Top Pediatrician, Medical Mission Organizer, (and a great cook too!)

Adele de Vera, MD, graduated medical school in the Philippines before completing her residency in the Bronx, New York. She is a practicing pediatrician at Monadnock Community Hospital, in Peterborough, New Hampshire. She’s been voted a “Top Doc” in New Hampshire Magazine for three years running. But as is true of many physicians, she uses her skills to go above and beyond.

In 2009, Adele’s 10-year old daughter Tia came home with an Advent calendar, which proposed that she do a good deed each day in preparation for Christmas. One of the good deeds was to write to a priest or a nun. She wrote to Fr. Robert Joerger, CP, who she had heard speak at Divine Mercy Parish in Peterborough, New Hampshire, earlier that year, and so began a friendly correspondence between the two of them. In 2011, Adele asked Father Bob to recommend a medical mission for her and he put her in touch with Bishop Neil Tiedemann, CP, who was then the Bishop of The Diocese of Mandeville, in Jamaica. In 2012, when Adele went to Jamaica, Bishop Neil suggested that physical exams be done in the schools that the children attend. These exams are required for children in Jamaica before they can start school. However, children in the remote rural communities don’t usually get a yearly health exam because access to health care, coupled with financial constraints, is very limited. To help parents get health care for their children, it was decided that once a year, Adele’s medical team would travel to the schools, which are temporarily converted into medical homes for the day.

Since then, Adele, with her ever-growing group of volunteers, has been going every summer to spend two weeks giving free yearly physical and dental exams to the children of the Diocese of Mandeville. She maintains records of all the children she sees. She has been seeing some of them for more than five years and has tracked their growth/progress. Health care is also provided to the
Women in Medicine

As a woman in medicine, it is empowering to see so many strong women becoming leaders in healthcare. I recently attended the American Medical Association annual meeting and for the first time in the history of the AMA the past president, Barbara McAneny, MD, (oncology) the current president, Patrice Harris, MD, MA, (psychiatry) and the president-elect, Susan Bailey, MD, (allergy, asthma and immunology) are all women. This is a very exciting time for women in healthcare. But women in medicine at all levels of healthcare are inspiring to me and should be inspiring to all of us. More and more women are becoming leaders in healthcare and are bringing a different perspective to the issues affecting the healthcare system.

Women as physicians are still outnumbered by men. Sixty-six percent of physicians are male and 34% are female despite medical schools having closer to 50% of female medical students. But other areas of medicine have higher numbers of females – nursing at all levels, medical assistants, and office staff.

While we are seeing large numbers of women in healthcare, gender bias is still occurring at all levels from the level of physician leaders to residents and medical students. Women physicians are more likely to be mistaken for a nurse than male physicians. This gender bias is not discussed openly and many women physicians often take this mistaken identity as a personal failure, not recognizing it for the inequality that it is. Studies have shown that gender also affects working with other professionals within healthcare. Ninety percent of nurses and medical assistants are female and 10% are male. However, women physicians report, and studies have shown, that nurses and support staff are more likely to help male physicians than female and that they view female physicians negatively. Nurses face their own issues with gender discrimination – sexual harassment, pay discrepancies and gender based assumptions as well.

I recently became part of a women physician leadership group that is meeting monthly to discuss how we can better mentor and work together with other women physicians to ensure an environment of collaboration and respect in our health system. It has been interesting to see that all of us have old stories and new that exemplify how there continues to be gender bias despite all of us coming as far as we have in moving the roles of women physicians forward.

Women in medicine at all levels need to come together, work together and empower each other to be strong and to continue to give the best care to each other and our families and friends.
Lack of Paid Family & Medical Leave Disproportionately Impacts Women

By Michael Padmore, NHMS Director of Advocacy

The issue of paid family and medical leave was front and center during this year’s legislative session in New Hampshire, raising awareness for a program that would give working families the ability to take paid leave from work to care for themselves or immediate family members in their time of need. Proponents of the program have been working on passing some form of the policy since Representative Mary Stuart Gile introduced legislation more than 20 years ago with New Hampshire Medical Society past president, Dr. Oge Young, by her side to advocate for the policy.

