Physicians’ Bi-Monthly

Substance Use & Addiction
Finding the Balance: Opioid Addiction and Patient Privacy

By Cinde Warmington, Esq. and Kara Dowal, Esq.

Statistics are unnecessary for what we already know – that New Hampshire has a severe crisis with respect to opioid addiction. Any meaningful response to this epidemic requires a multifaceted approach involving education, treatment, and law enforcement efforts. For healthcare providers, the opioid crisis can pose difficult challenges as they seek to balance public safety concerns with the confidential nature of the patient-physician relationship.

In order for providers to meet their primary responsibility and commitment to deliver health care services, it is essential that patients know that their privacy is protected. Patients must know that they may safely seek treatment and, when seeking treatment, that they can be candid with their provider. Law enforcement has a different role seeking to enforce the law and protect the public. There is a natural tension that exists between the provider’s obligation to protect patient privacy and the need for law enforcement to obtain information to forward its investigations.

When approached by law enforcement, some providers mistakenly think that the question of whether and how much information they should share with law enforcement is a straightforward application of the HIPAA rules permitting disclosure.

Is Your Practice Up to Code?

Under the New Hampshire Board of Medicine’s Administrative Rules, licensed physicians are required to adhere to the AMA Code of Medical Ethics.

Med 501.02 Standards of Conduct

(h) A licensee shall adhere to the Code of Medical Ethics – Current Opinions With Annotations (2012-2013 Edition) as adopted by the American Medical Association, as cited in Appendix II.

Administrative rules in New Hampshire are not able to refer to the “latest” or “current” edition of any publication. Therefore, physicians are required to follow the 2012-2013 AMA Code. After the rule was updated, the AMA released a 2014-2015 edition of the Code and, this past June, adopted an entire re-write of the Code.

The Board of Medicine’s rules will need to be updated to reference the 2016 edition of the AMA Code. Many of the ethical policies remain the same but are reorganized in the newer, streamlined version. For more updates, please visit: www.ama-assn.org

VaxNH: How the Immunization Registry Will Affect You

By Marcella J. Bobinsky, MPH, DPHS Acting Director

The New Hampshire Immunization Program (NHIP) is in the beginning stages of fully implementing an Immunization Information System (IIS), also known as a “Registry”. The name of the IIS is VaxNH, and NHIP will routinely communicate with health care providers about the rollout plan for the system.

What does this mean? An IIS is a confidential, population-based, computerized database that records all immunization doses administered by participating health care providers to patients residing within the State.

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Estate Planning 101

Texting in Your Practice

Goodbye from Janet Monahan

Upcoming conferences
President’s Perspective
The Fundamentals of Physician Belief Structure

It has been my experience in the work I have done in physician network development that there are three basic questions a physician will want clarified in looking at a new position: what he or she will be paid, what his or her call schedule will be, and whether he or she will be able to develop a professionally satisfying career (not necessarily in that order, but pretty close). Any one of these may end up being a deal breaker, but subject to negotiation. However, there are more profound, fundamental issues, not necessarily verbalized but very definitely on the table and not open to negotiation: the rights and responsibilities of professionalism.

As professionals, society has awarded us the rights (and license) to practice our profession, judge the quality of our own work, and act as stewards for the physical, mental & economic health and well-being of individuals and populations. These rights are not lightly bestowed and can be revoked should we fail in our professional and fiduciary (stewardship) duties including certification, documented quality metrics, compliance, and ethical behavior.

All physicians, whether experienced long-term practitioners or newly-minted practitioners, are expected to pass muster in a group of core competencies, all of which are agreed upon by policy-making, regulatory and certifying agencies such as the American College of Graduate Medical Education, the American Board of Medical Specialties, and the Institute of Medicine. These core competencies include patient care, medical knowledge, interpersonal and communication skills, professionalism, systems-based practice and practice-based learning. While not always easy to define, much less to measure, medical leadership is increasingly expected to keep real-time track of these metrics in order to justify recertification and re-privileging in the form of ongoing professional practice evaluation (OPPE) and maintenance of certification (MOC). Included in these expectations is the expectation that all providers remain in compliance of the local, state and federal regulations, e.g., bylaws and policies, board certification and licensure, and CMS & HIPAA regulations respectively. Failure in any of these areas can lead to practice limitations, loss of licensure or Medicare accreditation, or even criminal prosecution in worst-case scenarios.

