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happiness

Volume 5 | 2022

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Do you or a colleague need help?
The New Hampshire Professionals' Health Program (NH PHP) is here to help!
The NH PHP is a confidential resource that assists with identification, intervention, referral and case management of NH physicians, physician assistants, dentists, pharmacists, nursing licensees, veterinarians, chiropractors, dieticians, licensed drug and alcohol counselors, mental health practitioners, midwives, optometrists, podiatrists and psychologists who may be at risk for or affected by substance use disorders, behavioral/mental health conditions or other issues impacting their health and well-being. NH PHP provides recovery documentation, education, support and advocacy – from evaluation through treatment and recovery.
For a confidential consultation, please call Dr. Molly Rossignol @ (603) 491-5036 or email mrossignol@nhphp.org.

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Invited Guest: MGMA Representative	Dave Hutton

Eric Kropp, MD
NHMS President

Use every moment and don't let an opportunity to find happiness get past you.

President's Perspective

happiness

(noun) 'ha-pē-nəs: a state of well-being and contentment

Books and movies throughout our culture are enamored of the notion of the secret of life as though it were a singular thing to obtain. Reality is much less romantic. It takes careful consideration of what gives meaning to life and conscious determination to prioritize what you value in order to find happiness.

If you search the web with the phrase "Happy people are more…", you'll find the sort of adjectives that most of us strive for – productive, sociable, forgiving, flexible, open-minded, helpful, healthy. These qualities contribute to being an effective clinician. So, while a career in medicine requires many sacrifices, compromising one's own happiness need not be one of them. With strong conviction and sustained effort, you can determine your future.

Consider the agenda for this year's Annual Scientific Meeting. The speakers embody ways in which physicians can lead the change that they want to see. There's no silver bullet, but there are many directions in which one can take a step.

Some physicians find that being in control of their clinical and business decisions rather than playing second fiddle to administrators is key. Our primary care panel will feature three models of thriving physician-led primary care private practices. Dr. Jeffrey Gold, a leader in Direct Primary Care who speaks nationally about our country's addiction to health insurance, will share lessons about how eliminating the middlemen from primary and specialty can improve care, lower cost and improve satisfaction for both physicians and patients.

Several lectures will feature physicians with a generalist background, who have shifted their practice to nurture a particular interest. As a fam-

ily physician practicing functional medicine, Dr. Elisa Mercuro has the perfect background from which to share her knowledge of the nutritional supplements that so many of our patients are taking. Our Sunday opioid education series will also feature several family physicians. It is easy to get lost in the daily grind, but our speakers have applied their interests in pain management and substance use disorder treatment into fulfilling specialty and full scope primary care practices.

Ensuring that physicians, not administrators or insurance companies drive decisions about best practices within a larger healthcare system requires special skills and consideration. Dr. Zachary Soucy will share his experience in navigating the complexities involved with ensuring that as the use of point of care ultrasound grows, the right people make the decisions about policies, training, and implementation.

Physician training programs are key to providing the next generation with the tools and confidence to be leaders in the delivery of healthcare for increasingly complex patients. The frequent desire to age at home will be increasingly challenging. But will it be a burden or an opportunity to make a real difference in our beloved patients' ability to age with dignity and independence? Dr. Ana Castellanos Mendez, and her Chief Resident, Clare O'Grady will share their experience with housecalls and the frail elder program to help us all better manage this graying of the patient population.

We are fortunate that these and the other speakers are willing to give their time to share their stories and expertise.

Storytelling itself has the ability to connect people on both an emotional and a rational level. I hope that you will all be able to join us for our Friday afternoon session featuring Suzanne Schmidt, LCMHC, StorySlam Producer for nationally renowned program, The Moth, to learn how to craft and share your stories and learn the power of first-person narrative in the field of medicine.

Whether used to sway patients or legislators, or as a means of catharsis or connection, physicians listen to and tell patient stories all the time. So much so that we sometimes fail to fully appreciate the depth of their intimacy, and their power to affect change.

Sometimes we also fail to fully appreciate the value of the doctor-patient relationship. It is an opportunity to give our full attention and receive the same in return. It is building trust and personal relationships over time. It is sometimes a respectful push and pull or full-on debate. In the end we may agree to disagree on some matters, but not without affirming that there is more about us that is the same than is different. This is what brings me happiness, and also offers some hope for a better post-COVID world.

