Lyme Disease in the Granite State

In March, the Medical Society held a CME program on Lyme because of the high incidence of the disease and because diagnosis and treatment are a challenge. The well-attended program was hosted by Medical Society president, Dr. William Kassler, at the SERESC Conference Center in Bedford. State Epidemiologist, Dr. Jodie Dionne-Odom and State Public Health Director, Dr. Jose Montero, covered the biology of Lyme borreliosis as well as surveillance and prevention. Infectious disease specialist, Dr. David Itkin, presented treatment guidelines from IDSA (Infectious Disease Society of America) and family physician, Dr. Kevin Young, presented guidelines from ILADS (International Lyme and Associated Diseases Society). ILADS is an advocacy group which argues that the persistence of B. burgdorferi following the standard course of antibiotics is responsible for many of the sequelae of Lyme disease, and supports prolonged antibiotic therapy (sometimes for years). IDSA, CDC, and NIH advise against the long-term treatment of so-called chronic Lyme disease because of potential toxicity and the lack of scientific evidence that such treatment is effective. The program concluded with Dr. Kassler moderating a question and answer panel of the speakers for participants to ask specific clinical questions about their challenges with Lyme disease. The program evaluations were positive and numerous participants stated that the conflicting views (IDSA vs. ILADS) were handled very respectfully.
President’s Perspective

Coping with Change

William, J Kassler, MD, MPH

The practice of medicine appears to be changing at a rapid pace. We are challenged to keep up with the explosion in the medical literature, and the rate in which emerging technology is diffusing into the medical marketplace seems dizzying. With the dawn of the era of genomics and personalized medicine, the rate of change is poised to accelerate even more.

On top of those trends, we are entering a time of rapidly changing demographics. In January, the first of 76 million people classified as baby boomers turned 65 and became eligible for Medicare. Over the next year, 2.8 million will qualify. By the time the last boomer retires in 2030, the Medicare program will have grown from 47 million today to 80 million. And we know that this generation will live longer, have more chronic diseases, and use far more health care per individual than any previous generation.

At the same time, there is consensus among policy makers that our current health care system is not sustainable. States are desperate to find a way to contain Medicaid costs, and providers are concerned that Federal and State governments will seek budgetary relief through draconian cuts in reimbursement rates.

Partly in response to the all of these changes, we are now witness to a rapidly changing policy environment, which will also impact how we practice medicine.

Many of those policies will seek to change how we are reimbursed; and to hold us more accountable for greater quality, better outcomes and reduced costs.

These changes can seem very dislocating and threatening. Yet, for practices that are prepared, there will be significant opportunities. There will be new models that make it easier for doctors and clinicians in different care settings to work together to care for our patients; to be fairly reimbursed for care coordination, counseling and following evidence-based guidelines; and to share in any savings that accrue from more efficient care. Examples include patient-centered medical home models, and various forms of Accountable Care Organizations. If done well, these models of care can give us the latitude and even incentives to do more of the right things.

Whether we see these developments as unwarranted intrusion of third parties on the doctor-patient relationship, or we welcome them as much needed reforms, or a bit of both; these are trends that will continue regardless of which political party runs Congress or the White House. Beyond the ideological debates, sound bites and partisan rhetoric, there is a surprising amount of consensus among those who staff the committees and write the regulations.

To succeed in this rapidly changing world we will have to become better able to manage a panel of patients rather than just what happens face-to-face during the individual encounter. We have to become better able to coordinate care across multiple venues, better able to work in teams with other care providers, and become better not only at improving health outcomes, but at demonstrating that improvement.

It is my belief that to be successful in meeting these challenges we need to fully exploit technology, specifically the electronic health record. The capacities which are possible with the EHR, many of which are now in their infancy, give us an unprecedented opportunity to practice better medicine. These are tools that will facilitate the delivery of preventive services, that will enable us to become more effective practitioners “for

Continued on page 3
the betterment of public health” in ways that our predecessors could only dream about.