This year, Senate Bill 1, marked the first time paid family and medical leave legislation passed both the New Hampshire House and Senate. However, when the bill arrived on Governor Sununu’s desk, he vetoed it. In summary, this bill aimed to create a statewide paid family and medical leave insurance program that would provide working people up to 12 weeks of paid leave (60% wage replacement during that period), sustained by a .05% payroll deduction, paid by employers who could pass some or all of the cost on to their employees.

The New Hampshire Medical Society supported Senate Bill 1 through the advocacy of a number of our member physicians, sharing their perspective on how paid family and medical leave would benefit their patients. These cases offered lawmakers a valuable opportunity to learn about how this program would enable the patients you treat to take the time they need to heed your advice to heal or recover and provide more opportunities for their loved ones to take time off and be there to pick up the caregiving after patients leave your office.

Paid leave policies impact families across the board, but given this month’s newsletter’s theme of “Women in Medicine,” it’s important to note that lack of paid leave disproportionately impacts women. A 2016 study completed by Dr. Kristin Smith and Nicolas Adams at the University of New Hampshire’s Carsey School of Public Policy found, “While men are more likely to have access to paid family leave benefits, women are more likely to have ever taken paid or unpaid family and medical leave to provide care or to tend to their own illness. Sixty percent of employed women have “ever taken” paid or unpaid family and medical leave, compared with 40 percent of employed men. Women’s greater likelihood to take leave reflects gender differences in childbearing and family care as well as, perhaps, the cultural attitudes and workplace stigma surrounding men who provide care.”

The study continues further to explain the economic significance paid leave policies can have on women. “Given that women shoulder substantial caregiving responsibilities for their children and elderly relatives, the lack of paid family leave forces some women to choose between caring for a sick family member or a new child and contributing to their family’s economic well-being. Yet, women are less likely to leave the labor force when they have access to paid leave for family care or maternity.” This is a critical point. With the workforce shortage impacting New Hampshire employers, and family economics in the United States trending toward a dependence on dual-income households, it makes not just good public health sense but good economic sense to enact policies, such as paid leave, that are proven to support and keep women in our workforce.

For reference, you can find the full UNH Carsey School study here: https://carsey.unh.edu/publication/paid-family-leave-nh

Regardless of the Governor’s veto, the effort to establish family and medical leave insurance will continue moving forward. If you are interested in advocating for paid leave, please call me at (603) 858-4744 or email me at Michael.Padmore@nhms.org. I’m excited about the work we have already done on this issue and look forward to working with you in the future! ♦
Hello, I am Dr. Terri Vanderlinde, a Board-Certified Gynecologist as well as an AASECT Certified Sexuality Counselor, practicing in the seacoast area of New Hampshire for more than 22 years. I have had a thirst for learning my whole life. Each time I faced many women all facing the same problem, I was compelled to study that issue so that I could give better advice about their life, their health and their treatment options.

When I was teaching high school biology in an all-girls Catholic school and simultaneously volunteering at Planned Parenthood, I was frustrated by the simple questions about reproduction that I felt inadequately prepared to handle. So, I decided to embark on a career in OB-GYN. I applied to only DO schools, since I was drawn to the holistic, generalized medical approach.

After a military scholarship for medical school in Philadelphia, I endured an OB-GYN residency and an extra four years of payback time in the Army Medical Corps, giving episodic care, the antithesis of how I would eventually choose to practice.

I began my civilian career in a lovely OB-GYN group practice in Portsmouth, New Hampshire, which I left to start my own GYN practice, for the sole purpose of giving patients longer appointments to discuss their deepest concerns. Years later, after raising two great kids to adulthood, I noticed that I had hit a stride in my career. As an accomplished surgeon, I made a lifestyle decision to retire from the operating room and focus more on the greater need to address the lack of sexual counseling services in New Hampshire.

