Maine Medicine

a quarterly publication of the Maine Medical Association

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Maine Medical Association Mission: **SUPPORT** Maine physicians, **ADVANCE** the quality of medicine in Maine, **PROMOTE** the health of all Maine citizens.

PRESCRIBING FOR PAIN LIMITATIONS CONTINUING TO CHALLENGE PATIENTS AND PRESCRIBERS

Maine's landmark law limiting opioid prescriptions and mandating PMP checks and electronic prescribing continues to present challenges to patients who are over the daily dosage limits and to prescribers who are trying to sort out fact from fiction relative to the law and the emergency rule published by HHS on Jan. 2, 2017. Maine State Health Officer Christopher Pezzullo, D.O. also has communicated to prescribers stating that the state will not enforce the mandatory PMP checks (by reporting violations to the appropriate licensing boards) until March 1 and will not enforce dosage limitations prior to Oct. 1, 2017. MMA had requested a grace period in order for prescribers and patients to be educated on the emergency rule and also to accommodate for the conversion of the PMP to a new vendor which took place on Dec. 20, 2016. The conversion to the new platform resulted in all delegates having to re-register in the system, a process that also required approval by the prescriber.

The emergency rule did provide three important additional exceptions to the law but also attempts to limit the exemptions previously granted by the legislature in the original legislation (PL 2016, Chapter 488). The additional exemptions are:

1. A pregnant individual with a pre-existing prescription for opioids in excess of 100 Morphine Milligram Equivalent aggregate daily limit. This exemption applies only during the duration of the pregnancy.
2. Acute pain for an individual with an existing opioid prescription for chronic pain. In such situations the acute pain must be postoperative or new onset. The seven day prescription limit applies.
3. Individuals pursuing an active taper of opioid medications, with a maximum taper period of six months, after which time the opioid limitations will apply, unless one of the additional exceptions in this subsection apply.

The emergency rule attempts to limit the statutory exemptions by limiting the exception for active and aftercare cancer treatment to six months post remission. MMA does not believe that this limitation is lawful in that the rule-making provision authorized the Department "to establish reasonable exceptions to prescriber limits" not to limit those exceptions already granted by the law. There are several other provisions in the emergency rule that MMA will be seeking changes to, including the requirement to add the ICD-10 diagnosis code to each script over 100MME, mandatory reporting of unlawful scripts to the PMP coordinator and the broad definition of "dispenser" which threatens to make each prescriber who also dispenses a mandatory reporter to the PMP.

Maine law designates the PMP regulations as major substantive rules, requiring legislative approval. However, Chapter 488 assigned some of the rule changes as routine technical rules. Emergency routine technical rules are effective for up to 90 days. Emergency substantive rules may be effective for up to 12 months or until the Legislature has completed review of the rules. In its communication dated January 1, 2017 to prescribers, the Department announced its intention to "engage in a single rule-making which will make permanent the emergency technical rule provisions and which will also provisionally adopt the emergency major substantive rule provisions, which will then be submitted to the Maine Legislature for its review." In other words, MMA and other advocacy organizations, patients and prescribers will have at least three opportunities to provide input into the rule and the law. First is the opportunity to provide comments orally or in writing at or following the rule-making hearing February 13th at 9:00am at the Augusta Armory. Second is the opportunity to testify at the Legislative hearing on the proposed final rules and the third is an opportunity to testify on one or more of the many bills that have been submitted to this session of the legislature proposing to amend Chapter 488. There will also be hearings on the proposed amendments to Joint Rule 21 by the licensing boards. In some cases, the proposed amendments to the Chapter 21 rule goes further than the statute and the rules in mandating certain prescribing practices and universal precautions.

Watch the MMA *Weekly Update*, e-mailed each Monday, for timely information on the dates of these hearings. If you are not receiving the *Weekly Update* and would like to do so, communicate with Lisa Martin in the MMA membership office (622-3374 ext. 221 or e-mail lmartin@mainemed.com).

MMA attorneys have provided over forty CME presentations on Chapter 488 and the associated rules since May, 2016. If you would like a presentation at your practice site, your medical staff or medical specialty society, contact Gail Begin at gbegin@mainemed.com or EVP Gordon Smith, Esq., at 622-3374 ext. 212 or e-mail to gsmith@mainemed.com. Many of these presentations are supported through a contract with MaineCare and a grant through the Maine Health Access Foundation so there is no cost to the attendees.

Lani Graham, M.D., a member of the prevention/harm reduction task force of the Maine Opiate Collaborative speaks at January 18 community forum in Augusta.

SAVE THE DATE / JULY 10, 2017

MMA's 14th Annual Benefit Golf Tournament
Augusta Country Club, Manchester, ME

Contact Lisa Martin at 622-3374 ext. 221 or lmartin@mainemed.com for more details, including sponsorship opportunities.

Will you be ready to meet Maine's e-prescribing mandate by July 1, 2017?

See article on page 7.

MAINE QUALITY COUNTS

By Dr. Erik Steele, Interim Executive Director

OVERCOMING THE OPIOID EPIDEMIC IS THE WORK OF ALL OF US

Peter was a patient of mine to whom I prescribed opioids intermittently for several years. I remember to this day how shocked I was to finally discover that he was not only pathologically hooked on opioids, but was so hooked he was stealing money to buy them on the street. Even more shocking to me, was that a patient I liked and respected, an upstanding member of the community, had been deceiving me.

Well intentioned as I was, I did my part contributing to Peter's opioid use disorder (OUD), and by extension my part in contributing to Maine's opioid use disorder epidemic. I was not aware enough that every patient I prescribed opioids to even once had a real risk of developing OUD. I was too easy to convince that every patient's pain needed eradication, and that opioids were the best tool for doing that. I was intent on reducing the painful suffering of my patients, and too unaware of the suffering that might develop if my pills were used inappropriately. I failed to see that our efforts in healthcare to be more effective in treating pain – efforts promoted on a national level by healthcare regulators and pain experts – was 'opioid-dependent' itself, and would come back to haunt us all.

