NHMS Welcomes 184th President

There are countless challenges confronting society generally, and medicine specifically, in today's world. The temptation to try and address them all would, of course, result in successfully addressing none of them. For this coming year, I have chosen two challenges to which I would like to direct the attention of the New Hampshire Medical Society. The first is a social injustice that I believe is unacceptable in the wealthiest nation in the world: the fact that there are citizens of New Hampshire who are under or uninsured and do not have access to even the basic healthcare needs. The second could be considered, and perhaps rightfully so, self-serving for medicine: the

Getting a DUI

By Sally Garhart, MD, New Hampshire Professionals Health Program Medical Director

Getting a DUI (driving under the influence) in New Hampshire isn’t just an expensive hassle. If you are a physician or other health care professional, it can have serious implications for your medical career. Drug and alcohol abuse are among the most common triggers for licensing board attention. Having a license to practice medicine exposes a doctor to more severe collateral consequences than other drunk drivers who don’t have safety-sensi-

tive occupations.

In some states, like California, a physician may be disciplined by the Medical Board for a DUI that occurs while the physician is not working and which does not directly impact patient care. While the California Medical Board typically does not initiate any formal proceedings based on a single DUI offense, the California Business & Professions Code Section 2239 states that two DUls constitute unprofessional conduct and therefore, are basis for discipline under the Medical Prac-

DUI, cont. on page 6

For Better Blood Pressure Control - Keep it Simple

By Rudy Fedrizzi, MD, Director of Community Health Clinical Integration at Cheshire Medical Center/Dartmouth-Hitchcock Keene

In their 2010 book, SWITCH: How to change things when change is hard, Chip and Dan Heath describe a simple three part metaphor for the rational, emotional, and environmental aspects of behavior or organizational change. Their framework is perfect for visualizing what is needed to achieve health improvement as we work to achieve the Million Hearts goal of preventing one million heart attacks and strokes nationwide by 2017.

Picture a rider atop an elephant walking down a path (Figure 1). The rider is our (or our patient’s) rational side. These are the logical and intellectual aspects of behavior change that require clear direction to take the necessary steps to improve health. The elephant represents the emotional or feeling elements that facilitate change. It is depicted as a large elephant because emotion and motivation can be an overwhelming force and move the rider in desirable or undesirable

Million Hearts, cont. on page 7
Physicians’ Bi-Monthly

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Succession ............................ 3
National Diabetes Prevention Program .. 4
EVP Corner ............................. 5
Helping to Shape Healthcare Policy in NH......................... 7
Chronic Care Management Services ... 12
2015 NHMS Annual Scientific Conference Sponsors ........... 12
Emergency Equipment and Training in the Medical Practice......... 13
A Retirement Income Planning Primer. 15
ICD-10 Paper Filing................... 15
2016 NHMS Council .................. 17
NHMS Welcomes New Members........ 17

NHMS Welcomes 184th President, cont. from page 1

challenge of a process of healthcare reform that has become increasingly polarized, confusing, and potentially damaging to the health of the population and the people who entrust us with their well-being.

Martin Luther King is quoted as saying, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” As of January 2014, an estimated 158,000 citizens of the state of New Hampshire were without medical insurance. This is 13% of the population (about the same number that are chronically food insecure). As of March 2015, CMS approved the state’s request for a waiver to convert its implementation of the Affordable Care Act’s (ACA) Medicaid expansion to a Marketplace premium assistance model that would be in effect as of January 1, 2016. How this will translate into functional access to needed care remains to be seen; who will actually end up carrying the burden of this expensive is also unpredictable and unknown. It is our responsibility, as the ultimate providers of care, to help see to it that all members of the population we serve have sustainable access to the care they need. This social imperative of sustainable access to affordable health care for the disadvantaged in our state is inextricably linked to the larger issue of how healthcare reform is eventually implemented for the population at large.