So what feeds your happiness? Are you still searching for the perfect job? It will not exist until you make it yourself. But as the aphorism will attest, "every journey begins with a single step." Use every moment and don't let an opportunity to find happiness get past you.

Empowering Clinical Care Teams Through Value-Based Care

Alicia Voorhees
Provider Network &
Strategy Director

Kait Hogan
Growth Consultant

stellarhealth

Embracing a value-based approach to patient care will help ensure that your practice not only survives but thrives

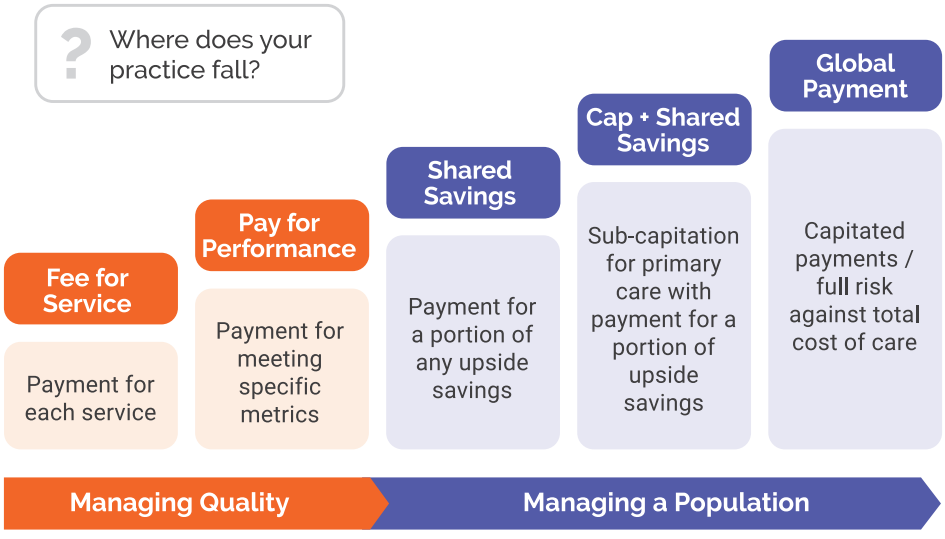
Despite the current reduction in COVID-19 cases, many physicians are still grappling with the aftermath of the pandemic in regards to cash flow, staff retention, and the survival of independent practice.

Fortunately, the resilience of medical professionals and their dedication to delivering high quality care have led to continued investments by health plans in alternative payment models, which can create more sustainable revenue streams in the long run. The most common model you've probably heard about is Value-Based Care (VBC).

In a VBC model, providers are compensated based on improved quality and outcomes rather than the quantity of care provided for each patient. While VBC contracts can vary depending on the population and health plan partner, the essential approach is aligning payments and incentives toward desired performance metrics. This could be in the form of pay-for performance models, primary care capitation, shared savings, or ultimately, taking on full risk.

While the shift from fee-for-service (FFS) can feel daunting, providers who have moved towards value-based care have seen more predictable revenue cycles, streamlined workflows, improved patient outcomes, and greater staff retention. If you're interested in exploring alternative payment methods for your practice or if you already hold a VBC contract today, keep reading to learn five steps you can take to optimize your performance.

Value-Based Care Continuum



Understand how your performance is measured in new or existing contracts. It's important to have a clear understanding of the performance metrics you're working towards in your contracts. Entering into a VBC contract with a health plan should be contingent on their ability to provide consistent and clear performance reports, detailing progress towards your specific metrics. This knowledge will give you more negotiating power and ensure that you aren't leaving money on the table.

Ask for real-time incentives to help fund investments in infrastructure and reward team members. Value-based payments are typically distributed months after the performance period, which means delayed gratification for your care team. Ask your health plan if a portion of the incentives can be pre-funded and paid out more closely to the time of action. To drive commitment to the work required to support value-based care, all team members who support care gap closure should receive a piece of the incentives earned. If you're not ready to share incentives directly, you can distribute a portion of the earnings through other means, such as gas cards or new office equipment to encourage staff engagement and retention.

Access data at the point of care to engage the whole team. Data is key to your performance and if it's not readily available within your practice, ask the health plan to provide it. Health plans invest heavily in analytics platforms - ensure you benefit from this investment.

