Maine Medicine

MMA STEPS UP TO ADDRESS STATE’S OPIOID/HEROIN PROBLEM

As directed by members in a Resolution passed at the Annual Meeting in September, the Maine Medical Association is engaged in a number of activities intended to address the state’s serious drug abuse epidemic, particularly the growing use of heroin. Most recently, MMA supported L.D. 1537 which was signed into law on January 20. The $3.7 million package included $1.2 million to help fund new positions within the Maine Drug Enforcement Agency and an additional $2.5 million for various treatment options, including $500,000 to establish and operate a new drug detoxification center in northern or eastern Maine. Some of the treatment money also will fund projects run by jails or local police departments to help connect individuals with substance use disorders with treatment resources.

On Jan.21, the Association presented its third of six educational programs for prescribers focusing on the Prescription Monitoring Program (PMP). Association leaders remain alarmed with recent data showing that only 7% of prescribers registered for the PMP are using it regularly (regularly being considered using it at least once per month). Over 400 health care practitioners attended the program in South Portland (see accompanying photos). Upcoming programs of a similar nature will occur on March 11 at MMA in Manchester (9:00am to noon) and on March 3rd at Mercy Hospital (Medical Staff meeting).

MMA has also been instrumental in the creation of the Task Forces in the state which are focusing on the opioid/heroin issue. Called the Maine Anti-Opiate Initiative, the effort is led by U.S. Attorney Thomas Delahanty, Attorney General Janet Mills and Commissioner of Public Safety John Morris. There are a dozen physicians spread across the three Task Forces which are organized around the topics of Treatment, Prevention/Harm Reduction and Law Enforcement. The Task Forces will make recommendations to policy makers after conducting ten Community Forums across the state. Physicians on the Task Forces include Rebecca Chagrasulis, M.D., Lani Graham, M.D., MPH, Chris Pezzullo, D.O., Matt Sholl, M.D., David Mitz, M.D., Meredith Norris, D.O., Mary Dowd, M.D., and Steve Diaz, M.D.

Since 2003, MMA has presented over 50 CME programs on the topic of prescribing for pain and preventing diversion and addiction. These programs will continue indefinitely. In addition, MMA's academic detailing program is currently presenting a module on prescribing for pain.

Compromise Achieved on Midwifery Legislation

In late December, following nearly a year of bi-weekly facilitated meetings, The Maine section of the American Congress of Obstetrics and Gynecology, the American College of Nurse Midwives, Maine Chapter; the Maine Association of Certified Professional Midwives and the Maine Medical Association and the Association of Women’s Health, Obstetrics and Neonatal Nurses (AWON) Maine came to agreement on proposed legislation (L.D. 690) which would establish a licensing board in the state for Certified Professional Midwives (CPMs) who attend home births or births in one of the three birthing centers in the state. Assisted by a grant from the AAM/National Medical Society Scope of Practice Partnership, this effort to achieve agreement among previously opposed organizations was watched very carefully across the country. As the Commissioner of the Department of Professional and Financial Regulation opposes the legislation, it is not certain as of this writing whether the bill can pass this session. The bill’s sponsor is Senator Amy Volk, (R, Scarborough). Twenty nine states currently license Certified Professional Midwives.

MACRA: The Good, The Bad, The Ugly

The Medicare, Access and Children’s Health Insurance Program Reauthorization Act of 2015 replaced the sustainable growth rate (SGR) formula which previously controlled physician payments under Medicare. The law enacted in 2015 represents the most significant changes to Medicare’s provider payment methodology since 1977 when the SGR was first introduced in an effort to slow the growth of healthcare costs. The SGR eventually proved to be a colossal problem for physicians and caused considerable payment uncertainty the past decade. Given the absolute necessity of permanently repealing the SGR formula, most medical organizations, including the American Medical Association, supported MACRA, believing that it would at least provide more predictability in provider payment.

A two-sided one page insert with this issue of Maine Medicine contains details of the new law which is intended to move Medicare from a primarily fee-for-service payment system to one based upon value-based payment. This is no easy task!

