**Therapeutic potential of physical exercise in early psychosis**


*Dr. Noordsy is one of the keynote speakers at Trending Topics 2018, this year’s NHMS Annual Scientific Conference. Registration details below.*

Individuals with psychotic disorders may benefit from establishing an exercise regimen as part of their care. Exercise effects neuroprotective mechanisms, such as decreasing inflammation, increasing neurogenesis and neuroplasticity, and remyelination of white matter tracts, resulting in at least a partial reversal of the regional brain matter loss that is seen in patients with psychosis. Clinically, there is substantial evidence that physical exercise can result in improvements in cognition, mood, and positive and negative symptoms. Further research is needed to assess optimal dose and type of exercise, motivational strategies, and potential impact on self-efficacy, reward, and social engagement. Initial evidence suggests that exercise may also have promise in early psychosis. It remains unknown whether exercise, in combination with other evidence-based interventions, might reduce the rate of conversion from attenuated psychosis syndrome or schizophreniform disorder to schizophrenia. Remission from early psychosis in

Therapeutic potential, cont. on page 5

**How Welcoming is Your Office?**

By Bobby Kelly, MD, MPH

Earlier this year, my practice’s Electronic Medical Record (EMR) had one of its famous “upgrades”. In addition to updated pharmacy formularies and more robust messaging capabilities, we were also informed of a new demographic field available called “gender identity”. As with most EMR upgrades, there was some fanfare during the initial transition, but after a few weeks, we were all back to working with our nose to the digital grindstone, so to speak. I did notice, however, that most folks (myself included) didn’t know how—or when—to use the gender identity field. That’s because it was located in

How Welcoming, cont. on page 6

**Intrigued? Be sure to catch Dr. Noordsy’s keynote address at this year’s NHMS Annual Scientific Conference.**

Trending Topics 2018

Fri.-Sun., November 9-11

Wentworth by the Sea Hotel and Spa, New Castle, NH

Earn up to 14 CME credits including the NH opioid prescribing competency requirement!

Registration and Room Reservation Info at: http://www.nhms.org/2018conference

**Also in this issue...**

Opiate Epidemic

Arsenic in Food and Water

Termination of the Physician-Patient Relationship
We are all aware of the very ominous opiate epidemic in New Hampshire and the country at large. As 2017 progressed we were initially hopeful that data was showing a decrease in opiate deaths in New Hampshire, but that expectation didn’t pan out as the final statistics showed that there were 483 deaths from opiates in New Hampshire in 2017, just two less than the 485 deaths in 2016. The totals for the United States actually showed an increase to 42,249 in 2017, more than the 41,070 deaths due to breast cancer that year (CDC).

One more statistic of note, also from the CDC: 106 killed by opiates per day in 2017, the same rate of death by firearms per day in 2017. Thus death by opiates and firearms are indeed a dual epidemic, as I have written about previously.

It is important to appreciate that the opiate epidemic of overdose deaths has morphed into becoming a fentanyl problem, in that the vast majority was due to fentanyl alone, or fentanyl combined with heroin. That is not to say that the origins of opiate addiction were not often due to use of prescribed opiate medications or stolen or misused opiate prescriptions.

So how can we imagine stemming this tide of opiate deaths in New Hampshire and the United States? In this blog I want to offer some general suggestions from the perspective of a psychiatrist practicing in the community.

1. **Decrease the amount of opiates prescribed.**

   In New Hampshire, and I think elsewhere we have made great strides at reducing the frequency and the amounts of opiates prescribed. The use of the PDMP has also helped tremendously to enhance careful prescribing practices and ensure patients are not accessing opiates from more than one practitioner.

2. **Facilitate the disposal of unused opiates.**

   This is a major problem that has not really been addressed. This is a continuing and very crucial problem that needs to be approached at a state or federal level. All too often opiates in medicine cabinets and elsewhere are misused by family members or stolen and then used to begin or aid in the addiction process.

3. **Provision of timely emergency services to begin the possibility of treatment for opiate addiction at.**

   This is important to appreciate that the opiate epidemic of overdose deaths has morphed into becoming a fentanyl problem, in that only one death in New Hampshire from opiate OD appeared to be due to heroin alone. The
Arsenic in Water and Food: Implications for New Hampshire

The NH Comprehensive Cancer Collaboration (NH CCC), in partnership with Dartmouth-Hitchcock Norris Cotton Cancer Center and its NCI National Outreach Network Educator Community Health Educator Site, recently released a new emerging issue brief, “Arsenic in Water and Food”. In New Hampshire, an estimated 61,000 individuals drink private well water that exceeds the EPA limit of containing greater than 10 parts per billion (ppb) of arsenic. Arsenic has been linked to cancers of the bladder, skin, kidney, liver, prostate, and lung, as well as to other negative health effects.

