Updated Guidelines for Influenza and HPV Vaccination

By Marie Ramas, MD

Influenza Guidelines

“Doc, I never get the flu shot because I get the flu.” “Doc, I am allergic to eggs so can’t get the vaccine.” “I’m healthy. I don’t need the vaccine.”

As a family doctor, this time of year is both busy and repetitive. As we try to convince our patients to get vaccinated, we also face a seemingly mounting resistance against live-saving vaccines. The CDC estimates that influenza was associated with more than 48.8 million illnesses, more than 22.7 million medical visits, 959,000 hospitalizations, and 79,400 deaths during the 2017–2018 influenza season, the most in recorded history. Although last year’s statistics were not as high, the virus appears to show more virulence, leaving both the healthy and immunocompromised at risk. The most widely affected group remains those who choose not to vaccinate or who were vaccinated too late in the season.

This year, the guidelines remain largely the same, with a few exceptions. All vaccines are now quadrivalent. In January 2019, the U.S. Food and Drug Administration (FDA) approved a change in dose volume for Fluzone Quadrivalent, a quadrivalent inactivated influenza vaccine. Children 6 through 35 months of age may now receive either 0.25 milliliters or 0.5 milliliters per dose. There is no preference for one or the other.

Vaccines for Healthcare Workers

By David Itkin, MD
Infectious Diseases Specialist, Portsmouth, NH

The re-emergence of measles in 2019 presents an opportunity to review immunization recommendations for healthcare workers. Thus far in 2019, there have been more than 1200 cases of measles, the most cases seen since 1992. It’s important to recognize that measles is a highly contagious disease, with a high potential for transmission within a closed environment such as the hospital. It is among the diseases for which assurance of healthcare worker immunity is recommended by the Centers for Disease Control and Prevention (CDC).

The CDC recommends that we verify immunity by virtue of prior infection, prior immunization, or newly provided immunization for certain infections. These include measles, mumps,
President’s Perspective
Addressing Vaccine Hesitancy

Throughout my year as President of the NH Medical Society, I have been advocating to spread the word that vaccines are safe and effective. The anti-vaccine movement has led to outbreaks of vaccine preventable diseases in the United States and throughout the world. I have attended the American Medical Association annual meeting and the Council of the New England Medical Societies and the New England Delegation meetings where vaccines have been a topic of conversation. It is distressing that one of the greatest scientific and public health advances ever needs to be repeatedly be addressed due to continued skepticism about the issue, but this does reinforce our need to be informed and able to give parents and patients an educated message regarding vaccines.

I thought I would review a few practical points to many of the hesitancy questions and concerns that parents come to me with.

Does the MMR vaccine or the vaccine preservative thimerosal (mercury) cause autism?

This concern continues to be brought up by parents due to a retracted journal article from 1998. I reassure parents that the initial article has been retracted due to the data in the article being fabricated – made up by the lead author who subsequently lost his license to practice medicine in England. The entire thing was a lie. There have been many studies of significantly more children that have shown no association between the MMR vaccine and autism. Additionally, all childhood vaccines (with the exception of some flu vaccines) have been thimerosal free since 2001, and the numbers of children diagnosed with autism actually increased and did not decrease as would be expected if it were the cause of autism.

Aren’t we doing too many vaccines too soon? Can I separate the vaccines so my child is not getting too many at one time?

I have two points I make with parents on this topic. One is that every day your child is exposed to thousands if not millions of antigens, proteins, viruses that are challenging your child's immune system. So the five to six vaccines given at one time is a drop in the bucket for your child’s immune system activity. One immunologist from MIT actually figured out that babies' immune systems could effectively respond to 100,000 vaccines at one time!