In trying to decide how I might best frame my concerns about how healthcare reform is evolving in the United States, I kept coming back to the Kübler-Ross model of grief in those suffering from major life crises, described by Elisabeth Kübler-Ross in her book On Death and Dying in 1969. My purpose in using the Kübler-Ross model in discussing the problems healthcare reform presents to us today is not to attempt to validate the emotions and frustration we are all experiencing, but to illuminate the very real danger we face if we allow ourselves to become mired in the negative emotions this process provokes, and fail to engage actively in achieving a solution that is nowhere near as dire or inevitable as death.

It is perhaps ironic that doctors faced with healthcare reform are experiencing this same emotional progression. There is no question that to a greater or lesser extent many of us are going through some stages of grief as we see our professional values becoming endangered by political imperatives.

There is valid reason to stick to a defense of denial. There are those among us who remember the managed care fiasco of the 1990s, which predictably failed when it became a political third rail for the Clintons. I say it predictably failed because for the most part the model was one of managing money, not managing care. Remember the TV commercials of Harry and Louise run by the Health Insurance Association of America?

Anger is certainly a prominent response of many healthcare providers today when asked to deliver a level of care that outstrips the resources allocated. While the politicians in Washington fight over Obamacare for partisan reasons, we see that they are toying with the health of our patients (and with our professional lives.) Bargaining is not an unreasonable response in this circumstance, but
Physicians' Bi-Monthly

November/December 2015

By Lukas Kolm, MD, MPH, MBA, FACEP

It is challenging for any organization to maintain focus and momentum on several key issues with so much change occurring. However, one of the most crucial challenges for the future of healthcare providers is how to prevent the dilution of what should be considered shared goals and fundamentals requisite to maintaining the delivery of quality health care in the United States. Healthcare providers, as content experts and those most intimately involved with patient care, need to recognize the importance of physician leadership, specifically, how awareness and advocacy through widespread physician leadership will continue to be one of the most effective quality drivers within healthcare organizations and amongst practices of all specialties.

In order to really understand how relevant it is to have a common ground and united front as it relates to effectively resolving public health issues and practicing medicine in the future, one only needs to look at the successes of other groups. The medical community as a profession and as a culture can be viewed as being somewhat paradoxical when compared to other professions. With many subspecialty societies, physicians and allied healthcare providers are often compelled to focus their membership loyalty with their respective specialties or societies. However, it is crucial to bring the groups together, ideally through an increased presence of state medical societies like the New Hampshire Medical Society (NHMS), to support provider-driven legislation both at state and national levels. We need to cultivate more camaraderie amongst physicians and allied healthcare providers, to grow legislative leadership as a necessary means of aligning and directing healthcare policy appropriately for our careers and our patients.

The medical community as a profession and as a culture can be viewed as being somewhat paradoxical when compared to other professions.

The largest lobby groups seemingly share a deeper sense of camaraderie on the big issues. Despite there being segregation within any profession, with skepticism of one another’s capabilities, level of expertise or potential competition, there is a palpable sense of power and pride in belonging to the body at large. Allied health careers are growing at a far greater rate than medical school graduates and residency slots in particular. This, too, is very disparate comparative to other professions. The projected impact on healthcare access and delivery is also unique in contrast to other professions that have similar professional associations. For example, paralegals are not licensed to go before a judge, and do not even remotely bare the same amount of accountability and exposure as do physician assistants and nurse practitioners.

Providers, healthcare organizations and insurers are all in motion, repositioning and strategizing on how to get it as right as possible, for both short and longer term outlooks. Without a larger more aligned group of healthcare providers who are intimately involved with legislation, there is greater likelihood that healthcare providers will simply suffer the biggest losses. With the projected physician shortage over the next decade, it is essential to cultivate new and deeper relationships by developing more robust post grad training experiences for allied healthcare providers. In general, post graduate training programs for all providers should remain uniform regarding quality and competency measures. Subsequent to an initial certification, there should be realistic processes that not only facilitate currency with prior and more recent didactic information, but effectively identify and support areas of deficits in both fund of knowledge and skill levels concurrently.