Public water supplies are regulated, tested, and treated to meet maximum contaminant levels, but private wells have no such requirements. It is the responsibility of the well owner to test, treat, and maintain the quality of their private water supply. Dietary arsenic exposure is also a concern. A 2016 study of New Hampshire Birth Cohort participants found that the intake of rice and rice products was associated with inorganic arsenic exposure in infants and suggested that every effort should be made to reduce arsenic exposure during this important phase of development.

In New Hampshire, arsenic exposure via contaminated drinking water or food happens every day. Simple steps, like testing well water or eating a varied diet, can make a real difference.

Learn more in the full version of the brief, which can be found under “Quick Links” on the NH CCC home page, http://www.nhcancerplan.org.
Vacant positions on the Board of Medicine and Medical Review Subcommittee.

The Board of Medicine has one (1) vacant public member positions on the Board.

RSA 329:3 Eligibility for Board Membership states “All appointed members who are physicians or surgeons shall be residents of the state, regularly licensed to practice medicine and shall have been actively engaged in the practice of their profession within the state for at least five years. The other members of the board shall have been residents of the state for at least 5 years.”

RSA 329:2, I states, in part, “Any public member of the board shall be a person who is not, and never was, a member of the medical profession or the spouse of any such person, and who does not have, and never has had, a material financial interest in either the provision of medical services or an activity directly related to medicine, including the representation of the board or profession for a fee at any time during the 5 years preceding appointment.”

If you meet the criteria above and wish to apply for the vacancy on the Board, please send your letter of interest and a current resume or curriculum vitae to:

His Excellency, Governor Christopher T. Sununu and The Honorable Council State House Concord, New Hampshire 03301

The Medical Review Subcommittee (MRSC) to the Board of Medicine, pursuant to RSA 329:17, V-a, is looking for two (2) physician members and one (1) public member to serve on the MRSC. For the physician members, the MRSC is in need of the following specialties: General Surgery and Internist/Hospitalist.

RSA 329:17, V-a states “A medical review subcommittee of 13 members shall be nominated by the board of medicine and appointed by the governor and council. The subcommittee shall consist of one member of the board of medicine and 12 other persons, 3 of whom shall be public members, one of whom shall be a physician assistant, and 8 of whom shall be physicians. One of the physician members shall practice in the area of pain medicine and anesthesiology. Any public member of the subcommittee shall be a person who is not, and never was, a member of the medical profession or the spouse of any such person, and who does not have, and never has had, a material financial interest in either the provision of medical services or an activity directly related to medicine, including the representation of the board or profession for a fee at any time during the 5 years preceding appointment. The terms of the public members shall be staggered so that no 2 public members’ terms expire in the same year. The subcommittee members shall be appointed for 3-year terms, and shall serve no more than 2 terms. Upon referral by the board, the subcommittee shall review disciplinary actions reported to the board under paragraphs II-V of this section, except that matters concerning a medical director involved in a current internal or external grievance pursuant to RSA 420-J shall not be reviewed until the grievance process has been completed. Following review of each case, the subcommittee shall make recommendations to the board. Funds shall be appropriated from the general fund for use by the subcommittee to investigate allegations under paragraphs I-V of this section. The board shall employ through the office of professional licensure and certification a physician as a medical review subcommittee investigator who shall serve at the pleasure of the board. The salary of the medical review subcommittee investigator shall be established by RSA 94:1-a.

If you meet the criteria above and wish to apply for the public member vacancy on the MRSC, please send your letter of interest and a current resume or curriculum vitae to:

Emily Baker, M.D., President NH Board of Medicine 121 South Fruit Street, Suite 301 Concord, New Hampshire 03301
the context of evidence-based coordinated specialty care is not entirely unexpected, independent of exercise. However, the patient described in our case rapidly achieved high levels of physical exercise in response to specific lifestyle recommendations and a behavioral reinforcement process in our early psychosis program that may have contributed to his good outcome.