Beginning in 2019, MACRA provides two payment models that encourage quality and efficiency. The first model is the Merit-based Incentive Payment System (MIPS) and it continues to rely primarily on fee for service payments, with annual 0.5% updates annually through 2019, at which time the base fee for the fee for service payments will remain at 2019 levels through 2025. In 2026, payment rates will increase by 0.25% annually. While some physicians oppose MACRA because of the failure of the key to keep pace even with inflation, there is every expectation that bills will be presented to the Congress seeking increased payments. And MIPS does provide physicians the opportunity to increase their payments beyond the base level through value-based performance. By 2019, MIPS will replace the following physician performance programs:

- Meaningful Use of EMR
- Physician Value-Based Modifier
- Physician Quality Reporting System (PQRS)

MIPS payments will be based on a composite performance score containing both positive and negative adjustments. The maximum penalty will start at 4.0% in 2019 and increase to 9% by 2022. The maximum reward during the same period will increase from 12% to 27%. For more details on the composite scoring, see the insert noted above.

The second and more complex methodology is called Alternative Payment Models (APMs) which are based on a risk-based approach to paying for medical care. These APMs are to be designed to incentivize quality and value for providers with a significant Medicare population. More details are included in the insert.

MACRA requires regulations to be drafted and implemented and CMS anticipates that proposed regulations may be issued as early as March, 2016 with final regulations expected in October, 2016. After final regulations are issued, CMS is committed to offer guidance and assistance to providers with respect to MIPS performance categories or in transitioning to the implementation of, and participation in, an APM. MMA will continue to report on these developments in Maine Medicine Weekly Update, published electronically each Monday.

Check out the inserts with this issue including the new MACRA Law and upcoming Educational Programs offered by MMA.
As I write this article, the Maine Legislature today has unanimously passed and the Governor signed LD 1537, a bill to address Maine’s addiction problem. The bill adds 10 new Maine DEA agents, a 10-bed detoxification facility and some funds for treatment of the insured population. Enforcement of drug laws is politically popular and probably was a necessary first step, but this bill does little to promote medication assisted treatment for addiction which has shown the best outcomes for long-term recovery.

I spent some time this fall reviewing the literature on addiction treatment while planning a small buprenorphine clinic as part of my direct primary care practice. There are mandatory training requirements for waivered physicians on addiction treatment and it is unconsionable to not promote this effective treatment given the current morbidity and mortality from addiction in Maine.

It’s quite easy for primary care physicians to get a DEA waiver to prescribe buprenorphine. A day spent on special CME at a conference or online suffices. Plenty of peer support is available for waivered physicians online and locally. More time and effort is needed to plan how to integrate addiction care into your office, train staff, etc. but this is also quite manageable. The physicians that I’ve interviewed who do this are very happy. We all see more than enough data supporting medication assisted treatment and it is unconscionable to not promote this effective, evidence-based care.

The Henry Ford Healthcare System, a Midwestern managed care program with over 200,000 members, represents the most widely heralded success story in the application of the principles of zero suicide. Through the implementation of the Perfect Depression Care program across their inpatient, outpatient and community care programs they saw a 75% reduction in suicide rates within 4 years during a time of generally rising suicide rates nationwide. The reduction in suicide rates has been maintained for more than a decade.

This particular program’s success was built upon a leadership-driven, system change in the approach to care where suicide prevention became a focus of care and part of the expectation for all staff, not just clinicians and medical providers. The success of a systemic approach to suicide prevention is increased where a system of care exists across outpatient, inpatient and community care. In a rural state like Maine, the effort may need to involve close working relationships across providers and organizations of half of people at increased risk.

Elements of a Zero Suicide Approach:

- Creating a leadership-driven, safety-oriented culture that commits to dramatically reducing suicide among people under care.
- Systematically identifying people at risk and assessing suicide risk levels using standardized instruments.
- Ensuring every person has a pathway to care that is both timely and adequate to meet their needs.
- Developing a competent, confident, and caring workforce through training and support.
- Using effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality.
- Ensuring active follow-up contact and support, especially after acute care, for those identified as at increased risk.
- Applying a data-driven quality improvement approach to inform system changes leading to improved patient outcomes.

What you can do:

The National Action Alliance and the Suicide Prevention Resource Center have developed a toolkit for implementation of a zero suicide approach which can be reviewed at http://zerosuicide.sprc.org/toolkit. The toolkit includes extensive trainings and support documents as well as workshops to support an organization in assessing readiness and taking the steps to implement the approach. Included are also online trainings and examples of evidence-based assessment tools and practices for use.