For these and other reasons, I contributed my small stream of unnecessary opioid pills to thousands of other such streams from physician offices, hospitals, and emergency departments across Maine. Together we created the flood of opioids that has now engulfed us, kills more Mainers each year than car crashes, wreaks OUD-induced havoc in homes and communities, and has made Maine a national showcase for the opioid tsunami.

Having helped make this mess, I now need to help fix it, by starting a different small stream. As I go back into family practice in Maine, I will take my 8 hour course and do other work to be able to prescribe suboxone therapy – one part of Medically Assisted Therapy (MAT) for OUD, and provide treatment for as many as I and my practice can capably manage. I will begin screening for OUD among my patients, and treating or referring those who need help. I will dramatically change my approach to the treatment of pain, avoiding use of opioids wherever possible, weaning patients off opioids wherever I can, and partnering with other healthcare providers and state government in meticulous management of opioid prescribing. That all amounts to a big, challenging pain in my practice, but I don't think any of us who helped get Maine and its people into this opioid mess can, in good conscience, do anything less.

There is a growing help for those on the challenging front lines of MAT; health systems across Maine have geared up substantial efforts to support their physicians, nurse practitioners, and other caregivers in this work. The Maine Medical Association, Maine Quality Counts, Maine state government, the Maine Health Access

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Check out the inserts with this issue including the MMA Upcoming Happenings, Golf Flyer, and June 17, 2017 Program.

A Message for Physicians and Physician Assistants of Maine

By Stephanie Podolski, MPH, MSPA, PA-C, President of the Maine Association of Physician Assistants

I am writing to you today as President of the Maine Association of Physician Assistants (MEAPA), but also as your colleague and friend. As an organization, MEAPA would like to thank our collaborating and supervising physicians for their continued dedication to our profession. Our unified teams have allowed us to provide excellent patient centered, quality care with expanded access to our rural and aging communities in Maine. During a changing and truly dynamic healthcare environment, it is crucial for us to continue to work hard to provide the best care for our patient populations, while keeping our larger public health issues in our sights. As you all know, we are currently in the trenches of an opiate epidemic. However, over the last year the Comprehensive Addiction and Recovery Act (CARA) of 2016 passed the U.S. House and Senate, amending federal law to permit PAs to become waivered to prescribe Buprenorphine for opiate addiction. The inclusion of PAs in CARA expands our ability as a medical community to provide more treatment options to Americans suffering from addiction.

Additionally, I write to remind you that there have been many changes in Physician Assistant regulations, laws, and principles of practice over the last year. The Maine Joint Chapter 2 Rules, which went into effect January 1, 2017, unite PA licensure and supervisory criteria under the Maine Board of Licensure in Medicine and Maine Board of Osteopathic Licensure. MEAPA Board of Directors has created a Joint Chapter 2 "compliance" rubric for your use. This document has also received approval from both licensing boards and has been mailed to all Maine PAs. **All practicing PA's and Primary Supervising Physicians (PSPs) must read the rubric and the Chapter 2 Rule. Plans of supervision should be reviewed and rewritten by PA/PSP teams as soon as possible to comply with the rules as they stand now. If you would like access to an electronic copy of this document, please see the contact below.**

There are more opportunities on the horizon for PAs and physicians to continue to work collaboratively and I hope to inspire physicians of the Maine to reach out to our leadership community at MEAPA for further engagement. Please consider joining us at our upcoming Annual Winter CME Conference at Sunday River from February 8-11, 2017. For more information, including registration, see our website at www.mainepa.com.

If you have additional questions, comments or concerns, please feel free to reach out to me directly at MEAPA4ME@gmail.com.

PRESIDENT'S CORNER

By Charles Pattavina, M.D., President, Maine Medical Association

RAMBLING THOUGHTS ON PROFESSIONALISM

A couple of weeks ago I was working in the E.D. alongside my esteemed colleague, Scott Thomas, D.O., and we found ourselves talking about some rewarding collegial experiences we have recently had with a couple of consultant cardiologists at a very large hospital in Portland - and what real professionals they are. It occurred to me - and I did remark to Scott - that I thought I might have known the father of one of them during my internship year in Framingham. The father was a highly regarded primary care internist (who might also have been an office cardiologist) – a real professional, a gentleman and a role model and I recalled he had a son who was a brand-new cardiologist at the time.

Fast forward to the week between Christmas and New Year's and in the middle of a particularly rough day, I found myself on the phone with that particular cardiologist and had the opportunity to ask if his father was the gentlemanly internist I knew from training. Indeed he was, and the pleasant conversation we had – including the part about the patient – really made my day and I went home with a smile on my face. I only regret that I didn't tell the cardiologist that we thought he was quite a gentleman professional too.

A few days later I was working with Scott again and discussing how it is we could impart those qualities of courtesy and patient-focus from lady and gentlemen professionals to other colleagues – and hoping we lived up to that standard ourselves. Scott has served on the osteopathic licensure board for years, so this is of particular interest to him as well. Your MMA board is discussing professionalism and we would appreciate your input.

We have another problem brewing that has been growing faster in other parts of the country, but is beginning to rear its ugly head in Maine. Certain surgical (and medical and radiological) specialties/subspecialties are developing their own hospitals or procedure centers and declining to serve on hospital staffs. My hospital just lost three of five people taking call in one subspecialty, so we have 22 days uncovered by that specialty in January. And this is a specialty we don't call very often!

