices not in use, and appropriate firewalls, virus protection and encryption for your ePHI, especially on your portable devices. If ePHI is not encrypted, what is your equivalent safeguard? Be sure to document all of your actions and protections.

And while you are reviewing your privacy and security compliance protections, have a look at the new educational initiative, ***Mobile Devices: Know the RISKS. Take the STEPS. PROTECT and SECURE Health Information*** launched by DHHS and the ONC. It offers basic tips for protecting ePHI on mobile devices at www.HealthIT.gov/mobiledevices.

The OCR wants to see that a healthcare entity or practice acts decisively to identify the reasons for the breach, and immediately implements compliance improvements, which will most likely lessen an enforcement penalty. HONI made prompt efforts to improve its privacy, security and breach notification policies and processes, and received (only) a $50,000 penalty together with a corrective action plan.

Finally, Rodriguez reportedly has stated that there is not enough "activity monitoring." Does your organization have a policy and practice for reviewing access to ePHI as required by the HIPAA Security Rule? By proactively and regularly reviewing a sample of your workforce's access to and use of ePHI, (and not just reacting to a potential concern), you will be taking common sense steps to help keep unauthorized exposure, and a potential breach of your ePHI, at bay.

Stacey Mondschein Katz, Esq. *is the founder and president of SMK Consulting Services, LLC, a healthcare compliance and education company. She may be reached at stacey@smkconsultingservices.com or through her website at www.smkconsultingservices.com.*

Upcoming Specialty Society Meetings

MARCH 6, 2013 *Exact location TBA – Lewiston, ME*
Maine Chapter, American College of Emergency Physicians
Spring Business Meeting
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

APRIL 18 - 19, 2013 *Marriott Portland at Sable Oaks*
Maine Association of Psychiatric Physicians
Spring General Membership Meeting & Clinical Conference
Contact: Dianna Poulin 207-622-3374, x223 or dpoulin@mainemed.com

MAY 3, 2013 *Harraseeket Inn – Freeport, ME*
Maine Society of Eye Physicians and Surgeons Spring Meeting
Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

MAY 17 - 19, 2013 *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Chapter, American College of Surgeons
Contact: 1-877-249-9321 or maine@mainefacs.org

JUNE 27, 2013 *Fisherman's Wharf – Boothbay Harbor, ME*
Maine Chapter, American College of Emergency Physicians
Lobster & Clam Bake on Cabbage Island
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

SEPTEMBER 4, 2013 *MMA Headquarters – Manchester, ME*
Maine Chapter, American College of Emergency Physicians
Fall Business Meeting
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

SEPTEMBER 20, 2013 *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 12th Annual Downeast Ophthalmology Symposium)
Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 20 - 22, 2013 *Harborside Hotel & Marina – Bar Harbor, ME*
12th Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 27 - 29, 2013 *Atlantic Oceanside – Bar Harbor, Maine*
American College of Physicians - Maine Chapter Annual Chapter Meeting
Contact: Warene Eldridge, Executive Director 207-215-7118 or warene54@yahoo.com

CMS Advice: Discuss ICD-10 Preparation With Your Billing Service

While implementation of the ICD-10 code set isn't until October 1, 2014, now is the time to initiate important conversations with your clearinghouses and billing services about their readiness.

Even if you are employed, you are responsible for claims and information submitted to payers according to the Centers for Medicare & Medicaid Services (CMS).

"The provider must ensure that medical record documentation supports the level of service reported to a payer. The volume of documentation should not be used to determine which specific level of service is billed," stated CMS.

Gloria Kirkham, practice advisor for the Indiana State Medical Association, suggested working closely with your coder and reviewing accounts receivable each month.

"If a claim is not submitted accurately, the payer can take the money back," said Kirkham. "Ninety days to submit a claim is not a lot of time. So when a claim is resubmitted, you miss the filing deadline and that costs money. That's why it is so important to know that claims are submitted accurately the first time."

Kirkham advised that you research and enlist in a reliable clearinghouse or billing service. Also ask your colleagues for recommendations.