Whether for the purpose of improving general health or the possibility of improving clinical symptoms, it would be beneficial for healthcare providers to assess physical activity and educate patients about exercise as a treatment option. Integrating exercise as a core component of early psychosis treatment for those who wish to undertake it has a range of potential benefits for mental and physical health, including potential synergies with other treatment components. Coordinated specialty care teams might incorporate a fitness instructor or link with a local fitness program to facilitate physical exercise. It is important to make specific recommendations for exercise and support and monitor adherence when patients choose exercise as part of their care. Knowledge of the evidence supporting the efficacy of exercise in psychiatric disorders and the principles of behavioral change outlined here will help clinicians to be effective in the use of exercise in clinical care.

the demographic screen, usually completed at initial registration and check-in. Furthermore, we hadn’t yet updated our paper intake forms, and there still wasn’t an area for a new patient to indicate their gender identity upon intake.

Over the last ten years, I have become rather interested in Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) health, including the very basic steps of making practices more open and inviting places for our LGBTQ patients to feel comfortable. I have worked with several LGBTQ Health Centers throughout the country, including New England’s very own Fenway Health in Boston. One area that we all can learn from is improving our intake forms to include collecting sexual orientation and gender identity (SO/GI) data. Rather than reinventing the wheel, there are many existing resources that have excellent ideas for how to structure an intake form that does not exclude people right out of the gate (one example is from the National LGBT Health Education Center http://www.lgbthealtheducation.org/wp-content/uploads/Collecting-SOGI-Data-in-EHRs-COM2111.pdf).

While most EMRs have the capability now built into them, many practices simply don’t ask patients for the data to include in these discrete fields. Not only is this information relevant to helping risk stratify patients and make appropriate preventive medicine recommendations, it also serves as a message to our LGBTQ patients that our practice is a welcoming environment that respects them as a whole person.

In addition to creating thoughtful and useful intake forms, providers can also help to make their practices more inviting places to members of the LGBTQ community by ensuring there is at least one gender-neutral (or single stall) restroom in the practice, featuring posters/materials that represent a diversity of families and patients, and using gender-neutral language when taking a sexual history. Further, there are many resources available which can help make office staff more aware and culturally sensitive to LGBTQ specific topics (www.lgbthealtheducation.org/topic/lgbt-health). These steps, while seemingly minor, can speak volumes to our LGBTQ patients if done in a genuine way, and will help decrease the health disparities that unfortunately currently exist for this patient population.

How Welcoming, cont. from page 1
The NH Professionals Health Program (NHPHP) is a confidential resource available to all NH licensed physicians, PAs, dentists, pharmacists and veterinarians who are experiencing difficulties with:

- alcohol, drugs or other substances of abuse
- depression, anxiety or other mental health issues
- professional burnout or work-related conflict
- marital or family life matters

For a confidential discussion call Dr. Sally Garhart at (603) 491-5036

LEARN MORE @ WWW.NHPHP.ORG

Congratulations to Peter Meyer on his induction as a Fellow of the American College of Trial Lawyers
the first notice of the problem.

This is an ongoing problem, as there is not generally available a relatively seamless and timely process for referral, so treatment cannot be initiated in our emergency departments, hospitals or our medical offices. Although NHMS-sponsored MAT programs have greatly increased the number of physicians and nurse practitioners who have been accredited to provide MAT (suboxone and subutex), it remains difficult for physicians in emergency departments, hospitals and medical offices to initiate MAT without readily available follow-up by qualified practitioners to continue MAT on an outpatient basis.

4. Sufficient state and federal support for outpatient treatment and rehab treatment of patients with opiate addiction.

The available funding for wrap-around treatment of opiate addiction is far from adequate. As an example, Medicaid funding for mental health and substance abuse treatment is inadequate, so that rehab facilities in New Hampshire are closing rather than expanding, limiting already limited resources. The federal government has recently provided $23,000,000 to New Hampshire, and although that is substantial, it is far from adequate to address this epidemic. Governor Sununu and the New Hampshire government are in the process of figuring out how to allocate those funds*, but again the support from both the federal and state govern-

5. Consider treatment versus imprisonment for opiate addicts.

Our jails and prisons are filled with prisoners with substance abuse problems. It is costly, and hasn’t worked well at all. It would be much better to offer substance abuse treatment rather than jail or prison. Drug courts in New Hampshire and elsewhere are beginning to make a difference and those efforts should be supported.

It is often said that “following the money” would clarify analysis of a problem. In order to really significantly impact the opiate epidemic raging in New Hampshire and throughout our country, we definitely need more financial resources to truly make a difference. So far, the will to do something meaningful on a state and federal level is just not evident, so my sense is that the epidemic of addiction and death from opiates will unfortunately continue to be astounding. I hope I’m wrong.