A subspecialist from the Augusta area recently wrote this to me: "Just saw a young kid about 10 years old from Addison because Tufts [same specialty] resident called me and I, while on call, agreed to see the patient so they would not have to go to Boston for a [non-operative surgical problem]. The resident had called [my colleagues] in Ellsworth and Bangor-- no one on call. Now there are five [of my colleagues] in Ellsworth and another eight in the Bangor area. If each one simply took one week out of 13 that would do it but no [one is willing]." I call that specialist from Augusta a "real doctor".

On one hand, this bothers me as an emergency physician because I see the people in their hour of need when they have to travel far (Boston sometimes) because no specialist here is willing to take care of them. It also simply bothers me as a physician. I'm not advocating we outlaw capitalism and I'm certainly not looking to compromise other people's wellness, but we have skills (and yes, we took an oath) to take care of people and we didn't complain or refuse the money when the general public subsidized our medical educations. The public probably has the reasonable expectation that we will take care of them some day.

Our patients really do appreciate the things we do for them, but they can never appreciate care they never got from doctors who didn't respond to help them. And when they have to go to Boston for care that a neighbor could have provided here, is it not understandable that they might actually be angry when they Google a specialty and see just how many of their neighbors in the needed specialty could have taken care of them? I think some introspection by our medical profession is needed here. Perhaps my own specialty of emergency medicine has lulled specialists into a kind of complacency. Perhaps some new thinking such as regional call panels may be appropriate, but it is not acceptable to have no one on call in the whole state for emergencies.

I welcome your comments, feedback and criticisms. Please feel free to reach me at 207-907-3350 or by email to president@mainemed.com.

NOTES FROM THE EVP

By Gordon H. Smith, Esq., Executive Vice President, Maine Medical Association

It is my pleasure to wish all MMA members, their families and their staffs a Happy New Year. All of us here at the MMA wish you all the best for 2017. For healthcare, it will be quite a year, with many challenges in both Augusta and Washington. At MMA, we will do all that is possible to advocate for actions consistent with our mission. We will advocate for healthcare coverage for everyone in Maine. We will work to improve the quality of care and to reduce the cost and for the improvement of public health. None of this will be easy, but we are not easily deterred. It is important work and it is work worth doing. Please help us by becoming active in your professional society. It may be a cliche now, but together we are stronger and physicians must stick together if they are to be successful.

As we begin another long legislative session, we will be at the State House everyday to represent your interests. As I write this article, we just concluded the first weekly legislative conference call. For the next 20 weeks or more, MMA members both as individual physicians and as representatives of various specialties, will join together to review legislative proposals impacting on physicians, patients and public health and to determine the position MMA will take. It is a very democratic process. Increase your engagement with MMA by joining the call and/or by serving as Doctor of the Day at the State House. It is an honor to be asked by legislative leaders year after year to make available a physician to handle any medical issues that arise. MMA and our partner the Maine Osteopathic Association need to be able to fill the Doctor of the Day slot every day. Please help us by volunteering. We will enjoy spending time with you, and your family, if you bring them along to the State House. Also plan on joining us at the State House on May 31 for Physicians' Day at the Legislature.

2016 was a good year for MMA in many ways. We increased membership to record levels, met the budget and improved upon it and continued our work on the opioid/heroin crisis. I thank our active and engaged leadership including the officers and the board for leading us through a great year. And I want to thank our amazing staff which is both experienced and dedicated. We are a good team. May 2017, despite posing its many challenges, be an even better year for MMA which will celebrate its 164th year on April 28.

I close on a personal note. On December 20 my wife Janet and I were blessed with our second grandchild. There is simply nothing in life that compares to holding a newborn infant in that crook in your arm where they so naturally fit. Colby Smith Conopka was just the most perfect Christmas present. Thank you to daughter Devon and husband Mark for making this possible. We were able to take big brother Quinn, age 3, to meet his baby brother. It was a special time and I am very grateful. I hope you had a special holiday as well. Happy New Year.

Overcoming the Opioid Epidemic... continued from page 1

Foundation, and many other organizations across the state are contributing educational, financial, legal, organizational, and other support. Some organizations with more expertise and resources are building hubs of advanced OUD management to which smaller practices and organizations can turn for expert consultation and other assistance. We all could do more, we all could do better, but what we are doing means that physicians and others who take on the obligation of providing MAT will feel less alone and more supported than many of them have in the past.

To that can be added the help of knowing that we are helping reduce the suffering of our patients and their families; MAT providers I speak with talk of how challenging this work can be, but also of how rewarding it can be to help turn around the lives being ruined by OUD.

Others must join this effort if they have not already done so. Every hospital that employs physicians must support those physicians to add to the MAT stream. Every physician who prescribes opioids on a regular basis must do his or her part; at a minimum fastidiously prescribe – and not prescribe - opioids in a responsible manner, screen for OUD and refer those who need it, and follow the state prescribing regulations, etc. Ideally, every primary care practice should develop enough MAT capacity to be able to care for its patients with OUD (and every practice has them) and a few more patients in their communities who do not have access to primary care. Every practice that fails to do that leaves their population of patients who needs MAT to some other practice to provide, potentially overwhelming those practices that step forward.

The people to whom I and others must offer this treatment for OUD are, in fact, us; they are our family members, some of our physician and other caregiver colleagues, our community members, our children's friends in school, the people who build our bridges and serve us food. They are the ones dying in Maine at the rate of one per day, and the grief their deaths bring is a cry for help to us all.

It took years for Maine to get into this mess, and it will take Maine years to get out of it. But a concerted effort, improved and sustained over the long haul, will turn back this tide. The scale of the effort needs to increase rapidly – we should be establishing a statewide goal that every community in Maine has adequate MAT access by the end of some finite date – perhaps the end of 2018? The clock is ticking on our efforts, and it is a terrible human clock; every second it ticks tells another story of the misery that OUD brings all it touches, and every 24 hours it tolls the death of another one of us from OUD. We cannot move quickly enough.

