JULY/AUGUST/SEPTEMBER 2013

Maine medicine

MAINE MEDICAL ASSOCIATION
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ASSOCIATION

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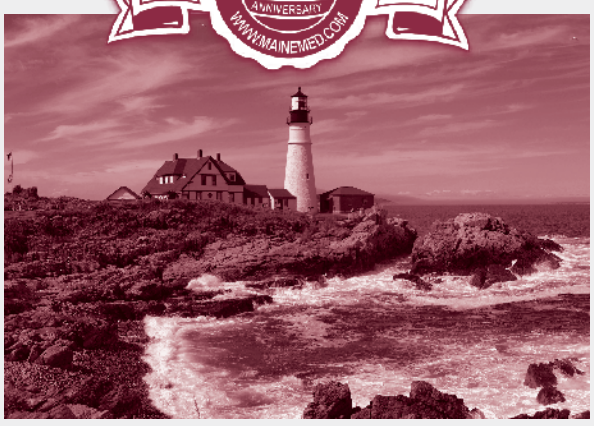
Bob Charest Band



MMA runners eagerly await competitors for the 33rd Annual Edmund G. Hardy Road Race, 7:00am on October 6, 2013

Maine Medical Association

160th Annual Session
The Changing Face of Medical Education
Undergraduate, Graduate and Post Graduate CME

October 4-6, 2013
Holiday Inn By the Bay, Portland, Maine

The Maine Medical Association invites you and your colleagues to attend this year's annual program focused on **THE CHANGING FACE OF MEDICAL EDUCATION: Undergraduate, Graduate and Post Graduate CME.**

We are excited to open the CME program Friday afternoon, October 4th at the Holiday Inn By The Bay with keynote presentations by Edison Liu, MD, PhD, President and CEO of The Jackson Laboratory on *Genomic Literacy in Maine* and Peter Bates, MD, Senior Vice President, Medical and Academic Affairs, Chief Medical Officer and Academic Dean for the Maine Medical Center - Tufts University School of Medicine. Dr. Bates will present on *The Changing Face of Medical Education.* Tours of the Hannaford Center for Safety, Innovation and Simulation at MMC Brighton Medical Center are also scheduled.

On Saturday morning, the MMA General Membership Session will be held in the State of Maine Grand Ball Room. MMA members who graduated from medical school in 1963 will be recognized with 50-year pins. The afternoon CME program will feature competing presentations by residents.

The Saturday evening events will start with the President's Reception at the Portland Museum of Art, followed by the MMA 160th Anniversary Gala, including award presentations and the traditional passing of the gavel from MMA President Dieter Kreckel, MD to President-elect Guy Raymond, MD. Following the program, we will be dancing to the music of the popular Bob Charest Band.

Bright and early Sunday morning begins with the 33rd Annual Edmund G. Hardy, MD Road Race. The closing CME session will be the *History of Medicine in Maine* by Richard Kahn, MD.

We look forward to you joining us for this event and the celebration of the 160th MMA Anniversary. You may register online at http://www.mainemed.com/cme-education-info/annual-session.

LEGISLATIVE UPDATE

126th Maine Legislature Adjourns First Regular Session *Sine Die*; Relationship With Governor Remains Contentious To The End

The 126th Maine Legislature completed the work of its First Regular Session at the State House in Augusta in the early morning hours of July 10, 2013. Tension between Republican Governor Paul LePage and the Democratic legislature was evident at the beginning of the session in January and remained so throughout the session over policy issues ranging from the FY 2014-2015 biennial budget (L.D. 1509), payment of the MaineCare hospital debt (L.D. 1555), drawing down additional federal dollars under the Affordable Care Act (ACA) for increased MaineCare coverage (L.D. 1066) to various personal squabbles between the Governor and the legislative leadership. By the end of the session, Governor LePage had vetoed a record 83 bills with the majority of them being sustained. Legislators will return to Augusta for their Second Regular Session on the first Wednesday after New Years Day 2014. The MMA thanks Amy Madden, M.D. for her strong leadership of the Legislative Committee during this session and also thanks all members and friends who participated faithfully in the weekly Legislative Committee conference calls.

EVP Gordon Smith and Deputy EVP Andrew MacLean both ran the International Bay of Fundy Marathon in June. Andy finished slightly ahead of Gordon, by about two hours!

Among the three most prominent health policy matters debated by the legislature during the past session, the bill to secure payment of the $484 million MaineCare debt owed to Maine hospitals attributable to settlements for the years 2009-2012 (L.D. 1555) passed the legislature and is one of the relatively few bills signed by the Governor (most have become law without the Governor's signature). Representative Linda Sanborn's bill (L.D. 1066) to accept additional federal funds available under the ACA to increase MaineCare coverage for nearly 65,000 low-income Mainers failed (by two votes) to achieve sufficient Republican votes to override the Governor's veto. Finally, the legislature did muster a 2/3 majority to override the Governor's veto of the FY 2014-2015 biennial budget (L.D. 1509), a unanimous bipartisan compromise from the Appropriations Committee. The biennial budget compromise included a number of cuts to health care programs, including a 10% cut in MaineCare outpatient hospital reimbursement. But, the Appropriations Committee process moderated the health care cuts in the Governor's initial proposal by, for example, avoiding a cut in MaineCare reimbursement for Critical Access Hospitals from 109% to 101% of costs.

The Insurance & Financial Services Committee (IFS) continued to discuss aspects of health insurance exchange (marketplace) implementation under the ACA in Maine, but did not act. The IFS Committee took a strong interest in the transparency of hospital charges and financing, and this discussion resulted in a Joint Order establishing a task force to study the topic and produce a report for the next session. The IFS Committee also has carried over to the next session a bill (L.D. 1345) proposing a single payer health care system for Maine. The Health & Human Services Committee has carried over to the next session a bill (L.D. 1487) to institute a managed care approach to the MaineCare program, rather than the "value-based purchasing" initiative currently advocated by the LePage Administration.

Key bills from the MMA's legislative agenda enacted this session were those modernizing language regarding substance use disorders in the physician licensing and disciplinary statutes (L.D. 411), clarifying physician delegation to unlicensed medical assistants (L.D. 198), and ensuring appropriate disclosure of a health care practitioner's credentials and position within a practice or health care institution (L.D. 727). The legislature enacted many other bills affecting the day-to-day practice of medicine in Maine, including two bills (L.D.s 23 and 1500) that will amend the limit on charges for providing medical records (on October 9, 2013, the limit on charges for paper records will be $5 for the first page and $0.45 for each additional page up a maximum total charge of $250 and for electronic records one may charge for reasonable labor and material costs up to a maximum total charge of $150). These will be listed in the MMA's legislative summary that will be available on the MMA web site shortly. The MMA staff will be available to provide a legislative update to help practices comply with the new laws throughout the fall.

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*.