I was finding that at least half of my patients had either sexual pain or low desire issues, which, again, I felt inadequately prepared to handle well. So, I embarked on a three-year long fellowship involving hundreds of hours of classwork and supervised patient counseling to become an AASECT Certified Sexual Counselor. AASECT is the governing and certifying board for all sex educators, counselors and therapists. It holds providers to a high standard of training and ethics, enforcing that we keep current on cutting edge therapeutics.

A sex counselor is a medical clinician who uses medical, hormonal, and some alternative approaches to sexual issues, whereas a sex therapist is more equipped to handle psycho-pathological and personality disorders. We both address psychological, emotional, relationship and past experiences to help patients draw conclusions and thereby affect change. We both work with patients and their partners to have meaningful conversations and give homework to help improve sexual relationships. I use cognitive-behavioral techniques (CBT) as well as draw on some spiritual aspects and address prior traumatic issues.

We begin by having the partners write out their concerns and their goals. Then we meet every few weeks for a few visits to figure out how to achieve their personal goals with some humor and much compassion. Some couples need to start over right from the beginning with holding hands, hugging and trying to kiss again. Others need help to get over an affair; many would like help to achieve their first orgasm. Most need help with pain and/or low desire. But they all need someone compassionate and knowledgeable about helping them with their deepest darkest concerns. I hold a safe and comfortable space for women to feel heard and learn what they need for their own happiness and ultimate pleasure. I am proud to be the only AASECT Certified OB-GYN Sex Counselor in New Hampshire. Feel free to consult me on any difficult case you may encounter. www.bestgyn.com, DrTerriV@Best-Gyn.com, 603-516-0000. §
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Friday-Sunday, November 15-17, 2019

http://www.nhms.org/2019conference

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Dear Colleagues:

The NHMS Annual Scientific Conference will take place at the lovely Mt. Washington Hotel in Bretton Woods, NH, on November 15-17, 2019. Please consider joining us for this opportunity to meet with colleagues and friends to enjoy the camaraderie that is so often missing in our everyday practices.

Our theme this year is “Trending Topics in Medicine 2019.” Scientific presentations will focus on many timely and current issues including vaccinations, intimate partner violence, pelvic floor pain, the new crisis – vaping, and the impact of leadership on public health. We have invited Dr. Jerome Adams, the US Surgeon General to give the keynote speech.

We will again be offering three hours of CME on opiate abuse and substance abuse issues, satisfying the requirements established by the NH Board of Medicine. Finally, we will offer an opportunity for an early morning fun run/walk and fun family activities for families while physicians are soaking up the education. The food and the views at the Mt. Washington are spectacular.

Please consider joining us for this weekend of education and fun in the magnificent setting of the Mt. Washington Hotel in Bretton Woods, NH.

Tessa Lafortune-Greenberg, MD
President, New Hampshire Medical Society

Top Pediatrician, cont. from page 1

various clinics of the diocese by gynecologists, podiatrists, and family practitioners.

If that wasn’t enough, Adele just finished a masters of Bioethics from Harvard University. She has a loving physician-husband (who instigated this article) and two other daughters in addition to Tia. On top of all that she’s a great cook!

You can learn more about Adele’s charity, the PBJ Traveling Clinic at http://pbjtravelingclinic.org/, or search @pbj.travelinghealthclinic on Facebook. 

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New Mother Becomes Chief Resident

Camilla Jones, MD, has been a member of the New Hampshire Medical Society since 1985!

This article appeared in 1964, in a newspaper whose name has been lost.

Camilla is now retired, but still very active in the medical realm. (Little Adam is now 55 years old.)

GET HELP NOW!

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:

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YOUR PRESCRIPTION MEDICATIONS

Camilla Jones, MD, has been a member of the New Hampshire Medical Society since 1985!

This article appeared in 1964, in a newspaper whose name has been lost.