I realize that suggestions I have offered are not a comprehensive list of changes that might help with the opiate epidemic. I would appreciate further suggestions of approaches that you think would be needed to impact this epidemic. Please consider contacting me at lenkorn.md@gmail.com with your ideas.

* Editor’s note: Gov. Sununu and state Health Commissioner Jeff Meyers unveiled their plan on Aug. 14, after the copy deadline for this issue.

---

**NH Alcohol and Drug Treatment Locator**

Are you looking for alcohol or drug treatment?

Visit: [www.nhtreatment.org](http://www.nhtreatment.org)

Treatment is available. Contact a provider in your area today.
2017-2018 NHMS Council

President: Leonard Korn, MD
President-Elect: Tessa J. Lafortune-Greenberg, MD
Immediate Past President: Deborah A. Harrigan, MD
Penultimate Past President: John R. Butterly, MD
Vice President: John L. Klunk, MD
Secretary: Eric A. Kropp, MD
Treasurer: Stuart J. Glassman, MD
Speaker: Richard P. LaFleur, MD
Vice Speaker: Daniel M. Philbin, MD
AMA Delegate: William J. Kassler, MD, MPH
AMA Alternate Delegate: P. Travis Harker, MD, MPH
Chair, Board of Trustees: John R. Butterly, MD
Trustee: Deborah A. Harrigan, MD
Medical Student: John R. Butterly, MD
Physician Assistant: Linda L. Martino, PA-C
Osteopathic Association Rep.: Maria T. Boylan, DO
Youth Physician Reps.: Kenton Allen, MD, Anthony M. Dinizio, MD
Members-at-Large: Diane L. Arsenault, MD, Albert L. Hsu, MD, Seddon R. Savage, MD, Doris H. Lotz, MD, MPH, Linda Kornfeld, MD
Board of Medicine Representative: Nick P. Perencevich, MD
Lay Person: Lucy Hodder, JD

Physician Representatives:
- Dept. of Health & Human Services: Benjamin P. Chan, MD
- Specialty Society Representatives:
  - NH Chapter of American College of Cardiology: Daniel M. Philbin, MD
  - NH Chapter of American College of Physicians: Richard P. LaFleur, MD
  - NH Academy of Family Physicians (2): Gary A. Sobelson, MD, Molly E. Rossignol, DO
  - NH Chapter of Emergency Physicians: Thomas J. Lydon, MD
  - NH Society of Eye Physicians & Surgeons: Lauren Branchini, MD
  - NH Pediatric Society: Skip M. Small, MD
  - NH Radiology Society: Terry J. Vaccaro, MD
  - NH Psychiatric Society: Jeffrey C. Fetter, MD
  - NH Society of Anesthesiologists: Steve J. Hattamer, MD
  - NH Society of Pathologists: Eric Y. Loo, MD
  - NH ACOG: Oge H. Young, MD
  - NH Orthopaedic Society: Glen D. Crawford, MD
Invited Guest: MGMA Representative: Dave Hutton

NHMS Welcomes
New Members

Amer Al-Nimr, MD
Michael S. Calderwood, MD
Robin K. Caron, DO
Susan B. Coulter, MD
Samuel M. DiCapua, DO
Trevor W. Eide, MD
Erin T. Hattan, MD
Amanda J. Hepler, MD
Barbara L. Nye, MD
Brian S. Porter, MD
Jonathan B. Thyng, MD

WANTED

Internal Medicine, Orthopedic, Neurologic, General or Family Practice
Physicians interested in providing part-time or full-time staff medical consultant services for the Social Security Disability program, through the state Disability Determination Services office in Concord, NH. Staff work involves reviewing disability claims on-site and requires no patient contact. SSA Training is provided.

OR

Physicians interested in performing consultative examinations in their office for the Social Security Disability program, through the state Disability Determination Services office. Compensation is provided per exam. All administrative aspects are performed by the DDS and no billing is required. Free dictation service and a secure web portal is provided for report submission. Any interested physician must be licensed by the state of NH and in good standing. Please email inquiries to: Anne.Prehemo@ssa.gov
Termination of the Physician-Patient Relationship

A physician’s improper termination of the physician-patient relationship may put the physician at risk for a claim of abandonment. Following the guidelines below may mitigate this risk.