The Maine Suicide Prevention Program strongly supports the integration of suicide prevention and management practices across healthcare systems. NAMI Maine and the Maine Medical Association are working in partnership to provide training and technical assistance in support of suicide prevention in medical and behavioral health practices and organizations across Maine.

For more information or to explore training opportunities, contact Matthew Bray, Suicide Prevention Training Coordinator at 622-5767 or mbray@namimaine.org. For content questions about suicide prevention, contact Greg Marley LCSW, Clinical Director, NAMI Maine (gmarley@namimaine.org), and to learn about the First Friday program on Suicide Awareness and Prevention in Primary Care on April 1st at MMA, contact Dee Kelly DeHaas (ddehaas@mainemed.com).
I hope all our members and other readers enjoyed the holidays and are healthy and looking forward to 2016. It was a busy time at MMA with year-end responsibilities that need to be completed, preparation for the legislative session and activities responding to the state’s opioid/heroin crisis. In addition to being active participants in the Task Forces focusing on Treatment and Prevention/ Harm Reduction, MMA has also received grants from the Maine Health Access Foundation (MehAF) and the Maine Community Foundation (MCF) to organize and facilitate ten Community Forums throughout the state. Please try to attend a Forum in your area as it is important for physicians to be part of this critical conversation. Dates and locations for the forums will be included in the Weekly Update and on the MMA website.

MMA has big plans for 2016, beginning with a Board Retreat January 22-24 in Portland. At the Retreat the Board will update its strategic plan, discuss increasing MMA presence on social media platforms and schedule more members “listening” sessions. The three listening sessions in 2015 (Augusta, Camden, and York) were all well attended and elicited many positive comments from both members and leadership. If you would like to assist with a listening session in your area, just let me know. Another new initiative involves inviting specialty society leaders to meet with the MMA Board following MMA Board meetings. I personally very much look forward to these discussions.

In all, MMA begins 2016 in a strong position. We have the most members we have ever had, a very engaged set of officers and Board of Directors and a balanced budget. And we have a very experienced and hardworking staff of fifteen individuals dedicated to serving Maine’s physicians. This is a very demanding time for Maine’s physicians and we want you to know that we are here for you. We have your back so never hesitate to let us know how we can help you.

As I begin my 23rd year as MMA’s Executive Vice President and my 36th year overall with the Association, I have never been more confident in the future of the Association and its ability to respond to the many challenges you and your patients face every day. Thank you for your support.

Please feel free to communicate with me at any time about anything. Best means to do that is through email at gsmith@mainemed.com or by calling me at the office at 622-3374 ext. 212 or on my cell phone at 215-7461.

STEPs WE CAN TAKE

What can we do? A lot.

• First of all, individuals suffering from substance use disorders deserve our compassion, empathy and respect. This disorder is a chronic disease and should be treated as such. These patients will struggle with the illness for the rest of their lives. Stigma about drug abuse is one of the biggest challenges to both addiction treatment and overdose prevention.

• Secondly, more state and federal resources need to be dedicated to both treatment and prevention.

While the hiring of more drug enforcement agents, as proposed by Gov. LePage, may have an impact on the supply of heroin coming into the state, other drugs will replace it as long as the demand is there. This problem requires a comprehensive approach. Fortunately, several initiatives are intended to address the problem.

The recent establishment of three task forces focusing on treatment, law enforcement and prevention and harm reduction has brought together dozens of volunteers dedicated to finding solutions.

These task forces were established by and have the support of Attorney General Janet Mills, Public Safety Commissioner John Morris and Thomas Delahanty, U.S. Attorney for the District of Maine. Legislative leaders have stated that the second session of the 127th Legislature will focus on the opioid-heroin problem. The problem is now getting the attention it deserves.

We’re proud to have you on the team, Mark.
QC 2016: Connecting Clinic and Community

In earlier columns, I have urged MMA readers to consider our role as physicians to not only deliver health care, but to improve the overall health of our patients and communities. At this year’s annual QC conference, QC 2016, “Taking it to the Streets: Building Clinical and Community Connections,” we will again be challenging attendees to explore new opportunities to prepare for, and meet, the challenge of delivering health.

It appears we are not alone in this quest: the Centers for Medicare and Medicaid Services (CMS) recently announced a new $157 million effort to pilot its “Accountable Health Communities” model in 44 communities to help physicians and practice teams identify and address social service needs that often stand in the way of better health outcomes, sending a powerful signal that it expects the high-value health care providers of the near future to partner with community organizations to address patients’ social and economic barriers to good health.