Camilla is now retired, but still very active in the medical realm. (Little Adam is now 55 years old.)
es that lead to human suffering like pain, loss, fear, loneliness or a lack of control.

We cannot objectively quantify suicidal thoughts from a blood sample, but tools like the Columbia Suicide Severity Rating Scale\(^4\) have a growing body of evidence for identifying and risk stratifying people with suicidal thoughts. Clinicians should become comfortable with screening their entire patient population, and healthcare organizations and communities should be prepared to offer interventions to those identified by that screening—in interventions not limited to psychiatric treatment.

I do not mean to minimize the importance of psychiatric treatment. Rather, I mean to say that psychiatric treatment is like a hammer—a tool suitable for specific tasks while unruly in others. There is no dose of fluoxetine that provides housing security, nor can sertraline mend a broken relationship. Eric Cassel noted, “Physicians’ failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.”\(^5\) If we truly intend to prevent suicide, we need to prioritize services addressing all of the social determinants of health\(^6\), not just disease burden.

Imagine a healthcare system that could provide access to a safe place to live, transportation to appointments, meals, support for people who use drugs, legal assistance, or even a job with competitive pay. There is evidence\(^7\) that such interventions delivered in healthcare settings improve health and well-being. Some even promise to reduce overall healthcare costs leading to changes\(^8\) in the way states think about reimbursing healthcare expenses.

Many states already offer reimbursement for interventions that address the non-clinical reasons someone might be having suicidal thoughts, but as long as clinicians only discuss suicide as a consequence of mental illness, as a “mental health crisis,” those resources will not reach many of the people who need them. It is time to empower all healthcare providers to screen for suicide and to support reimbursement for multifaceted interventions when suicide risks are identified. It is time to talk about suicide in the context of public health rather than mental illness.\(^\dagger\)

\(^1\) https://www.cdc.gov/vitalsigns/suicide/infographic.html
\(^3\) https://www.cdc.gov/vitalsigns/pdf/vs-0618-suicide-H.pdf
\(^6\) https://www.cdc.gov/socialdeterminants/index.htm
\(^7\) https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0170
\(^8\) https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/
Develop a Program:

Employers can be fined under OSHA’s General Duty Clause if they fail to provide their employees with a safe working environment, which can include acts of workplace violence. The Occupational Health and Safety Administration Guidelines recommend a written comprehensive workplace violence prevention program that includes the following elements:

1. Management commitment and employee participation
   o Acknowledgement of the value of a safe and violence-free workplace for both the workers and patients/clients
   o Allocating appropriate authority and resources to all responsible parties
   o Assign and ensure all managers and supervisors understand their role and maintain a system of accountability. Include employees from high risk areas.
   o Supporting and implementing appropriate recommendations from committees assigned to oversee this work
   o Establishing comprehensive coverage of medical and psychological counseling
   o Establishing policies that ensure the reporting, recording, and monitoring of incidents and near misses. Foster an open environment to promote the reporting of any act of violence.

2. Worksite analysis
   Analysis involves a mutual step-by-step assessment of the workplace to find existing or potential hazards that may lead to incidents of workplace violence. Information is generally collected through surveys from employees, patients/clients, job hazard analysis, and record analysis.

3. Hazard prevention and control
   o Identify and evaluate control options for each hazard
   o Select effective controls to eliminate or, at minimum, reduce hazard
   o Implement controls
   o Follow up on controls once in place to confirm that they are being used and maintained correctly
   o Continue to evaluate the controls, making changes as needed.

4. Safety and health training
   Training can help raise safety awareness, provide tools needed to identify hazards, and address potential problems ahead of time, reducing the likelihood of an incident. Training should be for all workers (include vendors and volunteers).

5. Record keeping and program evaluation
   It is necessary to keep records and evaluate the violence prevention program. This will help determine if what you are doing is working and will help identify those areas that need work.
   Examples of some of the documents are: minutes from committee meetings; hazard analyses; corrective action plans; training program; and lists of who attended.