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

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

Save the Dates

MMA 2013 First Fridays Education Programs

8:30am
Registrations and Breakfast

All programs
9:00am – Noon
Maine Medical Association

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

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

NOVEMBER 1
Annual Compliance Seminar:
1. Preventing Allegations of Fraud
2. Federal Sunshine Law
3. OSHA rules

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

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

MMA's 160th Annual Session

October 4-6, 2013

Holiday Inn by the Bay Portland, ME

SEPTEMBER 13, 2013

Fourth Annual Patient Safety Academy

9 am - 4 pm
University of Southern Maine, Portland Campus

Keynote Speaker:
Jonathan Welch, MD, MSc

Registration: $50
($25 for students)
includes lunch and parking

For more information contact:
Judy Tupper
jtupper@usm.maine.edu

President's Corner

Greetings!

I hope everyone is enjoying their summer, even if we have had a little bit of rain this year. Your staff at the MMA has just finished an extremely busy legislative session. They have spent virtually every day up at the Capitol discussing the numerous bills that were put forward dealing with the business, operation, regulations and the practice of medicine. They are issues that affect each and everyone of us in our daily lives as practicing physicians. As always your input is greatly appreciated and helps us determine whether or not we should support or not support any particular piece of legislation.

Dieter Kreckel, M.D., MMA President with Jenny Thompson, M.D., speaker at the MMA Corporate Affiliate Breakfast on April 18th. Dr. Thompson is a pediatric anesthesiologist with Spectrum Medical Group and holder of eight Olympic gold medals.

Last month your delegates and I attended the National AMA meeting in Chicago. Many different issues were discussed and voted on. I had the honor of representing all of you at the inauguration of the 168th President of the AMA, Ardis Dee Hoven, MD. It was great to see that there is still a fire/passion in physicians wanting to provide and advocate for the best care possible for our patients. The recognition that the patient/physician relationship remains the cornerstone of every medical practice was reassuring.

Soon it will be fall again and the glow of summer will fade until next year. All is not lost however because in October we will celebrate the 160th year of the MMA in Portland. The weekend of Oct 4-6 is the date to remember. Our emphasis this year is on medical education through the years. I invite all of you to join us in the festivities. Steven Stack, MD the chair of the AMA Board of Trustees will be our AMA representative. Please log on the MMA site (www.mainemed.com) and check out the planned events. You may register by mail or online. I hope to see you all there.

Once again, thank you for allowing me to represent you this past year. Please contact me at any time at 369-0146 or president@mainemed.com.

22nd Annual Practice Education Seminar Addresses Current Issues for Practices

MMA held its 22nd Annual Practice Education Seminar at the Augusta Civic Center on July 24, 2013. The Seminar attracted the participation of approximately one hundred physicians and practice managers from across the state. Keynote presenters included Jack Lewin, M.D., Chairman of the Board of the National Coalition on Health Care and a former CEO of both the American College of Cardiology and the California Medical Association, DHHS Commissioner Mary Mayhew and social media guru Rich Brooks.

Dr. Lewin presented an overview of the current issues nationally regarding health care reform and discussed the opportunities to both improve the quality of care and to moderate costs through the initiatives of the Affordable Care Act and other national, state and local programs. On a similar theme, Commissioner Mayhew, accompanied by MaineCare Medical Director Kevin Flanigan, M.D., spoke of the opportunities within the State Innovation Model grant provided to DHS through CMS. This three-year $33 million federal grant will be overseen by a steering committee chaired by Dr. Flanigan, who also spoke of the objectives of the grant. Rich Brooks of flyte new media (www.flyte.biz) presented attendees with some practical tips on using social media to advance the interests of a medical practice, including search engine optimization, e-mail marketing, blogs and state of the art websites.

In addition to the three plenary session speakers, there were a dozen breakout sessions on topics ranging from preparing for the conversion to ICD 10 to preventing prescription drug abuse. Copies of some of the presentations will be placed on the MMA website at www.mainemed.com.

MMA wishes to thank and acknowledge the exhibitors at the seminar:

Maine Independent Clinical Information Service (MICIS), Academic Detailing

Maine Community Health Options

Baystate Financial Services

Maine Quality Counts

Medical Professionals Health Program

IWP (Injured Workers Compensation Pharmacy)

Sebago Technics

Over one hundred physicians and support staff attended

Rich Brooks

Jessa Barnard, J.D.

Attorneys Ann Robinson and Jeff Parsons

DHHS Commissioner Mary Maybew

MaineCare Medical Director Kevin Flanigan, M.D.

Randal Manning, Executive Director of the Board of Medicine

Gordon H. Smith, Esq.

Notes from the EVP

Greetings from balmy Manchester! I am writing my notes on a very warm summer night during one of the heat waves. It has certainly been an interesting summer, weather-wise, and it's not over yet.

The recently completed legislative session was also a hot one! Not adjourning until early on the morning of July 10, the session was the most intense and most partisan I have seen in my thirty-seven years lobbying at the State House. In terms of issues impacting on medical practice, MMA presented an aggressive package of bills, several of which passed but three of which were vetoed (not including a veto of the bill which would have authorized an expansion of MaineCare to over 50,000 Mainers). By the time you receive this issue of *Maine Medicine,* a full summary of all the action on MMA's bills and the dozens of bills MMA was following will be on the newly designed MMA website at www.mainemed.com.

Many times, success at the State House means defeating a bad bill. MMA worked hard to defeat several proposals that were detrimental to patients and physicians. In one case, we worked closely with anesthesiologists to keep a bill from even being considered that would have given CRNA's prescribing privileges. Every week there were wins and losses, but the biggest disappointment was falling two votes shy of overriding the Governor's veto of L.D. 1066, Accepting Federal Funds to Expand Coverage for Maine Families. It is simply unfathomable that one-third of legislators could walk away from providing tens of thousands of Mainers with health coverage. This particular fight will continue.

But the session also had many positive moments. Of particular pleasure this session was working closely with the four physician legislators, Senator Gratwick and Representatives Sanborn, Dorney and Pringle. These four hard-working physicians and dedicated public servants significantly elevated the discussion of healthcare issues at the State House. Their constituents and physicians across the state owe them a huge thank you for their public service.

MMA's advocacy for you and your patients will continue. The Second Regular Session of the 126th Legislature begins January 8, 2014.

I hope to see many of you at the 160th Annual Session October 4-6 in Portland. The Annual Meeting provides a unique opportunity for the medical community to come together and discuss current issues of importance to physicians and to patients. If you haven't attended an Annual Meeting in a few years, give it a try.

