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A Reflection on the Practice of Medicine One Year After the Arrival of COVID-19 in The Granite State

Volume 2 | 2021

TOOLS FOR YOUR MENTAL & PHYSICAL WELLBEING DURING COVID-19

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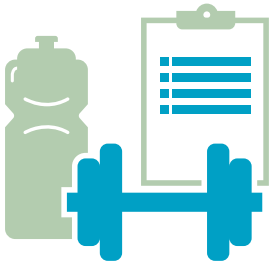
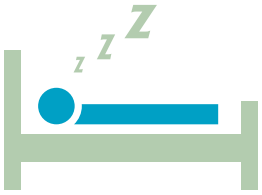
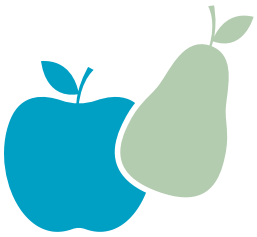


MANAGE STRESS
Exercise, meditate, and keep to a daily routine.



GET ENOUGH SLEEP
Sleep at least 7 hours/night. Rest helps manage your emotions.



EAT HEALTHY
Eat fruits and vegetables. Stay hydrated.

USE TECHNOLOGY
Call, text or video chat to stay connected with people.

BE COMPASSIONATE
Help those who are vulnerable.

SAVE ON YOUR PRESCRIPTIONS!

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Also in this issue...

Young Physician Focus: Choose Your Own Adventure

Estate Planning

The Latest Science From The Vaccine Front: What's coming next and how to reduce vaccine hesitancy

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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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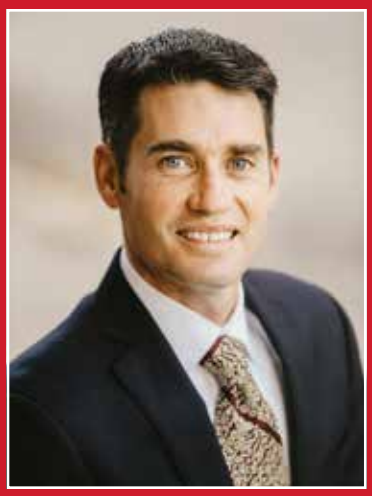

G. Kenton Allen, MD, MBA
NHMS President

...how much of the evolution in medical practice we have experienced in the last year will persist.

President's Perspective

A Reflection on the Practice of Medicine One Year After the Arrival of COVID-19 in The Granite State

On March 2, 2020, the announcement was made by state health officials that the first case of COVID-19 had arrived in New Hampshire. On March 13th a state of emergency was declared by Governor Sununu, and shortly thereafter, on March 14th, the United States Surgeon General, Dr. Jerome Adams, urged hospitals across the country to stop elective procedures.

Over the course of the ensuing year, the practice of medicine quickly evolved to better protect patients, providers and communities from the risks associated with the pandemic. Reflecting back on this year of practicing in the presence of COVID-19, there are several examples of how the field of medicine has evolved in New Hampshire as a direct result of COVID-19. Below are examples that have been most impactful in my own experience.

Regional communication and information sharing

Throughout the pandemic response, one of the greatest public health concerns was the capacity for New Hampshire healthcare facilities to collectively care for the number of patients requiring care. Efforts to mitigate these risks led to the development of systems to improve communication between healthcare systems within the state and across state lines. Not only was the volume of information shared impressive, but so too was the speed at which it was shared. Such routes of communication could remain valuable in the betterment of public health even after the pandemic is quelled.

Enhanced pre-hospital screening

There are varying protocols in place for pre-hospital screening of patients prior to their appointments and procedures, but all have the shared objective of minimizing the risk of spread of COVID-19 and ensuring the best possible patient outcomes. In my institution and in my field of anesthesiology, this evolution is most readily apparent in patients preparing for elective or non-emergency surgeries. Every patient undergoes a COVID-19 test

within days of their scheduled procedure. The implementation of this policy required the development of a testing site, the appropriate timing of specimen collection (as close to the procedure as possible while ensuring the result was available when needed), and the communication with patients regarding why they were being tested and the result of the test.

Use of medical space

The way patients enter medical facilities, flow through them, and ultimately leave has been completely redeveloped. In our own facility, options for sites of entry to the hospital have been reduced and lobbies function as sites of repeat screening and PPE compliance. Spaces within the facility have been redesigned to allow for as much distancing as possible. In my own practice, within the perioperative areas, patients use the same room before and after their procedures whenever possible and visitor policies are adapted according to local COVID-19 prevalence.

Telemedicine

Much has been said about the future of telemedicine in the context of its use over the course of the last year and it seems as though the prevailing opinion is that the accelerated adoption of telemedicine has been a positive development from the perspective of improving patient care. Within our local anesthesia practice, telemedicine has played the most significant role within our preoperative clinical services. It is now more common than not for a patient to be evaluated prior to their procedure without a physical appointment in our clinic or with their primary care physician's office, but rather via telephone or video communication. The system has improved efficiency and, anecdotally, many patients have seemed to prefer it.