Adopt technology and infrastructure to support value-based care workflows. Technology can support the intake of data from multiple payers to evaluate and monitor VBC performance. An integrated platform across payers is helpful in creating consistent VBC workflows for every patient, every time.

Understand what it takes to advance to the next contract. Health plans are motivated to drive consistent quality and cost outcomes year over year. As you achieve that consistency within your patient panel, ask for more from your value-based contracts with health plans.

Following these steps can help your practice make the leap from FFS into a VBC model. The long-term benefits include optimized performance, increased revenue, and improved staff and patient satisfaction, offering a significant return on investment. Embracing a value-based approach to patient care will help ensure that your practice not only survives but thrives! ■

Danielle Albushies, MD
Proudly starting her 20th year with Bedford Commons Ob/Gyn, she practices both low and high risk obstetrics as well as the full scope of gynecologic care

We must be advocates for our patients beyond the exam room so that our patients have autonomy...

Advocating Beyond the Exam Room

I appreciate all the efforts within the NHMS towards addressing physician burnout and moral injury. Undoubtedly, it is very useful identifying these challenges and talking about it. Sharing ideas that can alleviate physician burnwout is equally important. What I would like to share is an experience that reminded me why I went into medicine, how physicians can facilitate changes to laws that affect our patients in adverse ways and how brave patients and legislators can be inspiring.

As of January 1, 2021, the Fetal Health Protection Act was signed into law as part of the state budget. The Fetal Health Protection Act is otherwise known as the 24-week abortion ban. Unfortunately, also included in this new law was an ultrasound requirement at any gestational age prior to any termination of pregnancy, no exception for fatal fetal diagnoses and criminal penalties for any providers who did not comply with the law. This new law required that women have a trans-vaginal ultrasound when it otherwise would not be necessary and required that a woman, who received confirmation at or after 24 weeks that the fetus has a condition incompatible with life, would be forced to carry the pregnancy.

With the support of people like Mike Padmore, the Director of Advocacy from NHMS, and the team from Planned Parenthood of NE, we sought to make amendments to the law. Many physicians, both in person and via Zoom, testified to educate the legislators about how ultrasounds function in obstetrics, how and when fatal fetal diagnoses are made, and the physical and emotional harm the current law had created. Women sat at the microphone and told their stories regarding when they received the heartbreaking confirmation that their desired baby had a fatal fetal diagnosis. They re-lived the choices each of them made guided by their medical team, each situation unique and each so complicated. Seeing women have the courage

Advocating Beyond the Exam Room, cont. on page 11

Medical Record Retention Recommendations for Physician Office Practices and Hospitals

Patients' medical records are among the most vital documents maintained by a health care facility. A comprehensive medical record is essential for proper patient care. In addition, a well-documented record greatly aids the defense of potential malpractice lawsuits. The physician practice, provider, or healthcare facility owns the physical medical record; however, the information contained in the medical record is the confidential property of the patient.

General Overview

Age of Majority: (ME, NH, VT, MA): 18

Statute of Limitations: (ME, NH, VT, MA): 3 years (It is important to note that the statute of limitations may not begin to run until the injured person knew or should have known of the injury and of its negligent cause, whichever occurs first.

MMIC Medical Record Retention Recommendations** (unless state regulations/laws require a longer retention period):

- **Adults:** 10 years from the date of the last medical service for which a medical entry is required. (Exception Massachusetts: Inpatient: 20 years.)
- **Minors:** Age of majority plus state statute of limitations. (Exception Maine: Hospital: age of majority plus 6 years.)

  Note: Once a minor reaches 18, the adult retention recommendation applies, e.g., 10 years from the last medical service for which a medical entry is required.

- **Deceased adult patients:** 10 years from the time of death. (Exception Massachusetts: Inpatient death: permanent.)
- **Hospitals:** Newborns and Mothers of Newborns: Retain the mother's record and the electronic fetal monitoring (EFM) strips for the same period of time the newborn record is retained. The records of both patients would be needed in defense of any potential birth injury claim.

**MMIC retention suggestions are in accordance with the American Health Information Management Association's (AHIMA) medical record retention guidelines.

Hospital-owned Physician Practice

Hospital-owned physician practices may be obligated to retain records according to hospital policy. Consult the hospital risk manager or health information management director to determine requirements.