Of equal concern is the inviolability of our medical ethical framework. Being asked to practice within a system that neither rec-
Estate Planning 101

By Jennifer N. Shea, JD, MBA, Agency Director – Financial Planning and Advanced Markets, Baystate MD

Many people do not think twice about visiting their primary care physician for an annual check-up. However, they neglect to visit their Advisor for an annual check-up on their financial plan - a roadmap to make their financial goals a reality. One of the key areas that should be addressed is estate planning. Estate planning is one of the most important steps any person can take to make sure property is managed and distributed appropriately, health care wishes are honored, and loved ones are provided for. The following is a brief overview of the basic estate planning documents you should have regardless of your age, health or wealth.

Durable Power of Attorney for Financial Matters

This allows you to appoint a spouse, trusted friend or family member to make financial and legal decisions on your behalf. The individual granted this power is known as your Attorney-in-Fact. It is important to name a primary Attorney-in-Fact and at least one alternate.

If a Durable Power of Attorney for Financial Matters is not in place, or is outdated, individuals will not be able to access financial assets or make legal decisions on your behalf should you become incapacitated. If this occurs, an individual would need to petition the Probate Court.

Advanced Medical Directive

Advanced Medical Directives contain two sections. The Power of Attorney for Health Care allows you to appoint a spouse, trusted friend or family member to make medical decisions on your behalf when you are no longer able to do so. The individual granted this power is called your Health Care Agent. It is important to name a primary Health Care Agent and at least one alternate.

The Declaration or Living Will allows you to communicate your wishes regarding medically administered nutrition, hydration and life-sustaining treatment.

Last Will and Testament

A Last Will and Testament, or Will, is often said to be the cornerstone of an estate plan. The main purpose of a Will is to disburse property to heirs after your passing. If you haven’t executed a Will, your probate property will be disbursed according to state law, which might not be what you would want.

There are two other equally important aspects of a Will. You can nominate an Executor, which is the person or financial institution that will be responsible for administering your estate according to your wishes. If you do not nominate an Executor, the Probate Court will appoint someone to serve in this role.

You can also nominate a legal Guardian to care for minor children or dependents with special needs. If you do not nominate a Guardian, the Probate Court will do so and the person appointed may not be your first choice.

Revocable Living Trust

This is a separate legal entity you create to own property, such as your home or investments. It’s called a Living Trust because it’s meant to function while you’re alive. You control the property in the Trust and, whenever you wish, can change the Trust terms, transfer property in and out of the Trust, or end the Trust altogether.

Not everyone needs a Revocable Living Trust. The primary function is to avoid probate, as property owned by a Revocable Living Trust is not included in the probate estate. Family members are often grateful when Revocable Living Trusts have been used for this purpose. The probate process can be time-consuming and expensive. It is also public, meaning anyone can access the estate file and see what you owned, how much you were worth, and who is getting what.

Revocable Living Trusts can also be designed to hold and administer assets and investments for the benefit of minor children when you are no longer able to do so.

In Conclusion

Depending on your personal financial goals and wealth transfer wishes, additional techniques for estate planning may be appropriate. At Baystate MD, we can work in conjunction with your estate planning attorney to make sure your estate plan is seamlessly integrated with your financial plan. §
New Policy Released Concerning Texting in Your Practice. Are You Compliant?

The Joint Commission has updated its policy on texting orders. NHMS’s free member benefit, DocbookMD, remains the best way to ensure your practice’s compliance.

The new Joint Commission policy reads:

“Licensed independent practitioners or other practitioners in accordance with professional standards of practice, law and regulation, and policies and procedures may text orders as long as a secure text messaging platform is used and the required components of an order are included.”

So what does this mean for you and your practice? It means that you can finally take advantage of the ease and efficiency of communication that mobile text messaging brings, but you need a secure platform on which to do so—the built-in messaging app on your phone just won’t cut it.

A secure texting platform must include the following:

• Secure sign-on process
• Encrypted messaging
• Delivery and read receipts
• Date and time stamp
• Customized message retention time frames
• Specified contact list for individuals authorized to receive and record orders

DocbookMD meets and exceeds all of these requirements and is free to all NHMS members. Learn more about DocbookMD at http://www.docbookmd.com/. Then contact Catrina Watson at catrina.watson@nhms.org or 603.224.1909 to get your medical society ID number, so you can download for free from the Apple App Store or Google Play.