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THANKS TO 2017 SUSTAINING MEMBERS

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

Stephen Babirak, MD	Central Maine Orthopaedics
Maroulla Gleaton, MD	InterMed, P.A.
Jerald Hurdle, DO	Kennebec Anesthesia Associates
Jo Linder, MD	MidCoast Hospital
Michael Szela, MD	Spectrum Medical Group

Dr. Frederick Goggans and Sen. Dave Miramant

Sen. Dave Miramant, D-Camden, welcomed Dr. Frederick Goggans, of Camden, to the Maine Senate as the "Doctor of the Day" Jan. 11 at the State House in Augusta.

"It was an honor to have Dr. Goggans as a guest in the Senate," said Sen. Miramant, in a news release. "Our community in Camden is lucky to have someone with such strong credentials."

Goggans is the Medical Director at Borden Cottage in Camden. He oversees a team of professionals providing residential treatment for patients with substance use disorders, many of whom present with co-occurring psychiatric disorders.

Miramant is serving his second term in the Maine Senate representing District 12, which includes all of Knox County except the town of Washington.

MMA HAPPENINGS

All meetings take place at the MMA office, 30 Association Drive, Manchester, ME unless otherwise noted.

FEBRUARY 8
4:00pm – 6:00pm
MMA Public Health Committee

MARCH 8
4:00pm – 6:00pm
MMA Board of Directors

MARCH 14
4:00pm – 6:00pm
MMA Committee on Physician Quality

APRIL 12
4:00pm – 6:00pm
MMA Public Health Committee

MAY 5
8:00am – 5:00pm
Medical Professionals Conference:
Health, Wellbeing & Awareness at Holiday Inn by the Bay, Portland, ME

MAY 9
4:00pm – 6:00pm
MMA Committee on Physician Quality

MAY 22
6:00pm
Washington County Listening Session
at Helen's Restaurant, Machias, ME

MAY 31
8:00am – 4:00pm
Physicians' Day at the Legislature
State House, Augusta, ME

JUNE 7
4:00pm – 6:00pm
MMA Board of Directors

JUNE 14
4:00pm – 6:00pm
MMA Public Health Committee

JUNE 17
8:00am – 4:00pm
Challenges to Professionalism in a Time of Change Conference at Sheraton, Portsmouth, NH

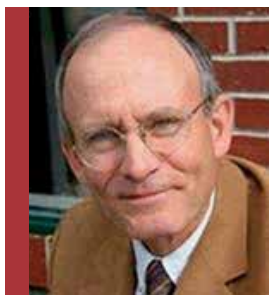
JULY 10
11:00am – 6:00pm
14th Annual MMA Benefit Golf Tournament at Augusta Country Club, Manchester, ME

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

AUGUST 9
4:00pm – 6:00pm
MMA Public Health Committee

PUBLIC HEALTH SPOTLIGHT

By James Maier, MD, DLFAPA, Member of the MMA Public Health Committee and MAPP



Marijuana Risks and Mental Illness in Youth

As Maine approaches implementation of the recreational marijuana referendum, controversy continues about possible risks attendant on wider availability. Many of these have been fiercely debated for years, e.g., whether marijuana use is a "gateway" leading to use of other, more harmful substances. Other concerns have emerged more recently. Media stories highlighting the poisonings of children in Colorado by ingestion of THC-laced gummy bears have led some municipalities to draft ordinances pre-emptively banning sales of such products. However, if experience with attempting to limit the availability of alcohol to adults is any indication, it's likely that despite attempts to restrict use by young people, legalization may make THC-containing products more widely available to children and adolescents. A recent study cited in JAMA Pediatrics stated that usage in 8th and 10th graders in Washington state has increased (2% and 4% respectively) following marijuana legalization in 2012, with rates of perceived harmfulness of marijuana dropping by 14% and 16% in these age groups.

One largely unrecognized risk of heavy daily exposure to THC-containing products in adolescence is the potential of "unmasking" or accelerating the emergence of major mental illness. The experience of researchers in Portland's PIER program and at other "early intervention" sites around the world attempting to prevent or merely attenuate or delay the emergence of schizophrenia, bipolar disorder or other psychotic illness confirms this danger for the small number of adolescents at higher risk of developing one of these serious and potentially disabling disorders. A family history of more serious mental illnesses may be a clue to vulnerability in a young person, but often there is no way to predict which individuals are at greater risk for the emergence of paranoid thinking or disturbances of perception and mood which may evolve, in the worst cases, to become lifelong mental illness. One young man whose "prodromal" psychotic symptoms including paranoid delusions and occasional hallucinations had been controlled with treatment in the PIER program traveled to Amsterdam where he smoked large quantities of readily available marijuana. Despite continuing to take antipsychotic medication, his former psychotic symptoms re-emerged with greater severity, terrifying him that he would never return to his normal level of mental functioning. Fortunately, after he stopped daily use of marijuana, his psychotic symptoms disappeared.

If greater numbers of young people in Maine use marijuana or THC-containing products daily, whether by smoking or by ingestion, they could essentially become part of a public health experiment in reverse: exposing a large population to a particular risk factor with potentially serious consequences (even for relatively few vulnerable individuals) and waiting to see which unlucky "subjects" get in serious trouble. This population at risk may be expanding, according to a recent study in Psychiatric Services reporting data from 5 large U.S. healthcare systems over a period from 2007 to 2013. The rate of initial presentation of psychotic symptoms in 15-19 year olds averaged nearly 1% each year.