Physical patient contact

In the instances when our interactions with patients are not virtual, the way in which we directly interact has changed. The previously common handshake to start and end a patient interaction quickly became taboo. Drawing from my own experience within the practice of anesthesiology through the height of the pandemic, components of the physical exam that involved physical patient contact and that were unlikely to alter the approach to a patient's care were deferred. When local prevalence was at a peak, consents were obtained verbally to avoid the physical passing of pen and paper. Several of these efforts to avoid physical patient contact have now become comfortable and routine.

In the year to come, the expectation is that the pandemic-related stressors that drove much of this evolution will begin to subside and we will have the ability to return to practice as it existed prior to the arrival to COVID-19. What remains less certain is even with the ability to return to our prior practice patterns, how much of the evolution in medical practice we have experienced in the last year will persist. ■

[1] https://www.nhpr.org/post/first-positive-test-results-coronavirus-identified-nh#stream/0

[2] https://www.nh.gov/covid19/news/documents/covid-19-update-03132020.pdf

[3] https://www.politico.com/news/2020/03/14/surgeon-general-elective-surgeries-coronavirus-129405

How HB544 endangers the practice of medicine

This piece ran in the Concord Monitor ahead of HB544's public hearing with the House Executive Departments and Administration Committee. The committee ignored our plea to defeat this bill and will move forward in the legislative process. NHMS will continue to fight this misguided legislation until it is defeated. Please contact Michael Padmore at Michael.Padmore@nhms.org if you are interested in getting involved!

The New Hampshire Medical Society, along with the New Hampshire American Academy of Pediatrics, New Hampshire Psychiatric Society, New Hampshire American College of Physicians, and New Hampshire Academy of Family Physicians, oppose House Bill 544 — "An Act relative to the propagation of divisive concepts". This bill defines and prohibits the dissemination of certain divisive concepts related to sex and race in state contracts, grants, and training programs.

From a public health standpoint, there is clear evidence that inequities and disparities disproportionately affect people of color and women. We need to learn about these topics in trainings in order to address them and create true health equity in New Hampshire - if we can't talk about the facts, we can't solve the problem.

There is an extensive body of evidence in the medical literature, and broad acceptance in the medical community, that racism and sexism have negatively impacted the health and well-being of people of color and women throughout the history of this country. In fact, many of the country's medical associations have recognized "racism is a public health crisis". COVID has shown us irrefutable differences in health outcomes between race and sex categories in New Hampshire. This is further described in the Governor's COVID-19 Equity Response Team *Initial Report and Recommendations* (July 2020).[1] We must be able to understand and address these differences, known as health disparities.

Understanding the impacts of racism and sexism on health is fundamental to our practice of medicine and public health in New Hampshire.

Training physicians, and other healthcare providers, to understand the impacts of racism and sexism on health is imperative to their ability to care for patients and improve health outcomes. Additionally, as physicians, we cannot be limited in our ability to treat diseases; not being able to train doctors on racism/sexism and its effects on health outcomes is tantamount to saying doctors can't learn about treating COVID or cancer. As physician scientists, we must practice evidence-based medicine to best care for our patients. Rather than serving as 'divisive concepts', regular training on racism and sexism in medicine is integral to understanding how to improve the health and well-being of all Granite Staters.

Health disparities impact the economy as well. This is evidenced by this month's [February 2021] *BusinessNH Magazine'* cover story highlighting "Racial Inequity in Health Care".[2] The reporter reached out to the NH Medical Society to begin her investigation reflecting the recognition that understanding these concepts is important for the business sector. Additionally, a healthy workforce is necessary for a vibrant economy. An American Hospital Association brief states that "health disparities amount to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year" and describes the vital "connection between health equity and value", as "improvements in health equity can provide tremendous value to patients, hospitals and the health care delivery system".[3]

While we wholeheartedly concur with the statement in HB544 that no one should be judged "by their color, race, ethnicity, sex, or any other characteristic protected by federal or state law" it is also crucial to acknowledge that prohibiting these important trainings would rob physicians of their ability to inform and treat their patients. It is our obligation to practice medicine with impartiality, regardless of our patients' gender and/or background. In order to do so, research has demonstrated that regular training on unconscious bias positively impacts physician-patient interactions and patient experiences within the health system.

Furthermore, if we don't fully understand the social determinants of health and how the structural determinants of racism and sexism impact health, we cannot fully inform our patients in their medical decision making. Censorship of our ability to accurately teach, assess and treat patients is against our Hippocratic oath. This applies especially for state funded health entities including federally qualified health centers, community mental health centers, and New Hampshire Hospital, which serve a disproportionate number of people of color and women in our state.

The medical profession in the Granite State acknowledges and supports a patient's right to make their own decisions that are fully informed, regardless of the physician's personal beliefs. We strongly oppose anything that would censor physicians' freedom of speech for patients to make informed decisions. We further affirm that the government should not interfere in the doctor-patient relationship. Thus, there is no place for government to legislate trainings that impact physicians' ability to care for people.

Understanding the impacts of racism and sexism on health is fundamental to our practice of medicine and public health in New Hampshire. Regular trainings help improve clinical and public health outcomes in both the private and public sectors. They help to promote a free and fair economy. And they help physicians support individuals in making better informed health decisions. Finally, they help to ensure that the government and health and healthcare organizations work for everyone because we all fare better when we **all** are well.