Specifically, CMS says that the Model will “test whether screening beneficiaries for health-related social needs and associated referrals to and navigation of community-based services will improve quality and affordability in Medicare and Medicaid. Many of these social issues, such as housing instability, hunger, and interpersonal violence, affect individuals’ health, yet they may not be detected or addressed during typical health care-related visits.”

Like the Institute for Healthcare Improvement’s “100 Million Healthier Lives” campaign and other recent initiatives, this new CMS Accountable Health Communities Model suggests that our profession will soon be encouraged, and even incented, to not only deliver health care but to deliver health itself.

This year’s QC conference will be held on April 6th at the Augusta Civic Center and will offer keynote speakers and 23 breakout sessions to help clinicians and practice teams build capacity and connections needed to help address the social determinants of your patients’ health. You’ll meet organizations that can help your patients make better food choices and remove financial barriers to high-cost medications. You’ll learn about innovative clinical/community partnerships, like St. Mary’s Hospital working with Bath Iron Works to reduce employees’ diabetes risk.

And you’ll hear from national health care thought leaders including Dr. Leana Wen, Baltimore’s innovative new health commissioner, a leader in the effort to address the national crisis of heroin and opioid addiction.

To get details on all the QC 2016 breakout sessions and speakers, please visit mainequalitycounts.org. While there, make sure to register before February 29th to receive an early-bird discount.

The transition from delivering health care to delivering health care and health is well under way. Join me and Maine’s entire health care community on April 6th to discover how you can leverage this movement to improve not just the health care, but the health of your patients.

Visit the mma website: www.mainemed.com

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**Legislative Update: 127th Maine Legislature’s Second Regular Session Features Bills Addressing State’s Opioid Abuse Epidemic**

The Second Regular Session began on January 6th and is scheduled to conclude in mid-April. By then the political focus will turn to the 2016 election campaigns for Governor, Maine’s two seats in the U.S. House of Representatives, and all 186 seats in the 128th Maine Legislature. During January, legislators’ attention was focused on L.D. 1537 addressing opioid abuse and, briefly, a failed effort in the Democratic House of Representatives to establish a House Special Investigative Committee (H.O. 34) that could have led to impeachment proceedings against Republican Governor Paul R. LePage.

Maine’s opioid abuse problem is one of the most significant health policy issues before legislators during the 2016 session. On January 5th, the day before the opening day of the session, the Appropriations & Financial Affairs Committee held a public hearing on L.D. 1537, An Act To Combat Drug Addiction through Enforcement, Prevention, Treatment and Recovery, a bill submitted by the Senate President and Speaker of the House. The MMA joined many other advocacy groups and individuals affected by addiction to support the bill with testimony from Lara Graham, M.D., M.P.H. Dr. Graham has a unique perspective on addiction as a former state public health officer, Co-Chair of the MMA Public Health Committee, Director of the Maine Medical Professionals Health Program, and member of the Prevention & Harm Reduction Team of the Maine Anti-Heroin/Health Program, and member of the Prevention & Treatment and Recovery committee. She also recently testified in support of a bill submitted by Senator Thomas Saviello (R-Franklin) on his bill carried over from the first session, L.D. 633, An Act To Improve the Health of Maine Citizens and the Economy of Maine by Providing Affordable Market-based Coverage Options to Low-income Uninsured Citizens in an effort to craft a bill that can gain sufficient bipartisan legislative support to override a gubernatorial veto.

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. The Legislative Committee conducts conference calls to review new bills and to provide updates on legislative activity every Tuesday evening at 8:00 p.m. during the session. Any interested member or staff person is welcome to participate. Please see each week’s Maine Medicine Weekly Update for conference call information.

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/.

Lastly, the MMA continues its important role as a member of the Steering Committee of the Cover Maine Now coalition (www.covermainenow.org) advocating the acceptance of federal funds available under the Affordable Care Act (“ACA”) to provide health care coverage for approximately 70,000 needy Mainers. The Coalition is working with Sen. Tom Saviello (R–Franklin) on his bill carried over from the first session, L.D. 633, An Act To Improve the Health of Maine Citizens and the Economy of Maine by Providing Affordable Market-based Coverage Options to Low-income Uninsured Citizens in an effort to craft a bill that can gain sufficient bipartisan legislative support to override a gubernatorial veto.