Secondly, by separating vaccines, parents are actually putting their children at risk of these vaccine preventable diseases during a time that they are more susceptible and vulnerable to becoming ill or having complications from these illnesses. I personally tell parents that it is better to have them all at once when their immune systems are developing.
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How to Keep You and the CME Auditor Happy

By Mary West, NHMS Director of CME and Accreditation

If you are one of the nearly 3,800 physicians whose New Hampshire medical license is due to expire on June 30, 2020, your CME Biennial Reporting Form should arrive in the mail around the first week of December. You will then have until February 28, 2020, to compile your CME documentation and return the report to NHMS for auditing. This process need not be painful. Here’s what you need to know:

- The CME requirements are the same for all licensees.
  - If you were (or are) in residency during 2018-2019, please submit documentation (typically a letter from your program director) that includes your name and the dates. Residency and fellowship qualify for 50 credits/year but only within your cycle. For example, if you were in residency from June 2017-June 2019 that would translate to 75 Category 1 credits (50 for 2018 and 25 for six months of 2019).
  - If you licensed partway through the cycle, you may still report credits from the full two year cycle, even if those credits were obtained prior to your NH licensure.

- You only need to report 100 hours of CME obtained between January 1, 2018 and December 31, 2019. If you’ve completed more than that, you can save on postage and keep the extra certificates in your files.

- Forty hours must be documented category 1. Many hospitals and national specialty societies, e.g. AAFP, ACOG, AOA, Dartmouth-Hitchcock, can provide you with transcripts. This saves time on both ends of the reporting process.

- If you have a DEA license (to prescribe Schedule II-IV controlled drugs), 3 of your Category 1 CME credits must be related to pain management and/or addiction disorders. This requirement applies to any physician with a DEA license linked to a New Hampshire address. These 3 credits must be obtained between January 1, 2018 and December 31, 2019, just like your other credits.

- You can fill the remaining 60 hours with either Category 1 or Category 2 hours. Just include a list of journals you’ve read, articles you’ve written, teaching duties, etc. and list the time spent on each activity to report Category 2. For example, “Read NEJM – one hour/month = 24 credits.”

- Quick file with one of the following, which qualify for 100 hours of CME:
  - Proof of board certifying or recertifying in your specialty (a copy of your certificate, the letter stating that you passed or even a printout from the specialty website if it shows your name and the date you certified).
  - Proof of being up to date with MOC (likely a printout from your specialty website).

- You must include a check for the $40 processing fee, payable to “CME Coordinator” or call in with a credit card payment before your audit can be completed.

- All the paperwork gets scanned and saved for reference so please avoid staples if possible.

If all else fails, I’m happy to answer your questions. I’m only in the office part-time, so reach me at mary.west@nhms.org.

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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.

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<thead>
<tr>
<th>Drug Name</th>
<th>QTY</th>
<th>Retail Price</th>
<th>Discount Price</th>
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<td>Azithromycin (Z-Pak) 250mg Tablet</td>
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<td>Fluticasone Propionate (Flonase) 50 MCG Spray 16 gm</td>
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<td>Oseltamivir (Tamiflu) 75MG Capsules</td>
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<tr>
<td>Amantadine (Symmetrel) 100mg Capsules</td>
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<td>Rimantadine HCL (Flumadine) 100mg Tablets</td>
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dose volume for this age group. All persons 3 years of age and older should receive 0.5 milliliters per dose. Like last season, CDC and ACIP recommend that vaccination be offered by the end of October. Children 6 months through 8 years of age who need two doses should receive their first dose as soon as possible after the vaccine becomes available, to allow the second dose (which must be administered at least 4 weeks later) to be received by the end of October.

Those who are unable to be vaccinated rely on us to provide immunity for them. Last year, several of my own patients were hospitalized due to influenza and one unfortunately died from complications from the flu. I hope that will not be the case again this year!

HPV Guidelines

Cervical cancer used to be the leading cause of cancer related death in women, until the HPV (human papilloma virus) vaccine came about in 2006, for young women, and in 2011, for young men. Since the distribution of the HPV vaccine, the new rates of cervical cancer have decreased, and, in combination with regular surveillance, can dramatically reduce morbidity and mortality. Although there are more than 100 strands of HPV, the majority of HPV-associated cancers are caused by HPV 16 or 18, types targeted by all three vaccines. In addition, 4vHPV and 9vHPV target HPV 6 and 11, types that cause anogenital warts. 9vHPV also protects against five additional high-risk types: HPV 31, 33, 45, 52, and 58. In October 2018, the Food and Drug Administration (FDA) approved the expanded age for vaccination from 9-26 years old to 9-45 years old, with 9vHPV vaccine only. Those aged 9-15 years require only two doses of HPV vaccine at least 6 months apart. Otherwise, they are to receive the three-dose series per routine.