With my term as the 183rd president of the NHMS coming to completion, it seemed worthwhile to be a bit redundant regarding areas where low lying fruit continues to hang for physicians and allied healthcare providers to reap benefits with sustainable value added for our professions and our patients.

Therefore, in addition to the aforementioned, all subspecialties should consider a unified front regarding the maintenance of certification (MOC) examinations. MOCs should be similarly designed to actually facilitate current clinical and other practice specific competencies and occur...
Diabetes costs New Hampshire about one billion dollars annually and the prevalence has been increasing over the last decade. In 2013, 9.2% of New Hampshire adults reported having diabetes. The Centers for Disease Control and Prevention (CDC) estimates that 37% of American adults have prediabetes, a precursor to type 2 diabetes. However, only 11% of people with prediabetes know they have the condition. Without intervention, 15 to 30% of people with prediabetes will develop type 2 diabetes within five years.

As part of a national effort led by CDC, public health, healthcare, community, and payer organizations in New Hampshire are collaborating to bring the National Diabetes Prevention Program (NDPP) to the state. According to Stephanie Gruss, PhD, MSW, Acting Team Lead for the NDPP at CDC, “National Diabetes Prevention Program is the largest effort underway to bring the most proven intervention for type 2 diabetes prevention to communities across the county. To date, over 720 organizations in 49 states, the District of Columbia and two U.S. territories are delivering the program.”

We hope the members of the New Hampshire Medical Society will become active contributors by embracing the state’s effort to identify this at-risk population and support the adoption of appropriate interventions as they are made available throughout the state.

**National Diabetes Prevention Program**

A new resource to help your high-risk patients prevent type 2 diabetes

Marisa Lara, MPH, RD
Manager, Diabetes, Heart Disease, Obesity & School Health
New Hampshire Department of Health and Human Services

Participants meet in groups with a trained lifestyle coach once a week for 16 weeks and then once a month for six months to learn ways to incorporate healthy eating, physical activity, problem-solving and coping skills into their daily lives. CDC monitors NDPPs through its recognition program to ensure quality control and adherence to scientific standards.

**Evidence**

The NDPP is based on National Institutes of Health research that showed a structured lifestyle intervention could reduce the risk of developing type 2 diabetes by 58%. The intervention was particularly effective in adults over 60 years of age, reducing risk by 71%. According to Dr. Gruss, “These results were the same across all races, ethnicities, and genders.” Even after 10 years, those who had participated in the lifestyle change program had a 34% lower rate of type 2 diabetes.

**National Efforts to Engage Healthcare Providers**

The American Medical Association and CDC have joined together to reach healthcare providers with information about prediabetes and NDPP. A new toolkit is available to help identify and refer patients at high risk: www.cdc.gov/diabetes/prevention/pdf/STAT_toolkit.pdf. Additionally, a one-hour CME module on prediabetes can be accessed at: www.stepsforward.org/modules/prevent-type-2-diabetes.

**Locating Programs in New Hampshire**

Concord Hospital and Greater Nashua YMCA currently offer NDPP. Additionally, five organizations are planning to offer the program within the next few months. To keep stakeholders updated on NDPP progress in New Hampshire, a new website will be launched in November: www.preventiondiabetesnh.org.

**For More Information**

Dr. Richard Friedman and Liz Kennett, RN, BSN, CDE, who serve on the Diabetes Prevention Advisory Group, serve with me as ambassadors of New Hampshire’s initiative. We hope to provide more informa-
EVP Corner
Q & A with New EVP James Potter

After an extensive nationwide search, James G. Potter was selected by the Council of the New Hampshire Medical Society, to serve as the Society’s new Executive Vice President.

Jim has had over 20 years of association executive experience at several national healthcare organizations, including the American College of Radiology and American Academy of Physician Assistants. He also worked for the American Medical Association early in his career, helping to establish multi-specialty initiatives, such as the Relative Value Scale (RVS) Update Committee, and has served on a number of nonprofit boards.