These challenges can only be met through the adoption and use of an electronic health record. As a profession, we are rapidly reaching the point where the complexities of medical care mean that we will not be able to practice quality medicine without one. Young physicians coming out of training will expect it, patients will insist on it, and physicians who don’t have those capacities and tools, will find it increasingly difficult to meet the demands of both public and private sector payers.

While all of this may be sobering for those who have not yet embraced the technology, there is good news. Certification means that vendors must now comply with national standards to assure different systems can communicate, and that sensitive patient data remains secure; financial incentives are available from Medicare and Medicaid; and technical assistance is available through the Regional Extension Center. There has never been a better time to get on board.

Did you know how **VALUABLE** the NHMS **INSURANCE PLAN** is to so many NHMS Members?

While this article will most likely find the most interest with those New Hampshire Medical Society [“NHMS”] members covered under our association health plan, it is important for all NHMS members to understand the tremendous benefit this program brings to NHMS members throughout the State. Not only does this program offer significant cost savings to our members, but it also offers a unique survivor spouse and retiree medical benefit.

NHMS prides itself on advocacy, education and offering a suite of business support services. While the former two benefits are realized by all physicians, (regardless of employment status), the latter offers the most benefit to those in private practice.

On February 1, 2011, NHMS announced that through a thorough and transparent process, it had selected a new insurance broker to lead the strategic direction for the NHMS plans, (health, dental, life, disability). The new broker, Workplace Benefit Solutions [“WBS”], has been working hard to ensure a smooth transition for our groups by providing the necessary infrastructure and expertise for the benefit of NHMS’ members. In addition, WBS will begin delivering the Anthem renewals on or shortly after April 1st which should be met favorably by our groups.

During this insurance renewal process, we learned several things about the size and composition of our health plan. Did you know…

- 500+ physicians participate in the NHMS medical plan;
- 800+ employed staff also participate in the medical plan;
- 2,500 +/- is the total number of people covered under the NHMS medical plan. This includes physicians, staff and dependents.

This important benefit plan is just one of NHMS staff’s priorities as it looks to find and preserve ways to support our members. As NHMS’ mission statement reads: “…for the well-being of our patients, for our profession and for the betterment of the public health…”

For more information on this or other benefits please contact Joy Potter, Membership Coordinator, NHMS at joy.potter@nhms.org.

~ Scott Colby

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**IMPORTANT NOTICE**

from NH Board of pharmacy

Both Drug Enforcement and the New Hampshire Controlled Substance Act requires that a complete inventory of controlled substances on hand be conducted on May 1, 1991, and repeated on May 1st of each odd numbered year thereafter (biennially). This should be completed on the required date and filed in such a fashion that it is separate and readily retrievable.

Each practitioner’s office (that engages in the possession of controlled drugs) should have THREE separate file folders for the following receipt records:

- All records of receipt of Class II drugs (CII)
- All records of receipt of Class III-V drugs (CIII-V)
- The biennial inventory

Should you have any questions or require any assistance, please call the Board of Pharmacy office (603-271-2350). Remember, Drug Enforcement applies civil fines to violations in the amount of $25,000 per violation. A telephone call for assistance can save you time and money.
On September 15, 2010, as I was continuing to orient myself to my new role, I attended a quarterly meeting of the New Hampshire Pediatric Society. The purpose of my attendance at this meeting was two-fold. In addition to being a “meet and greet,” this meeting afforded me the opportunity to meet with this NH chapter to learn more about its activities, issues of importance and how the New Hampshire Medical Society [“NHMS”] could support its efforts.

As with other similar meetings, members in attendance asked me about my background, asked about updates from NHMS and asked about my vision for how NHMS might be able to work more closely with them to the mutual benefit of our organizations. During this meeting, Suzie Boulter, MD, a well-known pediatrician and advocate for children, asked me if the NHMS had any plans to help physicians across NH, in all specialties, better understand the requirements under Maintenance of Certification.

Given my delay in writing this article, it may be that Dr. Boulter has wondered whether I ever intended to act on her suggestion. I am pleased to report to you Dr. Boulter that the answer is yes! This article is one way in which I believe the NHMS can help physicians better understand the rationale behind Maintenance of Certification and help shed some light on this process. I have reviewed the American Board of Medical Specialties’ website to educate myself on the history and requirements of this process.