Questions to ask:
CMS provides questions for you to consider when discussing ICD-10 preparedness with your clearinghouse or billing service:

- Are you prepared to meet the new ICD-10 deadline of October 1, 2014? Where is your organization in the transition process?
- Who will be my primary contact at your organization for the ICD-10 transition?
- Can we set up regular check-in meetings to keep progress on track?
- What are your plans for testing claims containing ICD-10 codes? How will you involve your clients, such as my practice, in that process?
- Can my practice send test claims with ICD-10 codes to see if they are accepted? If so, when will you begin accepting test claims?
- Can you provide guidance or training on how my clinical documentation will have to change to support ICD-10 coding?
- Do you anticipate any pricing changes for your services due to the switch to ICD-10?

Find additional information about ICD-10 at www.cms.gov/ICD10.

Know your A&P for ICD-10

Since ICD-10 requires a high level of specificity, it is necessary that coders have a good understanding of anatomy and physiology (A&P) in order to code properly.

The Maine Medical Association | The Maine Osteopathic Association

Welcomes you to the 126th Maine Legislature

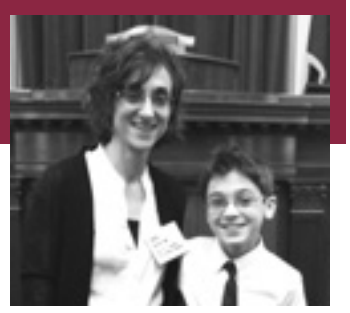
DOCTOR OF THE DAY PROGRAM 2013

Join your colleagues who have served as the "Doctor of the Day" at the Maine State Legislature. Established in 1997, the program is well respected and legislators are enthusiastic about it. Volunteering as the "Doctor of the Day" gives you a better sense of legislators' perception of the medical profession, the importance of developing a relationship with your legislators, and an opportunity to promote the medical profession among the State's leaders.

As the "Doctor of the Day," you are provided with a beeper to respond to any health care issues that may arise with legislators, staff, or public. You need to arrive at the State House by 9am (times may vary) with session ending around noon. The MMA works diligently to secure a "Doctor of the Day" for each day the legislature is in session from January through the end of the session, June or April, depending upon the year. When you are a confirmed "Doctor of the Day," the State House staff will mail you a confirmation letter with detailed information and a parking permit. If you have additional questions prior to participating, do not hesitate to contact the MMA legislative staff.

Serving as the "Doctor of the Day," you will be greeted warmly by the legislators and you also have the option to enroll your child(ren) to serve as a Page at the same time! Your Presence at the Maine Legislature is a critical element of the MMA's grassroots contacts program.

For more information or to register to serve as "Doctor of the Day," contact Maureen Elwell at 207-622-3374 ext: 219 or email docoftheday@mainemed.com or you can register online at https://www.mainemed.com/doctor-day.



Carla Burkley, MD and her son Benjamin

Visit the MMA website at: www.mainemed.com

Mayo Regional Increases Military Leave Benefit

Medical providers who are members of the National Guard or reserve members of the Armed Forces have a supportive environment at Mayo Regional Hospital in Dover-Foxcroft.

Mayo Regional has always been committed to protecting the employment rights of employees on military leaves of absence. Employees are granted leaves of absence for military service if they are inducted into the U.S. Armed Forces, or if they are members of the Armed Forces reserves or the National Guard.

Mayo stepped up its support for service members recently when the hospital revised its military leave policy to add a new benefit for full-time eligible employees who are in good standing and who have been employed at Mayo for one year or more.

Such employees who are involuntarily called to active duty for periods greater than 30 consecutive days will be paid the difference between total compensation from the military and the regular base wages/salary that would have been earned at Mayo each month, starting at the date the leave begins. The benefit pays up to a maximum of $5,000 per month for the first 12 months of leave.

"It has long been recognized that those who serve in the military do so for the simple reason they desire to serve and protect our nation, and often do this at pay far below civilian pay scales. Mayo employees who are called to active duty should not have to suffer a financial loss while they are serving their country," said Edward J. Hannon, Mayo's President and CEO.

Hannon, who is a U.S. Navy veteran, said the military leave policy revision is simply the right thing to do. Mayo has several members of its staff who are members of the Guard and Reserves who are subject to recall. A Physician Assistant in the hospital's Emergency Department was recently notified that he has been called to active duty in Kuwait with the U.S. Army Reserves Medical Specialist Corps.