While there are compelling arguments on both sides of the legalization question, awareness of this lesser known but more serious consequence can lead to earlier detection and referral to specialized intervention. Regrettably, the potential demand for the specialized multidisciplinary early intervention programs which are the most successful in addressing first episode psychotic illness is already exceeding capacity nationwide, according to Dr. John Kane, Chair of the Psychiatry Department at Hofstra North Shore LIJ School of Medicine. Maine cannot afford to terminate federal funding earmarked for the PIER program, risking aggravating the existing shortage of badly needed treatment programs for a vulnerable population at a critical time.

There will be a program on Maine's Marijuana Law and its Impact on Youth taking place on Saturday, March 4, 2017 from 4:00pm – 6:30pm at Sunday River Ski Resort in Newry, ME. For more information and to register, contact Dee Kerry at 207-480-4185 or dkerry@mainemed.com.

LEGISLATIVE UPDATE

By Andrew MacLean, Esq., Deputy Executive Vice President, Maine Medical Association

Legislative Update: 128th Maine Legislature Begins Work of First Regular Session

The 186 members of the 128th Maine Legislature were seated in early December 2016 and began the work of their First Regular Session on Wednesday, January 4, 2017. The work of this legislature coincides with the last two years of the Administration of Paul R. LePage (R). The 128th Legislature continues the partisan division in the legislature from the 127th Legislature with Republicans controlling the Senate by a slim margin of 18 Republicans, 17 Democrats and the Democrats controlling the House by a 77 Democrats, 71 Republicans, and 3 unenrolled members margin. The 128th Maine Legislature includes three returning physician members: Sen. Geoffrey Gratwick, M.D. (D-Penobscot), Rep. Patricia Hymanson, M.D. (D-York), and Rep. Heidi Brooks, M.D. (D-Lewiston). The Senate President is Sen. Michael Thibodeau (R-Winterport), the Senate Majority Leader is Sen. Garrett Mason (R-Androscoggin), and the Assistant Majority Leader is Sen. Andre Cushing (R-Penobscot). The Senate Minority Leader is Sen. Troy Jackson (D-Aroostook) and the Assistant Senate Majority Leader is Sen. Nate Libby (D-Androscoggin). The Speaker of the House is Rep. Sara Gideon (D-Freeport), the House Majority Leader is Rep. Erin Herbig (D-Belfast), and the Assistant House Majority Leader is Rep. Jared Golden (D-Lewiston). The House Minority Leader is Rep. Kenneth Fredette (R-Newport) and the Assistant House Minority Leader is Rep. Ellie Espling (R-New Gloucester). The 128th Legislature is scheduled to conclude its First Regular Session by Wednesday, June 21, 2017.

SAVE THE DATE: Physicians' Day at the Legislature is Wednesday, May 31, 2017 – please plan to join us at the State House!

The First Regular Session of each legislature begins relatively slowly as it takes some time for the Senate and House Republican and Democratic caucuses and the joint standing committees of the legislature to organize. During the first session, legislators can submit any number of bills and legislators have filed approximately 1800 bills by the December 30, 2016 cloture deadline. The Governor can submit bills at any time and legislators can submit "after deadline" bills upon approval by the Legislative Council, the 10 members comprising the leadership of the legislature. You can find the lists of bill requests (LRs) by subject matter and by sponsor on the Maine Legislature's web site here: http://legislature.maine.gov/lio/bill-requests/9317. The public generally doesn't know the details of these LRs until they are printed and referred to committee as LDs or "Legislative Documents."

Another significant task of every new legislature is to consider a new two-year or "biennial" state budget. In accordance with his constitutional obligation, Governor LePage submitted his budget proposal for the 2018-2019 state fiscal year biennium on Friday, January 6th. You can find the Governor's proposed budget documents on the web at: http://www.maine.gov/budget/. The legislature's consideration of the biennial budget usually occupies much of the First Regular Session and public hearings on the health and social service portion of the biennial budget are likely to take place some time in February.

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 this tool on the Maine Legislature's web site: http://legislature.maine.gov/house/townlist.htm. 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 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. The conference call information is published each week in the *Maine Medicine Weekly Update*. Look for these calls to begin again in mid-January 2017. 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 MMA'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, Deputy EVP & General Counsel, at amaclean@mainemed.com.

The "TIGER" Returns

By Richard C. Dillihunt, M.D., Retired Surgeon, Portland, Maine

DECADES AGO while I was in surgical training in New York, heroin was a terrible problem, a real tiger in New York City and now its back, worse than ever. Maine`s annual opioid deaths now approach 400 as jails overflow and treatment and rehabilitation programs are inadequate in bed numbers and funding, despite terrific work by police to accomplish results in this area. Federal and State governments have joined in serious efforts to control this epidemic and bring funds forward in what is now obviously a domestic war.

Only now is the critical role and scope our profession has played in aiding and abetting the spread of this epidemic becoming apparent, with many accidental addictions attributable to faulty prescribing of opioids. Likewise, the very deep involvement of the drug industry in overproduction and overzealous pushing of such drugs to market for profit motives is showing some transparency.

Our Governor has chipped in by insisting that more DEA professional agents be added to the roster to increase the forces of interdiction. Our Attorney General has also been a strong voice in spreading the word regarding the horrendous exponential growth of this uncontrolled epidemic. It is little wonder that we need to explore and utilize every avenue available to overcome this domestic problem, and bring the opioid epidemic under control. When we realize that fentanyl is manufactured in China and Mexico, and enters the US easily via borders that are wide open to its importation including from China to Canada to the U.S. Do we realize that a huge supply of fentanyl can reach us through birthday cards?

Have we thus done all we can? No Way. We have not done much at all to educate the young people of America to never start taking opioids. That a first try of an opioid may be their last. That late teens through twenties is an age of unreasonable reason, and virtually nobody can beat "The Tiger" alone.