Some patients ask what the benefit of additional vaccines would be if HPV is a sexually transmitted virus. Assuming most adults are sexually active, we cannot be certain which strands of HPV each person has come into contact with. For this reason, the vaccine has potential to protect from other HPV-related illnesses, including cervical cancer from one of the nine covered by the vaccine. HPV vaccine efficacy is high among persons who have not been exposed to vaccine-type HPV before vaccination.

From a public health standpoint, the overall benefit for vaccination of adults >26 years old is lower than when compared to vaccinating per the routine schedule. The Centers for Disease Control recommend that shared decision-making should be done to inform those older than 26 years of their options regarding vaccination. Some areas of consideration include that persons who are in a long-term, mutually monogamous sexual partnership are not likely to acquire a new HPV infection. Most sexually active adults have been exposed to some HPV types, although not necessarily all of the HPV types targeted by vaccination. No clinical antibody test can determine whether a person is already immune or still susceptible to any given HPV type.

HPV vaccines are equally important for those at risk for anal cancer, and recommendation of the vaccine for those who engage in anal intercourse should also be considered. This is in addition to anal pap smears for prevention of cancer.

In summary, the earlier you vaccinate the better, but something may be better than nothing for those at high risk.

Further reading: https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6832a3-H.pdf
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Electronic communication (e-communication) has increased significantly and is no longer limited to e-mail on the desktop. Smartphones and tablet computers make it possible to access information and send and receive messages anywhere there is a cell signal or wireless network. Mobile communication technologies have spread with remarkable speed.

Platforms and Risks

- **E-mail** has been available for years and many organizations such as the American Medical Association, American Health Information Management Association and the American Academy of Pediatrics have position statements, talking points and guidance on the use of e-mail to communicate with patients.

  **Risks:** Unless the e-mail is encrypted and secure, it is not appropriate for sending electronic protected health information (ePHI) over public networks. The exception to sending unsecured ePHI is by patient request. According to HIPAA, the patient has the right to request their PHI to be transmitted to them in the medium they select or request. E-mail is discoverable and may be recovered from hard drives even after deletion.

- **Text messaging** (also known as SMS) is a common platform on cell phones, smartphones and some tablet computers (mobile devices). It is possible to attach photographs and video and embed links in text messages. Depending on the type of phone plan, there may be a cost to both the sender and receiver for each message.

  **Risks:** Text messages are also very difficult to encrypt. The ability to attach images and embed links and the fact that most mobile devices do not have antivirus protection installed creates a significant risk of malware contamination. Text messages are discoverable without a separate text management platform. There is no direct way to incorporate text communications with patients directly into the patient record. They must be transcribed. Failure to document important clinical text messages into the medical record can create problems down the line if the record is needed to defend a claim or Board complaint. As of December 2016, The Joint Commission had deemed text messaging inappropriate for physician orders. CMS reiterated this position in December 2017, and further clarified “that texting patient orders is prohibited regardless of platform, however, members of the healthcare team may text patient information through a secure platform” (DHHS, 12/28/2017 Memo, “Texting of Patient Information among Healthcare Providers”).

- **Patient portals** are password protected web pages that facilitate the exchange of information. Portals are very secure; users must be authenticated before they can access/use the portal. They may be integrated with the organizational EHR, which facilitates medical record documentation of communications and facilitates sharing patient health information electronically. Some organizations provide patient’s access to their own EMR via the portal; others limit use to messaging and sharing of diagnostic test results.

- **Recording patient/physician communication:** Patients may request to record directions, instructions, or conversations with providers. It is important to have parameters around these requests. The patient may need to share this information with a loved one or they may need to hear instructions again. It is important to have conversations with patients regarding the use of their electronic devices for communication purposes.