At the conclusion of a military leave, Mayo employees generally have the right to return to the same position held prior to the leave or to positions with equivalent seniority, pay and benefits. For more information, contact Tom Lizotte at 207-564-4342.

Mayo Regional Hospital in Dover-Foxcroft

HHS Releases Final Omnibus HIPAA Rule

The long-awaited final rule updating several provisions in Health Insurance Portability and Accountability Act regulations was released January 17 by the Department of Health and Human Services Office for Civil Rights.

As promised, the omnibus rule embodies four final rules:

- modifications to the HIPAA Privacy and Security rules mandated in the Health Information for Economic and Clinical Health (HITECH) Act;
- changes to the HIPAA enforcement rule;
- final regulations concerning reporting of data breaches; and
- modifications to the Privacy Rule as required in the Genetic Information Nondiscrimination Act (GINA).

The rule becomes effective March 26, but covered entities and their business associates have until September 23 to comply. Among key provisions finalized in the rule are requirements that business associates—entities with which traditional HIPAA-covered entities have relationships that involve protected health information—comply with certain HIPAA Privacy and Security rule obligations.

The final rule also amends the so-called harm standard, used to determine when entities are required to report data breaches.

At a minimum, physician practices will have to update and redistribute their Notice of Privacy Practices and modify Business Associates Agreements to reflect changes in the rules. The MMA will be preparing sample policies and will post them on www.mainemed.com when they are complete.

The final rule is set for Jan. 25 Federal Register publication

Save the Date:

Physicians' Day at the Legislature
State House, Hall of Flags, Second Floor
March 19, 2013
8:00am – 4:00pm

UPCOMING AT MMA

February 21
6:00pm – 8:00pm
Maine Association of Psychiatric Physicians

February 28
8:00am – 3:00pm
Pathways to Excellence (Maine Health Management Coalition)

March 5
1:00pm – 4:00pm
Maine Council on Aging

March 6
8:00am – 12:30pm
Maine Health Management Coalition

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

March 11
9:00am – 12:00pm
Maine Independent Clinical Information Service (MICIS)

4:00pm – 7:00pm
Medical Professionals Health Program Committee

March 21
6:00pm – 8:00pm
Maine Association of Psychiatric Physicians

March 28
9:00am – 11:00am
Maine Health Management Coalition

April 3
8:00am – 12:30pm
Maine Health Management Coalition

April 5
9:00am – 12:00pm
First Fridays Educational Program

April 8
9:00am – 12:00pm
Maine Independent Clinical Information Service (MICIS)

April 9
4:00pm – 6:00pm
MMA Committee of Physician Quality

April 18
6:00pm – 8:00pm
Maine Association of Psychiatric Physicians

April 23
5:00pm – 9:00pm
ME Chapter American Academy of Pediatrics

April 24
11:30am – 2:00pm
MMA Senior Section

April 25
8:00am – 3:00pm
Pathways to Excellence (Maine Health Management Coalition)

May 1
8:00am – 12:30pm
Maine Health Management Coalition

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

continued on next page


Stephen D. Sears, M.D.

From the State Epidemiologist

By Stephen D. Sears, M.D., M.P.H., State Epidemiologist, Maine Center for Disease Control and Prevention

Reporting Diseases Helps Us All

Maine Center for Disease Control and Prevention (Maine CDC) wants you.

The Maine CDC wants you. Why and for what? We want you to report communicable diseases. Maine CDC relies on you to help us track diseases. To make Maine a healthy state and to protect Mainers from exposure to contagion and harm, we need accurate information. We need to hear about the diseases you see. Together, we can identify potential and ongoing disease risks. Without your eyes and ears, those of us in public health are often blind to what is happening and can't prevent disease effectively. Help us by reporting the diseases you see. So what are the specifics?

Do you know what to report, how to report, or even if a disease is reportable in Maine?

As health care professionals, you are on the front lines of treating diseases, infectious and otherwise. In our state, there are currently 72 notifiable conditions that should be reported to Maine CDC. While treating a patient with an infectious disease, have you ever found yourself wondering if the state should know about it? Do you know how to report? How soon must you notify public health? Here is a quick summary to help you remember (see enclosed insert for details).

Who must report and what should they report?