Legislative Update: 127th Maine Legislature’s Second Regular Session Features Bills Addressing State’s Opioid Abuse Epidemic

You can find a list of new bills approved by the Legislative Council for consideration during the second session on the web here: http://legislature.maine.gov/uploads/originals/legislative-council-accepted-r2-bills-1-8-16.pdf.

The MMA also will be involved in the debate this year about the following key bills carried over from the 2015 session:

1. L.D. 690, An Act To Ensure the Safety of Home Birth – Sen. Volk (R-Cumberland) (proposed to license Certified Professional Midwives);
2. L.D. 1305, An Act To Encourage Health Insurance Consumers To Comparison Shop for Health Care Procedures and Treatment – Sen. Whittome (R-Somerset) (proposa) on transparency of health care cost and quality data, identification of certain health care services for which patients might be incentivized to “shop”;

The legislation also will consider the following new bills on this topic:

1. L.D. 473, Resolve, to Increase Access to Opiate Addiction Treatment in Maine – Sen. Woodsome (R-York);
2. L.D. 1488, An Act to Establish the Law Enforcement Assisted Diversion Program in Maine – Rep. Dion (D-Portland);
4. L.D. 1534, An Act to Reduce the Trafficking of Illegal Drugs in the State – Sen. Burns (R-Washington);

**SAVETHEDATE**

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Delivering quality diagnostic imaging services at centers and hospitals throughout Maine and the surrounding area.

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**MMA’s 13th Annual Golf Tournament**

**July 11, 2016**

Augusta Country Club
Manchester, ME

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

**THANKS TO 2016 SUSTAINING MEMBERS**

Thank you to the following individuals and practices which have chosen to support the MMA’s long-term growth by renewing at an additional sustaining membership level.

Stephen Babirak, MD
Aziz Massaad, MD
Michael Parker, MD
Michael Szela, MD
William Zolper, MD
Central Maine Orthopaedics
Coastal Women’s Healthcare
InterMed
Northern Maine Medical Center
Plastic & Hand Surgical Associates

**Don’t be the Last to Know**

We live in challenging times – HIV, Ebola, tax scams and identity theft. Stay current by making sure you can get information quickly. Provide the MMA with your email address – and notify us when that address changes.

Don’t miss out on urgent, time-sensitive announcements. Take time now to send your current email address to the MMA’s Membership Director, Lisa Martin at lmartin@mainemed.com.

Prefer online communication? If you would like to receive only Maine Medicine Weekly Update, the online newsletter from MMA, and not this printed publication, we’re happy to make that change for you. Again, email Lisa at lmartin@mainemed.com to advise of your preference or give us a call at 207-622-3374 ext: 221.

**2015 Update of Physicians’ Guide to Maine Law Now Online**

The Physicians’ Guide to Maine Law, 2015 Edition, is now online at www.mainemed.com. The guide was completely updated after the 2015 session of the Maine Legislature and now includes all the relevant laws that went into effect in October 2015. When you have a question on what Maine law is on a particular topic, the Physicians’ Guide is the first place you should turn. Topics are arranged in alphabetical order, and discussions are written in “non-legalese” that is easily understandable without going to law school.

Check it out, and let us know what you think!
Health Insurance Marketplace Information for Patients and Physicians
By Susan Kring, ACA Outreach Coordinator

Health Insurance Marketplace Open Enrollment for 2016 has ended.

The Open Enrollment period for 2016 insurance coverage through the Health Insurance Marketplace ended on January 31, 2016. Outside the annual Open Enrollment Period some consumers may qualify for a Special Enrollment Period (SEP) in 2016 to enroll in health insurance.

The Health Insurance Marketplace is designed to help consumers find affordable health insurance. Most people who qualify are eligible for some form of savings. Depending on household income, consumers may be able to get lower costs on monthly Marketplace health insurance premiums and out-of-pocket costs.

What is a Special Enrollment Period?
www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment

Consumers may qualify for a Special Enrollment Period (SEP) if they have had certain life changes such as getting married, having a baby, moving to a new coverage area, experiencing a major change in income, aging off a parent’s plan at age 26, or losing health insurance (but not if lost due to non-payment or voluntarily dropping coverage).