Physician Office Practice: Medical Records Received from Other Provider or Patients

It is unnecessary to maintain medical information (records) received that are not pertinent to the specialty consult or applicable to treatment of the patient's condition. In cases where documents are not necessary records should be returned to their originator or destroyed through a confidential process.

State Regulations for Retention of Medical Records

New Hampshire

The New Hampshire Board of Medicine Rules state: "The licensee shall retain a complete copy of all patient medical records for at least 7 years from the date of the patient's last contact with the licensee, unless, before that date, the patient has requested that the file be transferred to another health care provider." Med 501.02 (f)

New Hampshire Hospitals: NH Code of Administrative Rules addresses the issue in NH (h) Patient records shall be retained 7 years after discharge of a patient, and in the case of minors, patient records shall be retained until at least one year after reaching age 18, but in no case shall they be retained for less than 7 years after discharge. ■

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.

Robert Dewey, MD

NH Healthcare Workers for Climate Action is a grassroots all-volunteer 501 (c)(3) organization...

Climate and Health, Our Next Challenge

After 35 years of practice in interventional and clinical cardiology, while still enjoying my work, but losing patience with the electronic medical record and other daily hassles, I decided to retire. After many months of processing this with family, patients, and colleagues, and following a wonderful retirement party, I awoke one day with nothing on the schedule. Now what?

Like most retirees, I had plans to do some volunteer work, travel, join a book group, ride my bike, get better at golf (that definitely hasn't panned out), and then the pandemic arrived. This left me with more free time than I really wanted or knew what to do with.

Then came a call from friend and retired oncologist, Bob Friedlander. We had occasionally spoken about our concern with climate change as the single greatest threat to humanity (including our grandchildren) and were both eager to find a vehicle to pursue this. Led by Bob, a group of us started getting together on "Zoom" during the summer of 2021. After several months of discussion and recruitment we founded NH Healthcare Workers for Climate Action, and I signed on as Vice Chair, something that took me out of my comfort zone.

2021 was a pivotal year in the awareness of the health effects of climate change. The World Health Organization declared the health effects of climate change to be "the single biggest health threat facing humanity", a National Resources Defense Council study demonstrated the annual health cost of climate change and fossil fuel pollution in the United States to be $800 billion, and the New England Journal of Medicine published an editorial "Call for Emergency Action" on climate and health.

NH HEALTHCARE WORKERS FOR CLIMATE ACTION

NH Healthcare Workers for Climate Action is a grassroots all-volunteer 501 (c)(3) organization with one full time employee. We feel that healthcare workers are uniquely positioned to increase public awareness of the links between health and climate change, and we seek to provide NH healthcare workers with the tools to educate and mobilize the public in support of climate solutions which will improve health for all. Studies show that healthcare workers are still trusted messengers regarding climate and health, and we hope to use this status to influence the climate debate.

To achieve this goal, we have developed an infrastructure that includes a Board of Directors, an Advisory Board, and have over 1000 participants (including medical and nursing students), of which 200 are actively involved in one of our five working groups. Our working groups include Behavioral Health, Children's Health, Climate Justice, Education & Communications, and Policy & Advocacy. We have also developed affiliations with 34 other New Hampshire health nonprofit groups, as well as with Geisel Medical School and University of New Hampshire.

Since our first goal is education, we have developed a robust webinar program geared toward healthcare professionals, with three to four programs a month. We sponsored an ECHO educational program about the links between climate and health. We also have an active Speakers Bureau that gives lay talks to Rotary and Kiwanis clubs, libraries, garden clubs, and faith groups to help raise community awareness.

As I look back on the last year, it has been one of learning and personal growth, and I have had many new challenges. As physicians, we are taught early in our training that what we do matters. That feeling is reinforced through our daily work, and in retirement we can lose that sense of importance. With NH Healthcare Workers for Climate Action, I know that I am again doing something that matters…and there is no EMR!