Upcoming Specialty Society Meetings

SEPTEMBER 7, 2013 *MMA Headquarters – Manchester, ME*
Maine Society of Anesthesiologists Fall Business Meeting
10:00am – 1:00pm, including lunch
Contact: Anna Bragdon 207-441-5989 or mesahq@gmail.com

SEPTEMBER 11, 2013 *Waterville, ME – Location TBA*
Maine Chapter, American College of Emergency Physicians Fall Business Meeting
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

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

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

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

OCTOBER 4 – 6, 2013 *Holiday Inn by the Bay – Portland, ME*
The following Specialty Societies will be holding meetings in conjunction with MMA's Annual Session taking place at the Holiday Inn by the Bay in Portland, Maine:

Maine Society of Orthopedic Surgeons Annual Education Sessions (Oct. 5)
Contact: Warene Eldridge, Executive Director 207-215-7118 or warene54@yahoo.com

Maine Urological Association
Contact: Dianna Poulin 207-622-3374 ext: 223 or dpoulin@mainemed.com

Maine Association of Psychiatric Physicians
Contact: Dianna Poulin 207-622-3374 ext: 223 or dpoulin@mainemed.com

NOVEMBER 2, 2013 *MaineHealth, Portland, ME*
American Academy of Pediatrics - Maine Chapter
Annual Fall Educational Conference "Quick Hits: Pediatric Updates on Hot Topics"
Contact: Leslie Goode, Executive Director 207-782-0856 or ldgoode@aap.net

FEBRUARY 5-8, 2014 *Grand Summit Hotel – Sunday River, ME*
Downeast Association of Physician Assistants
Annual Winter Conference
Contact: Diane McMahon 207-622-3374 ext: 216 or dmcmahon@mainemed.com

FEBRUARY 8-9, 2014 *Sugarloaf Mountain Hotel – Carrabassett Valley, ME*
Maine Society of Anesthesiologists Annual Winter Meeting
Contact: Anna Bragdon 207-441-5989 or mesahq@gmail.com

MMA wants to hear from you!

Issues or concerns you would like to see addressed by the MMA:

_____

_____

_____

_____

_____

Please provide your name and telephone number or e-mail address so that we may contact you if clarification or further information is needed.

Telephone:_____ E mail: _____

Return to MMA via fax at 207-622-3332

Thank you.

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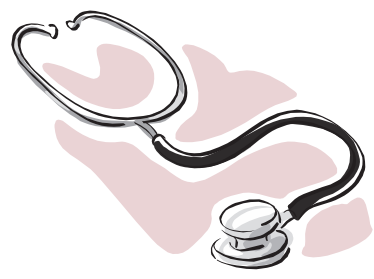


INVITE A PHYSICIAN TO JOIN MMA

Encourage your colleagues to become an MMA member and take advantage of the benefits of membership.

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

MMA Welcomes Our Newest Corporate Affiliate:

Maine Community Health Options

We appreciate their support!

Upcoming at MMA

AUGUST 14
11:30am – 2:00pm
MMA Senior Section

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

SEPTEMBER 3
1:00pm – 4:00pm
Maine Council on Aging

SEPTEMBER 4
8:00am – 12:30pm
Maine Health Management Coalition

SEPTEMBER 6
9:00am – 12:00pm
First Fridays Educational Program: Risk Management Seminar

SEPTEMBER 7
10:00am – 1:00pm
Maine Society of Anesthesiologists

SEPTEMBER 19
6:00pm – 8:00pm
Maine Association of Psychiatric Physicians

SEPTEMBER 20
8:30am – 12:30pm
Maine MGMA

OCTOBER 2
8:00am – 12:30pm
Maine Health Management Coalition

OCTOBER 3
8:00am – 3:00pm
Pathways to Excellence

OCTOBER 8
8:00am – 4:00pm
Spectrum Medical Group

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

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

OCTOBER 17
5:00pm – 7:00pm
QC Choosing Wisely Leadership Group

6:00pm – 8:30pm
Maine Association of Psychiatric Physicians

NOVEMBER 1
9:00am – 12:00pm
First Fridays Educational Program: Annual Compliance Seminar

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

NOVEMBER 11
4:00pm – 8:00pm
Maine Professional Health Program


Jessa Barnard, J.D.

Public Health Spotlight

By Jessa Barnard, J.D.,
Associate General Counsel, MMA

MMA Supports Effort to Reinstate Federal Funding for Syringe Exchange Programs

HIV/AIDS remains one of the country's most serious health challenges. According to an overwhelming body of evidence, needle and syringe exchange programs not only reduce the spread of HIV, but also save money, encourage the safe disposal of syringes, minimize the risk of needlestick injuries to law enforcement officials, and help link chemically dependent individuals to vital drug treatment services. In difficult budgetary times, investments in syringe exchange are a wise use of tax dollars. For every $1 invested in these programs, communities save $3 - $7 in HIV treatment costs alone. Even more money is saved when you take into account reductions in costly hepatitis treatment and liver transplants, and emergency room expenses associated with overdose and soft tissue infections.

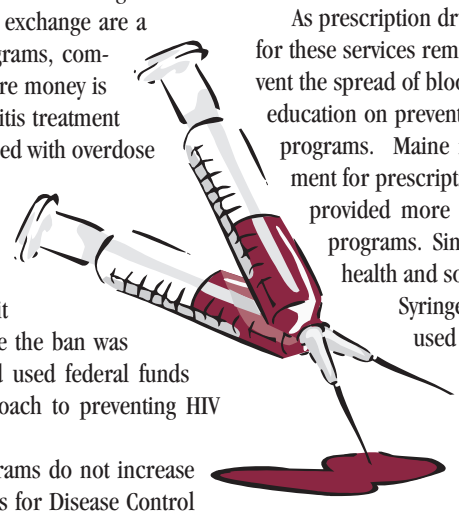
Unfortunately, a ban on federal funding for syringe exchange programs was first imposed by Congress in the 1980s; although it was briefly lifted in 2009, the ban was reinstated in a federal spending bill in December 2011, when it became a casualty of contentious budget negotiations. While the ban was lifted, several state and local health authorities sought and used federal funds for syringe exchange programs as part of a broader approach to preventing HIV infections.

Study after study has shown that syringe exchange programs do not increase drug use, and the American Medical Association, the Centers for Disease Control and Prevention, the National Institutes of Health, the General Accounting Office and the National Academy of Sciences have all said the programs work to help reduce the spread of HIV. AMA Policy H-95.958 states that the AMA encourages needle exchange programs and will initiate and support legislation revoking the 1988 federal ban on funding.

Maine currently has only five syringe exchange programs serving the entire state. These programs operate on shoestring budgets. Making federal funding for syringe exchange available could help these programs to reach even more Mainers with lifesaving services. Lifting the ban would require allocating no new federal dollars – it would simply free local communities to use existing federal HIV prevention funding as needed to address their local epidemic.

A significant portion of HIV in Maine stems from injection drug use. As of 2009, 16% of males and 31% of females living with HIV in Maine reported injecting drugs. The need for syringe exchange programs in the state continues to grow, as measured by new enrollments: in 2012, 895 new people enrolled in syringe exchange programs, a jump of 21% from 2011.