Need help using the DocbookMD app? The user manual and tutorial videos will walk you through everything you need to know from beginning to end:

• DocbookMD Tutorial Videos: https://www.docbookmd.com/videos/

Finding the Balance, cont. from page 1

Cinde Warmington, Esq. and Kara Dowal, Esq. are members of the Health Care Practice Group at Shaheen & Gordon, PA, and focus their practices on representing health care providers. They may be reached at (603)-225-7262.
The Importance of Tracking and Following in the Medical Practice

By Denise Condron, CMIC Group Director of Loss Prevention

Allegations of a failure to diagnosis and/or a delay in diagnosis are the leading causes of medical malpractice claims. Many of these failures and delays in diagnosis are directly related to the failure to receive and review diagnostic testing.

Having a good tracking system in place is important to ensure the receipt and review of all outstanding orders. Many patients believe that no news is good news and that if it was important or if anything was wrong, they would receive a call from the office. Waiting for a patient to follow-up on their own test results is not a best practice. A system to track clinical labs, diagnostic imaging, surgical procedures and referrals to other physicians is essential to patient safety.

Many practices are utilizing computerized physician order entry (CPOE) as a component of the electronic medical record (EHR). While CPOE has afforded physician practices safety related benefits, caution must be used to ensure the proper tracking of these elements. Whether utilizing a system of paper records or an EHR, the following components should be incorporated into the workflow:

1. Test results are received
2. Results are reviewed in a timely manner
3. The patient is notified of the results, normal or abnormal
4. The medical record is documented to show the results were received, the patient was notified with the results and the discussion surrounding the need for follow-up if necessary

It is not uncommon to encounter challenging issues when implementing a CPOE workflow, and in addition to a solid implementation and strong training, a post implementation audit should be considered. Just as you would check a written log book periodically, you should also be looking at the data in your EHR to ensure that the workflow is correct.

Still think all medical professional liability insurance providers are alike?

At CMIC Group, we take great pride in the communication, innovation and personalization that makes us truly unique.
In 1987, I answered a newspaper ad for a part-time position at the Medical Society. Due to a change in political leadership, I had recently left an eight-year stint in the New Hampshire House Speaker’s office.

It never occurred to me that the Medical Society would be my Monday-Friday home for nearly three decades. 29 Medical Society presidents, three executive directors and hundreds of physicians have helped to personally shape my professional life. The 424 member New Hampshire General Court also played a significant part of my daily life but it has been the physicians who have made my years here so rewarding.

The Medical Society tracks about 100 health-related bills each year. **Here is a quick look at decades of legislative challenges that I worked on for NHMS:**

1988 - Insurance coverage for mammograms
1989 - Raised seat belt law from age 5 to age 12

1990 - Enacted law to strictly regulate reproductive surrogates with emphasis on child protection
1991 - Expanded tobacco tax to chewing tobacco
1992 - Helped enact law to recognize living wills from other states
1993 - Requirement for emergency rooms to use standardized domestic violence protocols
1994 - Supported funding from state budget for domestic violence programs
1995 - Improved health insurance “explanation of benefits” laws
1996 - Requirement for health insurance utilization review criteria to be based on national specialty guidelines
1997 - Insurance mandate for post mastectomy reconstructive surgery
1998 - Requirement for insurers to provide clinical rational for “not medically necessary” denials
1998 - Limited the use of the word “physician” to MDs and DOs
1999 - Requirement for health plan medical directors to have NH license
1999 - Created a consumer advocate position at the Department of Insurance
2000 - Enacted health insurance prompt payment law
2001 - Requirement for tattoo artists to be licensed and utilize safety measures
2002 - Enacted a mental health parity law
2002 - Amended state law to place limitations to retroactive insurance denials
2003 - Passed a law to eliminate “loss of opportunity” in malpractice suits
2004 - Led the charge to enact indoor tanning safety measures including limitations for teens
2005 - Enacted mandatory pretrial panels for all medical malpractice cases
2006 - First in the nation to enact prescription privacy law to prohibit physician prescription profiling
2006 - Passed “Michelle’s Law” to protect critically ill college students from losing insurance coverage
2007 - Banned smoking in bars and restaurants
2007 - Established a statutory definition of “medical necessity”
2008 - Requirement for legitimate doctor-patient relationship for prescriptions, to curb Internet prescribing
2009 - Amended health insurance law to include telemedicine for otherwise covered services
2009 - Stopped five bills that would have adversely affected medical liability laws
2010 - Defeated seven bills proposed and supported by trial attorneys
2011 - Enacted legislation to enable the electronic exchange of patient health information
2011 - Permitted pharmaceutical take-back programs in cities and towns for unused prescription drugs
2012 - Enacted a prescription drug monitoring program (PDMP) law to assist prescribers and dispensers of controlled drugs