Maine health care providers, healthcare facilities, medical laboratories, health officers, administrators, veterinarians, and others are required to report notifiable diseases to Maine CDC. Maine has 72 notifiable conditions that we need to hear about. These conditions include infectious diseases, such as hepatitis, tuberculosis, Lyme disease, syphilis, and pertussis. Certain conditions are classified as immediately reportable (Category 1) and are bolded on the Notifiable Conditions List (enclosed). These conditions include potential bioterrorism agents and diseases requiring urgent and specific public health responses and interventions. The Notifiable Conditions List is a document maintained by Maine CDC with current information on what is reportable. In addition, there are certain organisms that laboratories are required to send to the State Public Health Lab (HETL) for further testing and confirmation. For instance, salmonella is sent to the state lab so we can do sero-typing and genetic fingerprinting to investigate the possibility of outbreaks and clusters. The details of what specimens need to be sent are also on the Notifiable List.

How and when to report?

Doctors and other public health partners are required to immediately report Category 1 diseases by telephone. All other conditions, or strong suspicion of other conditions, can be reported by telephone, fax, or mail within 48 hours of recognition. Reports can be made 24/7. There is always an epidemiologist on call at Maine CDC to help triage these reports and provide infectious disease consultations. So call us, fax us, or send us smoke signals, but please contact us. **800-821-5821, fax 800-293-7534**

Why report?

Disease surveillance, assessment of transmission or exposure, and specific public health interventions require timely and accurate reporting of diseases. In Maine and elsewhere in the country, the only way for public health to effectively provide these services is to understand the disease burden and risks for transmissions. Epidemiologists conduct investigations to determine the risks, exposures, and appropriate public health prevention and control measures. The data from these investigations are used to better understand disease impact in the state. This information is confidential.

Confidentiality

Maine CDC is legally authorized, via federal and state rules and statutes, to receive confidential reports for the prevention and control of disease, injury, and disability. Maine CDC epidemiologists are allowed access to patient health records for disease control and prevention purposes, such as investigating cases, controlling outbreaks, and determining exposures. In other words, we are HIPAA-exempt.

So what does this all mean?

By reporting diseases you help us improve public health. This is a vital partnership between providers, healthcare organizations, and public health to improve the health of all Mainers. So if you see one of these reportable conditions, think there is an outbreak, or you have any concerns at all, let us know. We are here 24 hours a day, 7 days a week at 1-800-821-5821. Call and call often. It's easy.

Resources:

More information on disease reporting (including the Notifiable reporting form, contact information for Maine CDC, and laboratory reporting) can be found at: www.maine.gov/idepi/disease-reporting/index.shtml

Maine Health and Environmental Testing Laboratory website:
www.mainepublichealth.gov/lab


Jessa Barnard, J.D.,

Public Health Spotlight

By Jessa Barnard, J.D., Director of Public Health Policy, MMA

Maine Doesn't Make the Grade in Lung Association's Annual Tobacco Report Card

Every year, the American Lung Association releases a State of Tobacco Control Report. In addition to summarizing advances and losses in the policy arena, the report evaluates state and federal tobacco control policies by comparing them against targets based on the most current, recognized criteria for effective tobacco control measures, and translating each state's relative progress into a letter grade of A through F. State level tobacco control policies are graded in four key areas: tobacco prevention and control funding, smokefree air laws, state cigarette excise taxes and coverage of tobacco cessation treatments and services.

Once hailed as the only state in the nation to earn all A's for its efforts to protect Mainers from the premature death and preventable disease caused by tobacco, Maine continued to slide backward in key measures, earning 2 'D's, a 'C' and just one 'A' in the latest report.

In fact, the report gives Maine a "thumbs down" for cutting funding for its successful tobacco prevention and cessation program by $1.5 million in 2012. The report also calls out Maine for the state's decision to eliminate coverage for cessation medication to MaineCare (Medicaid) recipients, with the exception of pregnant women.

Maine received the following grades for 2013:

Tobacco Prevention Control and Spending	D
Smokefree Air	A
Cigarette Tax	C
Cessation	D

Priorities that need to be addressed to improve Maine's State of Tobacco Control grades include:

- Raising the tobacco tax by at least one dollar in 2013
- Taxing "other" tobacco products, such as cigars and smokeless tobacco, at the same rate as cigarettes
- Restoring coverage for all 7 cessation medications to all MaineCare recipients, not just pregnant women
- Funding the state tobacco control program at or above the CDC recommended level

Currently, Maine has the second lowest tobacco tax in the Northeast. The state was previously one of the most aggressive in keeping cigarette prices high and as a result has achieved a dramatic decline in youth smoking. However, the last cigarette tax increase was in 2005 and Maine's youth smoking rate decline has stalled.