As prescription drug abuse continues to be a pressing problem in Maine, the need for these services remains great. Not only do syringe exchange programs help to prevent the spread of blood-borne diseases like HIV and hepatitis C, but they also provide education on preventing overdose and connect people to substance abuse treatment programs. Maine now tops the nation in the percent of residents seeking treatment for prescription drug abuse. In 2012 alone, the state's five syringe exchanges provided more than 400 people with referrals to substance abuse treatment programs. Since 2009, syringe exchanges helped link people to other vital health and social services more than 5,000 times.



Syringe exchange programs also improve public health by disposing of used syringes that may otherwise be left in parks and public spaces. Since 2009, Maine's syringe exchanges have safely disposed of nearly 400,000 used syringes.

Given all of these compelling reasons, the MMA will be contacting our Senators this summer to urge them to support lifting the ban on using federal funds for syringe exchange programs. We hope interested MMA members will do the same.

Maine's Congressional Officers:

Senator Susan Collins
413 Dirksen Senate Office Building
Washington, D.C. 20510
(202) 224-2523
http://www.collins.senate.gov

Senator Angus King
359 Dirksen Senate Office Building
Washington, D.C. 20510
(202) 224-5344
http://www.king.senate.gov

Representative Michael Michaud
1724 Longworth House Office Building
Washington, D.C. 20515
(202) 225-6306
http://michaud.house.gov

Representative Chellie Pingree
1318 Longworth House Office Building
Washington, D.C. 20515
(202) 225-6116
http://pingree.house.gov

AMA Annual Insurer Report Card Adds Measure of Administrative Burden in the Medical Claims Process

Your medical practice and others across Maine and the nation must work through a "maze of complex insurer rules" and administrative tasks that could save the industry up to $12 billion if reduced or removed, says the AMA.

In recent years, the organization has released its annual National Health Insurer Report Card as a way to lead the charge against administrative waste and advocate for improving health care billing and payment systems.

This year, for the first time, the AMA also examined the portion of health care expenses patients are responsible for through co-pays, deductibles, and co-insurance. During February and March of this year, patients paid an average 23.6 percent of the amount health insurers set for paying physicians.

"Physicians want to provide patients with their individual out-of-pocket costs, but must work through a maze of complex insurer rules to find useful information," said AMA Board Member Barbara L. McAneny, M.D. "The AMA is calling on insurers to provide physicians with better tools that can automatically determine a patient's payment responsibility prior to treatment."

About the Administrative Burden

The AMA's new Administrative Burden Index (ABI) ranks commercial health insurers according to the level of unnecessary cost they contribute to the billing and payment of medical claims. The AMA found that administrative tasks associated with avoidable errors, inefficiency and waste in the medical claims process resulted in an average ABI cost per claim of $2.36 for physicians and insurers.

Estimates indicate $12 billion a year could be saved if insurers eliminated unnecessary administrative tasks with automated systems for processing and paying medical claims. This savings represents 21 percent of total administrative costs physicians spend to ensure accurate payments from insurers.

"The high administrative costs associated with the burdens of processing medical claims annually should not be accepted as the price of doing business with health insurers," said Dr. McAneny. "The AMA is a strong advocate of an automated approach for processing medical claims that will save precious health care dollars and free physicians from needless administrative tasks that take time away from patient care."

Overall Administrative Burden Index

Payer	% of claims requiring rework	Overall rework cost per claim
Aetna	7.13%	$1.68
Anthem	14.30%	$2.64
Cigna	5.45%	$1.25
UnitedHealthcare	5.36%	$2.13

Open Enrollment in Maine's Health Insurance Marketplace for Individuals and Small Businesses Begins October 1st!

As we approach the October 1st beginning of open enrollment in the Health Insurance Marketplace, it is important that Maine physicians know how the changes coming will impact you and your patients. To learn more, consider attending one or more of the following trainings. Please contact Jessa Barnard at jbarnard@mainemed.com for patient-specific educational materials or with questions regarding how the Affordable Care Act impacts your practice.

AUGUST 19
Muskie School Colloquium, "The Affordable Care Act: What's Next for Maine?" 4-5:30 p.m. at Lee Hall, Wishcamper Center, University of Southern Maine. To register contact Donna Reed at 780-4846.

AUGUST 22
"Health Care Reform Forum" sponsored by Mainebiz, HarvardPilgrim HealthCare, Maine Community Health Options and Pierce Atwood LLP. 8:00-11:00 a.m. at Holiday Inn By the Bay, Portland. For more info contact Donna Brassard at 761.8379 x327 or dbrassard@mainebiz.biz.

SEPTEMBER 13
"What's Up with Health Care Reform?" Free seminar for employers on the ACA by Healey & Associates. 8:30 a.m.-11:00 a.m. at The Harraseeket Inn in Freeport. Topics covered will include: information on the HIM, employer penalties, and the benefits the ACA provides employers with over 50 employees that partially self-fund their employee health care programs. For more information or to register, contact Peggy Williams at Healey & Associates at 775-6177.

SEPTEMBER 17
"Successfully Implementing the ACA in Maine," Augusta Civic Center, organized by Maine Consumers for Affordable Health Care and other leaders of Maine's consumer health advocacy community. The half-day program will focus on the Marketplace opening, new insurance options, and MaineCare changes. Breakout sessions will spotlight changes and new benefits for: people with low income, patients and families with behavioral health needs, and women. For more information, contact Mitchell Stein at CAHC at mstein@mainecahc.org.

Are you and your patients ready?
To learn more visit www.healthcare.gov or call 1-800-318-2596, 24 hours a day, 7 days a week. (TTY: 1-855-889-4325)

Stephen D. Sears, M.D., M.P.H.

From the State Epidemiologist

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

Clostridium difficile Infections -THE MOST COMMON Nosocomial pathogen

Remember the 60's when we called it antibiotic-associated diarrhea? Then we called it Clindamycin-associated diarrhea (1974). Next we started diagnosing pseudomembranous colitis (1978). And then, in the last decade, we started seeing outbreaks and death - all caused by Clostridium difficile. Clostridium difficile (also known as C. diff) is a spore-forming, Gram-positive anaerobic bacillus. It is a toxin producer that damages the human colon. It is hard to get rid of C. difficile because the spores can survive in the environment for two years. Clostridium Difficile Infection (CDI) is transmitted through the fecal-oral route and direct contact with contaminated surfaces. The biggest risk is from antibiotics. More than 90% of healthcare-associated C. diff occurs after or during antibiotic therapy. Other risk factors for C. diff infection are increasing age, acid blockers such as, proton pump inhibitors or H2 blockers, gastrointestinal surgery, or underlying conditions including immune system suppression. Staying in healthcare settings for long periods of time also increases risk significantly. The problem has spread from hospitals to nursing homes and now to the community. CDI costs $7.5 billion and is killing patients and making many others very sick. So what can we do?