Reporting Life and Income Changes to the Marketplace

Life changes, such as getting married or having a child, may affect the amount of savings a consumer is eligible for. Consumers who have Marketplace coverage should report life and income changes to the Marketplace as soon as possible.

Taxes and the Marketplace
www.healthcare.gov/taxes

Consumers who enrolled in a health plan through the Marketplace and received premium tax credits in 2015 must file taxes even if they normally are not required to file, and will have to file a special form to report on their health insurance coverage and the amount of tax credit they received.

Health Insurance Marketplace information and enrollment assistance is available online, by phone, and in-person:
• Go to the Marketplace website at www.healthcare.gov for information and to apply online.
• Meet with a certified assister in your area. Find locations in Maine at www.enroll2017.com.
• Call the Health Insurance Marketplace Call Center at 1-800-318-2596.
• Call Consumers for Affordable Health Care’s toll-free HelpLine at 1-800-965-7476.

Marketplace Resources and Information
Thanks to a grant from the Maine Health Access Foundation, the Maine Medical Association has partnered with primary care practices to make Health Insurance Marketplace enrollment information available to patients. Contact Susan Kring at skring@mainemed.org if your practice is interested in partnering with MMA to distribute these materials, and to learn more about Marketplace resources, updates and training.

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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 207-337-4750 to subscribe.

PUBLIC HEALTH SPOTLIGHT
By Peter Michaud, J.D., R.N., Associate General Counsel

Physician Burnout

I’m burned out. Toast. Stressed out. Fried. Totally spent. Exhausted. Drained. I just don’t care anymore. What’s the use? There are plenty of ways to express the phenomenon of burnout, a physical or mental collapse caused by prolonged overwork, frustration, or stress.

The AMA reports physician burnout is the number one problem facing practicing physicians today. The Mayo Clinic reports, “From 2011 to 2014 physician burnout rates in US physicians increased AND the gap between physician burnout rates and burnout rates in the normal population widened.” Thirty-nine percent of physicians in the study screened positive for depression, and the rate of suicidal ideation among physicians jumped from 4.0 – 7.2 percent. Fifty-four percent reported at least one symptom of burnout, compared to 29 percent of the general population.

Burnout can lead to practice and personal issues such as increased errors; reduced empathy for patients; reduced patient satisfaction; increased physician desire to leave practice; and substance abuse. Signs of burnout may include physical and emotional exhaustion, depersonlization (cynicism, sarcasm, detachment from patients), and an overall “bad attitude”), reduced sense of personal accomplishment or value in one’s work, and lack of self-care.

It’s no secret that the practice of medicine is becoming increasingly stressful. Workload is increasing. Physicians are feeling less in control of their workplaces, and workplaces are becoming increasingly chaotic. Time and money pressures abound. Less time can be spent on the more meaningful aspects of practice as more and more time must be spent on reporting and billing issues, with “third party interference” being a major cause of physician frustration. Many doctors say electronic medical records will improve patient care, but the currently available packages are difficult to use and interfere with patient care more than they help. “Meaningful use” regulations are seen as having negative effects on physician satisfaction. Two physician families double the work stresses that come with practice and are faced with managing and coordinating from a partner who is experiencing the same stresses. For newer physicians, student debt ranks high on the list of stresses.

Resilient people seem to suffer less from burnout and be better able to deal with the stressors of work and life. Resilience is a capacity to recover from difficulties, the ability to spring back from or react the effects of stress and come away whole. Resilience generally improves with age as we are exposed to challenges and learn to deal with life’s problems. One can also deliberately enhance resilience by learning self-management skills and connecting with the meaning and purpose in one’s life. The AMA has published a series of online modules called STEPSforward (www.stepstoward.org). They provide strategies to revitalize practice and improve patient care...and self-care, too. To further reduce your stress, CME credit is available.

Whether you’re a medical student, a resident, or a long-time physician, it’s never too early or too late to find new ways to improve your life and your practice and prevent burnout. You’re worth it!

Social Security Claiming Strategies, the New Rules
By Anthony Bartlett, CHFC, CASL, AEP

President Obama recently signed into law the Bipartisan Budget Act (“BBA”) of 2015 which prospectively eliminates the popular “file and suspend” with “restricted application” Social Security claiming strategy. The law is effective as of May 1, 2016. The changes primarily affect married workers, their spouses, and ex-spouses.