Tobacco causes an estimated 2,235 deaths in Maine annually and costs the state's economy more than $1 billion in healthcare costs and lost productivity, a tremendous burden the state can ill afford. Yet, Maine receives $196 million in tobacco-related revenue annually and only invests 50 percent of what the Centers for Disease Control and Prevention (CDC) recommends should be spent on tobacco prevention and cessation programs.

"It's time we get serious about the deaths, disability and preventable health care costs resulting from tobacco use. Leaders in Augusta must provide smokers with the support they need to quit and adequately fund programs that help keep our kids off tobacco," said Ed Miller, Senior Vice President of Public Policy for the American Lung Association of the Northeast. "Maine policy makers have led the nation in the past on tobacco issues. It is time for us to reclaim our national leadership."

Maine State Facts: STATE FACTS

• Economic Cost Due to Smoking:	$1,084,231,000
• Adult Smoking Rate:	22.6%
• High School Smoking Rate:	15.2%
• Middle School Smoking Rate:	7.2%
• Smoking Attributable Deaths:	2,235
• Smoking Attributable Lung Cancer Deaths:	744
• Smoking Attributable Respiratory Disease Deaths:	660

ADULT SMOKING RATE IS TAKEN FROM CDC'S 2011 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM. HIGH SCHOOL SMOKING RATE IS TAKEN FROM THE 2011 YOUTH RISK BEHAVIORAL SURVEILLANCE SYSTEM. MIDDLE SCHOOL SMOKING RATE (7TH AND 8TH GRADE ONLY) IS TAKEN FROM THE 2009 MAINE INTEGRATED YOUTH HEALTH SURVEY.

Ethics Note: The Patient's Responsibilities in the Physician-Patient Relationship

What are the patient's responsibilities in the physician-patient relationship? The AMA's *Council on Ethical and Judicial Affairs* (CEJA), the body that developed and updates the medical profession's Code of Medical Ethics, addresses patient rights and responsibilities in Section 10 of the Code, Opinions on the Patient-Physician Relationship. While we often hear about patients' rights, they also have certain responsibilities to their treating health care practitioners that are described in Opinion 10.02, Patient Responsibilities. This Opinion provides as follows:

It has long been recognized that successful medical care requires an ongoing collaborative effort between patients and physicians. Physician and patient are bound in a partnership that requires both individuals to take an active role in the healing process. Such a partnership does not imply that both partners have identical responsibilities or equal power. While physicians have the responsibility to provide health care services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program. Like patients' rights, patients' responsibilities are derived from the principle of autonomy. The principle of patient autonomy holds that an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options. Autonomous, competent patients assert some control over the decisions which direct their health care. With that exercise of self-governance and free choice comes a number of responsibilities.

1. Good communication is essential to a successful patient-physician relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their physicians.
2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.
3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
4. Once patients and physicians agree upon the goals of therapy and a treatment plan, patients have a responsibility to cooperate with that treatment plan and to keep their agreed-upon appointments. Compliance with physician instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
5. Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited resource like health care and try to use medical resources judiciously.
6. Patients should discuss end-of-life decisions with their physicians and make their wishes known. Such a discussion might also include writing an advance directive.
7. Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients should take personal responsibility when they are able to avert the development of disease.
8. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.
9. Participation in medical education is to the mutual benefit of patients and the health care system. Patients are encouraged to participate in medical education by accepting care, under appropriate supervision, from medical students, residents, and other trainees. Consistent with the process of informed consent, the patient or the patient's surrogate decision maker is always free to refuse care from any member of the health care team.
10. Patients should discuss organ donation with their physicians and, if donation is desired, make applicable provisions. Patients who are part of an organ allocation system and await needed transplant should not try to go outside of or manipulate the system. A fair system of allocation should be answered with public trust and an awareness of limited resources.
11. Patients should not initiate or participate in fraudulent health care and should report illegal or unethical behavior by physicians and other providers to the appropriate medical societies, licensing boards, or law enforcement authorities.