Education of Millenials is a Critical Need

Bethany is a fictional 19 year old first-time user tempted to try heroin by addicts who are skilled at making the experience appear attractive and safe, fueling their own addiction. Her story is designed to deter temptation and emphasize the real danger and vivid results an overdose can cause, even with a first time experience. Bethany's story is available on the MMA website at www.mainemed.com.

SPECIALTY SOCIETY MEETINGS

February 16, 2017

Maine Medical Association– Manchester, ME – 6:00pm – 8:00pm

Maine Association of Psychiatric Physicians Executive Council Meeting

Contact: Dianna Poulin at 207-480-4194 or dpoulin@mainemed.com

February 25-26, 2017

Sugarloaf Mountain Hotel & Conference Center – Carrabassett Valley, ME

Maine Society of Anesthesiologists Annual Winter Business Meeting

Contact: Anna Bragdon at 207-441-5989 or mesahq@gmail.com

March 8, 2017

Grand Summit Hotel – Sugarloaf, ME – 6:00pm

Maine Chapter of the American College of Emergency Physicians Chapter Meeting (Held in conjunction with the Emergency Medicine Winter Symposium)

Contact: Maureen Elwell at 207-512-6108 or melwell@mainemed.com

March 17-19, 2017

Sugarloaf Mountain Hotel and Conference Center – Carrabassett Valley, ME

ME Section of the American Congress of Obstetricians and Gynecologists Winter Meeting and Symposium

Contact: Dianna Poulin at 207-480-4194 or dpoulin@mainemed.com

March 29-April 1, 2017

Hilton Garden Inn – Freeport, ME

25th Annual Family Medicine Update & Annual Meeting

Visit www.maineafp.org for brochure and registration.

Contact: Deborah Halbach at 207-938-5005 or maineafp@tdstelme.net

April 25, 2017

Maine Medical Association– Manchester, ME – 5:30pm – 8:30pm

Maine Chapter of the American Academy of Pediatrics Board Meeting

Contact: Dee Kerry at 207-480-4185 or dakerry@aap.net

April 27, 2017

Hilton Garden Inn – Freeport, ME – 5:30pm – 6:00pm

Maine Association of Psychiatric Physicians Executive Council Meeting

Contact: Dianna Poulin at 207-480-4194 or dpoulin@mainemed.com

April 27-28, 2017

Hilton Garden Inn – Freeport, ME

11th Annual Spring Meeting & Program of Maine Association of Psychiatric Physicians

Topic: Current Advances in Psychiatry

Contact: Dianna Poulin at 207-480-4194 or dpoulin@mainemed.com

May 6-7, 2017

Sable Oaks Marriott – Portland, ME – 8am – 4pm

Maine Chapter of the American Academy of Pediatrics Spring Conference

Contact: Dee Kerry at 207-480-4185 or dakerry@aap.net

May 12, 2017

Brunswick Hotel & Tavern, Brunswick, ME 12:00pm – 5:00pm

Maine Society of Eye Physicians and Surgeons Spring Educational Program & Business Meeting

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

Jo Linder, M.D., and Robert Bing-You, M.D. welcome the class of 2020

Tufts University School of Medicine – MMC Program Class of 2020

Kaitlyn Bergeron – Shapleigh, ME – Northeastern University – *Donald & Nancy Morse Endowed Scholarship Fund*

Mark Broadwin – Concord, MA – Colby College

Corinne Carland – Shapleigh, ME – Massachusetts Institute of Technology – *Curran Family Endowed Scholarship Fund*

Elena Cravens – Winterport, ME – Wellesley College – *Richard & Rakia Hatch Endowed Scholarship Fund*

Michael Delucia – Norwich, VT – Middlebury College

Eli Dibner-Dunlap – Cleveland, OH – Skidmore College

Gabrielle Donahue – Cape Elizabeth, ME – Colby College – *MMC General Scholarship Fund*

Jessica Evans – Van Buren, ME – Bowdoin College – *Doctors for Maine's Future Program*

James Finney – Kingston, NH – Dartmouth College

Sydney Ford – Brunswick, ME – University of St. Andrews, Scotland

Jodi Forward – Sherborn, MA – Colgate University

Eliot Gagne – Gorham, ME – University of Maine – *Richard & Rakia Hatch Endowed Scholarship Fund*

Laura Getchell – Raymond, ME – Wesleyan University – *Suffolk Endowed Scholarship Fund*

Alexandra Grzywna – Framingham, MA – Wellesley College

Ben Guido – Montville, ME – Colby College

William Hirschfeld – Hopkinton, NH – Dartmouth College

Samuel Lloyd – Yarmouth, ME – Boston College

William Long – Littleton, CO – Regis University

Micah Ludwig – Waldoboro, ME – Bowdoin College – *Doctors for Maine's Future Program*

Owen Maguire – Amherst, MA – Northeastern University

Anna Martens – Scarborough, ME – Muhlenberg College – *Burke Family Endowed Scholarship Fund*

Hannah Martin – Yarmouth, ME – Swarthmore College – *Women's Board Endowed Scholarship Fund*

Lauren McAllister – Bethel, ME – Bates College – *Bingham Scholarship Fund*

Parker Merrill – Brunswick, ME – University of Virginia – *Dean L. Fisher Scholarship Fund*

Robert Michaud – Limington, ME – Saint Joseph's College of Maine – *Boulos Asset Management Scholarship Fund*

Antigone Mitchell – Candia, NH – Bowdoin College

Grace Mueller – Edwardsville, IL – University of Southern Maine

Kelsey-An O'Neil – Cumberland, ME – University of Southern Maine – *Dean L. Fisher Scholarship Fund*

Jacqueline Ordemann – Groton, MA – Bates College

Brianna Philbrick – Brewer, ME – Boston College – *Doctors for Maine's Future Program*