Jim was awarded the FDA Commissioner’s Special Citation for coordinating a consensus approach on federal quality and coverage guidelines for mammography, and has led teams that received the Vice President of the United States’ Hammer Award, as well as the American Society of Association Executive’s Summit Award for advancing early detection and intervention for children with hearing loss.

What attracted you to NHMS?
Well first, becoming an EVP for a state medical society is something that I have wanted to do since becoming an association executive. Second, I grew up in Michigan, which is on the same general latitude as New Hampshire. I actually like having all four seasons and have enjoyed skiing in the White Mountains. But most of all, it’s the reputation of the NHMS leaders and members as smart, compassionate and innovative physicians who are highly committed to the Society’s mission of improving public health and making the practice of medicine deeply satisfying for all who take care of patients.

What do you bring to the EVP role?
Passion for patients, physicians and their teams, and a complete focus on doing what is right for them, based on good quality insights and a track-record of delivering value for members. I consider my service to physicians as a calling rather than a job.

What moves me is taking on complex problems, breaking them down into digestible chunks, and building teams with a collaborative partnership approach that can help mitigate or unlock longstanding disputes. Progress on these fronts can often set the groundwork for making the policy tumblers roll. My experiences have been marked by a honed capability to help build consensus and accomplish desired objectives, even among competing interests, that have collectively advanced the objectives of the key stakeholders.

What do you like to do in your personal time?
My wife, Karen, and I have been blessed with four great children. Our son (the oldest) is in college. And our three young ladies are all involved in travel soccer, which keeps us quite busy and often going in different directions on the weekends. I’m an avid New England Patriots fan. I also enjoy playing golf and hiking with our family dog, Harry.

In my spare time, it is my hope to do some research and possibly write about Dr. Josiah Bartlett – one of our country’s largely unsung founding fathers and Granite State patriot. It’s interesting to note that all three of his sons and seven of his grandsons would follow him as physicians.

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Why should your hospital or licensing board be concerned about a DUI occurrence that happens during non-work hours? It's best to answer that question with an equally compelling question: Does a hangover the next day affect work performance? Yes, according to Persistent Next-Day Effects of Excessive Alcohol Consumption on Laparoscopic Surgical Performance by Anthony Gallagher, et al., Archives of Surgery, 2011; 146(4)419-426. This study concluded that “excessive consumption of alcohol appeared to degrade surgical performance the following day even at 4 PM, suggesting the need to define recommendations regarding alcohol consumption the night before assuming clinical surgical responsibilities.” Other research suggests that 50% of those with a single DUI and 90% of those with two DUls meet the criteria for a substance use disorder (SUD) while those with three DUls have the diagnosis with certainty.

In the US in 2013, 10,076 people were killed in alcohol impaired driving crashes equaling 1/3 of US driving deaths. In 2012, 1.3 million US drivers were arrested for driving under the influence which is around 1% of the 121 million self-reported episodes of alcohol-impaired driving among US adults that same year. Using these statistics there are approximately 94 episodes of alcohol-impaired driving for every DUI arrest (Alcohol Impaired Driving among Adults – US, 2012 Morbidity and Mortality Weekly 64(30); 814-817). Based on self-reports from the 2012 Behavioral Risk Factor Surveillance System, 1.4% of New Hampshire adult drivers reported that they drove in 2012 while impaired. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) report listed New Hampshire in 2012, as having the highest per capita consumption based on sales of ethanol (4.65 gallons, twice the national average), which does include cross-border sales.

Medical Boards and other regulatory bodies throughout the US are working to develop uniform standards and regulations, similar to California, regarding the occurrence of a DUI. Currently in New Hampshire, the Medical Board reviews DUI reports on a case-by-case basis and often defers the investigative process to its Medical Review Subcommittee (MRSC). The MRSC will frequently ask the New Hampshire Professionals Health Program (NHPHP) to evaluate physicians and physician assistants who have been convicted of a DUI offense to determine if there is a “threat to public safety” and/or if there is a substance use disorder diagnosis that requires treatment and monitoring. The NHPHP encourages early intervention and self-referral of issues related to chemical dependency or alcohol before the problem escalates to the level of a DUI. The reality is that physicians are traditionally not good at asking for, or receiving help. A DUI arrest is often the healthcare professional’s first “out of the closet” confrontation with a problem that they have not been able to control on their own.