The “File and Suspend” has added thousands of dollars of additional income for some retirees who adopted it. The “File and Suspend” strategy provided some insurance in case Ricky has a heart attack before age 66 and age 70. If Ricky has a major stroke at age 69, then he can retroactively collect a lump sum of all of the monthly checks he would have received had he started at age 66.

The Change – And Who Can Still File And Suspend
To steal a line from Bob Dylan (who himself is on Social Security), “the times they are a changin’.

For anyone who is already using the File and Suspend strategy, the law doesn’t change anything; you can continue to use the strategy. For anyone who won’t reach age 66 by April 29, 2016, you are shut out. You won’t be able to File and Suspend in the future and receive the same benefits.

For individuals who will be 66 by April 29, 2016 (that is, your date of birth is April 30, 1950 or earlier), you can elect to File and Suspend – but only if you elect to File and Suspend by the April 29th deadline.

What To Do If You Are Still Eligible
Call your local Social Security office to make an appointment. While it is possible to file for retirement benefits online through SSA.Gov, there is no easy way to “File and Suspend” online. So do it at your local office.

Next, be sure to have done your homework prior to the meeting, or have a knowledgeable financial advisor join you. Social Security employees cannot provide advice, but they can help you complete the necessary paperwork if you know what you want to do.

Be prepared – because employing the wrong strategy or missing the April 29 deadline could cost you real money down the line.

For questions please contact Anthony Bartlett or Larry Perry (207) 775-6181 at Baystate Financial.

The “File and Suspend” Strategy Explained

Let’s say that husband and wife (Ricky and Lucy) are 66 years old and have been married for years. If Ricky starts to collect Social Security at age 66, then he can collect $1,800 per month. Lucy doesn’t have her own retirement benefits. They elect to collect one-half of Ricky’s benefit ($900) once Ricky starts to draw his Social Security.

But what if Ricky wants to keep working and not draw Social Security until age 70? Ricky knows that every year he waits to collect, his benefit increases until he starts taking it. So instead of getting just $1,800 per month starting at age 66, he chooses to take $2,449 per month starting at age 70. However, Lucy can’t collect anything until Ricky starts to collect.

With the File and Suspend strategy, Ricky and Lucy can have their cake and eat it, too. At age 66 Ricky Files and immediately Suspends – which enables Lucy to start collecting $900 per month right away and it allows Ricky to delay collecting his own benefit until age 70, when he’ll get $2,449 per month.

Even better, the File and Suspend strategy provides some insurance in case Ricky has a health change between age 66 and age 70. If Ricky has a major stroke at age 69, then he can retroactively collect a lump sum of all of the monthly checks he would have received had he started at age 66.
Free Statewide Prescription Assistance Program – Maine Rx Card

According to an article released by Drug Store News, the dispensing rate of generic medicines will increase from 88% to as high as 92% by year 2020. The IMS Institute for Healthcare Informatics is also predicting that 75 new medications will be introduced by the same timeframe – treating cancer, hepatitis-C, auto-immune disorders and heart disease among other illnesses. Patients may find themselves looking for assistance with prescription costs in the near future.

Physicians can help by educating their patients about the Maine Rx Card, which is a free statewide prescription assistance program. The Maine Rx Card was launched in an effort to make prescription medications more affordable for the uninsured, as well as the underinsured. The Maine Rx Card can be used for savings of up to 75% on prescription medications at more than 56,000 pharmacies nationwide.

The card discounts both brand and generic prescription medications for those individuals without prescription coverage. Additionally, those who have prescription drug coverage may still qualify and receive discounts on medications that meet the program’s requirements, and no age limitations.

Patients may visit https://www.mainemed.com/ to print a free Maine Rx Card. There, they can also search for participating pharmacies and compare medication pricing.

Physicians may request a supply of custom cards mailed directly to their office at no cost by contacting the program’s development director, Annie Bass, abass@mainerxcard.com.