Goodbye..., cont. on page 7
2012 - Stopped a bill to prohibit physicians from referring patients for any implant device if the physician had ownership interest in the device

2013 - Passed a bill to require self-insured companies to contribute funding to the state vaccine program

2013 - Played key role in getting important components into the therapeutic cannabis law to limit its abuse

2014 - Enacted legislation to legally recognize a spouse or other adult as a healthcare surrogate for an incapacitated patient without an advance directive

2014 - Stopped three bills that would have adversely affected tort and medical liability laws

2015 – Spearheaded effort to allow the prescribing of non-controlled drugs via telemedicine and to allow certain controlled drugs to be prescribed at certain state or federally certified clinics

2015 – Stopped three bills that proposed a workers’ compensation medical fee schedule

2015 – Helped enact legislation to limit out-of-pocket costs to patients for oral chemotherapy drugs

2016 – Led successful effort to require a uniform prior authorization form or electronic interface for prescription drugs

2016 – Supported legislation to prohibit geographic non-compete clauses in physician employment contracts

2016 – Supported adoption of the interstate medical licensure compact

Representing physician and Medical Society positions has been challenging, frustrating and fun. I was fortunate that I never had to lobby for a position that I did not personally believe in.

Thank you to every physician who helped me to be successful in all my endeavors. I wish the Society continued success and look forward to crossing paths in the future with the many friends I have made.

Most sincerely,
Janet Monahan

Goodbye..., cont. from page 6
According to multiple sources, including Fox News and USA today, dozens of health insurers selling plans under ObamaCare have requested hefty premium increases for 2016. Federal officials are claiming that premium costs will raise an average of 20 percent.

The insurers have cited higher-than-expected care costs from customers they gained under the Affordable Care Act’s coverage expansion and the rising cost of prescription drugs and other expenses as reasons for proposing the increases.

The New Hampshire Rx Card can lower out-of-pocket prescription costs as much as 75%. Average savings are around 30%. The program is completely confidential, without membership restrictions, income requirements, age limitations, or applications to complete. If you have a high deductible, take a medication that is not covered by insurance, or have no prescription coverage, log onto www.nhms.org to print your free card. You can also walk into any CVS pharmacy or Shaw’s Osco Pharmacy and request to use the New Hampshire Rx Card program. If you prefer a more durable card, or would like a supply for your office, contact Mary West at mary.west@nhms.org or 603.224.1909.

**WANTED**

Internal Medicine, Orthopedic, Neurologic, General or Family Practice Physicians interested in providing part-time or full-time staff medical consultant services or are interested in performing consultative examinations in your office for the Social Security Disability program, under contract at the state Disability Determination Services office in Concord, NH, should email a current CV to Anne.Prehemo@ssa.gov to begin the process. The medical contractor must be licensed in the state of New Hampshire. Staff work involves performing medical reviews of disability claims and requires no patient contact.
Appointments: Missed (No Show) & Canceled Appointments

By Lou Anne McLeod, Senior Risk Manager, Medical Mutual Insurance Company of Maine

The implementation of a missed/canceled appointment policy should assist the physician office practice in ensuring that patients return for follow-up appointments. The policy should reflect the following:

- During the patient's initial visit, the patient should be advised of the importance of keeping scheduled appointments.
- Every patient who misses (no shows) or cancels an appointment and does not reschedule should be contacted. The physician should be notified or provided with a list of patients who missed or canceled an appointment.
- When additional follow-up with the patient is directed by the physician, at least three contact attempts should be made.
  - The initial attempt would be the courtesy contact mentioned above.
  - The second contact attempt may be the same as used in the initial attempt, i.e., phone call, card or letter. It is not uncommon, however, for the first attempt to be made by telephone and the second attempt made by a letter sent first-class U.S. mail.
  - The third attempt should be a letter sent certified mail request return receipt, restricted delivery.
  - If a patient refuses a certified letter:
    - Note the refusal in the patient's record.
    - Place the unaccepted letter in the envelope in the chart with the refusal receipt.
    - Make a copy of the letter.
    - Send the copy back to the patient in a plain envelope with no office practice identifiers.
- Documentation should occur in the medical record and reflect:
  - Each contact or attempt to contact the patient including telephone contact or letters sent to the patient.
  - The date of the missed or canceled appointment and the date of the rescheduled appointment.
  - The reason why an appointment is no longer necessary (when applicable).
  - Refusal of the certified letter as discussed above.
- Referral patients:
  - When a referred patient neglects to schedule an initial appointment or fails to keep their initial consultative appointment, a letter should be sent to the referring physician within a reasonable timeframe, e.g., 30 days, notifying them that the patient never scheduled or did not show for the initial appointment. Return or destroy (in accordance with applicable policies/regulations) patient information that had been received from the referring physician.
  - A copy of the notification letter should be kept for the same number of years medical records are retained, i.e., 6-10 years.
- Patient portal and appointment management:
  - A patient portal may offer options designed to facilitate appointment management. Risk management recommendations are provided for each patient portal function that may be utilized by the practice to assist with the appointment management.
    - Verify the patient's appointment view is enabled so they may view all of their appointments on the portal.
    - Verify the patient referral appointments are listed in the patient's appointment view.
    - Enable a standard patient response to their attempt to schedule, reschedule or cancel an appointment via the patient portal.

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.
If current legislation is enacted, the JUA will sunset and — pow! — the specter of having to find new medical liability insurance coverage will become reality. There’s no need to panic. You have options. But if you’re looking for a true partner, not just a carrier or vendor, there’s really only one choice.

You see, clients of Medical Mutual, which already include 4 hospitals and over 300 physicians in New Hampshire, all cite the strength of the relationships they forge with key people at the Company for making their jobs easier.

A direct line to people you know, answers you can count on.

When you have a question about any aspect of your coverage, or need free risk management advice, you’ll know exactly who to call by name — and you’ll have a direct line to them. They may not be superheroes, but when you need them most, you may just feel like they are.

Medical Mutual and your organization: a dynamic duo.

So, if you’re looking for a partner as opposed to a vendor in the pursuit of healthcare quality and liability protection, call John Doyle, VP of Marketing and Administration, directly at (207) 523-1534 today. Because if New Hampshire House Bill 508 goes through as anticipated, there won’t be a moment to lose.
Current legislation is poised to sunset, and the specter of having to find new medical liability insurance coverage will become reality. There’s no need to panic. You have options.

But if you’re looking for a true partner, not just a carrier or vendor, there’s really only one choice. You see, clients of Medical Mutual, which already include 4 hospitals and over 300 physicians in New Hampshire, all cite the strength of the relationships they forge with key people at the Company for making their jobs easier.

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Having a Medical Mutual policy is like having a superhero on call to answer all of your medical questions.
Does My Medical Assistant Need to be Registered?

NHMS has received inquiries from physician offices regarding letters from the state about registering Medical Technicians.

The new Med Tech registration law, NH RSA 328, was enacted to help address the incident at a New Hampshire health facility where an infected medical staff person diverted pain medications, exposing patients to HepC from used needles. The staff person had been involved in similar incidents but without any method to gather basic registration information, the New Hampshire health care employer was in the dark.

Does the new law apply to medical staff in your office? The definition of “medical establishment” does apply to physician offices, but the registration is limited to a staff person who has access to controlled substances and contact with patients.

Note: Controlled drugs are those scheduled drugs that have a potential for abuse or addiction. Prescribers must possess a DEA license to prescribe controlled drugs.

NH RSA 328-I:1 Definitions. –

IV. “Health care facility” means health care facilities licensed under RSA 151.

V. “Medical establishment” means a setting where health care services are provided to patients, including, but not limited to, the office of a physician, dentist, naturopath, advanced practice registered nurse, optometrist, podiatrist, or a clinic, laboratory, or place not licensed under RSA 151.