Passage of this legislation would jeopardize the significant progress we have made in the Granite State in considering and understanding health disparities that are directly attributable to racial and gender inequities. It would therefore undermine public health initiatives and make it more difficult to improve the health of all citizens of this great state.

We strongly urge the House Executive Departments and Administration Committee to vote Inexpedient to Legislate on HB544.

L. John Klunk, MD
Immediate Past President, New Hampshire Medical Society

Marie-Elizabeth Ramas, MD
President Elect, New Hampshire Academy of Physicians
Council Member, New Hampshire Medical Society

Trinidad Tellez, MD. ■

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[1] https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/equity-response-team.pdf

[2] https://www.businessnhmagazine.com/back-issues/february-2021

[3] https://www.aha.org/system/files/2018-11/value-initiative-issue-brief-3-equity.pdf

Young Physician Focus
Choose Your Own Adventure

Eric Kropp, MD
is a family physician at Active Choice Healthcare, an independent Direct Primary Care practice

Young Physician Focus highlights young or early career physicians and their research/passions. If you'd like to contribute, please contact mary.west@nhms.org.

Five years ago, I was a young physician just half a dozen years out of residency, but already struggling with the symptoms we have come to know not as burnout, but as moral injury. Intent on changing the trajectory of my career and family life, I took a leap of faith and left my position as a hospital employed family physician to launch a solo practice in the innovative model of Direct Primary Care. The pathway has not been without its challenges, but it has been more fulfilling and has presented more opportunity than I imagined. I am keen to share my experience to inspire anyone who may feel that their current situation is something other than ideal.

I had found my calling in family medicine while in medical school. By the time I graduated residency, I was aware of the red tape I would face as an employed physician, and felt I had acquired the skills necessary to manage it and still enjoy clinical practice. But as the administrative burdens and irrelevant top-down directives grew, so too did my angst. It seemed no level of committee participation, organizational development training or providing valued feedback could move the needle on the factors causing my downward spiral of dissatisfaction and concessions. I needed to find a way to spend more time with my patients, and more time with my family.

While attending a national conference, I serendipitously learned of Direct Primary Care ("DPC"). It immediately clicked as the practice model that could fulfill the ideal I had held in my mind's eye for so long. Shortly thereafter, I struck out on my own with a shoestring budget and my wife by my side as the practice manager. A colleague proffered a cautious if not skeptical reckoning, "Good luck! There are a lot of people watching and waiting to see if you succeed." Having recently celebrated five years in business, I am pleased to report that there is no looking back! As anticipated, staying afloat while building the practice initially required some moonlighting, and

a few years of austerity. Thankfully, year to year we have witnessed a growing demand for this model of care and now have a stable, full and grateful patient panel.

With DPC, we cut out the middlemen. Patients pay a periodic fee to cover their primary care services (avg <$100/mo nationally). There is no wrangling with insurers for contracts or reimbursement, and no clicking boxes to justify codes. The time we save by reducing the administrative burden is returned to patients with longer visits and increased accessibility. Since we don't bill fee-for-service, we are free to provide care by any appropriate means -- office visits, telemedicine, or through a HIPAA compliant direct messaging platform. When COVID arrived, we were uniquely poised to seamlessly incorporate telephone and video visits, since our patients had already enjoyed these conveniences on a regular basis. While it is a tradeoff to be on call 24/7, it is a different experience to know well every single patient that contacts me. The investment in building a mutually trusting and respectful relationship has paid off as my patients tend to be very considerate and understanding if they need to reach me after hours.

Gaining the freedom to define my own professional course has led to numerous opportunities both expected and unanticipated. I have defined a healthier work-life balance as my kids grow up, and have also developed a deeper relationship and appreciation of my wife's skills and talents. When I opened my practice, there was a dearth of resources for "how to do DPC." With significant networking efforts and dedication, I was a founding member of the New England Direct Primary Care Alliance and the National Direct Primary Care Alliance, which is now the largest membership organization for DPC physicians in the nation. I have enjoyed my commitment to the NHMS council and physician advocacy work in the legislature. I spearheaded the effort to pass a state law to make New Hampshire the 26th state to define Direct Primary Care and protect it against inappropriate regulation, thus codifying a pathway for others who may find this model a good fit.

As President-Elect of NHMS, I look forward to next year, with an eye on promoting physician empowerment so that we who know best how to care for patients can lead the change in healthcare. We need to make healthcare healthier for ourselves, in order to best serve patients.

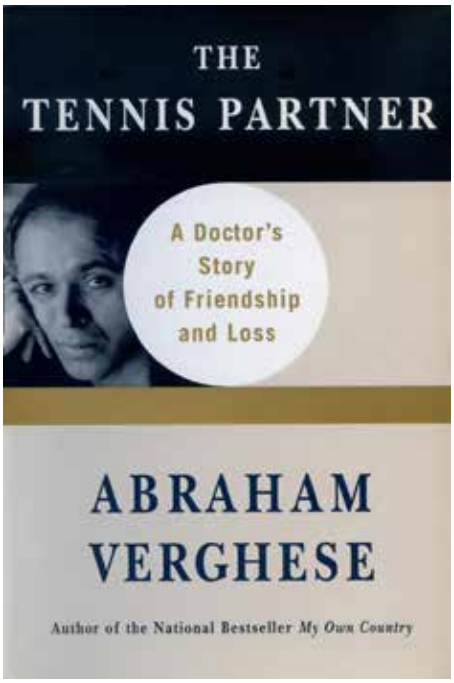
I hope that my story will motivate other physicians to examine their own inspirations and aspirations and not be afraid to take a leap of faith to make it happen. ■

Molly Rossignol, DO is a family and addiction medicine physician and is the medical director for the NH Professionals Health Program.