1. Establish a standardized specimen collection process.
2. Utilize two patient specific identifiers when performing biopsies.
   • Request the patient state their full name and date of birth upon check-in.
   • Confirm the same two patient identifiers when accessing the patient’s medical record. Consider establishing an individual patient identifier, e.g., unique patient number.
   • Use printed labels with the patient specific information to identify all biopsy specimens and patient forms.
3. Prepare for biopsy.
   • Prepare the biopsy trays in an area separate from the biopsy procedure room.
   • Take only the biopsy tray(s) necessary for this procedure into the procedure room.
   • Label specimen containers and forms in the procedure room after the patient has entered the room. Never pre-label specimen containers and forms.
4. Implement a double check system which includes a “time out” for biopsies. In the procedure room:
   • Have the patient review the labels and confirm the information is correct.
   • Have the provider review the labels to confirm the labels match the patient’s profile and medical record.
   • Prepare the lab requisitions and specimen containers. Attach the labels.
   • Have the patient reconfirm the labels on requisitions and specimen containers.
   • Have the physician reconfirm that the labels match the patient’s profile and medical record.
   • Place the specimen containers and the requisitions in the appropriate transport package. Complete the specimen pick-up log and place the specimen in the designated pick-up area.
   • Note: labeling the transport packaging with the patient name and second identifier is not a substitute for proper labeling of the specimen containers. Laboratories cannot accept unlabeled specimen containers. CAP regulations require the specimen be rejected.
5. Track the specimen.
   • Establish a system that tracks the send out and receipt date of pathology specimens. Reconcile results not received within a reasonable timeframe.
   • Provide physicians with a report of any manual or computerized errors.
   • Provide the patient with a copy of the report.
   • Provide the provider with a copy of the report.

Results of Member SurveyMonkey Poll

Thank you to those members who took a moment to respond to the three brief questions sent recently via SurveyMonkey. Here are the results. The next quarterly sampling of member opinion will take place in April unless an unexpected need arises sooner by virtue of state house activity.

1. Do you support MMIC’s position opposing the proposed mergers of Anthem-Cigna and Aetna-Humana? 307 = YES 18 = NO
2. Given the state’s serious opioid/heroin problem, would you support a community-wide guideline for prescribing for pain in your community? 292 = YES 42 = NO
3. L.D. 622, to be considered during the upcoming legislative session would require physicians and all other “mandated reporters” of suspected child abuse and neglect to have periodic training on what it means to have this responsibility. Do you support or oppose such a requirement? 171 = SUPPORT 162 = OPPOSE
Health Law
Medical Professional Liability
Medical Professional Licensing
Medical Credentialing
Estate Planning, Wills & Trusts
Family Law
Real Estate Law
State & Federal Tax Planning

When it comes to providing great care with legal issues regarding your practice—or personal life—we're here for you. You can put your trust in our expertise, experience, and results-oriented focus.

Our team is here to keep you and your practice healthy.

when you need help with:

We're here for you when you need help with:

You and Your Practice Healthy.

You AND YOUR PRACTICE HEALTHY.

OUR TEAM IS HERE TO KEEP

SUFFERING IN SILENCE: WILLS - EKBOM DISEASE

Do you have patients whose legs feel like shattered glass inside, necessitating getting up and walking around and stretching? Or being adversely affected during air travel, long auto rides, and while attending concerts or shows? Perhaps you yourself have this mysterious and invisible disease, Restless Legs Syndrome, and would like to affiliate with this long-standing and newly reinvigorated group.

Southern Maine Restless Legs Syndrome Support Group
April meeting from 7 to 9 p.m. Wednesday, April 20, 2016 at the Unitarian Universalist Church, 524 Allen Avenue, Portland.

Insomniacs, friends and family who may have underlying undiagnosed restless legs are welcome.

Attendees will share experiences with augmentation of dopamine agonists, non-dopamine medications, alternative medicine, cannabis, and other treatment regimens. A list of physicians in Maine treating RLS is being compiled. The group is gathering data on causes, onset, and concomitant diseases or conditions.

For more information and to RSVP:
Lindy Hough 510 508 8163
207 747 4709
soMaine@RLSgroups.org
lh@lindyhough.com

Beyond the Headlines: What Psychiatry and Primary Care Need to Know about Substance Use Disorders
8-4:30 p.m., April 29, 2016
Hilton Garden Inn, Freeport, Maine

US Senator Angus S. King, Jr. will join us for luncheon presentation and he will talk about:
Combatting Maine’s Opioid Epidemic: A Discussion about Curbing the Drug Crisis

There will be a full-day of presentations with distinguished speakers.

For more information and to register, go to MAPP’s website at www.mainepsych.org or call 207-622-7743.