A person can be colonized with C. diff; that is, the patient has no clinical symptoms but tests positive for C. diff and/or its toxin. Several studies have found that 10-15% of healthcare workers are colonized with C. diff. However, few of these develop C. difficile infection unless they take antibiotics. The antibiotics that greatly increase the risk are 3rd generation cephalosporins, fluoroquinolones, and Clindamycin - however, CDI can be triggered by almost any antibiotic. In Maine, the rate of hospital-associated C. diff infections is 6.6 per 10,000 patient days—that is a lot of infections, and this only includes inpatients. There are lots more C. diff infections in the community.

C. diff diagnosis has improved. Many hospital labs are now performing sensitive nucleic acid amplification testing. Testing should only be performed if the patient has had three or more loose stools in a day with no other reason for diarrhea (tube feedings, laxatives, etc.), or one loose stool if the patient has had C. diff in the past. Also, "test for cure" should not be performed, because a treated patient will continue to have a positive PCR, even when the infection is cured. A new laboratory test, Pulse field gel electrophoresis (PFGE), has been used by the Maine CDC in C. difficile outbreaks. PFGE is used to identify subtypes of C. diff. To date, PFGE testing has demonstrated 30 subtypes throughout Maine. The NAP 1 strain (a hyper-toxin producer) has been responsible for most outbreaks.

So what do we do to stop this scourge? First be aware—Think about it; diagnose it; and treat it. Treatment should be based on lab results and clinical symptoms. Unfortunately new strains of C. difficile that produce high levels of toxin and have high recurrence rates are becoming the norm. Disease does not respond as quickly as it used to. Currently it takes seven to eight days for symptoms to resolve. In patients with high white counts, abdominal pain and systemic symptoms, treat quickly and get consults if needed.

Much has been learned about C. difficile treatment and prevention. Yet, too many people are still getting C. difficile. What can we do? Well, we should start by following guidelines to prevent transmission and we should minimize unnecessary antibiotic usage. The CDC has suggested these major interventions to reduce CDI:

1) Antibiotic stewardship–use antibiotics wisely.
2) Early diagnosis with immediate precautions to avoid spread to others.
3) Environmental cleaning, especially of high touch areas, with 1:10 bleach.
4) Better communication with intra- and inter-facility transfers.

Treatment protocols are available. Always discontinue antibiotics if possible. Generally, Flagyl is used for uncomplicated cases. In severe disease, vancomycin should be used. A new drug that has recently become available is fidaxomicin (an expensive alternative) which may be used for reccurant disease. It has a similar cure rate to vancomycin. Other therapies that have been used in the past, such as probiotics, are not useful and may be harmful in patients on cancer chemotherapy. Some new therapies show promise. A new experimental therapy of non-toxigenic C. difficile is in a phase II trials. C. difficile vaccines offer another possible solution, but are still several years away. The most promising treatment is fecal transplant. This is also called IMT—intestinal microbiotic transplant. Stool from a relative is collected and given to the individual with multiple recurrent episodes of C. difficile. IMT has been highly effective, with an 89% success rate after a single treatment. Although this therapy is not for everyone, it may be life saving for some.

The bottom line is that CDI is an infection largely occurring in susceptible patients because of the use of antibiotics. It does not matter if the antibiotics were given appropriately or not—every time we prescribe an antibiotic, C. difficile is a possible consequence. Before exposing a patient to this possible outcome, always ask these questions: Is the antibiotic necessary? Is it the most appropriate antibiotic? What is the best dose, frequency, route, and duration? And is the treatment likely to be effective? Reducing the use of antibiotics may be the best prevention of C. difficile infection that we have.

Energy and Commerce Health Subcommittee Advances Legislation to Repeal Medicare SGR

On July 23, the House Energy and Commerce Subcommittee on Health approved by voice vote bipartisan draft legislation to repeal the sustainable growth rate (SGR) and implement a new Medicare physician payment update based on performance under an expanded PQRS program. The bill provides for an initial five years of positive updates at 0.5 per percent per year. Beginning in 2019, physicians would have the opportunity to earn an additional 1 percent for successful participation in an expanded PQRS program. Physicians who score poorly would be subject to a cut of 1 percent (a net cut of -0.5 percent). In addition, the draft provides for the development of alternative payment models that would allow physicians to opt out of the new reporting requirements.

The current draft reflects significant progress from previous versions of the legislation. The committee is committed to continuing its dialogue with the physician community to develop a new Medicare system that is better for physicians and patients. The AMA remains actively engaged in these discussions to ensure that committee members and staff are aware of its outstanding concerns and that the legislation will align with the principles put forth by the physician community.

The draft will be introduced as legislation by Rep. Mike Burgess, M.D., (R-TX) and co-sponsored by the Chairs and Ranking Members of both the full Energy and Commerce committee and the Health Subcommittee –Rep. Upton (R-MI), Waxman (D-CA), and Pallone (D-NJ) as well as Chair Emeritus John Dingell (D-MI). As of this writing, the full committee was scheduled to mark up the legislation during the week of July 29, just prior to the Congress adjourning for the August congressional recess.

Repeal of the flawed Medicare payment formula for physicians continues to be the highest legislative priority of the AMA and most of the national and state medical organizations. For the past decade, Congress has needed to annually override the SGR formula to undo deep cuts caused by flaws in the formula. This legislation permanently repeals the current Medicare SGR mechanism that places a global cap on Medicare spending on provider services.

Medicare SGR Update

On February 5, the Congressional Budget Office estimated that it would cost $138 billion over 10 years to repeal the problematic sustainable growth rate (SGR) formula used to calculate Medicare physician pay. This is substantially lower than last year's estimate of more than $300 billion. The reduced estimate has accelerated a top priority of Medicare: repealing the SGR formula and developing a payment system that rewards physicians for high-quality care and patient outcomes.

The New Plan

The AMA and national specialties are working with legislators on a three-phase SGR replacement plan developed jointly by Republican leaders of the House Energy and Commerce Committee and the House Ways and Means Committee. Unlike previous proposals that would force physicians into accountable care organizations and bundled-payment systems, this strategy would preserve the Medicare fee-for-service option, which is important to many specialties. In addition, the proposal allows specialties to help develop quality metrics and initiatives that improve on current Medicare value-based purchasing programs. It also credits physicians for participation in national specialty registry efforts.

Three Phases

The first phase of the reform is a two to three-year period of stable payments with the fee schedule update established by statute. During the second phase, provider payment rates are partly based on the quality of care provided to beneficiaries. Payment levels would be calculated on a base rate plus a variable rate tied to:

1. the physician's risk-adjusted performance ranking on several quality measures relative to his or her peers;
2. improvement over the prior year's score, and
3. participation in other quality improvement or patient safety initiatives.

The committees are considering allowing the quality measures to be assessed at either the individual physician or group practice level. In the third phase, providers could earn additional incentive payments based on efficient use of health care resources. Physicians who choose to participate in alternative payment models can opt out of this modified fee-for-service system.

Many policymakers believe that reforming physician payment, especially by moving away from the current fee-for-service approach, is essential to maintaining a high-performance health system and limiting cost increases. The Maine Medical Association continues to advocate for repeal of the flawed SGR formula and is in continuing communications with our Congressional delegation.