(I, IV, VI) Issued June 1994 based on the report "Patient Responsibilities", adopted June 1993; Updated June 1998, December 2000, and June 2001.

You may review the AMA's Code of Medical Ethics at the AMA web site: https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/doc/PolicyFinder/policyfiles/CEJA-TOC.HTM.

If Your Patient was Abusing Prescription or Illicit Drugs, Would You Know?

In 2011, 3.1 million persons aged 12 or older reported using an illicit drug for the first time within the past 12 months. This averages to approximately 8,500 initiates per day[1]. Additionally, 6.1 million persons aged 12 or older reported the nonmedical use of prescription psychotherapeutic drugs in the past month[1].

The National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, is interested in improving clinical outcomes by providing science-based resources to clinicians about drug abuse and addiction. To help achieve that goal, NIDA has developed NIDAMED, a portfolio of resources to help clinicians better address drug abuse in their patients. Visit the NIDAMED Web site now to view the portfolio of free resources: http://www.drugabuse.gov/nidamed-medical-health-professionals.

Available materials include:

- **The NIDA Drug Use Screening Tool**. This interactive Web tool, easily accessible from mobile devices, offers a single question Quick Screen to identify patients with recent substance use. If a patient is found to be at risk using the Quick Screen, the **NM ASSIST** provides more in-depth questions about patient drug use. A substance involvement score, generated from patient responses, suggests the level of intervention needed.
- ***Screening for Drug Use in General Medical Settings: Resource Guide***. This guide supplements the NIDA Drug Use Screening Tool by providing more detailed instructions to clinicians about how to use the tool, discuss screening results, offer brief interventions, make necessary referrals, conduct biological specimen screening, and locate substance abuse treatment facilities.
- ***Screening Tool Quick Reference Guide.*** This pocket guide provides an abbreviated version of the NIDA Drug Use Screening Tool and instructions on its use.
- **Patient Resources.** These materials were developed to help clinicians provide patients with information about drug use, addiction, and treatment. Resources include 1) one-page fact sheets about prescription drug abuse, marijuana, and substance abuse treatment options; 2) booklets about the science of addiction, facts about drugs, and tips for finding treatment; 3) posters to help start conversations with at-risk patients about their drug use; 4) an online tool that highlights parenting skills to prevent the initiation and progression of drug use among youth; and 5) a Web site written in simple, direct language to help readers understand drug abuse, addiction, and treatment.

- **Substance Abuse-Related Continuing Education Courses (CME/CEs)**. These two new MedScape CMEs/CEs, which offer up to three CME/CE credits, include video vignettes modeling clinician–patient conversations about the safe and effective use of opioid pain medications. The courses were created to help clinicians understand and address the complex problem of prescription drug abuse. More than 30,000 clinicians have completed the course for credit, and an additional 50,000 have viewed it.
- **Curriculum Resources**. This series includes ten innovative drug abuse and addiction curricula, which were designed to help teach students to identify and treat patients struggling with drug abuse and addiction. The resources were created to help fill gaps in current medical education related to both illicit and prescription drug abuse.

If you have questions about any of the NIDAMED resources, contact nidacoeteam@jbsinternational.com.

[1]Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Summary of National findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration.

UPCOMING AT MMA

continued from page 6

May 2
11:00am – 4:30pm
MMA Continuing Medical Education

May 3
9:00am – 12:00pm
First Fridays Educational Program

May 6
9:00am – 12:00pm
Maine Independent Clinical Information Service (MICIS)

May 13
4:00pm – 7:00pm
Medical Professionals Health Program Committee

NOTE: All MMA Committee Meetings are now being offered through WEBEX

Deadline to File for Attestation in EHR Incentive Program: Feb. 28

CMS reminds you – and any eligible professionals who participated in the Medicare Electronic Health Record (EHR) Incentive Program in 2012 – that it is time to complete attestation for the 2012 program year. The deadline is February 28, 2013.

CMS also noted that in order to be eligible to attest, you must have completed the 2012 reporting period by December 31, 2012.

See details and general information about the EHR incentive program at: **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html?redirect=/ERxIncentive/06_E-Prescribing_Measure.asp**

MMA Welcomes Our Newest Corporate Affiliates:

Lipman and Katz

Maine Community Health Options

We appreciate their support!

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