James Poulin – Lewiston, ME – University of Maine – *Marjorie Higbee Saunders, RN, BSN & Henry W. Saunders Endowed Scholarship Fund*

Samuel Poulin – Readfield, ME – Colby College – *Medical Mutual Insurance Co. of Maine Scholarship Fund*

Zachary Radford – Tuftonboro, NH – Bates College

Sheila Rajan – Orrington, ME – Colby College – *Tower Society Endowed Scholarship Fund*

John Royal, II – Ellsworth, ME – University of Maine – *MMC General Scholarship Fund*

Nabil Saleem – Alpharetta, GA – Bates College

Jennifer Scontras – Saco, ME – Brandeis University – *MMC General Scholarship Fund*

MEDICAL PROFESSIONALS HEALTH PROGRAM

Though the Medical Professionals Health Program (MPHP) has been in existence and serving physicians for 30 years, the nature of addiction and mental health illness have meant that many may be unaware of the life-saving and life-changing services available. On this 30th year, the MPHP is committed to working to celebrate the hard work of those who have contributed to building a strong assistance program and the many physicians and other medical professionals who are living strong healthy lives and serving our communities safely and effectively as a result of their own commitment to treatment and sobriety.

Myth: The MPHP is an arm of Maine's licensing boards.
Fact: The MPHP is an alternative reporting program for health professionals who might otherwise be reported to a licensing board. It is a program of the Maine Medical Association that contracts with the Maine licensing boards to assist with treatment and provide monitoring services to licensed professionals. In this way, MPHP is an alternative to discipline, offering physicians and physician assistants an opportunity to get treatment services in lieu of legal and/or licensure action by the board.

Myth: The actions of the MPHP are as much a form of discipline as board action.
Fact: The objectives of MPHP are to help medical professionals with their goals of getting well and returning to active practice. Monitoring agreements with the MPHP are rigorous and demanding which may at times feel punitive. There are however, distinctive differences.

- Each MPHP requirement is uniquely designed to address the medical professional's medical and clinical addiction and mental health needs, resulting in reduced incidents of relapse among participating professionals
- The toxicology testing objectively documents the participant's sobriety
- The collateral reporting is important documentation of the participant's wellness efforts from different perspectives
- Participants who engage with MPHP and are compliant with MPHP requirements are able to maintain confidentiality, avoiding board action and discipline.

Myth: MPHP services are only for professionals with substance use illnesses.
Fact: Within the last five years, MPHP has developed a behavioral health track for professionals who struggle professionally and personally but are not diagnosed with a substance use illness. It was a logical extension of our services since many medical professionals with substance use illnesses also have untreated mental health disorders like depression, bi-polar disorder, anxiety or PTSD. The evaluators, psychiatrists and therapists used by MPHP participants are adept at identifying and helping medical professionals with mental health disorders.

Myth: Referring a colleague is a betrayal of trust and professionalism.
Fact: Being appropriately treated for mental health and substance use illness is a gift. Substance use illnesses and mental health illnesses are often progressive. Allowing a colleague's illness or distress to remain untreated or be self-treated can result in profoundly greater consequences at a later date. Many who come to the MPHP for services feel that they have suffered the effects of their illness too long and are relieved to finally have appropriate treatment. This delayed referral is a pattern we are hoping to change in the coming years.

John C. Dalco, M.D. House in Manchester, Maine.

The work we do is saving lives, but we need the assistance of all medical professionals to ensure that intervention takes place early in the disease process. Healthcare supports appropriate treatment opportunities and medical professionals who return to work following intervention are treated with support and compassion.

To learn more about the MPHP, please visit our website at www.mainemphp.org or call us at 207-623-9266.

MMA Annual Appeal

Thank you to the following individuals who contributed to MMA's Annual Appeal. Contributors chose what they wanted their contribution to go towards (MMA Long Term Development, MMA Building, MMET General Education, MMET Scholarships, or MMEF Loans). Contributions totaled $9,194 for 2016.

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Medication Reconciliation: A Risk Management Process for Avoiding Adverse Drug Events

Medication reconciliation is a formal process of obtaining a complete and accurate list of each patient's home medications including name, dosage, frequency, and route. The list is then used to guide drug choice throughout the health care system and is included in the electronic health record (EHR) or paper chart. Medication reconciliation involves comparing the patient's current list of medications against the physician's medication orders for that patient at all transitions in care, e.g., admission, unit transfer or inter-hospital transfer, step-down care transfer, or discharge to home.

Suggested Implementation Steps for the Medication Reconciliation Process

1. **Develop policies, protocols, and procedures which address the following:**
   a. Development of a patient home medication list.
   b. Comparison of the home medication list to the current list of physician orders.
   c. Prohibition of "blanket orders." "Blanket orders" are general prescriber directions that do not provide specific information about the medication therapy prescribed, e.g., "continue previous medications," "resume postoperative orders." Orders previously written must be written out in their entirety.
   d. Identification of timeframes for completing the medication reconciliation process.
   e. Identification and resolution of high-risk situations.
      - Patients on high-risk medications.
      - Patients on greater than five medications.
      - Specific interventions for elderly or compromised patients.
      - Review of discrepancies in medication orders.
      - Need for specialist consult.

2. **Adopt a standardized format for reconciling medications.**
   a. Patient identification.
   b. Allergy verification.
   c. Preparer/verifier's signature.
   d. Physician signature.
   e. List each medication.
      - Dosage.
      - Frequency.
      - Date/time of last dose.
      - Compliance with prescribed dosages and frequency.
   f. Other data.
      - Person providing information.
      - Patient weight.
      - Pharmacy contact.
      - Over-the-counter medications and herbals.
      - Compromising conditions.
      - Pregnancy/breast feeding.