Please take a look at our website: nhclimatehealth.org and join our efforts. Or feel free to email me at bobdewey@nhclimatehealth.org. ■

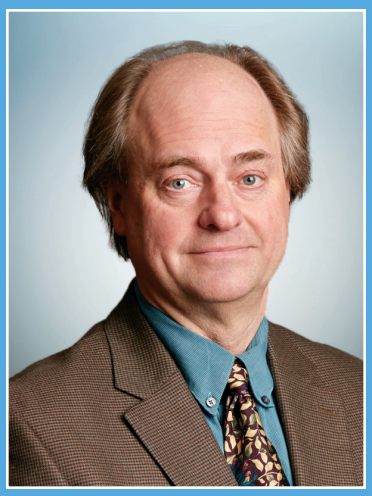
Advocating Beyond the Exam Room, cont. from page 13

to share grueling experiences about such pregnancies with tears in their eyes was overwhelming.

I worked with my colleague, Dr. Brenna Stapp to write a letter that was circulated to New Hampshire providers of women's health regarding our concerns. With phone calls, emails, and help from another colleague, Certified Nurse Midwife Kris Oretsis, we received more than 100 signatures in support of changes to the law.

When a Republican representative Dan Wolf, along with five other Republican representatives, introduced House Bill 1609, another opportunity to make changes to the Fetal Health Protection Act presented itself. Representative Wolf was inspired by a patient who shared her story with him. She was experiencing a complex twin gestation facing unnecessary pressure to make decisions towards the outcome of her pregnancy given the lack of an exception for a fatal fetal diagnosis in the 24-week abortion ban. On the day of the Senate hearing for the bill, Representative Wolf spoke with a deep understanding of the medical facts and compassion for the pregnant woman who inspired him to introduce HB1609. After passing both the House and Senate with bipartisan support, the Fetal Health Protection Act was amended to include the following changes: there is no longer an ultrasound requirement unless a woman is possibly 24 weeks pregnant and there is an exception for fatal fetal diagnoses.

Getting involved helped me realize how important it is to educate legislators so their decisions that affect the lives of our patients can be made based on medical knowledge and science. All the efforts by physicians, whether written or live testimony, a signature, or a composed letter, collectively make a difference. We must be advocates for our patients beyond the exam room so that our patients have autonomy, and we retain our cherished doctor-patient relationship. With patient stories and our advocacy, New Hampshire will remain a state where practicing medicine is rewarding. ■



By David Nagel, MD
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Thoughts on Pain, Public Policy, and the Practice of Medicine

"Always Remember Why You are Here…"

As the fires of physician burnout rage about me, I wonder why I am at peace…

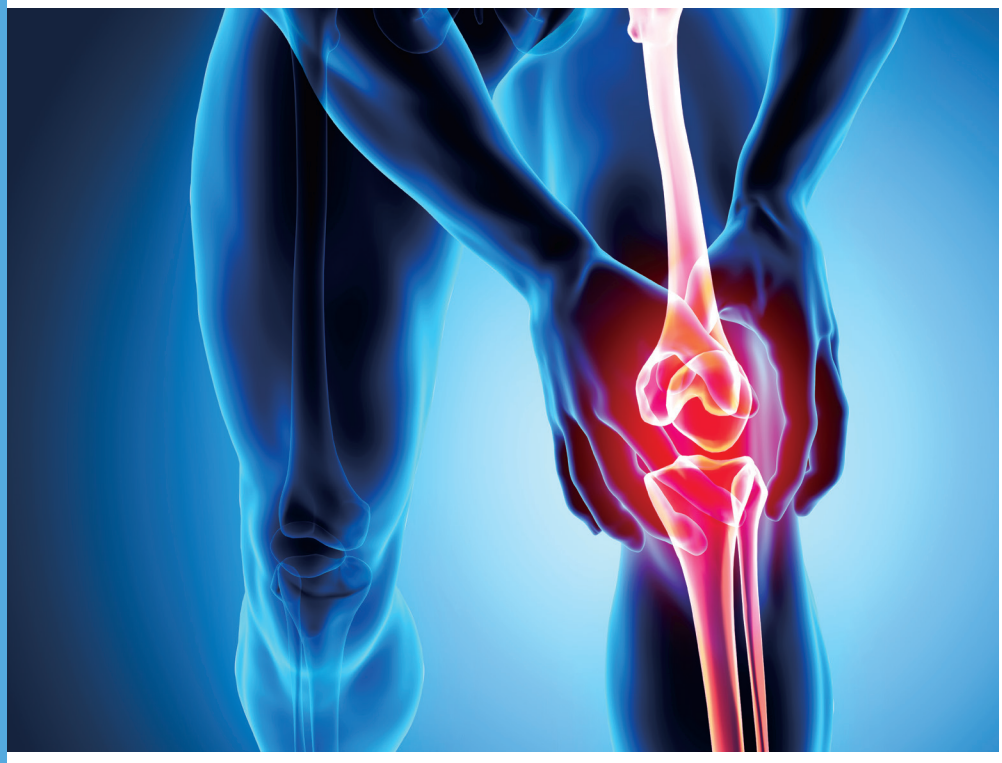
Perhaps it is because I am what I always wanted to be; like my mom.