VI. “Medical technician” means a health care worker who is not licensed or registered by a New Hampshire regulatory board and who assists licensed health care professionals in the diagnosis, treatment, and prevention of disease. For the purposes of this chapter, medical technicians shall be limited to health care workers with access to controlled substances and with access to or contact with patients in a health care facility or in a medical establishment.

Questions? State of NH Board of Registration for Medical Technicians, 121 South Fruit Street Concord, NH 03301, fax: (603) 271-8389, email: tina.kelley@nh.gov
A well-designed employee benefits program does more than just help employees. A well-designed employee benefits program aids in creating the best practice possible. It does so by making a practice more efficient and more profitable. Success requires more than a comprehensive lineup of products and excellent customer service - it takes a passion for great results.

After 27 years of delivering astounding results, medical practices throughout NH and the region have found NEEBCo to be a reliable and critical component in providing the best in practice with regard to employee benefit programs. As the endorsed broker of the NH Medical Society, let NEEBCo provide your practice with the best in practice as well.
Physicians' Bi-Monthly

AMA Code of Ethics, cont. from page 1

Code of Medical Ethics Modernized for Contemporary Medicine

AMA June 13, 2016

CHICAGO – The central role of ethics in medicine was demonstrated today as the nation’s physician leaders voted to adopt a modernized Code of Medical Ethics during the American Medical Association’s Annual Meeting. Today’s vote capped an eight-year project to modernize the Code’s ethical guidance for relevance, clarity and consistency.

“Contemporary medicine must remain moral medicine during the current rapid pace of change in health care delivery system, and just as it did during its founding, the AMA has responded to this challenge by again putting ethics on center stage,” said AMA President Steven J. Stack, M.D. “The comprehensive update to the Code’s ethics guidance keeps pace with emerging demands physicians face with new technologies, changing patient expectations and shifting health care priorities.”

The Code of Medical Ethics was one of the two principal orders of business at the first AMA meeting in 1847. Much in medicine has changed in 169 years, but this founding document – the first uniform code of ethics of its kind – still is the basis of an explicit social contract between physicians and their patients. It is regularly cited as the medical profession’s authoritative voice in legal opinions and in scholarly journals.

Guided by an open and collaborative process that incorporated substantial invited feedback from the medical community, the modernization project accomplished three primary objectives:

1. To improve relevance, the Code has language that applies to contemporary medical practice.
2. To improve clarity, the Code has an improved structure and formatting to ensure that foundational ethical principles and specific physician responsibilities are easy to find, read and apply.
3. To improve consistency, the Code has harmonized guidance that consolidates related issues into a single, comprehensive statement.

“The modernization project ensures that the Code of Medical Ethics will remain a useful and effective resource that physicians can continue to rely on, while remaining faithful to the virtues of fidelity, humanity, loyalty, tenderness, confidentiality and integrity enshrined in the original Code,” said Dr. Stack.

For additional information on the modernization of the Code of Medical Ethics, please visit the AMA website.

VaxNH, cont. from page 1

who wish to participate. Health care providers are not mandated to participate, but participation can be beneficial to both the provider and the patient.

For some health care providers, submission of immunization data to an IIS meets the core measures for meaningful use. A real-time interface can be created between a health care provider’s EMR/EHR and the IIS. The first release of VaxNH will allow for immunization data to be submitted to the IIS to meet stage 2 meaningful use requirements. The goal is for VaxNH to function in a “bi-directional” manner (information is sent to the IIS, and sent back to the EMR/EHR, and may be viewed in both the IIS and the EMR/EHR).