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rubella, varicella, pertussis, influenza, and hepatitis B. With the exception of hepatitis B, these recommendations are based on protection of our patients; the recommendation for hepatitis B is for protection of the healthcare worker against hepatitis B infection from a blood (or appropriate body fluid) exposure.

Upon employment, immunity status for these infections should be determined. Traditionally, birth prior to 1957 has implied immunity to measles, mumps, and rubella due to the prevalence of these infections at that time. However, it is somewhat more complex than that. Healthcare workers are considered to be at higher risk of infection; therefore, laboratory evidence of immunity by serology or documentation of adequate vaccination should be obtained. Those who do not meet these criteria should receive a two-dose series of MMR.

Varicella immunity should be verified by serology or documentation of adequate vaccination. Additionally, individuals with a history of varicella or herpes zoster as documented by a healthcare provider are also considered immune. In all other cases, a two-dose series of varicella vaccine should be offered. Recipients of this live virus vaccine are not precluded from providing direct patient care; there have been no reported cases of transmission of the vaccine viral strain to patients.

Pertussis is a common respiratory infection, recognized as a cause of hospital outbreaks. All healthcare workers should be immunized against pertussis. Adults should receive a one-time Tdap immunization, regardless of how recently they might have received Td.

Influenza outbreaks occur annually, with an average incidence of about 8%. Severe complications and deaths occur each season, and a high rate of employee absenteeism is common. Annual immunization for seasonal influenza for healthcare workers remains a priority. Influenza vaccine should be provided to all except those with a true medical contraindication. Most hospitals have hard-wired processes for mandatory annual immunization.

All healthcare workers with potential exposure to blood and body fluids should be offered hepatitis B vaccine. Hepatitis B immunity should be ascertained upon hire or 1-2 months after receiving vaccine. Those without immunity (HBsAb < 10 mIU/ml) should receive a second and final full series of hepatitis B vaccinations. HBsAb should be measured again 1-2 months after completion of this series.

Other vaccines such as pneumococcal or meningococcal vaccines are not considered necessary for all healthcare workers. Of course, those with certain medical conditions should be immunized for their own protection, based on standard recommendations.

In summary, healthcare workers have an obligation to treat and not injure our patients. Preventing communicable diseases in healthcare workers with vaccination, and robust employee health processes for evaluation of ill employees, are critically important as we strive to first do no harm. §
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Just the Vax

By Michael Padmore,
NHMS Director of Advocacy

In the midst of flu season, vaccines are top of mind. Have you received your flu shot yet? This past legislative session saw only a few vaccine related pieces of legislation. In years past, the New Hampshire Medical Society has been a key voice at the New Hampshire State House in defeating legislation offered up by the anti-vaccine movement. No such bills were filed last session. With that said, we are keeping a close eye as new legislation is made public day by day, screening for any anti-vaccine related bills. As we identify pro- or anti-vaccine legislation, please look for communication from me on how you can advocate for or against these bills.

One issue that we’ve heard from many of you on, is our state’s need for a mandatory vaccine registry. This registry will be a critical resource for physicians when administering vaccines to their patients. As the New Hampshire Department of Health and Human Services works on getting this registry up and running, the New Hampshire Medical Society will continue to support their efforts in any way we can.

Outside of our legislative work, the New Hampshire Medical Society has embarked on a public health campaign to organize and train physicians around the state to work within their communities to promote vaccine utilization. We understand that it’s critical that physicians feel empowered to speak with their communities about the benefits of vaccinations but realize many may not know

Just the Vax, cont. on page 12
Just the Vax, cont. from page 11

where to start. We hope to for-
malize this process by identifying
statewide partners who can help
facilitate conversations in local
schools and community organiza-
tions. Our goal is to have trusted
local physicians speaking directly
with parents in their community
about the merits of vaccines and
pushing back on any anti-vaccine
messages parents may be hearing.
I was very fortunate to grow up
in a family with parents who
made sure I got my flu shot every
year. My mom still texts me every
fall asking me if I’ve gotten my
shot yet! Sadly, not all children
are this lucky. With so much
easily accessible misinformation
being pushed by anti-vaccine or-
ganizations, it’s even more imper-
ative that the medical community
is standing up to educate their
communities on why we need
a vaccinated population. As we
continue this campaign, please
call or email me to let me know if
you would like to be involved.