While many providers have welcomed an NHPHP evaluation following a DUI, only a small number have willingly entered into a treatment and monitoring agreement to assist in ruling in or out, a diagnosis of SUD. Still others remain adamant that their DUI was an isolated episode of bad judgment and circumstances. Anecdotally, what we have observed among the latter subgroup is a thread of behavior that includes minimization of the event, denial of the amount of alcohol consumed, refusal to comply with the field sobriety or breath alcohol test (BAT), and even arrogance and hostility towards law enforcement officials. It’s important to remember that a refusal to blow a breath alcohol test (BAT) is considered a positive in the state of New Hampshire with few grounds for reversal provided the officer demonstrates a valid reason for the stop. And egregious behavior is not only well-documented in a police report, but it is almost always recorded on video by dash-cam, which can be sent to and reviewed by a licensing board investigator.

Alcohol use disorders are extremely common in the US. Approximately 10-15% of physicians can be expected to meet the criteria for a substance use disorder diagnosis during their career – slightly higher than the general population. DSM-IV categories of alcohol misuse, alcohol abuse and alcohol dependence have been replaced in DSM-V by one diagnosis: Alcohol Use Disorder (AUD) - mild, moderate and severe. Binge drinking is the most common alcohol pattern reported with DUI and is associated with the highest risk of injury. By definition, binge drinkers are males who consume five or more alcoholic beverages or females who consume four or more alcoholic beverages in one drinking episode. Frequently physicians are in this binge category at least early into their SUD.
directions regardless of logical intent. Lastly the path depicts the social, structural, and policy environments that make it more or less easy for behavior change and health improvement to occur.

It turns out that SWITCH principles are reflected in the 10 Steps for Improving High Blood Pressure Control in New Hampshire guidebook that was created as part of the ASTHO/Million Hearts Learning Collaborative in 2014. For example:

Direct the Rider: The guide scripts the critical moves a practitioner or practice might undertake, such as determining a concrete goal for improvement, selecting a blood pressure control indicator to gauge progress, and choosing best-practice interventions like consistent blood pressure monitoring techniques. It also displays the widely distributed “Know Your Numbers” blood pressure wallet card that gives clear, plain language suggestions for patients’ healthier eating and making physical activity a daily habit.

Motivate the Elephant: The guide helps practices establish a provider dashboard to make improvement visible, describes celebrating early wins to maintain momentum, and outlines the concept of clinical-community integration to enhance caregiver satisfaction since satisfaction is enhanced when the team can share in collective success.

Shape the Path: The guide describes pragmatic changes to the workflow, like evidence supported triage and treatment algorithms, registry management activities, and community-based supports that can make adequate blood pressure control easier to achieve and sustain for patients.

The 10 Steps guide is being implemented in practices across New Hampshire and Maine and as far away as Kansas and Maryland. It can be downloaded free-of-charge at: https://chhs.unh.edu/sites/chhs.unh.edu/files/departments/institute_for_health_policy_and_practice/010815_final_million_hearts_manual.pdf

The Heath brothers have shown that change thrives on clarity, emotion, and making healthier choices a bit easier to adopt and maintain. Experience implementing the 10 Steps for Improving High Blood Pressure Control suggests this is a relatively simple, low resource approach that can begin to support the Million Hearts goal for our state. For more information on how you or your practice might join the Million Hearts effort, contact Rudy Fedrizzi, MD at rfedrizzi@cheshire-med.com.

Helping to Shape Healthcare Policy in NH

Many of your physician colleagues volunteered their time last summer and fall, to represent you on various legislative committees and commissions.