According to its website, the Maintenance of Certification program was adopted in 2000 with the support of 24 Boards and assures competency by focusing in six (6) areas:

- Patient Care
- Interpersonal Skills and Communication
- Medical Knowledge
- Practice-Based Learning
- Systems-Based Practice
- Professionalism

As further detailed on its website, ABMS explains that these six(6) areas of competency are supported by a four(4) part process for continuous learning as follows (taken verbatim from the ABMS website):

**Part I - Professional Standing**
Medical specialists must hold a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories or Canada.

**Part II - Lifelong Learning and Self-Assessment**
Physicians participate in educational and self-assessment programs that meet specialty-specific standards that are set by their member board.

**Part III - Cognitive Expertise**
They demonstrate, through formalized examination, that they have the fundamental, practice-related and practice environment-related knowledge to provide quality care in their specialty.

**Part IV - Practice Performance Assessment**
They are evaluated in their clinical practice according to specialty-specific standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.

We know that several of NH’s specialty societies are helping their members with their Board-specific requirements and are offering training, educational sessions and CMEs to help member-physicians achieve Maintenance of Certification.

While the information in this article may seem somewhat rudimentary, it is our hope that a “refresher” on the basics of Maintenance of Certification will help shed some light on the rationale behind this important process as you continue to pursue your own certification. ‡

For more information, please visit the ABMS website:
http://www.abms.org/Maintenance_of_Certification/
2011 New Hampshire State Health Profile Released

Concord, NH – The 2011 New Hampshire State Health Profile is now available for use by state, community, and local public health agencies. This report provides updated data on many areas affecting the health of New Hampshire’s citizens including alcohol and drug abuse, physical activity, radon, cancer and much more.

“This comprehensive report contains a wealth of information on what we as a state are doing well, where we need to make improvements, and where our long-range planning efforts should be focused,” said Nicholas Toumpas, Commissioner of the Department of Health and Human Services (DHHS).

“Studies have rated New Hampshire the most livable state, and we have much to be proud of, but there are areas in which we must improve, such as obesity, nutrition, and substance abuse for the good of our citizens and our State.”

The data in the report indicate several positive trends, such as a decrease in the teen birth rate, a decrease in the percentage of adults who smoke, and an increase in the use of dental sealants. There are also some negative trends identified, including the number of residents living in poverty, the rate of obesity, and reports of substance abuse.

“Public health has been the driver of improvements in such areas as rates of disease, food safety, and clean water, so we need to keep that momentum going to focus on emerging challenges,” said Dr. José Montero, Director of Public Health at DHHS. “Some of these new challenges we face are the sharp rise in the obesity rate, access to health and dental care, and alcohol and illegal drug use. Our expectation is that this report will provide a framework for our public health partners as they plan their agendas for the future. There is much to do and we will rise to the challenge; it is time to start thinking about health as something to keep and not just something to attain.”

To read the report or download it, go to http://www.dhhs.nh.gov

Smoking Cessation

As you know, tobacco use affects many NH citizens and is the leading cause of chronic diseases. For example, in New Hampshire:

• 15% of pregnant women and 36% of pregnant teenagers report smoking during pregnancy; and 16% of respondents to the 2009 Behavioral Risk Factor Surveillance Survey reported smoking.

What works in clinical practice to help patients stop smoking?

It is well established that health care providers have a great impact on the health behaviors of their patients. Even brief tobacco use treatment interventions delivered by physicians, dentists and other clinicians increase quit attempts by patients. Each patient visit presents a teachable moment for clinicians to discuss tobacco addiction and offer assistance to improve the health of their patients.

In 2004, the Department’s advice was to follow the “5As”, recommended in the U.S. Public Health Service’s Clinical Practice Guidelines, Treating Tobacco Use and Dependence. In order to use your patient time more efficiently, I now recommend using the abbreviated promising practice of Ask, Assist, and Refer, which connects patients to the New Hampshire Smokers’ Helpline.