Members' Corner includes selections focusing on personal and professional issues impacting doctors in New Hampshire - a forum for sharing the "voices" of NHMS members. We also encourage "Letters to the Editor," responding to articles published in prior editions. Please submit articles for our Members' Corner to james.potter@nhms.org

Members' Corner
We Are All Affected

Abraham Verghese, MD, infectious disease specialist and physician author, was the editorial contributor in JAMA (*Writing Medicine*. May 5, 2020; vol 323, no 17) in which he describes the writing contributions that physicians offer to the world of literature. He cites Goodman and Gilman's Pharmacology text. In fact, this was one of my favorite books in medical school. I appreciate Dr. Verghese pointing this out, as I too, heard the author's voice as I learned about drug interactions.



Several of my favorite (reading) books were written by Dr. Verghese. *The Tennis Partner* is a true story about his friendship with a resident physician, David. Dr. Verghese was managing a recent divorce and being a single dad some weekends and otherwise feeling untethered as a new attending physician in El Paso, TX. David becomes his tennis partner, having been a tennis pro earlier in life. David also has a substance use disorder. The relationship is an example of respect and mutual gratitude for one another. Dr. Verghese describes what playing tennis did for him and David: "their opportunity to impose ORDER on a world that was fickle and capricious." Then his reflection: "This ORDER feeling of mastery would linger for a few days then wane. The urge to meet and play would build again" (a literary description of craving). He does a superb job of detailing the course of David's illness. How it wound itself, unsolicited but tightly around all those affected in the hospital and many in the community of El Paso.

The novel concludes with Dr. Verghese's reflections on the impact that such a unique and amazing individual had on so many, not least himself. He describes the loss of someone to the illness of addiction so vividly that in reading a few sentences, others can't help but feel the anguish. The emotion a wonderful writer can evoke. I thank Dr. Verghese for this piece of work. For describing the joys and sadness those who work in medicine, and addiction in particular, can identify with.

In offering this piece to the NHMS Member's Corner, I encourage all of us to use writing as a tool to express our connections and to help us all heal from the issues we face day to day.

I also want to practically introduce or re-introduce the New Hampshire Professionals Health Program (http://www.nhphp.org/). Dr. Verghese and David are not the rare pair of friends/colleagues who have to deal with this complex debilitating illness. So many are affected by this. Lives and careers are effectively "rollercoastered" and often times destroyed. Please reach out if you or someone you know needs help with drug or alcohol use, burn out issues or other potentially career impairing conditions: mrossignol@nhphp.org or 603-491-5036. ■

David Grebber, JD, LLM, LUTCF
Agency Director – Advanced Markets

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If Estate Planning was simply about what happens to your "stuff" when you die, it would be a simple task.

A Plan to Avoid Chaos and Hardship….an Estate Plan!

Our physician community has witnessed firsthand the chaos and hardship which occurs when well-thought out plans are absent in the face of a global crisis. To a lesser extent, but equally as important on a personal level, is the need for a plan - an Estate Plan - if the chaos and hardship which so often accompanies an unexpected death or serious incapacity is to be avoided.

If Estate Planning was simply about what happens to your "stuff" when you die, it would be a simple task. However, it is much more than that. For it is about you personally, and those you care most about. When you come face to face with this reality, it introduces a great deal of complexity; a level of complexity and intimacy which causes most everyone to recoil from acting to develop a plan for this important area of their lives.

The dying experience, or the suffering of a physical and/or intellectual incapacity, brings with it a complicated web of medical, financial, and legal decisions. No matter what stage of your career, Beginning, Mid, or Late, the lack of a well thought out, executed, and communicated plan for the labyrinth of these medical, financial, legal, and life issues, will inflict needless hardship upon those who depend on you, and who ultimately must address issues affecting your life, without your guidance.

The first step in estate planning is not an easy one. Facing the future is always difficult. Choosing who will make important decisions regarding your life, your loved ones, and your accumulated wealth when you cannot, is a great responsibility. This includes the selection of individuals to:

- Make medical decisions on your behalf if you become incapacitated.
  - ❖ There is nothing more intimate than granting someone the authority to decide what happens to your "person-hood". Legal documents

meant to provide this designee guidance are:

- HIPAA – Release
- Healthcare Proxy
- Living Will
- Do Not Resuscitate Orders

- Make financial decisions on your behalf if you are not mentally able to do so.
  - ❖ Sparing your family the emotional and financial chaos which accompanies unexpected death or serious incapacity can be accomplished by the proper execution of:
    - Limited Powers of Attorney
    - Last Will and Testament
- Take over guardianship of your minor children if both parents are deceased.
  - ❖ Experience has shown that decisions surrounding who will be charged with raising minor children in the event both parents are deceased can derail the entire estate planning process.
- Ensure that all your wishes are carried out as stated.
  - ❖ Once you have identified these trusted individuals, you need to designate the following:
    - Health care representative(agent) – Who will make medical decisions for you in the event of incapacitation
    - Executors – Who will administer your Will
    - Trustees – Who will hold assets for the benefit of yourself and others
    - Beneficiaries - Who will receive retirement and life insurance benefits
    - Guardians - Who will care for minor children
    - Custodians - Who will manage the financial assets for minor children

Actions you can take today

At each stage of your life and career, meeting with professionals and taking time to draft and review your current financial and estate plan is an important part of ensuring that you get to enjoy the future you hope for.