**HB 190 Collaborative Pharmacy Practice**: John Butterly, MD & Nick Perencevich, MD

**HB 330 Cost Transparency**: Richard Lafleur, MD & Doris Lotz, MD, MPH

**SB 31 Prescription Drug Monitoring Program**: David Strang, MD & Rep. John Fothergill, MD

**SB 56 Infection Reporting**: Everett Lamm, MD & Rep. Tom Sherman, MD

**SB 171 Handicap Plates**: Gary Sobelson, MD

**Therapeutic Cannabis Advisory Council**: Stuart Glassman, MD & Robert Andelman, MD

**Governor’s Commission on Alcohol and Drug Abuse, Prevention, Intervention, and Treatment, Opioid Task Force, and Naloxone Task Force**: Seddon Savage, MD, Rebecca Ewing, MD, & Molly Rossignol, MD
Physicians’ Bi-Monthly

November/December 2015

8

...it is our duty to try to make the future as bright as we can, if only because we all have to live in that future.

Getting a DUI, cont. from page 6

Studies of the effects of blood alcohol concentration (BAC) at 0.02 include feeling relaxed, warm and having an altered mood. At a BAC of 0.05 individuals still report feeling good and being relaxed in addition to altered alertness, impaired judgment and reduced coordination. Studies demonstrate trouble with vehicular steering control and decreased ability to respond to sudden and unexpected events. A BAC of 0.08 impairs judgment, reasoning, and self-control and results in degraded coordination and concentration. Individuals with a BAC of 0.08 are 10 to 50 times more likely to be involved in an accident. At a BAC of 0.15 muscle control worsens with difficulty maintaining balance. Research shows that impairment begins long before a person reaches a BAC necessary to be found guilty of drunken driving. The only safe driving BAC is 0.00, the same level that is required for providing hospital patient care and the only defensible BAC for a provider’s malpractice insurer in court.

SUDs are primary, chronic, progressive and sometimes fatal diseases. Most individuals with SUD deny that a problem exists and are resistant to treatment. The level of denial is even stronger and more pervasive among healthcare professionals! The diagnosis is so negative that many doctors would rather have cancer than be labeled an alcoholic, which is surprising when looking at the long-term recovery rates for physicians who have completed five years of successful treatment and monitoring. Many providers battle with problematic drinking as their coping mechanism for being depressed, isolated and burnt out. Please explore your own relationship with alcohol and ASK FOR HELP before you are REQUIRED to. Don’t become a statistic!

For more information about the NHPHP, please visit our website: www.nhphp.org
To assess your relationship with alcohol confidentially, please explore further at: www.rethinkingdrinking.niaaa.nih.gov www.drinkerscheckup.com
The Self-Empowering Addiction Treatment Association Directory: www.seatainfo.org
Alcoholics Anonymous: www.aa.org
International Doctors in Alcoholics Anonymous: www.idaa.org

NHMS Welcomes 184th President, cont. from page 2

only if someone is listening (more about this in a minute.)

We may all be depressed about this to some degree or another. This is a natural response to a difficult situation, such as being caught in a broken social contract (which we are), but it is positively adaptive only if it leads to thoughtful reconciliation and constructive action.

Finally, there is acceptance. I think of this as two different types of acceptance. There is active acceptance in the recognition of the inevitability of an outcome, such as death of a loved one, a traumatic life’s event such as divorce, or growing old. Acceptance in these situations, although difficult, leads to healing and strengthening of one’s humanity. Then there is passive acceptance, a failure to evolve out of the earlier stages of grief, to become a prisoner of one’s own anger or depression, and to allow a process to come to a bad conclusion with no intervention on our part. We would never practice medicine this way, and we should not allow a largely political process to proceed without our collective voices being heard. So we come back to bargaining.