I. POLICY:
- Identify common causes of termination such as non-payment, excessive missed or canceled follow-up appointments, failure to follow agreed upon treatment plan and the refusal of a patient to maintain acceptable behavior.
- Formalize your termination process in a policy and procedure.
- Provide all patients (active and new) with the termination policy.

II. CONSIDERATIONS:
- Don’t act hastily in making a decision. Try to salvage the relationship.
  - For “patient noncompliance,” facilitate a face-to-face conversation with the patient to clearly communicate expectations. Clarify any misunderstanding or misperceptions. Develop a documented mutually agreeable plan.
- Review the patient record to determine if the documentation supports termination.
- Review managed care contacts to determine if termination is permitted.
- For disabled patients or those in a protected class, consult an attorney before terminating.
- Threats of violence, actual violence or criminal acts may necessitate verbal and immediate termination. Follow-up with a termination letter.
- Do not terminate if:
  - Similar medical care is not locally available.
  - The patient is urgent, emergent or is being treated for an acute condition requiring continuous care.

III. PROCESS:
- Author a termination letter signed by the patient’s physician that contains the following:
  - Notification that the relationship is being terminated. In a group practice, specify if the termination involves only one or all physicians in the practice.
  - Stating the reason for termination in the letter is optional. If stated, the reason should be clear, concise, and objective.
  - A deadline. Thirty days is a general guideline, longer may be necessary based on patient circumstances.
  - Clarification that the physician is available to provide care during the transfer period.
  - Resources to assist in locating another physician.
  - The need for ongoing care and the consequences of forgoing continued care and treatment (as appropriate).
- A statement that the office will facilitate a transfer of records at the patient’s request. Include an authorization for release of records.
- Send the termination letter certified mail, return receipt requested.
  - If the certified letter is returned, resend it in a plain envelope.
- Document the termination process in the patient’s record. Include copies of letters, receipts and refusals.
- Advise staff not to schedule the patient after the termination effective date.
- For complex situations, consult with your professional liability insurance carrier or an attorney.

IV. PATIENT DISMISSES A PHYSICIAN
- Send a letter to the patient confirming that the relationship has been terminated.

V. PHYSICIAN ON-CALL TO THE EMERGENCY DEPARTMENT (ED)
- When a physician is on ED call, the physician must respond to requests to treat a patient even if the patient has been terminated from 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.
Partners in patient safety & medical liability protection

www.medicalmutual.com
Physicians’ Bi-Monthly

Ready to help in the Boardroom or the Courtroom

Michael Pignatelli  Steve Lauwers  Ken Bartholomew  Adam Varley
Barbara Greenwood  Adam Pignatelli  Larry Smith  Lindsey Dalton
RN Paralegal

ADVOCATES FOR THE MEDICAL PROFESSION
Rath, Young and Pignatelli, P.C.  www.rathlaw.com
Concord  (603) 226-2600  Nashua  (603) 889-9952
Boston  (617) 523-8080  Montpelier  (802) 229-8050

FREE 1-Credit Training for Healthcare Providers
Responsive Practice: Providing Health Care & Screenings to Individuals with Disabilities

Course overview: Online, on-demand & free for a limited time. Helps health care providers to:

- Describe disparities in health experienced by people with disabilities;
- Recognize barriers people with disabilities face when accessing health care & preventive services; and
- Acquire strategies & approaches to provide disability-competent, responsive care.

Register and access the training anytime at:
www.ResponsivePractice.org
(603) 862 4320  Relay 711
dph.iod@unh.edu

12
Streamline your benefits management process with NEEBCo Connect, a complete online enrollment and ACA compliance solution.

NEEBCo Connect provides employers with:

- Electronic benefits enrollment
- 1094/1095 completion
- Clear employee communications
- Compliance management
- Customized reporting
- Mobile app integration

Visit www.neebco.com or call (603) 228-1133 for more information.

Serving employers for more than 30 years.
The Question for Today’s Physician – To Lead or Not to Lead

By James Potter, NHMS EVP

With apologies to Will Shakespeare, our changing health care environment puts forward one of the most challenging questions for the medical profession today. Is it better to help lead in your practice, hospital, health system, local hamlet or even public office; or is a medical career’s fulfillment found in the clinical care of patients? Are these two pursuits mutually exclusive or phased elements of a physician’s career continuum?