Upcoming at MMA

NOVEMBER 12
8:00am – 4:00pm
Spectrum Medical Group

NOVEMBER 21
8:00am – 3:00pm
Pathways to Excellence

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

DECEMBER 3
1:00pm – 4:00pm
Maine Council on Aging

DECEMBER 4
8:00am – 12:00pm
Maine Health Management Coalition

DECEMBER 6
9:00am – 12:00pm
First Fridays Educational Program: Accountability, Transparency and Public Reporting

DECEMBER 10
8:00am – 4:00pm
Spectrum Medical Group

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

DECEMBER 11
4:00pm – 6:00pm
MMA Public Health Committee

DECEMBER 19
9:00am –11:00am
Maine Health Management Coalition BOD

5:00pm – 7:00pm
QC Choosing Wisely Leadership Group

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

***All MMA Committee Meetings are now being offered through WEBEX*

POISON Help™ 1-800-222-1222

Northern New England Poison Center

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

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

Maroulla Gleaton, M.D. Elected Chair of Board of Licensure in Medicine, David Jones, M.D., Secretary

At its July meeting, the Maine Board of Licensure in Medicine elected Augusta ophthalmologist Maroulla Gleaton, M.D., as chair of the Board and David Jones, M.D. as Secretary. Dr. Jones is a family physician currently practicing in the ER at Northern Maine Medical Center in Fort Kent.

Dr. Gleaton follows Auburn internist Gary Hatfield, M.D. who completed two six year terms on the Board at its June meeting. Dr. Gleaton previously served as Secretary of the Board and she is also a former MMA President. As a result of Dr. Hatfield leaving the Board, there remains one vacancy which will be filled by appointment of Governor Paul LePage. In addition, there will be one physician assistant appointed by the Governor to the Board after the effective date (Oct. 9) of the legislation enacted this year authorizing one PA to be appointed to the BOLIM and one PA to be appointed to the Board of Osteopathic Licensure.

The Board of Licensure in Medicine includes six physicians and three public members, all appointed by the Governor. Members serve six year terms and must have been actively practicing in the state for at least five years prior to their appointment.

Second Annual Let's Go! 5-2-1-0 Childhood Obesity Conference September 11-13

Please visit the event website at http://www.cvent.com/events/2nd-annual-let-s-go-childhood-obesity-conference/event-summary-2b83a41fba0c4d06ac0e6f3ae33c35b0.aspx to learn more about this opportunity or to register. Also, feel free to contact Emily Walters at waltee@mainehealth.org.

A Partnership of


Lisa M. Latourneau, M.D.

Maine Quality Counts

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

Making it OK to Ask: The Role of Physicians in Helping Patients to Choose Wisely

When I think back to my early days of medical education and training, one rarely thought about the costs of medical tests, procedures, or medications - it just wasn't what young doctors did. But the escalating concerns about rising health care costs - and my own recent experience accompanying my mother to an ED visit - have raised my awareness about the importance of including costs in our aim to "first do no harm."

The rising costs of health care in the U.S. now amount to a whopping national health care bill of $2.7 trillion annually and are increasingly known to physicians. Consumers likewise are becoming more aware of these costs – whether from the recent stream of media stories including the hard-hitting Time article, "Bitter Pill"[1], or even more likely, from the hefty out-of-pocket payments that nearly a third of Americans now face from their high-deductible and consumer-directed health plans.

But it was my own experience as a family member accompanying my 82 year old mother on a recent ED visit that I got to experience the cost issues first-hand, and got a personal reminder of the implications of high-cost choices in health care. My mother had struggled with a worsening upper respiratory infection and cough for five days before a trip to the local hospital ED and chest x-ray confirmed the pneumonia we suspected. Assuming the position of dutiful daughter, I was grateful for the thorough and kindly care she received, and experienced only a fleeting thought about costs when the ED physician immediately recommended a newer, broad spectrum flouroquinone for her 7days of antibiotic treatment, with no discussion of costs or other potential (and presumably less-expensive) options.

As I headed to the local pharmacy, I expected to pay considerably more than the old days of $7 amoxicillin, but was admittedly shocked by its cost - $140 for a 7-day course. Luckily I was fortunate enough to be able to pay the bill and walk out with the prescription. But even as I did so, I had to wonder how many people, particularly older adults like my mother living on a fixed income, simply would have walked away and not filled the prescription, hoping that "things will get better" or returning for a repeat trip to the ED a few days later when worse.

One effort to address the challenges of expensive resource use is Choosing Wisely®, a national initiative of the ABIM Foundation to help physicians and patients engage in conversations about making wise choices about the use of expensive health care tests and treatments. And while the specific example of my mother's $140 flouroquinone is not one of the areas specifically targeted in Choosing Wisely, my experience illustrates a key notion of the program – i.e. that patients will be willing to question a recommendation from their doctor.

Despite that assumption, we know from studies, surveys, and in my case, personal experience, that this questioning does not happen the majority of the time. Patients – particularly older adults – often report feeling unprepared and unwilling to challenge the perceived "authority" of their physician. They express understandable concerns that such questions could appear disrespectful, or could cause their doctor to view them as "difficult".

So in the face of these challenges, how can we expect even very well-intended efforts such as Choosing Wisely to work? The answer is first and foremost about creating culture change – i.e. we must, as physicians, actively invite questions, make time, and give permission for patients and families to ask questions and challenge recommendations, and be proactively attentive to issues of cost and affordability.