In the near future, NHIP will begin recruiting health care providers to enroll and utilize VaxNH in their health care practices. At no cost, NHIP will provide training and Help Desk support to all end users participating in the program. Stay tuned for further details.
President: John R. Butterly, MD  
President-Elect: Deborah A. Harrigan, MD  
Immediate Past President: Lukas R. Kolm, MD, MPH  
Penultimate Past President: Stuart J. Glassman, MD  
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Physician Member of NH Board of Medicine: Nick P. Perencevich, MD  
Lay Person: Lucy Hodder, Esq.  
Physician Rep. of the NH Dept. Health Human Services: Doris H. Lotz, MD, MPH  

**Specialty Society Reps:**

- **NH Chapter of the American College of Cardiology**
  - Danil M. Philbin, MD  
- **NH Chapter of the American College of Physicians**
  - Richard P. Lafleur, MD  
- **NH Academy of Family Physicians**
  - Gary A. Sobelson, MD  
- **NH Chapter of Emergency Physicians**
  - P. Travis Harker, MD, MPH  
- **NH Society of Eye Physicians & Surgeons**
  - Michelle S. Nathan, MD  
- **NH Pediatric Society**
  - Sonalee M. Desai-Bartoli, MD  
- **NH Psychiatric Society**
  - Leonard M. Small, III, MD  
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- **NH Society of Pathologists**
  - Steven J. Hattamer, MD  
- **NH Amer. College of Obstetricians & Gynecologists**
  - Eric Y. Loo, MD  
- **NH Orthopaedic Society**
  - Oge H. Young, MD  
- **NH Med. Group Management Assn. Rep.**
  - Glen D. Crawford, MD  

President’s Perspective, cont. from page 2

Ognized nor valued (or that did not support) the values of ethical medical practice would be intolerable to anyone worthy of the title of physician. These values include autonomy (all patients’ right of self-determination), beneficence (all conflicts must be resolved in the best interests of the patient), non-maleficence (*primum non nocere*) and an understanding of potential double effect (e.g., use of morphine to lessen suffering in a dying patient).

As health care reform evolves, physicians (and other providers, independent and otherwise) will continue to consider aspects of their practices that will allow them sustainability in their professional lives: financial stability, time with their families, and a rewarding career. It will be critical to also maintain focus on other essential values that may not be explicitly stated and might easily be overlooked (or sacrificed) if expediency and surrogates for quality take precedence over mission, vision and these fundamental values. Whether we are in for-profit or non-profit systems, we do not produce widgets and we are not merely service-based providers. Ultimately we have the essential responsibility and stewardship for the health and well-being of the people and populations who entrust us with their lives. If it comes to the point that a line must be drawn, to paraphrase the great American hero Jean Luc Picard, the line must be drawn here. And by us. §
NHMS Welcomes New Members

We’re happy to have a great number of residents and fellows join the NHMS ranks!

Cybele Arsan, MD
Alexandra K. Audu, MD
Christopher O. Audu, MD, PhD
Lauren A. Bailey, MD
Jonathan A. Barnes, MD
Luke A. Barre, MD
Joel M. Bradley, MD
Matthew C. Breeggemann, MD
Charles P. Burney, MD
Alice G. Caffrey, MD
Joan A. Chandra, MD
Xi Chen, MD
Eunjung Choi, MD
Jessica G.S. Clem, MD
Cameron K. Clinton, MD
Jason R. Cockerill, MD
Chelsey B. Coles, DO
Melissa E. Crowder, MD
Jonathan L. Curtis, MD
Robin Djang, MD
Angela D. Doswell, MD
Shane A. Elkenberry, MD
Lukas P. Emery, DO
Lindsey W. Fraser, MD
Christopher D. Funderburk, MD
Megan C. Gallagher, MD
Zachary P. Giesen, DO
Jenaya L. Goldwag, MD
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Samuel C. Hembree, MD
Tara M. Higgins, MD
Hieu C. Hoang, MD
John E. Howe, MD
Bryan G. Hybki, MD
Nigeen H. Janisch, MD
Christina Y. Jeong, MD
John H. Kanter, MD
Eva Kovacs, MD
Kevin J. Krughoff, MD
Ashley K. Lamb, MD
Edyth R. Lee-Barnes, MD
Emma L. LeWinter, MD
Eileen J. Li, MD
Sean X. Li, MD
Olivia Linney, MD
Francis E. Martinson, MD
Henry F. Martin-Yeboah, MD
Omid Moghimi, MD
Robin Moiseff, MD
Ilda B. Molloy, MD
Linzi B. Moss, MD
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John A. Mussatto, MD
Saiprasad Narsingam, MD
Brenton E. Nash, MD
Christopher M. Navas, MD
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Daniel A. Pierce, MD
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Alycia D. Reppel, MD
Karen Rodriguez, MD
Kristen N. Ruby, DO
Ashleigh N. Rushing, MD
Joel Sarmiento, MD
Robert M. Schiff, MD
Katrina Soriano, MD
Zachary T. Spalding, MD
Aaron Steen, MD
Alexander M. Strait, MD
Abhishek Swarup, MD
Nazneen Tata, MD
Nikhil Teja, MD
Raj K. Thakrar, MD
Maryn Torner, MD
Kristy T. Webster, MD
William Welte, MD
Matthew J. Wesley, MD
Jennifer Wu, MD
Muhammad Zair-ul-abideen, MD