We are the content experts, with a depth of understanding that is recognized and respected by the legislators in New Hampshire. We must bargain, we must negotiate, and we must be heard. The New Hampshire Medical Society is a voice for healthcare providers and our partners. There may be cynics among us who feel the task is too large, the process too ponderous. My favorite definition of a cynic is a person who is not so much unhappy about the past as he is bitterly disappointed in the future. I personally feel it is our duty to try to make the future as bright as we can, if only because we all have to live in that future. I look forward to working with this impressive and dedicated group, to see if a meaningful and effective bargain can be made.
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Having a Medical Mutual policy is like having a superhero on call to answer all of your medical questions.

expire, choose the carrier where contact will feel this easy.
NHMS has partnered with EHR & Practice Management Consultants, Inc. (EHRPMC) to provide all the tools and resources needed to participate in the CCM Program. NHMS.org/corporate-affiliates

On January 1, 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS), American Medical Association Current Procedural Terminology (CPT) code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

Chronic care management (CCM) services means at least 20 minutes of clinical staff time directed by a physician or other qualified health-care professional, per calendar month, with the following required elements:

- Two or more chronic conditions expected to last at least 12 months, or until the death of the patient,
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, and
- Comprehensive care plan established, implemented, revised, or monitored.

Only one practitioner (physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners, or physician assistants) may be paid for CCM services for a given calendar month.

The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology.

The Revenue Opportunity for participating in the CCM Program can quickly and dramatically increase your revenue as payments are made on a rolling 30-day calendar.

The biggest challenges for physicians are time and resources. In a recent survey over 70% of providers stated that they desired to participate in the CCM Program but lacked the internal resources and additional time to devote to the management of the program. §
Determining the need for equipment in the office should begin with the specialty and type of services provided. If you are doing testing that consists of conscious sedation, the level of emergency care that you should be prepared to provide should be greater. Consider how you want to handle the emergency. Are you prepared to provide full Advanced Cardiac Life Support care including shock energy, drug therapy and advanced airway placement or only CPR until the Emergency Response Team arrives?

Emergency medical equipment can vary in range from a stethoscope to an automatic external defibrillator (AED). The American Academy of Family Physicians and the American Heart Association are both good sources for equipment lists and employee training.

Once you determine the types of emergencies you wish to be prepared for, you should create policies and procedures outlining which employees will take on which responsibilities during an emergency. Open discussions or training sessions are important to keep staff current with skills that may have been taught but not exercised. Training in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) is recommended for any employee who qualifies.

It is important to remember that if you decide to keep lifesaving equipment in the office, your trained staff should be available during all times that patients are in the office. It is tragic, as well as a liability, when equipment is available to help a patient and it has not been maintained properly or there is no one in the office trained on the proper use. The American Medical Association has been asked to support legislation, approved by the American Heart Association, for the increased use of AEDs for the purpose of saving the life of another person in cardiac arrest provided that:

“A person or entity who acquires an AED ensures that: (A) Expected defibrillator users receive American Heart Association CPR and/or an equivalent nationally recognized course in defibrillator use and cardiopulmonary resuscitation; (B) The defibrillator is maintained and tested according to the manufacturer’s operational guidelines; and (C) Any person who renders emergency care or treatment on a person in cardiac arrest by using an automatic defibrillator activates the emergency medical services system as soon as possible.”

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contemporaneously on a year-to-year basis. More importantly, areas of deficiencies identified through annual CME-testing should be given more focused attention in subsequent CME-testing periods. This rolling CME life cycle would clearly address a provider’s specific areas of need. Overall, it would serve as the mission statement for any MOC for any specialty, rather than as a commercialized generic rubber stamp pedagogy.

The methodology of continuing to support an examination that requires intensive, last minute review courses and cram sessions to prepare for a day long test, once a decade, is absurd, particularly as it pertains to supporting the competencies and skills of physicians, surgeons and others over the continuum of a career. For those who have created rewarding businesses in association with the MOC recertification process there should be no worries, as they can simply be redirected to addressing the same needs on a different scale and focus more realistically on a real-time basis, attached to a far more genuine and meaningful pedagogy.