Ask your patients about tobacco use and readiness to quit;

Assist your patients by identifying reasons to quit and by prescribing medications; and

Refer your patients to the QuitWorks-NH program using the simple fax enrollment form found on http://www.quitworks-nh.org/. Electronic referral through your EMR is also possible. For more information, please call Donna M. Fleming, Administrator for the Tobacco Prevention and Control Program at 271-5898.

When your referral is received at the New Hampshire Smokers’ Helpline, our QuitWorks-NH counselors will call your patient within three days to complete a 7-minute intake and assessment. QuitWorks-NH will provide up to five telephone-based counseling sessions for each patient and other services, including feedback informing you of your patient’s status.

Submitted by Dr. Jose Montero
What You Need to Know: Version 5010 Testing Readiness

On January 1, 2012, the Version 4010/4010A electronic transaction standards used to send administrative transactions will be replaced with the upgraded Version 5010 standards. After this time, the Centers for Medicare & Medicaid Services (CMS) will no longer accept transactions in the Version 4010 format.

All health care providers that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) are required to comply with the new standards. This means providers, payers, vendors, and clearinghouses must be ready to implement the Version 5010 transaction standards on January 1, 2012. Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes, and must be in place first before the changeover to ICD-10. Version 5010 has the ability to tell your practice management or other system that you are using an ICD-10 versus an ICD-9 code. The Version 5010 change occurs well before the ICD-10 implementation date to allow adequate time for Version 5010 testing and implementation.

A key step in preparing your office for this upgrade is testing transactions in the new Version 5010 format. Testing transactions using Version 5010 standards will assure that you are able to send and receive compliant transactions effectively. Testing will allow you to identify any potential issues, and address them in advance of the January 1, 2012, compliance date.

All HIPAA covered entities that submit transactions electronically are required to upgrade to the Version 5010 transaction standards, and should conduct testing both internally, and with external business partners in preparation for the January 1, 2012, compliance deadline. Covered entities include: providers – physicians, including alternate site providers; payers; health care clearinghouses; pharmacies; and health plans.

The first step in testing can begin as soon as your software has been upgraded. CMS suggested completing a thorough internal testing of your upgraded transaction systems by December 31, 2010.

Internal testing allows you to identify and address any potential issues that may arise in advance of testing with external business partners. If you have not yet done so, take action now to complete your internal testing as soon as possible to ensure a smooth transition and begin external testing.

After you have completed internal testing, you can begin sending test data to your external business partners to ensure a smooth transition. Identify the partners you currently conduct transactions with, and create a schedule and timeline for external testing with each partner. Identify priority partners to conduct testing with if you trade with a large number of business partners. The following business partners would be included in external testing: billing services; clearinghouses; pharmacies; entities responsible for coverage and benefit determinations; and payers.

Confirm that your business partners are also engaged in testing with other external partners they may work with. This is crucial to completing comprehensive testing. Allow for sufficient time to train, and practice with staff using the new transactions. You will need to test transactions that you currently use on a daily basis such as: claims; eligibility determinations; remittances; and referral authorizations.

The Medicare Fee-for-Service (FFS) program began accepting test claims with the basic Version 5010 standards with external partners in January 2011. It will accept claims in both test and production mode using the errata Version 5010 standard (an X-12 updated version featuring corrections) beginning in April 2011. You can begin to test your transactions with Medicare now, and up until the January 1, 2012, mandatory compliance date.

After January 1, 2012, Medicare will no longer accept transactions using the Version 4010 standards. Don’t wait; begin testing as soon as possible to help reduce risk and avoid any last-minute rush to test with your business partners. Most importantly, test now to ensure there are no interruptions in your claim remittances or payments.

CMS has resources available to help you in the transition process – even help you get the conversation started with your business partners if you haven’t already. Go to the CMS web site, www.cms.gov/ICD10, for Provider and Vendor Resource pages that include fact sheets with tips on asking each other the right questions.
Save The Date

NHMS Annual Scientific Conference

November 4-6, 2011
Mountain View Grand Resort & Spa
Whitefield, NH

Hotel Amenities include:
- Indoor Pool Activities
- Horseback Riding
- Hiking
- Golf
- Spa Treatments
- Fitness Center
- Farm & More!