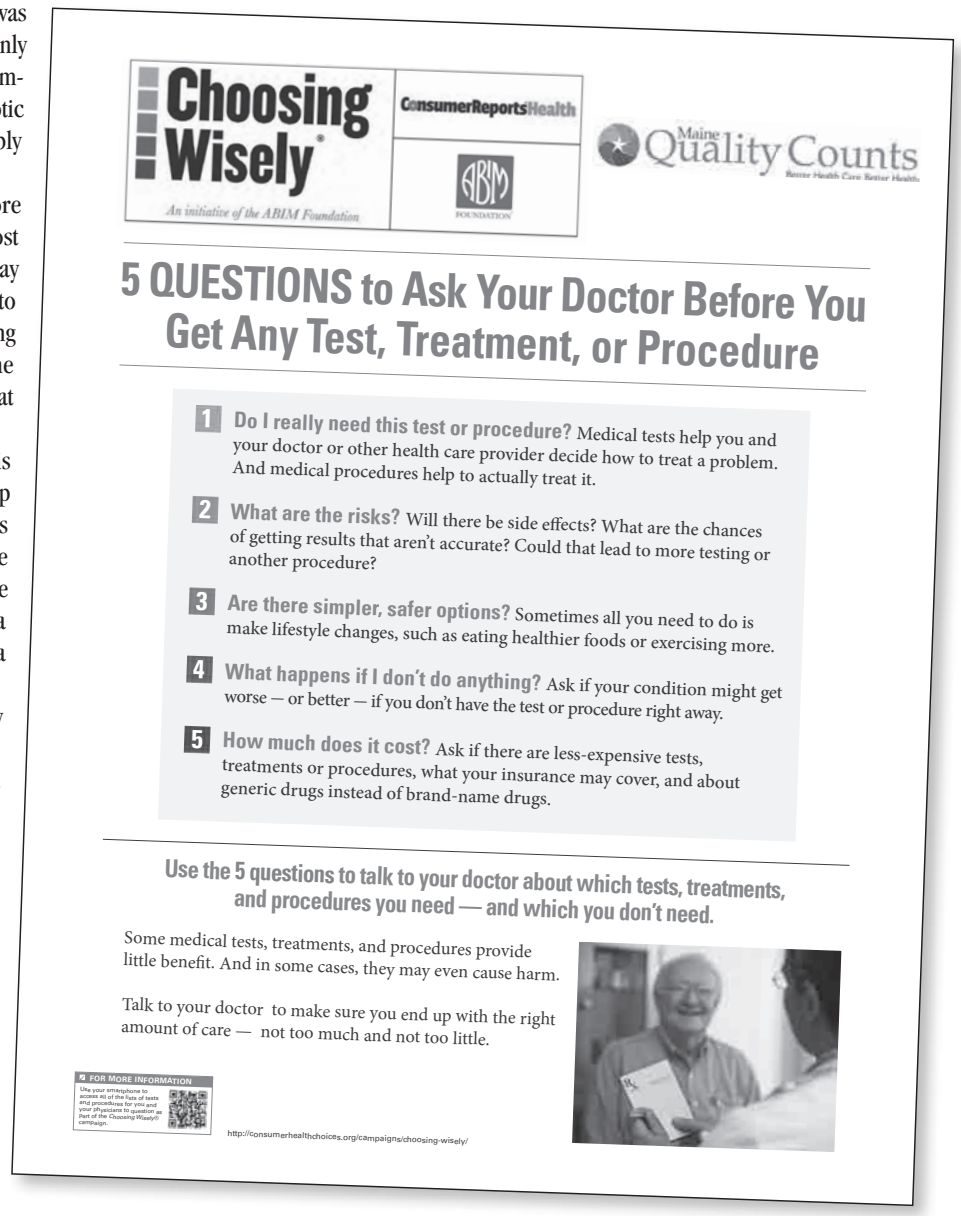
A recent opinion piece by Moriates and colleagues urges physicians to help patients avoid "financial harm" through several steps, including adopting a universal approach to screening for financial constraints in their patient's ability to pay for health care; understanding the financial impact of their treatment recommendations; and offering low-cost alternatives to optimize care plans for individuals.[2] We would arguably do far "less harm" as physicians by exhibiting a greater sensitivity to the challenges that many patients face in dealing with the costs of health care.

We can begin these needed conversations by actively using prompts to give patients permission to ask questions, such as Choosing Wisely's **"5 QUESTIONS to ask your doctor before you have any medical test or procedure".** This tool, available in poster and wallet card formats, was developed by *Consumer Reports*, a Choosing Wisely partner that has created free patient-friendly materials and includes the following key questions for patients:

1. Do I really need this test or procedure?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don't do anything?
5. How much does it cost?

Maine Quality Counts (QC) is leading a multi-stakeholder effort funded by the ABIM Foundation to develop a Choosing Wisely in Maine initiative that will focus on "**5** Things Physicians/Health Care Providers and Patients Should Question". Over the next several months, Maine Quality Counts and our Choosing Wisely Leadership Team, including the Maine Medical Association, will work to spread the word through several key strategies, including working with provider and consumer groups. So stay tuned – more to come soon!

For more information about Choosing Wisely in Maine, contact QC Communications Director, Kellie Slate Miller, MS, at kslatemiller@mainequalitycounts.org or 620.8526, x 1011. All of the above tools and resources for providers and patients can be found at: http://www.mainequalitycounts.org/page/896-882/maine-choosing-wisely.


Choosing Wisely®
An initiative of the ABIM Foundation
ConsumerReportsHealth
ABIM FOUNDATION
Maine Quality Counts
Better Health Care. Better Health.

5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure

1 **Do I really need this test or procedure?** Medical tests help you and your doctor or other health care provider decide how to treat a problem. And medical procedures help to actually treat it.

2 **What are the risks?** Will there be side effects? What are the chances of getting results that aren't accurate? Could that lead to more testing or another procedure?

3 **Are there simpler, safer options?** Sometimes all you need to do is make lifestyle changes, such as eating healthier foods or exercising more.

4 **What happens if I don't do anything?** Ask if your condition might get worse — or better — if you don't have the test or procedure right away.

5 **How much does it cost?** Ask if there are less-expensive tests, treatments or procedures, what your insurance may cover, and about generic drugs instead of brand-name drugs.

Use the 5 questions to talk to your doctor about which tests, treatments, and procedures you need — and which you don't need.

Some medical tests, treatments, and procedures provide little benefit. And in some cases, they may even cause harm.

Talk to your doctor to make sure you end up with the right amount of care — not too much and not too little.

FOR MORE INFORMATION
Use your smartphone to access #2 of the lists of tests and procedures for you and your clients to question as part of the Choosing Wisely® campaign.
http://consumerhealthchoices.org/campaigns/choosing-wisely/

(Endnotes)

1 Brill, S., Bitter Pill: Why Medical Bills are Killing Us, TIME Magazine, March 4, 2013.

2 Moriates, C, N Shah, V Arora, "First do no (financial) harm", *JAMA*, published online July 8, 2013, E1-2.

Medical Mutual Insurance Company of Maine Risk Management Practice Tip: e-Communication with Patients: e-mail, texting, portals and networks

Part II (Part I of this article can be found in the April/May/June 2013 issue of *Maine Medicine*.)

Mobile Communication technologies have spread with remarkable speed. The advent of smartphones and pad computers makes it possible to access information and send and receive messages anywhere there is a cell signal or wireless network. Physicians are embracing the technology. A Manhattan Research survey indicated that 85% of surveyed physicians used at least one smartphone, 75% had downloaded at least one application and 30% were using an iPad to access electronic health records, view images and communicate with patients.