My mom suffered from the pain posed on her by rheumatoid arthritis, which grossly disfigured all her joints, but, miraculously, not her smile. She never let pain get in the way of her putting the needs of others above her own, a lesson she taught me freely in word and deed. While she couldn't physically help others, she had a finger and a phone, and she could make a needed call. I came to call her methods "kitchen table advocacy."

Through her, I came to understand the limitations of our health care system. How we force the square peg of pain and complex disability into the round holes of our pre-conceived notions. How we fail to see the patient as a whole person with a whole life outside the artificial confines of our examining room. How the complex patients, with their biological, psychological, and social needs do not fit into our 15-minute visits, the EMR, productivity measures, or the bottom line.

She always taught me to stand up for the underdog. As someone in pain, she was one of those people: ostracized, stigmatized, blamed for their own infirmities, too often needlessly suffering because of the actions of others.

…I came to understand the limitations of our health care system



It became my mission to change the way pain and disability are perceived, judged, and treated, something which gave meaning to my medical practice impervious to the corporatization, institutionalization, and technological over-reach of the medical industrial complex.

I am most certainly not the alpha male; someone everyone will follow. At the same time, I absolutely refuse to follow blindly. And so, I have become used to being alone. I came to call my model of action "John the Baptist Advocacy," "a voice crying in the wilderness."

My musings led to my book, *Needless Suffering, How Society Fails Those with Chronic Pain*, which has been described as a "must read for all health care professionals," "a self-help book for society," "with the potential to change the way we treat pain in America." I am told over and over my book is important because I said what needed to be said.

My book has given me the opportunity to create local and national pain care policy. It has allowed me to create three non-profit organizations devoted to improving pain care and pain care policy across a broad spectrum. I have been able to meet people from many cultures and socio-economic groups, all as equals. My mind has been opened to many problems: poverty, despair, disparity, and others, but also to many solutions. The opportunity to be a part of this is such a gift!

I also chair the NFL PA pain management best practices committee. This was the dream of a lifetime because it gave me the opportunity to create something I felt was really needed, something never done: a consumer-oriented, best practices pain management guide, one I am the lead author of. While it is intended for professional athletes, I designed this to generalize to anyone with acute or chronic pain.

How much do I get paid for all this? It depends on how you define remuneration. If you mean cash, I get paid nothing. But my pay is priceless, the opportunity to live my faith, to be like my mom and give hope to the hopeless.

And, so I am at peace. Every day, when I wake up, I remember the words of one of my professors in medical school when he admonished us to:

"Never forget why you are here."

And that motivates me to do what I need to do.

I love you, Mom. Thanks! ■

James G. Potter
NHMS Executive Vice President

...for more information and to provide feedback on future services and locations scan the QR code with your phone's camera app

Medical Society Leads Launch of Mobile Health Clinic to Serve NH North Country

The New Hampshire Medical Society and North Country Health Consortium, which serves as the regional public health network in Coos County, launched the Northern New Hampshire Mobile Health Clinic in mid-September with ribbon-cutting celebrations at the four partner hospitals: Androscoggin Valley Hospital in Berlin, Littleton Regional Healthcare in Littleton, Upper Connecticut Valley Hospital in Colebrook, and Weeks Medical Center in Lancaster.

The mission of the mobile clinic is a community-based care option that will offer easy-to-access health care for people living in Coos and Grafton counties. The Medical Society has served as the fiscal and governance agent over the last year for the program, which now has funding commitments of over $1.2 million.

Dr. Bill Brewster, who currently serves as Vice President on the NHMS Council, helped provide the stimulus for the program as one of his last acts before retiring as Vice President of NH Markets for Harvard Pilgrim, by requesting and obtaining a $500,000 matching grant through the Point32Health Foundation.