The program should be reviewed regularly and after a major incident. In addition, policies and procedures should be reviewed on a regular basis.

Processes involved in an evaluation include:
   o Consistent reporting system and regularly reviewed reports
   o Review of safety meeting minutes and reports
   o Review of trends and rates in incidents
   o Measurement of improvements
   o Staying up-to-date on administrative and work practice changes
   o Closing the loop on all recommendations
   o Surveying employees
   o Compliance with all regulatory requirements
   o Inviting law enforcement to come in to review worksites and make recommendations for improvements.

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.
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Growing Body of Literature Links Income to Improved Health Outcomes

By Cary Gladstone, M.S., CED

A growing body of literature links health outcomes to social determinants of health, the social and economic factors where we live and work. Research conducted by the University of California at Davis specifically looked at a tax policy and its impact on birth weight.

The study found rates of low birth weight decrease with increased take-up of the Earned Income Tax Credit (EITC), a support for low-to-moderate income working families. The study correlated an increase of $1,000 with reduced rates of low birth weight by 7% overall and by 8.2% among African Americans. You can think of the EITC as a social determinant of health.

Here in New Hampshire, the CASH Coalition, a group of nonprofit, government and other providers works to reach people eligible for the EITC who do not claim it, by offering free income tax preparation. According to the IRS, about 20% of working families, some of our state’s most vulnerable families, leave about $36 million on the table annually. These include people with very low income, those with--or caring for someone with--a disability, or grandparents raising their grandchildren.

You and your practice staff can assist by simply providing literature this fall and into the new tax season in January, referring people to free tax sites in New Hampshire. If you have time, ask families if they claimed the Earned Income Tax Credit when they filed their income tax return, which can mean as much as $6,557 for families in 2019. At a time when 40% of Americans say they cannot weather a $400 unexpected expense without having to borrow, every dollar counts, and can improve health as well as bank accounts.

Cary Gladstone, M.S., CED, is Senior Director of Asset Building Strategies at Granite United Way and chairs the CASH (Creating Assets, Savings & Hope) Coalition of NH. He can be reached at cary.gladstone@graniteuw.org or (603) 625-6939 ext. 128.
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Flowchart for CME Reporting for New Hampshire Medical License Renewal

Use this flowchart to determine what and when you need to report CME to NHMS prior to renewing your license.

A. Does your NH medical license expire in 2020?

   Proceed to Steps B and C but know that you’re only halfway through your cycle.

B. Do you have a DEA license associated with a NH address?
   - Yes: You must complete 3 Category 1 credits related to pain management and/or addiction disorder within your two-year cycle.
   - No: The pain management CME requirement does not apply to you.

C. By Feb. 28, of your license renewal year, you must submit the following to NHMS:
   - signed CME reporting form (you’ll receive it via paper mail in early December)
   - documentation of 100 credits completed within your two calendar-year cycle (with at least 40 in Category 1)
   - $40 CME processing fee

Questions? Email mary.west@nhms.org or check out http://www.nhms.org/cme-reporting
Integrating MAT into Whole Patient Care

By Jim Potter, Executive Vice President

Over the last few decades, the medical community has had to respond to chronic health issues facing the Granite State, such as expanding treatment for HIV and diabetes. Today, the Granite State’s chronic disease challenge remains opioid use disorder (OUD), particularly with the prevalence of illicit fentanyl and the rise of poly-substance use disorders.

The first step is to utilize opioids thoughtfully with the principle of “the lowest effective dose for the shortest duration” to limit the addictive potential of these analgesics. New Hampshire continues to be a leader in the reduction of opioids prescribed over the last few years with the advent of the reasonable prescribing rules and the prescription drug monitoring program (PDMP). While not perfect, they allow the Granite State to be flexible and adaptive with the changing science and study of opioid prescribing and OUD treatment.