Privacy and Security

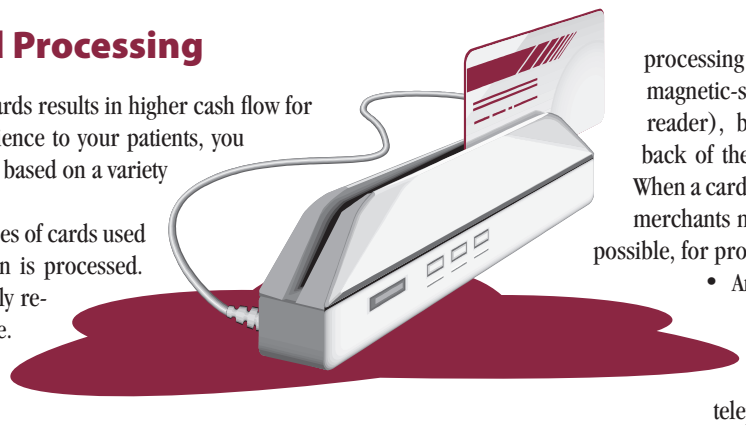
- Conduct electronic communication with patients over a secure network. Encrypt electronic protected health information from the point of creation, through transmission to the point of receipt. Instruct providers not to transmit protected health information over public networks such as airport, hotel or coffee shop Wi-Fi hotspots. Patient portals are one of the most secure methods of communicating.
- Establish clear mechanisms to authorize and authenticate patient users.
- Require passwords and current antivirus (malware) protection for all devices including providers' personal devices.
- Develop and enforce password requirements.
- Establish a mechanism to ensure user access termination in a timely manner when appropriate (patient or provider leaves organization, uses technology inappropriately, etc.).
- Inventory all portable devices used by providers to communicate protected health information. Ensure the ability to lock or remote wipe the devices if lost or stolen.
- Include a disclaimer on all outgoing messages. For example: This communication may contain health information that is private and intended solely for the use of the intended recipient.

Policies and Procedures

- Evaluate current confidentiality and information security policies and update to reflect e-communication with patients.
- Determine whether providers will be limited to organization provided devices for e-communication or will be permitted to bring their own devices (BYOD).
- Develop and enforce clear policies if personal devices are permitted.
- Determine the types of e-communication that will be used and establish guidelines.
- Include e-communication in current documentation policies. Clinical e-communication exchanges should be incorporated in the patient's medical record.
- Determine whether attachments such as photographs or videos are supported by the platform (portal, private network, mobile device) and if use will be permitted. For example: patient photographs of skin rashes and video of behavioral outbursts or seizure activity. Specify how the images will be stored and made part of the medical record.
- Provide education for physicians and staff on the e-communication policies and procedures including the establishment of a clear delineation between personal and professional use of e-communication.
- Include e-communications in the organization's "legal hold" policy. When a claim is anticipated and/or a request for information or subpoena includes electronic communications, specific action is required to preserve electronically stored information (such as e-mails). Notify users of the potential claim and direct that all patient communications and documentation (including e-mails) may not be deleted or modified.

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.

Understanding Credit Card Processing



Medical practices agree that accepting credit cards results in higher cash flow for their business. But in order to extend this convenience to your patients, you will pay transaction fees, which fluctuate in amount based on a variety of factors.

Transaction rates vary by merchant category, types of cards used for purchases and how the credit card transaction is processed. Qualifying for the best possible rate can significantly reduce the cost of accepting cards at the point of sale. Examining how credit card sales are processed is the best way to ensure each credit card sale will qualify for the lowest transaction cost.

Your processor should be able to assist you in identifying transactions that can be processed more cost effectively. But it's equally important for merchants to understand where the costs are, too.

What is interchange?

The most misunderstood term in credit card processing is "discount rate:. This term is applied to the percentage of each sale a merchant pays to a process credit card sale. To call it a discount would suggest something is being reduced… but it's not. It's a fee merchants pay to their processor to handle the transactions and deposit of credit card funds into their bank account.

The "discount" rate begins with interchange – the base fee assessed by credit card companies and distributed to card-issuing banks. Interchange, of which there are more than 100 different rates and categories, makes up the largest portion of the so-called discount rate.

How does interchange affect transaction costs?

Although interchange fees are applied to all credit card processors equally by the card associations, namely VISA® and MasterCard®, they fluctuate in amount based on a variety of factors. Factors include:

- How you Process – Merchants processing transactions in a mail, telephone or Internet environment pay higher interchange fees when a cardholder is not present for the sale, which creates a higher risk of charge-backs.
- How the Card Account Number is Captured – Merchants receive a lower processing rate for all transactions swiped through a magnetic-stripe reader (credit card terminal or card reader), because the encoded information on the back of the card can be verified through the issuer. When a card cannot be read through a magnetic reader, merchants need to get a manual imprint of the card, if possible, for protection against potential chargebacks.
- Amount of Data Submitted with Each Transaction – Visa and MasterCard have multiple levels of qualification. For example, transactions accepted by telephone that do not meet the requirement, such as when only a partial address is provided, for Address Verification (AVS) are assessed higher rates, which are passed to the merchant.

What You Can Do To Reduce Your Costs

The **Maine Medical Association** has partnered with **Elavon**, a leading merchant processor that is determined to help you save money on credit card processing fees.

The most important thing you can do is to enter all required data when prompted by your credit card terminal. Simply, you will save money. For example, we recently worked with a medical office that was considering a competitive offer. A review of the account by Elavon revealed a large portion of the practice's transactions were downgrading – failing to qualify for the best rate.

What Elavon discovered is that terminal prompts requesting information were being ignored and this resulted in higher transaction fees. We asked the Office Manager to instruct employees who handle credit card transactions not to ignore terminal prompts. Elavon watched the transactions for about a week and not a single transaction resulted in a downgrade. In other words, every transaction qualified at the best possible rate. At the end of the year and going forward, the office will save substantially on credit card fees.

Elavon invites you to take advantage of the special discounted rates available to you as a member of the MMA. Even if you are currently using another payment processor, call us for a free rate comparison.

To get started, please call the MMA dedicated Elavon Sales Executive Kimberly Layton at **(866) 638-8614** or email her at Kimberly.layton@elavon.com.

BRIEFLY STATED

Andrew MacLean, Esq., Deputy EVP and General Counsel of MMA will be on a three-month sabbatical from July 1 to Sept. 30, 2013. Andrew has been with the Association for fifteen years.

Maureen Elwell, a valuable employee of MMA for the past several years, has left the full-time employment of MMA to work in a family-related business. She will continue to assist MMA from time to time and will continue to provide administrative services to the Maine Chapter of the American College of Emergency Physicians.

MMA has contracted with **Jill Barkley** to provide support to the ACA Outreach grant from the Maine Health Access Foundation (MeHAF), replacing Sandy Nesin, J.D. who has taken a full-time position in provider relations with Maine Community Health Options. Jill most recently had a contracted position with the Mine Civil Liberties Union. We congratulate Sandy for passing the Maine Bar Exam a few months ago! She is the daughter of long-time MMA member Noah Nesin, M.D.

Condolences

MMA was sorry to learn of the passing of several MMA members who had been significantly involved in various aspects of medicine in Maine the last several decades. We express our sincere condolences to their families.

Omar "Chip" Crothers, M.D.,
Orthopedic Surgeon

Philip Whitney, M.D.,
Internist

Frank Mroz, M.D.,
Radiologist

Craig Young, M.D.,
Ophthalmologist and a former President of MMA

Maine medicine
Maine Medical Association
30 Association Drive • P.O. Box 190
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Visit us on the web at www.mainemed.com

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