Dr. Brewster offered during the launch events that 'this program was developed through a strong community collaboration between four local hospitals, a local not-for-profit health plan and its Foundation, a regional public health network, local businesses, foundations and agencies, and the New Hampshire Medical Society – all invested in working to eliminate barriers to accessing quality health care. The Mobile Health Clinic will be staffed by local community health practitioners offering preventative services such as immunizations, preventive care screenings, primary care medical services, telehealth connectivity and wellness education."

Northern New Hampshire Mobile Health Clinic

The Northern NH Mobile Health Clinic, a customized Mercedes 3500DX 4x4 sprinter van designed specifically for clinical services and to navigate North Country winters, will be available to local residents through the four hospital partners and the Consortium, making stops at locations across northern New Hampshire beginning this fall. Initially, the clinic will offer the following services:

- Immunizations
- Blood pressure, glucose and other preventive care screenings
- Primary care medical services
- Nutrition and wellness education, smoking cessation programs, and health literacy
- Wi-Fi capability and computer access for telehealth services
- Community connections to guide individuals to local health and social services

After the initial rollout phase, the groups will be seeking input from community members and partner organizations who have a deep understanding of the health disparities across the region. The objective of the second phase is to help the mobile clinic program identify specific locations for the Mobile Health Clinic and determine services that meet local needs and help increase access to quality health care for all. The goal of the third phase beginning this coming spring is to put the mobile clinic in operation at least 180 days of the year.

"It all started with an idea," said Dr. Ed Duffy, Chief Medical Officer at Littleton Regional Healthcare, during the launch events. "Every year we do a community health needs assessment where we go out and ask stakeholders what needs to be done to improve services and sustain healthcare. And every year, healthcare access is mentioned. This initiative here will help address healthcare access in the region."

"Rural healthcare is different than healthcare in other parts of New Hampshire with its own set of challenges," Dr. Duffy said. "Transportation is limited, we're spread out, people are geographically isolated, and we tend to have a little bit older population, so they don't get around as much."

The investment in the mobile van, along with other investments made by the local hospitals in mobile integrated health, will boost access and serve communities, Dr. Duffy added.

On behalf of the Medical Society, we are very grateful to our partners in this endeavor. In addition to the half million-dollar matching grant by Point32Health Foundation, formed by the combination of Harvard Pilgrim Health Care Foundation and Tufts Health Plan Foundation, the U.S. Department of Agriculture Rural Development has also funded a $281,000 grant to support the program. $50,000 was also contributed from each of the four hospitals, along with additional grants and sponsorships from the NH Charitable Foundation, NH Department of Health and Human Services and Fidelity Investments. In addition, each of the hospitals has agreed to pay a per diem use fee that will help sustain funding of the mobile clinic for the next 5-6 years.

A reporter at one of the launch events asked me why the Medical Society was involved in this project. I told her it was simple. The Society's mission is twofold with the second part "for the betterment of public health" in New Hampshire, which resonates with the mobile clinic effort. That is our mission. And that's what we have pledged to do in bringing people together to help make a difference in health outcomes for Granite Staters.

Currently, the Medical Society and our Bowler-Bartlett Foundation are also facilitating an additional $5 million in public health initiatives involving promotion of COVID and other immunizations, alcohol misuse information for health professionals, MOUD trainings, physician wellness, and offering continuing education about the NH Board of Medicine's disciplinary and complaint processes.

Community members are encouraged to visit www.northernnhmobileclinic.org for more information and to provide feedback on future services and locations, or scan the QR code with your phone's camera app.

If your local organization, business, or government body would like to have a briefing about and provide input on future services of the Northern NH Mobile Health Clinic Program, or is interested is developing a similar mobile clinic in your community, please contact me at james.potter@nhms.org or 603-224-1909, ext. 103. ■

L to R: Dr. Bill Brewster, NCHC Executive Director Lauren Pearson, Harvard Pilgrim VP Kate Skouteris, LRH CEO Bob Nutter, LRH CMO Dr. Ed Duffy, and NHMS EVP Jim Potter.

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Mission: *Our role as an organization in creating the world we envision.*

The mission of the New Hampshire Medical Society is to bring together physicians to advocate for the well-being of our patients, for our profession and for the betterment of the public health.

Vision: *The world we hope to create through our work together.*

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