<u>Medical Students, Residents and Fellows</u>

- Compile a list of your assets and debt liabilities.
- Consider refinancing your student loans.
- Draft a will, trust, healthcare proxy, and power of attorney naming the executor(s), trustee(s), guardian(s).
- Review account ownership designations of all assets including bank accounts, stock portfolios, life insurance policies, real estate, etc.
- Consider the purchase of life insurance and disability insurance.
- Ensure a trusted relative, friend, lawyer, or colleague retains copies of your estate plan documents.

<u>New Physicians entering a Practice</u>

- Review Medical Malpractice and business insurance needs.
- Review partnership agreements, employment contracts, worksite benefits.
- Consider practice structure to maximize tax minimization and asset liability.
- Review existing Estate Plan or begin the process of drafting a plan.
- Review long term care, disability, and life insurance needs for income replacement, asset protection, business succession, and estate planning.

<u>Seasoned Medical Professionals</u>

- Review existing estate – inventory assets, liabilities, charitable gift obligations.
- Review your existing Estate Plan documents and make changes or modifications as desired. Add trusts to segregate and protect assets while minimizing probate time and costs and estate tax exposure.
- Review your Practice corporate documents to ensure a smooth transition of ownership.
- Review current long-term care, disability and life insurance policies.
- Consider retirement solutions and income tax minimization strategies as retirement becomes a reality.
- Consider gifting using the annual and lifetime gift exclusions to reduce overall estate taxation.
- Consider charitable giving strategies to reduce overall estate taxation.

As physicians who are focused on gaining knowledge, establishing your practices, raising and educating your children, and accumulating wealth for your retirement years, you need to embrace the thought that Estate Planning is not simply a process "to get around to sometime," but rather, it is integral to living a successful life, one that allows you the opportunity to ensure the realization of the hopes and expectations you have for your life and the lives of those you care most about. ■

David Grebber, JD, LLM, LUTCF Agency Director – Advanced Markets, Co-Author Michael Genetti, CLU, ChFC*

Ben Locwin

Ben Locwin has spent the last 14 months on the front lines of the COVID-19 pandemic, reviewing viral genomes, regional and global epidemiology, and clinical trials for therapies and vaccines to end the public health and economic toll. He has been an international COVID-19 advisor and has overseen several of the top vaccine candidates in the global pipeline. He has worked closely with the CDC and FDA.

The Latest Science From The Vaccine Front: What's coming next and how to reduce vaccine hesitancy

We learned a lot in 2020. We learned about personal behaviors and attitudes when faced with public health mandates, stark divides in belief systems fueled by social media misinformation, and differential geopolitical approaches to managing a pandemic.

Not least of our learnings were the ongoing analyses of the epidemiology of *betacoronaviruses*, and how to accelerate development of vaccines – a tried-and-true regulatory process which generally takes upwards of three-quarters of a decade. Operation Warp Speed provided large-scale funding that was designed to de-risk the development process for vaccine manufacturers, though there were notable exceptions that weren't funded by Warp Speed (e.g., Pfizer/BioNTech).

In this brief, I'll cover what you need to know about the vaccine pipeline, what's coming next, and some best practices for dealing with vaccine hesitancy in patients.

Vaccine Distribution and Allocation

There have been over 155,000,000 vaccine doses administered nationwide, and 710,000 in the state. Though distribution of vaccines has been frequently cited in the media as an issue, there have been 200 million doses distributed so far by the Federal government. Over the next couple of months, the target is to have 240 million vaccine doses distributed.

As you may recall, the first two COVID-19 vaccines to receive Emergency Use Authorization (EUA) from the FDA were from Pfizer/BioNTech and Moderna, the two so-called 'mRNA' vaccines. Late February brought the authorization of Janssen's (Johnson & Johnson's) vaccine, which is a single-dose adenoviral-vectored vaccine. Janssen has committed to produce 100 million doses of their vaccine candidate for the American market by July 2021.

Administration Trends

As the former Surgeon General C. Everett Koop once noted, "drugs only work in people who take them." This is no different in the field of vaccinology; it's not vaccines which save lives – it's vaccination (as a verb). So having plenty of vaccine supply, once that day arrives, isn't synonymous with having full vaccine coverage. Immunity is conferred by administration of the vaccines, not just allocation to various districts.

National Trend

As of early April, over 154,000,000 COVID-19 vaccine doses have been administered nationwide, which is more than one-third of the population. There have been about 56,000,000 are considered fully immunized now (2 doses of 2) nationwide, which represents about 14% of the population. For a sense of scale, we are administering about 2.5 million doses per day across the United States at the moment.