President’s Perspective, cont. from page 2

parents there are no “alternative”
vaccine schedules. The sched-
ule by the CDC is the only vac-
cine schedule and it is based on
research to protect babies as soon
as it is safe and effective. One
published “alternative” schedule
has the author of that schedule
admitting that this schedule has
no research behind it and it has
never been studied to determine
if it is safe or beneficial.

My child is healthy. Why do I
need to vaccinate? We do not
see these illnesses, so why do I
need to protect my child?

Unfortunately, in the past year
this discussion has gotten easier
to discuss as we have seen the resur-
gence of measles in the United
States. Measles was considered
eliminated in the US in the year
2000, and now we are seeing
cases across the country. This is
why we vaccinate. These diseases
can cause serious illness, compli-
cations, lifelong disabilities and
death even in previously healthy
individuals.

Vaccinating your children helps to
protect them first and foremost,
but they are also preventing these
diseases from spreading in a com-
munity and potentially affecting
individuals who are not healthy,
are immunocompromised or are
allergic to vaccines. I remind par-
ents that I care for children who
are immunocompromised or go-
ing through cancer treatment and
may be unable to receive vaccines
and having unvaccinated children
in my practice puts these other
children at risk. This is often an
aspect of public health that fami-
ilies overlook and when I explain
this to parents they often recon-
sider not vaccinating and proceed
to vaccinate their child.

More information can be found
on the Centers for Disease Control
website (CDC.gov), the American
Academy of Pediatrics websites
(AAP.org and Healthychildren.
org), Immunization Action Coalit-
ion website (immunize.org) and
the Children’s Hospital of Phila-
delphia website (vaccine.chop.
.edu). I will often give handouts
from these websites to parents
with one of these specific concerns
and I have put together a packet
with many of these handouts that
my pediatric group will give to
parents who have multiple con-
cerns or are just requesting more
information.

By having current and accurate
information to provide parents
who are trying to protect their
children from risk, we can often
address their hesitancy and con-
vince parents to vaccinate their
children and protect them and
those around them.
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The Expanding Role of the Medical Society’s Bowler-Bartlett Foundation

By Jim Potter, Executive Vice President

Two years ago, the leadership of the Medical Society adopted changes to reconstitute its charitable, educational and scientific 501(c)3 organization as the Bowler-Bartlett Foundation, whose continuing mission is to advance the practice of medicine, enhance the quality of medical care, and better the health of New Hampshire citizens, as well as preserve and promote the history of medicine in the Granite State.

Physician Leadership

With this in mind, the Foundation established a Physician Leadership Institute whose goal is to build a physician-driven healthcare delivery system for New Hampshire by providing longitudinal learning experiences through case-based curriculum. Start-up funding from a two-year $150,000 grant from The Physicians Foundation has allowed an advisory council, chaired by Dr. Deb Harrigan, to create the unique New Hampshire Physician Leadership Development Program in collaboration with the New Hampshire Hospital Association and the University of New Hampshire's Paul College of Business and Economics. Directed by Dr. Neil Meehan, the program’s curriculum is designed with physician’s schedules in mind and consists of one morning modules to enhance physician leadership behavioral skills in the first year (emotional intelligence, teambuilding, managing transitions, conflict resolution, coaching and mentoring) and more of the analytical leadership skills in year two (executive presence, quality improvement, financial management and strategic thinking).

We currently have two cohorts with a total of 38 physicians participating in the program. Applications for our next cohort and further details about the program are available online at https://paulcollege.unh.edu/physicianleadershipnh.

Based on the success of the Physician Leadership Development Program, we are anticipating a follow-up grant from The Physicians Foundation to develop new and complimentary programs to expand the number of physicians involved in the NH Physician Leadership Institute, including activities for physician wellness and personal financial education, media and legislative advocacy training, a physician executive coaching network and an executive MBA program for physicians.