A historical perspective suggests that the answer to these questions is rooted in how physicians have organized themselves over the later half of the last century and into this one. Prior to the 1960s, it was almost unheard of for a physician not to be leading a hospital or for a health system not to be physician driven. At about this time, the medical profession began to more highly specialize with groups of similar specialty physicians organizing themselves into practices who would then have some contractual relationship with the hospital for those services. These specialty practices flourished through peer-to-peer credibility and reliance.

Add to this the fact that the preponderance of more recent studies indicates that physician-driven hospitals perform better across all metrics. This should be intuitive for most, as much as it is now confirmed empirically. An engaged, vested medical team is going to more consistently perform better.

The challenge today is that the trusted peer-to-peer dynamic appears to have significantly eroded as hospital systems over the last ten to fifteen years have aggressively bought various physician group practices, as a means to survive and strategically position themselves in an increasingly competitive environment with smaller margins. What has been surprising in this process is the cultural disconnects between some management teams and their core assets. These riffs appear to be reinforced when new administrators – and even chief medical officers – are chosen from outside the organization and the community, often operating under a different set of values and concerns than the medical team.

For many physicians living in New Hampshire, there has been a remarkably uniform response expressed in how these cultural disconnects have impacted their professional self-esteem. “We feel like cogs” is what I have heard in my travels across the state to hospital medical staff meetings. It is an expression both figuratively and quite literally. Physicians view themselves as replaceable “widget-makers” playing a small role in the larger health corporation. The once sole captains of patient care, physicians have seen their roles impacted by ever-changing technology, micro-specialization, fragmentation, documentation, over-scheduling, performance measurements, prior-authorizations and financial constraints imposed by insurance carriers.

While physicians can help streamline and enhance hospital culture, processes and decision making, many lack the leadership training and management expertise to effectively collaborate with administrators or serve in that capacity. This lack of leadership self-awareness and business know-how can also hold back physicians who aspire to pursue healthcare leadership roles in their careers.

Our goal is to develop the capacity within the Granite State to cultivate effective physician leadership from the bedside to the boardroom by teaching management, communication, and leadership skills. This means fostering effective communication and integration between the medical staff and administration, and empowering physicians to foster change among their colleagues.

As a first step in developing a New Hampshire Physician Leadership Institute, I’m pleased to report that the inaugural cohort of the New Hampshire Physician Leadership Development Program is completely full and ready to begin in late September. We very much appreciate our partnership in this endeavor with the New Hampshire Hospital Association and UNH Paul College of Business.

This two-year, one morning a month program focuses on both the soft and hard skills of physician leadership: personal leadership competencies such as how a leader communicates, influences, builds trust and creates effective teams. These “soft” skills also include leading others, such as how to create engagement, motivate others, develop talent and coach people. The other half of this equation for physician leaders is understanding the business – its core metrics, drivers, levers and paths to profitability. Finally, it’s about leading change by emphasizing that change is constant, consistent and here to stay.

Other activities for the NH Physician Leadership Institute that will be considered by our physician advisory group include:

- Media training – an entry-level seminar intended to help prepare physicians for media interviews.
- Advocacy training – an entry-level seminar intended to help prepare physicians for personal advocacy and testimony before legislators and regulators.
- Physician executive e-communities – in conjunction with NHMS’s new association management system, offer private e-communities to physician executives with similar responsibilities (e.g., Chief Medical Information Officers).
- Physician board of trustee development program – understanding that the role of trustee is a learned and nuanced skill set of group dynamics and the corporate requirements of a fiduciary.

We welcome your input. If you have other ideas on how we can continue to help build physician leadership capacity, please contact me at james.potter@nhms.org or 603-224-1909.
For more information or to order hard cards, please contact:

Mary West - New Hampshire Medical Society
603.224.1909 • www.nhms.org

Compliments of:

New Hampshire MEDICAL SOCIETY

Proud supporter:

Children’s Miracle Network Hospitals

SCAN FOR FREE APP OR VISIT FREERXICARD.COM TO DOWNLOAD

Available on the
App Store

Google Play
Does your license expire in June 2019?

Your CME requirement must be met by Dec. 31!

- 100 total credits obtained since Jan. 2017
- Documentation for 40 Category 1 credits

Do you have a DEA license linked to a NH address?

If so, your report must include:

- 3 Category 1 credits related to opioid prescribing/pain management
- Find suggested courses at:
  http://www.nhms.org/opioidcme

The CME Biennial Reporting Forms for 2017-2018 will be mailed in early December.

Questions? Contact mary.west@nhms.org