3. **Assure primary responsibility for reconciling medications is assigned to a healthcare professional with sufficient expertise.**

4. **Assure the medication reconciliation list is easily accessible within the patient's EHR, or paper chart and that reconciliation of medication occurs.**

5. **Documentation expectations.**
   a. Educate the patient when new and unfamiliar medications are prescribed. Encourage feedback from the patient and require a return demonstration of instructions to assure patient understanding. Document the elements of this encounter in the record.

6. **Provide access to drug information.**

7. **Provide orientation and ongoing education to all healthcare providers.**

8. **Develop strategies to educate patients/families in monitoring medications and maintaining accurate medication lists. Require return demonstration and document. Document changes and provide patient with a copy of his or her current medication list.**

9. **Review the process for quality improvement.**
   a. Review a random sample of medical records each month.
   b. Encourage reporting of errors identified through the reconciliation process.
   c. Develop a strategy to share the results of the process.

10. **Other considerations for successful implementation:**
    a. Involve the facility where the patient resides, e.g., LTC, SNF, assisted living, ind0ependent living.

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.

Caution: Entering The Breach Zone©

By Jane Carpenter, founder of Maine Identity Services, LLC

After assisting data breach victims for more than a decade, we have learned something interesting: There is a human equivalent for the Bermuda Triangle. We've named it "The Breach Zone.©"

This roughly one square meter is the area that includes an individual's eyes and brain, the computer screen and their hand on a mouse when they are seated in front of a computer. And, as ancient maps proclaimed: *Hic sunt dracones*. Here be dragons.

In the Breach Zone, unexplained circumstances compel us to re-use the same password we have used on other sites we visit.

This is the area where, after apparently suspending our disbelief, we open attachments of unknown origin.

Becoming disoriented, we use the office computer to visit social networking websites or bring a computer containing private information to our local WI-FI cafe.

And just as in the Bermuda Triangle, before there is time to radio a distress signal, malware has entered the computer system and data has disappeared from the screen, like airplanes suddenly disappearing from radar.

In May, the Ponemon Institute released its Sixth Annual Benchmark Study on Privacy and Security of Healthcare Data and the findings are not good news for the medical community. Rather than data becoming more secure and breaches becoming less frequent, the opposite is true. Trafficking in stolen information is a high growth industry and medical practices are a target-rich environment.

According to statistics from the Identity Theft Resource Center, the healthcare category accounted for 71% of all compromised records during the first quarter of this year. And employee errors are *still* the leading cause of data breaches.

So, what's the alternative? How do you ensure that your organization is navigating safely around the Breach Zone? The answer is simple: control the mouse.

Because so many data breaches originate at the employee's desktop, training staff in security and programs to promote awareness can have a profound impact on whether a data breach will occur. You may have invested thousands of dollars in technology to protect the information in your practice, but simply controlling the use of a $7 computer accessory may reduce your risk by as much as 70%.

"Controlling the mouse" also means instituting a culture of data security in your organization. This culture extends beyond the requirements set by federal and state regulation. And it also extends beyond the boundaries of your own practice to those businesses that support you.

Where do you begin? Here are some statements that may help you get started. Think of them as navigational aids to avoid the Breach Zone.

- Our employees' understanding of data security is part of their performance evaluation.
- We know (by name) who is in our offices at night.
- We have a policy concerning passwords.
- We know employees' password practices.
- We know what applications our employees download to their cell phones and tablets.
- We share employee records with third parties for payroll or benefits.
- Our employees never visit other web sites or use WI-FI environments when they are using our computers.

Jane Carpenter is the founder of Maine Identity Services, LLC, a veteran of the Maine Attorney General's Office and a member of the FBI-sponsored InfraGard organization. She trains police personnel and serves on the Advisory Committee of USM's Statistical Analysis Center, which informs Maine's criminal and juvenile justice systems. Over more than a decade, her expertise in identity theft and data breaches has resulted in new laws assisting victims of the crimes and her insight is regularly sought by lawmakers as they consider proposed identity theft and data breach legislation.

In addition to Data Breach: Day One©, Carpenter is the author of the Identity Theft Help Kit©, the Data Breach Repair Kit© and the Police Guide To Identity Theft© which provide assistance for victims and police and have been accepted by the U.S. Department of Homeland Security as authorized equipment under the Law Enforcement Terrorism Prevention Program.

Are You Ready To E-Prescribe? Find Out More About DrFirst and their E-Prescribing Products

July 1, 2017, is when Maine's new EPCS (e-prescribing controlled substances) law takes effect for the prescribing of opioids. Despite the limited application of the law, the benefits of e-prescribing are significant, which is why MMA encourages our members to implement e-prescribing technologies in their practices now instead of waiting for the legislative deadline.

To save you the time of vetting potential vendors and offer you another tangible membership benefit, we have chosen DrFirst as our preferred e-prescribing platform and negotiated a generous discount for MMA members. DrFirst offers a superior clinical workflow that is easy to use and affordable (especially with the discount we have negotiated for MMA members). Their package includes Rcopia® for legend drug e-prescribing, EPCS Gold 2.0℠ for controlled substance e-prescribing, and iPrescribePro℠, an app for mobile e-prescribing. (See informative product brochure inserted in this edition of *Maine Medicine*.)

Aside from legend drug and controlled substance e-prescribing within one workflow, you'll also get

- 24 months of patient medication history
- real-time benefit check (formulary data, drug cost, suggestions for cheaper alternatives)
- clinical alerts (e.g., duplicate therapy and allergy warnings)
- one-on-one guidance through DEA identity proofing and authentication
- patient adherence monitoring
- electronic prior authorization

For more information, MMA members can visit DrFirst's website at www.drfirst.com/mainemed/ and/or contact DrFirst's Eric Landry, a New Gloucester resident, at 888-481-4303.

Maine Medical Association

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