State Trend

In New Hampshire, we have vaccinated over 450,000 people with at least one dose, and over 228,000 in NH considered fully vaccinated (against an eligible population of 514,000 in the state at the moment based on the phase within which we currently reside).

So by late spring, there will be no supply-side problem, and plenty of vaccine doses should continue to be available for those who have not yet elected to receive one by that point.

Next Up In The Fight

The likely next vaccine candidate in our armamentarium to finish Phase 3 clinical trials (which are ongoing in the US) is by Novavax. How their vaccine differs from the current three available is that, instead of an mRNA approach, or an adenoviral vector, Novavax has pioneered the use of creating a prefusion coronavirus spike protein through recombinant nanoparticle technology. They use a virus that infects insect cells (*baculovirus*) to produce these proteins in cell culture.

They have had very successful Phase 3 clinical trials in the UK, though there is some hedging going on at the moment whether or not the FDA would accept Phase 3 clinical trial data from outside of the US for use in the decision to grant an EUA. We have had a lot of adjudication committee meetings about this, and for other vaccine candidates, in the industry for several months. I would estimate Novavax's EUA hearing with the Vaccines and Related Biological Products Advisory Committee to occur in the May timeframe if they choose to use the US clinical study data.

Novavax snapshot: Codename: NVX-CoV2373. Two-dose, recombinant protein-based vaccine candidate. Safety: Mild reactogenicity. Efficacy: 89.3% (UK, N = ~15,000). Storage: 2-8C.

Best Practices In Dealing With Vaccine Hesitancy

Refusal or hesitancy to take any medication is always a difficult behavior to identify, much less resolve. In developing clinical training protocols for this, and helping improve vaccination rates internationally through various interventions, here are some best practice concepts that I'd like to share:

- **Data (sometimes) are good:** This one seems to be a no-brainer, but unfortunately it's also often the only one we bring into battle with us when discussing with patients or the general public. It's true, some people are genuinely looking to understand a bit more in depth about the safety and effectiveness of the vaccine(s), so having some data at the ready can be helpful. But my caveat here: There is a large proportion of the public these days unduly swayed by social media, and for whom no amount of corroborative data can help you to convince them. But that's also why there needs to be other smart approaches:
- **Behavioral Economics:** Where I usually go first to quickly reduce vaccine hesitancy is to use principles of behavioral economics. Humans often don't behave rationally, which is why this field of study came to be – to understand those reasons why. In doing so, we've learned a lot about steering behavior. In developing a first principle (such as *primum non nocere*), it would be to remove what we call 'friction' in a set of behaviors. Friction refers to any layers of unwieldy bureaucracy or effort that would otherwise prevent someone from engaging in a behavior. Even if you think there are very few in certain circumstances, I would warn you that you would be surprised with how small a level of friction can prevent an activity – even one that is overwhelmingly deemed positive by that very person. In some studies, even reducing the number of mouse clicks that a user must endure – from 2 to 1 – is associated with vastly greater probabilities of people engaging in certain actions. *Primum tollere frictionem* [First, eliminate friction!]
- **Availability:** This ties in with the principle above. To see that vaccines are available at your hospital or clinic can make the difference between someone coming in to receive one, or simply driving right on past. Lots of social psychology interventions have shown that visuals which positively identify the availability of a product or service (such as COVID-19 vaccines) can drive behavior. You may feel that it's implicit there is vaccine supply in your organization, but that doesn't necessarily translate into the patient knowing those things which you do. We tend to think that belief always precedes action, but this isn't always true. Sometimes availability heuristics and aggressive reductions in behavioral friction can lead to people undertaking activities they otherwise wouldn't have, and then the positive beliefs in support of their behaviors retroactively follow. This isn't about convincing them. It's about making it easy for them.

As we begin to gain a foothold against the pandemic locally and nationally, we all have to continue acting together in each others' best interests. Eventually, we will begin to phase-out preventive measures, which were ostensibly designed and implemented to protect the most vulnerable in our society. A further footnote is that we have vaccine trials underway at the moment for pediatric indication; as you may remember, the current vaccines are authorized for ages 16/18 and older. Provided the clinical trial results are favorable, this would give an opportunity for vulnerable children to be able to receive immunization in our forward progress toward return-to-school and return-to-normalcy. ■

When Patients Hit Record in the Healthcare Setting

As technology advances, you may have more patients record their visits with or without your knowledge. Your first reaction may be to prohibit patients from recording any visit, but there is supporting evidence that it can be beneficial for recall and compliance. Since this is a growing issue, consider having a policy on video/audio recording in the healthcare setting. This tip will help you identify your state's laws regarding consent requirements and things to consider when developing a plan.

State Laws

Know your state's laws and requirements! Maine only requires one person to consent, and Vermont does not address it. Massachusetts and New Hampshire require all persons' consent before recording.

Maine

Maine law does not prohibit the recording of a conversation since only one consent is necessary, and it can be either the sender or receiver. https://legislature.maine.gov/lawlibrary/what-is-maines-law-on-recording-surveillance-of-private-conversations/9488

Massachusetts

Massachusetts law provides it is illegal to record an in-person or telephone communication without all parties' consent. https://malegislature.gov/Laws/GeneralLaws/PartIV/TitleI/Chapter272/Section99

New Hampshire

New Hampshire law provides that it is illegal to record an in-person or telephone conversation without the consent of all parties § 570-A: 2. However, New Hampshire law does make an exception in cases where the person or people communicating are doing so in an environment where they should not be under the expectation of privacy. N.H. Rev. Stat. Ann. § 570-A: 1. http://www.gencourt.state.nh.us/rsa/html/lviii/570-a/570-a-mrg.htm

Vermont

Vermont law does not contain any provisions regarding the legality of recording or sharing any audio-based conversations.