Please watch for more details
NH Medical Society (NHMS) put on another top notch CME event—held March 9th at the Grappone Center. It was facilitated and run by Stuart Glassman, MD, Treasurer of NHMS, with presentations from local and national experts on Concussion; i.e., Dr. Michael Collins, Ann McKee, MD, Dr. Neal McGrath and medico-legal issues of concussion management were discussed by Bradley Holt, Esq.

Many guidelines on evaluating, diagnosing and treating concussions were introduced. Evaluation tools such as ImPACT were described and recommended. Practical tools for clinicians to use in their practices were given for better recognition and awareness of concussion and concussion syndromes.

If you missed it this time, don’t worry- NHMS hopes to repeat this great conference.
Concussion Symposium II
Complaints Received in the Office Practice

Research studies show that most patients and their family members accept annoyances and frustrations and do not speak up to voice their concerns. Patients are willing to accept occasional annoyances if they recognize that the physician and staff care about them and are working to assist them.

Frequent sources of dissatisfaction include:

- A prolonged wait in the reception room
- Feelings of isolation in an exam room
- Difficulty in obtaining a convenient appointment
- Lack of understanding of treatment options

Patients and visitors need to know whom to complain to and that there is a mechanism in place to report and/or discuss their concerns. Physicians should be involved with any complaint related to quality-of-care issues.

How to respond when a patient complains:

1. Listen closely; do not interrupt; do not ask questions initially. Pay attention to body language, the patient’s and your own. Show sincere interest. Maintain eye contact. Meet complaints with understanding.
2. Empathize - imagine how the patient is feeling. Be willing to say “I understand.” “I’m sorry we made a scheduling error.”
3. Inquire - to add clarity to the complaint. Ask open-ended questions that cannot be answered with a “yes” or a “no” response. Ask, “Would you tell me about the situation that upsets you?”
4. Ask the patient what he/she thinks should be done about a particular situation/issue.
5. Offer alternatives or suggest solutions to resolve the issue satisfactorily. Commit to resolving the patient’s complaint.
6. Respond with a resolution or inform him/her when to expect a response. Acknowledge that steps will be taken to solve the problem.
7. Thank the patient for the opportunity to address his/her complaint.

Tracking, trending and monitoring complaints:

Soliciting and trending patient complaints supports the patient satisfaction process.

- Implement a mechanism and procedure for soliciting, responding and trending complaints. Consider using a form that enables patients to either check-off items or list their complaint.
- Identify patterns of complaints and implement corrective measures.

Recheck to ensure the response or the change is appropriate, acknowledging that others will benefit.

Complaint letters:

Correspondence should not be routinely placed in the patient’s medical record which is a legal document created to reflect the patients care and treatment. Correspondence should be kept in a Quality Improvement file. Reply promptly and include in the letter a summary of the problem.

- Letters should be short yet caring and professional.
- Document care issues identifying the patient’s concern, the method of communication and the outcome/solution.

If the complaint is complex in nature or the potential for a malpractice claim exists, contact your malpractice insurance carrier for assistance with letter writing.

Complaints may range from the simple to the complex. Whether reasonable or not, the basis for a complaint is the result or the perception of an unmet expectation. Address complaint handling as an opportunity to demonstrate to patients that they are valued and that their satisfaction is an important consideration in the practice.

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

MMIC is a NHMS Corporate Affiliate
There are insurance carriers that have shown themselves to be more than happy to settle a medical professional liability claim when it’s deemed a less expensive alternative to defending it — sometimes even when the case is without merit. We’ve even heard of cases where the decision to settle was made without consulting the physician who had been sued. Is that the kind of “coverage” you have?