However, stigma associated with OUD is regrettably still omnipresent in our current culture. And, in many respects, fear and retributive driving policy and lawsuits among government agencies, as well as among insurance carriers, pharmaceutical manufacturers and dispensers, which has made opioid prescribing more challenging with multiple and conflicting layers, particularly for chronic pain patients. Continuing to promote alternative treatment therapies for pain along with a balanced approach to opioid analgesic prescribing driven by science is likely to be the best path forward for patient care.

But to understand where we need to go, it is helpful to know where we have come from. The United States has had a historically ingrained ‘opioid addiction cycle’ and is in the midst of at least our fourth opioid use epidemic, ranging from the 1860s-1890s, 1920s, 1960s-1970s and the 2000s to present.

The longest opioid epidemics have been associated with changes in the delivery of opioids. The post-Civil War period marked the longest epidemic fueled by battle field injuries, along with the advent of the hypodermic needle and broad use of morphine. Treating morphine with acetic anhydride yielding heroin – up to eight times more powerful as an analgesic and addictive properties – helped to prompt the 20th century epidemics. The further synthesis of opioids in the 1990s gave rise to our current epidemic with illicit fentanyl now contributing to the vast majority of overdose deaths in New Hampshire.

To date, because of a lack of capacity, New Hampshire still highly relies on the pull-out model for OUD treatment – as it is the basis of our current State Opioid Response (SOR) plan. To break this historic cycle of stigma, the medical community can play a significant role by articulating OUD as a chronic disease and situating ongoing maintenance treatment from primary care settings to foster whole patient care, like other chronic diseases such as HIV and diabetes.

Three things health systems and local community hospitals can do to this end: 1) in the short run, have all possible primary care and emergency care teams (physicians, PAs and APRNs) become waived to provide medication-assisted treatment (MAT); 2) develop MAT integration plans including wrap-around behavioral services to support whole patient care for OUD; and 3) ensure that nursing and medical support team members are part of the MAT integration planning and training.

Even if not directly providing MAT services, becoming waived builds a common understanding of OUD as a chronic disease and potential support as systems and hospitals develop their own communities’ response plan. To assist with this effort, the Medical Society will host for free at your practice location an 8-hour MAT waiver course for as few as a dozen participants. This waiver course also has been approved as CME, as well as nursing contact hours to fulfill the state’s opioid prescribing competency requirement. It is truly one-stop shopping as participants additionally will be able to complete their waiver applications online after the course.

For more information, on our 8-hour MAT waiver courses, please contact me at james.potter@nhms.org or Joy Potter at joy.potter@nhms.org or 603-224-1909.

For information on MAT Learning Collaboratives (system integrations), please contact:

Rebecca Sky, MPH, NH Foundation for Healthy Communities, rsky@healthynh.com or 603-415-4277
Jeanne Ryer, MSc, EdD, UNH Project ECHO Hub, Jeane. Ryer@UNH.edu or 603-513-5126.

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New Hampshire Physician Volume 4, 2019
NHMS Welcomes New Members

*We are pleased to welcome many residents!

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Christopher C. Robertson, MD
Brian J. Rosen, MD
Dinesh Sangroula, MD
Timothy D. Scherer, MD
Ethan M. Senser, MD
Phillip T. Snodgrass, MD
Robert Sterling
Jonathan D. Stock, MD
Pirianithini Suntharalingam, MD
Dhruva T. Tangellamudi, MD
Harmanpreet Kaur Tiwana, MD
Alena N. Tofte, MD
Maris K. Toland, MD
Andrea M. Tou, MD
Andrew J. Van Pay, MD
Luke E. Viertalher, MD
Michelle Wang, MD
Jacob S. Warner, DO
Kyle Whelan, MD
Heather N. Wright, DO
Shuo-chich Wu, MD
Chaofan Yuan, MD
Anthony H. Zon, MD
September is the American Medical Association’s Women in Medicine (WIM) Month

This year’s theme is “Women in Medicine: Trailblazers, Advocates, Leaders.” Check out their website and social media for a showcase of accomplishments of women physicians, and highlights of advocacy related to women physicians and health issues impacting women.