Policy

When developing a policy on audio and visual recordings, you should ask the following questions:

Will patients ever be allowed to record a visit?

Yes

- Under what circumstances?
- Will individual providers be permitted to opt-out of being recorded?
- Specify that the patient's device will be used.
- When will a provider mandate that recording stops, such as in OB, and the delivery is not going as planned?
- Will you require a copy of the recording to be provided to the health center to be stored with the medical record?
- How should patients notify the provider that they wish to record the visit?
- Where can recording take place?
- How will you protect another patient's privacy?
- Is signage posted that specifies all of the above?

No

- How will this be communicated to patients (e.g., signage)?
- What if a provider wants to allow recording anyway?
- What will you do if you find a patient covertly making a recording?
- What will you do if you find a recording (known or unknown to you) posted on social media (Facebook, YouTube)?
- Who is responsible for enforcing all of the above?

Having a plan and sharing it with your staff will help you address this vital, growing issue. ■

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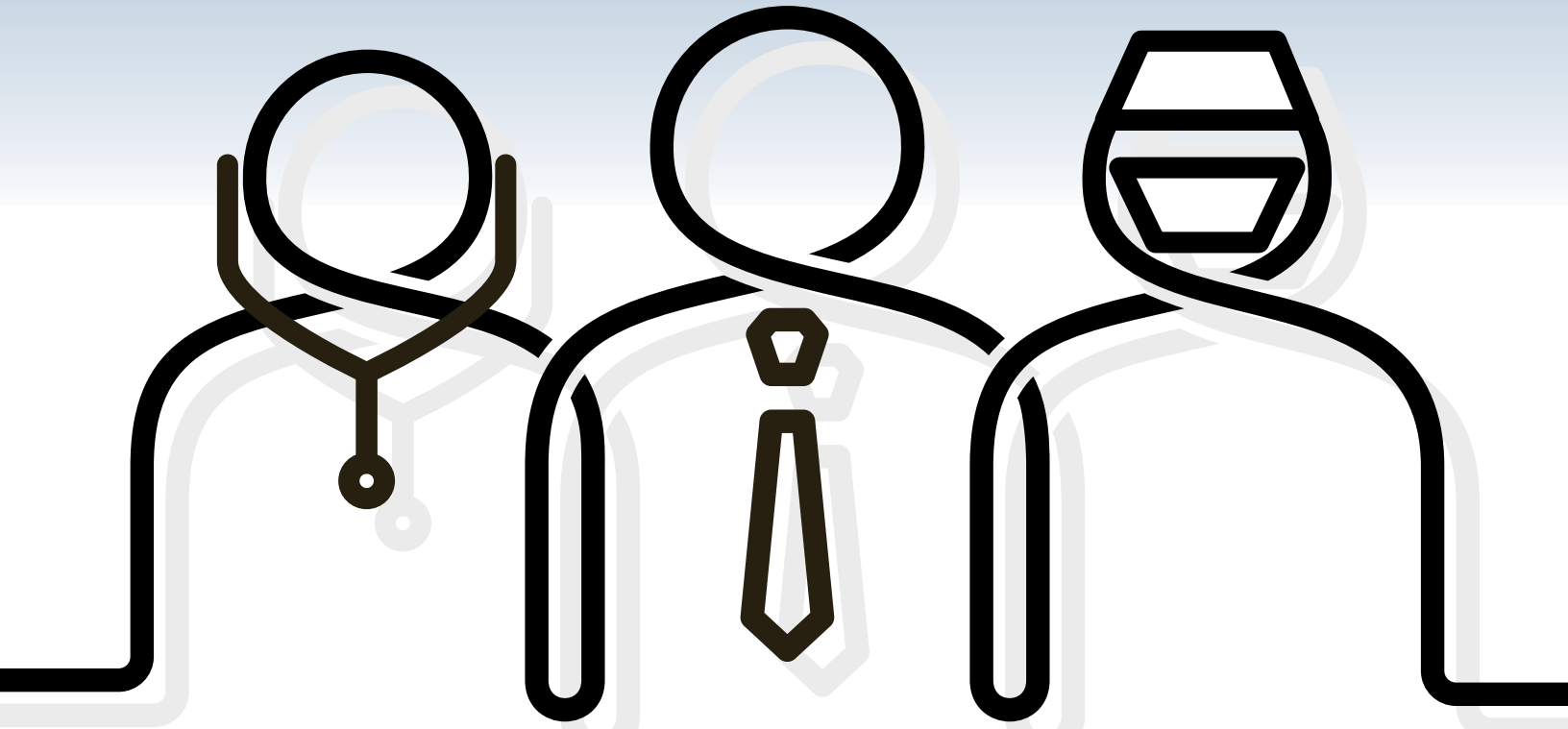

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James G. Potter
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Physicians Are Most Likely to Influence and Build Trust in COVID-19 Vaccines

The successful emergence of new COVID-19 vaccines has offered the dawning of a new hope this year in the year-long pandemic. The Pfizer BioNtech and Moderna mRNA vaccines and the Janssen adenovirus truly represent the "moonshot" of our generation, demonstrating remarkable levels of effectiveness (95%, 94% and 74% respectively) and safety in large-scale clinical trials. But, as I've heard pediatrician and former NHMS president, Dr. Tessa LaFortune-Greenberg often say, "Vaccines don't save lives, vaccinations do. Getting shots in arms is what counts."