Public Health Outreach

In an effort to have physicians more broadly involved in educating Granite Staters about public health issues impacting their communities, the NHMS Council early this year expanded the charge of our Education Committee to support the delivery of relevant, accurate health information to the public in a manner that is easily understandable and relatable. To this end, the Medical Society now more actively collaborates with physician organizations, state agencies, consumer, civic and other health professional organizations to develop/deliver public health educational activities, and foster public health information. Here are three new such activities undertaken in 2019.

Vaping Unveiled - Partnering with Breathe New Hampshire (formerly American Lung Association of NH), Dr. Albee Budnitz has trained a cohort of ten physicians to be able to give 35-40 minute presentations to middle school, high school and parent audiences, as well as healthcare professionals, medical students and physicians, on the perils of vaping. https://www.breathenh.org/programs/vaping-unveiled/resources

Tick-Borne & Insect Diseases - Partnering with Dr. Benjamin Chan and the New Hampshire Department of Public Health Services, we have established a physician advisory council to develop a one-hour CME program on the prevention, early identification and early intervention of tick bite infections based on changes to the 2019 draft ISDA/AAN/ACR clinical practice guidance, as well as a partnering with Tick Free New Hampshire to promote 15-20 minute public education sessions delivered by physicians.

Adolescent Immunizations - Partnering with New Hampshire Bureau of Public Health and New Hampshire School Nurses Association, Drs. Tessa Lafortune-Greenberg and Angela Shepard have spearheaded development of a letter and information packet to be distributed to fifth grade parents.

Bowler-Bartlett, cont. on page 15
on adolescent immunizations (meningococcal, human papillomavirus (HPV) and tetanus, diphtheria, and pertussis (Tdap) vaccines). A 15-minute presentation given by physicians is also under development, which is intended for parent-teacher associations (PTAs) and other education audiences.

If you would like to learn more or become involved in one of these public education and outreach efforts, please contact Michael Padmore at michael.padmore@nhms.org.

Expanding Opioid Use Disorders Treatment

The Medical Society is working with the New Hampshire Department of Health and Human Services through the State Opioid Response (SOR) plan to offer 8-hour MAT waiver courses with currently about 700 practitioners trained to date in the last three years. In addition, we are developing a 60-90 minute continuing education program aimed at nurses and medical support team members about implementation of MAT and behavioral health wrap around services.

You, too, can contribute to help positively impact New Hampshire’s health care systems and public health outcomes. This year, we will offer a contribution check-off opportunity to the Bowler-Bartlett Foundation through our annual dues statement. Please consider a tax-deductible donation to help us extend the Foundation’s education and public health activities.

We welcome your ideas for other programs to help promote physician leadership and public health educational opportunities. If you would like to learn more or are interested in participating, please drop me a line at james.potter@nhms.org or call me at 603-224-1909.

Bowler-Bartlett, cont. from page 14

New Hampshire Medical Society

Corporate Affiliate Program
Enhancing the Value of Your Membership

Affiliate Services

Billing Services  Employee Benefits  Pharmaceuticals
Business Management  Financial  Practice Management
Collection Service  Insurance  Telecommunications
Dental Benefits  Legal  Uniforms, Apparel & Linens
Electronic Medical Records  Office Supplies  Web-based Billing
Electronic Payment Systems

NHMS CAP is a paid membership program whose members meet criteria as posted at www.nhms.org
The Medical Review Subcommittee (“MRSC”) to the Board of Medicine (“Board”), 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: Emergency Medicine and Family Practice.

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 state of New Hampshire, by the board and the office of professional licensure and certification, and with the approval of governor and council, shall contract with a qualified physician to serve as a medical review subcommittee investigator.

The MRSC meets once monthly on the first Wednesday beginning at 1:00 P.M. The MRSC reviews all complaints, claims, etc. received by the Board and makes recommendations to the Board regarding final actions.

If you meet the criteria above and wish to apply for the public member vacancy or one of the physician vacancies 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, NH 03301