Healthcare providers should see themselves as members of a lifelong tribe. At times it is challenging to identify leadership, but we are all leaders, often with groups that segregate themselves from others in the tribe. Fundamentally, however, key issues that can greatly impact the tribe must be considered as such, and there must be avenues and a willingness to share and communicate the significance of the issues in order to limit unnecessary and inappropriate large scale decisions that often need to be undone or create unnecessary exposure for our careers. There are several examples of how important it is to belong to a tribe in order to be successful, particularly amongst periods of rapid transformation. Crossfit, patientslikeme.com, Starbucks, Pepsi and many others are referenced for their individual tribal existence, by Seth Godin, author and entrepreneur, who has become recognized worldwide.

Creating similar premises, such as “physicianslikeme.com” or “medicalsocieties.com” should not be looked at as far-fetched, particularly as medical society membership must grow in the future while being tremendously challenged, as healthcare organizations continue to undergo radical restructuring. “The tribe grows because individuals proudly segregate themselves and speak up on behalf of the tribe, simultaneously recruiting and hazing new members.” Godin, S., Tribes: We Need You to Lead Us. New York: Portfolio, 2008. p61.

I look forward to supporting the NHMS and the many ongoing public health issues that we work on together, for better patient outcomes along with supporting growth and development of healthcare leadership. §

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**National Diabetes Prevention Program, cont. from page 4**

...tion in upcoming newsletters. However, do not hesitate to contact any of us directly, with questions, concerns or for more information. Our email information is as follows: Marisa Lara at Marisa.lara@dhhs.state.nh.us, Dr. Richard Friedman at friedman946@yahoo.com, or Liz Kennett at Jimlizk@comcast.net. §

**References**


   Supplementary data available at: http://care.diabetesjournals.org/content/suppl/2013/03/05/dc122625.DC1/DC122625SupplementaryData.pdf


Prepared by MetLife  
Delivered courtesy of Troy Aarthun,  
Financial Services Representative,  
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When it comes to retirement planning, individuals need a map and directions, along with someone to help them on their journey. Particularly for those who may have been greatly affected by the market swings in the last few years, creating a reliable income stream in retirement may be the furthest thing from one’s mind. However, taking a few small steps now can lead to large rewards in the future.

**Save, save and save**  
Start off with the basic principle of money-management saving. Take advantage of the retirement plans offered by your employer and any matching contributions they may offer.

**Take steps to create reliable income**  
There is no magic number, but 60 percent of pre-retirement income before tax is often a good starting point for income to cover essential expenses in retirement. Social Security and pensions are great sources of dependable income, but most people will need additional sources. To that end, you may want to consider putting a portion of your savings into an annuity and adding to it over time, or purchasing an income annuity when you retire to cover any remaining expense gaps. Through annuitization, these products can provide a guaranteed income stream during retirement.

**Plan for liquidity AND growth**  
Having cash on hand for the unexpected is smart. You could have an expense, such as a health need, a job loss or a change to your income—perhaps from an earlier-than-planned retirement date. Too much cash in the bank earning little interest can be detrimental to your retirement savings, but there are a number of financial products that can enable you to access cash when it’s needed and still keep your money working hard for you. For a list of the options, consider speaking with a financial professional who can suggest products and services to help meet your needs.

**Know what you want your retirement to look like**  
Many of us know that we may need to work longer in order to save for retirement. For some, the idea of retirement may be spending time traveling or fulfilling a lifelong urge to go back to school for higher education. For others, it may be spending days working part-time or volunteering at a nonprofit that’s close to their heart. Figuring out what you want your retirement to look like, will help you take the steps necessary to get there.

For more information on MetLife products and services, please contact Troy Aarthun at taarthun@baystatefinancial.com.

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Make sure to put either a 9 or a 0 in box 21 to indicate whether you are using an ICD 9 or ICD 10 code.

For more info on the ICD-10 transition, check out: [http://www.roadto10.org/](http://www.roadto10.org/)

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Our Provider Outreach Specialists are available to provide you with resources intended to help you better understand the importance of Asking and learning what to do when the answer is “yes.” If you need technical assistance in working with a veteran, service member, or military family member, or if you would like more information about this initiative, please call 844-4ASK-VET or visit AskTheQuestionNH.com.

Ask the Question is an initiative of the NH Department of Health and Human Services.