Everyone involved in the NH COVID-19 vaccine allocation process to date is to be highly commended for its success. However, as summer comes to New England, the real test will be if enough Granite Staters will become vaccinated in sufficient numbers to create community-wide or herd immunity. The uphill hike with the vaccine distribution thus far has been demanding 'for sure.' But gaining the next needed 20-30 percent represents a much steeper challenge in reaching the needed immunity summit. It will require physicians to use their full range of clinical and communication skills to build trust and overcome the vaccine hesitancy remaining in the population.

Vaccine hesitancy is not a new phenomenon and is highly complex with many factors coming into play, including fear, confusion, misinformation, distrust and complacency. The unfortunate politicization of COVID-19 has further heightened distrust of government and corporations. Communities that have historically been marginalized also are often more hesitant given their experiences of very real disparities in care. These collective challenges make it even more important that we leverage the role of physicians as trusted messengers, building knowledge and supporting patients' ability to

Vaccine hesitancy is not a new phenomenon and is highly complex with many factors coming into play...

make informed decisions.

Past studies have shown that doctors and nurses are among the most highly trusted sources of health care information, and a recent survey from the Kaiser Family Foundation with residents of rural America[1] confirmed this fact. When asked whom they trust to deliver reliable information about COVID-19 vaccines and are most likely to influence vaccination behavior, doctors clearly came out on top:

My doctor	**86%**
FDA	**68%**
CDC	**66%**
Dr. Fauci	**59%**

An Ad Council survey[2] this past December corroborated similar rankings of trust. In comparison, both surveys showed that political and business leaders ranked much lower. It's clear that physicians must seize this opportunity and become knowledgeable about COVID-19 vaccines so we can communicate our trust in them to patients and the public at every opportunity.

In preparing for these conversations, it can be helpful to consider a framework for having conversations with your patients, such as the following guidance from the Ad Council[3] and Public Health Institute[4]. Here's a summary of the presentation I've given to school nurses and superintendents, public health councils and business leaders.

Lead with empathy. Be welcoming, personal and authentic. Respect people's hesitancy and acknowledge it's OK to have questions. Avoid condescension, negativity and guilt-mongering.

Provide scientifically-based, plain language answers. Facts about safety, expected side-effects or reactions and explaining why they happen are important. Be clear about the facts without any sugarcoating.

Emotional triggers are important. Moments missed serve as a powerful reminder of the end goal. It's more about getting back to life, rather than back to normal. Offer your own testament on willingness to get the vaccine by emphasizing that the vaccine is "protecting myself, my loved ones, work colleagues & community."

The messenger is just as important as the message. As noted earlier, most want information about vaccines from health experts and that's you – their physician.

It can also be helpful to be prepared and offer some talking points or FAQs, such as those developed by the NH Medical Society and School Nurses Association[5] (available at https://www.nhms.org/COVID-vaccine-FAQ in MSWord, PDF) that you can edit as appropriate and brand with your own practice or hospital logo as a validation and reference tool.

At the same time, physicians should recognize that some patients will continue to have doubts. When encountering persistent concerns, it can be helpful to ask patients what data they would need to be convinced that the vaccine is safe. However, some patients simply will not accept the vaccine, so be prepared to move on. It's better to avoid fruitless arguments or feeling that you need to convince everyone.

With effective vaccines, there is hope for better days ahead. And with the help of all physicians as essential voices in the vaccine effort – not only to your patients, but neighbors, family, friends, local community organizations, news and social media – we can help bring this pandemic to an end. ■

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1 Manning, El A. Kirzinger, C. Muñana, M. Brodie. Vaccine Hesitancy in Rural America. Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/poll-finding/vaccine-hesitancy-in-rural-america/. 1/7/21.

2 Ad Council, COVID Collaborative. COVID-19 Vaccine Education: VACCINE ADOPTION, ATTITUDES & MESSAGING INSIGHTS. https://adcouncilvaccinetoolkit.org/core-insights. March 2021.

3 Ad Council, COVID Collaborative. Messaging Recommendations. https://adc-covid-toolkit-production.s3.amazonaws.com/storage/TOOLKIT_Messaging-1.pdf?mtime=20210217153350&focal=none. 2/3/21.

4 Public Health Institute, Berkley Media Studies Group. Communicating about the COVID-19 vaccines: Guidance and sample messages for public health practitioners. https://www.phi.org/thought-leadership/communicating-about-the-covid-19-vaccines-guidance-and-sample-messages-for-public-health-practitioners/. 12/10/20.

5 New Hampshire Medical Society. COVID-19 Vaccine Frequently Asked Questions for School Faculty & Staff. https://www.nhms.org/News March 2021.

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