New Hampshire Chapter

Friday, October 28, 2016, Lyme Inn

Fostering Excellence in Internal Medicine

- Less Medicine, More Health: 7 Assumptions that Drive Too Much Medical Care
- Competing Paradigms in Chronic Pain Management: Self-Management, Opioids & Cannabis
- Anticoagulation for Venous Thromboembolism in the 21st Century
- How to Maintain Joy in Your Daily Practice
- The Annual Visit: Science or Art of Medicine
- Transgender Medicine: Essentials for the Primary Care Provider

And! Poster prizes, townhouse meeting, Governor’s dinner.

Register online: http://www.nhms.org/nhacp2016
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EVP Corner
Be Prepared to Help

By James Potter

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 diabetes and HIV. Today, our community’s challenge is substance use disorders (SUD), particularly with the rise of illicit fentanyl, either substituted or mixed with heroin, or as pills that resemble other, less potent opioids.

One of the therapy strategies most in need is expanding the number of physicians who can provide medication-assisted treatment (MAT) services. To this end, the Medical Society is hosting a free 8-hour MAT waiver course on November 4, in conjunction with our annual scientific conference at the Mountain View Grand in Whitefield, New Hampshire, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMSHA), Anthem BCBS, and the New Hampshire Bureau of Drug and Alcohol Services (BDAS). The waiver training also has been approved as CME to fulfill the state’s opioid competency requirement. It is truly one-stop shopping as participants additionally will be able to complete their waiver applications before leaving the training.

Why the call for MAT to be the standard of care in SUD treatment today? First, the growing body of evidence has clearly demonstrated improved outcomes with the use of MAT when tied to behavioral recovery services. According to SAMHSA, “medications such as buprenorphine, in combination with counseling and behavioral therapies, provide a whole-patient approach to the treatment of opioid dependency.” The unfortunate fact is that traditional behavior-only treatment approaches for SUD (e.g., abstinence pathway plus education or group counseling) have a significantly lower success rate.

Secondly, employment and family are significant parts of a fulfilling life for many people. They are also two potential sources of the stability and motivation that are critical to sustaining long-term recovery. The evidence shows that when people who are addicted to opioids receive MAT, their employment and marriage rates go up. When patients relapse, employment and marriage rates go down; people are less likely to relapse when they receive MAT.

You and your practice or hospital can contribute by developing a plan for helping increase MAT services capacity in your community. A buprenorphine prescriber must currently be a physician that has received a waiver through the Drug Enforcement Administration (DEA). Waivered physicians can prescribe for up to 30 patients in the first year and can then request an increase to treat 100 patients a year the second, and apply to increase up to 275 patients in following years, if needed. Through the recently passed Comprehensive Addiction and Recovery Act (CARA), PAs and APRNs also will be able to soon prescribe buprenorphine, and can attend the Nov. 4 waiver training, which will be honored by DEA once the regulations are finalized.

Sign up today for the Nov. 4 waiver course at http://www.nhms.org/buprenorphine-waiver-training and visit our Opioid and SUD Resources page for additional information. †
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Interested in seeking your waiver to prescribe buprenorphine?

• Earn 8 AMA PRA Category 1 credits and a Buprenorphine Training Completion Certificate

• Fulfill the opioid prescribing competency CME requirement

• Helpful resources and registration at: http://www.nhms.org/buprenorphine-waiver-training

• Come for the training, stay for the NHMS Annual Scientific Conference! (see page 18 for details)

New Hampshire Buprenorphine Waiver Training

Helping states connect the dots to more effectively address opioid use disorders

Friday, November 4, 2016
8:00 am – 5:30 pm

Mountain View Grand,
Whitefield, NH

Presenters: Joji Suzuki, MD, and Sanchit Maruti, MD

Cost: FREE!