With Medical Mutual you can be sure that if you’re ever the subject of a significant claim, our Claims Committee, comprised of practicing physicians like you, will review the details of your case. Then they — not businesspeople — determine whether it’s best to settle or defend, based on the medical facts. And in the end, we believe that since it’s your reputation and record that are on the line, the decision to settle or defend is your call.

Your patient filed a claim. Will your carrier conduct a peer review on your behalf, or a cost-benefit analysis?

If you prefer that kind of respectful, peer-directed coverage, make it your call to say so. Talk to your practice or hospital administrator about making sure you’re insured by Medical Mutual. For more information, contact John Doyle toll-free at (800) 942-2791, or via email at jdoyle@medicalmutual.com.
More than 22,000 healthcare professionals throughout the country depend on medical malpractice insurance from ProMutual Group for protection and peace of mind.

- We have the long-term vision and financial resources to provide the coverage you need today and in the future.
- We proactively partner with you to minimize risk, increase patient safety and improve patient care.
- And if you do face a claim, we will aggressively defend good medicine and provide the emotional support you need to rest assured.

To learn more about ProMutual Group, call us at (800) 225-6168 or visit us online at www.promutualgroup.com.
We are proud to have been named benefits broker for the New Hampshire Medical Society.

Since 2001, WBS has specialized in providing hospitals, health care providers and other companies with innovative tools and strategies to better manage employee benefit programs.
Established multi-disciplinary private practice group in Exeter, NH seeks adult/adolescent psychiatrist to assume active part-time practice of retiring physician. Great opportunity to expand to full time if desired. For more information call Paul Belliveau, MD at 603-778-0505 or email our office manager michele@coastalcounseling.com

Established multi-disciplinary private practice group in Exeter, NH seeks nurse practitioner to assume active part-time practice of retiring physician. Great opportunity to expand to full time if desired. For more information call Paul Belliveau, MD at 603-778-0505 or email our office manager michele@coastalcounseling.com

Oral health is critical to overall health.

Northeast Delta Dental is pleased to support the New Hampshire Medical Society as a Corporate Affiliate and offer a dental program designed for its members.

For more information, contact New England Employee Benefits Company at 603-228-1133.
Welcome New Members!

Glenn B. Adams, D.O.
Hossam A. Algamil, M.D.
Steven J. Andriola, M.D.
Frances R. Baccus, M.D.
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Jonathan D Casciano, M.D.
Eunice Y. Chen, M.D.
Peter C. Cook, M.D.
Michael B. Davidson, D.O.
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Jonathan J Eddinger, M.D.
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Evelyn L. Fleming, M.D.
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Eileen P. Kirk, M.D.
Brian R. Knab, M.D.
Geeta A. Kulkarni, M.D.
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Daiying Lu, M.D.
Elizabeth A Lynch, M.D.
Cathleen E. Morrow, M.D.
Mark D. Myers, M.D.
Michael R. Newton, M.D.
Tung T. Nguyen, M.D.
Sazia Nowrin, MD
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John M. Panopoulos, D.O.
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Christopher M Riccio, M.D.
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William C. Siroty, M.D.
Aaron D. Solnit, M.D.
Brian R Sponseller, M.D.
Keith A. Stahl, M.D.
Glen L. Steeves, M.D.
Tara L Thurston, D.O.
Veronica Triaca, M.D.
Tanja Vanderlinde, M.D.
Kathryn M. Vargo, M.D.
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Adrienne P. Williams, M.D.
Mitchell R. Young, M.D.
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NHMS CAP is a paid membership program whose members meet criteria as posted at www.nhms.org
New Hampshire Medical Society
7 North State Street
Concord, New Hampshire 03301-4018

ADDRESS SERVICE REQUESTED

Getting There
Meaningful Use and Your Practice

Monday, May 16, 2011     8:00 am – 12:00 pm
Frisbie Memorial Hospital
Community Education Conference Center, Strafford Room
11 Whitehall Road, Rochester, NH

Save The Date 5/25
Medical Home and Maintenance of Certification (MOC): Help Is On the Way
Join NH Pediatric Society on May 25
SERESC Conference Center, Bedford, NH
Featured Speaker: Paul Miles, MD